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"Not Good Enough for Government Work: Geographic Market Definition and The FTC's Case Against Chicagoland Physician Associations"

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NOT GOOD ENOUGH FOR GOVERNMENT WORK: GEOGRAPHIC MARKET DEFINITION AND THE FTC'S CASE AGAINST CHICAGOLAND PHYSICIAN ASSOCIATIONS

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What two can easily do
Is so hard
To be done
By one.[1]

I. Introduction

As part of its increasing focus on the health-care industry generally, the Federal Trade Commission (FTC) in the past decade has brought a large number of suits against doctors' independent practice associations (IPAs).[2] As explained in greater detail below, IPAs typically engage member physicians in many joint activities. The most notable of these, from an antitrust perspective, is collective bargaining on behalf of individual member doctors over the amounts that third-party insurers will reimburse doctors on behalf of patients covered by those insurers. As illustrated by a recent case involving Chicago-area

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[1] William "Smokey" Robinson, *What's Easy for Two is So Hard for One* (EMI Music, BMI). The song, popularized by Mary Wells, reached the # 29 position on the national Billboard charts in January 1964.

[2] Many of those cases are listed in Appendix A. We discuss this appendix further below.

IPAs, *In re Evanston Northwestern Healthcare Corp.*,[3] the FTC treated negotiation of rates on behalf of individual member-physicians by the IPA (Evanston Northwestern Hospital Medical Group) as, in effect, *per se* illegal, absent either financial or clinical integration.[4] In practice, the FTC has historically rejected claims of clinical integration as sufficient to justify rule of reason treatment of IPAs' joint price negotiations.[5]

There are two exceptions to the FTC's skepticism regarding clinical integration as justifying joint price negotiations by non-risk-sharing IPAs: the *MedSouth* matter in 2002 and the *GRIPA* matter in 2007.[6] In both of these instances, the FTC appears to have concluded that: (a) the level and type of clinical integration proposed by these IPAs was sufficient to warrant rule of reason treatment of the associated joint price negotiations of the IPA; (b) the joint price negotiations were ancillary to the clinical integration; and, (c) under a rule of reason analysis, the joint price negotiation was not on balance anticompetitive. Equally interesting, however, is the FTC's refusal to recognize another efficiency-

[3] FTC Docket No. 9315. The FTC brought its case against the medical group (IPA) when it was the "Evanston Medical Group." Due to events unimportant here, the IPA is now titled the NorthShare University HealthSystem, and is affiliated with the University of Chicago's Pritzker School of Medicine. The previous name of the IPA, Evanston Medical Group, against which the FTC action was filed, is used here.

[4] Statement 8: Enforcement Policy on Physician Network Joint Ventures. *Statement of Antitrust Enforcement Policy in Healthcare*, Department of Justice and Federal Trade Commission. (http://www.ftc.gov/bc/healthcare/industryguide/policy/statement8.pdf) In the *Evanston* case, the FTC ultimately retreated to a slightly less rigid position, arguing that the IPA's activities were "inherently suspect." The FTC's use of that standard to evaluate horizontal agreements was approved in *Polygram Holding, Inc. v. FTC*, 416 F.3d 29 (D.C. Cir. 2005), the so-called *Three Tenors* case. For further discussion, see McChesney, Singing in the Shadows of Law: The *Three Tenors* Case, 49 Antit. Bull. 633 (2004).

[5] See, for instance, In the Matter of Health Care Alliance of Laredo, L.C., Docket No. C-4158 (F.T.C. Mar. 23, 2006) Complaint at ¶30; In the Matter of Boulder Valley Individual Practice Association, File No. 0510252 (F.T.C. Dec. 24, 2008) Complaint at ¶24; In The Matter Of Alaska Healthcare Network, Inc., Docket No. C-4007, (F.T.C. Apr. 25, 2001) Complaint at ¶17.

[6] Federal Trade Commission, "MedSouth Advisory Opinion" February 19, 2002 and "Greater Rochester Independent Practice Association, Inc., Advisory Opinion," Sept. 17, 2007 (hereinafter "MedSouth Advisory Opinion" and "GRIPA Advisory Opinion"). These are staff opinions; as always with staff opinions, they are not binding on the Commission itself.

based advantage of IPAs, to both buyers and sellers: lower transaction costs in the multiple layers of contracting that make up the medical services industry today.

This article has two purposes. First, it argues that, as a matter of both economics and law, the FTC's traditional *per se* treatment of IPA price-negotiation practices is mistaken. We begin in Section II by providing more background on the activities of IPAs. We then explain why IPAs themselves can advance economic efficiency even without financial integration among the members of the IPA, and why doctors' joint price determination through an IPA may be necessary to achieve those efficiencies. It follows, then, that IPA activities should generally be judged under the rule of reason, not by the draconian *per se* standard invoked by the FTC, or even one that views IPA joint negotiations for groups of doctors as "inherently suspect."

That raises the second, more general purpose of this article. Rule of reason analysis of course requires that the relevant market be defined, and the possible anticompetitive costs in that market compared to the potential procompetitive benefits. Necessarily, both market definition and the cost-benefit comparison are complicated, and require considerable work in assembling and analyzing large amounts of data. That alone would explain the FTC's preference for *per se* treatment of IPAs; the fact that the Commission also has the burden of proof on market-definition and cost-benefit questions makes it all the easier to see why the FTC would eschew anything other than a *per se* approach.

But the data-assembly and -analysis issues are far from intractable, particularly in industries like medical care, where many useful data are relatively easy to obtain. In the *Evanston Medical Group* matter, the data appeared to play a critical role in the FTC's decision to take a consent order. We illustrate what was presented to the Commission in

Section III, with data developed (and never challenged by the FTC) in connection with that case.

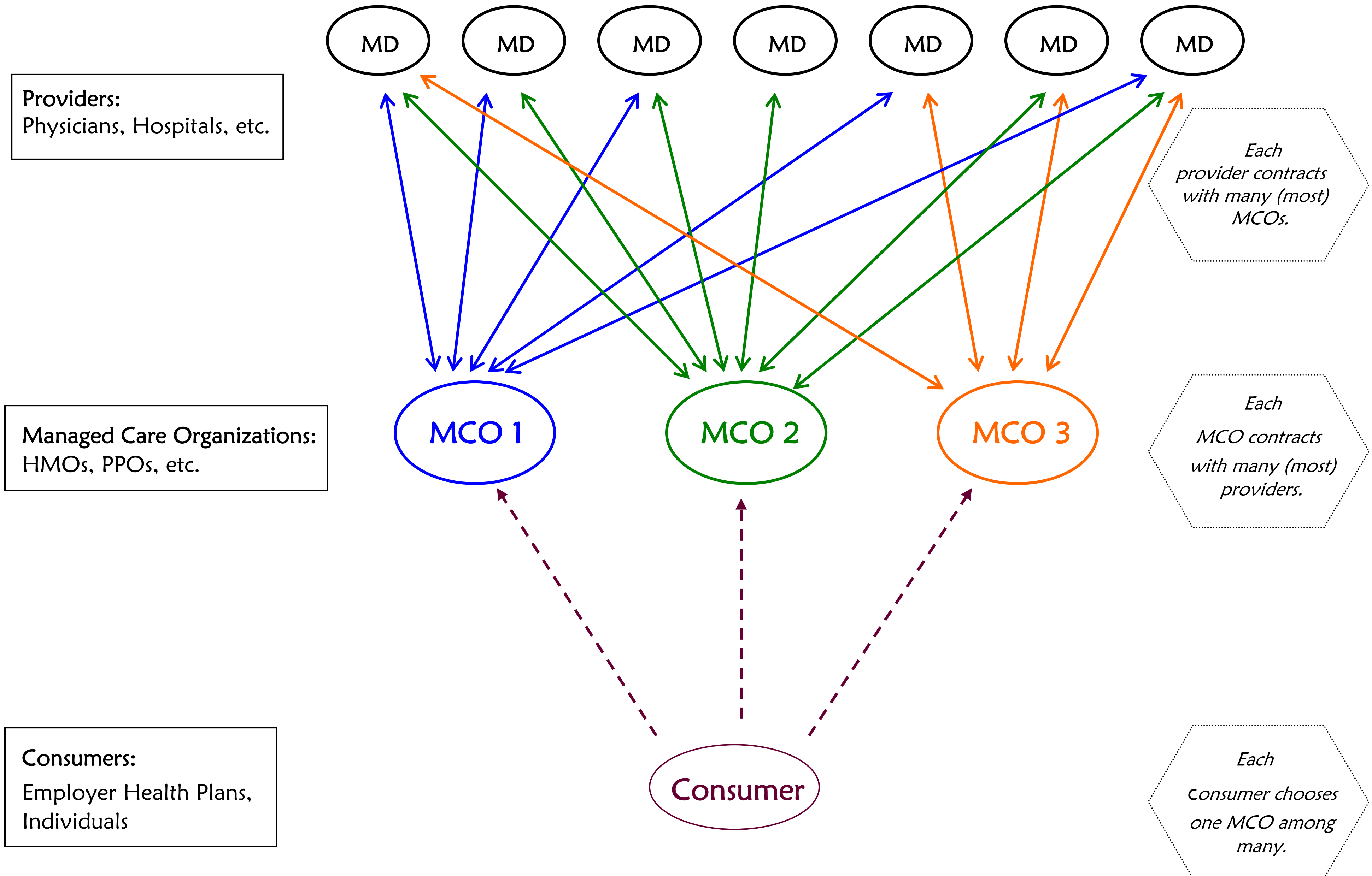
In addition to our analysis relative to that particular case, we believe that the qualitative approach and quantitative analysis of the relevant market-definition issues in the *Evanston Medical Group* case are useful more generally, in any case involving rule-of-reason types of evaluation. In particular, the detailed analysis of relevant markets offers methodological insights into the process of defining geographic markets rarely found in the antitrust economics and law literature.

II. Independent Practice Associations

To understand independent practice associations, it is useful to situate them in the overall vertical structure of medical services today.[7] Diagram 1 shows how that vertical contracting works.

[7] See generally *Improving Health Care: A Dose of Competition* (Federal Trade Commission/Department of Justice (2004) ("FTC Report"); D. Haas-Wilson, Managed Care and Monopoly Power (2003) ("Haas-Wilson").

Diagram 1.



In the past generation or so, the industry has shifted from one of "patient-driven" to one of "payer-driven" competition. Consumers and doctors typically do not negotiate and contract (i.e, determine prices) with one another directly. Rather than contract with physicians themselves, most consumers either rely on Medicare or obtain health insurance through their place of employment or that of a family member. Employers obtain insurance to cover their employees from various sources. The most relevant provider source is managed-care organizations (MCOs), such as Blue Cross/Blue Shield, Aetna and Humana. They offer different sorts of insurance coverage, such as that available through membership in a health maintenance organization (HMO) or a preferred provider organization (PPO). Ordinarily, a consumer (either individually or, more likely, through the employer) will contract with one of many available MCOs.

As a means of controlling costs, MCOs then contract on consumers' (including employers') behalf with hospitals and physicians to form a physician provider network from which employees can choose their providers. To work with MCOs and provide medical services to the MCO's members, physicians typically have to have a contract with the MCO. An important part of the negotiation concerns the prices that the hospital and physicians will charge members of the MCO for medical services. Employees, the ultimate consumers of medical services, want access to doctors with different areas of expertise (cardiology, orthopedics, etc.). An MCO therefore will include physicians with diverse specialties.

Typically there are many different MCOs who may have enrollees living in a given area. Therefore, a physician may see patients who are enrollees in many different MCOs. In order to serve all patients, the physician needs to contract with all of these

MCOs. Typically in the US, physicians practice in small groups. Thus, in order for an MCO to assemble network of physicians with the requisite specialty and geographic scope, the MCO will have to engage in hundreds or thousands of individual negotiations and contracts. This contracting process can be very burdensome, both for physician practices (many of which do not have professional contract negotiators or administrators) and for the MCOs (who have to contract with thousands of physicians in an area).

