

**TAX, ANTITRUST AND FRAUD AND ABUSE --
ARE THE LAWS COMPATIBLE?**

HEALTH ANTITRUST UPDATE

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Antitrust is a key consideration for health care providers and organizations seeking to adapt to changing market conditions and government policies. This presentation briefly reviews principal antitrust issues and boundaries in health care, and explores the latest judicial developments and enforcement initiatives. The push and tug of the antitrust laws sometimes intersect with the fraud and abuse laws and the tax law governing tax exempt non-profit organizations. This outline summarizes antitrust developments in the health field, and will be used in conjunction with the individual case scenarios and separate outlines for tax and fraud and fraud abuse law to foster discussion of these laws' interplay.

Topics include:

- Managed care networks and exclusive contracts
- Physician linkage strategies
- Hospital mergers, "virtual" mergers and joint ventures
- "Safety zones" (August 1996)
- Physician union activity

I. Evolving Market Initiatives

A. Stage 1 issues -- Individual practice associations ("IPAs"): associations of individually practicing physicians that contract, usually with health maintenance organizations, on an "at-risk" basis to provide medical services to HMO enrollees;

Preferred provider organizations ("PPOs"): entities sponsored either by providers or entrepreneurs that contract with payors for participating providers' services to be made available to covered individuals. Covered persons get increased levels of benefits, such as lower copayments or deductibles, if care is obtained from participating providers. PPOs have usually involved fee-for-service reimbursement without risk-sharing.

Hospital mergers: hospitals combine to achieve efficiencies and improve ability to compete in managed care environment.

B. Stage 2 -- "Group practices without walls": integration of private practice physicians into a group practice in which each doctor can retain a separate office, but administration is centralized and financial affairs are integrated.

Physician-hospital organizations ("PHOs"): joint ventures of a hospital and doctors on its medical staff, or of a hospital and an association or group practice of doctors on its medical staff, formed to contract with third party payors.

Medical foundations: non-profit organizations that provide medical services, through affiliation with or employment of physicians.

Practice acquisition: hospital or large group practice may "acquire" physician practices and employ physicians on staff.

Community care networks and hospital "alliances", involving "collaboration": a multi-hospital network may negotiate with third party payors, and also consolidate functions across a broad spectrum, including clinical programs, capital

budgeting, marketing, and the purchase of equipment. Network organizations might also include physicians and physician organizations.

Management services organization: a service organization for physician practices; may be sponsored by hospital, physicians themselves, or entrepreneur.

Mergers among managed care organizations -- independent HMOs and large insurers combining into larger MCOs.

C. Newest wrinkles

Physician unions – physicians in common salaried practice may act jointly in dealings with their employer. Physicians that contract with HMOs may claim to be “employees” able to act jointly. Physicians may also seek to employ union as “messenger” in contract negotiations, purportedly without colluding with one another.

Hospital joint operating agreements/"virtual mergers -- separate hospitals systems combine their operations into a single enterprise, but maintain separate ownership of their physical assets.

Hospital bars applications for medical staff privileges for physicians associated with firms that compete with hospital through outpatient clinics or surgery centers.

II. Enforcement Authority

A. Federal Agencies

1. Federal Trade Commission ("FTC") -- both under FTC Act and Clayton Act.
2. Department of Justice ("DOJ") -- under Clayton Act and Sherman Act.

B. State Agencies

1. Attorneys General -- state antitrust laws and *parens patriae* under federal law
2. Departments of Insurance -- NAIC Insurance Holding Company System Model Act and Regulations.

C. Private Plaintiffs

1. Employers and employer coalitions
2. Providers -- A Kansas federal court has found that a

physician clinic could have suffered antitrust injury as a result of a hospital's alleged attempted monopolization of the physician services market in the Wichita, Kansas area by hiring physicians away from the physician clinic. The lawsuit arose from unsuccessful negotiations between the clinic and the hospital to create an integrated health care delivery system. Wichita Clinic, P.A. v. Columbia/HCA Healthcare Corp. and HCA Health Services of Kansas, Inc., 1997-1 Trade Cas. (CCH) P71,829 (D. Kan. 1997). See also HTI Health Services, Inc. v. Quorum Health Group, Inc., 960 F.Supp. 1104 (S.D. Miss. 1997) (rejecting on the merits plaintiff hospital's challenge to a competing hospital's acquisition of leading medical group).

3. Consumers -- A federal court has held that consumers in Wisconsin who allegedly paid monopolistic prices have standing to seek damages and injunctive relief as a result of an alleged conspiracy among a clinic, its HMO subsidiary, and another HMO and medical center to divide markets and allocate customers, territories, and products for health plan and health care services. In denying the defendants' motions to dismiss, the court noted that a conspiracy could be reasonably inferred where the prices for physician services were raised and stabilized at high and supra-

competitive levels. Rozema v. Marshfield Clinic, 1997-1 Trade Cas. (CCH) P71,796 (W.D. Wis. March 10, 1997).

4. HMOs and other payors

III. Key Antitrust Issues

A. Price-fixing agreements among competitors are per se illegal. The rule was applied by the Supreme Court in Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982) (striking down maximum fee schedule agreed to by members of a medical foundation). See also Association of Independent Dentists, 100 F.T.C. 518 (1982) (consent order barring association with majority of area's dentists from bargaining or negotiating over price on behalf of member dentists); Rochester Anesthesiologists, 100 F.T.C. 175 (1988) (consent order settling charges that anesthesiologists conspired to reject reimbursement levels proposed by Blue Cross plan and to force higher compensation from HMO); M.D. Physicians of Southwest Louisiana, Inc., FTC Dkt. No. C-3824 (Sept. 4, 1998 (consent agreement); Alaska Healthcare Network, FTC File No. 991 0103 (consent agreement announced Sept. 20, 2000) In that case, the Commission put limits on the membership that a physician association could maintain, triggering concerns by two of its commissioners whether the Commission's action could cramp practical options for managed care networks in rural areas.

