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The MedSouth Joint—(Ad)venture
The Antitrust Implications of Virtual Health Care Networks

Andrew S. Oldham*

I. INTRODUCTION

The health care industry remains in the throes of regulatory, technological, and competitive flux; as a result of the industry's dynamism, health care antitrust continues to clamor through its own "Copernican Revolution."¹ Payers' continued cost-cutting, our society's continued demographic graying, and providers' continued innovations in delivery strategies have converged to create unprecedented pressures toward horizontal consolidation and structural change within managed care networks and independent physician practices.² Antitrust policy has

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¹ See William M. Sage & Peter J. Hammer, Is the Health Care Revolution Finished?: A Copernican View of Health Care Antitrust, 65 LAW & CONTEMP. PROBS. 241, 246 (2002) ("advances in both medical care and econometrics over the past half-century have placed greater demands on antitrust policy to generate competition not only on price and output, but also on linear quality, choice, and innovation, and have highlighted the absence of a workable model for evaluating these price-quality and quality-quality tradeoffs. Similarly, the expansion of public funding for health care and the social consequences of restricted access to insurance or services have not been incorporated logically into competition policy, though they indisputably influence the evolution of medical markets.").

² See W. Kip Viscusi et al., Economics of Regulation and Antitrust 195 (3d ed. 2000) ("The merger wave of the 1990s appears to be different from the LBOs [leveraged buy-outs] of the 1980s. Many mergers seem to be taking place in industries in the midst of or anticipating deregulation: electric power, telecommunications, and banking and financial services. Because of structural changes and enhanced competition, mergers are made in order to gain entry to new markets. In pharmaceuticals, mergers between direct competitors have been made in order to gain economies of scale and scope. Downsizing and consolidation are other factors in mergers taking place in the defense and health-care

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struggled to keep pace. After a quarter-century in the shadows of larger, more integrated, and generally more efficient health maintenance organizations (HMOs), smaller groups of physicians—such as individual practice associations (IPAs)—have finally begun to level the managed care playing field. However, to pose a truly competitive threat to HMOs, IPAs will require regulators and policymakers to rethink the application of traditional antitrust principles to modern health care markets.

In an effort to modernize its increasingly obsolete and untenable policy assumptions, and to respond to the ever-changing managed care landscape,
the Federal Trade Commission (FTC) marked the possible beginning of a new era in antitrust and health care on February 19, 2002. It is difficult to overstate the radical nature of the FTC’s break with the conventional wisdom of the antitrust community: the notion that a physician-controlled joint venture would be allowed to negotiate jointly and fix prices without demonstrating any economic integration is completely antithetical to the essentialist perspective that pervaded antitrust scrutiny of joint ventures before 1996.9

In an advisory opinion letter to MedSouth, an IPA in Denver, Colorado,10 the FTC offered the first public insights into its “clinical integration” analysis under the Statements of Antitrust Enforcement Policy in Health Care (Health Care Statements), promulgated in conjunction with the Department of Justice Healthcare Task Force in 1996.11 By approving a

9. As Professor Brodley explains, the now-superseded 1988 Antitrust Enforcement Guidelines premised the definition of a “joint venture” as “an integration of operations between two or more separate firms, in which the following conditions are present: (1) the enterprise is under the joint control of the parent firms; (2) each parent makes a substantial contribution to the joint venture; (3) the enterprise exists as a business entity separate from its parents; and (4) the joint venture creates significant new enterprise capability in terms of new productive capacity, new technology, a new product, or entry into a new market.” Joseph F. Brodley, Joint Ventures and Antitrust Policy, 95 HARV. L. REV. 1521, 1526 (1982). The Antitrust Division, in its prior international guidelines, noted that a “joint venture is essentially any collaborative effort of firms, short of a merger, with respect to [research and development], production, distribution, and/or the marketing of products or services ... that typically achieves integrational efficiencies.” U.S. DEP’T OF JUSTICE, ANTITRUST ENFORCEMENT GUIDELINES FOR INTERNATIONAL OPERATIONS (1988) § 3.4, reprinted in 4 TRADE REG. REP. (CCH) ¶ 13,109. The more recent international guidelines do not attempt to define joint venture or provide substantive analysis. See U.S. DEP’T OF JUSTICE, ANTITRUST GUIDELINES FOR THE LICENSING OF INTELLECTUAL PROPERTY (1995), reprinted in 4 TRADE REG. REP. (CCH) ¶ 13, 132.


11. 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, § 8(B) (Sept. 5, 1996) [hereinafter HEALTH CARE STATEMENTS]. A number of previous opinions had discussed the requirements for “financial integration” of IPAs under § 8(A)(4). See, e.g., Associates in Neurology, Inc., To Robert C. Norton, August 13, 1998 (IPA network composed of eleven neurologists formed to contract with managed care plans); Phoenix Medical Network, Inc. To William T. Harvey, May 19, 1998 (physician network of osteopathic services providers formed to contract with third party payers); Yellowstone Physicians, L.L.C. To David V. Meany, Esq., May 14, 1997 ( multispecialty physician network joint venture formed to contract with third party payers); Uronet of Louisiana, L.L.C. To Christopher C. Johnston, January 23, 1996 (IPA network of urologists formed to contract with managed care plans); Eastern Ohio Physicians Organization, Inc. (EOPO) to Stephen P. Nash, Esq., September 28, 1995 ( multispecialty physician organization established to contract on behalf of its participating physicians with third party payers);
plan for the partial integration of physicians’ practices through the joint negotiation of fee-for-service contracts, the FTC opened the door to a form of competition that has the potential to impose unprecedented competition along the dimensions of both quality and price within the managed care industry.\(^2\)

The highly fact-specific nature of antitrust litigation and the ill-defined parameters of the federal authorities’ enforcement decisions pose significant uncertainties to would-be innovators. These uncertainties must be recognized and overcome in order to continue the developmental evolution that could follow in the wake of the MedSouth Staff Opinion. On the one hand, MedSouth’s success may finally allow individual physicians to strike back at traditional managed care organizations by fixing fee-for-service prices as ancillary restraints to their larger “clinical integration” plans.\(^3\) On the other hand, it is far from clear that MedSouth will be able to honor the promises it made to the FTC, and the enormous logistical, financial, and capital-intensive obstacles that MedSouth will have to overcome may make its information technology (IT)-intensive “virtual IPA” model difficult (or impossible) to replicate.\(^4\)

To analyze both the potential importance and the undeniable difficulty of the MedSouth “clinical integration” proposal, this article simultaneously

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\(^{12}\) See James C. Robinson, The End of Managed Care, 285 JAMA 2622, 2624 (2001) (“Physician organizations are retreating from global capitation to partial capitation, case rates, or fee-for-service.”).  

\(^{13}\) MedSouth Staff Opinion, supra note 10, at *7.  

\(^{14}\) MedSouth has been collaborating with an IT venture capital firm to implement a “virtual infrastructure” for its IPA. Their IT-intensive program has two parts: “(1) a web-based electronic clinical data record system that will permit MedSouth physicians to access and share clinical information relating to their patients; and (2) the adoption and implementation of clinical practice guidelines and performance goals relating to the quality and appropriate use of services provided by MedSouth physicians.” MedSouth Staff Opinion, supra note 10, at *3.
proceeds along two tracks. From a macro perspective, I attempt to reconcile the FTC's treatment of MedSouth against the backdrop of the antitrust principles at work in the health care industry. However, the skeletal sketch of the "virtual IPA" model presented in the MedSouth Staff Opinion can be effectuated only when coupled with numerous micro-level assumptions about the IPA's internal operations. Thus, each of the macro-level conclusions and policy recommendations presented below must be accompanied by a healthy dose of skepticism with respect to the daunting project MedSouth has made for itself.

Part II of this paper analyzes the FTC's treatment of MedSouth's IPA proposal under section 5 of the Federal Trade Commission Act\textsuperscript{15} and assesses the costs and benefits of IPAs as joint ventures under the Health Care Statements. I evaluate the implications of MedSouth's integration proposal and argue that the FTC's tentative approval is only the first of many antitrust hurdles that physician-centered and technology-driven IPAs must overcome. Part III then places MedSouth within the larger antitrust context by analyzing MedSouth's potential exposure to private enforcement actions under either the Sherman Act\textsuperscript{16} or the Clayton Antitrust Act.\textsuperscript{17} After tracing the jurisprudential evolution of the rule-of-reason approach to federal antitrust enforcement,\textsuperscript{18} Part IV then proposes a formalized model for the \textit{ex ante} assessment of joint ventures and applies the model to MedSouth.

In conclusion, I argue that the MedSouth Staff Opinion is a welcome statement of the FTC's philosophical principles. Important questions remain unanswered, however, regarding the initiation, resolution, and implications of antitrust litigation related to physicians' joint ventures. The potential ramifications of MedSouth's plans are both exciting and frightening: the possibility of its success is matched by a countervailing possibility of its failure. Insofar as the MedSouth project encourages the reckless expenditure of venture capital on difficult (or impossible) "clinical

\begin{itemize}
  \item \textsuperscript{15} 15 U.S.C. § 45 (2000).
  \item \textsuperscript{17} Clayton Act, 15 U.S.C. §§ 12-27, 44.
  \item \textsuperscript{18} Note that this paper considers only the federal antitrust laws. The MedSouth IPA is, of course, subject to Colorado's state antitrust laws and regulations, as well. See, e.g., Nicholas v. N. Colo. Med. Ctr., 902 P.2d 462 (Colo. Ct. App. 1995) (affirming the findings and conclusions of the Colorado State Board of Medical Examiners' Committee on Anticompetitive Conduct (CAC), which held defendant's action in restricting plaintiff's staff privileges was the result of unreasonable anti-competitive conduct under the Colorado Unfair Trade Practices Act, Colo. Rev. Stat. §§ 6-2-101 et seq.); Ryals v. St. Mary-Corwin Reg'l Med. Ctr., 10 P.3d 654 (Colo. 2000) (holding that "based on the plain language of the Colorado Professional Review Act (CPRA) [Colo. Rev. Stat. §§ 12-36.5-101 to -106] and the statutory scheme as a whole, that the CAC has jurisdiction only over those claims of anticompetitive conduct that arise out of professional review committee activity").
\end{itemize}
integration” plans elsewhere, the FTC’s opinion letter may ultimately prove to be counterproductive to the development of competitive alternatives to traditional managed care organizations. The prospect of being held liable for treble damages according to the whims of an ambiguous and uncertain antitrust regime is an enormous disincentive for innovation. The exposure to potential liability seems particularly acute when it is premised on the failure of a high-risk business plan like MedSouth’s. Federal authorities—in the halls of both courts and bureaucracies—have begun to recognize the deleterious effects of ad hoc antitrust policies that exclude non-price variables in their competitive calculi.19 A formal model that utilizes both price and non-price factors (i.e., price and quality) to reduce investors’ uncertainty and assuage providers’ antitrust concerns is an essential cornerstone for the modern health care industry, which is increasingly driven by capital-intensive development strategies. By providing clear and predictable antitrust principles, policymakers could remove much of the “adventure” from joint ventures. Using MedSouth as a vehicle for analysis, this paper (in general) and the model presented in Part IV (in particular) attempt to provide answers for some of the insuperable horizontal price-fixing and price-coordination constraints that have impeded the development of IPAs as bona fide competitors within the managed care industry.

II. MEDSOUTH AS AN IPA JOINT (AD)VENTURE

The FTC first announced its drastic change of course in the regulation of physician-controlled joint ventures in 1996.20 Prior enforcement principles

19. See John J. Miles, Joint Venture Analysis and Provider-Controlled Health Care Networks, 66 ANTITRUST L.J. 127, 128 & n.6 (1997) (discussing then-FTC Chairman Robert Pitofsky’s approach to balancing the anti- and pro-competitive effects of physician-controlled networks and joint ventures: “[o]ne interpretation is a purpose to establish new groups of physicians that can more effectively compete against other forms of health care delivery and financing, such as health maintenance organizations, by increasing the efficiency with which services are delivered and providing a product more attractive than the individual physicians themselves could provide. Another interpretation, however, is a purpose to aggregate the physicians’ market power as sellers to offset the countervailing power that the physicians believe large managed care plans can exercise as purchasers of physician services. The second interpretation, of course, may conflict with the goals of the antitrust laws.”).

20. The Health Care Statements define a joint venture network as an independent practice association (IPA), a preferred provider organization (PPO), or a substantively equivalent arrangement that is designed to market the services of the participating physicians to health plans. HEALTH CARE STATEMENTS, supra note 11, § 8. When physicians participate in networks, they typically continue to compete with each other for patients who are not enrolled in the network. This distinguishes the network from a fully integrated group practice, where the physicians are partners, shareholders, or employees, and do not compete with each other. Id. at § 8, n.21.
in place at the FTC and the Department of Justice (DOJ) posed significant antitrust obstacles to the formation of joint venture health care networks. Although the MedSouth Staff Opinion helpfully elucidates the FTC’s thinking with respect to collaboration between physicians in today’s health care markets, many open questions continue to plague the FTC’s analysis. The resultant uncertainty that surrounds federal antitrust policy for joint ventures extends beyond the FTC and threatens to stymie innovative strategies for cutting costs and improving quality in the modern health care marketplace.

A. The MedSouth IPA

The MedSouth IPA includes about 430 doctors who practice in the fields of primary care and forty specialties and sub-specialties. The MedSouth physicians coordinate activities by (1) sharing clinical information; (2) coordinating treatment, particularly the interface between primary care doctors and specialists; (3) developing practice protocols; and (4) monitoring the compliance of individuals in the group. MedSouth hopes its integration will improve patient outcomes, decrease use of physician resources and provide the IPA 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 be “financially integrated”; that is, the IPA will not negotiate capitated contracts or share profits of a joint enterprise. Instead, MedSouth will rely solely on the pro-competitive effects of “clinical integration” measures to justify its ancillary price-fixing agreements;
nevertheless, the venture will be non-exclusive, and members can contract individually with payers who do not choose to negotiate with the group.\textsuperscript{28}

\textbf{B. Joint Ventures Under the FTC Act}

In response to MedSouth's request for an advisory opinion, the FTC concluded that a "\textit{per se} analysis would not be appropriate in evaluating MedSouth's proposed course of conduct."\textsuperscript{29} 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."\textsuperscript{30} 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."\textsuperscript{31}

Analysis under section 5 of the FTC Act, like analysis under section 1 of the Sherman Act, proceeds through a two-step process. First, the FTC determines whether the proposed integration plan should be treated as \textit{per se} illegal because it is "conclusively presumed to be unreasonable."\textsuperscript{32} Almost all inquiries proceed to the second step of the FTC's analysis under the rule-of-reason.\textsuperscript{33} In determining whether to apply \textit{per se} illegality, as well as in applying the rule-of-reason analysis, "the inquiry is confined to a consideration of impact on competitive conditions."\textsuperscript{34} In contrast to the rule

\begin{footnotesize}
\begin{enumerate}
\setcounter{enumi}{27}
\item MedSouth Staff Opinion, \textit{supra} note 10, at *5.
\item \textit{Id.} at *6.
\item \textit{Id.} at *1.
\item \textit{Id.}
\end{enumerate}
\end{footnotesize}
of reason, there is no defense to \textit{per se} illegality once an agreement is demonstrated.\textsuperscript{35} Price-fixing agreements, whether to raise, depress, fix, or stabilize a commodity’s price, are \textit{per se} illegal regardless of their anti-competitive effects (or lack thereof).\textsuperscript{36}

Because the consequences are severely different between \textit{per se} treatment and the rule-of-reason, and because choosing between them necessarily requires applying the latter, Supreme Court Justice Sandra Day O’Connor has suggested scrapping the formalities of the “\textit{per se}” charade altogether.\textsuperscript{37} Nevertheless, the FTC began its MedSouth inquiry by noting that \textit{per se} treatment of its integration plan was inappropriate because joint negotiation of fee-for-service contracts and price-fixing are permissible, so long as the physician network is sufficiently clinically integrated.\textsuperscript{38} Determining whether MedSouth’s plans to share patient data and employ evidence-based practice guidelines and clinical protocols are sufficient to make the IPA “clinically integrated” requires a full-blown rule-of-reason analysis.\textsuperscript{39} And in the context of an opinion letter, the FTC’s \textit{ex ante} assessment remains highly tentative.

1. Benefits

While the MedSouth Staff Opinion refers only generically to the “potential efficiencies” of its proposed IPA structure, any antitrust enforcement action is certain to involve a highly specified accounting of the costs and benefits of the joint venture at issue. Therefore, before discussing the FTC’s treatment of MedSouth in particular, it might be helpful to analyze the strengths and weaknesses of joint ventures in general.

