

The Antitrust Implications of “Clinical Integration:” An Analysis of FTC Staff’s Advisory Opinion to MedSouth

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This article will focus on a single fourteen-page letter from an Assistant Director in the Federal Trade Commission’s (hereinafter referred to as “Commission”) Bureau of Competition to a law firm in Washington, D.C., in response to that law firm’s request for an advisory opinion on a business proposal.<sup>1</sup> MedSouth, Inc., a physician independent practice association, located in Denver, Colorado, proposed to integrate partially the practices of its members and to negotiate for their services collectively with payors. Counsel for the association wanted to know whether Commission staff would recommend an antitrust challenge. Staff advised that it would not recommend a challenge, but that it would monitor future developments.<sup>2</sup>

The resulting staff opinion is worthy of study for a number of reasons. First, the opinion provides a useful discussion of general antitrust principles applicable to joint ventures. Second, it is the first opinion that applies the so-called “clinical integration” test under the joint DOJ/FTC

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\* Commissioner, Federal Trade Commission. This article is an expanded version of a speech delivered at the Saint Louis University Health Law Symposium on April 12, 2002. The views expressed are individual, and not necessarily shared by other Commissioners. I acknowledge the assistance of my advisor, Holly L. Vedova.

<sup>1</sup> Letter from Jeffrey W. Brennan, Assistant Director Health Care Services & Products, FTC, to John J. Miles, Ober, Kaler, Grimes & Shriver (February 19, 2002), at <http://www.ftc.gov/bcadops/medsouth.htm> [hereinafter MedSouth Staff Opinion]. The Commission’s advisory opinion process allows interested parties to request advice from the Commission with respect to a course of action that the requesting party proposes to pursue. In practice, most advisory opinions are staff letters. The Commission’s advisory opinion procedure is contained in 16 C.F.R. §§ 1.1-1.4 (1993).

<sup>2</sup> MedSouth Staff Opinion, *supra* note 1.

Statements of Antitrust Enforcement Policy in Health Care.<sup>3</sup> Third, if the MedSouth experiment succeeds, it could have a profound effect on the future evolution of managed care.

The article will discuss the background, the rationale and the implications of this opinion letter, with consideration of complicating factors.

## I. *Background Setting*

### A. *Special Economic Factors*

The antitrust analysis of a joint venture proposed by health care providers must take account of the special characteristics of the marketplace in which they operate. Most notable is the fact that people who seek medical treatment normally do not directly and individually pay for the full cost of the treatment. They may pay a great deal for health care, indirectly and collectively through insurance premiums and taxes, but these payments are not associated with particular services. The incremental costs of the services to insured patients may be close to zero. This means that these people tend to “over-consume” health care services.<sup>4</sup>

Health care providers (like doctors) have a corresponding incentive to “over-supply” some services, to the extent they are paid for each procedure or test that they supply.<sup>5</sup> This tendency to “over-supply” will not be disciplined by patients, who have neither the specialized knowledge to recognize it, nor the incentive to do anything about it. Someone has to perform a

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<sup>3</sup> U.S. DEP’T OF JUSTICE & FED. TRADE COMM’N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE (1996), *reprinted in* 4 Trade Reg. Rep. (CCH) ¶13,153, at §§ (8)(B)-(C) (Sept. 5, 1996) [hereinafter HEALTH CARE STATEMENTS]. A number of previous opinions have discussed “financial integration.”

<sup>4</sup> *See, e.g.*, David M. Cutler, *A Guide to Health Care Reform*, 8 J. ECON. PERSP. 13 (1994).

<sup>5</sup> Doctors may also be tempted to practice “defensive medicine” (i.e., excessive tests and procedures) to reduce the risk of malpractice claims. *Id.* at 16.

gatekeeper function to moderate these mutually reinforcing tendencies to over-supply and to over-consume.

In countries with socialized medicine, the gates are tended by the state and care is rationed by a queue; in the United States, the gates are tended by private entities like Health Maintenance Organizations (“HMOs”) and care is rationed according to their guidelines. Neither system is popular.

