UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

Bureau of Competition
Health Care Services & Products Division

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March 28, 2006

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Indianapolis, Indiana 46282

Re: FTC Staff Advisory Opinion Concerning Suburban Health Organization, Inc.

Dear Messrs. Johnson and Thompson:

You have requested a staff advisory opinion concerning the antitrust implications of a proposal by Suburban Health Organization, Inc. (hereinafter "SHO"), to undertake a program involving partial integration among eight independent SHO member hospitals and the 192 primary care physicians that, in total, they employ (the "program"). You have asked whether the staff would recommend that the Commission challenge joint negotiation by SHO with payors regarding the fees to be charged for those physicians' services provided under the program.

This advisory opinion is based on the information that you have provided to us in an initial submission, in a telephone conference with you and SHO's President and CEO, and in your responses to two requests for additional information. All references to facts regarding the program are based on your representations; we have not conducted an independent investigation, or otherwise verified the information that you provided.

We believe that SHO's program involves some integration among its hospital participants that has the potential to generate efficiencies in the provision of physician services, but also that the integration and potential efficiency benefits appear to be significantly limited. Further, the program's competitive restraints do not appear to be reasonably necessary in order to achieve its potential efficiencies, and therefore would unnecessarily eliminate competition. Accordingly, we believe that the program's restraints would not be permissible under the antitrust laws. Our analysis is set forth below.

Description of SHO

SHO is an Indiana non-profit corporation formed in 1994 to undertake risk-based contracts with health plans and other payors of health care services, such as self-insured employers. SHO functions as a "super-PHO" (physician-hospital organization), consisting of seven local PHOs in the Indianapolis area, each affiliated with a local hospital, and one multi-facility health system.[1] The seven PHOs involve

community hospitals, including one osteopathic hospital in Indianapolis and six county hospitals, each in a different "collar" county surrounding Indianapolis.[2] The multi-facility health system, St. Vincent Health, Inc., is affiliated with St. Vincent Hospital and Health Center, Inc., a tertiary care medical center.[3]

The eight SHO member hospitals together employ a total of 192 primary care physicians,[4] who generally practice medicine within their respective hospitals' primary service areas. SHO states "there is very little overlap" between any pairing of SHO's member community hospitals' employed physicians, but SHO does not claim that the physicians involved in the program ("participating physicians") are not competitors for antitrust purposes. This may be because St. Vincent's employed primary care physicians – constituting about 45% of all the physicians in the program – are located in several areas served by other SHO member hospitals and their employed primary care physicians, and thus appear to be competitors of those physicians.

SHO is governed by a sixteen-person board of directors, and currently has a staff of 45 full-time equivalents, and an annual operating budget of $7.9 million.[5] It currently has two risk-based contracts, covering about 41,000 lives, with an estimated $116 million in annual capitation revenue. SHO has "facilitated" seven non-risk contracts between payors and physicians using a "messenger model," and states that it also "coordinates quality improvement initiatives for all covered lives," and "provides physician support services and shared administrative services."

SHO's Proposed Program

SHO proposes to adopt a program – which it refers to as a "clinical integration program"[6] – to promote the quality and efficiency of care provided by the program's hospital-employed participating physicians. If the program is successful, SHO anticipates "encourag[ing] additional contracting physicians to participate so that SHO will be a competitive alternative network in this new environment." However, SHO has not asked us to analyze its proposal as a first step in a broader program to provide physician services and, accordingly, we have not done so.

SHO states that its proposed program consists of four "interrelated components:"

(i) medical management activities, which will include monitoring patients to identify specific diseases and conditions that require special attention, and adopting and disseminating practice guidelines and medical management protocols for those diseases to participating physicians;

(ii) quality management programs, which will measure compliance with the guidelines and protocols, assess quality outcomes to evaluate the effectiveness of the care processes, and identify necessary changes to improve the system;[7]

(iii) practice support, which "involves the distribution to individual physician practices of the educational resources, practice guidelines and outcomes data needed to enhance professional practice patterns," with explanation of the materials provided to physicians by SHO staff. This function also will include credentialing physicians in accordance with National Committee for Quality Assurance guidelines; and

(iv) a physician incentive plan, which is intended to "encourage active participation and to reward physician compliance" in the program, and will "reward . . . physicians based on both individual and group performance." If the participating physicians meet certain quality management targets, they each could receive up to an additional 5% of their compensation from an incentive pool funded by the SHO hospitals, half of which would be based on total group performance, and half

on the physician's individual performance.[8]

SHO's program also will include efforts to educate patients, and to prevent disease and encourage healthy lifestyles, for example through smoking cessation and diet control programs, weight loss and exercise interventions, and promoting immunizations. It also will employ case management of specific patients with certain conditions, such as diabetes and asthma. These activities seek to reduce the incidence of avoidable medical interventions and their attendant costs.

The program will use web-based technology to deliver and track information. SHO will extensively program and customize "technology platforms" that it already uses for its current risk business.[9] Implementation of these systems will take 18 to 24 months. Pending full deployment of this web-based system, SHO will use "more traditional means" of collecting data, tracking physician performance, and educating participating physicians, such as medical records review, claims form analysis, and verbal and written communications with physicians.

SHO estimates that initial investment for the program will be $75,000 to $100,000 over two years, plus salaries for new personnel for data support, program initiatives, pharmacy management, and administration over the same period, at an estimated annual cost of $300,000.

SHO's Requested Opinion

SHO has asked for an advisory opinion whether the Commission Staff would recommend a challenge under either the *per se* or rule of reason standard to SHO's proposed collective negotiation of contracts with payors, including uniform fees, on behalf of the eight SHO hospitals that are participating in the proposed program, regarding the services of their combined 192 employed primary care physicians.[10] SHO states we should assume that "SHO will be the employed-physicians' exclusive agent for negotiating non-risk contracts with large regional and national managed care plans."[11]

Analysis

Legal Standard

SHO's proposed joint contracting on behalf of its member hospitals regarding their employed physicians' services and fees, and the accompanying prohibition on individual contracting for those services by the hospitals, eliminate price competition among the eight otherwise competing providers of those services.[12] Without this program restraint, payors could contract individually with SHO member hospitals for the services of their respective employed physicians, and competition for payor contracts could lead the hospitals to reduce prices or enhance the quality of those services. Absent a valid and cognizable justification under the antitrust laws, SHO's pricing conduct would be presumed to injure competition, and would be summarily condemned.[13] More extensive analysis of the arrangement's procompetitive and anticompetitive effects would be warranted if the competitive restraints were determined to be "ancillary" to – *i.e.*, related and subordinate to, and reasonably necessary to achieve the efficiencies of – some primary, potentially efficiency-enhancing economic integration among the joint venture's participants.[14]

The Federal Trade Commission, applying guidance from the decisions of the Supreme Court and other federal courts, has addressed the concept of ancillary restraints both in guidelines regarding joint arrangements among physicians and other health care providers, as well as among competitors generally.[15] Most recently, the Commission has discussed and applied this type of antitrust analysis regarding restraints accompanying joint ventures in its decisions in *Polygram Holding, Inc.*,[16] and *North Texas Specialty*

Physicians.[17]

Thus, analysis of SHO's proposal requires that we first consider whether it involves potentially efficiency-enhancing integration among the joint venture's otherwise competing participants, and then evaluate whether the accompanying restraints are reasonably necessary – *i.e.*, "ancillary" – to the achievement of the proposed program's integrative efficiencies.[18] If the restraints are ancillary, then ultimate determination of the legality of the restraints requires a weighing of the arrangement's procompetitive and anticompetitive effects.

