MEMORANDUM

TO: Medical Associations Interested in Forming Physician Networks

FROM: Ed Hirshfeld

DATE: September 30, 1994

SUBJECT: New Antitrust Guidelines

This memorandum summarizes the positive and negative aspects of the new "Statements of Enforcement Policy and Analytical Principles Relating to Antitrust".

Positive Aspects of the New Guidelines

Dialogue with Payers about Scientific Information. Statement Three of the old guidelines allowed independent, competing physicians to collectively present underlying medical data, such as outcomes information and practice parameters, to a payer. However, it was not clear whether the physicians could then have a dialogue with the payers about the merits of a set of outcomes measures or about a practice guideline. Statement Four of the new guidelines says: "In the course of providing underlying medical data, providers may collectively engage in discussions with purchasers about the scientific merit of that data."

Therefore, physicians participating in a health plan may collectively discuss the scientific merit of the medical policy used by the plan. In addition, medical associations such as the AMA can engage payers in such a dialogue. In summary, the scientific debate about what constitutes good care may continue unimpeded by the antitrust laws.

Presentation of "Future Fee Related Information". The AMA has advocated that independent physicians should be able to make presentations to a payer about future fee levels, provided that the physicians do not agree on price levels or jointly negotiate an agreement with the payer. Statement Five now says: "In some circumstances, the collective provision of this type of fee-related information [meaning future fees] also may be helpful to a purchaser and, as long as independent decisions on whether to accept a purchaser's offer are truly preserved, may not raise antitrust concerns."

The AMA has also been advocating that physicians should be able to go beyond making a presentation, but should be able to have a dialogue about future fees, provided that they do not engage in price fixing. This is not included in the new Statement Five. However, the Statement goes on to say that the DOJ\FTC will evaluate collective provisions of future fee related information to payers on a case by case basis to determine which are legal and which are illegal. In that evaluation, they will look at, among other factors, "the nature and extent of the communications among the providers and between the providers and the purchaser." In our negotiations with the DOJ\FTC, the agency representatives said that this statement indicates that a dialogue may occur, but that the agencies will evaluate the content of the dialogue to be sure that it does not indicate an agreement or amount to an implied or express to boycott.

Size of Physician Networks. There is now a safety zone that allows nonexclusive physician networks to have up to 30% of the physicians in a market, in aggregate and by specialty. The previous limit was 20%. However, the network has to demonstrate that it is truly nonexclusive. In addition, examples provided in Statement Nine indicate that substantially larger percentages may be permissible in rural areas.

While this is an improvement, panel size is still an issue. Many kinds of physician networks need to offer a wide choice of physicians in order to be successful, and need panels in excess of 30% of the physicians in the market to offer that choice. However, the agencies will closely examine any physician panel that contains 35% or more of the physicians in a market.

Foreclosure of Physicians from a Dominant Network. One concern that physicians have is not being allowed to participate in networks that serve the beneficiaries of managed care plans. New Statement Nine recognizes that exclusion of physicians from a dominant market can harm competition by preventing them from competing for patients. In that regard, the Statement says: "[E]xclusion may present competitive concerns if providers are unable to compete effectively without access to the network, and competition is thereby harmed."

While this statement is helpful, its application is limited. The exclusion of providers from the network must result in discernable harm to competition in the market before the guideline would require a managed care plan to accept physicians into its network. For example, if there was only one managed care plan serving 80% of the patients in a market, and a physician had to be part of that plan in order to compete in the market, the plan might be required to accept physicians that it would ordinarily exclude.

However, if there were ten managed care plans serving a market, none of which had more than 20% of the patients, and all of them had closed panels, the guideline would not require any one of the plans to accept physicians that it would ordinarily exclude. The reason is that it would not be necessary to be on any given one of the panels in order for a physician to compete in the market, because no single one of the plans controls a large enough block of patients. The fact that the panels of all of the plans are closed is not relevant to the antitrust analysis.

Negative Aspects of the Guidelines

The new guidelines still make it difficult for physicians to organize and operate a PPO which pays physicians on a discounted fee for service basis. In other words, the guidelines make it difficult for physicians just becoming familiar with managed care to start and operate a simple network. Some of the reasons why are summarized below.

Requirement that Networks Accept Insurance Risk to be "Legitimate". The new guidelines still bar physicians from jointly agreeing on prices to offer payers unless they have merged their practices or otherwise share substantial financial risk. The guidelines do not refer to the risk that must be shared as insurance risk, but that's what it is. The risk is defined as capitation or substantial fee withhold arrangements. We know from advisory opinions and business review letters of the agencies that the fee withholds must be large enough and cover enough patients to have a significant impact on the physicians involved.

The AMA has argued that most physicians do not have the skills to accept fee withhold

arrangements or capitation, and that they must gain experience with discounted fee for service arrangements before they are ready to assume insurance risk. Therefore, the AMA has advocated that equity investments in a network be considered substantial financial risk. New Statement Eight now says that insurance risk is not the only form of financial risk that will be considered adequate, but they do not say what other kinds of risk will be accepted. Instead, the Statement says: "[T]he agencies will consider other forms of economic integration that amount to the sharing of substantial financial risk; the enumeration of the two examples above [fee withholds and capitation] is not meant to foreclose the possibility that substantial financial risk can be shared in other ways."

Requirement that Messenger Model be used if the Network is not "Legitimate". If a network does not involve a merger of physician practices and does not involve the sharing of insurance risk, pricing arrangements must be arrived at with use of the "Messenger Model". That model requires a third party to work with each physician individually to determine the prices that the physician will accept, to then convey information about the prices the physicians will accept to the payer, and to relay offers from the payer to each physician. The physicians must individually decide whether to be part of the offer, they cannot be coordinated or influenced by the payer in any way.

The AMA has argued that the Messenger Model is expensive and cumbersome to use, and puts physician sponsored PPOs at a competitive disadvantage when negotiating against an insurance sponsored PPO for the business of a self insured employer. However, the agencies see it as the way to reconcile the fact that a physician sponsored PPO is in fact a "product" recognized by the market, and their own concerns that such PPOs may be used as price fixing vehicles. They allow the physician sponsored PPO to be formed but require that it use the messenger model.

Failure to Recognize the Provider Sponsored PPO as a New Product. The new guidelines provide that a physician network which does not accept insurance risk can be legal if the combination allows the physicians to offer a "new product" that generates substantial efficiencies, such as economies of scale, reduced administrative costs, and improved utilization review, quality assurance, and case management. Under the antitrust laws, the product does not have to be new in the sense of being newly invented, it simply has to be a new offering of any kind of product. In spite of this language, we know that the DOJ\FTC will not recognize a physician sponsored PPO as a "new product" that enables the member physicians to agree on fees to be charged through the PPO.

The AMA has argued that since the industry recognizes PPOs as a distinct product, that physician sponsored PPOs should be recognized as a product. However, that has not been allowed by the agencies. They will allow physician sponsored PPOs only if they take on insurance risk or use the messenger model.

Panel Size. As mentioned in the section on positive aspects of the guidelines, panel size is still an issue. An insurance company, hospital, or entrepreneur may organize a PPO or other type of health plan and have very large percentages of physicians in the market as participants. That makes it difficult for physician sponsored PPOs to compete with them.

There are indications in the guidelines that the agencies will allow larger panels provided that the messenger model is used to develop price arrangements. However, the larger the panel the more difficult it is to apply the messenger model.

Conclusion

The new guidelines have some positive aspects to them, but still are more restrictive than the AMA believes is warranted. The AMA will continue to press for modification of the guidelines or legislative relief.

However, to be successful in further modifications or in passing new legislation, the AMA will have to present compelling evidence that the antitrust laws are in fact deterring the entry of physician sponsored networks that could benefit the market, or that they are causing physician sponsored networks to fall in competition with non-physician controlled networks. Obtaining this evidence would be labor intensive and therefore expensive, because it would require AMA staff to survey numerous physicians and physician networks. There is also the risk that the expense necessary to obtain the effort would not yield the expected results.

The AMA hopes that state, county, and specialty societies will be interested in helping to develop the information necessary to press for antitrust reforms.

likelihood of legislation?

U.S. Department of Justice
Antitrust Division

8/17/94

Counselor to the Assistant Attorney General

Jennifer,

This is the up-to-date version of our Statements -- major difference with what was sent earlier is Statement 9, which we just finished.

Bob

DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION JOINT STATEMENTS OF ENFORCEMENT POLICY AND ANALYTICAL PRINCIPLES RELATING TO HEALTH CARE AND ANTITRUST

In September 1993, the Department of Justice and the Federal Trade Commission (the "Agencies") set forth six statements of their antitrust enforcement policies regarding mergers and various joint activities in the health care area. The six policy statements addressed: (1) hospital mergers; (2) hospital joint ventures involving high-technology or other expensive medical equipment; (3) physicians' provision of information to purchasers of health care services; (4) hospital participation in exchanges of price and cost information; (5) joint purchasing arrangements among health care providers; and (6) physician network joint ventures. The Agencies also committed to expedited Justice Department business reviews and Federal Trade Commission advisory opinions in response to requests for antitrust guidance on specific proposed conduct involving the health care industry.

The 1993 policy statements and expedited specific Agency guidance were designed to provide education and instruction to the health care community in a time of tremendous change, and to resolve, as completely as possible, the problem of antitrust uncertainty that some have said may deter mergers, joint ventures, or other activities that would lower health care costs. Sound antitrust enforcement, of course, continued to protect consumers against anticompetitive activities.

When the Agencies issued the 1993 health care antitrust enforcement policy statements, they recognized that additional guidance might be desirable in the areas covered by those statements as well as in other health care areas, and committed to issuing revised and additional policy statements as warranted. The Agencies welcomed and have received a variety of comments on the policy statements from participants in the health care industry, as well as others, and have responded expeditiously to all health care business review and advisory opinion requests. In light of the comments the Agencies have received and the Agencies' own experience, the Agencies now believe it is appropriate to revise and expand the health care antitrust enforcement policy statements issued in September 1993.

As set forth herein, the Agencies are issuing nine statements of their antitrust enforcement policies and analytical principles relating to mergers and various joint activities in the health care area. The nine statements address: (1) hospital mergers; (2) hospital joint ventures involving high-technology or other expensive medical equipment; (3) hospital joint ventures involving specialized clinical or other expensive medical services; (4) providers' furnishing of non-fee-related information to purchasers of health care services; (5) providers' furnishing of fee-related information to purchasers of health care services; (6) provider participation in exchanges of price and cost information; (7) joint purchasing arrangements among health care providers; (8) physician network joint ventures; and

(9) multiprovider networks. These statements supersede the September 1993 health care antitrust enforcement policy statements. The major differences between the September 1993 statements and the statements set forth herein are summarized below.

Hospital Mergers

The hospital merger statement is unchanged.

Hospital Joint Ventures Involving High-Technology or Other Expensive Medical Equipment

In the September 15, 1993 statement on hospital joint ventures involving high-technology or other expensive medical equipment, the Agencies established an antitrust safety zone for joint ventures among hospitals to purchase, operate, and market the services of high-technology or other expensive medical equipment if the joint venture included only those hospitals whose participation is needed to support the equipment. The Agencies also described the rule of reason analysis they applied to such joint ventures that fell outside the safety zone.

Since issuing the 1993 statement, the Agencies have received comments to the effect that the reasoning contained in that statement also should be applied in situations in which existing, not newly purchased, equipment will be the subject of a joint venture. Upon consideration of those comments, the Agencies have revised this statement so as to make it applicable to joint ventures involving existing, as well as new, high-technology or other expensive medical equipment. The revised statement also

contains two new examples, including an example focused on equipment sharing by rural providers, explaining how the Agencies would analyze joint ventures involving existing equipment.

Hospital Joint Ventures Involving Specialized Clinical or Other Expensive Medical Services

The Agencies also received requests that they address in a policy statement their analysis of hospital joint ventures involving shared clinical or other expensive medical services. In response to those comments, the Agencies are issuing a new statement that explains the analysis the Agencies use in reviewing shared service joint ventures and includes an example of how such a venture is evaluated.

Providers' Provision of Non-Fee-Related Information to Purchasers of Health Care Services

Providers' Provision of Fee-Related Information to Purchasers of Health Care Services

The September 1993 statement on provision of information to purchasers was limited to physicians and addressed both non-fee and fee-related information. After receiving comments, the Agencies are issuing two separate statements in this area, one addressing the provision of non-fee-related information, and one addressing the provision of fee-related information. The new statements also cover the collective provision of information by any group of competing providers, not just physicians.

Other than extending its coverage to all providers and deleting its discussion of fee-related information, the revised statement that covers the provision of non-fee-related

information is essentially unchanged. The statement covering the provision of fee-related information is new.

Provider Participation in Exchanges of Price and Cost Information

The September 1993 statement on exchanges of price and cost information was limited to hospital participation in exchanges of price and cost information. The revised statement covers the participation by any group of providers in exchanges of price and cost information, not just hospitals.

Joint Purchasing Arrangements

The September 1993 statement on joint purchasing arrangements among health care providers has been supplemented by the addition of an example that focuses on rural joint purchasing arrangements.

Physician Network Joint Ventures

The September 1993 statement on physician network joint ventures established an antitrust safety zone for joint ventures comprised of 20 percent or less of the physicians in each physician specialty with active hospital staff privileges who practice in the relevant geographic market and share substantial financial risk. The antitrust safety zone applied equally to "exclusive" and "non-exclusive" physician network joint ventures, but noted that the exclusive or non-exclusive nature of a physician network is important in the rule of reason analysis of ventures falling outside the safety zone. Consistent with that

analysis, the Agencies believe that the antitrust safety zone appropriately can be bifurcated, so as to set different market share thresholds for "exclusive" and "non-exclusive" physician network joint ventures.

An "exclusive" venture significantly restricts the ability of its members to affiliate with any other physician network joint ventures or to contract individually with health insurance plans. A "non-exclusive" venture, on the other hand, does not impose any significant explicit or implicit restriction on the ability of its members either to affiliate or contract with such other organizations, or to contract individually with health insurance plans.

Because it does not restrict the ability of its members to contract outside the venture, a non-exclusive venture is likely to allow for a greater number of competitors in a market and allow new entry to occur more easily than does an exclusive venture. For this reason, the Agencies generally have less concern about foreclosure of competing plans if a venture is non-exclusive. While the Agencies have recognized this in their rule of reason analysis, the September 1993 statement did not do so in its safety zone. Because it corresponds to actual Agency practice, the Agencies believe it is now appropriate to recognize, in revised safety zones, the differences between exclusive and non-exclusive physician network joint ventures. Therefore, the Agencies have added a safety zone that is applicable to non-exclusive physician network joint ventures

comprised of 30 percent or less of the physicians in each physician specialty with active staff privileges who practice in the relevant geographic market and share substantial financial risk. The 20 percent safety zone applicable to exclusive joint ventures is unchanged.

The Agencies also have added two additional examples of non-exclusive physician joint ventures, more specifically tailored to very rural areas.

Multiprovider Networks

The new statement on multiprovider networks sets out several important analytical principles that the Agencies apply in their antitrust analyses of such networks. These principles are most important to the formulation of overall enforcement policy regarding multiprovider networks, but the Agencies are continuing to learn about the competitive dynamics of the markets in which such networks are evolving. Thus, to provide maximum guidance to the health care community at this time, the Agencies have determined to describe the analytical principles they apply rather than issue a more formal and structured statement of enforcement policy.

This statement discusses antitrust principles in a number of areas that are important to the analysis of multiprovider networks, including integration and joint pricing, service specialization, market definition, market concentration, competitive effects, and exclusivity.