There are at least five potentially significant benefits of joint ventures.\textsuperscript{40} First, joint ventures may offer significant economies of scale in product

\textsuperscript{38} HEALTH CARE STATEMENTS, supra note 11, § 8(A)(4) n.33.
\textsuperscript{39} MedSouth Staff Opinion, supra note 10, at *6.
\textsuperscript{40} Miles has identified several more than five potential benefits. See Miles, supra note 19, at 134-35 (noting that joint venture “networks can do much more than merely reduce transaction costs. Through financial risk sharing, strong and effective utilization review, development and implementation of practice parameters, and case management, they can reduce unnecessary utilization and thus reduce costs. Some of these programs, as well as credentialing, selective contracting, and quality assurance programs, can increase quality without increasing costs or resource use. Thus, networks do have the potential to generate the kinds of benefits that justify their being labeled and analyzed as joint ventures for antitrust analytical purposes.”).
development, production, and distribution. For example, joint ventures among firms pursuing similar research agendas can help participants minimize or eliminate duplication. They can also enable participants to more efficiently advertise and market their products. Second, joint ventures can potentially foster reductions in transaction costs. For example, an Internet business-to-business exchange can eliminate a series of exchanged voice mails, faxes, purchase orders and invoices, thus shaving hundreds of dollars off the cost of a transaction.

Third, joint ventures can create synergies by pooling and using complementary resources—including such diverse resources as patents, know-how, production facilities, and even human expertise and ingenuity—to create a whole greater than the sum of its parts. A firm with manufacturing expertise, for example, might share its expertise with a firm possessing marketing expertise to manufacture and bring a product to market. Fourth, joint ventures can also solve “hold up” problems. In some fields, particularly those that involve cutting edge technology or complex issues of standardization, a new product may infringe on the patents of many different firms. The producer of such a product must get

44. HOVENKAMP, supra note 27, § 5.2(c), at 192; see also Broadcast Music, Inc. v. CBS Inc., 441 U.S. 1, 8-12 (1979) [hereinafter BM]; Chicago Bd. of Trade v. United States, 246 U.S. 231, 235-39 (1918).
47. See, e.g., In re General Motors Corp., 103 F.T.C. 374 (1984) (ratifying the proposed production joint venture between General Motors and Toyota).
permission from each patent holder to produce that product. Unfortunately, each patent holder then has the incentive to "hold up" for the biggest share of the producer's expected surplus, impeding the development of new products. A joint venture can create efficiencies by pooling together the diverse array of patents and licensing them together in a single bundle. 49 Fifth, and finally, joint ventures can also perform important insurance functions by allowing their participants to reduce large risks to commercially acceptable levels. 50 In the most common examples, insurance and lending consortia, underwriting syndicates, and exploration joint ventures quite literally spread risk among their participants. 51

2. Structural Flaws

In addition to the anti-competitive concerns that serve as the focus of traditional legal inquiries under the antitrust laws, it is important to note that the efficiencies offered by joint ventures are likely to be impeded by at least two countervailing forces of inefficiency that are endemic to the joint venture model. 52 First, joint ventures imperfectly align the incentives of their participants insofar as participants in a joint venture bear only a portion of the costs of the joint venture and gain only a portion of its benefits. 53 As a result, participants have an incentive to refrain from doing


52. These problems have been explored extensively in the economics literature, and globalization has made them increasingly important in recent years. See Bettina Buchel, Joint Venture Development: Driving Forces Towards Equilibrium, 37 J. WORLD BUS. 199-207 (2002); Jean-Francois Hennart & Ming Zeng, Cross-Cultural Differences and Joint Venture Longevity, 33 J. INT'L BUS. STUD. 699-716 (2002); Ping Lin & Kamal Saggi, Under-Provision of Inputs in Joint Ventures with Market Power, 54 BULL. ECON. RESEARCH 189-96 (2002); Maria R. Battaggion & Paolo G. Garella, Joint Venture for a New Product and Antitrust Exemptions, 40 AUSTRALIAN ECON. PAPERS 247-62 (2001); Yannis Katsoulacos & David Ulph, Endogenous Spillovers and the Performance of Research Joint Ventures, 46 J. IND. ECON. 333-57 (1998).

things that would benefit the joint venture as a whole, while putting the joint venture's property to uses that benefit themselves but harm the joint venture as a whole.54 Second, because participants retain their independent identities, joint ventures are inherently more cumbersome than single firms.55 Decisions must be reached through negotiation and consensus rather than edict.

C. Application of the Health Care Statements

After it decides that a per se condemnation of an integration proposal is inappropriate, the FTC's rule-of-reason analysis of physician-controlled joint ventures proceeds according to section 8 of the 1996 Health Care Statements.56 While the antitrust laws have prohibited any form of horizontal price-fixing since at least 1926,57 the Health Care Statements carve out two novel "safety zone" exceptions that empower physicians to coordinate their fee-for-service contracting efforts in ways that have long been deemed per se illegal. First, they allow networks that share "substantial financial risk" to contract with a self-funded employer on a fee-for-service basis and to be eligible for a reward if it meets budgetary goals. A network is then capable of realizing many of the benefits of full-risk or global capitation;58 since it is not subject to downside risk, it need not acquire an insurance license. Second, the Health Care Statements also allow "clinically integrated" fee-for-service networks to enjoy the same price coordination benefits enjoyed by financially integrated networks, although the former need not share any risk. Both financially integrated and clinically integrated networks are evaluated under the rule-of-reason analysis because the efficiencies of the physicians' cooperative activity may benefit consumers more than the detriments caused by reduced competition.

A group of independent physicians which does nothing more than agree

54. See Rothery Storage & Van Co. v. Atlas Van Lines, Inc., 792 F.2d 210, 212-13 (D.C. Cir. 1986) [hereinafter Rothery Storage] (discussing this problem and explaining that joint ventures should be afforded some flexibility in overcoming it).
to provide services pursuant to a discounted fee schedule is considered to be
unintegrated. Such an agreement can create efficiencies by reducing
transaction costs for payers who want a network of physicians willing to
discount fees because the payer need not approach and negotiate with each
physician individually. However, the agencies do not believe that these
efficiencies are substantial enough to justify the potential adverse effects on
competition of the fee agreement among the physicians. The agencies are
concerned that the physicians will attempt to negotiate fees that are higher
than would prevail in free competition, and then will back up those
negotiations with a threat of boycott. Therefore, these arrangements among
unintegrated physicians are per se illegal and do not qualify for rule-of-
reason analysis.

1. The Safety Zones

For a network to be in the safety zone, its members must share
substantial financial risk, which the agencies regard as a form of financial
integration. The physicians may not account for more than twenty percent
of any specialty in the market if the network is exclusive, and no more
than thirty percent of the market if nonexclusive. Substantial financial risk
is created through arrangements whereby the venture assumes capitation,
receives a percentage of the premium, uses global fees, or uses

59. Miles, supra note 19, at 134-35; see also supra text accompanying note 40.

60. For example, the DOJ has said: “An agreement among competitors to set a minimum
price, for example, would not be saved from per se condemnation simply because the
defendants claimed that the agreement eliminated the transaction costs that consumers would
otherwise incur in searching out the lowest price.” U.S. DEP’T OF JUSTICE, ANTITRUST DIV.,
ANTITRUST ENFORCEMENT GUIDELINES FOR INTERNATIONAL OPERATIONS (1988), reprinted in
4 TRADE REG. REP. (CCH) ¶ 13,109.10, at 20,594 (Apr. 11, 1995). The 1988 version of these
guidelines was superseded by the ANTITRUST ENFORCEMENT GUIDELINES FOR
11, 1995). The 1995 revision does not address the issue of efficiencies; the 1988 version is
still an accurate view of the DOJ on this subject.

61. See generally HEALTH CARE STATEMENTS, supra note 11, § 9(C) & n.65; see also
LAWRENCE A. SULLIVAN, HANDBOOK OF THE LAW OF ANTITRUST § 102 at 285-86 (“It
seems clear enough, in the absence of any claim of integration efficiencies of the kind which
might be obtained where two or more competitors agree to hire a joint sales or service agent,
that if the [sellers] negotiate concertedly with [buyers] over the price charged by the [sellers]
on sales to the [buyers], the [sellers] would be violating the per se rule against concerted
action by competitors affecting price.”).

62. HEALTH CARE STATEMENTS, supra note 11, §§ 8(A)(1) & (2).
63. Id. § 8(A)(4)(1) & n.30.
64. Id. § 8(A)(4)(2).
65. Id. § 8(A)(4)(4) & n.32 (Global fees involve an “agreement by the venture to
provide a complex or extended course of treatment that requires the substantial coordination
of care by physicians in different specialties offering a complementary mix of services, for a
significant financial incentives to achieve specified cost containment goals. This includes substantial fee withholds as well as penalties or rewards based on whether the network meets cost or utilization goals. The Health Care Statements operate on the premise that if the joint venture is financially integrated, it is safe to assume that market forces will exercise adequate discipline against any organization that fails to generate actual efficiencies.

The twenty and thirty percent safety zones operate as rebuttable presumptions against the legality of the joint venture. The FTC will allow a network to exceed the safety zones under one of two sets of circumstances. First, the FTC will condone a joint venture that exceeds the relevant specialty concentration limits if the network is comprised of physicians who are sharing substantial financial risk while generating significant efficiencies in the form of reduced costs and higher quality. The FTC has previously explored the financial exception to the safety zones. In contrast, MedSouth is the first opportunity the FTC has seized to explain the other exception to the market concentration limits: clinical integration.

2. Clinically Integrated

The FTC will also exempt from its safety zones networks that are not engaged in substantial risk sharing, but that use techniques to reduce costs and enhance quality that are used by risk-assuming networks. For example, a network in a competitive market may want to market itself to payors who prefer to deal on a fee-for-service basis, such as preferred provider organizations and self-insured employers, and may want to get a competitive edge by using techniques to lower cost and improve quality.

66. Id. § 8(A)(4)(3)(a) (Fee-withhold arrangements involve "withholding from all physician participants in the network a substantial amount of the compensation due to them, with distribution of that amount to the physician participants based on group performance in meeting the cost-containment goals of the network as a whole.").

67. See HEALTH CARE STATEMENTS, supra note 11, § 8 n.24.

68. Leary, supra note 22, at 223.

69. See MedSouth Staff Opinion, supra note 10.

70. It is important to note the magnitude of the FTC's revisions to the 1996 Health Care Statements. The pre-1996 Enforcement Statements did not state clearly that non-financially integrated organizations could justify rule-of-reason treatment, and as a result, some commentators thought financial integration was the sine qua non of the ancillary restraint justification. See Comments of the American Medical Association on the Need for Revisions to the Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust of the United States Department of Justice and the Federal Trade Commission at 33-34 (June 21, 1996) ("the only forms of economic integration that [are] recognized for
Statement Eight recognizes that if a network uses some or all of these techniques, it has a plausible argument that it is generating efficiencies and therefore qualifies for a rule-of-reason analysis. The agencies will evaluate the network to determine if the efficiencies generated by the techniques outweigh any adverse effect on competition. The Statements consider a network to be “clinically integrated” if it is implementing an active and ongoing program to evaluate and modify practice patterns by the network’s physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality. This program may include: (1) establishing mechanisms to monitor and control utilization of health care services that are designed to control costs and assure quality of care; (2) selectively choosing network physicians who are likely to further these efficiency objectives; and (3) the significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies.

This description appears to condemn networks that do no more than achieve “transactional efficiencies” such as arranging for broad geographic and specialty coverage at discounted prices. Transactional efficiencies reduce costs, but are insufficient to affect the nature and overall value of the health care services delivered by the network. Moreover, the addition of administrative services (such as claims payment) is unlikely to generate sufficient efficiencies to outweigh the anti-competitive harms posed by price-fixing. Networks that rely on transactional efficiencies must use the messenger model to arrive at price arrangements with payers. It is equally
unlikely that the addition of physician credentialing justifies a price-fixing restraint, insofar as merely establishing the qualifications of physicians does not do enough to affect the overall value of the medical care delivered. Similarly, an IPA could institute credentialing practices without fixing prices.\footnote{Miles, supra note 19, at 149 ("It would seem, for example, that a network easily could institute effective utilization review, quality assurance, and credentialing programs that would generate the network's efficiencies without the members agreeing on the prices that they would charge through the network.").}

A network that implements transactional and administrative efficiencies, physician credentialing, utilization review, and/or preauthorization of hospital admissions moves into a gray area.\footnote{McCann, supra note 76, at 246 ("From the standpoint of traditional antitrust law, it is difficult to understand how the Agencies reached the conclusion that integration through utilization management would legitimize joint pricing and contract negotiation. Traditional joint venture analysis holds that embedded agreements (e.g., on price) must be necessary to the achievement of the productive efficiencies of the venture. Providers who come together to perform UM/QA [utilization management/quality assurance] clearly need to engage in some forms of joint activity, such as sharing utilization and cost data. While the development of a common fee schedule may be convenient in terms of marketing a UM/QA network, it is far from clear that joint pricing is an essential attribute of a functional UM/QA organization.").}

Such a network is likely to be too similar to the network found to be \textit{per se} illegal in \textit{Maricopa}.\footnote{Ariz. v. Maricopa County Med Soc'y, 457 U.S. 332, 356-57 (1982). The defendant medical society in \textit{Maricopa} performed three functions. First, it set a schedule of maximum fees that participating physicians agreed to accept as payment in full for services performed for patients insured under plans approved by the foundation. Second, defendant medical society reviewed the medical necessity and appropriateness of treatment provided. Third, acting in its capacity as an "insurance administrator," defendant medical society drew checks on insurance company accounts to pay doctors for services performed for covered patients. \textit{Id.} at 339-40.}

Statement Eight seems to require that a “clinically integrated” IPA must monitor individual physicians in such a way as to change their practice patterns to achieve efficiencies.\footnote{Health Care Statements, supra note 11, § 8(B)(1) ("Such integration can be evidenced by the network implementing an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality." (emphasis added)).} By focusing on the necessity of “mechanisms to monitor and control utilization” of services, while minimizing costs and also assuring quality of care, the Health Care
Statements are meant to ensure that the joint venture’s price restraints are logically connected to (and at least partially necessary for) the network’s proposed integration plans.81

The adoption of practice guidelines, in addition to implementing administrative efficiencies, physician credentialing, and utilization review procedures, may move the joint venture out of Maricopa’s shadow and into the solid ground of a rule-of-reason analysis. However, to generate efficiencies, the physicians in the network must actually apply the practice guidelines,82 which should be consistent with the protocols applied through the utilization review process.83 The use of practice guidelines may help qualify a network for a rule-of-reason analysis because it reflects an effort to have all of the network physicians follow a best practice.84 This use, coupled with a utilization review process targeted at criteria that are consistent with the guidelines, shows that the network is clearly coordinating the care of the physicians to achieve higher quality and/or lower costs, thereby attempting to distinguish itself from competitors by

81. Id. § 8(B). See Sullivan, supra note 61, § 77, at 208 (noting that “the price restraint must arise inevitably from the integration . . . . If the integration is to be permitted at all, the consequent reduction in price competition must be tolerated.”); see also id. at 206 (“the elimination of price competition . . . must result directly from the partial integration”).


83. See Eleanor D. Kinney, The Brave New World of Medical Standards of Care, 29 J.L. Med. & Ethics 323, 329 (2001) (attempting to define “the liability of a sponsoring provider or health plan for selecting a medical standard of care and incorporating it into a computerized patient records system of an integrated delivery system for use in clinical care and utilization review.”).

developing and applying its own concepts about how to deliver a good value to patients. But implementing and enforcing the combination of practice guidelines and utilization review measures poses practical difficulties—not the least of which is the new realm of liability standards to which the network exposes itself by integrating its members into a common guideline regime. 85

The Health Care Statements offer only one example of a network that meets the agencies’ “clinical integration” test: the hypothetical “Charlestown IPA.” 86 This network maintained systems to establish quality goals and monitor appropriate utilization of services by network participants. It regularly evaluated both the physicians’ performance (individually) and the network’s performance (collectively). Where necessary, the network acted to modify physicians’ practices based on those evaluations. It also engaged in case management, preauthorization, concurrent and retrospective review of inpatient stays, developed practice standards and protocols to govern treatment and utilization of services, and planned to actively review the care rendered by each physician in light of these standards and protocols. 87 The hypothetical network was organized


86. HEALTH CARE STATEMENTS, supra note 11, § 8(C)(1).

87. Id.
around a core of primary care physicians and included specialists who were selected based on their established referral relationships with the primary care physicians as well as their willingness to cooperate with the goals of the network and the need to provide convenient services to beneficiaries. Network physicians who failed to adhere to the network’s standards and protocols were subject to remedial action, including expulsion.

