The Antitrust Implications of "Clinical Integration:" An Analysis of FTC Staff's Advisory Opinion to MedSouth

Statements of Antitrust Enforcement Policy in Health Care.[3] Third, if the MedSouth experiment succeeds, it could have a profound effect on the future evolution of managed care.

The article will discuss the background, the rationale and the implications of this opinion letter, with consideration of complicating factors.

I. *Background Setting*

A. *Special Economic Factors*

The antitrust analysis of a joint venture proposed by health care providers must take account of the special characteristics of the marketplace in which they operate. Most notable is the fact that people who seek medical treatment normally do not directly and individually pay for the full cost of the treatment. They may pay a great deal for health care, indirectly and collectively through insurance premiums and taxes, but these payments are not associated with particular services. The incremental costs of the services to insured patients may be close to zero. This means that these people tend to "over-consume" health care services.[4]

Health care providers (like doctors) have a corresponding incentive to "over-supply" some services, to the extent they are paid for each procedure or test that they supply.[5] This tendency to "over-supply" will not be disciplined by patients, who have neither the specialized knowledge to recognize it, nor the incentive to do anything about it. Someone has to perform a

---

[3] U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE (1996), *reprinted in* 4 Trade Reg. Rep. (CCH) ¶13,153, at §§ (8)(B)-(C) (Sept. 5, 1996) [hereinafter HEALTH CARE STATEMENTS]. A number of previous opinions have discussed "financial integration."

[4] *See, e.g.*, David M. Cutler, *A Guide to Health Care Reform*, 8 J. ECON. PERSP. 13 (1994).

[5] Doctors

gatekeeper function to moderate these mutually reinforcing tendencies to over-supply and to over-consume.

In countries with socialized medicine, the gates are tended by the state and care is rationed by a queue; in the United States, the gates are tended by private entities like Health Maintenance Organizations ("HMOs") and care is rationed according to their guidelines. Neither system is popular.

The basic problem is that people can comprehend the need to reduce health care expenditures in the aggregate, and recognize that some gatekeeping is necessary, but we all tend to assign an almost infinite value to the life of any identifiable person. There will always be individual horror stories, where public or private gatekeepers appear to have acted callously, and no group is more outraged by these incidents than people in the provider community—who have firsthand experience with many

B. *General Antitrust Principles*

The applicable legal standards also contain some internal anomalies. Virtually all antitrust cases involve the activities of a number of people, but it makes a significant difference in the analysis if these activities are deemed to be the work of a single entity or a combination of separate entities. The critical question is whether there is or is not an "efficiency-enhancing integration of economic activity."[8] The anomaly is that the distinction between the two categories can involve some close judgements up-front,[9] but thereafter the analysis proceeds in a very different way. As a practical matter, these delicate up-front distinctions may ultimately be outcome determinative.

Specifically, a group of doctors can probably negotiate collectively with payers about payment terms if they meet the criteria for treatment as a single entity, but they are guilty of a *per se* antitrust violation if they do not meet the criteria.[10] Before considering this issue in greater depth, it is necessary to look at the substance of the MedSouth proposal.

II. *The MedSouth Facts and the Staff Opinion*

MedSouth, Inc. is an independent practice association in Denver, Colorado, that currently includes about 450 doctors who practice in the fields of primary care and forty specialties and

---

13 (2001); John J. Miles, *Joint Venture Analysis and Provider—Controlled Health Care Networks*, 66 ANTITRUST L.J. 127,h [8]

sub-specialties. This group of doctors proposes to coordinate activities by sharing clinical information; coordinating treatment, particularly the interface between primary care doctors and specialists; developing practice protocols; and monitoring the compliance of individuals in the group. The stated objectives are to improve patient outcomes, decrease use of physician resources and provide MedSouth with a competitive advantage over other practices in the area.

Prices for treatment will be collectively negotiated with payers, but doctors will bill individually and directly on a fee-for-service basis. MedSouth will not negotiate capitated contracts or share profits of a joint enterprise. However, the venture will be non-exclusive, and members can contract individually with payers who do not choose to negotiate with the group.

In response to MedSouth's request for an advisory opinion, FTC staff followed the analytical process described above in Section I.B. and concluded that a "*per se* analysis would not be appropriate in evaluating MedSouth's proposed course of conduct."[11] The rationale for this conclusion was that the proposed plan "appears to involve partial integration among MedSouth physicians that has the potential to increase the quality and reduce the cost of medical care."[12] In addition, the staff opined that the proposed "joint contracting appears to be sufficiently related to, and reasonably necessary for, the achievement of the potential benefits to be regarded as ancillary to the operation of the venture."[13]

The integration rationale is specifically addressed in the Health Care Statements and there have been a substantial number of previous staff opinions to the same effect.[14] However, the

---

[11] MedSouth Staff Opinion, *supra* note 1.

