

1995

## Are the Antitrust Agencies Overregulating Physician Networks?

Clark C. Havighurst

*Prof. Duke University Law School*

Follow this and additional works at: <http://lawcommons.luc.edu/lclr>



Part of the [Health Law and Policy Commons](#)

---

### Recommended Citation

Clark C. Havighurst *Are the Antitrust Agencies Overregulating Physician Networks?*, 8 Loy. Consumer L. Rev. 78 (1995).

Available at: <http://lawcommons.luc.edu/lclr/vol8/iss2/13>

This Feature Article is brought to you for free and open access by LAW eCommons. It has been accepted for inclusion in Loyola Consumer Law Review by an authorized administrator of LAW eCommons. For more information, please contact [law-library@luc.edu](mailto:law-library@luc.edu).

## Are The Antitrust Agencies Overregulating Physician Networks?

by Clark C. Havighurst

When the antitrust laws were first seriously applied to the medical profession following the Supreme Court's 1975 decision in *Goldfarb v. Virginia State Bar*,<sup>1</sup> a principal objective of antitrust enforcers was to contest organized medicine's control of health care financing. In the ensuing years, most health care markets evolved under antitrust protection so that they now feature a variety of financing entities that are not only independent of professional control but also highly aggressive in forcing physicians to sell their services on competitive terms. Although competition has not yet come to every local market, concerted action by physicians is no longer an ubiquitous obstacle to its emergence. Indeed, in mature markets for medical services, antitrust enforcers may do more harm than good if they continue to view concerted action by physicians with the skepticism that was appropriate in earlier years.

Antitrust enforcers today are too quick to presume anticompetitive results when physicians organize so-called network joint ventures for the purpose of contracting with competing health plans or with employers purchasing health services for their employees. As a species of joint selling agency, a physician network joint venture certainly deserves close antitrust scrutiny since it may

entail some agreement concerning the price and other terms on which otherwise independent competitors sell their services. Unless such a venture qualifies as a sham rather than as a legitimate effort to reduce marketing and other transaction costs, however, it is not an appropriate candidate for condemnation under the venerable principle that price fixing is illegal per se.<sup>2</sup> Nonetheless, current antitrust enforcement policy appears to give too little credence to the possibility that a physician network controlled by physicians might yield marketing efficiencies that more than offset any loss of competition among the joint venturers themselves. In one of nine joint statements of enforcement policy regarding antitrust issues arising in the health care field, the U.S. Department of Justice ("DOJ") and the Federal Trade Commission ("FTC") have specified certain conditions that any network joint venture must meet before they will view it as anything other than a per se violation.<sup>3</sup> These

---

*Mr. Havighurst is a William Neal Reynolds Professor of Law at Duke University. The author is grateful to Charles D. Weller of the Ohio bar for calling his attention to the problem addressed in this article, for other insights, and, in particular, for pointing out the extent to which current antitrust policy ignores the special needs and circumstances of self-insured employers as purchasers of physician services.*

---

conditions are too restrictive and should, for both doctrinal and policy reasons, be relaxed.

To say that the current policy of the DOJ and the FTC toward physician networks is overregulatory is not to say that Congress or the enforcement agencies should accede to demands by organized medicine that ordinary antitrust principles be bent to accommodate physician collaboration. The problem is not a problem with antitrust law, instead the agencies have simply made a doctrinal error, adopting a rule of thumb when they should have applied the rule of reason. Regrettably, this error gives added ammunition to organized medicine in its continuing battle for legislative relief from antitrust strictures; relief that would inevitably shelter more than just procompetitive activity by professional groups.<sup>4</sup> By the same token, giving collaborating physicians a chance to demonstrate that their joint venture poses no ultimate threat to competition, despite its failure to pass the agencies' objective test, would weaken the policy argument for softening antitrust rules applicable to physician collaboration.<sup>5</sup> Moreover, it would do so without sacrificing antitrust principles or authorizing anticompetitive conduct. Most importantly, it would remove an impediment that currently forces innovation in the delivery of medical services into narrow channels, with adverse consequences for the range of consumer choice and possibly also for the quality of care provided.

### **Origins of current enforcement policy concerning physician collaboration**

The successful antitrust campaign against physician control of the financing and delivery of health services in the 1970s and 1980s was one of the great victories in the history of anti-

trust law. Beginning in the 1930s, the medical profession created a panoply of Blue Shield and other profession-controlled health care financing plans that enabled physician interests to dictate the economic conditions of medical practice. To be sure, independent financing programs also existed in the marketplace. But these plans were subject both to legal restrictions imposed at the behest of professional interests and to the threat of coercive boycotts by professional groups, and consequently also played by the profession's preferred rules.<sup>6</sup> In addition, even after Blue Shield and similar plans were freed from direct professional control, many of them protected their dominant market positions by serving local providers as their principal marketing agent. In return for marketing provider services on noncompetitive terms, a dominant Blue plan could count on providers collectively to deny competing plans discounts of the kind the Blues themselves typically enjoyed, to resist incursions by alternative financing and delivery systems, and to stonewall efforts by commercial insurers to introduce competition by selectively contracting with providers.<sup>7</sup>

However, the health care marketplace began to show signs of competitive life in the 1970s as alternative financing and delivery mechanisms began to get a foothold. In self-defense, physician groups in many local markets organized a second generation of profession-controlled entities. So-called foundations for medical care ("FMCs") and individual practice associations ("IPAs") served the profession well for a while as effective defenses against both independent health maintenance organizations ("HMOs") and innovative purchasing practices by conventional health insurers. In the *Maricopa County Medical Society* case,<sup>8</sup> for example,

---

FMCs in two Arizona counties established maximum prices for physician services and performed utilization review for health insurers that agreed to pay physicians under their fee schedules. The apparent purposes of the Arizona doctors in creating the FMCs were to collectively set a limit-entry price for their services (thus making the market less attractive to independent HMOs) and to induce health insurers not to embark on independent paths in procuring physician services on competitive terms. More recently, dominant physician interests have sought to use preferred-provider organizations ("PPOs") or other network joint ventures to maintain solidarity in the face of purchasers' new efforts to break the profession's ranks. Antitrust enforcers have been appropriately alert to these collective efforts.<sup>9</sup>

The success of the medical profession in controlling the economic environment of physicians from the 1930s to the 1980s (particularly in delaying the emergence of corporate middlemen able and willing to act as purchasing agents for consumers in procuring physician services on competitive terms) was arguably the most successful restraint of trade ever perpetrated by private interests against American consumers.<sup>10</sup> By the same token, the antitrust battles that hastened the breakup of medical cartels paved the way for the revolution that is occur-

ring in American health care today.<sup>11</sup> Indeed, without uncompromising antitrust enforcement against physicians, the nation would have had to wait much longer for private innovations that make providers effectively accountable to consumers for the cost as well as the quality of medical care.<sup>12</sup> More likely, without antitrust enforcement clearing the way for private innovation, government would have assumed a dominant role in financing and regulating health care, as it has in other countries.

---

**The success of the medical profession in controlling the economic environment of physicians from the 1930s to the 1980s ... was arguably the most successful restraint of trade ever perpetrated by private interests against American consumers.**

---

To be sure, the danger of physician collaboration to suppress competitive developments in local markets has not disappeared, and continuing antitrust vigilance is still warranted. Nevertheless, there are many markets in which doctors can no longer reasonably hope to forestall unwanted developments by banding

together. Too many large purchasers now have the incentives, the tools, the bargaining power, and the independence they need to prevent doctors from exercising market power. This includes Blue Cross and Blue Shield, whose plans were finally forced by competition to use their market strength on behalf of consumers rather than providers<sup>13</sup>, commercial health insurers, and large self-insured employers. Selective contracting and discounting of physician fees in return for assured patient load are now common practices.

