

NEW ANTITRUST DEVELOPMENTS  
FOR PROVIDERS AND PAYORS:  
VIEWS FROM THE ENFORCERS

Arthur Lerner  
Crowell & Moring LLP

American Health Lawyers Association  
Annual Meeting  
San Diego, California  
June 28-29, 2005

## NEW ANTITRUST DEVELOPMENTS FOR PROVIDERS AND PAYORS: VIEWS FROM THE ENFORCERS<sup>1</sup>

Arthur Lerner  
Crowell & Moring LLP  
Washington, D.C.  
alerner@crowell.com

### **I. Looking Back at a Busy Year and Peering into the Next**

- FTC and Department of Justice issue health care competition and antitrust report
- Continued enforcement against provider boycotts and price fixing activity
- Line drawing in the messenger model
- Payor mergers and practices
- Pitfalls in coping with certificate of need requirements/ DOJ challenges alleged hospital market allocation scheme
- Dentsply monopolization ruling
- What's next? "All or none" contracting practices by powerful hospital systems in DOJ's sights? Pay for performance and clinical integration – rule of reason or free pass?

### **II. FTC-DOJ Report on Health Care Competition and Antitrust**

The FTC and DOJ released a joint report in July 2004 following months of hearings on health care competition and antitrust. <http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf>. The transcripts of the sessions are posted on the FTC website, as are presentations by many of the speakers and panelists. See <http://www.ftc.gov/ogc/healthcarehearings/index.htm>. The report contains an excellent overview on the structure, players and legal and

---

<sup>1</sup> The views expressed in this presentation are the authors, and not necessarily those of the other panelists, Mark Botti, Chief of the Litigation I section at the Antitrust Division of the Department of Justice, and Jeffrey Brennan, Associate Director of the Bureau of Competition of the Federal Trade Commission.

economic environment of the health care industry. While the report does not appear to stake out surprising new ground, it does provide some tip-offs to likely enforcement perspectives and actions.

- The agencies make a series of policy recommendations for government decision-makers, noting concerns, for example, about health insurance coverage benefit mandates, exemption of collective bargaining by providers from the antitrust laws and state certificate of need laws.
- The report indicates that the agencies will continue to pursue antitrust remedies against anticompetitive conduct in health care markets, but specific enforcement priorities are not discussed much. There is no indication that either agency will roll out new enforcement weapons, such as criminal enforcement by DOJ, or FTC monetary disgorgement or restitution remedies, against violations of the type the agencies have challenged for years.
- The agencies support initiatives that will give consumers more information on health care services' price and quality, suggesting potential close scrutiny for provider obstruction of such programs, while at the same time the report also suggests the agencies may give the benefit of the doubt in close cases where joint provider activities can plausibly be said to foster improved patient care through "pay for performance" incentives or other quality enhancing features.
- States should consider broadening membership of state licensing boards and consider uniform licensing standards to reduce barriers to telemedicine and competition from out-of-state providers.
- Governments should reexamine the role of subsidies in health-care markets in light of their inefficiencies and the potential to distort competition.
- The agencies are exploring ways to improve geographic market definition in hospital merger cases and oppose affording different treatment to hospitals in mergers based on a hospital's for profit or nonprofit status.
- The report clarifies that the safety zone created in the agencies policy statements on health care antitrust for provider group purchasing organization activities, explaining that a GPO within the numerical thresholds of the safety zone could still run into antitrust trouble if it engaged in anticompetitive exclusionary practices.
- The agencies express skepticism about the frequency of monopsony market power in payor markets, and oppose efforts that would foster countervailing power among providers as a response to power on the part of payors.

### III. Provider Collusion against Managed Care Plans

The FTC continued a steady stream of complaints and consent agreements addressing alleged anticompetitive collusion by providers against managed care organizations. It employed a variety of remedial cease and desist provisions, seeking to undo the ongoing market effects of anticompetitive behavior, and continued a trend of naming consultants as well as providers and provider organizations as respondents. But it has not taken the additional step of seeking monetary relief, either disgorgement or restitution. The absence of private treble damage suits may reflect the limited size and scope of some of the challenged schemes, making them unattractive to plaintiffs' lawyers, as may be the difficulty of showing measurable damages for individual consumers. Why don't payors sue?

