

## STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE

### STATEMENT 9: 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.<sup>44</sup> 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 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.<sup>45</sup> 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.<sup>46</sup>

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.<sup>47</sup> In such cases, the setting of price would be integral 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;<sup>48</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>49</sup>

(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 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.<sup>50</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 multiprovider network joint venture may share substantial financial risk in the provision of health care services or products through the network.<sup>51</sup> 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 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.<sup>52</sup> 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 reasonably necessary for the network to realize significant procompetitive benefits, it similarly would be subject to rule of reason analysis.<sup>53</sup> 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.<sup>54</sup> The hospitals, however, would not necessarily be permitted to agree on what services they would provide to non-network patients.<sup>55</sup>

## B. 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 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.<sup>56</sup>

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.<sup>57</sup>

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 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)<sup>58</sup>, 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 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.<sup>59</sup> 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.<sup>60</sup> 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 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.<sup>61</sup> 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.<sup>62</sup> 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 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 provid-

ers 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 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.<sup>63</sup>

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.<sup>64</sup> 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 collective decision-making by network providers, rather than independent, unilateral, decisions.<sup>65</sup> 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 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.<sup>66</sup>

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 creat-

ing 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.

\* \* \* \*

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.

#### FOOTNOTES:

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.

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 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.
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.
52. See Section B(1) of the Agencies’ Statement Of Enforcement Policy On Physician Network Joint Ventures.
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.
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*.
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.
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.
61. See discussion in Statement of Enforcement Policy on Physician Network Joint Ventures.
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.
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.
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.
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.