



NEW DEVELOPMENTS IN HEALTH CARE ANTITRUST

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I. Looking Back at a Busy Year¹

- Months of hearings!!!
- Lots of cases!! Especially continued vigorous enforcement by FTC against provider boycotts and price fixing activity
- Hospital combo look-backs – An FTC retrospective hospital merger suit emerges, but a private suit fails
- Government v. Government – Testing the “state action” doctrine
- Going after the payors
- Hospital privileges – more tough times for plaintiffs
- What’s next?

II. Remarkable Season of Hearings

The FTC and DOJ concluded six months of public hearings on competition and antitrust in health care in the fall. The hearings focused on a broad range of policy and enforcement issues. The transcripts of the sessions are posted on the FTC website, as are presentations by many of the speakers and panelists. A comprehensive joint report may follow. Information about the hearings is available at <http://www.ftc.gov/ogc/healthcarehearings/index.htm>.

¹ The electronic version of this outline contains hyperlinks to actions and decisions, where available. This outline does not cover developments in antitrust enforcement affecting the pharmaceutical industry, such as cases involving alleged manipulation of the Orange Book through bogus patent references or alleged collusive settlements of patent disputes between brand name and generic drug manufacturers.

III. Looking back at hospital combinations

The federal antitrust enforcement agencies have been on a long losing streak in hospital merger cases. At the same time, payors have reported that hospital consolidation, and the greater emphasis of employer customers on health plans having diverse provider networks, has meant that hospitals are able to exercise increased market leverage in dealings with health plans and to drive up hospital prices. The issues are contentious and the facts in dispute.

The FTC has taken a hard look backwards to see if some of the mergers that have been permitted in the past actually have resulted in harm to competition and higher prices to consumers. After investigating the impact of mergers in a number of states, including Missouri, Illinois, North Carolina and California, the Commission has pulled the trigger and filed suit challenging a four year old hospital acquisition in Evanston, Illinois. Empirical evidence of harm may be valuable proof to use either in taking on one of these consummated mergers, or in analyzing new proposed mergers. The evidence turned up in these post-merger reviews might also help the enforcers to persuade courts of the likelihood of anticompetitive effects in future enforcement actions against planned mergers.

- [In Evanston Northwestern Healthcare Corporation and ENH Medical Group, Inc.](#), FTC Dkt No. 9315 (Feb. 10, 2004) (complaint), the Commission has challenged the 2000 acquisition by Evanston Northwestern Healthcare Corporation's of Highland Park Hospital. The Commission claims that the acquisition resulted in significantly higher prices to health insurers and higher costs to purchasers of insurance and consumers of hospital services. The Commission alleged a product market of general acute care hospital services to private health care payors.

The Commission also names a hospital-affiliated medical group as a respondent and claims that it unlawfully fixing physician prices by contracting on a fee-for-service basis for its employed physicians and for community physicians under contract to it.

- [In HealthAmerica Pennsylvania, Inc. v. Susquehanna Health System](#), 2003-2 Trade Cas. (CCH) ¶ 74,237 (M.D. Pa. July 22, 2003), a federal court in Pennsylvania threw out a health plan's challenge to a years-old hospital combination in Williamsport, Pennsylvania. On July 22, 2003, the U.S. District Court for the Middle District of Pennsylvania granted summary judgment to defendant Susquehanna Health Systems ("SHS"), dismissing an antitrust challenge to the combination of three hospitals in Lycoming County in north-central Pennsylvania. . The plaintiff health plan had contended that the hospital alliance was not effectively a merger of the cooperating

hospitals, and therefore was a price fixing conspiracy. The court disagreed, finding that the hospitals had effectively become a single economic unit for antitrust purposes. Given the posture of the case at that time, the legality of the combination, were it viewed as a merger, was not before the court.