At this juncture independent practice associations become especially important. They are intermediaries between the MCOs and the MDs (physicians) shown in Diagram 1 above. An IPA contracts (a) with MCOs to provide a network of doctors with various specialties to consumers, and (b) with doctors for a specific rate to be paid to all member physicians in the same type of practice when they render services. This contract intermediation performed by IPAs occurs in various ways, as shown in Diagram 2.

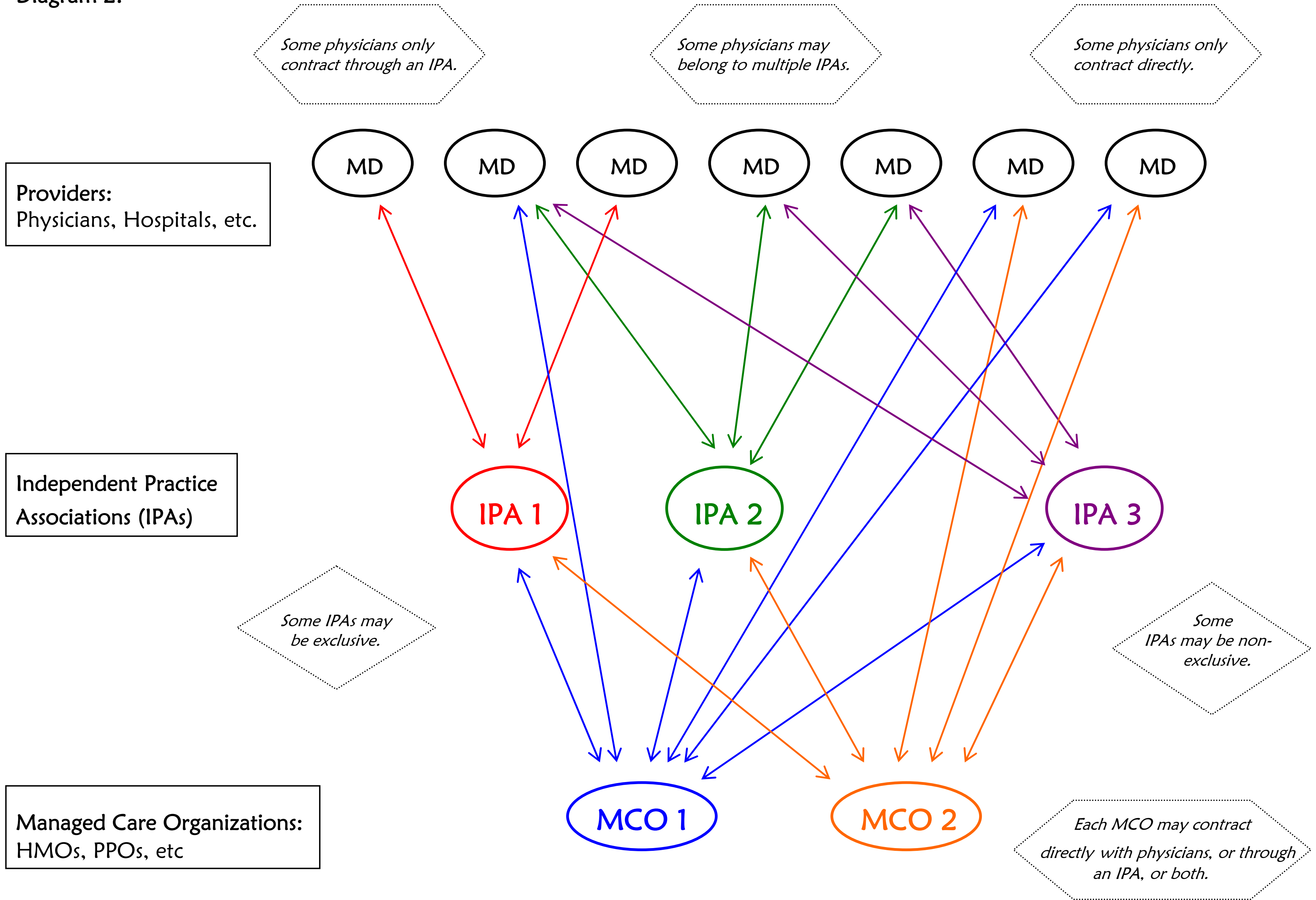


Diagram 2.
Some physicians only contract through an IPA.
Some physicians may belong to multiple IPAs.
Some physicians only contract directly.
Providers:
Physicians, Hospitals, etc.
MD
MD
MD
MD
MD
MD
MD
Independent Practice Associations (IPAs)
IPA 1
IPA 2
IPA 3
Some IPAs may be exclusive.
Some IPAs may be non-exclusive.
Managed Care Organizations:
HMOs, PPOs, etc
MCO 1
MCO 2
Each MCO may contract directly with physicians, or through an IPA, or both.

Many IPAs are affiliated with a particular hospital or hospital network. The member physicians of hospital affiliated IPAs may be of two sorts. Some may work directly for the hospital(s), although the compensation for these so-called "employed" doctors for most part comes from third-party payers (e.g., Aetna, Blue Cross/Blue Shield, etc.) They ordinarily have their offices at the hospital, and work solely through the hospital. On the other hand, "non-employed" (or "affiliated") doctors are not hospital employees. They maintain their own practices, but use the hospital for consultations and procedures that cannot be carried out in their own offices.

IPAs provide a number of potential economic benefits, both to their member physicians, as well as to MCOs and the enrollees of those MCOs (i.e., patients). These benefits include a reduction in transaction costs associated with contracting and credentialing, the development of more cohesive referral networks, and the ability to implement integrated clinical and practice management programs. Joint contracting by member physicians of IPAs also entails potential economic costs. In particular, the joint price negotiations by what might otherwise be competing suppliers of medical services has the potential to confer market power on the IPA and result in higher prices.

A. Economic Benefits of IPAs

Independent practice associations provide several benefits in the complex vertical contracting web that makes up modern American medicine. But the FTC has recognized only some of those as antitrust-valid. In particular, the FTC has been largely unmoved by transaction-cost arguments, preferring to study only more traditional concepts of production economies of scale (especially clinical integration) as justifying horizontally collective activity among doctors. But the benefits of collective activity among doctors must include consideration of transaction and related costs.

1. Reduction in Transaction and Information Costs

IPAs enroll doctors, and then negotiate and (sometimes) monitor contracts with MCOs on behalf of their members. In a multi-tiered contractual system such as that prevalent in American medicine today, perhaps the principal economic benefit of IPA-insurer agreements is the saving in transaction and information costs, both for doctors and for MCOs.

Consider two alternatives. A consumer could forego insurance altogether, hiring doctors and hospitals in a spot market when medical needs arise. But this would require last-minute contracting, at a time when leisurely decisions about doctors and hospitals might not be possible.[8] Moreover, it would require patients to have some information about the right doctors and hospitals for their needs.

Alternatively, one could avoid the transaction costs of last-minute contracting by purchasing insurance that would cover physician and hospital costs as they arise.[9] While advantageous to an individual insured, the insurance solution by itself requires that the insurance company enter into a variety of contracts of the sort that individuals would have to undertake without insurance. That is, the insurance company would have to have information about the appropriate physicians and hospitals for the sorts of procedures its insured would likely demand. And, to be able to price its insurance product to its potential insureds, the insurer must know what its exposure – in terms of reimbursement rates to physicians (and hospitals) – foreseeably will be.

[8] Patients who engaged in such spot contracting would have little bargaining power and would be expected to pay high prices.

[9] In addition to saving on transactions costs, membership in an MCO gives patients greater bargaining power with providers (physicians and hospitals). An MCO can credibly threaten to direct its members away from a specific provider and thereby bargain for lower prices from that provider. The larger the MCO, the more potent this threat. In this respect, an MCO is a mirror image to an IPA. The MCO allows consumers to jointly negotiate prices for medical services, and if an MCO is sufficiently large, there may be injury to competition from its market power (that is not outweighed by the transaction costs savings and other benefits of the MCO). However, the FTC does not treat MCOs as per se illegal, or even inherently suspect. Rather, it evaluates MCOs using a rule of reason analysis much like what we suggest here for IPAs.

An insurance company can ascertain those rates by negotiating in advance with individual doctors as to the reimbursement they will accept in the future for various procedures. But in a large city, with hundreds or thousands of doctors attached to a hospital (either as employed or affiliated physicians), the transactions costs of each insurer contracting with so many doctors would be extraordinary. Having the IPA deal with an insurer on behalf of so many doctors greatly lowers the costs to insurers of reaching the contracts necessary to price an insurance product to the ultimate beneficiaries, the insured. A "one-signature" contract with an MCO obviously entails lower transaction costs than would an insurer having to deal individually with the myriad doctors that the insurer would offer as available to its insureds.

These benefits are well understood. In the joint hearings conducted by the Federal Trade Commission and the Department of Justice leading up to their report on improving health care,[10] the agencies noted that hearing panelists "stated that IPAs reduce contracting costs by lowering administrative and search costs for physicians and allowing payers to contract efficiently with pre-existing networks."[11] Dr. Deborah Haas-Wilson has made a similar point. "Horizontal consolidation," such as an IPA, she writes, "can reduce transaction costs both with and across geographic markets by reducing the number of contracts that must be negotiated, written, monitored, and enforced."

> For example, within a geographic market as physicians consolidate into larger groups/networks, it may be less costly for hospitals and insurers to contract with fewer large physician groups/networks, rather than with more numerous solo or small group practices. The hospitals, insurers, and consolidated physicians may be able to realize significant transaction cost savings….Since transaction costs may be

[10] *Improving Health Care: A Dose of Competition* (Federal Trade Commission/Department of Justice, 2004) ("FTC Report).

[11] FTC Report, Ch.1, p. 5.

> quite high in the health care industry, the efficiency gains that result from horizontal consolidation may be large.[12]

2. Other Benefits from IPA Contracting

There is an important interplay between the "one-signature" arrangement that an IPA offers to an insurer and other benefits that the IPA provides. Lower transaction costs translate into larger sizes of physician referral networks that the insurers can offer their insureds, a benefit to insurers and insureds alike. And larger numbers of physicians in the referral network allows for specialization in credentialing of doctors, a function that IPAs are more efficient in providing than are insurers.

Payer firms require that the doctors whose work they will reimburse be credentialed. This is time-consuming (therefore costly) process for doctors, involving much red tape. Licenses must be verified, for example; lengthy state-mandated forms must be filled out and filed. Credentialing is so time consuming that IPAs hire full-time credentialing specialists to deal with the process, saving MCOs and physicians the expense of doing it themselves. Because the MCO lowers costs (transaction costs, the cost of credentialing) for doctors, MCOs are able to enroll more physicians, clearly desirable to both doctors and their patients.

Larger IPAs have an advantage in the ease with which referrals to other doctors can be made. When an IPA negotiates contracts for its members, all the physicians in the IPA are automatically contracted for. Therefore, physicians in an IPA can refer patients to other IPA members without having to check in each instance whether the referred-to-physician has the necessary MCO contract and medical credentials. Likewise, IPA physicians can accept patient referrals from other IPA member physicians

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[12] Deborah Haas-Wilson, Managed Care and Monopoly Power,145-46 (2003, footnote omitted).

without having to check on patients' managed care coverage or the referring doctor's credentials. Ease of referrals is likewise beneficial to consumers.

IPA membership also allows groups of physicians to better implement integrated clinical and practice management programs. These programs may include activities such as cross-physician patient education and monitoring; implementation and monitoring compliance with clinical guidelines; and the practice-wide adoption of information technology systems (such as electronic medical records systems) that support these other activities.

The FTC has recognized and accepted some of these potential economic benefits, but has explicitly rejected others. For instance, in its GRIPA advisory opinion, the FTC recognized that the IPA's activities were likely to increase clinical integration and improve the quality of care provided by the IPA members.[13] The FTC also recognized the value of a more integrated and cohesive referral network.[14] However, the FTC explicitly rejected transactions costs savings related to MCO contracting as a cognizable economic benefit, claiming (without empirical evidence) that transaction cost savings, "while theoretically cognizable, are also like to be relatively modest in practice."[15]

B. Economic Costs of IPAs

Although IPAs engage in various activities on behalf of their members, it is their price negotiation on behalf of member-doctors that has elicited the concern of federal antitrust authorities. It was a

[13] GRIPA Advisory Opinion, pp. 11-19.

