DEPARTMENT OF JUSTICE

Statements of Antitrust Enforcement Policy in Health Care

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DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE

INTRODUCTION

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

The 1993 policy statements and expedited specific Agency guidance were designed to advise the health care community in a time of tremendous change, and to address, as completely as possible, the problem of uncertainty concerning the Agencies' enforcement policy that some had said might deter mergers, joint ventures, or other activities that could lower health care costs. Sound antitrust enforcement, of course, continued to protect

consumers against anticompetitive activities.

When the Agencies issued the 1993 health care antitrust enforcement policy statements, they recognized that additional guidance might be desirable in the areas covered by those statements as well as in other health care areas, and committed to issuing revised and additional policy statements as warranted. In light of the comments the Agencies received on the 1993 statements and the Agencies' own experience, the Agencies revised and expanded the health care antitrust enforcement policy statements in September 1994. The 1994 statements, which superseded the 1993 statements, added new statements addressing hospital joint ventures involving specialized clinical or other expensive health care services, providers' collective provision of fee-related information to purchasers of health care services, and analytical principles relating to a broad range of health care provider networks (termed "multiprovider networks"), and expanded the antitrust "safety zones" for several other statements.

Since issuance of the 1994 statements, health care markets have continued to evolve in response to consumer demand and competition in the marketplace. New arrangements and variations on existing arrangements involving joint activity by health care providers continue to emerge to meet consumers', purchasers', and payers' desire for more efficient delivery of high quality health care services. During this period, the Agencies have gained

additional experience with arrangements involving joint provider activity. As a result of these developments, the Agencies have decided to amplify the enforcement policy statement on physician network joint ventures and the more general statement on multiprovider networks.

In these revised statements, the Agencies continue to analyze all types of health care provider networks under general antitrust principles. These principles are sufficiently flexible to take into account the particular characteristics of health care markets and the rapid changes that are occurring in those markets. The Agencies emphasize that it is not their intent to treat such networks either more strictly or more leniently than joint ventures in other industries, or to favor any particular procompetitive organization or structure of health care delivery over other forms that consumers may desire. Rather, their goal is to ensure a competitive marketplace in which consumers will have the benefit of high quality, cost-effective health care and a wide range of choices, including new provider-controlled networks that expand consumer choice and increase competition.

The revisions to the statements on physician network joint ventures and multiprovider networks are summarized below. In addition to these revisions, various changes have been made to the language of both statements to improve their clarity. No revisions have been made to any of the other statements.

Physician Network Joint Ventures

The revised statement on physician network joint ventures provides an expanded discussion of the antitrust principles that apply to such ventures. The revisions focus on the analysis of networks that fall outside the safety zones contained in the existing statement, particularly those networks that do not involve the sharing of substantial financial risk by their physician participants. The revised statement explains that where physicians' integration through the network is likely to produce significant efficiencies, any agreements on price reasonably necessary to accomplish the venture's procompetitive benefits will be analyzed under the rule of reason.

The revised statement adds three hypothetical examples to further illustrate the application of these principles: (1) a physician network joint venture that does not involve the sharing of substantial financial risk, but receives rule of reason treatment due to the extensive integration among its physician participants; (2) a network that involves both risk-sharing and non-risk-sharing activities, and receives rule of reason treatment; and (3) a network that involves little or no integration among its physician participants, and is per se illegal.

The safety zones for physician network joint ventures remain unchanged, but the revised statement identifies additional types

of financial risk-sharing arrangements that can qualify a network for the safety zones. It also further emphasizes two points previously made in the 1994 statements. First, the enumeration in the statements of particular examples of substantial financial risk sharing does not foreclose consideration of other arrangements through which physicians may share substantial financial risk. Second, a physician network that falls outside the safety zones is not necessarily anticompetitive.

Multiprovider Networks

In 1994, the Agencies issued a new statement on multiprovider health care networks that described the general antitrust analysis of such networks. The revised statement on multiprovider networks emphasizes that it is intended to articulate general principles relating to a wide range of health care provider networks. Many of the revisions to this statement reflect changes made to the revised statement on physician network joint ventures. In addition, four hypothetical examples involving PHOs ("physician-hospital organizations"), including one involving “messenger model” arrangements, have been added.

Safety Zones and Hypothetical Examples

Most of the nine statements give health care providers guidance in the form of antitrust safety zones, which describe conduct that the Agencies will not challenge under the antitrust

laws, absent extraordinary circumstances. The Agencies are aware that some parties have interpreted the safety zones as defining the limits of joint conduct that is permissible under the antitrust laws. This view is incorrect. The inclusion of certain conduct within the antitrust safety zones does not imply that conduct falling outside the safety zones is likely to be challenged by the Agencies. Antitrust analysis is inherently fact-intensive. The safety zones are designed to require consideration of only a few factors that are relatively easy to apply, and to provide the Agencies with a high degree of confidence that arrangements falling within them are unlikely to raise substantial competitive concerns. Thus, the safety zones encompass only a subset of provider arrangements that the Agencies are unlikely to challenge under the antitrust laws. The statements outline the analysis the Agencies will use to review conduct that falls outside the safety zones.

Likewise, the statements' hypothetical examples concluding that the Agencies would not challenge the particular arrangement do not mean that conduct varying from the examples is likely to be challenged by the Agencies. The hypothetical examples are designed to illustrate how the statements' general principles apply to specific situations. Interested parties should examine the business review letters issued by the Department of Justice and the advisory opinions issued by the Federal Trade Commission and its staff for additional guidance on the application and

interpretation of these statements. Copies of those letters and opinions and summaries of the letters and opinions are available from the Agencies at the mailing and Internet addresses listed at the end of the statements.

The statements also set forth the Department of Justice's business review procedure and the Federal Trade Commission's advisory opinion procedure under which the health care community can obtain the Agencies' antitrust enforcement intentions regarding specific proposed conduct on an expedited basis. The statements continue the commitment of the Agencies to respond to requests for business reviews or advisory opinions from the health care community no later than 90 days after all necessary information is received regarding any matter addressed in the statements, except requests relating to hospital mergers outside the antitrust safety zone and multiprovider networks. The Agencies also will respond to business review or advisory opinion requests regarding multiprovider networks or other non-merger health care matters within 120 days after all necessary information is received. The Agencies intend to work closely with persons making requests to clarify what information is necessary and to provide guidance throughout the process. The Agencies continue this commitment to expedited review in an effort to reduce antitrust uncertainty for the health care industry in what the Agencies recognize is a time of fundamental change.

The Agencies recognize the importance of antitrust guidance in evolving health care contexts. Consequently, the Agencies continue their commitment to issue additional guidance as warranted.

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

Introduction

Most hospital mergers and acquisitions ("mergers") do not present competitive concerns. While careful analysis may be necessary to determine the likely competitive effect of a particular hospital merger, the competitive effect of many hospital mergers is relatively easy to assess. This statement sets forth an antitrust safety zone for certain mergers in light of the Agencies' extensive experience analyzing hospital mergers. Mergers that fall within the antitrust safety zone will not be challenged by the Agencies under the antitrust laws, absent extraordinary circumstances.[1] This policy statement also briefly describes the Agencies' antitrust analysis of hospital mergers that fall outside the antitrust safety zone.

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

The Agencies will not challenge any merger between two general acute-care hospitals where one of the hospitals (1) has

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

an average of fewer than 100 licensed beds over the three most recent years, and (2) has an average daily inpatient census of fewer than 40 patients over the three most recent years, absent extraordinary circumstances. This antitrust safety zone will not apply if that hospital is less than 5 years old.

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

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

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

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

Commission 1992 Horizontal Merger Guidelines.

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

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

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If hospitals are considering mergers that appear to fall within the antitrust safety zone and believe they need additional certainty regarding the legality of their conduct

under the antitrust laws, they can take advantage of the Department's business review procedure (28 C.F.R. § 50.6 (1992)) or the Federal Trade Commission's advisory opinion procedure (16 C.F.R. §§ 1.1-1.4 (1993)). The Agencies will respond to business review or advisory opinion requests on behalf of hospitals considering mergers that appear to fall within the antitrust safety zone within 90 days after all necessary information is submitted.

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

Introduction

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

This statement of enforcement policy sets forth an antitrust safety zone that describes hospital high-technology or other expensive health care equipment joint ventures that will not be challenged, absent extraordinary circumstances, by the Agencies

under the antitrust laws. It then describes the Agencies' antitrust analysis of hospital high-technology or other expensive health care equipment joint ventures that fall outside the antitrust safety zone. Finally, this statement includes examples of its application to hospital high-technology or other expensive health care equipment joint ventures.

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

The Agencies will not challenge under the antitrust laws any joint venture among hospitals to purchase or otherwise share the ownership cost of, operate, and market the related services of, high-technology or other expensive health care equipment if the joint venture includes only the number of hospitals whose participation is needed to support the equipment, absent extraordinary circumstances.[2] This applies to joint ventures involving purchases of new equipment as well as to joint ventures involving existing equipment.[3] A joint venture that includes

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

[3] Consequently, the safety zone would apply in a situation in which one hospital had already purchased the health care equipment, but was not recovering the costs of the equipment and

additional hospitals also will not be challenged if the additional hospitals could not support the equipment on their own

sought a joint venture with one or more hospitals in order to recover the costs of the equipment.

or through the formation of a competing joint venture, absent extraordinary circumstances.

For example, if two hospitals are each unlikely to recover the cost of individually purchasing, operating, and marketing the services of a magnetic resonance imager (MRI) over its useful life, their joint venture with respect to the MRI would not be challenged by the Agencies. On the other hand, if the same two hospitals entered into a joint venture with a third hospital that independently could have purchased, operated, and marketed an MRI in a financially viable manner, the joint venture would not be in this antitrust safety zone. If, however, none of the three hospitals could have supported an MRI by itself, the Agencies would not challenge the joint venture.[4]

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

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

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

B. The Agencies' Analysis Of Hospital High-Technology Or Other Expensive Health Care Equipment Joint Ventures That Fall Outside The Antitrust Safety Zone

The Agencies recognize that joint ventures that fall outside the antitrust safety zone do not necessarily raise significant antitrust concerns. The Agencies will apply a rule of reason analysis in their antitrust review of such joint ventures.[5] The objective of this analysis is to determine whether the joint venture may reduce competition substantially, and, if it might, whether it is likely to produce procompetitive efficiencies that outweigh its anticompetitive potential. This analysis is flexible and takes into account the nature and effect of the joint venture, the characteristics of the venture and of the hospital industry generally, and the reasons for, and purposes

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

of, the venture. It also allows for consideration of

efficiencies that will result from the venture. The steps involved in a rule of reason analysis are set forth below.[6]

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

Step two: Evaluate the competitive effects of the venture. This step begins with an analysis of the structure of the relevant market. If many providers would compete with the joint

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[6] Many joint ventures that could provide substantial efficiencies also may present little likelihood of competitive harm. Where it is clear initially that any joint venture presents little likelihood of competitive harm, the step-by-step analysis described in the text below will not be necessary. For example, when two hospitals propose to merge existing expensive health care equipment into a joint venture in a properly defined market in which many other hospitals or other health care facilities operate the same equipment, such that the market will be unconcentrated, then the combination is unlikely to be anticompetitive and further analysis ordinarily would not be required. See Department of Justice/Federal Trade Commission 1992 Horizontal Merger Guidelines.

venture, competitive harm is unlikely and the analysis would continue with step four described below.

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

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

instances, the potential impact on competition of the joint venture would be substantially reduced.[7]

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

Step four: Evaluate collateral agreements. This step examines whether the joint venture includes collateral agreements or conditions that unreasonably restrict competition and are unlikely to contribute significantly to the legitimate purposes of the joint venture. The Agencies will examine whether the collateral agreements are reasonably necessary to achieve the efficiencies sought by the joint venture. For example, if the participants in a joint venture formed to purchase a mobile

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

lithotripter also agreed on the daily room rate to be charged lithotripsy patients who required overnight hospitalization, this collateral agreement as to room rates would not be necessary to achieve the benefits of the lithotripter joint venture. Although the joint venture itself would be legal, the collateral agreement on hospital room rates would not be legal and would be subject to challenge.

C. Examples Of Hospital High-Technology Joint Ventures

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

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

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

2. Joint Venture To Purchase Expensive Equipment

All five hospitals in a relevant market agree to jointly purchase a mobile health care device that provides a service for which consumers have no reasonable alternatives. The hospitals will share equally in the cost of maintaining the equipment, and the equipment will travel from one hospital to another and be available one day each week at each hospital. The hospitals' agreement contains no provisions for joint marketing of, and protects against exchanges of competitively sensitive information regarding, the equipment.[8] There are also no limitations on the prices that each hospital will charge for use of the equipment, on the number of procedures that each hospital can perform, or on each hospital's ability to purchase the equipment on its own. Although any combination of two of the hospitals could afford to purchase the equipment and recover their costs within the equipment's useful life, patient volume from all five hospitals is required to maximize the efficient use of the equipment and lead to significant cost savings. In addition, patient demand would be satisfied by provision of the equipment one day each week at each hospital. The joint venture would result in higher use of the equipment, thus lowering the cost per patient and potentially improving quality.

This joint venture does not fall within the antitrust safety

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

zone because smaller groups of hospitals could afford to purchase and operate the equipment and recover their costs. Therefore, the joint venture would be analyzed under the rule of reason. The first step is to define the relevant market. In this example, the relevant market consists of the services provided by the equipment, and the five hospitals all potentially compete against each other for patients requiring this service.

The second step in the analysis is to determine the competitive effects of the joint venture. Because the joint venture is likely to reduce the number of these health care devices in the market, there is a potential restraint on competition. The restraint would not be substantial, however, for several reasons. First, the joint venture is limited to the purchase of the equipment and would not eliminate competition among the hospitals in the provision of the services. The hospitals will market the services independently, and will not exchange competitively sensitive information. In addition, the venture does not preclude a hospital from purchasing another unit should the demand for these services increase.

Because the joint venture raises some competitive concerns, however, it is necessary to examine the potential efficiencies associated with the venture. As noted above, by sharing the equipment among the five hospitals significant cost savings can be achieved. The joint venture would produce substantial efficiencies while providing access to high quality care. Thus,

this joint venture would on balance benefit consumers since it would not lessen competition substantially, and it would allow the hospitals to serve the community's need in a more efficient manner. Finally, in this example the joint venture does not involve any collateral agreements that raise competitive concerns. On these facts, the joint venture would not be challenged by the Agencies.

