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I. INTRODUCTION

Are "clinically integrated" physician networks[2] that jointly contract with third-party payors such as Blue Cross little more than "candy-coated" cartels?[3] If the answer is not necessarily, then how can one distinguish the good (*i.e.*, those that raise consumer welfare) from the bad (*i.e.*, those that do not)? While the Antitrust Division of the U.S. Department of Justice ("DOJ") and the Federal Trade Commission ("FTC") (collectively, "the Agencies") have provided some general guidance on this issue, there has been a call for the Agencies to provide additional guidance.[4]

In what follows, I review the variety of organizational forms that populate the market for physician services. I then discuss the antitrust treatment of one type of organizational form—the clinically integrated physician network joint venture. Then I present an economic analysis of clinical integration. I conclude with some thoughts on additional guidance.

II. INDUSTRIAL ORGANIZATION OF THE MARKET FOR PHYSICIAN SERVICES

The healthcare industry not only produces innovative medical treatments, it has produced innovative organizations for providing its product. These innovative organizational structures arise, at least in part, from the unique features of the healthcare industry: consumers have difficulty assessing the quality of the healthcare services they receive; they have difficulty assessing the quality of services they would have received if they had chosen another healthcare provider; the provision of healthcare is fragmented across generalists and specialists who may have little knowledge of each others' interactions with the same patient and who typically receive a fee for each service provided; and consumers pay indirectly for the healthcare services by purchasing (or their employer purchasing) health insurance. The market failure that arises under such conditions—the overconsumption of healthcare services—is well documented.[5]

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[1] Vice President, Compass Lexecon. I thank Marcus Petersen for preparing the figures. All remaining errors are my own.

[2] I use the term "physician networks" broadly to include physician-hospital organizations as well.

[3] At the FTC's conference on clinical integration in May 2008, Kenneth Bowden of CIGNA HealthCare described some clinical integration models as "[a] thin sugary veneer of medical "science" … [o]ver a yummy core of price fixing." *See*, Kenneth T. Bowden, *Clinical Integration: What Is Really Going On?*, FTC Conference on Clinical Integration (May 29, 2008).

[4] In a June 7, 2007 letter to FTC Chairman Majoras and Assistant Attorney General Barnett, five U.S. senators—Herb Kohl (D-WI), Arlen Specter (R-PA), Chuck Grassley (R-IA), Richard Durbin (D-IL), and Sheldon Whitehouse (D-RI)—urged the Agencies to provide additional guidance to providers eager to undertake clinical integration programs.

[5] *See, for example*, Ezekiel J. Emanuel & Victor R. Fuchs, *The Perfect Storm of Overutilization*, 299 JAMA 2789 (June 18, 2008).

A recent study found that Medicare beneficiaries who were treated at least once by a Community Tracking Study physician in 2000 "saw a median of two primary care physicians and five specialists working in four different practices."[6] The figures are even higher for sicker patients. For example, those with seven or more conditions (38 percent of the sample) saw a median of three primary care physicians and eight specialists in seven different practices. Another study found that "[t]he typical primary care physician has 229 … other physicians working in 117 … practices with which care must be coordinated, equivalent to an additional 99 physicians and 53 practices for every 100 Medicare beneficiaries managed by the primary care physician."[7] Still another study—this one of the use of electronic medical records ("EMRs") to coordinate care—reached six conclusions, including:

1) "EMRs facilitate within-office care coordination, chiefly by providing access to data during patient encounters and through electronic messaging;"
2) "EMRs are less able to support coordination between clinicians and settings, in part due to their design and a lack of standardization of key data elements required for information exchange;" and
3) "current fee-for-service reimbursement encourages EMR use for documentation of billable events (office visits, procedures) and not of care coordination (which is not a billable activity)."[8]

These studies suggest that coordination of care—an important component of the quality of care—is challenging at best (if all the physicians belong to the same practice organization) and may be virtually impossible if each physician belongs to a different organization and those organizations do not communicate with one another. As a result, one physician may know little about what the patient's other physicians have done, or are doing. The result is likely to be unnecessary duplication of tests, the writing of prescriptions for medications with adverse interactions with those written by another of the patient's physicians, patient confusion as to which physician is primarily responsible for which of the patient's medical conditions, as well as a general lack of oversight and accountability to ensure that the patient is receiving quality care. Conceptually, if a way could be found to coordinate or manage the entire bundle of healthcare services needed by each patient, the benefit to consumers could be great.

The healthcare industry has become populated by a wide variety of organizational structures for the provision of healthcare services, including:[9]

- Independent practice associations ("IPAs"): IPAs contract with physicians (who maintain their own practices) to provide services to the enrollees of health maintenance organizations ("HMOs") or Preferred Provider Organizations ("PPOs"). IPAs differ from one another with respect to a number of attributes: organizational form (*e.g.*, sole

[6] Hoangmai H. Pham, Deborah Schrag, Ann S. O'Malley, Beny Wu & Peter B. Bach, *Care Patterns in Medicare and Their Implications for Pay for Performance*, 356 N. ENGL. J. MED. 1130 (March 15, 2007), p. 1130.

[7] Hoangmai H. Pham, Ann S. O'Malley, Peter B. Bach, Cynthia Salontz-Martinez & Deborah Schrag, *Primary Care Physicians' Links to Other Physicians Through Medicare Patients: The Scope of Care Coordination*, 150 ANNALS INT. MED. 236 (February 17, 2009), p. 236.

[8] Ann S. O'Malley, Joy M. Grossman, Genna R. Cohen, Nicole M. Kemper & Hoangmai H. Pham, *Are Electronic Medical Records Helpful for Care Coordination? Experiences of Physician Practices*, 25 J. GEN. INT. MED. 177 (2009), p. 177.