---

In addition, integrated health care systems, combining in various ways the functions of financing and delivery, are being constructed by many players and are now significant factors in most local markets. Although there remain some places where the doctors' old strategies may still be capable of heading off unwanted change, the market forces that have been unleashed in most communities cannot easily be reversed by counter-revolutionary professional action. In most circumstances, antitrust enforcers should no longer presume that physician collaboration that is not certifiably innocuous is intended to restrain trade rather than to achieve efficiencies or to offer purchasers a fuller range of health care options. Suspicions that were well justified when physicians possessed the means of controlling their economic environment are not generally justified today.

### **Networks under today's enforcement policy and the rule of reason**

Although the health care industry is undergoing a remarkable transformation, the one group of players that might develop the most efficient systems for delivering high-quality personal health care at reasonable cost are somewhat constrained in doing so by the way antitrust law is currently applied to their endeavors. Specifically, physicians organizing joint ventures for the purpose of marketing themselves to major purchasers are being forced by unrealistic antitrust standards into arrangements that may serve consumers less well than arrangements that such standards foreclose. The problem lies principally in the insistence by the antitrust enforcement agencies that any physician-controlled network have objective features that make it distin-

guishable on its face from anticompetitive arrangements appropriately condemned in the past.

The joint DOJ/FTC enforcement policy states that physician network joint ventures "will be reviewed under a rule of reason analysis and not viewed as per se illegal either if the physicians in the joint venture *share substantial financial risk* or if the combining of the physicians into a joint venture enables them to *offer a new product* producing substantial efficiencies." These requirements are not laid down merely as conditions that must be met to qualify for a so-called "safety zone" in which private parties are promised freedom from government attack. To be sure, the guideline does delineate two "safety zones;" one for exclusive networks, which are the sole marketing agents for participating physicians, and one for nonexclusive networks, which do not preclude their members from marketing themselves through other networks as well. In each case, the cited conditions, plus a market share screen relating to the percentage of physicians engaged, must be met to satisfy the agencies. The guideline goes on to state (in the quoted language), however, that networks not meeting these requirements, while not necessarily unlawful, can satisfy the rule of reason only if the two stated conditions are met. Although the context of the guideline suggests that the drafters had in mind only networks that fail the market share tests (20 percent for exclusive networks and 30 percent for nonexclusive ones), the guideline is written in such a way that the two conditions apply even to very small joint ventures. Moreover, a footnote underscores that the rule of reason will apply only if "the joint venture is not likely merely to restrict competition and decrease output, such as, for example, an agreement among physicians who do not share

substantial financial risk that fixes the price that each physician will charge." Subsequent statements and applications of the guideline by agency personnel confirm that even very small joint ventures are expected either to impose financial risks on participating physicians or to integrate their practices so thoroughly as to yield "a new product."<sup>14</sup>

Thus, current enforcement policy declares specific conditions that must be met if any physician network joint venture is to avoid being classified as a violation per se, making it conclusively indefensible by reference to conditions in the marketplace, to efficiencies it might achieve, or to other procompetitive features or consequences of the undertaking. To be sure, the policy statement is only a guide to the prosecutors' policy and not a regulatory rule, and one might wonder whether or not enforcement policy is as restrictive in fact as it seems to be on paper. Nevertheless, because antitrust counselors report that the agencies are taking their policy statement at face value, collaborating physicians must be advised that, to avoid a risk of litigation, they must comply with the agencies' dictates until enforcement policy is modified in some authoritative way.

The guidelines put the government on record as conclusively deeming any physician network joint venture of any size to be unlawful unless it is demonstrably something more than a joint selling agency wholesaling the services of the doctors in the group. A group of physicians would thus be absolutely barred from appointing an agent to negotiate on their behalf with sophisticated purchasers, such as insurers, employers, and other prepaid health plans, if the agent, rather than the individual physicians, had authority to set prices. Yet the practical difficulties that

individual physicians face in finding secure places in the world of managed care are such that efficiencies in the form of saved transaction costs, not the elimination of competition, may easily be their principal objective in organizing such a sales agency. Purchasers, too, may realize significant cost savings from arrangements that spare them from having to bargain with numerous physicians individually. A proper application of the rule of reason would allow a physician network a chance to show that procompetitive effects predominate, whether or not the physicians "share substantial financial risk" or "offer a new product." Although many proposed arrangements would fail a rule of reason test, some joint ventures representing significant subsets of practitioners and not satisfying the guideline requirements might be found in particular circumstances to have more positive than negative effects.

As a doctrinal matter, only certifiably "naked" restraints of trade, those having no object other than suppression of competition, are or should be subject to per se rules. To be sure, the Supreme Court's opinion in the *Maricopa* case seemed to say that per se rules may be applied to certain kinds of conduct even though there may be some question concerning the nakedness of the restraint.<sup>15</sup> But the Court's method in that case demonstrated the excessiveness of its rhetoric justifying the arbitrary use of per se rules. A careful reading of the majority opinion by Justice Stevens reveals that he actually applied the rule of reason and took what has come to be called a "quick look" at all the circumstances before finding unsupportable the FMCs' claim that their fixing of maximum prices was procompetitive; specifically, that it made costs more predictable for both insurers and insureds,

thereby lowering the cost and improving the quality of health insurance coverage. Indeed, Justice Stevens showed notable insight in his appraisal of the challenged practice. For example, he observed that, to achieve the efficiencies claimed, "it is not necessary that the doctors do the price-fixing."<sup>16</sup> He thus focused on the availability of a less restrictive, more procompetitive way in which better insurance coverage could be provided — namely, by having an insurer itself set the fee schedule and contract with those physicians who were willing to abide by it. Since such selective contracting with physicians was practically unheard of at the time and was precisely what the doctors hoped to discourage, his prescience was particularly commendable.<sup>17</sup>

Thus, despite what Justice Stevens said in *Maricopa* about having no choice but to apply a per se rule to maximum price fixing, the Court did not in fact find a violation until after it had discredited the physicians' claim that their maximum fee schedules were procompetitive. Thus, Justice Stevens stated that "the record in this case is not inconsistent with the presumption that the respondents' agreements will not significantly enhance competition."<sup>18</sup> Such consulting of the record to see whether a presumption of illegality might be successfully rebutted demonstrates that the presumption was not conclusive; as a per se rule would be. Likewise, the Court said, "It is entirely possible that the potential or actual power of the foundations to dictate the terms of such insurance plans may more than offset the theoretical efficiencies upon which the respondents' defense rests."<sup>19</sup> Obviously, the question whether market power offsets efficiencies would not come up if the Court were truly bent on applying a per se rule. Although the *Maricopa* opinion is certainly confusing to any-

one who follows Justice Stevens's rhetoric rather than his footwork, the Court's ruling was in no way inconsistent with the generally respected principle that only naked restraints of trade and, apparently, not all of them<sup>20</sup> are appropriate candidates for per se treatment.<sup>21</sup>

