

THIRTY YEARS OF SOLICITUDE: ANTITRUST LAW AND PHYSICIAN CARTELS

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For over thirty years the United States Department of Justice and Federal Trade Commission (“Agencies”) have confronted bands of businessmen who have steadfastly refused to pay attention to legal precedent, repeated governmental pronouncements, and administrative sanctions imposed on their colleagues. The conduct revealed in these cases evidences a willingness to blatantly disregard the law by repeatedly undertaking arrangements already deemed illegal by the enforcers or by concocting schemes that raise untested but dubious justifications. Who are these lawbreakers? Organized criminals? Internet spam artists? Boiler-room operators? No, these cases involve physicians, some grouped in associations numbering in the thousands and almost always proceeding with the advice of business consultants and counsel.¹ The conduct challenged by the government involves the formation of loosely-structured organizations, ranging from Independent Practice Associations to Preferred Provider Organizations (PPO) to other kinds of loose “networks” that collectively bargain with employers or managed care organizations for provider contracts.²

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¹ See, e.g., Mem'l Hermann Health Network Providers, No. C-4104 (Jan. 8, 2004) (consent order) (administrative complaint indicating a physician organization of 3,000 physicians in Houston, Texas), available at <http://www.ftc.gov/os/caselist/0310001/040113comp0310001.pdf>; SPA Health Org., No. C-4088 (July 17, 2003) (consent order) (administrative complaint indicating a physician organization of 1,000 physicians in Dallas–Fort Worth, Texas), available at <http://www.ftc.gov/os/2003/07/spahealthcomp.pdf>.

² See Health Care Alliance of Laredo, No. C-4158 (Mar. 23, 2006) (consent order) (IPA); Cal. Pac. Med. Group, Inc., No. 9306 (May 10, 2004) (consent order) (PPO); Wis. Chiropractic Ass'n, No. C-3943 (May 18, 2000) (consent order) (loose “network” in which executive director of chiropractic association encouraged members to attend seminars at which the director discussed pricing, urged members to question third-party payors, and later organized a member boycott of third-party payors). Some organizations discussed in this article and included in the data presented are Physician Hospital Organizations (PHOs), control of which is typically shared by independent physicians with one or more hospitals. Because negotiations concerning member physicians' prices is done by a common agent

What the federal antitrust Agencies regard as an epidemic of price-fixing schemes has transpired despite their extensive efforts to delineate a boundary between permissible physician collaboration and illegal cartelization. As early as 1976, the FTC was challenging physician attempts to thwart competition by denying reimbursement to physicians providing services to HMOs,³ penalizing physicians who accepted salaries or payment on other than a fee-for-service basis⁴ or limiting price competition by other means.⁵ Since 1996, the FTC has initiated and settled by consent decrees approximately forty-one enforcement actions against hospital-contracting and physician-contracting networks for jointly negotiating on behalf of their members with payors in a manner that constituted unlawful horizontal price-fixing agreements.⁶ Remarkably, this vigorous record of prosecution has not deterred the challenged conduct: since the beginning of this decade, the FTC has brought thirty-four such cases.⁷ For its part, the Antitrust Division of the DOJ has challenged at least five similar arrangements as illegal horizontal restraints but has shied away from using its criminal enforcement powers.⁸ In ad-

(the PHO), these organizations are treated as physician networks for the purposes of the antitrust issues discussed in this article.

³ Med. Serv. Corp. of Spokane County, 88 F.T.C. 906 (1976) (consent order).

⁴ *In re* Am. Med. Ass'n, 94 F.T.C. 701 (1979), *aff'd as modified*, 638 F.2d 443 (2d Cir. 1980), *aff'd by an equally divided Court*, 455 U.S. 676 (1982) (order modified 99 F.T.C. 440 (1982), 100 F.T.C. 572 (1982), and 114 F.T.C. 575 (1991)); Am. Soc'y of Anesthesiologists, 93 F.T.C. 101 (1979) (consent decree).

⁵ Am. Coll. of Obstetricians & Gynecologists, 88 F.T.C. 955 (1976) (consent decree) (publication and adherence to relative value scales with the effect of limiting price competition); Am. Coll. of Radiology, 89 F.T.C. 144 (1977) (consent order) (same).

⁶ See MARKUS H. MEIER & BRADLEY S. ALPERT, BUREAU OF COMPETITION, FED. TRADE COMM'N, OVERVIEW OF FTC ANTITRUST ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS (2007), available at <http://www.ftc.gov/bc/0608hcupdate.pdf>. Since this report's issuance, the FTC has also brought two enforcement actions: New Century Health Quality Alliance, Inc., No. C-4169 (Sept. 29, 2006) (consent order), available at <http://www.ftc.gov/os/caselist/0510137/0510137nchqaprimeorder.pdf>; Advocate Health Partners, FTC File No. 0310021, (complaint filed Dec. 29, 2006), available at <http://www.ftc.gov/os/caselist/0310021/061229cmp0310021.pdf>.

⁷ See MEIER & ALPERT, *supra* note 6 (thirty-two cases since 1990); New Century Health Quality Alliance, No. C-4169 (Sept. 29, 2006); Advocate Health Partners, FTC File No. 0310021, (complaint filed Dec. 29, 2006).

⁸ United States v. Fed'n of Physicians & Dentists, No. 1:05-CV-431 (S.D. Ohio, complaint filed June 24, 2005); United States v. Mountain Health Care, P.A., No. 1:02-CV-288-T (W.D. N.C., complaint filed Dec. 13, 2002); United States v. Fed'n of Certified Surgeons & Specialists, No. 99-167-CIV-T-17F (M.D. Fla., complaint filed Jan. 26, 1999); United States v. Fed'n of Physicians & Dentists, Inc., No. 98-475 (D. Del., complaint filed Aug. 12, 1998); United States v. Woman's Hosp. Found., No. 96-389-BM2 (M.D. La., complaint filed Apr. 23, 1996). All cases are accessible through the Antitrust Division website, <http://www.usdoj.gov/atr/cases.html>. The Department of Justice has used its criminal enforcement

dition, the Agencies have issued ten advisory opinions since 2000 and have promulgated and revised detailed Statements of Enforcement on these matters.⁹

The puzzle explored in this essay is why the government's deployment of extensive resources has not curtailed physician attempts to engage in collective bargaining and other attempts to restrain price competition. It first analyzes the hypothesis that overly cautious government enforcement policies created a mismatch between penalties and rewards that invited abuse. While finding merit in this explanation, the essay offers a more nuanced account. It suggests that a convergence of factors including doctrinal shortcomings, political pressures, and institutional constraints may have deterred the Agencies from seeking stronger remedies and em-

powers only twice over the last thirty years in cases involving physician collective bargaining. *United States v. Alston*, 374 F.2d 1206 (1992) (discussed *infra*, note 24); *United States v. Lake Country Optometric Soc'y*, Cr. No. W59CR114 (W.D. Tex., filed July 9, 1996) (guilty plea; \$30,000 fine). In one other case, staff working on the investigation recommended criminal prosecution, but the Department of Justice proceeded with a civil lawsuit, settled by a consent decree. *United States v. Mass. Allergy Soc'y, Inc.*, 1992-1 Trade Cas. (CCH) ¶ 69846, 1992 WL 178713 (D. Mass. 1992) (consent decree). The DOJ's reluctance to seek criminal penalties has not gone unnoticed by commentators. See David Marx, Jr., *Messenger Models: What Can the Agencies Do To Prevent Provider Networks From Violating the Antitrust Laws?*, AHLA HEALTH LAWYERS NEWS, Apr. 2004, at 24 (stating that the DOJ should consider a return to the use of criminal penalties in rare cases where justified); *but cf.* RICHARD A. POSNER, *ANTITRUST LAW* 270 (2d ed. 2001) ("[T]he distinctive criminal sanction of imprisonment . . . should be regarded as a sanction of last resort . . .").

⁹The FTC has issued five advisory opinions regarding physician networks. See Letter from David R. Pender, Acting Ass't Dir., Bureau of Competition, FTC, to Clifton E. Johnson & William H. Thompson (Mar. 28, 2006) (FTC Staff Advisory Opinion Concerning Suburban Health Org., Inc.) [hereinafter SHO Advisory Opinion]; Letter from Jeffrey W. Brennan, Ass't Dir., Bureau of Competition, FTC, to Gerald Niederman (Nov. 3, 2003) (Staff Advisory Opinion to Medical Group Mgmt. Ass'n); Letter from Jeffrey W. Brennan, Ass't Dir., Bureau of Competition, FTC, to Martin J. Thompson (Sept. 23, 2003) (Staff Advisory Opinion to Bay Area Preferred Physicians) [hereinafter BAPP Advisory Opinion]; Letter from Jeffrey W. Brennan, Ass't Dir., Bureau of Competition, FTC, to Gregory G. Binford (Feb. 6, 2003) (Staff Advisory Opinion to PriMed Physicians); Letter from Jeffrey W. Brennan, Ass't Dir., Bureau of Competition, FTC, to John J. Miles (Feb. 19, 2002) (Staff Advisory Opinion to MedSouth, Inc.) [hereinafter MedSouth Advisory Opinion].

Likewise, the DOJ has issued five business review letters. See Letter from R. Hewitt Pate, Ass't Att'y Gen., Antitrust Division, DOJ, to Diana West (May 25, 2004) (Business Review Letter to Internationally Board-Certified Lactation Consultants); Letter from Charles A. James, Ass't Att'y Gen., Antitrust Division, DOJ, to Jerry B. Edmonds (Sept. 23, 2002) (Business Review Letter to Wash. State Medical Ass'n); Letter from Charles A. James, Ass't Att'y Gen., Antitrust Division, DOJ, to Clifton E. Johnson (Apr. 3, 2002) (Business Review Letter to Mich. Hospital Group, Inc.); Letter from Charles A. James, Ass't Att'y Gen., Antitrust Division, DOJ, to Patrick R. Gordon (Aug. 29, 2001) (Business Review Letter to Rio Grande Eye Associates, P.A.); Letter from Joel I. Klein, Ass't Att'y Gen., Antitrust Division, DOJ, to Jaye L. Martin (Feb. 4, 2000) (Business Review Letter to Midwest Behavioral Healthcare, L.L.C.).

boldened parties who questioned the role of competition in health markets generally. A related claim of this essay is that the Agencies may have inadvertently precipitated some of this conduct by the regulatory efforts they have undertaken. Finally, the essay offers some lessons learned from the FTC's recent North Texas Specialty Physicians case.

I. PHYSICIAN RESISTANCE TO COMPETITIVE PAYMENT SYSTEMS AND THE GOVERNMENT'S RESPONSE

The history of physicians resisting payment plans that threatened their incomes or professional autonomy is a long one. As early as 1943, Thurman Arnold, Franklin Roosevelt's Attorney General, brought criminal indictments against organized physician groups that had engineered a boycott of a health maintenance organization in the District of Columbia.¹⁰ Explicit threats of boycott against the proposed Medicare law in 1964 led President Johnson to accede to a "customary and reasonable" payment methodology that, while making the program palatable to doctors, ever since has been the driving force for inflationary cost increases in the program.¹¹ Some of the most important obstacles to competition were institutionalized in organized medicine's infrastructure, such as AMA ethics code restrictions on contract practice of medicine and advertising which were challenged by the FTC in a path-breaking case in the mid-1970s.¹² As discussed above, from the inception of competition in health care in the mid-1970s, antitrust enforcers have encountered numerous instances of physician cartels engaged in actual or threatened boycotts of third-party payors seeking discounts, refusals to deal with other physicians or hospitals supporting health maintenance organizations, and entities formed to negotiate collectively with third-party payors.¹³

Over this extended period, physicians have advanced a variety of justifications for collective actions resisting competition. For ex-

¹⁰ *Am. Med. Ass'n v. United States*, 317 U.S. 519 (1943). General Arnold once remarked that American Medical Association president Morris Fishbein and labor leader John L. Lewis were "brothers under the skin." Clark C. Havighurst, *A Comment: The Antitrust Challenge to Professionalism*, 41 MD. L. REV. 30, 31-32 n.10 (1981).

¹¹ See THEODORE R. MARMOR, *THE POLITICS OF MEDICARE* 80 (1973).