[9] For an overview of organizational structures, *see, for example*, American Hospital Association, *Clinical Integration – The Key to Real Reform*, TRENDWATCH (February 2010) and Thomas L. Greaney, *Managed Competition, Integrated Delivery Systems and Antitrust*, 79 CORNELL L.R. 1507 (1994).

proprietorship, partnership), ownership (*e.g.*, physician-members, individual physicians, hospital), exclusivity (*e.g.*, physician-members can—or cannot—belong to other physician networks), specialization (*e.g.*, primary-care physicians and specialists, single-specialty), and integration (*e.g.*, financial, clinical). Examples of IPAs include MedSouth (Denver), Greater Rochester (NY) Independent Practice Association (GRIPA), and North Texas Specialty Physicians.

- Management Services Organizations ("MSOs"): MSOs perform practice management and administrative support functions for physician groups, such as billing, collection, and group purchasing, as well as provide services for managed care contracting, such as utilization review, management information systems, and negotiation services. Examples include Physician Health Partners (Denver) and UAHSF [University of Alabama Health Service Foundation] Management Services Organization.
- Physician-hospital organizations ("PHOs"): PHOs link one or more hospitals with one or more physician groups to create a network—in economic terms, a new product—that can be marketed to third-party payers, with the PHO serving as the negotiating agent for the physicians and hospitals. PHOs differ from one another along four attributes: exclusivity (*e.g.*, to what extent is membership limited), integration (*e.g.*, financial, clinical), ownership and control (*e.g.*, joint ownership by member physicians and hospitals, sole ownership by hospital), and organizational base (*e.g.*, one hospital, multiple hospitals). Examples of PHOs include Advocate Health Partners (Chicago), Suburban Health Organization (Indiana), and TriState Health Partners (Maryland).
- One or more hospitals whose medical staff includes both physician-employees and independent physicians. Examples include Presbyterian Health (Albuquerque), Virginia Mason Hospital (Seattle), Geisinger Hospital (Danville, PA), and Intermountain Health Care (Utah).
- One or more hospitals whose medical staffs include only (or almost only) physician-employees. Examples include Cleveland Clinic (Ohio) and Kaiser Permanente (multi-state).
- Accountable care organizations ("ACOs"): ACOs aim to incentivize member hospitals and physicians to achieve cost savings by sharing a portion of the savings with them. The U.S. government is funding demonstration projects of ACOs.

Within a given organizational structure, there can be numerous variations. At one extreme are those characterized by substantial financial integration of the members. There are a number of arrangements that result in the sharing of substantial financial risk.[10] One is capitation, or the receipt of a fixed, predetermined payment per covered individual from a health plan for the provision of a defined set of covered services by the physician network joint venture for a specified period of time, regardless of the amount of services actually provided to that individual. Venture members share substantial financial risk because the venture's costs will increase as the services provided to the individual increases. Thus, members have an incentive to avoid duplication of tests (and the ordering of unnecessary tests more generally), to make sure that the individual is referred to a specialist only when necessary, and, in the case of a hospitalization, to work to avoid readmission for the same condition.

[10] *See*, DOJ & FTC, *Statements of Antitrust Enforcement Policy in Health Care* (August 1996), pp. 68-69.

The sharing of substantial financial risk does not require capitation. For example, the venture could receive from a health plan a fixed, predetermined payment for the entire course of an individual's treatment for a specific condition. Alternatively, the venture may provide designated services to a health plan for a pre-determined percentage of the health insurance premium or pre-determined percentage of the health plan's revenue. Another arrangement for the sharing of substantial financial risk is the implementation of financial incentives for members to achieve specified cost-containment goals. For example, a portion of physicians' compensation could be withheld and distributed only if the group meets specified cost-containment goals. Once again, under each of these arrangements, venture members have an individual incentive to contain costs—and to monitor their fellow members to ensure that they are containing costs as well.

At the other extreme are those ventures that produce few efficiencies or quality-of-care improvements, except possibly a reduction in the transactions costs of negotiating with payors. This is the so-called "messenger model," which FTC Commissioner Leary describes as follows:

> Properly used, a messenger model is an arrangement designed to reduce transaction costs associated with negotiation of contracts between providers and payors; it is not a device for facilitating horizontal agreements among providers on prices or price-related terms. In a messenger model, a physician network uses the agent to convey to payors information obtained individually from the providers about the prices or price-related terms that the providers are willing to accept, but the agent does not negotiate on behalf of the providers. The agent may convey to the providers all contract offers made by purchasers, and each provider then makes an independent, unilateral decision to accept or reject the contract offers. Alternatively, the agent may receive authority from individual providers to accept contract offers that meet certain criteria as long as the agent does not negotiate on their behalf. The agent can also assist providers to understand the contracts offered, by supplying objective or empirical information about the terms of an offer. For example, the agent may provide a comparison of the offered terms with other contracts agreed to by network participants. On the other hand, it would be dangerous for the agent to express an opinion on the terms offered…
>
> If a messenger model is used improperly, it can facilitate an unlawful price-fixing agreement. In a legal messenger model, the agent only facilitates independent, unilateral decisions of the network providers… It is illegal to use the messenger model in a way that creates or facilitates collective decisions on prices or price-related terms.[11]

In some cases these "messengers" are little, if anything, more than price-fixers—their overwhelming effect is to fix prices through joint contracting with payors. Asserted efficiencies are minimal or do not require joint contracting. The FTC has entered into numerous consent orders involving both IPAs and PHOs. For example, the FTC alleged that Advocate Health Partners—a "super-PHO"—"negotiated the prices and other terms at which their otherwise competing member physicians would provide services to the subscribers of health plans without any efficiency-enhancing integration of their practices sufficient to justify their conduct."[12] In the case of Alta Bates Medical Group (ABMG), a multi-specialty IPA, the FTC explained:

[11] Thomas Leary, *Opinion of the Commission, In the Matter of North Texas Specialty Physicians*, FTC Docket No. 9312 (November 29, 2005), p. 25.

[12] FTC, *Analysis of Agreement Containing Consent Order to Aid Public Comment, In the Matter of Advocate Health Partners et al.*, File No. 031 0021 (December 29, 2006), p. 1.