[12] *Id.*

[13] *Id.*

[14] A list of health care antitrust advisory opinions by Commission and staff is available at http://www.ftc.gov/bc/advisory.htm (last visited Aug. 29, 2002).

previous opinions were based on a prediction that financial risk sharing would provide the incentives for the achievement of substantial efficiencies.[15] In *MedSouth*, for the first time, the opinion addressed a venture with no (or trivial) financial risk sharing and relied on so-called "clinical integration" to yield the expected efficiencies.[16] Note that the underlying justification for a "financial integration" and a "clinical integration" test is similar (potential for improved efficiencies), but the former seems to rely on the existence of incentives to improve whereas the latter seems to rely on the stated plans for improvement.

The staff opinion's further conclusion that joint contracting with payers should be treated as an ancillary restriction will be discussed below. The bottomline is that this finding, along with the application of a clinical integration test, justifies a rule-of-reason analysis of the venture. In my view, this conclusion is consistent with the Commission's own guidelines and policy statements, and mandated by applicable case law.[17] The difficult issue that the opinion does not tackle is precisely how a subsequent rule-of-reason inquiry would proceed. Discussion of this issue would be speculative because the venture was only in the proposal stage and because there have been no subsequent rule-of-reason challenges to ventures that were given comparable comfort. There was no particular need for staff to embark on this speculative exercise, but that is what this article will now attempt to do.

III. *Conceptual Problems in a Two-Step Analysis*

There is something anomalous about the whole idea of a "two-step" analysis, that involves, first, a determination whether rule-of-reason treatment is appropriate and, second, an

---

[15] *See* HEALTH CARE STATEMENTS, *supra* note 3, at § (8)(A)(4).

[16] *See id.* at § (8) 3Ci0 3.75 0 TD -0.03omline ei10e022 Tc 0.3537 0.375M

MedSouth, where step I has been completed before the venture is even up and running, the step II analysis may be separated by a period of years, if it is undertaken at all. Nevertheless, it may be useful to examine some of the issues that would arise in a step II inquiry into a venture like *MedSouth*, because such an inquiry is bound to occur in the future.

The general framework for a step II rule-of-reason inquiry is set out in the Collaboration Guidelines.[23] This inquiry may itself proceed in a stepwise fashion. The first step typically will involve market definition and calculation of market shares. If the market shares are low enough, the inquiry can stop at this point. (For physician joint ventures specifically, market share "safety zones" of twenty percent for exclusive ventures, and thirty percent for non-exclusive ventures,

A. *Markets and Market Shares*

The apparent "market share" of a venture like Medsouth obviously depends on the geographic area considered and how the various specialties are broken down. The staff opinion letter did not attempt a rigorous analysis of this issues, but instead referred to some worst-case shares as illustrations (for example, the letter states: "In a number of specialties, they [MedSouth] constitute half or more of the physicians with admitting privileges at the three hospitals in south Denver.").[27]

A rigorous analysis was not deemed necessary for a step I decision on whether to apply a *per se* or a rule-of-reason test. But what would happen if the shares had been substantially different? If the shares were lower, the venture might fall within a "safety zone" or require only a cursory analysis for approval.[28] The outcome in the converse situation is less clear because there is no express upper-limit "danger zone" that balances the lower limit safety zones in the *Health Care Statements*. At very high percentages, it could be difficult to overcome a strong market-share presumption in a step II rule-of-reason inquiry,[29] and it would be appropriate for a hypothetical opinion letter to highlight this caveat.

There are other potential difficulties in a complete analysis that the opinion letter did not need to address such as, "How do you measure the 'market share' of a physicians' association anyway?" and "What is the significance of either a growing or declining share?"

---

[27] MedSouth Staff Opinion, *supra* note 1.

[28] *See* HEALTH CARE STATEMENTS, *supra* note 3, at §§ (8)(A), (8)(B)(4).

[29] The examples of high-share ventures in *Health Care Statements* impliedly suggest that collective negotiation of fee-for-service rates would be problematic. *See* HEALTH CARE STATEMENTS, *supra* note 3, at §§ (8)(C)(6)-(7). *See also* Thomas B. Leary, *An Inside Look at the Heinz Case*, ANTITRUST, Spring 2002, at 32 (discussing the formidable hurdles that face parties who propose 3-2 or 2-1 mergers).

prediction that provides the justification for rule-of-reason treatment, namely, the expectation that clinical integration will result in better care and "provide MedSouth with a competitive advantage."[32] You would think the venture would attract more members and grow larger if this prediction held true. After all, the success of any enterprise is frequently measured by its growth or "market acceptance." On the other hand, there could be a less benign explanation for an increase in membership—doctors might be attracted to the venture simply because they want to be able to bargain collectively.