¹² *In re Am. Med. Ass'n*, 94 F.T.C. 701, 1011-12 (1979), *aff'd as modified*, 638 F.2d 443 (2d Cir. 1980) (overturning AMA's "corporate practice" ethical standards which opposed physicians working on a salary basis, accepting "inadequate" compensation, or "underbidding" other physicians).

¹³ See *supra* notes 3-9; see also *infra* note 17 and accompanying text.

ample, physician groups initially claimed that antitrust law did not apply to “learned professions” or that it hampered the provision of high quality health care services.¹⁴ As managed care began to grow, the AMA argued that antitrust doctrine inhibited physicians’ efforts to adopt cost-saving practices by discouraging development of efficiency-enhancing joint ventures.¹⁵ Later, with competitive contracting in full bloom, the claim was that strict application of the law was inappropriate because of the power of managed care entities on the buying side; collective action by physicians was needed to “level the playing field” with powerful managed care organizations.¹⁶ While none of these rationalizations have found acceptance from the FTC and Department of Justice or the courts, they reflect organized medicine’s consistently held belief that physicians should enjoy latitude under the antitrust laws to permit them to engage in collective bargaining.

An examination of the cases brought by the Agencies over the last thirty years reveals that despite repeated prosecution of clear-cut violations of settled antitrust norms, overt cartelization schemes have not disappeared. In the period from 1976 through 1996, approximately fifty-nine cases involving physician collective actions were initiated by the FTC and six were brought by the DOJ.¹⁷ Reflecting the fact that these cases were doctrinally uncontroversial, virtually all were settled without administrative or judicial hearings. In a large percentage of these cases, physicians formed vehicles for negotiating with third-party payors that were either thinly veiled attempts to collectively bargain without integrating their operations in any way (which the Agencies call “sham” PPOs) or purported “messenger model” arrangements that transparently allowed an

¹⁴ See, e.g., *Arizona v. Maricopa County Med. Soc’y*, 457 U.S. 332, 348–49 (1982) (rejecting argument that doctors’ status as professionals foreclosed per se condemnation of price-fixing agreement). *Goldfarb v. Va. State Bar*, 421 U.S. 773, 780 (1975) is the seminal case rejecting a categorical “learned professions” exception to the antitrust laws.

¹⁵ See James S. Todd, *Physicians As Professionals, Not Pawns*, HEALTH AFF., Fall 1993, at 145, 145–47.

¹⁶ See Robert Pitofsky, Chairman, Fed. Trade Comm’n, Thoughts on “Leveling the Playing Field” in Health Care Markets, Remarks Before the Nat’l Health Lawyers Ass’n Twentieth Annual Program on Antitrust in the Health Care Field (Feb. 13, 1997); see also William S. Brubaker III, *Will Physician Unions Improve Health System Performance?*, 27 J. HEALTH POL. POL’Y & L. 575, 577–85 (2002).

¹⁷ MEIER & ALPERT, *supra* note 6. The data in the text includes only cases involving physicians and physician-hospital organizations such as PHOs; cases involving pharmacies are not included.

agent to do the price-fixing on behalf of the physicians who controlled the entity.¹⁸

Recent history indicates that there has been no let up in the quantity or gravity of physician cartelization schemes. Between 1996 and 2006, forty-six cases were brought by federal enforcement Agencies, a total exceeding the amount brought in the preceding decade.¹⁹ Moreover, the nature of the conduct involved in these cases reveals an increased propensity to undertake the kind of conduct most clearly prohibited under antitrust horizontal restraint analysis. Table 1 categorizes the complaints filed between 1996 and 2000 by the FTC and between 2001 and 2006 based on whether the government's allegations included indicia of blatant cartelization (e.g., price agreements accompanied by threats of boycott, statements of intent to disregard the law, coercion, etc.) or in which agents expressly coordinate the response of member physicians (e.g., by pre-polling or employing a fee schedule) before ultimately transmitting the payors' offers for "individual" acceptance or rejection.

TABLE 1: CATEGORIES OF COMPLAINTS FILED BY THE FTC BETWEEN 1996 AND 2006

	1996-2000	2001-2006
Blatant Cartelization	7	22
Express Coordination	4	8
Total	11	30

The data indicate that the percentage of cases brought involving cartelization conduct actually increased during 2001-2006 (73%) compared to the previous period (64%). Moreover, it appears that few of the cases involved in either period involved colorable claims of integration. A large number of the challenged cases involved

¹⁸ See *Health Care Reform Issues: Antitrust, Medical Malpractice Liability, and Volunteer Liability: Hearing on H.R. 2925, H.R. 911 and H.R. 2938 Before the H. Comm. on the Judiciary*, 104th Cong. (1996) (statement of Robert Pitofsky, Chairman, FTC) ("These groups have often portrayed themselves as 'networks,' 'independent practice association,' or other such potentially procompetitive ventures (even including utilization review or quality assurance programs)—but in fact often have turned out to be nothing but sham efforts to forestall or undermine new forms of health care."), available at <http://judiciary.house.gov/Legacy/148.htm> [hereinafter Pitofsky Testimony]. For an explanation of the messenger model, see *infra* notes 82-97 and accompanying text.

¹⁹ MEIER & ALPERT, *supra* note 6.

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agents purportedly acting as “messengers”²⁰ and not relying on claims of financial or clinical integration.²¹

II. EXPLAINING NONCOMPLIANCE: UNDER-ENFORCEMENT OR UNCERTAINTY?

This section explores two broad hypotheses explaining the government’s long running—and perhaps unprecedented—failure to gain compliance with antitrust norms. The first posits that flaws in federal antitrust enforcement policy and inadequacies in sanctions imposed invited physician groups and their advisers to disregard the commands of antitrust law. A second explanation faults uncertainty in antitrust doctrine and ambiguity in the law and the pronouncements and policies of the Agencies. Although the latter hypothesis may underlie the susceptibility of some to participate in the illegal conduct, the former provides a preliminary, albeit incomplete, account for physician cartelization.

The case for the under-enforcement hypothesis is straightforward. There is a mismatch between the rewards to physicians for successful cartelization (enhanced reimbursement for their services from managed care organizations) and the penalties imposed by the government for violating the antitrust laws.²² Despite the persistence and magnitude of cartelization schemes, the remedies applied by the FTC and DOJ have been mild, lending credence to the claim that providers’ continuing willingness to skirt the edges of the law

²⁰ See North Tex. Specialty Physicians, No. 9312 slip op. n. 38 (FTC Nov. 29, 2005) (opinion of the commission), available at <http://www.ftc.gov/os/adjpro/d9312/051201opinion.pdf> (listing ten previous commission consent orders involving conduct that deviated from the messenger model); see also discussion of the messenger model *infra* notes 82-97 and accompanying text.

²¹ Based on the FTC’s “Analysis of Proposed Consent Order to Aid Public Comment” filed with virtually all settlements in these cases, the parties did not undertake significant efforts to integrate. See *e.g.*, *In re* Mont. Associated Physicians, Inc., No. 911-0008 (consent order) (“Neither the physician members of MAPI, nor the physician members of BPHA, have integrated their practices in any economically significant way, nor have they created efficiencies sufficient to justify their acts or practices described above.”), available at <http://www.ftc.gov/os/1996/10/9110008a.htm>.

²² The large academic literature on efficient remedies broadly agrees that penalties should equal harm caused subject to adjustment reflecting the likelihood of escaping liability. See generally A. Mitchell Polinsky & Steven Shavell, *Punitive Damages: An Economic Analysis*, 111 HARV. L. REV. 869, 873 (1998) (stating “the basic principle” that “to achieve appropriate deterrence, injurers should be made to pay for the harm their conduct generates, not less, not more. If injurers pay less than for the harm they cause, under-deterrence may result . . .”).

is in part the result of under-enforcement of antitrust law.²³ For example, there have been no criminal prosecutions of networks, even for blatant cartelizing schemes such as “sham” PPOs and transparent efforts to use provider-sponsored networks as a cover for refusals to negotiate with independent HMOs and other third-party payors seeking concessions on price and utilization.²⁴ In addition, the Agencies have been reluctant to impose structural remedies, such as disbanding offending organizations, or to impose injunctive sanctions on individuals for knowing participation in naked restraints.²⁵ Typically, the government’s consent orders have been wrist slaps, doing little more than enjoining future misconduct—even in cases involving obvious cartel activities.²⁶ Of the forty-six cases brought by the government since 1996 examined for this arti-

²³ See Thomas L. Greaney, *Chicago’s Procrustean Bed: Applying Antitrust Law in Health Care*, 71 ANTITRUST L.J. 857, 893–94 (2004); Marx, *supra* note 8; Jeff Miles, *Ticking Antitrust Time Bombs: A Message to Messed-Up Messenger Models*, AHLA HEALTH LAWYERS NEWS, Nov. 2002, at 5.

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²⁴ An opinion that may have chilled the willingness of the Justice Department to seek criminal sanctions against physician cartels is *United States v. Alston*, 974 F.2d 1206 (9th Cir. 1992), in which the government met with mixed results in criminal charges brought against dentists who agreed to collectively refuse to accept the price list proposed by a third-party payor. The case did not involve a network as such, but, rather, informal meetings among disgruntled dentists. While the Court upheld the government’s contention that an agreement fixing co-payment amounts constituted illegal price-fixing, it expressed sympathy for physicians who must deal with large third-party payors and seemed to suggest that greater leeway should be afforded in such circumstances. *Id.* at 1214. In a remarkably naive passage, Judge Kozinski seemed to endorse competitors engaging in the kinds of communications that almost any experienced antitrust counselor would find troublesome. Noting that “‘price-fixing’ is a term of art that is hardly self-defining,” it suggested that some arrangements among health professionals that might appear to be price-fixing could be perfectly legal: “Dentists commiserating over the low fee schedules; or impugning the motivations or integrity of the Plans; or even sabre-rattling about economic retribution at some indefinite time in the future if their grievances remain unaddressed.” *Id.* at 1213–14.

²⁵ For example, the DOJ has ordered the dissolution of an offending organization in only one case over the past decade. *United States v. Mountain Health Care, P.A.*, No. 1:02-CV-288-T (W.D. N.C., judgment entered Sept. 15, 2003), available at <http://www.usdoj.gov/atr/cases/f201200/201291.htm>. For its part, the FTC has ordered a dissolution in only three cases: *New Millenium Orthopedics L.L.C.*, No. C-4140 (June 13, 2005) (consent order), available at <http://www.ftc.gov/os/caselist/0310087/050617do0310087.pdf>; *Carlsbad Physicians Ass’n*, No. C-4081 (June 13, 2003) (consent order), available at <http://www.ftc.gov/os/2003/06/carlsbaddo.htm>; *Obstetrics and Gynecology Med. Corp. of Napa Valley*, No. C-4048 (May 14, 2002) (consent order), available at <http://www.ftc.gov/os/2002/05/obgyndo.pdf>. In *Surgical Specialists of Yakima*, the FTC ordered a structural alternative to dissolution, instead requiring SSY to revoke the membership of one of its two surgical groups. *Surgical Specialists of Yakima, P.L.L.C.*, No. C-4101 (Nov. 13, 2003) (consent order), available at <http://www.ftc.gov/os/2003/11/031118do0210242.pdf>.

²⁶ See Marx, *supra* note 8, at 25 (characterizing FTC remedies as amounting to a charge to “go forth and sin no more”).

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cle, only four resulted in dissolution of the entity accused of cartelizing the market through attempted price-fixing or market allocation.²⁷ Moreover, in the nine cases in which individuals—all consultants—were sanctioned, decrees typically imposed only limited prohibitions on their participation in the formation of future networks.²⁸ Indeed, in one notable Justice Department case, a physician union, which had entered into such a decree settling a case involving flagrant misuse of a messenger model arrangement, subsequently engaged in similar misconduct which became the subject of a second lawsuit.²⁹

Incentives to collude became especially strong as managed care contracting began to take hold. Not only did successful collusion among physicians have the potential to produce significant financial rewards by limiting the impact of discounting and utilization review, to some degree it could restore to physicians their lost sense of autonomy as they achieved more equal bargain-

²⁷ See *supra* note 25.