[14] GRIPA Advisory Opinion, pp. 5-9.

[15] GRIPA Advisory Opinion, pp. 23-24: "Except in such rare and unusual situations as *Broadcast Music,* transaction cost efficiencies alone are unlikely to be sufficiently significant to justify rule-of-reason treatment of an otherwise facially anti-competitive horizontal agreement on price by competitors."

principal concern of the FTC in the *ENH Medical Group* case. The Commission feared that combining two IPAs into one would give the single IPA the ability to negotiate higher prices with insurers.

Price comparisons are tricky in this context, however, for several reasons. Even if one assumes *arguendo* that concerted price negotiation through an IPA results in higher reimbursement rates to be paid by insurers, insurers may be paying for the transaction cost savings and other benefits made possible by an IPA. Even in a purely competitive system, that is, those who receive greater benefits would predictably pay more for them.[16] Following its settlement with the Evanston Medical Group, the FTC in its GRIPA advisory opinion recognized that higher prices may only indicate higher quality – a position it did not take in the *Evanston Medical Group* case.[17]

The system is all the more competitive, given that the contracts physicians sign with IPAs typically are not exclusive. Insurers who do not like the reimbursements established by the IPAs are always free to contract with each doctor individually, or through other IPAs that the doctor may be a member of. The dual ways of contracting with physicians establishes an illuminating natural experiment. Insurers who find the IPA reimbursements too high can contract directly with doctors, but doing so means forgoing the lower transaction costs of dealing just with the IPA. Evidence in the *Evanston Medical Group* case, at least, indicated strongly that, however (if at all) the IPAs contracted-for reimbursements had risen, insurers still found IPA contracts preferable to contracting with doctors directly, one-by-one.

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[16] Payment of higher prices for greater benefits in competitive markets is the basis for the Supreme Court's approval of vertical price fixing in *Leegin Creative Leather Products, Inc. v PSKS, Inc*., __ U.S. __ (2007).

[17] GRIPA Advisory Opinion, p. 26-28: "'GRIPA's higher fee levels are anticipated as part of a program that seeks, and through the participants' integration appears to have significant potential to achieve, greater overall efficiency and improved quality….Under these circumstances, quality-adjusted prices to GRIPA's customers for the services of its physicians may not be higher and, even if they are, customers may be willing to pay those higher unit prices in order to both raise the level of quality and to reduce total costs expended in providing medical services….[A]ny higher fee levels that GRIPA'S physician members may be able to obtain for their services provided through the program likely will be due to purchasers in the market valuing those services as super to existing alternative, rather than as a result of the exercise of market power by physicians through GRIPA."

Moreover, although price comparisons focus on the horizontal combination of physicians, the horizontal combination is actually undertaken to facilitate vertical contracting between doctors and insurers. To the extent that the horizontal agreement is necessary to facilitate the transaction-cost-reducing vertical contracts between doctors and insurance companies, it is just ancillary to the true purpose of the agreement: making it cheaper for both physicians and insurance companies to contract on a very large scale. The true essence of the agreement among doctors (through the IPA) is not horizontal collusion, but ease of vertical contracting.[18]

Also, IPAs are differentiated products. There is no such thing as a widget in the physician industry; all doctors are different, and all independent practice associations are different. An MCO buys IPAs in a very thin market. Therefore, MCOs, as insurers, purchase physicians' services through *negotiated* contracts. IPAs contract with payer organizations for different products (e.g., capitated and fee-for-service contracts).[19] The reimbursement rates that result from bargaining between MCOs and IPAs will predictably not be the same in every situation. Some IPAs are of higher quality than others; some provide a wider array of services than others; some cover a broader geographic area than others; and some are better bargainers than others.

In addition, some MCOs are better negotiators than others, and some may have different demands for different sets of doctors than others. Both parties seek contracts contoured to their particular

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[18] In that sense, the relevant case law is unclear. In *Arizona v. Maricopa County Medical Society*, 457 U.S. 322 (1982), the Supreme Court held that an agreement among physicians accepting single rates of reimbursement was illegal *per se*. However, in *Broadcast Music v. Columbia Broadcasting System*, 441 U.S. 1 (1979), the Court approved a pricing agreement among those owning rights to play music as a legitimate way to lower the costs of those playing music. Analytically, the cases are seemingly identical. Of course, the FTC relied on the *Maricopa County* decision in arguing its case against the ENH Medical Group, while the IPA relied on *Broadcast Music*.

[19] The FTC has rejected the contention that IPAs are "new products" from an antitrust perspective. GRIPA Advisory Opinion pp. 20-23. The discussion there, as elsewhere, concerning whether something is a "new product" are more metaphysical than economic.

demands. As a matter of economics, there is nothing necessarily untoward, in terms of competition, about some IPAs obtaining different, even higher, rates than others. It all depends on what the negotiating parties seek, what the IPAs have to offer, and what the parties can agree upon.[20]

Notwithstanding the above, the joint determination of prices by otherwise horizontal competitors clearly has the potential to result in the exercise of market power, and in this context, higher physician prices to MCOs, and ultimately higher MCO premiums to consumers. Whether the joint price negotiation will lead to an exercise of market power depends on the traditional economic market structure factors that are common to most antitrust analyses.

A critical consideration in this respect is whether insurers have alternatives to the IPA in dealing with doctors they desire to include in their networks. In many cases, for example, that negotiation of physician rates through the IPA is not the only way of including physicians in an insurer's network. Physicians may belong to multiple IPAs and/or may both belong to an IPA and also contract individually with some MCOs. So long as membership in the IPA is not exclusive (in that membership requires that the physician not contract outside of the IPA), MCOs are free to reject the proposed IPA prices and negotiate with other IPAs enrolling many of the same doctors, or bargain one-on-one with individual doctors. In that case, insurers choice to deal with the particular IPA indicates that -- however "high" the negotiated prices are -- it is actually cheaper for the insurer to contract with doctors through that IPA. Any higher price paid by the insurer to doctors paid according to the IPAs negotiated rates merely re-

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[20] In economic terms, the negotiation between MCOs and IPAs (or individual doctors) reflects a thin-market situation (where each sale is individually negotiated), not a thick-market transaction such as buying a box of cereal at the grocery store. An MCO cannot go to an "IPA store" and just pick an independent practice association off the shelf. Rather, contracts will be contoured to the particular needs and qualifications of both sides in the deal, resulting in different prices. Better products will fetch higher prices, as in any competitive market. And because some organizations are better negotiators than the party on the other side of the table, prices in thin markets will not be uniform. (Economists would point to the "Edgeworth Box" characterization of thin-market negotiation, in which any number of different divisions of trade among contracting parties are all efficient.)

flect the advantages of working through the IPA, not any anticompetitive impact of collective contracting.[21]

In addition to the IPA's members' abilities and practice of contracting outside of the IPA, the size – or market share – of the IPA is relevant in determining the likelihood for the exercise of market power. Put simply, if an IPA demands supracompetitive prices, can an MCO simply do without the IPA and its member physicians? The answer depends on the relative size of the IPA; relative to both the number of other (non-IPA member) physicians in the area, and relative to the number of physicians that an MCO needs in its provider network in order to be competitive in selling insurance to employers and employees. Since most IPAs are multi-specialty (comprising both primary care physicians and specialists), this analysis needs to be performed for each relevant specialty.

Also, issues of hospital affiliation may be important. Market power may reside, not in the IPA or its affiliated physicians, but in the hospital where the physicians have privileges (perhaps because the hospital has a local monopoly). It is sometimes asserted that some hospitals are "must have" for an MCO provider network, that is, that marker power is at the hospital level. Assuming this is correct, then for enrollees of an MCO to have access to that hospital, the MCO must also have contracts with an adequate number of physicians who practice at that hospital. One could imagine that, in a dense metro area, there may be (say) 250 cardiologists in close enough proximity so as to all be in the same geographic market. An IPA may include only (say) 25 of these cardiologists. Normally, a market share of 10% would not cause market power concerns. However, if the subject area had a high profile "must have" hospital, and the 25 cardiologists represented all or most of the cardiologists at that must-have facility,

[21] To put the point slightly differently, no one could claim that hundreds or thousands of doctors, negotiating individually, could charge anticompetitive prices. The IPA in effect is competing with its own members in establishing a "group price" for its members' services.

then the IPA may have market power derived from the market power of the hospital – notwithstanding the large number of other cardiologists in the area.

C. Benefits and Costs: Summary

The potential benefits of IPAs are clear. In a market requiring multi-tier contracting among various vertical levels, IPAs can lower transaction and information costs by reducing hundred or thousands of contracts to a "one-signature" arrangement. Lower transaction costs increase the number of physicians to whom patient-consumers have access. The IPA system lowers the costs of physician credentialing, patient referrals, and other medical services, such as medical records systems.

With the potential benefits, however, come potential costs. IPAs allow collective setting of reimbursement rates among competing doctors. Higher rates obviously may ensue, as in the textbook price-fixing case. Alternatively, the IPA system may allow hospitals possessing market power of their own to charge higher prices.

Aspects of the IPA system, however, may mitigate or even defeat the possibility of higher prices from collective setting of reimbursement rates. Physician membership in IPAs are often not exclusive. Thus, insurers are free to deal with other IPAs, or to contract with physicians individually, outside the IPA system altogether. In addition, not all competing physicians belong to IPAs in the first place.

In the end, as with any benefit-cost comparison (and per the antitrust rule of reason), the issue in any case can only be resolved empirically. Given the fact that IPAs have cost-reducing benefits, any case against them should rest on a convincing showing of costs. The rule-of-reason approaches the issue in essentially the same way: it is the plaintiff who must first show some reason for concern.

The next section demonstrates the sorts of benefit-cost information presented to the FTC in its *Evanston Medical Group* case. As will be seen, the evidence concerned various considerations ad-

dressed above, including whether the Evanston Medical Group had market power in any relevant geographic market. The way that issue was addressed provides a template for examining geographic markets in the many cases being brought today against independent physician associations. Also considered are various other calculations that measure the extent that the Evanston Medical Group could exercise any market power. Again, it is suggested, these approaches have more general application in other cases raising market-power issues about IPAs.

III. The *Evanston Medical Group* Case: Costs

In February 2004, the FTC brought suit to undo the merger four years earlier of Evanston and Highland Park Hospitals, both located outside of Chicago very close to Lake Michigan and about 15 miles from one another. Evanston Hospital was already affiliated with Glenbrook Hospital some miles to the west of Lake Michigan, so the Highland Park merger increased the number of hospitals in the Evanston Hospital "system" to three. Some months after the Evanston/Highland Park hospital merger, the IPAs associated with the two hospitals also merged; indeed, the IPA merger had always been considered an integral, ultimate part of the hospital merger itself.

The combined IPAs became the Evanston Northwestern Healthcare Medical Group (ENHMG or Medical Group).[22] The Commission attacked the already-completed hospital merger, but in Count III of its complaint also challenged the IPA merger. The IPA-merger count in the complaint focused on prices for non-risk (fee-for-service) contracts negotiated on behalf of doctor-members of the Medical Group with various payer organizations (insurers).

[22] The Medical Group consisted of approximately 850 physicians, including both primary care doctors (some 33 percent of the member physicians) and specialists (about 66 percent). There were about 40 specialties represented in the Medical Group. Members of the Medical Group practice over a wide geographical region, including six counties, as discussed below concerning the relevant geographic market in the case against the IPAs.

Citing the *Maricopa County* case¸ the FTC initially took the position that the IPAs' negotiation for a single price at which member doctors would be reimbursed was illegal *per se*.[23] The respondent IPAs countered that a rule-of-reason approach was required. The IPAs claimed there was no possible anticompetitive impact of the IPAs collective negotiations on behalf of member physicians. That argument was based principally on two factors: (a) the market at issue in the FTC's complaint; and (b) within that market, the likelihood that procompetitive benefits on net exceeded anticompetitive costs.

Several aspects of the FTC's case against the Chicagoland IPAs were notable. First, there are many IPAs in the Chicagoland area, and most major hospitals in the area (there are many of them) have an IPA associated with them. Many of the Chicagoland IPAs include non-employed physicians, and for years many of these IPAs had negotiated fee-for-service contracts with payers on behalf of their non-employed physicians. Yet the FTC had never challenged any of those arrangements.