3. Joint Venture Of Existing Expensive Equipment Where One Of The Hospitals In The Venture Already Owns The Equipment

Metropolis has three hospitals and a population of 300,000. Mercy and University Hospitals each own and operate their own magnetic resonance imaging device ("MRI"). General Hospital does not. Three independent physician clinics also own and operate MRIs. All of the existing MRIs have similar capabilities. The acquisition of an MRI is not subject to review under a certificate of need law in the state in which Metropolis is located.

Managed care plans have told General Hospital that, unless it can provide MRI services, it will be a less attractive contracting partner than the other two hospitals in town. The five existing MRIs are slightly underutilized -- that is, the average cost per scan could be reduced if utilization of the machines increased. There is insufficient demand in Metropolis for six fully-utilized MRIs.

General has considered purchasing its own MRI so that it can compete on equal terms with Mercy and University Hospitals. However, it has decided based on its analysis of demand for MRI services and the cost of acquiring and operating the equipment that it would be better to share the equipment with another hospital. General proposes forming a joint venture in which it will purchase a 50 percent share in Mercy's MRI, and the two hospitals will work out an arrangement by which each hospital has equal access to the MRI. Each hospital in the joint venture will independently market and set prices for those MRI services, and the joint venture agreement protects against exchanges of competitively sensitive information among the hospitals. There is no restriction on the ability of each hospital to purchase its own equipment.

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

The first step of the rule of reason analysis is defining the relevant product and geographic markets. Assuming there are no good substitutes for MRI services, the relevant product market in this case is MRI services. Most patients currently receiving MRI services are unwilling to travel outside of Metropolis for those services, so the relevant geographic market is Metropolis.

Mercy, University, and the three physician clinics are already offering MRI services in this market. Because General intends to offer MRI services within the next year, even if there is no joint venture, it is viewed as a market participant.

The second step is determining the competitive impact of the joint venture. Absent the joint venture, there would have been six independent MRIs in the market. This raises some competitive concerns with the joint venture. The fact that the joint venture will not entail joint price setting or marketing of MRI services to purchasers reduces the venture's potential anticompetitive effect. The competitive analysis would also consider the likelihood of additional entry in the market. If, for example, another physician clinic is likely to purchase an MRI in the event that the price of MRI services were to increase, any anticompetitive effect from the joint venture becomes less likely. Entry may be more likely in Metropolis than other areas because new entrants are not required to obtain certificates of need.

The third step of the analysis is assessing the likely efficiencies associated with the joint venture. The magnitude of any likely anticompetitive effects associated with the joint venture is important; the greater the venture's likely anticompetitive effects, the greater must be the venture's likely efficiencies. In this instance, the joint venture will avoid the costly duplication associated with General purchasing an MRI, and will allow Mercy to reduce the average cost of operating its MRI by increasing the number of procedures done. The competition between the Mercy/General venture and the other MRI providers in the market will provide some incentive for the joint venture to

operate the MRI in as low-cost a manner as possible. Thus, there are efficiencies associated with the joint venture that could not be achieved in a less restrictive manner.

The final step of the analysis is determining whether the joint venture has any collateral agreements or conditions that reduce competition and are not reasonably necessary to achieve the efficiencies sought by the venture. For example, if the joint venture required managed care plans desiring MRI services to contract with both joint venture participants for those services, that condition would be viewed as anticompetitive and unnecessary to achieve the legitimate procompetitive goals of the joint venture. This example does not include any unnecessary collateral restraints.

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

4. Joint Venture Of Existing Equipment Where Both Hospitals In The Venture Already Own The Equipment

Valley Town has a population of 30,000 and is located in a valley surrounded by mountains. The closest urbanized area is over 75 miles away. There are two hospitals in Valley Town: Valley Medical Center and St. Mary's. Valley Medical Center

offers a full range of primary and secondary services. St. Mary's offers primary and some secondary services. Although both hospitals have a CT scanner, Valley Medical Center's scanner is more sophisticated. Because of its greater sophistication, Valley Medical Center's scanner is more expensive to operate, and can conduct fewer scans in a day. A physician clinic in Valley Town operates a third CT scanner that is comparable to St. Mary's scanner and is not fully utilized.

Valley Medical Center has found that many of the scans that it conducts do not require the sophisticated features of its scanner. Because scans on its machine take so long, and so many patients require scans, Valley Medical Center also is experiencing significant scheduling problems. St. Mary's scanner, on the other hand, is underutilized, partially because many individuals go to Valley Medical Center because they need the more sophisticated scans that only Valley Medical Center's scanner can provide. Despite the underutilization of St. Mary's scanner, and the higher costs of Valley Medical Center's scanner, neither hospital has any intention of discontinuing its CT services. Valley Medical Center and St. Mary's are proposing a joint venture that would own and operate both hospitals' CT scanners. The two hospitals will then independently market and set the prices they charge for those services, and the joint venture agreement protects against exchanges of competitively sensitive information between the hospitals. There is no restriction on

the ability of each hospital to purchase its own equipment.

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

The second step of the analysis is determining the competitive effect of the joint venture. Because the joint venture does not entail joint pricing or marketing of CT services, the joint venture does not effectively reduce the number of market participants. This reduces the venture's potential anticompetitive effect. In fact, by increasing the scope of the CT services that each hospital can provide, the joint venture may increase competition between Valley Medical Center and St. Mary's since now both hospitals can provide

sophisticated scans. Competitive concerns with this joint venture would be further ameliorated if other health care providers were likely to acquire CT scanners in response to a price increase following the formation of the joint venture.

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

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

The last step of the analysis is to determine whether there are any collateral agreements or conditions associated with the joint venture that reduce competition and are not reasonably necessary to achieve the efficiencies sought by the joint venture. Assuming there are no such agreements or conditions, the Agencies would view this joint venture favorably under a rule of reason analysis.

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

Also, if neither of the hospitals in Valley Town had a CT scanner, and they proposed a similar joint venture for the purchase of two CT scanners, one sophisticated and one less sophisticated, the Agencies would be unlikely to view that joint venture as anticompetitive, even though each hospital could independently support the purchase of its own CT scanner. This conclusion would be based upon a rule of reason analysis that was virtually identical to the one described above.

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Hospitals that are considering high-technology or other expensive equipment joint ventures and are unsure of the legality of their conduct under the antitrust laws can take advantage of the Department's expedited business review procedure for joint ventures and information exchanges announced on December 1, 1992 (58 Fed. Reg. 6132 (1993)) or the Federal Trade Commission's advisory opinion procedure contained at 16 C.F.R. §§ 1.1-1.4

(1993). The Agencies will respond to a business review or advisory opinion request on behalf of hospitals that are considering a high-technology joint venture within 90 days after all necessary information is submitted. The Department's December 1, 1992 announcement contains specific guidance as to the information that should be submitted.

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

Introduction

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

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

This statement of enforcement policy sets forth the Agencies' antitrust analysis of joint ventures between hospitals to provide

specialized clinical or other expensive health care services and includes an example of its application to such ventures. It does not include a safety zone for such ventures since the Agencies believe that they must acquire more expertise in evaluating the cost of, demand for, and potential benefits from such joint ventures before they can articulate a meaningful safety zone. The absence of a safety zone for such collaborative activities does not imply that they create any greater antitrust risk than other types of collaborative activities.

A. The Agencies' Analysis Of Hospital Joint Ventures Involving Specialized Clinical Or Other Expensive Health Care Services

The Agencies apply a rule of reason analysis in their antitrust review of hospital joint ventures involving specialized clinical or other expensive health care services.[9] The objective of this analysis is to determine whether the joint venture may reduce competition substantially, and if it might, whether it is likely to produce procompetitive efficiencies that outweigh its anticompetitive potential. This analysis is flexible and takes into account the nature and effect of the joint venture, the characteristics of the services involved and of the hospital

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

industry generally, and the reasons for, and purposes of, the

venture. It also allows for consideration of efficiencies that will result from the venture. The steps involved in a rule of reason analysis are set forth below.[10]

Step one: Define the relevant market. The rule of reason analysis first identifies the service that is produced through the joint venture. The relevant product and geographic markets that include the service are then properly defined. This process seeks to identify any other provider that could offer a service that patients or physicians generally would consider a good substitute for that provided by the joint venture. Thus, if a joint venture were to produce intensive care neonatology services, the relevant market would include only other neonatal intensive care nurseries that patients or physicians would view as reasonable alternatives.

Step two: Evaluate the competitive effects of the venture. This step begins with an analysis of the structure of the relevant market. If many providers compete with the joint venture, competitive harm is unlikely and the analysis would continue with step four described below.

If the structural analysis of the relevant market showed that

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[10] Many joint venturers that could provide substantial efficiencies also may present little likelihood of competitive harm. Where it is clear initially that any joint venture presents little likelihood of competitive harm, it will not be necessary to complete all steps in the analysis to conclude that the joint venture should not be challenged. See note 7, above.

the joint venture would eliminate an existing or potentially viable competing provider of a service and that there were few competing providers of that service, or that cooperation in the joint venture market might spill over into a market in which the parties to the joint venture are competitors, it then would be necessary to assess the extent of the potential anticompetitive effects of the joint venture. In addition to the number and size of competing providers, factors that could restrain the ability of the joint venture to act anticompetitively either unilaterally or through collusive agreements with other providers would include: (1) characteristics of the market that make anticompetitive coordination unlikely; (2) the likelihood that others would enter the market; and (3) the effects of government regulation.

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

primary or secondary services, the hospitals may also face substantial competition for the joint-ventured tertiary service.[11]

Step three: Evaluate the impact of procompetitive efficiencies. This step requires an examination of the joint venture's potential to create procompetitive efficiencies, and the balancing of these efficiencies against any potential anticompetitive effects. The greater the venture's likely anticompetitive effects, the greater must be the venture's likely efficiencies. In certain circumstances, efficiencies can be substantial because of the need to spread the cost of the investment associated with the recruitment and training of personnel over a large number of patients and the potential for improvement in quality to occur as providers gain experience and skill from performing a larger number of procedures. In the case of certain specialized clinical services, such as open heart surgery, the joint venture may permit the program to generate sufficient patient volume to meet well-accepted minimum standards for assuring quality and patient safety.

Step four: Evaluate collateral agreements. This step examines whether the joint venture includes collateral agreements or conditions that unreasonably restrict competition and are

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

unlikely to contribute significantly to the legitimate purposes of the joint venture. The Agencies will examine whether the collateral agreements are reasonably necessary to achieve the efficiencies sought by the venture. For example, if the participants in a joint venture to provide highly sophisticated oncology services were to agree on the prices to be charged for all radiology services regardless of whether the services are provided to patients undergoing oncology radiation therapy, this collateral agreement as to radiology services for non-oncology patients would be unnecessary to achieve the benefits of the sophisticated oncology joint venture. Although the joint venture itself would be legal, the collateral agreement would not be legal and would be subject to challenge.

B. Example -- Hospital Joint Venture For New Specialized Clinical Service Not Involving Purchase Of High-Technology Or Other Expensive Health Care Equipment

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

sufficient demand to support one local open-heart surgery unit.

The two hospitals in Midvale propose a joint venture whereby they will share the costs of recruiting a cardiac surgery team and establishing an open-heart surgery program, to be located at one of the hospitals. Patients will be referred to the program from both hospitals, who will share expenses and revenues of the program. The hospitals' agreement protects against exchanges of competitively sensitive information.

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

The second step is determining the competitive impact of the joint venture. Here, the joint venture does not eliminate any existing competition, because neither of the two hospitals previously was providing open-heart surgery. Nor does the joint

venture eliminate any potential competition, because there is insufficient patient volume for more than one viable open-heart

surgery program. Thus, only one such program could exist in Midvale, regardless of whether it was established unilaterally or through a joint venture.

Normally, the third step in the rule of reason analysis would be to assess the procompetitive effects of, and likely efficiencies associated with, the joint venture. In this instance, this step is unnecessary, since the analysis has concluded under step two that the joint venture will not result in any significant anticompetitive effects.

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

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

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Hospitals that are considering specialized clinical or other expensive health care services joint ventures and are unsure of

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

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

Introduction

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

This statement sets forth an antitrust safety zone that describes providers' collective provision of non-fee-related information that will not be challenged by the Agencies under the antitrust laws, absent extraordinary circumstances.[12] It also describes conduct that is expressly excluded from the antitrust safety zone.

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[12] This statement addresses only providers' collective activities. As a general proposition, providers acting individually may provide any information to any purchaser without incurring liability under federal antitrust law. This statement also does not address the collective provision of information through an integrated joint venture or the exchange of information that necessarily occurs among providers involved in legitimate joint venture activities. Those activities generally do not raise antitrust concerns.

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

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

In the course of providing underlying medical data, providers may collectively engage in discussions with purchasers about the scientific merit of that data. However, the antitrust safety

zone excludes any attempt by providers to coerce a purchaser's decisionmaking by implying or threatening a boycott of any plan that does not follow the providers' joint recommendation. Providers who collectively threaten to or actually refuse to deal with a purchaser because they object to the purchaser's administrative, clinical, or other terms governing the provision of services run a substantial antitrust risk. For example, providers' collective refusal to provide X-rays to a purchaser that seeks them before covering a particular treatment regimen would constitute an antitrust violation. Similarly, providers' collective attempt to force purchasers to adopt recommended practice parameters by threatening to or actually boycotting purchasers that refuse to accept their joint recommendation also would risk antitrust challenge.

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

submitted. The Department's December 1, 1992 announcement contains specific guidance as to the information that should be submitted.

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

Introduction

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

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

[13] This statement addresses only providers' collective activities. As a general proposition, providers acting individually may provide any information to any purchaser without incurring liability under federal antitrust law. This statement also does not address the collective provision of information through an integrated joint venture or the exchange of information that necessarily occurs among providers involved in legitimate joint venture activities. Those activities generally do not raise antitrust concerns.

conduct that are expressly excluded from the antitrust safety

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

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

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

In assembling information to be collectively provided to purchasers, providers need to be aware of the potential antitrust consequences of information exchanges among competitors. The principles expressed in the Agencies' statement on provider participation in exchanges of price and cost information are applicable in this context. Accordingly, in order to qualify for this safety zone, the collection of information to be provided to purchasers must satisfy the following conditions:

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

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

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

The conditions that must be met for an information exchange among providers to fall within the antitrust safety zone are intended to ensure that an exchange of price or cost data is not used by competing providers for discussion or coordination of provider prices or costs. They represent a careful balancing of a provider's individual interest in obtaining information useful in adjusting the prices it charges or the wages it pays in response to changing market conditions against the risk that the exchange of such information may permit competing providers to communicate with each other regarding a mutually acceptable level of prices for health care services or compensation for employees.

