MEDICAL ANTITRUST REFORM:
ARROW, COASE AND THE CHANGING STRUCTURE OF THE FIRM
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Medical Antitrust Reform: Arrow, Coase and the Changing Structure of the Firm
by
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Abstract

The collapse of national health care reform has focused attention on private markets as the primary mechanism driving change in medical markets, but physicians and hospitals continue to seek legislation changing the antitrust rules that govern those markets. Physicians seek reforms that would permit greater collective action against third party payors. Hospitals want rules governing mergers relaxed to permit greater collective decision making in the allocation of medical resources. These proposals present a direct challenge to the prerogative of private markets and raise questions over when markets should be trusted and when they should be supplemented or displaced with social institutions. Kenneth Arrow envisions a range of possible non-market institutions filling the “optimality gaps” caused by medical market failures. Ronald Coase’s theory of the firm provides a framework for understanding the transformation of the health care industry and for determining which interventions are likely to be helpful and which are likely to be harmful in emerging medical markets.

This paper examines these theories and proposes a set of evaluative criteria for assessing health care reforms, concluding that appropriate non-market interventions should (1) be targeted at correcting recognized market failures; (2) result in a net increase in social welfare (static efficiency); and (3) not structurally interfere with the prospective development of efficient market operations (dynamic efficiency). Physician and hospital antitrust reforms are then evaluated in light of these criteria. Physician calls to collectively bargain or to form physician networks in the absence of substantial integration are largely unpersuasive. Antitrust rules should be defined in terms of structural economic considerations that are likely to facilitate more rational behavior in the health care sector. Permitting physician combinations or collective bargaining without integration or risk sharing will not yield the same economic benefits and will likely frustrate future market development. Hospital antitrust reforms raise a different set of questions. The central issue is whether greater cooperation among hospitals is necessary to counteract rent dissipating forms of non-price competition -- the so-called medical arms race. While such claims possessed a plausible economic foundation in pre-integrated health care markets, the claims are outdated and unpersuasive by contemporary standards. Integrated firms directly internalize the costs of underutilized capital and equipment and are likely to make appropriate investment decisions. Moreover, to the extent that excess hospital capacity does exist in many markets, such capacity will play an important role in ensuring that future health care markets are maximally competitive. Rather than justifying exceptions to antitrust laws, emerging medical markets call for vigilant antitrust enforcement. Competition between integrated health plans not only facilitates lower prices, it also checks the most significant danger associated with integration: the potential under provision of care. Whether such competitive forces will be sufficient, or whether additional remedies are called for, particularly in markets too small to engender effective competition, remains an important policy question.
INTRODUCTION

The collapse of national health care reform has focused attention on private markets as the primary mechanism driving change in the provision and consumption of medical services. The past two decades have witnessed a blizzard of entrepreneurial activity, marking fundamental changes in the way health care is financed and delivered. Physicians are forming new and larger practice groups. Hospitals are buying physician practices. Insurance companies are creating managed care networks that directly provide medical services. At the same time, an increasing number of health care providers are marketing their services as insurance products in direct competition with traditional insurance companies.

While it is sometimes difficult to move beyond industry buzz words and the flood of organizational acronyms, it is meaningful to distinguish between integration and consolidation. The dominant theme is integration: the creation of health plans that combine in a single entity (bound either by common ownership or contractual relations) the components of physician services, hospital services, and medical insurance. An increasingly important sub-theme is horizontal consolidation: collaborative arrangements within component parts, such as a merger between two hospitals or the formation of a new or larger physician group.

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1 I am grateful to Clark Havighurst and the other participants in the Georgetown University Law Center’s Symposium on “The Privatization of Health Care Reform” for their comments and suggestions on an earlier draft of this chapter. I am also grateful for comments and suggestions from Steven Croley, Heidi Li Feldman, Richard Friedman, Peter Jacobson, Thomas Kauper, Kyle Logue, Theodore Sims, John R.C. Wheeler, and the participants in the University of Michigan Law School’s Law & Economics Workshop. I wish to extend particular thanks to Gregg Bloche for his insightful comments, encouragement and editorial assistance.

2 The terminology of integration and consolidation roughly tracks the antitrust distinction between vertical and horizontal relations, which in turn plays a significant role in determining the applicability of the “per se” rule and the “rule of reason.” See infra notes 23-27 and accompanying text. The “vertical” label, however, fails to capture the full nature of an integrated health plan. The joint provision of insurance and medical services is not “vertical” in the traditional sense of reflecting different stages of physical production, such as the mining of bauxite and the forging of aluminum ingot. Baxter & Kessler similarly criticize antitrust law’s distinction between vertical and horizontal relations, advocating instead a distinction between arrangements that involve economic complements and substitutes. See William F. Baxter & Daniel P. Kessler, Toward a Consistent Theory of the Welfare Analysis of Agreements, 47 Stan. L. Rev. 615 (1995). In health care, integration would roughly track the notion of complementarity, while consolidation would track the notion of substitutes.

3 A complete distinction between integration and consolidation breaks down at the edges. In certain markets, effective integration may require a scope of geographic coverage of physician and hospital services that can only be accomplished through greater consolidation. Moreover, consolidation may be a stepping stone to integration. Integration may take place either in the form of agreements between
Integration in medical markets reflects a fundamental reorganization of the “firms” providing health care services and financing. Increasingly, the function of selling medical insurance is being combined “in house” with the function of delivering medical services. This organization of the firm contrasts with the historically dominant structure in which physicians, hospitals and insurers constituted a triumvirate of separate and distinct entities — each pursuing independent economic objectives and each relating to the other through a series of separate market-based transactions. The significance of this transformation cannot be overstated. Economic structure dictates economic behavior. Integrating the financing and delivery of medical services fundamentally alters the decision rule governing when services will be provided and when treatment will be denied. The old decision rule, which was spawned by fee-for-service systems of compensation (contractual relations between independent providers and insurers) and passive third party payor supervision (relaxed contractual monitoring of the actions of independent economic actors), essentially provided medical care whenever there was a positive expected benefit to the patient. The integrated provider, however, directly internalizes the economic costs of additional treatment and is not likely to provide care when the expected marginal costs of treatment exceed the expected marginal benefits. The difference between these decision rules is profound. Whereas the old rule was systematically biased in favor of over providing care, the new rule raises the specter that care may be systematically under provided.

Health care disputes frequently spill from the economic into the political arena and back again. Proposed legislative reforms to the nation’s antitrust laws have triggered intense political battles. Physicians seek reforms that would permit greater collective action against third party payors, as well as rules making it easier to form physician networks. Hospitals want rules governing mergers relaxed to permit greater collective decision making in the allocation of medical resources. These proposals present a direct challenge to the prerogative of private markets and raise questions over when markets should be trusted and when they should be supplemented or displaced with social institutions? Kenneth Arrow envisions a range of possible non-market institutions filling the “optimality gap” caused by medical market failures. Ronald Coase’s theory of the firm provides a framework for understanding the constituent parts (a relationship between an existing insurance carrier and an existing physician group) or through a process of internal expansion (a large physician group marketing its services as an insurance product). Further complicating the problem is the increasing level of consolidation between integrated entities such as mergers between HMOs or managed care plans.

An illustration of the fluidity of this process is instructive. The number and size of physician groups has increased dramatically. These groups may enter into contractual relationships with third party payors forming the basis of a managed care network, or independently market their services as an insurance product. Alternatively, physician groups may enter into relationships with hospitals, ranging from loose contractual affiliations to fully integrated Physician Hospital Organizations (PHOs). The same story can be retold from the perspective of hospitals and insurance companies, each entailing a possible combination of mergers, joint ventures, new contractual affiliations or efforts at internal expansion. In the end, depending upon the route taken, the physician may be a business partner, owner, independent contractor or salaried employee of a hospital or insurance company. This fluid environment where ownership and contract are each viable competing forms of market organization naturally lends itself to a Coasian “theory of the firm” analysis. See infra notes 12-15 and accompanying text.
transformation of the health care industry and for determining which interventions are likely to be helpful and which are likely to be harmful in emerging medical markets.

This Chapter examines these theories and proposes a set of evaluative criteria for assessing health care reforms, concluding that appropriate non-market interventions should (1) be targeted at correcting recognized market failures; (2) result in a net increase in social welfare (static efficiency); and (3) not structurally interfere with the prospective development of efficient market operations (dynamic efficiency). Physician and hospital antitrust reforms are then evaluated in light of these criteria. The case for antitrust reforms giving physicians the right to collectively bargain or to form physician networks in the absence of substantial integration is unpersuasive. Antitrust rules should be defined in terms of structural economic considerations that are likely to facilitate more rational behavior in the health care sector. Coase’s theory of the firm suggests that some level of actual integration should be required before physicians are entitled to more lenient antitrust treatment. Permitting physician combinations or collective bargaining without integration or risk sharing will not yield the same economic benefits and will likely future market development.

Hospital antitrust reforms raise a different set of questions. The central issue is whether greater cooperation among hospitals is necessary to counteract non-price competition. While such claims possessed a plausible economic foundation in pre-integrated health care markets, the claims are outdated and unpersuasive by contemporary standards. Integrated firms directly internalize the costs of underutilized capital and equipment and are likely to make appropriate investment decisions. Moreover, to the extent that excess hospital capacity does exist in many markets, such capacity will play an important role in ensuring that future health care markets are maximally competitive. Physical capacity facilitates the creation of additional integrated health plans and creates incentives for active price competition.

Rather than justifying exceptions to antitrust laws, emerging medical markets call for vigilant antitrust enforcement. Competition between integrated health plans not only facilitates lower prices, it also checks the most significant danger associated with integration: the potential underprovision of care. Whether such competitive forces will be sufficient, or whether additional remedies are called for, particularly in markets too small to engender effective competition, remains an important policy question. This last issue is taken up in the conclusion as a postscript on health care reform.

HEALTH CARE MARKETS, MARKET FAILURES AND COASE'S THEORY OF THE FIRM: A FRAMEWORK FOR EVALUATING HEALTH CARE REFORMS

Market Failures and Arrow’s Optimality Gap: The Role of Social Institutions.
The difficulties in understanding medical markets are undeniable. Health care markets fail to correspond with many of the assumptions made about the behavior of buyers and sellers in textbook models of competition. Acknowledging the complexity of the issues, however, does not mean that health care problems are intractable, or that economic analysis cannot generate substantial insight. Private health care decisions, whether it is the purchase of insurance or the acquisition of medical services, are essentially economic decisions that can be understood in economic terms. That being
said, it is necessary to acknowledge that these decisions take place within the context of substantial market failures. Imperfect information lies at the heart of these problems. Patients lack complete information about such fundamental issues as their need for, the marginal benefits of, and the relative quality of competing medical services. Physicians, on the other hand, are both sources of medical knowledge and providers of medical services. A result of this informational asymmetry is the formation of an awkward agency relationship between the consumers and the sellers of medical services. The prevalence of health care insurance and the shifting of incentives to behave in a price-sensitive manner from consumers and to frequently distant third party payors constitute additional complicating factors.

Market failures have direct implications for economic analysis and the propriety of antitrust reform. According to the first theorem of welfare economics, general competitive equilibria are Pareto efficient, meaning that there exists no other allocation of resources that will make all participants better off. Under such circumstances, there is generally no necessary or appropriate role for government regulation and the proper focus of antitrust law is to safeguard the conditions necessary for effective competition. One implication of the market failures endemic in the health care sector is that any resulting market equilibrium is likely to deviate, perhaps substantially, from the socially optimal allocation of resources. Under such circumstances, it is at least conceivable that some external intervention could result in an outcome that would be Pareto superior.

In private settings, suboptimal resource allocations will trigger bargaining and additional transactions until the mutual gains of trade are exhausted. Kenneth Arrow postulates a social analogue
to this phenomenon: “when the market fails to achieve an optimal state, society will, to some extent at least, recognize the gap, and nonmarket social institutions will arise attempting to bridge it.” Arrow attributed many of the distinctive social institutions characteristic of traditional health care markets to society’s efforts to bridge the “optimality gap.”

[T]he special structural characteristics of the medical-care market are largely attempts to overcome the lack of optimality due to the nonmarketability of the bearing of suitable risks and the imperfect marketability of information. These compensatory institutional changes, with some reinforcement from usual profit motives, largely explain the observed noncompetitive behavior of the medical-care market.

