

## STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE

### STATEMENT 8: 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.<sup>21</sup> 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 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.<sup>22</sup> Other types of health care network joint ventures are not directly addressed by this statement.<sup>23</sup>

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 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.<sup>24</sup> 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 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<sup>25</sup> in each physician specialty with active hospital staff privileges who practice in the relevant geographic market.<sup>26</sup> 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 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.<sup>27</sup>

The safety zones are limited to networks involving substantial financial risk sharing not because 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.<sup>28</sup> 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:<sup>29</sup>

- (1) agreement by the venture to provide services to a health plan at a “capitated” rate;<sup>30</sup>
- (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;<sup>31</sup>
- (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.<sup>32</sup>

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 through the network.<sup>33</sup> 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.<sup>34</sup> Likewise, physician network joint ventures that do not involve the sharing of substantial financial risk also may be 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.<sup>35</sup> In accord with general antitrust principles, physician network joint ventures will be analyzed 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.<sup>36</sup>

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 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.<sup>37</sup>

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.<sup>38</sup> 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.

**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 physi-

cians 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.<sup>39</sup> 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.

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.**<sup>40</sup> 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.

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.<sup>41</sup> Similarly, attempts by a physician network joint venture to exclude competitors or classes of competitors of the network's physician participants from the 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 utili-

zation 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.<sup>42</sup>

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 of 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.

es, 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.<sup>43</sup> 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 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.

\* \* \* \*

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.

#### FOOTNOTES:

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."
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.
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).
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.
  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.
  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.
  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.
  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 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.
  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.
  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.”
  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*.
  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).
  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.

41. This analysis of collateral agreements also applies to physician network joint ventures that fall within the safety zones.
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.
43. See *supra* Example 1.