SCHOOL OF LAW
CASE WESTERN RESERVE UNIVERSITY

Health Matrix: The Journal of Law-Medicine

Volume 6 | Issue 1

1996

Physician-Sponsored Managed Care Networks: Two Suggestions for Antitrust Reform

Jack R. Bierig

PHYSICIAN-SPONSORED MANAGED CARE NETWORKS: TWO SUGGESTIONS FOR ANTITRUST REFORM

*Jack R. Bierig**

A **SOCIAL TRANSFORMATION** is occurring across American medicine. This transformation is the result of an increasingly recognized need to manage the delivery of medical services in the interests of both cost and quality. The transformation involves the emergence of large networks of physicians who hold forth the prospect of managing the care of patients and of benefiting from economies of scale, profitting better than they would in a series of small, atomistic practices acting independently of one another.

These networks of physicians usually have been put together by large insurance companies. For at least three reasons, however, physicians want to form their own networks to compete for patients:

1. Physicians feel strongly that they can manage care in a more patient-sensitive manner than insurance companies;
2. Physicians want to retain autonomy that comes with ownership; and,
3. Physicians believe that they can make more money by owning a network than by being employed by an insurance company.

Despite the increasing tendency toward capitation and other forms of prepayment, many physicians have concluded that they can compete successfully on a discounted fee-for-service basis. They are comfortable with this form of payment. Moreover, they believe that by controlling utilization, by managing care, and by reducing fees, they can offer a competitively viable plan that will attract large numbers of patients.

---

* Attorney with Sidley & Austin, Chicago, Illinois.

Significantly, when physicians come together to form a network to compete on a discounted fee-for-service basis, they immediately encounter two antitrust obstacles. First, they may not agree upon a schedule of fees at which the network will price its services. To do so in the absence of "risk-sharing" would be regarded as price fixing that is unlawful per se.[1] Risk-sharing generally is viewed by the federal antitrust enforcement agencies as either (a) pricing on a capitated basis, or (b) being subject to substantial withholds.[2] Investing capital that is at risk if the network fails is not regarded as risk-sharing for these purposes.[3]

Second, if the physician-sponsored network has more than thirty percent of the practitioners in any specialty in a geographic market, it falls outside a safety zone established by the federal antitrust agencies and is, therefore, subject to antitrust investigation.[4] A network meeting the thirty percent limit will fall outside the safety zone even if it is "non-exclusive," that is, individual physicians participating in the network are free to — and do in fact — join competing networks.[5] By contrast, physician networks put together by insurance companies are under no similar size constraints, even though such networks are likely to be far better capitalized and far more likely to achieve power in a relevant market.

Antitrust enforcement policy forbids the setting of a fee schedule by loosely integrated groups of physicians who seek to compete on a discounted fee-for-service basis, and puts at risk any such groups that include more than thirty percent of the practitioners in any medical specialty. These two facts have combined to create an antitrust paradox in health care, that is the antitrust laws are supposed to promote competition. Instead, they are suppressing competition by discouraging physicians from offering to patients and payors the alternative of a physician-sponsored network operating on a discounted fee-for-service basis.

---

1. *See* U.S. Dep't of Justice and Fed. Trade Comm'n, STATEMENTS OF ENFORCEMENT POLICY AND ANALYTICAL PRINCIPLES RELATING TO HEALTH CARE AND ANTITRUST (SEPT. 27, 1994) [hereinafter 1994 ANTITRUST ENFORCEMENT GUIDELINES] 70.

2. *Id.* at 70.

3. *Id.*

4. *Id.*

5. *Id.*

The cure for this paradox is neither radical nor difficult. With respect to the first issue, antitrust policy should recognize that the development of fee schedules by physician-sponsored networks may involve significant efficiencies and benefits for patients, even if the participating physicians do not share insurance risks. Such fee schedules, therefore, should be analyzed under the rule of reason rather than the per se rule. With respect to the second issue, antitrust policy should treat physician-sponsored and insurer-controlled networks alike in terms of the percentage of local physicians who may participate without raising legal risks. These changes will have the salutary effect of promoting competition and consumer choice in the provision of physician services.