²⁸ FTC Consent Orders involving consultants have stopped short of an outright ban on network consulting and have been limited to prohibiting future participation in the networks involved in the subject proceeding. See, e.g., New Century Health Quality Alliance, Inc., No. C-4169 (Sept. 29, 2006) (consent order); White Sands Health Care System, L.L.C., No. C-4130 (Jan. 11, 2005) (consent order); Southeastern N.M. Physicians IPA, Inc., No. C-4113 (Aug. 5, 2004) (consent order); Physician Network Consulting, L.L.C., No. C-4094 (Aug. 27, 2003) (consent order); Carlsbad Physicians Ass'n, No. C-4081 (June 13, 2003) (consent order); Prof'ls in Women's Care, No. C-4063 (Oct. 8, 2002) (consent order); Physician Integrated Services of Denver, Inc., No. C-4054 (July 16, 2002) (consent order); Aurora Associated Primary Care Physicians, L.L.C., No. C-4055 (July 16, 2002) (consent order); Wis. Chiropractic Ass'n, No. C-3943 (May 18, 2000) (consent order).

²⁹ In *United States v. Federation of Physicians and Dentists, Inc.*, No. 98-495 (D. Del., filed Aug. 12, 1998), the Department claimed that physicians negotiated exclusively through the Federation to oppose Blue Cross and Blue Shield of Delaware's proposed reduction in fees and to inhibit other insurers from reducing the fees. Notably, the consent decree entered into by the government forbade future actions to orchestrate collective bargaining, but permitted defendant to continue to serve as a messenger provided it notified payors that it cannot negotiate on behalf of physicians. In its Competitive Impact Statement, the DOJ acknowledged that it had "considered a final judgment that would have flatly prohibited the Federation from acting as a third-party messenger nationwide [and] limitations on the areas and specialties for which the Federation would be allowed to function as a third-party messenger." Competitive Impact Statement, *United States v. Fed'n of Physicians and Dentists, Inc.*, No. 98-495 (D. Del., filed October 22, 2001), available at <http://www.usdoj.gov/atr/cases/f9300/9378.htm>. A few years later, the Department filed suit against the same union, claiming it had again misused the messenger model and engaged in other acts, such as threats of contract termination, to coordinate and implement the demands of member OB-GYNs in Ohio for higher fees and other favorable terms in their contracts with managed care organizations. *United States v. Fed'n of Physicians and Dentists, Lynda Odenkirk, Warren Metherd, Michael Karram, and James Wendel* Civil Action No. 1:05-CV-431 (filed June 24, 2005), available at <http://www.usdoj.gov/atr/cases/f209700/209759.htm>.

ing power vis-à-vis managed care over clinical and administrative matters. The impact of managed care contracting on physician income throughout the 1990s is well documented: steep discounting and utilization review forced significant concessions from physicians.³⁰ While overt collusion or network agreements might seem to run the risk of provoking treble damages actions, for several reasons private litigation has not served as an effective deterrent in these cases. Perhaps owing to their need to maintain good will and confidence of the providers in local communities, third-party payors have only brought litigation challenging a handful of cases, none of which have produced significant legal precedents.³¹ In a rare private case, an arbitration panel found no antitrust violation by a large physician network engaged in contracting in Chicago.³² The FTC subsequently brought an administrative proceeding against the network based in part on the same facts; the network promptly agreed to the entry of a consent order which contained the standard, modest injunctive remedies.³³ Insureds and employers who are also victims of price-elevating physician practices face collective action problems and may be barred from litigating under antitrust indirect purchaser rules.³⁴ In sum, while not entirely risk-free, in the absence of meaningful monetary or criminal sanctions, physicians engaging in collective bargaining forbidden by antitrust laws may enjoy some degree of insulation from discounting while facing little risk of significant financial or reputational loss.

³⁰ *First Hearing in a Series on Tax Exemption: Pricing Practices of Hospitals Before the Subcomm. on Oversight of the H. Comm. on Ways and Means*, 108th Cong. (2004) (statement of Paul Ginsburg, President, Center for Studying Health System Change), available at <http://waysandmeans.house.gov/hearings.asp?formmode=view&id=1687>.

³¹ See, e.g., *Levine v. Cent. Fla. Med. Affiliates, Inc.*, 72 F.3d 1538, 1549 (11th Cir. 1996) (discussed *infra* note 86). Another dubious precedent is *Int'l Healthcare Mgmt. v. Haw. Coal. for Health*, 332 F.3d 600, 608 (9th Cir. 2003); see Greaney, *Antitrust's Procrustean Bed*, *supra* note 23.

³² The arbitration decision involved a price-fixing claim by United Healthcare against the practices of a large Chicago area health system (Advocate Health Care Network) contracting on behalf of over 2,500 physicians. Applying the rule of reason, the panel found competitive benefits in promised clinical integration sufficient to offset harms to consumers and concluded that Advocate's market share, approximately fifteen percent, was not enough to constitute market power. *United Healthcare of Ill. Inc. v. Advocate Health Care Network*, American Arbitration No. 51-193-Y-01990-03 (2005), available at http://www.hmltd.com/article_advocate_decision.pdf.

³³ *In re Advocate Health Partners*, No. 031-0021 (Dec. 29, 2006) (consent order), available at <http://www.ftc.gov/os/caselist/0310021/0310021.htm>.

³⁴ See generally, PHILLIP E. AREEDA & HERBERT HOVENKAMP, *ANTITRUST LAW: AN ANALYSIS OF ANTITRUST PRINCIPLES AND THEIR APPLICATION* (2d. ed. 2000).

The uncertainty hypothesis holds that the line between price-fixing and legal, procompetitive cooperation among physicians has remained unsettled and that the enforcement policies and pronouncements over the years have contributed to uncertainty. Lawyers seeking to structure arrangements for physicians in small practices that would permit them to participate in managed care contracting through networks with transaction-cost reducing networks encountered mixed signals because case law and governmental pronouncements led them to believe there was leeway to permit nonexclusive physician controlled networks to operate.³⁵ Price agreements among network physicians thus seemed a natural and inevitable part of network operations and posed little risk of harm where the physician network lacked market power.

Uncertainty about legal doctrine governing physician collaboration undoubtedly exists; however, uncertainty did not surround the specific kind of conduct challenged in the government's cases. A brief exposition of the doctrinal and regulatory history of physician network issues illustrates the point. As far back as 1982 the Supreme Court applied a conclusive presumption of illegality—the “per se rule”—in *Arizona v. Maricopa County Medical Society*, a case involving two physician-controlled foundations for medical care which closely resembled today's loosely-integrated, physician-controlled PPOs and other networks.³⁶ Concluding the arrangement constituted a horizontal price-fixing agreement, the plurality explained its reasoning by emphasizing that, even if there were efficiencies associated with the arrangement, it was not necessary that the doctors do the price-setting.³⁷ The Court went on to distinguish the foundations from HMOs and other true joint ventures in which financial risk was shared:

If a clinic offered complete medical coverage for a flat fee, the cooperating doctors would have the type of partnership arrangement in which a price-fixing agreement among the doctors would be perfectly proper. But the fee arrangements disclosed by the record in this case are among independent competing entrepreneurs. They fit squarely into the horizontal price-fixing mold.³⁸

The plurality's decision in *Maricopa* elicited a sharp dissent from Justice Powell, who argued that plausible efficiencies attributa-

³⁵ See Amy Lynn Sorrel, *The Cost of Confusion: Trying to Decipher the FTC's Rules on Negotiation*, AM. MED. NEWS, Nov. 6, 2006, at 5.

³⁶ 457 U.S. 332 (1982).

³⁷ *Id.* at 352–54, 357.

³⁸ *Id.* at 357.

ble to joint contracting merited application of the “rule-of-reason.”³⁹ The decision also drew strong criticism in the academic literature⁴⁰ and repeated calls for legislative action.⁴¹ Indeed, the FTC and Department of Justice were never entirely comfortable with applying a strict dichotomy between risk-sharing ventures and all other kinds of integration for purposes of applying “per se” analysis. After some early pronouncements suggesting that some shared commitment to utilization review or other integrative activity might be sufficient to avoid “per se” scrutiny,⁴² in 1994 the Agencies issued Health Care Policy Statements identifying a number of specific examples of cognizable financial risk sharing; however, this guideline did not specify what other kinds of integration might suffice to avoid “per se” treatment, stating only that physician networks must demonstrate that “the combining of the physicians into a joint venture enables them to offer a new product producing substantial efficiencies.”⁴³ Two years later, responding in part to political pressures and seeking to offer more concrete guidance and demonstrate regulatory flexibility,⁴⁴ the Agencies revised the Policy Statements and specifically endorsed certain kinds of non-financial integration options

³⁹ *Id.* at 362–64 (Powell, J., dissenting).

⁴⁰ See Greaney, *Procrustean Bed*, *supra* note 23, at 889–91; see also Peter M. Gerhart, *The Supreme Court and the (Near) Triumph of the Chicago School*, 1982 SUP. CT. REV. 319, 344–48 (1984) (criticizing the Court’s wooden application of the per se rule).

⁴¹ See, e.g., Clark C. Havighurst, *Are the Antitrust Agencies Overregulating Physician Networks?*, 8 LOY. CONSUMER L. REP. 78, 93 (1996); see *infra* notes 61–73 and accompanying text. Even some leading advocates of antitrust policy in health care viewed these networks as first steps toward an efficiency-enhancing integration of physician practices, a necessary condition for the promise of managed care competition to be realized.

⁴² See, e.g., J. Paul McGrath, Ass’t Att’y Gen., Antitrust Division, U.S. Dep’t of Justice, Remarks Before the 33rd Annual ABA Section of Antitrust Law Spring Meeting (March 22, 1985) (efficiency-enhancing integration sufficient to avoid *Maricopa*’s per se rule could flow from the following aspects of a provider-sponsored PPO’s operations, among others: an agreement among the physicians to accept discount fees with no balance-billing of patients; utilization review by the PPO; joint marketing or PPO administration of claims; and an agreement by a panel of limited size to bid for contracts against other such groups) (cited in Letter from M. Elizabeth Gee, Fed. Trade Comm’n to Michael Duncheon (March 17, 1986) (staff advisory opinion)).

⁴³ See U.S. Dep’t of Justice & Fed. Trade Comm’n, *Statements of Antitrust Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust*, reprinted in 4 Trade Reg. Rep. (CCH) ¶ 13,152, at 20,788 (Sept. 30, 1994) (Eighth Statement) [hereinafter 1994 Policy Statements].

⁴⁴ See notes 61–75 and accompanying text describing the influence of proposed legislation on the issuance of revised policy statements.

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open to networks.⁴⁵ They also outlined so-called “messenger model” arrangements that would avoid antitrust problems altogether.⁴⁶

Under “messenger model” network agreements endorsed in the Health Care Policy Statements, physicians may use a common agent to convey information to and from payors about the prices and price-related terms they are willing to accept.⁴⁷ In essence, the 1996 Policy Statements establish a presumption that physicians complying with the model’s parameters have not collectively agreed upon prices, but instead have determined their prices individually. Central to the concept is the integrity of the messenger—he must function solely as a conduit for offers and exchanges between payors and individual providers.⁴⁸ The Agencies found themselves elaborating or conceding endless refinements to the “messenger model” concept and proposing various other arrangements by which parties could escape “per se” condemnation. The data presented earlier demonstrate that the “messenger model” has been the subject of abuse, as many networks challenged by the Agencies were operating under a messenger model structure that seemed designed to disguise collective decision-making rather than facilitate individual negotiations between physicians and payors.⁴⁹

⁴⁵ See U.S. Dep’t of Justice & Fed. Trade Comm’n, *Statements of Antitrust Enforcement Policy in Health Care*, Statement 9.C (1996) [hereinafter *Policy Statements*], available at <http://www.usdoj.gov/atr/public/guidelines/1791.pdf>. For analysis of the messenger model see *infra* notes 82–97 and accompanying text; for clinical integration see *infra* notes 98–111 and accompanying text.

⁴⁶ See *Policy Statements*, *supra* note 45.

⁴⁷ *Id.*

⁴⁸ The Statements identify conduct that would not satisfy the requirements of the model:

[T]he 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.

Id.