D. Conclusion

Given the specifics of the MedSouth proposal and the background information provided by the Health Care Statements, I conclude this part of the essay by offering a critical assessment of the FTC’s IPA-joint venture analysis. I argue that the FTC’s treatment of MedSouth may ultimately prove to be counterproductive insofar as it invites would-be innovators to expose their business plans to legal risk without sufficient guidance for avoiding antitrust condemnation. In its attempts to regulate a health care industry facing continued pressures for horizontal integration and cost containment, the FTC has heretofore failed to address the risky antitrust “adventures” inherent in joint ventures.

With only a single illustration of a clinically integrated joint venture from the Health Care Statements to supplement our understanding of the FTC’s treatment of MedSouth, it seems that the Commission’s tentative approval of the “virtual IPA” model was driven in large part by the agency’s faith in MedSouth’s ability to incorporate and consistently implement a common set of clinical guidelines. Unfortunately, the FTC’s faith may well have been misplaced. MedSouth has promised to promulgate 100 to 150 clinical guidelines, only 48 of which were even under development at the time of the Staff Opinion. 88 Moreover, even if MedSouth successfully imposes a full panoply of guidelines, it will be difficult or impossible to monitor and ensure physicians’ compliance unless the guidelines are fully hardwired into the common electronic medical record—all of which will require enormous investments of time and money. The literature is replete with examples of providers’ recalcitrance in the face of mandatory clinical guidelines. 89

With enormous up-front fixed costs staring them in the face, MedSouth will have equally enormous incentives to do as little as possible and to integrate itself clinically only to the minimum extent necessary so that its price-fixing practices will not be deemed per se illegal. 90 If MedSouth is

88. MedSouth Staff Opinion, supra note 10, at *4.
89. See sources cited supra note 82.
90. See Thomas F. Greaney, Much Ado About Networks, 29 J. HEALTH L. 307, 309 (1996) ("Less clear, of course, is how much clinical integration is required. This is likely to
motivated by nothing more than physicians' collective desires to aggregate and exercise their market power vis-à-vis competing managed care plans,\footnote{Stephen H. Siegel, Consolidation of Physicians and Other Noninstitutional Providers, 72 Fl. B.J. 18, 19-20 (1998) ("For many physicians their primary objective has become to regain some control over their economic and professional future in a climate of reduced reimbursement rates... An individual physician is not likely to have significant ability to negotiate with an HMO. A group of physicians may have improved bargaining 'clout.'").} and if MedSouth focuses on the "how much (or little) can we get away with" question, then the FTC's "clinical integration" experiment clearly will have failed. On the other hand, if MedSouth's participants are motivated by the efficiencies (notwithstanding \textit{Maricopa})\footnote{See supra note 79 and accompanying text.} that network pricing agreements can generate, and if the IPA has sufficient venture capital support for deploying its IT infrastructure, then the FTC's experiment may succeed. Regardless of the eventual outcome, however, it is unclear whether the FTC approached MedSouth's proposed integration with a sufficient degree of skepticism relative to the magnitude of the challenges facing the nascent IPA.\footnote{The MedSouth Staff Opinion is suffused with optimism with respect to the IT and administrative costs associated with getting the IPA off the ground. For example, the FTC addresses at great length the \textit{benefits} MedSouth hopes (and plans) to reap from its common clinical information technology systems, and it emphasizes that "[t]he cost of developing the system is spread over a larger number of practices, and those physicians who are less knowledgeable about information technology can benefit from the experience and interest of those who are more conversant with it." MedSouth Staff Opinion, \textit{supra} note 10, at *7. However, the Commission effectively ignores any potential \textit{costs} to the project by relegating to a footnote the fact that "[i]n this instance, much of the cost of developing the system is being borne by MedSouth's partners—the system vendor and a clinical laboratory company." \textit{Id.} at *7 n.10.} 

Additionally, the FTC's conclusions with respect to MedSouth's "clinical integration" seem to be paradoxical. On the one hand, the FTC seems concerned that MedSouth will have some significant market powers that pose potentially anti-competitive concerns;\footnote{MedSouth Staff Opinion, \textit{supra} note 10, at *9 (noting that MedSouth's current members are 51% of the internists, 33% of the family practitioners, and from 50% to 100% of the specialists in 19 other practice areas at Swedish Hospital; additionally, MedSouth's current members are 44% of the family practice physicians, 48% of the internists, and from 50% to 100% of the specialists in 21 other fields at the two Adventist hospitals).} on the other hand, the
FTC dismisses the potential for MedSouth’s antitrust violations because “we do not know how many of these physicians will remain members of MedSouth after the venture is launched. A significant decrease in the number of MedSouth participating physicians would lessen the risk of anticompetitive harm.” What remains altogether unclear is why the FTC believes MedSouth would lose participating physicians after the launch of the joint venture. Presumably, the Commission’s approval of the MedSouth proposal is premised on the likelihood that the IPA will generate pro-competitive efficiencies on balance. A participating physician would be reluctant to leave an efficiency-generating IPA in order to compete on her own against her erstwhile joint partners and against larger and even more powerful HMOs. Physicians’ abandonment of the MedSouth project would seem to suggest both that the IPA was insufficiently “integrated,” and as a consequence, its price-fixing arrangement is less likely to be deemed “ancillary” to the enterprise.

The FTC’s presumption that some members of MedSouth will leave after the IPA is launched is made even more curious by the investments of time and money that will be necessary to get MedSouth off the ground. In addition to the exorbitant expenses that will be required to hardwire the IPA’s clinical guidelines into its common electronic medical record, MedSouth will also face huge administrative costs in implementing common credentialing and utilization review procedures. Each of these investments is explicitly mandated by Statement Eight, which requires that physicians invest “significant... capital, both monetary and human,” in the necessary infrastructure and the capability to realize the claimed efficiencies. The purpose of this requirement is to ensure that the network

95. *Id.*
96. See *infra* Section III.C., notes 161–210 and accompanying text.
97. Miles, *supra* note 19, at 137-38 (arguing that “a restraint is ancillary if: (1) it is related to and implemented in connection with a venture that itself is likely to generate significant pro-competitive effects through significant partial economic integration; (2) it significantly promotes the venture’s achievement of those effects; and (3) there is no obvious method for promoting those effects that would have a significantly less restrictive effect on competition.”); Joseph Kattan & David A. Balto, *Analyzing Joint Ventures’ Ancillary Restraints, Antitrust*, Fall 1993, at 14 (“Assessment of the pro-competitive potential turns on whether the restraint is reasonably necessary for the efficiencies sought to be achieved by the restraint. A restraint is reasonably necessary if it is “substantially related to the efficiency enhancing or pro-competitive purposes” of the venture and the efficiencies cannot be obtained through means that are less restrictive of competition.” (footnotes omitted)); BORK, *supra* note 35, at 266 (an ancillary restraint is “subordinate to the main transaction,” “contribute[s] to its efficiency,” and is “no broader than the need it serves”); SULLIVAN, *supra* note 61, § 77, at 208 (defining ancillary restraint as a “restraint which is a necessary consequence of some degree of integration of distribution functions”).
98. *Health Care Statements, supra* note 11, § 8(B)(1). See also *supra* note 71 and accompanying text.
is not a sham and that the physicians involved have a stake in the success of the network as an enterprise. But by presuming that MedSouth will prove to be more than a mere sham, the FTC effectively puts the cart before its antitrust horse: the rule of reason per se dichotomy is intended to filter out facially anti-competitive farces. However, giving an IPA-joint venture the benefit of the doubt that it will be able to complete a highly ambitious (and arguably impossible) clinical integration plan may prove to be an ill-conceived misapplication of both the per se rule and the rule of reason. Federal antitrust authorities have retained both analytical instruments precisely because the differences between them give policymakers and judges a convenient schema within which to judge the audaciousness of paradigm-shifting business models like MedSouth’s. The mere fact that the FTC was willing to bless MedSouth’s clinical integration proposal does not mean that other federal antitrust authorities will be similarly charitable and trusting. The FTC’s credulous treatment of the MedSouth proposal arguably does a disservice to other “joint-(ad)venturers” because it encourages future entrepreneurs to expose themselves to antitrust vanquishment without firm guidance with respect to the likely legal implications of their business plans.

In sum, the FTC’s analysis of MedSouth as an IPA-joint venture left unresolved two fundamental questions regarding the huge investment and “clinical integration” requirements that the Commission seems to take for granted. First, why would anyone ever leave the MedSouth IPA? Either the physicians will be tied to the joint venture by the huge up-front costs required to launch their project, in which case they are unlikely to leave, even in the absence of pro-competitive efficiencies, or they will not make huge capital investments, in which case they are unlikely to leave voluntarily because the IPA would provide a shield for fee-for-service price-fixing that would otherwise be impossible. Second, the investment and “clinical integration” requirements raise the question of how much the network physicians must invest both in the aggregate and on a per-

99. The agencies assume that if the physicians do not have a stake in its success, the efficiencies might not be achieved, and the network might be used merely as a vehicle to coordinate fees among the physicians. See, e.g., In re Southbank IPA, Inc., 114 F.T.C. 783 (1991); see also Miles, supra note 19, at 144 & n.66 (discussing “sham networks”).

100. See, e.g., STEPHEN F. ROSS, PRINCIPLES OF ANTITRUST LAW 127-28 (1993) (explaining that under the per se rule, a category of restraints may be deemed so anti-competitive in nature that it can be presumed illegal a priori—without an elaborate analysis of the history, purpose, and effect of the restraint). Ross notes that the per se rule is applied in a case where the court, by experience, can “predict with confidence that the rule of reason will condemn [the restraint].” Id. at 128. See also Robert H. Bork, The Rule of Reason and the Per se Concept: Price Fixing and Market Division II, 75 YALE L.J. 373, 464 (1966); M. Gregg Bloche, The Invention of Health Law, 91 CAL. L. REV. 247, 296 (2003).
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Physician basis to qualify for rule-of-reason treatment. Presumably, there is some undefined threshold investment level, below which the FTC would condemn MedSouth as per se illegal. Even if the physicians are adequately invested and the joint venture is adequately "clinically integrated," the FTC's analysis proceeds along the lines of a rule-of-reason inquiry that parallels a court's analysis in a private antitrust enforcement action. Thus, even if MedSouth is cleared by the FTC, the IPA's antitrust considerations are far from finished.

III. BEYOND THE FTC

The "adventures" inherent in MedSouth's proposed joint venture extend beyond section 5 of the FTC Act. However, the short shrift the Commission gave to the per se rule and the Commission's nebulous application of the rule of reason are indicative of broader uncertainties surrounding health care antitrust. In this Part, I trace the federal courts' movement away from strict applications of the per se rule and towards a uniformly ill-defined rule of reason. The ambiguities presented in this Part—combined with the incertitude inherent in the FTC's analysis presented above—serve as the foundations for the policy recommendations presented in Part IV.

In addition to the FTC’s inquiry, MedSouth's IPA proposal raises antitrust issues under the merger provisions of the Clayton Act, as well as sections 1 and 2 of the Sherman Act. Fortunately for MedSouth, the per se rule has become increasingly unpopular in antitrust caselaw, as evidenced by at least five examples of the United States Supreme Court's reluctance to invoke Socony-Vacuum's\(^\text{101}\) categorical bar on price fixing. First, the Supreme Court applied the rule of reason to normally per se illegal restraints when it identified joint ventures that essentially created a new product or established new efficiencies through integration.\(^\text{102}\) Second, the Court has noted that not all joint ventures that have an impact on price are per se violations of the Sherman Act.\(^\text{103}\) Third, the Court has realized that certain industries require horizontal restraints in order to produce a

\(^{101}\) United States v. Socony-Vacuum Oil Co., 310 U.S. 150 (1940), was the first case in which the Court held price fixing as a category to be per se illegal under the Sherman Act. However, thirteen years earlier the Court had invoked the ad hoc application of the per se rule in its holding that a detailed industry analysis was gratuitous in the context of the defendants' price-fixing agreement because of the difficulty in monitoring price reasonableness and the power exerted over the market with the attendant potential for harm. United States v. Trenton Potteries Co., 273 U.S. 392 (1927).


\(^{103}\) Id. at 23.
particular product. Fourth, the Court has recognized that it cannot always describe the types of business activities that should automatically fall into the forbidden per se category. Fifth and finally, the Court expressed its unwillingness to adhere to a rigid per se analysis where the economic impact of particular activities is not immediately clear. Many appellate court decisions have supported the Court’s reluctance to adhere to a summary condemnation of certain business practices.

Joint ventures raise three general sets of antitrust issues. First, antitrust issues routinely arise when a joint venture is formed; second, others seek to join an existing joint venture; and third, a joint venture puts limits on competition among its members or between itself and its members (so-called “ancillary restraints”). These issues present distinct, though related, legal questions, and this section explores each in turn.

A. Formation

With formation, the threshold question is whether the venture is a true joint venture, or merely a price-fixing cartel in disguise. While the definition of a joint venture is necessarily flexible and inexact, all true joint ventures involve some degree of cooperation to achieve a legitimate competitive objective. Firms that intend only to fix prices or allocate markets may claim the joint venture label, but a court will not countenance a sham joint venture that has no apparent purpose other than to restrict competition. Thus, beyond the FTC, MedSouth’s first antitrust hurdle

107. See, e.g., Polk Bros., Inc. v. Forest City Enters., Inc., 776 F.2d 185 (7th Cir. 1985); Nat’l Bancard Corp. (NaBanco) v. Visa U.S.A., Inc., 779 F.2d 592 (11th Cir. 1986) [hereinafter Nat’l Bancard], cert. denied, 479 U.S. 923 (1986); Rothery Storage, 792 F.2d 210. These courts found efficiencies through integration as well as other pro-competitive benefits resulting from an agreement or collaboration among competitors that included restraints that are normally illegal per se. For a summary of these cases and others, see AMERICAN BAR ASSOCIATION, ANTITRUST LAW DEVELOPMENTS 393-428 (4th ed. 1997).
108. Gregory J. Werden, Antitrust Analysis of Joint Ventures: An Overview, 66 ANTITRUST L. J. 701, 712 (1998) (“Perhaps the most important feature that distinguishes cartels from other joint ventures is the absence of a potentially efficiency-enhancing economic integration among the participants.”).
109. See Timken Roller Bearing Co. v. United States, 341 U.S. 593, 598 (1951) (“Nor do we find any support in reason or authority for the proposition that agreements between legally separate persons and companies to suppress competition among themselves and others can be justified by labeling the project a ‘joint venture.’ Perhaps every agreement and combination to restrain trade could be so labeled.”); Palmer v. BRG of Ga., 498 U.S. 46, 49-50 (1990) (per curiam) [hereinafter Palmer] (finding “unlawful on its face” an agreement
will be to convince its competitors (or, more precisely, its competitors' lawyers and the judges to whom they are prone to complain) that its IPA-based joint venture is more than a mere pretextual charade designed to give cover to physicians' price-fixing ploys.

If an incipient joint venture is more than a blatant sham, courts will use the rule of reason to analyze the competitive effects likely to flow from its "formation." In **United States v. Penn-Olin Chemical Co.**, the government challenged the formation of a joint venture by Pennsalt Chemicals Corporation (Penn) and Olin Mathieson Chemical Corporation (Olin) under both section 7 of the Clayton Act and section 1 of the Sherman Act. The district court rejected the government's challenge, concluding that both Penn and Olin would not have entered the relevant market absent the joint venture. Although it did not disturb the district court's finding on the entry of Penn and Olin, the Supreme Court vacated the lower court's decision by analogizing joint ventures to mergers. Having held that the government could challenge the proposed joint venture under section 7 of the Clayton Act, it applied that statute's "probability of a lessening of competition" standard. Under that standard, the Court held, the district court should have decided whether either Penn or Olin would have entered the market independently and whether the other would have remained a significant potential competitor.

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10. Micah Berman, *The "Quality Health Care Coalition Act": Can Antitrust Law Improve Patient Care?*, 53 STAN. L. REV. 695, 706 (2000); Robert J. Enders, *Hospital Counseling Issues: The Antitrust "Hot Spots" in Contracting Networks*, in ANTITRUST AND HEALTH CARE: NEW APPROACHES AND CHALLENGES 129, 134 (Douglas C. Ross ed. 1998). See **In re Preferred Physicians, Inc.,** 110 F.T.C. 157 (1988) (consent order prohibiting agreement among doctors to resist competitive pressures from health plans to discount fees and to refuse reimbursement on any basis other than the traditional fee-for-service method of payment); **HEALTH CARE STATEMENTS, supra** note 11, § (8)(C)(3) (stating that an IPA will be challenged as per se unlawful where it is "merely a vehicle for collective decisions by its physicians on price and other significant terms of dealing" and where "[t]he physicians' purpose in forming the IPA is to increase their bargaining power with payers").


12. *Id.* at 168, 173-74. The Court noted that "[c]ertainly the sole test would not be the probability that both companies would have entered the market. Nor would the consideration be limited to the probability that one entered alone. There still remained for consideration the fact that Penn-Olin eliminated the potential competition of the corporation that might have remained at the edge of the market, continually threatening to enter. Just as a merger eliminates actual competition, this joint venture may well foreclose any prospect of competition between Olin and Pennsalt in the relevant sodium chlorate market." *Id.* at 173.