IV. FTC continues string of cases against provider price fixing and boycotts

The Commission had an exceptionally active year pursuing physician and other provider network organizations for improperly collectively bargaining, amounting to price fixing or illegal group boycotts. Abuses of the “messenger model” were typically alleged. The Commission has been exploring a variety of remedial tactics, and has also been more active in suing individuals, managers and consultants, rather than just the network organizations. A Commission anesthesia case from California is particularly interesting, because it involves collusion in seeking stipends from a hospital for on-call services and treatment of indigent patients, rather than concerted action in dealing with third party payors. DOJ was less active, but made its own enforcement contribution. The Commission also continued to provide advisory opinions on permissible contracting activities. Examples have been:

- [California Pacific Medical Group, Inc.](#) FTC Dkt. 9306 (Feb. 9, 2004) (consent agreement). The Commission issued a complaint against California Pacific Medical Group, dba Brown & Toland Medical Group, and then reached a settlement with the group, barring it from jointly negotiating managed care contracts on behalf of its physician network, except in risk-sharing arrangement or where the group could show the action were part of a clinically integrated initiative where joint contracting was key to the venture’s success. The case is notable because it involved a challenge to the non-risk contracting activity of a physician network organization that had a large capitation (at risk) business as well. The Commission complaint rejected the proposition that the fee for service non-risk contracting was protected as incidental to the risk contracting activity, or that the fee-for service contracting came with efficient practice management initiatives that could justify joint price contracting. The Commission’s action is already making a number of physician groups and IPAs in California review their existing contracting practices.
- [North Texas Specialty Physicians](#), FTC Dkt 9312 (Sept. 17, 2003) (complaint) – FTC complaint challenges network’s non-risk contracting as unlawful restraint on price competition among physicians. The complaint

outlines alleged transgression of “messenger model” boundaries. For example, FTC claims that the physician organization polls its participating physicians to determine the minimum fee that they would accept for medical services provided pursuant to a network agreement. Once this information is collected, the network then calculates the averages of the reported minimum acceptable fees and reports these measures to its participating physicians, confirming to the participating physicians that these will be the minimum fees that the network will entertain when negotiating any contract with a payor.

- [Surgical Specialists of Yakima, P.L.L.C.; Cascade Surgical Partners, Inc., P.S.; and Yakima Surgical Associates, Inc., P.S.](#), FTC Dkt No. C-4101 (Nov. 18, 2003) (complaint and consent order). The Commission settled allegations that two surgery organizations had combined unlawfully to negotiate with managed care plans. The Commission enforcement action rejected any contention by the groups that they had integrated their practices to a degree that justified joint contracting actions. The order also required that a combined venture of the groups terminate its affiliation with one of the groups.
- [Memorial Hermann Health Network Providers](#), FTC Dkt. C-4104 (Jan. 13, 2004) (complaint and consent order). Confronting another allegedly “messed up” messenger model, the Commission settled charges that a 3000 physician Houston-area physician organization had improperly negotiated physician pricing and other terms with payors. The FTC alleged that the physician organization polled its members, asking each to disclose the minimum fee he or she would accept in return for providing medical services. This conduct alone is not objectionable. However, the Commission claimed that the organization then calculated minimum acceptable fees for use in payor negotiations based on the results of the poll. The FTC claimed that the physician group told payors that it would not even forward to its physician members any offer that did not satisfy the fee minimums.
- [Tenet Healthcare Corporation and Frye Regional Medical Center, Inc.](#), FTC Dkt. C-4106 (Feb. 3, 2004) (complaint and consent order); [Piedmont Health Alliance](#), FTC Dkt. 9314 (Dec. 23, 2003) (complaint). A settlement with the Frye hospital and its parent Tenet represented the time the FTC named a hospital as a participant in an alleged physician price-fixing conspiracy. The complaint alleged that the hospital played a central role setting up and facilitating price fixing activities by a hospital-physician organization in a four county area in North Carolina. An administrative complaint against the Piedmont Health Alliance and ten individual

physicians allegedly instrumental in its joint pricing activities is still pending.

