

THE TANGLED WEB: INTEGRATION, EXCLUSIVITY, AND MARKET POWER IN PROVIDER CONTRACTING

Thomas L. Greaney

TABLE OF CONTENTS

| | |
|---|----|
| I. INTRODUCTION | 60 |
| II. ANTITRUST DOCTRINE AFFECTING PROVIDER-CONTROLLED NETWORKS..... | 61 |
| a. Background: The Evolution of Standards | 61 |
| b. Integration..... | 65 |
| c. Market Power | 70 |
| d. Exclusivity..... | 73 |
| e. The Economic Underpinnings of the Legal Standard | 77 |
| III. ENFORCING AN AMBIGUOUS LEGAL STANDARD..... | 78 |
| a. The Tradeoffs Among Integration, Exclusivity and Market Power | 78 |
| b. When Should “Non-exclusivity” Justify Large Networks? | 82 |
| c. Is Price Fixing Necessary? Market Power and Ancillarity | 84 |
| IV. ADMINISTERING COMPETITION POLICY | 88 |
| V. CONCLUSION AND RECOMMENDATIONS | 92 |

*Antitrust law often proclaims itself in such general standards that private parties on all sides simply do not know where they stand, and the courts are often no better advised on the proper disposition of the controversy. Some uncertainty is of course inevitable, but we should be cautious about expanding it to the point that the legal rule becomes incoherent.*¹

I. INTRODUCTION

For health reform to succeed, much depends on provider integration. Indeed, a great deal of the Affordable Care Act (ACA) addresses the twin problems that bedevil the American health care system: fragmented delivery of services and payment incentives that fail to encourage provision of cost effective care.² The law's goal is to foster integration, as evidenced by provisions directly sponsoring development of new organizational arrangements such as accountable care organizations and patient centered medical homes and relaxation of laws and regulations that might inhibit integration. Critical to achieving this goal are the law's provisions designed to spur the formation of entities capable of receiving global payments or shared savings, delivering seamless and cost-effective services, and doing so in a competitive market.

Change in myriad laws and regulation is underway in support of this effort. For example, the ACA promotes payment system change through shifts to global payment, value-based purchasing, and shared savings arrangements. It encourages, and in some cases subsidizes, innovations aimed at restructuring delivery such as Accountable Care Organizations (ACOs), medical homes and other arrangements developed through the Center for Medicare and Medicaid Innovation.³ Clearing away the regulatory underbrush to

¹ 3A PHILIP C. AREEDA & HERBERT HOVENKAMP, *ANTITRUST LAW: AN ANALYSIS OF ANTITRUST PRINCIPLES AND THEIR APPLICATION*, ¶ 774e, at 223 (2nd ed. 1988).

² See Thomas L. Greaney, *The Affordable Care Act and Competition Policy: Antidote or Placebo?*, 89 OR. L. REV. 811, 825-36 (2011).

³ Congress created the Innovation Center for the purpose of testing "innovative payment and service delivery models to reduce program expenditures . . . while preserving or enhancing the quality of care." Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §3021,

facilitate these changes has necessitated adjustments in a wide variety of state and federal law, including fraud and abuse, insurance regulation, antitrust, and tax laws.

This article examines the tensions inherent in adapting laws to promote provider integration. Specifically, it considers the problems presented by certain joint venture networks of providers, including ACOs, independent practice associations, and physician hospital organizations, that can pose threats to robust competition. While supporting provider integration as an essential element of effective competition under managed care, antitrust law enforcers have long sought to discourage network formation that lacks meaningful integration or creates oligopolistic or monopolistic bargaining units. In formulating legal standards, a central problem has been finding (and articulating) the proper balance among a triad of factors: the degree and nature of integration; the size of networks; and provider commitments of exclusivity to their networks. Section II of this article traces the development of law in these three domains and Section III goes on to describe the uncertainties that have accrued as a result of the interplay of these factors. Analyzing the administration of antitrust enforcement involving physician networks and ACOs, Section IV considers justifications for ambiguity and light-handed enforcement and identifies problems with continued deference to overinclusive networks. Section V concludes with several suggestions to tighten oversight of networks and ACOs coupled with a plea for inter-agency efforts to develop better metrics and needed data about the market effects of their policies.

II. ANTITRUST DOCTRINE AFFECTING PROVIDER-CONTROLLED NETWORKS

a. Background: The Evolution of Standards

Provider-controlled networks have been the focus of attention

124 Stat. 389(2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029. The law provides the Secretary of Health and Human Services with broad authority to expand the scope and duration of models being tested through rulemaking, including the option of testing on a nationwide basis. See *About the CMS Innovation Center*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://innovation.cms.gov/About/index.html> (last visited June 1, 2013).

from the federal antitrust enforcement agencies for over thirty years. Beginning with numerous cases challenging outright price fixing and cartelizing schemes,⁴ followed by issuance of numerous advisory opinions and policy statements designed to clarify the boundary line between legitimate joint ventures and price fixing schemes,⁵ and most recently seen in close attention directed to the formation of accountable care organizations,⁶ the federal antitrust enforcement agencies (the FTC and Department of Justice) have provided an extraordinary store of guidance. Yet criticisms abound. Some fault the agencies for failing to define with specificity the meaning of "clinical integration," others believe more latitude is needed in allowing for safe harbors from scrutiny, while still others assert that under-enforcement of antitrust laws has encouraged concentration and flouting of legal standards.⁷ The issue drew particular attention during the Clinton Administration's unsuccessful efforts to enact health care reform. Because the proposed law relied heavily on expanding managed care to control costs, the Justice Department and FTC established guidelines to clarify the antitrust boundaries affecting anticipated consolidation, information sharing, group purchasing, and a variety of other issues raising possible antitrust scrutiny.⁸ The resulting Policy Statements specify the characteristics

⁴ See, e.g., *Am. Med. Ass'n v. F.T.C.*, 94 F.T.C. 701 (1979), *aff'd as modified*, 638 F.2d 443 (2d Cir. 1980), *reh'g denied*, 456 U.S. 966 (1982); *United States v. N.D. Hosp. Ass'n*, 640 F. Supp. 1028 (D.N.D. 1986); *In re Mich. State Med. Soc'y*, 101 F.T.C. 191 (1983). See generally BARRY R. FURROW ET AL., *HEALTH LAW* §14-10 (2000); Thomas L. Greaney, *Whither Antitrust? The Uncertain Future of Competition Policy in Health Care*, 21 *HEALTH AFF.* 185, 185 (2002).

⁵ See *infra* notes 38 – 42 and accompanying text.

⁶ U.S. Dept. of Justice & Federal Trade Commission, Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67,026 (Oct. 28, 2011) [hereinafter ACO Policy Statement].

⁷ U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-12-291R, FEDERAL ANTITRUST POLICY: STAKEHOLDERS' PERSPECTIVES DIFFERED ON THE ADEQUACY OF GUIDANCE FOR COLLABORATION AMONG HEALTH CARE PROVIDERS (Mar. 16, 2012) (summarizing views of industry and expert sources and finding disagreement on whether the agencies have provided sufficient guidance on the meaning of clinical integration).

⁸ The first health care policy statements were issued by the FTC and Department of Justice in 1993 and 1994. U.S. DEP'T OF JUST. & FED. TRADE COMM'N, ANTITRUST ENFORCEMENT POLICY STATEMENTS ISSUED FOR HEALTH CARE INDUSTRY (1993); U.S. DEP'T OF JUST. & FED. TRADE COMM'N, NEW ANTITRUST ENFORCEMENT POLICY STATEMENTS ISSUED FOR HEALTH CARE INDUSTRY (1994). The agencies issued a revised statement in 1996 that, among other things,

of joint ventures that in the government's view could be subject to per se condemnation and set forth "safety zones" containing specific market share delineations that would usually absolve the venture from further scrutiny.⁹ More recently, the agencies weighed in again, this time addressing the conditions under which joint ventures, formed to participate as ACOs under the Medicare Shared Savings Program, would raise antitrust issues when they also served commercial clients.¹⁰

Controversy regarding the legality of physician controlled networks traces back to the Supreme Court's 1982 decision in *Arizona v. Maricopa County Medical Society*, which applied the per se rule—a conclusive presumption of illegality—to two physician-controlled foundations for medical care that set maximum reimbursement levels for their members.¹¹ Not unlike many PPOs and IPAs that have flourished since that decision, the Maricopa foundations did not involve financial risk sharing or clinical integration among its participating physicians. The Court concluded that the arrangement constituted a horizontal price-fixing agreement,¹² and then stressed that even if there were efficiencies associated with the arrangement, it was not necessary that the doctors do the price-setting.¹³ The Court went on to distinguish the foundations from HMOs and other true joint ventures in which financial risk was shared:

If a clinic offered complete medical coverage for a flat fee, the cooperating doctors would have the type of partnership arrangement in which a price-fixing agreement among the doctors would be perfectly proper. But the fee agreements disclosed by the record in this case are among independent competing entrepreneurs. They fit squarely into the horizontal price-fixing mold.¹⁴

refined and expanded the scope of permissible integration. U.S. Dep't of Just. & Fed. Trade Comm'n, Statements of Antitrust Enforcement Policy in Health Care (1996) [hereinafter HEALTH POLICY STATEMENTS].

⁹ *Id.*

¹⁰ ACO Policy Statement, *supra* note 6.

¹¹ 457 U.S. 332, 357 (1982).

¹² *Id.*

¹³ *Id.* at 352–54.

¹⁴ *Id.* at 357.