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

The safety zone set forth in this policy statement does not

apply to collective negotiations between unintegrated providers and purchasers in contemplation or in furtherance of any agreement among the providers on fees or other terms or aspects of reimbursement,[14] or to any agreement among unintegrated providers to deal with purchasers only on agreed terms. Providers also may not collectively threaten, implicitly or explicitly, to engage in a boycott or similar conduct, or actually undertake such a boycott or conduct, to coerce any purchaser to accept collectively-determined fees or other terms or aspects of reimbursement. These types of conduct likely would violate the antitrust laws and, in many instances, might be per se illegal.

Also excluded from the safety zone is providers' collective provision of information or views concerning prospective fee-related matters. In some circumstances, the collective provision of this type of fee-related information also may be helpful to a purchaser and, as long as independent decisions on whether to accept a purchaser's offer are truly preserved, may not raise antitrust concerns. However, in other circumstances, the collective provision of prospective fee-related information or views may evidence or facilitate an agreement on prices or other competitively significant terms by the competing providers. It

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

also may exert a coercive effect on the purchaser by implying or threatening a collective refusal to deal on terms other than those proposed, or amount to an implied threat to boycott any plan that does not follow the providers' collective proposal.

The Agencies recognize the need carefully to distinguish possibly procompetitive collective provision of prospective fee-related information or views from anticompetitive situations that involve unlawful price agreements, boycott threats, refusals to deal except on collectively determined terms, collective negotiations, or conduct that signals or facilitates collective price terms. Therefore, the collective provision of such prospective fee-related information or views will be assessed on a case-by-case basis. In their case-by-case analysis, the Agencies will look at all the facts and circumstances surrounding the provision of the information, including, but not limited to, the nature of the information provided, the nature and extent of the communications among the providers and between the providers and the purchaser, the rationale for providing the information, and the nature of the market in which the information is provided.

In addition, because the collective provision of prospective fee-related information and views can easily lead to or accompany unlawful collective negotiations, price agreements, or the other types of collective conduct noted above, providers need to be aware of the potential antitrust consequences of information

exchanges among competitors in assembling information or views concerning prospective fee-related matters. Consequently, such protections as the use of a third party to manage the collection of information and views, and the adoption of mechanisms to assure that the information is not disseminated or used in a manner that facilitates unlawful agreements or coordinated conduct by the providers, likely would reduce antitrust concerns.

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

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

Introduction

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

This statement sets forth an antitrust safety zone that describes exchanges of price and cost information among providers that will not be challenged by the Agencies under the

antitrust laws, absent extraordinary circumstances. It also

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

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

The Agencies will not challenge, absent extraordinary circumstances, provider participation in written surveys of (a) prices for health care services,[15] or (b) wages, salaries, or benefits of health care personnel, if the following conditions are satisfied:

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

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

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

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

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

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

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

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

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

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

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

Introduction

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

Joint purchasing arrangements are unlikely to raise antitrust concerns unless (1) the arrangement accounts for so large a portion of the purchases of a product or service that it

can effectively exercise market power[16] in the purchase of the product or service, or (2) the products or services being purchased jointly account for so large a proportion of the total cost of the services being sold by the participants that the joint purchasing arrangement may facilitate price fixing or otherwise reduce competition. If neither factor is present, the joint purchasing arrangement will not present competitive concerns.[17]

This statement sets forth an antitrust safety zone that describes joint purchasing arrangements among health care providers that will not be challenged, absent extraordinary circumstances, by the Agencies under the antitrust laws. It also describes factors that mitigate any competitive concerns with joint purchasing arrangements that fall outside the antitrust safety zone.[18]

A. *Antitrust Safety Zone:* Joint Purchasing Arrangements Among

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

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

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

Health Care Providers That Will Not Be Challenged, Absent Extraordinary Circumstances, By The Agencies

The Agencies will not challenge, absent extraordinary circumstances, any joint purchasing arrangement among health care providers where two conditions are present: (1) the purchases account for less than 35 percent of the total sales of the purchased product or service in the relevant market; and (2) the cost of the products and services purchased jointly accounts for less than 20 percent of the total revenues from all products or services sold by each competing participant in the joint purchasing arrangement.

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

arrangements for food services, data processing, and many other products and services.

The second condition addresses any possibility that a joint purchasing arrangement might result in standardized costs, thus facilitating price fixing or otherwise having anticompetitive effects. This condition applies only where some or all of the participants are direct competitors. For example, if a nationwide purchasing cooperative limits its membership to one hospital in each geographic area, there is not likely to be any concern about reduction of competition among its members. Even where a purchasing arrangement's membership includes hospitals or other health care providers that compete with one another, the arrangement is not likely to facilitate collusion if the goods and services being purchased jointly account for a small fraction of the final price of the services provided by the participants. In the health care field, it may be difficult to determine the specific final service in which the jointly purchased products are used, as well as the price at which that final service is sold.[19] Therefore, the Agencies will examine whether the cost of the products or services being purchased jointly accounts, in the aggregate, for less than 20 percent of the total revenues from all health care services of each

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

competing participant.

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

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

These safeguards will reduce substantially, if not completely eliminate, use of the purchasing arrangement as a vehicle for discussing and coordinating the prices of health

care services offered by the participants.[20] The adoption of these safeguards also will help demonstrate that the joint purchasing arrangement is intended to achieve economic efficiencies rather than to serve an anticompetitive purpose. Where there appear to be significant efficiencies from a joint purchasing arrangement, the Agencies will not challenge the arrangement absent substantial risk of anticompetitive effects.

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

The existence of a large number and variety of purchasing groups in the health care field suggests that entry barriers to forming new groups currently are not great. Thus, in most circumstances at present, it is not necessary to open a joint purchasing arrangement to all competitors in the market. However, if some competitors excluded from the arrangement are unable to compete effectively without access to the arrangement, and competition is thereby harmed, antitrust concerns will exist.

C. Example -- Joint Purchasing Arrangement Involving Both Hospitals In Rural Community That The Agencies Would Not Challenge

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

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

The joint venture will be an independent corporation, jointly owned by the participating hospitals. It will purchase the

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

Competitive Analysis

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

The Agencies would then inquire whether the supplies to be

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

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

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

Introduction

In recent years, health plans and other purchasers of health care services have developed a variety of managed care programs that seek to reduce the costs and assure the quality of health care services. Many physicians and physician groups have organized physician network joint ventures, such as individual practice associations ("IPAs"), preferred provider organizations ("PPOs"), and other arrangements to market their services to these plans.[21] Typically, such networks contract with the plans to provide physician services to plan subscribers at predetermined prices, and the physician participants in the networks agree to controls aimed at containing costs and assuring the appropriate and efficient provision of high quality physician services. By developing and implementing mechanisms that encourage physicians to collaborate in practicing efficiently as part of the network, many physician network joint ventures promise significant procompetitive benefits for consumers of

[21] An IPA or PPO typically provides medical services to the subscribers of health plans but does not act as their insurer. In addition, an IPA or PPO does not require complete integration of the medical practices of its physician participants. Such physicians typically continue to compete fully for patients who are enrolled in health plans not served by the IPA or PPO, or who have indemnity insurance or pay for the physician's services directly "out of pocket."

health care services.

As used in this statement, a physician network joint venture is a physician-controlled venture in which the network's physician participants collectively agree on prices or price-related terms and jointly market their services.[22] Other types of health care network joint ventures are not directly addressed by this statement.[23]

This statement of enforcement policy describes the Agencies' antitrust analysis of physician network joint ventures, and presents several examples of its application to specific hypothetical physician network joint ventures. Before describing the general antitrust analysis, the statement sets forth

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

[23] The physician network joint ventures discussed in this statement are one type of the multiprovider network joint ventures discussed below in the Agencies' Statement Of Enforcement Policy On Multiprovider Networks. That statement also covers other types of networks, such as networks that include both hospitals and physicians, and networks involving non-physician health professionals. In addition, that statement (see infra pp. 106-141), and Example 7 of this statement, address networks that do not include agreements among competitors on prices or price-related terms, through use of various "messenger model" arrangements. Many of the issues relating to physician network joint ventures are the same as those that arise and are addressed in connection with multiprovider networks generally, and the analysis often will be very similar for all such arrangements.

antitrust safety zones that describe physician network joint ventures that are highly unlikely to raise substantial competitive concerns, and therefore will not be challenged by the Agencies under the antitrust laws, absent extraordinary circumstances.

The Agencies emphasize that merely because a physician network joint venture does not come within a safety zone in no way indicates that it is unlawful under the antitrust laws. On the contrary, such arrangements may be procompetitive and lawful, and many such arrangements have received favorable business review letters or advisory opinions from the Agencies.[24] The safety zones use a few factors that are relatively easy to apply, to define a category of ventures for which the Agencies presume no anticompetitive harm, without examining competitive conditions

[24] For example, the Agencies have approved a number of non-exclusive physician or provider networks in which the percentage of participating physicians or providers in the market exceeded the 30% criterion of the safety zone. See, e.g., Letter from Anne K. Bingaman, Assistant Attorney General, Department of Justice, to John F. Fischer (Oklahoma Physicians Network, Inc.) (Jan. 17, 1996) ("substantially more" than 30% of several specialties in a number of local markets, including more than 50% in one specialty); Letter from Anne K. Bingaman to Melissa J. Fields (Dermnet, Inc.) (Dec. 5, 1995) (44% of board-certified dermatologists); Letter from Anne K. Bingaman to Dee Hartzog (International Chiropractor's Association of California) (Oct. 27, 1994) (up to 50% of chiropractors); Letter from Mark Horoschak, Assistant Director, Federal Trade Commission, to Stephen P. Nash (Eastern Ohio Physicians Organization) (Sept. 28, 1995) (safety zone's 30% criterion exceeded for primary care physicians by a small amount, and for certain subspecialty fields "to a greater extent"); Letter from Mark Horoschak to John A. Cook (Oakland Physician Network) (Mar. 28, 1995) (multispecialty network with 44% of physicians in one specialty).

in the particular case. A determination about the lawfulness of physician network joint ventures that fall outside the safety

zones must be made on a case-by-case basis according to general antitrust principles and the more specific analysis described in this statement.

A. *Antitrust Safety Zones*

This section describes those physician network joint ventures that will fall within the antitrust safety zones designated by the Agencies. The antitrust safety zones differ for "exclusive" and "non-exclusive" physician network joint ventures. In an "exclusive" venture, the network's physician participants are restricted in their ability to, or do not in practice, individually contract or affiliate with other network joint ventures or health plans. In a "non-exclusive" venture, on the other hand, the physician participants in fact do, or are available to, affiliate with other networks or contract individually with health plans. This section explains how the Agencies will determine whether a physician network joint venture is exclusive or non-exclusive. It also illustrates types of arrangements that can involve the sharing of substantial financial risk among a network's physician participants, which is necessary for a network to come within the safety zones.

1. Exclusive Physician Network Joint Ventures That The Agencies Will Not Challenge, Absent Extraordinary Circumstances

The Agencies will not challenge, absent extraordinary

circumstances, an exclusive physician network joint venture whose physician participants share substantial financial risk and constitute 20 percent or less of the physicians[25] in each physician specialty with active hospital staff privileges who practice in the relevant geographic market.[26] In relevant markets with fewer than five physicians in a particular specialty, an exclusive physician network joint venture otherwise qualifying for the antitrust safety zone may include one physician from that specialty, on a non-exclusive basis, even though the inclusion of that physician results in the venture consisting of more than 20 percent of the physicians in that specialty.

2. Non-Exclusive Physician Network Joint Ventures That The Agencies Will Not Challenge, Absent Extraordinary Circumstances

The Agencies will not challenge, absent extraordinary circumstances, a non-exclusive physician network joint venture whose physician participants share substantial financial risk and constitute 30 percent or less of the physicians in each physician specialty with active hospital staff privileges who practice in

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

[26] Generally, relevant geographic markets for the delivery of physician services are local.

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

3. Indicia Of Non-Exclusivity

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

(1) that viable competing networks or managed care plans with adequate physician participation currently exist in the market;

(2) that physicians in the network actually individually participate in, or contract with, other networks or managed care plans, or there is other evidence of their willingness and incentive to do so;

(3) that physicians in the network earn substantial revenue from other networks or through individual contracts with

managed care plans;

(4) the absence of any indications of significant de-participation from other networks or managed care plans in the market; and

(5) the absence of any indications of coordination among the physicians in the network regarding price or other competitively significant terms of participation in other networks or managed care plans.

Networks also may limit or condition physician participants' freedom to contract outside the network in ways that fall short of a commitment of full exclusivity. If those provisions significantly restrict the ability or willingness of a network's physicians to join other networks or contract individually with managed care plans, the network will be considered exclusive for purposes of the safety zones.

4. Sharing Of Substantial Financial Risk By Physicians In A Physician Network Joint Venture

To qualify for either antitrust safety zone, the participants in a physician network joint venture must share substantial financial risk in providing all the services that are jointly priced through the network.[27] The safety zones are limited to networks involving substantial financial risk sharing not because

[27] Physician network joint ventures that involve both risk-sharing and non-risk-sharing arrangements do not fall within the safety zones. For example, a network may have both risk-sharing and non-risk-sharing contracts. It also may have contracts that involve risk sharing, but not all the physicians in the network participate in risk sharing or not all of the services are paid for on a risk-sharing basis. The Agencies will consider each of the network's arrangements separately, as well as the activities of the venture as a whole, to determine whether the joint pricing with respect to the non-risk-sharing aspects of the venture is appropriately analyzed under the rule of reason. See infra Example 2. The mere presence of some risk-sharing arrangements, however, will not necessarily result in rule of reason analysis of the non-risk-sharing aspects of the venture.

such risk sharing is a desired end in itself, but because it normally is a clear and reliable indicator that a physician network involves sufficient integration by its physician participants to achieve significant efficiencies.[28] Risk sharing provides incentives for the physicians to cooperate in controlling costs and improving quality by managing the provision of services by network physicians.