Arrow’s apparently uncritical acceptance of the welfare-enhancing nature of health care’s distinctive characteristics has been criticized by commentators including Mark Pauly and Paul Starr. According to Pauly, “the problem is that such arrangements do not necessarily improve matters; we have no assurance that these characteristics really are attempts by politicians and medical trade associations to do what the welfare economists would suggest.”

Starr makes a similar argument:

Arrow looks at the structure of the medical market as a rational adaption to certain inherent characteristics of medical care . . . There is the presumption that what is real is rational, or, as the economists say “optimal”. . . The result is not so much to explain as to explain away the particular institutional structure medical care has assumed in the United States.

Certainly, the optimality gap is likely to invite private opportunistic behavior as well. Arrow’s critics are appropriately skeptical of the welfare-enhancing attributes of traditional non-market institutions, and rightfully call for a more sophisticated analysis of special interest legislation. Nevertheless, Arrow’s insight that social institutions and peculiar non-market deviations from competitive norms can serve corrective economic functions in markets dominated by market failures should not be over looked. The presumption that “what is real is rational” has pragmatic force. While it is doubtful that traditional health care structures yielded Pareto optimal results, it is equally doubtful


9 Arrow, Uncertainty and Medical Care, supra note 8 at 947.


that such institutions could have endured and become so entrenched if they had no welfare-enhancing attributes, or if there existed a plainly more efficient way of organizing the market.

Meaningful economic discussions, therefore, must recognize that social institutions may have significant economic content, not only as static constraints upon individual decision making, but because these institutions may themselves be the endogenous product of the very constellation of economic forces and market failures that they seek to regulate and control. As such, these institutions may possess economic information that can help explain how health care markets function (or fail to function). At a minimum, an understanding of the possible economic functions played by traditional institutions is helpful in identifying the problems that will be caused by their abandonment through integration. Integration, after all, is simply a different response to the same market failures that spawned traditional structures. Consequently, the equilibrium of the new market, one dominated by integrated firms, will likely result in its own optimality gap, and potentially a new array of corrective non-market institutions.

*Traditional Markets, Integration and Coase’s Theory of the Firm.* Coase’s 1937 article, *The Nature of the Firm,* raises the basic question of why some economic decisions take place in the form of arms length market transactions, while other economic decisions are made internally by firms in the absence of a functioning market or an active price mechanism. Traditional health care markets have many distinctive characteristics, including the important role of non-profit status, state licensing requirements, and the pervasive self-regulatory activities of health care professionals. Underlying all of these features, however, is a distinctive structure of the market itself with its fragmented and economically segregated provision of (1) medical insurance, (2) physician services (human capital) and (3) hospital services (physical capital). This fractured structure necessitates a series of market exchanges between consumers, as separate purchasers of medical insurance and

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12 Ronald H. Coase, *The Nature of the Firm,* 4 ECONOMICA 386 (1937). The “firm” is the most basic building block of a market economy. Coase’s primary insight is that the boundary line separating the firm from the market is fluid. The ultimate location of the line, the organization of the firm relative to the market, however, has significant economic content. The internal makeup of the firm reflects a fundamental division between economic activities that are performed “internally” and those that are carried out by market transactions between distinct economic entities. An alternative way of formulating the distinction is in terms of decisions that are made in terms of hierarchical command (intra-firm decisions) and those that are guided by the price mechanism (inter-firm, market-based transactions). *See generally Ronald H. Coase, The Firm, The Market and the Law* (1988); Harold Demsetz, *The Economics of the Business Firm,* (1995); Michael Dietrich, *Transaction Cost Economics and Beyond: Towards a New Economics of the Firm* (1994); *The Economics Nature of the Firm: A Reader* (Louis Putterman & Randall S. Kroszner eds., 2d ed. 1996).

13 In reality, the operation of a hospital is a very labor-intensive activity. It is not uncommon for hospitals in some cities to be the community’s largest single employer. Still, it is meaningful to focus upon the separation of the ownership and control of specialized physician expertise and the hospital’s physical resources and, for simplicity, to phrase this distinction in terms of a division between “physical” and “human” capital.
medical services, and a triumvirate of insurers, hospitals and physicians, all independent and distinct economic actors.

The complementary nature of physician and hospital services makes it even more remarkable that these services are not jointly provided.\(^{14}\) Factors that increase the demand for hospital services will also increase the demand for certain physician services. Similarly, the pricing decisions of hospitals will affect the demand for physician services and vice versa. Independent decision making by physicians and hospitals will not internalize these effects. Given this complementarity, a Physician Hospital Organizations (PHOs) that integrated hospital and physician services could produce lower prices and higher levels of output simply by internalizing the pricing externality, independent of its ability to attain greater efficiencies.\(^{15}\)

There is no a priori reason why hospitals could not hire physicians as employees or, alternatively, why physicians could not own the hospital facilities at which they work. Few other industries so completely separate the human and physical capital associated with the provision of services. Lawyers, for example, form partnerships and own the physical assets of the firm. Automobile mechanics own their own tools and garage, or work as employees of the entity that controls the physical resources. Similarly, there is no a priori reason why the provision of medical services and the purchase of medical insurance takes place in two separate market transactions. Segregating these functions substantially alters the economic incentives governing both the provision of medical care and the acquisition of technology. Moreover, segregating the functions of insurance and the delivery of

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\(^{14}\) Two products are complementary if the demand for one is positively correlated with the demand for the other, such as the demand for pencils and erasers. Since the demand for “product A” affects the demand for “product B,” the pricing decisions of producer A will affect the pricing decisions of producer B, and vice versa. This raises a classic externality problem. Lower prices for product A will increase the demand for product B, which will increase producer B’s profits. If producers A and B are separate economic entities, however, these effects will not necessarily be internalized. Neither economic entity will have an incentive to independently incorporate the interrelated effects of their pricing decisions. Consequently, if firms have any discretion in setting prices and decisions are made independently, prices for products A and B will be higher and output for each product will be lower than if a single economic entity were to jointly produce and price the two commodities. Common ownership can lead to lower prices and higher output than separate ownership. Of course, contractual arrangements short of common ownership may also provide a mechanism to internalize the externality. For a discussion of the possible role of contracts and other informal responses to this problem see Richard D. Friedman, *Antitrust Analysis and Bilateral Monopoly*, 1986 Wis. L. Rev. 873, 878-83 (1986).

\(^{15}\) The complementary nature of physician and hospital services may help explain some of the attributes of traditional physician-hospital relations. The fact that physicians typically used hospital facilities without charge may have reduced the detrimental effects of the lack of integration. If hospitals charged physicians for the use of facilities, it would increase physician costs and prices, which would negatively affect the hospital’s own demand. One can postulate that many aspects of traditional physician-hospital relations that otherwise appear anomalous were in fact designed to approximate or attempt to approximate the behavior of a truly integrated firm.
medical services introduces substantial transaction costs associated with contracting, monitoring and utilization review. Again, either integrated health care providers could price their services in the form of an insurance commodity or, alternatively, insurance companies could integrate forward and arrange the intra-firm provision of medical services for their insureds.

Typically, high market-based transaction costs produce incentives to perform economic functions internally. From a Coasian perspective, therefore, one might expect integrated health care providers to represent the dominant firm structure. The strength of contemporary incentives motivating the creation of integrated health plans is undeniable. These incentives have triggered a substantial restructuring of health care markets, reducing the previous kaleidoscope of market exchanges often into a single economic transaction between consumers, on the one hand, and sellers of integrated health plans on the other. Such integration, in turn, has fundamentally changed both the nature of the economic entities providing medical services and the very nature of the “product” being sold.

Understanding Our Past. If contemporary incentives for integration are so strong, how can one explain the “anomalous” structure of traditional health care markets? In other words, why are traditional markets structured in a manner that is apparently “irrational” from a Coasian perspective? The answer can be phrased largely in terms of imperfect information and agency problems. The structure of traditional health care markets is primarily a response to the informational asymmetry that exists between health care providers and health care consumers. Patients purchase medical services without a clear understanding of the nature of their medical needs and without an ability to accurately assess the marginal benefits of treatment options. As such, patients must rely upon the expertise and advice of the sellers of medical services. In turn, physicians assume an agency relationship with their patients. The physician-patient agency relationship is not perfect, but various methods of structuring health care markets can make the agency relationship more or less imperfect.

While physicians in private practice can abuse the agency relationship with respect to the services they directly control, the fractured structure of traditional markets affords physicians some degree of institutional independence. This independence may permit doctors to act as credible agents with respect to other suppliers of medical services, such as other physicians or free-standing hospitals.16

16 Alternatively, this structure may simply provide another avenue through which the agency relationship can be abused. The independence of physicians, combined with the physician’s control over patient decision making has historically encouraged non-price competition by hospitals for physician loyalty and affiliation as the primary source of inpatient demand. For discussions of the institutional factors motivating non-price competition, see Paul L. Joskow, The Effects of Competition and Regulation on Hospital Bed Supply and the Reservation Quality of the Hospital, 11 Bell J. Econ. 421, 431-33 (1980); James C. Robinson & Harold S. Luft, Competition and the Cost of Medical Care, 1972-1982, 257 J. Am. Med. Ass’n. 3241, 3241-42 (1987); James C. Robinson & Harold S. Luft, The Impact of Hospital Market Structure on Patient Volume, Average Length of Stay, and Cost of Care, 4 J. Health Econ. 333, 334-35(1985); George W. Wilson & Joseph M. Jadlow, Competition, Profit Incentives, and Technical Efficiency in the Provision of Nuclear Medicine Services, 13 Bell J. Econ. 472, 473 (1982).
More importantly, the structural independence of physicians from third party payors, combined with a fee-for-service system of compensation, aligns the physician's private economic incentives with those of the patient. Under this system, health care professionals maximize revenue by providing rather than denying care, consciously biasing the expected direction of agency abuse. As a result, traditional structures, for all of their shortcomings in terms of economic efficiency, are fairly well-designed for meeting patient needs, to the point of over-treating those individuals who can access the system.

Unfortunately, a medical system biased in favor of overproviding care imposes its own costs. Given the efficiencies that could be gained through integration, one would have expected to see active exploration of alternative systems for delivering and financing health care. Wide-scale experimentation, however, failed to materialize until fairly recently.\(^17\) Early experimentation was discouraged by laws that helped entrench traditional health care structures, with physicians at the center. Laws prohibiting the corporate practice of medicine, for example, constrained the ability of insurance companies to integrate forward and directly arrange for the provision of medical services.\(^18\) Moreover, a move from fee-for-service compensation to capitation or other systems of pre-payment necessarily entails the creation of closed panels of providers and the ability to engage in selective contracting. Historically, such practices were inconsistent with many state insurance regulations.\(^19\)

Just as one cannot unquestionably accept the optimality of Arrow’s non-market institutions, the mere existence of laws inhibiting the creation of alternative market structures, standing alone, is an insufficient explanation for the longevity of traditional structures. Expected efficiency gains should motivate efforts to change prevailing laws, although the necessity of such changes can increase the costs associated with creating alternative systems. Nor, is it sufficient to contend that traditional structures were maintained solely because they were in the interests of powerful groups such as

\(^{17}\) This is not to say that there were no efforts to design alternative structures. See Emily Friedman, *Capitation, Integration, and Managed Care: Lessons from Early Experiments*, 275 J. AM. MED. ASS’N 957 (1996).


\(^{19}\) The creation of a closed panel of physicians is a prerequisite for any form of meaningful integration. Traditionally, however, “freedom of choice” acts and “anti-discrimination” laws forced third party payors to compensate their insured’s expenses regardless of where the insured received medical treatment. These laws severely restricted the ability of third party payors to form entities like Preferred Provider Organizations (PPOs), which are predicated on imposing some limits on where insureds receive care. For a discussion of these and other state laws inhibiting the ability of third party payors to bargain and engage in selective contracting, see Thomas L. Greaney, *Competitive Reform in Health Care: The Vulnerable Revolution*, 5 YALE J. ON REG. 179, 185-89 (1988).
physicians and hospitals. The self-interest of any particular constituency is unlikely to dominate an entire system over time unless the network of arrangements is broadly “acceptable” to other constituencies, with acceptability defined in terms of the benefits that could be collectively obtained within the next-best set of possible arrangements.  