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Most of the nine statements set forth herein give health care providers guidance in the form of "antitrust safety zones," which describe the circumstances under which the Agencies will not challenge conduct as violative of the antitrust laws. The inclusion of certain conduct within the antitrust safety zones does not imply that conduct falling outside the safety zones is likely to be challenged by the Agencies. The Agencies want to emphasize this point to the health care community to ensure there is no misunderstanding of the meaning of the safety zones. Antitrust analysis is inherently fact-intensive. The statements set forth an outline of the analysis the Agencies will use to review conduct that falls outside the antitrust safety zones.[1]

The statements also set forth the Department's expedited business review procedure and the Federal Trade Commission's advisory opinion procedure under which the health care community can obtain the Agencies' antitrust enforcement intentions. The statements continue the commitment of the Agencies to respond to requests for business reviews or advisory opinions from the health care community no later than 90 days after all necessary information is received regarding any matter addressed in the statements, except requests relating to hospital mergers outside the antitrust safety zone and multiprovider networks. The Agencies also will respond to business review or advisory opinion

[1] These statements are intended to describe the Agencies' analysis of conduct falling outside the antitrust safety zones in understandable terms, not to deviate from applicable law or policy statements.

requests regarding multiprovider networks or other non-merger health care matters within 120 days after all necessary information is received. The Agencies intend to work closely with persons making requests to clarify what information is necessary and to provide guidance throughout the process. The Agencies continue this commitment to swift and certain expedited review in an effort to reduce antitrust uncertainty for the health care industry in what the Agencies recognize is a time of fundamental and far-reaching change.

The Agencies recognize that additional antitrust guidance may continue to be desirable in the areas covered by these statements as well as in other evolving health care contexts. Consequently, the Agencies continue their commitment to issue additional or revised statements as warranted.

1. STATEMENT OF DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION ENFORCEMENT POLICY ON MERGERS AMONG HOSPITALS

Introduction

Most hospital mergers and acquisitions ("mergers") do not present competitive concerns. While careful analysis may be necessary to determine the likely competitive effect of a particular hospital merger, the competitive effect of many hospital mergers is relatively easy to assess. This statement sets forth an antitrust safety zone for certain mergers in light of the Agencies' extensive experience analyzing hospital mergers. Mergers that fall within the antitrust safety zone will not be challenged by the Agencies under the antitrust laws, absent extraordinary circumstances.[2] This policy statement also briefly describes the Agencies' antitrust analysis of hospital mergers that fall outside the antitrust safety zone.

A. *Antitrust Safety Zone:* Mergers of Hospitals That Will Not Be Challenged, Absent Extraordinary Circumstances, By the Agencies

The Agencies will not challenge any merger between two general acute-care hospitals where one of the hospitals (1) has an average of fewer than 100 licensed beds over the three most recent years, and (2) has an average daily inpatient census of

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[2]The Agencies are confident that conduct falling within the antitrust safety zones contained in these policy statements is very unlikely to raise competitive concerns. Accordingly, the Agencies anticipate that extraordinary circumstances warranting a challenge to such conduct will be rare.

fewer than 40 patients over the three most recent years, absent extraordinary circumstances. This antitrust safety zone will not apply if that hospital is less than 5 years old.

The Agencies recognize that in some cases a general acute care hospital with fewer than 100 licensed beds and an average daily inpatient census of fewer than 40 patients will be the only hospital in a relevant market. As such, the hospital does not compete in any significant way with other hospitals. Accordingly, mergers involving such hospitals are unlikely to reduce competition substantially.

The Agencies also recognize that many general acute care hospitals, especially rural hospitals, with fewer than 100 licensed beds and an average daily inpatient census of fewer than 40 patients are unlikely to achieve the efficiencies that larger hospitals enjoy. Some of those cost-saving efficiencies may be realized, however, through a merger with another hospital.

B. The Agencies' Analysis Of Hospital Mergers That Fall Outside The Antitrust Safety Zone

Hospital mergers that fall outside the antitrust safety zone are not necessarily anticompetitive, and may be procompetitive. The Agencies' analysis of hospital mergers follows the five steps set forth in the Department of Justice Federal Trade Commission 1992 Horizontal Merger Guidelines.

Applying the analytical framework of the Merger Guidelines to particular facts of specific hospital mergers, the Agencies often have concluded that an investigated hospital merger will

not result in a substantial lessening of competition in situations where market concentration might otherwise raise an inference of anticompetitive effects. Such situations include transactions where the Agencies found that: (1) the merger would not increase the likelihood of the exercise of market power either because of the existence post-merger of strong competitors or because the merging hospitals were sufficiently differentiated; (2) the merger would allow the hospitals to realize significant cost savings that could not otherwise be realized; or (3) the merger would eliminate a hospital that likely would fail with its assets exiting the market.

Antitrust challenges to hospital mergers are relatively rare. Of the hundreds and hundreds of hospital mergers in the United States since 1987, the Agencies have challenged only eleven, and in several cases sought relief only as to part of the transaction. Most reviews of hospital mergers conducted by the Agencies are concluded within one month.

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If hospitals are considering mergers that appear to fall within the antitrust safety zone and believe they need additional certainty regarding the legality of their conduct under the antitrust laws, they can take advantage of the Department's business review procedure (28 C.F.R. § 50.6 (1992)) or the Federal Trade Commission's advisory opinion procedure (16 C.F.R. §§ 1.1-1.4 (1993)). The Agencies will respond to business review or advisory opinion requests on behalf of

hospitals considering mergers that appear to fall within the antitrust safety zone within 90 days after all necessary information is submitted.

2. STATEMENT OF DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION ENFORCEMENT POLICY ON HOSPITAL JOINT VENTURES INVOLVING HIGH-TECHNOLOGY OR OTHER EXPENSIVE MEDICAL EQUIPMENT

Introduction

Most hospital joint ventures to purchase or otherwise share the ownership cost of, operate, and market high-technology or other expensive medical equipment and related services do not create antitrust problems. In most cases, these collaborative activities create procompetitive efficiencies that benefit consumers. These efficiencies include the provision of services at a lower cost or the provision of a service that would not have been provided absent the joint venture. Sound antitrust enforcement policy distinguishes those joint ventures that on balance benefit the public from those that may increase costs without providing a countervailing benefit, and seeks to prevent only those that are harmful to consumers. The Agencies have never challenged a joint venture among hospitals to purchase or otherwise share the ownership cost of, operate and market high-technology or other expensive medical equipment and related services.

This statement of enforcement policy sets forth an antitrust safety zone that describes hospital high-technology or other expensive medical equipment joint ventures that will not be challenged, absent extraordinary circumstances, by the Agencies under the antitrust laws. It then describes the Agencies' antitrust analysis of hospital high-technology or other expensive

medical equipment joint ventures that fall outside the antitrust safety zone. Finally, this statement includes examples of its application to hospital high-technology or other expensive medical equipment joint ventures.

A. *Antitrust Safety Zone*: Hospital High-Technology Joint Ventures That Will Not Be Challenged, Absent Extraordinary Circumstances, By The Agencies

The Agencies will not challenge under the antitrust laws any joint venture among hospitals to purchase or otherwise share the ownership cost of, operate, and market the related service of, high-technology or other expensive medical equipment if the joint venture includes only the number of hospitals whose participation is needed to support the equipment, absent extraordinary circumstances.[3] This applies to joint ventures involving purchases of new equipment as well as to joint ventures involving existing equipment.[4] A joint venture that includes additional hospitals also will not be challenged if the additional hospitals

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[3]A hospital or group of hospitals will be considered able to support high-technology or other expensive medical equipment for purposes of this antitrust safety zone if it could recover the costs of owning, operating, and marketing the equipment over its useful life. If the joint venture is limited to ownership, only the ownership costs are relevant. If the joint venture is limited to owning and operating, only the owning and operating costs are relevant.

[4]Consequently, the safety zone would apply in a situation in which one hospital had already purchased the medical equipment, but was not recovering the costs of the equipment and sought a joint venture with one or more hospitals in order to recover the costs of the equipment.

could not support the equipment on their own or through the formation of a competing joint venture, absent extraordinary circumstances.

For example, if two hospitals are each unlikely to recover the cost of individually purchasing, operating, and marketing the services of a magnetic resonance imager (MRI) over its useful life, their joint venture with respect to the MRI would not be challenged by the Agencies. On the other hand, if the same two hospitals entered into a joint venture with a third hospital that independently could have purchased, operated, and marketed an MRI in a financially viable manner, the joint venture would not be in this antitrust safety zone. If, however, none of the three hospitals could have supported an MRI by itself, the Agencies would not challenge the joint venture.[5]

Information necessary to determine whether the costs of a piece of high-technology medical equipment could be recovered over its useful life is normally available to any hospital or group of hospitals considering such a purchase. This information may include the cost of the equipment, its expected useful life, the minimum number of procedures that must be done to meet a machine's financial breakeven point, the expected number of

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[5]The antitrust safety zone described in this statement applies only to the joint venture and agreements reasonably necessary to the venture. The safety zone does not apply to or protect agreements made by participants in a joint venture that are related to a service not provided by the venture. For example, the antitrust safety zone that would apply to the MRI joint venture would not apply to protect an agreement among the hospitals with respect to charges for an overnight stay.

procedures the equipment will be used for given the population served by the joint venture and the expected price to be charged for the use of the equipment. Expected prices and costs should be confirmed by objective evidence, such as experiences in similar markets for similar technologies.

B. The Agencies' Analysis of Hospital High-Technology or Other Expensive Medical Equipment Joint Ventures That Fall Outside the Antitrust Safety Zone

The Agencies recognize that joint ventures that fall outside the antitrust safety zone do not necessarily raise significant antitrust concerns. The Agencies will apply a rule of reason analysis in their antitrust review of such joint ventures.[6] The objective of this analysis is to determine whether the joint venture may reduce competition substantially, and, if it might, whether it is likely to produce procompetitive efficiencies that outweigh its anticompetitive potential. This analysis is flexible and takes into account the nature and effect of the joint venture, the characteristics of the venture and of the hospital industry generally, and the reasons for, and purposes of, the venture. It also allows for consideration of

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[6]This statement assumes that the joint venture arrangement is not one that uses the joint venture label but is likely merely to restrict competition and decrease output. For example, two hospitals that independently operate profitable MRI services could not avoid charges of price fixing by labelling as a joint venture their plan to obtain higher prices through joint marketing of their existing MRI services.

efficiencies that will result from the venture. The steps involved in a rule of reason analysis are set forth below.[7]

Step one: Define the relevant market. The rule of reason analysis first identifies what is produced through the joint venture. The relevant product and geographic markets are then properly defined. This process seeks to identify any other provider that could offer what patients or physicians generally would consider a good substitute to that provided by the joint venture. Thus, if a joint venture were to purchase and jointly operate and market the related services of an MRI, the relevant market would include all other MRIs in the area that are reasonable alternatives for the same patients, but would not include providers with only traditional X-ray equipment.

Step two: Evaluate the competitive effects of the venture. This step begins with an analysis of the structure of the relevant market. If there are many providers that would compete with the joint venture, it is unlikely that competitive harm would result from

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[7]For many joint ventures, it will be clear initially that the likelihood of competitive harm is small or that the venture will provide substantial efficiencies. In such cases, it will not be necessary to complete all steps in the analysis to conclude that the joint venture should not be challenged. For example, when two hospitals propose to merge existing expensive medical equipment into a joint venture in a market in which many other hospitals or other health care facilities operate the same equipment, it is likely that the market will be unconcentrated, and under the Department of Justice-Federal Trade Commission 1992 Horizontal Merger Guidelines, mergers resulting in unconcentrated markets are unlikely to have adverse competitive effects and ordinarily require no further analysis.

the joint venture in the relevant market and the analysis would continue with step four described below.

If the structural analysis of the relevant market determined that the joint venture would eliminate an existing or potentially viable competing provider and that there were few other competing providers, or if there is a danger that cooperation in the joint venture market may spill over into a market in which the parties to the joint venture are competitors, it then would be necessary to assess the extent of the potential anticompetitive effects of the joint venture. In addition to the number of competing providers, other factors that could restrain the ability of the joint venture to raise prices either unilaterally or through collusive agreements with other providers would include: (1) regulatory restraints on price; (2) characteristics of the market that make anticompetitive agreements unlikely; and (3) the likelihood that other providers would enter the market and start competing.

The extent to which the joint venture restricts competition among or between the hospitals participating in the venture is evaluated during this step. In some cases, a joint venture to purchase or otherwise share the cost of high-technology equipment may not substantially eliminate competition between the hospitals in providing the related service made possible by the equipment. For example, two hospitals might purchase a mobile MRI jointly, but operate and market MRI services separately. In such

instances, the potential impact on competition of the joint venture would be substantially reduced.[8]

Step three: Evaluate the impact of procompetitive efficiencies. This step requires an examination of the venture's potential to create procompetitive efficiencies, and the balancing of these efficiencies against any potential anticompetitive effects. In the case of high-technology or other expensive medical equipment, efficiencies can be substantial because of the need to spread the cost of expensive equipment over a large number of patients and the potential for improvements in quality to occur as providers gain experience and skill from performing a larger number of procedures.

Step four: Evaluate ancillary agreements. This step determines whether the joint venture includes ancillary agreements or conditions that unreasonably restrict competition and are unlikely to contribute significantly to the legitimate purposes of the joint venture. For example, if the participants in a joint venture formed to purchase a mobile lithotripter also were to agree on the daily room rate to be charged lithotripsy patients who required overnight hospitalization, this ancillary agreement as to room rates would be unnecessary to achieve the benefits of the lithotripter joint venture. Although the joint venture itself

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[8]If steps one and two reveal no competitive concerns with the joint venture, step three is unnecessary, and the analysis continues with step four described below.

would be legal, the ancillary agreement on hospital room rates would not be legal and would be challenged.

C. Examples of Hospital High-Technology Joint Ventures

The following are examples of hospital joint ventures that are unlikely to raise significant antitrust concerns. Each is intended to demonstrate an aspect of the analysis that would be used to evaluate the venture.

1. New Equipment That Can Be Offered Only By A Joint Venture

All the hospitals in a relevant market agree that they jointly will purchase, operate and market a helicopter to provide emergency transportation for patients. The need for the helicopter is not great enough to justify having more than one helicopter operating in the area and studies of similarly sized communities indicate that a second helicopter service could not be supported. This joint venture falls within the antitrust safety zone. It would make available a service that would not otherwise be available, and for which duplication would be inefficient.

2. Joint Venture to Purchase Expensive Equipment

All five hospitals in a relevant market jointly agree to purchase a mobile medical device that provides a service for which consumers have no reasonable alternatives. Each will share equally in the cost of maintaining the equipment, and the equipment will travel from one hospital to another and be available one day each week at each hospital. The hospitals'

agreement contains no provisions for joint marketing of, and protects against exchanges of competitively sensitive information regarding, the equipment.[9] There are also no limitations on the prices that each hospital will charge for use of the equipment, on the number of procedures that each hospital can perform, or on each hospital's ability to purchase the equipment on its own. Although any combination of two of the hospitals could afford to purchase the equipment and recover their costs within the equipment's useful life, patient volume from all five hospitals is required to maximize the efficient use of the equipment and lead to significant cost savings. In addition, patient demand would be satisfied by provision of the equipment one day each week at each hospital. The joint venture would result in higher use of the equipment, thus lowering the cost per patient and potentially improving quality.

This joint venture does not fall within the antitrust safety zone because smaller groups of hospitals could afford to purchase and operate the equipment and recover their costs. Therefore, the joint venture would be analyzed under the rule of reason. In this example, the relevant market consists of the services provided by the equipment and the five hospitals all potentially compete against each other for patients requiring this service.

Because the joint venture is likely to reduce the number of these medical devices in the market, there is a potential

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[9]Examples of such information include prices and marketing plans.

restraint on competition. The restraint would not be substantial, however, for several reasons. First, the joint venture is limited to the purchase of the equipment and would not eliminate competition among the hospitals in the provision of the services. Each hospital will market its services independently, and will not exchange competitively sensitive information. In addition, the venture does not preclude a hospital from purchasing another unit should the demand for these services increase. Because the joint venture raises some competitive concerns, however, it is necessary to examine the potential efficiencies created by the venture. The joint venture would produce substantial efficiencies while providing access to high quality care. Thus, this joint venture would on balance benefit consumers since it would not lessen competition substantially, and it would allow the hospitals to provide a service in a more efficient manner. On these facts, the joint venture would not be challenged by the Agencies.