In any event, despite the tendency of antitrust lawyers to dichotomize between "per se" and "rule of reason" cases; per se rules are not at war with the rule of reason, but are instead products of its application to particular facts.<sup>22</sup> Such rules should therefore never be applied without first applying the rule of reason. Applying a lawyerly factual analysis ensures that the case does indeed call for invoking the policy inherent in past rulings condemning comparable practices as indefensible restraints. The antitrust agencies, however, are apparently unwilling to look at the whole picture in judging physician network joint ventures. Indeed, if the guidelines are taken literally, a joint venture representing, on a nonexclusive basis, no more than a modest proportion (say, ten percent) of community physicians in each specialty would be condemned as a per se violation. Physicians are thus barred by the threat of antitrust attack from forming joint selling agencies that do not meet government specifications. Although antitrust prosecutors are not chartered to wield prescriptive powers, they have in this instance, by publicly committing themselves to exercise their prosecutorial discretion in a particular way, become de facto regulators.<sup>23</sup>

There is no mystery about the source in case law of the agencies' insistence that physician-controlled networks, to escape antitrust challenge, must either impose financial risks on the joint venturers or integrate the doctors' practices so substantially as to "offer a new product." In

the *Maricopa* case, the Supreme Court rejected the FMCs' claim that they were engaged in price fixing "only in a 'literal sense'" by stating that "their combination in the form of the foundation does not permit them to sell any different product."<sup>24</sup> The Court went on to distinguish the FMCs from "joint arrangements in which persons who would otherwise be competitors pool their capital and share the risks of loss . . . ."<sup>25</sup> The Court concluded its analysis as follows:

If a clinic offered complete medical coverage for a flat fee, the cooperating doctors would have the type of partnership arrangement in which a price-fixing agreement among the doctors would be perfectly proper. But the fee arrangements disclosed by the record in this case are among independent competing entrepreneurs. They fit squarely within the horizontal price-fixing mold.<sup>26</sup>

The agencies' position is thus seemingly supported by clear dicta in a Supreme Court opinion (for a four-Justice majority), and might easily carry the day in another court even though *Maricopa* involved a market very different from most of those one finds today. But the agencies' job is not to prosecute every case they might win on the basis of questionable dicta or precedent. Instead, it is to employ their expertise and fact-finding capability to prevent true restraints harmful to competition and consumer welfare while encouraging arrangements that create efficiencies.

Certainly, risk sharing and integration are

appropriate requirements in defining safe harbors for certain physician collaborations. But they should not be made mandatory in all joint ventures by denying noncomplying ones a hearing under the rule of reason even when the parties make a plausible claim that their purpose is procompetitive and that their agreement on prices is ancillary to that purpose. In fact, absence of the features specified by the agencies does not unerringly identify a naked restraint deserving automatic condemnation without proof of the parties' anticompetitive purpose, of their power to affect competition in the market at a whole (not merely *inter se*), or of the actual or probable effect of their arrangement. Thus, a correct analysis of a physician-sponsored network falling outside the guidelines' safety zones would walk sensitively through the elements of purpose, power, and effect, condemning it only if there is a probable net harm to competition or if the parties have employed unreasonable means to achieve their legitimate objectives. Such an analysis of physician network joint ventures, which could often be completed with only a "quick look," might sometimes result in a clean bill of health rather than a decision to prosecute.

### **Physician networks as joint selling agencies**

Physician network joint ventures are best viewed for antitrust purposes not as naked restraints of trade, but as joint selling agencies ("JSAs"), a type of arrangement that has not generally been condemned as a *per se* violation.<sup>27</sup> In a passage quoted with approval by the Supreme Court in the *NCAA* case, Professor Philip Areeda has observed that "joint buying or selling arrangements are not unlawful *per se*."<sup>28</sup>



---

Likewise, Professor Lawrence Sullivan has opined that:

[S]ome joint arrangements to buy or sell will not be summarily held to be unlawful . . . because summary analysis does not suggest a degree of market power which clearly demands that integration benefits be forbidden because price competition will be reduced. Joint agency cases such as these must be analyzed under the rule of reason, fully blown.

If the proposed selling or buying agency would materially increase concentration and if as a result the balance of forces would shift significantly away from rivalry and toward accord, the arrangement should be rejected as unreasonable. Just as surely, if competition could be expected to continue unabated, or even to improve, the rule of reason will mandate that the market's manner of striving for efficiency not be choked off.<sup>29</sup>

The Supreme Court cited Professor Sullivan's observations with approval in *Broadcast Music, Inc. v. CBS*,<sup>30</sup> overturning a decision condemning per se, as price fixers, two performing-rights societies that jointly marketed musical compositions on behalf of their composer-members. The Court held that the composers, through the societies, were engaged in price fixing only "in a literal sense" and that their pooling of compositions for licensing purposes was "not a 'naked

restrain[t] of trade with no purpose except stifling of competition.'"<sup>31</sup>

Despite the favorable treatment of joint selling arrangements in *BMI*, however, that case is the ultimate source of much of the reasoning in the *Maricopa* case that apparently led the DOJ and FTC to insist that physician-controlled networks must either force the doctors to share financial risk or enable them to "offer a new product." To be sure, the Court praised the procompetitiveness of the performing-rights societies in making it easier, in a complex market, for composers to market their music and for users to hire it. But the Court's overall analysis, by emphasizing that the arrangement involved more than joint selling alone, may appear to justify hostility to less integrated physician joint ventures. Thus, the Court stressed that the societies each offered users of copyrighted music a particularly convenient form of blanket license, which it characterized as "to some extent, a different product."<sup>32</sup> Moreover, it went on to say that "to the extent that the blanket license is a different product, [a performing-rights society] is not really a joint selling agency offering the goods of many sellers,"<sup>33</sup> thus implying that a mere JSA would not qualify for rule of reason treatment. The *Maricopa* Court cited this discussion in rejecting the FMCs' claim that they, too, were engaged in price fixing "only in a literal sense."<sup>34</sup>

It is a mistake in judging physician networks, however, for the enforcement agencies to focus so minutely on these two cases and on others blurring the line between naked and ancillary restraints<sup>35</sup> rather than consulting general antitrust principles, under which per se rules apply only to certain categories of the former. In *BMI*, the Court needed to find very strong

procompetitive features in the arrangements because the societies, between them, dominated the licensing of musical compositions and were highly vulnerable to condemnation in the absence of a strong business justification.<sup>36</sup> Thus, if all the facts are considered, a physician network representing only a fraction of the physicians in an area, especially on a nonexclusive basis, might be able to make as persuasive a case for joint marketing as the *BMI* defendants. Certainly the efficiencies they could point to (based on the high transaction costs that both physicians and bulk purchasers would face in creating relationships by individual negotiation and in administering those relationships) would be similar in kind, and probably in magnitude, to the efficiencies achieved by performing-rights societies.

Moreover, a significant fact noted by the Court as favoring application of the rule of reason in the *BMI* case was the retention by the composers of the right to license their respective compositions on an individual basis.<sup>37</sup> As a practical matter, however, that alternative method of marketing was highly inefficient. It also did little to offset the market power of the societies, especially since the composers were not free to license their works through competing agents.<sup>38</sup> Nonexclusive physician networks, on the other hand, would permit physicians not only to service individual patients on a fee-for-service basis but also to join other networks, thus posing much less of a threat to competition. Such nonexclusivity should, in fact, save any network, whatever its size, that exists in a market where large employers and other payers have, and exercise, real opportunities either to organize their own networks or to patronize other existing physician groups. Of course, the enforcement agencies might reasonably require network physicians

to show that they are participating in competing ventures in fact, not merely that they are free to do so on paper. In addition, sponsorship of the venture by a local medical society, rather than by a subset of competing physicians, should defeat any claim that it is a procompetitive, rather than a defensive, undertaking.