Note also that if the venture succeeds, its members will presumably acquire knowledge of superior diagnostic and treatment methods, and some of that knowledge will be portable. If these members drift away, there will be an ever-increasing "free-rider" problem that could ultimately

The difficulty of measuring output by counting doctors has been discussed above. Suppose, hypothetically, that instead of measuring output by counting doctors, output was measured by the number of tests and procedures performed by individual doctors. The trouble with this measure is that the unusual economics of health care creates incentives for the oversupply of these services,[33] and a reduction could well be an indication that the venture has improved the quality of patient care or the health of patients. Better informed and more confident doctors may be able to diagnose with fewer tests and better preventive care may result in fewer procedures. The apparent "output" reduction could be an efficiency, which suggests the need for some quality adjustments, at the least, or perhaps a more fundamental reorientation to view the quantum of services rendered as an input rather than an output.

Given the problems in measuring output, suppose a fact finder were to focus directly on prices. The issues here could also be equally difficult. The Commission encountered situations where there was a relatively rapid increase in the price of a venture's services that was obviously attributable to an increase in collective bargaining power rather than improved quality.[34] These cases are easy. But, what if prices changed slowly over time and there is evidence the venture implemented innovative programs to provide better care?

In these situations, the fact the per-capita income of the association members has increased, or the prices per test or procedure has increased, may not prove the exercise of market power. Wholly apart from the quality dimension, prices could be increasing across the board. Even if the market worked efficiently, this would not be surprising—people in an increasingly

---

[33] *See* discussion *supra* Section I.A.

[34] *See, e.g.*, Tex. Surgeons, P.A., No. C-3944, 2000 WL 66997 (FTC May 18, 2000); Wis. Chiropractic Ass'n., No. C-3942, 2000 WL 670031 (FTC May 18, 2000).

affluent society might be expected to spend larger amounts of discretionary income on health care, and thereby increase demand. Then, there are the difficult quality issues discussed above. Payers may be willing to pay MedSouth doctors more money for fewer services simply because these doctors are better at deciding when services are necessary and get better results when they perform those services.

Suppose you wer

evidence when evaluating various business proposals.[35] The tough ca[redacted] middle. We need to recognize that doctors, like other providers of go[redacted] mixed incentives both to improve their efficiency and their collective [redacted]

C. *Less Restrictive Alternatives*

A key finding in the staff opinion is the conclusion that joint c[redacted] related and essential to the success of the venture.[37] This may be tru[redacted] MedSouth nor other similar associations are likely to embark on such [redacted] absent assurance they can bargain with payers as a group. Another in[redacted] opinion is the finding that the venture will be non-exclusive. This is n[redacted] standard antitrust doctrine that non-exclusive ventures are viewed mo[redacted] ventures.[38] There is, however, an unacknowledged tension between t[redacted] joint contracting and its reliance on non-exclusivity.

The opinion advances two rationales in support of joint contra[redacted] that "doctors need to be able to rely on the participation of other mem[redacted] network and its activities on a continuing basis," and joint contracting [redacted] participation."[39] Joint contracting will surely reinforce this assurance [redacted]

---

[35] *See* David Scheffman, Director, Bureau of Economics, Fed[redacted] Sources of Information and Evidence in Merger Investigations, Addre[redacted] of Antitrust Law and the Association of the City of New York (June 1[redacted] http://www.ftc.gov/speeches/other/ scheffmanabanycbar.pdf.

[36] *See* HEALTH CARE STATEMENTS, *supra* note

s TW(See) Tj 4.25 0 TD /F6 ... 0.0203 Tc 0.0203 Tw (note) Tj 24 TD Tw (3626 (http://) T[redacted]
36

I would like to conclude on a personal note. This article, like a number that I have written, emphasizes complications and provides more questions than answers. The reader should not conclude, however, that I disagree with the *MedSouth* staff opinion or that I believe a subsequent rule-of-reason inquiry would be too difficult to undertake.

On the contrary, I believe that staff had no choice but to respond as it did. In *California Dental*,[42] the Supreme Court reaffirmed once more that government agencies cannot summarily condemn particular practices absent an extensive body of experience that would indicate they are almost invariably pernicious. No such experience is available here. Moreover, the MedSouth proposal is innovative and appears to offer the potential for improved medical care at lower costs. The venture may not develop that way, but we cannot strangle it before it has a chance to develop.

Similarly, the discussion of complications and anomalies does not signal any personal reluctance to proceed further in these matters in order to determine whether promised performance has been delivered and whether customers overall have been helped or hurt. In fact, I believe we have an obligation to do so, lest our integration tests be treated as pure formalities. All I am saying is that these cases—like so many others that we see—will be complicated, and decisions will be hard. But, that is what makes this job interesting.

,

[42] Cal. Dental Ass'nn