3. Joint Venture of Existing Expensive Equipment Where One of the Hospitals in the Venture Already Owns the Equipment

Metropolis has three hospitals and a population of 300,000. Although Mercy and Brothers Hospitals own and operate their own magnetic resonance imaging device ("MRI"), St. Johns does not. Managed care plans have told St. Johns that, unless it can provide MRI services, it will be a less attractive contracting partner. Although the two existing MRIs are already slightly underutilized, St. Johns is considering the possibility of

purchasing its own MRI so that it can compete on equal terms with Mercy and Brothers Hospitals.

Local employers and managed care plans have made it clear that they will not support the unnecessary purchase and operation of expensive medical equipment such as MRIs. Rather than have St. Johns purchase its own MRI, St. Johns and Mercy have been strongly encouraged to form a joint venture in which St. Johns would have access to Mercy's MRI. Under the joint venture, St. Johns will purchase a 50 percent share in Mercy's MRI, and the two hospitals will work out an arrangement by which each hospital has equal access to the MRI. The joint venture will charge each hospital a price that reflects its average variable cost of providing those services plus a reasonable rate of return on capital. Each hospital in the joint venture will independently market, and set prices for, those MRI services.

The proposed joint venture does not fall within the antitrust safety zone because St. Johns apparently could independently support the purchase and operation of its own MRI. Accordingly, the Agencies would analyze the joint venture under a rule of reason.

The first step of the rule of reason analysis is defining the relevant product and geographic markets. The relevant product market in this case is MRI services. Most patients currently receiving MRI services are unwilling to travel outside of Metropolis for those services, so the relevant geographic market is Metropolis. Mercy and Brothers are already offering MRI

services in this market. Because St. Johns may offer MRI services within the next year, even if there is no joint venture, it is viewed as a future market participant.

The second step is determining the competitive impact of the joint venture. That there could have been three independent MRIs in the market raises some competitive concerns with the joint venture. Since the joint venture will not entail joint price setting or marketing of MRI services to purchasers, however, all three hospitals will compete in the near future with each other in the sale of MRI services. This significantly reduces the venture's potential anticompetitive effect. The competitive analysis would also consider the likelihood of additional entry in the market. If, for example, a physician clinic is likely to purchase a MRI in the event that the price of MRI services were to increase, any anticompetitive effect from the joint venture becomes less likely. The competitive analysis would also consider the likelihood of increased collusion among the hospitals in the market. Although Mercy and St. Johns will have similar costs from their joint ownership of the equipment, competition from the Brothers MRI will reduce potential anticompetitive effects in the market.

The third step of the analysis is assessing the likely efficiencies associated with the joint venture. The magnitude of any likely anticompetitive effects associated with the joint venture is important; the greater the likely anticompetitive effects of the joint venture, the greater must be the likely

efficiencies associated with the joint venture to offset such effects. In this instance, the joint venture will allow St. Johns to avoid the costly duplication associated with purchasing and operating its own MRI, and will allow Mercy to reduce the average cost of operating its MRI. The competition between the Mercy/St. Johns MRI and the Brothers MRI will provide incentives for the joint venture to operate the MRI in as low-cost a manner as possible. Thus, there are efficiencies and savings associated with the joint venture.

The final step of the analysis is determining whether the joint venture has any unnecessary ancillary agreements or conditions that reduce competition. For example, if the joint venture required that managed care plans desiring MRI services must contract with both joint venture participants for those services, that condition would be viewed as anticompetitive and unnecessary to achieve the legitimate procompetitive goals of the joint venture.

On balance, when weighing the likelihood that the joint venture will significantly reduce competition for these services, versus its potential to result in efficiencies, the Agencies would view this joint venture favorably under a rule of reason analysis.

In this example, it was assumed that the joint venture did not include joint price setting or marketing of MRI services to purchasers. Restricting the scope of a joint venture in this fashion significantly reduces the competitive concerns with the

joint venture, and thus significantly reduces the likelihood that the Agencies would view the joint venture as anticompetitive under a rule of reason analysis.

4. Joint Venture of Existing Equipment Where Both Hospitals in the Venture Already Own the Equipment

Valley Town has a population of 30,000 and is located in a valley surrounded by mountains. The closest urbanized area is over 75 miles away. There are two hospitals in Valley Town: Valley Medical Center and St. Mary's. Valley Medical Center offers a full range of primary and secondary services. St. Mary's offers primary and some secondary services. Although both hospitals have a CT scanner, Valley Medical Center's scanner is more sophisticated. Because of its greater sophistication, Valley Medical Center's scanner is more expensive to operate, and can conduct fewer scans in a day. A physician clinic in Valley Town operates a third CT scanner; this CT scanner is comparable to St. Mary's scanner and is not fully utilized.

Valley Medical Center has found that many of the scans that it conducts do not require the sophisticated features of its scanner. Because scans on its machine take so long, and so many patients require scans, Valley Medical Center also is experiencing significant scheduling problems. St. Mary's scanner, on the other hand, is underutilized, partially because many individuals go to Valley Medical Center because they need the more sophisticated scans that only Valley Medical Center's scanner can provide. Despite the underutilization of St. Mary's scanner, and

the higher costs of Valley Medical Center's scanner, neither hospital has any intention of discontinuing its CT services. Valley Medical Center and St. Mary's are proposing a joint venture that would own and operate both hospitals' CT scanners. The joint venture will sell CT services to each hospital at the same price; this price will equal the joint venture's average variable cost of providing those services plus a reasonable rate of return on capital. The two hospitals will then independently market and set the prices they charge for those services.

The proposed joint venture does not qualify under the Agencies' safety zone since the participating hospitals can independently support their own equipment. Accordingly, the Agencies would analyze the joint venture under a rule of reason. The first step of the analysis is to determine the relevant product and geographic markets. As long as other diagnostic services such as conventional X-rays or MRI scans are not viewed as a good substitute for CT scans, the relevant product market is CT scans. If patients currently receiving CT scans at Valley Medical Center and St. Mary's are unlikely to switch to providers offering CT scans outside of Valley Town in the event that the price of CT scans in Valley Town increased by a small but significant amount, the relevant geographic market is Valley Town. There are three participants in this relevant market: Valley Medical Center, St. Mary's, and the physician clinic.

The second step of the analysis is determining the competitive effect of the joint venture. Because the joint

venture does not entail joint pricing or marketing of CT services, the joint venture does not effectively reduce the number of market participants. This significantly reduces the venture's potential anticompetitive effect. In fact, by increasing the scope of the CT services the two hospitals can provide, the joint venture may even increase competition between Valley Medical Center and St. Mary's since now both hospitals can provide sophisticated scans. Competitive concerns with this joint venture would be further ameliorated if other health care providers were likely to acquire CT scanners in response to a price increase following the formation of the joint venture.

The third step is assessing whether the efficiencies associated with the joint venture outweigh any anticompetitive effect associated with the joint venture. This joint venture will allow both hospitals to make either the sophisticated CT scanner or the less sophisticated, but less costly, CT scanner available to patients at those hospitals.

Thus, the joint venture should increase quality of care by allowing for better utilization and scheduling of the equipment, while also reducing the cost of providing that care. The joint venture will also increase quality of care by making more capacity available to Valley Medical Center; while Valley Medical Center faced capacity constraints prior to the joint venture, it can now take advantage of St. Mary's underutilized CT scanner. The joint venture will also improve access by allowing patients requiring routine scans to be moved from the sophisti-

cated scanner at Valley Medical Center to St. Mary's scanner where the scans can be performed more quickly. Finally, the competition between the St. Mary's/Valley Medical Center CT scanners and the physicians' scanner provides the Agencies with some assurance that the joint venture will have incentives to operate as efficiently as possible; absent this competition with the physicians' scanner, the Agencies might have concerns about the joint venture's incentives to minimize operating costs and reduce costs.

The last step of the analysis is to determine whether there are any ancillary and unnecessary agreements or conditions associated with the joint venture that reduce competition. Assuming there are no such agreements or conditions, the Agencies would accordingly view this joint venture favorably under a rule of reason analysis.

As noted in the previous example, excluding price setting and marketing from the scope of the joint venture significantly reduces any anticompetitive effect of the joint venture, and thus reduces the likelihood that the Agencies will find the joint venture to be anticompetitive. If joint price setting and marketing were, however, a part of that joint venture, the Agencies would have to determine whether the loss of competition between the two hospitals offset the cost savings and quality improvements associated with the joint venture.

Also, if neither of the hospitals in Valley Town had a CT scanner, and they proposed a similar joint venture for the

purchase of two CT scanners, one sophisticated and one less sophisticated, the Agencies would be unlikely to view that joint venture as anticompetitive, even though each hospital could independently support the purchase of its own CT scanner. This conclusion would be based upon a rule of reason analysis that was virtually identical to the one described above.

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Hospitals that are considering high-technology or other expensive equipment joint ventures and are unsure of the legality of their conduct under the antitrust laws can take advantage of the Department's expedited business review procedure for joint ventures and information exchanges announced on December 1, 1992 (58 Fed. Reg. 6132 (1993)) or the Federal Trade Commission's advisory opinion procedure contained at 16 C.F.R. §§ 1.1-1.4 (1993). The Agencies will respond to a business review or advisory opinion request on behalf of a hospital high-technology joint venture within 90 days after all necessary information is submitted.

3. STATEMENT OF DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION ENFORCEMENT POLICY ON HOSPITAL JOINT VENTURES INVOLVING SPECIALIZED CLINICAL OR OTHER EXPENSIVE MEDICAL SERVICES

Introduction

Most hospital joint ventures to provide specialized clinical or other expensive medical services do not create antitrust problems. The Agencies have never challenged an integrated joint venture among hospitals to provide a specialized clinical or other expensive medical service.

Many hospitals wish to enter into joint ventures to offer these services because the development of these services involves expensive investments and the recruitment and training of specialized personnel that a single hospital may not be able to support. In many cases, these collaborative activities could create procompetitive efficiencies that benefit consumers, including the provision of services at a lower cost or the provision of a service that would not have been provided absent the joint venture. Sound antitrust enforcement policy distinguishes those joint ventures that on balance benefit the public from those that may increase costs without providing a countervailing benefit, and seeks to prevent only those that are harmful to consumers.

This statement of enforcement policy sets forth the Agencies' antitrust analysis of joint ventures between hospitals to provide specialized clinical or other expensive medical services and includes an example of its application to such ventures. It does

not include a safety zone for such ventures since the Agencies believe that they must acquire more expertise in evaluating the cost of, demand for, and potential benefits from such joint ventures before they can articulate a meaningful safety zone. The absence of a safety zone for such collaborative activities does not imply that they create any greater antitrust risk than other types of collaborative activities.

A. The Agencies' Analysis of Hospital Joint Ventures Involving Specialized Clinical or Other Expensive Medical Services

The Agencies apply a rule of reason analysis in their antitrust review of hospital joint ventures involving specialized clinical or other expensive medical services.[10] The objective of this analysis is to determine whether the joint venture may reduce competition substantially, and if it might, whether it is likely to produce procompetitive efficiencies that outweigh its anticompetitive potential. This analysis is flexible and takes into account the nature and effect of the joint venture, the characteristics of the services involved and of the hospital industry generally, and the reasons for, and purposes of, the venture. It also allows for consideration of efficiencies that

[10]This statement assumes that the joint venture is not likely merely to restrict competition and decrease output. For example, if two hospitals that both profitably provide open heart surgery and a burn unit simply agree without entering into an integrated joint venture that in the future each of the services will be offered exclusively at only one of the hospitals, the agreement would be viewed as illegal market allocation.

will result from the venture. The steps involved in a rule of reason analysis are set forth below.[11]

Step One: Define The Relevant Market. The rule of reason analysis first identifies the service that is produced through the joint venture. The relevant product and geographic markets that include the service are then properly defined. This process seeks to identify any other provider that could offer a service that patients or physicians generally would consider a good substitute to that provided by the joint venture. Thus, if a joint venture were to produce intensive care neonatology services, the relevant market would include all other neonatal intensive care nurseries that patients or physicians would view as reasonable alternatives, but would not include level I (routine birth) nurseries.

Step Two: Evaluate The Competitive Effects Of The Venture. This step begins with an analysis of the structure of the relevant market. If there are many providers that would compete with the joint venture, it is unlikely that competitive harm would result from the joint venture in the relevant market and the analysis would continue with step four described below.

If the structural analysis of the relevant market determined that the joint venture would eliminate an existing or potentially

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[11]For many joint ventures, it will be clear initially that the likelihood of competitive harm is small or that the venture will provide substantial efficiencies. In such cases, it will not be necessary to complete all steps in the analysis to conclude that the joint venture should not be challenged.

viable competing provider of a service and that there were few other competing providers of that service, or if there is a danger that cooperation in the joint venture market may spill over into a market in which the parties to the joint venture are competitors, it then would be necessary to assess the extent of the potential anticompetitive effects of the joint venture. In addition to the number of competing providers, other factors that could restrain the ability of the joint venture to raise prices either unilaterally or through collusive agreements with other providers would include: (1) regulatory restraints on price; (2) characteristics of the market that make anticompetitive agreements unlikely; and (3) the likelihood that others would enter the market and start providing the service.

The extent to which the joint venture restricts competition among or between the hospitals participating in the venture is evaluated during this step. In some cases, a joint venture to provide a specialized clinical or other expensive medical service may not substantially limit competition. For example, if the only two hospitals providing primary and secondary acute care inpatient services in a relevant geographic market were to form a joint venture to provide a tertiary service, they would still continue to compete on primary and secondary services. Because the geographic market for a tertiary service may in certain cases be larger than the geographic market for primary or secondary

services, the hospitals may also face substantial competition for the joint-ventured tertiary service.[12]

Step Three: Evaluate The Impact Of Procompetitive Efficiencies. This step requires an examination of the joint venture's potential to create procompetitive efficiencies, and the balancing of these efficiencies against any potential anticompetitive effects. In the case of specialized clinical services, efficiencies can be substantial because of the need to spread the cost of the equipment or recruitment and training of personnel over a large number of patients and the potential for improvement in quality to occur as providers gain experience and skill from performing a larger number of procedures. In the case of certain specialized clinical services, such as open heart surgery, the joint venture may permit the program to generate sufficient patient volume to meet well-accepted minimum standards for assuring quality and patient safety, which none of the joint venture partners could attain alone.

Step Four: Evaluate Ancillary Agreements. This step determines whether the joint venture includes ancillary agreements or conditions that unreasonably restrict competition and are unlikely to contribute significantly to the legitimate purposes of the joint venture. For example, if the participants in a joint venture to provide highly sophisticated oncology services were to agree on

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[12]If steps one and two reveal no competitive concerns with the joint venture, step three is unnecessary, and the analysis continues with step four described below.

the prices to be charged for all radiology services whether the oncology services are provided to patients undergoing radiation therapy or not, this ancillary agreement as to radiology services for non-oncology patients would be unnecessary to achieve the benefits of the sophisticated oncology joint venture. Although the joint venture itself would be legal, the ancillary agreement would not be legal and would be challenged.

B. Example

1. Hospital Joint Venture for New Specialized Clinical Service Not Involving Purchase of High-Technology or Other Expensive Medical Equipment

Midvale has a population of about 75,000, and is geographically isolated in a rural part of its state. Midvale has two general acute care hospitals, Community Hospital and Religious Hospital, each of which performs a mix of basic primary, secondary, and some tertiary care services. The two hospitals have largely non-overlapping medical staffs. Neither hospital currently offers open-heart surgery services, nor has plans to do so on its own. Local residents, physicians, employers, and hospital managers all agree that Midvale needs to have the capability to provide open-heart surgery locally.