Relatedly, the FTC had not challenged the IPAs at Evanston or Highland Park hospitals until the two hospitals merged. Yet each IPA, independently, was already engaged in the sort collective price negotiation on behalf of hundreds of doctors that the FTC attacked following the merger. Particularly given that the FTC was pursuing the IPAs essentially on a *per se* price-fixing basis, it is hard to understand why merging the two price-negotiating IPAs made collective price negotiations any more illegal *per se* than the same negotiation activities that the separate IPAs had undertaken prior to the merger.

Of course, it made tactical sense for the FTC to characterize the IPAs' activities as *per se* illegal. Had the FTC abandoned its *per se* approach to respondents' activities, instead treating the matter as one

[23] The FTC 's legal theory changed, at least nominally, when it moved for Partial Summary Decision on the relevant count (Count III) of its action against the Chicagoland IPAs. There, it claimed to be following the FTC's recent decision in the so-called *Three Tenors* case (*In the Matter of Polygram Holding, Inc.,* FTC Docket no 9298, July 24 2003). However, while claiming that the collective rate negotiations by the respondent IPAs were "inherently suspect," the FTC never addressed the procompetitive rationales advanced by respondents, which is part of the *Three Tenors* formula. In effect, then, the FTC was treating respondents' negotiation as *per se* illegal.

involving a weighing of the pro- and possibly anticompetitive aspects of the Medical Group's activities, it would have to define the relevant market for the Medical Group, then an analysis of whether the Medical Group might possibly have any market power, and finally (assuming there was some market power) a weighing of the pro-competitive benefits that the Medical Group's actions had against the exercise of any market power.

The following evidence – uncontroverted by the FTC – shows that no reasonable inference of market power on the part of the Illinois IPAs was possible. The evidence concerning the relevant geographic market is particularly compelling.

A. Relevant Market

1. Product Market

The relevant product market necessarily implied by the FTC's complaint was the market for physician services. The FTC alleged that the affiliated members of the Medical Group were engaged in horizontal price fixing. In order to engage in horizontal price fixing, the participants in that conduct have to be horizontal competitors, supplying substitutable services.[24] This implies that every doctor in the Medical Group competes with every other doctor, e.g., that a podiatrist competes with a cardiologist. While this is of course not literally true, "physician services" is a useful product grouping in which to analyze the FTC's claims.[25]

Physician services is the product that the Medical Group provides and the product for which MCOs contract. Demanders of medical services, both the ultimate consumers of medical services

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[24] "The ENH Doctors and the Independent Doctors 'absolutely' compete against each other, and the Independent Doctors compete among themselves….[T]he ENH Doctors and the Independent Doctors provide comparable medical services…." Summary Decision Memo, p. 5.

[25] A similar situation arises in hospital cases. Typically, hospital mergers are evaluated in a market for "all inpatient services." Clearly, for a specific patient a (say) appendectomy is not a good substitute for a (say) coronary by-pass.

(enrollees in insurance plans) and the MCOs through which they are provided medical services, seek a broad-based network (portfolio) of physicians providing a wide range of expertise (general practice, oncology, pediatrics, cardiology, etc.). The MCOs approach IPAs precisely because, for the various reasons already noted (e.g., transaction-cost savings), they prefer to deal with organizations that can provide a full range of medical services via a single contract. Payers can always purchase the services of a particular supplier (doctor) individually, and the doctors sell their services to MCOs individually as well. But many insurers prefer to contract with an organization that can provide, in effect, a physician "blanket license."

Demanders' preference for a bundle of physician services is clear from the way contracts between MCOs and insurers are priced. MCOs in Chicago tend to contract with physicians, physician groups and IPAs with a "single price" for all physician services. MCO contracts with physicians — including those contracts about which the FTC complained — typically specify a single Medicare RBRVS conversion factor that is applied to all physician services.[26] The rates that the FTC allege were anticompetitively raised in 2000 are rates for all physician services as determined by agreement on a single conversion factor. Although the RBVRS index treats different specialties differently, MCO contracts with physicians typically do not specify one conversion factor for some type of services and another conversion factor for other physician services.[27]

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[26] The resource-based relative value scale (RBRVS) is a government-developed index determining the rates at which Medicare will will reimburse physicians. Under the RBVRS formulae, different specialities are reimbursed at different rates.

[27] In a Merger Guidelines sense, market definition requires analysis of buyer reaction to a hypothetical price increase. In this case, that hypothetical price increase would be an increase in the conversion factor for all physician services.

In addition to evaluating demand side factors when defining a relevant market, some economists assess supply side factors as well.[28] The supply side perspective on the relevant product focuses attention on the fact that IPAs can easily add new services and/or physicians to the portfolio they offer if competing organizations raise prices anti-competitively. "Supply substitutability between various physician services appears to be quite high – that is, multi-specialty physician organizations appear able to introduce new services with relative ease by hiring additional physicians when rival physician organizations raise their prices or lower their quality for those services."[29] In the ENHMG, doctors are free to join other IPAs, and do so frequently, as will be shown below. Thus, defining the relevant product market in terms of a portfolio of all physicians services in the relevant geographic market appears to be appropriate.[30]

2. Geographic Market

There was no substantial disagreement between the FTC and the physician IPAs as to what the relevant product market was: physician services. However, the issue of the relevant geographic market remained.

To define the relevant geographic market, one must recall the basic economic structure of the medical care market. Although the contracts at issue here are nominally between MCOs and the Medi-

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[28] See the Merger Guidelines for the "demand-side only" perspective. See also, e.g., Haas-Wilson, supra note __, at 105-06 for a discussion on supply-side substitution in market definition.

[29] Haas-Wilson at 105-06. Judge Posner makes a similar point in *Blue Cross & Blue Shield of Wisconsin v. Marshfield Clinic*, 65 F.3d 1406 (7th Cir. 1995): "If the Clinic overprices a particular procedure, other physicians capable of performing that procedure will have an added incentive to do so, knocking down the excessive price."

[30] An alternative definition might define the relevant product as IPAs. Statically, IPAs are the existing portfolios from which consumers (through MCOs) can choose today. But dynamically, definition of the relevant product should also take into account those doctors outside existing IPAs who tomorrow might join them, or who might form new IPAs, or who can contract with MCOs independently of existing IPAs. The Medical Group was one of only many IPAs which payers could use.

cal Group, the MCOs demand for a portfolio of physician services is a derived demand. That is, the MCOs' demands reflect what employers seek from the MCOs, and employer demands in turn take into account what their employees want. Thus, in determining the relevant geographic market, one should look at what the ultimate employee-consumers and the MCOs seeking to satisfy their consumers' demands would find as substitute physician inputs when constructing a portfolio of physician services.

The question is the area within which consumers, operating through MCOs, and in which the MCOs themselves, would select doctors alternative to those who are part of the Medical Group, in the event that the Medical Group raised its prices anti-competitively. Of course, there are different ways to estimate where consumers and MCOs would go in the event of supra-competitive pricing: "Market definition is not an exact science."[31] But a conservative approach would look at whether different contours of possible markets make a difference, and then at whether any market power might possibly exist under *any* of these proposed market definitions. If, however defined, *no* definition of a market could possibly raise market power concerns, there is no reason to split hairs over exactly which market is the right one for antitrust purposes. That was the approach taken by respondent IPA in the *Evanston Medical Group* case.

a. Possible Geographic Markets

In that matter, three alternative geographic areas for physician services suggested themselves. With maps for each of these three possible markets, once can discuss the alternative geographic areas and the rationale for each area as a possible geographic market.

(1) Definition A

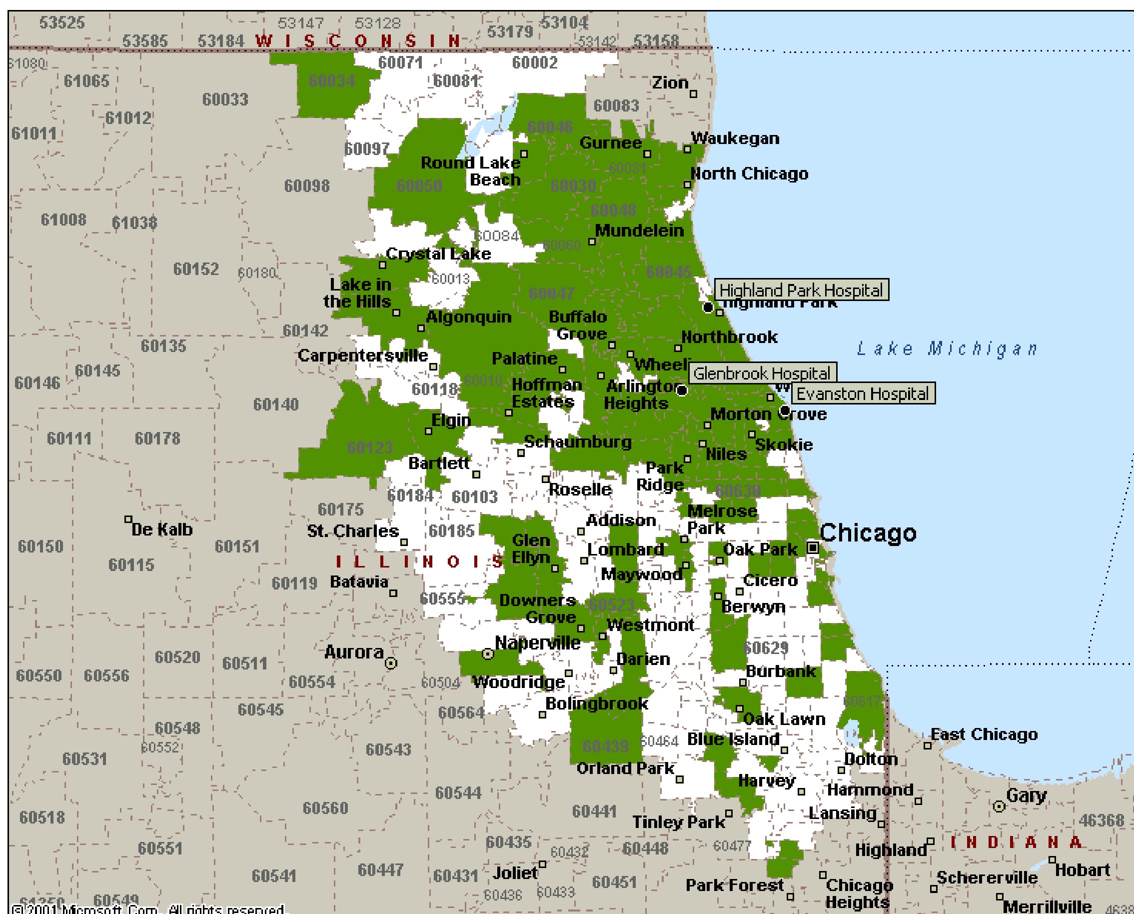
[31] Haas-Wilson at 91.

This area includes all zip codes in which at least one ENHMG physician practices, as well as all zip codes that do not have a Medical Group physician practice but that are within (or in between) those zip codes containing a Medical Group physician practice. This area roughly comprises the zip codes that fall within a 30 mile radius of the ENH hospitals.

Although the FTC did not define, qualitatively or otherwise, any geographic market, their allegations of horizontal price fixing imply this area as the appropriate geographic market.[32] In order for all members of the Medical Group to be engaged in price fixing, these members must be competitors of one another. This requires that they all compete in the same geographic (and product) market. Put simply, the geographic market must be at least as broad as the area over which the challenged conduct and the anticompetitive effect is alleged to have occurred. That area is shown in Map A, shows the zip codes containing at least one Medical Group member. As shown, that area stretches north of Chicago to the Wisconsin border and south of Chicago to the Indiana border.

[32] "[The ENH Doctors and the Independent Doctors] practice in close geographic proximity to each other." Summary Decision Memo, p. 5.

Map A



Note: Green=Zip codes with at least one ENHMG member; White=Zip codes selected to create a contiguous area. Physicians may practice in more than one zip code location.