13. *Id.* at 175-76. The Court noted that "[t]he existence of an aggressive, well equipped and well financed corporation engaged in the same or related lines of commerce waiting..."
In *Yamaha Motor Co. v. FTC*, the FTC seemingly applied *Penn-Olin* in challenging a proposed joint venture between Yamaha and Brunswick. At the time, Brunswick was the second largest manufacturer of outboard motors in the United States, and Yamaha was a significant importer through its subsidiary Sanshin. Under the terms of their agreement, Brunswick and Yamaha would become co-owners of Sanshin. Brunswick would gain the exclusive right to sell Sanshin motors under its brand in North America and several other markets, while Yamaha would gain the exclusive right to sell Sanshin motors under its brand in Japan. Then-Commissioner Pitofsky found that the agreement violated section 7 of the Clayton Act and section 5 of the FTC Act.

The Eighth Circuit affirmed. It agreed with the FTC that there was ample evidence that Yamaha had the "means for entering the American outboard-motor market." It expressly rejected Brunswick's argument that in order to enter the market Yamaha needed a dealer network because, *inter alia*, Yamaha had widespread name recognition in the United States, a network of motorcycle dealers through which it could sell motors, and most dealers of marine motors were signed to only one-year contracts. It found the various ancillary agreements wholly unjustified.

While the Tenth Circuit (which includes MedSouth's operations in Colorado) has never had the chance to apply the *Penn-Olin* doctrine to the formation of a joint venture, the Tenth Circuit has applied *Yamaha Motor's* anxious to enter an oligopolistic market would be a substantial incentive to competition which cannot be underestimated." *Id.* at 174. On remand, the district court found that neither Penn nor Olin would have entered the relevant market independent of the joint-venture and so dismissed the government's action. United States v. Penn-Olin Chem. Co., 246 F. Supp. 917 (D. Del. 1965). The Supreme Court affirmed *per curiam* by an equally divided court. United States v. Penn-Olin Chem. Co., 389 U.S. 308 (1967).

115. *Id.* at 977 (applying *Penn-Olin*’s “actual potential entrant doctrine,” under which § 7 of the Clayton Act bars “acquisitions by a large firm in an oligopolistic market, if the acquisition eliminate[s] the acquired firm as a potential competitor, and if the acquired firm would otherwise have been expected to enter the relevant market de novo”).
116. *Id.* at 973-74.
117. *Id.* at 974. Other provisions of the agreement (1) prevented Yamaha from manufacturing or re-selling engines similar to those made by Sanshin, (2) limited competition between Yamaha and Brunswick in those markets where both could sell Sanshin-produced motors, and (3) forbade Brunswick from producing products, other than snowmobiles, in competition with Yamaha. *Id.*
118. *Id.* at 975-76.
119. *Yamaha Motor*, 657 F.2d at 979.
120. *Id.* at 977-78.
121. *Id.* at 981. The court struck down the parties’ territorial limitation agreement, the parties' “non-exclusive markets” agreement, and the parties’ “Technical Assistance Agreement,” which, *inter alia*, granted reciprocal licenses to use each other's technical information.
analysis in affirming an FTC divestiture order against a merger that would create even greater entry barriers in the highly oligopolistic coal industry.122

B. Participation

A second important group of joint venture antitrust issues relates to the question of access or "membership." Unlike formation issues, which generally involve the enforcement agencies and frequently are resolved without much, if any, public discussion, the question of access to joint venture property (through membership or otherwise) has been the subject of relatively frequent private litigation.123

1. From Per Se to the Rule of Reason

At the turn of the twentieth century, the Supreme Court held that associations could run afoul of the antitrust laws by failing to deal on nondiscriminatory terms with competitors of members of the association.124 In a series of cases, the Supreme Court slowly extended this principle until it reached the conclusion that any "concerted refusals by traders to deal with other traders" were subject to per se condemnation under section 1 of the Sherman Act.125

The Supreme Court extended its per se analysis in the leading "essential facility," or duty-to-deal case, United States v. Terminal Railroad Association of St. Louis.126 St. Louis Terminal involved a joint venture of

122. Kennecott Copper Corp. v. FTC, 467 F.2d 67 (10th Cir. 1972). In Kennecott, the FTC imposed a divestiture order after plaintiff copper producer agreed to merge with a leading coal company. The court affirmed and held that competition would be lessened should the conglomerate merger occur because the merger would have the effect of creating entry barriers and the market would become a tight oligopoly. Id. at 77-78. The court also found that plaintiff was a potential entrant into the coal industry and exerted substantial influence on the market which would be highly concentrated after a merger. Id. at 78-79.

123. See, e.g., McKenzie v. Mercy Hosp. of Independence, Kan., 854 F.2d 365 (10th Cir. 1988) (hospital's denial of physician's staff privileges did not constitute antitrust violation, under essential facilities doctrine, in that hospital's facilities were not essential to physician's medical practice under § 2 of the Sherman Act), overruled by Systemcare, Inc. v. Wang Labs. Corp., 117 F.3d 1137 (1997); McElhinney v. Med. Protective Co., 549 F. Supp. 121 (E.D. Ky. 1982) (joint venture on part of defendant hospital and three staff physicians concerning alleged refusal to deal with plaintiff surgeon did not fall within the group boycott category requiring application of the per se rule where direct competitors of plaintiff were not involved in a refusal to deal, remaining defendants were not competitors but members of an illusory or hypothetical medical team, there was glaring absence of evidence that members of medical team possessed any sort of monopolistic powers, and even if defendants' actions were labeled a group boycott, the per se rule was not applicable because the restraints were at most temporary and for purpose of improving morale).


railroads that controlled transit across the Mississippi in St. Louis at the turn of the century. At the time, approximately twenty-four railroads terminated on either the Missouri or Illinois side of the river at St. Louis. A system of ferries and bridges enabled railroad cars to move from one side of the river to another. In 1899, fourteen of these railroads, under the leadership of Jay Gould, formed an association to acquire the various ferries and bridges. The rules of the association required the members to use the associations' facilities exclusively, and unanimous consent of the current members for either admission of new members or use of the associations' facilities by non-members.

The Supreme Court concluded that this arrangement violated the Sherman Act. Aside from concluding that the terminal association was an "essential facility," the Court found that the association had failed to meet the "impartial agency" standard. It took particular issue with the association's "arbitrary discrimination" of non-members, finding it "obviously injurious to the commerce and manufacturers of St. Louis." However, the Court did not, as the government had asked, order the dissolution of the association. Rather, consistent with its finding on discrimination, the Court ordered the association to allow all railroads to use the association's facilities on non-discriminatory terms.

In Associated Press v. United States, the government charged that the

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127. Id. at 391.
128. Id. at 392-93.
129. Id.
130. Id. at 391.
131. Id. at 399-400.
133. Id. at 410-11.
134. Id. at 408.
135. Id. at 410-11. The Tenth Circuit applied St. Louis Terminal most recently in McKenzie. McKenzie, 854 F.2d at 369. In McKenzie, the court held that a plaintiff's claim under the "essential facilities doctrine" "must show (1) that Mercy Hospital controls emergency room and obstetrical care facilities that are essential to competition in the northern half of Montgomery County, Kansas; (2) his own inability to duplicate, practically or economically, the emergency room and obstetrical care facilities that Mercy Hospital controls; (3) a denial by Mercy Hospital of the use of its emergency room and obstetrical care facilities; and (4) the feasibility of Mercy Hospital sharing its emergency room and obstetrical care facilities without impairing its own ability to care for patients adequately. It is Dr. McKenzie's task to demonstrate the presence of all these elements of an essential facilities claim in the facts of this case. If even one element is absent, his argument under the doctrine is unavailing." Id. at 370. Dr. McKenzie's § 2 claim failed because even without access to the defendant's facilities, he was able to continue competing against the defendant hospital by performing obstetrical care in his clinic. Id. at 371.
Associated Press violated sections 1 and 2 of the Sherman Act. The core of the government’s challenge was directed at the AP’s bylaws “which prohibited all AP members from selling news to non-members, and which granted each member powers to block its non-member competitors from membership.” The Supreme Court agreed explaining that “the Sherman act was specifically intended to prohibit independent businesses from becoming ‘associates’ in a common plan which is bound to reduce their competitor’s opportunity to buy or sell the things in which the groups compete.” The Court rejected the AP’s argument that its rules did not violate the Sherman Act because competing news services existed.

The Court’s per se analyses of joint venture formations ended in *Northwest Wholesale Stationers, Inc. v. Pacific Stationary & Printing Co.* in which Pacific Stationery claimed that Northwest Wholesale Stationers, a purchasing cooperative, treated members more favorably than non-members. According to the Supreme Court, its long line of per se group boycott cases often involved “access to a supply, facility, or market necessary to enable the boycotted firm to compete.” Having reconceived these cases as involving some essential facility, the Court inquired whether the challenged practice merited per se treatment. Finding that exclusion from a wholesale purchasing co-op likely would not result in anti-competitive effects, the Court declined to apply the per se rule. In so doing, the Court followed its earlier opinion in *Broadcast Music, Inc. v. CBS, Inc.*

Although the risk of a per se claim looms, lower courts have been faithful to *Northwest Wholesale Stationers*’ reformulation of the group boycott cases. In *Rothery Storage & Van Co. v. Atlas Van Lines,* an

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138. Id.
139. Id. at 15.
140. The Tenth Circuit most recently followed Associated Press in *Aspen Highlands Skiing Corp. v. Aspen Skiing Co.*, 738 F.2d 1509 (10th Cir. 1984) (holding defendant ski resort liable for violating § 2 under the essential facilities doctrine because defendant controlled three of the four skiing mountains in the Aspen area, and defendant’s intent in refusing to market a multi-day multi-mountain ticket with plaintiff was to create or maintain a monopoly).
142. Id. at 294.
143. 441 U.S. 1.
144. For example, in *Addamax Corp. v. Open Software Foundation, Inc.*, 152 F.3d 48 (1st Cir. 1998), the First Circuit declined the plaintiff’s invitation to invoke the per se rule in its review of a joint venture intended to produce a new software package. The court explained that “courts have been very careful to confine per se treatment to conduct of the type that is almost always actually or potentially anti-competitive and has no redeeming benefits (e.g., reduced costs, increased competition) worthy of being weighed against the negative effects.” Id. at 51. The court held that “[j]oint venture enterprises ... unless they
independent moving company challenged Atlas's decision to terminate its affiliation with moving companies that "persisted in handling interstate carriage on [their] own account as well as for Atlas."\textsuperscript{146} Rothery insisted that because Atlas was a joint venture of 490 independent moving companies and not a single carrier, these rules amounted to a "group boycott."\textsuperscript{147} After recounting the long and somewhat tortured jurisprudential prelude to \textit{Northwest Wholesale Stationers}, the D.C. Circuit refused to apply the "group boycott" doctrine to Rothery's claim. Instead, it read \textit{Northwest Wholesale Stationers} "[to make] explicit what had always been understood . . . that 'not all concerted refusals to deal should be accorded \textit{per se} treatment.'"\textsuperscript{148} The D.C. Circuit, therefore, rejected Rothery's claim that exclusion from a joint venture amounted to a \textit{per se} violation of the Sherman Act.

Membership issues were also at the core of \textit{SCFC ILC, Inc. v. Visa USA, Inc.} (Dean Witter).\textsuperscript{149} Visa was a joint venture of some 6,000 financial institutions that allowed new members to join at any time. Although Visa reserved the right to bar additional entry, it had excluded only two firms from issuing Visa payment cards—its single-firm competitors American Express and Discover (now part of Morgan Stanley Dean Witter Discover). Dean Witter challenged its exclusion from Visa as a horizontal restraint of trade. Foreclosed by the success of its proprietary card program from arguing that it needed access to Visa in order to compete, Dean Witter argued that Visa, by leaving itself open to others, had shown that exclusion was unnecessary to the success of the joint venture. Following \textit{Northwest Wholesale Stationers}, the Tenth Circuit refused to condemn Visa's exclusionary policy \textit{per se}. Instead, the court focused on "the ultimate consumer," explaining that "[t]o be judged anti-competitive, the [policy] must actually or potentially harm consumers."\textsuperscript{150} The court found no harm to consumers because (1) the credit card issuer market in which the policy would have any effect was unconcentrated, and (2) Dean Witter did not need access to Visa in order to compete in that market.\textsuperscript{151}

\footnotesize{amount to complete shams . . . are rarely susceptible to \textit{per se} treatment." \textit{Id.} at 52 (internal citation omitted).}

\textsuperscript{145} 792 F.2d 210 (D.C. Cir. 1986).
\textsuperscript{146} \textit{Id.} at 213.
\textsuperscript{147} \textit{Id.}
\textsuperscript{148} \textit{Id.} at 216.
\textsuperscript{149} 36 F.3d 958 (10th Cir. 1994).
\textsuperscript{150} \textit{Id.} at 965.
\textsuperscript{151} Professor Herbert Hovenkamp has criticized the Tenth Circuit's decision. Where the Tenth Circuit saw no evidence in the record of injury to competition, Professor Hovenkamp identifies two anti-competitive forces: "(a) that the venture acting as a unit may maximize its own profits at the expense of consumers, through tacit or express collusion; or
2. Northwest Wholesale Stationers and Health Care

Although not a joint venture case, *Blue Cross & Blue Shield United of Wisconsin v. Marshfield Clinic*\(^{152}\) illustrates the application of *Northwest Wholesale Stationers* to the managed care industry. In *Marshfield Clinic*, Blue Cross & Blue Shield's HMO subsidiary (Compcare) complained that the Marshfield Clinic (a 400-member physician-owned clinic with twenty-one branches) and its HMO subsidiary (Security) had excluded Compcare from the HMO "market" in north central Wisconsin.\(^{153}\) Marshfield allegedly accomplished this goal in many ways, including acquiring physician practices and opening new clinics in admittedly underserved rural locations. Marshfield's HMO subsidiary (Security) operated a network which included the 400 physicians employed by Marshfield and some 900 other independent "affiliates."\(^{154}\) The agreements with the affiliates were nonexclusive; in addition to their HMO patients, the affiliates cared for fee-for-service patients covered by indemnity insurers such as Blue Cross and participated in other PPO and HMO networks. Marshfield's conduct allegedly injured Blue Cross as an indemnity insurer because the Clinic charged Blue Cross's insureds "monopoly" prices, some or all of which Blue Cross was required to pay. Marshfield had also allegedly injured Blue Cross's largest HMO subsidiary, co-plaintiff Compcare, by excluding it from the market for HMO services. This was allegedly accomplished by Marshfield's refusal to enter into a contract (on terms that Blue Cross deemed "reasonable") to make its employed physicians part of Compcare's HMO network.

The Seventh Circuit, in an opinion by Judge Posner, held that absent a showing of monopoly power, a facility would not be considered essential. The court rejected Compcare's argument that the clinic's reputation for excellence could substitute for a showing of monopoly power: "[t]he suggestion that the price of being 'best' is to be brought under the regulatory aegis of antitrust law and stripped of your power to decide whom to do business with does not identify an interest that the antitrust laws protect."\(^{155}\) The opinion in *Marshfield Clinic* is indicative of courts' increasing recognition that suppliers' exclusionary practices oftentimes serve worthy and important quality-control functions; thus, a rigid *per se*
rule is inappropriate and counterproductive.\textsuperscript{156}

The Tenth Circuit followed \textit{Northwest Wholesale Stationers} in \textit{Diaz v. Farley}.\textsuperscript{157} In \textit{Diaz}, plaintiffs (anesthesiologists with hospital privileges) brought an antitrust suit against three other anesthesiologists and two business entities, alleging that the individual defendants engaged in a horizontal group boycott in violation of section 1 of the Sherman Act by refusing to schedule the plaintiffs for labor and delivery services to OB-GYN patients in the Cottonwood Hospital. The court held that the defendants did not possess market power, nor did the defendants "control access to an element ‘essential’ to plaintiffs’ ability to compete... and practice anesthesiology at Cottonwood."\textsuperscript{158} Citing \textit{Northwest Wholesale Stationers}, the court then considered the defendants’ plausible arguments concerning possible pro-competitive effects in determining whether the \textit{per se} rule or the rule of reason should apply to a horizontal group boycott.\textsuperscript{159} After entertaining the plausible argument that the agreements in question actually enhanced competition by increasing a doctor’s ability to choose which anesthesiologists he or she would use at Cottonwood Hospital, the court concluded that application of the \textit{per se} rule was inappropriate and held that the plaintiffs “failed to ‘present a threshold case that the challenged activity falls into a category likely to have predominately anti-competitive effects.’”\textsuperscript{160}

\textbf{C. Ancillary Restraints}

The final set of antitrust issues raised by joint ventures is restraints on competition among venture participants or between the joint venture and its members. The legitimacy of a joint venture does not give its members license to implement any anti-competitive practices it deems necessary to maximize profit; that is, its rules must be reasonably related to the nature

\textsuperscript{156} Posner’s logic from \textit{Marshfield Clinic} is echoed in \textit{Levine v. Central Florida Medical Affiliates, Inc.}, 72 F.3d 1538 (11th Cir. 1996). In \textit{Levine}, the Eleventh Circuit held that a physician network’s decision to exclude one physician from its network was not subject to the \textit{per se} rule under a group boycott theory. \textit{Id.} at 1550. \textit{See also} Retina Assoc. v. S. Baptist Hosp. of Fla., Inc., 105 F.3d 1376 (11th Cir. 1997) (affirming \textit{per curiam} a district court’s decision that Levine precluded a \textit{per se} attack on an exclusive referral agreement between one group of doctors and a specialist); N.W. Med. Labs., Inc. v. Blue Cross & Blue Shield of Or., Inc., 775 P.2d 863 (Or. Ct. App. 1989); Capitol Imaging Assoc., P.C. v. Mohawk Valley Med. Assoc., Inc., 996 F.2d 537 (2d Cir. 1993); Hahn v. Or. Physicians’ Serv., 868 F.2d 1022 (9th Cir. 1988); Hassan v. Indep. Practice Assoc., 698 F. Supp. 679 (E.D. Mich. 1988).