Neither hospital in Midvale has set up an open-heart surgery unit to date, because neither hospital alone generates enough cases to make it economically feasible to recruit a cardiac surgery team or to meet the minimum volume level that widely accepted studies have shown is generally necessary to provide quality services and assure patient safety. As a result, the two

hospitals in Midvale propose a joint venture whereby the two hospitals will share the costs of recruiting a cardiac surgery team and establishing the open-heart surgery program, to be located at one of the hospitals. Patients will be referred to the program from both hospitals, who will share expenses and revenues of the program.

As stated above, the Agencies would analyze such a joint venture under a rule of reason. The first step of the rule of reason analysis is defining the relevant product and geographic markets. The relevant product market in this case is open-heart surgery services, because there are no reasonable alternatives for patients needing such surgery. The relevant geographic market may be limited to Midvale. Although patients now travel to alternative hospitals for open-heart surgery, it is significantly more costly for patients to obtain surgery from them than from a provider located in Midvale. Physicians, patients, and payers believe that after the open heart surgery program is operational, most Midvale residents will choose to receive these services locally.

The second step is determining the competitive impact of the joint venture. Here, the joint venture does not eliminate any existing competition, because neither of the two hospitals previously was providing open-heart surgery. Nor does the joint venture eliminate any potential competition, because there is insufficient patient volume for more than one viable open-heart surgery program. Thus, only one such program could exist in

Midvale, regardless of whether it was established unilaterally or through a joint venture.

Normally, the third step in the rule of reason analysis would be to assess the procompetitive effects of, and likely efficiencies associated with, the joint venture. In this instance, this step is unnecessary, since the analysis has concluded under step two that the joint venture will not result in any significant anticompetitive effects. However, if the Agencies were to assess the joint venture's efficiencies, it would be relevant that the joint venture will result in the establishment of a new open-heart surgery program to the benefit of Midvale residents.

The final step of the analysis is to determine whether the joint venture has any unnecessary ancillary agreements or conditions that reduce competition. The joint venture does not appear to involve any such agreements or conditions; it does not eliminate or reduce competition between the two hospitals for any other services, or impose any conditions on use of the open-heart surgery program that would affect other competition.

Because the joint venture described above is unlikely significantly to reduce competition among hospitals for open-heart surgery services, and will in fact increase the services available to consumers, the Agencies would view this joint venture favorably under a rule of reason analysis.

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Hospitals that are considering specialized clinical or other expensive medical services joint ventures and are unsure of the legality of their conduct under the antitrust laws can take advantage of the Department of Justice's expedited business review procedure announced on December 1, 1992 (58 Fed. Reg. 6132 (1993)) or the Federal Trade Commission's advisory opinion procedure contained at 16 C.F.R. §§ 1.1-1.4 (1993). The Agencies will respond to a business review or advisory opinion request on behalf of hospitals who are considering jointly providing such services within 90 days after all necessary information is submitted. The Department's December 1, 1992 announcement contains specific guidance as to the information that should be submitted.

4. STATEMENT OF DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION ENFORCEMENT POLICY ON PROVIDERS' PROVISION OF NON-FEE RELATED INFORMATION TO PURCHASERS OF HEALTH CARE SERVICES

Introduction

The collective provision of non-fee-related information by competing health care providers to a purchaser in an effort to influence the terms upon which the purchaser deals with the providers does not necessarily raise antitrust concerns. Generally, providers' collective provision of certain types of information to a purchaser is likely either to provide procompetitive benefits or to raise little risk of anticompetitive effects.

This statement sets forth an antitrust safety zone that describes collective provider provision of non-fee-related information that will not be challenged by the Agencies under the antitrust laws, absent extraordinary circumstances.[13] It also describes conduct that is expressly excluded from the antitrust safety zone.

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[13]This statement is limited to providers' collective activities. As a general proposition, providers acting individually may provide any information to any purchaser without incurring liability under federal antitrust law. Moreover, this statement is limited to the collective provision of information other than through an integrated joint venture. The exchange of information that necessarily occurs among providers involved in joint venture activities generally does not raise antitrust concerns.

A. *Antitrust Safety Zone:* Providers' Collective Provision Of Non-Fee-Related Information That Will Not Be Challenged, Absent Extraordinary Circumstances, By The Agencies

Providers' collective provision of underlying medical data that may improve purchasers' resolution of issues relating to the mode, quality, or efficiency of treatment is unlikely to raise any significant antitrust concern and will not be challenged by the Agencies, absent extraordinary circumstances. Thus, the Agencies will not challenge, absent extraordinary circumstances, a medical society's collection of outcome data from its members about a particular procedure that they believe should be covered by a purchaser and the provision of such information to the purchaser. The Agencies also will not challenge, absent extraordinary circumstances, providers' development of suggested practice parameters--standards for patient management developed to assist providers in clinical decisionmaking--that also may provide useful information to patients, providers, and purchasers. Because providers' collective provision of such information poses little risk of restraining competition and may help in the development of protocols that increase quality and efficiency, the Agencies will not challenge such activity, absent extraordinary circumstances.

Excluded from the antitrust safety zone is any attempt by providers to coerce a purchaser's decisionmaking by implying or threatening a boycott of any plan that does not follow the providers' joint recommendation. Providers who collectively threaten to or actually refuse to deal with a purchaser because

they object to the purchaser's administrative, clinical, or other terms governing the provision of services run a substantial antitrust risk. For example, providers' collective refusal to provide X-rays to a purchaser that seeks them before covering a particular treatment regimen would constitute present an antitrust violation. Similarly, providers' collective attempt to force purchasers to adopt recommended practice parameters by threatening to or actually boycotting purchasers that refuse to accept their joint recommendation also would risk antitrust challenge.

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Competing providers who are considering jointly providing non-fee-related information to a purchaser and are unsure of the legality of their conduct under the antitrust laws can take advantage of the Department of Justice's expedited business review procedure announced on December 1, 1992 (58 Fed. Reg. 6132 (1993)) or the Federal Trade Commission's advisory opinion procedure contained at 16 C.F.R. §§ 1.1-1.4 (1993). The Agencies will respond to a business review or advisory opinion request on behalf of providers who are considering jointly providing such information within 90 days after all necessary information is submitted. The Department's December 1, 1992 announcement contains specific guidance as to the information that should be submitted.

5. STATEMENT OF DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION ENFORCEMENT POLICY ON PROVIDERS' PROVISION OF FEE-RELATED INFORMATION TO PURCHASERS OF HEALTH CARE SERVICES

Introduction

The collective provision by competing health care providers to purchasers of health care services of factual information concerning the fees charged currently or in the past for the providers' services, and other factual information concerning the amounts, levels, or methods of fees or reimbursement, does not necessarily raise antitrust concerns. With reasonable safeguards, providers' collective provision of this type of factual information to a purchaser of health care services may provide procompetitive benefits and raise little risk of anticompetitive effects.

This statement sets forth an antitrust safety zone that describes collective provision of fee-related information that will not be challenged by the Agencies under the antitrust laws, absent extraordinary circumstances.[14] It also describes types of conduct that are expressly excluded from the antitrust safety

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[14] This statement is limited to providers' collective activities. As a general proposition, providers acting individually may provide any information to any purchaser or payer without incurring liability under federal antitrust law. Moreover, this statement is limited to the collective provision of information other than through an integrated joint venture. The joint provision to purchasers of information and views about aspects of the integrated joint venture's legitimate activities generally does not raise antitrust concerns.

zone, some clearly unlawful, and others that may be lawful depending on the circumstances.

A. Antitrust Safety Zone: Providers' Collective Provision Of Fee-Related Information That Will Not Be Challenged, Absent Extraordinary Circumstances, By The Agencies

Providers' collective provision to purchasers of health care services of factual information concerning the providers' current or historical fees or other aspects of reimbursement, such as discounts or alternative reimbursement methods accepted (including capitation arrangements, fee risk withhold arrangements, or use of global fees), is unlikely to raise significant antitrust concern and will not be challenged by the Agencies, absent extraordinary circumstances. Such factual information can help purchasers efficiently to develop reimbursement terms to be offered to providers. The information may be useful to a purchaser when it is provided in response to a request from the purchaser or at the initiative of physicians.

In assembling information to be collectively provided to purchasers, providers need to be aware of the potential antitrust consequences of information exchanges among competitors. The principles expressed in the Agencies' Statement on Provider Participation in Exchanges of Price and Cost Information are applicable in this context. Accordingly, in order to qualify for this safety zone, the collection of information to be provided to purchasers or payers must satisfy the following conditions:

(1) the collection is managed by a third party;

(2) although current fee-related information may be provided to purchasers, any information that is shared among or is made available to the competing providers providing the data must be more than three months old; and

(3) for any information that is available to the providers providing data, there must be at least five providers reporting data upon which each disseminated statistic is based, no individual provider's data may represent more than 25 percent on a weighted basis of that statistic, and any information disseminated must be sufficiently aggregated such that it would not allow recipients to identify the prices charged by any individual provider.

B. The Agencies' Analysis Of Providers' Collective Provision Of Fee-Related Information That Falls Outside The Antitrust Safety Zone

The safety zone set forth in this policy statement does not apply to negotiations by or among unintegrated providers in contemplation of any agreement that would bind the purchasers or the providers,[15] or to any agreement among providers to deal with purchasers only on agreed terms. Providers also may not collectively threaten, implictly or explicitly, to engage in a boycott or similar conduct, or actually undertake such a boycott or conduct, to coerce any purchaser to accept collectively-determined fees or other terms or aspects of reimbursement. These types of conduct likely would violate the antitrust laws and, in many instances, might be per se illegal.

Also excluded from the safety zone is providers' collective provision of information or views concerning future-oriented fee-related matters. In some circumstances, the collective provision

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[15] Whether communications between providers and purchasers will amount to negotiations depends on the nature of the communications, not solely the number of such communications.

of this type fee-related information also may be helpful to purchasers and not raise antitrust concerns. However, in other circumstances, the collective provision of future-oriented information or views may evidence an underlying agreement on prices or terms of dealing by the competing providers. It also may exert a coercive effect on the purchaser by implying or threatening a collective refusal to deal on terms other than those proposed, or amount to an implied threat to boycott any plan that does not follow the providers' collective joint proposal.

Because of the need carefully to distinguish possibly procompetitive collective provision of future-oriented fee-related information or views from anticompetitive situations that involve unlawful price agreements, boycott threats, refusals to deal except on collectively determined terms, and collective negotiations, the collective provision of such future-oriented information or views will be assessed on a case-by-case basis. While not dispositive, the provision of future-oriented fee-related information or views is less likely to raise competitive concerns where the information or views are provided in response to a request from a purchaser, such as where a purchaser asks providers for an analysis or critique of a proposed reimbursement system. Likewise, the agencies are likely to have less antitrust concern where the information or views relate to a narrow issue, such as the reimbursement level for an innovative or otherwise uncommon medical procedure, rather than where they deal with a

broad aspect of fees or reimbursement, such as an entire fee schedule or a general method or aspect of reimbursement (for example, capitation, establishment of fee withhold levels, the setting of "usual, customary, and reasonable" fee levels or screens, or discounts from usual fee levels).

In addition, because the collective provision of future-oriented information and views can easily lead to, or accompany, unlawful negotiations, price agreements, or the other types of unlawful coercive conduct noted above, providers need to be aware of the potential antitrust consequences of information exchanges among competitors in assembling information or views concerning future-oriented fee-related matters. Consequently, such protections as the use of a third party to manage the collection of information and views, and the adoption of mechanisms to assure that the information is not disseminated or used in a manner that facilitates unlawful agreements or coordinated conduct by the providers, likely would reduce antitrust concerns.

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This Statement discusses how providers, with appropriate safeguards, may collectively provide fee-related information to purchasers, while at the same time assuring that such activities do not involve or lead to anticompetitive conduct. Competing providers who are considering collectively providing fee-related information to purchasers, and are unsure of the legality of their conduct under the antitrust laws, can take advantage of the Department of Justice's expedited business review procedure

announced on December 1, 1992 (58 Fed. Reg. 6132 (1993)) or the Federal Trade Commission's advisory opinion procedure contained at 16 C.F.R. §§ 1.1-1.4 (1993). The Agencies will respond to a business review or advisory opinion request on behalf of providers who are considering collectively providing fee-related information within 90 days after all necessary information is submitted. The Department's December 1, 1992 announcement contains specific guidance as to the information that should be submitted.

6. STATEMENT OF DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION ENFORCEMENT POLICY ON PROVIDER PARTICIPATION IN EXCHANGES OF PRICE AND COST INFORMATION

Introduction

Participation by competing providers in surveys of prices for medical services, or surveys of salaries, wages or benefits of hospital personnel, does not necessarily raise antitrust concerns. In fact, such surveys can have significant benefits for health care consumers. Providers can use information derived from price and compensation surveys to price their services more competitively and to offer compensation that attracts highly qualified personnel. Purchasers also can use price survey information to make more informed decisions when buying medical services. Without appropriate safeguards, however, information exchanges among competing providers may facilitate collusion or otherwise reduce competition on prices or compensation, resulting in increased prices, or reduced quality and availability of medical services. A collusive restriction on the compensation paid to medical employees, for example, could create personnel shortages that would adversely affect the availability of health care services.

This statement sets forth an antitrust safety zone that describes exchanges of price and cost information among providers that will not be challenged by the Agencies under the antitrust laws, absent extraordinary circumstances. It also

briefly describes the Agencies' antitrust analysis of information exchanges that fall outside the antitrust safety zone.

A. *Antitrust Safety Zone:* Exchanges of Price and Cost Information Among Providers That Will Not Be Challenged, Absent Extraordinary Circumstances, By The Agencies

The Agencies will not challenge, absent extraordinary circumstances, provider participation in written surveys of (a) prices for medical services,[16] or (b) wages, salaries or benefits of medical personnel, if the following conditions are satisfied:

(1) the survey is managed by a third-party (e.g., a purchaser, government agency, health care consultant, academic institution, or trade association);

(2) the information provided by survey participants is based on data more than 3 months old; and

(3) there are at least five providers reporting data upon which each disseminated statistic is based, no individual provider's data represents more than 25 percent on a weighted basis of that statistic, and any information disseminated is sufficiently aggregated such that it would not allow recipients to identify the prices charged or compensation paid by any particular provider.

The conditions that must be met for an information exchange among providers to fall within the antitrust safety zone are intended to ensure that an exchange of price or cost data is not

[16]The "prices" at which providers offer their services to purchasers can take many forms, including billed charges for individual services, discounts off billed charges, or per diem, capitated, or diagnosis related group rates.

used by competing providers for discussion or coordination of provider prices or costs. They represent a careful balancing between a provider's individual interest in obtaining information useful in adjusting the prices it charges or the wages it pays in response to changing market conditions against the risk that the exchange of such information may permit competing providers to communicate with each other regarding a mutually acceptable level of prices for medical services or compensation for employees.

B. The Agencies' Analysis of Provider Exchanges of Information That Fall Outside the Antitrust Safety Zone

Exchanges of price and cost information that fall outside the antitrust safety zone generally will be evaluated to determine whether the information exchange may have an anticompetitive effect that outweighs any procompetitive justification for the exchange. Depending on the circumstances, public, non-provider initiated surveys may not raise competitive concerns. Such surveys could allow purchasers to have useful information that they can use for procompetitive purposes.

Exchanges of future prices for provider services or future compensation of employees are very likely to be considered anticompetitive. If an exchange among competing providers of price or cost information results in an agreement among competitors as to the prices for medical services or the wages to be paid to medical employees, that agreement will be considered unlawful per se.

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Competing providers that are considering participating in a survey of price or cost data and are unsure of the legality of their conduct under the antitrust laws can take advantage of the Department's expedited business review procedure announced on December 1, 1992 (58 Fed. Reg. 6132 (1993)) or the Federal Trade Commission's advisory opinion procedure contained at 16 C.F.R. §§ 1.1-1.4 (1993). The Agencies will respond to a business review or advisory opinion request on behalf of providers who are considering exchanging information within 90 days after all necessary information is submitted. The Department's December 1, 1992 announcement contains specific guidance as to the information that should be submitted.