(2) Definition B

While the FTC's allegations in this case imply Definition A as the appropriate geographic market, and although some physicians testified that they did get patients from an area this broad or broader, Definition A may be too broad as a geographic market for physician services. It is perhaps unlikely that an MCO, or most MCO enrollees, would find a physician in South Chicago (or further, close to the Indiana border) an acceptable substitute for a physician in Evanston.

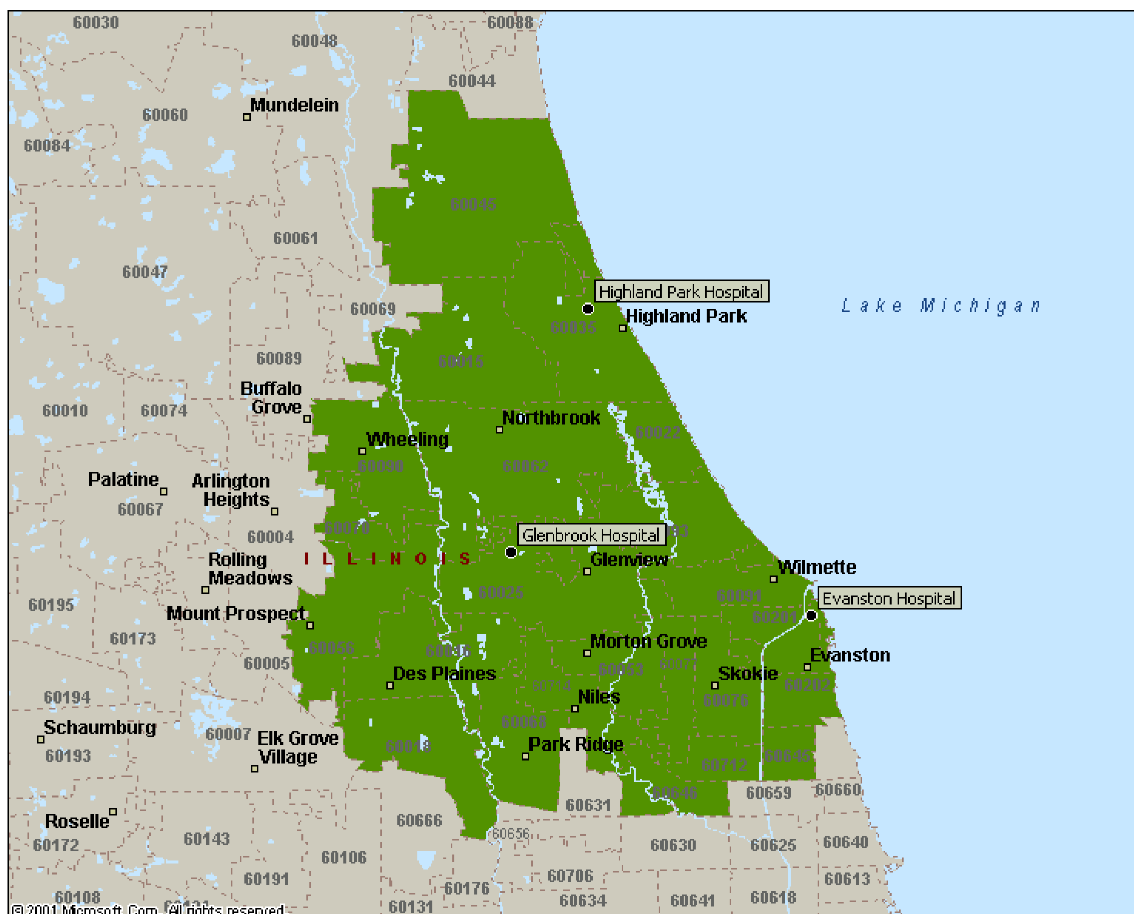
A more conservative geographic market might be the area specified by the FTC as the relevant geographic market for hospital (as opposed to physician) services provided by the ENH hospitals, given that the Medical Group is affiliated with the ENH hospitals. This area is similar to the geographic market views expressed by MCOs.[33] Moreover, this area is within the geographic parameters testified to by physicians.[34] This area, based on the FTC's suggestion of the relevant hospital market,[35] roughly comprises the zip codes falling within a 10 mile radius of the ENH hospitals, as shown in Map B.

[33] An official of one MCO testified that the MCO generally tries to have provider panels such that enrollees do not have to travel more than 15 miles. Another MCO apparently has slightly tighter criteria, requiring panels such that enrollees do not have to travel more than 8 or 10 miles. Finally, the area in Map B approximates, but is somewhat narrower than, the Service Area as defined by the Medical Group in its internal document, "Community Needs Assessment."

[34] For instance, two physicians both testified that most of their patients were from Lake County Another testified that most of her patients come from Lake and Cook counties. Two doctors described an area of about 15 miles radius as the location where most of their patients live

[35] Complaint Counsel's Answers and Objections to Respondents' First Set of Interrogatories, Response to Interrogatory No. 5.

Map B



(3) Definition C

An even more conservative geographic market would be the area adjacent to the three ENH hospitals (Evanston, Glenbrook, Highland Park). This area was the geographic market proposed by the FTC's expert, Dr. Haas-Wilson, in the hospital case.[36] It is also generally congruent with the central

[36] In the hospital rather than the IPA portion of the case, the economic experts retained by ENH to investigate the hospital issues (Counts I and II) believed the relevant geographic market for hospital services to be significantly broader than that asserted by Dr. Haas-Wilson. Definition C is included here merely to demonstrate that, under whatever geographic market the FTC could plausibly put forth, the Medical Group lacks market power.

service area of the Medical Group.[37] This area might seem too small to constitute a relevant geographic market, as it is much smaller than any of the areas testified to by either MCOs or physicians, and is much smaller than the total area in which the Medical Group operates. Nonetheless, one might examine this constricted area to see whether, under the narrowest possible geographic area, the Medical Group might conceivably have market power. This area includes only those zip codes falling within a 5 mile radius of the three ENH hospitals, as shown in Map C.

[37] Evanston Northwest Healthcare, Primary Care Community Needs Assessment, p. 5.

Map C

B. Market Power and Market Shares

With plausible alternative markets defined, one can then investigate the possibility of market power. For better or for worse, market share is of course the traditional antitrust yardstick used to measure whether market power exists. To calculate the shares of the Evanston Medical Group in the three alternative geographic markets described above, data concerning physicians in and around the areas served by doctors in the Medical Group were gathered. From various databases relating to individual

physicians, information was collated for a doctor's (1) one or more specialties,[38] (2) location(s) by zip code,[39] (3) status as a member or not of the Medical Group, and (4) if a Medical Group member, status as an employed or an affiliated physician.[40]

Regardless of which definition of the geographic market is chosen, the doctors who were members of the Medical Group have a modest share. This is shown in Table 1.

Table 1

ENHMG MARKET SHARE

Area Definition	*SHARE OF ENHMG MEMBERS*			*SHARE OF ENHMG AFFILIATES*		
	All Doctors	Specialist	Primary Care	All Doctors	Specialist	Primary Care
A	4.8%	4.6%	5.5%	2.6%	2.6%	2.9%
B	23.1%	22.1%	26.9%	11.1%	11.0%	12.3%
C	27.3%	26.8%	29.8%	13.0%	13.1%	13.7%

This same conclusion — that the Medical Group has a modest market share — also holds true regardless of whether one considers all members of the group (including the employed physicians), or

[38] In particular, doctors were separated between primary care (family practice, general practice, internal medicine and pediatrics) and all other specialties, as will be explained.

[39] Some physicians practice in more than one zip-code area.

[40] The physician database used for the market-share computations presented was constructed by merging together several separate sources of data, including Illinois Medicare records, Medical Group membership files, and pre-merger Highland Park physician lists. To avoid double-counting physicians whose records differ slightly in spelling or form across multiple data sources, data were cross-checked by first, last and middle names, Medicare identification numbers, and practice areas using a series of matching algorithms. The result is a combined database of nearly 22,000 physicians practicing in Cook, DuPage, Kane, Kendall, Lake, McHenry counties.

just the affiliated doctors, as Table 1 also shows.[41] Even if all doctors are included, the share of the market is only 40 percent in the most narrowly drawn market (Definition C). As Judge Posner wrote in one case involving the relevant geographic market for physician services, "50 % is below any accepted benchmark for inferring [market] power from market share."[42]

However, the conduct challenged by the FTC was the negotiation of non-risk MCO contracts by the Medical Group for its affiliated members. There was no allegation that the Medical Group refused to contract with MCOs for only the employed physicians, so the appropriate market share measure seemingly would be that for just the affiliated physicians. The market shares for affiliated doctors do not even reach 15 percent, regardless which geographic market is deemed appropriate. Clearly, under standard antitrust indicia of market power based on shares, the Medical Group has had no such power.[43]

The numbers above are noteworthy in other respects. First, these share figures are quite unimpressive compared to those of other independent practice associations against which the FTC has filed suit. As shown in Appendix A, the percentages of doctors involved in those cases, when given, were uniformly much higher than the share figures shown above. Moreover, the shares shown in Table 1 are

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[41] The share figures are also consistent with physician testimony in this case. One physician, for example, when asked about the gastroenterology practices with which he competed in "the areas that your patients come from," replied that there were "15 gastroenterology practices in the city on [the] north, and I think all of them compete for the same, compete in our area." He then said that only three of these practices were members of the Medical Group.

[42] *Blue Cross & Blue Shield of Wisconsin v.Marshfield Clinic*, 65 F.3d 1406 (7th Cir. 1995).

[43] See, e.g., Carlton and Perloff, at 611. "There is no agreement as to exactly what share (or change in share) is 'high,' but many economists regard a share in the range of 30 percent to 50 percent as too low to indicate significant market power in an industry with a competitive fringe comprising the remainder of the market."

generally well within the antitrust safety zones defined by the FTC in its Guidelines for Antitrust Enforcement in Healthcare Markets.[44]

C. Market Power and Market Coverage of All MCO Networks

The above market shares are particularly notable when compared to the market coverage of typical MCO networks. Such a comparison reveals that even without the Medical Group, there are more than enough physicians available to MCOs to allow them to form a competitive provider network. As Table 2 shows, the major MCOs in Chicago do not include most of the physicians in that MCO's provider network.

[44] Department of Justice & Federal Trade Commission Statements of Antitrust Enforcement Policy in Healthcare (1996) available at http//www.ftc.gov/reports/hlth3s.pdf.

Table 2:
Market Coverage of Selected PPO Products[45]

MCO	Product	Area	Date	Percent of Physicians in Area on MCO Provider Panel
United	United Healthcare Select	Cook, DuPage, McHenrey, Kane, and Lake Counties	2002	19%
Beech Street	PPO	5 mile radius of Zip 60201	2004	35%
Humana (Primary Care Physicians only)	PPO	5 mile radius of Zip 60201	2004	43%
Great West (One Health)	PPO	5 mile radius of Zip 60201	2004	50%

As evidenced by their contracting practices in the Chicago area, MCOs can and do develop competitive and marketable products while contracting with only a minority of all physicians in an area. For instance, in the 5-county area of Cook, DuPage, Kane, McHenry and Lake, United has only about 4,000 contracted physicians for its PPO product. However, there are over 21,000 practicing physicians in that area. United apparently needs to deal only with about 20% of the physicians. Beech Street lists 641 physicians in its PPO product within a 5-mile radius of Evanston. This is only 35 percent of the physicians practicing in that area. Similarly, Humana includes less than half the primary care physicians in the 5-mile radius around Evanston on the Humana PPO panel.

[45] Source: CRA physician database and MCO Provider lists. MCO provider lists were developed from various online and hardcopy provider manuals from the subject MCOs.

Therefore, the ENH affiliates, who at best only comprise about 30 percent of the practicing physicians in any area, are simply not in any way essential to MCOs.[46] Even if MCOs had to contract with the Medical Group in order to gain access to the affiliated members (and they do not), MCOs can easily fill out their networks without including the Medical Group physicians, by negotiating directly with physicians outside the Medical Group. It is also interesting that, for MCOs whose provider network circumscribes zip code 60201, the location of Evanston Northwestern Hospital, the percentage of physicians on the MCOs' provider list runs from 35 to 50 percent. MCOs seeking alternatives to the Evanston Medical Group obviously had many choices.