The following are examples of some types of arrangements through which participants in a physician network joint venture can share substantial financial risk:[29]

(1) agreement by the venture to provide services to a health plan at a "capitated" rate;[30]

(2) agreement by the venture to provide designated services or classes of services to a health plan for a predetermined percentage of premium or revenue from the plan;[31]

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[28] The existence of financial risk sharing does not depend on whether, under applicable state law, the network is considered an insurer.

[29] Physician participants in a single network need not all be involved in the same risk-sharing arrangement within the network to fall within the safety zones. For example, primary care physicians may be capitated and specialists subject to a withhold, or groups of physicians may be in separate risk pools.

[30] A "capitated" rate is a fixed, predetermined payment per covered life (the "capitation") from a health plan to the joint venture in exchange for the joint venture's (not merely an individual physician's) providing and guaranteeing provision of a defined set of covered services to covered individuals for a specified period, regardless of the amount of services actually provided.

[31] This is similar to a capitation arrangement, except that the amount of payment to the network can vary in response to

changes in the health plan's premiums or revenues.

(3) use by the venture of significant financial incentives for its physician participants, as a group, to achieve specified cost-containment goals. Two methods by which the venture can accomplish this are:

(a) withholding from all physician participants in the network a substantial amount of the compensation due to them, with distribution of that amount to the physician participants based on group performance in meeting the cost-containment goals of the network as a whole; or

(b) establishing overall cost or utilization targets for the network as a whole, with the network's physician participants subject to subsequent substantial financial rewards or penalties based on group performance in meeting the targets; and

(4) agreement by the venture to provide a complex or extended course of treatment that requires the substantial coordination of care by physicians in different specialities offering a complementary mix of services, for a fixed, predetermined payment, where the costs of that course of treatment for any individual patient can vary greatly due to the individual patient's condition, the choice, complexity, or length of treatment, or other factors.[32]

The Agencies recognize that new types of risk-sharing arrangements may develop. The preceding examples do not foreclose consideration of other arrangements through which the participants in a physician network joint venture may share substantial financial risk in the provision of medical services

[32] Such arrangements are sometimes referred to as "global fees" or "all-inclusive case rates." Global fee or all-inclusive case rate arrangements that involve financial risk sharing as contemplated by this example will require that the joint venture (not merely an individual physician participant) assume the risk or benefit that the treatment provided through the network may either exceed, or cost less than, the predetermined payment.

through the network.[33] Organizers of physician networks who are uncertain whether their proposed arrangements constitute substantial financial risk sharing for purposes of this policy statement are encouraged to take advantage of the Agencies' expedited business review and advisory opinion procedures.

B. The Agencies' Analysis Of Physician Network Joint Ventures That Fall Outside The Antitrust Safety Zones

Physician network joint ventures that fall outside the antitrust safety zones also may have the potential to create significant efficiencies, and do not necessarily raise substantial antitrust concerns. For example, physician network joint ventures in which the physician participants share substantial financial risk, but which involve a higher percentage of physicians in a relevant market than specified in the safety zones, may be lawful if they are not anticompetitive on balance.[34] Likewise, physician network joint ventures that do not involve the sharing of substantial financial risk also may be

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[33] The manner of dividing revenues among the network's physician participants generally does not raise antitrust issues so long as the competing physicians in a network (continued...) share substantial financial risk. For example, capitated networks may distribute income among their physician participants using fee-for-service payment with a partial withhold fund to cover the risk of having to provide more services than were originally anticipated.

[34] See infra Examples 5 and 6. Many such physician networks have received favorable business review or advisory opinion letters from the Agencies. The percentages used in the safety zones define areas in which the lack of anticompetitive effects ordinarily will be presumed.

lawful if the physicians' integration through the joint venture creates significant efficiencies and the venture, on balance, is not anticompetitive.

The Agencies emphasize that it is not their intent to treat such networks either more strictly or more leniently than joint ventures in other industries, or to favor any particular procompetitive organization or structure of health care delivery over other forms that consumers may desire. Rather, their goal is to ensure a competitive marketplace in which consumers will have the benefit of high quality, cost-effective health care and a wide range of choices, including new provider-controlled networks that expand consumer choice and increase competition.

1. Determining When Agreements Among Physicians In A Physician Network Joint Venture Are Analyzed Under The Rule Of Reason

Antitrust law treats naked agreements among competitors that fix prices or allocate markets as per se illegal. Where competitors economically integrate in a joint venture, however, such agreements, if reasonably necessary to accomplish the procompetitive benefits of the integration, are analyzed under the rule of reason.[35] In accord with general antitrust principles, physician network joint ventures will be analyzed

[35] In a network limited to providers who are not actual or potential competitors, the providers generally can agree on the prices to be charged for their services without the kinds of economic integration discussed below.

under the rule of reason, and will not be viewed as per se illegal, if the physicians' integration through the network is likely to produce significant efficiencies that benefit consumers, and any price agreements (or other agreements that

would otherwise be per se illegal) by the network physicians are reasonably necessary to realize those efficiencies.[36]

Where the participants in a physician network joint venture have agreed to share substantial financial risk as defined in Section A.4. of this policy statement, their risk-sharing arrangement generally establishes both an overall efficiency goal for the venture and the incentives for the physicians to meet that goal. The setting of price is integral to the venture's use of such an arrangement and therefore warrants evaluation under the rule of reason.

Physician network 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. Such integration can be evidenced by the network implementing an active and ongoing program to

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[36] In some cases, the combination of the competing physicians in the network may enable them to offer what could be considered to be a new product producing substantial efficiencies, and therefore the venture will be analyzed under the rule of reason. See Broadcast Music, Inc. v. Columbia Broadcasting System, Inc., 441 U.S. 1, 21-22 (1979) (competitors' integration and creation of a blanket license for use of copyrighted compositions results in efficiencies so great as to make the blanket license a "different product" from the mere combination of individual competitors and, therefore, joint pricing of the blanket license is subject to rule of reason analysis, rather than the per se rule against price fixing). The Agencies' analysis will focus on the efficiencies likely to be produced by the venture, and the relationship of any price agreements to the achievement of those efficiencies, rather than on whether the venture creates a product that can be labeled "new" or "different."

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. This 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.

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. However, in all cases, the Agencies' analysis will focus on substance, rather than form, in assessing a network's likelihood of producing significant efficiencies. To 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.

In contrast to integrated physician network joint ventures, such as these discussed above, there have been arrangements among physicians that have taken the form of networks, but which in purpose or effect were little more than efforts by their

participants to prevent or impede competitive forces from operating in the market. These arrangements are not likely to produce significant procompetitive efficiencies. Such arrangements have been, and will continue to be, treated as unlawful conspiracies or cartels, whose price agreements are per se illegal.

Determining that an arrangement is merely a vehicle to fix prices or engage in naked anticompetitive conduct is a factual inquiry that must be done on a case-by-case basis to determine the arrangement's true nature and likely competitive effects. However, a variety of factors may tend to corroborate a network's anticompetitive nature, including: statements evidencing anticompetitive purpose; a recent history of anticompetitive behavior or collusion in the market, including efforts to obstruct or undermine the development of managed care; obvious anticompetitive structure of the network (e.g., a network comprising a very high percentage of local area physicians, whose participation in the network is exclusive, without any plausible business or efficiency justification); the absence of any mechanisms with the potential for generating significant efficiencies or otherwise increasing competition through the network; the presence of anticompetitive collateral agreements; and the absence of mechanisms to prevent the network’s operation from having anticompetitive spillover effects outside the network.

2. Applying The Rule Of Reason

A rule of reason analysis determines whether the formation and 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 the joint venture. The rule of reason analysis takes into account characteristics of the particular physician network joint venture, and the competitive environment in which it operates, that bear on the venture's likely effect on competition.

A determination about the lawfulness of a network's activity under the rule of reason sometimes can be reached without an extensive inquiry under each step of the analysis. For example, a physician network joint venture that involves substantial clinical integration may include a relatively small percentage of the physicians in the relevant markets on a non-exclusive basis. In that case, the Agencies may be able to conclude expeditiously that the network is unlikely to be anticompetitive, based on the competitive environment in which it operates. In assessing the competitive environment, the Agencies would consider such market factors as the number, types, and size of managed care plans operating in the area, the extent of physician participation in those plans, and the economic importance of the managed care plans to area physicians. See infra Example 1. Alternatively, for example, if a restraint that facially appears to be of a kind

that would always or almost always tend to reduce output or increase prices, but has not been considered per se unlawful, is not reasonably necessary to the creation of efficiencies, the

Agencies will likely challenge the restraint without an elaborate analysis of market definition and market power.[37]

The steps ordinarily involved in a rule of reason analysis of physician network joint ventures are set forth below.

Step one: Define the relevant market. The Agencies evaluate the competitive effects of a physician network joint venture in each relevant market in which it operates or has substantial impact. In defining the relevant product and geographic markets, the Agencies look to what substitutes, as a practical matter, are reasonably available to consumers for the services in question.[38] The Agencies will first identify the relevant services that the physician network joint venture provides. Although all services provided by each physician specialty might be a separate relevant service market, there may be instances in which significant overlap of services provided by different physician specialties, or in some circumstances, certain nonphysician health care providers, justifies including services from more than one physician specialty or category of providers in the same market. For each relevant service market, the relevant geographic market will include all physicians (or other providers) who are good substitutes for the physician participants in the joint venture.

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[37] See FTC v. Indiana Federation of Dentists, 476 U.S. 447, 459-60 (1986).

[38] A more extensive discussion of how the Agencies define relevant markets is contained in the Agencies' 1992 Horizontal Merger Guidelines.

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

In assessing whether a particular network arrangement could raise prices or exclude competition, the Agencies will examine whether the network physicians collectively have the ability and incentive to engage in such conduct. The Agencies will consider not only the proportion of the physicians in any relevant market who are in the network, but also the incentives faced by physicians in the network, and whether different groups of physicians in a network may have significantly different incentives that would reduce the likelihood of anticompetitive conduct. The Department of Justice has entered into final judgments that permit a network to include a relatively large proportion of physicians in a relevant market where the percentage of physicians with an ownership interest in the network is strictly limited, and the network subcontracts with

additional physicians under terms that create a sufficient divergence of economic interest between the subcontracting physicians and the owner physicians so that the owner physicians have an incentive to control the costs to the network of the subcontracting physicians.[39] Evaluating the incentives faced by network physicians requires an examination of the facts and circumstances of each particular case. The Agencies will assess whether different groups of physicians in the network actually have significantly divergent incentives that would override any shared interest, such as the incentive to profit from higher fees for their medical services. The Agencies will also consider whether the behavior of network physicians or other market evidence indicates that the differing incentives among groups of physicians will not prevent anticompetitive conduct.

If, in the relevant market, there are many other networks or many physicians who would be available to form competing networks or to contract directly with health plans, it is unlikely that the joint venture would raise significant competitive concerns. The Agencies will analyze the availability of suitable physicians to form competing networks, including the exclusive or non-exclusive nature of the physician network joint venture.

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[39] See, e.g., Competitive Impact Statements in United States v. Health Choice of Northwest Missouri, Inc., Case No. 95-6171-CV-SJ-6 (W.D. Mo.; filed Sept. 13, 1995), 60 Fed. Reg. 51808, 51815 (Oct. 3, 1995); United States and State of Connecticut v. HealthCare Partners, Inc., Case No. 395-CV-01946-RNC (D. Conn.; filed Sept. 13, 1995), 60 Fed. Reg. 52018, 52020 (Oct. 4, 1995).

The Agencies recognize that the competitive impact of exclusive arrangements or other limitations on the ability of a network's physician participants to contract outside the network can vary greatly. For example, in some circumstances exclusivity may help a network serve its subscribers and increase its physician participants' incentives to further the interests of the network. In other situations, however, the anticompetitive risks posed by such exclusivity may outweigh its procompetitive benefits. Accordingly, the Agencies will evaluate the actual or likely effects of particular limitations on contracting in the market situation in which they occur.

An additional area of possible anticompetitive concern involves the risk of "spillover" effects from the venture. For example, a joint venture may involve the exchange of competitively sensitive information among competing physicians and thereby become a vehicle for the network's physician participants to coordinate their activities outside the venture. Ventures that are structured to reduce the likelihood of such spillover are less likely to result in anticompetitive effects. For example, a network that uses an outside agent to collect and analyze fee data from physicians for use in developing the network's fee schedule, and avoids the sharing of such sensitive information among the network's physician participants, may reduce concerns that the information could be used by the network's physician participants to set prices for services they

provide outside the network.

Step three: Evaluate the impact of procompetitive efficiencies.[40] This step requires an examination of the joint venture's likely procompetitive efficiencies, and the balancing of these efficiencies against any likely anticompetitive effects. The greater the venture's likely anticompetitive effects, the greater must be the venture's likely efficiencies. In assessing efficiency claims, the Agencies focus on net efficiencies that will be derived from the operation of the network and that result in lower prices or higher quality to consumers. The Agencies will not accept claims of efficiencies if the parties reasonably can achieve equivalent or comparable savings through significantly less anticompetitive means. In making this assessment, however, the Agencies will not search for a theoretically least restrictive alternative that is not practical given business realities.

Experience indicates that, in general, more significant efficiencies are likely to result from a physician network joint venture's substantial financial risk sharing or substantial clinical integration. However, the Agencies will consider a broad range of possible cost savings, including improved cost controls, case management and quality assurance, economies of scale, and reduced administrative or transaction costs.

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

In assessing the likelihood that efficiencies will be realized, the Agencies recognize that competition is one of the strongest motivations for firms to lower prices, reduce costs, and provide higher quality. Thus, the greater the competition facing the network, the more likely it is that the network will actually realize potential efficiencies that would benefit consumers.

Step four: Evaluation of collateral agreements. This step examines whether the physician network joint venture includes collateral agreements or conditions that unreasonably restrict competition and are unlikely to contribute significantly to the legitimate purposes of the physician network joint venture. The Agencies will examine whether the collateral agreements are reasonably necessary to achieve the efficiencies sought by the joint venture. For example, if the physician participants in a physician network joint venture agree on the prices they will charge patients who are not covered by the health plans with which their network contracts, such an agreement plainly is not reasonably necessary to the success of the joint venture and is an antitrust violation.[41] Similarly, attempts by a physician network joint venture to exclude competitors or classes of competitors of the network's physician participants from the

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

market could have anticompetitive effects, without advancing any legitimate, procompetitive goal of the network. This could happen, for example, if the network facilitated agreements among the physicians to refuse to deal with such competitors outside the network, or to pressure other market participants to refuse to deal with such competitors or deny them necessary access to key facilities.