Other recent enforcement cases include Texas Surgeons, P.A., C-3944 (consent order issued May 18, 2000). The FTC claimed that Texas Surgeons, P.A., an independent physician association, organized a collective refusal to deal with two health plans, including Blue Cross of Texas, in order to force reimbursement rate increases. In Colegio de Cirujanos Dentistas de Puerto Rico, FTC File No. 971-0038 (proposed consent order issued March 20, 2000), the FTC charged that an association of 1800 dentists acted as the collective bargaining agent for its members, and fixed prices, and boycotted Puerto Rico's public health benefit plan.

In Wisconsin Chiropractic Association, C-3943 (consent order issued May 18, 2000), the Commission alleged that the association and its executive director conspired to boycott third-party payors to obtain higher reimbursement rates, in response to the introduction of new billing codes by private insurers and the federal government. The association allegedly advised its members to collectively raise their prices to specific levels, circulated fee schedules to coordinate pricing among its members, advised members to discuss contract offers to improve their bargaining position with payors, and assisted in boycotts of two payors to obtain higher reimbursement rates.

Another example of agency enforcement against a threatened concerted refusal to deal in support of price demands is FTC v. College of Physicians-Surgeons of Puerto Rico, File No. 971 0011, Civil No. 97-2466 HL (D.P.R. Oct. 2, 1997) (complaint, final order and stipulated permanent injunction) (injunction and restitution required to settle charges that defendants attempted to coerce the government into recognizing the College as the exclusive bargaining agent for all physicians of Puerto Rico, and called a strike of all physicians on the island for all non-emergency patient care for patients in health plan for the disadvantaged).

The FTC also challenged the Mesa County Physicians Independent Practice Association, Inc. for erecting a blockade against managed care, rather than being a legitimate joint venture for managed care contracting. The resulting consent order, like others, permits the IPA to operate on a non-exclusive basis and to enter into risk sharing arrangements or "qualified clinically integrated joint arrangements" in which the physicians undertake cooperative activities to achieve efficiencies in the delivery of clinical services, without necessarily sharing substantial financial risk. Mesa County Physicians Independent Practice Association, Inc., D. 9284 (proposed consent order) 63 *Fed. Reg.* 9549 (Feb. 25, 1998). See also Institutional Pharmacy Network, File No. 961 0005 (FTC May 21, 1998) (consent agreement); M.D.

Physicians of Southwest Louisiana, Inc., File no. 941 0095 (FTC June 19, 1998)(consent agreement).

In the first criminal antitrust prosecution in the health care area in years, a Texas trade association of optometrists was charged with fixing prices for eye examinations in central Texas on December 15, 1995. The Lake Country Optometric Society pled guilty to charges that it conspired with others to raise the prices charged and to adhere to the new prices, and then monitored and enforced compliance with the price agreement. The Society pled guilty on March 6, 1996, and was fined \$75,000. U.S. v. Lake Country Optometric Society, 6 Trade Reg. Rep. (CCH) ¶ 45,095 at 44,781 (W.D. Tex., Dec. 15, 1995).

New settings can be focal point for old-fashioned price fixing allegations. FTC challenged alleged price fixing by urologists at a lithotripsy center in Chicago, claiming that while the facility properly charged a set price for its services, there was no justification for agreement among physicians on the on rates that urologists seeing patients there would charge. Urological Stone Surgeons, Inc., FTC Dkt. C-3791 (consent order) ___ Fed. Reg. ___ (final consent order issued April 10, 1998).

B. Group boycotts can also be per se unlawful, or condemned under a rule of reason analysis that is quick. See FTC v. Indiana Federation of Dentists, 476 U.S. 447 (1986) (dentists' group liable for concerted refusal to cooperate with insurer utilization review requirement to submit x-rays in advance of treatment); Michigan State Medical Society, 101 F.T.C. 191 (1983). A boycott over a requirement that treatment by specialists requires referral from a "gatekeeper" primary care physician can also be challenged. See Southbank IPA, Inc., 114 F.T.C. 783 (1991) (consent order); Mesa County Physicians Independent Practice Association, Inc., 63 Fed. Reg. 9549 (Feb. 25, 1998)(consent order).

Dentists in three communities in Puerto Rico settled Federal Trade Commission charges that they fixed prices and engaged in an illegal boycott in

order to obtain higher reimbursement rates for dental services under Puerto Rico's government managed care plan for the indigent. The FTC charged that, as a result of these actions, indigents in the three municipalities were unable to obtain dental care. Under the settlement, the dentists would be prohibited from jointly negotiating prices or other more favorable economic terms for dentists or jointly boycotting, threatening to boycott, or refusing to provide dental services to any payor or provider. Dentists of Juana Diaz, Coamo, and Santa Isabel, Puerto Rico, FTC File No. 981-0154 (Sept. 16, 1998).

C. Mergers and other linkages that substantially lessen competition are unlawful. Law applies to combinations of hospitals, of managed care organizations and even of physician practices.

D. Exclusive contracts, rights of "first refusal" and "most favored customer" agreements that create bottlenecks and obstruct competition can also be suspect under the antitrust laws. U.S. v. HealthCare Partners, Inc., No. 395-CV-01946RNC (D. Conn. 9/13/95); RxCare of Tennessee, FTC Dkt. C-3664 (consent order, June 10, 1996); United States v. Medical Mutual of Ohio, Civil Action No. 1:98-CV-2172 (N.D. Ohio Sept. 23, 1998) (consent agreement).

IV. Department of Justice-Federal Trade Commission Guidelines

Antitrust agencies' policy statements (August 1996) provide "safety zone" protection in eight areas, and an explanation of enforcement policy in ninth area. Conduct within a "safety zone" will not be subject of enforcement action except in "extraordinary" circumstances. Conduct outside safety zone is exactly that -- not in safety zone. Statements are not binding on courts, but are likely to have significant persuasive value.