- [Bay Area Preferred Physicians](#) (Sept. 24, 2003) (staff advisory opinion). The FTC staff issued a favorable advisory opinion for a “messenger model” physician organization. The opinion is the review and discussion of a carefully organized PPO network. The PPO plans to execute and administer a managed care contract if 50 percent or more of its physicians are willing to accept a particular payor's offer based on prior submission of acceptable contract terms by the physicians, or if the payor bears contract administration costs. A payor whose offer would not be accepted by 50 percent of the doctors may elect to approach physicians directly to negotiate individual contracts. In that case, the PPO would provide the payor with the names of the physicians who were willing to accept the contract offer. The staff's approval of this model does not mean that to be an acceptable “messenger model,” a PPO must operate on this particular protocol.
- [Washington University Physician Network](#), FTC File No. 021 0188 (July 11, 2003). The Commission settled charges that the Washington University Physician Network engaged in price-fixing on behalf of its members in the St. Louis area. The network includes approximately 900 faculty physicians and 600 independent community doctors, each group of which is involved in governance of the network entity. The order includes the usual exception for negotiated contracts where risk sharing or clinically integration is present, and also permits contract negotiations that are limited solely to the faculty physicians.
- [South Georgia Health Partners, LLC](#), FTC Dkt. C-4100 (Nov. 4, 2003). This complaint and consent order settled charges that a large “super-PHO” and its five owner PHOs and three physician organizations had joined together to improperly negotiate for 15 hospitals and approximately 500 physicians.
- [Physician Network Consulting, L.L.C.](#), FTC Dkt. C-4094 (Aug. 27, 2003). The FTC settled charges that a Baton Rouge, Louisiana-based independent practice association, the three orthopedic practices whose doctors are members of the IPA, the IPA's agent, and the agent's managing director had orchestrated and implemented agreements to fix prices and other terms on which they would deal with a health insurance company.
- [Maine Health Alliance](#), FTC Dkt. C-4095 (Aug. 27, 2003). The Commission settled charges with a network of doctors and hospitals in

northeast Maine, barring the organization from negotiating jointly on behalf of its members with third-party payors. The case, which also included the organization's executive director, was the first brought by the FTC involving charges that a provider organization engaged in price-fixing and other anticompetitive collusive conduct in the provision of hospital services.

- [United States v. Mountain Health Care, P.A.](#), Civ.1:02CV288-T (W.D.N.C. Sept.15, 2003) (final consent judgment) . Following issuance of a complaint in December 2002, a final consent judgment was entered in September requiring Mountain Health Care, an independent physicians organization headquartered in Asheville, North Carolina, to cease its operations and dissolve. The Department had accused Mountain Health Care of adopting a uniform fee schedule governing the prices of its participating physicians and on that basis negotiating and contracting unlawfully with health care plans on behalf of its participating physicians, resulting in higher prices.
- [Anesthesia Service Medical Group, Inc.](#), FTC Dkt. C-4085 (July 15, 2003); [Grossmont Anesthesia Services Medical Group, Inc.](#), FTC Dkt. C-4086 (July 15, 2003). The FTC settled charges that two anesthesia groups practicing at the same San Diego area hospital had conspired on payment amounts to demand from the hospital for taking obstetric call and for rendering services to uninsured emergency room patients.
- [SPA Health Organization, d/b/a Southwest Physician Associates](#), FTC Dkt. C-4088 (July 17, 2003). The Commission settled charges that SPA Health Organization had improperly restrained competition among its participating physicians. Having moved away from risk-based contracting, the company acted inconsistently with the “messenger model,” and actively bargained with third-party payors, often proposing and counterproposing fee schedules. It allegedly discouraged its participating physicians from entering into unilateral agreements with payors and communicated to its physicians that specific fees and other contract terms being offered by third-party payors may be inadequate. The organization also did not convey to its participating physicians third-party payor offers that SPA deemed deficient, including offers that provided for fees that did not satisfy SPA's Board of Directors.