Herein lies the problem. The relevant comparison is not between existing arrangements and some ideal state, but between existing arrangements and other feasible (even if imperfect) alternatives. Comparing sets of next-best arrangements is a difficult task. One is likely to find an entire range of second-best equilibria, each associated with distinct sets of Arrow’s corrective institutions. These equilibria and associated institutions may be radically different from each other. The numerous and varied visions of reform in the national health care debate illustrated the point -- serious reform proposals ranged from single payor systems to various forms of managed competition, with the specter of direct government administration or decentralized medical savings accounts lurking in the background. Within this environment, policy choices are likely to be of a discrete rather than a continuous nature, with competing options representing sharply different sets of strengths and weaknesses. The reality of discrete policy choices means that the political option of “compromise” is not necessarily available. Two discrete policy options cannot simply be melded together into a workable system in an effort to “split the difference.” From this perspective, the committee-style decision making of the Clinton Health Care Task Force may have been exactly the wrong approach to meaningful health care reform.

When confronting such uncertainty, it is desirable to encourage experimentation to generate information and test the viability of competing systems. From this perspective, the legal damper placed on innovation (by corporate practice laws and state insurance regulations), coupled with the ability of physicians to independently frustrate the development of alternative systems of health care delivery and financing contributed greatly to the entrenchment of traditional structures. These innovations were not simply melded together into a workable system in an effort to “split the difference.” From this perspective, the committee-style decision making of the Clinton Health Care Task Force may have been exactly the wrong approach to meaningful health care reform.

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20 I do not intend to minimize the difficulties associated with making political and economic changes, or to disallow the possibility that existing structures in health care (or other sectors) could be both entrenched and suboptimal. Collective action problems may be substantial, particularly where the expected benefits of change are dispersed over large, unorganized groups. Moreover, actions that are collectively rational may be irrational from an individual perspective. The contention here, rather, is that such problems in health care markets are likely to be relatively isolated in scope and non-robust over time. Health care occupies a central role both for individuals and society. Entities such as large employers and lobbying groups for the elderly (or a variety of high-profile ailments) help circumvent many collective action problems. Finally, old coalitions can fracture over time with individual, profit-motivated defections, as witnessed by the contemporary division between physicians in managed care practices and those fighting to retain traditional fee-for-service systems of compensation.

21 FTC Commissioner Calvani has cataloged the allegations that have been made against health care providers in their efforts to resist integration and managed care. This list includes claims that hospitals conspired to boycott PPOs; that trade associations refused to deal with non-Blue Cross reimburses such as HMOs except at prices higher than Blue Cross rates; that trade associations organized hospitals to refuse to accept contracts with managed care entities unless the contracts maintained levels of charges at
rates equal to the providers' usual private rates; that providers collectively refused to accept third party payor reimbursement as payment in full; and that providers have collectively resisted utilization review efforts. In the Matter of Hospital Corporation of America, 106 F.T.C. 361, 1985 FTC LEXIS 15 at *280 n.32 (F.T.C. 1985) (citing cases), aff’d, 870 F.2d 1381 (7th Cir. 1986), cert. denied, 481 U.S. 1038 (1987).
Informational asymmetries. The provider-patient agency relationship still exists and, as with all agency relationships, is still subject to abuse. If anything, integration exacerbates the problem. Within an integrated firm, individual physicians lack the structural independence that once may have enhanced their ability to act as credible agents. Moreover, within an integrated firm, the provider’s economic incentives are adverse to the patients’. Simplistically, revenues are maximized (for at least the short term) by reducing the amount of care provided and resources expended. Whereas the agency relationship under traditional structures was abused by providing too much care (because it was in the agent's self-interest), abuse in integrated structures will be manifested by providing too little care (because it is in the agent's self-interest).

Given that integration will not fully remedy the market failures characteristic of the health care sector, it is inevitable that the new market equilibrium will be Pareto inefficient, creating its own optimality gap. If Arrow is correct, then one would expect to see new social institutions and non-market mechanisms arise in an effort to potentially bridge the gap. If Starr and Pauly are correct, not every proposed non-market intervention is likely to be in the public interest. Consequently, it is necessary to distinguish those non-market interventions that are likely to be welfare-enhancing from those that will have the primary effect of furthering the private interests of particular groups.

In assessing non-market institutions, the critical question is whether the proposed intervention will in fact bridge the optimality gap and result in a superior distribution of social resources. At a minimum, such interventions should be able to satisfy the following criteria. First, the intervention should be directly responsive to one of the underlying market failures triggering the optimality gap. This factor screens reforms that have a plausible economic foundation from those that do not. Second, the intervention should result in an increase in the social welfare as compared with the unmodified market equilibrium. This factor separates the public from the purely private interest of reform advocates, and ensures that any change will be efficiency enhancing, at least from a short-term, static perspective. Finally, non-market institutions should not unnecessarily hinder the efficient structure, operation and evolution of competitive markets. This last requirement seeks to ensure that changes will be dynamically efficient and seeks to avoid short term gains that may harm the long term structural performance of the market. As a corollary to these principles, a justification for one of Arrow’s institutions should not be predicated upon a rationale that the market itself is capable of recognizing and rewarding.

PHYSICIAN PROPOSALS FOR MEDICAL ANTITRUST REFORM

Physicians seek reforms of federal antitrust laws that would exempt doctors from the per se rule against price fixing and that would expand the types of networks examined under the rule of

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22 This discussion takes the existing societal distribution of resources as given and asks whether those resources, as distributed, could be used differently to increase social welfare. Social welfare may also be improved by policies with a direct redistributive focus. Such policy analysis is beyond the scope of this Chapter. Regardless of the initial distribution, it is reasonable to seek to ensure that social resources (however allocated) are put to their most productive use.
Federal antitrust laws establish the basic ground rules governing the operation of private economic markets. Fundamentally, antitrust law strives to preserve the benefits that are engendered when economic conduct is motivated by independently rational and autonomous decision making. Section 1 of the Sherman Antitrust Act broadly prohibits “every contract combination . . . or conspiracy in restraint of trade.” 15 U.S.C. § 1. Section 2 of the Sherman Antitrust Act prohibits monopolization and attempted monopolization. 15 U.S.C. § 2. While section 1 is directed at agreements between separate and independent economic entities, section 2 is directed at the unilateral conduct of firms possessing market power. Other relevant antitrust provisions include section 7 of the Clayton Act, which prohibits mergers and acquisitions where the effect “may be substantially to lessen competition, or to tend to create a monopoly,” 15 U.S.C. § 18, and section 5 of the Federal Trade Commission Act, which prohibits “unfair methods of competition.” 15 U.S.C. § 45. Both the Department of Justice (“DOJ”) and the Federal Trade Commission (“FTC”) (collectively the “enforcement agencies”) have jurisdiction to enforce the antitrust laws.

See, e.g., National Soc’y of Professional Eng’rs v. United States, 435 U.S. 679, 695 (1978) (declaring the Society’s ethical cannon prohibiting competitive bidding to be per se illegal). Courts have readily incorporated these beliefs in evaluating restraints of trade in health care markets. See Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982) (declaring a schedule of fees established by the County Medical Society a per se illegal price fixing agreement); F.T.C. v. Indiana Fed’n of Dentists, 476 U.S. 447 (1986) (declaring the Federation’s concerted practice of refusing to submit dental x-rays to third party payors for utilization review an unreasonable restraint of trade).

Section 1 of the Sherman Act only outlaws agreements that constitute unreasonable restraints of trade. The strictest level of antitrust scrutiny is reserved for anticompetitive agreements between independent horizontal competitors (roughly the agreements previously characterized as reflecting consolidation in the industry). Traditionally, four categories of horizontal agreements have been classified as per se illegal: (1) price fixing; (2) territorial allocations; (3) group boycotts; and (4) tying arrangements. Today, a hard per se rule applies primarily to price fixing agreements and territorial allocations, although group boycotts and tying arrangements continue to raise serious antitrust concerns (particularly in health care markets). For a general discussion of per se rules, see Robert H. Bork, THE ANTITRUST PARADOX: A POLICY AT WAR WITH ITSELF at 18-19, 66-67, 267-70, 276-77 (1993); Lawrence Anthony Sullivan, HANDBOOK OF THE LAW OF ANTITRUST 182-86, 192-97 (1977); Richard A. Posner, ANTITRUST LAW: AN ECONOMIC PERSPECTIVE at 23-26 (1976).
expected anticompetitive and potential procompetitive effects. Restraints, even those affecting price, may be permitted under the rule of reason so long as the agreements are ancillary to a legitimate purpose and are sufficiently narrow in scope.

Antitrust law treats the conduct of economically integrated firms differently than it treats agreements between independent economic actors. Sufficiently integrated undertakings (such as a bona fide joint venture) will be analyzed under the rule of reason. Ancillary aspects of these such agreements will be judged in light of their competitive effects. Integration into a single corporate entity or partnership can entirely shield conduct from section 1 scrutiny. Under the Copperweld doctrine, actions taken by different components of the same corporate entity do not constitute “agreements,” and therefore fall outside the scope of section 1 of the Sherman Act.

It is helpful to illustrate these principles in the health care context. An agreement between independent physicians who are horizontal competitors would implicate section 1’s prohibition against restraints of trade. If the agreement pertained solely to the price physicians would charge insurance companies for their services, then the agreement would be per se illegal. The Supreme Court clearly established this rule in Arizona v. Maricopa County Medical Society. If, instead, the agreement formed a new physician group in which the doctors combined practices then, depending upon the level and type of integration, the agreement would be assessed under the rule of reason. If the legal entity formed by the agreement was a new corporation (or partnership), then no Sherman Act section 1 issues would be raised by the entity’s subsequent pricing practices. As a matter of comparison, agreements between third party payors and individual physicians forming a managed care network would typically be subject to rule of reason analysis, given the non-horizontal nature of the relationship (integration as opposed to consolidation).

Rule of reason analysis involves a case-by-case assessment in which courts examine the economic impact that the alleged restraint will have on competition. See Continental T.V., Inc. v. GTE Sylvania, Inc., 433 U.S. 36, 49 (1977) (“Under this rule, the fact finder weighs all of the circumstances of a case in deciding whether a restrictive practice should be prohibited as imposing an unreasonable restraint on competition.”); Monsanto Co. v. Spray-Rite Services, Corp., 465 U.S. 752, 762 (1984) (“In Sylvania we emphasized that the legality of arguably anticompetitive conduct should be judged primarily by its ‘market impact’.”). See also Sullivan, supra note 25, at 186-89; Herbert Hovenkamp, Federal Antitrust Policy: The Law of Competition and Its Practice 185 (1994).

The formulation of the test for ancillary restraints is generally attributed to Judge (later President and Chief Justice) Taft. See United States v. Addyston Pipe & Steel Co., 85 F. 271 (6th Cir. 1898), aff’d, 175 U.S. 221 (1899).

Different components of the same corporate entity are incapable of entering into an “agreement” in violation of section 1 of the Sherman Act. See Copperweld Corp. v. Independence Tube Corp., 467 U.S. 752 (1984) (rejecting the doctrine of intraenterprise conspiracies). Actions by single economic actors are still subject to section 2’s prohibition against monopolization and attempted monopolization. Moreover, the initial decision to create the new corporate entity may itself be subject to antitrust scrutiny.

See Maricopa, supra note 24.
The challenge, as a matter of law and policy, is to identify the characteristics that should distinguish those agreements that are considered per se illegal from those agreements that are examined under the rule of reason. In 1994 and 1996, the Department of Justice and the Federal Trade Commission jointly issued health care enforcement policy statements to provide guidance in this area. Unfortunately, the 1994 Statements and the 1996 Statements drew the line separating the per se rule and the rule of reason in distinctly different places. According to the 1994 Statements, rule of reason analysis will be applied to physician networks if the network either engages in substantial risk sharing or offers a new product. No examples of what constitutes a “new product” was provided. The 1994 Statements did, however, elaborate on the risk sharing requirement. A network shares substantial financial risk:

(1) when the venture agrees to provide services to a health benefits plan at a “capitated” rate; or (2) when the venture creates significant financial incentives for its members as a group to achieve specified cost-containment goals, such as withholding from all members a substantial amount of the compensation due them, with distribution of that amount to the members only if the cost-containment goals are met.