Statements cover:

1. Mergers among hospitals;
2. Hospital joint ventures involving high technology or other expensive health care equipment;
3. Hospital Joint ventures involving specialized clinical or other expensive health care services;
4. Providers' collective provision of non-fee-related information to purchasers of health care services;
5. Providers' collective provision of fee-related information to purchasers of health care services;
6. Provider participation in exchanges of price and cost information;
7. Joint purchasing arrangements among health care providers;
8. Physician network joint ventures; and
9. Analytical principles relating to multiple provider networks.

A. Provider network guidelines are often a primary focus of antitrust analysis in managed care arrangements -- Key concerns for provider network -- be it IPA, PPO, PHO, MSO, alliance or any other acronym -- are whether it is a scheme for fixing prices, e.g., merely a negotiating agent for providers collectively, and whether the breadth of its provider participation, and terms of their participation, erect barriers to managed care and competition.

Physician controlled network organization has "safety zone" protection where it involves no more than 30% of physicians in any single specialty in a geographic market and physicians are integrated, such as through financial risk sharing; Limit of safety zone is 20% where physicians are exclusive with network entity.

Financial risk sharing could mean that participating providers share responsibility for staying within a defined budget; it can mean that more efficient providers may end up subsidizing less efficient providers. Share incentive could also focus on "quality" or "health outcome" factors. Both types of risk sharing have the potential benefit of inducing or encouraging collaboration in more cost effective or higher quality health care delivery, in a way that traditional fee-for-service reimbursement would not. Antitrust therefore gives some recognition to this potential benefit.

Indicia of non-exclusivity:

(1) that viable competing networks or plans with adequate provider participation currently exist in the market;

(2) that providers in the network actually participate in other networks or contract individually with health benefits plans, or there is other evidence of their willingness and incentive to do so;

(3) that providers in the network earn substantial revenue outside the network;

(4) the absence of any indications of significant departicipation from other networks in the market;

(5) the absence of any indications of coordination among the providers in the network regarding price or other competitively significant terms of participation in other networks or plans.

Where percentage of doctors in network exceeds safety zone threshold, legality depends on market impact, including assessment whether network serves

as competitive stimulus to market, or blockade against competing networks or penetration by managed care.

The agencies have provided new examples of payment arrangements (which are also included in the revised statement on multiprovider networks) that include risk sharing, namely, percentage of premium revenue or global case rate methodologies, in addition to capitation and withhold arrangements contained in the original guidelines.

Where no risk-sharing, network has option of "messenger model" to avoid greater risk of "price-fixing" problems. Under messenger model, network entity does not negotiate or agree to price or other central terms of dealing, but leaves that decision to individual providers, based on proposal from payor. Individual provider can give "sign off" authority to network agent within specified range.

The most recent revisions to the guidelines also explain that a provider network that achieves significant clinical coordination and integration among its members might be able to negotiate managed care rates, even in the absence of capitation or another risk-sharing payment mechanism. The change does not, however, open the doors to price fixing agreements by loosely organized networks that function as contracting entities without significant clinical or other operational integration among the members.

Significant integration can generally be evidenced by "the network implementing an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality." Those provider network entities that do not undertake significant operational activity, beyond credentialing, participation in peer review, and marketing, likely would not meet the rule of reason integration threshold described in the new statements.

The guidelines also provide helpful clarification to provider networks that enter into risk-sharing arrangements but also would like the flexibility to enter into some non-risk sharing arrangements without strictly adhering to the so-called "messenger model." The guidelines basically conclude that rule of reason analysis is appropriate for a network's fee-for-service payer arrangements, provided that a "substantial majority" of the network's contracting arrangements with payors include risk sharing, the network actively seeks to manage the provision of provider services, using the same types of quality and cost management for its fee-for-service enrollees as it does for its risk-based enrollees.

The statements also explain how the agencies analyze network ventures that are subject to "rule of reason" treatment. First, the agencies define the relevant geographic market and the relevant "product" market, and the market "concentration" of the joint venture activities. Second, the agencies evaluate the competitive effects of the physician joint venture, such as whether the joint venture will have the market position to raise prices, or whether the venture is likely to have "spillover" effects in the physicians' non-venture activities.

Third, the agencies will evaluate the impact of any procompetitive efficiencies that result from the network joint venture, and weigh them against the likely anticompetitive effects. However, the guidelines stress that claims of efficiency, even if substantiated, will not be justified if they could be achieved by less restrictive means that are practical and feasible under the market conditions faced by the providers. Likewise, if anticompetitive effects are unlikely to result from the venture, the agencies will not require the same degree of proof of efficiencies that they might with a more restrictive venture.

Finally, the agencies will evaluate any "collateral agreements," such as an agreement among participating physicians to give the network the right of first refusal to contract with any managed care plan that seeks an agreement with a participating physician, and other similar restraints. Normally, such collateral agreements must be necessary to the success of the venture in order to be considered defensible.

Watch out for "false fixes" -- use of a negotiating "agent", assumption that opt out provision solves problem, or paper fix that is ignored in practice.

B. Notable applications of policy statements in DOJ business review letters and FTC advisory opinions -- The DOJ and FTC continue to issue business review and advisory opinion letters. Most give approval for proposed provider joint ventures. Agencies will provide index of opinions on request, and copies. Agency web pages are also good source of information.

One notable disapproving letter was issued denying approval to a physician joint venture composed of greater than 30 percent of the pediatricians practicing in parts of southern New Jersey. DOJ concluded that the network's "right of first refusal" in negotiating contracts for participating physicians, accompanied by evidence that network providers had already begun to refuse to renew individual contracts with managed care plans, could amount to an exclusive arrangement in fact. DOJ found that in the area in question family practice doctors were not sufficient substitutes for pediatricians to be considered in the same market. DOJ also rejected the requester's proposed geographic market, which would have included a much larger area. The DOJ not only denied safety zone protection, but also asserted that it would challenge the venture if it proceeded as represented in the request. See Letter from Anne K. Bingaman, Assistant Attorney General, Antitrust Division, DOJ, to Steven J. Kern and Robert J. Conroy (March 1, 1996). The letter also implied that physicians on salaried staff of closed panel HMO might

not be considered part of market for purposes of competitive analysis, but such a position could be unwarranted in many instances.