V. FTC scrutiny of state imposed restraints on competition

The FTC has expressed increased interest in pursuing restraints on competition imposed via abuse of regulatory or licensing schemes. In this arena, the Commission leadership is openly seeking to narrow the perceived reach of the

“Noerr-Pennington” government petitioning immunity and of the antitrust “state action” doctrine. A speech in the fall by Commission Chairman Tom Muris focused on the importance of attacking public restraints on competition. [“State Intervention/State Action – A U.S. Perspective,”](#) Fordham Annual Conference on International Antitrust Law & Policy (Oct. 24, 2003).

The Commission’s antitrust complaint against the South Carolina Board of Dentistry, the state regulatory agency for dentists and dental hygienists, is an example of the FTC’s enforcement interest in this area [In the Matter of South Carolina State Board of Dentistry](#), FTC Dkt No. 9311 (Sept. 25, 2003). The Commission charged that the board had exceeded its authority by seeking to suppress the lawful provision of services by dental hygienists in the state’s schools. The Commission claims that the board went beyond its contemplated authority, contrary to state law, and does not have the protection of the antitrust “state action” doctrine. . According to the complaint, the Board is composed of seven dentists, one dental hygienist, and one public member. The licensed dentists in South Carolina elect six of the dentist members for approval by the governor, and the dental-hygienist member is elected by licensed dental hygienists in South Carolina for approval by the governor. The governor of South Carolina appoints one of the dentist members and the public member.

The FTC alleges that in July 2001, the Board passed an emergency regulation that contradicted state law by reinstating a requirement that a dentist examine a patient before the patient is eligible for treatment in school from a hygienist, and then taking further action to prevent dental hygienists from providing service to school children without a pre-check by a dentist. The Board also sought to impose a permanent regulation to the same end, but it did not become final. The FTC alleges that the Board’s actions hindered competition in the delivery of preventive dental services to school-aged children and deprived thousands of school children – particularly economically disadvantaged children – of the benefits of preventive oral health care. The complaint also alleges risk that the Board will act to hinder dental hygienists from providing services in other public health settings under the direction of the Department of Health and Environmental Control, as permitted by state legislation.

In an unusual procedural step, the Board’s motion to dismiss on state action grounds is being heard directly by the Commission, rather than by an administrative law judge.

VI. Challenges to Payor Actions and Network Pressures

- [Pennsylvania hospital ends dispute with Independence Blue Cross](#)

A suburban Philadelphia hospital agreed to drop its lawsuit against Independence Blue Cross (“IBC”) in February 2004, as the hospital and the plan agreed to new contract terms. Chester County Hospital v. Independence Blue Cross, No. 02-CV-2746 (E.D.Pa. Feb. 17, 2004) (complaint withdrawn). The hospital had filed suit in May 2002, claiming, among other things, that through most favored nation’s clauses, all product participation policies, pressure on employers to enroll employees principally through IBC, and hospital reimbursement rates depressed unreasonably and below hospital costs, IBC had raised barriers to competition by other health plans in violation of the antitrust laws, and caused injury to the plaintiff hospital.² The defendant vigorously denied the allegations as to market power and anticompetitive conduct, and claimed the plaintiff’s economic problems were the result of its own business judgments.

■ Humana settles with doctors alleging conspiracy to limit physician reimbursement

After a state court judge certified a class and denied the defendant HMOs’ motion to dismiss charges that they had conspired to reduce reimbursement rates to health care providers in violation of state antitrust law, Humana reached a settlement with the plaintiff physicians. Academy of Medicine v. Aetna et al., No. A0204947 (Ohio Ct. Com. Pl. Dec. 29, 2003) (settlement approved). Humana agreed to increase aggregate reimbursement to physicians by specified amounts through 2006, and also agreed that from 2007 to 2010 a three-person oversight committee will monitor the fairness of Humana’s reimbursement rates by looking at random cases. Announcements of the settlement do not discuss how the increases compare to amounts that would have been paid by Humana in any event.