\textsuperscript{157} 215 F.3d 1175 (10th Cir. 2000).

\textsuperscript{158} \textit{Id.} at 1183.

\textsuperscript{159} \textit{Id.} at 1183-84 (citing \textit{Northwest Wholesale Stationers}, 472 U.S. at 294).

\textsuperscript{160} \textit{Id.} at 1184-85 (quoting \textit{Northwest Wholesale Stationers}, 472 U.S. at 298).
and needs of the joint venture.\[161\] Keeping in mind the general preference for competition over collaboration, both the permissible scope of a venture’s activities and the legitimacy of its limitations on competition must be balanced against the efficiencies that justify the venture in the first place.\[162\] In other words, the only question in cases questioning limitations on competition among venture members or between the venture and its members is whether the restraint is “reasonably necessary” to the venture’s legitimate operations.\[163\]

United States v. Topco Associates, Inc.\[164\] involved a joint venture of twenty-five small and medium-sized supermarket chains. The joint venture acted as a purchasing agent for its members—thus allowing its participants to compete with private label brands of the larger chains—by buying various grocery goods and packaging them under the Topco brand.\[165\] The United States challenged two aspects of the joint venture. First, the government argued that Topco’s membership rules gave its current members a virtual veto over the admission of additional chains from the regions in which existing members operated.\[166\] And second, the government alleged that Topco’s rules prohibited current members from selling the brand’s products outside of their licensed territories.\[167\] The

161. Compare Bd. of Regents of Univ. of Okla. v. NCAA, 546 F. Supp. 1276, 1307-08 (W.D. Okla. 1982), aff’d 468 U.S. 85 (1984) (“The colleges are clearly able to negotiate agreements with whatever broadcasters they choose. We are not dealing with tens of thousands of relatively brief musical works, but with three-hour football games played eleven times each year.”), with BMI, 441 U.S. at 22-23 ("[T]o the extent the blanket license is a different product, ASCAP is not really a joint sales agency offering the individual goods of many sellers, but is a separate seller offering its blanket license, of which the individual compositions are raw material. ASCAP, in short, made a market in which individual composers are inherently unable to compete fully effectively.” (footnotes omitted)).

162. See Bork, supra note 35, at 262-79 (naked horizontal restraints should be per se illegal, but reasonably ancillary ones should be lawful), 280-97 (all vertical restraints benefit consumers, and thus all should be legal), 331-44 (only naked boycotts should be per se illegal, and boycotts reasonably ancillary to productive purpose should be lawful), 365-81 (efficient tying arrangements should be legal); See also Nolan Ezra Clark, Antitrust Comes Full Circle: The Return to the Cartelization Standard, 38 VAND. L. REV. 1125, 1160-61 (all vertical restraints should be lawful), 1161-62 (horizontal price fixing and market division should be prohibited unless defendants can demonstrate lack of market power or efficiencies from integration), 1163-64 (joint ventures should be lawful unless they create monopoly power), 1164-65 (boycott in support of cartel should be unlawful), 1165-66 (other horizontal agreements should be unlawful if disguised cartels) (1985).

163. As many have noted, this approach to such agreements has its roots in the famous opinion by Judge (later President and Chief Justice) William Howard Taft in United States v. Addyston Pipe & Steel Co., 85 F. 271 (6th Cir. 1898), aff’d 175 U.S. 211 (1899). Rothery Storage, 792 F.2d at 224.

164. 405 U.S. 596 (1972).

165. Id. at 599-600 & n.3.

166. Id. at 602.

167. Id. at 602-03. The Government argued that Topco’s market division practices
district court, applying the rule of reason to both sets of regulations, struck them down.

The Supreme Court affirmed, but applied a per se rule rather than the rule of reason. According to the Court, "[o]ne of the classic examples of a per se violation of § 1 is an agreement between competitors . . . to allocate territories in order to minimize competition."168 Dismissing Topco's argument that its rules actually promoted, rather than inhibited, competition, the Court explained that it "ha[d] consistently rejected the notion that naked restraints of trade are to be tolerated because they are well intended or because they are allegedly developed to increase competition."169

The Supreme Court took a much less categorical approach to this same issue—restraints ancillary to a joint venture—in Broadcast Music, Inc. v. CBS, Inc.170 BMI acted as a clearinghouse for composers.171 Members granted BMI non-exclusive rights to license their works for public performance. BMI then issued and enforced those licenses, and distributed royalties to its members.172 CBS complained that BMI violated the Sherman Act by offering only one license, a "blanket license," to all compositions in its catalog for a specific term. The district court disagreed, but the Second Circuit reversed, concluding that the blanket license arrangement was an illegal price-fixing arrangement.

violated the Sherman Act because it prohibited competition in Topco-brand products amongst retail grocery chains. Additionally, the government's complaint cited Topco's bylaws, under which members were not permitted to sell any products supplied by the association at wholesale, whether trademarked or not, without first applying for and receiving special permission from the association to do so. Before granting permission, the defendant association would consult with other licensees (usually retailers), whose interests potentially could be affected by wholesale operations. And while defendant's members had repeatedly applied for permission to make wholesale agreements, Topco universally denied each new licensing request. Id. at 603-04.

168. Id. at 608.

169. Id. at 610. Topco has been criticized, by then-chairman of the FTC, for ignoring the joint venture character of the challenged arrangement. See Pitofsky, supra note 21, at 1620-21. But it continues to be cited by the Supreme Court as good law. See, e.g., Palmer, 498 U.S. at 49-50. However, at least one court has suggested that Topco's "broader proposition" may no longer be good law. See Mass. Food Ass'n v. Mass. Alcoholic Beverages Control Comm'n, 197 F.3d 560, 564 n.2 (1st Cir. 1999) [hereinafter Mass. Food] ("Topco may no longer be good law for its broader proposition that such a restraint is condemned per se even where it is ancillary to a productive joint venture. Cf. Broadcast Music, Inc. v. CBS, 441 U.S. 1, 20-24 (1979); Rothery Storage & Van Co. v. Atlas Van Lines, Inc., 792 F.2d 210, 224-29 (D.C. Cir. 1986), cert. denied 479 U.S. 1033 (1987). But no one doubts that an independent agreement between private parties to limit output or divide markets is to be condemned per se. See Palmer v. BRG of Georgia, Inc., 498 U.S. 46 (1990.")."

170. BMI, 441 U.S. 1.

171. Id. at 5.

172. Id. at 5.
The Supreme Court, in turn, reversed the Second Circuit. The Court held that although the arrangement “literally ‘fixed’ a ‘price,’” it did not carry the competitive consequence that warranted application of a *per se* rule striking it down.\(^{173}\) In essence, the Court distinguished BMI’s blanket licensing scheme on the facts, noting that it “ha[d] never examined a practice like this one before.”\(^{174}\) The Court recognized that the blanket licensing approach offered certain economic benefits, reducing both the transaction costs that individual negotiations for particular songs would require and the costs involved in monitoring and enforcing individual licenses.\(^{175}\) In contrast with a truly pernicious price-fixing agreement, BMI appeared to *increase* output and *reduce* prices.\(^{176}\) BMI created synergistic and pro-competitive effects that would not have been realizable in absence of the joint venture’s blanket licensing scheme. As a result, the Supreme Court held application of the *per se* rule to be inappropriate.\(^{177}\)

The Court again took a flexible approach to horizontal combination in *NCAA v. Board of Regents of the University of Oklahoma* (NCAA).\(^{178}\) There, the University of Oklahoma challenged the NCAA’s rules restricting both the total number of televised college football games and the number of games any one school could show. The University of Oklahoma claimed that the rules were classic horizontal restraints of trade and asked the courts to strike them down as *per se* illegal.

The Supreme Court struck down the NCAA’s rules, but in sharp contrast with *Topco*, the Court applied the rule of reason.\(^{179}\) Building on *BMI*,\(^{180}\) the

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173. *Id.* at 9.
174. *Id.* at 10.
175. *Id.* at 20-21.
177. *Id.* at 24. The Court rationalized the synergetic and pro-competitive effects of the blanket license thus: “The blanket license is composed of the individual compositions plus the aggregating service. Here, the whole is truly greater than the sum of its parts; it is, to some extent, a different product.” *Id.* at 21-22.
178. 468 U.S. 85.
179. *Id.* at 100-01. The Court explained: “Horizontal price fixing and output limitation are ordinarily condemned as a matter of law under an ‘illegal *per se*’ approach because the probability that these practices are anti-competitive is so high; a *per se* rule is applied ‘when the practice facially appears to be one that would always or almost always tend to restrict competition and decrease output.’ In such circumstances a restraint is presumed unreasonable without inquiry into the particular market context in which it is found. Nevertheless, we have decided that it would be inappropriate to apply a *per se* rule to this case. This decision is not based on a lack of judicial experience with this type of arrangement, on the fact that the NCAA is organized as a nonprofit entity, or on our respect for the NCAA’s historic role in the preservation and encouragement of intercollegiate amateur athletics. Rather, what is critical is that this case involves an industry in which horizontal restraints on competition are essential if the product is to be available at all.” *Id.* (footnotes omitted) (emphasis added).
Court synthesized the \textit{per se} rule and the rule of reason explaining that under either rubric, "the essential inquiry remains the same—whether or not the challenged restraint enhances competition."\(^{181}\) Although the Court expressed sympathy for the NCAA's position that its rule simply preserved the integrity of the game and was intended to help college football compete with other sports,\(^{182}\) the Court refused to disturb the district court's findings that the rules had actually raised prices and restricted output.\(^{183}\)

By the end of the 1980s, the combination of \textit{BMI} and \textit{NCAA} had cast doubt over the current viability of Topco's \textit{per se} rule.\(^{184}\) Finally, in \textit{California Dental Association v. Federal Trade Commission} (California Dental),\(^{185}\) the Court reconsidered how flexible a court should be in analyzing an association rule. \textit{California Dental} involved a challenge by the FTC to a rule of the California Dental Association (CDA) that limited the ability of member dentists to advertise their prices.\(^{186}\) The Commission challenged the agreement as a naked restraint of trade. The appellate court affirmed the FTC, but the Supreme Court reversed, holding that the Ninth Circuit had erred by taking only a "quick look."\(^{187}\) The Court explained that given the professional context, the economic consequences of a rule

\begin{itemize}
\item[180.] \textit{BMI}, 441 U.S. 1. The NCAA Court noted that \textit{BMI} "squarely holds that a joint selling arrangement may be so efficient that it will increase sellers' aggregate output and thus be pro-competitive." \textit{NCAA}, 468 U.S. at 103.
\item[181.] \textit{NCAA}, 468 U.S. at 104.
\item[182.] \textit{Id.} at 101-02. The Court also cited Judge Bork's use of league sports as the classic illustration of a joint venture. \textit{See BORK, supra} note 35, at 278 ("some activities can only be carried out jointly. Perhaps the leading example is league sports. When a league of professional lacrosse teams is formed, it would be pointless to declare their cooperation illegal on the ground that there are no other professional lacrosse teams.").
\item[183.] \textit{NCAA}, 468 at 106-07 ("The anti-competitive consequences of this arrangement are apparent. Individual competitors lose their freedom to compete. Price is higher and output lower than they would otherwise be, and both are unresponsive to consumer preference. This latter point is perhaps the most significant, since "Congress designed the Sherman Act as a 'consumer welfare prescription.'" (citing Reiter v. Sonotone Corp., 442 U.S. 330, 343 (1979) (footnotes omitted)).
\item[184.] Some courts have recognized that the combination of \textit{BMI} and \textit{NCAA} has the effect of limiting Topco's \textit{per se} rule. \textit{See Mass. Food}, 197 F.3d at 564 n.2; \textit{See also Miles, supra} note 19, at 145-47 (discussing the effect of \textit{BMI} and \textit{NCAA} on \textit{Topco}).
\item[185.] 526 U.S. 756 (1999).
\item[186.] Seventy-five percent of the dentists in California were members of the CDA. \textit{California Dental}, 121 F.T.C. 190, 196 (1996).
\item[187.] The "quick look" rule grew out of \textit{NSPE}'s holding that "no elaborate industry analysis is required to demonstrate the anti-competitive character of" horizontal agreements among competitors to refuse to discuss prices. \textit{Nat'l Soc. of Prof'l Eng'rs v. United States}, 435 U.S. 679, 692 (1978). Under the rule of reason's "quick-look" analysis, an observer with "even a rudimentary understanding of economics" could conclude that the arrangements in question would have an anti-competitive effect on customers and markets. \textit{NCAA}, 468 U.S. 99-100.
\end{itemize}
barring price advertising were not obvious. The Court remanded the case to the Ninth Circuit with instructions to consider more carefully whether the California Dental Association’s restrictions on price advertising would, in fact, harm competition. On remand, the Ninth Circuit concluded that the Commission had failed to prove that the challenged rules restricted competition.

Taking their cue from BMI and NCAA, the circuit courts have evidenced a new willingness to uphold horizontal restraints, once summarily condemned as per se unlawful, by analogizing them to joint ventures or, at least where market power is not shown, as ancillary restraints. In General Leaseways, Inc. v. National Truck Leasing Association, for example, the Seventh Circuit considered defendant’s joint venture (the National Truck Leasing Association (NTLA)), which was an association of 130 companies that leased trucks to businesses. As a part of its strategy to compete against national companies like Hertz and Avis, the NTLA established reciprocal obligations among the affiliated companies, allowing those companies to service their trucks across the country. Among other things, NTLA granted its members a franchise on a particular location and forbid them from operating as an NTLA affiliate elsewhere. General Leaseways—a member-participant in the defendant’s joint venture—defied those rules and raised an antitrust objection when the NTLA attempted to expel it from the organization.

The Seventh Circuit affirmed an injunction against NTLA’s anti-
competitive behavior. Writing for the court, Judge Posner characterized BMI and NCAA as cases in which the Supreme Court recognized that cooperation among competitors might benefit consumers where the competitors' restraints are merely ancillary to their larger, lawful, and pro-competitive purposes. 195 He explained, however, that this principle has a limit: "[i]t does not follow that because two firms sometimes have a cooperative relationship there are no competitive gains from forbidding them to cooperate in ways that yield no economies but simply limit competition." 196 The court applied the *per se* rule to NTLA’s policies because, after taking a “quick look,” it found NTLA to be “a horizontal market division that does not appear to be ancillary to the reciprocal provision of service or any other lawful activity.” 197

The Seventh Circuit’s cautionary opinion in *General Leaseways* should make clear, the mere fact that a joint venture has a lawful, pro-competitive purpose does not give that joint venture license to adopt rules unrelated to its purpose. For example, in *Law v. NCAA*, 198 the Tenth Circuit quickly dispatched an NCAA rule that limited compensation for entry level coaches to $16,000 per year, finding that on balance the NCAA could not justify this restraint as reasonable. 199 However, if the joint venture can survive a “quick look” test, its horizontal restraints are increasingly likely to pass muster under the BMI-NCAA analyses because courts are increasingly willing to accept evidence of pro-competitive effects proffered by

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195. *Id.* at 595:

*NCAA* may seem to go a step beyond [Bmi] toward a regime in which only unreasonable horizontal restraints are illegal, because the Court in *NCAA* did not condition the applicability of the Rule of Reason on proof that the particular restriction that had been challenged was necessary if the product was to be brought to market at all. There was, however, a plausible connection between the specific restriction and the essential character of the product. Since the balance of power among the teams in the NCAA might be disturbed by disparities in team wealth, limiting the ability of the more popular teams to cash in on their popularity through unrestricted televising of their games might have promoted the NCAA’s essential lawful objectives. It was arguable, in other words, that the television output restriction was ‘ancillary’ to a lawful main purpose.