The *Maricopa* decision has drawn strong and continuing criticism. Beginning with a sharp dissent from Justice Powell,¹⁵ followed by academic rebukes and legislative proposals to reverse the holding, the FTC and Department of Justice moved away from insisting solely on financial integration as a talisman of the potential for networks to enhance efficiency. In doing so the agencies rejected a strict dichotomy between risk-sharing ventures and all other kinds of integration for purposes of applying per se analysis. After some early pronouncements suggesting that some shared commitment to utilization review or other integrative activity might be sufficient to avoid per se scrutiny,¹⁶ the Agencies issued Health Care Policy Statements in 1994 identifying a number of specific examples of cognizable financial risk sharing; however, this guideline did not specify what other kinds of integration might suffice to avoid per se treatment, stating only that physician networks must demonstrate that “the combining of the physicians into a joint venture enables them to offer a new product producing substantial efficiencies.”¹⁷ Two years later, responding in part to political pressures and seeking to offer more concrete guidance and demonstrate regulatory flexibility,¹⁸ the Agencies revised the Policy Statements and specifically endorsed certain kinds of non-financial or “clinical” integration options for networks and outlined so-called “messenger model” arrangements that would avoid antitrust problems

¹⁵ *Id.* at 362-64 (Powell, J., dissenting).

¹⁶ See, e.g., Letter from M. Elizabeth Gee, Assistant Dir., Bureau of Competition, FTC, to Michael A. Duncheon, 7 n.7 (March 17, 1986) (FTC Staff Advisory Opinion to California PPO citing remarks of J. Paul McGrath before the American Bar Association Antitrust Spring Meeting 7-8, where he stated, “efficiency-enhancing integration sufficient to avoid *Maricopa*’s per se rule could flow from the following aspects of a provider-sponsored PPO’s operations, among others: an agreement among the physicians to accept discount fees with no balance-billing of patients; utilization review by the PPO; joint marketing or PPO administration of claims; and an agreement by a panel of limited size to bid for contracts against other such groups.”).

¹⁷ See U.S. DEP’T OF JUST. & FED. TRADE COMM’N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY AND ANALYTICAL PRINCIPLES RELATING TO HEALTH CARE AND ANTITRUST, reprinted in 4 Trade Reg. Rep.(CCH) ¶ 13,152, at 20,788 (Sept. 27, 1994) (Eighth Statement) [hereinafter 1994 Policy Statements].

¹⁸ See Thomas L. Greaney, *Antitrust and the Healthcare Industry: The View from the Three Branches*, 32 J. HEALTH L. 391 (1999).

altogether.¹⁹

Antitrust law countenances joint ventures that improve consumer welfare by increasing efficiency, typically by integrating complementary resources, even if the venture includes arrangements that otherwise would be judged as illegal restraints on competition, provided they are reasonably necessary to achieve those benefits.²⁰ Such restraints are evaluated under the rule of reason, which entails a weighing of the potential efficiency-enhancing benefits against the competition-restraining effects. The underlying doctrinal framework, referred to as the “ancillary restraint doctrine” based on then-Circuit Court Judge Taft’s seminal *Addyston Pipe* decision, permits restraints of trade that are subordinate to a broader, procompetitive endeavor, and are reasonably necessary for that endeavor to operate efficiently or to operate at all.²¹ By contrast, agreements lacking such indicia of efficiency-enhancement, usually labeled as “naked” agreements, are condemned under the per se rule which acts as a conclusive presumption of illegality and bars considerations of effect, market power or other factors. An important aspect of the *Addyston Pipe* analysis is “ancillarity”: are joint negotiations reasonably related and necessary to achieve the network’s procompetitive benefits?²² Simply framed, the question presented is whether network physicians can improve efficiency and performance but still set their own prices and negotiate independently.

b. Integration

A strong consensus among health policy experts holds that fragmentation in health care delivery is a major source of inefficiency

¹⁹ See HEALTH POLICY STATEMENTS, *supra* note 8. For analysis of the messenger model see *infra* notes 49 and accompanying text. For analysis of clinical integration see *infra* notes 36-44 and accompanying text.

²⁰ See U.S. DEP’T OF JUST. & FED. TRADE COMM’N, ANTITRUST GUIDELINES FOR COLLABORATIONS AMONG COMPETITORS § 3.2 (2000), available at <http://www.ftc.gov/os/2000/04/ftcdojguidelines.pdf>.

²¹ *United States v. Addyston Pipe & Steel Co.*, 85 F. 271, 282 (6th Cir. 1898), *aff’d as modified*, 175 U.S. 211 (1899).

²² *Id.*; see also *SCFC ILC, Inc. v. Visa USA, Inc.*, 36 F.3d 958, 970 (10th Cir. 1994) (restraints that are “reasonably related” to the venture’s operations and makes them “more effective in accomplishing its purposes” should be assessed under the rule of reason).

in the health care system,²³ with harms found at the clinical level due to inadequate care attributable to lack of provider coordination²⁴ and at the administrative level resulting from high administrative costs and ineffectual competition.²⁵ Consequently, enhancing provider integration was a major objective of the ACA with numerous provisions affecting Medicare and Medicaid payment policies, fraud and abuse law, and antitrust law.²⁶ In addition, as a matter of antitrust doctrine, the extent of integration among otherwise independent providers plays a critical role. Sufficient integration serves as a proxy for the efficiency-enhancing potential of a joint venture and removes the venture from per se scrutiny.

Provider integration is not a unitary phenomenon. Doctors, hospitals and other professionals and entities delivering health care and related services may come together under a wide variety of arrangements. Combinations into a single entity, typically referred to as “integrated delivery systems,” typically involve unified ownership and are accomplished by acquisition of practices and facilities; however some IDSs, like Kaiser Permanente, achieve the same kind of linkage through lasting contractual commitments.²⁷ Providers may

²³ See generally Randal Cebul et al., *Organizational Fragmentation and Care Quality in the U.S. Health Care System*, in THE FRAGMENTATION OF U.S. HEALTH CARE: CAUSES AND SOLUTIONS 38-43 (Einer R. Elhauge ed., 2010) (analyses by fourteen contributors of causes, effects, and remedies to excessive fragmentation in American health system).

²⁴ *Id.*

²⁵ *Id.* at 44-45 (citing administrative costs of thirty-one percent of total health care expenditures); Alain Enthoven, *Curing Fragmentation with Integrated Delivery Systems: What They Do, What Has Blocked Them, Why We Need Them, and How to Get There from Here*, in THE FRAGMENTATION OF U.S. HEALTH CARE: CAUSES AND SOLUTIONS, *supra* note 23, at 65-68 (citing evidence of lower costs in prepaid multispecialty group practices).

²⁶ See Greaney, *supra* note 2, at 833-34, 839-41.

²⁷ Some integrated delivery systems are united in a single corporate structure, e.g. Intermountain Health Care while others such as Kaiser link medical practice and hospitals by contractual bond. Integrated Delivery systems may be organized under several different models including the foundation model, under which a single corporation (the foundation), typically a nonprofit corporation under state law, is created to obtain all assets needed to operate clinics and physician offices, and possibly one or more hospitals and acquires services of physicians and other professionals either through employment or independent contract. Other models include arrangements that are controlled by a hospital system or medical clinics or joint control of physicians and hospitals. See Charles F. Kaiser & John F. Reilly, *Integrated Delivery Systems*, IRS: EXEMPT ORGANIZATION CPE FOR FY 1994 (July 1993), <http://www.irs.gov/pub/irs-tege/eotopicn94.pdf>. Many also have their own insurance

also come together through contractual arrangements, or joint ventures, that bind the parties to agreed-upon practice protocols, revenue sharing, capital investments and other commitments. These arrangements, which some analysts refer to as “virtual integration,” may have certain advantages over unified ownership under the IDS model,²⁸ although some policy analysts assume they are mere stepping stones to prepare providers for unified ownership under an IDS model.²⁹ Another way of categorizing integration distinguishes between “fully integrated” networks in which providers merge all their operations as in, for example, a staff-model HMO and “partially integrated” networks, in which the participating providers join together only to serve particular customers through the network while otherwise remaining separate, independent competitors.³⁰

Financial integration, favored in the *Maricopa* decision discussed earlier, may take several forms including providing services in return for capitated payments;³¹ a predetermined percentage of the premium paid the health plan by plan members; payments that include “withholds” of a fixed percentage of revenues due the participants for their services which is returned to the providers if they collectively cost containment or other network efficiency goals; payments or penalties tied to specific cost or utilization targets; or payments for a cluster of services.³² The Policy Statements provide that financial integration through substantial risk sharing

subsidiary and work under contracts in which they agree to deliver comprehensive medical services to consumers for a fixed-dollar amount.

²⁸ See James C. Robinson & Lawrence P. Casalino, *Vertical Integration and Organizational Networks in Healthcare*, 15 HEALTH AFF. 8, 19-20 (1996) (citing advantages of virtual integration in the “potential for autonomous adaptation to changing environmental circumstances” and preservation of “risks and rewards for efficient performance”).

²⁹ Molly Gamble, *ACOs: The Least Agreed-Upon Concept in Healthcare?*, BECKERS HOSP. REV. (May 6, 2013), <http://www.beckershospitalreview.com/accountable-care-organizations/acos-the-least-agreed-upon-concept-in-healthcare.html>.

³⁰ John J. Miles, 2 HEALTH CARE AND ANTITRUST LAW, §15A.2 n.1 at 15A-4.

³¹ Under capitation providers receive a fixed, predetermined periodic payment to provide all services the health plan's members need. Patrick C. Alguire, *Understanding Capitation*, AM. COLL. OF PHYSICIANS, http://www.acponline.org/residents_fellows/career_counseling/understandcapit.htm (last visited Mar. 22, 2014).