Integration Through SHO's Proposed Program

SHO asserts its proposed program is not a "naked restrain[t] of trade with no purpose except stifling of competition," and therefore should be evaluated under the rule of reason.[19] As we discuss below, SHO's proposed program appears to involve a degree of integration among its member hospitals that holds out some potential to improve the quality and efficiency in the participating physicians' provision of their professional medical services under the program, and thereby potentially promote competition. We therefore agree the competitive restraints that are part of SHO's proposed program should not be summarily condemned as naked price fixing or as an output restriction.

The legitimacy of SHO's program, or the bona fides of its participants, however, do not alone determine the legality of the program's competitive restraints. A legitimate joint venture may be found to have engaged in unlawful competitive restraints.[20] Therefore, even if the arrangement will involve integration among the competitors that is likely to create efficiencies, the analysis still must address whether the proposed competitive restraints are ancillary (*i.e.*, reasonably necessary) to creating that integration and achieving those efficiencies. Without such an integral connection between a restraint and the achievement of the venture's efficiencies, the restraint is viewed as unnecessarily eliminating competition, and therefore as having no legitimate reason to be sanctioned by the antitrust laws.

The integration in SHO's program has four main elements: (1) joint development of practice protocols and disease-specific treatment parameters regarding a limited set of medical conditions;[21] (2) centralized collection and use of data to monitor physician behavior and outcomes with respect to the treatment protocols; (3) jointly produced educational materials; and (4) agreement by the eight participant hospitals to have their employed primary care physicians abide by the common practice standards, reinforced by the program's jointly funded bonus pool to reward desirable behavior and results. This integration is being undertaken and jointly funded through SHO by the eight SHO hospitals that employ the physicians whose services SHO proposes to market, rather than by the physicians themselves, as might be the case if they were in independent medical practices, rather than hospital employees.

SHO states that "by packaging the proposed clinical program with traditional primary care physician services, it [SHO] will offer a level and quality of physician services that no one SHO hospital could develop on its own." However, SHO does not explain why a single hospital could not develop this type of program and itself provide higher quality services. Subject to the ability to sustain the costs of doing so, it is not apparent that an individual hospital could not develop educational materials, adopt practice protocols and standards for its employed physicians, monitor compliance with those standards through data systems, and encourage or require participation in the program through financial rewards for good performance, or other means.

SHO provides a mechanism for sharing some program costs by its member hospitals. It also likely offers some efficiency benefits in developing and implementing the program, due to its ability to use the systems and equipment already in place from the hospitals' previous investment and joint participation in SHO's risk-based contracts. Participation also allows the member hospitals to pool data on physician

performance, which may provide more reliable performance benchmarks than would the smaller data set available from a single hospital's physicians.[22]

Despite these joint activities, SHO appears to rely largely on each individual hospital to motivate its own employed physician participants in the program,[23] and relies entirely on the individual hospitals to discipline those physicians regarding their performance. SHO may encourage efficient behavior by the program's physician participants,[24] but it has no direct authority or control over their actions or performance, and appears to lack any enforcement mechanism or authority to discipline or remove from the program chronically non-compliant physicians.[25] Rather, the task of assuring physician compliance with the program largely will rest with each individual employer hospital. In that regard, SHO states:

> Performance data will be tracked and shared with the individual PCP [primary care physician] to motivate change, and with the PCP's employer hospital to assist the SHO in reinforcing the . . . program. This data also may be used in the performance appraisal process of the employed PCP. Ultimately, this information could be used by the hospital-employer with respect to employment status decisions of the PCP.

SHO's program also apparently lacks a mechanism for dealing with a member hospital that fails to adequately assure its physicians' compliance and cooperation with the program requirements, except, perhaps, for the ultimate penalty of exclusion from the program.

A hallmark of integration is interdependence. SHO states that interdependency among the program's participating physicians is to be found in "the coordination of the various contributions made by the stakeholders to the joint venture's efficiency enhancing program." Participating physicians will become interdependent through "the development and implementation of, and adherence to, common clinical goals and clinical practice guidelines, participation on quality management committees, and submission to focused peer review." SHO "will develop performance expectations for all participating physicians despite [their] having different hospital employers. Because the goals will be set for the group, individual physicians will need to work collaboratively in order for the group to attain those goals."[26] Participating physicians will have access to educational materials, will be given treatment protocols for use with identified patients having certain medical conditions, will be monitored for adherence to established standards, and will be provided with data and feedback regarding their performance.

SHO does not explain, however, how the physicians will or can work collaboratively to attain the program's goals, since the program does not appear to involve collaborative provision of physician services, or direct involvement by participating physicians from any SHO hospital in the delivery of services by physicians at any other SHO hospital.[27] In fact, SHO states that, beyond the development of quality management programs, outcomes measurement, and professional peer review, little interaction will occur between or among primary care physicians at different SHO hospitals. And, although SHO states that "[b]ecause the goals will be set for the group, individual physicians will need to work collaboratively in order for the group to attain those goals," it provides no explanation of how such collaborative activity among the 192 employed primary care physicians will or can occur. Rather, it appears that the program will involve little or no contact or interaction -- much less interdependence -- among the participating physicians across the eight member hospitals in the actual delivery of care to patients.[28]

Limitations on the Program's Potential Efficiencies

SHO's program appears to have the potential to improve quality and efficiency, at least with regard to those medical conditions addressed by the program. The program's limited nature and scope, however, appear to significantly limit the magnitude and range of those potential efficiencies. Another significant limiting factor is the program's inclusion only of hospital-employed primary care physicians,

which appears to preclude its efficiencies in the provision of services to patients requiring referral to specialists or other non-participating physicians.[29] SHO states that:

> the care provided to patients will involve primary care physicians and specialists who will not fall under the scope of the contracts SHO negotiates with payors. For example, a preferred specialist network has been established under SHO's risk contracting program. SHO expects these specialists to render care consistent with the guidelines and processes developed by SHO's clinical committees in order to ensure consistent levels of high quality care.

SHO also asserts that the program will include "evaluation of preferred specialty and facility referrals," and that treatment in local hospitals and tertiary care services "will be consistent [with that under the proposed program], due to adherence to inpatient practice guidelines compatible with those used in the primary care physician's office." However, SHO does not satisfactorily explain how this "consistency" can or will be achieved or assured through the program, inasmuch as those specialist physicians will not participate in the program's integration or be subject to the program's efficiency-enhancing activities and mechanisms.[30] In essence, SHO is asserting that its program will assure efficient and effective treatment of patients who are referred to, and treated by, physicians not participating in its program, and thus not subject to its standards or oversight, or participating in its educational or financial incentive aspects. Such a claim either appears implausible on its face, or brings into question whether SHO's program and its competitive restraints are needed to achieve the types of modifications in physician performance and adherence to set standards that the program purports to seek.

Ancillarity of Joint Pricing and Exclusive Dealing to Achieving SHO's Efficiencies

We next address whether SHO's proposed pricing restraints and exclusive contracting requirement are reasonably necessary – *i.e.*, ancillary – to achieving the program's procompetitive integration and efficiencies.