7. STATEMENT OF DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION ENFORCEMENT POLICY ON JOINT PURCHASING ARRANGEMENTS AMONG HEALTH CARE PROVIDERS

Introduction

Most joint purchasing arrangements among hospitals or other health care providers do not raise antitrust concerns. Such collaborative activities typically allow the participants to achieve efficiencies that will benefit consumers. Joint purchasing arrangements usually involve the purchase of a product or service used in providing the ultimate package of health care services or products sold by the participants. Examples include the purchase of laundry or food services by hospitals, the purchase of computer or data processing services by hospitals or other groups of providers, and the purchase of prescription drugs and other pharmaceutical products. Through such joint purchasing arrangements, the participants frequently can obtain volume discounts, reduce transaction costs, and have access to consulting advice that may not be available to each participant on its own.

Joint purchasing arrangements are unlikely to raise antitrust concerns unless (1) the arrangement accounts for so large a portion of the purchases of a product or service that it can effectively exercise market power[17] in the purchase of the product or service, or (2) the products or services being

[17]In the case of a purchaser, this is the power to drive down the price of goods or services being purchased below competitive levels.

purchased jointly account for so large a proportion of the total cost of the services being sold by the participants that the joint purchasing arrangement may facilitate price fixing or otherwise reduce competition. If neither factor is present, the joint purchasing arrangement will not present competitive concerns.[18]

This statement sets forth an antitrust safety zone that describes joint purchasing arrangements among health care providers that will not be challenged, absent extraordinary circumstances, by the Agencies under the antitrust laws. It also describes factors that mitigate any competitive concerns with joint purchasing arrangements that fall outside the antitrust safety zone.[19]

A. *Antitrust Safety Zone:* Joint Purchasing Arrangements Among Health Care Providers That Will Not Be Challenged, Absent Extraordinary Circumstances, By The Agencies

The Agencies will not challenge, absent extraordinary circumstances, any joint purchasing arrangement among health

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[18]An agreement among purchasers that simply fixes the price that each purchaser will pay or offer to pay for a product or service is not a legitimate joint purchasing arrangement and is a per se antitrust violation. Legitimate joint purchasing arrangements provide some integration of purchasing functions to achieve efficiencies.

[19]This statement applies to purchasing arrangements through which the participants acquire products or services for their own use, not arrangements in which the participants are jointly investing in equipment or providing a service. Joint ventures involving investment in equipment and the provision of services are discussed in separate policy statements.

care providers where two conditions are present: (1) the purchases account for less than 35 percent of the total sales of the purchased product or service in the relevant market; and (2) the cost of the products and services purchased jointly accounts for less than 20 percent of the total revenues from all products or services sold by each competing participant in the joint purchasing arrangement.

The first condition compares the purchases accounted for by a joint purchasing arrangement to the total purchases of the purchased product or service in the relevant market. Its purpose is to determine whether the joint purchasing arrangement might be able to drive down the price of the product or service being purchased below competitive levels. For example, a joint purchasing arrangement may account for all or most of the purchases of laundry services by hospitals in a particular market, but represent less than 35 percent of the purchases of all commercial laundry services in that market. Unless there are special costs that cannot be easily recovered associated with providing laundry services to hospitals, such a purchasing arrangement is not likely to force prices below competitive levels. The same principle applies to joint purchasing arrangements for food services, data processing, and many other products and services.

The second condition addresses any possibility that a joint purchasing arrangement might result in standardized costs, thus facilitating price fixing or otherwise having anticompetitive

effects. This condition applies only where some or all of the participants are direct competitors. For example, if a nationwide purchasing cooperative limits its membership to one hospital in each geographic area, there is not likely to be any concern about reduction of competition among its members. Even where a purchasing arrangement's membership includes hospitals or other health care providers that compete with one another, the arrangement is not likely to facilitate collusion if the goods and services being purchased jointly account for a small fraction of the final price of the services provided by the participants. In the health care field, it may be difficult to determine the specific final service in which the jointly purchased products are used, as well as the price at which that final service is sold.[20] Therefore, the Agencies will examine whether the cost of the products or services being purchased jointly accounts, in the aggregate, for less than 20 percent of the total revenues from all health care services of each competing participant.

B. Factors Mitigating Competitive Concerns With Joint Purchasing Arrangements That Fall Outside The Antitrust Safety Zone

Joint purchasing arrangements among hospitals or other health care providers that fall outside the antitrust safety zone do not necessarily raise antitrust concerns. There are several

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[20]This especially is true because some large payers negotiate prices with hospitals and other providers that encompass a group of services, while others pay separately for each service.

safeguards that joint purchasing arrangements can adopt to mitigate concerns that might otherwise arise. First, antitrust concern is lessened if members are not required to use the arrangement for all their purchases of a particular product or service. Members can, however, be asked to commit to purchase a voluntarily specified amount through the arrangement so that a volume discount or other favorable contract can be negotiated. Second, where negotiations are conducted on behalf of the joint purchasing arrangement by an independent employee or agent who is not also an employee of a participant, antitrust risk is lowered. Third, the likelihood of anticompetitive communications is lessened where communications between the purchasing group and each individual participant are kept confidential, and not discussed with, or disseminated to, other participants.

These safeguards will reduce substantially, if not completely eliminate, use of the purchasing arrangement as a vehicle for discussing and coordinating the prices of health care services offered by the participants.[21] The adoption of these safeguards also will help demonstrate that the joint purchasing arrangement is intended to achieve economic efficiencies rather than to serve an anticompetitive purpose. Where there appear to be significant efficiencies from a joint

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[21]Obviously, if the members of a legitimate purchasing group engage in price fixing or other collusive anticompetitive conduct as to services sold by the participants, whether through the arrangement or independently, they remain fully subject to antitrust challenge.

purchasing arrangement, the Agencies will not challenge the arrangement absent substantial risk of anticompetitive effects.

The existence of a large number and variety of purchasing groups in the health care field suggests that entry barriers to forming new groups currently are not great. Thus, in most circumstances at present, it is not necessary to open a joint purchasing arrangement to all competitors in the market. The exclusion from the arrangement of some competitors will raise antitrust concerns only if those who are excluded are put at a significant competitive disadvantage in competing with the participants.

C. Example

1. Joint Purchasing Arrangement Involving Both Hospitals in Rural Community That the Agencies Would Not Challenge

Smalltown is the county seat of Rural County. There are two general acute care hospitals, County Hospital ("County") and Smalltown Medical Center ("SMC"), both located in Smalltown. The nearest other hospitals are located in Big City, about 100 miles from Smalltown.

County and SMC propose to join a joint venture being formed by several of the hospitals in Big City through which they will purchase various hospital supplies--e.g., bandages, antiseptics, surgical gowns and masks. The joint venture will likely be the vehicle for the purchase of most such products by the Smalltown hospitals, but under the joint venture agreement, both retain the option to purchase supplies independently.

The joint venture will be an independent corporation, jointly owned by the participating hospitals. It will purchase the supplies needed by the hospitals and then resell them to the hospitals at average variable cost plus a reasonable return on capital. The joint venture will periodically solicit from each participating hospital its expected needs for various hospital supplies, and negotiate the best terms possible for the combined purchases. It will also purchase supplies for its member hospitals on an ad hoc basis.

Competitive Analysis

A key issue in this situation is whether the proposed joint purchasing arrangement would fall within the safety zone set forth in this policy statement. In order to make this determination, the Agencies would first inquire whether the joint purchases would account for less than 35 percent of the total sales of the purchased products in the relevant markets for the sales of those products. Here, the relevant hospital supply markets are likely to be national or at least regional in scope. Thus, while County and SMC might well account for more than 35 percent of the total sales of many hospital supplies in Smalltown or Rural County, they and the other hospitals in Big City that will participate in the arrangement together would likely not account for significant percentages of sales in the actual relevant markets. Thus, the first criterion for inclusion in the safety zone is likely to be satisfied.

The Agencies would then inquire whether the supplies to be purchased jointly account for less than 20 percent of the total revenues from all products and services sold by each of the competing hospitals that participate in the arrangement. In this case, County and SMC are competing hospitals, but this second criterion for inclusion in the safety zone is also likely to be satisfied, and the Agencies would not challenge the joint purchasing arrangement.

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Hospitals or other health care providers that are considering joint purchasing arrangements and are unsure of the legality of their conduct under the antitrust laws can take advantage of the Department of Justice's expedited business review procedure for joint ventures and information exchanges announced on December 1, 1992 (58 Fed. Reg. 6132 (1993)) or the Federal Trade Commission's advisory opinion procedure contained at 16 C.F.R. §§ 1.1-1.4 (1993). The Agencies will respond to a business review or advisory opinion request on behalf of a health care provider joint purchasing arrangement within 90 days after all necessary information is submitted. The Department's December 1, 1992 announcement contains specific guidance as to the information that should be submitted.

8. STATEMENT OF DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION ENFORCEMENT POLICY ON PHYSICIAN NETWORK JOINT VENTURES

Introduction

In recent years, many independent physicians and physician groups have organized individual practice associations ("IPAs"), preferred provider organizations ("PPOs"), and similar physician network joint ventures to market their services to health insurance plans and other purchasers.[22] Typically, such ventures contract to provide physician services to plan subscribers at reduced prices, and commit to utilization review and other limits on the provision of unnecessary care. Because of their potential for providing quality services at reduced costs, IPAs, PPOs, and similar physician network joint ventures promise significant procompetitive benefits for consumers of health care services.

As used in this policy statement, a physician network joint venture is a physician-controlled venture that jointly markets the services of its member physicians. Other types of health care network joint ventures are not addressed by this policy statement. For example, joint ventures that do invovle coordination or restraint of prices or other significant terms of

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[22]An IPA or PPO typically provides medical services to the subscribers of health insurance plans, but it does not act as the insurer of the subscribers. In addition, an IPA or PPO does not require complete integration of the medical practices of its member physicians. Such physicians typically continue to compete for patients who are enrolled in health insurance plans not served by the IPA or PPO.

competition typically do not raise significant competitive concerns.

This statement of enforcement policy sets forth antitrust safety zones that describe physician network joint ventures that will not be challenged, absent extraordinary circumstances, by the Agencies under the antitrust laws.[23] As set forth below, the antitrust safety zones differ for "exclusive" and "non-exclusive" physician network joint ventures. An "exclusive" venture significantly restricts the ability of its members to affiliate with other physician network joint ventures and to contract individually with health insurance plans. A "non-exclusive" venture, on the other hand, does not impose any significant explicit or implicit restriction on the ability of its members either to affiliate with other organizations or contract individually with plans.

This statement also describes the Agencies' antitrust analysis of physician network joint ventures that fall outside the antitrust safety zones and presents examples of its application to physician network joint ventures.

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[23]Although this statement refers to IPAs and PPOs as examples of physician network joint ventures, the Agencies' competitive analysis focuses on the substance of such arrangements, not on their formal title. This policy statement applies, therefore, to all entities that are substantively equivalent to a physician network joint venture.

A. *Antitrust Safety Zone*: Exclusive Physician Network Joint Ventures That Will Not Be Challenged, Absent Extraordinary Circumstances, By The Agencies

The Agencies will not challenge, absent extraordinary circumstances, an exclusive physician network joint venture comprised of 20 percent or less of the physicians in each physician specialty with active hospital staff privileges who practice in the relevant geographic market[24] and share substantial financial risk. In relevant markets with less than five physicians in a particular specialty, a physician network joint venture otherwise qualifying for the antitrust safety zone may include one physician from that specialty even though the inclusion of that physician results in a physician network joint venture consisting of more than 20 percent of the physicians in that specialty.[25]

B. *Antitrust Safety Zone*: Non-exclusive Physician Network Joint Ventures That Will Not Be Challenged, Absent Extraordinary Circumstances, By the Agencies

The Agencies will not challenge, absent extraordinary circumstances, a non-exclusive physician network joint venture comprised of 30 percent or less of the physicians in each physician specialty with active hospital staff privileges who

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[24]Generally, relevant geographic markets for the delivery of physician services are localized.

[25]For purposes of the antitrust safety zones, in calculating the number of physicians in a relevant market and the number participating in a physician network joint venture, each physician ordinarily will be counted individually, whether the physician practices in a group or solo practice.

practice in the relevant geographic market and share substantial financial risk. In relevant markets with less than four physicians in a particular specialty, a non-exclusive physician network joint venture otherwise qualifying for the antitrust safety zone may include one physician from that specialty even though the inclusion of that physician results in a physician network joint venture consisting of more than 30 percent of the physicians in that specialty.

Because of the different market share thresholds for the safety zones for exclusive and non-exclusive physician network joint ventures, the Agencies caution participants in a non-exclusive physician network joint venture to be sure that the network is non-exclusive in fact and not just in name. The Agencies will determine whether a physician network joint venture is exclusive or non-exclusive by its and its members' activities and not simply by the terms of the contractual relationship. In making that determination the Agencies will examine the following indicia of non-exclusivity, among others:

(1) That viable competing networks or plans with adequate provider participation currently exist in the market;

(2) That providers in the network actually participate in other networks or contract individually with health insurance plans;

(3) That providers in the network earn substantial revenue outside the network;

(4) The absence of any indications of significant de-participation from other networks in the market; and

(5) The absence of any indications of coordination among the providers in the network regarding the terms of participation in other networks or plans.

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To qualify for either antitrust safety zone, the physicians participating in a physician network joint venture must share substantial financial risk. The following are examples of situations in which substantial financial risks are shared among members of a physician network joint venture:

(1) when the venture agrees to provide services to a health insurance plan at a "capitated" rate;[26] or

(2) when the venture creates significant financial incentives for its members as a group to achieve specified cost-containment goals, such as withholding from all members a substantial amount of the compensation due to them, with distribution of that amount to the members only if the cost-containment goals are met.

C. The Agencies' Analysis Of Physician Network Joint Ventures That Fall Outside The Antitrust Safety Zone

Physician network joint ventures that fall outside the antitrust safety zone do not necessarily raise substantial antitrust concerns. Indeed, even joint ventures that contain a higher percentage of physicians in a relevant market than the percentages falling within the respective safety zones can be procompetitive. Physician network joint ventures will be

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[26] A "capitated" rate is a fixed, predetermined payment per covered life (the "capitation") from a health insurance plan to the joint venture in exchange for the joint venture's providing and guaranteeing provision of a defined set of covered services to covered individuals for a specified period of time, regardless of the amount of services actually provided.

reviewed under a rule of reason analysis and not viewed as per se illegal[27] either if the physicians in the joint venture share substantial financial risk or if the combining of the physicians into a joint venture enables them to offer a new product producing substantial efficiencies. A rule of reason analysis determines whether the joint venture may have a substantial anticompetitive effect and, if so, whether that potential effect is outweighed by any procompetitive efficiencies resulting from the joint venture. The rule of reason analysis is flexible, and takes into account all characteristics of the particular physician network joint venture that bear on its likely effect on competition. The steps involved in a rule of reason analysis of physician network joint ventures are set forth below.

Step one: Define the relevant market. The rule of reason analysis first identifies the relevant services that the physician network joint venture provides. Although all services provided by each physician specialty ordinarily will be considered a separate relevant service market, there may be instances in which significant overlap of services provided by different specialties of physicians justifies including physicians from more than one specialty in the same market. For each relevant service market, the relevant geographic market will include all physicians whom

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[27]This statement assumes that the joint venture is not likely merely to restrict competition and decrease output, such as, for example, an agreement among physicians that simply fixes the price that each purchaser will pay.

health insurance plans and their subscribers consider to be good substitutes for physicians participating in the joint venture.