C. Examples Of Physician Network Joint Ventures

The following are examples of how the Agencies would apply the principles set forth in this statement to specific physician network joint ventures. The first three are new examples: 1) a network involving substantial clinical integration, that is unlikely to raise significant competitive concerns under the rule of reason; 2) a network involving both substantial financial risk-sharing and non-risk-sharing arrangements, which would be analyzed under the rule of reason; and 3) a network involving neither substantial financial risk-sharing nor substantial clinical integration, and whose price agreements likely would be challenged as per se unlawful. The last four examples involve networks that operate in a variety of market settings and with different levels of physician participants; three are networks that involve substantial financial risk-sharing and one is a network in which the physician participants do not jointly agree on, or negotiate, price.

1. Physician Network Joint Venture Involving Clinical Integration

Charlestown is a relatively isolated, medium-sized city. For the purposes of this example, the services provided by primary care physicians and those provided by the different physician specialties each constitute a relevant product market; and the relevant geographic market for each of them is Charlestown.

Several HMOs and other significant managed care plans operate in Charlestown. A substantial proportion of insured individuals are enrolled in these plans, and enrollment in managed care is expected to increase. Many physicians in each of the specialties participate in more than one of these plans. There is no significant overlap among the participants on the physician panels of many of these plans.

A group of Charlestown physicians establishes an IPA to assume greater responsibility for managing the cost and quality of care rendered to Charlestown residents who are members of health plans. They hope to reduce costs while maintaining or improving the quality of care, and thus to attract more managed care patients to their practices.

The IPA will implement systems to establish goals relating to quality and appropriate utilization of services by IPA participants, regularly evaluate both individual participants' and the network's aggregate performance with respect to those goals, and modify individual participants' actual practices,

where necessary, based on those evaluations. The IPA will engage in case management, preauthorization of some services, and concurrent and retrospective review of inpatient stays. In addition, the IPA is developing practice standards and protocols to govern treatment and utilization of services, and it will actively review the care rendered by each doctor in light of these standards and protocols.

There is a significant investment of capital to purchase the information systems necessary to gather aggregate and individual data on the cost, quantity, and nature of services provided or ordered by the IPA physicians; to measure performance of the group and the individual doctors against cost and quality benchmarks; and to monitor patient satisfaction. The IPA will provide payers with detailed reports on the cost and quantity of services provided, and on the network's success in meeting its goals.

The IPA will hire a medical director and a support staff to perform the above functions and to coordinate patient care in specific cases. The doctors also have invested appreciable time in developing the practice standards and protocols, and will continue actively to monitor care provided through the IPA. Network participants who fail to adhere to the network's standards and protocols will be subject to remedial action, including the possibility of expulsion from the network.

The IPA physicians will be paid by health plans on a fee-for-

service basis; the physicians will not share substantial financial risk for the cost of services rendered to covered individuals through the network. The IPA will retain an agent to develop a fee schedule, negotiate fees, and contract with payers on behalf of the venture. Information about what participating doctors charge non-network patients will not be disseminated to participants in the IPA, and the doctors will not agree on the prices they will charge patients not covered by IPA contracts.

The IPA is built around three geographically dispersed primary care group practices that together account for 25 percent of the primary care doctors in Charlestown. A number of specialists to whom the primary care doctors most often refer their patients also are invited to participate in the IPA. These specialists are selected based on their established referral relationships with the primary care doctors, the quality of care provided by the doctors, their willingness to cooperate with the goals of the IPA, and the need to provide convenient referral services to patients of the primary care doctors. Specialist services that are needed less frequently will be provided by doctors who are not IPA participants. Participating specialists constitute from 20 to 35 percent of the specialists in each relevant market, depending on the specialty. Physician participation in the IPA is non-exclusive. Many IPA participants already do and are expected to continue to participate in other managed care plans and earn substantial income from those plans.

Competitive Analysis

Although the IPA does not fall within the antitrust safety zone because the physicians do not share substantial financial risk, the Agencies would analyze the IPA under the rule of reason because it offers the potential for creating significant efficiencies and the price agreement is reasonably necessary to realize those efficiencies. Prior to contracting on behalf of competing doctors, the IPA will develop and invest in mechanisms to provide cost-effective quality care, including standards and protocols to govern treatment and utilization of services, information systems to measure and monitor individual physician and aggregate network performance, and procedures to modify physician behavior and assure adherence to network standards and protocols. The network is structured to achieve its efficiencies through a high degree of interdependence and cooperation among its physician participants. The price agreement, under these circumstances, is subordinate to and reasonably necessary to achieve these objectives.[42]

[42] Although the physicians in this example have not directly agreed with one another on the prices to be charged for services rendered through the network, the venture's use of an agent, subject to its control, to establish fees and to negotiate and execute contracts on behalf of the venture amounts to a price agreement among competitors. However, the use of such an agent should reduce the risk of the network's activities having anticompetitive spillover effects on competition among the physicians for non-network patients.

Furthermore, the Agencies would not challenge under the rule of reason the doctors' agreement to establish and operate the IPA. In conducting the rule of reason analysis, the Agencies would evaluate the likely competitive effects of the venture in each relevant market. In this case, the IPA does not appear likely to limit competition in any relevant market either by hampering the ability of health plans to contract individually with area physicians or with other physician network joint ventures, or by enabling the physicians to raise prices above competitive levels. The IPA does not appear to be overinclusive: many primary care physicians and specialists are available to other plans, and the doctors in the IPA have been selected to achieve the network's procompetitive potential. Many IPA participants also participate in other managed care plans and are expected to continue to do so in the future. Moreover, several significant managed care plans are not dependent on the IPA participants to offer their products to consumers. Finally, the venture is structured so that physician participants do not share competitively sensitive information, thus reducing the likelihood of anticompetitive spillover effects outside the network where the physicians still compete, and the venture avoids any anticompetitive collateral agreements.

Since the venture is not likely to be anticompetitive, there is no need for further detailed evaluation of the venture's potential for generating procompetitive efficiencies. For these

reasons, the Agencies would not challenge the joint venture. However, they would reexamine this conclusion and do a more complete analysis of the procompetitive efficiencies if evidence of actual anticompetitive effects were to develop.

2. Physician Network Joint Venture Involving Risk-Sharing And Non-Risk-Sharing Contracts

An IPA has capitation contracts with three insurer-developed HMOs. Under its contracts with the HMOs, the IPA receives a set fee per member per month for all covered services required by enrollees in a particular health plan. Physician participants in the IPA are paid on a fee-for-service basis, pursuant to a fee schedule developed by the IPA. Physicians participate in the IPA on a non-exclusive basis. Many of the IPA's physicians participate in managed care plans outside the IPA, and earn substantial income from those plans.

The IPA uses a variety of mechanisms to assure appropriate use of services under its capitation contracts so that it can provide contract services within its capitation budgets. In part because the IPA has managed the provision of care effectively, enrollment in the HMOs has grown to the point where HMO patients are a significant share of the IPA doctors' patients.

The three insurers that offer the HMOs also offer PPO options in response to the request of employers who want to give their employees greater choice of plans. Although the capitation contracts are a substantial majority of the IPA's business, it also contracts with the insurers to provide services to the PPO programs on a fee-for-service basis. The physicians are paid according to the same fee schedule used to pay them under the IPA's capitated contracts. The IPA uses the same panel of

providers and the same utilization management mechanisms that are involved in the HMO contracts. The IPA has tracked utilization for HMO and PPO patients, which shows similar utilization patterns for both types of patients.

Competitive Analysis

Because the IPA negotiates and enters into both capitated and fee-for-service contracts on behalf on its physicians, the venture is not within a safety zone. However, the IPA's HMO contracts are analyzed under the rule of reason because they involve substantial financial risk-sharing. The PPO contracts also are analyzed under the rule of reason because there are significant efficiencies from the capitated arrangements that carry over to the fee-for-service business. The IPA's procedures for managing the provision of care under its capitation contracts and its related fee schedules produce significant efficiencies; and since those same procedures and fees are used for the PPO contracts and result in similar utilization patterns, they will likely result in significant efficiencies for the PPO arrangements as well.

3. Physician Network That Is Per Se Unlawful

A group of physicians in Clarksville forms an IPA to contract with managed care plans. There is some limited managed care presence in the area, and new plans have announced their interest

in entering. The physicians agree that the only way they can effectively combat the power of the plans and protect themselves from low fees and intrusive utilization review is to organize and

negotiate with the plans collectively through the IPA, rather than individually.

Membership in the IPA is open to any licensed physician in Clarksville. Members contribute $2,000 each to fund the legal fees associated with incorporating the IPA and its operating expenses, including the salary of an executive director who will negotiate contracts on behalf of the IPA. The IPA will enter only into fee-for-service contracts. The doctors will not share substantial financial risk under the contracts. The Contracting Committee, in consultation with the executive director, develops a fee schedule.

The IPA establishes a Quality Assurance and Utilization Review Committee. Upon recommendation of this committee, the members vote to have the IPA adopt two basic utilization review parameters: strict limits on documentation to be provided by physicians to the payers, and arbitration of disputes regarding plan utilization review decisions by a committee of the local medical society. The IPA refuses to contract with plans that do not accept these utilization review parameters. The IPA claims to have its own utilization review/quality assurance programs in development, but has taken very few steps to create such a program. It decides to rely instead on the hospital's established peer review mechanisms.

Although there is no formal exclusivity agreement, IPA physicians who are approached by managed care plans seeking

contracts refer the plans to the IPA. Except for some contracts predating the formation of the IPA, the physicians do not contract individually with managed care plans on terms other than those set by the IPA.

Competitive Analysis

This IPA is merely a vehicle for collective decisions by its physicians on price and other significant terms of dealing. The physicians' purpose in forming the IPA is to increase their bargaining power with payers. The IPA makes no effort to selectively choose physicians who are likely to further the network's achievement of efficiencies, and the IPA involves no significant integration, financial or otherwise. IPA physicians' participation in the hospital's general peer review procedures does not evidence integration by those physicians that is likely to result in significant efficiencies in the provision of services through the IPA. The IPA does not manage the provision of care or offer any substantial potential for significant procompetitive efficiencies. The physicians are merely collectively agreeing on prices they will receive for services rendered under IPA contracts and not to accept certain aspects of utilization review that they do not like.

The physicians' contribution of capital to form the IPA does not make it a legitimate joint venture. In some circumstances, capital contributions by an IPA's participants can indicate that

the participants have made a significant commitment to the creation of an efficiency-producing competitive entity in the market.[43] Capital contributions, however, can also be used to fund a cartel. The key inquiry is whether the contributed capital is being used to further the network's capability to achieve substantial efficiencies. In this case, the funds are being used primarily to support the joint negotiation, and not to achieve substantial procompetitive efficiencies. Thus, the physicians' agreement to bargain through the joint venture will be treated as per se illegal price fixing.

4. Exclusive Physician Network Joint Venture With Financial Risk-Sharing And Comprising More Than Twenty Percent Of Physicians With Active Admitting Privileges At A Hospital

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

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

[43] See supra Example 1.

practicing each specialty.

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

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

A number of health plans that contract selectively with hospitals and physicians already operate in County Seat. These plans and local employers agree that other County Seat physicians, and the hospitals to which they admit, are good substitutes for the active admitting physicians and the inpatient services provided at County Seat Medical Center. Physicians with

medical practices based outside County Seat, however, are not good substitutes for area physicians, because such physicians would find it inconvenient to practice at County Seat hospitals due to the distance between their practice locations and County Seat.

Competitive Analysis

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

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

For purposes of analyzing the effects of the venture, all of the physicians in County Seat should be considered market participants. Purchasers of health care services consider all physicians within each specialty, and the hospitals at which they have admitting privileges, to be relatively interchangeable.

Thus, in this example, any attempt by the joint venture's physician participants collectively to increase the price of

physician services above competitive levels would likely lead third-party purchasers to recruit non-network physicians at County Seat Medical Center or other area hospitals.

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

5. Physician Network Joint Venture With Financial Risk-Sharing And A Large Percentage Of Physicians In A Relatively Small Community

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

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

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

In this example, other health plans already have entered

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

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

Competitive Analysis

This proposed physician network joint venture would not fall within the antitrust safety zone because it would comprise over 30 percent of the physicians in a number of relevant specialties in the geographic market. However, the Agencies would not challenge the joint venture because a rule of reason analysis indicates that its formation would not likely hamper the ability of health plans to contract individually with area physicians or with other physician network joint ventures, or enable the physicians to raise prices above competitive levels. In addition, the joint venture's agreement to accept capitated fees creates incentives for its physicians to achieve cost savings.

That health plans have requested formation of this venture also is significant, for it suggests that the joint venture would offer additional efficiencies. In this instance, it appears to

be a low-cost method for plans to enter an area without investing in costly negotiations to identify and contract with individual physicians.

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

Although the joint venture has a relatively large percentage of some specialties, it appears unlikely to present competitive concerns under the rule of reason because of three factors: (1) the demonstrated ability of health plans to contract with physicians individually; (2) the possibility that other physician network joint ventures could be formed; and (3) the potential benefits from the coverage to be provided by this physician network joint venture. Therefore, the Agencies would not challenge the joint venture.

6. Physician Network Joint Venture With Financial Risk Sharing And A Large Percentage Of Physicians In A Small, Rural County

Rural County has a population of 15,000, a small primary care hospital, and ten physicians, including seven general and family practitioners, an obstetrician, a pediatrician, and a general surgeon. All of the physicians are solo practitioners. The nearest urban area is about 60 miles away in Big City, which has a population of 300,000, and three major hospitals to which patients from Rural County are referred or transferred for higher levels of hospital care. However, Big City is too far away for most residents of Rural County routinely to use its physicians for services available in Rural County.

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

Initially, two of the general practitioners and two of the specialists express interest in forming a network, but Insurance Company says that it intends to market its plan to the larger local employers, who need broader geographic and specialty coverage for their employees. Consequently, Insurance Company needs more of the local general practitioners and the one remaining specialist in the IPA to provide adequate geographic, specialty, and backup coverage to subscribers in Rural County. Eventually, four of the seven general practitioners and the one

remaining specialist join the IPA and agree to provide services to Insurance Company's subscribers, under contracts providing for capitation. While the physicians' participation in the IPA is structured to be non-exclusive, no other managed care plan has yet entered the local market or approached any of the physicians about joining a different provider panel. In discussing the formation of the IPA with Insurance Company, a number of the physicians have made clear their intention to continue to practice outside the IPA and have indicated they would be interested in contracting individually with other managed care plans when those plans expand into Rural County.