> At times … IPAs will act as a conduit between physician members and health plans regarding fee-for-service contracts to facilitate the contracting process. Under this model, the IPA merely acts as a messenger and does not negotiate the terms of the contract.
>
> Although claiming to employ a lawful messenger arrangement, ABMG, on behalf of its physician members, instead orchestrated collective negotiations for fee-for-service contracts. Specific acts by ABMG that are alleged in the complaint are: making proposals and counter-proposals, as well as accepting or rejecting offers, without consulting with its individual physician members regarding the prices they unilaterally would accept, and without transmitting the payors' offers to its individual physician members until ABMG had approved the negotiated prices.
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> The complaint also alleged a concerted refusal to deal intended to impede competition by one of ABMG's major competitors, the Permanente Medical Group, which provides physician services exclusively to Kaiser Foundation Health Plan, Inc…
>
> ABMG did not engage in any activity that might justify collective agreements on the prices its members would accept for their services. For example, the physicians in ABMG have not clinically or financially integrated their practices to create efficiencies sufficient to justify their acts and practices. As a consequence, the Respondent's actions have restrained price and other forms of competition among physicians in the Berkeley and Oakland, California, area and thereby harmed consumers (including health plans, employers, and individual consumers) by increasing the prices for physician services.[13]

Somewhere between the two extremes lie "clinically integrated" physician networks. Clinical integration, as FTC Chairman Jon Leibowitz explained, is "a framework for otherwise competing physicians to collaborate to reduce costs and provide improved health care."[14] Four indicia of clinical integration are: "(1) the use of common information technology to ensure exchange of all relevant patient data; (2) the development and adoption of clinical protocols; (3) care review based on the implementation of protocols; and (4) mechanisms to ensure adherence to protocols."[15] A successful clinical integration program requires nontrivial financial and time commitments on the part of venture members. The proper antitrust treatment of clinically integrated physician networks is a much-discussed subject.[16]

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[13] FTC, *Analysis of Agreement Containing Consent Order to Aid Public Comment, In the Matter of Alta Bates Medical Group, Inc.*, File No. 051 0260 (June 4, 2009), pp. 2-3.

[14] Jon Leibowitz, *A Doctor and a Lawyer Walk Into a Bar: Moving Beyond Stereotypes*, speech to the American Medical Association House of Delegates (June 14, 2010), p. 5.

[15] FTC & DOJ, *Improving Health Care: A Dose of Competition* (July 2004), chapter 2, p. 37.

[16] *See, for example*, John J. Miles, *Joint Venture Analysis and Provider-Controlled Health Care Networks*, 66 ANTITRUST L.J. 127 (1997); Scott D. Danzis, *Revising the Revised Guidelines: Incentives, Clinically Integrated Physician Networks, and the Antitrust Laws*, 87 VIRGINIA L.R. 531 (2001); Thomas B. Leary, *The Antitrust Implications of "Clinical Integration:" An Analysis of FTC Staff's Advisory Opinion to MedSouth*, 47 ST. LOUIS U. L.J. 223 (2003); Lawrence P. Casalino, *The Federal Trade Commission, Clinical Integration, and the Organization of Physician Practice*, 31 J. HEALTH POLITICS POL. & L. 569 (2006); Thomas (Tim) Greaney, *Thirty Years of Solicitude: Antitrust Law and Physician Cartels*, 7 HOU. J. HEALTH L. & POL'Y 189 (2007); Taylor Burke & Sara Rosenbaum, *Aligning Health Care Market Incentives in an Information Age: The Role of Antitrust Law*, 5 J. HEALTH & BIOMED. L. 151 (2009); and Taylor Burke & Sara Rosenbaum, *Accountable Care Organizations: Implications for Antitrust Policy*, 19 BNA HEALTH L. REPORTER (March 11, 2010).

III. ANTITRUST ANALYSIS OF CLINICALLY INTEGRATED PHYSICIAN NETWORK JOINT VENTURES

In August 1996, the DOJ and FTC revised their *Statements of Antitrust Enforcement Policy in Health Care* ("Statements"). While the earlier Statements required substantial financial integration in order for a physician network joint venture to be treated under a rule of reason analysis rather than as a *per se* antitrust violation, the revised Statements (specifically, *Statement 8: Enforcement Policy on Physician Network Joint Ventures*) state that such "joint ventures that do not involve the sharing of substantial financial risk may also involve sufficient integration to demonstrate that the venture is likely to produce significant efficiencies" and such integration "can be evidenced by the network implementing an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality."[17]

The revised Statements do not actually define the term "clinical integration." Nor do the revised Statements provide detailed guidance on what a clinical integration program must entail. The Statements note that a clinical integration program "may include: (1) establishing mechanisms to monitor and control utilization of health care services that are designed to control costs and assure quality of care; (2) selectively choosing network physicians who are likely to further these efficiency objectives; and (3) the significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies"—but immediately add that the foregoing "are not, however, the only types of arrangements that can evidence sufficient integration to warrant rule of reason analysis, and the Agencies will consider other arrangements that also may evidence such integration."[18]

The revised Statements explain that, "in all cases, the Agencies' analysis will focus on substance, rather than form, in assessing a network's likelihood of producing significant efficiencies" and "[t]o the extent that agreements on prices to be charged for the integrated provision of services are reasonably necessary to the venture's achievement of efficiencies, they will be evaluated under the rule of reason."[19]

In a September 2007 speech, FTC Commissioner J. Thomas Rosch summarized the Agencies' antitrust treatment of clinically integrated physician networks as follows:

> There has been some blurring of the lines between what is considered *per se* unlawful price fixing by competing physicians and something closer to a rule of reason analysis. This is due to the fact that sometimes when physicians jointly negotiate fees, there may be some form of integration, and the antitrust inquiry must determine whether the integration is likely to achieve significant efficiencies before determining the legality of the joint negotiation of fees. If there is no efficiency-enhancing integration, the conduct can be summarily condemned as unlawful price fixing. If there is an efficiency-enhancing integration, and the joint negotiation of fees is reasonably necessary to achieve the efficiencies, the conduct is evaluated under a rule of reason analysis.[20]

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[17] DOJ & FTC, *supra* note 10, pp. 72-73.

[18] *Id.*, p. 73.