Step two: Evaluate the competitive effects of the physician joint venture. The structure and activities of the physician network joint venture and the nature of competition in the relevant market are examined to determine whether the formation or operation of the venture is likely to have an anticompetitive effect. Two key areas of competitive concern are whether a physician network joint venture could raise the prices for physician services charged to health insurance plans above competitive levels or prevent the formation of other physician network joint ventures that would compete with it.

If in the relevant market there are many other physician network joint ventures or many physicians who would be available to form competing physician network joint ventures or be available to contract directly with health insurance plans, it is unlikely that the joint venture would raise any competitive concerns. In assessing the availability of physicians in the relevant market for forming competing physician network joint ventures, it will be necessary to analyze both the number of physicians in each relevant service market and the competitive significance of the exclusive or non-exclusive nature of the physician network joint venture. If a physician network joint venture is non-exclusive, the anticompetitive risks posed by such a venture may be substantially less than if the participating

physicians had formed an exclusive physician network joint venture.[28]

Step three: Evaluate the impact of procompetitive efficiencies. This step requires an examination of the venture's potential to create procompetitive efficiencies, and the balancing of these efficiencies against any potential anticompetitive effects. The potential of physician network joint ventures to generate efficiencies by lowering the costs of health care to consumers can vary substantially. Efficiencies that the Agencies are most likely to recognize include any cost savings associated with the assumption of financial risk by the participating physicians. The Agencies will also consider other possible efficiencies, such as reduced administrative costs, improved utilization review, improved case management, quality assurance and economies of scale.

Step four: Evaluation of ancillary agreements. This step determines whether the physician network joint venture includes ancillary agreements or conditions that unreasonably restrict competition and are unlikely to contribute significantly to the legitimate purposes of the physician network joint venture. For example, if the physicians participating in a joint venture agree on the prices they will charge patients who are not covered by the health insurance plans with which their joint venture contracts,

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[28]If steps one and two reveal no competitive concerns with the physician network joint venture, step three is unnecessary, and the analysis continues with step four below.

such an agreement plainly is unnecessary to the success of the joint venture and is an antitrust violation.[29]

D. Examples of Physician Network Joint Ventures That The Agencies Would Not Challenge

The following are examples of physician network joint ventures that are unlikely to raise significant antitrust concerns. Each is intended to demonstrate an aspect of the analysis that would be used to evaluate such ventures under this policy statement.

1. Physician Network Joint Venture Comprising More Than 20 Percent Of Physicians with Active Admitting Privileges At a Hospital

County Seat is a relatively isolated, medium-sized community of about 350,000 residents. The closest town is 50 miles away. County Seat has five general acute care hospitals, which offer a mix of basic primary, secondary, and tertiary care services.

A total of 500 physicians have medical practices based in County Seat, and all maintain active admitting privileges at one or more of County Seat's hospitals. No physician from outside County Seat has any type of admitting privileges at a County Seat hospital. The physicians represent 10 different specialties and are distributed evenly among the specialties, with 50 doctors practicing each specialty.

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[29]This analysis of ancillary agreements also applies to physician network joint ventures that fall within the antitrust safety zones.

One hundred physicians (also distributed evenly among specialties) maintain active admitting privileges at County Seat Medical Center. County Seat's other 400 physicians maintain active admitting privileges at other County Seat hospitals.

Half of County Seat Medical Center's 100 active admitting physicians propose to form an IPA to market their services to purchasers of health care services. The physicians are divided evenly among the specialties. Under the proposed arrangement, the physicians participating in the joint venture would agree to meaningful cost containment and quality goals, including utilization review, quality assurance, and other measures designed to reduce the provision of unnecessary care to the plan's subscribers, and a substantial amount (in this example 20 percent) of the compensation due to member physicians would be withheld and distributed only if these measures are successfully met. This physician network joint venture would be exclusive in that participating physicians would not be free to contract individually with health insurance plans or to join other physician joint ventures.

A number of health insurance plans that contract selectively with hospitals and physicians already operate in County Seat. These plans as well as local employers agree that other County Seat physicians, and the hospitals to which they admit, are good substitutes for the active admitting physicians and the inpatient services provided at County Seat Medical Center. Physicians with medical practices based outside County Seat, however, are not

good substitutes for area physicians, because such physicians would find it inconvenient to practice at County Seat hospitals due to the distance between their practice locations and County Seat.

Competitive Analysis

A key issue is whether a physician network joint venture, such as this IPA, comprised of 50 percent of the physicians in each practice specialty with active privileges at one of five comparable hospitals in County Seat would fall within the antitrust safety zone. The physicians within the joint venture represent less than 20 percent of all the physicians in each specialty in County Seat.

County Seat is the relevant geographic market for purposes of analyzing the competitive effects of this proposed physician joint venture. Within each specialty, physicians with admitting privileges at area hospitals are good substitutes for one another. However, physicians with practices based elsewhere are not considered good substitutes.

For purposes of analyzing the effects of the venture, all of the physicians in County Seat should be considered market participants. Purchasers of health care services consider all physicians within each specialty, and the hospitals at which they have admitting privileges, to be relatively interchangeable. Thus, in this example, any attempt by the joint venture's participants collectively to increase the price of physician

services above competitive levels would likely lead third-party payers to recruit nonparticipating physicians at County Seat Medical Center or other area hospitals.

Because physician network joint venture participants comprise less than 20 percent of each group of specialists in County Seat and because the physicians agreed to share substantial financial risk, this proposed joint venture would fall within the antitrust safety zone.

2. Physician Network Joint Venture With A Large Market Share In A Relatively Small Community

Smalltown has a population of 25,000, a single hospital, and 50 physicians, most of whom are family practitioners. All the physicians practice exclusively in Smalltown and have active admitting privileges at the Smalltown hospital. The closest urban area, Big City, is located some 35 miles away and has a population of 500,000. A little more than half of Smalltown's working adults commute to work in Big City. Some of the health insurance plans used by employers in Big City are interested in extending their network of providers to Smalltown to provide coverage for subscribers who live in Smalltown, but commute to work in Big City (coverage is to include the families of commuting subscribers). However, the number of commuting Smalltown subscribers is a small fraction of the Big City employers' total workforce.

Responding to these employers' needs, a few health insurance plans have asked physicians in Smalltown to organize a

nonexclusive IPA large enough to provide a reasonable choice to subscribers who reside in Smalltown, but commute to work in Big City. Because of the relatively small number of potential enrollees in Smalltown, the plans prefer to contract with such a physician network joint venture, rather than engage in what may prove to be a time-consuming series of negotiations with individual Smalltown physicians to establish a panel of physician providers there.

A number of Smalltown physicians have agreed to form a physician network joint venture. The joint venture will contract with health insurance plans to provide physician services to subscribers of the plans in exchange for a monthly capitation fee paid for each of the plans' subscribers. The physicians forming this joint venture would constitute about half of the total number of physicians in Smalltown. They would represent about 35 percent of the town's family practitioners, but higher percentages of the town's general surgeons (50 percent), pediatricians (50 percent), and obstetricians (67 percent). The health insurance plans that serve Big City employers say that the IPA must have a large percentage of Smalltown physicians to provide adequate coverage for employees and their families in Smalltown and in a few scattered rural communities in the immediate area and to allow the doctors to provide coverage for each other.

In this example, other health insurance plans already have entered Smalltown, and contracted with individual physicians.

They have made substantial inroads with Smalltown employers, signing up a large number of enrollees. None of these plans has had any difficulty contracting with individual physicians, including many who would participate in the proposed joint venture.

Finally, the evidence indicates that Smalltown is the relevant geographic market for all physician services. Physicians in Big City are not good substitutes for a significant number of smalltown residents.

Competitive Analysis

This proposed physician network joint venture would not fall within the antitrust safety zone because it would be comprised of over 30 percent of the physicians practitioners in a number of relevant specialties in the geographic market. However, the Agencies would not challenge the joint venture because a rule of reason analysis indicates that its formation would not likely hamper the ability of health insurance plans to contract individually with area physicians or with other physician network joint ventures. In addition, the joint venture is likely to result in cost savings because the physicians have agreed to accept capitated fees.

That health insurance plans have requested formation of this venture also is significant, for it suggests that the joint venture would offer additional efficiencies. In this instance, it appears to be a low-cost method for plans to enter an area

without investing in costly negotiations to identify and contract with individual physicians.

Moreover, in small markets such as Smalltown, it may be necessary for purchasers of health care services to contract with a relatively large number of physicians to provide adequate coverage and choice for enrollees. For instance, if there were only three obstetricians in Smalltown, it would not be possible for a physician network joint venture offering obstetrical services to have less than 33 percent of the obstetricians in the relevant area. Furthermore, it may be impractical to have less than 67 percent in the plan, because two obstetricians may be needed in the venture to provide coverage for each other.

Despite the joint venture's relatively large market share of some specialists, it appears unlikely to have anticompetitive effects because of three factors: the demonstrated ability of health insurance plans to contract with physicians individually, if they so desire; the possibility that other physician network joint ventures could be formed; and the benefits that health insurance plans perceive in obtaining the coverage provided by this physician network joint venture. Therefore, the Agencies would not challenge this physician network joint venture.

3. Physician Network Joint Venture With A Large Market Share In A Small, Rural County

Rural County has a population of 15,000, a small primary care hospital, and ten physicians, including seven general and family practitioners, an obstetrician, a pediatrician, and a general

surgeon. All the physicians are solo practitioners. The nearest urban area is about 60 miles away in Big City, which has a population of 300,000, and three major hospitals to which patients from Rural County are referred or transferred for higher levels of hospital care. However, Big City is too far away for most residents of Rural County to use for services available in Rural County.

Insurance Company, which operates throughout the state, is attempting to offer "managed care" programs in all areas of the state, and has asked the local physicians in Rural County to form an IPA to provide services under the program to covered persons living in the County. No other managed care plan has attempted to enter the County previously.

Initially, two of the general practitioners and two of the specialist physicians express interest in forming a network, but Insurance Company says that it intends to market its plan to the larger local employers, who need broader geographic and specialty coverage for their employees. Consequently, Insurance Company needs more of the local general practitioners and the one remaining specialist in the IPA in order to provide adequate geographic, "specialty," and backup coverage to subscribers in Rural County. Eventually, four of the seven general practitioners and the one remaining specialist join the IPA and agree to provide services to Insurance Company's subscribers, under contracts providing for capitation. While the physicians' participation in the IPA is structured to be non-exclusive, no

other managed care plan has yet entered the local market or approached any of the physicians about joining a different provider panel. In discussing the formation of the IPA with the Insurance Company, a number of the physicians have made clear their intention to continue to practice outside the IPA and have indicated they would be interested in contracting individually with other managed care plans when those plans expand into Rural County.

Competitive Analysis

This proposed physician network joint venture would not fall within the antitrust safety zone because it would consist of over 30 percent of the general practitioners in the geographic market. Under the circumstances, however, the Agencies would not challenge the formation of the joint venture, for the reasons discussed below.

For purposes of this analysis, Rural County is considered the relevant geographic market. Generally, the Agencies will closely examine joint ventures that comprise a large percentage of physicians in the relevant market. However, in this case the establishment of the IPA and its inclusion of more than half of the general practitioners and all the specialists in the network is the result of the payer's expressed need to have more of the local physicians in its network in order to sell its product in the market. Thus, the level of physician participation in the

network does not appear to be overinclusive, but rather appears to be the minimum necessary to meet the employers' needs.

While the IPA has more than half of the general practitioners and all of the specialists in it, under the particular circumstances this does not, by itself, raise sufficient concerns of possible foreclosure of entry by other managed care plans to warrant antitrust challenge to the joint venture by the Agencies. Because it is the first such joint venture in the County, there is no way absolutely to verify at the outset that the joint venture in fact will be non-exclusive. However, the physicians' participation in the IPA is formally non-exclusive, and they have expressed a willingness to consider joining other managed care programs if they begin operating in the area. Moreover, the three general practitioners who are not members of the IPA are available to contract with other managed care plans. The IPA also was established with participation by the local area physicians at the request of the Insurance Company, indicating that this structure was not undertaken as a means for the physicians to increase prices or prevent entry of managed care plans. Given these facts, the Agencies would not challenge the joint venture. However, they would caution the parties that if it later became apparent that the physicians' participation in the joint venture in fact was exclusive, and consequently other managed care plans that wanted to enter the market and contract with some or all of the physicians at competitive terms were unable to do so, the Agencies would have to re-examine the joint

venture's legality. The joint venture also would raise antitrust concerns if it appeared that participation by all the local physicians in the joint venture resulted in anticompetitive effects in markets outside the joint venture, such as uniformity of fees charged by the physicians in their solo medical practices.

Finally, the joint venture can benefit consumers in Rural County through the creation of efficiencies. The physicians have jointly put themselves at financial risk for controlling the use and cost of health care services through capitation. In order to make the capitation arrangement financially viable, the physicians will have to control the use and cost of health care services they provide under Insurance Company's program. Through the physicians' network joint venture, Rural County residents will be offered a beneficial product, while competition among the physicians outside the network will continue.

4. Physician Network Joint Venture With All The Physicians In A Small, Rural County

Rural County has a population of 10,000, a small primary care hospital, and six physicians, consisting of a group practice of three family practitioners, a general practitioner, an obstetrician and a general surgeon. The nearest urban area is about 75 miles away in Big City, which has a population of 200,000, and two major hospitals to which patients from Rural County are referred or transferred for higher levels of hospital

care. However, Big City is too far away for most residents of Rural County to use for services available in Rural County.

HealthCare, a managed care plan headquartered in another state, is thinking of marketing a plan to the larger employers in Rural County. However, it finds that the cost of contracting individually with providers, administering the system and overseeing the quality of care in Rural County is too high on a per capita basis to allow it to convince employers to switch from indemnity plans to its plan. HealthCare believes its plan would be more successful if it offered higher quality and better access to care by opening a clinic in the northern part of the County where no physicians currently practice.

All of the local physicians approach HealthCare about contracting with their recently-formed, non-exclusive, IPA. The physicians are willing to agree through their IPA to provide on a rotating basis coverage at the new clinic that HealthCare will establish in the north and to implement the utilization review procedures that HealthCare has adopted in other parts of the state.

HealthCare wants to negotiate with the new IPA. It believes that the local physicians collectively can operate the new clinic more efficiently than it can from its distant headquarters, but HealthCare also feels that collectively negotiating with all of the physicians will result in it having to pay higher fees or capitation rates. So it encourages the IPA to appoint a non-physician agent to negotiate the non-fee related aspects of the

contracts and to facilitate fee negotiations with the group practice and the individual doctors. The group practice and the individual physicians each will sign and negotiate their own individual contract as to fees and will unilaterally determine whether to contract with HealthCare, but will agree through the IPA to provide physician and administrative and utilization review services to the new clinic. The agent will facilitate these individual fee negotiations by discussing separately and confidentially with each physician the physician's fee demands and presenting the information to HealthCare. No fee information will be passed among the physicians.

Competitive Analysis

For purposes of this analysis, Rural County is considered the relevant geographic market. Generally, the Agencies are concerned with joint ventures that comprise all or a large percentage of the physicians in the relevant market. In this case, however, the joint venture is on balance procompetitive. The potential for competitive harm from the venture is insignificant and far outweighed by the efficiencies likely to be generated by the arrangement.

The physicians are not jointly negotiating fees or exchanging fee information. Therefore, the IPA would be evaluated under a rule of reason rather than per se analysis. Any possible competitive harm would be balanced against any likely

efficiencies to be realized by the venture to see whether, on balance, the IPA is anticompetitive or procompetitive.

It is true that the physicians are jointly negotiating non-price terms of the contract. However, this raises little likelihood of competitive harm. These terms are primarily administrative, such as the number of hours that the new clinic will be open and how HealthCare utilization review procedures will be implemented. In addition, because the IPA is non-exclusive, the potential for competitive harm is further reduced. Its physicians are free to contract with other managed care plans or individually with HealthCare if they desire.