The joint determination through SHO of prices to be charged for one or more of SHO's educational, monitoring, data collection, and other potentially efficiency-enhancing services – the "product" that SHO's member hospitals actually are creating by integrating through the joint venture – likely would raise little or no antitrust concern. Since the individual SHO hospitals previously were not actual competitors (and, arguably, not potential competitors) with regard to developing and providing such services, the setting of prices for the "new" services that the joint venture makes available likely would not be characterized as a horizontal price agreement. Rather, it likely would be viewed as unilateral price setting by a single business entity – the joint venture – that newly entered this separate line of business.[31]

SHO asserts that these services are inextricably intertwined with the provision of medical services by the physicians participating in the program, such that the program is, in effect, a new and different product from primary care physician services provided without SHO's enhancements. SHO argues that this creation of a new product justifies the agreement through SHO on the prices to be charged by the member hospitals for the services of all of their employed primary care physicians. We do not agree with SHO's conclusion.

At the outset, SHO's claimed need to jointly negotiate the fees for the hospitals' employed primary care physicians appears to be undercut by its current operation of a "standing offer messenger model" arrangement in facilitating contracts with payors on behalf of about 350 independently practicing SHO physicians. That mechanism processes payor contract offers that do not involve financial risk sharing by SHO's members, without the physicians engaging in collective price setting. In the case of SHO's proposed program, contract offers would only need to be transmitted between a payor and SHO's eight

member hospitals that together employ all of the program's participating physicians. This is a far simpler task than SHO currently undertakes for some 350 independently practicing physicians, and is an approach that would not restrict price competition among SHO's member hospitals regarding physician services. Additionally, it is not evident, and SHO provides no explanation, why agreement on the entire schedule of fees to be charged for all medical services performed by the employed primary care physicians in SHO is necessary to implement a program that only addresses treatment of a very limited subset of medical conditions treated by those physicians.

SHO asserts two reasons why joint pricing on behalf of all the hospital-employed primary care physicians in the program is ancillary to the program's integration:

> First, SHO will be offering payors a new, integrated product, whose components – the physicians' medical services and the clinical integration program under which those services will be provided – are inextricably linked, and a single price must be established for the products together. Second, the physicians (and their hospital employers) are joined together in an interdependent manner.

SHO adds that, to be successful, it must "motivate physicians to participate in quality management programs, change long held practice patterns, accept outcomes measures and monitoring, share best practices, and submit to peer review and re-education programs." SHO also identifies what it characterizes as a potential "free rider" problem that it believes can only be addressed by joint pricing by SHO as the contracting party with payors on behalf of all the program's participating physicians:

> Absent uniform contracting (and uniform prices), SHO fears that its members' incentives would be disparate rather than aligned. Each hospital would have the incentive to facilitate support for the program among its employed physicians, while using the benefits of the program generated by others to negotiate as high a price as possible for physician services. Ultimately, the entire program would fail because each hospital would recognize the opportunistic behavior of others and engage in the same behavior itself. . . . [T]he bottom line is that, absent joint negotiation, the clinical integration program likely would not survive.

SHO also argues that the price agreement is necessary to address liability risk arising from the program and its use of protocols. We discuss these proffered justifications below.

New Product

SHO asserts that the proposed program's price agreement should be subject to rule-of-reason analysis, rather than *per se* condemnation, because the integration through the program will create a "new product" – *i.e.*, something fundamentally different from the services provided by the participating physicians outside of SHO.

In *Broadcast Music, Inc. v. Columbia Broad. Sys., Inc.*, 441 U.S. 1 (1979), the Supreme Court applied the "new product" characterization to a joint venture by numerous individual music copyright holders to offer and set the price of a blanket license to use all of their individually copyrighted songs. The Court found that the blanket license "cannot be wholly equated with a simple horizontal arrangement among competitors," was "quite different from anything any individual owner could issue," and was "to some extent a different product" than the aggregation of its components.[32] The Court concluded that the joint setting of fees for that product was subject to rule-of-reason analysis, rather than *per se* condemnation, because "a necessary consequence of an aggregate license is that its price must be established," and "the agreement on price is necessary to market the product at all."[33]

Subsequently, in *Arizona v. Maricopa County Medical Society*,[34] the Court declined to apply rule-of-reason treatment to arrangements whereby medical care foundations comprising numerous independent physicians set the maximum fees that the member physicians would charge for their medical services when providing those services to patients under contracts between the foundations and insurers. The Court contrasted the foundation arrangements with other joint health care arrangements that offered something more than just the services of the individual joint venture participants, such as where competing physicians come together to guarantee, for a predetermined fee, the provision of care for patients' complete medical needs, as occurs in a capitated HMO arrangement, or where a multi-specialty medical clinic offers patients a broad range of medical specialty services and expertise at a flat fee. 457 U.S. at 356-357. In those circumstances, the Court reasoned, the joint venture provides something that none of the individual physicians alone could provide, and that is intrinsically different from what those physicians normally offer in their individual practice of medicine – *i.e.*, insurance risk coverage or one-stop access to a broad range of medical specialty services that a patient might need. Such arrangements, the Supreme Court noted, were fundamentally different from the simple aggregation and joint contracting for individual physicians' services through network arrangements like the foundations for medical care at issue in *Maricopa*, which the Court condemned as *per se* illegal price fixing.[35]

In distinguishing the foundations in *Maricopa* from the *Broadcast Music* joint venture, the Court rejected the idea that the foundations created a new product:

> [t]his case is fundamentally different [from the blanket license in *Broadcast Music*]. Each of the foundations is composed of individual practitioners who compete with one another for patients. . . . The members of the foundation sell medical services. Their combination in the form of the foundation does not permit them to sell any different product. . . . The agreement under attack is an agreement among hundreds of competing doctors concerning the price at which each will offer his own services to a substantial number of consumers. . . . [T]he fee agreements . . . are among independent competing entrepreneurs. They fit squarely into the horizontal price-fixing mold.[36]

Like the foundations in *Maricopa*, SHO proposes an arrangement for joint contracting on price and other terms with payors on behalf of SHO's individual members (here eight hospitals) in order for the payors to obtain access, at contractually agreed-to prices, to primary care physician services offered by those otherwise competing sellers of those services. The program does not fundamentally alter the nature of the services to patients, or to payors that arrange for access to those services on patients' behalf. The additional benefits resulting from SHO's program may enhance the attractiveness to patients and payors of the physicians' medical services, and ideally will improve the quality and efficiency of patient care by regulating what specific services the physicians provide to individual patients with certain conditions. This does not mean, however, that the physicians' provision of medical services thereby becomes a new product.

Patients under SHO's program will continue to seek individual physicians' services, not the services of some combined entity that involves the unification of physicians at SHO's eight hospitals. Each of SHO's hospital members likewise will continue to individually bill and collect payment for the services of their respective employed physicians on a fee-for-service basis, based on the specific services provided to each patient by each individual physician. Thus, the SHO hospitals will still compete regarding the sale of their respective employed physicians' services under the proposed program. Patients and payors, moreover, will continue to make fee-for-service payments only for the medical services actually provided by an individual physician to an individual patient. They will not obtain access to prepaid and guaranteed comprehensive services, or to the broader range of services and expertise provided by full-service, multi-specialty clinics – both of which the Court in *Maricopa* contrasted to the medical care foundations in that case, which consisted of individual physician practices that charged for their

services on a fee-for-service basis.