Another DOJ letter disapproved an anesthesiology network that would, among other things, have been the exclusive negotiating agent for anesthesia groups practicing at a number of Orange County, California hospitals. The DOJ refused to approve the proposal to deal jointly through a single price-setting unit with managed care plans because it concluded that it would likely result in higher health care costs without any countervailing procompetitive benefits. See Letter from Anne K. Bingaman, Assistant Attorney General, Antitrust Division, DOJ, to Tad R. Callister (March 8, 1996).

The FTC staff also declined to approve a proposal for Montana physicians to participate in a medical society sponsored program. The physicians would be subject to a 15% withhold from a fee schedule set at the 88th percentile of statewide physician fees, where little other managed care activity and majority of state's doctors may participate. The FTC staff concluded that the existence of some "withhold" does not necessarily mean that there is enough risk sharing to escape price fixing scrutiny. See FTC Staff Opinion Letter to Paul W. McVay (July 5, 1994).

Most opinions have been favorable though. An example is Department of Justice's approval of a physician group affiliation in Pennsylvania. Letter regarding the Heritage Alliance and Lackawanna Physicians Organization (Sept. 15, 1998). Favorable FTC opinions have addressed a network of eleven neurologists formed to contract with managed care plans (Associates in Neurology, Inc., Aug. 13, 1998), a network of osteopathic service providers formed to contract with third party payers (Phoenix Medical Network, Inc., May 19, 1998), and whether sales of pharmaceuticals by a non-profit hospital to patients of the hospital's cancer treatment center could still be within the "own use" exception to the Robinson-

Patman Act for charitable organizations (North Mississippi Health Services, Jan. 7, 1998).

V. Case law developments

A. Most Favored Nation Clauses -- DOJ and FTC have pursued injunctive relief against unduly restrictive "most favored nation" arrangements that they believe can obstruct competition and maintain higher prices. "MFN" clauses require the provider to give the benefits of their lowest contract prices to the contracting plan. Most "MFN" clause use will not trigger serious antitrust problems, but issues are most likely to arise when the managed care entity imposing the restriction on its providers is itself a provider network joint venture, and it has a high proportion of area providers included, and its enrollees represent a substantial portion of its providers' patient load.

The FTC entered into a consent decree with a pharmacy network sponsored by the Tennessee Pharmacists Association that prohibits the network, RxCare, from requiring its participating pharmacies to agree to a most favored nation clause in order to participate in the network. RxCare of Tennessee, File No. 951-0059 (FTC Jan. 19, 1996) (consent agreement).

DOJ has pressed the issue both where MFNs are imposed by joint venture network organizations and also where the restraint was imposed by a dominant payor entity. See United States v. Medical Mutual of Ohio, Inc., 63 *Fed. Reg.* 52,764 (October 1, 1998)(consent agreement with payor); U.S. v. Delta Dental of Rhode Island, 943 F. Supp. 172 (D.R.I. 1996)(denying dismissal); consent decree, 1997-2 Trade Cas. (CCH) ¶71,860 (D.R.I. 1997).

Usually, these types of clauses are a problem only where they are adopted by a managed care network sponsored by competing providers, but even where the restriction is "vertical" only, there can be risk where the predominant effect is to foreclose competition. See, e.g., Medical Mutual, supra (payor allegedly required

providers to contractually commit to give it substantially lower prices than those charged to any other payor); but cf. Ocean State Physicians Health Plan v. Blue Cross and Blue Shield of Rhode Island, 883 F.2d 1101 (1st Cir. 1989), cert. denied (March 19, 1990) (upholding imposition of MFN as reasonable).

B. PHO enforcement -- The DOJ settled two separate investigations of physician-hospital joint ventures, one in Danbury, Connecticut, and the other in Buchanan County, Missouri. U.S. v. HealthCare Partners, Inc., No. 395-CV-01946RNC (D. Conn. 9/13/95); U.S. v. Health Choice of Northwest Missouri, Inc., No. 95-6171-CVSJ6 (W.D. Mo. 9/13/95). DOJ alleged that both PHOs had a high percentage of physicians as members (98% of physicians on the staff of the Danbury hospital and 85% of physicians practicing in Buchanan County), and required all managed care contracting by member physicians to be through the PHO. Because of their alleged market power, they were able to require higher fee schedules and more liberal utilization review policies from managed care organizations, without sharing any meaningful risk associated with higher utilization, DOJ claimed.

DOJ entered into consent decrees with both PHOs. Orders prohibited them from, among other things, discouraging physicians from contracting with payors, obtaining rights of first refusal from providers for contracting with payors, and disclosing commercially sensitive information about one physician to any other physician except in limited circumstances. In the Danbury settlement, the order barred physicians from owning an interest in any organization that sets, negotiates, or expresses views on competitive terms and conditions for competing physicians. Limited exceptions were included for bona fide integrated delivery system joint ventures, which would need to include risk sharing features. If physician participation is to surpass specified levels, then certain physicians would have to be contracting providers without being members of the joint venture entity itself, in an

arrangement that preserved the entity's incentive to bargain hard with the additional contracting providers.

See also United States v. Women's Hospital Foundation, 1996-2 Trade Cas. (CCH) ¶ 71,561 (M.D.La. Sept. 11, 1996)(consent agreement); Cf. Letter from Joel I. Klein to David Marx, Jr., Esquire, counsel for Santa Fe Managed Care Organization (Feb. 12, 1997) (approving managed care network organization with participation in excess of safety zone levels, with structure creating disparate interests among two categories of participating physicians).