The basic problem is that people can comprehend the need to reduce health care expenditures in the aggregate, and recognize that some gatekeeping is necessary, but we all tend to assign an almost infinite value to the life of any identifiable person. There will always be individual horror stories, where public or private gatekeepers appear to have acted callously, and no group is more outraged by these incidents than people in the provider community—who have firsthand experience with many of them and a powerful ethical commitment to individuals in their care.

These providers have a legitimate incentive to engage in collective action that will increase their bargaining power on issues that relate to the quality of care. The problem is that, like any other group, providers also have a less legitimate incentive to engage in collective action that will increase their own income.<sup>6</sup> The challenge for antitrust is to distinguish between collective conduct that primarily addresses a legitimate objective and conduct that does not, recognizing there may be spillover effects and the future is always uncertain. This is not just a technical legal problem because an antitrust policy that is perceived to be overly aggressive is likely to be tempered by a strong political response.<sup>7</sup>

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<sup>6</sup>See *FTC v. Superior Court Trial Lawyers Ass’n*, 493 U.S. 411 (1990).

<sup>7</sup> See Warren S. Grimes, *The Sherman Act’s Unintended Bias Against Lilliputians: Small Players’ Collective Action as a Counter to Relational Market Power*, 69 ANTITRUST L.J. 195, 212-

## B. *General Antitrust Principles*

The applicable legal standards also contain some internal anomalies. Virtually all antitrust cases involve the activities of a number of people, but it makes a significant difference in the analysis if these activities are deemed to be the work of a single entity or a combination of separate entities. The critical question is whether there is or is not an “efficiency-enhancing integration of economic activity.”<sup>8</sup> The anomaly is that the distinction between the two categories can involve some close judgements up-front,<sup>9</sup> but thereafter the analysis proceeds in a very different way. As a practical matter, these delicate up-front distinctions may ultimately be outcome determinative.

Specifically, a group of doctors can probably negotiate collectively with payers about payment terms if they meet the criteria for treatment as a single entity, but they are guilty of a *per se* antitrust violation if they do not meet the criteria.<sup>10</sup> Before considering this issue in greater depth, it is necessary to look at the substance of the MedSouth proposal.

## II. *The MedSouth Facts and the Staff Opinion*

MedSouth, Inc. is an independent practice association in Denver, Colorado, that currently includes about 450 doctors who practice in the fields of primary care and forty specialties and

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13 (2001); John J. Miles, *Joint Venture Analysis and Provider—Controlled Health Care Networks*, 66 ANTITRUST L.J. 127, 152 (1997).

<sup>8</sup> See FED. TRADE COMM'N & U. S. DEP'T OF JUSTICE, ANTITRUST GUIDELINES FOR COLLABORATIONS AMONG COMPETITORS (2000), reprinted in 4 TRADE REG. REP. (CCH) ¶ 13,161, at § 1.2 (Apr. 12, 2000) [hereinafter COLLABORATION GUIDELINES].

<sup>9</sup> Cf. *Fraser v. Major League Soccer, L.L.C.*, 284 F.3d 47, 59 (1st Cir. 2002) (“Once one goes beyond the classic single enterprise . . . it is difficult to find an easy stopping point or even decide on the proper functional criteria for hybrid cases.”).

<sup>10</sup> See, e.g., *Obstetrics and Gynecology Med. Corp. of Napa Valley*, No. C-4048, 2002 WL 1005063 (FTC May 14, 2002); *Physician Integrated Serv. of Denver, Inc.*, No. 0110173, 2002 WL 988023 (FTC May 14, 2002); *Aurora Associated Primary Care Physicians, L.L.C.*, No. 0110174, 2002 WL 988024 (FTC May 14, 2002).

sub-specialties. This group of doctors proposes to coordinate activities by sharing clinical information; coordinating treatment, particularly the interface between primary care doctors and specialists; developing practice protocols; and monitoring the compliance of individuals in the group. The stated objectives are to improve patient outcomes, decrease use of physician resources and provide MedSouth with a competitive advantage over other practices in the area.

Prices for treatment will be collectively negotiated with payers, but doctors will bill individually and directly on a fee-for-service basis. MedSouth will not negotiate capitated contracts or share profits of a joint enterprise. However, the venture will be non-exclusive, and members can contract individually with payers who do not choose to negotiate with the group.