[19] *Id.*

[20] J. Thomas Rosch, *Clinical Integration in Antitrust: Prospects for the Future*, speech to the American Health Lawyers Association, ABA Antitrust Section and ABA Health Law Section's 2007 Antitrust in Health Care, Washington, D.C. (September 17, 2007), p. 4.

A few years earlier, FTC Commissioner Thomas Leary noted some conceptual problems with "a 'two-step' analysis that involves, first, a determination whether rule-of-reason treatment is appropriate and, second, an analysis under the rule of reason."[21] For example, what happens if the claimed efficiencies or quality improvements fail to materialize? One possibility is to retroactively impose *per se* treatment. That approach may be logical if the venture made little or no attempt to achieve its claimed clinical integration goals. But where the venture actually tries to achieve those goals and fails, imposing *per se* treatment may be too harsh, as it may deter ventures from even attempting clinical integration.

The DOJ and FTC have offered relatively little additional guidance to physicians and hospitals considering the formation of some type of clinically integrated network. In July 2004, the FTC and DOJ produced a report titled *Improving Health Care: A Dose of Competition*, which listed six sets of questions the Agencies are likely to ask in evaluating a particular physician network joint venture:

1. What do the physicians plan to do together from a clinical standpoint?
    - What specific activities will (and should) be undertaken?
    - How does this differ from what each physician already does individually?
    - What ends are these collective activities designed to achieve?
2. How do the physicians expect actually to accomplish these goals?
    - What infrastructure and investment is needed?
    - What specific mechanisms will be put in place to make the program work?
    - What specific measures will there be to determine whether the program is in fact working?
3. What basis is there to think that the individual physicians will actually attempt to accomplish these goals?
    - How are individual incentives being changed and re-aligned?
    - What specific mechanisms will be used to change and re-align the individual incentives?
4. What results can reasonably be expected from undertaking these goals?
    - Is there any evidence to support these expectations, in terms of empirical support from the literature or actual experience?
    - To what extent is the potential for success related to the group's size and range of specialties?
5. How does joint contracting with payors contribute to accomplishing the program's clinical goals?
    - Is joint pricing reasonably necessary to accomplish the goals?
    - In what ways?

[21] Leary, *supra* note 16, p. 227.

6. To accomplish the group's goals, is it necessary (or desirable) for physicians to affiliate exclusively with one IPA or can they effectively participate in multiple entities and continue to contract outside the group?

    - Why or why not?[22]

More recently, FTC Commissioner Pamela Jones Harbour, in a 2009 speech, explained that in its analysis of purported clinical integration arrangements, the FTC's job is to ensure that (1) "cognizable efficiencies are indeed likely to result;" (2) "any price-fixing agreements are reasonably related to achieving those efficiencies;" and (3) "the arrangement is not likely to create market power."[23]

The question of whether an arrangement can successfully achieve clinical integration and generate efficiencies requires evidence of "the establishment and operation of active and ongoing processes and mechanisms to facilitate, encourage, and assure the necessary cooperative interaction" and this (1) "may necessitate selectively restricting participation in the network, both initially and as the program continues, including even expelling persistently uncooperative members," (2) "may require significant investment in the venture by the physician participants, either monetary or in terms of human capital (i.e., investing time and effort by committing to active participation in the mechanisms and processes by which the network hopes to achieve its efficiencies), in order to assure that all participants are committed to working together to achieve the venture's goals," (3) "requires having the capability to collect and evaluate information relating to practice performance, in order to determine whether the integration is effective and achieving the network's goals, and to identify where changes need to be made to improve individual and collective performance," and (4) requires "an appreciation by employers, patients, and payers of the potential benefits of such programs, and the willingness to contract for what the programs offer."[24]

> Clinical integration programs typically employ some or all of the following tools:
>
> development or adoption of appropriate performance standards and goals, referral guidelines or requirements, or other performance criteria and measures for the participants, both individually and as a group; establishment of mechanisms, including information systems that permit collection and analysis of relevant data to monitor and evaluate both individual and group performance relative to the established standards, goals, and measures; and provision for appropriate educational, behavior modification, and remedial action, where warranted, to improve both individual and overall group performance.[25]
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> The FTC commented:
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> For a physician network, having such tools is a necessary, but not sufficient, predicate for the network to achieve clinical integration among its participants. The test of that integration is what the participants, through the network, actually do – i.e., how they use those tools to create cooperation and interdependence in their provision of medical care, thereby facilitating their efforts to jointly reduce

[22] FTC & DOJ, *supra* note 15, chapter 2, pp. 40-41.

[23] Pamela Jones Harbour, *Clinical Integration: The Changing Policy Climate and What It Means for Care Coordination*, speech to the American Hospital Association, Annual Membership Meeting, Washington, D.C. (April 27, 2009), p. 3.

[24] Markus H. Meier, *Follow-Up to 2002 MedSouth, Inc. Staff Advisory Opinion*, Federal Trade Commission (June 18, 2007), p. 3.

[25] *Id.*

> unnecessary costs, improve quality of care, and otherwise increase their efficiency in the provision of medical care.[26]

The question of whether joint contracting is "reasonably necessary" to achieve the claimed efficiencies and quality improvements may be difficult to answer because some (possibly lesser) efficiencies or quality improvements may be achievable without it. Thus, in some cases, all (or virtually all) efficiencies or quality-of-care improvements may be achievable without joint contracting. For example, consider an arrangement in which cost savings and quality-of-care improvements will allegedly be produced by closely monitoring medical journals and organizations regarding recommended clinical guidelines and distributing the articles and guidelines to member-physicians via email. While this activity may generate cost savings, and even raise the quality of care, joint contracting is not necessary to implement the program.