There is no good reason in antitrust doctrine or policy why the antitrust agencies should not, in proper cases, be willing to treat physician-sponsored networks as JSAs and their attendant limitations on price competition as ancillary restraints subject to the usual test of reasonableness. Under the appropriate analysis, the authorities would give due recognition to the severe practical difficulties that physicians in solo or small group practices face in marketing their services to numerous large buyers. Lacking appreciable business experience and the staff resources necessary to negotiate and to keep track of their relationships with multiple payers, physicians should be free, within normal limits imposed by antitrust law, to form and operate JSAs. In mature markets for medical care, purchasers are generally capable of looking out for themselves and should be free to do business with physician networks that do not follow the current prescriptions of the antitrust authorities. In such markets, physicians are more likely to form JSAs as vehicles for competing on a price-discounted basis for particular contracts than as cartelizing devices.

### **Less restrictive alternatives?**

The evaluation of ancillary restraints of trade does not end with their classification as such. Even if the parties' purposes are unexceptionable, there must still be an inquiry into the probable state

---

of competition if the collaboration is allowed. Such an inquiry begins with an estimate of both the parties' market power — their ability to affect market price and overall output by their collaborative decisions. If the parties turn out to possess market power in fact, even though they do not need such power to accomplish their ostensible procompetitive purpose, the net effect of their collaboration could easily be more harmful than beneficial to consumers.

A case can frequently be resolved without finally balancing procompetitive against anticompetitive effects simply by asking whether the parties could achieve their legitimate purposes in a manner less dangerous to competition. If such a "less restrictive alternative" was available and was not adopted by the collaborators, the antitrust enforcers might conclude either that their purpose was actually anticompetitive, thus justifying application of the *per se* rule, or that, despite their lawful purpose, the parties' choice of the more restrictive method of achieving it can itself be penalized. In reviewing physician-sponsored networks possessing a degree of market power, therefore, antitrust agencies must determine whether the anticompetitive features of the arrangement are reasonable in the sense that they are well-tailored to achieve their procompetitive purposes with minimal harm to competition.

Because the less-restrictive-alternative requirement is an element of a rule of *reason*, it should not be used by the antitrust agencies simply as a warrant for closely second-guessing the way the parties have chosen to structure their relationship. The less restrictive alternative should be invoked only if the methods chosen betray an anticompetitive motive or materially increase the threat to competition. Before antitrust enforc-

ers require a physician joint venture to restructure itself in a way that sacrifices available efficiencies, they should have substantial reasons to fear that the arrangement jeopardizes competition in the market as a whole. For reasons similar to those already discussed, an agency should not, without at least a quick look power analysis, invoke the less-restrictive-alternative requirement to force the joint venturers to meet its prescriptions regarding risk-sharing or the nature and extent of their integration. It is not enough to say, as the *Maricopa* Court did, that "it is not necessary that the doctors do the price fixing."<sup>39</sup> Even though an enforcement agency can imagine less restrictive methods by which the doctors could market themselves, it should not require use of such methods unless to do so would avert an unreasonable threat to competition in the larger market.

Reflecting the demands of antitrust authorities, the current practice in forming physician-sponsored networks is to design arrangements that avoid the noncompetitive fixing of prices for the services of the individual physicians in the group. Lawyers for physician JSAs have developed so-called "messenger" models in an effort to obtain some of the efficiencies of joint marketing while preserving a semblance of price competition.<sup>40</sup> Indeed, the apparent frequency with which networks are formed using some kind of messenger mechanism demonstrates that physicians set up JSAs primarily to achieve efficiencies, not to fix prices. It is not obvious why antitrust policy requires that they adopt cumbersome marketing methods that purchasers themselves do not insist upon. The enforcement agencies have uncharacteristically exalted form over substance in their analysis, ignoring valid efficiency considerations that nor-

mally would be given weight.

Messenger arrangements do not so obviously qualify as less restrictive alternatives that every physician-sponsored JSA should be required to use them. To be sure, they are *theoretically* less restrictive than letting the joint venturers agree on price. But because they are cumbersome to operate, they are not equally satisfactory as alternatives for getting the marketing job done. Their use therefore sacrifices some of the efficiency that JSAs can otherwise create.

Indeed, antitrust authorities apparently insist that physician JSAs employ a particularly cumbersome mechanism called the "pure" messenger model. Under these arrangements, the marketing agent must communicate offers back and forth between bulk purchasers and

individual doctors without disclosing to the latter the price terms that others are quoting. Because the pure messenger model is unwieldy, some networks employ "modified" messenger arrangements, which may take the form of a standing offer of individual physicians' services on uniform terms that a purchaser is free to accept or reject. Such arrangements have never been approved by enforcement officials, however, and have sometimes been rejected. Thus, if a physician-sponsored network provides neither for risk sharing nor for enough integration to create a "new product," the antitrust authorities will apparently deem it unlawful unless it takes maxi-

mum precautions (at whatever cost in inconvenience to both doctors and purchasers) to eliminate all price-fixing features. Although it is hard to judge the relative efficiency of all the possible messenger arrangements, the antitrust agencies might somewhat improve the situation by tolerating modified versions whenever competition in the market as a whole is not specifically in danger.<sup>41</sup> The better approach, however, would be to apply the rule of reason.

Insistence on a second-best alternative is

---

**Insistence on a second-best alternative is appropriate in antitrust enforcement and under the rule of reason only if a specific risk to competition outweighs the efficiencies forgone.**

---

appropriate in antitrust enforcement and under the rule of reason only if a specific risk to competition outweighs the efficiencies forgone. To be sure, use of a messenger model should be required in many circumstances, often identifiable with only a "quick look." But in

instances where the danger of anticompetitive harm is unclear, a more extensive evaluation is required. Such an analysis would consider such factors as sponsorship of the JSA by physicians in an aggressive competitive posture rather than in a defensive, anticompetitive one (that is, by interests other than a local medical society); the percentage of competing physicians engaged in the effort; their freedom to participate in competing ventures; their actual participation in other marketing schemes; the sophistication, effectiveness, and preferences of the purchasers with which they deal, and the overall vigor of competition in the market being served. Even if a net-

---

work was the exclusive marketer for its member doctors, there would still be no threat to competition if the market featured a variety of other plans. In such a mature market, purchasers can decide for themselves whether to patronize JSAs in which physicians have not expressly undertaken to share financial risk, to integrate their practices, or to maintain any kind of independent pricing. Indeed, the availability of meaningful purchaser options itself puts the collaborating physicians at risk of contract nonrenewal and should go far toward satisfying government officials that competition is not in danger.<sup>42</sup>

### **The danger of prejudging market outcomes**

The hostility of the antitrust agencies to physician network joint ventures results in part from their looking backward to the time when it was reasonable to presume that physicians collaborated only for anticompetitive purposes. Like many a wayward golf shot, however, the current enforcement policy suffers also from looking ahead, away from the object at hand and toward an intended goal. Thus, the agencies appear to be anticipating where they think the health care marketplace is headed and attempting to steer physician-sponsored networks in that foreordained direction. Therefore, their prescription of the form that such networks must take reflects a prejudgment of the way physician services should, and will eventually, be bought and sold in the future health care marketplace. In writing such a prescription, however, the agencies run the risk of choking off (in Professor Sullivan's words) "the market's manner of striving for efficiency."

