The Steering Committee is interested in forming a clinically integrated network to better deliver care, achieve economies of scale, and better position themselves in the relevant markets. The purpose of this memorandum is to briefly outline the antitrust issues inherent in forming such a clinically integrated network.

General Antitrust Considerations

General Prohibition Against Price-Fixing Agreements. Unless an exemption or exception applies, agreements among competing individuals or entities regarding any aspect of price – including the setting of maximum or minimum prices, adopting joint negotiation strategies, exchanging price information, and developing joint fee schedules or price terms – is automatically illegal under the antitrust laws regardless of the size of the competitors involved, their innocent intent, or whether and to what extent competition is adversely affected..[1]

General Prohibition Against Allocating the Market. Similarly, absent an exemption or exception, agreement among competing individuals or entities to divide or allocate customers or markets between them also is automatically illegal under the antitrust laws regardless of the size of the competitors involved, their innocent intent, or whether and to what extent competition is adversely affected.[2]

General Prohibition Against Boycotts or Concerted Refusal to Deal. Agreements among competitors not to deal with other competitors, customers, or suppliers may also violate

[1] *See, e.g., Arizona v. Maricopa County Med. Soc'y*, 457 U.S. 332 (1982); *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150 (1940); *United States v. Trenton Potteries Co.*, 27 U.S. 392 (1927).
[2] *See Addyston Pipe & Steel Co. v. United States*, 175 U.S. 211 (1899); .*United States v. Bluefield Regional Med. Ctr*., 2005 WL 3299362 (S.D. W.Va. 2005). *State of Florida v. HCA, Inc.*, 2002 WL 32116840 (M.D. Fla. 2002).

the antitrust laws.[3] For example, competitors cannot come together and act collectively to resist entry of managed care programs into a community.[4]

Actions The Steering CommiteeCan Take

Independent Practice Associations. In general, agreements among two or more competing health care providers on the prices they are going to charge for their services are *automatically* illegal without regard to the providers' market power, market impact, or reasons for entering into the agreement. If, however, the competing providers form and operate a legitimate joint venture – such as an independent practice association – then agreements between them regarding price negotiations with payers, territories, customers, or payers are evaluated under the more lenient antitrust rule of reason.

To be considered a legitimate joint venture there must be financial or clinical integration involving the members, and the alleged anticompetitive agreement at issue must be reasonably necessary to accomplish the pro-competitive benefits of the venture. If these conditions are met, the rule of reason evaluates whether the agreement is likely to have substantial anticompetitive effects and, if so, whether the agreement's potential pro-competitive efficiencies are likely to outweigh those effects.

The Financial Integration Model. The federal antitrust enforcement agencies have repeatedly stated that health care providers involved in a venture can demonstrate satisfactory financial integration by, among other things, the venture members using capitation payments or significant financial incentives to achieve specified cost-containment goals. The federal antitrust

[3] *See United States v. General Motors Corp*., 384 U.S. 127 (1966); *Klor's, Inc. v. Broadway-Hale Stores, Inc*., 359 U.S. 207 (1959).
[4] *See American Med. Ass'n v. United States*, 317 U.S. 519 (1943); *In re Eugene M. Addison, M.D*., 111 F.T.C. 339 (1988)

enforcement agencies have also stated that health care provider joint ventures that do not involve the sharing of substantial financial risk may involve sufficient clinical integration to demonstrate that the venture is likely to produce significant economic efficiencies, and thereby not be considered automatically unlawful.

The Clinical Integration Model. According to the federal antitrust enforcement agencies, clinical integration can be evidenced by the network implementing an active and ongoing program to evaluate and modify practice patterns by the network's participants and create a high degree of interdependence and cooperation among the providers to control costs and ensure quality. Recommended features of an acceptable clinical integration model 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 providers who are likely to further these efficiency objections; and (3) the significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies.

Based on our initial review of the Steering Committee's proposed concept, we believe that a clinical integration model can be established which would, if properly implemented and maintained, would provide sufficient clinical integration to pass muster under the antitrust laws. Moving forward, it is vitally important that care be taken in the design of the governance, operational, and managed care contracting structures to ensure that the clinical integration model continues to pass muster under the antitrust laws and has a reasonable and substantial likelihood of success. Some important considerations are listed below.

The governance and operational structure of the venture must be designed to ensure that all venture members have a sufficient economic and time investment in the venture so as to "buy in" to its success. This is an important consideration, because the antitrust enforcement agencies recognize that the more investment that network participants have in a venture, the more likely they are to want it to succeed, and therefore the more willing they are to do the things that make the venture's clinical integration succeed.

Second, a key concern of the antitrust enforcement agencies is that the venture members will use the price and other information they obtain as participants in the venture to enter into anticompetitive arrangements outside of the venture. The agencies don't want the collaboration inside the venture to "spill over" outside the venture. To ensure this will not occur, it is important that safeguards are put into place to ensure that data and pricing information is kept confidential, and that access to this important information by venture participants is limited to what is reasonably needed to operate the venture. Also, consideration should be given to having the venture's managed care contracting being done by an employee of the Network who otherwise is unaffiliated with any of the network participants.

The following is a summary list of future tasks that we believe should be undertaken by counsel with regard to the antitrust issues while the clinical integration model is being designed, implemented, and put into operation: (1) Undertake analysis of relevant market to confirm that the clinically integrated venture will not be able to exercise undue or inappropriate market power; (2) participate in drafting of the venture's creation and governance documents to ensure they maximize success of the clinical integration model and avoid antitrust issues; (3) participate in the initial round of the managed care contracting process undertaken by the venture to

minimize antitrust risk; and (4) design antitrust compliance plan to ensure that, when the clinical integration model becomes operational, antitrust risk is minimized.