Although SHO and its member hospitals will encourage participating physicians to practice according to jointly-developed and agreed-upon standards, and will monitor their practices for compliance with those standards, this is not fundamentally different from other common "managed care" arrangements that do not involve fee agreements. Many physician networks adopt practice protocols and standards, and monitor provider performance. Provider networks also frequently offer services such as medical and case management, disease management, utilization and peer review, provider monitoring, and delegated credentialing to payors at separately established prices for those services. Likewise, various consortia of payors, providers, and consumers have developed similar types of programs to encourage and reward efficient and effective treatment of patients by physicians and other health care providers.[37]

Further distinguishing SHO's program from the "new product" in *Broadcast Music* is the fact that, notwithstanding the blanket license arrangement in that case, the individual music copyright holders continued to be able to individually sell the rights to use their songs. The blanket license was an efficient joint sales arrangement that added a new alternative, otherwise unavailable in the market, by which customers could purchase the right to use a broad range of copyrighted material through a single licensing transaction.[38] This alternative was in addition to what previously existed – and continued to exist – in the market. The arrangement therefore increased total output, without reducing either price competition or output in the market outside the joint venture.[39] While non-exclusivity itself does not establish that a joint venture creates a new product, it does avoid an output-reducing elimination of competition among the venture's participants. SHO's proposed program does not share this attribute present in *Broadcast Music*; rather, it offers its joint product by largely eliminating its eight member hospitals as individual competitors of each other in offering the services of their respective employed primary care physicians in the marketplace.

Motivating Physicians

SHO contends that to motivate the hospital-employed primary care physicians to participate in the program and accept its requirements, it is necessary to allow its hospital participants to jointly set the fees for the services of those physicians.

It is not obvious why it should be necessary for SHO to have a joint mechanism, much less one premised on joint setting of fees, to motivate those physicians to comply with the program's requirements and embrace its goals. Each participating physician is an employee of a SHO member hospital, and each hospital has decided to participate in the program. Those employed physicians can be expected to be responsive to quality and other practice-related requirements set by their employers. The employed physicians can be expected to be responsive to their employers' practice-related requirements, and undoubtedly operate under numerous directions or suggestions from their employer hospitals to fulfill the hospitals' operational, business, contractual, and legal needs and obligations. Thus, the employed physicians at each SHO hospital can already be presumed to have their incentives aligned to a large degree with those of their employing hospital. Employed physicians – like employees in other occupations – already have a substantial incentive to perform in ways that further their employers' goals and interests.[40]

Even assuming that SHO has a need to motivate the participating physicians, SHO does not explain how joint fee setting provides that motivation. The individual employer hospitals, not the salaried physicians, will bill the charges and receive the payments for each employed physician's services under the program, as is the case for services provided by those physicians outside of the program. The employed physicians may not even know what fees their employers are charging and collecting for those services. The physicians' compensation may be affected to a degree by the amount that is billed for their services, but the specific charges for their services are removed in importance – and thus in potential motivating

power – from what might be the case if those physicians were independent practitioners who set their own fees, and who received the full benefit of their pricing decisions.[41]

To the extent that additional motivation is necessary for employed physicians in the program, each hospital could independently devise its own motivating incentives, best attuned to its particular employees, without engaging in the price agreement in SHO's proposed program. Beyond that, SHO and its member hospitals could, just as effectively or more effectively, devise a program that directly sets and apportions the hospitals' contribution to any financial incentive pool, without involving agreement on the fees they charge for their physicians' services.[42] Any need to motivate cooperation in the proposed program by the hospitals' employed primary care physicians cannot justify an approach that – like SHO's proposal – is indirect and tenuous, at best, in its motivational effects, that inherently has the potential to undermine the cooperation and the efficiency goals it seeks to encourage, and that unnecessarily eliminates price competition among the eight SHO hospitals for their employed primary care physicians' services.

SHO's arguments as to the need to set prices in order to motivate cooperation with its proposed program by the employed primary care physicians also are undermined by other of its assertions. SHO states that hospital and tertiary care physician services – neither of which is a part of the program – will be provided "consistent" with the integrated primary care physician services "due to adherence to inpatient practice guidelines compatible with those used in the primary care physician's office." SHO has provided little or no explanation as to how these services can or will be provided consistently with the integrated primary care physician services, except to say that it will rely on "developed referral relationships with certain specialty physicians and facilities," apparently referring to providers who participate in SHO's risk contracts. Insofar as such preexisting referral relationships and voluntary adherence by specialists to practice guidelines alone are adequate to assure efficient provision of services, this would appear to indicate that SHO's program does not require agreement on the prices to be charged for the services of the primary care physicians who are part of, and subject to the strictures imposed by, SHO's program in order to achieve a similar level of cooperation.

SHO believes that the program's success in improving quality and achieving "value enhancement" depends in large part on its ability to align provider incentives. However, as discussed above, the issue of incentive alignment appears to relate less to the employed physicians than to the eight hospital employers participating in the proposed program. The question then is whether, in order to align the SHO hospitals' incentives regarding the program, and to avoid what SHO characterizes as a "free rider" problem,[43] it is reasonably necessary for the hospitals to agree through SHO on the prices to be charged for the services of their employed primary care physicians, and not to deal with payors other than through SHO for the services of those physicians.

The "Free Rider" or Equity Problem

SHO expresses concern that, unless SHO jointly and uniformly sets the prices for the services of its member hospitals' employed primary care physicians, any individual hospital that participates in the proposed program will be reluctant to fully commit its time, resources, and expertise to the program, since other hospital participants will be able to benefit from the arrangement despite a lesser commitment and contribution to the venture. SHO identifies apparently contradictory concerns about how this problem – which it calls "free riding" – might occur.[44] SHO states that, absent joint pricing, a hospital could unfairly benefit from its participation in SHO by "negotiat[ing] as high a price as possible for physician services," which then would be followed by the other hospital participants. Elsewhere, SHO expresses concern that, if its member hospitals made significant investments in SHO and its clinical integration program, "[i]t would clearly be inequitable to allow a SHO-member hospital to take advantage of these investments and offer the benefits of SHO's clinical integration program independently at lower prices."

Both concerns appear to relate to the need to have equitable distribution of costs and benefits among the program's hospital participants. SHO raises the possibility of an individual SHO member hospital obtaining an "unfair" or disproportionate benefit from participation in SHO – by generating disproportionately higher revenues and profits than other SHO hospitals, either by pricing its physician services higher than them (and thus, presumably earning more per unit of service delivered), or by charging lower unit prices, and thus gaining a disproportionately larger share of primary care physician services than the other SHO hospitals. SHO is concerned that this type of problem may fatally undermine the entire program, but asserts that it can be remedied by SHO jointly negotiating and holding all managed care contracts, since "each participant [thereby] is assured that all participants will be treated equally under each contract." However, all payors will continue to contract at individually negotiated prices with each SHO hospital for hospital services, and certain smaller, local payors will be allowed to continue to contract individually with the SHO hospitals for services provided by their employed primary care physicians, apparently without concern by SHO that individual hospitals may benefit unequally in this respect from their identification as SHO members.[45]