³² HEALTH POLICY STATEMENTS, *supra* note 8, Statements 8 & 9.

arrangements is a “clear and reliable indicator that a physician network involves sufficient integration [to achieve] significant efficiencies.”³³

As noted above, despite language in *Maricopa* strongly favoring financial integration as a means to avoid per se scrutiny, the antitrust agencies have recognized additional ways by which a network may demonstrate that it is “sufficiently integrated” so as to avoid per se condemnation. The Policy Statements explain the concept as follows:

Physician network joint ventures that do not involve the sharing of substantial financial risk may also involve sufficient integration to demonstrate that the venture is likely to produce significant efficiencies. Such integration can be evidenced by the network implementing an active and ongoing program to evaluate and modify practice patterns by the network’s physician participants and create a high degree of cooperation among the physicians to control costs and ensure quality. This program may include (1) establishing mechanisms to monitor and control utilization of health care services that are designed to control costs and assure quality of care; (2) selectively choosing network physicians who are likely to further these efficiency objectives; and (3) the significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies.³⁴

This concept of nonfinancial integration, or “clinical integration,” has been a focus of considerable attention from antitrust authorities. The FTC has provided extensive guidance elaborating its views on the matter in five lengthy staff advisory opinions³⁵ on specific

³³ *Id.*; see North Texas Specialty Physicians’ Response to Post-Trial Complaint Counsel’s Proposed Findings of Fact at 17; N. Tex. Specialty Physicians v. F.T.C. 528 F.3d 346 (5th Cir. 2008).

³⁴ HEALTH POLICY STATEMENTS, *supra* note 8, Statement 8 at 91.

³⁵ Letter from Jeffrey W. Brennan, Assistant Dir., Bureau of Competition, FTC, to John J. Miles (Feb. 19, 2002) (hereinafter, FTC Staff Advisory Opinion to MedSouth, Inc.); Letter from David R. Pender, Acting Assistant Dir., Bureau of Competition, FTC, to Clifton E. Johnson & William H. Thompson (Mar. 28, 2006) (hereinafter FTC Staff Advisory Opinion to Suburban Health Organization); Letter from Markus H. Meier, Assistant Dir., Bureau of Competition, FTC, to Christi J. Braun & John J. Miles (Sept. 17, 2007) (hereinafter FTC Staff Advisory Opinion to Greater Rochester Independent Practice Association, Inc. or GRIPA); Letter from Markus H. Meier, Assistant Dir., Bureau of Competition, FTC, to Christi J. Braun (April 13, 2009) (hereinafter FTC Staff Advisory Opinion to TriState Health Partners, Inc.); Letter from Markus H. Meier, Assistant Dir., Bureau of Competition, FTC, to Michael E. Joseph (Feb. 13, 2013) (hereinafter Staff Advisory Opinion to Norman PHO).

proposals, Congressional testimony,³⁶ journal articles,³⁷ a public workshop,³⁸ and numerous speeches.³⁹ The several advisory opinions addressing the indicia of acceptable clinical integration have identified a long list of factors that are considered.⁴⁰ Appraisals of the guidance provided by the FTC is varied. By some accounts, uncertainty surrounding the legal standard has inhibited development of clinically integrated networks.⁴¹ Others question

³⁶ See, e.g., *Antitrust Enforcement in the Health Care Industry: Hearing Before the Subcomm. on Courts and Competition Policy of the H. Comm. on the Judiciary*, 111th Cong. 1 (2010) (statement of Richard A. Feinstein, Dir., Bureau of Competition, Fed. Trade Comm'n).

³⁷ See, e.g., Thomas B. Leary, *The Antitrust Implications of "Clinical Integration": An Analysis of the FTC's Staff Advisory Opinion to MedSouth*, 47 ST. LOUIS U. L. J. 223, 223 (2003); Robert F. Leibenluft & Tracy Weir, *Clinical Integration: Assessing the Issues*, in HEALTH CARE HANDBOOK 2004 (A. Gosfield, ed. 2004).

³⁸ FED. TRADE COMM'N, *Clinical Integration in Health Care: A Check-Up* (May 29, 2008), <http://www.ftc.gov/bc/healthcare/checkup/>.

³⁹ See Miles, *supra* note 30, at 15A:8 n.4 (listing speeches and testimony by government officials).

⁴⁰ John Miles' Treatise lists the following factors contained in most clinically integrated programs:

- (1) a method, preferably electronic, by which providers in the network can exchange information regarding network patients, such as diagnoses, tests, and procedures;
- (2) development of practice protocols, guidelines, or parameters sufficient to improve quality and utilization, sufficient to apply to all medical specialties in the network, and sufficient to cover a large majority of services provided by participants;
- (3) adoption of the protocols by the network's board of directors and dissemination of the protocols to participating providers;
- (4) agreement among the participating providers and between the providers and the network to abide by the protocols;
- (5) development of a methodology and process by which participating providers report their compliance with the protocols to the network;
- (6) development of network goals or benchmarks relating to quality, utilization, efficiency, and cost that the network seeks to achieve and that reflect improvement over current performance;
- (7) review by the network of the individual performance of participating providers under the protocols;
- (8) review by the network of the aggregate performance of the network in relation to the benchmarks;
- (9) a method for identifying participating providers who fail to achieve the network performance goals;
- (10) development and implementation of corrective-action plans for providers failing to achieve the network's goals;
- (11) a program for the network's monitoring of such providers' performance; and
- (12) in the case of physicians who either refuse to abide by the protocols or habitually fail to meet network-performance goals, sanctions, including ultimate expulsion from the network. The ultimate general goal is to generate interdependence among the network providers in the way they provide care.

Miles, *supra* note 30.

⁴¹ See, e.g., Lawrence P. Casalino, *The Federal Trade Commission, Clinical Integration, and the*

whether meaningful clinical integration is likely given the absence of financial incentives and provider reluctance to cede autonomy.⁴²

c. Market Power

Today, market power in hospital and specialty physician markets is a commonplace. Many, perhaps most, provider markets today are characterized by high levels of concentration, and an extraordinary merger and acquisition wave has been underway for some time.⁴³ Lax antitrust enforcement and questionable court decisions fostered an open season for hospital mergers for at least ten years beginning in the mid-1990s.⁴⁴ Likewise, although the FTC challenged numerous cartels posing as messenger model or clinically integrated networks and IPAs, the weak penalties imposed have had little deterrent effect.⁴⁵

Joint ventures examined under antitrust law's "Rule of Reason" will be condemned only if they are likely to have an anticompetitive effect. This inquiry requires courts to find either direct evidence or effect, such as an ex post increase in prices, or market power, which operates as a proxy for effect and shifts the burden to prove a net benefit to competition to defendants. In an attempt to delineate an administrable enforcement standard for reviewing physician networks, the Health Policy Statements established "safety zones"—conditions under which networks will survive agency scrutiny absent any extraordinary circumstances because such arrangements are seen as highly unlikely to have anticompetitive effects. To qualify however, a physician arrangement must be financially integrated;

Organization of Physician Networks, 31 J. HEALTH POL. POL'Y & L. 569, 579 (2006).

⁴² See J. Thomas Rosch, Comm'r, Federal Trade Comm'n, *Clinical Integration in Antitrust: Prospects for the Future*, Prepared Remarks at the Antitrust in Healthcare Conference of the American Bar Association/American Health Lawyers Association (Sept. 27, 2007); Thomas L. Greaney, *Thirty Years of Solicitude: Antitrust Law and Physician Cartels*, 7 HOUS. J. HEALTH L. & POL'Y 189, 192 (2007).

⁴³ See *Health Care Consolidation and Competition after PPACA: Hearing Before the Subcomm. on Intellectual Property, Competition and the Internet of the H. Comm. on the Judiciary*, 113th Cong. (2012) (statement of Thomas L. Greaney, Chester A. Myers Prof. of Law & Dir. of the Ctr. for Health Law Studies, St. Louis Univ. Sch. of Law).

⁴⁴ See *id.*

⁴⁵ See Greaney, *supra* note 42, at 190.

clinically integrated networks are not eligible for safety zone status.⁴⁶ The safety zone thresholds differ based on whether a physician arrangement is exclusive. Exclusive physician arrangements fall within a safety zone if they are financially integrated and constitute 20% or fewer of the physicians in each medical specialty in the relevant market; for nonexclusive networks, the threshold is 30%. Notable exceptions abound however.⁴⁷ The Health Policy Statements disclaim applicability of these thresholds in markets with a few physicians in given specialties⁴⁸ and many staff advisory opinions have given a green light to networks comprised of physician specialists exceeding the thresholds.⁴⁹ Moreover, the safety zones only establish rough benchmarks for identifying concerns about market power. As summarized by one treatise, the Agencies look to several

⁴⁶ Health Policy Statements, *supra* note 8, Statement 8.

⁴⁷ *See id.*

⁴⁸ *Id.* The Statements provide that in markets with fewer than five physicians in a given specialty, an exclusive physician arrangement otherwise qualifying for a safety zone may include one physician from that specialty and still qualify for a safety zone even if it exceeds the 20% threshold. Similarly, in markets with fewer than four physicians in a given specialty, a nonexclusive physician arrangement otherwise qualifying for a safety zone may include one physician from that specialty and still qualify for a safety zone even if it exceeds the 30% threshold.