The small risk of anticompetitive harm in this situation is far outweighed by the substantial benefits inuring to the economy from the improvements in the quality of care and access to physician services that the venture will engender. The new clinic in the north will make it easier for residents of that area to receive the care they need. Given these facts, the Agencies would not challenge the joint venture.

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Physicians who are considering forming joint ventures and are unsure of the legality of their conduct under the antitrust laws can take advantage of the Department of Justice's expedited business review procedure for joint ventures and information exchange programs announced on December 1, 1992 (58 Fed. Reg. 6132 (1993)) or the Federal Trade Commission's advisory opinion procedure contained at 16 C.F.R. §§ 1.1-1.4 (1993). The Agencies

will respond to a business review or advisory opinion request on behalf of a physician network joint venture within 90 days after all necessary information is submitted.

9. STATEMENT OF DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION ANALYTICAL PRINCIPLES RELATING TO MULTIPROVIDER NETWORKS

The health care industry is changing rapidly as it looks for new and innovative ways to control costs and efficiently provide quality services. During this period of change, health care providers are forming a wide range of new relationships and affiliations, including networks among otherwise competing providers as well as networks of providers offering services that are either complementary or unrelated to those offered by other participants. These affiliations, frequently referred to as multiprovider networks, can present numerous antitrust questions, particularly if the network is comprised, in whole or in part, of competing providers.

Antitrust law does not prohibit collaborative activity that benefits consumers by producing efficiencies without unduly restricting competition. Antitrust evaluation of a particular collaboration requires information about the efficiencies to be produced and about competitive conditions in the market where the conduct takes place.

Multiprovider networks are ventures among providers jointly to market their services to health insurance plans and other purchasers. Such ventures typically contract to provide services to subscribers at reduced prices, and commit to

utilization review or other limits on the provision of unnecessary care.[30]

Multiprovider networks can vary substantially as to providers included, the types of contractual obligations imposed, competitive conditions, and efficiencies likely to be realized. In addition, health care markets are undergoing rapid change and new types of collaborative activities are emerging. The Agencies do not yet have experience with evaluating the full complement of possible arrangements or the competitive impact of those activities on consumers. Thus, to provide maximum guidance to the health care community at this time, the Agencies are describing the analytical principles they apply rather than issuing a more formal and structured statement of their enforcement policy regarding multiprovider networks.

The Agencies will evaluate a particular multiprovider network to determine whether, on balance, it is procompetitive and beneficial to consumers. That evaluation will be done in accordance with the principles described below. These principles are described in the following order:

1. Integration and Joint Pricing
2. Service Specialization
3. Market Definition

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[30]As used in this Statement, multiprovider networks provide health care services to the subscribers of health insurance plans, but do not necessarily act as the insurer of the subscriber. In addition, a multiprovider network may not require complete integration of the practices of its members. Its providers typically continue to compete for patients who are enrolled in health insurance plans not served by the multiprovider network.

4. Market Concentration

5. Competitive Effects

6. Exclusivity

1. Integration and Joint Pricing

A fundamental principle of antitrust law is the prohibition of competitor price-fixing agreements that are not ancillary (i.e., necessarily related and subordinate) to efficiency-enhancing economic integration. Consequently, in provider networks that include some direct competitors,[31] participants either must avoid price agreements by making unilateral decisions on the prices they will charge, or they must assure that common pricing decisions are ancillary to a significant economic integration among network members that is capable of producing efficiencies.[32]

A network that does not engage in joint fee negotiations or fee setting, or joint agreements on other significant terms of competition, need not be economically integrated. For example, joint fee agreements can be avoided through the use of a "messenger model" arrangement. A messenger model typically involves an agent or third party conveying to purchasers

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[31] A network limited to providers who compete solely in different product or geographic markets generally can agree on the prices to be charged for its members' services without the kind of economic integration discussed below.

[32] The discussion in this section is limited to issues relating to price-fixing. Antitrust issues that can arise from the inclusion in a network of a large proportion of available health care providers in a market are discussed later.

information obtained individually from providers in the network about the prices the network participants are willing to accept,[33] and conveying to providers any contract offers made by purchasers. Each provider then makes an independent, unilateral decision to accept or reject each contract offer. Such networks, when properly designed and administered, rarely present substantial antitrust concerns.

The critical feature of a messenger model network is that individual providers make their own separate, independent decisions about whether to accept or reject a purchaser's proposal, without regard to whether other providers will accept the offer and independent of any influence or views of the agent or third party who is acting as the messenger. Antitrust concerns arise when the messenger seeks to persuade individual providers regarding how they should respond to a particular proposal, disseminates to members other providers' views or intentions as to the proposal, acts as an agent for collective negotiation and agreement by the providers, or otherwise serves to facilitate collusive behavior among network participants.

If a messenger seeks to negotiate or act as the collective bargaining agent for the providers as a group, network participants can run a serious risk of engaging in illegal price-fixing. The critical antitrust issue is whether the arrangement

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[33] Guidance about the antitrust standards applicable to collection of fee information can be found in the DOJ/FTC Antitrust Enforcement Policy Statements on Providers' Provision of Fee-Related Information to Purchasers of Health Care Services and Provider Participation in Exchanges of Price and Cost Information.

actually operates without price-related agreements among the provider members of the network. Use of an intermediary or "independent" third party to convey price offers to payers or to negotiate agreements with payers, or giving to individual providers an opportunity to "opt out" of particular jointly agreed-upon contracts with payers, does not by itself establish that there is no price agreement. On the contrary, to the extent that an agent is authorized by a group of providers to negotiate agreements with payers on price or other terms of dealing, the opportunity to opt out of contracts does not negate the existence of a price agreement or eliminate the antitrust issue.

If a network chooses to use joint pricing among competing hospitals or other providers, the price agreements must be ancillary to the sharing of substantial financial risk or other significant economic integration.[34] Joint pricing entails a significant restriction of competition among network members for contracts with payers. Under the antitrust laws, agreements that otherwise would significantly restrict competition are permissible only if they are reasonably necessary to joint activity that, on balance, promotes competition. Accordingly, the focus of antitrust analysis is the relationship between the agreement that otherwise would be illegal -- in this case, the joint pricing -- and the efficiency that is claimed to justify that agreement. The efficiency must be directly related to the

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[34]Capitation, withholds and global fees/DRG pricing are the most common form of financial risk-sharing.

price agreement, and cannot simply be the reduced costs of negotiating with a single agent rather than having to negotiate prices with each individual network participant, as would result from any price-fixing agreement. For example, an IPA that contracts to treat members of an employee group on a capitation basis[35] must of necessity decide on the capitation rate and how to distribute the income to its members. Since the price agreement among the IPA members on those matters is necessary to the provision of the capitated product, it is not considered illegal price-fixing.

Risk sharing applicable to some services or contracts cannot justify agreements that restrict competition in other areas where there is no significant integration. For example, risk-sharing in connection with joint pricing for IPA patients covered under a capitation arrangement would not justify agreement among those same IPA members on prices to be charged to non-capitated patients -- for instance, patients for whom the IPA had agreed to provide services under a preferred provider organization arrangement with payment being made to individual physicians on a discounted fee-for-service basis. Similarly, agreement on the prices to be charged for medical services furnished by individual providers is not ancillary to cooperation among those providers in matters that do not involve risk sharing, such as the establishment of a utilization review program.

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[35]This example refers to the acceptance of group capitation, rather than separate capitation of individual medical practices.

If a network of providers is financially integrated, the manner of dividing revenues among participants generally does not raise antitrust issues. For example, capitated organizations commonly distribute income among their members using fee-for-service payment with a partial withhold fund to cover the risk of having to provide more services than were originally anticipated.

2. Service Specialization

Analytically, the Agencies approach market allocation arrangements in a similar manner to price agreements. First, it is necessary to define the nature and probable competitive consequences of any agreements among competitors. On the one hand, a market allocation agreement among competitors, standing alone, is per se illegal. Thus, it is illegal for two hospitals that are both providing services in competition with one another to decide that henceforth each hospital will provide only some of those services, so that the two hospitals no longer compete regarding those services. At the other extreme, actions that are not the product of a horizontal agreement may not raise antitrust issues. For example, a hospital unilaterally may decide to concentrate on its strongest services and not to offer services in which it would be weaker than others in the market, and seek to enter a network joint venture with other hospitals that provide the services that the hospital unilaterally decided to drop. If such decisions in fact are unilateral, rather than pursuant to an express or covert agreement, the arrangement would not be considered a per se illegal market allocation scheme.

A horizontal agreement on service allocation or specialization that is ancillary to significant economic integration would be subject to rule of reason analysis. Again, the Agencies would look at the connection between the allocation agreement and efficiency-enhancing joint activity. For example, hospital participants in an integrated multiprovider network could decide that only specific hospitals would provide certain services to network patients. The network agreement would not by itself, however, justify an agreement that the hospitals would discontinue offering to the public the services that they were not supplying through the network. Likewise, it is not per se illegal for hospitals to agree jointly to develop and operate new services that the participants could not profitably support individually or through a less inclusive joint venture, and to decide where the jointly operated services are to be located.[36]

If an agreement is reasonably related to efficient joint activity, the Agencies under a rule of reason analysis would consider the nature and probable effects of the joint venture, the nature and magnitude of cost and quality efficiencies flowing from the agreement, the size and number of other competitors in the market, entry conditions, and the existence of any spillover effects from the agreement on other aspects of competition. It is important to note that agreements relating to the offering of

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[36] The DOJ/FTC Antitrust Enforcement Policy Statement on Hospital Joint Ventures Involving Specialized Clinical or Other Expensive Medical Services offers additional guidance on joint ventures involving services.

services may be more likely than those relating to price to affect participants' activities outside the network, and to persist even if the network is disbanded.

3. Market Definition

The Agencies will evaluate the competitive effects of multiprovider networks in each of the markets in which they operate or have substantial impact. The possible product markets for multiprovider networks likely would include both the market for such networks themselves, and the markets for those service components of the network (e.g., inpatient hospital services, outpatient services provided both by hospitals and by non-hospital providers, laboratory services, physician services, and services of providers of certain medical specialties) that generally are, or could be, sold separately outside of the network. Geographic markets are determined based on a factually specific analysis in each case. In determining both geographic and product markets, the agencies look to what substitutes, as a practical matter, are reasonably available to consumers for those services in question.

If a multiprovider network uses risk-based pricing (e.g., capitation or global fees/DRG-type pricing), then it may be seen as competing in both the markets for provision of hospital and medical services, and in the health insurance/financing markets, just as many HMOs do. In all cases, the agencies will analyze the competitive effects of a network in each relevant product market in which it competes.

4. Market Concentration

In measuring the market concentration/market share of multiprovider networks, the Agencies will consider each product market in which the network could affect competition and measure the market concentration/share for each in a relevant geographic area. Thus, the Agencies will determine the market concentration of each important service component of the network that is a separate product as well as that of the network itself, if there is a distinct market for such networks. For example, in analyzing a physician-hospital organization ("PHO"), the Agencies would be concerned about the network's market share (and the market concentration) in terms of service components such as inpatient hospital services (as measured by such indicia as number of institutions, number of hospital beds, patient census, and revenues), physician services (in individual medical specialities as well as overall), and any other services provided by institutional or noninstitutional health care providers participating in the network. If a particular network had a substantial market share of any of the service components, particularly if those services are only available through the network (i.e., if their participation in the network is exclusive), it could impede or preclude formation of competing networks and increase the price of such services in the market. For example, a network that had most or all of the area's surgeons in it, and involved an agreement that the surgeons would not participate in any other networks, could create market power

in the market for surgical providers, and also might effectively preclude the formation of other networks in the area (because of the absence of available surgeons). Moreover, even if participation in a network was formally non-exclusive, participation in it by a very large share of a category of providers might affect the providers' incentives so that they were less inclined to form or participate in competing networks.

A network's use of risk-based pricing (e.g., capitation or global fee/DRG-type price) probably would not change the way the Agencies determine the network participants' market share when looking at the network's effects in the market(s) for hospital and medical services. However, if the network is assuming the entire insurance risk for a subscriber population, such as HMOs do, then the network's effects in a health care insurance/financing market also must be assessed. For this assessment, covered lives might be an appropriate measure of market share, along with such other measures as premium volume or number of insurers in the market. The Agencies would look at those measures of market share that most accurately reflect the current and future competitive significance of the market participants.

The Agencies do not take the position that hospitals automatically are precluded from entering into network arrangements in markets with only one or two hospitals. If there is only one hospital in the market, the arrangement, by definition, cannot eliminate any current competition among

hospitals; however, it could raise vertical antitrust issues because it includes other categories of health care providers.[37] If there are two hospitals in the market, the participation of both hospitals in a network would be analyzed to determine whether, on balance, the arrangement was procompetitive or anticompetitive. The Agencies would carefully evaluate the nature and competitive impact of the agreements accompanying creation of the network, and would consider arguments and information supporting the need for, and procompetitive effect of, having both hospitals participate in the network.

5. Competitive Effects

The Agencies will evaluate the competitive effects of a legitimate multiprovider network under the rule of reason. If a network includes a hospital and physicians in an area, the Agencies would examine the impact of the formation of the network on prices and quality in any market where the network will have a significant market share. The Agencies will examine the potential "horizontal" and "vertical" competitive effects of the arrangement. Agreements between direct competitors are considered "horizontal" under the antitrust laws. Agreements

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[37] The network could, however, have horizontal competitive effects in other markets. A multiprovider network could involve elimination of competition within other categories of providers, e.g., among physicians in the network. It also could involve some elimination of competition between the hospital and non-hospital providers for certain services, such as outpatient surgery, which the hospital provides but which also are offered by non-hospital providers.

between providers who are not direct competitors, such as a hospital and a physician, are "vertical" in nature.

The 1992 Horizontal Merger Guidelines ("the Guidelines") provide a useful framework for how the Agencies use the information they collect to analyze the possible horizontal anticompetitive effects and efficiencies of multiprovider networks. The Guidelines discuss the principles behind relevant market definition, the assessment of horizontal anticompetitive effects, the importance of entry in the analysis, and how efficiencies are incorporated into the analysis. In defining a relevant market, as well as assessing the likely competitive effects of a multiprovider network, the Agencies are particularly interested in the ability and willingness of third-party payers to switch between different health care providers or networks in response to a price increase, and the factors that determine the willingness of patients and purchasers to change providers. If third-party payers are able to contract with other multiprovider networks or with individual providers and still receive the same or better quality and range of services that are as convenient for their enrollees to use, the formation of the network is less likely to cause competitive concerns.

Although the 1992 Horizontal Merger Guidelines are general, they address some specific issues that are directly relevant to analyzing multiprovider networks, such as how the Agencies' analysis takes entry possibilities into consideration and how

efficiencies are evaluated.[38] The Guidelines also specifically note that, while market share calculations are a useful starting point in the competitive effects analysis, the Agencies' ultimate conclusion is based upon a much more complete competitive analysis, thus diminishing the importance of how market shares are defined.

Multiprovider networks can raise vertical, as well as horizontal, issues. Key concerns for the Agencies in analyzing the vertical aspects of a network are the extent to which the multiprovider network will foreclose competition, the duration of the foreclosure and whether new entry would allow a competing network or plan to be formed. If the network has only a small percentage of the physicians practicing a particular specialty, and there are enough alternative physicians in that community practicing that specialty to form other competing networks, any foreclosure is less likely to raise antitrust concerns. On the other hand, if the multiprovider network has contracted exclusively with a large percentage of a group of specialists and payers could not form a satisfactory network using the remaining physicians in the community, could not send patients to another

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[38] The magnitude of any efficiencies associated with a network must be larger the greater the anticompetitive risks of the network. In assessing efficiency claims, the Agencies focus on net efficiencies, and those efficiencies that will be passed on to consumers in the form of lower prices or higher quality. Finally, in assessing the likelihood that the efficiencies will be realized, the Agencies recognize that competition is one of the strongest motivations for firms to lower prices, reduce costs, and provide higher quality; thus, the greater the competition facing the network, the more likely the network will realize potential efficencies and pass those efficiencies onto consumers.

community to receive the care provided by these specialists, and could not hire new specialists to work in the community, the exclusivity provision will restrict competition.