A number of reasons have been suggested why joint contracting is reasonably necessary to achieve claimed cost savings or quality improvements in some cases. Former FTC chairman Leary co-authored a working paper for the American Hospital Association that identified five such reasons:

> First, for a CI [clinical integration] program to be effective, it must be able to count on the active participation of all of the group's members. This cannot be guaranteed without collective negotiations that would assure that, if an agreement is reached with a payer, all of the program's physicians would participate. Thus, there may be a need for an agreement that if the payer's contracts satisfy certain price and non-price criteria, all of the program's physicians will participate.
>
> Second, the CI program may wish to allocate revenues achieved from contracts in a way that provides incentives for physicians to make the investments in time and effort to develop and implement the program to meet the program's goals. This may involve negotiating contracts in a way that provides greater compensation to some of the program participants, and less compensation to others, both to ensure participation of a broad provider network and to allocate revenues fairly based on the contributions and efforts made by the participants in implementing the program. In some cases, the program also may wish to implement financial rewards and penalties as part of an enforcement mechanism, and joint contract negotiations will be needed for such an effort.
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> Third, joint negotiations may be necessary to guard against the possibility of "free-riding" by certain physician members. The concern is that unless the program can negotiate and contract on behalf of all of its members, some physicians could free ride on the contributions of their colleagues and the accomplishments of the program, so that they can offer more efficient, higher quality services, and then contract independently to provide these services at a lower price by undercutting other program members. If this can occur, physicians may be reluctant to fully commit themselves to the program at the outset, thereby limiting the potential of the program.
>
> Fourth, collective negotiations may be necessary to assure the active and ongoing participation of the physician members. CI programs require substantial commitments in both time and money by network providers. Without the joint negotiation that can help them recover these costs, many providers might be unwilling to participate in the CI program in the first place. Therefore, such price agreements can be viewed as reasonably necessary for the success of the program.

[26] *Id.*

> Finally, by implementing a CI program, the providers can sell a new and different product—that is, an integrated package consisting of more than merely the individual provider services, but, rather, an integrated package of those services tied to the CI program… This entire package could not be offered by providers individually.[27]

Examples of ventures where joint contracting was concluded by the FTC not to be "reasonably necessary" to the realization of claimed efficiencies and quality-of-care improvements are Suburban Health Organization ("SHO") and North Texas Specialty Physicians. The former concerned a proposed program to partially integrate eight independent SHO member hospitals and the 192 primary care physicians that those hospitals employed. Note that the program did not cover specialists.

In its advisory opinion, the FTC staff rejected each of SHO's arguments why joint contracting was reasonably necessary: (1) SHO argued that its program would create a new product and thus it was justified in obtaining an agreement among members as to the price that would be charged for that product, but the FTC staff countered that SHO's joint product is offered "by largely eliminating its eight member hospitals as individual competitors of each other in offering the services of their respective employed primary care physicians in the marketplace;" (2) SHO argued that joint contracting was reasonably necessary to motivate the physicians to comply with the program's requirements and to embrace its goals, but the FTC staff countered that "the employed physicians at each SHO hospital can already be presumed to have their incentives aligned to a large degree with those of their employing hospitals" because, like employees in other occupations, employed physicians "already have a substantial incentive to perform in ways that further their employers' goals and interests;" (3) SHO argued that joint contracting was reasonably necessary to prevent free-riding by member hospitals, but the FTC staff countered that, "to the extent that individual pricing of services of the SHO hospitals' employed primary care physicians potentially creates an equitable treatment problem for SHO's members—what SHO calls a "free rider" problem—it appears: 1) that agreement on those prices through SHO will not remedy the problem; and 2) reasonable alternatives exist to address the problem without resort to horizontal price fixing;" and (4) SHO argued that the distribution of clinical protocols to network physicians would increase liability risk if there was less than full participation in SHO's corresponding clinical monitoring and quality management programs, but the FTC staff countered that "there is no logical connection between an agreement among the SHO hospitals to fix the prices of their employed primary care physicians and the reduction of any liability exposure of the hospitals or SHO."[28]

In the case of North Texas Specialty Physicians ("NTSP"), NTSP's executive director argued that NTSP had "achieved a certain amount of cost savings, satisfaction, quality of care for the members" and "[t]hat basically is reflected in the rates that we ask the payors to give us because that's the value we provide them …," whereas the FTC countered that "[i]ndividual non-risk physicians might well be able to command higher fees from payors if they can promise

[27] Thomas B. Leary, Robert F. Leibenluft, Sharis Arnold Pozen & Theresa E. Weir, *Guidance for Clinical Integration*, working paper prepared for the American Hospital Association (April 2007), pp. 22-23 (footnotes omitted).

[28] David R. Pender, *FTC Staff Advisory Opinion Concerning Suburban Health Organization, Inc.*, Federal Trade Commission (March 28, 2006), pp. 6-13.

superior outcomes, but this superior efficiency alone would not justify the exercise of collective bargaining power."[29]

The question of whether an arrangement is likely to create market power may entail an analysis of the market shares of the joint venture and those of its competitors, whether the arrangement is exclusive or nonexclusive (*e.g.*, can a physician belong to another venture as well, can a health plan contract with individual venture members), and whether spillover price effects are likely (*e.g.*, whether the joint contracting covers services not supplied by the venture).

All else equal, an arrangement is less likely to create market power if (1) the market share of the clinically integrated entity is relatively small, (2) the arrangement is nonexclusive so that payors have the option of contracting with individual venture members rather than with the venture itself, and (3) the services over which joint contracting occurs do not include any services not provided by the venture itself. The first and third of these conditions are relatively uncontroversial. However, the exclusivity versus non-exclusivity question arguably raises an interesting question as to whether joint contracting is "reasonably necessary" to achieve the claimed efficiencies and quality improvements. FTC Commissioner Leary asked: (1) "if joint bargaining is necessary, how can the venture tolerate non-exclusivity?" and, alternatively, (2) "if non-exclusivity is tolerable, what does this say about the need for joint bargaining?"[30]

In their working paper for the American Hospital Association, former FTC commissioner Leary and his co-authors identify three conditions under which a clinical integration program should entail little antitrust risk: (1) "neither the hospital nor the physicians have market power in the relevant market," (2) "the health plan is given the option of having totally separate negotiations with the hospital or physician venture," or (3) "the health care services delivered by the hospital and physicians through the CI program can be considered to be a single, integrated product."[31]

