

**Report of the Section of Antitrust Law of the American  
Bar Association on "The Antitrust Health Care  
Advancement Act of 1997"**

These views are being presented only on behalf of the Section of Antitrust Law ("the Antitrust Section"). They have not been approved by the House of Delegates or the Board of Governors of the American Bar Association, and should not be construed as representing the position of the ABA.

**Introduction**

On January 9, 1997, Representative Henry Hyde reintroduced the "Antitrust Health Care Advancement Act of 1997" (hereinafter "Antitrust Health Advancement Act" or "Act"), H.R. 415, which is virtually identical to the bill he introduced in 1996.<sup>1</sup> Like its predecessor, it would amend federal and state antitrust laws by exempting individual providers attempting to establish a "Health Care Provider Network," and the conduct of such networks, from *per se* analysis under federal and state antitrust laws.

The Antitrust Section opposed the Antitrust Health Advancement Act in 1996 on the basis that the creation of a broad exemption from *per se* liability was unnecessary and would have entailed a significant risk of raising prices and diminishing choices for consumers.<sup>2</sup> Those concerns apply with equal force to the new Act. In addition, it is the Antitrust Section's position that any perceived need for antitrust relief in provider network legislation has been eliminated by the issuance of the most recent "Statements of

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<sup>1</sup> See Report of the Section of Antitrust Law of the American Bar Association on the "Antitrust Health Advancement Act of 1996," H.R. 2925, February 8, 1996 (hereinafter "1996 Antitrust Health Act").

<sup>2</sup> In general, both in and outside the health care field, the Section has opposed the creation of antitrust exemptions and immunities which ultimately interfere with the operation of competitive markets. See, e.g., Identification and Description of Antitrust and Competitive Issues Raised by Key Health Care Reforms Bills, Section of Antitrust Law, American Bar Association, 1994 (hereinafter "Antitrust Section Analysis of Health Reform"); Report of the Section of Antitrust Law of the American Bar Association on the Proposed Major League Baseball Antitrust Reform Act of 1995; ABA Commission to Improve the Liability Insurance System, Report No. 107 to the House of Delegates, February, 1989.

Antitrust Enforcement Policy in Health Care” by the federal antitrust enforcement agencies.<sup>3</sup>

### **Summary of the Act**

The Act would exempt the exchange of information among providers, *e.g.* doctors and hospitals, attempting to establish a Health Care Provider Network ("Network"), and the conduct of such Networks, from *per se* analysis under the federal antitrust laws. Under the Act, the exemption from *per se* analysis would apply to the exchange of information on prices, fees, marketing information and the like among providers, if such exchange was “reasonably” necessary, and if the information was exchanged “solely for purpose of establishing a health care provider network.” Likewise, the *per se* exemption would apply to conduct of a Network to the extent that it is “negotiating, making or performing” a contract for health care services.<sup>4</sup>

A Network is defined in the Act as an organization of providers that is organized and operated by health care providers for the purpose of providing health care services.<sup>5</sup> A Network can range from a loosely affiliated physician group, such as an independent practice association, to a tightly integrated venture, such as a physician-hospital organization that shares financial risk. In addition to being composed of providers, the organization must satisfy other requirements, involving capital contributions, quality assurance programs, utilization review programs, management oversight, and grievance procedures, in order to qualify as a Network.<sup>6</sup>

The exemption from *per se* analysis in the Act applies to specified conduct of both individual providers and the Networks themselves. The Act also mandates that within 180 days of its enactment the federal antitrust enforcement agencies -- the Federal

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<sup>3</sup> Department of Justice and Federal Trade Commission, Statements of Antitrust Enforcement Policy in Health Care, 4 Trade Reg. (CCH) ¶ 13,153 ("1996 Policy Statements"). These Policy Statements were published on August 1, 1996 and have been well received by the health care community, including one of the major proponents of the 1996 version of the Act -- the American Medical Association ("AMA"). In a letter to Representative Sensenbrenner, the AMA described the Health Policy Statements as "a significant step forward in recognizing the benefits to consumers of procompetitive physician designed and controlled joint ventures" and "consistent with the legislative efforts successfully led by . . . Henry Hyde." *Letter to the Honorable F. James Sensenbrenner, Jr. from P. John Seward, M.D., AMA Executive Vice President of 9/2/96 at 1.*

<sup>4</sup> Act, § 2(a).