■ Pharmacy chains “drug” down in antitrust challenge to exclusion from Blue Cross of Rhode Island’s pharmacy network.

Stop & Shop and Walgreen failed in their antitrust challenge to their exclusion from a limited pharmacy network established by Blue Cross & Blue Shield of Rhode Island and a pharmacy network owned by CVS. Stop & Shop v. Blue Cross & Blue Shield of Rhode Island, 99-CV-282 (D.R.I. June 24, 2003). The court had denied summary judgment for the defendants, but then ordered a directed verdict for the defendants after trial, before sending the case to the jury. The court ruled that the plaintiffs had failed to offer sufficient evidence that the

² The speaker was co-counsel for the plaintiff in filing of the complaint, but is no longer involved in the case.

exclusion of the plaintiffs pursuant to an limited pharmacy network agreement was anticompetitive or part of a illicit conspiracy with another health plan.³

■ Federal court cracks claim that health plan conspired against chiropractors

A federal trial court granted summary judgment to Trigon Healthcare Inc. and affiliated companies against chiropractors' claims they were harmed by discriminatory practices allegedly adopted pursuant to a conspiracy with physicians or other organizations. [American Chiropractic Association v. Trigon Healthcare Inc.](#), 258 F.Supp.2d 461 (2003). The plaintiffs identified as co-conspirators the doctors on a Trigon Managed Care Advisory Panel who helped establish a clinical practice guideline on the treatment of low back pain that allegedly de-emphasized the importance of spinal manipulation. The court ruled there was insufficient evidence to support claims that the plaintiffs had been harmed by conspiratorial conduct. Under the antitrust "single entity" doctrine, the court found that the defendant was not capable of conspiring with employees within its own business enterprise. The court found that the intracorporate immunity doctrine bars the majority of the plaintiffs' conspiracy allegations in this case because Trigon, as a matter of law, cannot conspire with its employees and agents. For the remainder of the plaintiffs' allegations, Trigon's sworn denials of conspiracy, the affidavits, and the deposition testimony establish that Trigon acted unilaterally and that there is no basis for any inference of a conspiracy, according to the court. Doctors on advisory committees, the court ruled, did not compete directly with the plaintiffs, and served only in advisory relationship to Trigon.

■ First Circuit kicks podiatrists' conspiracy claims against Puerto Rico health plans

The First Circuit Court of Appeals upheld summary judgment for Puerto Rico's two major health plans on antitrust and disparagement claims by podiatrists. [Podiatrist Ass'n, Inc. v. La Cruz Azul de Puerto Rico, Inc.](#), 332 F.3d, 6 (1st Cir. 2003). The upheld a ruling that there was no evidentiary support for a claim that the La Cruz Azul de Puerto Rico (Blue Cross) and Triple-S, Inc. conspired with medical doctors to exclude podiatric care from benefit packages. The court ruled that that physicians did not control the boards of either defendant, and found no evidence that they otherwise controlled policymaking. Other courts have previously held that mere collective advocacy of coverage policies unfavorable to a competing class of professionals is not an unlawful restraint of trade.

³ The speaker was counsel for another defendant in the litigation, United HealthCare of New England. UHCNE settled with the plaintiffs in 2000.

■ Ninth Circuit says aloha to antitrust case

The Ninth Circuit Court of Appeals rejected application of the per se rule and threw out a challenge to joint activity by physician and consumer advocacy groups to influence the terms of a managed health care plan's participating provider agreements, resulting in a competing managed care network's market difficulties. [International Healthcare Management v. Hawaii Coalition for Health](#), 332 F.3d 600 (9th Cir. 2003). The court ruled that joint efforts to modify non-fee terms of a PPO's proposed contracts with physicians is not in a class of restraints previously held to be per se unreasonable, and is not facially likely to be anticompetitive. The Court also quoted favorably from another decision's observation that "[a]n organization's towering reputation does not reduce its freedom to speak out."