⁴⁹ The FTC summarized the instances of abuse it has witnessed in connection with the messenger model:

Many physicians and physician networks that label themselves “messenger models” have created or facilitated agreements among members of the network not to compete with one another on price terms. Some networks, for example, have aggressively negotiated for higher prices, and transmitted payer offers to the physicians only after achieving a price offer that the organization’s agent or committee deemed acceptable. Others have transmitted only offers that meet a predetermined price. In such situations, network members sometimes have agreed in advance to demand that price, many times with the assistance of an agent to help forge consensus. Other times, an agent has solicited member physicians’ individ-

A further source of uncertainty in the Agencies' analysis of physician-controlled networks has been the kind of integration that will suffice to avoid price-fixing characterization. As noted earlier, Maricopa was widely interpreted to suggest that physician networks needed to share financial risk in order to have their price-setting agreements deemed ancillary and hence not subject to "per se" condemnation.⁵⁰ Although the government had long taken the position that financial risk sharing was necessary to satisfy the ancillary restraints doctrine,⁵¹ it reversed its course in the 1996 Policy Statements, stating that "clinically integrated" entities might escape summary condemnation.⁵² While this change afforded long-sought leeway for networks that undertake meaningful non-financial integration and adopt measures to assure implementation, it has not found widespread adoption in the market.⁵³ The implications of the lack of take-up are not obvious: it may be due to uncertainty about the parameters of the clinical integration rule, to practical and finan-

ual price demands, then used an average or other calculation from the submitted information to determine a collective price to demand from payers.

In other instances, networks have prompted coordinated pricing by encouraging physician members to deal with payers only through the organization, thereby bolstering the physicians' collective leverage. Some networks have prohibited members from contracting independently—either permanently or for some period while the network negotiates with the payer, or while a network contract with that payer is in effect. Other networks have acted as their member physicians' agent, by collectively terminating the physicians' existing individual payer contracts, or have exhorted members to terminate such contracts on a coordinated basis and to contract only through the network.

BAPP Advisory Opinion, *supra* note 9.

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⁵⁰ See *supra* notes 36–41 and accompanying text.

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⁵¹ See, e.g., Letter from Robert F. Leibenluft, Ass't Dir., Bureau of Competition, FTC, to Robert C. Norton (Aug. 13, 1998) (FTC Staff Advisory Opinion to Associates in Neurology); Letter from Robert F. Leibenluft, Ass't Dir., Bureau of Competition, FTC, to David V. Meany (May 14, 1997) (FTC Staff Advisory Opinion to Yellowstone Physicians, L.L.C.). See J. Paul McGrath, Ass't Att'y Gen., Antitrust Division, U.S. Dep't of Justice, Remarks Before the 33rd Annual ABA Section of Antitrust Law Spring Meeting (Mar. 22, 1985); Charles F. Rule, Ass't Att'y Gen., Antitrust Division, U.S. Dep't of Justice, Remarks to Connecticut Health Lawyers Ass'n (Mar. 11, 1988).

⁵² See Policy Statements, *supra* note 45, at Statement 8.C; see also MedSouth Advisory Opinion, *supra* note 9; SHO Advisory Opinion, *supra* note 9.

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⁵³ Lawrence Casalino, *The Federal Trade Commission, Clinical Integration, and the Organization of Physician Practice*, 31 J. HEALTH POL. POL'Y & L. 569, 573 (2006) ("[S]ince the FTC identified clinical integration as a safety zone for joint negotiations, there has been very little overt "take-up" by physicians of this safety zone.").

cial obstacles to implementation,⁵⁴ or to a belief that even more lenient policies could be expected in the future.⁵⁵

Assessment

Although the long-running debate over physician-controlled networks has undoubtedly engendered much confusion and numerous contested legal boundaries still exist, it would be a mistake to attribute the widespread incidence of antitrust violations by physicians to a mere misunderstanding of the law. Simply put, the violations are so blatant they do not come close to any of the grey areas of doctrine. With virtually all of the cases involving unvarnished attempts to collectively negotiate prices and no meaningful efforts to integrate financially or clinically, there can be little question that their purpose was to obtain bargaining leverage for their members.⁵⁶ While it is true that the Supreme Court has not been clear or consistent in delineating boundaries between presumptively illegal conduct and cooperation requiring more exacting proof of harm,⁵⁷ it has

⁵⁴ *Id.* at 573–76. A particularly important, and as yet unresolved, question concerns the required showing of a nexus between the parties’ clinical integration and the price-setting function of the network. See Greaney, *Procrustean Bed*, *supra* note 23, at 902–05. For further discussion, see *infra* notes 98–110 and accompanying text.

⁵⁵ See Casalino, *supra* note 53, at 573 (“Initially, many articles, from a variety of perspectives, claimed that the 1996 statements were a ‘breakthrough’ for physicians.”).

⁵⁶ See, e.g., In the matter of Piedmont Health Alliance, Inc., No. 9314 (Analysis of Agreement containing Consent Order to Aid Public Comment) (internal report stating member physicians “stated a need to form the group to negotiate with group clout and power” and “maintain their income” in anticipation of managed care negotiations). Indeed, in the only case initiated by the FTC that has been litigated, the parties offered only hollow claims that cognizable procompetitive justifications flowed from their arrangement. N. Tex. Specialty Physicians, 2005-2 Trade Cas. (CCH) ¶ 75,032 at 103,477 (FTC 2005), available at <http://www.ftc.gov/os/adjpro/d9312/051201opinion.pdf>. See *supra* notes 19–21 and accompanying text. See also Jeff Miles, *Analyzing the Federal Trade Commission’s North Texas Specialty Physicians Decision*, THE HEALTH LAWYER, Apr. 2006, at 1.

⁵⁷ Beginning with *National Society of Professional Engineers v. United States*, 435 U.S. 679 (1978), the Supreme Court initiated a series of cases that sought to move away from a rigid, bipolar methodology that branded conduct as per se illegal or required extensive examination under the rule of reason. However, subsequent cases, many of which involved the health care industry, failed to clarify the requisite standards and often employed confusing and inconsistent formulations. See, e.g., *Broadcast Music, Inc. v. Columbia Broadcasting, Inc.*, 441 U.S. 1, 19–20 (1979) (rule of reason to be generally applied where efficiency justifications proffered); *Arizona v. Maricopa Med. Soc’y*, 457 U.S. 332 (1982) (per se rule applied despite claimed efficiencies); *Nat’l Collegiate Athletic Ass’n v. Bd. of Regents of Univ. of Oklahoma*, 468 U.S. 85 (1984) (depth of scrutiny should be regarded as occurring across a “continuum” rather than in discrete categories); *FTC v. Indiana Fed. of Dentists*, 476 U.S. 447 (1986) (highly truncated analysis appropriate where conduct is plainly anticompetitive); *Cal. Dental Ass’n v. FTC*, 526 U.S. 756, 770 (1999) (requiring “an enquiry meet for the case, looking to a restraint’s circumstances, details, and logic.”). See discussion of legal doctrine *infra* notes 111–22 and accompanying text.

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never signaled that price setting lacking some procompetitive justification can be excused. Moreover, given that putting together these networks required advice from consultants and attorneys familiar with the health care industry, it is highly improbable that these individuals were in the dark about their legal obligations under antitrust law. In sum, whatever uncertainties existed about the boundaries of the “messenger model” and the meaning of clinical integration, the cases brought by the government did not present such issues.

The under-enforcement hypothesis also finds substantial support in the mismatch between the rewards and penalties facing physicians and their advisers. A utility-maximizing *medicus economicus* would confront the following calculus: substantial upside financial gains from collective bargaining (plus psychic rewards from preserving professional autonomy and resisting managed care) weighed against relatively small costs and risks even if the government took action and prevailed (e.g., an injunction against continuing the practice in the future). Of course other factors enter into the calculus. The probability of detection is high, as network arrangements are in the open and payors are acutely aware of their operations. On the other hand, the risks of private treble damages litigation appear attenuated and there is little reason to believe physicians suffer from reputational harms from participating in challenged networks. Indeed, professional norms seem to have promoted, rather than discouraged, efforts to pose a collective counterforce to managed care.⁵⁸

Scholarship on law enforcement strategies suggests that many unrefined deterrence-focused approaches fail to assure compliance because they do not address business perceptions of the morality of regulated behavior. An approach that simply exacts a price for non-compliance succeeds in deterring illegality only if the price is not too low; if too high on the other hand, the resulting over-deterrence produces inefficiency and punishes the innocent. Theorists advocating “responsive regulation” argue that in order to secure moral commitment to compliance with the law regulation strategies should be structured to progress from cooperative to punitive approaches as needed when the former prove inadequate.⁵⁹ By this account, norms

⁵⁸ See *infra* notes 69–75 and accompanying text.

⁵⁹ See IAN AYRES & JOHN BRAITHWAITE, *RESPONSIVE REGULATION: TRANSCENDING THE DEREGULATION DEBATE* (1992); Christine Parker, *The “Compliance” Trap: The Moral Message in Responsive Regulatory Enforcement*, 40 L. & SOC. REV. 591, 592 (2006) (responsive regulation suggests that strategies should be “arranged in a regulatory pyramid, with more coopera-

and informal pressures can secure compliance without enforcement actions. On the other hand, the failure to accelerate punishments when initial strategies fail—for example by increasing penalties, broadening the scope of culpable parties or expanding the scope of enforcement—can exacerbate noncompliance. While responsive regulation is itself subject to risks of being undermined in the absence of strong political support,⁶⁰ its underlying thesis is an important one. Effective regulation requires a nuanced approach that seeks to achieve deterrence through tactics that respond to changing conditions and counterstrategies and that promotes social norms to help achieve its goals. The outcome of the Agencies' approach to physician cartels confirms the predictions of responsive regulation theorists. Weak sanctions and a failure to adjust tactics in the face of blatant violations appear to have contributed to a lack of moral commitment to compliance with antitrust law by physician leaders and their advisors.

While the foregoing analysis exposes the incentive and opportunity for unlawful conduct, it does not afford an entirely satisfactory account of the government's enforcement failure. There remain a number of questions that are important for future antitrust policy: What are the underlying causes of prosecutorial failure? What accounts for the persistence of the problem? Why has the government not changed its enforcement strategy over time? The following section addresses some features of federal antitrust enforcement in the health care area that help answer these questions.

III. ANTITRUST ENFORCEMENT IN THE SHADOW OF POLITICS, REGULATORY GOALS AND UNCERTAIN LEGAL DOCTRINE

The Political Context

Physician networks have long been the subject of intense interest in Congress and neither the FTC nor the Antitrust Division of the Department of Justice has been immune from political pressures. Within a few years of the Supreme Court's decision in *Mari-copa*, the American Medical Society began lobbying efforts to require that the rule of reason apply to physician networks.⁶¹ From their

tive strategies deployed at the base of the pyramid and progressively more punitive approaches utilized if and when more cooperative strategies fail.”).

⁶⁰ Parker, *supra* note 59, at 593.

⁶¹ In the wake of the FTC's challenge to its ethical rules banning physicians engaging in contract medicine, the AMA almost prevailed in obtaining a special exemption from FTC

inception, the Health Care Policy Statements issued by the Agencies had an overtly political dimension. Issued one day after the unveiling of the Clinton Health Plan, the 1994 Policy Statements were designed to demonstrate that antitrust law would not impede the nation's switch to managed care and that legislative relief for providers was therefore unnecessary.⁶² Throughout the debate over health reform, and over the ensuing three years, organized medicine vigorously proclaimed that the law was unacceptably opaque with respect to the circumstances under which physicians could join together to form their own networks and bid collectively for managed care contracts.⁶³ So much so, it was asserted, that antitrust was having the perverse effect of inhibiting the development of an important competitive alternative in the marketplace.⁶⁴ In fact, the Agencies had issued numerous advisory opinions approving virtually every provider-controlled network that sought clearance, including several in which the providers represented a significant portion of the practitioners in their markets.⁶⁵

Nevertheless, following extensive lobbying, Congress responded in March 1996 when the House Judiciary Committee reported the Antitrust Health Care Advancement Act of 1996 (the

jurisdiction in Congress. The House passed a bill placing a moratorium on FTC investigations and lawsuits against the professions until Congress expressly approved such activity; a bill was defeated in the Senate by a vote of fifty-nine to thirty-seven. Carl Ameringer, *Federal Antitrust Policy and Physician Discontent: Defining Moments in the Struggle for Congressional Relief*, 27 J. HEALTH POL. POL'Y & L. 543, 552 (2002); see also Carl Ameringer, *Organized Medicine on Trial: The Federal Trade Commission vs. the American Medical Association*, 12 J. POL. HIST. 445 (2000).