<sup>5</sup> Act, § 2(b)(5).

<sup>6</sup> Id.

Trade Commission and the Department of Justice -- promulgate guidelines specifying the “enforcement polices and analytical principles that will be applied” to providers and to Networks for the purpose of implementing the *per se* exemption.

### **Free Competition and the Antitrust Laws**

The basic objectives of the antitrust laws are to encourage the competitive process that ensures the most efficient allocation of resources so as to offer consumers low-priced, high-quality and accessible goods and services, while at the same time inhibiting practices that interfere with free competition.<sup>7</sup>

Arguments advanced for antitrust exemptions or immunities are often a guise for an effort to protect their proponents from these competitive pressures, which otherwise would lead to the most advantageous allocation of resources and promote consumer welfare. Sound antitrust policy, as expressed by the courts, rejects efforts to immunize the health care field from antitrust scrutiny.<sup>8</sup>

The wisdom of this approach is highlighted by those situations where health care industry participants have engaged in activities to insulate themselves from competition or to exclude alternative providers from offering services to consumers. Instead of letting consumers make informed purchasing decisions, certain providers have attempted to arrogate those decisions to themselves. Antitrust enforcement has been largely responsible for preventing or ending practices that restrict competition and for opening markets to new and innovative forms of health care, such as HMOs and PPOs.<sup>9</sup>

The Antitrust Section strongly endorses competition in the health care industry, and disfavors any exemption that is not demonstrably necessary to achieve a specific

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<sup>7</sup> See Northern Pacific Railway v. United States, 356 U.S. 1, 4-5 (1958).

<sup>8</sup> The Supreme Court has thus rejected the notion that the health care industry should be entitled to any special immunity or relaxed antitrust standard (Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982); Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 435 U.S. 2, 26-29 (1984)).

<sup>9</sup> See, e.g., United States v. American Medical Assn, 317 U.S. 519 (1943); American Medical Assn v. FTC, 455 U.S. 676 (1982); FTC v. Indiana Federation of Dentists, 476 U.S. 447 (1986); United States v. Alston, 974 F.2d 1206 (9th Cir. 1992); United States v. Classic Care Network, 1995-1 Trade Cas. (CCH) ¶79,997 (E.D.N.Y. 1995)(consent order); Medical Staff of Doctors' Hospital of Prince George's County, 110 F.T.C. 476 (1988)(consent order); United States v. Lake County Optometric Soc'y, No. W-95-CR-114 (W.D. Tex. Dec. 15, 1995); J. McDavid, "Antitrust Issues in Health Care Reform," 43 DePaul L. Rev. 1045 (1994).

policy objective that cannot be accomplished in a manner consistent with antitrust law.<sup>10</sup> For the reasons set forth below, the antitrust exemption in the Antitrust Health Advancement Act carries a substantial risk of weakening antitrust enforcement and potentially decreasing the vigorous competition that promotes low-cost, high-quality, accessible health care services. Such a broad exemption is neither necessary to nor consistent with consumer welfare.

### **The Per Se Rule vs. the Rule of Reason**

To appreciate the effect of the exemption in the Act it is essential to understand not only the difference between the *per se* rule and rule of reason analysis under the antitrust laws, but also the wide berth antitrust law affords to a broad range of provider network conduct even without the exemption.

The *per se* rule is a judicial doctrine created by the Supreme Court to apply to a limited group of practices known as “naked” restraints on competition, i.e., those limited categories of concerted conduct, such as price-fixing, horizontal market allocation and (in some circumstances) group boycotts, that are so pernicious to the competitive process as to be deemed unlawful on their face, without further inquiry into justifications or competitive effects.<sup>11</sup> The *per se* rule is indispensable to effective antitrust enforcement because it provides a bright line rule and a clear deterrent against unambiguously anticompetitive conduct, and avoids protracted litigation and enforcement proceedings.