Sometimes, a PHO in a community with a dominant hospital provider may affiliate with a separate physician organization comprised of physicians on the medical staff. If the physician organization obstructs competition, the PHO organization could get caught up in the legal troubles. See, for example, the FTC's October 1996 settlement and January 1997 final consent order against a physician organization and a PHO in Billings, Montana. The FTC's principal claim is that Montana Associated Physicians, Inc. acted to thwart cost containment and obstruct entry of managed care plans, and the PHO organization, Billings Physician Hospital Alliance, Inc., was a vehicle for continuing the anticompetitive activities of the physician organization. Montana Associated Physicians, Inc., Dkt. No. C-3704 (FTC Jan. 1997) (complaint and consent order).

C. Hospital joint operating agreements/virtual mergers. Hospitals have been pursuing arrangements that fall short of actual merger, but bring participating institutions' operations and finances under common control. Hospitals will continue to have separate ownership, but new joint venture entity is given control over operations and finances are integrated. Where properly undertaken, per se rules against price fixing or market allocation should not apply, and arrangement will be subject to analysis comparable to that applied to mergers. However, if separate organizations retain reserve powers that effectively preserve power, finances are

not integrated, and joint venture functions basically as tool for common price negotiations and avoidance of competition, “per se” antitrust challenge may be brought. The New York attorney general successfully made these charges in a challenge to a joint operating agreement in New York v. St. Francis Hospital, Civ. A. No. 98-0939, 2000 U.S. Dist. Lexis 4655 (S.D.N.Y. April 20, 2000).

D. Provider network exclusions -- Providers sometimes resort to antitrust litigation to challenge their exclusions from PPO and HMO networks. Most fail. See Capital Imaging Assoc., P.C. v. Mohawk Valley Medical Assoc., Inc., 996 F.2d 537 (2d Cir. 1993)(court finds agreement to exclude, but plaintiff fails to show anticompetitive effect). In Levine v. Central Florida Medical Affiliates, 72 F.3d 1538 (11th Cir. 1996), another circuit court of appeals reaffirmed that in order to prove anticompetitive effect from an exclusion, a provider must be able to show injury to competition, not merely to his or her own competitive standing. See also Fogel v. Metropolitan Life Ins. Co., 871 F.Supp. 571 E.D.N.Y. 1994) and Orthopedic Studio, Inc. v. Health Insurance Plan of Greater New York, 1996-1 Trade Cas. (CCH) P71,319 E.D.N.Y. 1996) (both dismissing challenges to exclusions from managed care plans). Nor can a provider build a case from a plan's “take it or leave it” approach or from its stated intention to terminate a hospital if anesthesiologists at hospital do not participate in plan. See Ambroze v. Aetna Health Plans, Inc., 1996-1 Trade Cas. (CCH) P71,450 (S.D.N.Y. May 28, 1996).

E. Non-physician provider discrimination -- Allegations of anticompetitive discrimination against non-physician health care providers also may provoke litigation. See, e.g., Day v. Fallon Community Health Plan, C.A. No. No. 94-40148-NMG (D. Mass., dismissed 2/22/96) (suit brought by chiropractors against numerous HMOs alleging unfair, discriminatory, and anticompetitive denial of chiropractor inclusion in HMO networks). Again, most cases will fail, but where restraint can be

shown to be product of conspiracy with physicians, and exclusion has significant anticompetitive effects, violation may be found. Allegations of anticompetitive discrimination against non-physician health care providers also continue to provoke litigation.

F. HMO mergers -- The federal government and state authorities (Missouri, New Hampshire and Massachusetts) have required divestiture or imposed conduct relief to remedy allegedly anticompetitive mergers between competing HMOs.

In the Aetna-Prudential merger, the Department of Justice for the first time challenged a managed care company merger. Acting jointly with the Texas Attorney General, it required divestiture of Aetna HMO operations in Houston and Dallas/Fort Worth, Texas. DOJ identified HMO and HMO-based point of service products as the product market. It claimed the evidence showed that these product segments were sufficiently distinct from other health benefits products to be a separate product market. United States v. Aetna, Inc., 7 Trade Reg. Rep. (CCH) ¶ 50,868 (N. D. Tex. 1999).

The combination would have given Aetna 63 percent and 42 percent of the alleged product market in Houston and Dallas/Forth Worth, respectively. This, DOJ claimed, would give Aetna too much power in dealings with customers and would result in higher prices. DOJ did not address whether there were special circumstances that might lead to a different analysis in other communities.

DOJ also claimed that the merger would give Aetna undue market power in its dealings with health care providers. Note that a particular percentage of HMO enrollment would not translate into the same percentage of health care providers' revenues or patient encounters. Obviously, many people are not enrolled in HMOs. Also, Medicare patients obtain more health care than other patients, and the HMOs in Texas did not have a high proportion of Medicare patients. This means that Aetna likely represented less than 20% of physicians' revenues. This would have

suggested to many that “buyer power” would not be a concern, particularly in light of DOJ-FTC guidelines suggesting that group buying ventures by providers are generally not a problem when they represent less than 35% of the purchases in any particular market. Nonetheless, DOJ alleged that Aetna would have too much power in its physician dealings in these Texas communities.

DOJ has explained that whereas in most markets a supplier unhappy with the terms offered by a buyer can simply shift its sales to another purchaser, this is not so easy for physicians. Patients may be tied to particular health plans through their employment. The employer may offer only one or two health plan choices. If the physician opts to quit the plan and join another, he or she may risk losing a high proportion of patients. Therefore, even though Aetna’s total share of physician patient encounters in the affected areas might have been less than 20% in the aggregate, DOJ claimed that Aetna would be able to insist upon non-competitive terms of dealings with physicians. It further insisted that Aetna’s “all or nothing” requirement that physicians sign up for all Aetna product offerings enhanced its power.

The merger would have given Aetna increased power to depress prices and otherwise demand non-competitive terms of dealing with providers, physicians in particular. See Marius Schwartz, Economics Director of Enforcement, Antitrust Division, U.S. Department of Justice “Buyer Power Concerns and the *Aetna-Prudential* Merger,” 5th Annual Health Care Antitrust Forum, Northwestern University School of Law, Chicago, Illinois (Oct. 20, 1999).