In conducting a rule of reason analysis of a multiprovider network, the Agencies rely upon a wide variety of data and information. One important source of information is interviews with individuals familiar with the market in question. The Agencies typically interview purchasers of health care services (e.g., health plans such as HMOs and PPOs), competitors of the providers in the network, and employers who offer health insurance, as well as any other parties who have relevant information for analyzing the competitive effects of the network. It is important to note that the Agencies do not simply count the number of parties who support, or oppose, the formation of the multiprovider network. Instead, the Agencies interview these parties as a means of learning what factors determine the competitive dynamics in the particular community where the health care network is forming. The Agencies are not interested in simply assessing the degree of community support for the network but rather focus on why different parties support or oppose the network and whether the benefits of the network could be realized in an alternative, but less anticompetitive, fashion.

The Agencies also seek out parties who have had actual experience in the relevant areas. For example, in defining relevant markets the Agencies are likely to give substantial weight to the opinions of payers who have attempted to switch

between providers in the face of a price increase or who otherwise have the experience and knowledge to provide well thought out responses. Similarly, an employer with locations in several communities may have had an experience with a network comparable to the proposed network, and thus be able to provide the Agencies with useful information about the likely effect of the proposed network. On the other hand, the Agencies generally attach less significance to parties whose views are based upon incomplete, biased or inaccurate information, such as an employer who has only been told generally by the involved providers about possible benefits from the proposed network but who has no basis for determining the likelihood that the efficiencies will be realized.

Finally, in assessing the information provided during interviews, the Agencies take into account the interviewees' own economic incentives or concerns. For example, competitiors may try to provide information that could lead the Agencies to believe the proposed network is anticompetitive, while an employer whose president serves on the board of, or whose firm does significant business with, one of the involved hospitals may try to provide information that would lead the Agencies to believe the proposed network is not anticompetitive. Also, purchasers may sometimes support even an anticompetitive health care network if they believe the network is likely to be formed

and are afraid that their opposition will antagonize a critical future contracting partner.

6. Exclusivity

A. Exclusive arrangements

In forming multiprovider networks, participants sometimes wish to enter into exclusive agreements limiting the ability of the providers to join other multiprovider networks or to contract with payers individually. An exclusive arrangement may increase the provider's loyalty to the network and ensure that the provider will be dedicated to furthering the interests of the network. However, the use of an exclusive provision also means that the provider is not available to competing networks or to payers who wish to contract individually with providers.

Because it does not restrict the ability of its members to contract outside the network, a non-exclusive network is likely to allow for a greater number of competing networks, whether put together by providers or insurers.

In determining whether an exclusive arrangement will raise antitrust concerns, the Agencies will examine the degree to which the arrangement will limit the ability of competing networks or plans to form or remain in the market. Factors that are significant are the terms of the arrangement, such as the time period of and ability of providers to cancel the contract, the market share of the providers subject to the exclusivity, as well as the minimum number of providers that need to be included for

the network to be marketable and the justification for exclusivity.

The Agencies will look at the extent to which the arrangement will foreclose competition, the duration of the foreclosure and whether new entry would allow a competing network or plan to be formed. If the network has only a small percentage of the physicians practicing a particular specialty, and there are enough alternative physicians in that community practicing that specialty to form other competing networks, the exclusive provision is less likely to raise antitrust concerns. On the other hand, if the multiprovider network has contracted exclusively with a large percentage of a group of specialists and payers could not form a satisfactory network using the remaining physicians in the community, could not send patients to another community to receive the care provided by these specialists, and could not hire new specialists to work in the community, the exclusive provision will restrict competition.

The Agencies recognize that exclusivity provisions may not be explicit. In some cases, providers will refuse to contract with other networks or payers, even though they have not entered into a contract specifically forbidding them from doing so. Thus, if a network included a large share of physicians in a certain specialty, those specialists may perceive that they are likely to obtain more favorable terms from third-party payers by dealing collectively rather than as individuals. The Agencies will treat a multiprovider network as exclusive if the members refuse to

contract outside the network regardless of the specific language used in the contract.

In determining whether a network is truly non-exclusive, the Agencies would consider a number of factors, including the following:

1. That viable competing networks or plans with adequate provider participation currently exist in the market;

2. That providers in the network actually participate in other networks or contract individually with health insurance plans;

3. That providers in the network earn substantial revenue outside the network;

4. The absence of any indications of substantial departicipation from other networks in the market; and

5. The absence of any indications of coordination among the providers in the network regarding the terms of participation in other networks or plans.

Finally, in assessing whether a network will substantially limit the ability of managed care plans to enter or expand in the area by contracting with providers individually or forming their own networks, the Agencies will consider the market share of that network in the context of its non-exclusive nature. Market share data alone is not determinitive; the key to evaluating a network's legality is its overall competitive effect.

B. Exclusion of Providers

As a general matter, a multiprovider network will contract with some but not all providers in an area. Selective contracting by networks, which involves the selection of some providers and possibly the exclusion of others, may be a method

through which networks limit their panels in an effort to achieve quality and cost containment goals. A reason often proffered for selective contracting is to ensure that the network can direct a sufficient patient volume to its providers in order to justify price concessions or adherence to strict quality controls. Where a geographic market can support several multiprovider networks, there are not likely to be significant competitive problems associated with exclusion of particular providers.[39] A rule of reason analysis usually is applied in judging the legality of excluding providers from a network. One of the most important factors in assessing the antitrust legality of exclusion of providers is whether the network has market power in any relevant market (i.e., whether it could impede or preclude formation of competing networks and increase the price of services in a market). The focus of the analysis is not whether a particular provider has been "harmed" by the exclusion, but rather whether the exclusion reduces competition among providers in the market and thereby hurts consumers. If the network has market power, then exclusion may present competitive concerns if it is used to preserve a cartel or providers need access to the network to compete.

In addition to the issue of market power, relevant factors may include whether the network has formulated objective criteria

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[39]This statement does not consider such issues as state "willing provider" laws or other laws or regulations that require or purport to require the inclusion of all providers in a network.

for membership that are uniformly applied. Examples of such criteria could include geographic location of the provider, capacity to provide services, competence or professional qualifications, and willingness to abide by the standards set forth by the network. Additionally, the analysis will examine whether the exclusion of a provider was undertaken for an anticompetitive reason; e.g., was the provider excluded because it offers (or would be willing to accept) lower prices than other members of the network, or was the provider excluded because it offers to contract outside of the network?

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Persons who are considering forming multiprovider networks and are unsure of the legality of their conduct under the antitrust laws can take advantage of the Department of Justice's expedited business review procedure for joint ventures and information exchange programs announced on December 1, 1992 (58 Fed. Reg. 6132 (1993)) or the Federal Trade commission's advisory opinion procedure contained at 16 C.F.R. §§ 1.1-1.4 (1993). The Agencies will respond to a business review or advisory opinion request on behalf of a multiprovider network within 120 days after all necessary information is submitted.

More antitrust stuff.

Thanks –
Jen

Council on the Economic Impact of Health Care Reform

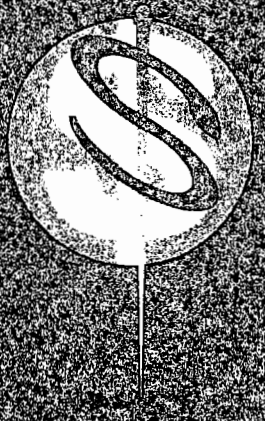
#3
November 1994

EXECUTIVE SUMMARY

MARKET CONCENTRATION, ANTITRUST, AND PUBLIC POLICY IN THE HEALTH CARE INDUSTRY

Prepared by:

David Shactman



DRAFT

EXECUTIVE SUMMARY

MARKET CONCENTRATION, ANTITRUST, AND PUBLIC POLICY IN THE HEALTH CARE INDUSTRY

Prepared for:

THE COUNCIL ON THE ECONOMIC IMPACT OF HEALTH CARE REFORM

November 28, 1994

Washington, D.C.

Prepared By:

David Shactman

EXECUTIVE SUMMARY

The American health care system is undergoing a period of prodigious change. Even without national health care reform, the emergence of competition through managed care, selective contracting, and vertically integrated health networks is changing the traditional structure of health care markets. Managed care plans, now insuring nearly 50 million Americans, have been effective in negotiating discounted prices with hospitals and physicians, and have been a contributing factor in reducing the rate of increase in health care spending.

Balanced against them, hospitals and physicians have engaged in unprecedented consolidation through mergers, acquisitions, and joint ventures. Such consolidation offers the potential for increased efficiency and enhances the ability of providers to bargain more effectively with managed care plans.

As both forces have sought to increase their market strength, their activities have come under the purview of antitrust. The extent of market consolidation and the future structure and control of the health care system could be determined by antitrust enforcement policies. The purpose of this paper is to examine the consolidation now occurring in the health care industry and to identify pertinent issues of concern to members of the health care community, public policy makers and the general public.

The first section of the study presents a brief historical perspective of the economic forces that have prompted market consolidation and the government response through antitrust enforcement. The central questions of the study are then posed:

- In a market with competitive health networks, what is the most efficient system in terms of cost, access, and quality? Is it one structured through strong antitrust enforcement challenging consolidation and integration, or is it one structured through lenient antitrust enforcement, allowing potential efficiencies through collaborative mergers and acquisitions? What policies result in a competitive balance of institutional forces?

- What are the health policy issues that inform the above questions, and are the antitrust divisions of the Federal Trade Commission (FTC) and the Department of Justice (DOJ) the proper decision making bodies to analyze those issues?

- Should our health care system be structured by a system of competing managed care networks regardless of antitrust policy?

The second section of the study presents a summary of the recent literature regarding the relative efficiencies of concentrated and competitive health markets. Studies are reviewed that compare the costs of health care in California under selective contracting with less competitive markets.

The final section reviews the legal statutes that are the basis for antitrust enforcement. It then presents an overview of the methodology of merger analysis and the current enforcement policy statements of the FTC and the DOJ, a detailed summary of which appears in the appendix. The final section also presents a discussion of pertinent federal and state legislative initiatives.

Historical Perspective

Since 1960 there has been explosive growth in the cost of health care in the United States. Fueled by government programs, increases in technology and the availability of health insurance, health expenditures increased from 5% of our gross domestic product (GDP) in 1960, to over 14% today.[1] Beginning in the 1970's, federal and state governments made numerous attempts to reduce the growth in health spending, but met with little success. Beginning in the mid 1980's, with the introduction of Medicare prospective payment, policy makers succeeded in reducing the rate of increase in inpatient hospital services. However, total health expenditures continued to increase faster than the economy as a whole.

Hospitals, partly encouraged by government programs such as Hill Burton, Medicare, and Medicaid had been building capacity for decades. Beginning in the 1980s however, the confluence of several factors such as prospective payment, changes in technology, and patterns of reimbursement, left hospitals with excess acute care capacity. Concurrently, hospitals began to face other financial pressures. Reimbursement rates from Medicare and Medicaid often were insufficient to cover hospital costs, and hospitals assumed the growing burden of providing care to the uninsured. In addition, managed care plans began to negotiate aggressively to procure discounts from hospitals and other providers.

Hospitals had thus far been able to maintain their financial margins by increasing outpatient revenues and by raising prices to the private sector. However, all of the above factors made their future ability to do so uncertain. Facing accumulating pressures in a new competitive environment, hospitals sought collaborative arrangements through mergers, acquisitions, and joint ventures. Their goals were to increase efficiency by reducing excess capacity and duplication of services, and to maintain operating margins by increasing their bargaining power with managed care plans.

Antitrust Laws

Mergers and acquisitions enabled hospitals to increase their market power and gave some the potential to raise prices. As a result, the FTC and the DOJ challenged several hospital mergers in the 1980s and established their jurisdiction over both for-profit and non-profit health merger transactions. The hospital community and the American Hospital Association

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[1]Prospective Payment Assessment Commission, Medicare and the American Health Care System, Report to the Congress, June 1994.

(AHA) feared strong government enforcement and claimed that the regulatory agencies were having a "chilling effect," preventing efficient collaborations among providers.

The government defended its enforcement policies, pointing out that out of 397 mergers from fiscal 1981 through fiscal 1993 only 15, or 4% of mergers, were either challenged, withdrawn or resulted in consent decrees. The FTC and the DOJ issued "Horizontal Merger Guidelines" and "Antitrust Enforcement Policy Statements" to clarify their policies and to stave off efforts to legislate limitations on antitrust enforcement.

Hospitals, physicians and their supporters lobbied federal and state governments for legislation that would grant antitrust exemptions and safe harbors to collaborative activities by providers. Insurance companies, managed care plans and their supporters opposed all such legislative initiatives and lobbied for strong enforcement of antitrust. Under lobbying pressure from both forces, Congressional hearings were held and bills were introduced that provided antitrust protection for providers. However, none of those bills was enacted in the 103rd Congress. Twenty four states enacted programs of "State Action Immunity" to provide antitrust exemptions to providers that undertook collaborative actions pursuant to a program of state regulation. Thus far, federal and state actions have primarily been the result of stakeholder pressure rather than informed, independent study and research.

Issues

The basic issues in this discussion concern both efficiency (in terms of cost, access, and quality) and a balance of market power. Insurance companies and managed care plans believe that efficiency will be maximized by competitive markets that will result from strong enforcement of antitrust. They warn that lenient antitrust will allow providers to acquire market power, and that providers will use that power to raise prices and negate the advantages of competition.

Hospitals and physicians argue that only through collaborative actions (such as mergers, acquisitions and joint ventures), will they be able to increase efficiency by reducing excess capacity and duplication of services. They also claim that they need countervailing market power to "level the playing field" and negotiate effectively with insurance companies and managed care plans.

Both managed care plans and hospitals have been engaged in vertical integration in an attempt to control their own health networks. Insurance plans have been contracting with or acquiring hospitals and physician groups, and hospitals have been contracting with or acquiring physician groups and insurance plans. Combining the financing and delivery of care may reduce competition, but it has not been the primary focus of antitrust. The creation of large, vertically integrated networks changes the structure and financial incentives of our traditional heath institutions. What will be the nature of these institutions and will they maintain a mission to serve their communities?

Some analysts believe that competitive managed care systems will not produce the most efficient health markets. Because of particular aspects of health markets such as insurance and large government purchasers, they argue that some amount of regulation is needed to make markets work and to provide an equitable distribution of health services. Other analysts question whether we should depend on managed care to be the basis of our health system. They question whether managed care provides real production efficiencies and, if it does, who will be the beneficiary of those savings.

The issues involved in these decisions involve access and quality of care as well as market efficiency and cost. Competitive markets will reduce excess capacity through hospital closures. Opponents argue that some closures may occur in areas in which hospitals provide essential services to their communities. They believe that hospitals that support charitable missions and that serve a disproportionate share of the poor and uninsured will be the least able to compete. Hospitals argue that if they are denied the economic benefits of collaboration, they will not have the financial strength to support their charitable missions. Furthermore, they argue, that financially weak hospitals will not be able to sustain a high quality of care or maintain investments in new technology.

Proponents of strong antitrust policy believe that services will be allocated most efficiently by competition. They argue that allowing hospitals to consolidate will result in higher prices and less affordability to consumers. They argue that if services are allocated, monopoly practices will develop in those product markets, and both cost and quality of care will be adversely affected.

Conclusion

Profound changes are occurring in our health care system. Decisions regarding mergers, acquisitions and joint ventures that could transform the structure and control of the health industry, are being decided in corporate board rooms and antitrust regulatory agencies. Legislative remedies are being proposed by stakeholders and lobbyists. Authoritative and independent sources of information are needed to raise the visibility of these issues and to provide research that can be the basis for sound public policy.

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