The rule of reason applies to all other practices which might raise competitive issues under the antitrust laws, including most varieties of joint venture or “network” conduct.<sup>12</sup> The rule involves an extended inquiry into the competitive effects of particular conduct, balancing the procompetitive and the anticompetitive effects of the conduct.

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<sup>10</sup> Antitrust Section Analysis of Health Reform, at 59-62.

<sup>11</sup> Broadcast Music, Inc. v. CBS, 441 U.S., 19-20 (1979); Northern Pacific Railway, 356 U.S. at 5 (1958). Of course, not all “price fixing” is illegal *per se*, particularly where it is undertaken pursuant to a joint venture or other arrangement that brings a new product to market that would not otherwise exist. See Broadcast Music, *supra*. Similarly, a boycott is not subject to the *per se* rule unless the parties to the boycott possess market power or unique access to a business element necessary for effective competition. Northwest Wholesale Stationers, Inc. v. Pacific Stationery and Printing Co., 472 U.S. 284, 293-98 (1985). See also, NCAA v. Board of Regents of University of Oklahoma, 468 U.S. 85, 104 n.26 (1984).

<sup>12</sup> “A rule of reason analysis determines whether the formation or operation of the joint venture may have a substantial anticompetitive effect and, if so, whether that potential effect is outweighed by any procompetitive efficiencies resulting from that joint venture.” 1996 Policy Statements, 4 Trade Reg. Rep. (CCH) ¶ 13,153, at 20,818.

## **The Broad Scope and Flexibility of the Rule of Reason in Sanctioning Legitimate Network/Joint Venture Conduct**

Both in and outside of the health care field, antitrust law promotes joint ventures which introduce new products and services or efficiencies into the marketplace.<sup>13</sup> 1996 Policy Statements, 4 Trade Reg. Rep. (CCH) ¶ 13,153, at 20,827.<sup>14</sup> 1996 Policy Statements, 4 Trade Reg. Rep. (CCH) ¶ 13,153, at 20,827.<sup>15</sup> The federal antitrust enforcement agencies have long encouraged the formation of procompetitive health care joint ventures,<sup>16</sup> such as innovative types of provider networks and collaborative services in the health care marketplace, through such entities as HMOs and preferred provider organizations.<sup>17</sup> Moreover, when analyzing joint venture or network conduct, the courts view with favor, and apply the rule of reason to, those “restraints” ancillary to a venture -- including, for example, non-competition covenants, and even pricing and output restrictions -- which are reasonably related to the operation of a joint venture and

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<sup>13</sup> Courts have refused to apply the per se rule to procompetitive joint ventures. See, e.g., Broadcast Music, 441 U.S. 1; Retina Associates, Inc. v. Southern Baptist Hosp. of Florida, 105 F.3d 1376 (11th Cir. 1997); Levine v. Central Florida Medical Affiliates, Inc., 72 F.3d 1538 (11th Cir.), cert. denied, 117 S. Ct. 75 (1996); Hassan v. Independent Practice Associates, P.C., 698 F. Supp. 679 (E.D. Mich. 1988).

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<sup>16</sup> The Policy Statements specifically address several types of health care joint ventures, including, for example, the sharing of high technology or expensive equipment (Statement 2) or of specialized clinical or expensive services (Statement 3); the collective provision of non-fee related (Statement 4) or, under certain circumstances, fee-related information to purchasers of health care services (Statement 5); group purchasing (Statement 7); and physician or multiprovider networks (Statements 8 and 9). The statements explain that the rule of reason is instrumental to the analysis of most such arrangements, and that generally such joint arrangements should not create antitrust liability.