In response to MedSouth's request for an advisory opinion, FTC staff followed the analytical process described above in Section I.B. and concluded that a "*per se* analysis would not be appropriate in evaluating MedSouth's proposed course of conduct."<sup>11</sup> The rationale for this conclusion was that the proposed plan "appears to involve partial integration among MedSouth physicians that has the potential to increase the quality and reduce the cost of medical care"<sup>12</sup> In addition, the staff opined that the proposed "joint contracting appears to be sufficiently related to and reasonably necessary for, the achievement of the potential benefits to be regarded as ancillary to the operation of the venture."<sup>13</sup>

The integration rationale is specifically addressed in the Health Care Statements and there have been a substantial number of previous staff opinions to the same effect.<sup>14</sup> However, the

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<sup>11</sup> MedSouth Staff Opinion, *supra* note 1.

<sup>12</sup> *Id.*

<sup>13</sup> *Id.*

<sup>14</sup> A list of health care antitrust advisory opinions by Commission and staff is available at <http://www.ftc.gov/bc/advisory.htm> (last visited Aug. 29, 2002).

previous opinions were based on a prediction that financial risk sharing would provide the incentives for the achievement of substantial efficiencies.<sup>15</sup> In *MedSouth*, for the first time, the opinion addressed a venture with no (or trivial) financial risk sharing and relied on so-called “clinical integration” to yield the expected efficiencies.<sup>16</sup> Note that the underlying justification for a “financial integration” and a “clinical integration” test is similar (potential for improved efficiencies), but the former seems to rely on the existence of incentives to improve whereas the latter seems to rely on the stated plans for improvement.

The staff opinion’s further conclusion that joint contracting with payers should be treated as an ancillary restriction will be discussed below. The bottomline is that this finding, along with the application of a clinical integration test, justifies a rule-of-reason analysis of the venture. In my view, this conclusion is consistent with the Commission’s own guidelines and policy statements, and mandated by applicable case law.<sup>17</sup> The difficult issue that the opinion does not tackle is precisely how a subsequent rule-of-reason inquiry would proceed. Discussion of this issue would be speculative because the venture was only in the proposal stage and because there have been no subsequent rule-of-reason challenges to ventures that were given comparable comfort. There was no particular need for staff to embark on this speculative exercise, but that is what this article will now attempt to do.

### III. *Conceptual Problems in a Two-Step Analysis*

There is something anomalous about the whole idea of a “two-step” analysis, that involves, first, a determination whether rule-of-reason treatment is appropriate and, second, an

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<sup>15</sup> See HEALTH CARE STATEMENTS, *supra* note 3, at § (8)(A)(4).

<sup>16</sup> See *id.* at § (8)(B).

<sup>17</sup> See *Cal. Dental Ass’n v. FTC*, 526 U.S. 756 (1999).

analysis under the rule of reason. One problem is that it may be necessary to look at some aspects of “reasonableness” in the first step, as well. The *MedSouth* opinion letter, for example, refers to the efficiency-enhancing “potential” of the proposed venture, which requires the exercise of some judgment, and then goes on to find that joint contracting “appears to be sufficiently related . . . and reasonably necessary.”<sup>18</sup> Factual judgment is needed to support a conclusion that a fuller examination of the facts is necessary.

This seemingly awkward process is not unique. For example, a tying case requires an initial inquiry into factual issues like market power and product definition before deciding whether *per se* or rule-of-reason treatment is appropriate.<sup>19</sup> Similarly, the National Cooperative Research and Production Act provides that certain joint ventures qualify for rule-of-reason treatment,<sup>20</sup> but the statutory definition excludes those ventures that will exchange sensitive information “not reasonably required to carry out the purpose of the venture.”<sup>21</sup>

A reasonableness test to determine whether to apply the rule-of-reason raises interesting questions in the context of a nascent venture like *MedSouth*, when no one knows whether certain assumptions will prove to be true. What happens if some plans for clinical integration are not carried out or predicted quality improvements do not materialize? As a matter of strict logic the venture should be deemed *per se* illegal—perhaps even retroactively. Since findings of *per se* illegality can have serious collateral consequences, this appears to be a harsh sanction for failure to fulfill a business plan. On the other hand, if the consequences are not serious, there may be a

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<sup>18</sup> *MedSouth* Staff Opinion, *supra* note 1.

<sup>19</sup> *See, e.g.,* *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2 (1984).