The antitrust agencies are not alone in assuming that all health care will eventually be

provided by integrated health plans.<sup>43</sup> Many other observers also believe that physicians must bear financial risk if they are to be induced to provide health care efficiently and without the chronic excesses that have characterized much fee-for-service medicine. However, it is dangerous for regulators to dictate market outcomes on the basis of *a priori* assumptions about what is and what is not efficient or responsive to the needs and preferences of purchasers.<sup>44</sup> Current antitrust enforcement policy with respect to physician networks is an exercise of prosecutorial discretion that, in attempting to provide guidance to the industry, has become overly regulatory and prescriptive, foreclosing options that might attract followers in a competitive market.

The American Medical Association ("AMA"), in advocating greater freedom for physicians to create their own networks, has been somewhat careful about challenging directly the conventional view that physicians will ultimately either be put under managed-care arrangements operated by third parties or be organized in competing groups with explicit individual or collective incentives to control costs. Thus, AMA officials have sought to persuade antitrust enforcers that physicians need more freedom to collaborate only so that they can take incremental steps toward fuller integration or can explore new methods of payment without having to take the plunge all at once.<sup>45</sup> Citing physicians' lack of capital, experience, and management skills necessary to organize a fully integrated plan, the AMA group argues that physicians need an opportunity to test the waters and to evolve gradually toward full-blown integration of their practices. Observing that simple networks and management service organizations ("MSOs") could either serve as building blocks for larger plans

---

to incorporate in their systems or evolve into physician-sponsored entities capable of bearing financial risks or offering "new products," it advocates antitrust relief that would facilitate physician experimentation with new ways of organizing themselves. This article argues more explicitly than does the AMA that some JSAs may have immediate procompetitive value in their own right and should therefore survive antitrust scrutiny without regard to the speculative, though probably valid, claim that they are also valuable as half-way houses on the way to fuller integration. Whereas the AMA hopes for some legislative relaxation of antitrust requirements, agency application of the rule of reason would alone be enough to give physicians all the freedom of action that is compatible with effective competition.

The AMA has also argued that impeding the creation of doctor-controlled plans fosters the unnatural growth of health plans operated by large corporate sponsors, which it alleges are less attuned than physician groups to patient welfare and the quality of care. Although granting legislative relief to physician collaboration would be a serious policy error,<sup>46</sup> antitrust enforcers should not, without good reason, deny physician-designed arrangements a fair chance to compete against lay-controlled entities in finding efficient ways to cope with disease at reasonable cost. In competitive markets, some such plans might prove attractive to many consumers. Able to rely on professionalism, collegiality, and consensus rather than exclusively on rules and regulations imposed from the corporate top down, physician-sponsored plans should have a comparative advantage in finding and implementing cost-saving methods that maintain essential quality and preserve intangible values that are at risk in many

of today's managed-care systems.<sup>47</sup>

In any event, putting doctors at financial risk in treating their patients is not so obviously a wise and prudent policy that all physician-sponsored health plans should be forced into that mold. Financial risk creates interest conflicts, diminishes loyalty to patients, and may undermine professionalism, with consequences that some consumers would find objectionable. Not only do the incentives employed in many integrated plans engender *sub rosa* rationing of care that consumers have no way to monitor, but consumers and their agents lack other kinds of reliable information permitting them to compare the overall performance of competing plans. Thus, they have much to worry about in purchasing health care today and might therefore feel safer in dealing with plans that did not put physicians at financial risk.<sup>48</sup> Physician-sponsored JSAs, if they do not dominate their local market, might add usefully to the competitive mix precisely because they do not feature direct financial incentives to withhold care, corporate control of medical practice, or integration and income pooling that lessen productivity incentives. A marketplace lacking arrangements designed by physicians themselves (not by antitrust authorities) could easily fail to serve consumers well or to be fully reliable, from the standpoint of society as a whole, as a place for working out the difficult trade-offs with which health care necessarily abounds.

One consequence of the current and emerging problems with managed care could be a rising tide of regulation. Already, a combination of physician criticism, rumor, unverified consumer complaints, and occasional press reports of beneficial care denied is causing increasing skepticism and critical comment about the new

---

generation of health plans. This discontent could easily ripen into a further backlash of regulation and litigation. Although designed to protect consumers, such legal developments would raise health plan costs and limit the ability of plans to adopt innovations responsive to the wishes of consumers and their agents. Indeed, overregulation is already a problem in many states, and only the fortuitous presence of the federal Employee Retirement Income Security Act ("ERISA") as a barrier to intrusive state regulation and judicial oversight of employee benefit plans<sup>49</sup> has per-

mitted the market to make as much progress as it has toward bringing costs under appropriate control. ERISA is under constant challenge, however, and may eventually give way as a defense against heavy-

handed state regulators. For federal antitrust authorities to mandate risk sharing that in turn invites either relaxation of ERISA preemption or new state regulatory controls could be highly destructive of the market's ability to achieve efficiency.

In this connection, it should be noted that the National Association of Insurance Commissioners has recently declared its members' intention to treat any network of physicians that contracts with an employer to assume any degree of financial risk as an insurer requiring state licensure as such.<sup>50</sup> Thus, the antitrust requirement that physician-sponsored networks be structured to impose financial risks on physicians is driving such plans directly into the arms of state

insurance regulators. State insurance regulation would increase the difficulty of creating new network joint ventures, would raise their costs, and would limit their ability to meet purchaser needs and expectations, thus undermining the efficiencies that such networks might otherwise achieve. Physician JSAs, on the other hand, would escape such regulation and would thus greatly enhance the freedom of self-insured employers and other purchasers to obtain the services they require without encountering the delays, obstacles, and costs that state regulators impose.

---

**ERISA is under constant challenge, however, and may eventually give way as a defense against heavyhanded state regulators.**

---

The assumption that competition will eventually induce virtually all Americans to enroll in some form of managed-care organization fails to take account of the fact that nearly 100 million

Americans are currently covered by self-insured ERISA plans. This is roughly twice the number who receive their employer-purchased benefits through entities that integrate financing and delivery in ways that would satisfy the antitrust authorities in a physician-controlled arrangement. There are some markets such as California where the market penetration by conventional HMOs and managed-care organizations is impressive, but there are many others, for example, large parts of the Middle West, where competition has operated for some time without inducing employers to rely heavily on corporate middlemen or integrated or risk-bearing physician networks. In these markets, many large employers do not require either that physician

networks assume financial risk or that physicians integrate themselves in some formal fashion. Instead, they have employed either in-house benefit managers or third-party administrators who contract with physicians or physician networks directly at negotiated prices and work with them, often in highly creative ways, to control costs. Such employers apparently prefer the cost savings achieved through careful selection of physicians and through cooperation with them in addressing cost problems over the savings they might gain by contracting out the business on a capitated basis. Antitrust enforcers should not deny employers the option of dealing with physician JSAs, which they can hold responsible for selecting physicians who provide appropriate care without overcharging for their services.