<sup>17</sup> See, e.g., Letter from Anne K. Bingaman, Assistant Attorney General, Antitrust Division, Department of Justice, to Andrew Feldman re: podiatry network (Sept. 14, 1994); Letter from Anne K. Bingaman, Assistant Attorney General, Antitrust Division, Department of Justice, to George Miron re: chiropractic network (Dec. 9, 1993); Letter from Mark J. Horoschak, Assistant Director, Bureau of Competition, Federal Trade Commission, to California Managed Imaging Medical Group, Inc. (Nov. 1, 1993); Letter from Mark J. Horoschak to Assistant Director, Bureau of Competition, Federal Trade Commission, George Q. Evans re: physician-based managed care plans (July 5, 1994); and n.4, supra.

necessary to achieve goals of the joint venture which enhance consumer welfare and which do not depend for their success on increasing price or reducing output.<sup>18</sup>

In amplifying this basic antitrust principle and expanding the 1994 Policy Statements on physician and multiprovider networks (Statements 8 and 9), the 1996 Policy Statements have now explicitly addressed the issues which the Act had been designed to address. The revised Policy Statements provide additional guidance and flexibility to hospitals and physicians as to the types of joint activities they can engage in without violating the antitrust laws. This guidance is furnished in the form of expanded "antitrust safety zones," which describe the circumstances under which the Agencies will not challenge provider conduct under the antitrust laws. The Policy Statements also set forth the analysis the Agencies will use to review conduct which falls outside the antitrust safety zones. In addition, the Agencies have established and actively engage in the review procedure outlined in the Policy Statements to provide guidance on specific proposals.

- ***Statement 8: Physician Networks***

Expanded Safety Zones. Policy Statement No. 8 applies to the formation of physician network joint ventures that are controlled by physicians and jointly price and market the services of their member physicians. It establishes two antitrust safety zones for these networks. The first safety zone covers exclusive physician networks comprised of 20 percent or less of the physicians in each physician specialty with active hospital staff privileges in the relevant geographic market, where the members share substantial financial risk. The second safety zone applies to non-exclusive physician networks comprised of 30 percent or less of the physicians in each physician specialty with active staff privileges in the relevant geographic market, where the members share substantial financial risk.

To qualify for the antitrust safety zone, physicians participating in a physician network must share substantial financial risk in providing the services offered by the network. In 1994, the Agencies provided two examples of situations in which members of a physician network share substantial financial risk: 1) when the physicians agree to provide services to a health insurance plan at a capitated rate, and 2) when the network creates significant financial incentives for its members as a group to achieve cost-containment goals, such as withholding a substantial amount of the compensation due to its members and distributing it only if the cost-containment goals are met.

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<sup>18</sup> Broadcast Music, 441 U.S. at 23; United States v. Addyston Pipe & Steel Co., 85 F.271 (6th Cir. 1898), aff'd, 175 U.S. 211 (1899); Rothery Storage & Van Co. v. Atlas Van Lines, 792 F.2d 210, 224 (D.C. Cir. 1986), cert. denied, 479 U.S. 1033 (1987); see Mary L. Azcuenaga, Commissioner, Federal Trade Commission, "Integrated Joint Ventures," Remarks Before the American Bar Association Section of Antitrust Law and Section of Business Law, Chicago, Ill. (Aug. 7, 1995).

The 1996 Policy Statements add three new examples of acceptable financial risk-sharing: 1) agreements by the network to provide services to a health plan for a predetermined percentage of the plan's premiums or revenues; 2) establishing financial rewards or penalties based on the network as a whole meeting cost or utilization targets; and 3) the use of global fees or all-inclusive case rates for specific services. The Agencies also clarified that the individual physician members within a network can enter into different types of risk-sharing arrangements.

Expanded Rule of Reason Analysis; Examples of Procompetitive Integration. Under the 1994 Policy Statements, the Agencies stated that physician networks that fall outside the safety zone will not be *per se* illegal and will be analyzed under the more flexible "rule of reason" standard if 1) the physicians in the network share substantial financial risk or 2) the combining of the physicians into a joint venture enables them to offer a new product producing substantial efficiencies. In emphasizing that physician networks outside the antitrust safety zone can be procompetitive and do not necessarily raise substantial antitrust concerns, the 1996 Policy Statements expand the application of the rule of reason to such networks and provide important examples of the use of the rule of reason to sanction procompetitive network integration.