One case now on appeal to the full Commission from a decision by an administrative law judge, *North Texas Specialty Physicians*, FTC Dkt. 9312 (Nov. 15, 2004) (<http://www.ftc.gov/os/adjpro/d9312/041116initialdecision.pdf>), will give the Commission the opportunity to address in an adjudicative context one respondent's claims to have operated within the bounds of a reasonable "messenger model" arrangement and to have avoided violating the antitrust laws. While it seems that the respondent may well have reached agreements on price improperly, the ALJ opinion is not very clear about when the physician group crossed the line.

The ALJ summarized the respondent's conduct as follows:

Upon receipt of a payor offer of a non-risk contract, Respondent evaluates the offer and determines whether to send . . . it to its participating physicians. Respondent does not messenger to its physician members any offers on non-risk contracts that fall below minimum rates established by the NTSP Board . . . NTSP establishes Board minimums by conducting polls among its physician members that ask each physician to disclose the minimum price that he or she would accept . . . .

Assuming no collusion among the physicians in setting their individual minimums and no exclusivity running from the physicians to the network, is it price-fixing for a network to decide that it will not contract with a payor if the payor's offer will not yield the participation of a majority of the network's members? Does a network have to messenger out price proposals that physicians have individually already said they will not accept? In all circumstances? In some circumstances? Must a network using the messenger model merely be a clearinghouse? These are among the questions the Commission may address in resolving the case.

The rest of the past year's cases have included:

- *San Juan IPA, Inc.*, FTC File No. 031-0181 (proposed consent order issued May 16, 2005) -- complaint charged that a physician organization representing

approximately 80 percent of the doctors in the Farmington, New Mexico area, agreed to fix prices at no less than billed charges minus a 10 percent discount and by refusing to deal to enforce the collectively determined terms. In addition, while purporting to employ a “messenger model” for contracting, the network refused to transmit some payor proposals to its providers.

- *New Millennium Orthopaedics, LLC*, FTC File No. 031-0087 (proposed consent order issued May 2, 2005) -- complaint charged that two orthopedic group practices and an IPA jointly negotiated rates and boycotted a plan that would not agree to their terms. A bonus scheme rewarded all IPA physicians, including non-surgeons, with higher rates if the IPA as a whole met targets for increasing the percentage of surgeries performed by some IPA physicians at ambulatory surgery centers. The proposed order requires dissolution of the IPA, and includes cease and desist requirements for the groups.
- *Evanston Northwestern Healthcare Corporation.*, D. 9315 (consent order with one respondent issued May 17, 2005 to resolve portion of pending case. Complaint had alleged that respondent improperly negotiated prices for both 460 salaried physicians and 450 physicians in an IPA that was not financially or clinically integrated with the salaried physicians and insisted that payors contract for both sets of physicians as a package.
- *Preferred Health Services, Inc.*, C-4134 (consent order issued April 13, 2005) -- complaint charged that a physician-hospital organization representing approximately 100 physicians and a hospital in South Carolina restrained competition by acting as a collectively negotiating for its members and threatening refusals to deal with health plans.
- *White Sands Health Care System, L.L.C.*, C-4130 (consent order issued January 11, 2005) – complaint charged a physician-hospital organization, a 45 member physician group, a consulting firm and the consulting firm’s president with conspiring to fix prices and refusal to deal with payors. The network included an IPA with approximately 80% of the physicians in the area, 31 non-physician healthcare providers (including the only 5 nurse anesthetists in the area), and the only hospital in the area. The respondents allegedly claimed to operate under a messenger model, but in fact, the FTC said, the consultant negotiated price and other terms that were then approved by provider representatives.
- *Southeastern New Mexico Physicians IPA, Inc.*, C-4113 (consent order issued August 5, 2004 – complaint alleged that IPA representing over 70% of the physicians in the Roswell, New Mexico area and two of its employees orchestrated agreements to fix prices and refuse to deal with payers except on collectively agreed-upon terms. According to the complaint, the IPA surveyed its members on the minimum price levels they would accept and sent them information about the prices they were paid by payers under contracts

previously negotiated by the IPA, and they refused to deal individually with payers unless the contract was approved by the IPA leadership, resulting in higher prices.