By implication, if physicians enter into price-related agreements that do not meet the above standards, the enforcement agencies would consider such agreements to be per se illegal.

The 1996 Statements build upon this framework, but make two important changes. First, the 1996 Statements expand the types of arrangements that constitute the sharing of substantial financial risk. Second, and more importantly, under the 1996 Statements, a physician network can

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30 See Department of Justice and Federal Trade Commission Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust, reprinted in 4 TRADE REG. REP. (CCH) ¶ 13,152 (hereinafter 1994 Statements); Department of Justice and Federal Trade Commission Statements of Antitrust Enforcement Policy in Health Care, reprinted in 4 TRADE REG. REP. (CCH) ¶ 13,153 (hereinafter 1996 Statements). The purpose of the Statements is “to provide education and instruction to the health care community in a time of tremendous change, and to resolve, as completely as possible, the problem of antitrust uncertainty.” 1994 Statements at 20,769. The enforcement agencies’ statements, however, do not have the force of law and are not binding upon the courts. Nevertheless, the statements are significant because they indicate how the enforcement agencies will exercise their prosecutorial discretion.

31 Statement of Department of Justice and Federal Trade Commission Enforcement Policy on Physician Network Joint Ventures, 1994 Statements, supra note 30, at 20,788 (“Physician network joint ventures will be viewed under a rule of reason analysis and not viewed as per se illegal either if the physicians in the joint venture share substantial financial risk or if the combining of the physicians into a joint venture enables them to offer a new product producing substantial efficiencies.”) (Eighth Statement).

32 1994 Statements, supra note 30, at 20,788.

33 1996 Statements, supra note 30, at 20,816 (defining payment systems based upon a predetermined percentage of premium or revenue from the plan, global fees, and all-inclusive rates as legitimate forms of financial risk sharing, in addition to the capitation and fee withholding systems recognized in the
1994 Statements. This provision is largely uncontroversial. The 1994 Statements never intended capitation and fee-withholding to be the only forms of risk sharing recognized by the enforcement agencies. 1994 Statements, supra note 30, at 20,788 (“[T]he Agencies will consider other forms of economic integration that amount to the sharing of substantial risk; the enumeration of the two examples above is not meant to foreclose the possibility that substantial financial risk can be shared in other ways.”).

1996 Statements, supra note 30, at 20,816-17.

1996 Statements, supra note 30, at 20,817.

1996 Statements, supra note 30, at 20,817 (“To the extent that agreements on prices to be charged for the integrated provision of services are reasonably necessary to the ventures achievement of efficiencies, they will be evaluated under the rule of reason.”).

applied to the conduct of “provider service networks” contracting for Medicare services.38 Similarly, the Antitrust Health Care Advancement Act of 1997, championed by Representative Hyde, would have legislated that entities qualifying as “health care provider networks” be evaluated under rule of reason analysis.39

Alternatively, physicians have advocated broadening the categories of integration and risk sharing to include forms of physician equity investment. Under such a standard, a physician network would be evaluated under the rule of reason so long as participating doctors had a sufficient amount of capital invested in the common venture.40 Other measures would effectively displace the antitrust laws all together. H.R. 3770, a bill introduced in 1996, would have granted complete antitrust immunity for physicians negotiating with third party payors regarding physician wages, rates of payment and hours of work.41 A similar proposal, H.R. 4277, was introduced again in 1998. H.R. 4277 would have applied the same antitrust exemption afforded to unionized workers to the collective actions of independent health care providers.42
Discussing the need for antitrust reform is complicated by ambiguities inherent in the antitrust laws. Despite the aura of certainty created by labeling conduct *per se* illegal, the actual boundary separating *per se* illegal conduct from conduct that will be evaluated under the rule of reason is frequently unclear.\(^{43}\) Efforts to delineate the standard governing physician networks must begin with the Supreme Court’s decision in *Maricopa*.\(^{44}\) After *Maricopa*, it is uncontroversial that section 1 of the Sherman Act applies to agreements between physicians and that certain types of physician pricing agreements are *per se* illegal. The exact reach of the Court’s holding, however, is controversial. This controversy is heightened when one acknowledges that *Maricopa’s per se* rule must be read against the backdrop of twenty years of Supreme Court precedence generally expanding the scope of rule of reason analysis.

The enforcement agencies’ 1994 *Statements* conservatively interpret *Maricopa* as holding that physician price-related agreements are *per se* illegal unless the arrangement produces a new product or involves the sharing of substantial financial risk, the later being defined in terms of capitation and fee-withholding. The exemptions for new products and for networks sharing financial risk come directly from the Supreme Court’s efforts to distinguish *Maricopa* from its earlier holding in *Broadcast Music v. Columbia Broadcasting Systems*.\(^{45}\) The Court suggested that rule of reason analysis would be appropriate if the physicians were able to market a “new product” (not in competition with their individually provided services), formed a “single firm” (an application of the principles underlying the subsequently announced *Copperweld* doctrine), or offered their services for a “flat fee” (capitation).\(^{46}\) The Court rejected the physicians’ claim that purported efficiencies, standing alone, justified the joint setting of prices,\(^{47}\) and the Court was careful to distinguish the agreement it approved in *Broadcast Music* from a “joint sales agency.”\(^{48}\)

The enforcement agencies’ 1996 *Statements* take a more expansive view of *Maricopa*, contending that price-related agreements in conjunction with substantial clinical integration will be subject to rule of reason analysis (in the absence of the sharing of financial risk), so long as the price-related agreements are reasonably necessary for obtaining the alleged efficiency gains.\(^{49}\)


\(^{44}\) *Maricopa*, supra note 24.


\(^{46}\) See *Maricopa*, supra note 24, 457 U.S. at 356-57.

\(^{47}\) *Id.* at 353-54.

\(^{48}\) *Id.* at 355 n. 31.

\(^{49}\) 1996 *Statements*, supra note 30, at 20,817-18.
Havighurst also advocates a more expansive view of Maricopa. He argues that physician networks should be viewed as joint sales agreements that lower the transaction costs of physician/payor contracting and hence justify rule of reason analysis.\textsuperscript{50} Havighurst’s characterization of physician networks as joint sales agreements differs importantly from the substantial clinical integration standard adopted in the 1996 Statements. Clinical integration produces economic efficiencies that are only tangentially related to network price agreements. Havighurst, on the other hand, focuses directly on the efficiency attributes of joint pricing agreements -- the reduced costs of negotiating and drafting a single contract.

In evaluating reform proposals, it is useful to distinguish between physician agreements that constitute classic examples of horizontal price fixing (uncontroversially governed by the \textit{per se} rule); physician agreements that satisfy the enforcement agencies’ 1994 Statements requirement of substantial risk sharing (uncontroversially governed by the rule of reason); and physician agreements falling short of the enforcement agencies’ 1994 standards for sharing financial risk and yet not reminiscent of classically prohibited \textit{per se} illegal conduct. This last category lies in a doctrinally indeterminant zone, where courts interpreting Maricopa may or may not apply the rule of reason standard and where the enforcement agencies’ line has shifted over time. The most extreme physician antitrust reforms would legalize forms of collective bargaining falling within the first category -- behavior that would uncontroversially be considered \textit{per se} illegal. Other reforms would focus on behavior in the third category -- seeking to extend the scope of the rule of reason to include physician networks predicated on shared equity investment, the 1996 Statements’ substantial clinical integration requirement, or Havighurst’s joint sales arrangements. The merits of each type of proposal will be considered in turn.

\textit{Collective Physician Bargaining -- Assessing the Wisdom of the Per Se Rule.} The original Clinton administration health care reform proposal would have granted physicians limited authority to collectively negotiate over fees with newly-created state or regional health care purchasing cooperatives.\textsuperscript{51} The demise of national health care reform did not temper physician desires to engage in collective bargaining, it simply shifted the target of such negotiations to private insurance companies. H.R. 3770 would have granted blanket antitrust immunity to physicians engaging in collective negotiations with health service plans regarding wages, rates of pay, hours of work and other terms and

\textsuperscript{50} Havighurst presents an extensive critique of enforcement agencies’ 1994 Statements governing physician network formation. \textit{See} Clark C. Havighurst, \textit{Are the Antitrust Agencies Overregulating Physician Networks?}, 8 LOY. CONSUMER L. REP. 78 (1996) (hereinafter Havighurst, \textit{Overregulating}).

\textsuperscript{51} \textit{Health Security Act}, H.R. 3600, 103d Cong., 2d Sess. § 1322 (1993). Such proposals are not entirely different from the Canadian (or German) system where physicians collectively negotiate with the government at the Provincial level for the annual budget to be spent on health care services. \textit{See} Daniel W. Srsic, \textit{Collective Bargaining by Physicians in the United States and Canada}, 15 COMP. LAB. L J. 89, 94 (1993).
conditions of contract, so long as the health care service plan had a “presumption of market power.” H.R. 4277 would have gone even further and immunized collective physician conduct even in the absence of alleged countervailing market power. H.R. 4277 proposed extending groups of independent health care professionals the same antitrust immunity that the law extends to labor unions.

Legislative action in this area is required because Maricopa’s per se rule would clearly outlaw collective bargaining by independent health care professionals. While the per se rule is firmly established as a matter of antitrust doctrine, these legislative proposals force us to ask whether the law’s prohibition against physician price fixing is defensible as a matter of health care policy. To answer this question it is helpful to recall the evaluative criteria developed earlier and ask whether collective bargaining is responsive to an identifiable market failure; whether a collectively bargained for equilibrium would result in an increase in the social welfare (static efficiency); and whether collective bargaining would disrupt the structure and efficient operation of health care markets (dynamic efficiency).

To qualify as one of Arrow’s optimality-gap-filling, non-market institutions, a reform must be responsive to an underlying market failure. The most significant market failures plaguing the health care industry involve agency problems and imperfect information. While physicians frequently cloak proposed antitrust reforms in a rhetoric of patient rights, there is no immediate or logical connection between concerns over patient care and the right of physicians to fix prices. Collective bargaining does not facilitate the ability of physicians to act as credible agents for their patients, and community levels of physician compensation are unrelated to the underlying problem of informational asymmetries. Market failures may justify some types of external intervention -- informational market failures may call for measures protecting the physician’s right to openly communicate with and inform patients of treatment options -- but the right to fix prices is not one of them. The physician-patient agency relationship is atomistic in nature and safeguards for the relationship, if necessary at all, should entail carefully designed individual protections rather than warrants for collective action.

In an effort to justify collective bargaining, physicians complain that individually negotiated fees result in insufficient levels of physician compensation. Two conflicting claims are often put forward to explain why fees may be suboptimal. The first concerns the possible exercise of market power by third party payors. The other explanation concerns a possible oversupply of physicians. Neither explanation justifies a change in the antitrust laws to relax the per se prohibition against price

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52 H.R. 3770, 104th Cong., 2d Sess., § 4 (1996). A presumption of market power is defined as a Herfindahl-Hirschman Index (HHI) level exceeding 2,000. Id. §2(2). An HHI level of 2,000 corresponds to the presence of 5 or fewer equally sized health plans competing for physician services.

53 H.R. 4277, 105th Cong., 2d Sess., § 2(a) (1998) (“The members of any group of health care professionals . . . which is negotiating with a health insurance insurer . . . shall, in connection with such negotiations, be entitled to the same treatment under the antitrust laws as that which is accorded to members of a bargaining unit recognized under the National Labor Relations Act.”). For a critical assessment of this proposal see Statement of Federal Trade Commission Presented by Robert Pitofsky, Chairman of the Federal Trade Commission, before the Committee on the Judiciary United States House of Representatives, 105th Cong., 2d Sess. (July 29, 1998).
fixing. If third party payors possess monopsony power capable of forcing subcompetitive rates of compensation, then the appropriate solution is to apply the antitrust laws directly against the source of third party payor market power, not to sanction collective bargaining in the form of an antitrust exemption. Similarly, if low levels of compensation are caused by an oversupply of physicians in particular markets, collective bargaining is not the answer. Lower rates of compensation serve the necessary economic function of encouraging physicians to move to markets where there is a relatively greater need for their services. Permitting physicians to collectively bargain in such circumstances would simply perpetuate existing market dislocations and prevent what would ultimately be a more desirable allocation of social resources. More particularly, this is precisely the type of misallocation that competitive markets are well-equipped to handle. This argument applies to the appropriate allocation of physician resources across specialties and subspecialties, as well as the allocation of physician services geographically.