196. *Id.* at 594.

197. *General Leaseways*, 744 F.2d at 595.

198. 134 F.3d 1010 (10th Cir. 1998).

199. Applying the “quick look” rule-of-reason test, the court noted that “anti-competitive effect is established, even without a determination of the relevant market, where the plaintiff shows that a horizontal agreement to fix prices exists, that the agreement is effective, and that the price set by such an agreement is more favorable to the defendant than otherwise would have resulted from the operation of market forces.” 134 F.3d at 1020. The court held that the anti-competitive harm of cutting salaries from $60,000 to $16,000 outweighed the defendant’s pro-competitive arguments (that the league’s desire to (1) retain low-level coaching positions, (2) contain recent trends of rapid inflation in coaches’ salaries, and (3) maintain competitiveness in college sports). *Id.* at 1021-24.
According to Judge Bork’s opinion in *Rothery*, the BMI and NCAA cases forsook *Topco* and returned the law to Judge Taft’s original formulation: “an ancillary horizontal restraint, one that is part of an integration of the economic activities of the parties and appears capable of enhancing the group’s efficiency, is to be judged according to its purpose and effect.” In contrast to the policy at issue in *General Leaseways*, the challenged rule in *Rothery* simply prevented Atlas’s members from free-riding on the efficiencies made possible by the entire organization and its attendant horizontal restraints. Indeed, in striking down the defendants’ anti-competitive policies in *General Leaseways*, Judge Posner noted that an evidentiary showing of a free-rider problem would go a long way to substantiating the joint venture’s pro-competitive effects.

**D. Conclusion**

In sum, while some patterns may be discernable, the antitrust principles underlying joint ventures’ ancillary restraints nevertheless remain unclear. BMI and NCAA have carved out large exceptions to *Topco’s* per se rule, but joint ventures do not possess carte blanche to implement unrelated and unreasonable horizontal restraints of trade. In recent years, courts have increasingly required antitrust plaintiffs to prove actual evidence of anti-competitive effects, and courts have increasingly agreed to balance evidence of pro-competitive effects (such as the prevention of free-riding and the creation of welfare-enhancing efficiencies) against the facially anti-competitive effects of price-fixing. Nevertheless, vast uncertainty surrounds the degree of connection the courts will require between a joint venture’s lawful purposes and its avowedly efficiency-enhancing horizontal restraints. BMI and NCAA seem to require the restraint to be “essential” to the joint venture’s pro-competitive effects; but the Supreme Court’s earlier cases (most notably *Northwest Wholesale Stationers*), as well as several

200. See, e.g., Nat’l Bancard, 779 F.2d at 601 (holding Visa’s “interchange” policy was “a necessary element in the creation of [an] efficiency creating integration”).

201. See *Rothery Storage*, 792 F.2d 210; see also supra text accompanying notes 54, 145-48.


203. Id. at 223.

204. *General Leaseways*, 744 F.2d at 592-93.

205. Post-California Dental courts have been less reluctant to throw out challenges to association rules that are not accompanied by evidence of anti-competitive effects. For example, in *Viazis v. Am. Ass’n of Orthodontists*, 314 F.3d 758 (5th Cir. 2002), the court upheld a judgment as a matter of law in favor of an association. The court held that a plaintiff challenging the professional association’s advertising restrictions was required to present data demonstrating that the restrictions have a net anti-competitive effect. Id. at 766.

206. *Northwest Wholesale Stationers* set forth no requirement that the restraint be
lower court cases (most notably General Leaseways and Rothery), seem only to require that the restraint is "substantially" or "reasonably related" to the joint venture's pro-competitive effects.

These ambiguities in the caselaw dovetail nicely with Statement 8 of the Health Care Statements, as applied by the FTC. According to Statement 8, the restraint must be "reasonably necessary to realize [the network's] efficiencies," which seems to be a middle ground between the restraint having to be "essential" to and having to be "related" to the venture's efficiency-generating policies and/or restraints. Of course, any standard based on "reasonableness" is inherently uncertain—and it is precisely this sense of uncertainty that threatens to impede the innovative formation of new joint ventures. Thus, in the following section, I attempt to formulate an efficiency model for joint venture-IPAs that circumvents some of the ex ante riskiness inherent in pioneering new quality- and cost-effective solutions in modern health care markets.

IV. AN EFFICIENCY MODEL FOR MEDSOUTH (SANS "ADVENTURE")

As the foregoing discussion should make clear, the per se and rule-of-reason rubrics are highly fact-specific, and it is often difficult (or impossible) to generalize across cases or to make prospective predictions about the likely outcome of a given court's analysis of a given joint venture. Nevertheless, the competitive forces operating on the health care industry are undeniable, and independent practitioners are increasingly challenged by the threat of losing their autonomy and/or their heretofore sizable fee-for-service margins. Thus, would-be innovators—like the physicians...
comprising MedSouth—face a daunting dilemma: they can form a joint venture and risk ambiguous application of antitrust principles, or they can resist the forces of horizontal integration and hope to ride out managed care organizations’ competitive tidal wave. By positing an efficiency model that removes some of the uncertainty, that is—that is, some of the “adventure”—from an antitrust analysis of an IPA-joint venture like MedSouth, this Part attempts to give independent physicians their cake, while allowing them to eat it, too.

MedSouth has identified an alternative business plan that promises to preserve individual physicians’ economic viability outside of large HMO networks, while also allowing them to bargain collectively for attractive fee-for-service contracts. However, as one FTC commissioner recently noted, the ex ante risks facing a group of would-be joint-venture operators are huge.212 Notwithstanding the FTC’s blessing in its February 2002 opinion letter, if some of MedSouth’s clinical integration plans are not carried out, or if some of the IPA’s predicted quality improvements do not materialize, then “[a]s a matter of strict logic the venture should be deemed per se illegal—perhaps even retroactively.”213 Per se illegality seems to be a harsh sanction for failure to fulfill a business plan—if venture capitalists employed a similar mindset in Silicon Valley during the 1990s, their hostility to innovation likely would have significantly impeded the dot-com boom.

Thus, in this section, I attempt to formalize the forgoing discussion of the caselaw into a synthetic model of the costs and benefits of joint ventures in general, and MedSouth’s IPA proposal in particular. The fundamental insight revealed in the model below is that contemporary antitrust law’s parochial concentration on price as the sole basis of competition is misguided and counterproductive.214 Focusing on price—to the exclusion

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212. Leary, supra note 22, at 230.
213. Id. at 227.
214. "The microeconomic focus of contemporary antitrust doctrine tends to assess anti- and pro-competitive effects predominantly in terms of implications for price and output, even when such simple models seem forced or inappropriate given the facts of cases. In [NCAA], for example, the colleges’ collective allocation of television broadcast rights was summarily condemned because it reduced the number of games that would be broadcast
of non-price factors—in the formulation of antitrust policies and practices creates uncertainty in health care markets, which operate along multiple dimensions. The model presented below broadens the horizons of antitrust policy and its application to modern health care institutions by including quality as an important measurement of competition and efficiency. By adopting an analysis similar to what follows, in conjunction with others’ ongoing attempts to quantify quality-based variables, the courts and the FTC would reduce the uncertainty facing would-be innovators who are attempting to adapt and survive in the health care industry’s modern competitive environment.

A. The Model: Quality & the “Efficiency Defense”

In many ways, Oliver Williamson foretold the shift away from per se antitrust analyses. In 1968—more than fifteen years before the Supreme Court’s decision in Northwest Wholesale Stationers—Williamson (output).” Sage & Hammer, supra note 1, at 257 n.61.

215. Other scholars have made similar criticisms of the modern antitrust regime and its application to health care markets. See, e.g., Bloche, supra note 100, at 320 (“By construing consumer welfare to incorporate... intangibles like trustworthiness, antitrust decision makers can and should give health care providers safe harbor to act collectively on nonprice matters of concern to consumers.”); Sage & Hammer, supra note 1, at 244 (arguing antitrust law itself needs to be further revolutionized by placing less emphasis on price competition and giving weight to the nonprice (quality) dimensions of health care); Jennifer R. Conners, A Critical Misdiagnosis: How Courts Underestimate the Anti-competitive Implications of Hospital Mergers, 91 CAL. L. REV. 543, 549-50 (2003) (arguing that hospital “mergers may detract substantially from the quality of patient care by eliminating the incentive for hospitals to compete over nonprice factors such as better nursing, more specialists, and other products and services”); Tomas Philipson, Managed Care and the Quality of Health Care: A Misguided Debate?, 30 J. LEGAL STUD. 753, 758 (2001) (arguing that modern quality regulations raise costs beyond profitable levels given HMOs’ prevailing capitation rates).

216. See Sage & Hammer, supra note 1, at 261 (“From an economic perspective, whether competition will help or harm the quality of health care depends upon whether increases in quality can be translated into increases in profits. There are at least four different ways that quality and profits can be related. First are demand-side models in which increases in provider-specific quality either increase the price that providers can charge or the number of patients seeking services. Second, quality and profits can be related through the provider’s production function. ... Third, quality and profits can be related, sometimes perversely, through various forms of risk selection. ... Finally, certain forms of competition can destroy value because of health care’s strong relational character. Specifically, medical trust may evaporate if consumers feel that health care is nothing more than a series of marketplace decisions. This last consideration is not as remote from marketplace processes as it may seem; trust and other hard-to-quantify social factors are necessary for private markets to be viable institutions in the first place.”).

counseled that market power paranoia threatens to undermine efficiency-enhancing innovations and to prevent potential Pareto optimality.\footnote{218}{Oliver E. Williamson, \textit{Economies as an Antitrust Defense: The Welfare Tradeoffs}, 58 AM. ECON. REV. 18 (1968).} Williamson argued that “economies” of both scale and scope should be an effective antitrust defense that mitigates against a supplier’s possible accretion of market power.\footnote{219}{\textit{Id.} at 33-34.} Williamson’s thesis is almost universally accepted today, but courts theretofore had explicitly rejected the notion that market power is not anti-competitive in itself, and no showing of potential “efficiency effects” would warrant a full-blown rule-of-reason analysis in the wake of \textit{Klor’s} in the 1960s.\footnote{220}{See \textit{Klor’s}, Inc. v. Broadway-Hale Stores, Inc., 359 U.S. 207 (1959); \textit{see also supra text accompanying note 125.}}

Figure 1 is an attempt to formalize the insights underlying Williamson’s theory and the increasing popularity of rule-of-reason analyses of mergers and joint ventures, in the context of an IPA, such as MedSouth. The horizontal line, $AC_0$, represents the level of average costs of two independent fee-for-service practices, and $AC_1$ represents those firms’ average costs after they pool their resources to operate as a combined entity under the aegis of MedSouth.\footnote{221}{For or the sake of clarity, the analysis that follows treats “joint ventures” and “mergers” as functional equivalents. While this assumption is imprecise, the essential aspects of firms under either combination are similar or identical for the purposes of this paper. Namely, firms in either a “joint venture” or “merger” setting are able to function collectively and set prices, in the name of potential offsetting efficiencies. \textit{See Viscusi et al., supra} note 2, at 199.} Before MedSouth’s formation, its would-be members are tiny independent players in a large and competitive market that is dominated by large health care providers. Thus, before their combination, the independent firms are unable to charge any price in excess of $AC_0$. After MedSouth’s creation, however, its members’ average “prices” fall to $AC_1$ (as the group of doctors coordinates activities by sharing clinical information, coordinating treatment between primary care doctors and specialists, developing practice protocols, and monitoring the compliance of individuals in the group). It is important to note that the definitions of “average cost” and “prices” used here reflect more than mere pecuniary variation: MedSouth’s clinical integration plans are premised on the fact that new IPA will be able to generate significant non-price or quality-based efficiencies.\footnote{222}{MedSouth Staff Opinion, \textit{supra} note 10, at *1.} In addition to creating efficiencies, MedSouth’s formation also spawns market power and empowers the group to raise prices from $p_0$ to $p_1$ (as the IPA collectively negotiates prices with payers and individual physicians continue to charge on an uncapitated fee-
for-service basis).

**FIGURE 1: THE COSTS AND BENEFITS OF PRICE-FIXING JOINT-VENTURES**

As prices rise to $p_1$ and MedSouth rations the quantity of health care goods and services it supplies (reducing output from $q_0$ to $q_1$), consumer surplus decreases by the area of the vertically shaded triangle marked $A_1$. While $A_1$ represents a social cost, triangle $A_2$ represents a social benefit insofar as MedSouth is able to supply $q_1$ units of output more efficiently, at a lower average cost than its individual physicians could have in
MedSouth’s absence. To the extent that the area of $A_2$ exceeds that of $A_1$, MedSouth’s formation is socially efficient, notwithstanding the IPA’s ability to raise prices and restrict output in the exercise of its newfound market power.

We can calculate the percentage cost reductions that would be sufficient to offset the changes in average cost, price, and quantity supplied in a partial equilibrium model:

$$A_1 = \frac{1}{2} (\Delta p)(\Delta q) \text{ and } A_2 = (\Delta AC)q_1$$

Substituting for $\Delta q$ from the definition of price elasticity, $\eta$,\textsuperscript{223}

$$N A_1 = \frac{1}{2} (\Delta p)(\eta q_0 \Delta p) \quad \frac{1}{p_0}$$

And equating $A_1$ and $A_2$ yields,

$$(\Delta AC)q_1 = \frac{1}{2} (\Delta p)(\eta q_0 \Delta p) \quad \frac{1}{p_0}$$

Because $AC_0 = p_0$, the left side can be divided by $AC_0 q_1$ and the right side by $p_0 q_1$:

$$\left(\frac{\Delta AC}{AC_0}\right) = \frac{1}{2} \eta \left(\frac{q_0}{q_1}\right) \left(\frac{\Delta p}{p_0}\right)^2 \text{\textsuperscript{224}}$$

\textsuperscript{223}. Price elasticity of demand measures the percentage change in quantity demanded resulting from a 1% change in price. The value of the elasticity of demand for a product varies depending on the level of price and quantity at which it is evaluated. In other words, at different combinations of price and quantity demanded, the elasticity of demand for a particular product can vary significantly. As a convention, elasticity measures reported in the literature are typically evaluated at the mean value of price and quantity in the data used in the estimation. In practice, the price elasticity of demand will always be negative. This indicates that as the price of a good increases all other factors held constant, consumers will demand less of that good. The magnitude of the elasticity estimate provides a measure of how responsive demand is. If the value of the price elasticity estimate is greater than one in absolute value, then demand is said to be elastic. When demand is elastic, consumers are very responsive to changes in price. As such, a small price change will lead to a relatively large change in quantity demanded. In contrast, if the value of the elasticity of demand estimate is less than one in absolute value, then demand is said to be inelastic and consumers are not very responsive to price changes. The demand for health care services is expected to be relatively inelastic, in large part because there are few close substitutes for medical goods and services. \textit{See Thomas D. Cook & Donald T. Campbell, Quasi-Experimentation: Design and Analysis Issues for Field Settings 142, 144-46 (1979).}

\textsuperscript{224}. This equation can be understood as a formalization of the “efficiency defense” for horizontal price-fixing.
Assuming a demand curve with constant elasticity,

\[
\frac{q_0}{q_1} = \left( \frac{1}{1 + \frac{\Delta p}{p_0}} \right)^{-\eta}
\]

And thus, for \( \eta = 1 \), \( \frac{\Delta p}{p_0} = 0.2 \); \( \frac{q_0}{q_1} = 1.2 \); and \( \frac{\Delta AC}{AC_0} = 0.024 \).

That is, if a joint venture is expected to increase its prices by 20%, only a 2.4% cost reduction is required to equate the \( A_1 \) and \( A_2 \) areas. If the joint venture can generate efficiencies exceeding 2.4%, then society as a whole benefits from the price-fixing arrangement, notwithstanding the 20% increase in prices.

Similarly, we can calculate various cost reductions that are necessary to offset percentage price increases for selected values of the elasticity of demand (\( \eta \)). See Table 1.

**TABLE 1: ILLUSTRATIVE COSTS AND BENEFITS FOR PRICE-FIXING JOINT-VENTURES WITH CONSTANT DEMAND ELASTICITY**

<table>
<thead>
<tr>
<th>( \frac{\Delta P}{P} )</th>
<th>( \eta )</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>5</td>
<td>0.43</td>
</tr>
<tr>
<td>10</td>
<td>2.00</td>
</tr>
<tr>
<td>20</td>
<td>10.37</td>
</tr>
</tbody>
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Although the range of price elasticity estimates varies widely in the literature, a recent paper concluded that the average value of \( \eta \) tends to center around \(-0.17\), meaning that a 1% increase in the price of health care will lead to a 0.17% reduction in health care expenditures.\(^2\) Thus, assuming that the health care market in the Denver metropolitan area exhibits average demand elasticities, MedSouth would be able to offset relatively large price increases with relatively modest efficiency enhancements. For example, as Table 1 illustrates, a 5% price increase would be offset by a 0.021% reduction in the IPA’s system-wide costs; similarly, a 20% price increase would be offset by a 0.351 percent efficiency increase.