I. BACKGROUND

A. Physician-Sponsored Networks

As used in this Article, the term "physician-sponsored network" refers to a joint venture in which physicians in different locations and medical specialties come together to offer their services to managed care organizations (MCOs), large employers, and other purchasers of health care without fully merging their practices. Such collaboration increasingly is necessary to enable physicians to compete for managed care contracts. The reason is that large purchasers have little interest in steering patients to traditional solo practitioners or to small groups. Rather, they are looking for broad-based networks that can offer services across the full geographic area in which employees and other covered individuals reside, and across a full array of medical specialties.

In theory, physicians could fully integrate their practices in order to produce a network that is attractive to large purchasers. Complete mergers, however, involve significant transactional costs. They also raise legal impediments such as the combining of different pension plans. Moreover, complete mergers require a degree of integration with which most physicians are uncomfortable and which is better achieved gradually rather than through one major transaction. For these reasons, a partially integrated, physician-sponsored network is the most practical alternative for physicians desiring to compete for managed care contracts.

A physician-sponsored network may wish to offer its services to potential purchasers on a capitated basis, on a discounted fee-for-service basis, or use a combination of ap-

proaches. Regardless of which payment mechanism is selected, a physician-sponsored network must compete with other networks offering physician services. If physician-sponsored networks offering services on a discounted fee-for-service basis do not control costs, they will be economically unattractive and will fail in the marketplace. Therefore, such networks commonly engage in credentialing, in utilization control, and in other processes designed to make them competitive.

B. The Market For Physician Networks and Antitrust Regulation of Such Networks

As noted above, physician-sponsored networks must compete with networks developed by large insurance companies. Such networks routinely establish fee schedules that bind participants even though those physicians do not share risk among themselves or with the insurer. These networks often include a significant percentage of local physicians, sometimes as high as seventy percent. Yet, unlike physician-sponsored networks, insurer-controlled networks may establish fee schedules without requiring participating physicians to share risk. Moreover, while physician-sponsored networks run antitrust risks if they include more than thirty percent of practicing local physicians in any medical specialty,[6] insurer-sponsored networks face no restrictions on panel size.

The disparate treatment of physician-sponsored networks is not mandated by the language of the antitrust statutes. Rather, this disparate treatment is the result of enforcement policy. It arises out of doctrines developed by federal enforcement agencies to guard against the possibility of anticompetitive conduct by physicians who seek to offer a physician-sponsored fee-for-service alternative in the market for medical services.

These prophylactic doctrines were developed in an era when physicians were viewed as likely to erect obstacles to the development of innovative forms of health care financing and delivery. That era has ended. Today, most geographic markets—at least in urban areas—are dominated by sophisticated purchasers and large delivery systems generally controlled by insurance companies such as Blue Cross and Blue Shield plans.

---

6. *Id.* at 68-69.

Physician-sponsored networks must be prepared to compete on merits if they are to succeed in the market. They are in no position to dictate terms to purchasers. In these circumstances, it is both anticompetitive and unfair to require physician-sponsored networks to comply with prophylactic rules that are not applied to insurer-sponsored networks.

II. SUGGESTIONS FOR REFORM

A. Pricing Issues

1. The Problem

The first area in which current antitrust enforcement policy requires reform relates to pricing mechanisms by physician-sponsored networks. Suppose that physicians who practice independently want to form a network to compete on a discounted fee-for-service basis for contracts to perform services for MCOs and self-insured employers. Suppose further that the physicians are committed to intensive utilization control and quality assurance efforts and that they are prepared to invest their money to fund the operating costs of the venture.

In order to market the network effectively, the physicians must establish a fee schedule to inform prospective purchasers what they will be asked to pay if they contract with the network. Indeed, establishing a fee schedule is precisely what an insurer-sponsored network must do when it markets its services. An insurer's establishment of a fee schedule is viewed as unilateral action outside the scope of section 1 of the Sherman Act[7] and section 5 of the Federal Trade Commission Act.[8]

Under current policy, however, the establishment of a fee schedule by a physician-sponsored network would be condemned as a *per se* violation of the antitrust laws.[9] The setting of a fee schedule by the participating physicians would be deemed an agreement on price among competitors. As such, it would be prohibited without any economic analysis of the actual competitive effects of the venture—regardless of how procompetitive the venture might be.