D. IPA Membership

It is highly probative that most doctors in the geographic area served by the hospitals and the Medical Group are *not* members of the Medical Group. The Medical Group is open to all doctors who have privileges at the ENH hospitals and meet the objective credentialing requirements of the Medical Group. If the rates obtained by the Medical Group for its members were supra-competitive, with membership open to all, one would expect all doctors to seek to join the Medical Group. But just the reverse has occurred: most doctors do not join the Medical Group.

E. Cross-Admission Data

As discussed earlier, the Medical Group might have market power derived from any market power possessed by hospitals where Medical Group physicians practice. That is, if employers and insurers regard those as "must-have" hospitals, doctors and IPAs practicing there might have some control

[46] At least from a numerical perspective, if the Medical Group affiliates are "essential" to MCOs because of the superior quality and reputation of these physicians, then one would expect these physicians to obtain higher prices from MCOs. But this would not be an antitrust problem, just the expected outcome in a well functioning market.

over the price of the medical services they provide. If, for instance, the Evanston or Highland Park Hospitals were considered "must- have" facilities by MCOs, it would be important to examine whether Medical Group members at those hospitals would consequently be "must-have" physicians as well. If so, the bundling of ENH physicians and the "must-have" hospitals might confer on the physicians some modicum of market power.

Perhaps an MCO is forced to pay a higher price to IPA physicians in order to gain access to particularly desirable hospitals at which IPA doctors can admit patients.[47] Thus, relevant to an analysis of the Medical Group's market power is the extent to which the doctors in the Medical Group admit patients to hospitals other than the three ENH hospitals (Evanston, Highland Park and Glenbrook), which would indicate that ability to practice at those hospitals confers no market power on the doctors.

Likewise relevant is the extent to which doctors other than those in the Medical Group admit patients to the ENH hospitals. It could be the case that an MCO is forced to pay a higher price to IPA physicians in order to gain access to particularly desirable hospitals at which IPA doctors can admit patients. But if IPAs and their doctors other than one particular IPA (such as the Evanston Medical Group) can all gain access to those same hospitals, that particular IPA cannot possess market power.

[47] Although this argument is sometimes encountered in the cases involving hospitals and their IPAs, it is unclear why a hospital possessing market power (perhaps quite legitimately) would allow physicians practicing at that hospital, otherwise lacking market power, to reap the returns that the hospital could garner for itself from its "must-have" status. The familiar analysis of successive monopolies in fact would indicate that a hospital with market power would only lose by allowing a complementary vertical level of production to exercise its own market power. See *Town of Concord v. Boston Edison Co.*, 915 F2d 17 (1st Cir. 1990) (Breyer, C.J.)

Table 3a shows data for admissions at all three ENH hospitals in 2000-2001, as well as admissions to all Illinois hospitals by any Medical Group affiliated physician.[48] Admissions to the three ENH hospitals are broken down into admissions by non-ENH physicians, and those by Evanston Medical Group doctors (divided into employed and affiliated physicians). These data show that the affiliated members of the Medical Group are not essential to an MCO, even if that MCO "must have" the ENH hospitals.

Table 3a:
Admissions to ENH Hospitals by All Physicians[49]

	Evanston	Highland Park	Glenbrook	All ENH Hospitals
Total Number of Admissions at Hospital	58,989	22,957	18,739	100,685
Admissions by ENHMG Affiliates	12,136	11,939	6,532	30,607
Percent of All Admissions by ENHMG Affiliates	**36.2%**	**29.7%**	**25.3%**	**32.7%**
Admissions by non-ENHMG Physicians	21,343	6,828	4,747	32,918
Percent of All Admissions by non-ENHMG Physicians	**20.6%**	**52.0%**	**34.9%**	**30.4%**

Medical Group affiliates are the admitting physician for only about one third of all patients at the ENH hospitals (ranging from 25% at Glenbrook to 36% at Evanston). Therefore, an MCO does not need to contract with the affiliated members of the Medical Group, even if it, and its enrollees, desire to be treated at the ENH hospitals. The same conclusion largely holds when considering the entire set of physicians (affiliated plus employed) in the Medical Group. Physicians outside the Medical Group ("non-ENHMG physicians" in Table 3a) are the admitting physicians for over 30 percent of all patients at the ENH Hospitals (ranging from over 50 percent at Highland Park to approximately 20 percent at

[48] The data describe all patient admissions to all Illinois hospitals and identify the admitting physician by his or her Medicare and/or state ID number.

[49] Source: Illinois Hospital Association COMPdata 1997-2003; Discharges for all patients admitted in 2000 – 2002. An Admission is counted as by EHNMG if any of the four listed treating physicians is a member of EHNMG.

Evanston). The numerous doctors outside the Medical Group who admit to the ENH hospitals demonstrates that an MCO need not contract with the Medical Group, even if ENH hospitals are the desired hospital for treatment.

Similarly, the data in Table 3b show that affiliated members of the Medical Group admit most of their patients to hospitals other than the ENH hospitals.

Table 3b:
Admissions to All Hospitals by ENHMG Affiliates[50]

Admissions by ENHMG Affiliates at ENH Hospitals	30,607
Admissions by ENHMG Affiliates at non-ENH Hospitals	37,628
Percent of ENHMG Affiliate Admissions at ENH Hospitals	**44.9%**

In other words, many doctors who are not in the Medical Group admit patients to the three ENH hospitals, and the affiliated Evanston Medical Group doctors admit more patients to non-ENH hospitals than they do to Evanston, Highland Park and Glenbrook. The ability of Medical Group doctors to admit patients to hospitals other than ENH would mean that the portfolio of doctors that payers can assemble for consumers is not constrained by any "requirement" that the ENH hospitals be the hospitals selected by the physician. Bundling of the hospitals and the IPA physicians simply has not occurred.

F. Cross-Membership in Other IPAs

As noted earlier, Medical Group membership entails no exclusivity: doctors are free to make other arrangements with payers, including membership in other IPAs.[51] Doctors' membership in IPAs

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[50] Source: Illinois Hospital Association COMPdata 1997-2003; Discharges for all patients admitted in 2000 – 2002. An Admission is counted as by EHNMG if any of the four listed treating physicians is a member of EHNMG.

other than the Medical Group means that payers can include those doctors in the portfolio they present to the ultimate consumer without going through the Medical Group, increasing the geographic areas available to consumers. The data demonstrate that in fact doctors belonging to the Medical Group to a considerable extent belong to other IPAs.

[51] Primary care physicians in the Medical Group could not belong to other IPAs, because the Medical group had capitated contracts for primary care services. However, primary care doctors who already had multiple IPA affiliations were grand-fathered into the Medical Group. This amounted to 48 primary care physicians from the former Highland Park IPA.

Table 4:
Membership by ENHMG Affiliates in Other IPAs[52]

Total Number of ENHMG Affiliates Identified in Humana Database	321
Number of ENHMG Affiliates Identified in Humana Database with No Additional IPA Affiliation	175
Number of ENHMG Affiliates Identified in Humana Database with 1 Additional IPA Affiliation	87
Number of ENHMG Affiliates Identified in Humana Database with 2 Additional IPA Affiliations	34
Number of ENHMG Affiliates Identified in Humana Database with 3 or more Additional IPA Affiliations	25
Total Number of ENHMG Affiliates Identified in Humana Database with At Least 1 Additional IPA Affiliation	146
Percent of ENHMG Affiliates Identified in Humana Database with At Least 1 Additional IPA Affiliation	45.5%

Table 4 shows that almost 50% percent of the affiliated doctors belonging to the Medical Group are members of at least one other IPA.[53] It should not be forgotten, either, that physicians contract with MCOs directly, either individually or through their physician groups, and Medical Group members are not restricted from contracting outside of the Medical Group at whatever price they choose.

[52] Source: CRA data on current ENHMG membership, and CRA developed data on membership in other IPAs.

[53] Table 4 was based on partial data regarding membership in other IPAs (although the only data then available). With complete data on the membership of all IPAs in the Chicago area, it is likely that the degree of cross-membership would increase.

Further, membership in the Medical Group does not in any way require that most specialist member physicians provide services exclusively through the Medical Group.[54] Indeed, quite the contrary is true. The Medical Group's specialist physicians (which comprise approximately 66 percent of the membership) are free to join other IPAs — and do so regularly. Their fee-for-service (FFS) contracts can then be billed through those other IPAs.[55] Almost 50 percent of the affiliated doctors in the ENH Medical Group belonged to more than one IPA. In addition, many IPA members had individual contracts with some of the same MCOs that contracted with the IPA. There is no evidence of a concerted refusal to deal, and interestingly produced to the FTC showed that, in some cases, the prices in the individual contracts were higher than the prices in contracts negotiated by the IPA.

F. Summary on Market Power

In summary, the Medical Group operated over a large geographic area, and across a large number of specialties. However, in no plausible product or geographic market could the Medical Group be said to have market power. The share of the Medical Group members, as a percentage of the number of practicing physicians of that specialty in any given plausible geographic market, was small. Moreover, MCOs in the area effectively competed with provider panels that contained only a minority (indeed, a significant minority) of the practicing physicians in the area. In addition, the members of the IPA did not admit a large share of the patients to the subject hospitals. Therefore, the members of the Medical

[54] Primary care physicians were handled differently with respect to their capitated contracts. See note __, supra.

[55] Membership in multiple IPAs does create potential confusion and burdens for payers who have contracts with doctors in different IPAs having different reimbursement rates. To address the problem of physicians being reimbursed at the wrong rates, the Medical Group took various steps suggested to them by the payers. The fact that the payers preferred to reimburse physicians according to the Medical Group contract indicates that the rates contracted for were hardly exorbitant.

Group were not essential to MCOs in any way, and MCOs had ample available substitutes to the Medical Group IPA or its individual members.

In addition, membership in the IPA was not exclusive for most physicians. Evidence showed that member physicians could and did belong to other IPAs, and could and did contract individually with MCOs. Therefore, if an MCO did not like the prices proposed by the Medical Group, it could still contract with individual members of the Group on terms that were negotiated independently, or with other IPAs, to which member physicians also belonged. Taken together, these facts show that the Medical Group could not possibly possess market power.

IV. The *Evanston Medical Group* Case: Benefits

As discussed above, the FTC bore the burden in an economically sensible, rule-of-reason case of showing that the Evanston Medical Group had market power in negotiating collective-price contracts on behalf of their member physicians. The FTC never attempted to do so, once the evidence summarized above was presented to them. Even had the FTC tried to show antitcompetitive costs due to the IPA's market power, however, it would still have had to compare those costs to the benefits created by the IPA.

The Medical Group had clear economic benefits to its members, as well as to the MCOs and patients. These included decreases in the transaction costs associated with contracting and credentialing, the development of more cohesive referral networks, and the ability to implement integrated clinical and practice management programs.

Testimony taken during the FTC's case against the Chicagoland IPAs exemplified the transaction-cost savings afforded by IPAs, in this case the Medical Group (as consolidated) IPA. Payer testimony confirmed that lower transaction costs were benefits from dealing with the Medical Group. One

MCO official noted that dealing with an IPA creates a “one-signature contract.” He continued, “It’s less work. It’s faster.” He agreed that “Transaction costs are lower.” Another MCO official, when asked if there were “benefits from negotiating IPAs,” answered, “Yes, there’s benefits….Getting a large number of physicians under a single contract.” Yet a third MCO representative, when asked whether there was a benefit for her in dealing with a network, responded “you may get a large group of doctors when the contract is signed versus doing a lot of work contracting individually. . . . If you’re building a network, it helps you get a network potentially in theory quicker.”

An MCO representative from yet another insurer noted that that while his payer organization could always contract individually with doctors, it preferred to negotiate a single contract with the Medical Group. “[W]e would have to go out and independently contract with the independent physicians. And … we did not want to do that because of, one, the workload requirement….The workload requirement [involved] going out and contacting physicians individually….” A Medical Group doctor made the same point: the payers “used to tell us they would rather negotiate with us and get the 70 doctors that we had rather than try to negotiate individually because it took so much effort.”