<sup>20</sup> 15 U.S.C. §§ 4301-05 (2000).

<sup>21</sup> *Id.* § 4301(b)(1).

perverse incentive for ventures to promise innovations that they have no intention of implementing. It may be that the best option in this hypothetical circumstance would be to simply withdraw the opinion letter in light of changed circumstances, and, thereafter, the venture would be subject to *per se* condemnation if it did not modify its behavior.

There is another awkward feature of a two-step analysis. Regardless of the verbal formulation, I am not sure the human mind is capable of reasoning in so disciplined a way—at least, when it is necessary to take the two steps in close sequence. A decision-maker cannot help forming an overall impression and this sense of the ultimate destination may affect an analysis in step I. Actually, the impression could cut either way; a decision-maker might be particularly generous to the venture in step I, knowing that it would fail the analysis in step II. Thus, the law on the distinctions between *per se* and rule-of-reason offenses could be subtly distorted.

This anomaly is less problematic when, as here, the step I analysis in the *MedSouth* opinion will be separated in time from a full inquiry that might be conducted down the road. When deciding step I, staff did not have any sense of how the facts, relevant in a step II inquiry, would play out.<sup>22</sup> As will become clear from the discussion below, however, these issues will not go away entirely if there are later proceedings because step II also involves a number of individual steps.

#### IV. *Analysis Under the Rule-of-Reason in Step II*

Once it is determined in step I that rule-of-reason treatment is appropriate, the decision-maker in most cases will move promptly to step II, the actual rule-of-reason analysis. In cases like

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<sup>22</sup> For similar reasons, I do not believe it is all that difficult for a Federal Trade Commissioner to distinguish between a “reason-to-believe” that a complaint should issue and a later determination on the merits. However, I do believe that existing case law on the “reason-to-believe” standard is not particularly helpful—a subject for a different paper.

*MedSouth*, where step I has been completed before the venture is even up and running, the step II analysis may be separated by a period of years, if it is undertaken at all. Nevertheless, it may be useful to examine some of the issues that would arise in a step II inquiry into a venture like *MedSouth*, because such an inquiry is bound to occur in the future.

The general framework for a step II rule-of-reason inquiry is set out in the Collaboration Guidelines.<sup>23</sup> This inquiry may itself proceed in a stepwise fashion. The first step typically will involve market definition and calculation of market shares. If the market shares are low enough, the inquiry can stop at this point. (For physician joint ventures specifically, market share “safety zones” of twenty percent for exclusive ventures, and thirty percent for non-exclusive ventures, are specified in the separate Health Care Policy Statements.)<sup>24</sup> If further inquiry is needed, the second step will be to “examine whether the relevant agreement is reasonably necessary to achieve procompetitive benefits that likely would offset anticompetitive harms.”<sup>25</sup> Note that this formulation combines elements that are sometimes expressed separately as two additional steps: one is the balance of likely anticompetitive harm and procompetitive benefits, and another is the issue of whether a less restrictive alternative is available.<sup>26</sup>

Each of these two (or three) steps in the rule-of-reason analysis will raise interesting issues in the context of a venture like *MedSouth*. The discussion below will be organized as if there were three steps.

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<sup>23</sup> COLLABORATION GUIDELINES, *supra* note 8, at §§ 1.2, 3.3; HEALTH CARE STATEMENTS, *supra* note 3, at § (8)(B)(2) (requiring a similar four step approach).

<sup>24</sup> HEALTH CARE STATEMENTS, *supra* note 3, at § (8)(A).

<sup>25</sup> COLLABORATION GUIDELINES, *supra* note 8, at § 3.3.