Competitive Analysis

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

For purposes of this analysis, Rural County is considered the relevant geographic market. Generally, the Agencies will closely examine joint ventures that comprise a large percentage of physicians in the relevant market. However, in this case, the establishment of the IPA and its inclusion of more than half of the general practitioners and all of the specialists in the

network is the result of the payer's expressed need to have more of the local physicians in its network to sell its product in the market. Thus, the level of physician participation in the network does not appear to be overinclusive, but rather appears to be the minimum necessary to meet the employers' needs.

Although the IPA has more than half of the general practitioners and all of the specialists in it, under the particular circumstances this does not, by itself, raise sufficient concerns of possible foreclosure of entry by other managed care plans, or of the collective ability to raise prices above competitive levels, to warrant antitrust challenge to the joint venture by the Agencies. Because it is the first such joint venture in the county, there is no way absolutely to verify at the outset that the joint venture in fact will be non-exclusive. However, the physicians' participation in the IPA is formally non-exclusive, and they have expressed a willingness to consider joining other managed care programs if they begin operating in the area. Moreover, the three general practitioners who are not members of the IPA are available to contract with other managed care plans. The IPA also was established with participation by the local area physicians at the request of Insurance Company, indicating that this structure was not undertaken as a means for the physicians to increase prices or prevent entry of managed care plans.

Finally, the joint venture can benefit consumers in Rural

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

Given these facts, the Agencies would not challenge the joint venture. If, however, it later became apparent that the physicians' participation in the joint venture in fact was exclusive, and consequently other managed care plans that wanted to enter the market and contract with some or all of the physicians at competitive terms were unable to do so, the Agencies would re-examine the joint venture's legality. The joint venture also would raise antitrust concerns if it appeared that participation by most of the local physicians in the joint venture resulted in anticompetitive effects in markets outside the joint venture, such as uniformity of fees charged by the physicians in their solo medical practices.

7. Physician Network Joint Venture With No Price Agreement And Involving All Of The Physicians In A Small, Rural County

Rural County has a population of 10,000, a small primary care

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

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

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

HealthCare wants to negotiate with the new IPA. It believes that the local physicians collectively can operate the new clinic more efficiently than it can from its distant headquarters, but HealthCare also believes that collectively negotiating with all of the physicians will result in it having to pay higher fees or capitation rates. Thus, it encourages the IPA to appoint an agent to negotiate the non-fee related aspects of the contracts and to facilitate fee negotiations with the group practice and the individual doctors. The group practice and the individual physicians each will sign and negotiate their own individual contracts regarding fees and will unilaterally determine whether to contract with HealthCare, but will agree through the IPA to provide physician, administrative, and utilization review services. The agent will facilitate these individual fee negotiations by discussing separately and confidentially with each physician the physician's fee demands and presenting the information to HealthCare. No fee information will be shared among the physicians.

Competitive Analysis

For purposes of this analysis, Rural County is considered the relevant geographic market. Generally, the Agencies are concerned with joint ventures that comprise all or a large percentage of the physicians in the relevant market. In this case, however, the joint venture appears on balance to be

procompetitive. The potential for competitive harm from the venture is not great and is outweighed by the efficiencies likely to be generated by the arrangement.

The physicians are not jointly negotiating fees or engaging in other activities that would be viewed as per se antitrust violations. Therefore, the IPA would be evaluated under the rule of reason. Any possible competitive harm would be balanced against any likely efficiencies to be realized by the venture to see whether, on balance, the IPA is anticompetitive or procompetitive.

Because the IPA is non-exclusive, the potential for competitive harm from foreclosure of competition is reduced. Its physicians are free to contract with other managed care plans or individually with HealthCare if they desire. In addition, potential concerns over anticompetitive pricing are minimized because physicians will continue to negotiate prices individually. Although the physicians are jointly negotiating non-price terms of the contract, agreement on these terms appears to be necessary to the successful operation of the joint venture.

The small risk of anticompetitive harm from this venture is outweighed by the substantial procompetitive benefits of improved quality of care and access to physician services that the venture will engender. The new clinic in the northern part of the county will make it easier for residents of that area to receive the care they need. Given these facts, the Agencies would not

challenge the joint venture.

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

9. STATEMENT OF DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION ENFORCEMENT POLICY ON MULTIPROVIDER NETWORKS

Introduction

The health care industry is changing rapidly as it looks for innovative ways to control costs and efficiently provide quality services. Health care providers are forming a wide range of new relationships and affiliations, including networks among otherwise competing providers, as well as networks of providers offering complementary or unrelated services.[44] These affiliations, referred to herein as multiprovider networks, can offer significant procompetitive benefits to consumers. They also can present antitrust questions, particularly if the network includes otherwise competing providers.

As used in this statement, multiprovider networks are ventures among providers that jointly market their health care services to health plans and other purchasers. Such ventures may

[44] The multiprovider networks covered by this statement include all types and combinations of health care providers, such as networks involving just a single type of provider (e.g., dentists or hospitals) or a single provider specialty (e.g., orthodontists), as well as networks involving more than one type of provider (e.g., physician-hospital organizations or networks involving both physician and non-physician professionals). Networks containing only physicians, which are addressed in detail in the preceding enforcement policy statement, are a particular category of multiprovider network. Many of the issues relating to multiprovider networks in general are the same as those that arise, and are addressed, in connection with physician network joint ventures, and the analysis often will be very similar for all such arrangements.

contract to provide services to subscribers at jointly determined prices and agree to controls aimed at containing costs and assuring quality. Multiprovider networks vary greatly regarding the providers they include, the contractual relationships among those providers, and the efficiencies likely to be realized by the networks. Competitive conditions in the markets in which such networks operate also may vary greatly.

In this statement, the Agencies describe the antitrust principles that they apply in evaluating multiprovider networks, address some issues commonly raised in connection with the formation and operation of such networks, and present examples of the application of antitrust principles to hypothetical multiprovider networks. Because multiprovider networks involve a large variety of structures and relationships among many different types of health care providers, and new arrangements are continually developing, the Agencies are unable to establish a meaningful safety zone for these entities.

A. Determining When Agreements Among Providers In A Multiprovider Network Are Analyzed Under The Rule Of Reason

Antitrust law condemns as per se illegal naked agreements among competitors that fix prices or allocate markets. Where competitors economically integrate in a joint venture, however, such agreements, if reasonably necessary to accomplish the procompetitive benefits of the integration, are analyzed under

the rule of reason.[45] In accord with general antitrust principles, multiprovider networks will be evaluated under the rule of reason, and will not be viewed as per se illegal, if the providers' integration through the network is likely to produce significant efficiencies that benefit consumers, and any price agreements (or other agreements that would otherwise be per se illegal) by the network providers are reasonably necessary to realize those efficiencies.[46]

In some multiprovider networks, significant efficiencies may be achieved through agreement by the competing providers to share substantial financial risk for the services provided through the network.[47] In such cases, the setting of price would be integral

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[45] In a network limited to providers who are not actual or potential competitors, the providers generally can agree on the prices to be charged for their services without the kinds of economic integration discussed below.

[46] In some cases, the combination of the competing providers in the network may enable them to offer what could be considered to be a new product producing substantial efficiencies, and therefore the venture will be analyzed under the rule of reason. See Broadcast Music, Inc. v. Columbia Broadcasting System, Inc., 441 U.S. 1 (1979) (competitors' integration and creation of a blanket license for use of copyrighted compositions result in efficiencies so great as to make the blanket license a "different product" from the mere combination of individual competitors and, therefore, joint pricing of the blanket license is subject to rule of reason analysis, rather than the per se rule against price fixing). The Agencies' analysis will focus on the efficiencies likely to be produced by the venture, and the relationship of any price agreements to the achievement of those efficiencies, rather than on whether the venture creates a product that can be labeled "new" or "different."

[47] The existence of financial risk sharing does not depend

(continued...)

to the network's use of such an arrangement and, therefore, would warrant evaluation under the rule of reason.

The following are examples of some types of arrangements through which substantial financial risk can be shared among competitors in a multiprovider network:

(1) agreement by the venture to provide services to a health plan at a "capitated" rate;[48]

(2) agreement by the venture to provide designated services or classes of services to a health plan for a predetermined percentage of premium or revenue from the plan;[49]

(3) use by the venture of significant financial incentives for its provider participants, as a group, to achieve specified cost-containment goals. Two methods by which the venture can accomplish this are:

(a) withholding from all provider participants a substantial amount of the compensation due to them, with distribution of that amount to the participants based on group performance in meeting the cost-containment goals of the network as a whole; or

(b) establishing overall cost or utilization targets for the network as a whole, with the provider

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[47](...continued)
on whether, under applicable state law, the network is considered an insurer.

[48] A "capitated" rate is a fixed, predetermined payment per covered life (the "capitation") from a health plan to the joint venture in exchange for the joint venture's (not merely an individual provider's) furnishing and guaranteeing provision of a defined set of covered services to covered individuals for a specified period, regardless of the amount of services actually provided.

[49] This is similar to a capitation arrangement, except that the amount of payment to the network can vary in response to changes in the health plan's premiums or revenues.

participants subject to subsequent substantial financial rewards or penalties based on group performance in meeting the targets; and

(4) agreement by the venture to provide a complex or extended course of treatment that requires the substantial coordination of care by different types of providers offering a complementary mix of services, for a fixed, predetermined payment, where the costs of that

> course of treatment for any individual patient can vary greatly due to the individual patient's condition, the choice, complexity, or length of treatment, or other factors.[50]

The Agencies recognize that new types of risk-sharing arrangements may develop. The preceding examples do not foreclose consideration of other arrangements through which the participants in a multiprovider network joint venture may share substantial financial risk in the provision of health care services or products through the network.[51] Organizers of multiprovider networks who are uncertain whether their proposed arrangements constitute substantial financial risk sharing for purposes of this policy statement are encouraged to take advantage of the Agencies' expedited business review and advisory opinion procedures.

Multiprovider networks that do not involve the sharing of substantial financial risk may also involve sufficient

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[50] Such arrangements are sometimes referred to either as "global fees" or "all-inclusive case rates." Global fee or all-inclusive case rate arrangements that involve financial risk sharing as contemplated by this example will require that the joint venture (not merely an individual provider participant) assume the risk or benefit that the treatment provided through the network may either exceed, or cost less than, the predetermined payment.

[51] The manner of dividing revenues among the network's provider participants generally does not raise antitrust issues so long as the competing providers in a network share substantial financial risk. For example, capitated networks frequently distribute income among their participants using fee-for-service payment with a partial withhold fund to cover the risk of having to provide more services than were originally anticipated.

integration to demonstrate that the venture is likely to produce significant efficiencies. For example, as discussed in the Statement Of Enforcement Policy On Physician Network Joint Ventures, substantial clinical integration among competing physicians in a network who do not share substantial financial risk may produce efficiency benefits that justify joint pricing.[52] However, given the wide range of providers who may participate in multiprovider networks, the types of clinical integration and efficiencies available to physician network joint ventures may not be relevant to all multiprovider networks. Accordingly, the Agencies will consider the particular nature of the services provided by the network in assessing whether the network has the potential for producing efficiencies that warrant rule of reason treatment. In all cases, the Agencies' analysis will focus on substance, not form, in assessing a network's likelihood of producing significant efficiencies. To the extent that agreements on prices to be charged for the integrated provision of services promote the venture's achievement of efficiencies, they will be evaluated under the rule of reason.

A multiprovider network also might include an agreement among competitors on service allocation or specialization. The Agencies would examine the relationship between the agreement and efficiency-enhancing joint activity. If such an agreement is

[52] See Section B(1) of the Agencies' Statement Of Enforcement Policy On Physician Network Joint Ventures (pp. 71-74).

reasonably necessary for the network to realize significant procompetitive benefits, it similarly would be subject to rule of reason analysis.[53] For example, competing hospitals in an integrated multiprovider network might need to agree that only certain hospitals would provide certain services to network patients in order to achieve the benefits of the integration.[54] The hospitals, however, would not necessarily be permitted to agree on what services they would provide to non-network patients.[55]

B. Applying The Rule Of Reason

[53] A unilateral decision to eliminate a service or specialization, however, does not generally present antitrust issues. For example, a hospital or other provider unilaterally may decide to concentrate on its more profitable services and not offer other less profitable services, and seek to enter a network joint venture with competitors that still provides the latter services. If such a decision is made unilaterally, rather than pursuant to an express or implied agreement, the arrangement would not be considered a per se illegal market allocation.

[54] Hospitals, even if they do not belong to a multiprovider network, also could agree jointly to develop and operate new services that the participants could not profitably support individually or through a less inclusive joint venture, and to decide where the jointly operated services are to be located. Such joint ventures would be analyzed by the Agencies under the rule of reason. The Statement of Enforcement Policy On Hospital Joint Ventures Involving Specialized Clinical Or Other Expensive Health Care Services offers additional guidance on joint ventures among hospitals to provide such services.

[55] The Agencies' analysis would take into account that agreements among multiprovider network participants relating to the offering of services might be more likely than those relating to price to affect participants' competition outside the network, and to persist even if the network is disbanded.

A rule of reason analysis determines whether the formation and 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 the venture. The rule of reason analysis takes into account characteristics of the particular multiprovider network and the competitive environment in which it operates to determine the network's likely effect on competition.

A determination about the lawfulness of a multiprovider network's activity under the rule of reason sometimes can be reached without an extensive inquiry under each step of the analysis. For example, a multiprovider network that involves substantial integration may include a relatively small percentage of the providers in each relevant product market on a non-exclusive basis. In that case, the Agencies may be able to conclude expeditiously that the network is unlikely to be anticompetitive, based on the competitive environment in which it operates. In assessing the competitive environment, the Agencies would consider such market factors as the number, type, and size of managed care plans operating in the area, the extent of provider participation in those plans, and the economic importance of the managed care plans to area providers. Alternatively, for example, if a restraint that facially appears to be of a kind that would always or almost always tend to reduce output or increase prices, but has not been considered per se

unlawful, is not reasonably necessary to the creation of

efficiencies, the Agencies will likely challenge the restraint without an elaborate analysis of market definition and market power.[56]

The steps ordinarily involved in a rule of reason analysis of multiprovider networks are set forth below.