Collective physician bargaining fails the second criterion as well -- bargaining is likely to decrease (not increase) social welfare. At its most benign, it would systematically increase the price

54 If a single third party payor is exercising market power, then physicians can file a section two claim alleging the exercise of monopoly or monopsony power. While courts to date have not been very receptive to provider allegations of monopsony power, see Kartell v. Blue Shield, 749 F.2d 922 (1st Cir. 1984), cert. denied, 471 U.S. 1029 (1985); Ball Memorial Hosp. v. Mutual Hosp. Ins., Inc., 784 F.2d 1325 (7th Cir. 1986), the correct antitrust prescription is to attack market power directly (where and if it exists), not to facilitate the creation of countervailing market power in the form of collective bargaining. If third party payors are colluding to artificially suppress physician fees, conduct that would itself be per se illegal, then physicians can file a section one antitrust claim against the offending parties. The problem is more complicated if the payor in question is the federal government. The solution, however, would still not be a right to collectively negotiate with private third party payors. The result of such a remedy would be an inefficient system of cross-subsidization, where physicians could exact supracompetitive prices from private payors in order to subsidize Medicare and Medicaid patients (assuming that the same physicians or health plans treated a sufficiently diverse patient mix to make such a scheme workable). The appropriate remedy to inadequate levels of government compensation lies in the political realm. Governments are not immune from economic reality. Paying non-competitive rates will decrease the number of physicians taking Medicare patients and decrease the quality of the Medicare physician pool. Either of these effects should result in political lobbying from patient constituents that could form the basis of a political solution.

55 If the third party payor market is reasonably competitive, then the exercise of physician market power would result in higher prices, decreased output and a reduction in social welfare. If third party payors possessed monopsony power, however, then it is theoretically possible that the exercise of countervailing market power by physicians could improve upon the suboptimum monopsony outcome, resulting in an increase in total welfare. By the same token, it is possible that the exercise of countervailing market power could make the monopsony outcome even worse, further decreasing social welfare. The burden should rest on the advocates of collective bargaining to demonstrate that countervailing market power would be welfare enhancing and, therefore, constitute an acceptable second best solution to alleged third party payor market power. To my knowledge, no persuasive case for this position has even been attempted.
that third party payors (and ultimately patients) would pay for physician services. Higher prices would further increase health care costs and further limit patient access to the health care system. The absolute degree of the price increase would depend upon how effective physicians were in presenting a united front to third party payors and the nature of the sanctions physicians would be able to impose upon doctors who chose to defect from the collective agreement and offer their services at a lower price. On a distributional level, collective bargaining would shift a greater portion of whatever economic rents are available in health care markets to the respective physician constituencies. Doctors would gain, while the hospitals, third party payors and patients would lose.

Finally, collective physician bargaining runs the risk of undermining the dynamic efficiency of the market, violating the third criterion. Cooperative action between otherwise independent physicians could be used to block the creation of new integrated health plans. Physicians who favored traditional health care market structures with the fee-for-service system of compensation, the segregation of insurance, physician, and hospital services, and the pivotal role of physicians as the patient’s point-of-entry into the system would be given a powerful tool. Boycotts of alternative systems of delivery have long been used to prevent and forestall change in the health care system.\(^{56}\) To the extent that integration reflects a Coasian transformation of the firm and a more rational method of arranging health care transactions as intra-firm decisions rather than separate market-driven exchanges, these efficiencies would be lost.

**Risk Sharing Requirements for Physician Networks -- Defining the Scope of the Rule of Reason.** More subtle questions are raised by physician proposals to permit the formation of physician networks in the absence of substantial risk sharing. Under the enforcement agencies’ 1994 Statements, physicians were free to form provider networks so long as the network marketed its services as a pre-paid insurance product (capitation) or engaged in structured fee-withholding arrangements.\(^{57}\) Efforts to eliminate or substantially weaken these requirements should be closely scrutinized. Economic form dictates economic behavior. Integrated providers have incentives to directly compare the costs and benefits of treatment decisions.\(^{58}\) Integration can also reduce

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\(^{56}\) *See* cases cited in *Hospital Corporation of America*, *supra* note 21, 1985 FTC LEXIS 15 at *280 n.32.

\(^{57}\) *See* 1994 Statements, *supra* note 30, at 20,788. The 1996 Statements broaden the categories of acceptable risk sharing to include compensation calculated as a “pre-determined percentage of premium or revenue from the plan,” global fees and all-inclusive rates. 1996 Statements, *supra* note 30, at 20, 816. These changes are consistent with the 1994 Statements financial risk sharing requirement.

\(^{58}\) This Chapter employs an admittedly simplistic model of the incentive structure of integrated health plans, focusing on the first order effects of combining the payment and treatment function within the same economic entity. Integrated firms have strong incentives to compare the costs and benefits of treatment. As such, the integrated firm will generally not provide care when the costs exceed the expected benefits, even when the expected benefits of care are still positive. The actual behavior of integrated health plans will be influenced by a number of additional factors, such as the length of expected enrollment of plan participants, the demographics of the patient population, the ability to engage in risk selection or exclude coverage for pre-existing conditions, and the structure of the market (i.e., the degree of competition among
transaction costs, such as the need for third party monitoring and post-treatment utilization review. Finally, depending upon the anticipated length of the plan/patient relationship, the integrated health plan will have economic incentives to make investments that decrease the expected long-term costs of an enrollee’s medical care. Other proposed triggers for rule of reason analysis will not necessarily have the same economic effects.

Capitation is not the only form of risk sharing recognized by the 1994 Statements. A fee-for-service physician network will also be evaluated under the rule of reason if the network engages in structured fee-withholding. Physicians contend that the same objectives could be achieved through equity investment and advocate joint capital investment as an equivalent rule of reason trigger. Fee-withholding, however, embodies more than just the efficiencies associated with cost-minimizing network operation. Fee-for-service systems of compensation are systematically biased in favor of over-providing care (prescribing treatment beyond the point where the marginal benefits of additional care equal the marginal costs). Capitated reimbursement is one means of counteracting these incentives. A different solution involves the imposition of external constraints that establish limits on a physician’s ability to abuse the patient-provider agency relationship. Fee-withholding constitutes just such a device. The cost containment objectives represent pre-committed limits on the charges that the network will make. To be credible, of course, the system must be properly structured. If the amount withheld is too small, then the potential profits earned by over-providing care may be large enough to justify forfeiting the withheld portion.

Replacing fee-withholding devices with joint equity investment will not achieve the same objectives. Physicians argue that equity investments give each physician a stake in the network and commit each physician to the financial success of the venture. The problem, however, is not with ensuring the physicians’ commitment to the profitability of the venture, but rather with pre-determining how it is that the network will maximize its profits. Under a capitated system, networks make profits by strictly controlling costs and limiting expenses. Under a system of fee-withholding, the value of the withheld fee serves as a countervailing incentive for traditional fee-for-service networks, under which

health plans. For present purposes, however, the incentives to directly compare costs and benefits, as contrasted with the incentives of traditional health care structures, provide a sufficiently clear distinction for antitrust policy analysis.

While fee-withholding retains a fee-for-service system of compensation, the network participants establish an incentive structure under which a certain percentage of fees are withheld and subsequent bonuses paid once specified cost-containment objectives are achieved. 1994 Statements, supra note 30, at 20,788. See also 1996 Statements, supra note 30, at 20,816 (recognizing both fee-withholding, as well as systems of financial rewards and penalties based upon overall cost and utilization targets).

McCormick, supra note 40, at 1. (“Substantial investment in the network itself also puts the member doctors at financial risk, AMA lawyers said, and should be recognized as integrating the physicians enough to eliminate antitrust risk.”).

Id. (“It’s classic capitalism at work,’ he said, arguing that the promise of increasing the value of an initial investment is a strong inducement to run an efficient network.”) (quoting Edward Hirshfeld, AMA Associate General Counsel).
profits are maximized by meeting cost containment objectives, i.e., limiting aggregate levels of care. Physician networks anchored in equity investment have no such countervailing incentives. These networks can be expected to maximize profits both by using whatever market power they possess to charge higher prices and by practicing medicine by traditional standards which are intrinsically biased in favor of over-providing care.

The 1996 Statements implicitly recognize the limitations of simple equity investment and reject joint capital contributions as an independent trigger for rule of reason analysis. The 1996 Statements will permit rule of reason analysis (in the absence of financial risk sharing) only if the network (1) establishes mechanisms to monitor and control utilization to control costs and to assure quality, (2) selectively chooses network physicians who are likely to further efficiency objectives, and (3) engages in significant investment in the physical and human capital infrastructure needed to realize the claimed efficiencies.62 Ironically, none of these actions raise serious antitrust issues by themselves. Physicians could easily enter into limited agreements to jointly invest in utilization, monitoring and management systems, and such joint actions would be evaluated under the rule of reason. Under the 1996 Statements, however, a physician network engaging in the above actions can then proceed to jointly fix prices, to the extent that such price agreements are deemed “reasonably necessary to the venture’s achievement of efficiencies.”63

The treatment of price agreements in the context of substantial clinical integration is a straightforward example of ancillary restraints analysis.64 The weakness of the 1996 Statements is not its characterization of the legal standard, but rather its implied assertion of fact. The factual nexus between the ability to engage in utilization review and the need to collectively negotiate with third party payors over the price of physician services is highly suspect. In the 1996 Statements’ only example of a legitimate physician network joint venture based on substantial clinical integration, the purported need to fix prices is asserted as a conclusion without explanation.65 The ultimate scope of the clinical integration exception will depend upon the rigor with which the enforcement agencies demand that price-related agreements, in fact, be reasonably necessary for achieving alleged efficiencies. Rigorous enforcement of the “reasonably necessary” requirement would render the exception a narrow one. A relaxed standard, on the other hand, would permit physician networks to bootstrap price fixing agreements onto largely unrelated efforts to engage in monitoring and utilization review.

Early experience with the 1996 Statements suggests that the actual sharing of financial risk is still the favored approach. The physician networks receiving favorable responses from the enforcement agencies under the Business Review Procedure typically involve express forms of risk

63 1996 Statements, supra note 30, at 20,817.
64 If a restraint is ancillary to and reasonably necessary for a lawful objective, e.g., information systems and cost/utilization review, and the restraint is narrow in scope, then the restraint will be lawful under the rule of reason. See Addyston Pipe, supra note 27.
65 1996 Statements, supra note 30, at 20,820-21 (“The price agreement under these circumstances is subordinate to and reasonably necessary to achieve these objectives.”).
Moreover, the enforcement agencies have continued to condemn as *per se* illegal physician price setting arrangements in the absence of meaningful integration. The FTC has also ruled that joint investment in physical capital, standing alone, does not constitute substantial clinical integration because the subsequent joint setting of prices was not reasonably necessary to sustain the initial investment. Unfortunately, however, there is still no clear understanding of exactly what constitutes substantial clinical integration.

Clark Havighurst also advocates extending rule of reason analysis to encompass

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66 See, e.g., *Response Letter on Behalf of Vermont Physician’s Clinic*, 1997 WL 432402 (D.O.J.) (July 30, 1997) (“VPC’s participating physicians will share ‘substantial financial risk’ as that term is described in the Statements of Antitrust Enforcement Policy in Health Care.”); *Staff Advisory Opinion on Behalf of New Jersey Pharmacists Association*, 1997 WL 458499 (F.T.C.) (Aug. 12, 1997) (“This form of risk sharing among network members, based upon capitation, is sufficient to bring the joint fee setting arrangement outside the *per se* treatment and into the rule of reason.”); *Response Letter on Behalf of Joint Venture Proposed by First Priority Health*, 1997 WL 688781 (D.O.J.) (Nov. 3, 1997) (“As proposed, FPHS is a bona fide joint venture in which all its participating owners, including all of the NEPPO physicians will share substantial financial risk as described in the Policy Statements.”); *Staff Advisory Opinion on Behalf of Phoenix Medical Network*, 1998 WL 293759 (F.T.C.) (May 19, 1998) (“If Phoenix operates in the manner described, its members will share substantial financial risk through contracts with third-party payers to provide medically necessary services to certain of their enrollees for a percentage of the premiums collected”); *Response Letter on Behalf of The Heritage Alliance (“THA”) and Lackawanna Physicians Organization (“LPO”),* 1998 WL 678339 (D.O.J.) (Sept. 15, 1998) (“In this case, the members of the Network propose to share substantial financial risk in providing Network services.”).