The Messenger Model. If the Network IPA is neither financially nor clinically integrated, then the only way that Association members legally can undertake joint negotiations regarding managed care contracting is through a messenger model arrangement. A messenger-arrangement network serves as a conduit for transmitting price offers and contracting decisions back and forth between payers and the network's individual members. An IPA implements a messenger arrangement to prevent any agreements about prices (or other competitively sensitive terms) among competing network providers through the network. Rather, all competing providers determine the prices they will accept from payers individually.

In the simplest messenger model format, the messenger is typically an employee of the network or an independent third party. The messenger should not be one of the providers or one of the providers' employees.

The messenger receives contract offers from payers and then transmits the offers to each IPA network provider individually. When doing so, the messenger may not negotiate prices with either the providers or payers, disclose the prices of any providers to competing providers, indicate to providers whether other providers plan to accept or reject particular offers, or recommend to providers whether to accept or reject particular offers. The messenger must transmit all offers received from payer's to providers, regardless of the messenger's judgment about the acceptability of the offered reimbursement.

The messenger also may present objective, factual information, even with respect to fees, to both payers and IPA network providers to aid their decision-making. The messenger may

suggest to payers where they might obtain fee information to use in developing fee offers to IPA network providers. But the messenger should not suggest to the payer what fee schedules would be "acceptable" or "unacceptable" to network participants.

Once the messenger conveys a payer's offer to the individual IPA providers, each provider then decides unilaterally whether to accept the offer, reject it, or make a counteroffer. Once there is an accepted offer, the provider may contract with the payer individually, or the IPA may enter into a contract with the payer on behalf of those providers who accepted the payer's offers.

In a more complex messenger model, the messenger obtains from each provider on a periodic basis the minimum fees or fee ranges each provider will accept. The messenger then synthesizes these into a document that shows the payer the number or percentage of network providers that would accept certain fee levels.

This process typically results in a "standing offer," "single contract" model, in which IPA providers individually authorize the messenger to contract with payers on their behalf if the payer's offer is equal to or higher than the minimum fee the provider has told the network it will accept.

Under this model, the messenger need not messenger all payer offers to IPA members. If the payer's offer is less than the acceptable fees provided to the messenger individually by providers, the messenger may then transmit the payer's offer to those provider members for their individual acceptance or rejection, or counteroffer. Providers may specify that their standing offers will be effective for a fixed time period so the messenger need not obtain new acceptable fees for every potential contract.

In a variant of this model, the messenger might obtain from each provider individually a schedule of fees acceptable to it (based, for example, on CPT codes) and then obtain a fee schedule of offers from the payer. The messenger compares the fee schedules and then contracts with the payer on behalf of all physicians whose fee schedules for some percentage of all CPT codes on the schedules (75%, for example) are equal to or less than the payer's fee schedule.

A review of the pronouncements of the various antitrust enforcement agencies, as well as the relevant case law, reveals what conduct is prohibited for a messenger model to undertake.

For example, the messenger cannot obtain standing-offer prices from providers, negotiate the best prices it can with the payer, and then "messenger" those prices to each provider member for his or her individual acceptance or rejection. As the federal antitrust enforcement agencies explain, in this case, "[t]he participants' joint negotiation through a common agent confronts the payer with the combined bargaining power of the [network] participants, even though they ultimately have to agree individually to the contract negotiated on their behalf."

Other highly problematic activities for a network to undertake when implementing a messenger model include: (1) The IPA polling its members about the fees members would find acceptable and then using this information in discussions with payers. (2) The IPA refusing to messenger payer offers that the network's staff believes are too low. (3) A requirement that the IPA's contracting (or similar) committee recommend acceptance or rejection of the offer before it can be messengered. (4) A requirement that the IPA board of directors approve the payer's offer before it can be messengered. (5) The IPA's use of contract parameters or fee guidelines in discussions with payers. (6) The IPA encouraging its members not to contract with payers directly or through other networks. (7) The IPA threatening to terminate contracts or not to

contract with payers if particular fee-related demands are not met. (8) The IPA bragging about its success in increasing reimbursement. (9) The IPA using powers of attorney by which participating providers appoint the network as their agent for dealing with payers.

In sum, as a general rule, messenger-arrangement networks should messenger all offers they receive. Narrow exceptions do exist, but the rationale cannot be to increase the level of the payer's offer. For example, an IPA need not messenger offers from payers who refuse to pay the IPA's access fee or refuse to provide clear and complete offers. But the IPA should develop clear written guidelines covering situations in which it will not messenger offers, and these guidelines should be applied consistently and in a non-discriminatory fashion to all payers.

Please also take note that messenger arrangements can raise a host of practical problems in addition to legal issues. They are usually administratively burdensome and cumbersome to operate, especially if manual, rather than electronic, means are used to keep track of offers, acceptances, rejections, counteroffers, and the potentially differing prices of a large number of participating providers. In addition, the offer and counteroffer process that often ensues can take long periods of time before a provider panel is established.

Related to that, neither the providers or customers know, until the end of the process, which providers will be in, or out of, the network. Payers used to dealing with networks using a fee schedule can become frustrated when they find it difficult to contract with a particular practice they want because they and that practice cannot agree on terms. In some cases, the customer blames the IPA for not "forcing" the provider to participate, which a messenger-arrangement IPA cannot do. Related to that, there may be different panels of providers for different payers, and the physicians left out of particular panels will tend to blame the IPA and its

staff rather than their own failure to accept or submit an offer the payer finds acceptable. In addition, a participating physician may discover that physicians providing referrals, physicians to whom he or she referred, or physicians who had been providing coverage are not participating in a particular contract or with a particular payer