⁴⁹ The Antitrust Division of the Department of Justice and the FTC have issued favorable letters for a number of risk-sharing physician networks with percentages higher than 30% of the physicians in the relevant market. *See, e.g.*, Letter from Robert Liebenluft, Assistant Director, Bureau of Competition, to William Harvey (May 19, 1998) (approving network arrangement with market percentages of 100% in some physician specialty markets); Letter from Anne K. Bingaman, Assistant Attorney General, Antitrust Div., Dep't of Justice, to George Miron (Dec. 8, 1993) (Dep't of Justice Business Review Letter to California Chiropractic Association having 50%); Letter from Anne K. Bingaman, Assistant Attorney General, Antitrust Div., Dep't of Justice, to John R. Cummins (Oct. 28, 1994) (Dep't of Justice Business Review Letter to Physician Care, Inc.) (approving arrangement with percentages in certain specialties "significantly higher than 30[%]"). Some advisories also justify large participation percentages based on the need to effectively market a network. Letter from Robert Liebenluft, Assistant Director, Bureau of Competition, FTC, to David V. Meany (May 14, 1997). In advisory opinions involving networks using a bona fide "messenger model", *see* 1994 Policy Statements, *supra* note 8, at 94-96, under which individual providers do not agree on or jointly negotiate prices or other significant terms of competition, there is little concerns about participation percentages because physicians are making independent decisions independent of decisions by other network members. *See, e.g.*, Letter from Anne K. Bingaman, Assistant Attorney General, Antitrust Div., Dep't of Justice, to Marc Peterzell (Nov. 3, 1995) (Dep't of Justice Business Review Letter to Georgia Preferred Podiatric Medical Network with 88% eligible).

relevant variables in assessing market power: (1) the network's participation percentages, (2) incentives faced by network physicians, (3) different incentives among network physicians, (4) the number of other networks in the relevant market, (5) the availability of physicians to form competing networks or to contract directly with health plans, and (6) the network's exclusive or nonexclusive operation.⁵⁰

The guidance issued by the Agencies concerning ACOs participating in the Medicare Shared Savings Program ("MSSP") and also serving commercial customers employs criteria that for the most part parallel the guidance contained in the Health Policy Statements and the FTC's advisory opinions. The ACO Statement also establishes "safe harbors" that generally track the Health Policy Statements' "safety zones": ACOs that bring together in a joint venture independent providers that furnish the same service can have no more than 30 percent for each service in each provider's primary service area (PSA).⁵¹ However, the Statement contains several departures from previous guidance concerning physician networks. First, the safe harbor threshold does not vary based on whether the ACO involves exclusive contracting among its physicians.⁵² Moreover, any hospital or ambulatory surgical center within an ACO must be nonexclusive.⁵³ Finally, ACOs meeting CMS's eligibility requirements for participation in the Medicare Shared Savings Program, would qualify for the rule of reason analysis as long as they participate in the program and use the same legal structure and clinical and administrative process used for the MSSP for their private, non-Medicare patients.⁵⁴ However, while the Policy Statement on ACOs adopts the position that the ACO networks that meet the Center for Medicare & Medicaid Services' requirements for participation in the MSSP⁵⁵ are sufficiently integrated,⁵⁶ that assurance

⁵⁰ Miles, *supra* note 30; Health Policy Statements, *supra* note 8, Statement 8.

⁵¹ *Id.* at 67,028.

⁵² *Id.* at 67,029.

⁵³ *Id.* at 67,028-29.

⁵⁴ *Id.* at 67,027.

⁵⁵ The requirements include that the ACO have "(1) a formal legal structure that allows the ACO to receive and distribute payments for shared savings; (2) a leadership and

does not on its face apply to networks engaged in contracting with commercial payors.

d. Exclusivity

Exclusivity can mean several things in the joint venture context. It may refer to limitations placed on the eligibility for membership of the venture. That is, the venture may only admit a certain class or number of members and thus exclude willing participants from joining the network. Less commonly, exclusivity may also refer to the network's commitment to contract exclusively with only one third party payer. These agreements are usually analyzed as "exclusive dealing" arrangements and are for the most part given wide berth under antitrust law.⁵⁷ The third kind of exclusivity agreements which are the subject of analysis in this article are those that bind the members of the joint venture and restrict their ability to join other networks. As described in the Health Policy Statements, a network is "exclusive" if "the network's physician participants are restricted in their ability to, or do not in practice, individually contract or affiliate with other network joint ventures or health plans."⁵⁸ Conversely, the Statements indicate that a network is non-exclusive if "the physician participants in fact do, or are available to, affiliate with other

management structure that includes clinical and administrative processes; (3) processes to promote evidence-based medicine and patient engagement; (4) reporting on quality and cost measures; and (5) coordinated care for beneficiaries." *Id.*

⁵⁶ See ACO Policy Statement, *supra* note 6, at 67,028 ("[T]he Agencies will treat joint negotiations with private payers as reasonably necessary to an ACO's primary purpose of improving health care delivery, and will afford rule of reason treatment to an ACO that meets CMS's eligibility requirements for, and participates in, the Shared Savings Program and uses the same governance and leadership structures and clinical and administrative processes it uses in the Shared Savings Program to serve patients in commercial markets.").

⁵⁷ Excluding providers from a network may enhance the competitive potential of the network. Miles, *supra* note 30, at §13:5 ("Since a primary antitrust concern of joint ventures is over-inclusiveness—that the venture may include too large a percentage of actual or potential competitors and thus obtain too great a degree of market power, exclusion may be procompetitive in that it may induce excluded parties to enter the market independently of the venture and compete against it, perhaps by forming competing joint ventures.").

⁵⁸ Health Policy Statements, *supra* note 8, Statement 8 at 64; SCFC ILC v. Sears, 36 F.3d 958, 972 n.20 (10th Cir. 1994) (citing Justice Department, International Operations Antitrust Enforcement Policy 42 (Nov. 10, 1988) (CCH Supp.)) ("Selectivity in the membership of a joint venture often enhances a joint venture's competitive potential...forcing joint ventures to open membership...would decrease incentives to form joint ventures.").

networks or contract individually with health plans.”⁵⁹

The concept of exclusivity carries with it an explicit or tacit understanding that participating physicians will contract with payers only through that network—that is, refuse to contract directly with payers not approved by the network or join other networks and contract with payers through them. As will be discussed, a network may be deemed “de facto exclusive” for purposes of analyzing the competitive effects of the venture even if the network imposes no contractual obligation on its members and those members simply refuse to contract outside the network. By itself exclusivity does not necessarily impair competition. Indeed it may serve to enhance the efficiency and hence the competitiveness of a network because, as the Health Policy Statements acknowledge, providers committed to a single network are more likely to invest capital, time and effort to the enterprise.⁶⁰

On the other side of the coin, exclusivity can serve to reinforce a network’s ability to exercise market power. Networks with a large proportion of providers in relevant markets can prevent entry of rivals and cement their dominant or oligopolistic market position by denying others the necessary complement of providers. For this reason, a commitment to “nonexclusivity” carries considerable importance in antitrust analyses of physician networks and ACOs. If providers for a given network are willing to join other networks or contract with health plans directly, in theory it would be difficult for that network to exercise market power because it would face competitive alternatives if it raised price to a supra-competitive level. Indeed, even extremely high market shares might be tolerated if “nonexclusivity” were assured.⁶¹ The FTC and Antitrust Division

⁵⁹ Health Policy Statements, *supra* note 8, Statement 8 at 79.

⁶⁰ Health Policy Statements, *supra* note 8, at Statement 9 at 118 n.62 (“[A]n exclusive arrangement may help ensure the . . . network’s ability to serve its subscribers and increase its providers’ incentives to further the interests of the network.”); *see also*, James F. Rill, Assistant Attorney General, Antitrust Div., Antitrust Enforcement Policy and the Treatment of Horizontal Restraints: Lessons for the Health Care Industry, Prepared Remarks Before the National Health Lawyers Association (Feb. 15, 1991) (citing pro-competitive benefits where exclusivity is “needed to demonstrate a commitment to prospective plan members”).

⁶¹ Miles, *supra* note 30, at §15.08 (“In theory, even participation percentages of 100 percent should not cause antitrust concern if the network is actually non-exclusive and thus its physicians can and do negotiate direct contracts with payers. A payer not wishing to

have specifically cited such assurances in approving networks in which the shares of member providers in some relevant markets reached monopoly levels.⁶²

However, whether a network is nonexclusive *in practice* may be hard to determine and assessing the likelihood of exclusivity *ex ante* will be at best an educated guess. The Health Policy Statements list several factors that focus on physician participants' activities rather than on contractual terms: 1) that viable competing networks or managed care plans with adequate physician participation currently exist in the market, 2) that physicians in the network actually individually participate in, or contract with, other networks or managed care plans, or there is other evidence of their willingness and incentive to do so, 3) that physicians in the network earn substantial revenue from other networks or through individual contracts with managed care plans, 4) the absence of any indications of significant de-participation from other networks or managed care plans in the market, and 5) the absence of any indications of coordination among the physicians in the network regarding price or other competitively significant terms of participation in other networks or managed care plans.⁶³ Additionally, the Agencies have stressed that if networks limit or condition physician participants' freedom to contract outside the network in ways that significantly restrict the ability or willingness of a network's physicians to join other networks or contract individually with managed care plans, the network will be considered exclusive for purposes of safety zones.⁶⁴

As a practical matter, providers are likely to be unwilling to contract outside of a network into which they have made significant human and personal commitments. Physicians' investments of time

contract with the network could still obtain sufficient providers and thus the network would lack market powers.”).

⁶² See, e.g., FTC Staff Advisory Opinion to Norman PHO, *supra* note 35 (noting PHO's assurances that participating providers “will remain free to contract independent of Norman PHO with any payer that chooses not to contract with the network,” that the network will “clearly inform” participating providers and payors that the network is nonexclusive and that it will also provide antitrust counseling and training to its participating providers).

⁶³ HEALTH POLICY STATEMENTS, STATEMENT 8 *supra* note 8, at 121.