---

7. 15 U.S.C. § 1 (1994).
8. 15 U.S.C. § 45 (1994).
9. *See Arizona v. Maricopa County Med. Soc'y*, 457 U.S. 332 (1982).

To avoid the application of the per se rule, the physician network, but not the insurer-sponsored network, must become financially "integrated." In other words, the participating physicians must accept a substantial amount of risk. The Antitrust Division of the Department of Justice (DOJ) and the Federal Trade Commission (FTC) explicitly have recognized only two acceptable ways of taking on sufficient risk:

> 1. The physicians can agree to be paid on a capitated basis in exchange for their agreement to provide a specified package of medical services to a specified population; or
> 2. The physicians can agree to have a significant portion of their payments held back in a withhold pool which may be recaptured if costs exceed projections.[10]

Both of these alternatives involve the acceptance by the physicians of insurance risk.

The DOJ's and the FTC's reliance on the sharing of insurance risk represents an effort to distinguish between legitimate joint ventures and naked price-fixing schemes. But the standards applied by the agencies to physician-sponsored joint ventures are far too rigid. A physician network that (a) enables physicians to provide wide geographic and specialty coverage that no physician or group could provide individually and (b) that generates significant efficiencies, such as utilization review and quality assurance, is not a naked price-fixing scheme. Such a network should not be found to have engaged in *per se* illegal price-fixing when it establishes a schedule of fees in order to compete. Rather, the network should be viewed as a legitimate joint venture competing in the market for network services.

The agencies' reliance on the bearing of financial risk as the sole indicium of the legitimacy of a physician joint venture can be traced back to the 1982 decision of the Supreme Court in *Arizona v. Maricopa County Medical Society*.[11] But *Maricopa*, however, does not mandate the agencies' rigid insistence on the bear-

---

10. *See* 1994 ANTITRUST ENFORCEMENT GUIDELINES, *supra* note 1, at 70.

11. At issue in *Maricopa* was a physician-sponsored Foundation formed to offer services to subscribers on a discounted fee-for-service basis. The Foundation, which included 70% of the practitioners in Maricopa County, established a fee schedule which set forth the maximum price that a subscriber would have to pay for any given service. No patient or employer had to subscribe to the Foundation, and no physician had to participate. Nevertheless, in a 4-3 decision with two Justices not participating, the Supreme Court condemned the fee schedule as *per se* illegal price fixing. Interestingly, the Court of Appeals decision that was reversed by the Supreme Court had been concurred in by Judge — now Justice — Anthony Kennedy.

ing of insurance risk. To the contrary, *Maricopa* specifically recognizes that the per se rule does not apply to "partnerships or other joint arrangements in which persons, who would otherwise be competitors, pool their capital and share the risks of loss as well as the opportunities for profit."[12] Despite this language in *Maricopa*, the DOJ and FTC agencies are unwilling to treat the investment of capital as a form of risk-sharing, or to recognize that integrative efficiencies may be generated without the sharing of insurance risk.

This was not always the case. For a brief period during the 1980s, the Justice Department acknowledged that a physician-sponsored preferred provider organization could generate significant efficiencies through "integration that falls short of financial participation and sharing of risks."[13] The FTC, by contrast, consistently has required financial risk-sharing as a prerequisite to the establishment or negotiation of fees by a physician network. The joint policy statements adopted by the agencies in 1993 and 1994 appear to indicate that the FTC approach has carried the day.[14]

It is true that capitation and withholds give some assurance that a network is generating efficiencies rather than operating as a collective bargaining unit. But even without these forms of risk-sharing, a network can offer a new and attractive product that is easily distinguishable from a cartel. This is particularly true where the network offers not only a package of medical services, but distinct network services, such as utilization review and quality assurance, that themselves generate efficiencies attractive to purchasers.

Physician-sponsored networks appear to be the only type of venture for which the DOJ and the FTC require financial risk-sharing as a prerequisite to examination under the rule of reason. They are the only type of venture for which agencies refuse to

---

12. *Maricopa*, 457 U.S. at 356.