<sup>26</sup> *See* 1 ABA SECTION OF ANTITRUST LAW, ANTITRUST LAW DEVELOPMENTS 75-76 (5th ed. 2002)

### A. *Markets and Market Shares*

The apparent “market share” of a venture like Medsouth obviously depends on the geographic area considered and how the various specialties are broken down. The staff opinion letter did not attempt a rigorous analysis of this issues, but instead referred to some worst-case shares as illustrations (for example, the letter states: “In a number of specialties, they [MedSouth] constitute half or more of the physicians with admitting privileges at the three hospitals in south Denver.”).<sup>27</sup>

A rigorous analysis was not deemed necessary for a step I decision on whether to apply a *per se* or a rule-of-reason test. But what would happen if the shares had been substantially different? If the shares were lower, the venture might fall within a “safety zone” or require only a cursory analysis for approval.<sup>28</sup> The outcome in the converse situation is less clear because there is no express upper-limit “danger zone” that balances the lower limit safety zones in the *Health Care Statements*. At very high percentages, it could be difficult to overcome a strong market-share presumption in a step II rule-of-reason inquiry,<sup>29</sup> and it would be appropriate for a hypothetical opinion letter to highlight this caveat.

There are other potential difficulties in a complete analysis that the opinion letter did not need to address such as, “How do you measure the ‘market share’ of a physicians’ association anyway?” and “What is the significance of either a growing or declining share?”

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<sup>27</sup> MedSouth Staff Opinion, *supra* note 1.

<sup>28</sup> See HEALTH CARE STATEMENTS, *supra* note 3, at §§ (8)(A), (8)(B)(4).

<sup>29</sup> The examples of high-share ventures in *Health Care Statements* impliedly suggest that collective negotiation of fee-for-service rates would be problematic. See HEALTH CARE STATEMENTS, *supra* note 3, at §§ (8)(C)(6)-(7). See also Thomas B. Leary, *An Inside Look at the Heinz Case*, ANTITRUST, Spring 2002, at 32 (discussing the formidable hurdles that face parties who propose 3-2 or 2-1 mergers).

The opinion letter estimated “shares” based on the number of doctors in various specialties affiliated with the venture divided by the total number of doctors in these specialties in the appropriate geographic region. Leaving aside the problem of defining the geographic market - a complex issue with lore and learning of its own<sup>30</sup>—there is a question whether it is useful to assign shares by counting doctors. If there are qualitative differences between the doctors in the venture and those outside (and there well might be if the clinical integration is successful) shares measured by headcount do not accurately reflect the real competitive significance of the venture.

Another problem is a headcount measure may make it more difficult to decide an ultimate issue in the case. An ultimate issue is whether a particular venture has either a history of, or a potential ability to, reduce output and increase prices. In the usual case, the number used to compute a market share (units or dollars, as appropriate) is also a measure of output, but that is not the case here. You cannot measure the output of a venture like MedSouth by counting doctors. (In fact, as will be discussed below, you probably cannot just count tests or procedures performed.)

The incongruity of a headcount tally is highlighted by one aspect of the Staff Opinion that may be troublesome down the road. The opinion seems to draw comfort from the fact that “MedSouth expects that . . . it will represent fewer physicians in negotiations with payers than currently are members.”<sup>31</sup> A prediction that members will drift away runs contrary to another

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<sup>30</sup> Cf. Gregory Vistnes, *Hospitals, Mergers, and Two-Stage Competition*, 67 ANTITRUST L.J. 671, 685-92 (2000). The article discusses the difficulties of defining geographic market, and in particular, the use of patient-flow data, in the context of hospital mergers. The analysis of the proper “market” for a physician’s venture might be done in a similar way, and the challenges could be even greater with physicians, whose offices can be spread out over a large geographic area. *Id.*

<sup>31</sup> MedSouth Staff Opinion, *supra* note 1.

prediction that provides the justification for rule-of-reason treatment, namely, the expectation that clinical integration will result in better care and “provide MedSouth with a competitive advantage.”<sup>32</sup> You would think the venture would attract more members and grow larger if this prediction held true. After all, the success of any enterprise is frequently measured by its growth or “market acceptance.” On the other hand, there could be a less benign explanation for an increase in membership—doctors might be attracted to the venture simply because they want to be able to bargain collectively.

Note also that if the venture succeeds, its members will presumably acquire knowledge of superior diagnostic and treatment methods, and some of that knowledge will be portable. If these members drift away, there will be an ever-increasing “free-rider” problem that could ultimately reduce incentives for continued improvement. So, the prospect of a reduced “market share,” however measured, is here an ambiguous fact. There are more such ambiguous facts.