⁶⁴ *Id.* at 83.

in developing and adopting a network's protocols and technology and familiarizing themselves with referral options for patients are akin to sunk costs that cannot be readily transferred across networks. Further, it may make little strategic sense for doctors to participate in a second network that will only serve to undermine the bargaining power of the dominant or first-mover network to which they belong.⁶⁵ Although the antitrust enforcement agencies have acknowledged these disincentives,⁶⁶ they have frequently allowed networks to proceed where the only assurance of nonexclusivity is a pledge by the network that exclusivity is not expected.⁶⁷

Finally, determining whether a network is in fact exclusive may necessitate careful investigation. That is, a network might employ a number of devices that encourage exclusivity and amount to what a leading antitrust authority calls "quasi-exclusive" arrangements.⁶⁸ For example, a network might prohibit its providers from participating in identical types of networks but not other types of networks or health plans,⁶⁹ or forbid members from accepting offers

⁶⁵ Miles, *supra* note 30, at 15A:9 ("As a practical matter, ...as the network's participation percentages increase, physician members may be less willing to negotiate direct contracts because they realize individually that each is better off if all bargain only through the network. They recognize their interdependence, so each may decide unilaterally, but interdependently, not to contract individually with health plans, forcing health plans to accede to the network's demand for higher reimbursement [C]ooperation of competitors in even a legitimate joint undertaking may dull the incentives of the participants to continue competing vigorously with one another outside the joint venture.")

⁶⁶ See, e.g., HEALTH POLICY STATEMENTS, *supra* note 8, Statement 9 ("[I]f a network includes a large percentage of physicians in a certain market, those physicians may perceive that they are likely to obtain more favorable terms from plans by dealing collectively through one network, rather than as individuals."); see also ROBERT F. LEIBENLUFT, ANTITRUST ISSUES RAISED BY RURAL HEALTH CARE NETWORKS (1998).

⁶⁷ Problems associated with promises of nonexclusivity are discussed *infra* Section III.b. In one business review letter, however, the Justice Department rejected a network's promise of non-exclusivity premised on the fact that physician members had contracted with other managed care companies in the past. Letter from Anne K. Bingaman, Assistant Attorney General, Antitrust Div., Dep't of Justice, to Steven J. Kern & Robert Conroy (Mar. 1, 1996)(noting that "it is necessary to look beyond whether the bylaws and membership agreements are facially nonexclusive, and attempt carefully to determine whether [the network's] members are in fact likely to contract directly with managed care health plans or to participate in competing physician network organizations on competitive terms.").

⁶⁸ Miles, *supra* note 30, at § 15A:9.

⁶⁹ *Id.*; see Letter from Anne K. Bingaman, Assistant Attorney General, Antitrust Div., Dep't of

from other networks accepting capitation payments while those allowing fee-for-service arrangements.⁷⁰ Concerns about these types of arrangements have prompted the Department of Justice to challenge the use of “most favored nations” agreements by large health insurers.⁷¹

e. The Economic Underpinnings of the Legal Standard

So far we’ve seen that the legal standard applicable to physician networks is complex and nuanced. However there is a compelling economic logic to this body of law. The following five principles underlie the economic reasoning of applicable antitrust doctrine:

Provider integration is critical to promoting effective competition and antitrust law encourages joint ventures that entail significant interdependence among members;

Although financial integration is the most efficacious means of ensuring interdependence, meaningful clinical integration can accomplish the same result;

Networks need to acquire an efficient size to capture the benefits of effective integration and serve market demand, but the extent of provider combinations must be cabined so that networks do not acquire market power;

Exclusive contracting by network providers is an important means by which networks can assure efficiency through integration; and

Exclusive contracting by providers in large networks can create barriers to entry, enhance market power and undermine the

Justice, to Steven F. Banghart (Dec. 8, 1994) (Dep’t of Justice Business Review Letter to Chicago and Radiological Network).

⁷⁰ Letter from Robert F. Leibenluft, Assistant Dir., Bureau of Competition, FTC, to Robert C. Norton (Aug. 13, 1998) (FTC Staff Advisory Opinion to eleven neurologists proposing the establishment of an independent practice association (IPA), disapproving the network’s policy allowing providers to participate in networks with capitation arrangements only if it had first declined opportunity to contract with payer). Variations on the theme include an HMO using “gatekeepers” to prohibit its participating physicians from participating in other gatekeeper models, an IPA might prohibit its members from dealing individually with an HMO if the IPA and HMO reach an impasse in their negotiations. Miles, *supra* note 30, at §15A:9.

⁷¹ Complaint, *United States v. Blue Cross Blue Shield of Mich.*, No. 2:10-cv-14155-DPH-MKM (E.D. Mich. 2010); *United States v. Delta Dental*, 943 F.Supp. 172 (D.R.I. 1996).

consumer welfare benefits from integration.

These principles require that legal doctrine and enforcement policies make delicate judgments as to integration, size, and exclusivity. As the following section discusses, despite the sound economic logic underlying the law and the good intentions of the federal agencies, their guidance has failed to produce compliance, transparency, and in some cases, may have undermined competitive market conditions.

III. ENFORCING AN AMBIGUOUS LEGAL STANDARD

To put it mildly, applying the triad of factors driving competitive appraisals of provider networks and ACOs—integration, size, and exclusivity—is not a straightforward task. What has emerged from dozens of enforcement proceedings and other administrative actions (including advisory opinions, policy statements, and speeches) is a set of rather abstruse and, to some extent, conflicting standards. The following section examines the uncertainties arising out of the interplay of these factors.

a. The Tradeoffs Among Integration, Exclusivity and Market Power

As discussed earlier, provider integration is at the heart of antitrust analyses of horizontal joint ventures because of its propensity to yield significant efficiencies otherwise unattainable in the delivery of health care services. A key predictor of a network's integrative potential is its members' commitment of human and financial capital to the enterprise. In its policy statements and reviews of clinically integrated networks, the FTC has repeatedly stressed the need to demonstrate meaningful joint and interdependent efforts to improve quality of care and reduce costs.⁷² The FTC has also recognized that exclusive contracting may enhance networks' abilities to achieve efficiencies by engendering loyalty and

⁷² See, e.g., FTC Staff Advisory Opinion to Norman PHO, *supra* note 35, at 8 (citing standard as evidence of "participating physicians' commitment and motivation—both individually and as a group—to improve quality of care, to reduce costs of care, and to otherwise jointly offer services that payers find to be both attractive and attractively priced").

encouraging dedicated efforts by physician members.⁷³ As discussed above, exclusivity can be a powerful tool when used to enhance the market power of networks. As a result, the agencies have attempted to fashion a standard that permits, or even encourages, exclusive arrangements but only up to the point (measured by the networks' market power) where such arrangements may serve to lessen competition.⁷⁴ These distinctions, though sound in theory, have proven muddled in application.

First, the link between exclusivity and integrative benefits is imprecise. While one may intuit that network exclusivity agreements may foster physicians' "commitment and motivation," there is no economic model that accurately predicts the precise circumstances under which those benefits will be realized. For example, in markets in which physicians are primarily serving payers and employers with fee for service payments, an exclusivity commitment is not likely to carry a significant added impetus to advance the network's goals. Unless a network has strong incentives that counter the incentives to increase volume under fee for service arrangements (e.g. clearly defined and effective clinical protocols, effective monitoring of utilization; and penalties and "deselection" of noncompliant providers), exclusivity adds little to the potential of a network to realize benefits of integration. The research literature suggests that networks must undertake continuing efforts to change the culture and habits of members and the mere existence of network protocols does not contribute to changing physician behavior.⁷⁵ A further

⁷³ See HEALTH POLICY STATEMENTS, *supra* note 8, Statement 9 n. 62 (exclusive arrangements help ensure a "network's ability to serve its subscribers and increase its providers' incentives to further the interests of the network").

⁷⁴ See Health Policy Statements, *supra* note 8, Statement 8 at 79 (delineating stricter participation percentages on exclusive networks than nonexclusive networks); ACO Policy Statement, *supra* note 6, at 67,026 to 67,029 (to qualify for safety zone, hospitals and ambulatory surgery centers must be nonexclusive to the ACO; safety zone inapplicable if ACO includes "dominant provider" with market share greater than 50%, unless provider is nonexclusive to the ACO and does not require plans to contract exclusively with it or prevent plans from contracting with other provider networks). Unlike their statements for physician controlled networks, the Agencies draw no distinction for ACOs regarding safety zones between exclusive and nonexclusive networks.

⁷⁵ See e.g., Michael D. Cabana et al., *Why Don't Physicians Follow Clinical Practice Guidelines? A Framework for Improvement*, 282 J. AM. MED. ASS'N 1458, 1458 (1999) (guidelines have had limited effect on changing physician behavior; see generally Scott D. Danzis, *Revising the*

complication arises with respect to “de facto” exclusive networks discussed earlier.⁷⁶ As participation shares increase, network providers may recognize that it is in their economic self-interest *not* to contract with other networks.⁷⁷ Indeed, as some agency advisory opinions suggest, de facto exclusivity may be a means to forestall development of more cost-effective rival networks.⁷⁸ The most that can be said is that the exclusivity may help bind providers to their networks, but evaluation of a host of other considerations is necessary to evaluate the significance of exclusivity to the network’s efficient operation. And, as the following section discusses, promised “nonexclusivity” does not always assure that network competition will flourish.