These results make sense clinically for two reasons: (1) the “efficiencies”

\(^2\) Jeanne S. Ringel et al., The Elasticity of Demand for Health Care 20 (2002).
included in the model above include both price and nonprice variables (such as quality), and (2) physicians control a large portion of both health care costs and quality. Higher quality will often justify higher prices, and recognizing the fact that physicians can control both cost and quality variables requires a reconfiguration of our models of the health care marketplace. Allowing physicians to capture the increased prices (in the form of higher revenues for the joint venture) will give the IPA even greater incentives to squeeze out higher efficiency enhancements from its “clinical integration” protocols. And by supplementing the typical demand elasticities in health care markets with a definition of “efficiency” that includes quality considerations, small efficiencies can justify rather large price increases.

B. The Model’s Caselaw Context

The model presented above is open to serious practical challenges, insofar as measuring $A_1$ and $A_2$ is difficult—if not hopelessly impracticable. As the FTC has pointed out, cost savings are notoriously difficult for antitrust authorities to authenticate because the firms under investigation are the sole sources of price, quantity, and output information.226 Judge Posner has argued:

Not only is the measurement of efficiency . . . an intractable subject for litigation; but an estimate of a challenged merger’s cost savings could not be utilized in determining the total economic effect of the merger unless an estimate was also made of the monopoly costs of the merger—and we simply do not know enough about the effect of marginal increases in the concentration ratio . . . to predict the price effects.227

As explained above,228 Posner’s refusal to countenance the “efficiency defense” was consistent with courts’ prevailing hostility towards horizontal combinations during the first seventy years of the twentieth century. Merger policy was based on rigid structural assumptions implying that high degrees of concentration were harmful to the economy and thus should be prohibited, even if they entailed improved efficiency.229 The dominant approach stressed the absolute value of competition as a regulatory tool against market power’s unqualified deleteriousness.230 The Supreme Court

228. See supra notes 124-141 and accompanying text.
famously stated that a merger producing an anti-competitive effect "is not saved because, on some ultimate reckoning of social or economic debits and credits, it may be deemed beneficial." Accordingly, a merger was categorically prohibited if it lessened competition substantially. Efficiency entered into the debate, if at all, in determining the scope of the antitrust rules. Based on this approach, agencies and courts developed unitary market share rules for \textit{prima facie} illegality, based on the presumption that higher concentration creates negative effects on competition.\footnote{United States v. Von's Grocery Co. was the high-water mark for the Supreme Court's hostility toward horizontal mergers, notwithstanding the possibilities of efficiencies and economic counsel to the contrary. Von's was the third largest grocery chain in the Los Angeles area in 1960 when it acquired the sixth largest chain, Shopping Bag Food Stores. The combined firm controlled only 7.5\% of the market and remained a distant second to the market leader, Safeway Stores. Despite Von's miniscule market share, and despite the lack of evidence that the merged firm possessed any market power, the Court struck down the merger as a violation of section 7 of the Clayton Act, as amended by the Celler-Kefauver Act of 1950. Because the 1950 amendments to the Clayton Act were explicitly motivated by congressional intentions to protect small businesses, Von's turned on nothing more than \textit{prima facie} evidence of consolidation within the grocery industry. The Court noted that the number of single-store grocery firms decreased from 5,365 in 1950 to 3,818 in 1961, and by 1963 had dropped still further to 3,590, while from 1953 to 1962 the number of chains with two or more grocery stores increased from 96 to 150; moreover, small companies were continually being absorbed by the larger firms through mergers, and nine of the top twenty chains acquiring 126 stores from their smaller competitors in the period from 1949 to 1958. The Court struck down the merger, despite the lack of market power, and despite the possibility of efficiency-enhancing synergies that might result from Von's effective competition against Safeway because "the basic purpose of the..."}
1950 Celler-Kefauver Act was to prevent economic concentration in the American economy by keeping a large number of small competitors in business.\footnote{Id. at 275.} In his sharp dissent, Justice Stewart famously lamented that “[t]he sole consistency that I can find is that [under the majority’s interpretation of the Clayton and Celler-Kefauver Acts], the Government always wins.”\footnote{Id. at 301 (Stewart, J., dissenting).}

After Von’s, legislative and judicial skepticism toward horizontal combination and coordination began to relax. In 1974, the Supreme Court handed the Department of Justice its first defeat on a market definition issue,\footnote{United States v. Gen. Dynamics Corp., 415 U.S. 486 (1974).} and in 1976, Congress passed the Hart-Scott-Rodino Antitrust Improvements Act,\footnote{15 U.S.C. §§ 1311-14 (2004).} which provides for the prior notification of large proposed mergers to both the FTC and the DOJ’s antitrust division. Throughout the 1980s, federal authorities grew increasingly permissive of horizontal combinations if participants in such combinations could carry the burden of persuasion that their coordination produced significant efficiencies.\footnote{See Cal. Dental Ass’n v. FTC, 526 U.S. 756, 794 (1999) (Breyer, J., concurring in part and dissenting in part) (noting that Von’s marked the beginning of an era of ‘gradual evolution within the courts over a period of many years. That evolution represents an effort carefully to blend the pro-competitive objectives of the law of antitrust with administrative necessity. It represents a considerable advance, both from the days when the Commission had to present and/or refute every possible fact and theory, and from antitrust theories so abbreviated as to prevent proper analysis. The former prevented cases from ever reaching a conclusion, and the latter called forth the criticism that the ‘Government always wins.’” (internal citations omitted) (citing Von’s, 384 U.S. at 301 (Stewart, J., dissenting)).} Importantly, throughout the 1980s and early 1990s, the courts also began to broaden their interpretation of “efficiency” to include non-price considerations, such as the quality of health care.\footnote{By admitting that providers can, and do, compete on more than mere price, courts found it increasingly difficult to identify pernicious effects in market power. As the definition of “efficiency” broadened to include price and quality, courts reasoned that one provider’s decision to raise price could easily be offset by another’s decision to compete on quality-based terms instead. For example, in Ball Mem. Hosp. v. Mutual Hosp. Ins., Inc., Judge Easterbrook described the meaning and implications of hospital market power: “[The Hospitals] claim that the Blues have (and abused) ‘market power,’ the ability to raise price significantly higher than the competitive level by restricting output . . . [T]he Blues do not have the power to restrict output in the market or to raise price because they furnish a fungible product that other people can and do supply easily.” 784 F.2d 1325, 1331 (7th Cir. 1986) (citations omitted).} Then, in 1992, the DOJ and FTC jointly promulgated its landmark “Horizontal Merger Guidelines,”\footnote{U.S. Dep’t of Justice & Fed. Trade Comm’n, 1992 Horizontal Merger Guidelines, 57 Fed. Reg. 41,552 (1992); 4 TRADE REG. REP. (CCH) ¶ 13,200.} which made several important innovations in...
Antitrust policy, including (1) the explicit definition of relevant product and geographic markets,\(^{243}\) (2) the formalization of market concentration indices,\(^{244}\) and (3) the promulgation of “safe harbors” that are analogous to those in the 1996 Health Care Statements.\(^{245}\) By the late 1990s, lower courts had explicitly adopted broad definitions of “efficiency,” which specifically include non-price terms, such as quality.\(^{246}\)

The Supreme Court’s post-Von’s evolution culminated in *California Dental* in 1999.\(^{247}\) Insofar as the Court opened the door to “efficiency defenses” for horizontal combinations that were theretofore condemned under a *per se* rule, some commentators are already describing *California Dental* as a “major antitrust event”\(^{248}\) and “a watershed in the Court’s approach to Section One conduct.”\(^{249}\) In remanding the case to the FTC, the Court endorsed a “sliding scale” approach, under which the degree of inquiry used for particular competitors’ collaborations would vary according to their likely competitive effect.\(^{250}\) While the Court did not

\[ HHI = \sum_{i=1}^{f} S_i^2 \]

with market shares of 30 percent, 30 percent, 20 percent and 20 percent has an HHI of 2600 (302 + 302 + 202 + 202 = 2600).\(^{245}\) \(\text{Id.}\) at n.17

243. 57 FED. REG. 41, 554-57.
244. 57 FED. REG. 41, 557-58. The DOJ and FTC adopted the Herfindahl-Hirschman Index (“HHI”) to measure market concentration. \(\text{Id.}\) at 41,557. The HHI is calculated by summing the squares of the individual market shares of all the participants, \( HHI = \sum_{i=1}^{f} S_i^2 \). \(\text{Id.}\) For example, a market consisting of four firms

245. \(\text{Id.}\) at 41, 558. The “safe harbors” are defined according to the HHI. The HHI ranges from 10,000 (in the case of a pure monopoly) to a number approaching zero (in the case of an atomistic market). The 1992 Merger Guidelines divide the spectrum of market concentration as measured by the HHI into three regions that can be broadly characterized as “unconcentrated” (HHI below 1000), “moderately concentrated” (HHI between 1000 and 1800), and “highly concentrated” (HHI above 1800). \(\text{Id.}\)

246. See, e.g., Sokol v. Akron Gen. Med. Ctr., No. 5:95CV1108, 1997 U.S. Dist. LEXIS 22078, at *29 (N.D. Ohio Sept. 30, 1997) (“An antitrust plaintiff must show that challenged conduct affected the price, quality or output of medical services available to consumers in the relevant market.”). In Sokol, the plaintiff claimed an anti-competitive effect with respect to both the price and quality of cardiac care. \(\text{Id.}\) at *6. See also U.S. Healthcare, Inc. v. Healthsource, Inc., 986 F.2d 589, 599 (1st Cir. 1993) (“Competition remains an essential force in controlling costs and improving quality in health care.”).

247. See supra notes 185-189 and accompanying text.

248. Charles P. Weller, *A New Rule of Reason from Justice Brandeis: “Concentric Circles” and Other Changes in Law*, 44 ANTITRUST BULL. 881, 949 (1999). Mr. Weller praises both the majority and dissenting opinions in *California Dental*: “Rarely in the history of antitrust law have there been one, let alone two, civil, first-class and fascinating Supreme Court antitrust opinions . . . *California Dental* is one of those rare cases.” \(\text{Id.}\)


250. The Court pointed out that “[f]here is always something of a sliding scale in appraising reasonableness . . . [T]he quality of proof required should vary with the circumstances.” *California Dental*, 526 U.S. at 780 (citing PHILLIP AREEDA, ANTITRUST LAW
wholly discard its per se rule, the California Dental majority severely limited the circumstances in which the analysis could be invoked.\textsuperscript{251} Since there was a plausible pro-competitive explanation for the California Dental Association's advertising restrictions, the FTC and the Ninth Circuit should not have indulged in a presumption as to their anti-competitive effects.\textsuperscript{252} Unfortunately, the Court neglected to explain how the sliding scale should be applied,\textsuperscript{253} and many commentators have worried that the "sliding scale" will eviscerate Maricopa's per se rule.\textsuperscript{254} For better or for worse, California Dental signaled the Court's willingness to consider the "pro-competitive" justifications for even the most naked horizontal restraints and its receptiveness to an "efficiency defense," such as the one presented here.\textsuperscript{255}

By the end of the 1990s, it was clear that proper scrutiny of a horizontal

\textsuperscript{251} 526 U.S. at 769-70.

\textsuperscript{252} Justice Breyer argued in his dissenting opinion that the Court had no reason to confuse Section One analysis by rejecting the Ninth Circuit's quick look approach. California Dental, 526 U.S. at 781-82 (Breyer, J., dissenting). He pointed out that the Ninth Circuit, in "applying ordinary antitrust principles, reached an unexceptional conclusion." \textit{Id.} at 793. Indeed, the Ninth Circuit's quick look approach was "the same legal conclusion that this Court itself reached in Indiana Federation." \textit{Id.} Breyer argued that consumers were even more likely to be adversely affected by the dentists' advertising restrictions in California Dental than by the Indiana dentists' refusal to supply x-rays, which the Court had summarily condemned in Indiana Federation. \textit{Id.} There was, therefore, no reason for the majority to reject a quick look analysis of the advertising restrictions. \textit{Id.} at 793-94.

\textsuperscript{253} The Court created a Section One continuum, but did nothing to differentiate its categories. Instead, the majority simply stated that no categorical line can be "drawn between restraints that give rise to an intuitively obvious inference of anti-competitive effect and those that call for more detailed treatment." \textit{Id.} at 780-81; \textit{See also} Marina Lao, Comment, The Rule of Reason and Horizontal Restraints Involving Professionals, 68 \textit{Antitrust L.J.} 499, 526 (2000) ("[T]here are no rules for determining where a particular restraint should fall on the continuum and, hence, the appropriate standard of proof in each case."). Lao refers to the opinion as "an enigma." \textit{Id.} at 508.

\textsuperscript{254} \textit{See} Stephen Calkins, California Dental Association: Not a Quick Look but Not the Full Monty, 67 \textit{Antitrust L.J.} 495, 521 (2000); William J. Kolasky, California Dental Association v. FTC: The New Antitrust Empiricism, \textit{Antitrust}, Fall 1999, at 68, 70 ("Many have expressed concern that California Dental may make summary disposition of antitrust cases, short of a full-blown rule of reason analysis, more difficult. The Court, however, goes out of its way to make clear that this is not its intent ... The point is simply that in California Dental itself, the Ninth Circuit needed to take a more careful ('more sedulous') look than it did.").

\textsuperscript{255} Havighurst worries that "[t]he Supreme Court, it seems, has opened the door for market-failure defenses much wider than is prudent." Clark C. Havighurst, Health Care as a (Big) Business: The Antitrust Response, 26 \textit{J. Health Pol.}, Pol'y & L. 942, 952 (2001).
merger or joint venture—under federal caselaw or the FTC and DOJ’s competition guidelines—required thorough and complex cost-benefit analyses. Thus, it is in this context of messy and fact-specific market analyses that the model presented here is more useful. Having committed themselves to systematic market analyses, and having responsibility for an industry that is facing increased pressures toward horizontal coordination and/or mergers, the federal antitrust authorities—and the firms they regulate—could benefit greatly from clarifying and formalizing the boundaries of their “safe harbors.” In the next section, I draw a rough sketch of the formal application of the “efficiency defense” model to MedSouth.

C. The Model’s Application to MedSouth

The model outlined above fits easily within the FTC’s analysis in its MedSouth Opinion Letter. The FTC, at least implicitly, seems to have adopted the “efficiency defense” model insofar as the Commission blessed the proposed IPA, notwithstanding their finding that “the MedSouth membership as presently constituted likely would be able to exercise significant market power, and thus to extract higher prices.” The relevant inquiry thus becomes whether the IPA’s cost-saving efficiencies are sufficient to offset the potentially pernicious effects of its market power.

Ideally, an inquiry into the pro- and anti-competitive effects of MedSouth’s business practices would compare pricing and output data from each of the IPA’s 432 physicians in 216 practices both before and after MedSouth’s formation. Unfortunately, the practicality of this best-case scenario is undermined by two factors. First, revenue and output data from individual physicians’ practices are currently unavailable. Second, and perhaps more importantly, any analysis of MedSouth’s competitive effects is necessarily prospective in nature, and such an analysis therefore requires a host of simplifying assumptions that may or may not be borne out in

256. JOHN H. SHENEFIeld & IRWIN M. STELZER, THE ANTITRUST LAWS 63 (3d ed. 1998) (noting how far antitrust caselaw and administrative procedures have diverged from Von’s).

257. See sources cited supra note 211.

258. See MedSouth Staff Opinion, supra note 10, at *9 (“The fundamental concern of antitrust analysis is whether a given arrangement may have a substantial anti-competitive effect and, if so, whether that potential effect is offset by any pro-competitive efficiencies resulting from the conduct. The central question is whether, taking into account both potential pro-competitive and anti-competitive effects, the arrangement is likely to harm competition by increasing the ability or incentive of the participants to raise price above—or reduce output, quality, service, or innovation below—the level that likely would prevail in the absence of the agreement.” (citations omitted)).

259. Id.
While necessarily an imperfect proxy, hospital data provide possible insights into potential efficiency effects of MedSouth's formation. Courts often insist on quantitative economic evidence in antitrust litigation, such as sales volume, customer flows, market concentration, price, costs, revenues, and the like, and hospital data provides at least a rough estimate of the health care practices physicians are using to drive the institution's charges and revenues. Despite its shortcomings, hospital data can be used to analyze MedSouth's likely competitive effects because (1) MedSouth's would-be participants are concentrated in only three of Denver's hospitals; (2) MedSouth's would-be participants are (fairly) evenly distributed across subspecialties that generate both high and low levels of charges and revenues for their respective hospitals; and (3) revenue and charge data for each of Denver's hospitals are publicly available and easily comparable.