13. Charles F. Rule, Antitrust in the Health Care Field: Distinguishing Resistance from Adaptation, Address Before the Antitrust and Health Care Seminar of the Antitrust Section of the Connecticut Bar Association and the Connecticut Health Lawyers Association (Mar. 11, 1988), *in* JOHN J. MILES, 4 HEALTH CARE & ANTITRUST LAW, app. at E 11-7 (1992) (noting that agreement to adhere to limitations on billing and treatment may generate integrative efficiencies without financial risk-sharing).

14. *See* 1994 Antitrust Enforcement Guidelines, *supra* note 1; DEP'T OF JUSTICE & FED. TRADE COMM'N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN THE HEALTH CARE AREA (Sept. 15, 1993) [hereinafter 1993 ANTITRUST ENFORCEMENT GUIDELINES].

view the contribution of capital and the sharing of opportunities for profit and loss as legitimate forms of integration. The refusal to acknowledge that the investment of capital is a legitimate form of risk-sharing that warrants analysis under the rule of reason seems unjustified.

In any event, antitrust laws should not determine the particulars of how specific types of competitors should be paid. Further, antitrust policy should not preempt the business judgment of purchasers who are willing to enter into fee-for-service arrangements with physician-sponsored networks. Unless a network is packaged and priced in a manner that is appealing to purchasers, it will fail in the market. The important point is that the network ought to be given a fair chance to compete.

Of course, if participating physicians engage in a boycott or other coercive negotiating tactics, the antitrust laws can be invoked, to prevent and punish this conduct, quite apart from any doctrine of financial integration. However, absent such conduct, antitrust policy should not be used to preempt competition. Let the market, not antitrust enforcers, decide whether fee-for-service, physician-sponsored networks have something to offer to purchasers.

To be sure, physician-sponsored networks that do not involve financial risk-sharing may utilize the so-called "messenger model" to arrive at the price at which participating physicians will provide services.[15] Invocation of the messenger model, however, simply highlights the divergent treatment of physician-sponsored and insurer-sponsored plans. Under the messenger model, an intermediary shuttles back and forth between each purchaser and each physician in the network to arrive at separate fee agreements for each physician.

When was the last time an insurer-sponsored network used this approach to establish fees? It is doubtful whether any insurer has ever used it. The messenger model is universally recognized as inefficient and cumbersome, particularly given the thousands of medical procedures and the large numbers of physicians involved in physician networks.

Physician-sponsored networks cannot be expected to be competitive if they are exposed to severe antitrust sanctions for

15. The "messenger model" is described in the 1994 ANTITRUST ENFORCEMENT GUIDELINES, *supra* note 1, at 94-96.

engaging in precisely the same activities that their insurer-sponsored competitors find necessary for effective competition. It must be emphasized that insurers routinely establish uniform fee schedules applicable to scores, sometimes hundreds, of physicians. They regularly form contracting networks that do not involve capitation payments or risk-sharing among the participating physicians. Presumably, insurers do these things in response to a perceived market demand. Why, then, should an irrebuttable presumption of anticompetitiveness arise when physicians do the very same thing?

2. The Proposed Reform

The reform that would cure the perversely anticompetitive application of the antitrust laws described above is quite simple. It involves no antitrust exemptions, nor does it require any cumbersome regulatory mechanisms. Instead, it consists simply of analyzing the establishment of fee schedules by physician-sponsored networks under the rule of reason.

This approach would require antitrust enforcement agencies and courts to take into account the purpose of the venture, the nature of the market, and other relevant considerations bearing on the competitive effects of establish of a fee schedule, such as, the amount and purpose of any capital contribution at risk. If on balance the establishment of the fee schedule was deemed anticompetitive, an antitrust violation would be found. Otherwise, the physicians would be permitted to develop a fee schedule. A judgment would be formed based on review of the facts rather than on invocation of a presumption that is likely to be incorrect.