67 See *In re Mesa County Physicians Independent Practice Association*, Docket No. 9284 (F.T.C.) (Feb. 19, 1998) (Agreement Containing Consent Order to Cease and Desist) (“Mesa IPA’s members have not integrated their medical practices so as to create efficiencies sufficient to justify their collective contract negotiations.”).

68 See *In re Urological Stone Surgeons, Inc.*, File No. 931-0028 (F.T.C.) (1998) (Agreement Containing Consent Order to Cease and Desist) (“The Complaint charges that while the owners of USS and SCA have financially integrated by jointly investing in the purchase and operation of the two lithotripsy machines the Parkside operates, collective setting of the price for their lithotripsy professional services, or for other non-investor urologists using Parkside, is not reasonably necessary (or ‘ancillary’) to achieving any efficiencies that may be realized through their legitimate joint ownership and operation of the machines.”).

69 The enforcement agencies have acknowledged the difficulties involved in precisely defining the meaning of substantial clinical integration. “In drafting the definition of clinically integrated arrangements, the Agencies sought to be flexible due to the wide range of providers who may participate, types of clinical integration possible, and efficiencies available. Consequently, the definition of a clinically integrated arrangement is by necessity less precise than that of a risk sharing arrangement.” *In re M.D. Physicians of Southwest Louisiana, Inc.*, File No. 941-0095 (F.T.C.) (1998) (Agreement Containing Consent Order to Cease and Desist).
physician price setting, but he bases his argument on the efficiencies that are directly attributable to joint negotiations and contracting.\textsuperscript{70} Even in the absence of substantial clinical integration, physician networks can reduce the transaction costs associated with separate and independent negotiations between physicians and third party payors. Havighurst contends that these transaction cost savings alone provide a sufficiently strong procompetitive justification to warrant application of the rule of reason. I disagree. The “economies” associated with reduced bargaining costs should not be treated in the same manner as the “economies” associated with capitation and fee-withholding. Meaningfully integrating the financing and delivery of medical services affects the manner in which medicine is practiced, introducing an express comparison between the costs and benefits of additional treatment. Transaction-cost-reducing networks, on the other hand, will not practice medicine any differently. At the same time, physician networks that serve only a transactional function pose serious anticompetitive risks, both from the direct exercise of market power and from indirect forms of spillover collusion. While effective application of the rule of reason might reduce some of these threats, the application of the rule of reason is not costless. At a minimum, the added antitrust enforcement costs would have to be balanced against any alleged contracting efficiencies.

Havighurst’s strongest contention in support of a more liberal application of the rule of reason is his caution against prejudging the market.\textsuperscript{71} An antitrust standard predicating rule of reason analysis upon capitation, global fees and fee-withholding will have the effect of encouraging these types of networks and discouraging other forms of physician collaboration. Ideally, private parties would be able to make unconstrained choices regarding the structure of their business agreements. Taken to an extreme, however, this argument proves too much. The entire purpose of antitrust law is to permit some forms of agreements and to prohibit others, based on the realization that the profits derived from successfully obtaining and exercising market power can motivate business agreements just as powerfully as the drive for legitimate economic opportunities. Almost every antitrust doctrine has the effect of constraining some forms of private conduct and pre-judging the market. Under \textit{Copperweld}, for example, intra-firm conspiracies are not subject to section 1’s prohibition against restraints of trade. Such a rule undoubtedly encourages integration in some instances where it might not otherwise occur.

At the same time, it is easy to exaggerate the likelihood of integration requirements prejudging the market. The higher transaction costs associated with individual bargaining act more like a tax than a prohibition. Third party payors are still free to form arrangements with a network of independent physicians through separate negotiations, and physicians are still free to operate within the confines of a messenger model PPO. In a messenger model, the PPO acts as a literal messenger carrying price quotes between third party payors and individual physicians without disclosing the bargaining position of individual members to physicians as a group.\textsuperscript{72} The relatively higher costs

\textsuperscript{70} See Havighurst, \textit{Overregulating}, supra note 50, at 84-87.
\textsuperscript{71} See Havighurst, \textit{Overregulating}, supra note 50, at 89-92.
associated with this type of negotiation mean that fewer such networks will be formed, not that such networks will be unavailable to market participants if there is sufficient market demand.\footnote{73}

Economic arguments in favor of relaxing antitrust standards to permit network formation by physicians who are equity stakeholders or who engage in substantial clinical integration without financial risk sharing, or on the basis of the reduced transaction costs of joint bargaining should be rejected. In the absence of economic structures inducing more rational decision making with respect to how medical resources are consumed, the \emph{per se} prohibition against price fixing is warranted. By the same token, while capitation, global fees and structured fee-withholding constitute defensible forms of risk sharing, they do not exhaust the type of structural arrangements that can engender more rational intra-firm decision making with respect to the provision of health care. From a policy perspective, courts and the enforcement agencies should continue be sensitive to other organizational forms and firm structures that meet the risk sharing criteria.

\textbf{Physician Barriers to Entry.} Physicians claim that they face distinct disadvantages in the battle to form integrated health plans. Physicians maintain that antitrust requirements forcing doctors to price their services on a capitated basis discourage network formation because physicians lack the knowledge and experience necessary to price medical services as an insurance product.\footnote{74} Physicians also claim that they have more difficulty accessing capital markets. Finally, given that the physician component of the integrated health plan involves the largest number of actors, physicians claim that they face greater collective action problems in network formation than do hospitals and insurance companies. Doctors contend that these problems mean that most health plans of today and in the foreseeable future will be dominated by hospitals and third party payors. Physicians further assert that policy makers should be concerned about their comparative disadvantage in network formation because physician-dominated networks are superior to payor-dominated networks.\footnote{75} and that

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\footnote{73}To date, messenger model PPOs have been infrequently utilized. There is a tendency to blame higher costs for the infrequent use of the vehicle. An equally plausible explanation would focus on the ability of the messenger model to effectively prevent anticompetitive behavior such as physician collusion that might result in higher prices. If the messenger format effectively prevents physicians from exercising market power, then the expected benefits (profits) of network formation would be reduced and fewer such networks would be formed.

\footnote{74}“Since physicians generally do not have the accounting sophistication necessary to organize capitation and fee-withholding arrangements, nor the necessary funds to make capitation successful, they cannot offer a PPO product that would be characterized as legal under current antitrust doctrine.”\textit{Statement of Merle W. Delmer, M.D., American Medical Association, Before the Economic and Commercial Law Subcommittee, Committee on the Judiciary, United States House of Representatives, 103d Cong., 2d Sess. (June 15, 1994) (hereinafter AMA Delmer Testimony).}

\footnote{75}Id. (“Appropriate modification of the antitrust laws will enable physicians to reassert their traditional role as patient advocates, even in a health care arena dominated by managed care organizations. The market power of these organizations must be balanced by encouraging the formation of physician-directed health care networks. Physicians, with their knowledge and skill in clinical decision making, can provide
physicians are able to practice managed care medicine in a more cost-effective manner. Allegedly, these claims entitle physicians to special assistance in eliminating or reducing the barriers to physician entry into the market for integrated health plans.

Physician claims to practice managed care medicine in a more cost effective manner are self-defeating in terms of justifying special antitrust treatment. If physician claims are true, then physician-dominated plans should enjoy relatively greater success in the market. Active physician control and involvement may indeed be a significant factor in predicting network performance, and this difference may correspond to the provision of better medical services. Similarly, physician control may serve as an effective signaling device and a foundation for greater patient trust, much the same way that non-profit-status may have functioned in the past. If physician claims are true, however, these attributes will be rewarded in the market and give physician-dominated plans a comparative economic advantage.

Physician claims that they face unique barriers that prevent them from entering the market deserve more serious attention. It is true that most physicians lack the knowledge and experience to price a capitated insurance product. It is equally true that most insurance executives lack the knowledge, experience and state certification required to practice medicine. This fact, however, has not stopped insurance companies from establishing integrated health plans. Third party payors hire or contract with physicians to treat patients. Similarly, if physicians want to form integrated health plans, the solution is not to price the capitated product themselves, but rather to hire or contract for the insurance expertise. Just as there is a market for physician services, there is a market for actuaries and management personnel who can price health plans. Similarly, access to capital markets, particularly if physicians are correct in their contention that they can provide managed care in a more effective manner, should not stand as a prohibitive obstacle to physician-sponsored network formation. Finally, physician collective action presents no significant antitrust obstacles, once physicians cross the hurdle of sufficient integration. Physicians in an integrated network can act collectively and their conduct will be evaluated under the rule of reason -- the same legal standard applied to similarly situated hospitals and third party payors.

The sheer number of physicians involved in a managed care network is an unavoidable fact of life. The problem, however, is not unique to physician-sponsored networks. While it is a
HOSPITAL AGREEMENTS PERTAINING SOLELY TO PRICE, TERRITORY, OR SERVICE MENUS WOULD CONSTITUTE PER SE ILLEGAL ANTITRUST VIOLATIONS.  SIMILARLY, MERGERS BETWEEN HOSPITALS MAY VIOLATE SECTION 7 OF THE CLAYTON ACT IF THEY SUBSTANTIALLY LESSEN COMPETITION OR TEND TO CREATE A MONOPOLY.  THE ENFORCEMENT AGENCIES TREATMENT OF HOSPITAL MERGERS IS OUTLINED IN THE 1994 STATEMENTS.  SEE STATEMENTS OF DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION ENFORCEMENT POLICY ON Mergers Among Hospitals, 1994 STATEMENTS, supra note 30, at 20,774-75 (FIRST STATEMENT).  Finally, hospital joint ventures, such as those designed to share the cost of new equipment or clinical services, constitute “agreements” between horizontal competitors, which may constitute restraints of trade.  See Statements of Department of Justice and Federal Trade Commission Enforcement Policy on Hospital Joint Ventures Involving High Technology or Other Expensive Health Care Equipment, 1994 Statements, supra note 30, at 20,775-79 (SECOND STATEMENT); Statement of Department of Justice and Federal Trade Commission Enforcement Policy on Hospital Joint Ventures Involving Specialized Clinical or Other Expensive Health Care Services, 1994 Statements, supra note 30, at 20,779-82 (THIRD STATEMENT).  THE 1996 STATEMENTS MADE NO SUBSTANTIVE CHANGES IN THE EVALUATION OF HOSPITAL CONDUCT.

HOSPITAL PROPOSALS FOR MEDICAL ANTITRUST REFORM

The Desirability of Hospital Competition and a Preliminary Assessment of Reform Proposals. Antitrust principles constrain the conduct of hospitals as well as physicians. Hospitals advocate antitrust reform that would permit increased consolidation and greater hospital authority in planning the provision of medical services. In essence, hospitals maintain that increased concentration or the express sanctioning of cooperative agreements is necessary to compensate for the inability of competitive market forces to efficiently allocate social resources. “The AHA believes that increased collaboration will allow local communities to establish programs designed to prevent or reduce excess capacity and unnecessary duplication of services, equipment, and facilities.”

Some proposals have been introduced at the federal level to introduce greater levels of “planning” in the allocation of health care resources, particularly as it affects the needs of underserved segments of the community. See, e.g., Essential Health Facilities Investment Act of 1997, H.R. 735, 105th Cong., 1st Sess. (1997) (to establish a program of assistance for essential community providers of health care services, to establish a program to update and maintain the infrastructure requirements of safety net hospitals, and to require States to develop plans for the allocation and review of expenditures for the capital-related costs of health care services). H.R. 735 would have immunized cooperative conduct taken
cooperation in lieu of competition. According to the hospitals, competition creates incentives to over-invest in capacity and equipment. Cooperation is necessary to counteract the effects of unfettered economic rivalry.