SHO's concerns about the possible adverse effects of inequitable sharing of costs and benefits by the participants in its proposed program is the type of problem common to virtually all joint ventures, which usually address the problem without the need to resort to horizontal price fixing. Moreover, allowing uniform pricing by SHO would not eliminate the possibility of differences among the SHO hospitals in the benefit each would receive from the program. Different SHO hospitals have different numbers of employed primary care physicians and different cost structures, and are likely to provide different mixes and amounts of services, thereby generating different amounts of revenue and profit under the program, regardless of whether a hospital has the same price levels as the other SHO hospitals for its physicians' services.[46]

SHO's arguments for uniform pricing are flawed in other respects as well. Regarding the first scenario – where, absent joint pricing, a SHO hospital could "unfairly" benefit by raising the prices for its physicians' services – SHO seems to be suggesting that a member hospital will be able to raise the prices for its employed physicians' services due to its identification as a "superior product" from being a participant in SHO. SHO claims that this would provide an unfair advantage relative to the other hospitals participating in SHO which, in turn, would then also raise their prices. However, an individual SHO hospital that raised its physicians' prices above a quality-adjusted market price potentially would face the loss of business from payors to other competing SHO hospitals not charging supra-competitive prices for their physicians' services. SHO's scenario also is inconsistent with commonly accepted understanding of economic behavior on which the antitrust laws are premised. In essence, SHO's argument postulates that competitors that price independently are likely to set their prices higher than when those competitors all agree on uniform prices, as SHO proposes to do. In a competitive market, which SHO asserts exists in its service area, market forces should constrain such price increases by reducing the quantity of primary care physician services demanded from any SHO hospital that sought to charge higher than a quality-adjusted market price.

SHO's second scenario, which also concerns possible inequitable gaining of benefits by a SHO hospital, involves a SHO hospital charging less than the other SHO hospitals for the services of its employed primary care physicians. This scenario implies that lower prices by an individual SHO hospital will increase the quantity demanded of its employed primary care physicians' services, thereby resulting in disproportionately higher revenue for that hospital, and perhaps some concomitant reduction in demand for the services of the primary care physicians employed by the other SHO hospitals that charge higher prices. SHO expresses concern that, as a result, some hospitals might decide not to participate in its program. Basic economic theory agrees that lower quality-adjusted prices should increase the quantity demanded for the firm with lower prices. However, if the SHO hospitals' prices for their physicians' services are set at competitive levels (as SHO implicitly asserts by claiming that it faces competition and lacks market

power), then none of the SHO hospitals will have an economic incentive to cut prices below that level, since doing so would reduce the price-cutting hospital's profits, even if it increased the quantity of its services that were demanded. If, however, SHO hospitals collectively were to set prices for the services of their employed physicians at the monopoly price level, then an individual SHO hospital could increase its profits by offering those services at lower prices, and other SHO hospitals then also would have the incentive to cut their prices.[47] Moreover, as noted previously, even if SHO jointly sets uniform price levels for the services of its eight hospitals' employed primary care physicians, each SHO hospital still will receive different amounts of revenue and profit from the program. Thus, to the extent that SHO perceives a member hospital charging lower prices than other SHO hospitals as a problem, joint pricing will not cure the problem.

Various ways exist for SHO to fairly apportion the costs and share the benefits of operating its proposed program, without fixing the prices of the hospital-employed primary care physicians' services. For example, any potential inequity to an individual hospital could be remedied by each hospital assuming a portion of the joint venture's expenses, or by sharing revenue from business under SHO contracts, in proportion to the volume of the business or revenue each hospital derived from the program. This could be done without the hospitals agreeing on uniform fees for their physicians' services. Another possible approach would be to allocate costs based on some other, less direct, measure of potential benefit of SHO participation, such as the number of employed physicians in the program. Numerous alternative approaches like these exist, without reliance on a horizontal price agreement. Regardless of how SHO chose to apportion costs among its member hospitals, each hospital would have the incentive to participate, so long as it was better off economically being in SHO than not participating in the program. Still another alternative to address SHO's stated concerns – albeit one that itself potentially carries some antitrust risk – might be to prohibit participants in the program from selling any of their employed primary care physicians' services outside of the program, which SHO has partially done.[48] SHO thereby might be able to identify and "capture" a measure of whatever benefit a SHO member hospital obtained from participating in SHO.[49]

In summary, to the extent that individual pricing of services of the SHO hospitals' employed primary care physicians potentially creates an equitable treatment problem for SHO's members – what SHO calls a "free rider" problem -- it appears: 1) that agreement on those prices through SHO will not remedy the problem; and 2) reasonable alternatives exist to address the problem without resort to horizontal price fixing. Thus, SHO's concerns do not necessitate or justify joint pricing of the services of the SHO hospitals' employed primary care physicians.

Increased Liability Risk

SHO states that it:

> likely will incur increased liability risk with respect to clinical protocols distributed to network physicians if they do not fully participate in SHO's corresponding clinical monitoring and quality management programs. If the physician is contracted [with payors] through SHO, however, SHO has the ability to facilitate compliance with the quality management programs or terminate the contract. SHO will not have such influence over physicians if it does not hold the contract.

First, it is not apparent why developing and distributing treatment protocols, and monitoring physicians' compliance with them, should increase liability exposure, either for SHO or its member hospitals, which employ the physicians who will be using the protocols. Nor does SHO provide any factual support for its concern. Protocols already are widely available and frequently employed within the medical care industry today and, insofar as they are evidence-based and aimed at improving the quality of

care rendered, should reduce, rather than increase, both bad treatment outcomes and liability exposure by physicians who adhere to them.

Second, and more importantly, there is no logical connection between an agreement among the SHO hospitals to fix the prices of their employed primary care physicians and the reduction of any liability exposure of the hospitals or SHO. SHO's expressed concern relates more to assuring compliance by the physicians with the program's protocols and standards. As discussed above concerning the need to motivate physicians in the program, much of this compliance obligation is left to the individual hospitals, and SHO's joint actions in this regard are not facilitated by, and do not require, the competitive restraints of the proposed program. Regardless of whether SHO holds the contracts with payors, it can require as a condition of membership and participation in the proposed program that the member hospitals agree to assure that their employed primary care physicians will cooperate with the program's monitoring procedures and adhere to its practice standards and procedures. Moreover, to the extent that there is a concern about increased liability exposure, however well-founded, this can be addressed more directly and effectively without resort to price fixing. Any concern about liability exposure can be addressed by obtaining liability insurance coverage, which can be funded by the joint venture and its participants.[50] The competitive restraints that SHO's proposed program would entail are unnecessary, and do not address the liability concerns SHO raises.

Conclusion

SHO's proposed program appears to have the potential to create limited efficiencies in the provision of primary care physician services. However, as discussed above, horizontal agreement among SHO's eight member hospitals on the fees to be charged for the services of their combined 192 employed primary care physicians, and elimination of the individual hospitals' freedom to compete with SHO and each other in the sale of those physician services, do not appear to be reasonably necessary or "ancillary" to achieving those efficiencies. Accordingly, the staff concludes, without the need for further analysis under the rule of reason, that the price agreement and exclusivity requirement components of SHO's proposed program are likely to be unlawful restraints on competition.

This letter sets out the views of the staff of the Bureau of Competition, as authorized by the Commission's Rules of Practice. Those views are based on information provided to Commission staff by you and your client. Staff have not engaged in independent factual investigation regarding the proposal. Under Commission Rule § 1.3(c), 16 C.F.R. § 1.3(c), the Commission is not bound by this staff opinion and reserves the right to rescind it at a later time.