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260. Inter alia, we must assume that the 432 physicians who have expressed interest in the IPA will indeed participate; and of course, we can only make assumptions about the pricing and output decisions that each of MedSouth's members will make when confronted with Denver's newly competitive health care landscape in the future.


262. All MedSouth physicians have a practice location in South Denver, and staff privileges at one of the three hospitals located in that area: Swedish Medical Center, Porter Adventist Hospital, and Littleton Adventist Hospital. The other Denver-area hospitals are Denver Health Medical Center, Exempla Lutheran Medical Center, Exempla Saint Joseph Hospital, North Suburban Medical Center, Platte Valley Medical Center, Presbyterian/St. Luke's Medical Center, Rose Medical Center, St. Anthony Hospitals, The Children's Hospital, The Medical Center of Aurora, and the University of Colorado Hospital.

263. MedSouth's current members are 51% of the internists and 33% of the family practitioners at Swedish Hospital, and from 50% to 100% of the specialists in 19 other practice areas at that hospital (allergy/immunology, cardiology, endocrinology, hematology/oncology, infectious disease, nephrology, neurology, oncology, pulmonary medicine, radiology, rheumatology, hand surgery, neurosurgery, pathology, podiatric surgery, urology, vascular surgery, pediatric cardiology, and pediatric neurology). They are 44% of the family practice physicians and 48% of the internists at the two Adventist hospitals, and from 50% to 100% of the specialists in 21 other fields at those two hospitals (allergy, cardiology, cardiovascular surgery, endocrinology, gastroenterology, gynecology, infectious diseases, nephrology, neurology, neurosurgery, oncology, otorhinolaryngology, otology, pathology, podiatry, pulmonology, radiation oncology, radiology, rheumatology, hand surgery, and urology).

264. See COLORADO HEALTH & HOSPITAL ASSOCIATION, REFERENCE GUIDE TO FINANCIAL AND UTILIZATION DATA (2002).
Table 2: Aggregate Quantity and Price Data for Denver-Area Hospitals

<table>
<thead>
<tr>
<th>Category</th>
<th>Patient Days</th>
<th>Inpatient Charges</th>
<th>Outpatient Charges</th>
<th>Total Charges</th>
<th>Uncollected Charges</th>
<th>Revenues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>215,183</td>
<td>$1,007,796,041</td>
<td>$326,503,093</td>
<td>$1,334,299,134</td>
<td>$891,157,758</td>
<td>$443,141,376</td>
</tr>
<tr>
<td>Medicaid</td>
<td>98,314</td>
<td>$427,917,855</td>
<td>$156,213,888</td>
<td>$584,131,743</td>
<td>$326,137,205</td>
<td>$257,994,538</td>
</tr>
<tr>
<td>Self Pay</td>
<td>55,410</td>
<td>$246,137,199</td>
<td>$248,933,594</td>
<td>$495,070,793</td>
<td>$17,195,070</td>
<td>$477,875,723</td>
</tr>
<tr>
<td>Champus</td>
<td>2,707</td>
<td>$14,304,247</td>
<td>$9,372,766</td>
<td>$23,677,013</td>
<td>$11,250,664</td>
<td>$12,426,349</td>
</tr>
<tr>
<td>Mang. Care</td>
<td>378,270</td>
<td>$1,940,734,866</td>
<td>$1,167,838,986</td>
<td>$3,108,573,852</td>
<td>$1,801,422,410</td>
<td>$1,307,151,442</td>
</tr>
<tr>
<td>Others</td>
<td>72,629</td>
<td>$276,289,072</td>
<td>$302,656,360</td>
<td>$578,945,432</td>
<td>$301,286,617</td>
<td>$277,658,815</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>874,166</strong></td>
<td><strong>$4,202,240,665</strong></td>
<td><strong>$2,387,771,994</strong></td>
<td><strong>$6,590,012,659</strong></td>
<td><strong>$3,457,353,394</strong></td>
<td><strong>$3,132,659,265</strong></td>
</tr>
</tbody>
</table>

Table 3: Aggregate Quantity and Price Data for MedSouth-Affiliated Hospitals

<table>
<thead>
<tr>
<th>Category</th>
<th>Patient Days</th>
<th>Inpatient Charges</th>
<th>Outpatient Charges</th>
<th>Total Charges</th>
<th>Uncollected Charges</th>
<th>Revenues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>64,380</td>
<td>$237,219,915</td>
<td>$71,702,380</td>
<td>$308,922,296</td>
<td>$216,236,613</td>
<td>$92,685,683</td>
</tr>
<tr>
<td>Medicaid</td>
<td>5,363</td>
<td>$20,284,710</td>
<td>$7,567,564</td>
<td>$27,852,273</td>
<td>$18,115,565</td>
<td>$9,736,708</td>
</tr>
<tr>
<td>Self Pay</td>
<td>7,563</td>
<td>$23,287,091</td>
<td>$14,568,564</td>
<td>$37,855,654</td>
<td>$0</td>
<td>$37,855,654</td>
</tr>
<tr>
<td>Champus</td>
<td>0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Mang. Care</td>
<td>95,146</td>
<td>$379,739,453</td>
<td>$280,629,546</td>
<td>$660,368,999</td>
<td>$350,759,107</td>
<td>$309,609,892</td>
</tr>
<tr>
<td>Commercial</td>
<td>10,094</td>
<td>$49,561,554</td>
<td>$36,178,497</td>
<td>$85,740,051</td>
<td>$22,330,080</td>
<td>$63,409,970</td>
</tr>
<tr>
<td>Others</td>
<td>25,350</td>
<td>$102,827,057</td>
<td>$43,009,924</td>
<td>$145,836,981</td>
<td>$110,100,229</td>
<td>$35,736,751</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>207,896</strong></td>
<td><strong>$812,919,779</strong></td>
<td><strong>$453,656,474</strong></td>
<td><strong>$1,266,576,254</strong></td>
<td><strong>$717,541,595</strong></td>
<td><strong>$549,034,659</strong></td>
</tr>
</tbody>
</table>

Table 4: MedSouth Market Shares

<table>
<thead>
<tr>
<th>Category</th>
<th>Patient Days</th>
<th>Inpatient Charges</th>
<th>Outpatient Charges</th>
<th>Total Charges</th>
<th>Uncollected Charges</th>
<th>Revenues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>29.92%</td>
<td>23.54%</td>
<td>21.96%</td>
<td>23.15%</td>
<td>24.26%</td>
<td>20.92%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>5.45%</td>
<td>4.74%</td>
<td>4.84%</td>
<td>4.77%</td>
<td>5.55%</td>
<td>3.77%</td>
</tr>
<tr>
<td>Self Pay</td>
<td>13.65%</td>
<td>9.46%</td>
<td>5.85%</td>
<td>7.65%</td>
<td>0.00%</td>
<td>7.92%</td>
</tr>
<tr>
<td>Champus</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Mang. Care</td>
<td>25.15%</td>
<td>19.57%</td>
<td>24.03%</td>
<td>21.24%</td>
<td>19.47%</td>
<td>23.69%</td>
</tr>
<tr>
<td>Commercial</td>
<td>19.54%</td>
<td>17.15%</td>
<td>20.53%</td>
<td>18.43%</td>
<td>20.50%</td>
<td>17.79%</td>
</tr>
<tr>
<td>Others</td>
<td>34.90%</td>
<td>37.22%</td>
<td>14.21%</td>
<td>25.19%</td>
<td>36.54%</td>
<td>12.87%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>23.78%</strong></td>
<td><strong>19.34%</strong></td>
<td><strong>19.00%</strong></td>
<td><strong>19.22%</strong></td>
<td><strong>20.75%</strong></td>
<td><strong>17.53%</strong></td>
</tr>
</tbody>
</table>

Applying the equation accompanying note 224, supra, to the data presented in Tables 2-4, the model presented here would provide MedSouth with an “efficiency defense” for possible price increases that may follow the formation of the IPA-joint venture. For example, from Table 1 we
know that a 5% price increase would be offset by a 0.021% reduction in the IPA’s system-wide costs; similarly, a 20% price increase would be offset by a 0.351% efficiency increase. These calculations from Table 1 can be applied to any appropriate price and quantity combination from Tables 2-4 to determine the cost justifiability of MedSouth’s operations. Thus, if we take the average total charges per patient-day as a proxy for “efficiency,” Table 5 presents sample calculations for offsetting price increases for corresponding demand-price elasticities.265

<table>
<thead>
<tr>
<th>ΔP</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>½</th>
<th>0.17</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>$25.93</td>
<td>$16.89</td>
<td>$7.84</td>
<td>$3.62</td>
<td>$1.27</td>
</tr>
<tr>
<td>10</td>
<td>$120.62</td>
<td>$72.97</td>
<td>$33.17</td>
<td>$15.68</td>
<td>$5.19</td>
</tr>
<tr>
<td>20</td>
<td>$625.40</td>
<td>$347.37</td>
<td>$144.74</td>
<td>$66.34</td>
<td>$21.17</td>
</tr>
</tbody>
</table>

According to Table 5, if we assume the health care market exhibits a constant demand-price elasticity of 0.17,266 and if we assume “average charges per patient-day” are a suitable proxy for an IPA’s efficiency, MedSouth would be able to justify a 5 percent increase in its prices by a reduction of $1.27 in charges per patient-day, and the IPA-joint venture could justify a 20 percent increase in prices by an offsetting reduction of $21.17 in charges per patient-day. Of course, average charges per patient-day are a poor proxy for system-wide costs, but Table 5 at least gives an illustrative example for the application of the model presented here.

Even outside of the model presented here, MedSouth is highly unlikely to garner antitrust scrutiny or condemnation. As Tables 2-4 illustrate, MedSouth’s physicians have the potential to exercise only a modest degree of market power. The “Revised Joint Statement” indicated, inter alia, that the federal agencies would not challenge, absent extraordinary circumstances, physician network joint ventures whose membership totals 20% or less of the physicians in a relevant geographic market and 20% or less of the physicians in each specialty within that market.267 Given the fact

265. MedSouth’s average charges per patient-day can be calculated from Table 3 to be $6,030.82 ($1,266,576,254/207,896).

266. See supra note 225 and accompanying text.

267. Dept. of Justice & U.S. Federal Trade Comm’n, Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust, ANTITRUST & TRADE REG. REP. (BNA) No. 67, at 764 (Sept. 27, 1994). The statement contains an exception for small communities with less than five physicians in a given practice. The exception states that in
that the FTC has never monitored a physician joint venture after granting conditional approval in an advisory opinion, and given the fact that the federal enforcement agencies have focused their limited resources on prosecuting near-monopolies and naked cartels, the model presented above suggests MedSouth is particularly unlikely to face further scrutiny from the FTC or DOJ. Even if the agencies filed complaints against MedSouth and its members, the sanctions recently imposed upon two medical groups in Denver for price-fixing and the orchestration of boycotts suggest MedSouth has little to fear from the federal authorities.

Even given the data presented in Tables 2-4, private plaintiffs could challenge MedSouth’s compliance with the federal antitrust laws and force the IPA to defend itself under the rule of reason. The likelihood that MedSouth will be challenged by a rival HMO or one of its contracting insurers appears even greater when considered in light of the practical difficulties inherent in MedSouth’s proposal, and given the fact that MedSouth’s competitors have enormous incentives to try and squelch the relevant markets with less than five physicians in a particular specialty, a physician network joint venture otherwise qualifying for the antitrust safety zone may include one physician from that specialty even though the inclusion of that physician results in a physician network joint venture consisting of more than 20 percent of the physicians in that specialty. See Hassan v. Indep. Practice Assoc., 698 F. Supp. 679, 694 (E.D. Mich. 1988). The court, citing Jefferson Parish, held that a 20% market share did not constitute sufficient market power in light of competition from other providers in the area. Id.


269. See Greaney, supra note 6, at 190 (noting that “the federal enforcement agencies have been slow to challenge physician or other provider networks.... Generally, they have targeted only near-monopolies and outright cartels. Further, the agencies’ advisory opinions in many cases have generously extended the safe-harbor limits contained in their own policy statements. Consequently, many private attorneys advise clients that it is a relatively low risk proposition to form networks that encompass large segments of the market. In sum, agencies’ failure to back up their advisory opinions with enforcement actions may have undermined the prophylactic potential of their advisories.”).

270. See In re Physician Integrated Servs. of Denver, Inc., 2002 F.T.C. 27 (May 13, 2002), 2002 F.T.C. LEXIS 27; In re Physician Integrated Servs. of Denver, Inc., 2002 F.T.C. 38 (July 16, 2002), 2002 F.T.C. LEXIS 38. Under the settlements, the defendants were prohibited from entering into, participating in, or facilitating: (1) any agreement to negotiate on behalf of physicians with any payor or provider; (2) any agreement to deal, or to refuse to deal, with any payor or provider; (3) any agreement regarding any term or condition on which physicians deal, or are willing to deal, with any payor; or (4) any agreement not to deal individually with any payor, or not to deal with any payor through any arrangement other than PISD or AAPCP. The order would also bar defendants from exchanging or facilitating the exchange of information concerning any physician’s willingness to deal with a payor, or the terms or conditions on which any physician is willing to deal with a payor. Both orders provided that the defendants could participate in a “qualified risk-sharing joint arrangement” or a “qualified clinically-integrated joint arrangement,” so long as they do not prevent the participating physicians from contracting individually or through other arrangements.
IPA’s “clinical integration” model at its incipiency. Recognizing the horizontally collusive threat its business model poses, and facing the administrative nightmare posed by its clinical integration plans, MedSouth might do well to supplement its IPA with some form of financial risk-sharing. The 1996 Health Care Statements are silent with respect to the methods the FTC would use to analyze such a hybrid joint venture, but the Supreme Court’s decision in California Dental suggests that a horizontal combination of professional service providers would at least garner a presumption of pro-competitive efficiencies. 271

V. CONCLUSION

Against the backdrop of perceived widespread dissatisfaction with the state of the health care industry in the latter-half of 1990s, 272 MedSouth can be understood as part of a larger physician-sponsored backlash against managed care organizations. For example, in a documentary on physicians’ drives to unionize, CBS News reported:

Dr. Janice Nelson: “And this is why we want to stick together as a group of physicians, so that our voices be heard [sic], because for so long, they’ve been totally ignored.”

Bill Whitaker (CBS News reporter): “[Physicians argue that] there’s strength in numbers when negotiating with managed care firms.”

Dr. Sam Fink: “An insurance company does not care about one practitioner. They might care about a few thousand.” 273

Insofar as the continued power struggle between physicians and managed care organizations has continued to manifest itself in new and different
forms, there can be little doubt that one of the primary motivations behind the formation of MedSouth was its participants’ collective desire to retake some of the bargaining power they were forced to cede in previous years.\footnote{Robert A. Berenson, Beyond Competition, 16 HEALTH AFF. 171, 174-75 (1997) (“Physicians get involved in integrated delivery system activities or sell their practices for defensive reasons: to take back some of the control they have ceded to managed care . . .”);} With the FTC’s Staff Opinion under its belt, MedSouth has climbed an enormous mountain. The federal enforcement agencies are understaffed and underfunded, and the likelihood that the FTC will monitor, much less sue to enforce, MedSouth’s compliance with its integration proposal is slim. Even after winning the battle at the FTC, MedSouth still might lose the larger antitrust war. The administrative costs required to get the “virtual IPA” model off the ground will be enormous, and MedSouth may financially self-destruct, just like the traditional HMOs to which MedSouth was supposed to be an alternative. If MedSouth succeeds, the novelty of its business model may continue to attract attention from both public and private potential plaintiffs who would condemn the IPA as anti-competitive. In addition to implementing the initial logistics of its integration plans, MedSouth will face continued administrative costs in its daily operations.\footnote{In addition to enforcing its clinical guidelines and utilization review, MedSouth will also be forced to discipline sub-par physician participants. The Staff Opinion suggests MedSouth will retain the right to expel its members, if necessary. MedSouth Staff Opinion, supra note 10, at *4.} There may be strength in numbers, but big is not always beautiful.

Many of MedSouth’s remaining problems, from its administrative costs to the practicalities of its technological and clinical integration plans, cannot be remedied by antitrust policy. Insofar as health care policymakers desire to give incentives to would-be innovators to devise inventive ways to cut costs and improve quality, they would do well to recognize both the problems and possibilities posed by MedSouth’s formation and potential success. Modernizing health care antitrust law to include non-price variables in a formalized model like the one presented here would go a long way towards removing the sword of Damocles that has heretofore made an IPA-joint venture far too much of an “adventure.”