It is true that many hospital markets have substantial amounts of what might be termed “excess” capacity and that occupancy rates as low as fifty percent are not unusual. Historically, the pervasiveness of private insurance, fee-for-service systems of reimbursement, the price insensitivity of purchasing health care consumers, and government subsidies all helped to contribute to the over-bedding of America. These perverse incentives were exacerbated by the “irrational” structure of the firm and the fractured economic relations between third party payors, hospitals and physicians. The role of physicians as patient-brokers gave hospitals incentives to engage in intense competition for physicians as a surrogate means of stimulating inpatient demand. Most of this competitive energy was diverted along non-price dimensions in the form of physician amenities, additional capacity, and new technology and equipment.

Earlier, this chapter developed evaluative criteria to assess proposed antitrust reforms. An application of these standards to hospital proposals reveals that hospital calls for greater horizontal cooperation are actually third-best, rather than a second-best solutions. Hospital reforms are not aimed at remedying market failures such as imperfect or asymmetric information. Rather, hospital reforms are aimed at reducing the detrimental side effects of traditional non-market responses to these underlying market failures. In essence, hospital proposals are designed to remedy the inefficiencies associated with the peculiar, non-Coasian structure of traditional health care markets and the corresponding tendency of these structures towards the over consumption of medical resources. The real problem is not with competition per se, but with competition between improperly organized firms. Competition between newly integrated entities, however, is unlikely to produce the same inefficient results. Consequently, the emergence of integrated health plans eliminates much of the underlying economic justifications for hospital antitrust reform.

Rejecting antitrust reforms in integrated health care markets, however, does not constitute a complete response to the problems raised by reform proponents. Hospital markets are predominately local in nature. While the case against greater physician cooperation was largely invariant to market structure (physician proposals are no more persuasive in concentrated markets than they are in competitive markets), hospital proposals require a tiered analysis that distinguishes between integrated markets, markets where integration is possible, and markets that are unlikely to ever cross the threshold of substantial integration. As just stated, antitrust reforms are largely unpersuasive in integrated markets. In smaller markets, however, there may be little or no chance of inducing substantial levels of integration, or in achieving effective competition between integrated health plans. While the welfare effects of hospital consolidation in these markets is ambiguous, a plausible argument can be made that hospital market power may curb pressures for non-price competition and may improve social welfare. Consequently, it is appropriate to discuss the desirability of reforming antitrust

pursuant to the act from federal and state antitrust laws.

81 See articles cited supra note 16.
law in these settings.

In markets that have not yet experienced substantial integration, but which are capable of being integrated, the antitrust prescription is essentially the same as that for integrated markets. The dominant concern here is dynamic efficiency. Antitrust policy should be directed at maintaining the conditions necessary for effective prospective competition between integrated health plans. Antitrust standards should be strictly enforced in these markets, even in the face of significant levels of excess capacity and calls for increased cooperation. Competition in these markets is likely to produce desirable results and the level of physical capacity that is retained in these pre-integrated markets will determine the degree to which effective price competition will ultimately emerge. This suggestion runs contrary to the prevailing wisdom, which tends to view retiring capacity from hospital markets as an unambiguous efficiency gain. The common wisdom, however, fails to appreciate the strategic incentive that health care providers have to establish capacity constraints as a means of restricting price competition. The full competitive virtues of existing hospital capacity must be recognized and expressly balanced against whatever efficiency gains might be obtained from its elimination.

**Firm Structure and the Incentives to Acquire Capital and Technology.** In evaluating hospital arguments for antitrust reform, it is necessary to understand the degree to which historic incentives to invest in hospital capacity and technology were influenced by the structure of hospitals, physicians and insurance companies as separate and independent economic firms. Ordinarily, a firm will invest in new capacity if it believes that the discounted revenues generated from being able to serve a greater number of customers will exceed the cost of the investment. Similarly, a firm will invest in a new technology if it believes that the cost savings from a superior method of production or the increased revenue derived from increased demand for the new service will exceed the cost of the investment.

There are many ways in which the fractured organization of traditional markets altered these basic calculations. A fee-for-service system of reimbursement, coupled with passive third party payor supervision, eliminated much of the economic penalty associated with underutilized capacity and technology. Rather than engaging in marginal cost pricing, hospitals traditionally charged a set mark-up over the average total cost of the service, passing the costs of underutilization to third party payors in the form of higher charges. The third party payors that ultimately paid for the technology had little or no input into the investment decisions. Furthermore, given that insurance companies reviewed hospital charges on the basis of a “reasonable and customary” community standard, there was no penalty when other hospitals in the same market invested in the same underutilized equipment. If another hospital acquired the same device, decreasing per-hospital rates of utilization, each hospital could submit a comparably higher “community” charge reflecting the equally underutilized nature of their respective services.

The fractured nature of the firm created additional incentives for acquiring new technology and services. In markets where patients implicitly selected a hospital through their choice of physician, hospitals could increase demand by cultivating physician loyalty and affiliation -- forms of non-price competition. Given that physicians were independent economic actors who did not
internalize the costs associated with underutilized hospital equipment, physicians had incentives to
demand levels of capacity and technology that exceeded what they would rationally choose for
themselves. For example, physicians might demand built-in excess hospital capacity if such capacity
facilitated the physician’s ability to access the facility by better accommodating the physician’s
scheduling needs.

These economic incentives are substantially altered once the disparate functions of
insurance, physical capital and human capital are integrated into a single economic firm. The
integrated entity internalizes the costs associated with underutilized capacity. Moreover, in assessing
the need for new technology, the firm will consider only the increased revenue that can be generated by
the device in terms of increased utilization or reduced costs. Similarly, integration eliminates incentives
to engage in non-price competition for physicians. Competition for physician loyalty and affiliation can
take place directly in terms of compensation, bonuses and salary. Finally, if firms are properly
structured, the incentives of physician as stake-holders of the firm to demand new capacity and
technology will be aligned with the needs of the organization.

The Superficial Case for Antitrust Reform. The irrational structure of the firm
courages the over consumption of health care resources. Competition between these fractured
entities exacerbates these effects. Historically, hospital competition has manifested itself in terms of
higher levels of capital acquisition and non-price competition in competitive markets than in markets that
were relatively less competitive. These activities can come at a substantial price. The consensus of
empirical research employing data from traditionally structured markets finds a consistently positive and
statistically significant relationship between indicia of competition and measures of hospital costs. All
other things being equal, the more hospitals there are, the higher the expenses associated with providing
hospital care. Simplistically, if hospital expenses are “higher” in competitive markets than in
concentrated markets, and one believes that hospital expenses in general are “too high,” then one
possible means of reducing health care expenses is to encourage greater hospital consolidation, or to
permit arrangements in competitive markets that mimic the types of resource allocations observed in
economically concentrated hospital markets. Instead of integration, hospital consolidation and provider

As with the discussion of the integrated firm’s incentives to provide incremental care, this discussion
presents a simplified analysis that focuses primarily upon the effects of having the same decision maker
consider the costs and benefits of the investment. Even with integration, market imperfections may continue
to distort investment decisions. For example, in a world of imperfect information, new technology may
serve reputational and signaling functions, acting as a proxy for product quality. If this is the case, then even
firms in integrated markets will exhibit a tendency to over invest in medical technology. This tendency,
however, will be less pronounced than similar tendencies in unintegrated markets.

cooperation are advocated as solutions to the problem of increasing medical costs.

Determining whether this is an appropriate antitrust policy requires a better understanding of what the empirical evidence actually proves. It is necessary to examine more carefully the social value of non-price competition. For hospital reform proposals to be persuasive, proponents must be able to demonstrate that the lower level of non-price competition observed in concentrated markets represents a superior distribution of resources. In terms of the second criterion outlined earlier, consolidation must produce a net increase in social welfare (static efficiency). This proposition has yet to be demonstrated with any level of economic rigor, because the existing research says nothing about consumer valuation of the non-price attributes. While many commentators are quick to condemn non-price competition as “wasteful duplication,” these amenities have some positive value to consumers. To assess the impact of consolidation on total welfare, one must acknowledge the loss to consumers and balance it against any potential increase in hospital surplus (profits) associated with curtailing non-price investments. If the gain to hospitals more than offsets the loss to consumers, then the reduction in non-price competition would result in a net increase in social welfare.84

Ironically, even if increased hospital concentration resulted in an improved allocation of resources, there is no guarantee that the resulting outcome would be optimal from an economic perspective. The resource distribution characteristic of concentrated hospital markets could represent either an overinvestment in non-price attributes (if the underlying market failures are sufficiently strong), or an underinvestment in non-price attributes (if the monopoly or oligopoly outcome overcompensates for the underlying market failures). This is one of the difficulties inherent with relying upon second-best (or in this case potentially third-best) remedies to the problem of market failures. A Pareto superior outcome, when compared with a suboptimal starting point, only represents a defensible move in the right direction, not necessarily the appropriate ending point.

The Coasian restructuring of the firm, on the other hand, is a more direct and theoretically more defensible response to the problem of non-price competition. Integration internalizes the costs and benefits of the investment decision into a single economic decision maker. This will produce fundamentally different incentives and behavior. The incentives to over-invest in resources that characterized traditional health care markets are substantially muted, if not eliminated. Moreover, there is greater reason to be confident that informed consumer choices between the variety of price/non-price packages likely to be offered by integrated health plans will more closely reflect the amount consumers are willing to pay for non-price attributes, at least to the extent that differences in premiums reflect actual differences in the costs of services.

If integration and consolidation were complementary strategies to the problem of overinvestment, then hospital antitrust reforms might still be warranted, regardless of the simultaneous transformation of health care markets through integration. The two strategies, however, are not

84 These issues are explored in greater depth in Peter J. Hammer, Questioning Traditional Antitrust Presumptions: Price and Non-Price Competition in Hospital Markets, 33 Mic. J. L. Ref. ___ (forthcoming 1999).
complementary. Greater cooperation between hospitals, just as collective physician bargaining, could be used to forestall or block integration. Moreover, increases in hospital concentration will constrain the total number of integrated health plans that can operate in any given market. Competition between integrated plans is necessary both to engender effective price competition, and to protect patients from the specter of integrated plans underproviding care. Increased provider cooperation will dull the market penalty for denying care and could introduce the possibility of collusive underinvestment strategies amongst providers. Consequently, integration increases rather than decreases the need for vigilant antitrust enforcement.

Designing Future Markets -- The Competitive Virtues of Excess Capacity. Decisions made today regarding physical capacity will influence the extent to which the competitive promise of integration will be realized. Efforts to facilitate horizontal cooperation and eliminate “excess capacity” can substantially undermine the development of competitive markets and the stimulation of future price competition. Even if hospital consolidation was to produce a short term increase in social welfare (static efficiency), in those markets capable of making the transition to complete integration, long-term competitive concerns militate in favor of strict antitrust enforcement (dynamic efficiency). Physical capacity represents the most serious constraint upon the total number of health plans. The addition of new capacity is discrete, expensive, and can take place only with a relatively long lag period. These barriers are substantially higher than the barriers associated with the entry of physicians or third party payors, both of which have substantial inter-market mobility.

Physical capacity, including potential “excess” capacity, can have substantial pro-competitive virtues. Aggregate market capacity plays a significant role in determining the strength of incentives to engage in price competition. It is important to remember that the level of capacity present in any market is, in part, determined by the decisions of market participants themselves. Not surprisingly, if given the option, market participants will often choose to be capacity constrained -- enter the market with less productive capacity than they would be capable of both producing and selling. By reducing the amount of market capacity, private actors know that they can credibly pre-commit to strategies that yield higher market prices and higher profits.

Understanding the dynamics of this process provides the tools with which to evaluate proposals to reduce hospital capacity in the name of reducing medical costs. Some basic models of industrial organization help illustrate the role that market capacity plays in encouraging active price competition, as well as the countervailing incentives that individual competitors have to be capacity constrained. The Bertrand model of price competition shows how market capacity can yield low prices, even when there are relatively few producers in the market.85 In the Bertrand model, competitors independently submit price bids. The lowest bidder wins, and is obligated to supply the entire market demand triggered by the successful bid. If more than one bidder submits the same low bid, the winners equally divide the market demand. In the resulting Bertrand equilibrium, each

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85 For discussions of Bertrand competition see KEEPS, MICROECONOMICS, supra note 5, at 330-35; VARIAN, INTERMEDIATE, supra note 5, at 461-62; JEAN TIROLE, THE THEORY OF INDUSTRIAL ORGANIZATION at 209-11 (1988).
competitor submits a bid equal to their marginal costs and equally divides market demand at that price. *So long as each firm has sufficient individual capacity to supply the entire market*, as few as two firms can generate a competitive equilibrium characterized by marginal cost pricing.  