The transaction-cost saving point applies on the physician side as well. If the IPA does not negotiate a contract with the MCOs, doctors will have to do it themselves, and this is costly. One physician, for example, spoke of her physician practice’s possibly negotiating its own contracts with certain MCOs, and of the additional cost required to do that. She said, “my attorney has to look at the contracts. My office manager has to use his time to review it. And we have to – I have to employ someone to perform referral – to do referrals within that insurance company, whereas before the IPA did those – did that for you.”

Consequently, "one-signature" contracting through the IPA lowers transaction costs for both payers and for doctors.[56] Lower transaction costs through IPA negotiation on behalf of all doctors also has an important, more dynamic implication. Because the IPA can negotiate on behalf of affiliated doctors, those doctors have an incentive to join the IPA. That is, the ability to negotiate a single contract will, *ceteris paribus*, increase the number of doctors in the IPA. As already noted, the ability of the Medical Group to increase the size of the IPA has additional efficiency-enhancing consequences for MCOs, physicians, and patients. When then asked what the benefits of being in the IPA were, one doctor responded, "Essentially the contracting negotiations is done for us, which allows us, the doctor, to practice medicine." Another physician testified that he joined the IPA because "I was going to have contracts negotiated." (The same physician said he did not expect that the Medical Group would get any higher rates than he already was receiving.)

In addition to contracting, IPAs may also provide a variety of other services to their member physicians and to payers, such as credentialing. That was certainly the case with the Medical Group. As one MCO representative testified, "Sometimes [IPA] groups do the credentialing, so we're able to delegate credentialing to the groups. In other words, we don't have to take on that administrative burden….It's a savings."

V. Conclusion

[56] It is not clear that there are any viable, less restrictive alternatives (e.g., the messenger model) that would mitigate the sorts of transaction costs discussed here. Testimony in the case showed some MCOs apparently preferred the "single signature" contracting with the IPA that the FTC challenged over the messenger-model-type contracting because the former was "easier administratively".

Relying on its *per se* approach, followed by its characterization of the IPAs' price negotiations on behalf of hundreds of member as "inherently suspect," the FTC challenged none of the evidence adduced by respondent IPAs summarized above. The FTC tried to hold 'em, but knew when to fold 'em. It ultimately abandoned that count of its complaint challenging the merger of the two IPAs.

The IPA activities that the FTC complained of do not amount to what economically could be called price fixing. Admittedly, the Medical Group does negotiate reimbursement rates for its members. But it does not attempt to maintain rates in the market at that level. Numerous alternatives exist for payers and doctors to contract over collectively-negotiated reimbursement rates, alternatives that they often use. The Medical Group neither monitors rates nor tries to enforce rates negotiated outside the Medical Group that at least equal the rates negotiated by the Medical Group.

The activities to which the FTC objected entailed numerous procompetitive benefits. Principal among them was the ability to reduce transaction costs on both the payer and physician side of managed care contracts. This benefit provided a motivation for physicians to join the Medical Group, which then leads to further economic benefits.

There are many reasons to believe that the rates resulting from the Medical Group's contracting are not anticompetitive. Payers dissatisfied with those rates have ample alternatives to negotiate other rates, and do so. Further, the structure of the market here shows, numerically, that the Medical Group has no market power to raise rates anticompetitively. Market shares of Medical Group members in the relevant geographic market fall far short of anything that, in modern antitrust, would indicate market power.

These conclusions are not surprising to an economist. The FTC's rigid insistence against collective rate negotiations (except under very narrow exceptions) by IPAs is based on no economic theory or evidence. There is every reason, in fact, to regard IPA reimbursement rate contracts as economically benign, particularly given the circumstances presented in this matter. In her book, the FTC's own expert, Dr. Haas-Wilson, had noted,

> In geographic areas characterized by one or only a few hospitals or physician organizations, MCCs [managed care companies, alternatively called MCOs] and employers (in the case of employers contracting directly with providers) have less bargaining power…In markets characterized by many hospitals or physician organizations, on the other hand, MCCs and employers can bargain for lower reimbursements to providers…..In fact, the vast majority of … joint ventures will have neutral or positive net impacts on competition.[57]

Not surprisingly, then, the FTC dropped its case against the Evanston Medical Group, which had spent over a million dollars to defend itself. One might well ask whether there was any defensible reason for filing the case in the first place.

[57] Haas-Wilson at 73.

APPENDIX A. Recent FTC Cases Against IPA's

Case	Percentage of Doctors
In the Matter of Advocate Health Partners et al., File No. 0310021.	Respondents are physician-hospital organizations that include competing physicians and physician practice groups that account for over 2,900 physicians in the Chicago metropolitan area. In the Matter of Advocate Health Partners et al., File No. 0310021.
In The Matter Of Alaska Healthcare Network, Inc., Docket No. C-4007, (F.T.C. Apr. 25, 2001)	Respondent AHN's members included approximately 63% of all physicians, 48% of the family and general practitioners, 72% of the internists, 100% of the pediatricians, 80% of the obstetrician-gynecologists, and 86% of the general surgeons. In The Matter Of Alaska Healthcare Network, Inc., Docket No. C-4007, (F.T.C. Ap. 25, 2001)
In the Matter of Anesthesia Service Medical Group, Inc., Docket no. C-4085 (F.T.C. July 11, 2003)	ASMG and GAS are competing anesthesiology groups that provide anesthesia services for a fee to patients in San Diego County, California. ASMG employs approximately 180 anesthesiologists; GAS is composed of approximately 10 anesthesiologists. ASMG and GAS anesthesiologists are members of the medical staff of Grossmont Hospital in La Mesa, a municipality in central San Diego County. ASMG and GAS anesthesiologists make up approximately 75% of the anesthesiologists with active medical staff privileges at Grossmont Hospital and work on approximately 70% of the cases that require anesthesia services at the hospital. In the Matter of Anesthesia Service Medical Group, Inc., Docket no. C-4085 (F.T.C. July 11, 2003).
In the Matter of Aurora Associated Primary Care Physicians, L.L.C., File No. 0110174 (F.T.C. July 16, 2002)	Respondent AAPCP has approximately 45 members, all of whom are primary care physicians licensed to practice medicine in the State of Colorado. AAPCP consists of internists, pediatricians, family physicians, and general practitioners with offices in the Aurora, Colorado area. In the Matter of Aurora Associated Primary Care Physicians, L.L.C. File No. 0110174 (F.T.C. July 16, 2002).
In the Matter of Boulder Valley Individual Practice Association, File No. 0510252	Boulder Valley IPA consists of approximately 365 competing independent physicians and physician practice groups in Boulder County, Colorado. In the Matter of Boulder Valley Individual Practice Association, File No. 0510252.
In the Matter of California Pacific Medical Group, Inc., Docket No. 9306 (F.T.C. Feb. 9, 2004)	Brown & Toland is a risk-sharing IPA that contracts with HMOs to provide services to HMO enrollees who live or work in San Francisco, California. Approximately 1,500 physicians who provide physician services in San Francisco participate in, or have contracts with, Brown & Toland. In the Matter of California Pacific Medical Group, Inc., Docket No. 9306 (F.T.C. Feb. 9, 2004).
In the Matter of Carlsbad Physician Association, Inc., Docket No. C-4081 (F.T.C. June 13, 2003)	CPA was organized in 1998-1999 and consists of 38 physician members. Its members represent 76% of all physicians and 83% of the primary care physicians practicing in the Carlsbad area, which is located in southeastern New Mexico. In the Matter of Carlsbad Physician Association, Inc., Docket No. C-4081 (F.T.C. June 13, 2003).
In the Matter of Colegio de Cirujanos Dentistas de Puerto Rico, Docket No. C-3953 (F.T.C. June 12, 2000)	Approximately 1,800 dentists are members of the Colegio, constituting almost all of the dentists licensed to practice in Puerto Rico. Membership in the Colegio is required by statute in order to practice dentistry in Puerto Rico (with the exception of certain dental faculty and dentists in the United States Armed Forces). In the Matter of Colegio de Cirujanos Dentistas de Puerto Rico, Docket No. C-3953 (F.T.C. June 12, 2000).

In the Matter of Colegio de Optometras de Puerto Rico, et al., Docket No. C-4199 (F.T.C. Sept. 6, 2007)	Colegio consists of 500 optometrists, which constitutes 100% of all optometrists licensed to practice in Puerto Rico. Membership is required by statute to practice optometry. In the Matter of Colegio de Optometras de Puerto Rico, et al., Docket No. C-4199 (F.T.C. Sept. 6, 2007)
In the Matter of The Connecticut Chiropractic Association and The Connecticut Chiropractic Council, and Robert L. Hirtle, Esq., Docket No. C-4217 (F.T.C. April 14, 2008)	CCA has a membership of approximately 375 chiropractors; CCC consists of approximately 150 members. Respondent's members practice throughout the state of Connecticut. In the Matter of The Connecticut Chiropractic Association and The Connecticut Chiropractic Council, and Robert L. Hirtle, Esq., Docket No. C-4217 (F.T.C. April 14, 2008).
In the Matter of Grossmont Anesthesia Services Medical Group, Inc., Docket No. C-4086 (F.T.C. July 11, 2003)	Anesthesia Service Medical Group, Inc. (ASMG) employs approximately 180 anesthesiologists; GAS consists of 10 anesthesiologists. The member physicians are located in the San Diego area. Together, these anesthesiologists make up approximately 75% of the anesthesiologists with active medical staff privileges at Grossmont Hospital and work on approximately 70% of the cases that require anesthesia services at the hospital. In the Matter of Grossmont Anesthesia Services Medical Group, Inc., Docket No. C-4086 (F.T.C. July 11, 2003).
In the Matter of Health Care Alliance of Laredo, L.C., Docket No. C-4158 (F.T.C. Mar 23, 2006)	The Health Care Alliance of Laredo consists of approximately 80 physicians practicing in Laredo, Texas. In the Matter of Health Care Alliance of Laredo, L.C., Docket No. C-4158 (F.T.C. Mar 23, 2006).
In the Matter of Independent Physician Associates Medical Group, Inc., dba AllCare IPA, Docket No. 4245 (F.T.C. Feb.2, 2009)	AllCare members come from multiple, independent medical practices. Approximately 500 physicians in the Modesto, CA area are members of AllCare, 200 of which are primary care physicians. The percentage of all physicians practicing in the Modesto, CA area represented by AllCare is not given. In the Matter of Independent Physician Associates Medical Group, Inc., dba AllCare IPA, Docket No. 4245 (F.T.C. Feb.2, 2009).
In the Matter of M.D. Physicians of Southwest Louisiana, Inc., Docket No. C-3824 (F.T.C. Aug. 31, 1998)	The members of respondent MDP constitute a majority of all physicians practicing in Calcasieu Parish, Louisiana. In certain physician specialties, the members of respondent MDP constitute all or most of the physician specialists practicing in Calcasieu Parish. More than 200 physicians have been members of respondent MDP since it was formed in 1987. During the relevant time period, respondent MDP has had as many as 165 members at one time. In the Matter of M.D. Physicians of Southwest Louisiana, Inc., Docket No. C-3824 (F.T.C. Aug. 31, 1998).
In the Matter of The Maine Health Alliance, Docket No. C-4095 (F.T.C. Aug. 27, 2003)	The Alliance of 11 hospitals and approximately 325 physicians was formed in 1995. It represents by the vast majority of physicians and hospitals in five counties in northeastern Maine. More than 85% of the physicians on staff at Alliance member hospitals are Alliance members, as are 11 of the 16 hospitals in the five-county area. In the Matter of The Maine Health Alliance, Docket No. C-4095 (F.T.C. Aug. 27, 2003).
In the Matter of Memorial Herman Healthnet Providers, Inc., Docket No. C-4104 (F.T.C. Jan. 8, 2004)	Memorial Herman Healthnet Providers (MHHNP) consists of approximately 3,000 physician members practicing in the Houston metropolitan area. In the Matter of Memorial Herman Healthnet Providers, Inc., Docket No. C-4104 (F.T.C. Jan. 8, 2004).
In the Matter of Mesa County Physicians Independent Practice Association, Inc., Docket No. 9284, 1999 WL 33913003 (F.T.C.), 127 F.T.C. 564 (F.T.C. May 4, 1999)	Mesa County IPA consists of more than 180 members, comprising at least 85% of the physicians (medical doctors and doctors of osteopathic medicine) in private practice in Mesa County, as well as at least 90% of the primary care physicians (family practitioners, general practitioners, internists, and pediatricians). These physicians compete in the Mesa County area. In the Matter of Mesa County Physicians Independent Practice Association, Inc., Docket No. 9284, 1999 WL 33913003 (F.T.C.), 127 F.T.C. 564 (F.T.C. May 4, 1999).