Self-insured employers should therefore be free to work directly with physician-designed JSAs and not forced instead either to form their own networks or to hire independent entities to assume risk, to manage care, or to form fully integrated health plans. Such entities naturally expect to profit both from investing the employer's advance payments and, most importantly, from economizing on the provision of health care to employees and their families. Many employers might prefer to eliminate the middleman and to take direct responsibility for both the cost and the quality of medical care that their employees receive. In this effort, physician networks organized by physicians themselves could be valuable allies. Antitrust enforcers are simply wrong to insist that, when physicians organize a network joint venture, the only issue is whether the sponsors have either preserved a semblance of price competition among themselves or followed the agencies' prescriptions in allocating risks or integrating their practices. Ironically, the ques-

tion they should ask is whether the market features *other* plans that meet the agencies' conditions. Once a market has matured to this extent, purchasers should be allowed to choose for themselves how they want physicians to be organized and compensated for their services.

### **An invitation for congressional intervention?**

Agency obtuseness on the issue addressed in this article comes at a particularly inopportune time; as Congress is considering major reforms of the Medicare program. The version of the reform legislation that passed the House of Representatives in the Fall of 1995 included two provisions relating to antitrust law applicable to physicians. One would have explicitly required application of the rule of reason rather than a *per se* rule to "physician-sponsored networks" ("PSNs") contracting with "physician-sponsored organizations" ("PSOs") to deliver Medicare services under a PSO capitation contract with the government.<sup>51</sup> Thus, the House bill opted for letting physicians deal with "MedicarePlus" contractors through JSAs to the same extent that, under the aforementioned analysis, physicians could employ JSAs in dealing with ERISA plans and other private or public purchasers. The need for the House provision would therefore be obviated if the antitrust agencies were to relax the policy criticized in this article. Indeed, that outcome would be highly preferable to a legislative fix precisely because it would extend to physician networks of all kinds, not just to those organized to serve Medicare beneficiaries. In addition, it is always preferable to solve problems in the administration of antitrust law by refining doctrine so that it better



---

promotes competition rather than by turning to Congress.

A more troubling provision in the House bill would have created a sweeping antitrust exemption for so-called "medical self-regulatory entities,"<sup>52</sup> rolling back twenty years of painstaking development (since *Goldfarb*) of antitrust principles applicable to concerted action by professional groups. Physician interests have long contended that antitrust enforcers misconstrue their motives in taking collective action in the marketplace. The agencies have successfully maintained, however, that the law requires the uncompromising maintenance of competition in professional fields, even when professionals can plausibly claim that their anticompetitive actions are motivated by concern for the public interest.<sup>53</sup> Thus, the antitrust movement has successfully brought to bear in medicine the wholeheartedly objective principle that parties with a conflict of interests ought never to exercise coercive powers that are subject to anticompetitive abuse. A concept that the House bill would have converted to an impractical, and much too forgiving, subjective test. Experience under the antitrust laws since the 1970s has generally vindicated the premise that competitive markets are preferable to professional control precisely because they are more hospitable to innovations responsive to consumer interests.

Unfortunately, unwise administration of the antitrust laws, either by the agencies or by the courts, invites Congress to intervene on behalf of politically powerful physician interests and to enact confusing, possibly over broad correctives or destructive immunities like the ones in H.R. 2425.<sup>54</sup> The agency policy discussed is thus doubly unwise. In addition to being wrong as a matter of antitrust doctrine, it may prove a

political disaster. Precisely because it has been based more on hostility toward physicians and suspicions about their motives than on reasoned application of antitrust policy, it has given medical interests a wedge with which to get Congress into the act, creating the potential for legislation virtually repealing antitrust law as it affects organized medicine. Antitrust is ultimately a political enterprise on which turns the fate of competition in the economy as a whole.<sup>55</sup> If competition is not to be undercut by congressional tinkering, antitrust enforcement must reflect astute political judgment as well as sound legal and economic analysis. An overly aggressive trust-busting mentality, such as the attitudes manifested by the agencies toward physician-sponsored JSAs, can easily have political repercussions harmful to competition in health care.

## Conclusion

Americans are currently being denied access, ironically by antitrust authorities, to a variety of doctor-sponsored physician networks that could perform useful services for some purchasers in some health care markets. In particular, the current policy of antitrust enforcers, in requiring all such networks to meet certain organizational or financial requirements, neglects at least three realities. First, self-insured ERISA plans have very different needs than other purchasers of health care and physician networks are capable of responding directly to these needs. Second, the antitrust agencies fail to recognize the heavy regulatory burdens and litigation threats facing the kinds of health plans they visualize as the wave of the health care future; precisely because ERISA plans and physician JSAs both escape many of these burdens, they may be

jointly capable of efficiencies that are difficult for other plans to achieve. Finally, the antitrust agencies seem trapped in a time warp that keeps them fearful of physician conspiracies that are much less likely to prosper, and thus less likely to be attempted, today than in an earlier era.

The Sherman Act's rule of reason was designed specifically to ensure that antitrust authorities consult the realities of actual markets in making judgments about whether competition is in jeopardy or is operating in healthy though possibly unpredictable ways. Conscientious antitrust analysis should enable the DOJ and FTC to recognize, often with only a "quick look,"

whether specific physician joint ventures or joint selling arrangements are more likely to suppress competition or to efficiently serve the needs of both their members and sophisticated purchasers, especially large employers and their employees. The threat that current enforcement policy poses to all physician network joint ventures that fail to meet the agencies' own prescriptions should be removed, either by a new policy statement or by an official clarification prominently announced. It would be a terrible reflection on the performance of the antitrust agencies if Congress had to put them on the correct doctrinal path in evaluating physician networks.

---

## E N D N O T E S

---

<sup>1</sup> Goldfarb v. Virginia State Bar, 423 U.S. 886 (1975).

<sup>2</sup> See, e.g., United States v. Socony-Vacuum Oil Co., 310 U.S. 150 (1940), See also United States v. Trenton Potteries Co., 273 U.S. 392 (1927).

<sup>3</sup> Statement 8, *Physician Network Joint Ventures*, in U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N (Sept. 27, 1994) (statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust), reprinted in 3 HEALTH LAW RPTR. (BNA) 1391 (1994).

<sup>4</sup> See *infra* text accompanying notes 50-54.

<sup>5</sup> On the appropriateness of accommodating political pressures of this kind in antitrust enforcement and even in antitrust doctrine itself, see *infra* note 20 and text accompanying notes 53-54.

<sup>6</sup> See, e.g., Lawrence E. Goldberg & Warren Greenberg, *The Effect of Physician-Controlled Health Insurance: U.S. v. Oregon State Medical Society*, 2 J. HEALTH POL., POL'Y & L. 48 (1977). For examples of provider boycotts and similar restraints aimed at payers, see FTC v. Indiana Fed'n of Dentists, 476 U.S. 447 (1986); *In re Mich. State Med. Soc'y*, 101 F.T.C. 191 (1983).

<sup>7</sup> For cases in which Blue plans acted, not as aggressive purchasers, but as marketing agents for provider cartels (but escaped antitrust penalties because courts failed to recognize the mo-

nopolistic character of their conduct), see *Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of R.I.*, 883 F.2d 1101 (1st Cir. 1989), *cert. denied*, 494 U.S. 1027 (1990); *Travelers Ins. Co. v. Blue Cross of W. Pa.*, 481 F.2d 80 (3d Cir. 1973), *cert. denied*, 414 U.S. 1093 (1973). See generally Clark Havighurst, *The Questionable Cost-Containment Record of Commercial Health Insurers*, in HEALTH CARE IN AM. 221, 245-54 (H. Frech ed. 1988).

<sup>8</sup> *Arizona v. Maricopa County Med. Soc'y*, 457 U.S. 332 (1982).