DOJ did not contend that the all products clauses, or reducing the rate of compensation to physicians, were inherently antitrust violations. DOJ’s thrust was that a merger that would give a health plan the additional power with which to force such contract terms could be an antitrust violation, and that this power could arise at buyer market share levels that might be questionable in other industries. It also felt that the “all products clause” could help create power, where it would

prevent physicians from limiting their dependence on Aetna as a single payer. They were forced into an all-or-nothing choice. DOJ imposed divestiture as a negotiated remedy; it did not seek an injunction against use of all products clauses.

DOJ claimed that divestitures would “preserve competition and protect consumers from higher prices for HMO and HMO-based POS services [and] . . . deny Aetna the ability to unduly depress physician reimbursement rates and thereby impair the quantity and quality of physician services provided to patients.” It is too early to assess whether this concern for a lack of balance in the relationship between the payor and the provider will influence the antitrust agencies’ posture on future antitrust matters. Apparently, there was considerable disagreement within DOJ on this aspect of the complaint in the Aetna-Prudential matter.

See also Harvard Community Health Plan, Inc. and Pilgrim Health Care, Inc., No. 95-0331E (Mass. Sup'r Ct. Jan. 18, 1995) (assurance of discontinuance); Proposed Acquisition of GenCare Health Systems, Inc., Case No. 94-10-03-0110 (Mo. Dept. of Ins. Dec. 1994)(findings of fact and conclusions of law, approval, consent and order); Proposed Acquisition of MetLife HealthCare Network, Inc., Case No. 95-07-13-0006 (Mo. Dept. of Ins. Sept. 28, 1995) (findings of fact, conclusions of law and consent requiring divestiture); Matthew Thornton Health Plan (N.H. Ins. Dept. January 12, 1996)(approval, with conditions, of Harvard Pilgrim Health Care's acquisition of Matthew Thornton Health Care HMO) (followed state attorney general conditional approval, but merger subsequently dropped); Proposed Acquisition of HealthLink Inc. and HealthLink HMO, Case No. 95-06-13-0645 (Mo. Dept. Ins. Aug. 2, 1995) (findings of fact and conclusions of law, approval, consent and order).

Issues of product market definition, geographic market definition, and barriers to entry are key.

Antitrust-like enforcement authority rests in many cases with state insurance departments, under state insurance holding company acts based on the National Association of Insurance Commissioners Model Insurance Holding Company Act. See, e.g., Ariz. Rev. Stat. Ann. § 20-481.258; Ga. Code Ann. § 33-13-3.1; Ill. Rev. Stat. § 5/131.12; Mo. Rev. Stat. § 382.095; N.J. Rev. Stat. § 17:27A-4.1; Pa. Stat. Ann. § 40-10-103. These laws impose stricter market share thresholds for presumptive illegality than current federal antitrust guidelines.

G. Hospital and other provider mergers -- The federal enforcement agencies and some state attorneys general will challenge mergers that appear to result in a potential for monopoly power or collusion, due to increased concentration and high barriers to entry, especially if there are relatively low efficiencies being created. The Pennsylvania Attorney General has issued its own guidelines in this area. The agencies often must rely on willingness of payors, such as HMOs, to speak out on the potential harm to competition that a merger may cause. The enforcement agencies' recent "batting average" has been poor.

Perhaps the most recent defeat for the FTC was the most frustrating. In Federal Trade Commission v. Tenet Healthcare Corp., 1999-2 Trade Case ¶ 72578 (8th Cir. July 21, 1999), the Court of Appeals overturned a preliminary injunction blocking a merger. It explicitly questioned the district court's "reliance on the [suspect] testimony of managed care payers, in the face of contrary evidence, that these for-profit entities would unhesitatingly accept a price increase rather than steer their subscribers to hospitals in [more distant communities]." The court of appeals' comment is exceptional in that it describes the payors' testimony – including testimony by both employers and health plan officials – as contrary to their own economic interest, and yet offers no explanation why they would mistakenly testify that the merger would harm their interests as customers.

The effect of these losses may be to raise the bar in the agencies' case selection. This would appear to have opened the door to a flurry of hospital mergers and combinations. Yet, there does not appear to be such a trend developing. A few reasons seem to account for this.

First, much of the merger activity a few years ago seemed to be driven by a fear by non-profit hospitals of for-profit hospital chain expansion. Nonprofit hospitals seemed to think that by merging or forging joint operating agreements they could fend off entry or expansion of for-profit hospitals that they considered a danger. With the for-profit threat seemingly receding, the merger and joint operating agreement ferment has lessened. Also, many of the mergers and joint ventures that were forged over the past few years have unraveled. They may not have produced the cost savings, efficiencies, or increased leverage that their participants had hoped for.

Still, in some recent cases, state and federal antitrust enforcement scrutiny has contributed to abandonment of plans for combinations. The collapse of the planned affiliation of LifeSpan and Care New England in Rhode Island is an example. Also, in New York, the Attorney General acted decisively against a hospital joint operating arrangement or "virtual merger" that he alleged was, in effect, nothing more than a cartel arrangement. The challenge in Poughkeepsie to the combination of St. Francis Hospital and Vassar Brothers Hospital was successful. New York v. St. Francis Hospital, No. 98-0939 (S.D.N.Y.). The decision leaves open debate on the extent to which systems can combine, but retain some autonomy, while still being viewed as a "single entity" rather than as colluding competitors. Also, last summer, the Department of Justice and the State of Florida forced two hospital systems in the Tampa/St. Petersburg area to reform their affiliation, after they had violated an earlier consent order. They had been permitted to merge some of their operations, while keeping others separate. They admitted violating the order, were required to pay a fine, and have agreed to

additional reforms to foster a return of competition between them. U.S. v. Morton Plan Health System, Inc., Civ. A. No. 94-748-CIV-T-23E (M.D. Fla. July 12, 2000) (stipulated enforcement order agreement). In all three cases, health plans had actively urged enforcement officials to press forward with antitrust initiatives.