In the Matter of New Century Health Quality Alliance, Inc. and Prime Care of Northeast Kansas and Elizabeth Gallup, M.D., J.D., et al., Docket No. C-4169 (F.T.C. Sept. 29, 2006)	New Century is an IPA consisting of 87 primary care physicians from 16 medical practices in the Kansas City area. Prime Care consists of approximately 40 physicians from 9 medical practices in the Kansas City Area. Prime Care physicians represent about 95% of Humana Medicare HMO's primary care network in Wyandotte County and 50% in Johnson County. In the Matter of New Century Health Quality Alliance, Inc. and Prime Care of Northeast Kansas and Elizabeth Gallup, M.D., J.D., et al., Docket No. C-4169 (F.T.C. Sept. 29, 2006).
In the Matter of New Millennium Orthopaedics, et al., Docket No. C-4140 (F.T.C. June 13, 2005)	New Millennium Orthopedics (NMO) is an IPA that was formed by Wellington and Beacon in 2002; Wellington is an orthopaedic physician group with 22 members; Beacon is an orthopaedic physician group with 10 members. NMO is located in the Cincinnati area. In the Matter of New Millennium Orthopaedics, et al., Docket No. C-4140 (F.T.C. June 13, 2005)
In the Matter of North Lake Tahoe Medical Group, Inc., Docket No. C-3885 (F.T.C. July 21, 1999)	Respondent Tahoe IPA's physician membership consists of the majority of the physicians in both the North and South Lake Tahoe markets. Tahoe IPA's members include at least 78% of the physicians (medical doctors and doctors of osteopathic medicine) in the North Lake Tahoe area and at least 70% of the physicians in the South Lake Tahoe area. In the North Lake Tahoe area, the IPA's members include at least 67% of the primary care physicians in private practice and at least 89% of the specialty physicians in private practice. In the South Lake Tahoe area, Tahoe IPA's members include at least 70% of the primary care physicians in private practice and at least 72% of the specialty physicians in private practice. In the Matter of North Lake Tahoe Medical Group, Inc., Docket No. C-3885 (F.T.C. July 21, 1999).
In the Matter of North Texas Specialty Physicians, Docket No. 9312 (F.T.C. Sept. 16, 2003)	NTSP has approximately 600 participating physicians licensed to practice medicine in the State of Texas who are engaged in the business of providing professional services to patients in the Dallas-Fort Worth metropolitan area, mostly in Fort Worth and the "Mid Cities." In the Matter of North Texas Specialty Physicians, Docket No. 9312 (F.T.C. Sept. 16, 2003).
In the Matter of Obstetrics and Gynecology Medical Corporation of Napa Valley, Docket No. C-4048 (F.T.C. May 14, 2002)	OGMC is an IPA consisting of members of the medical staffs of the two general acute care hospitals in Napa County, CA. They constitute virtually all of the obstetricians and gynecologists with active medical staff privileges at both hospitals. In the Matter of Obstetrics and Gynecology Medical Corporation of Napa Valley, Docket No. C-4048 (F.T.C. May 14, 2002).
In the Matter of Partners Health Network, Inc., Docket No. C-4149 (F.T.C. Sept. 19, 2005).	Partners Health consists of 225 physicians and 2 hospitals (the only 2 hospitals in Pickens County, South Carolina). Approximately 150 members of Partners health practice in Pickens County, accounting for 75% of the physicians there. In the Matter of Partners Health Network, Inc., Docket No. C-4149 (F.T.C. Sept. 19, 2005)..
In the Matter of Physician Integrated Services of Denver, Inc., Docket No. C-4054 (F.T.C. July 16, 2002)	PISD consists of approximately 41 members, all of whom are primary care physicians, licensed to practice medicine in the State of Colorado. The membership of Respondent PISD consists of internists, pediatricians, family physicians, and general practitioners with offices in the southern part of the Denver metropolitan area. In the Matter of Physician Integrated Services of Denver, Inc., Docket No. C-4054 (F.T.C. July 16, 2002).

In the Matter of Physician Network Consulting, L.L.C., Docket No. C-4094 (F.T.C. Aug. 27, 2003)	Professional Orthopedic Services is an independent practice association consisting of approximately 28 physicians who practice orthopedic medicine. Its members provide approximately 70% of the orthopedic medicine services in the Baton Rouge, Louisiana, area. The Bone and Joint Clinic is a group practice consisting of approximately 10 physicians. Baton Rouge Orthopaedic Clinic is a group practice consisting of approximately 15 physicians. Orthopaedic Surgery Associates is a partnership of 3 physicians. In the Matter of Physician Network Consulting, L.L.C., Docket No. C-4094 (F.T.C. Aug. 27, 2003).
In the Matter of Preferred Health Services, Inc., Docket No. C-4134 (F.T.C. Apr. 13, 2005)	Preferred Health is a PHO formed in 1996, consisting of Oconee Memorial Hospital and over 100 physicians. The Preferred Health physician members account for approximately 70% of the independent physicians in the Seneca, South Carolina area. In the Matter of Preferred Health Services, Inc., Docket No. C-4134 (F.T.C. Apr. 13, 2005)
In the Matter of R. T. Welter and Associates, Inc., Docket No. C-4063 (F.T.C. Oct. 8, 2002)	Approximately 88 OB/GYNs participate in Professionals in Women's Care (PIWC). These PIWC participants constitute a significant percentage of the OB/GYNs practicing in the Denver metropolitan area. About half of the participants in PIWC are OB/GYNs who practice medicine through one of the eight Respondent Practice Groups. In the Matter of R. T. Welter and Associates, Inc., Docket No. C-4063 (F.T.C. Oct. 8, 2002).
In the Matter of San Juan IPA, Inc., Docket No. C-4142 (F.T.C. June 30, 2005)	The San Juan IPA consists of approximately 120 physicians, which accounts for about 80% of the physicians that independently practice in the Farmington, New Mexico area. In the Matter of San Juan IPA, Inc., Docket No. C-4142 (F.T.C. June 30, 2005).
In the Matter of South Georgia Health Partners, L.L.C., Docket No. C-4100 (F.T.C. Oct. 31, 2003)	SGHP is physician-hospital organization (PHO) that consists of 15 hospitals and approximately 500 physicians. Five other PHOs (the "Owner PHOs") jointly own and are part of SGHP. Each Owner PHO has multiple physician members and at least one hospital; in total, the Owner PHOs include 10 hospitals. Physician members in three of the Owner PHOs are also organized IPAs. Five additional hospitals are member of SGHP. Approximately 90% of all physicians practicing in South Georgia are SGHP members. With one exception, SGHP's member hospitals are the sole hospitals in each of the 15 counties where they are located. In the Matter of South Georgia Health Partners, L.L.C., Docket No. C-4100 (F.T.C. Oct. 31, 2003).
In the Matter of Southeastern New Mexico Physicians IPA, Inc., a corporation, and Barbara Gomez and Lonnie Ray, individually, Docket No. C-4113 (F.T.C. Aug. 5, 2004)	The Southeastern New Mexico Physicians IPA has approximately 68 members. Approximately 73% of the physicians independently practicing in the Roswell area are members of the IPA. In the Matter of Southeastern New Mexico Physicians IPA, Inc., a corporation, and Barbara Gomez and Lonnie Ray, individually, Docket No. C-4113 (F.T.C. Aug. 5, 2004).
In the Matter of Southbank IPA, Inc., Docket No. C-3355 (F.T.C. Dec. 20, 1991)	The physician respondents are members of the medical staff of Southern Baptist Hospital of Florida, Inc. d/b/a Baptist Medical Center in Jacksonville, Florida. They constitute nearly the entire active staff of obstetrician/gynecologists at Baptist Medical Center. Because only members of the hospital's medical staff may admit patients to Baptist Medical Center, the physician respondents, when acting in concert, effectively control access to Baptist Medical Center's obstetrical/gynecological facilities and services. In the Matter of Southbank IPA, Inc., Docket No. C-3355 (F.T.C. Dec. 20, 1991).

In the Matter of SPA Health Organization, File No. 011-0197 (F.T.C. June 9, 2003)	SPA Health consists of approximately 1,000 participating physicians who are licensed to practice medicine in the State of Texas. Its members provide medical services to patients in the eastern part of the Dallas-Fort Worth metropolitan area. In the Matter of SPA Health Organization, File No. 011-0197 (F.T.C. June 9, 2003).
In the Matter of Surgical Specialists of Yakima, P.L.L.C., File No. 0210242 (F.T.C. Sept. 24, 2003)	SSY has approximately 24 physician members who provide physician services to patients in the Yakima, Washington area in the following specialties: ENT, OB/GYN, General Surgery, Ophthalmology, and Plastic Surgery. SSY has 90% of the physicians who specialize in general surgery who practice in the Yakima, Washington area. In the Matter of Surgical Specialists of Yakima, P.L.L.C., File No. 0210242 (F.T.C. Sept. 24, 2003)
In the Matter of System Health Providers, Inc., Docket No. C-4064 (F.T.C. Oct. 24, 2002)	Respondent GPG has approximately 1,250 members, almost all of whom are physicians licensed to practice medicine in the State of Texas and provide professional services to patients in the eastern part of the Dallas-Fort Worth metropolitan area. In the Matter of System Health Providers, Inc., Docket No. C-4064 (F.T.C. Oct. 24, 2002).
In the Matter of Texas Surgeons, P.A., Docket No. C-3944 (F.T.C. May 18, 2000)	Respondent Texas Surgeons consists of 26 or more general surgeons practicing in the Austin area. In the Matter of Texas Surgeons, P.A., Docket No. C-3944 (F.T.C. May 18, 2000).
In the Matter of Washington University Physician Network, Docket No. C-4093 (F.T.C. Aug. 22, 2003)	Washington University and approximately 1,500 physicians are members of WUPN. All of the WUPN physicians practice medicine in the greater St. Louis area. These physicians include approximately 900 members of the clinical faculty of the Washington University School of Medicine ("faculty physicians") and approximately 600 independent physicians, whom WUPN refers to as "community physicians." In the Matter of Washington University Physician Network, Docket No. C-4093 (F.T.C. Aug. 22, 2003).
In the Matter of White Sands Health Care System, L.L.C., the Alamogordo Physicians' Cooperative, Inc., Dacite, Inc., and James R. Laurenza, Docket No. C-4130 (F.T.C. Jan. 11, 2005 and Sept. 13, 2005)	White Sands is a PHO, consisting of Gerald Champion Regional Medical Center and Alamogordo Physicians (an IPA with 45 physicians in Otero County, New Mexico) and 31 non-physician health care professionals. The members of Alamogordo Physicians account for approximately 80% of the physicians in the Alamogordo area. In the Matter of White Sands Health Care System, L.L.C., the Alamogordo Physicians' Cooperative, Inc., Dacite, Inc., and James R. Laurenza, Docket No. C-4130 (F.T.C. Jan. 11, 2005 and Sept. 13, 2005).
In the Matter of the Wisconsin Chiropractic Association, Docket No. C-3943 (F.T.C. May 18, 2000)	Approximately 900 chiropractors are members of respondent WCA, constituting a substantial majority of the chiropractors licensed to practice in Wisconsin. In the Matter of the Wisconsin Chiropractic Association, Docket No. C-3943 (F.T.C. May 18, 2000).
In the Matter of Piedmont Health Alliance, Inc., Docket No. 9314 (F.T.C. Dec. 22, 2003)	PHA consists of approximately 450 physician shareholders and non-shareholder subcontracted physicians. The physicians practice in the "Unifour area" of North Carolina, which comprises Alexander, Burke, Caldwell, and Catawba Counties. In the Matter of Piedmont Health Alliance, Inc., Docket No. 9314 (F.T.C. Dec. 22, 2003).