<sup>9</sup> See, e.g., *In re Southbank IPA, Inc.*, 114 F.T.C. 783 (1991). See also Richard D. Raskin, *Antitrust Issues for Independent Health Care Providers: "Integration" and the Per Se Rule*, in ANTITRUST AND EVOLVING HEALTH CARE MARKETS at 73 (1995) (discussing recent enforcement efforts with respect to provider networks); Thomas L. Greaney, *Managed Competition, Integrated Delivery Systems and Antitrust*, 79 CORNELL L. REV. 1507 (1994); John J. Miles, *Provider-Controlled Networks, Market Power, and Price Fixing* (Nat. Health Lawyers Ass'n, Managed Care Law Inst., Chi.), Dec. 4-6, 1995.

<sup>10</sup> See Clark C. Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 DUKE L. J. 303 (1978).

<sup>11</sup> See, e.g., Clark C. Havighurst, *The Antitrust Challenge to the Professional Paradigm in Medical Care* (cited in Center for Health Admin. Studies, U. of Chicago, (1990)); Clark C.

Havighurst, *The Changing Locus of Decision Making in the Health Care Sector*, 11 J. HEALTH POL., POL'Y & L. 697 (1986).

<sup>12</sup> Accountability remains a problem in the current market, however. See *infra* note 43.

<sup>13</sup> See, e.g., *Ball Memorial Hosp., Inc. v. Mutual Hosp. Ins. Inc.*, 784 F.2d 1325, 1337 (7th Cir. 1986) (quoting a 1983 memorandum by a Blue Cross plan proposing a new strategy, novel for the plan and many others like it; namely, that the plan "use its market position and its control over substantial sums of health care dollars to negotiate lower fees for provider services").

<sup>14</sup> See *supra* note 3 (emphasis added).

<sup>15</sup> See, e.g., *Maricopa*, 457 U.S. at 351 ("The anticompetitive potential inherent in all price-fixing agreements justifies their facial invalidation even if procompetitive justifications are offered for some.").

<sup>16</sup> *Maricopa*, 457 U.S. at 352.

<sup>17</sup> *Id.* at 353. Justice Stevens cited *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979) for the proposition that insurers could obtain binding contractual fee commitments from physicians. That case upheld an insurer's selective contracting with low-price pharmacies against an antitrust challenge. Its citation in this context is noteworthy because, at the time, selective contracting and insurer-initiated price competition had not yet emerged in medicine. *Id.*

<sup>18</sup> *Id.* at 333.

<sup>19</sup> *Id.* at 354

<sup>20</sup> Neither courts nor commentators have ever made it clear why a per se rule does not apply to all naked restraints, applying instead only to certain categories of such restraints. The best rationale (arguably underlying Justice Stevens's seemingly extreme rhetoric in *Maricopa*, *supra* note 15) is that, in many imperfect markets, there is more than a negligible chance that a restraint addressed to a matter other than price or output might actually yield an outcome closer to that which would result if the market were efficiently competitive. Wisdom might counsel, of course, against creating a doctrinal loophole for naked restraints of any kind since competitors rarely, if ever, restrain trade solely in the interest of consumers. Nevertheless, a conclusive presumption that competitor cooperation aimed at limiting some aspect of competition in the market as a whole is always anticonsumer would be politically unwise, especially in professional fields. Possibly for this reason, courts have been "slow to condemn rules adopted by professional associations as unreasonable *per se*." *FTC v. Indiana Fed. of Dentists*, 476 U.S. 447, 458 (1986). In addition, the enforcement agencies themselves have been circumspect in such matters; as in the *IFD* case itself, *supra*, where the FTC fully (though arguably unnecessarily) investigated the dentists' claims that the naked restraint in question enhanced the quality of dental care. Agency and judicial willingness to listen to defenses based on an alleged market failure (even if such defenses are rarely accepted) has the virtue of weakening the ability of professional interests to appeal to Congress for antitrust relief. See *infra* text accompanying notes 50-54.

<sup>21</sup> In two later cases, the Court appeared to apply per se rules too

readily, without even a quick look that would probably have changed the outcome in one case but not the other. See *FTC v. Superior Ct. Trial Lawyers Ass'n*, 493 U.S. 411 (1990) (overlooking objection that market power could not be presumed (as it usually is, implicitly, in price-fixing cases) solely on the basis of defendants' attempt to fix prices, since defendants had alleged a plausible objective other than restraint of trade); *Palmer v. BRG of Ga. Inc.*, 498 U.S. 46 (1990) (per curiam) (treating restraint, easily condemnable as over broad, as a per se violation without regard to its plausible business purpose).

<sup>22</sup> See *National Soc'y of Prof. Engineers v. United States*, 435 U.S. 679, 692 (1978) (describing rule of reason and how it yields "two complementary categories of antitrust analysis").

<sup>23</sup> Others have observed the increasingly regulatory character of antitrust enforcement; not only in the health care field. See, e.g., Thomas L. Greaney, *Regulating for Efficiency in Health Care Through the Antitrust Laws*, 1995 UTAH L. REV. 465, 486-89; Thomas E. Kauper, *The Justice department and the Antitrust Laws: Law Enforcer or Regulator?*, 1 THE ANTI-TRUST IMPULSE: AN ECONOMIC, HISTORICAL AND LEGAL ANALYSIS 435 (Theodore P. Kovaleff ed., 1994). The Greaney article, although observing the agencies' regulatory role in health care, does not observe the particular instance of overregulation that is the subject of this article. Indeed, Greaney raises a quite different (and equally valid) concern; namely the possibility that "assumption of financial risk by physicians will trump most concerns about anticompetitive risks." See Greaney *supra* note 9, at 479 n.57.

<sup>24</sup> *Maricopa*, 457 U.S. at 356 (quoting *Broadcast Music, Inc. v. CBS*, 441 U.S. 1, 8 (1979)).

<sup>25</sup> *Id.* at 356.

<sup>26</sup> *Id.* at 357.

<sup>27</sup> See, e.g., *Appalachian Coals, Inc. v. United States*, 288 U.S. 344 (1933) (treating some very minor and otherwise attainable benefits of joint selling in a difficult market as justifications for allowing a high percentage of sellers of coal to market through a single agent). The *Appalachian Coals* case is generally understood to be an aberration in the law, occasioned by the Great Depression. Nevertheless, even though more recent precedent places a heavy burden on JSAs, elementary principles entitle them to be evaluated under the rule of reason if their sponsors' purposes are not obviously anticompetitive. See e.g., *Virginia Excelsior Mills v. FTC*, 256 F.2d 538, 539-41 (4th Cir. 1958).

<sup>28</sup> *National Collegiate Athletic Ass'n v. Board of Regents of the Univ. of Okla.*, 468 U.S. 85, 109 n.39, (quoting PHILIP AREEDA, THE "RULE OF REASON" IN ANTITRUST ANALYSIS: GENERAL ISSUES 37-38 (1981) and observing that in some circumstances the power of the combining parties might be so obvious that "the rule of reason [could] be applied [to condemn the joint-selling arrangement] in the twinkling of an eye"). See also 7 PHILIP AREEDA, ANTITRUST LAW (1986).

<sup>29</sup> LAWRENCE SULLIVAN, HANDBOOK OF THE LAW OF ANTITRUST § 104 (1977).

<sup>30</sup> *Broadcast Music Inc. v. CBS*, 441 U.S. 1 (1979).