Finally, an issue that is sometimes sidestepped is the question of how much integration is needed for the venture to be treated as a "single entity" and thus fall outside the scope of Section 1 of the Sherman Act. The FTC has argued that, in the case of financial integration in the form of capitated (per member per month) payments, "the IPA is treated as a single entity for purposes of these contract negotiations, and not as a group of competing physicians."[32] On the other hand, in the case of North Texas Specialty Physicians, where claimed efficiencies and quality benefits allegedly arose from "teamwork," not clinical integration, the FTC concluded, and the appeals court agreed, that NTSP was not a single-entity for antitrust purposes.[33]

Should a "substantially" clinically integrated venture likewise be treated as a single entity? In its recent *American Needle v. National Football League* decision, the U.S. Supreme Court seems to suggest the answer is no. The Court emphasized a number of key points, including: (1) "[t]he question is whether the agreement joins together "independent centers of decisionmaking"" and "[i]f it does, the entities are capable of conspiring under §1;" (2) "[c]ommon interests in the NFL brand '*partially* unit[e] the economic interests of the parent firms,' … but the teams still have distinct, potentially competing interests;" (3) "[t]he justification for cooperation is not relevant to

[29] Leary, *supra* note 11, pp. 29-30.
[30] Leary, *supra* note 16, p. 233.
[31] Leary, *et al.*, *supra* note 27, p. 14.
[32] FTC, *supra* note 13, p. 1.
[33] North Texas Specialty Physicians v FTC, 528 F.3d 346 (5th Cir. 2008), and Leary, *supra* note 11.

whether that cooperation is concerted or independent action;" and (4) "[i]f the fact that potential competitors shared in profits or losses from a venture meant that the venture was immune from §1, then any cartel 'could evade the antitrust law simply by creating a "joint venture" to serve as the exclusive seller of their competing products.'"[34] Since the members of a clinically integrated venture arguably continue to be "independent centers of decisionmaking" and "have distinct, potentially competing interests," such a venture would not be a single-entity and thus would not be immune from §1.

In summary, the clinical integration policy of the DOJ and FTC was a response to criticisms that substantial financial integration was too strict a standard for avoiding *per se* treatment of joint contracting. However, clinical integration is, according to its critics such as Thomas Greaney, too lenient a policy:

> The problem with the clinical integration policy lies in the imprecision of the standard and the danger that it may signal a far more lenient standard than was intended by the government. The central concept, clinical integration, defies clear definition and may include a wide variety of processes, protocols, and understandings. As several commentators have observed, this ambiguity has generated considerable uncertainty and there has been little additional guidance forthcoming from the Agencies. In addition, no one is entirely certain "how much" integration (or modification of physician practice) is sufficient. Perhaps most problematic is the lack of agreement on the circumstances in which price agreements are "reasonably necessary" to achieve the claimed efficiencies.[35]

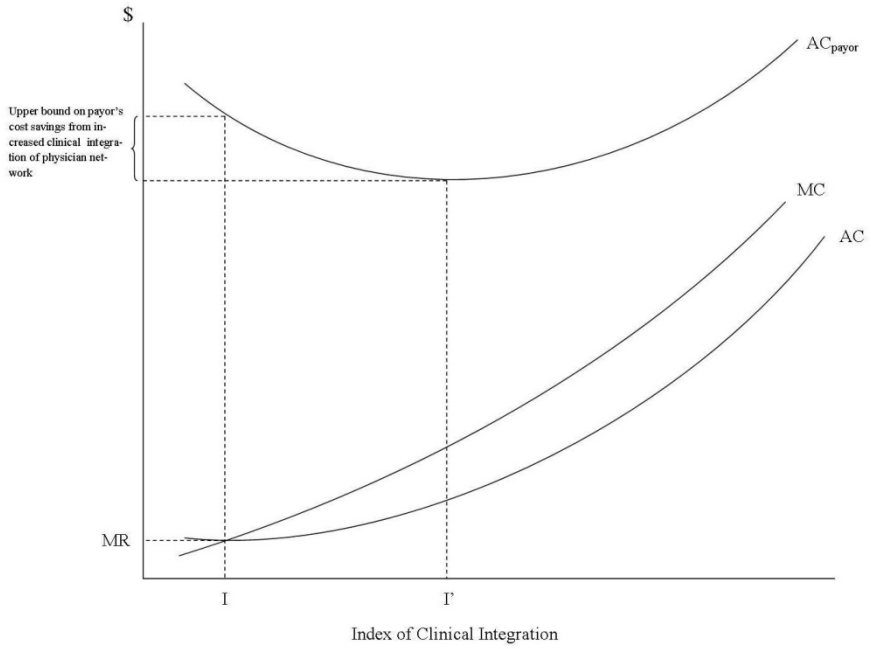
IV. AN ECONOMIC ANALYSIS OF CLINICAL INTEGRATION

In this section, I present a brief economic analysis of clinical integration. Although the graphical analysis has general application, the precise results will depend on the shapes of the relevant cost and revenue functions.

Figure 1 illustrates a case where greater clinical integration, up to a point, benefits both the physician network and the payor. The horizontal axis is an index of clinical integration. The optimal amount of clinical integration for the physician network is where marginal revenue equals marginal cost. Beyond a low level of clinical integration, the physician network's average cost curve (AC) is upward sloping—the cost of clinical integration increases as the extent of clinical integration increases. MC is the network's marginal cost curve for clinical integration. I initially assume that the network's marginal revenue from clinical integration is constant (MR). The optimal amount of clinical integration (I) occurs where MR = MC.

[34] American Needle, Inc. v. National Football League, No. 08-661 (U.S. 05/24/2010) (2010).
[35] Greaney, *supra* note 16, pp. 216-17. (footnotes omitted).