The rule of reason approach is precisely the one advocated by the dissenting opinion in *Maricopa* and by Justice (then Judge) Kennedy's concurring opinion in the court of appeals. As Justice Powell wrote, for himself and for Chief Justices Burger and Rehnquist, with respect to the physician-sponsored plan at issue in *Maricopa*:

> The fact that . . . [the] plan *literally* involves the setting of ceiling prices among competing physicians does not, of itself, justify condemning the plan as per se illegal. Only if it is clear from the record that the agreement among physicians is "so plainly anticompetitive that no elaborate study of [its effects] is needed to establish [its] illegality" may a court properly make a per se judgment. And, as our cases demonstrate, the per se label should not be assigned without carefully considering sub-

stantial benefits and procompetitive justifications.[16]

Given the composition of the Supreme Court today, this approach would be virtually certain to command a majority, assuming that the Court were to address the issue now for the first time. In fact, it probably would have commanded a majority in 1982 had Justices Blackmun and O'Connor participated.

Finally, the majority opinion in *Maricopa* essentially invited congressional action to undo the application of the per se rule if that approach were deemed inappropriate. Specifically, Justice Stevens wrote: "The respondents' arguments against application of the per se rule in this case . . . are better directed to the Legislature. Congress may consider the exception that we are not free to read into the statute."[17] It is time to accept Justice Stevens's invitation. Congress should enact legislation overturning *Maricopa* to the extent to which that case requires a per se approach to the setting of fee schedules by physician-sponsored networks whose participants do not bear insurance risk.

B. Size Issues

1. The Problem

The second area in which current antitrust enforcement policy requires reform relates to the size of physician-sponsored networks. In examining the antitrust implications of such networks, the DOJ and the FTC view the number of physicians in the provider panel as a key consideration. Their concern is that an overly inclusive panel—one that includes a high percentage of physicians in particular medical specialties—could create a barrier to entry by competing managed care networks.[18] In other words, competing plans could have difficulty recruiting their own panels if physician-sponsored networks were too large.

This concern is a legitimate one insofar as the network is exclusive, that is, participating physicians do not offer their services through competing networks. Indeed, the combination of

16. *Maricopa*, 457 U.S. at 363-64 (Powell, J., dissenting) (emphasis in original; citations omitted).

17. *Maricopa*, 457 U.S. at 354-55. In a footnote to this quotation, Justice Stevens points out that Congress "can, of course, make *per se* rules inapplicable in some or all cases . . . ."

18. *See, e.g.*, Letter from Mark J. Horoschak, Assistant Director, Federal Trade Commission, to J. Bert Morgan, Morgan, Miller & Blair (Nov. 17, 1993) (on file with *Health Matrix*).

exclusivity and a large panel ought to raise concerns whether the network is physician-sponsored or not.[19] But the DOJ and the FTC do not limit themselves to networks that impose some measure of exclusivity.

Non-exclusive physician-sponsored networks also are subject to antitrust challenge if they include too many physicians. Specifically, the 1994 Antitrust Enforcement Guidelines indicate that a non-exclusive network in which the participating physicians share financial risk will qualify for a "safety zone" only if the panel includes no more than thirty percent of the physicians in any relevant specialty market.[20] The 1994 Antitrust Enforcement Guidelines place no limits on the size of insurer-sponsored networks. However, they announce that physician-sponsored networks are at risk if they include more than thirty percent of local physicians in any particular medical specialty.

To be sure, the thirty percent figure represents only a safety zone. A physician-sponsored venture can include more than thirty percent of local physicians in a specialty without necessarily violating the antitrust laws. In fact, the DOJ and the FTC have approved ventures that include somewhat more than thirty percent of local physicians in a particular specialty.

However, the fact that the thirty percent figure is only a safety zone does not make this rule insignificant. Physicians tend to be conservative. Moreover, the networks that they wish to form have not built up substantial capital reserves. In these circumstances, the mere prospect of an antitrust investigation where a network exceeds the thirty percent rule often is enough to dissuade physicians from including more than thirty percent of the practitioners in a particular field of medicine in a network.