#### B. *The Attainment of Efficiencies*

It is one thing to decide that a proposed business plan facially holds promise to satisfy a “clinical integration” requirement. The prediction may be hazy, but the predicted effects of “financial integration” are just as hazy and the FTC’s own guidelines make a decision unavoidable. But, when the time comes, how does a finder of fact decide whether the efficiencies have outweighed the anticompetitive effects of collective action?

As stated above, the ultimate question is whether the venture has raised prices and reduced output. In the usual case, the two have a reciprocal relationship but, at least, they can be separately identified. The relevant numbers are the units produced and the price per unit. The situation here is more muddled.

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<sup>32</sup> *Id.*

The difficulty of measuring output by counting doctors has been discussed above. Suppose, hypothetically, that instead of measuring output by counting doctors, output was measured by the number of tests and procedures performed by individual doctors. The trouble with this measure is that the unusual economics of health care creates incentives for the oversupply of these services,<sup>33</sup> and a reduction could well be an indication that the venture has improved the quality of patient care or the health of patients. Better informed and more confident doctors may be able to diagnose with fewer tests and better preventive care may result in fewer procedures. The apparent “output” reduction could be an efficiency, which suggests the need for some quality adjustments, at the least, or perhaps a more fundamental reorientation to view the quantum of services rendered as an input rather than an output.

Given the problems in measuring output, suppose a fact finder were to focus directly on prices. The issues here could also be equally difficult. The Commission encountered situations where there was a relatively rapid increase in the price of a venture’s services that was obviously attributable to an increase in collective bargaining power rather than improved quality.<sup>34</sup> These cases are easy. But, what if prices changed slowly over time and there is evidence the venture implemented innovative programs to provide better care?

In these situations, the fact the per-capita income of the association members has increased, or the prices per test or procedure has increased, may not prove the exercise of market power. Wholly apart from the quality dimension, prices could be increasing across the board. Even if the market worked efficiently, this would not be surprising—people in an increasingly

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<sup>33</sup> See discussion *supra* Section I.A.

<sup>34</sup> See, e.g., *Tex. Surgeons, P.A.*, No. C-3944, 2000 WL 66997 (FTC May 18, 2000); *Wis. Chiropractic Ass’n.*, No. C-3942, 2000 WL 670031 (FTC May 18, 2000).

affluent society might be expected to spend larger amounts of discretionary income on health care, and thereby increase demand. Then, there are the difficult quality issues discussed above. Payers may be willing to pay MedSouth doctors more money for fewer services simply because these doctors are better at deciding when services are necessary and get better results when they perform those services.

Suppose you were to assume that the “service” the doctors are selling is not the provision of tests and procedures, but rather better health? How do you put a price on that? One proxy might be the amount of money that people have to spend on health care. Over the long run, healthier people may require less medical attention, so the total costs per patient may decrease if the venture delivers superior care. But, costs may increase in the short run with heavier reliance on preventive care. And, of course, healthier people may still incur higher costs in the long run if they live longer. At this point, heads begin to spin and it may be tempting to fall back on the traditional “market test” of increased consumer acceptance, demonstrated by increased market share. This could indicate that the overall price-quality package of the group is appealing. However, as mentioned above, it could also mean association membership has grown because of the perceived advantages of collective bargaining.

One way to avoid these ambiguities would be to focus instead on the elements of the association’s business plan and examine whether the members have done what they promised to do. At least, this might help to sort out the extreme cases. This test might show, on the one hand, that the promised “clinical integration” was simply a pretext to avoid *per se* condemnation. At the opposite pole, the test might show the group has followed its plan with enthusiasm and has achieved widespread professional and customer approval. It is not unusual to rely on such opinion

evidence when evaluating various business proposals.<sup>35</sup> The tough cases, of course, will lie in the middle. We need to recognize that doctors, like other providers of goods and services, may have mixed incentives both to improve their efficiency and their collective bargaining power.<sup>36</sup>

*C. Less Restrictive Alternatives*

A key finding in the staff opinion is the conclusion that joint contracting was closely related and essential to the success of the venture.<sup>37</sup> This may be true in the sense that neither MedSouth nor other similar associations are likely to embark on such a promising experiment absent assurance they can bargain with payers as a group. Another important element of the opinion is the finding that the venture will be non-exclusive. This is not at all surprising. It is standard antitrust doctrine that non-exclusive ventures are viewed more benignly than exclusive ventures.<sup>38</sup> There is, however, an unacknowledged tension between the opinion's findings on joint contracting and its reliance on non-exclusivity.