⁶² 1994 Policy Statements, *supra* note 43. For a discussion of the political context of the Policy Statements, see Thomas L. Greaney, *A Critique: The Department of Justice/FTC Health Care Policy Statements*, 8 ANTITRUST 20 (1994).

⁶³ Catherine Hanson, Remarks Before the Federal Trade Commission Workshop on Health Care Competition Law and Policy, "On Integration, Physician Joint Contracting and Quality: Taking a Fresh Look at Some 'Settled' Questions," (Sept. 9, 2002).

⁶⁴ Rebutting this assertion, the FTC argued that its policies allow for flexibility in the development of innovative, procompetitive organizational forms. See Pitofsky Testimony, *supra* note 18.

⁶⁵ *Id.* (stating that the FTC issued eleven, and the Antitrust Division issued eighteen, favorable opinions subsequent to the 1993 Guidelines). For an example of a favorable advisory opinion in which the providers had a significant market share, see Letter from Robert F. Leibenluft, Ass't Dir., Bureau of Competition, FTC, to David V. Meany (May 14, 1997) (FTC Staff Advisory Opinion Concerning Yellowstone Physicians, L.L.C.), available at <http://www.ftc.gov/bc/healthcare/industryguide/advisory.htm#1994>. The Yellowstone Physicians joint venture represented thirty-nine percent of the overall market in Billings, Montana. *Id.* Market shares were further pronounced in some sub-specialties: radiation oncologists (sixty-seven percent); general surgeons (sixty-four percent); obstetrician/gynecologists (fifty-three percent); and cardiovascular surgeons (fifty percent). *Id.*

“Hyde bill”).⁶⁶ The Hyde bill required that courts examine provider networks under the broader “rule of reason” analytic methodology rather than the presumptive “per se” approach, even when the networks were not characterized by any significant clinical or financial integration.⁶⁷ Alarmed by the prospect that mandating “rule of reason” treatment would ossify the development of the law and impede effective enforcement in this area, Robert Pitofsky, the Chairman of the Federal Trade Commission, told the House Judiciary Committee that the initial policy statements might be “eased” a bit to satisfy Congressional concerns.⁶⁸ Bringing along a somewhat reluctant FTC staff and an even more skeptical Antitrust Division, the Chairman managed to forge agreement on numerous revisions to those portions of the Statements dealing with provider-sponsored networks.

Although the revisions succeeded in heading off the Hyde bill, their promulgation was viewed by the AMA as a triumph and interpreted by some as a signal that only those networks with obvious indicia of anticompetitive intent will be at risk in the future.⁶⁹ An AMA editorial summed up (and took credit for) the changes:

These landmark reforms are the direct result of a diligent five-year campaign by the AMA. No other organization could have taken on this fight anywhere near as effectively.

The journey began in 1991. It was clear to AMA analysts then that large, well-organized and profit-oriented managed care plans were gaining strong positions in many local markets

The AMA embarked on a broad campaign to challenge [the government’s] faulty reasoning. AMA staff researched and developed alternatives. AMA attorneys wrote numerous articles and made more than 100 speeches before meetings of lawyers and physicians to explain the AMA’s position and garner support. The AMA gathered actual case histories to prove the need for reform, and flew some of the individuals involved to Washington as part of an extensive lobbying effort among both regulators and lawmakers. A key element of the AMA’s strategy was to push for antitrust reform in every manner possible. It promoted antitrust changes in national health system reform legislation, and AMA ideas ultimately appeared in both Democratic and Republican proposals.

⁶⁶ H.R. 2925, 104th Cong. (1996).

⁶⁷ *Id.* at § 2(a).

⁶⁸ See Pitofsky Testimony, *supra* note 18.

⁶⁹ See Ronald M. Harris, *New Antitrust Guidelines for Physician Networks, Part 1*, 276 JAMA 1450–51 (Nov. 6, 1996) (noting that the Statements were issued to circumvent pending legislation and deeming the five year campaign a success); see also *Antitrust Guidelines Could Shift Power from Hospitals to Physicians*, 5 HEALTH L. REP., Oct. 31, 1996, at 43 (citing remarks of prominent antitrust attorney stating that Statements shift the balance of power from hospitals to physicians).

The AMA helped enact reforms in a number of states. The Association's work with regulators resulted in incremental antitrust reforms in 1993 and 1994.

Most recently, the AMA pressed for a national legislative solution in the stand-alone Hyde bill, which attracted 153 co-sponsors in the House of Representatives. The prospect of congressional legislation was fundamental to regulators' change of heart

The new guidelines, released in August in a joint statement by the Federal Trade Commission and Justice Dept., are an about face from past enforcement policy Physicians shouldn't expect a free ride, but the new guidelines offer an enormous opportunity that did not exist before.⁷⁰

A few years later, however, with managed care continuing to flourish, the AMA's House of Delegates grew restive and voted to reverse the organization's longstanding policy opposing physician union activity and established an AMA-affiliated bargaining arm.⁷¹ Following extensive lobbying, the AMA and other physician organizations returned to Congress and secured passage in the House of Representatives of H.R. 1304, sponsored by Representative Tom Campbell, which would have effectively granted independent physicians antitrust immunity when engaged in collective bargaining.⁷² Although the legislation never reached the Senate floor, it was the subject of intense concern to antitrust officials who vehemently opposed its passage.⁷³

The foregoing reveals that federal enforcers have been operating for more than twenty years under the threat of a legislative override of their antitrust enforcement authority over physician net-

⁷⁰ See Editorial, *Antitrust Relief*, AM. MED. NEWS, Sept. 23, 1996, available at http://www.ama-assn.org/amednews/1996/amn_96/edit0923.htm.

⁷¹ Sarah A. Klein, *AMA bargaining unit: From concept to reality*, AM. MED. NEWS, July 26, 1999, available at http://www.ama-assn.org/amednews/1999/pick_99/gvl10726.htm. In 1999, the AMA approved the formation of Physicians for Responsible Negotiations (PRN), which it described as "an AMA-affiliated labor organization dedicated to representing physicians in collective bargaining with employers." After attracting only a small membership and failing in some advocacy efforts, PRN was separated from the AMA in 2004, and operates as an independent physician labor organization. U.S. Dept. of Justice and Fed. Trade Comm'n, *IMPROVING HEALTH CARE: A DOSE OF COMPETITION*, Ch. 2 at 20 (July, 2004).

⁷² Quality Health-Care Coalition Act of 1999, H.R. 1304, 106th Cong. (1999).

⁷³ FTC Chairman Pitofsky and Ass't Att'y Gen. Klein voiced strong opposition to the Campbell bill in testimony before the House Judiciary Committee H.R. Rep. No. 106-625, at 39-40 (statement of Chairman Pitofsky); *id.* at 48-49 (statement of Ass't Atty Gen. Klein). Perhaps not coincidentally, the Department of Justice announced its decision to challenge for the first time a merger of two large managed care companies. *United States v. Aetna Inc.*, No. 3-99CV 1398-H, 1999 U.S. Dist. LEXIS 19691 (N.D. Tex. Dec. 7, 1999); *see also United States v. Aetna Inc.*, 64 Fed. Reg. 44946 (Aug. 18, 1999) (competitive impact statement). *See* William Kopit, *White Coats and Blue collars: Physician Collective Bargaining Legislation on the National State Levels*, A.L.L.-A.B.A. Continuing Legal Educ. (Oct. 2000).

works. The Agencies' response—in speeches, advisory opinions, and guidelines—can be read as seeking to reassure Congress that they would apply the law judiciously and that physicians would have sufficient leeway to form and control networks. Their unwillingness to invoke stronger sanctions can be seen as a pragmatic appraisal of the limits Congress would tolerate or perhaps (in some cases) reflecting less than full enthusiasm for the antitrust agenda in health care.⁷⁴ While Congress never adopted Representative Campbell's proposed legislative exemption, organized medicine continued its advocacy and three states adopted laws granting a modest protection for collective negotiations by physicians.⁷⁵ Ultimately, this long running lobbying effort paid dividends, reinforcing the AMA's message that concerns about professionalism, quality of care, and the power of managed care were legitimate concerns. In the minds of some, it may have also served to rationalize conduct violative of the law.

Antitrust Enforcement as Regulation

As a number of commentators have noted, government agencies charged with administering antitrust law have shifted perceptibly over the last twenty-five years from a litigation-oriented "law enforcement model" to one that employs tools associated with economic regulation.⁷⁶ Nowhere is this change more evident than the health care sector where the FTC and DOJ have undertaken significant efforts to give guidance and specific advice on how to comply with antitrust law. Through formal guidelines, advisory opinions, legislative testimony, and speeches, the Agencies have frequently provided specific advice plainly intended to influence the conduct

⁷⁴ Ass't Att'y Gen. Charles James disbanded the DOJ's health care task force and was reputed to be skeptical about the prior enforcement efforts in health care. See Thomas L. Greaney, *Whither Antitrust? The Uncertain Future of Health Care*, HEALTH AFF., Mar.–Apr. 2002, at 186.

⁷⁵ TEX. INS. CODE ANN. art. 29.06(a) (Vernon 2006); see Brewbaker, *supra* note 16.

⁷⁶ Thomas E. Kauper, *The Justice Department and the Antitrust Laws: Law Enforcer or Regulator?* 35 ANTITRUST BULL. 83 (1990); E. Thomas Sullivan, *The Antitrust Division as a Regulatory Agency: Antitrust Policy in Transition*, 64 WASH U.Q. 997 (1986); Jon Leibowitz, Commissioner, Fed. Trade Comm'n, Health Care and the FTC: The Agency as Prosecutor and Policy Wonk, Remarks at the Antitrust in HealthCare Conference of the American Bar Association/American Health Lawyers Association (May 12, 2005), available at <http://www.ftc.gov/speeches/leibowitz/050512healthcare.pdf> (discussing FTC's dual roles in health care, specifically regarding the pharmaceutical industry).

and organizational structure of the health care industry.⁷⁷ In testimony and speeches, top officials at both Agencies unabashedly undertook to “advocate competition,” reminding legislators and other regulators that health markets would be best served by reducing regulations and promoting competition.⁷⁸ In addition, in some litigated cases, the government’s focus has turned to engineering complex, conduct-oriented settlements rather than seeking structural or criminal remedies.⁷⁹ The content of those efforts has a distinctly regulatory flavor, as the guidance provided has often extended beyond generalities about enforcement priorities or assessments of the

⁷⁷ See Thomas L. Greaney, *Regulating for Efficiency in Health Care Through the Antitrust Laws*, 1995 UTAH L. REV. 465, 475–81 (discussing the Agencies’ attempts at regulation through the Policy Statements and advisory opinions).

⁷⁸ See, e.g., Pitofsky Testimony, *supra* note 18.

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A legislative directive as to what price related conduct deserves per se versus rule of reason treatment would be almost unprecedented, might allow certain clearly anticompetitive behavior to escape per se treatment, and would rigidify the development of physician networks in the sense that organizers would seek to establish networks that fall within the technical requirements of the legislation rather than those networks that insure maximum patient benefit. Indeed, the legislation could create the same chilling effect on new forms of provider networks that some say has resulted from the current guidelines—forcing new provider arrangements into inflexible categories.

The Commission, in consultation with the Department of Justice, plans to make further guidance available to the health care industry and to this Committee at the conclusion of our own review which will be within a matter of months.

A key function of the antitrust laws in the operation of health care markets is to keep those markets open and competitive, so that new ways of delivering and financing health care services can compete for acceptance by purchasers. Because the development of these new arrangements depends on vigorous competition among market participants—including providers, insurers, and others—it is important to prevent price fixing and market allocation agreements among competitors that are not reasonably related to cooperative activity that can produce countervailing advantages to consumers.

For a recent speech reiterating the point, see Deborah Platt Majoras, Chairman, Fed. Trade Comm’n, Remarks at the World Congress Leadership Summit: The Federal Trade Commission: Fostering a Competitive Health Care Environment That Benefits Patients (Feb. 28, 2005), available at <http://www.ftc.gov/speeches/majoras/050301healthcare.pdf>:

[L]aw enforcement is not the only procedure we use to cure anticompetitive ailments. The FTC actively engages in advocacy before states and other federal Agencies, urging the adoption of pro-competitive strategies for improving health care quality and bringing costs down [A]dvocacy can be very effective. Competition advocacy . . . can prevent legislation that might unintentionally injure competition—and raise patients’ costs—from getting on the books in the first place.