1. Market Definition

The Agencies will evaluate the competitive effects of multiprovider networks in each of the relevant markets in which they operate or have substantial impact. In defining the relevant product and geographic markets, the Agencies look to what substitutes, as a practical matter, are reasonably available to consumers for the services in question.[57]

A multiprovider network can affect markets for the provision of hospital, medical, and other health care services, and health insurance/financing markets. The possible product markets for analyzing the competitive effects of multiprovider networks likely would include both the market for such networks themselves, if there is a distinct market for such networks, and the markets for service components of the network that are, or could be, sold separately outside the network. For example, if

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[56] See FTC v. Indiana Federation of Dentists, 476 U.S. 447, 459-60 (1986).

[57] A more extensive discussion of how the Agencies define relevant markets is contained in the Agencies' 1992 Horizontal Merger Guidelines.

two hospitals formed a multiprovider network with their medical

and other health care professional staffs, the Agencies would consider potential competitive effects in each market affected by the network, including but not necessarily limited to the markets for inpatient hospital services, outpatient services, each physician and non-physician health care service provided by network members, and health insurance/financing markets whose participants may deal with the network and its various types of health care providers.

The relevant geographic market for each relevant product market affected by the multiprovider network will be determined through a fact-specific analysis that focuses on the location of reasonable alternatives. The relevant geographic markets may be broader for some product markets than for others.

2. Competitive Effects

In applying the rule of reason, the Agencies will examine both the potential "horizontal" and "vertical" effects of the arrangement. Agreements between or among competitors (e.g., competing hospitals or competing physicians) are considered "horizontal" under the antitrust laws. Agreements between or among parties that are not competitors (such as a hospital and a physician in a physician-hospital organization ("PHO")), may be considered "vertical" in nature.

a. Horizontal Analysis

In evaluating the possible horizontal competitive effects of

multiprovider networks, the Agencies will define the relevant markets (as discussed earlier) and evaluate the network's likely overall competitive effects considering all market conditions. Determining market share and concentration in the relevant markets is often an important first step in analyzing a network's competitive effects. For example, in analyzing a PHO, the Agencies will consider the network's market share (and the market concentration) in such service components as inpatient hospital services (as measured by such indicia as number of institutions, number of hospital beds, patient census, and revenues), physician services (in individual physician specialty or other appropriate service markets)[58], and any other services provided by competing health care providers, institutional or noninstitutional, participating in the network.

If a particular multiprovider network had a substantial share of any of the relevant service markets, it could, depending on other factors, increase the price of such services above competitive levels. For example, a network that included most or all of the surgeons in a relevant geographic market could create market power in the market for surgical services and thereby

[58] Although all services provided by each physician specialty or category of non-physician provider might be a separate relevant service market, there may be instances in which significant overlap of services provided by different physician specialties or categories of providers justifies including services from more than one physician specialty or provider category in the same market.

permit the surgeons to increase prices.

If there is only one hospital in the market, a multiprovider network, by definition, cannot reduce any existing competition among hospitals. Such a network could, however, reduce competition among other providers, for example, among physicians in the network and, thereby, reduce the ability of payers to control the costs of both physician and hospital services.[59] It also could reduce competition between the hospital and non-hospital providers of certain services, such as outpatient surgery.

Although market share and concentration are useful starting points in analyzing the competitive effects of multiprovider networks, the Agencies' ultimate conclusion is based upon a more comprehensive analysis. This will include an analysis of collateral agreements and spillover effects.[60] In addition, in assessing the likely competitive effects of a multiprovider network, the Agencies are particularly interested in the ability and willingness of health plans and other purchasers of health care services to switch between different health care providers or networks in response to a price increase, and the factors that

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[59] By aligning itself with a large share of physicians in the market, a monopoly hospital may effectively be able to insulate itself from payer efforts to control utilization of its services and thus protect its monopoly profits.

[60] See Statement of Enforcement Policy on Physician Network Joint Ventures, pp.61-105.

determine the ability and willingness of plans to make such changes. The Agencies will consider not only the proportion of the providers in any relevant market who are in the network, but also the incentives faced by providers in the network, and whether different groups of providers in a network may have significantly different incentives that would reduce the likelihood of anticompetitive conduct.[61] If plans can contract at competitive terms with other networks or with individual providers, and can obtain a similar quality and range of services for their enrollees, the network is less likely to raise competitive concerns.

In examining a multiprovider network's overall competitive effect, the Agencies will examine whether the competing providers in the network have agreed among themselves to offer their services exclusively through the network or are otherwise operating, or are likely to operate, exclusively. Such exclusive arrangements are not necessarily anticompetitive.[62] Exclusive networks, however, mean that the providers in the network are not available to join other networks or contract individually with health plans, and thus, in some circumstances, exclusive networks

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[61] See discussion in Statement of Enforcement Policy on Physician Network Joint Ventures, pp. 61-105.

[62] For example, an exclusive arrangement may help ensure the multiprovider network's ability to serve its subscribers and increase its providers' incentives to further the interests of the network.

can impede or preclude competition among networks and among individual providers. In determining whether an exclusive arrangement of this type raises antitrust concerns, the Agencies will examine the market share of the providers subject to the exclusivity arrangement; the terms of the exclusive arrangement, such as its duration and providers' ability and financial incentives or disincentives to withdraw from the arrangement; the number of providers that need to be included for the network and potentially competing networks to compete effectively; and the justification for the exclusivity arrangement.

Networks also may limit or condition provider participants' freedom to contract outside the network in ways that fall short of a commitment of full exclusivity. The Agencies recognize that the competitive impact of exclusive arrangements or other limitations on the ability of a network's provider participants to contract outside the network can vary greatly.

b. Vertical Analysis

In addition to the horizontal issues discussed above, multiprovider networks also can raise vertical issues. Generally, vertical concerns can arise if a network's power in one market in which it operates enables it to limit competition in another market.

Some multiprovider networks involve "vertical" exclusive arrangements that restrict the providers in one market from

dealing with non-network providers that compete in a different market, or that restrict network provider participants' dealings with health plans or other purchasers. For example, a multiprovider network owned by a hospital and individually contracting with its participating physicians might limit the incentives or ability of those physicians to participate in other networks. Similarly, a hospital might use a multiprovider network to block or impede other hospitals from entering a market or from offering competing services.

In evaluating whether such exclusive arrangements raise antitrust concerns, the Agencies will examine the degree to which the arrangement may limit the ability of other networks or health plans to compete in the market. The factors the Agencies will consider include those set forth in the discussion of exclusive arrangements on pages 118-119, above.

For example, if the multiprovider network has exclusive arrangements with only a small percentage of the physicians in a relevant market, and there are enough suitable alternative physicians in the market to allow other competing networks to form, the exclusive arrangement is unlikely to raise antitrust concerns. On the other hand, a network might contract exclusively with a large percentage of physicians in a relevant market, for example general surgeons. In that case, if purchasers or payers could not form a satisfactory competing network using the remaining general surgeons in the market, and could not induce new general surgeons to enter the market, those purchasers and payers would be forced to use this network, rather than put together a panel consisting of those providers of each needed service who offer the most attractive combination of price and quality. Thus, the exclusive arrangement would be likely to restrict competition unreasonably, both among general surgeons (the horizontal effect) and among health care providers in other service markets and payers (the vertical effects).

The Agencies recognize that exclusive arrangements, whether they are horizontal or vertical, may not be explicit, so that labeling a multiprovider network as "non-exclusive" will not be determinative. In some cases, providers will refuse to contract with other networks or purchasers, even though they have not entered into an agreement specifically forbidding them from doing so. For example, if a network includes a large percentage of physicians in a certain market, those physicians may perceive that they are likely to obtain more favorable terms from plans by dealing collectively through one network, rather than as individuals.

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

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

(2) that providers in the network actually individually participate in, or contract with, other networks or managed care plans, or there is other evidence of their willingness and incentive to do so;

(3) that providers in the network earn substantial revenue from other networks or through individual contracts with managed care plans;

(4) the absence of any indications of substantial departicipation from other networks or managed care plans in the market; and

(5) the absence of any indications of coordination among the providers in the network regarding price or other competitively significant terms of participation in other networks or managed care plans.

c. Exclusion Of Particular Providers

Most multiprovider networks will contract with some, but not all, providers in an area. Such selective contracting may be a method through which networks limit their provider panels in an effort to achieve quality and cost-containment goals, and thus enhance their ability to compete against other networks. One reason often advanced for selective contracting is to ensure that the network can direct a sufficient patient volume to its providers to justify price concessions or adherence to strict quality controls by the providers. It may also help the network create a favorable market reputation based on careful selection of high quality, cost-effective providers. In addition, selective contracting may be procompetitive by giving non-participant providers an incentive to form competing networks.

A rule of reason analysis usually is applied in judging the legality of a multiprovider network's exclusion of providers or classes of providers from the network, or its policies on referring enrollees to network providers. The focus of the analysis is not on whether a particular provider has been harmed by the exclusion or referral policies, but rather whether the conduct reduces competition among providers in the market and thereby harms consumers. Where other networks offering the same types of services exist or could be formed, there are not likely to be significant competitive concerns associated with the

exclusion of particular providers by particular networks. Exclusion or referral policies may present competitive concerns, however, if providers or classes of providers are unable to compete effectively without access to the network, and competition is thereby harmed. In assessing such situations, the Agencies will consider whether there are procompetitive reasons for the exclusion or referral policies.

3. Efficiencies

Finally, the Agencies will balance any potential anticompetitive effects of the multiprovider network against the potential efficiencies associated with its formation and operation. The greater the network's likely anticompetitive effects, the greater must be the network's likely efficiencies. In assessing efficiency claims, the Agencies focus on net efficiencies that will be derived from the operation of the network and that result in lower prices or higher quality to consumers. The Agencies will not accept claims of efficiencies if the parties reasonably can achieve equivalent or comparable savings through significantly less anticompetitive means. In making this assessment, however, the Agencies will not search for a theoretically least restrictive alternative that is not practical given business realities.

Experience indicates that, in general, more significant efficiencies are likely to result from a multiprovider network

joint venture’s substantial financial risk-sharing or substantial clinical integration. However, the Agencies will consider a broad range of possible cost savings, including improved cost

controls, case management and quality assurance, economies of scale, and reduced administrative or transaction costs.

In assessing the likelihood that efficiencies will be realized, the Agencies recognize that competition is one of the strongest motivations for firms to lower prices, reduce costs, and provide higher quality. Thus, the greater the competition facing the network, the more likely the network will actually realize potential efficiencies that would benefit consumers.

4. Information Used In The Analysis

In conducting a rule of reason analysis, the Agencies rely upon a wide variety of data and information, including the information supplied by the participants in the multiprovider network, purchasers, providers, consumers, and others familiar with the market in question. The Agencies may interview purchasers of health care services, including self-insured employers and other employers that offer health benefits, and health plans (such as HMOs and PPOs), competitors of the providers in the network, and any other parties who may have relevant information for analyzing the competitive effects of the network.

The Agencies do not simply count the number of parties who support or oppose the formation of the multiprovider network. Instead, the Agencies seek information concerning the competitive dynamics in the particular community where the network is

forming. For example, in defining relevant markets, the Agencies are likely to give substantial weight to information provided by purchasers or payers who have attempted to switch between providers in the face of a price increase. Similarly, an employer or payer with locations in several communities may have had experience with a network comparable to the proposed network, and thus be able to provide the Agencies with useful information about the likely effect of the proposed network, including its potential competitive benefits.

In assessing the information provided by various parties, the Agencies take into account the parties' economic incentives and interests. In addition, the Agencies attach less significance to opinions that are based on incomplete, biased, or inaccurate information, or opinions of those who, for whatever reason, may be simply indifferent to the potential for anticompetitive harm.

C. Arrangements That Do Not Involve Horizontal Agreements On Prices Or Price-Related Terms

Some networks that are not substantially integrated use a variety of “messenger model” arrangements to facilitate contracting between providers and payers and avoid price-fixing agreements among competing network providers. Arrangements that are designed simply to minimize the costs associated with the contracting process, and that do not result in a collective determination by the competing network providers on prices or

price-related terms, are not per se illegal price fixing.[63]

Messenger models can be organized and operate in a variety of ways. For example, network providers may use an agent or third party to convey to purchasers information obtained individually from the providers about the prices or price-related terms that the providers are willing to accept.[64] In some cases, 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. In others, the agent may have received from individual providers some authority to accept contract offers on their behalf. The agent also may help providers understand the contracts offered, for example by providing objective or empirical information about the terms of an offer (such as a comparison of the offered terms to other contracts agreed to by network participants).

The key issue in any messenger model arrangement is whether the arrangement creates or facilitates an agreement among competitors on prices or price-related terms. Determining whether there is such an agreement is a question of fact in each case. The Agencies will examine whether the agent facilitates

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[63] See infra Example 4.

[64] Guidance about the antitrust standards applicable to collection and exchange of fee information can be found in the Statement of Enforcement Policy On Providers' Collective Provision Of Fee-Related Information To Purchasers Of Health Care Services, and the Statement of Enforcement Policy On Provider Participation In Exchanges Of Price And Cost Information.

collective decision-making by network providers, rather than independent, unilateral, decisions.[65] In particular, the Agencies will examine whether the agent coordinates the providers' responses to a particular proposal, disseminates to network providers the views or intentions of other network providers as to the proposal, expresses an opinion on the terms offered, collectively negotiates for the providers, or decides whether or not to convey an offer based on the agent's judgment about the attractiveness of the prices or price-related terms. If the agent engages in such activities, the arrangement may amount to a per se illegal price-fixing agreement.

D. Examples Of Multiprovider Network Joint Ventures

The following are four examples of how the Agencies would apply the principles set forth in this statement to specific multiprovider network joint ventures, including: 1) a PHO involving substantial clinical integration, that does not raise significant competitive concerns under the rule of reason; 2) a PHO providing services on a per case basis, that would be analyzed under the rule of reason; 3) a PHO involving substantial financial risk sharing and including all the physicians in a

[65] Use of an intermediary or "independent" third party to convey collectively determined price offers to purchasers or to negotiate agreements with purchasers, or giving to individual providers an opportunity to "opt" into, or out of, such agreements does not negate the existence of an agreement.

small rural county, that does not raise competitive concerns under the rule of reason; and 4) a PHO that does not involve horizontal agreements on price.