<sup>31</sup> *Id.* at 20, (quoting *White Motor Co. v. United States*, 372 U.S.

253, 263 (1963)).

<sup>32</sup> *Id.* at 21-22.

<sup>33</sup> *Id.* at 22.

<sup>34</sup> *Maricopa*, 457 U.S. at 356.

<sup>35</sup> See *supra* note 21. See also *United States v. Topco Assocs.*, 405 U.S. 596 (1972) (applying the per se rule condemning market-division agreements to a minor limitation on joint venturers' freedom despite its value in protecting the parties against each other's opportunistic conduct and thus in facilitating formation of the procompetitive joint venture in the first place). Unfortunately for coherence in the law, this holding, although effectively discredited in *Rothery Storage & Van Co. v. Atlas Van Lines*, 792 F.2d 210, 227-29 (D.C. Cir. 1986), was cited favorably by Justice Stevens in *Maricopa*, 457 U.S. at 354.

<sup>36</sup> Indeed, the Court should probably have broken up the societies themselves in any event, since as the only two licensors of musical compositions they wielded undue market power and engaged in suspiciously parallel conduct. The private plaintiff, however, for reasons of its own, did not seek such relief, asking only for the invalidation of blanket licenses (which served the interests of its competitors more than its own) and not for the restoration of unbridled competition (which would have benefitted its competitors more than itself). See *Broadcast Music*, 441 U.S. at 16-18 (discussing CBS's theory and desired remedy).

<sup>37</sup> *Broadcast Music*, 441 U.S. at 23 ("The individual composers and authors have [not] agreed not to sell individually in any other market . . .").

<sup>38</sup> The arrangement was comparable in this respect to the more restrictive ("exclusive") type of physician networks identified in the DOJ/FTC policy statement.

<sup>39</sup> *Maricopa*, 457 U.S. at 352.

<sup>40</sup> See *Raskin*, *supra* note 9, at 86-91. See also *Law Firm Warns of FTC's and DOJ's Increased Focus on Messenger Models*, 4 HEALTH L. RPT. 603 (BNA) (1995).

<sup>41</sup> It is not known whether anyone has studied the actual operation of various messenger models to see what costs they incur or whether purchasers benefit in fact from the price competition they seemingly preserve. Although the doctrinal basis for doing so would be highly artificial, the agencies might obviate some of the inefficiency by expressly letting joint venturers agree on nonprice terms, using the messenger model only for price terms (which may be more amenable to individual negotiation).

<sup>42</sup> Another kind of risk that should reassure antitrust enforcers concerning the compatibility of a JSA with competition in the larger market is the risk of "deselection" faced by individual physicians participating in the network and subject to periodic "profiling" of their practice patterns. Although the agencies are reported to take a narrower view, a joint venture might argue that it is offering "a new product" if it reserves, and occasionally exercises, the power to exclude doctors who overuse resources or provide care of doubtful quality. On the other hand, a state "any-willing-provider" law, mandating

that a network include any physician willing and able to meet its terms, would diminish the risk of deselection. In states where such inclusiveness is mandated by law, the antitrust agencies could reasonably take the position that any joint venture should satisfy their requirements with respect to risk sharing or integration.

<sup>43</sup> See, e.g., Greaney, *supra* note 8.

<sup>44</sup> Although it is often assumed that fee-for-service practice is inherently inefficient, physician practice styles may be changing as physicians become more accountable for their competitive performance (see *supra* note 41), as cost-consciousness becomes pervasive, and as changes in the prevailing standard of care reduce legal pressures to over treat patients. Indeed, efficient practices have often been observed in some multi specialty groups treating patients under traditional indemnity insurance. See also Jeff C. Goldsmith, *The Illusive Logic of Integration*, HEALTHCARE FORUM J. 26 (Sept.-Oct. 1994) (questioning the presumed benefits of much of the organizational integration sweeping the health care industry).

<sup>45</sup> See generally letter from James S. Todd, M.D., Executive Vice President, AMA, to Anne K. Bingaman, Assistant Attorney General, Antitrust Division, U.S. Department of Justice, (May 11, 1994) (discussing antitrust issues addressed by certain legislative proposals). See also Edward B. Hirshfeld, *Antitrust Reform and Physician Groups*, in HEALTH CARE ANTITRUST: A MANUAL FOR CHANGING PROVIDER ORGANIZATIONS ¶ 1000-89 (Thomas Campbell & Daniel D. McDevitt, eds., 1995) (authored by the AMA's Vice President Health Law).

<sup>46</sup> See *infra* notes 50-54 and accompanying text.

<sup>47</sup> One physician sophisticated in health policy and generally appreciative of the role of antitrust law in medicine has argued that doctors must have a larger role in decision making and management if health care quality is not to suffer in the brave new world of managed care, "gatekeepers," and capitation. See Robert A. Berenson, *Do Physicians Recognize Their Own Best Interests?*, HEALTH AFFAIRS 185 (1994).

<sup>48</sup> The author has recently argued at length that the failure of health plans to write subscriber contracts saying anything meaningful about the degree to which the plan and its providers will ration services and balance health benefits against costs is a severe impediment both to offering consumers meaningful options in the marketplace and to holding providers and plans accountable for complying with any but a generally applicable (poorly defined, but relatively expensive) standard of care. See CLARK C. HAVIGHURST, HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM (1995).

<sup>49</sup> 29 U.S.C. § 1001 (1994). See, e.g., *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985) (suggesting that ERISA preempts state mandated-benefit laws that are not deemed to be traditional insurance laws). See also *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) (holding that ERISA preempts state law remedies for bad faith in administration of employee health benefits plans).

<sup>50</sup> See NAIC *Bulletin to Address Application of Insurance Laws to Provider Groups*, HEALTH L. RPT. (BNA) 1177 (discussing NAIC bulletin issued Aug. 10, 1995). See also *Storm Warning*, HEALTH SYSTEMS REV. 26-37 (Sept.-Oct. 1995) (dis-

---

cussing state insurance regulation of provider networks).

<sup>51</sup> H.R. 2425, 104th Cong., 1st Sess. § 15021 (1995).

<sup>52</sup> H.R. 2425, 104th Cong., 1st Sess. § 15221 (1995).

<sup>53</sup> See, e.g., *FTC v. Indiana Fed'n of Dentists*, 476 U.S. 447 (1986); *Nat'l. Soc. of Prof. Eng. v. United States*, 435 U.S. 679 (1978). But see *supra* note 20.

<sup>54</sup> Congress last modified the application of antitrust law to the health care industry (also at the behest of organized medicine) in the Health Care Quality Improvement Act of 1986. 42 U.S.C. § 11101-51 (1988 & Supp.). Because courts had been unable to find in the antitrust doctrine any reasonable and expeditious basis for distinguishing between meritorious

and nonmeritorious private antitrust challenges to staff privileges decisions in hospitals, see, e.g., *Patrick v. Burget*, 486 U.S. 94 (1988), Congress felt compelled to provide qualified antitrust immunity for hospital-based peer-review (and other similar professional) activities. On the other hand, if courts (perhaps with wise and balanced guidance from the antitrust agencies) had focused their efforts on distinguishing between actions of hospitals themselves and actions of medical staffs empowered by hospitals finally to decide the fate of their competitors, there would probably have been no need for congressional intervention. See Clark C. Havighurst, *Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships*, 1984 DUKE L. J. 1071, 1108-42 (1984).

<sup>55</sup> See *supra* note 20-21.

---