The opinion advances two rationales in support of joint contracting. First, it is asserted that “doctors need to be able to rely on the participation of other members of the group in the network and its activities on a continuing basis,” and joint contracting will assure this “continuing participation.”<sup>39</sup> Joint contracting will surely reinforce this assurance, but non-exclusivity will

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<sup>35</sup> See David Scheffman, Director, Bureau of Economics, Federal Trade Commission, Sources of Information and Evidence in Merger Investigations, Address Before the ABA Section of Antitrust Law and the Association of the City of New York (June 14, 2002), *available at* <http://www.ftc.gov/speeches/other/scheffmanabanycbar.pdf>.

<sup>36</sup> See HEALTH CARE STATEMENTS, *supra* note 3, at § 8(B)(2).

<sup>37</sup> MedSouth Staff Opinion, *supra* note 1.

<sup>38</sup> See, e.g., COLLABORATIONS GUIDELINES, *supra* note 8, at §§ 3.3, 3.34(a); HEALTH CARE STATEMENTS, *supra* note 3, at §§ 8(A), 8(B)(2) (different safety zones for exclusive and non-exclusive ventures and rule-of-reason analysis).

<sup>39</sup> MedSouth Staff Opinion, *supra* note 1.

surely undercut it. Lawyers are familiar with this notion, too, as most law firms mandate exclusivity partly to assure availability.

The opinion's second rationale for joint contracting is that it will assure a more "equitable" distribution of returns among the members of the venture.<sup>40</sup> Again, this is surely important—if a few opportunistic prima donnas parlay the superior skills they acquire inside the venture to bargain for extraordinarily high individual fees, they not only "free ride" on the work of their colleagues, but detract from the customer appeal of the venture overall. But, if these same prima donnas are free to contract on their own for high fees outside the venture, they also take a free ride and, of course, these outside engagements would tend to reduce their availability.

In short, if joint bargaining is necessary, how can the venture tolerate non-exclusivity? Alternatively, if non-exclusivity is tolerable, what does this say about the need for joint bargaining? It is entirely possible that some ventures like MedSouth will turn out to be substantially exclusive de facto, if not wholly exclusive de jure, and will have to be analyzed on that basis. Anomalies of this kind are not only present in the *MedSouth* opinion but also present in the broad body of antitrust doctrine.<sup>41</sup> The thing distinguishing a bare cartel that is *per se* illegal from a legitimate joint venture is the presence of some degree of integration, which can potentially yield efficiencies. The Health Care Statements recognize the efficiency-creating potential of both financial and clinical integration. An exclusive joint venture would clearly have more of both. On the other hand, it could raise competitive problems of a different kind.

## V. CONCLUSION

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<sup>40</sup> *Id.*

<sup>41</sup> Note, for example, the apparent anomaly that an agreement between two entities not to compete on a single aspect of competition (like price) will be *per se* illegal but a merger that extinguishes competition entirely is subject to the rule of reason.

I would like to conclude on a personal note. This article, like a number that I have written, emphasizes complications and provides more questions than answers. The reader should not conclude, however, that I disagree with the *MedSouth* staff opinion or that I believe a subsequent rule-of-reason inquiry would be too difficult to undertake.

On the contrary, I believe that staff had no choice but to respond as it did. In *California Dental*,<sup>42</sup> the Supreme Court reaffirmed once more that government agencies cannot summarily condemn particular practices absent an extensive body of experience that would indicate they are almost invariably pernicious. No such experience is available here. Moreover, the MedSouth proposal is innovative and appears to offer the potential for improved medical care at lower costs. The venture may not develop that way, but we cannot strangle it before it has a chance to develop.

Similarly, the discussion of complications and anomalies does not signal any personal reluctance to proceed further in these matters in order to determine whether promised performance has been delivered and whether customers overall have been helped or hurt. In fact, I believe we have an obligation to do so, lest our integration tests be treated as pure formalities. All I am saying is that these cases—like so many others that we see—will be complicated, and decisions will be hard. But, that is what makes this job interesting.

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<sup>42</sup> Cal. Dental Ass'n v. FTC, 526 U.S. 756, 781 (1999).