1. PHO Involving Substantial Clinical Integration

Roxbury is a relatively isolated, medium-sized city. For the purposes of this example, the services provided by primary care physicians and those provided by the different physician specialists each constitute a relevant product market; and the relevant geographic market for each of them is Roxbury.

Several HMOs and other significant managed care plans operate in Roxbury. A substantial proportion of insured individuals are enrolled in these plans, and enrollment in managed care is expected to increase. Many physicians in each of the specialties and Roxbury's four hospitals participate in more than one of these plans. There is no significant overlap among the participants on the physician panels of many of these plans, nor among the active medical staffs of the hospitals, except in a few specialties. Most plans include only 2 or 3 of Roxbury's hospitals, and each hospital is a substitute for any other.

One of Roxbury's hospitals and the physicians on its active medical staff establish a PHO to assume greater responsibility for managing the cost and quality of care rendered to Roxbury residents who are members of health plans. They hope to reduce costs while maintaining or improving the quality of care, and

thus to attract more managed care patients to the hospital and their practices.

The PHO will implement systems to establish goals relating to quality and appropriate utilization of services by PHO participants, regularly evaluate both the hospital's and each individual doctor's and the network's aggregate performance concerning those goals, and modify the hospital's and individual participants' actual practices, where necessary, based on those evaluations. The PHO will engage in case management, preadmission authorization of some services, and concurrent and retrospective review of inpatient stays. In addition, the PHO is developing practice standards and protocols to govern treatment and utilization of services, and it will actively review the care rendered by each doctor in light of these standards and protocols.

There is a significant investment of capital to purchase the information systems necessary to gather aggregate and individual data on the cost, quantity, and nature of services provided or ordered by the hospital and PHO physicians; to measure performance of the PHO, the hospital, and the individual doctors against cost and quality benchmarks; and to monitor patient satisfaction. The PHO will provide payers with detailed reports on the cost and quantity of services provided, and on the network's success in meeting its goals.

The PHO will hire a medical director and support staff to

perform the above functions and to coordinate patient care in specific cases. The doctors and the hospital's administrative staff also have invested appreciable time in developing the practice standards and protocols, and will continue actively to monitor care provided through the PHO. PHO physicians who fail to adhere to the network's standards and protocols will be subject to remedial action, including the possibility of expulsion from the network.

Under PHO contracts, physicians will be paid by health plans on a fee-for-service basis; the hospital will be paid a set amount for each day a covered patient is in the hospital, and will be paid on a fee-for-service basis for other services. The physicians will not share substantial financial risk for the cost of services rendered to covered individuals through the network. The PHO will retain an agent to develop a fee schedule, negotiate fees, and contract with payers. Information about what participating doctors charge non-network patients will not be disseminated to participants of the PHO, and the doctors will not agree on the prices they will charge patients not covered by PHO contracts.

All members of the hospital's medical staff join the PHO, including its three geographically dispersed primary care group practices that together account for about 25 percent of the primary care doctors in Roxbury. These primary care doctors generally refer their patients to specialists on the hospital's

active medical staff. The PHO includes all primary care doctors and specialists on the hospital's medical staff because of those established referral relationships with the primary care doctors, the admitting privileges all have at the hospital, the quality of care provided by the medical staff, their commitment to cooperate with the goals of the PHO, and the need to provide convenient referral services to patients of the primary care doctors. Participating specialists include from 20 to 35 percent of specialists in each relevant market, depending on the specialty. Hospital and physician participation in the PHO is non-exclusive. Many PHO participants, including the hospital, already do and are expected to continue to participate in other managed care plans and earn substantial income from those plans.

Competitive Analysis

The Agencies would analyze the PHO under the rule of reason because it offers the potential for creating significant efficiencies and the price agreement among the physicians is reasonably necessary to realize those efficiencies. Prior to contracting on behalf of competing physicians, the PHO will develop mechanisms to provide cost-effective, quality care, including standards and protocols to govern treatment and utilization of services, information systems to measure and monitor both the individual performance of the hospital and physicians and aggregate network performance, and procedures to

modify hospital and physician behavior and assure adherence to network standards and protocols. The network is structured to achieve its efficiencies through a high degree of interdependence and cooperation among its participants. The price agreement for physician services, under these circumstances, is subordinate to and reasonably necessary to achieve these objectives.[66]

[66] Although the physicians have not directly agreed among themselves on the prices to be charged, their use of an agent subject to the control of the PHO to establish fees and to negotiate and execute contracts on behalf of the venture would amount to a price agreement among competitors. The use of such an agent, however, should reduce the risk of the PHO's activities having anticompetitive spillover effects on competition among provider participants for non-network patients.

Furthermore, the Agencies would not challenge establishment and operation of the PHO under the rule of reason. In conducting the rule of reason analysis, the Agencies would evaluate the likely competitive effects of the venture in each relevant market. In this case, the PHO does not appear likely to limit competition in any relevant market either by hampering the ability of health plans to contract individually with area hospitals or physicians or with other network joint ventures, or by enabling the hospital or physicians to raise prices above competitive levels. The PHO does not appear to be overinclusive: many primary care physicians as well as specialists are available to other plans, and the doctors in the PHO have been included to achieve the network's procompetitive potential. Many PHO doctors also participate in other managed care plans and are expected to continue to do so in the future. Moreover, several significant managed care plans are not dependent on the PHO doctors to offer their products to consumers. Finally, the venture is structured so that physician participants do not share competitively sensitive information, thus reducing the likelihood of anticompetitive spillover effects outside the network where the physicians still compete, and the venture avoids any anticompetitive collateral agreements.

Since the venture is not likely to be anticompetitive, there is no need for further detailed evaluation of the venture's potential for generating procompetitive efficiencies. For these

reasons, the Agencies would not challenge the joint venture. They would reexamine this conclusion, however, and do a more complete analysis of the procompetitive efficiencies if evidence of actual anticompetitive effects were to develop.

2. PHO That Provides Services On A Per Case Basis

Goodville is a large city with a number of hospitals. One of Goodville's hospitals, together with its oncologists and other relevant health care providers, establishes a joint venture to contract with health plans and other payers of health care services to provide bone marrow transplants and related cancer care for certain types of cancers based on an all inclusive per case payment. Under these contracts, the venture will receive a single payment for all hospital, physician, and ancillary services rendered to covered patients requiring bone marrow transplants. The venture will be responsible for paying for and coordinating the various forms of care provided. At first, it will pay its providers using a fee schedule with a withhold to cover unanticipated losses on the case rate. Based on its operational experience, the venture intends to explore other payment methodologies that may most effectively provide the venture's providers with financial incentives to allocate resources efficiently in their treatment of patients.

Competitive Analysis

The joint venture is a multiprovider network in which competitors share substantial financial risk, and the price agreement among members of the venture will be analyzed under the rule of reason. The per case payment arrangement involves the sharing of substantial financial risk because the venture will receive a single, predetermined payment for a course of treatment that requires the substantial coordination of care by different types of providers and can vary significantly in cost and complexity from patient to patient. The venture will pay its provider participants in a way that gives them incentives to allocate resources efficiently, and that spreads among the participants the risk of loss and the possibility of gain on any particular case. The venture adds to the market another contracting option for health plans and other payers that is likely to result in cost savings because of its use of a per case payment method. Establishment of the case rate is an integral part of the risk sharing arrangement.

3. PHO With All The Physicians In A Small, Rural County

Frederick County has a population of 15,000, and a 50-bed hospital that offers primary and some secondary services. There are 12 physicians on the active medical staff of the hospital (six general and family practitioners, one internist, two pediatricians, one otolaryngologist, and two general surgeons) as

well as a part-time pathologist, anesthesiologist, and radiologist. Outside of Frederick County, the nearest hospitals are in Big City, 25 miles away. Most Frederick County residents receive basic physician and hospital care in Frederick County, and are referred or transferred to the Big City physician specialists and hospitals for higher levels of care.

No managed care plans currently operate in Frederick County. Nor are there any large employers who selectively contract with Frederick County physicians. Increasingly, Frederick County residents who work for employers in Big City are covered under managed care contracts that direct Frederick County residents to hospitals and to numerous primary care and specialty physicians in Big City. Providers in Frederick County who are losing patients to hospitals and doctors in Big City want to contract with payers and employers so that they can retain these patients. However, the Frederick County hospital and doctors have been unsuccessful in their efforts to obtain contracts individually; too few potential enrollees are involved to justify payers' undertaking the expense and effort of individually contracting with Frederick County providers and administering a utilization review and quality assurance program for a provider network in Frederick County.

The hospital and all the physicians in Frederick County want to establish a PHO to contract with managed care plans and employers operating in Big City. Managed care plans have

expressed interest in contracting with all Frederick County physicians under a single risk-sharing contract. The PHO also will offer its network to employers operating in Frederick County.

The PHO will market the services of the hospital on a per diem basis, and physician services on the basis of a fee schedule that is significantly discounted from the doctors' current charges. The PHO will be eligible for a bonus of up to 20 percent of the total payments made to it, depending on the PHO's success in meeting utilization targets agreed to with the payers. An employee of the hospital will develop a fee schedule, negotiate fees, and contract with payers on behalf of the PHO. Information about what participating doctors charge non-PHO patients will not be disseminated to the doctors, and they will not agree on the prices they will charge patients not covered by PHO contracts.

Physicians' participation in the PHO is structured to be non-exclusive. Because no other managed care plans operate in the area, PHO physicians do not now participate in other plans and have not been approached by other plans. The PHO physicians have made clear their intention to continue to practice outside the PHO and to be available to contract individually with any other managed care plans that expand into Frederick County.

Competitive Analysis

The agreement of the physicians on the prices they will charge through the PHO would be analyzed under the rule of reason, because they share substantial financial risk through the use of a pricing arrangement that provides significant financial incentives for the physicians, as a group, to achieve specified cost-containment goals. The venture thus has the potential for creating significant efficiencies, and the setting of price promotes the venture's use of the risk-sharing arrangement.

The Agencies would not challenge formation and operation of the PHO under the rule of reason. Under the rule of reason analysis, the Agencies would evaluate the likely competitive effects of the venture. The venture does not appear likely to limit competition in any relevant market. Managed care plans' current practice of directing patients from Frederick County to Big City suggests that the physicians in the PHO face significant competition from providers and managed care plans that operate in Big City. Moreover, the absence of managed care contracting in Frederick County, either now or in the foreseeable future, indicates that the network is not likely to reduce any actual or likely competition for patients who do not travel to Big City for care.

While the venture involves all of the doctors in Frederick County, this was necessary to respond to competition from Big City providers. It is not possible to verify at the outset that the venture will in fact be non-exclusive, but the physicians' participation in the venture is structured to be non-exclusive, and the doctors have expressed a willingness to consider joining other managed care plans if they begin operating in the area.

For these reasons, the Agencies would not challenge the joint venture. However, if it later became apparent that the physicians' participation in the PHO was exclusive in fact, and consequently managed care plans or employers that wanted to contract with some or all of the physicians at competitive terms

were unable to do so, or that the PHO doctors entered into collateral agreements that restrained competition for services furnished outside the PHO, the Agencies likely would challenge the joint venture.

4. PHO That Does Not Involve Horizontal Agreements On Price

A hospital and doctors and other health care providers on its medical staff have established a PHO to market their services to payers, including employers with self-funded health benefits plans. The PHO contracts on a fee-for-service basis. The physicians and other health care providers who are participants in the PHO do not share substantial financial risk or otherwise integrate their services so as to provide significant efficiencies. The payers prefer to continue to use their existing third-party administrators for contract administration and utilization management, or to do it in-house.

There is no agreement among the PHO's participants to deal only through the PHO, and many of them participate in other networks and HMOs on a variety of terms. Some payers have chosen to contract with the hospital and some or all of the PHO physicians and other providers without going through the PHO, and a significant proportion of the PHO's participants contract with payers in this manner.

In an effort to avoid horizontal price agreements among competing participants in the PHO while facilitating the

contracting process, the PHO considers using the following mechanisms:

A. An agent of the PHO, not otherwise affiliated with any PHO participant, will obtain from each participant a fee schedule or conversion factor that represents the minimum payment that participant will accept from a payer. The agent is authorized to contract on the participants' behalf with payers offering prices at this level or better. The agent does not negotiate pricing terms with the payer and does not share pricing information among competing participants. Price offers that do not meet the authorized fee are conveyed to the individual participant.

B. The same as option A, with the added feature that the agent is authorized, for a specified time, to bind the participant to any contract offers with prices equal, to or better than, those in a contract that the participant has already approved.

C. The same as option A, except that in order to assist payers in developing contract offers, the agent takes the fee authorizations of the various participants and develops a schedule that can be presented to a payer showing the percentages of participants in the network who have authorized contracts at various price levels.

D. The venture hires an agent to negotiate prices with payers on behalf of the PHO's participants. The agent does not disclose to the payer the prices the participants are willing to accept, as in option C, but attempts to obtain the best possible prices for all the participants. The resulting contract offer

then is relayed to each participant for acceptance or rejection.

Competitive Analysis

In the circumstances described in options A through D, the Agencies would determine whether there was a horizontal agreement on price or any other competitively significant terms among PHO participants. The Agencies would determine whether such agreements were subject to the per se rule or the rule of reason, and evaluate them accordingly.

The existence of an agreement is a factual question. The PHO's use of options A through C does not establish the existence of a horizontal price agreement. Nor is there sharing of price information or other evidence of explicit or implicit agreements among network participants on price. The agent does not inform PHO participants about others' acceptance or rejection of contract offers; there is no agreement or understanding that PHO participants will only contract through the PHO; and participants deal outside the network on competitive terms.

The PHO's use of option D amounts to a per se unlawful price agreement. The participants' joint negotiation through a common agent confronts the payer with the combined bargaining power of the PHO participants, even though they ultimately have to agree individually to the contract negotiated on their behalf.

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

You may contact the Antitrust Division regarding business review letters:

By writing or calling:
Legal Procedure Unit
Antitrust Division
U.S. Department of Justice
Suite 215, 325 7th St., NW
Washington, D.C. 20530
(202) 514-2481

You may access public documents by using the Internet:

gopher@justice.usdoj.gov
http://www.usdoj.gov

You may contact the Federal Trade Commission regarding advisory opinions:

By writing or calling:
Health Care Division
Bureau of Competition
Federal Trade Commission
Washington, D.C. 20580
(202) 326-2756

You may access public documents by using the Internet:

http://www.ftc.gov