Specifically, the Agencies now recognize that a physician network may also produce substantial cost savings and efficiencies through clinical integration even though there is no financial risk-sharing in the network. Thus, the Agencies will apply the rule of reason standard not only to economically integrated networks, but also to clinically integrated networks that produce efficiencies without any sharing of financial risk. Sufficient clinical integration can be shown by the network implementing a program to evaluate and modify practice patterns by the network's physicians and to create a high degree of interdependence among the physicians to control costs and ensure quality. This program may include: 1) mechanisms to monitor and control utilization that are designed to control costs and assure quality of care; 2) selectively choosing network physicians who will further these efficiency objectives; and 3) significant investments of monetary and human capital in the necessary infrastructure and capability to realize the efficiencies. In addition, networks that enter into both risk-sharing and non-risk-sharing contracts may be judged under the rule of reason standard if significant efficiencies from the risk-sharing contracts carry over to the other contracts.

- ***Statement 9: Multiprovider Networks***

In Policy Statement No. 9, the Agencies acknowledge the "wide range of new relationships and affiliations" occurring as networks form among providers at different levels in the health care system, involving (among other things) the joint marketing of services to health benefits plans and other purchasers. Since many issues are common to both physician and multiprovider networks, Statement 9 generally follows and incorporates the analytical approach contained in Policy Statement No. 8, with the principal exception that there are no antitrust "safety zones" for multiprovider networks.

Thus, for example, Statement 9 describes the analytical principles the Agencies will apply in evaluating multiprovider networks, such as PHOs. The Agencies will analyze agreements among competitors within the multiprovider network that may restrict competition, such as setting a single price for services, first by determining whether the competitors are sufficiently integrated so that their agreements will be treated under the rule of reason analysis, and then by determining the markets in which the network could affect competition and the competitive effects in such markets.

The Agencies also indicate that agreements among competitors within the multiprovider network on price or other terms of competition, which otherwise may be *per se* unlawful, may be procompetitive (and thus governed by the rule of reason) where the competitors are sufficiently integrated, either economically or clinically, to produce significant efficiencies. In these situations, the Agencies will consider whether the agreements are reasonably necessary to accomplish the procompetitive benefits of the integration.

In addition, although not contained in "safety zones," Statement 9 adds essentially the same three new examples of financial risk-sharing as does Statement 8 (to the two examples contained in the corresponding 1994 Statements) -- conduct which would, under rule of reason analysis, exemplify the reasonableness of joint provider pricing in the network.<sup>19</sup> 1996 Policy Statements, 4 Trade Reg. Rep. (CCH) ¶ 13,153, at 20,827.<sup>20</sup> 1996 Policy Statements, 4 Trade Reg. Rep. (CCH) ¶ 13,153, at 20,827.<sup>21</sup> Furthermore, consistent with their treatment of physician networks, the 1996 Policy Statements indicate that rule of reason analysis will be applied to multiprovider networks which are clinically integrated but do not involve financial risk-sharing. In addition, market or service allocation agreements among network members that are reasonably necessary for the network to realize procompetitive benefits will be subject to rule of reason analysis.<sup>22</sup>

The 1996 Policy Statements also contain a more expansive interpretation of permissible activities under the so-called "messenger model" approach, applicable to the situation where the network is not economically integrated. In this situation, under the Policy Statements, the Agencies have sanctioned the use of a "messenger" to make pricing arrangements with payers. Under the approach outlined in the 1994 Policy Statements, an agent or third party could deal individually with the providers in the network, tell purchasers what prices and terms each of them is willing to accept, and then convey back to individual providers any contract offers made by the purchasers. Each provider would make an independent, unilateral decision to accept or reject the

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<sup>19</sup> 1996 Policy Statements, 4 Trade Reg. Rep. (CCH) ¶ 13,153, at 20,826-27.