Further, the thirty percent rule also has symbolic significance. It bespeaks a government distrust of physician-sponsored networks. The fact is that the 1994 Antitrust Enforcement Guide-

---

19. *See Antitrust Analysis of Physician Network Joint Ventures: Physicians Payment Review Commission* 13 (Oct. 28, 1994) (prepared statement by Mark J. Horoschak, Assistant Director, Bureau of Competition, Federal Trade Commission). (stating, "[t]ake, for example, an insurance company that entered into contracts with a substantial proportion of the doctors practicing in a market, and those contracts obligated the doctors to contract exclusively with that company. To the extent that entry by other provider networks might be precluded, we would be just as concerned, and would use the same analysis, as if that conduct were engaged in by a physician-directed plan.").

20. 1994 ANTITRUST ENFORCEMENT GUIDELINES, *supra* note 1, at 69.

lines make no mention of any antitrust risks that might arise when an insurer-sponsored plan exceeds the thirty percent figure.

Thus, the thirty percent rule puts physician-sponsored plans at an unwarranted competitive disadvantage. In many markets, a network attempting to compete effectively must include substantially more than thirty percent of physicians in certain specialties, particularly primary care specialties such as family practice, internal medicine, and obstetrics and gynecology. The reason is that individuals often will select a particular network based on whether their primary care physicians participate in that network. A network that includes more than fifty percent of local primary care physicians simply will be more attractive to more potential subscribers than a network limited to thirty percent of such physicians.

Significantly, the DOJ and the FTC have not explained why differential treatment of physician-sponsored networks and insurer-sponsored networks is warranted. The thirty percent limit appears to be based on a presumption that any physician-sponsored network is likely to be viewed as *de facto* exclusive by its participating physicians. For at least two reasons, however, this presumption is unwarranted.

First, the enforcement agencies are quite capable of distinguishing truly non-exclusive networks from those that are exclusive in name only. Indeed, the 1994 Antitrust Enforcement Guidelines set out specific criteria for making this distinction.[21] For example, the agencies look at whether there are viable competing plans in the market; whether providers in the network actually participate in other networks or contract individually with health plans; and whether providers in the network earn substantial revenue outside the network. Examination of these and the additional factors listed by the agencies ought to provide more than adequate protection against the possibility that the participating physicians would treat a nominally non-exclusive network as their exclusive vehicle for managed care contracting.

Second, there is no factual basis for assuming that physicians will discontinue their participation in insurer-sponsored networks once a physician-sponsored network is formed. Quite to the contrary, many physicians prefer to participate in as many managed care organizations as possible so that they may main-

21. *Id.* at 69-70.

tain relationships with existing patients and gain access to a large pool of potential patients. In any event, the agencies' review of physician networks ought to be based on the examination of specific facts, rather than on broad-based, and often erroneous, assumptions about physician behavior.

Networks that are truly non-exclusive simply do not create a barrier to the formation of competing networks. Indeed, in many communities, there are several competing networks that have each signed up a majority of the physicians in the market. This could not happen if panel size alone created a barrier to entry. Moreover, physicians increasingly compete in a nationwide market for affiliation with major health care systems.[22] Payors who are dissatisfied with the available selection of physicians often are quite capable of recruiting new physicians to the community, at least where non-primary care physicians are concerned.

2. The Proposed Reform

The DOJ and the FTC agencies should not be concerned with panel size unless size is coupled with some degree of express or de facto exclusivity. In any event, however, there is no justification for putting physician networks at a disadvantage by requiring them to submit to size limitations that are not imposed on insurer-sponsored networks. Insurers regularly put together large panels of physicians in multiple specialties, capable of serving the medical needs of a diverse and widely dispersed population. Again, physician-sponsored networks face restrictions on panel size that insurer-sponsored networks do not. Unless the DOJ and the FTC modify the size requirements for physician networks, appropriate legislation should be enacted to address this discrepency.

III. CONCLUSION

Reform is needed in the application of the antitrust laws to physician-sponsored networks. Specifically, the following two reforms are needed:

1. Congress should enact legislation making the establishment of fee schedules by physician-sponsored networks subject to analy-

22. *See* Collins v. Associated Pathologists, Inc., 844 F.2d 473, 478-79 (7th Cir. 1988).

sis under the rule of reason even where the physicians do not bear insurance risk; and

2. The antitrust enforcement agencies should be encouraged to treat all physician networks alike with respect to the percentage of local physicians who participate. Failing that change in policy, appropriate legislation should be enacted.