Sincerely,

David R. Pender
Acting Assistant Director

1. The seven PHOs are: Health Link Network; Hancock Regional PHO, Inc.; Hendricks PHO, Inc.; Morgan County Health Delivery Network, Inc.; Riverview Health Network; Westview Delivery System, Inc.; and Boone County PHO. The health system is St. Vincent Health, Inc.

2. These seven community hospitals are: Westview Hospital in Indianapolis; Witham Memorial Hospital in Lebanon; Hancock Memorial Hospital & Health Services in Greenfield; Hendricks Regional Health in Danville; Henry County Memorial Hospital in New Castle; Morgan Hospital and Medical Center in Martinsville; and Riverview Hospital in Noblesville. All except Westview Hospital are county hospitals, which are considered political subdivisions of the state under Indiana law. Ind. Code § 34-6-2-110 (2005). SHO declines to assert that its proposal is lawful based on a state action exemption from the antitrust laws.

3. St. Vincent Health, Inc., is the sole corporate member of St. Vincent Hospital and Health Care Center, Inc. The latter provides tertiary level medical services not offered by SHO's other member hospitals, as well as lower level services, including medical care provided by the 87 primary care physicians employed by St. Vincent Hospital and Health Care Center, Inc.

4. SHO defines "primary care" as including family practice, internal medicine, general medicine, and pediatrics. The number of employed primary care physicians at each SHO hospital is as follows: Westview Hospital (7); Witham Memorial Hospital (11); Hancock Memorial Hospital (21); Hendricks Regional Health (24); Henry County Memorial Hospital (14); Morgan Hospital and Medical Center (7); Riverview Hospital (21); and St. Vincent Hospital (87). The eight SHO hospitals also employ a number of specialist physicians.

5. The SHO Board includes two representatives appointed by each of SHO's seven PHO members, one appointed by St. Vincent Health, Inc., and one appointed by the Suburban Physician Organization, which represents nearly 400 physician investors from the approximately 2500 contracted independent (*i.e.*, non-hospital-employed) primary care and specialty physicians that are in SHO's provider network for its capitated contracts.

6. We focus our analysis on the nature and extent of the efficiency-enhancing joint activity among the program's participants, rather than relying on the label "clinical integration."

7. The standards of care to be measured through the program "predominantly will address medical conditions that are typically treated in the PCP [primary care physician] office setting – *i.e.*, wellness and stable phases of chronic illnesses common to the general population." The primary focus of the program will be to address treatment of four medical conditions – asthma, cardiovascular disease, congestive heart failure, and diabetes – and provision of preventive health care services. SHO will monitor and measure "process indicators" (physician performance related to the established practice parameters) and "outcome indicators" (assessing "the effectiveness of care management interventions on patient well-being"). Outcome indicators will be measured by review of data that SHO compiles, and will include evaluation of inpatient admissions and readmissions, emergency department utilization patterns related to asthma, cardiovascular disease, and diabetes, and "quality of life indices." SHO will use these measures to guide improvements in the program. Cost efficiency will be assessed by comparing pre- and post-intervention costs related to fluctuations in avoidable utilization of services, including hospital admissions, emergency visits, and average lengths of stay in facilities.

8. Each participating physician could earn a bonus of up to 2.5% of his or her previous year's compensation, based on group performance. This amount appears to be non-trivial, at least in absolute amount, though it is not clear how significant an incentive a potential bonus of this size is likely to be in generating interdependence among, and modifying the behavior of, the physicians in the program. SHO does not claim, however, that the program's shared financial incentive aspect independently justifies the program's competitive restraints.

9. SHO states that its program will include an "outcomes-based interactive learning system" to deliver physician education modules, track scores on interactive exercises and quizzes, and collect feedback from participating physicians." Later, SHO will add "on-line survey (including patient satisfaction) and quality auditing data collection capabilities." Finally, all of the data will be integrated into a "data warehouse" capable of generating network-wide trend reports.

10. Current antitrust analytical standards no longer involve such a "dichotomous categorical approach," whereby restraints are either labeled as *per se* illegal, or are subject to a full rule-of-reason analysis. *See Polygram Holding, Inc. v. FTC*, 416 F.3d 29, 33-35 (D.C. Cir. 2005).

11. As an exception to this exclusive dealing policy, SHO will allow each hospital to market the services of its employed primary care physicians independently to "small local employers, local governmental units and school districts, and some small managed care plans."

12. The physicians employed by any single SHO member hospital are not considered competitors of each other. *See Copperweld v. Independence Tube Corp.*, 467 U.S. 752, 769 (1984) ("employees of the same firm do not provide the plurality of actors imperative for a § 1 conspiracy").

13. Under the analysis used by the Commission in *Polygram Holding, Inc.*, 5 Trade Reg. Rep. (CCH) ¶ 15,453 (FTC 2003) (available at http://www.ftc.gov/os/2003/07/polygramopinion.pdf), and affirmed by the Court of Appeals, *Polygram Holding, Inc. v. FTC*, 416 F.3d 29 (D.C. Cir. 2005), this type of conduct could be described as "inherently suspect," because there is a "close family resemblance between the suspect practice and another practice that already stands convicted in the court of consumer welfare." 416 F.3d at 37 (quoted in the Commission's opinion in *North Texas Specialty Physicians*, Dkt. No. 9312, at 12 (FTC Nov. 29, 2005) (available at http://www.ftc.gov/os/adjpro/d9312/051201opinion.pdf)), *appeal docketed*, No. 06-60023 (5th Cir. Jan. 10, 2006).

14. *See United States v. Addyston Pipe & Steel Co.*, 85 F. 271, 282-283 (6th Cir. 1898), *modified*, 175 U.S. 211 (1899); *Rothery Storage & Van Co. v. Atlas Van Lines*, 792 F.2d 210, 224 (D.C. Cir. 1986), *cert. denied*, 479 U.S. 1033 (1987) ("To be ancillary, and hence exempt from the per se rule, an agreement eliminating competition must be subordinate and collateral to a separate, legitimate transaction. The ancillary restraint is subordinate and collateral in the sense that it serves to make the main transaction more effective in accomplishing its purpose. . . . [T]he restraint imposed must be related to the efficiency sought to be achieved. If it is so broad that part of the restraint suppresses competition without creating efficiency, the restraint is, to that extent, not ancillary."); *Gen. Leaseways, Inc. v. Nat'l. Truck Leasing Ass'n.*, 744 F.2d 588, 595 (7th Cir. 1984) (there must be an "organic connection between the restraint and the cooperative needs of the enterprise that would allow us to call the restraint a merely ancillary one"); *North Texas Specialty Physicians* at 29 (finding that NTSP had "failed to articulate a logical nexus between these [anticompetitive] activities . . . and the claimed efficiencies," and reiterating that "[a]s we stated in *Polygram*, a defendant '. . . must articulate the specific link between the challenged restraint and the purported justification to merit more searching inquiry into whether the restraint may advance procompetitive goals'. . .").

15. *See* U.S. Department of Justice and Federal Trade Commission, *Statements of Antitrust Enforcement Policy in Health Care* (1996) (hereinafter *Health Care Statements*) (available at http://www.ftc.gov/reports/hlth3s.pdf) at Statement 8 at ¶ B.1 and Statement 9 at ¶ A; Federal Trade Commission and U.S. Department of Justice, *Antitrust Guidelines for Collaborations Among Competitors* (hereinafter *Joint Venture Guidelines*) at § 3.2 (2000) (available at http://www.ftc.gov/os/2000/04/ftcdojguidelines.pdf).