Second, the requisites for “sufficient” integration to avoid per se scrutiny are unclear. The FTC’s advisories offer a large number of conditions conducive to effective clinical integration, but no comprehensive retrospective analysis has confirmed the efficacy of those undertakings.⁷⁹ One source of the problem is the inherent

Revised Guidelines: Incentives, Clinically Integrated Physician Networks, and the Antitrust Laws, 97 VA. L. REV. 531 (2001) (summarizing studies); Nikola Biller-Andorno & Thomas H. Lee, *Ethical Physician Incentives—From Carrots and Sticks to Shared Purpose*, 368 NEW ENG. J. MED. 980 (March 14, 2013) (need to address incentives in “psychological and social terms” in order to change physician behavior); see also David A. Davis et al., *Changing Physician Performance: A Systematic Review of the Effect of Continuing Medical Education Strategies*, 274 J. AM. MED. ASS’N 700 (1995) (common methods of CME have little direct impact on improving professional practice).

⁷⁶ See notes 66-74 *supra* and accompanying text.

⁷⁷ See Miles *supra* note 30, at 15A:9 (“physician members may be less willing to negotiate direct contracts because they realize individually each is better off if all bargain only through the network. They recognize their interdependence, so each may decide unilaterally, but interdependently, not to contract with [other] health plans . . .”).

⁷⁸ See, e.g., Letter from Mark J. Horoschak, FTC Bureau of Competition, to Paul W. McVay (July 5, 1994) (noting risks that de facto exclusivity arising from PPO’s sanction by State medical society may forestall development of rival plans); Business Review Letter from Anne Bingaman, Assistant Attorney General, U.S. Dept. of Justice, to Steven J. Kern & Robert J. Conroy (Mar. 1, 1996) (de facto exclusivity may enable supra competitive pricing and inhibit potential competition among plans).

⁷⁹ The FTC undertook a limited follow-up inquiry into the results of the MedSouth network but reported only general conclusions regarding efficiencies flowing from integration based on representations from the network. See Letter from Marcus Meier, Assistant Director, Bureau of Competition, FTC, to John J. Miles (June 18, 2007) (citing MedSouth’s statement that “its efforts at integration appear to be having some success in achieving efficiencies” and that care has “incrementally improved annual” based on community benchmarks).

difficulty in performing reviews of networks' potential to enhance efficiency *ex ante*. Assessing a network's capacity for clinical integration and its likelihood of achieving efficiencies necessarily entails applying some specific indicia of successful integration. The problem, acknowledged by the agencies, is that detailed specification may devolve into a "checklist" and risk "channeling" market behavior instead of encouraging innovation and structures sensitive to the needs of individual markets.⁸⁰ On the other hand, although the agencies have given detailed advice on the meaning of clinical integration, some have expressed concerns that the guidance is insufficient.⁸¹ However, in the absence of empirical evidence regarding effective integration or detailed agency directives, cautious practitioners are likely to rely on the "kitchen sink" list of factors previously approved by the FTC.

Third, the line between permissible and impermissible exclusive provider contracting remains obscure. To begin with, specifying the nature and extent of integration likely to yield meaningful efficiency benefits has been controversial. While most courts and the antitrust agencies have readily assumed that significant financial integration will create interdependence among providers sufficient to assure realization of such efficiencies, whether clinical integration will do the same is questionable. Skeptics emphasize that promises of meaningful change flowing from clinical integration can be chimerical without the network adopting an array of administrative arrangements including effective practice protocols, significant

⁸⁰ Health Policy Statements, Statement 9, *supra* note 8. In the only litigated case involving a physician network, an FTC Administrative Law Judge found the network under review had not undertaken sufficient clinical integration, noting the network did not: engage in case management; provide feedback to physicians concerning patient care; require adherence to its clinical guidelines and protocols; operate or refer patients to any disease management programs or patient registries; or engage in any meaningful patient education. He also found that the network's medical director had no responsibility for controlling costs for patients, its medical management committee did not evaluate the care of patients; its hospital utilization management program does not apply to patients under relevant contracts relevant to claimed clinical integration. *In re North Texas Specialty Physicians*, No. 9312, 2005WL3366980 (F.T.C. 2005) (initial decision), *aff'd*, N. Tex. Specialty Physicians v. FTC, 526 F.3d 346 (5th Cir. 2008).

⁸¹ U.S. GOV'T ACCOUNTABILITY OFFICE, FEDERAL ANTITRUST POLICY, *supra* note 7 (survey indicating divided opinions among expert sources on the adequacy of agency guidance on the meaning of clinical integration).

investments, and strong “rewards and punishments” of participating providers.⁸² The conditions under which exclusivity advances these goals is unclear. To be sure, some guidance can be found in the case law discussing exclusive contracting. For example, in *U.S. Healthcare, Inc. v. Healthsource, Inc.*, the court allowed an HMO to contract exclusively with physicians where there was substantial competition from other physician networks.⁸³ Thus, where there is robust, inter-network competition, exclusivity is unlikely to do any harm. But many questions still remain. How many networks are enough to alleviate concerns about harm to competition? Should qualitative differences among networks play into the analysis of exclusivity? How should the analysis weigh the offsetting power of potential entrants (e.g. the fact that there are a sizeable number of physicians who are not in exclusive networks)?

b. When Should “Non-exclusivity” Justify Large Networks?

As seen in many cases, physician networks comprised of a large percentage of providers in relevant markets have avoided condemnation under the antitrust laws with the promise that the providers will be “nonexclusive” to the network. Likewise, the agencies’ ACO guidelines distinguish between exclusive and nonexclusive arrangements for hospitals and ambulatory surgery centers.⁸⁴ While such commitments have assuaged the agencies’ concerns about the possibility the network would be able to exercise market power, the premises underlying their analysis is questionable.

The standard for testing whether a provider network is truly nonexclusive presents a serious problem of administration. Ex ante assurances that network providers will contract directly with payers

⁸² See, e.g., Rosch, *supra* note 42, at 17 (“[P]art of the reason why clinical integration that passes muster is so hard is because the incentives for physicians to create efficiencies with clinical integration are not nearly as obvious or direct as the incentives with financial integration. Those incentives are what makes financial integration work. If a clinical integration program includes a very strong system of rewards and punishment, I personally think it could be successful I think it is extremely difficult for a physician group to create a strong enough system of rewards and punishment to create the proper incentives for successful clinical integration.”).

⁸³ *U.S. Healthcare, Inc. v. Healthsource, Inc.*, 986 F.2d 589, 596-97 (1st Cir. 1993).

⁸⁴ See ACO Policy Statement, *supra* note 6 and accompanying text.

or other networks may be of little value absent a demonstrated history of such contracting by members. Enforcing *ex post* a network's or ACO's commitment to non-exclusivity would require the agencies and the courts to examine the degree of extra-network contracting actually taking place as well as ongoing attempts by rival networks to solicit contracts from members. Such evaluations would necessitate the agency or the courts to parse the reasons for unsuccessful provider contracting. This, in turn, would require an evaluation of the reasonableness of the proposed contracting terms, including reimbursement levels, administrative requirements, and a host of clinical considerations that may weigh on a member's decision of whether to enter into a contract or not. The myriad uncertainties embedded in such inquiries undermine the reliability of any factual determinations.

For example, consider a situation in which network physicians turn down an offer to join a rival network and the issue arises as to whether the declination reflects *de facto* exclusivity. To answer that question a fact finder would have to determine whether the rival network offered a reasonable reimbursement package to the physicians. That inquiry would likely require an evaluation of a host of factors (e.g., the going reimbursement rate in the particular physician service markets, the nature and cost of compliance with network protocols, and the added administrative costs for physicians joining the network). The complexity of tasks such as this has led courts to express skepticism about their capacity to make sound judgments in comparable antitrust cases. In litigation involving claims that an entity or entities monopolize an "essential facility," plaintiffs have sought injunctive relief mandating that defendants shared access to those facilities to the extent that the plaintiffs needed them in order to compete.⁸⁵ However, courts have been extremely wary of undertaking the complexities of the quintessential regulatory

⁸⁵ See, e.g., *AT&T v. Iowa Utils. Bd.*, 525 U.S. 366, 428 (1999) ("Even the simplest kind of compelled sharing, say, requiring a railroad to share bridges, tunnels or track, means that someone must oversee the terms and conditions of that sharing."); see also *Chicago Prof'l Sports Ltd. v. NBA*, 95 F.3d 593, 597 (7th Cir. 1996) ("[T]he antitrust laws do not deputize district judges as one-man regulatory agencies."); see generally, 3A AREEDA & HOVENCAMP, *supra* note 1, at 224 ("courts are not well equipped to deal with claims" that defendant's price for access is too high).

tasks of assessing the reasonableness of proposed terms for access. Moreover, they have generally sidestepped making detailed rulings governing the terms of compelled sharing.⁸⁶ Indeed, the Supreme Court has expressed skepticism about the essential facility doctrine itself.⁸⁷

The underlying difficulty with the agencies' policy in this area is the inevitable tension between the insistence on non-exclusivity and the rationale for integration. As we have seen, a central element of the analysis of integrative efforts and effects has been the need for close cooperation among providers and indicia of their commitment to the network's undertakings. Requiring problematically overinclusive networks to be nonexclusive seems to turn the tables on this principle. As one FTC Commissioner succinctly put it, "[I]f joint bargaining is necessary, how can the venture tolerate non-exclusivity? Alternatively, if non-exclusivity is tolerable, what does this say about the need for joint bargaining?"⁸⁸

c. Is Price Fixing Necessary? Market Power and Ancillarity

Networks that are financially or clinically integrated must still answer two questions to survive scrutiny under the rule of reason. First, is the agreement to set prices collectively ancillary to, and "reasonably necessary" for the network to achieve its efficiency benefits through integration? Second, is the network too large in each relevant provider market so that it might exercise market power or deter the formation of rival networks? Answering these questions brings us back to the interplay between market power, integration, and exclusivity.