Figure 1



AC_{payor} is the payor's average cost curve with respect to the network's clinical integration. Notice that I assume that the payor's average cost initially declines as the network becomes more clinically integrated, but eventually begins to increase. Also notice that at the network's optimal clinical integration level (I), the payor's average cost is not minimized and, in fact, the payor's costs would be minimized if the amount of clinical integration were increased to I'. Thus, the payor may be willing to provide some financial assistance to the network to increase its clinical integration.[36]

Now consider Figure 2. In this case, the network's marginal revenue no longer remains constant as clinical integration increases. Instead, the network has market power and its marginal revenue from clinical integration ($MR_{market\ power}$) rises as it becomes more clinically integrated. The network's optimal amount of clinical integration (I'') is where $MR_{market\ power}$ = MC. The introduction of network market power shifts the payor's average cost curve upward to AC''_{payor}. Note that at I'', the payor's average cost is increasing so that, from the payor's standpoint, the network may be too clinically integrated.

[36] The analysis becomes complicated because the financial assistance would presumably shift the payor's average cost curve upward, thereby offsetting at least some of the benefits of greater clinical integration.

Figure 2

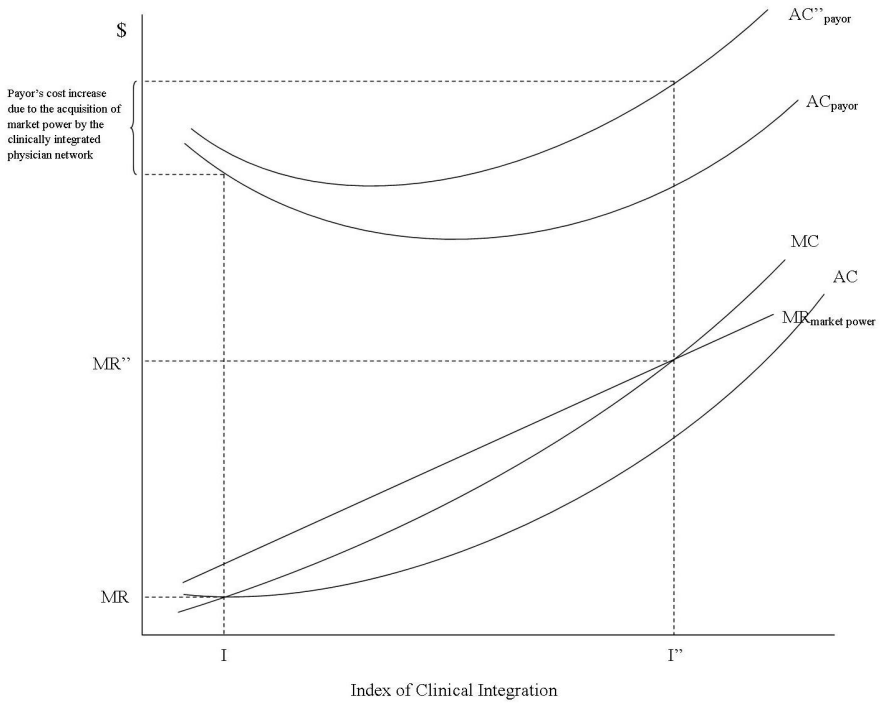
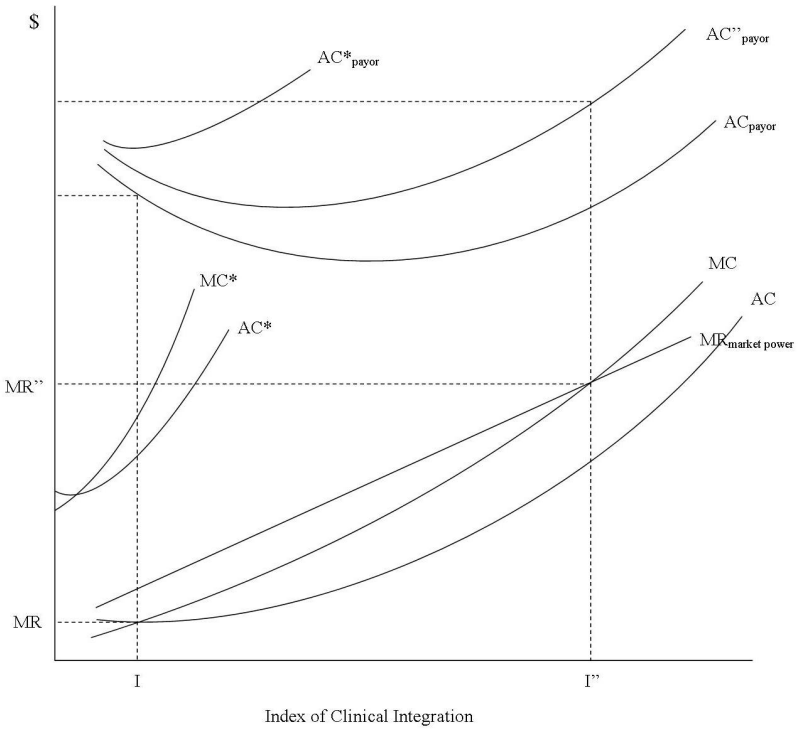


Figure 3 illustrates a failed clinical integration program—the network's average cost curve (AC*) lies far above that depicted in Figures 1 and 2, and the payor's average cost curve (AC^*_{payor}) begins increasing at a much lower level of clinical integration. Notice that the marginal cost curve associated with the failed program (MC*) never intersects the marginal revenue curve ($MR_{market\ power}$), which means that the network's optimal amount of clinical integration is zero.

Figure 3



Even though the network's optimal amount of clinical integration is zero, the network may benefit if it can continue receiving the jointly contracted physician fees. Thus, the network may have an incentive to obscure just how little clinical integration (and its associated benefits) it has actually achieved. In other words, even if a network expected clinical integration to produce efficiencies and made a sincere attempt to realize those efficiencies, if that attempt fails, the network may have an incentive to maintain the appearance that it is successfully clinically integrated in order to receive the marginal revenue associated with clinical integration without bearing the costs.