16. 5 Trade Reg. Rep. (CCH) ¶ 15,453 (FTC 2003) at 22,453-54, 22,465, 22,468-69 (articulating and applying ancillarity analysis in holding that an anticompetitive restraint regarding the sale of products produced by earlier joint ventures among the parties was not justified by their joint production of a different product by the current joint venture involving the same parties).

17. Dkt. No. 9312 (FTC Nov. 29, 2005) (applying the *Polygram* analysis, and concluding that a physician network's proffered justifications for price agreements and collective refusals to deal were not cognizable and plausible, so as to warrant further consideration. *See also Id.* at 13 n. 20 (noting that "[t]he concept of ancillary restraints . . . is subsumed in the Commission's *Polygram* analysis" and quoting from the Commission's *Polygram* Opinion at n. 42 that "[t]he ancillary restraints doctrine retains its vitality in evaluating efficiency claims."); and at 28 n. 43 (again stating that ancillarity analysis is subsumed within the *Polygram* analysis, and noting that the Commission's "use [of] the terminology of *Polygram* rather than the terminology of ancillary restraints . . . does not mean that we disagree with . . . [that] alternative analysis.").

18. Availability of less competitively restrictive alternatives to achieving the efficiencies of an integration among competitors may be part of the analysis as to whether the joint venture's competitive restraints are reasonably necessary, and thus ancillary, to achieving those efficiencies. *See Nat'l Collegiate Athletic Ass'n. v. Bd. of Regents of the Univ. of Oklahoma,* 468 U.S. 85 (1984) (*"NCAA"*) at 97 (quoting the decision of the Court of Appeals [707 F.2d at 1152] agreeing with the District Court's finding "that any contribution the plan [to restrict individual college's sale of rights to televise football games] made to [address the joint venture's concern about its operation] . . . could be achieved by less restrictive means."); *Los Angeles Mem'l Coliseum Comm'n v. Nat'l Football League,* 726 F.2d 1381, 1396 (9th Cir. 1984), *cert. denied,* 469 U.S. 990 (1994) (analyzing territorial allocations by the NFL, and stating that "[t]he same goals can be achieved in a variety of ways which are less harmful to competition. . . . [A] factor in determining the reasonableness of an ancillary restraint is the 'possibility of less restrictive alternatives' which could serve the same purpose. . . . [W]e find that the jury could have reasonably concluded that the NFL should have designed its 'ancillary restraint' in a manner that served its needs but did not so foreclose competition."). *See also* Bork, The Antitrust Paradox 266 (1978) ("[Judge Taft's definition of 'ancillarity' in *Addyston Pipe & Steel Co.*] requires that the agreement eliminating competition be no broader than the need it serves."); *Joint Venture Guidelines* at § 3.2 ("[a]n agreement may be 'reasonably necessary' without being essential. However, if the participants could achieve an equivalent or comparable efficiency-enhancing integration through practical, significantly less restrictive means, then . . . the agreement is not reasonably necessary.").

19. SHO asserts that its program "integrates participating physicians sufficiently to withstand Rule of Reason scrutiny under *Broadcast Music* [*Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*, 441 U.S. 1 (1979)] and its progeny." SHO claims that its program should be subject to rule-of-reason analysis based on the Supreme Court's decision in *State Oil Co. v. Kahn*, 522 U.S. 3 (1997). In *Kahn*, the Court held that vertical maximum price fixing henceforth would be subject to rule-of-reason analysis. SHO argues that, post-*Kahn*, the Supreme Court would have treated differently, and applied a rule-of-reason analysis to, the arrangement at issue in *Arizona v. Maricopa County Med. Soc'y*, 457 U.S. 332 (1982). In *Maricopa*, the Court held that a medical society's adoption, through a medical care foundation, of a maximum fee schedule for its physician members was *per se* illegal horizontal price fixing. *Kahn*, however, dealt with vertical, not horizontal, price fixing, and the Court, citing and quoting from its decision in *Maricopa,* reiterated that *per se* treatment continued to be appropriate for horizontal price fixing. 522 U.S. at 10.

20. *See, e.g., NCAA,* 468 U.S. 85 (1984) (holding unlawful a sports league's restriction on its members' rights to individually negotiate television contracts for their games, which raised price and reduced output, where the evidence did not support assertions that the restraint furthered the legitimate procompetitive purposes of the league arrangement – itself a legitimate joint venture).

21. These conditions include asthma, cardiovascular disease, congestive heart failure, and diabetes, as well as provision of certain non-specified "wellness" activities. SHO does not discuss the basis for selecting the medical conditions to be addressed by its program. However, these may be among the areas within primary medical care that have greater potential for improvement in quality and efficiency.

22. However, it is not apparent why such data pooling by the proposed network, and sharing of associated costs, could not be accomplished without the joint price agreement and exclusive dealing requirement proposed by SHO.

23. For example, each individual hospital will continue to determine the method and amount of compensation of its employed physicians regarding the medical services they provide under the program.

24. For example, by providing feedback through performance data, implementing the bonus incentive program, and possibly arranging for provision of continuing medical education credits for participating in SHO's educational programs.

25. SHO does state, without any elaboration, that "[q]uality management findings will be taken into account during the provider recredentialing process."

26. SHO acknowledges that integration among the primary care physicians in its proposed program will be different from that which is present in joint ventures involving the sharing of financial risk, where "participating physicians are interrelated in that the poor performance of one will necessarily be absorbed by other members of the group."

27. SHO makes one reference to "peer to peer mentoring," but provides no information as to who this will involve, or what it will entail (*e.g.*, whether this refers to feedback to individual physicians by program staff regarding the physicians' performance, or actually involves interaction among participating physicians).

28. Because of their largely informational character, the types of efficiencies likely to result from the program appear equally capable of being achieved through a joint venture comprising physicians in diverse areas who are not competitors of each other.

29. In this respect, SHO's program differs significantly from the subject of the Commission staff's advisory opinion regarding MedSouth, Inc. That program involved intensive coordination and oversight of patient care across the entire spectrum of medical specialties and treatment levels. Letter from Jeffrey W. Brennan, Assistant Director, Bureau of Competition, to John J. Miles, Ober, Kaler, Grimes & Shriver (Feb. 19, 2002) (available at http://www.ftc.gov/bc/adops/medsouth.htm) ("MedSouth Advisory Opinion").

30. The program also will not apply to care provided by other non-participant providers, including care provided in hospitals or other health care facilities that are not under the supervision of an employed primary care physician participating in SHO's program.

31. *See Health Care Statements* at Statement 8, n. 35. This view is consistent with the analysis applied by the Supreme Court in its recent decision in *Texaco Inc. v. Dagher*, 547 U.S. __ (February 28, 2006), holding that the determination of the price to be charged for the products produced and sold by the joint venture was subject to evaluation under the rule of reason, rather than *per se* treatment, and contrasting that situation to pricing agreements "between competing entities with respect to their competing products" (*Id.* at slip op. at 4), which more aptly describes SHO's member hospitals regarding the sale of the services of their respective employed primary care physicians.

32. 441 U.S. at 22, 23.

33. 441 U.S. at 21, 23.

34. 457 U.S. 332 (1982).