The FTC has addressed the rather ambiguous issue of ancillarity in its several advisory opinions concerning clinically integrated

⁸⁶ See, e.g., *Fishman v. Wirtz*, 807 F.2d 520, 539 (7th Cir. 1986) (finding violation of essential facilities obligation but only awarding damages); *Consol. Gas v. City Gas Co. of Fla.*, 665 F. Supp. 1493, 1527 (D. Fla. 1987) (leaving details of mandated sharing to regulatory agency). See 3A AREEDA & HOVENCAMP, *supra* note 1, at 224 (summarizing cases and concluding "the few decisions that have granted relief never offer detailed directives for dealing.").

⁸⁷ *Verizon Commc'ns Inc. v. Law Offices of Curtis Trinko*, 540 U.S. 398, 407 (2004).

⁸⁸ Leary, *supra* note 37, at 233.

networks.⁸⁹ As a general matter, the need to collectively set prices is satisfied when verifiable risks to the business model of the plan are present. For example, an agreement on physicians' fees may be necessary to discourage free riding or prevent some physicians from taking a disproportionate benefit from the collective efforts of others, or to align incentives to encourage cooperation. Thus the advisory opinions have relied on representations that collective pricing was necessary to assure that all network members would participate in all contracts negotiated, citing a variety of considerations such as the need to offer a consistent network, to maximize the number of patients subject to the agreement, and to assure the complete commitment of providers to the network's development.⁹⁰ This issue, which is the most challenging in ancillary restraints analysis, rests on the supposition that (1) close cohesion is necessary, (2) the only effective avenue for achieving promised efficiencies is for the network to mandate all providers to participate in all contracts and (3) the network must negotiate those contracts for all members. Underlying this analysis however is a complex web of facts regarding the nature and extent of integrative efforts in the network, the expectations of participation and effort of members, and the transaction costs associated with contracting with third party payers and referral arrangements.⁹¹

The second issue, inextricably interrelated with ancillarity

⁸⁹ See note 35 *supra*.

⁹⁰ The FTC summarized the arguments supporting the ancillarity of price setting as follows:

[N]ot having all member physicians participating under all contracts would seriously undermine the ability of the program to function efficiently and achieve its hoped-for benefits; . . . various aspects of the proposed program, which require physicians to cooperate and interact in both their development and implementation, will be far more effective if all physicians are maximally involved because, through joint contracting, they are participating in all payer contracts under the program.

FTC Staff Advisory Opinion to Tri-State Health Partners, Inc., *supra* note 35, at 26-28; *see also* FTC Staff Advisory Opinion to Greater Rochester Independent Practice Association, Inc., *supra* note 35.

⁹¹ *See* FTC Staff Advisory Opinion to Tri-State Health Partners, *supra* note 35, at 18-19, 23 (listing costs and inefficiencies for networks lacking uniform participation and reciting benefits of joint contracting); FTC Staff Advisory Opinion to GRIPA Advisory Opinion, *supra* note 35.

analysis and exclusivity, is the core problem of network affiliation: market power. That is, is the network or ACO “overinclusive” so that it will be able to exercise power over prices or inhibit the development of rival networks? Thus a network that has demonstrated meaningful integration and that price and other ancillary agreements are necessary, still may run afoul of the law if it is overinclusive. Clearly, the need to assure cohesion, loyalty and commitment of network members, which underlie the ancillarity showing, is in tension with establishing that a network’s high participation percentages do not evidence potential market power. Thus, the stronger the showing of ancillarity, the greater the danger of market power, because members are less likely to join rival networks, and even if they do, they will not be devoted wholeheartedly to its efforts.

Moreover, the criteria for establishing competitive risks arising from market power further complicate the analysis. As previously discussed, safety zones and safe harbors establish rough benchmarks for identifying possible market power concerns and various factors—such as the nature of the incentives faced by network physicians, the number of other networks in the relevant market, the availability of physicians to form competing networks or to contract directly with health plans and the network’s exclusive or nonexclusive operation—are all relevant to assessing the potential to exercise market power.⁹² However, it is far from clear how these standards are applied in practice or whether they are even followed by enforcers or practitioners. Discussions of market power in the FTC’s advisory opinions are often based exclusively on the requestor’s factual representations about participation percentages and typically avoid drawing specific conclusions.⁹³ While it has challenged a large number of networks for price fixing and settled all but one by consent decree, the FTC has not been put to the test of proving a network is overinclusive under the rule of reason.⁹⁴ Indeed, the

⁹² See Health Policy Statements, *supra* note 8, at Statement 8.

⁹³ See, e.g., FTC Staff Advisory Opinion to Norman PHO, *supra* note 35 (finding PHO not likely to have substantial anticompetitive effects despite failure to identify or measure market power based on promises of nonexclusivity).

⁹⁴ See *N. Tex. Specialty Physicians v. F.T.C.*, 528 F.3d 346 (5th Cir. 2008).

absence of challenges to risk sharing or legitimate clinically integrated joint venture networks in the face of extensive integrative activity in the last two years may reflect excessive caution by the agencies or a preference to “wait and see” as the delivery system evolves after health care reform.

Measuring market power raises a host of difficult problems in evaluating network joint ventures and ACOs. The number of doctors in a network as a measure of market power is an imperfect proxy. As one FTC Commissioner has observed, “there is a question whether it is useful to assign shares by counting doctors. If there are qualitative differences between the doctors in the venture and those outside—and there well might be if the clinical integration is successful—shares measured by headcount do not accurately reflect the real competitive significance of the venture.”⁹⁵ More accurate measures, such as output, outcomes, or volume of procedures, are all but impossible to obtain. Further, where ex-post price increases by networks reflect improved quality, is inappropriate to assign causality to market power. Finally, a network may have market power in only a subset of all the product markets in which it offers services. For example, it may exceed acceptable market share thresholds in a few specialty services, but otherwise not demonstrate overinclusive physician membership. In such cases, the ability of the network to bargain for supra-competitive reimbursement may be limited.

The dynamic nature of the market has been cited to support contentions that the initial market participation shares are not a reliable indicator of a network’s potential market power. Several proposed clinically integrated networks with memberships far exceeding Agency safe harbors have attempted to justify large market shares by contending that membership attrition will naturally occur as the network refines its methodologies and requirements. Without endorsing this argument, FTC advisory opinions have nevertheless noted this possibility in approving some networks without explaining why membership should be expected to decline.⁹⁶ It is, of course, curious to give credence to a network’s promise that

⁹⁵ Leary, *supra* note 37, at 230.

⁹⁶ See, e.g., FTC Staff Advisory Opinion to Norman PHO, *supra* note 35.

members will likely withdraw in the future. As one FTC Commissioner noted, given a network's claim that its clinical integration will result in better care and provide it with a competitive advantage, "you would think the venture would attract more members and grow larger if this prediction held true."⁹⁷

In sum, while coordinated pricing is probably reasonably necessary to enable networks to achieve the benefits of integration, it should not trump the risk of harm associated with market power of overinclusive networks. Yet, as we have seen, identifying the point at which market power poses risks of monopolistic or oligopolistic pricing is far from straightforward. In such circumstances economic analysis must yield to administrative judgments (or guesses) about the trajectory of market developments. With virtually no case law existing despite years of government enforcement, the "law" regarding network and ACO contracting must be derived from policy statements and the settlement provisions of consent orders. Hence the agencies' policy preferences play a central role in guiding the development of such arrangements.

IV. ADMINISTERING COMPETITION POLICY

Not surprisingly, the "tangled web" of issues underlying legal doctrine described in this article—integration, market power and exclusivity—has given rise to considerable uncertainty in the private sector. With respect to compliance, uncertainty can cut two ways: it can result in over-deterrence in the sense that providers are reluctant to undertake procompetitive arrangements, or it can cause under-deterrence, meaning providers will form over-inclusive networks that have the power to charge supra competitive prices and inhibit formation of rivalrous networks or ACOs. While empirical evidence is lacking, there are several reasons to think the latter scenario is more likely to occur.

Since the early 1990s, the FTC and DOJ have relied on regulatory modes of enforcement in health care. Using policy statements, negotiated consent decrees, advisory opinions and speeches, the agencies have adopted a rule-oriented approach that aims to

⁹⁷ Leary, *supra* note 37, at 230.

encourage compliance and articulate policy in rapidly evolving markets.⁹⁸ At the same time, wary of adopting an overly prescriptive approach, the agencies' directives remain shrouded by ambiguities inherent in issuing nonbinding statements and employing standards that direct attorneys to perform vague "balancing" analyses in advising clients. The agencies have gone to great lengths to avoid the prescriptive approach and have not imposed strong remedies in cases involving overly inclusive joint ventures. Despite having issued over thirty advisory opinions and business review letters⁹⁹ and having initiated over forty enforcement actions in the last ten years involving physician networks, IPAs, PHOs and other arrangements,¹⁰⁰ the agencies have stopped short of requiring structural relief. Instead, the FTC's consent orders have generally imposed "conduct" relief, prohibiting collective negotiations, refusals to deal, and improper exchanges of information.¹⁰¹ Structural relief, in the form of orders of dissolution or placing limitations on the percentage of participating physicians, has been rare.¹⁰²

Moreover, in reviewing proposed conduct, the FTC has exhibited extraordinary deference, allowing large networks to pass muster with little guarantee that market power will not be exercised. Indeed the agencies have not challenged any legitimately integrated network under the rule of reason based on over inclusiveness. In its most recent advisory opinion, the FTC staff concluded it had no present

⁹⁸ See Thomas L. Greaney, *Regulating for Efficiency in Health Care Through the Antitrust Laws*, 1995 UTAH L. REV. 465, at 465 (1995); E. Thomas Sullivan, *The Antitrust Division as a Regulatory Agency: Antitrust Policy in Transition*, 64 WASH. U. L. REV. 997 (1986); Jon Leibowitz, Comm'r, Fed. Trade Comm'n, Health Care and the FTC: The Agency as Prosecutor and Policy Wonk, Remarks at the Antitrust in HealthCare Conference of the American Bar Association/American Health Lawyers Association (May 12, 2005), available at <http://www.ftc.gov/speeches/leibowitz/050512healthcare.pdf>.