In other cases, the government has lost. The Justice Department alleged that the proposed combination of two academic medical institutions would likely lead to higher hospital prices for health care consumers in the Long Island, New York, area. The Department further alleged that the merging hospitals compete head to head to be the "flagship" or "anchor" hospital in the networks of hospitals that managed care companies assemble on Long Island. After a trial on the merits, the District Court granted judgment in favor of the defendants and dismissed the complaint. United States v. Long Island Jewish Medical Center and North Shore Health System, Inc., 1997-2 Trade Cas. (CCH) ¶ 71,960 (E.D.N.Y. Oct. 23, 1997).

The FTC dropped its challenge to a hospital merger in Grand Rapids, Michigan, after its efforts to secure a preliminary injunction failed. The federal district court concluded that preventing managed care plans from obtaining price reductions would not harm competition since, in the court's view, these price reductions represent cost shifting to non-managed care patients. FTC v. Butterworth Health Corp., 946 F.Supp. 1285 (W.D. Mich. 1996), *aff'd*, 1997-2 Trade Cas. P 71,863 (6th Cir. 1997).

The courts in two other cases considered the government's definition of the geographic market to be too narrow, in part because of the impact of managed care on patient travel patterns. United States v. Mercy Health Services, 902 F. Supp. 968 (N.D. Iowa 1995); FTC v. Freeman Hosp., No. 95-5015-CV-SW-1, 1995 U.S. Dist. LEXIS 8757 (W.D. Mo. June 9, 1995), *aff'd*, 69 F.3d 260 (8th Cir. 1995). These courts found that the agencies' geographic market definition failed to consider referrals from clinics in fringe areas, the strong emphasis that regional hospitals place on expanding their service areas, and the willingness of managed care

enrollees and plans to make changes in their health care providers for financial reasons.

H. Denial of hospital privileges -- Physicians and other practitioners have brought numerous antitrust challenges to termination of their hospital privileges. Where the issue involves problems surrounding an individual doctor's qualifications or practice, these cases almost always fail, for lack of antitrust injury or harm to competition, insufficient evidence of conspiracy, or because of "state action" immunity, protection from damage awards under the federal Health Care Quality Improvement Act or failure to exhaust administrative or state remedies. Poor controls on the process can lead to difficulties, though, and in some instances plaintiffs may have a valid claim.

However, certain types of economic credentialing can raise antitrust difficulties for the hospital. For example, if a hospital that is dominant in its market area adopts a policy to withhold privileges, or even the right to apply for privileges, from physicians associated with any entity that competes with the hospital through an ambulatory surgery center, diagnostic clinic, cardiac stress testing clinic or other outpatient program, there could be significant monopolization issues. Section 1 Sherman Act issues could arise if applicants are required to agree that their continued privileges will be contingent on their continuing not to have such affiliations.

VI. Evolving issues

A. Vertical integration -- HMOs, hospitals, physicians and other providers integrated into large organizations. The Marshfield clinic case a few years ago was only the first of a series of major litigation addressing these issues. Blue Cross & Blue Shield United of Wisconsin v. Marshfield Clinic, 65 F.3d 1406 (7th Cir. 1995), cert. denied, 116 S.Ct. 1288 (1996). A verdict won by Blue Cross & Blue Shield

United of Wisconsin and its HMO subsidiary, CompCare Health Services, was overturned. The court of appeals rejected the contention that the Clinic's HMO subsidiary, Security Health Plan of Wisconsin, had monopoly power, because it found that HMOs did not constitute a separate product market. The court also held that the Clinic's employment of slightly less than 50% of the physicians serving any relevant geographic market did not give it monopoly power in that market. The court also declined to infer monopoly power from the Clinic's high prices, and high rate of return. It refused to find that the Clinic constituted an essential facility, because the Clinic did not have a monopoly in any properly-defined market, having a high reputation for quality not constituting evidence of market power in the court's view. It also found the Clinic's refusal to provide back-up services to other physicians to be legitimate business behavior.

A Mississippi federal court rejected an antitrust challenge by one Vicksburg hospital company to another hospital firm's acquisition of two medical group practices. The acquisition gave the acquiring hospital over 50% of the primary care physicians in the local marketplace. Nonetheless, the court found that this advantage was not anticompetitive, since a fear of reduced admissions to the complaining hospital was speculation, and there were low barriers to recruitment of new primary care physicians. HTI Health Services, Inc. v. Quorum Health Group, Inc., 960 F.Supp. 1104 (S.D. Miss. 1997).

A Kansas federal court has found that a physician clinic could have suffered antitrust injury as a result of a hospital's alleged attempted monopolization of the physician services market in the Wichita, Kansas area by hiring physicians away from the physician clinic. The lawsuit arose from unsuccessful negotiations between the clinic and the hospital to create an integrated health care delivery system. Wichita Clinic, P.A. v. Columbia/HCA Healthcare Corp. and HCA Health Services of Kansas, Inc., 1997-1 Trade Cas. (CCH) P71,829 (D. Kan. April 8, 1997).

As noted above in the discussion of denials of medical staff privileges, enforcement activity is likely to develop as hospitals that may have market dominance in inpatient business seek to bar area physicians from acquiring or maintaining admitting privileges if the physicians are associated with outpatient facilities that compete with the hospital, such as ambulatory surgery centers or diagnostic clinics.

The FTC has also been active policing vertical integration issues in the pharmaceutical area as well. In a recent action, the FTC took a second look at the years old Merck-Medco combination of a drug manufacturer with a leading prescription benefits manager, to check on concerns that Medco would unfairly favor Merck drugs or would share sensitive pricing information from other manufacturers with Merck. The resulting consent agreement requires Medco to offer an open formulary and to keep sensitive information away from Merck. Merck & Co., Inc., File No. 951 0097 (Aug. 27, 1998). The agreement is similar to one entered into previously with Eli Lilly after it acquired over PCS. Eli Lilly & Co. Dkt. No. C-3594 (FTC July 1995)(consent agreement).