V. SOME THOUGHTS ON FURTHER GUIDANCE

Physicians have made numerous attempts to obtain antitrust immunity for their joint contracting with third-party payors, only to have the proposed legislation fail to pass Congress amid the Agencies' opposition.[37] The Agencies' clinical integration policy may be viewed by physicians as a second-best alternative to antitrust immunity. That would be unwise, as it has the wrong focus—physicians should not be asking themselves "What is the minimum we have to do under the Agencies' clinical integration policy to avoid antitrust scrutiny so we can engage in joint contracting?" In fact, the Agencies may be wise to be skeptical of any overly enthusiastic

[37] One such piece of legislation was H.R. 1304, The Quality Health-Care Coalition Act of 1999. FTC chairman Robert Pitofsky and Assistant Attorney General Joel Klein testified before the House Judiciary Committee in opposition to the legislation on June 22, 1999.

physician support for a clinical integration program for two reasons: clinical integration programs are costly and physicians are not altruists.

Clinical integration of physician practices is a costly undertaking, not only financially but also in terms of the substantial time commitment required to make it work. While physicians may truly care about their patients, they are closer to profit-maximizers than altruists. Physicians do not like to incur costs any more than anyone else. They can be expected to enthusiastically pursue those aspects of a clinical integration programs that yield direct benefits (*e.g.*, joint contracting resulting in higher physician fees) and to be much less enthusiastic in pursuing the costly aspects (*e.g.*, actually working to improve patient care). The Agencies should be skeptical of physicians' justifications for their actions (*e.g.*, quality-of-care improvements) when one of the results of those actions is higher fees. Of course, it is possible that on a quality-adjusted basis, physicians' fees fall. But "improving patient care" should not be a pretext for physician collusion.

Physicians will invest in clinical integration if the return on that investment is sufficiently high, and not otherwise. In order for an investment in clinical integration to be profitable, physicians must either obtain more patients or obtain higher profits per patient, or both.

Clinical integration arrangements vary across the cost spectrum. Network-wide distribution of best practices for various diagnostic categories would entail low costs. Implementing a computer system to track physician performance (*e.g.*, adherence to best-practices, frequency of hospital readmission, frequency of avoidable complications) could be quite costly. Running a system by which physician-members are held accountable to, and disciplined by, their peers would entail a substantial time commitment. Implementing a computer system to coordinate care among all the network physicians who see a particular patient could be extremely costly. The greater the returns that physicians obtain from a given level of clinical integration, the more they will invest in clinical integration. Therefore, all else equal, higher fees from third-party payors will lead to more investment in clinical integration by physicians. The Agencies should recognize that if prevailing fee rates are sufficiently low, the equilibrium level of clinical integration may be minimal.

Under certain conditions, an increase in physician fees could benefit both physicians and payors. Higher fees could lead to greater physician investment in clinical integration (because it attracts more patients or improves profit margins) and also lower a payor's costs (because the effect of lower patient utilization rates more than offsets the effect of higher physician fees). This is a best-case scenario since a payor that possesses some market power will pass-along at least a portion of its firm-specific cost savings to consumers.[38] It is a win-win-win scenario for physicians, payors, and consumers.

There is an unfortunate dearth of empirical studies that examine the actual results of existing clinical integration programs. Physicians presumably have obtained higher fees through joint contracting, but have the programs reduced patient utilization rates sufficiently to actually reduce payors' costs? The complaints of some payors suggest that at least some clinical integration programs have not. If the programs simply have the effect of raising payors' costs, and those cost increases are passed, in whole or in part, to consumers in the form of higher quality-adjusted prices for health insurance, then the Agencies should act to protect consumers.

[38] For a discussion of the pass-through of firm-specific cost savings in the context of merger efficiencies, *see, for example*, Paul Yde & Michael Vita, *Merger Efficiencies: The "Passing-on" Fallacy*, 20 ANTITRUST 59 (Summer 2006).

What if the clinical integration program fails to reduce costs despite the best efforts of all concerned? Should it be challenged as a *per se* antitrust violation? Although it may be argued that doing so would be a harsh penalty for a failed business endeavor, what is the alternative? Allow it to continue charging anticompetitive prices?

And what would be the effect on physician incentives? Physicians would have a strong incentive to make the joint contracting portion of the clinical integration program work since the result is higher fees for themselves, but they would have much less incentive to undertake the costs of making the program work as a whole. In other words, the cost of a failed clinical integration program for physicians would be higher fees for themselves. Not a bad consolation prize.

One counterargument is that if a clinical integration program fails, competition from other providers may make the higher physician fees unsustainable. But what about those clinical integration programs which the Agencies did not challenge, despite their possible market power effects if the networks are operated in ways different from that described to the FTC?[39] Will competition be sufficient to eliminate that market power? Once again, the dearth of empirical evidence is unfortunate.

VI. CONCLUSION

Are clinical integration arrangements simply physician cartels in an attractive disguise? That is certainly the concern of the DOJ and FTC, as well as the insinuation of some third-party payors. Unfortunately, there is a dearth of empirical studies that have examined clinically integrated networks so the extent to which claimed efficiencies have actually been realized is unknown.

The FTC should conduct additional "follow-up" studies to its clinical integration advisory opinions, as it did for MedSouth. The Agencies need to understand which, if any, clinical integration programs have achieved claimed efficiencies and increased patient quality-of-care. For those that have done so, what have been the competitive effects? Did physicians' fees increase? Has the clinically integrated network gained market share? What are the views of the payors? Have quality-adjusted health insurance rates risen or fallen? The Agencies also need to understand what happens when a network fails to achieve claimed efficiencies and improve quality-of-care. What have been the competitive effects? Have they lost market share? Have their physician fees fallen? Once the Agencies are able to provide some answers to these questions, it may be time to update their *Statements of Antitrust Enforcement Policy in Health Care.*

[39] For example, the FTC staff advisory opinion for TriState Health Partners, a PHO, said that the FTC staff "would not recommend that the Commission challenge the program." However, the FTC staff also said that, "[w]hile TriState's physician members as a group, and TriState's hospital member, may have market power in their respective markets, it appears that the program as described is unlikely to enable them to exercise or increase any such power," but added that "[i]f participants were to operate in ways different from what TriState has proposed, TriState's program could raise serious competitive concerns." *See*, Markus H. Meier, *TriState Health Partners, Inc. Advisory Opinion*, Federal Trade Commission (April 13, 2009), pp. 1-2.