⁹⁹ See Greaney, *supra* note 42.

¹⁰⁰ Miles *supra* note 30 at 15A-3; See also Greaney, *supra* note 42.

¹⁰¹ See Miles *supra* note 30 at §15.08.

¹⁰² See *In the Matter of Surgical Specialists of Yakima*, (Sept. 24, 2003)(consent order requiring entity that bargained on behalf of two independent surgical groups revoke the membership of one of the two groups). See also *In the Matter of Renown Health* (Nov. 30, 2012) (consent order resolving challenge to hospital's acquisition of cardiology practices by agreement to release physicians from noncompete contract clauses). <http://www.ftc.gov/sites/default/files/documents/cases/2003/11/031118do0210242.pdf>.

intention of recommending an enforcement action against the Norman Oklahoma PHO or its participating providers.¹⁰³ The Norman PHO, which had previously used “messenger model” contracting, proposed to develop a clinically integrated program. Notably, the FTC did not conduct an independent investigation of market concentration, acknowledged that the PHO had failed to provide direct evidence of the actual efficiencies or procompetitive effects, and noted the requestor’s prediction that prices would increase as a result of the start-up costs of the network.¹⁰⁴ Nevertheless, the agency contented itself with promises that PHO providers would participate on a nonexclusive basis and that the PHO would counsel participating providers about the antitrust concerns associated with concerted refusals to deal and concluded that the program appeared likely, on balance, to be precompetitive or competitively neutral.

Antitrust oversight of ACO development has also recently assumed a laissez-faire approach. Although the Agencies initially played an important role in the development of the Medicare Shared Savings Program,¹⁰⁵ antitrust oversight seems to have waned as the Agencies have given no indication that they are actively reviewing the formation or performance of ACOs despite their rapid development over the last two years.¹⁰⁶ As noted earlier, the CMS Final Rule and the joint FTC—Department of Justice Final Statement backed away from requiring mandatory reviews of proposed MSSP ACOs, offering instead to provide “expedited voluntary” reviews of antitrust for requesting parties.¹⁰⁷ As of this writing, the Agencies have received only two requests for voluntary reviews and have

¹⁰³ FTC Staff Advisory Opinion to Norman PHO, *supra* note 35.

¹⁰⁴ *Id.* at 2, 36.

¹⁰⁵ See Thomas L. Greaney, *Regulators as Market-Makers: Accountable Care Organizations and Competition Policy*, 46 *Az. St. L. J.* 1 (2014).

¹⁰⁶ See MATTHEW PETERSON ET AL., LEAVITT PARTNERS, GROWTH AND DISPERSION OF ACCOUNTABLE CARE ORGANIZATIONS: AUGUST 2013 UPDATE, <http://leavittpartners.com/wp-content/uploads/2013/11/Growth-and-Dispersion-of-ACOs-August-2013.pdf> (survey tracking 488 ACOs in existence as of July 2013, 253 of which participate in the Medicare Shared Service Program; 55 MSSP ACOs also participate in commercial ACO arrangements).

¹⁰⁷ ACO Policy Statement, *supra* note 6.

provided no significant information about any investigations, enforcement efforts, or policies.¹⁰⁸

A plausible defense for this light-handed approach to ACO and network formation might be advanced in view of the alternatives. The Agencies have devoted considerable resources with some success to reviewing and challenging hospital mergers and, more recently, acquisitions of physician practices by hospitals and combinations of physician practices.¹⁰⁹ From the perspective of competition policy, joint ventures are regarded as somewhat less troublesome than mergers because they are less permanent and easier to unwind. The district court in Idaho analyzing a horizontal combination of primary physician practices has cited the possibility of contractual integration as a basis for rejecting claimed efficiencies from the merger.¹¹⁰ Countenancing intermediate forms of integration may also be rationalized as serving to help providers ascend learning curves and develop efficiencies that require time and experimentation. Thus, seen as a short term strategy, the policy might enable the development of more vigorous and sustainable integrated entities.

¹⁰⁸ A joint working group of the antitrust enforcement agencies published a remarkably uninformative summary of their activities between 2011 and 2013 and a list of thirty-three questions and responses regarding ACOs. Other than providing some guidance on calculating market concentration shares, the documents contain no substantive discussion of antitrust policy regarding ACOs or of investigative activities undertaken by the Agencies. FTC/DEPARTMENT OF JUSTICE ACO WORKING GROUP, SUMMARY OF ACTIVITIES FOLLOWING ISSUANCE OF THE STATEMENT OF ANITRUST ENFORCEMENT POLICY REGARDING ACCOUNTABLE CARE ORGANIZATIONS PARTICIPATING IN THE MEDICARE SHARED SAVINGS PROGRAM, *available at* http://www.justice.gov/atr/public/health_care/295587a.pdf (last visited June 24, 2014); INDEX OF QUESTIONS AND ANSWERS RECEIVED IN THE PSA SHARE CALCULATION ELECTRONIC MAILBOX ESTABLISHED UNDER THE ACO POLICY STATEMENT (Mar. 21, 2013), *available at* http://www.justice.gov/atr/public/health_care/295587.pdf.

¹⁰⁹ *E.g.*, *St. Alphonsus Med. Cntr.-Nampa v. St. Luke's Health Center*, __ F.Supp. 3d __ (D. Idaho 2014); *ProMedica Health Syst. v. FTC*, F.3d. (6th Cir. 2014); In the Matter of Renown Health, FTC Dkt. No. Docket No. C-4366 (December 4, 2012), *available at* www.ftc.gov/enforcement/cases-proceedings/1110101/renown-health-matter; *see generally*, Robert Pear, *As Health Law Spurs Mergers, Risks Are Seen*, N.Y. TIMES (Nov. 21, 2010) at A1; Julie Creswell & Reed Abelson, *New Laws and Rising Costs Create a Surge of Supersizing Hospitals*, N.Y. Times (Aug. 12, 2013).

¹¹⁰ *St. Alphonsus Med. Cntr.-Nampa and FTC v. St. Luke's Health Center*, __ F.Supp. 3d __ (D. Idaho 2014) (“[W]hile employing physicians is one way to put together a unified and committed team of physicians, it is not the only way. The same efficiencies have been demonstrated with groups of independent physicians.”).

Yet this strategy carries its own risks. Excessive provider concentration is likely to stiffen resistance to cost-cutting which in turn could ultimately undermine confidence in the competition framework on which the ACA is predicated. Indeed, proposals for rate regulation and reference pricing have been advanced for dealing with markets in which dominant hospitals prove resistant to pressures to lower cost.¹¹¹ Moreover, the assumption that joint ventures might prove to be a safety valve to inhibit the spread of anticompetitive mergers is questionable. The development of pathways and agreed upon clinical and administrative seems more likely to cement provider relationships and reduce incentives to incur transaction costs and uncertainty of dealing with alternative arrangements.

V. CONCLUSION AND RECOMMENDATIONS

While the caution historically exercised by the agencies in confronting head-on the issues of market power and exclusivity may have been justified in order to encourage integration, a reordering of antitrust enforcement policy may now be in order. First, with integration proceeding apace, antitrust enforcers should reconsider their willingness to rely on promises of nonexclusivity and instead insist on evidence of effective, extant competition among networks before allowing wide departures from market share standards suggested by their network and ACO policy statements. Second, clearer guidance on market power is needed. The agencies should clarify the circumstances under which either unilateral (monopoly) or coordinated (oligopoly) effects may be presumed from market structure. Again, firm evidence of actual or potential network rivalry should be required to offset significant market shares. At the same time, blunt measures of market power based on concentration should be qualified in certain circumstances. In particular, specific guidance and perhaps new safe harbors are needed for rural markets that cannot accommodate competition because of minimum efficient scale considerations. Further, advisory opinions and consent agreements

¹¹¹ See e.g., Catalyst for Payment Reform, *Ensuring Competitive Markets for Health Care Services*, available at <http://www.catalyzepaymentreform.org/images/documents/Competition.pdf>.

should contain commitments for periodic disclosures of specific quality and cost data, and the agencies should formalize ex-post reviews of market impact of networks and ACOs.¹¹² Finally, effective and ongoing oversight of concentrative networks and ACOs is hampered by the absence of preclearance procedures and interagency sharing of clinical and cost data on existing arrangements.¹¹³ A short-form version of pre-merger analysis could provide an efficient means to screen ventures at an early stage to resolve uncertainties that likely distort decisions in the market. In this instance, a dose of preemptive regulation might advance the cause of ensuring effective competition.

¹¹² Health policy analysts have concluded that antitrust reviews of clinically integrated networks cannot meaningfully assess quality and cost impacts without an ongoing production of data. *See* Engelberg Center for Health Care Reform at Brookings, *BENDING THE CURVE, PERSON-CENTERED HEALTH CARE REFORM: A FRAMEWORK FOR IMPROVING CARE AND SLOWING HEALTH CARE COST GROWTH* 30 (recommending use of “timely, comparable set of quality and cost measures at the patient and population level as an important consideration for [antitrust] enforcement” regarding clinically integrated networks and large integrated delivery systems).

¹¹³ A similar clearance procedure was anticipated under the CMS ACO rulemaking, but subsequently abandoned because of perceived violation of administrative law requirements regarding subdelegation issues under the Administrative Procedures Act. *See* Greaney, *supra* note 105.