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<sup>22</sup> 1996 Policy Statements, 4 Trade Reg. Rep. (CCH) ¶ 13,153, at 20,827.

purchaser's offer. However, many providers viewed the messenger model approach as impractical and unduly limited.

The 1996 Policy Statements now recognize that messenger models can operate in a variety of acceptable ways. For example, the messenger can obtain "standing offers" from individual providers about the fees they would be willing to accept, and contact payers on their behalf. The revised Policy Statements also give messengers greater discretion to accept or reject offers from health care plans and to provide their members with information about those offers. For example, messengers are permitted to accept offers from health care plans if they have received explicit authority to do so and to provide objective information about the terms of an offer from a third-party payor to the members of a network so that they can compare the offers with the terms offered by other plans.

Even before the 1996 Policy Statements, it was clear that most conduct of provider networks (including the Networks proposed by the Act), such as selective and exclusive contracting, practice parameters or other standard-setting, objective membership criteria, the quality assurance and utilization review required by statute, and joint pricing by financially integrated networks, is evaluated under the rule of reason. The importance of the 1996 Policy Statements -- the impact which renders the Act unnecessary -- is in enhancing the ability of physicians and other providers to form integrated networks in which they jointly price and market their services. By expanding the forms of acceptable risk-sharing arrangements and recognizing that substantial efficiencies and benefits can be produced by networks which are clinically integrated but do not have financial risk-sharing, the Agencies have given providers additional flexibility and options in structuring their networks so as to provide high quality, accessible and cost-effective care.

### **The Critical Need for the Per Se Rule**

It is precisely because the *per se* rule is confined to those few categories of conduct which raise the most severe competitive problems that its elimination is unwise and unnecessary. There is *nothing* in the Act or otherwise to safeguard against the potential that certain provider networks may engage in that type of conduct which some provider "networks" have been found to undertake: "sham" activity with the principal purpose of fixing prices or fees and raising costs to payors, employers and consumers. In the network context, the Act carries the potential that provider networks with market power would find it less risky to boycott cost-cutting health plans and demand higher prices if the *per se* rule and sanctions (including criminal penalties) were not available to challenge such conduct. There is also a substantial risk that the Act could have the unintended and unfortunate effect of protecting sham joint ventures -- even ventures involving all of the providers in a market -- which technically might be engaged in conduct protected under the Act, but which have no redeeming efficiency justifications or benefits for consumers. It is precisely in those instances which involve the most egregious types of anticompetitive conduct that the *per se* rule is most critical to effective

antitrust enforcement. Indeed, the antitrust enforcement agencies have aggressively prosecuted such efforts, with the *per se* rule as an indispensable enforcement tool.<sup>23</sup> Its evisceration in the context of provider networks covered by the Act will substantially weaken antitrust enforcement and have a serious adverse impact on consumers of health care services.

Moreover, there is no convincing justification for applying an exemption from the *per se* rule to provider networks. The justifications put forward have asserted that the *per se* rule presents a serious obstacle to the formation of provider networks.<sup>24</sup> But, as noted above, most of their conduct will escape *per se* condemnation under existing law and the recent, more flexible, enforcement guidance -- unless the conduct is blatantly anticompetitive, in which case the *per se* rule should apply. Fear of overdeterrence is unwarranted.

In sum, the 1996 Policy Statements should erase any question about the need for legislation to protect legitimate provider networks from *per se* liability. The Act is overbroad and unnecessary, and its enactment would undermine the analytical principles and guidelines which have been the foundation for principled antitrust enforcement in the health care industry. The *per se* rule remains the consumer's ally against price-fixing and other blatantly anticompetitive conduct. Provider networks should not be exempt from its application.

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<sup>23</sup> See, n. 9, supra.

<sup>24</sup> See Compare Letter to Speaker Gingrich from the American Medical Association, July 28, 1995, with AMA reaction to 1996 Policy Statements, supra, n. 3.