35. 457 U.S. at 356-357. The Court reached its conclusion that the arrangements did not create a new product despite the fact that the medical care foundations also performed peer review as to the medical necessity and appropriateness of the services provided to patients by the physicians under the program, and performed the claims payment function for services provided by the physicians. *Id.* at 339-340.

36. 457 U.S. at 356-357. The Court did not characterize the joint price setting by the physicians as ancillary to their integration, even though the foundations performed legitimate and potentially efficient joint activities, including peer review and claims payment services. *Id.* at 339-340.

37. *See, e.g.*, Bridges to Excellence at www.bridgestoexcellence.org/bte/index.html; Integrated Healthcare Association at www.iha.org/index.html.

38. The Court in *Broadcast Music* noted that the arrangement there "made a market in which individual composers are inherently unable to compete fully effectively." 441 U.S. at 23. Here, by contrast, SHO states that its proposed program will face competition from other provider networks in the area with which SHO seeks to compete more effectively.

39. *See NCAA*, 468 U.S. at 114 ("In *Broadcast Music*, the availability of a package product that no individual could offer enhanced the total volume of music that was sold. . . . [T]here was no limit of any kind placed on the volume that might be sold in the entire market and each individual remained free to sell his own music without restraint."). *See also Regents of the Univ. of California v. Am. Broad. Companies, Inc.*, 747 F.2d 511, 518 (9th Cir. 1984).

40. The physician integration in the MedSouth proposal (*see* n. 29, *supra*) stands in contrast to SHO's program. In MedSouth, absent joint contracting by the more than 400 independent physicians, who practiced in over 200 separate groups, it was unlikely that the physicians in the program could know in advance which other physicians would participate in the program. The ability to rely on continuing participation in the venture by an identified group of physicians was essential "[i]n order to establish and maintain the on-going collaboration and interdependence among physicians from which the projected efficiencies flow." MedSouth Advisory Opinion at 6. SHO's proposed program, by contrast, involves only eight providers of primary care physician services (the eight hospitals). It also does not include any independent physician practices with which care must be coordinated, and does not include any specialist physicians to whom the primary care physicians might refer their patients and with whom they would need to maintain ongoing relationships, so as to assure achievement of efficiencies from coordinating provision of medical services under the program.

41. SHO states that "[t]he compensation [of the primary care physicians under the "vast majority" of their hospital employment contracts] is structured as a combination of a base salary and a productivity incentive . . . [which is] based on the professional services personally performed by the physician, . . . or collections. The base salary usually accounts for the largest percentage of the physicians' total compensation, although at least one SHO hospital compensates its employed physicians based entirely on productivity." Relying on the hospitals' fixed prices for their employed physicians' services as a motivator for physician cooperation in the program also potentially could undermine, rather than advance, the efficiency goals of the program. Insofar as each SHO physician's compensation from his or her employer hospital is tied to the dollar volume billed for the individual physician's services under the program, this will maintain a financial incentive for the physician to provide more services to patients. Billings for additional services, whether or not consistent with the program's guidelines, will increase the physician's compensation under the hospitals' existing payment methods.

42. The bonus pool will include funds equal to between 1% and 10% of the total non-risk commercial reimbursement received by each SHO member hospital for services rendered by its employed primary care physicians under the program. However, nothing in the bonus arrangement requires that its funding be based on revenues derived from the use of uniform, agreed-to, fees, rather than some other method of apportioning each hospital's benefit from the program.

43. As we discuss below, the problems that SHO identifies are more properly characterized as ones involving equitable distribution of the joint venture's costs and benefits, rather than a true economic "free rider" problem.

44. The court in *Rothery Storage & Van Co. v. Atlas Van Lines, Inc.* described the free rider problem in the context of a joint venture: "A free ride occurs when one party to an arrangement reaps benefits for which another party pays, though that transfer of wealth is not part of the agreement between them. The free ride can become a serious problem for a . . . joint venture because the party that provides capital and services without receiving compensation has a strong incentive to provide less, thus rendering the common enterprise less effective." 792 F.2d at 212-213.

45. That different participants in a joint venture will receive different benefits or have different costs of participation does not necessarily imply that there is a free rider problem in the joint venture. Differences in benefits and costs among participants are common in joint ventures, which may impose greater costs of participation on participants that stand to benefit disproportionately from the venture. The key from an individual participant's standpoint is whether the benefits of participation will outweigh the costs (both direct and opportunity costs) of doing so. If so, then the participant will be better off participating in the arrangement than not doing so, regardless of how the arrangement benefits other participants.

46 For example, St. Vincent's has 87 of the 192 total primary care physicians employed by the eight SHO hospitals, and therefore can be expected to generate considerably greater revenues from the proposed program than any other SHO hospital, none of which has more than 24 employed primary care physicians.

47. This type of behavior often is seen regarding cartels, where individual members have an economic incentive to "cheat" on the cartel, thereby increasing the cheating firm's profits. However, if this scenario were to present regarding SHO, the ability of SHO hospitals to set monopoly prices would factually contradict SHO's fundamental assertion in its advisory opinion request that SHO and its members lack market power and face substantial competition in the provision of primary care physician services. Moreover, if SHO and its member hospitals had

market power regarding primary care physician services, allowing SHO to set (and presumably police adherence to) monopoly pricing would leave consumers worse off than if the price cutting about which SHO expresses concern was to occur.

48. As noted previously, requiring SHO's hospital participants to contract with most payors exclusively through SHO regarding the services of their employed primary care physicians itself raises an antitrust issue, since it is a horizontal agreement that eliminates competition among those entities. This "exclusivity" aspect of SHO's proposed operation, in effect, involves an agreement by SHO's eight member hospitals to refuse to deal individually with those types of payors regarding sale of the services of their employed primary care physicians, and only to contract on collectively determined terms, including price terms, through SHO. However, just like price agreements, an exclusivity requirement in a joint venture may have different effects, and receive a different conclusion as to its legality under the antitrust laws, depending on the circumstances in which it is employed. For example, "exclusivity" – *i.e.*, refusal by health care provider network participants to deal except through the network and on jointly determined terms – is a common approach used to facilitate illegal price-fixing agreements by those networks and their members. As discussed previously, the absence of exclusivity also was an important factor in the Supreme Court's determination that the blanket licensing arrangement in *Broadcast Music* created a new product and was procompetitive, justifying rule-of-reason analysis of the price agreement that arrangement entailed. Similarly, non-exclusivity in contracting with payors by the program's physicians, both as a formal program characteristic, and in actual subsequent practice, was an important factor in the Commission staff's analysis and conclusion in the MedSouth advisory opinion, *supra* n. 29. By contrast, exclusivity was determined by the court in *Rothery Storage & Van Co.* to be a necessary and appropriate mechanism (*i.e.*, an ancillary restraint) for avoiding free riding in that particular joint venture. And in the *Health Care Statements* (at Statement 8, ¶ 1A), the Commission and the Department of Justice have even identified a "safety zone" where, absent extraordinary circumstances, certain exclusive physician networks may rely on not being challenged as violating the antitrust laws.

49. While SHO states that its proposed program will be "exclusive" – *i.e.*, include such a prohibition on sales other than by the joint venture – as noted previously, it nevertheless also states that it will allow the individual SHO hospitals to independently sell their services – including those of their employed primary care physicians participating in the proposed program – directly to certain smaller local payors.

50. SHO and its hospital participants may even be sufficiently large and financially able to self-insure this risk exposure.