VII. Physicians continue to struggle in hospital privileges lawsuits

Individual physicians continue to find success elusive in antitrust challenges to hospital medical staff denials and restrictions on scope of practice.

- A defunct hospital in Missouri won summary judgment against an antitrust challenge to its termination of staff privileges of HIV specialist from its infectious disease clinic. [Lee v. Trinity Lutheran Hospital](#), No. 1 00-0716-CV-W-HFS (W.D.Mo. Jan. 29, 2004). The court decided that the hospital's peer review of the plaintiff was within the immunity granted by the Health Care Quality Improvement Act of 1986, 42 U.S.C. §11112(a) *et seq.* The court noted that some evidence supported finding that the plaintiff met the requisite standard of care. However, the court also found that there was evidence casting doubt on the quality of care provided by the plaintiff, so that the defendants might have been motivated by either a lawful or an unlawful purpose. Since the allegations of an anticompetitive purpose or conspiracy were not supported, the court granted summary judgment for the defense.
- The Third Circuit Court of Appeals affirmed a jury verdict for the defense against a cardiothoracic surgeon who claimed that three hospitals had violated the antitrust laws when they denied him surgical privileges. [Angelico v. Lehigh Valley Hospital](#), No. 01-2585 (3rd Cir. Jan. 12, 2004) (unpublished ruling). The ruling included a finding that one hospital's professional review board action was within the immunity protections of the Health Care Quality Improvement Act.
- The Sixth Circuit screened out a Sherman Act claim by a physician who challenged a hospital policy that excluded the physician from evaluating heart tests. [Arani v. TriHealth Inc.](#), No. 01-4331 (6th Cir. Oct. 1, 2003)

(unpublished). The court upheld a ruling that the plaintiff failed to allege facts to demonstrate that the policy caused anticompetitive effects and failed to properly allege monopoly power by the defendant to support the plaintiff's monopolization claim.

- The Health Care Quality Improvement Act also barred damages suit by a physician who was denied reappointment to the medical staff of a Kentucky hospital. He had sued the hospital and the trustees, doctors and others who participated in his peer review. [Meyers v. Columbia/HCA Healthcare Corp.](#), No. 01-6190, (6th Cir. Aug. 20, 2003). The appeals court found that the evidence supported a conclusion that the parties acted reasonably and in furtherance of ensuring the quality of health care delivered at the hospital.

VIII. “Resident Match” Lawsuit Will Continue

A federal district court has refused to dismiss class action antitrust claims challenging operation of the National Resident Matching Program as a conspiracy to depress and standardize salaries paid to medical residents. [Paul Jung v. Association of American Medical Colleges](#), No. 1:02CV00873. (D.D.C. Feb. 11, 2004).

Plaintiffs have attacked the system broadside. The claim has been filed against a Who's Who of health education and training organizations and teaching institutions. It is denominated a class action, both for plaintiffs, and for defendant institutions.

The fundamental claim is that applicants are effectively forced to apply through the match program and then are assigned to a single program. This prevents applicants from benefiting from competition among programs, such as by programs bidding higher resident salaries and stipends for the most desirable candidates.

IX. What's next

- Challenge to hospital network joint price-setting not justified by alleged “clinical integration”?
- A challenge to a managed care merger?
- Court test to FTC strict application of “messenger model”?
- Challenge to powerful multi-market hospital system “all or none” contracting insistence, or “no tiering” requirements for managed care contracts?
- More hospital merger cases?
- Challenge to monopoly hospital “economic credentialing” against physicians who establish ambulatory or specialty facilities in competition with hospital?