⁷⁹ U.S. v. HealthCare Partners, Inc., 1996-1 Trade Cas. (CCH) ¶ 71337 (D. Conn. 1996) (consent decree); U.S. v. Health Choice of Nw. Mo., Inc., 1996-2 Trade Cas. (CCH) ¶ 71605 (consent decree).

proper construction of precedent. In the case of physician networks, the guidance regularly commends specific contractual arrangements and network operations that are likely to satisfy the Agencies' interpretation of antitrust law.⁸⁰

While there are sound arguments for deploying regulatory tools in complex industries, especially those undergoing rapid change, there is no gainsaying the fact that this approach inevitably requires the Agencies to make a host of policy judgments and predictions about the future. Further, applying antitrust law in this dynamic context requires a forward-looking perspective and entails making projections about the trajectory of competition and forming normative judgments about the nature of institutional change. Clark Havighurst has argued that the Agencies' prejudgments about the market influenced their adoption of legal standards regarding physician networks.⁸¹ The perspective of most competition advocates over the past several decades has led them to believe that the inevitable spread of competitive bargaining in health markets would lead providers to undertake increasing integration, most likely in firms that help manage the financial risks assumed by risk contracting.

Wearing their regulatory hats, the FTC and DOJ may therefore have been inclined to be somewhat tolerant of loose physician networks because they felt confident that more complete integration would follow. By this view, physicians, long unaccustomed to participating in firms or even joint enterprises with others, needed to put a toe in the water by joining associations which might begin a process of moving toward financial integration and risk sharing. This perspective would reject an enforcement policy that closed the door on "intermediate" integration and views insistence on criminal or other rigorous relief as draconian and counterproductive. While not undermining the enforcement role of the Agencies—at least with respect to pursuing cases of clear-cut abuse—the regulatory perspective militated in favor of a cooperative, advisory approach to foster development of competitive institutions and norms in the long term. Examples of these policies are discussed next.

⁸⁰ See Policy Statements, *supra* note 45, at Statement 8 (describing risk-sharing arrangements and clinical integration); BAPP Advisory Opinion, *supra* note 9.

⁸¹ Clark C. Havighurst, *Are the Antitrust Agencies Overregulating Physician Networks?*, 8 *LOY. CONSUMER L. REP.* 78, 89 (1996).

Regulating While Litigating: Conundrums Arising From the Messenger Model and Clinical Integration

Adopting “enforcement polices” that are highly prescriptive, the Agencies have detailed specific arrangements that physicians may adopt to avoid charges of price-fixing. While their literal terms are sound from a doctrinal standpoint, two of these options, the messenger model and clinical integration, have proved controversial. Both entail subtle and somewhat elusive distinctions that in practice do not yield bright-line rules; consequently complying with these arrangements has generated significant confusion and dispute. The problem identified here is that the Agencies may have bent too far in seeking to be flexible and the resulting gray areas of compliance may have inadvertently precipitated some of the patently illegal conduct discussed above.

The Messenger Model

As described earlier, messenger model network agreements endorsed in the Health Care Policy Statements enable physicians using a common agent to convey information to and from payors about the prices and price-related terms they are willing to accept to escape charges of price-fixing.⁸² When undertaken in strict compliance with the parameters set forth in the Statements, there can be no claim that physicians have collectively agreed upon prices, thus precluding application of Section 1 of the Sherman Act, even though the physicians may control other aspects of the network’s operation.⁸³ Central to the concept, of course, is the integrity of the messenger—he must function solely as a conduit for offers and exchanges between payors and individual providers.⁸⁴ But as demonstrated by the cases cited at the outset of this essay, a large number of physician networks claiming to adhere to the messenger model were in blatant noncompliance with the letter and spirit of

⁸² See Policy Statements, *supra* note 465, at Statement 9.

⁸³ *Id.*

⁸⁴ The Health Care Policy Statements identify conduct that would *not* satisfy the requirements of the model:

[T]he 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.

Id.

the model.⁸⁵ One implication of the remarkable dissonance between the government’s roadmap and the path taken by a large number of networks is that the model itself inadvertently conveyed the wrong message.

To be sure, the complexity of the model engendered considerable confusion. For example, in the only reported decision dealing with the issue, the Eleventh Circuit mistakenly concluded that a PPO in which the physicians did not themselves decide on price terms, but allowed the PPO’s board (which included four physician members) to negotiate fees with insurers, constituted a purported messenger model arrangement.⁸⁶ The model also generated numerous requests for business review letters and advisory opinions regarding many subtle variations on the theme.⁸⁷ However, as previously discussed, the complexity and variability of options does not excuse the conduct in the administrative cases filed. Given the nature of the conduct involved (e.g., boycott threats directed at payors, overt “polling” and reporting of results to physicians), there is little doubt that someone knowingly orchestrated a violation of the antitrust laws. The extent to which physicians were duped by their messengers or by leaders of their organizations will never be known. However, as discussed below, messengers were imperfect agents in that their incentives were not completely aligned with the interests of their physician principals or, for that matter, of payors. It seems quite likely that some messengers would conceive (perhaps correctly) that their usefulness to physicians would be measured not by efficient delivery of unilateral messages, but by the overall profitability of the network, which most logically entailed achieving favorable terms in dealings with payors.

The government’s detailed discussion of the conditions necessary to avoid prosecution goes beyond explaining the law of hori-

⁸⁵ See *supra* notes 17–19 and accompanying text; see also *In re N. Tex. Specialty Physicians*, No. 9312, slip op. (FTC Nov. 29, 2005) (opinion of the commission), available at <http://www.ftc.gov/os/adjpro/d9312/051201opinion.pdf>.

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⁸⁶ *Levine v. Central Fla. Med. Affiliates, Inc.*, 72 F.3d 1538, 1539 (11th Cir. 1996). The court incorrectly assumed that the absence of formal control refuted the claim of conspiracy; however the central issue for Sherman Act purposes is whether there has been a meeting of the minds of the parties, something likely accomplished through the purported messenger arrangement at issue in that case. See Greaney, *Procrustean Bed*, *supra* note 23, at 898.

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⁸⁷ See, e.g., Letter from Robert F. Leibenluft, Ass’t Dir., Bureau of Competition, Fed. Trade Comm’n to Timothy C. Cashmore (Dec. 22, 1997) (FTC Staff Advisory Opinion); Letter from Mark J. Horoschak, Ass’t Dir., Bureau of Competition, Fed. Trade Comm’n, to Jacqueline C. Cox (Jul. 11, 1995); Letter from Mark J. Horoschak, Ass’t Dir., Bureau of Competition, Fed. Trade Comm’n, to John A. Cook (Mar. 28, 1995). For more recent examples, see *supra* note 9.

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zontal agreements. Indeed, as Professor Harrison has put it, the Statement “reads like an effort to describe an ex ante settlement agreement in which there is something for both buyers and sellers.”⁸⁸ When its provisions are held up against real-world relationships among physicians, their agents and payors, Statement 9 can be read to countenance, perhaps *sub rosa*, some degree of coordination among physicians on price or price-related matters. For example, while the model strictly forbids collective negotiation by or through the messenger and warns against other conduct such as “coordinat[ing of] providers’ responses” and “disseminat[ing] to network providers the views or intentions of other network providers,” the process specifically countenances a role for the messenger that far exceeds the mere transmittal of offers and acceptances or rejections.⁸⁹ Further, the Statement forbids the dissemination of information regarding “prices or price-related terms” but fails to delineate the boundary of those words.⁹⁰ This oversight is particularly troubling because of the peculiar economics of health care financing in which controls over intensity of care and broader quality-related issues are key elements in shaping the net cost of services to payors.⁹¹ Likewise, the model is replete with other ambiguities such as the degree to which a messenger may present information about past offers or contracts or disseminate data that is not “competitively sensitive.”⁹²

Other flaws in the model are more palpable. One is the assumption that messenger-agents will operate free of transaction costs, conflicts of interest, or opportunistic motives.⁹³ As several cases dramatically illustrate, messengers, who are often professional negotiators, labor organizers, or serve other functions for the physician network, do not enter their role free of such influences.⁹⁴ Indeed, the model places the messenger in a position of divided loyalty. It assumes that an agent chosen and paid by the sellers (physicians) will faithfully represent the interests of the buyers

⁸⁸ Jeffrey L. Harrison, *The Messenger Model: Don't Ask, Don't Tell?*, 71 ANTITRUST L.J. 1017, 1017 (2004).

⁸⁹ Policy Statements, *supra* note 465, at Statement 9.C.

⁹⁰ *Id.*

⁹¹ As the earlier discussion of *Indiana Federation of Dentists*, *Alston*, and *Hawaii Coalition* suggests, courts have failed to give helpful guidance in this area despite its central importance in health care. See *supra* notes 24, 51, and 113 and accompanying text.

⁹² See Harrison, *supra* note 88, at 1029–30.

⁹³ See Greaney, *Procrustean Bed*, *supra* note 23, at 899.

⁹⁴ See Harrison, *supra* note 88 (discussing the dual roles played by many messengers).

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(third-party payors) in abiding by the various limitations on disclosure and tacit signaling discussed above. In other contexts, it is customary to rely on bonding, professional norms, or other extralegal devices to reduce risks inherent in situations of divided loyalty.⁹⁵ Yet the model insists on no such provisions. A further difficulty that the model fails to account for is the possibility that physicians will use the selection and retention of the agent or limit his authority in a manner that would convey price signals. In a multi-period negotiation, the physicians can (through dismissal, threats, or other actions in connection with the retention of the messenger) coordinate their acceptance of terms.⁹⁶

In sum, it is plausible to read the government's decision to permit (perhaps encourage) agents to conduct sensitive discussions with competitors on price offers as amounting to a "wink and nod" approval that some degree of tacit coordination may occur.⁹⁷ With antitrust's fine line between tacit agreements (impermissible under Section 1) and conscious parallelism (not a "contract, combination or agreement") still perplexing courts, the endorsement of the communications permitted by the messenger model countenances a degree of coordination in some circumstances. More problematically, this solicitude could have signaled continued willingness to refrain from seeking punitive remedies. Finally, as evidenced by the North Texas Specialty Physicians case discussed below, the messenger model's most pernicious effect may have been in encouraging some network managers to devise complex mechanisms to disguise their effect.

Clinical Integration

Following extensive debate and controversy, the government's endorsement of clinical integration in the 1996 Policy Statements was heralded as a major victory for organized medicine and a potential sea change that would encourage the formation of physician

⁹⁵ See Eugene F. Fama & Michael C. Jensen, *Separation of Ownership and Control*, 26 J.L. & ECON. 301, 304 (1983) (discussing the role of monitoring and bonding in limiting agency costs).

⁹⁶ See Greaney, *Procrustean Bed*, *supra* note 23, at 900 (describing the need to consider strategic behavior in negotiations over time). See generally BAPP Advisory Opinion, *supra* note 9.

⁹⁷ Professor Harrison offers an economic model that explains the government's willingness to permit a degree of price-fixing via the messenger model. Under certain conditions, he argues, it is necessary to allow physicians to share in the rewards of undertaking the costs of the model in order for consumers to realize benefits from the transaction cost savings. Harrison, *supra* note 88, at 1028 (arguing that the Agencies "purposefully created [a] gray area of enforcement").

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networks.⁹⁸ The revised statements for the first time allowed that a network that did not share financial risk would pass antitrust muster, *Maricopa* notwithstanding, if it qualified as “clinically integrated” and met other requirements. Noting that the key issue, even under the financial risk sharing standard, was whether there was a “clear and reliable indicator that a physician network involves sufficient integration . . . to achieve significant efficiencies,”⁹⁹ the Statements offer a number of detailed elements that would suffice to satisfy this standard without requiring financial risk sharing. In general, the clinical integration protocol looks for evidence of processes, standards and controls that would limit costs and improve quality in the provision of network services.¹⁰⁰

The problem with the clinical integration policy lies in the imprecision of the standard and the danger that it may signal a far more lenient standard than was intended by the government. The central concept, clinical integration, defies clear definition and may include a wide variety of processes, protocols, and understandings.¹⁰¹ As several commentators have observed, this ambiguity has generated considerable uncertainty and there has been little additional guidance forthcoming from the Agencies.¹⁰² In addition, no

⁹⁸ See Editorial, *Antitrust Relief*, AM. MED. NEWS, *supra* note 70.