The Bertrand model is problematic given its restrictive and arguably unrealistic cost assumptions. The model assumes that there are constant returns to scale and that there are no fixed costs. Both of these assumptions are violated in medical markets. Hospitals have high fixed costs and, at least initially, there are significant increasing returns to scale in terms of hospital size. Furthermore, the model assumes that each competitor is capable of supplying the entire market demand, although this assumption can be relaxed as the number of firms increases beyond two. The basic lessons of the Bertrand model, however, that the relative strength of incentives to engage in price competition is affected by levels of productive capacity, and that physical capacity, to some extent, can substitute for the usual competitive assumption that there are a larger numbers of producers, are valid and are generalizable to health care markets.

In the Cournot equilibrium, price and profits are a function of the number of firms in the industry. Cournot prices will always be higher than marginal costs, with prices converging to marginal costs in the limit case of perfect competition, i.e., as the number of firms in the market approaches infinity. *See Keeps, MICROECONOMICS, supra note 5, at 326-28; Varian, INTERMEDIATE, supra note 5, at 447-58; Tirole, supra note 85, at 217-21; Hovenkamp, supra note 26, at 152-54.*

The Cournot model, in contrast, illustrates how unilaterally imposed capacity constraints can permit supracompetitive pricing. In the Cournot model, firms compete in terms of output rather than price. Each firm independently selects a level of output, assuming that its decision will not influence the decisions of other firms. Prices are determined by the aggregate output of the market. In a Cournot equilibrium, firms rationally choose to be capacity constrained, with the ultimate severity of the constraint determined by the total number of firms in the market. The fewer the number of firms in the industry, the lower the level of industry output, and the higher the market price and equilibrium producer profits. The Cournot model illustrates how the number of firms in the market effects how closely the market can approximate the competitive outcome. Generally speaking, the fewer the number of firms, the less competitive the outcome.

The strategic nature of a firm’s incentive to manipulate levels of capacity can be illustrated by a two-stage game in which firms first independently select their physical capacities and then, knowing the capacity choices made by other firms in the first stage, engage in Bertrand price competition. The resulting equilibrium of this two-stage game is not the desirable equilibrium characteristic of the one stage Bertrand game, where firms have the ability to produce unlimited quantities and prices reflect marginal costs. Rather, the equilibrium of the two stage game is exactly the same as that of the one stage Cournot game. Why? The answer is that firms intentionally choose to constrain their ability to produce, because imposing capacity constraints represent one of the few means available for establishing prices that are above marginal costs. The relative strength of the incentives to
reduce or eliminate capacity is, in turn, determined by the number of firms in the market. The larger the number of firms, the more capacity will be on the market and the lower will be the market price. This two-stage model is important because it illustrates how active price competition alone will not guarantee a truly competitive outcome. Price competition must be coupled with sufficient levels of market capacity in order to achieve competitive results.\(^8\)

If firms have rational, private incentives to be capacity constrained, how can one explain the pervasive “excess” capacity that characterizes most hospital markets? The answer is that the level of capacity that exists today is the result of an historic shift in the operative economic regime governing health care markets. Hospital markets are currently characterized by levels of physical capacity that hospitals would not knowingly select if they knew that they would have to engage in active price competition (selective contracting as opposed to fee-for-service reimbursement). By the same logic, hospitals have strong contemporary incentives to retire capacity from the market in an effort to impose new capacity constraints. Just as rational firms in the two-stage game would not choose to build the level of capacity that hospitals are currently saddled with, so hospitals saddled with that capacity today will rationally choose to eliminate as much of it as possible, so as to impose meaningful new capacity constraints as they enter an economic regime characterized by increased price competition.

As the beneficiaries of a shift in prevailing economic regimes, antitrust and health care policy makers have a unique opportunity. If nothing is done, physical capacity will be systematically retired from the market and a Cournot-type equilibrium characterized by newly imposed capacity constraints will assert itself. The social costs of such an equilibrium will consist of relatively higher prices than would otherwise exist and relatively more restricted patient access. The elimination of capacity will also limit the number of integrated health plans that are likely to be formed. The smaller the number of plans in a market, the less likely it is that competition between plans will effectively temper incentives to abuse the plan-patient agency relationship by underproviding care. Alternatively, antitrust laws could be employed and policies designed to take advantage of the competitive opportunities wrought by the additional capacity. A strong case can be made in favor of adopting policies that strive to retain the physical capacity that hospitals might otherwise want to retire from the market.

**Balancing Competition, Capacity and Efficiency.** Emphasizing the often neglected virtues of excess capacity does not mean that legitimate arguments for eliminating capacity cannot be

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8\(^9\) This discussion has not considered the effect that new market entry can have on aggregate market capacity. Market entry serves as an important check on the efforts of individual firms to limit output. Market entry will occur so long as a new firm’s expected profits exceed the costs of entry. If existing firms sufficiently restrict output and raise prices to the point where industry profits are high enough for a new firm to profitably enter the market, entry should occur. As a result of entry, market capacity will increase and prices and profits will fall. Consequently, while there is an internal market dynamic for existing firms to restrict output in an effort to raise prices, there is another dynamic stimulating entry, which ultimately limits the ability of firms to raise prices.
made in some markets. Markets with substantial excess capacity are subject to criticism in terms of the potential sustainability of the resulting market equilibrium and in terms of the efficiency costs associated with underutilized productive resources. There is a necessary tradeoff between the benefits derived from enhanced competition and the costs associated with decreased efficiency. Devising the appropriate balance involves weighing the benefits of increased competition against the potential loses in efficiency due to firms operating below the minimum efficient scale of production or due to the higher fixed costs associated with underutilized capacity. Health care markets are not the first markets in which such tradeoffs have been made. In markets for military contracts, for example, the government frequently makes a conscious decision to preserve competition by cultivating multiple suppliers, even when fewer suppliers might be able to fulfill contract requirements. Increased competition is purchased at the price of decreased economic efficiency. The costs of preserving capacity in hospital markets are significantly less than the costs of systematically building in similar redundancy. The capacity already exists.

The costs and benefits of retaining hospital capacity can be assessed on a case-by-case basis. The inherent pro-competitive virtues of physical capacity combined with the anticompetitive private incentives to impose capacity constraints justify a policy presumption favoring the retention of capacity on the market. Proponents of increasing economic concentration, however, should be allowed to make a contrary case. If the evidence indicates that the efficiency gains of eliminating capacity exceed the competitive benefits of retaining the capacity, then the capacity should be retired from the market. Some markets may simply not be capable of supporting more than one or two facilities. In these circumstances, it is not wise to force competition or preserve redundant capacity. Some level of market power either by a free-standing hospital or a single integrated health plan may be inevitable. If this is the case, then the appropriate policy response may be the adoption of forms of regulation like those employed with natural monopolies -- e.g., public utilities.

Similar problems are raised by hospitals that function substantially below the minimum efficient scale of operation. This problem can be addressed by the efficiency defense in merger cases. The 1994 Statements carve out a safety zone for hospitals with less than 100 beds and less than 40% occupancy for the last three years. Similarly, the 1994 Statements suggest that the enforcement agencies will consider hospital efficiencies and projected cost savings in deciding whether to prosecute those mergers that fall outside of the safety zone.

It is important that the special problems confronting some small hospitals and small markets not obscure the larger picture. The Coasian reformation of modern health care markets largely renders obsolete the once plausible argument that increased economic concentration was necessary as a third-best solution to the pressures driving non-price competition. Beyond the fact that contemporary incentives are no longer biased in favor of acquiring additional capacity and technology, existing levels of capacity have the positive virtue of facilitating active competition. In general, the greater the capacity in the market, the greater the level of competition and the lower the price of health care services.

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CONCLUSION AND A POSTSCRIPT ON HEALTH CARE REFORM

Disputes over the structure of health care markers will continue in both economic and political arenas. Arrow’s welfare analysis helps bridge these realms and provides a framework within traditional economic analysis to assess when private markets should be supplemented with social institutions. A careful examination of physician and hospital proposals to reform federal antitrust law, however, reveals that increased provider cooperation is largely undesirable in emerging health care markets. This conclusion flows from the realization that integration represents a Coasian transformation of the firms delivering health care services and financing. Newly integrated firms have very different economic incentives and should make substantially more rational decisions concerning when medical care is provided and when new medical equipment is acquired. Furthermore, competition between integrated firms will not only produce lower prices, it should help counteract whatever incentives integrated health plans may have to underprovide care.

Recognizing that active antitrust enforcement will play an important role in emerging health care markets does not mean that a case cannot be made for other forms of non-market interventions. The market equilibrium characteristic of competition between integrated firms will likely suffer its own “optimality gap,” engendered by the same informational market failures that have always plagued the medical industry. While efforts to systematically reform the health care system failed in 1993 and are unlikely to be revived soon, incentives targeted at particular aspects of the system will continue. Some of these proposals attempt to control the type of integration that is taking place or to influence the behavior of integrated firms. Other initiatives represent a general backlash against managed care providers. This backlash is motivated by a growing appreciation of the incentives that managed care plans may have to underprovide care and a realization that the current legal system may not be adequately developed to hold plans accountable for their actions.

Proposals to control the type of integration that takes place include “any willing provider” laws designed to restrict the ability of networks to exclude otherwise qualified physicians who want to participate in their health plan. Other initiatives attempt to give physician-sponsored networks more favorable legal treatment than payor-sponsored networks, such as the exemptions from federal and state antitrust laws examined in this chapter or efforts to exempt physician-sponsored networks

Health care providers that market their services as an insurance product, such as those that assume risk by accepting capitated payments, are potentially subject to state insurance regulation. To date, there has been little consistency in state approaches, see Risk-Bearing Network Regulations Described as “All Over the Board”, 23 PENSION & BENEFITS REP. (BNA) No. 10 at 598 (Mar. 4, 1996), although the National Association of Insurance Commissioners generally favors greater state regulation of provider-sponsored networks. See State Insurance Laws Should Apply to Risk-Bearing Networks, NAIC Says, 22 PENSION & BENEFITS REP. (BNA) No. 35 at 1953 (Aug. 28 1995). Physicians generally oppose such regulatory efforts and have sought federal protection. The House version of the 1995 Medicare reform bill, for example, would have exempted physician-sponsored-networks contracting for Medicare services from state insurance regulations and established separate federal standards for such organizations. See H.R. 2425, 104th Cong., 1st Sess. § 1854 (1995). A similar provision was enacted into law in the Balanced Budget Act of 1997 which, among other things, established the Medicare+Choice Program. See 42 U.S.C. § 1395w-25 (1998). For a discussion of these provisions see James J. Unland, The Range of Provider/Insurer Configurations, 24 J. Health Care Fin. 1, 3-5 (Winter 1998).

contain provisions designed to protect open communication between patients and health care providers, prohibiting so-called “gag orders.” Other provisions of these bills attempt to regulate the substantive decision making of providers, such as rules establishing the conditions under which it is appropriate to seek emergency treatment or setting the number of days a plan must provide inpatient care after certain medical procedures and performed. Finally, a common feature in many of these bills are provisions to provide greater legal accountability for integrated health plans, the most important of which would expose employer-sponsored ERISA plans to state tort liability.

The evaluative criteria developed in this Chapter can be applied to these proposals as well. Desirable legislative reform should have as its primary objective the remedy of identifiable market failures. Calls for the adoption of “any willing provider” laws and differential state insurance treatment of provider-sponsored networks generally fail this first criterion. Some provisions of the “patient protection acts,” however, are aimed at providing patients information, imposing disclosure requirements for health plans, and preventing abuses of the plan-patient agency relationship. These initiatives are responsive to medical market failures. Whether such reforms are ultimately desirable will depend upon whether they would result in a net increase in social welfare (static efficiency) and whether their implementation would unnecessarily interfere with the effective structure and operation of the market (dynamic efficiency). Regardless of whether these laws are enacted, strict antitrust enforcement and facilitating effective competition between health plans may be the first and best response to plan/provider agency failures in integrated markets.