By analogy, the Merck-Medco order suggests that the Commission could have concerns if a particular provider-sponsored managed care organization threatened to become a vehicle through which price information of competing providers were shared in circumstances that posed a threat to competition, or where a dominant provider could further entrench its position to the detriment of smaller providers by excluding them from access to its managed care venture.

B. Managed care organization erection of barriers to competing plans.

Individual managed care organizations may, in today's market, conceivably be viewed as having market power in a defined product and geographic market. Contracting provisions that effectively deny competing plans access to a viable

physician could be challenged as anticompetitive. See U.S. Healthcare, Inc. v. Healthsource, Inc., 986 F.2d 589 (1st Cir. 1993)(defendant HMO not liable for including semi-exclusivity provisions in contracts with physicians, but court implies possibility of different result on a different factual record). Abuse of MFN clauses by payors with local market dominance can also raise serious antitrust concerns. See Medical Mutual, supra; Delta Dental, supra. Similarly, managed care organizations should be careful about contracting with network of providers, such as a joint venture of hospitals in local market area, where there is intent to erect blockade against competing health plans via foreclosure of their access to viable hospital network. Proper definition of product and geographic market in these types of cases is tough, but MCOs should proceed with caution.

Also, even where antitrust may not provide a remedy, there may be a viable tort case where a payor appears to have engaged in abusive behavior to exploit customers or providers, or gain an advantage over its competition. In Brokerage Concepts, Inc. v. U.S. Healthcare, Inc., No. 95-1698 (E.D. Pa. Jan 25, 1999), a jury awarded \$105,000 in compensatory damages and \$1.855 million in punitive damages in a tortious interference case to a plaintiff third party administrator who lost a local drug store chain as an account in response to a threat to the chain that it would be dropped from the U.S. Healthcare provider network unless it purchased TPA services for its self-insured employee health benefit program from a U.S. Healthcare affiliate. An earlier antitrust-based suit had been dismissed, but the court in Brokerage Concepts instructed the jury that the competitor's privilege defense to plaintiff's tortious interference claim could be overcome by a showing that the defendant had used "wrongful means" by "taking away a competitor's business by applying economic pressure in an area that is unrelated to the field in which the parties compete".

C. Group practices without walls -- Providers are seeking to affiliate in "medical groups" to find "integration" that will allow compliance with antitrust laws, and with Stark law and fraud and abuse proscriptions. In some cases, these groups, though, may not be much more than negotiating vehicles with a tax ID number. Agencies are starting to address when an affiliation of competitors provide sufficient integration that it can be viewed as a single competitor for antitrust purposes.

D. Physician unionization. The Department of Justice has sued the Federation of Physicians and Dentists in Delaware for facilitating a group boycott by orthopedic surgeons to force higher reimbursement rates. United States v. Federation of Physicians and Dentists, Civ. Act. No. 98-475 (D.Del. Aug. 12, 1998). The complaint alleges that the Federation has recruited nearly all of the orthopaedic surgeons in Delaware to serve as the surgeons' collective bargaining agent in negotiations regarding their fees. DOJ seeks to bar the Federation from continuing an illegal boycott designed to insulate the physicians' fees from competitive market forces.

See also United States v. Federation of Certified Surgeons and Specialists, Inc., and Pershing Yoakley & Associates, Case No. 99-167-CIV-T-17F (M.D. Fla. Jan. 26, 1999)(consent agreement against physician organization and consulting firm).

Elsewhere, physicians are seeking to establish that the degree of control exercised over their practice by HMOs have effectively made the physicians into "employees" so that they may avail themselves of the rights to collective bargaining and joint action provided by the National Labor Relations Act. This would also would provide a degree of antitrust immunity. In New Jersey, physicians sought to establish that the degree of control exercised over their practice by an HMO effectively made the physicians into "employees" so that they could avail themselves of the rights to collective bargaining and joint action provided by the National Labor

Relations Act. This would also indirectly provide a degree of antitrust immunity. In October 1999, the National Labor Relations Board upheld dismissal of the petition by primary care and specialist physicians under contract to AmeriHealth HMO for recognition of a labor union as their bargaining agent with AmeriHealth HMO. The Board upheld its regional director's finding that the physicians were independent contractors and not employees. Although the Board said the regional director gave too much weight to the physicians' degree of independence in examining patients, diagnosing illnesses, and performing specific procedures, it still concluded that the physician lacked the indicia of employed status. It said that its ruling did not foreclose the possibility that contracting physicians would qualify as "statutory employees" in another factual setting. AmeriHealth HMO and United Food and Commercial Workers Union, Local 56, AFL-CIO, 329 NLRB No. 76 (Oct. 18, 1999).

VII. Conclusion

What are the parties seeking to achieve? Lock out competition? Blockade against competing managed care plans? Real efficiencies? A better mousetrap?

Some activities are well motivated, but can slip into antitrust difficulty from inadequate planning.

Some activities are not well motivated -- in an antitrust sense, and need to be redirected.

Sound antitrust planning is critical -- in advance and as proposals become more concrete. Planning documents that describe opportunity to become "dominant" competitor or to secure "leverage" in dealings with payors and providers can be extremely troublesome. Planning documents that explain how competition will be advanced through improved coordination of care, reduction in unnecessary costs, enhanced quality, and more vigorous participation in managed care market can help sustain health care initiatives.

Schedule clients for a one year later check up after network or joint venture formation. Things do not always go as planned.

Give strong substantive education to client regarding antitrust requirements. Be wary of instructions that focus undue client attention on procedural aspects of antitrust compliance program and also be wary of client staff who can mouth all the antitrust buzzwords. It is not enough to have antitrust compliance policy on paper, for meeting chair to insist that only actual business of joint venture be discussed at meetings, and for participants to avoid “hallway” conspiracies. Problem can arise where official topic of meeting, in practical effect, is price fixing.