⁹⁹ Policy Statements, *supra* note 465, at Statement 8.A.

¹⁰⁰ See Casalino, *supra* note 53; Miles, *Ticking Antitrust Time Bombs*, *supra* note 23.

¹⁰¹ Without using the term “clinical integration” the Policy Statements give a broad definition of what may qualify under this framework that would include cost saving efficiencies that go beyond “clinical” savings:

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 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 evidence such integration.

Policy Statements, *supra* note 45, at Statement 8. Some specific examples are set forth in the Statements discussion of a hypothetical arrangement. See *id.* at Example 1.

¹⁰² See Casalino, *supra* note 53; JOHN J. MILES, 2 HEALTH CARE AND ANTITRUST LAW §15A: 7 (2005) (describing the “yellow light” given to the MedSouth proposal); see also Thomas B. Leary, *Special Challenges for Antitrust in Health Care*, ANTITRUST, Spring 2004, at 23, 26 (“Be-

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one is entirely certain “how much” integration (or modification of physician practice) is sufficient.¹⁰³ Perhaps most problematic is the lack of agreement on the circumstances in which price agreements are “reasonably necessary” to achieve the claimed efficiencies.¹⁰⁴ Thus, for some the take away message of the government’s endorsement of physician collaboration under such an amorphous standard could well have been that evolution toward a more “flexible” or relaxed view of networks was underway. Contributing to the view that antitrust norms may be weakening at this time was the government’s string of litigation losses in antitrust challenges to hospital mergers, which had a deterrent effect on the government’s willingness to challenge mergers in court.¹⁰⁵

While some degree of uncertainty is inevitable in drafting guidelines in these matters, the Agencies’ failure to more sharply delineate the differences between clinical and financial integration contributed to the blurred picture that emerged. As I have argued elsewhere, the underlying economics of health markets requires that antitrust enforcers make a close appraisal of market imperfections in evaluating physician conduct. Because providers are paid for services, rather than outcomes, “pricing” in health care is a function of both per-service fees and the volume of services rendered. The social costs of the overprovision of care resulting from the passive supervisory role of fee for service medicine is recognized by virtually all economists as central to the market failures of health systems.¹⁰⁶ Albeit imperfect, risk sharing can alter the group’s incentives in a

cause we have encountered so few examples of genuine efforts to achieve clinical integration, and there are no litigated cases, it is not yet possible to provide a blueprint.”).

¹⁰³ See MILES, HEALTH CARE AND ANTITRUST LAW, *supra* note 102:

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Too frequently, physicians and other providers forming networks are more interested in increasing reimbursement than they are in creating a network that will deliver health-care services more efficiently. As the “how much integration is enough” question suggests, they make the mistake of trying to determine how little integration they can get away with and still fix prices.

Id.

¹⁰⁴ SHO Advisory Opinion, *supra* note 9 (reasonable necessity not shown); Greaney, *Procrustean Bed*, *supra* note 23, at 904 (discussing confusion over “free rider” analysis in analyzing whether price agreements are reasonably necessary).

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¹⁰⁵ See Greaney, *Whither Antitrust?*, *supra* note 74.

¹⁰⁶ See Peter J. Hammer, *Medical Antitrust Reform: Arrow, Coase, and the Changing Structure of the Firm* 3 (Univ. of Mich. Ctr. for Law and Econ., Working Paper No. 00-012, 2000) [hereinafter Hammer, Arrow, Coase, and the Changing Structure of the Firm]. See generally David Dranove & Mark A. Satterthwaite, *The Industrial Organization of Health Care Markets*, in HANDBOOK OF HEALTH ECONOMICS 1093, 1095 (Anthony J. Culyer & Joseph P. Newhouse eds., 2000).

manner that focuses providers' efforts on volume as well as price.¹⁰⁷ For this reason, the strong presumption the government's guidelines attached to financial risk sharing was an appropriate doctrinal tool grounded firmly on an understanding of the economics of health payment systems.¹⁰⁸ "Clinical integration," on the other hand, merits a much weaker presumption that it will result in integrative benefits. When clinically integrated networks are left unconstrained by financial incentives, the mere existence of clinical norms and protocols does not itself give much assurance of influencing physician behavior.¹⁰⁹ Their efficacy, of course, depends on whether a variety of factors such as investments in the network and whether the threat of de-selection from the network will approximate the effect of financial incentives.¹¹⁰

Although organized medicine had argued strenuously prior to the revision of the government's policy in 1996 that antitrust law was chilling the adoption of protocols and other forms of clinical integration that would promote quality of care, the new standard did not lead to widespread adoption of that option by physician networks. There may be several reasons, financial and practical, underlying the lack of uptake including uncertainty surrounding the precise boundaries of the government's policy.¹¹¹ However, one possible explanation is that the existing policies and legal precedent,

¹⁰⁷ Greaney, *Procrustean Bed*, *supra* note 23, at 903:

It should be noted that merely sharing risk through capitation arrangements or fee withholds does not by itself ensure that individual providers will face incentives to alter practice styles and internalize costs. For example, capitation payments to a broad risk pool of HMO physicians do not place strong cost penalties on each physician for the consequences of her treatment decisions.

Id.

¹⁰⁸ See Hammer, Arrow, Coase, and the Changing Structure of the Firm, *supra* note 106.

¹⁰⁹ Michael D. Cabana et al., *Why Don't Physicians Follow Clinical Practice Guidelines? A Framework for Improvement*, 282 JAMA 1458, 1458 (1999) ("Despite wide promulgation, guidelines have had limited effect on changing physician behavior.").

¹¹⁰ Thus, in its Suburban Hospital advisory opinion, the FTC correctly noted that a multi-hospital "super PHO" run by hospitals and consisting largely of primary care physicians who were employees of the hospitals was an unlikely setting for realizing the kind of interdependent physician cooperation that ancillary restraint analysis would require. SHO Advisory Opinion, *supra* note 9. See generally Scott D. Danzis, *Revising the Revised Guidelines: Incentives, Clinically Integrated Physician Networks, and the Antitrust Laws*, 87 VA. L. REV. 531, 537 (2001) (changes in Policy Statements favoring clinical integration "will allow physicians to entrench themselves in fee-for-service reimbursement systems that retard progress toward cost-effective medicine"); *id.* at 562 (physician deselection is "an extremely clumsy and ineffective tool for changing behavior patterns.").

¹¹¹ See Casalino, *supra* note 53.

albeit muddled, give ample elbowroom for networks to operate with minimal risk of legal challenge.

The Doctrinal Context: Adapting to the Supreme Court's Shifting Treatments of Horizontal Restraints

A final factor creating background noise for antitrust enforcers is the Supreme Court's opaque and shifting treatment of the appropriate methodology for assessing competitor collaboration. While steadfastly adhering to the rule that "naked restraints"—those utterly lacking in any procompetitive justification—should be condemned summarily, the Court's several attempts to explain how to treat other kinds of restraints—those that are "ancillary" to legitimate cooperation among rivals—has been less clear. While it has moved away over the last two decades from a sharp dichotomy between horizontal restraints that are per se illegal and those that warrant a "full blown" rule of reason inquiry, the Court has dispensed rather muddled directions on how to evaluate proffered justifications short of conducting the broadest inquiry. Although not entirely consistent in its articulation of the standard, the Court suggested on several occasions that a "structured rule of reason" was possible. In *NCAA*¹¹² and *Indiana Federation of Dentists*,¹¹³ the Court seemed willing to truncate analysis where appropriate and suggested that the appropriate depth of scrutiny should be regarded as occurring across a "continuum" rather than in discrete categories.

It was not until 1999 in *California Dental* that the Court addressed the methodology for this review using the term "quick look" to characterize the truncated review process.¹¹⁴ Unfortunately, Justice Souter's opinion did little to clarify the standard to be applied by lower courts. Holding that the FTC had applied the quick look analysis too quickly in striking down the dentists' restraints on price and non-price advertising,¹¹⁵ the Court offered some singularly unhelpful guidelines. Henceforth, "inherently suspect" or quick-look analysis would be appropriate only when "an observer with even a rudimentary understanding of economics could conclude that the arrangements in question would have an anticompetitive effect."¹¹⁶ While reaffirming that truncated analysis was still

¹¹² Nat'l Collegiate Athletic Ass'n v. Bd. of Regents of Univ. of Okla., 468 U.S. 85 (1984).

¹¹³ FTC v. Indiana Fed'n of Dentists, 476 U.S. 447 (1986).

¹¹⁴ Cal. Dental Ass'n v. FTC, 526 U.S. 756, 770 (1999).

¹¹⁵ *Id.* at 779 ("[T]he Court of Appeals's conclusion at least required a more extended examination of the possible factual underpinnings than it received . . .").

¹¹⁶ *Id.* at 770.

possible, it gave what may politely be called less than precise guidance as to the scope of inquiry needed: “What is required . . . is an enquiry meet for the case, looking to the circumstances, details, and logic of a restraint.”¹¹⁷ Thus, the *California Dental* majority seemed to endorse a rule under which the scope of the fact-finder’s analysis would be determined case by case depending on its evaluation of the seriousness of the restraint in the particular circumstances before it. In contrast to Justice Breyer’s dissent, which offered a roadmap for quick look analysis and attached presumptive significance to certain prescribed findings,¹¹⁸ the majority’s approach left most key methodological issues for truncated analysis unresolved. The problem seemed especially difficult in health care cases because the Court’s holding stressed that claims that market imperfections justified a horizontal restraint had to be given some attention by the finder of fact.

Seeking to accommodate the limited teachings of *California Dental* with its prior administrative decisions that had assayed a formula for truncated review,¹¹⁹ the FTC undertook, in *PolyGram*,¹²⁰ to clarify the substantive questions under review and cabin the factual inquiries required by a process of categorizing conduct and shifting presumptions. Under this approach, conduct deemed “inherently suspect” (“behavior that past judicial experience and current economic learning have shown to warrant summary condemnation” because of a “likely tendency to suppress competition”) may be condemned without further analysis unless defendants proffer a procompetitive justification.¹²¹ Defendants’ justifications (e.g., “plausible reasons why [the] practices . . . may not be expected to have adverse consequences”) must satisfy a standard of proof (“cognizable,” i.e., limited to those claims consistent

¹¹⁷ *Id.* at 780 (emphasis added).

¹¹⁸ *Id.* at 782 (Breyer, J., dissenting). Justice Breyer distinguishes his approach from that of the majority:

I would not simply ask whether the restraints at issue are anticompetitive overall. Rather, like the Court of Appeals (and the Commission), I would break that question down into four classical, subsidiary antitrust questions: (1) What is the specific restraint at issue? (2) What are its likely anticompetitive effects? (3) Are there offsetting procompetitive justifications? (4) Do the parties have sufficient market power to make a difference?

Id.

¹¹⁹ See Mass. Bd. of Optometry, 110 F.T.C. 549 (1988).

¹²⁰ *PolyGram Holding, Inc.*, Docket No. 9298, slip op. at 29–35 (FTC July 21, 2003) (final order), available at <http://www.ftc.gov/os/adjpro/d9298/030724commopinionandfinalorder.pdf>.

¹²¹ *Id.* at 29.

with antitrust law's goals of furthering competition; and "facially plausible," i.e., one that cannot be rejected without an extensive factual inquiry and specifically linking the restraint to the purported justification).¹²² In an important decision written by Judge Douglas Ginsburg (a former Assistant Attorney General of the Antitrust Division), the D.C. Circuit affirmed the Commission's holding and employed its methodology.¹²³ Because of its potential to clear up the methodological muddle left by *California Dental*, *PolyGram* is of enormous significance from both a doctrinal and pragmatic standpoint. It clarifies the steps antitrust tribunals may undertake in attempting to sort out facts underlying claimed justifications for horizontal restraints and makes these cases more administrable. At the same time, it invokes standards consonant with the ancillary restraint foundations of Section 1 Sherman Act jurisprudence that lend economic rationality to these inquiries. As the following section suggests, one of *PolyGram*'s most significant contributions may be to clear a path for courts to deal summarily with "easy" cases and thereby perhaps encourage prosecutors to take a firmer hand.

North Texas Specialty Physicians

In the North Texas Specialty Physicians ("NTSP") case,¹²⁴ the first FTC administrative complaint involving a physician network to be litigated, the Commission confronted a number of the issues discussed in this article. Finding that NTSP closely paralleled the consent order cases discussed in this article (which it characterized as having a "common theme [of] coordinated bargaining by groups of competing physicians, in order to increase their reimbursement rate"),¹²⁵ the Commission concluded that the organization had engaged in price-fixing and imposed its customary injunctive remedies. However, the Commission did not require dissolution or impose sanctions on individuals.¹²⁶ Although the facts of NTSP seemed to present a relatively straightforward case of price-fixing, the FTC's opinion had to sidestep a number of landmines, several of which may have been of its own creation.

¹²² *Id.* at 29–30.

¹²³ *PolyGram Holding, Inc. v. FTC*, 416 F.3d 29 (D.C. Cir. 2005).

¹²⁴ *In re N. Tex. Specialty Physicians*, No. 9312 slip op. (FTC Nov. 29, 2005) (opinion of the Commission) [hereinafter *NTSP*], available at <http://www.ftc.gov/os/adjpro/d9312/051201opinion.pdf>.

¹²⁵ *Id.* at 1–3.

¹²⁶ *Id.* at 37–40. On the scope of FTC remedies, see *supra* note 25.

The FTC charged that NTSP, an independent practice association controlled by nearly six hundred specialists and primary care physicians engaged in price-fixing with regard to non-risk contracts.¹²⁷ The practices giving rise to this allegation left little doubt that there was a price-related agreement among the physicians to use NTSP as an agent to effect collective negotiations with payors. This conduct included NTSP conducting an annual individual poll of its physicians as to the minimum fees each physician was willing to accept. NTSP then disseminated the mean, median, and mode of those responses to the physicians and used the data to generate a minimum-fee schedule that it used to negotiate contract offers with payors. Without negotiating specific prices above the threshold, it informed payors that it would not enter into contracts at prices below its minimum fees and in practice sent back to physicians only those offers that met or exceeded its minimum-fee schedule.¹²⁸ While physicians then were left to make independent decisions whether to participate in the contract, the governing documents provided that NTSP would enter into the contract only if fifty percent or more of its physicians accepted the offer.¹²⁹ Further, while maintaining that physicians were free to contract with payors independent of NTSP's decision, NTSP required reporting of negotiations.¹³⁰ Occasionally, NTSP would then obtain powers of attorney from the physicians authorizing NTSP to negotiate on the physicians' behalf, which it sometimes used to threaten termination of physicians' contracts.¹³¹

NTSP's defense was something of a bouillabaisse, mixing together contentions based on the messenger model, clinical integration and the legal standard to be applied to physician collaboration. First, it sought to exploit the ambiguities of the messenger model by contending there was no horizontal agreement among physician members, asserting its internal arrangements and contracting procedures were really nothing more than a hyper-efficient and sophisti-

¹²⁷ NTSP had initially been formed to enable physicians to enter into contracts involving capitation or other forms of risk sharing. Following *Maricopa* and the government Policy Statements, Policy Statements, *supra* note 45, at Statement 8, price agreements among network physicians contracting under such arrangements would not incur per se treatment. The conduct challenged by the FTC involved price agreements through NTSP in recent years concerning fee-for-service contracts with third party payors. At the time period examined in the litigation, NTSP was involved in only one risk contract. *NTSP*, *supra* note 124, at 4.

¹²⁸ *NTSP*, *supra* note 124, at 3–4.

¹²⁹ *Id.*

¹³⁰ *Id.* at 4.

¹³¹ *Id.*

cated mechanism for messengering, and obtaining approvals of unilateral offers. As such, NTSP claimed, it amounted in substance to nothing different than what the FTC had accepted as a legitimate messenger arrangement.¹³² Second, NTSP invoked the Commission's pronouncements on efficiencies flowing from clinical integration to assert that its activities were of the same ilk and that efficiencies from risk contracting would "spill over" to physicians under non-risk contracts.¹³³ Further, NTSP argued that clinical integration is only one form of efficiency recognized under the rule of reason and that its various rules and operations serve to spread information, realize the benefits of teamwork, and reduce transactional costs involved in managed care contracting.¹³⁴ Thus, NTSP argued, it was incumbent upon the Commission to evaluate the efficiency benefits of each aspect of its messenger arrangement before condemning it as a restraint of trade. Finally, relying on *California Dental*, NTSP claimed that the Commission was required to undertake a full-blown rule of reason analysis (requiring proof of a relevant market, a showing of market power, and proof of actual anticompetitive effect) whenever a defendant asserts plausible procompetitive justifications, as NTSP claimed it had done.

What is notable about these defenses is their reliance on an expanded conception of justification for price-fixing that is at least in part traceable to the Agencies' own efforts at clarification and guidance. As has been seen, the messenger model and clinical integration guidance left considerable room for interpretation and elaboration with physicians contending that efficiency and quality of care concerns militated in favor of a more expansive view. Further, the messenger model seemed to imply that some degree of coordination would be tolerated from an enforcement standpoint even if it was not strictly permissible under antitrust doctrine. Likewise, in leaving the parameters of clinical integration unspecified, the Agencies may have inadvertently encouraged physician networks to assert efficiencies from transactions cost savings that are at best loosely related to care improvements. Thus, the NTSP case provided a vehicle for the FTC to bring some doctrinal order to these issues, which it did in a lucid opinion authored by Commissioner Thomas Leary.

¹³² Brief of Respondent at 46–49, *In re N. Tex. Specialty Physicians*, No. 9312 (FTC 2005) [hereinafter *Brief of Respondent*], available at <http://www.ftc.gov/os/adipro/d9312/050113respappealbrief.pdf>.

¹³³ *Id.* at 49–51.

¹³⁴ *Id.* at 51.

As to the claim that the NTSP's arrangement complied, at least in principle, with the messenger model standard, the Commission made it clear that the framework did not alter longstanding anti-trust precedent that organizations controlled by competitors are considered a combination of the organization's members and that its price setting actions constitute concerted action within the meaning of Section 1 of the Sherman Act.¹³⁵ In demonstrating that the agreement was an agreement on price, notwithstanding the fact that members were not bound to adhere to contract terms negotiated in the first instance by NTSP, the Commission reviewed the nature and effect of each element of the respondent's operations described above and evaluated whether they were "designed to facilitate communications or, instead, to enhance the bargaining power of the providers."¹³⁶ Significantly, the FTC avoided the trap of fragmenting its review of the evidence,¹³⁷ treating the several parts of the arrangement as an integrated operation whose likely effect was to elevate price. An unfortunate shortcoming of the opinion is that it missed the opportunity to make absolutely clear that the details of its messenger model were not safe harbors for conduct, but merely examples of conduct that could be pursued if not part of an agreement or understanding to affect price or price related terms in contract negotiations.¹³⁸ For example, the opinion recited the potential benefits of the model in reducing transactions costs and included a discussion entitled "Deviations from the 'Messenger Model'" in analyzing challenged restraints. The danger here being that a reviewing court might treat conformance with "government approved" features of the model as excusing conduct that contributes to price-fixing when considered in context.

Next, the FTC dealt with claimed justifications. As mentioned above, the opinion addressed the likely effect of each part of the

¹³⁵ *Id.* at 15.

¹³⁶ *NTSP*, *supra* note 124, at 26; *Brief of Respondent*, *supra* note 132, at 17.

¹³⁷ *Brief of Respondent*, *supra* note 132, at 17 ("We want to make clear, however, that our ultimate conclusions in this case do not stand or fall on our assessment of separate actions; the ultimate conclusions are rather predicated on the likely effects of the actions taken together.").

¹³⁸ The opinion gave several examples of actions permissible under the messenger model:

[T]he agent may receive authority from individual providers to accept contract offers that meet certain criteria . . . assist providers to understand the contracts offered, by supplying objective or empirical information about the terms of an offer . . . [or] provide a comparison of the offered terms with other contracts agreed to by network participants.

NTSP, *supra* note 124, at 25.

NTSP's contracting role but evaluated the net impact on price of the arrangement taken as a whole. Significantly, the Commission downplayed justifications premised on potential reductions of the transaction costs of negotiating contracts. As the Commission pointed out, such savings are common in most cartels. More persuasive is a point not stressed by the Commission: the underlying economics of the market for health care provider services reveals that transaction cost savings are not analogous to the efficiencies accruing from clinical integration, which correct for market failures and therefore should be afforded less deference in making tradeoffs under a quick look analysis.¹³⁹ The opinion also successfully walked the narrow line of relying on complaint counsel's evidence that the activities in question had the propensity to raise price—based on the nature of the actions, the parties' own assessments, and expert opinion—without shouldering the burden of proving an actual effect on price.

The FTC's approach here illustrates the importance of the *PolyGram* analysis discussed earlier. Not only does it set forth a sensible and administrable methodology for assessing restraints of trade, but it also enables a fact finder to adjust the quantum of proof required to the circumstances before it, including prior experience, with the restraint in question and the relative strength of the plaintiff's prima facie showing. Indeed, a legitimate question can be raised as to why per se analysis was not invoked, as the Commission's Complaint counsel had urged. While acknowledging that the record before the Commission would merit summary condemnation under *Maricopa* as a per se price-fixing arrangement given the extraordinary conduct involved and the fact that (after thirty years!) the FTC was sufficiently experienced in these matters to justify a per se approach, the FTC offered a rather unconvincing excuse. It explained that it was concerned about chilling efforts to develop new forms of health care delivery and hence "wants to encourage providers to engage in efficiency-enhancing collaborative activity."¹⁴⁰ But the lesson of the past thirty years seems to point in the opposite direction. One might plausibly argue that the lack of take up on clinical integration options and physicians' willingness to misuse the messenger model was evidence that underenforcement is responsible for the lack of innovation in this area. Finally, one may speculate that this excess of caution once again spilled over to the

¹³⁹ See earlier discussion of clinical integration, *supra* notes 105–09.

¹⁴⁰ *NTSP*, *supra* note 124, at 11.

FTC's choice of remedies, as it imposed only the conventional "go forth and sin no more" sanctions against NTSP.¹⁴¹

The refusal to apply per se analysis and the limited remedies imposed are all the more noteworthy in view of the tone of the Commission's opinion. In a concluding paragraph, Commissioner Leary wrote: "This is not really a close case. NTSP's conduct is similar to conduct that has been held per se unlawful and summarily condemned in other contexts."¹⁴² A possible explanation for the Commission's disinclination to follow Maricopa is the reception its most recent efforts to apply per se analysis has received in the courts.¹⁴³ However, given how thin NTSP's justifications were, the Commission's willingness to shoulder the added evidentiary burden might also evidence the continuing influence on the FTC of the political and regulatory factors discussed in this article.

IV. CONCLUSION

The federal antitrust enforcers' thirty years' war over physician contracting tells us something about the federal antitrust process. It demonstrates the push and pull of legislative oversight and political pressures on enforcers. While not cowed by the intensive oversight, the Agencies nevertheless may have muted their actions in response to those forces by not pursuing enhanced sanctions and perhaps tolerating some sub rosa avoidance schemes via the messenger model. The dual regulator/enforcement role may have pushed the Agencies toward presenting an overly expansive exposition of alternatives that may have inadvertently encouraged some to violate the law. With physician-controlled networks undoubtedly posing new questions in the era of consumer directed care and pay for performance incentives, it may be useful for enforcers to take stock of what has and has not worked so far.

¹⁴¹ See Marx, *supra* note 8, at 25.

¹⁴² NTSP, *supra* note 124, at 41.

¹⁴³ See *In re Cal. Dental Ass'n*, 121 F.T.C. 190 (1996), *aff'd* 128 F.3d 720 (9th Cir. 1997), *rev'd* 526 U.S. 756 (1999); see also *In re Schering-Plough*, No. 9297 (Dec. 8, 2003) (final order), *rev'd* 402 F.3d 1056 (11th Cir. 2005), available at <http://www.ftc.gov/os/adjpro/d9297/031218finalorder.pdf>.