- *Piedmont Health Alliance*, D. 9314 (consent order issued October 1, 2004) – complaint had charged a physician-hospital organization in North Carolina and ten of its individual members with agreeing to fix prices for the organization’s 450 doctors. FTC said the PHO’s “modified messenger model” was not legitimate because, among other things, the PHO sent information to its physician members concerning prices under what were apparently previously improperly price-fixed contracts as a basis for setting up minimum price levels physicians would accept under the “modified messenger model” and for two contracts the PHO negotiated the overall average price levels paid to its physicians and the specific fee schedules to be used.

#### **IV. Dentsply Victory for DOJ – Govt. Brings and Wins a Non-Per Se Health Industry Case!**

- The Third Circuit reversed the trial court and sustained DOJ’s allegations that the nation’s dominant artificial tooth maker monopolized by imposing exclusivity requirements on distributors that raised barriers to entry and competition. *U.S. v. Dentsply International Inc.*, 399 F.3d 181 (3<sup>rd</sup> Cir. 2005). <http://www.ca3.uscourts.gov/opinarch/034097p.pdf>. Dentsply’s business justification was pretextual, the court found. The court rejected the lower court’s reliance on low barriers to entry in the distributor field and the hypothetical availability of alternative distribution routes.

The decision is notable beyond its specific context, as a lonely example of government pursuit of a non-per se antitrust challenge to a dominant firm in the health care industry.

#### **V. Waiting for Results from the Look at Past 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 prices.

The FTC took 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. After investigating the mergers in a number of states, including Missouri,

Illinois, North Carolina and California, the Commission pulled the trigger in early 2004 and challenged a four year old hospital acquisition in Evanston, Illinois. *Evanston Northwestern Healthcare Corporation*, FTC Dkt No. 9315 (Feb. 10, 2004) (complaint). <http://www.ftc.gov/os/caselist/0110234/040210emhcomplaint.pdf>. Closing argument before the Administrative Law Judge has been scheduled.

## **VI. Allegedly Anticompetitive Hospital System Contracting and Coercive Practices**

- A federal trial court upheld a punitive damages jury verdict against the Peace Health hospital system in Oregon for attempting to monopolize the acute care hospital market, using bundled pricing of its various system hospitals as an anticompetitive tool. *McKenzie-Willamette v. PeaceHealth*, 2004 U.S. Dist. LEXIS 20980; 2004-2 Trade Cas. (CCH) P74,600 (D. Or. Oct. 13, 2004). McKenzie alleged that PeaceHealth, in its nonexclusive insurance arrangements, priced services in which it competed with McKenzie below cost while linking these prices to its pricing services for which PeaceHealth had no effective competition substantially in excess of cost. McKenzie claimed that this pricing scheme enabled PeaceHealth to depress the price of services in which it competed with McKenzie while recouping revenues through supracompetitive prices for services in which it had no competition. McKenzie also alleged that PeaceHealth formed a preferred provider agreement with health insurer Regence Blue Cross Blue Shield of Oregon under which Regence agreed to exclude McKenzie from preferred provider status in exchange for PeaceHealth providing Regence with large discounts.

The decision is a leading entry in the coming antitrust battles over bundled pricing. When can price discounting that is not below variable cost be anticompetitive? When is bundled pricing that has attributes like tying anticompetitive? How are the lines to be drawn? Is the bundling a legitimate efficiency enhancing strategy? If not, is it a “mere” manifestation of market power, or can it be itself anticompetitive?

- An ambulatory surgical center defeated summary judgment motions on three of its antitrust claims against a hospital. *Rome Ambulatory Surgical Center, LLC v. Rome Memorial Hospital, Inc.*, 349 F. Supp. 2d 389 (N.D.N.Y. 2004). The court permitted the plaintiff to move forward with claims that the hospital engaged entered into anticompetitive exclusive contracts with third party payers, conspired with affiliated physicians to obstruct referrals to the plaintiff for surgery, and intimidation of physicians who used the plaintiff’s facility.

## VII. Antitrust Enforcement Interplay with State Regulation<sup>2</sup>

- The Federal Trade Commission refused to dismiss its complaint against the South Carolina State Board of Dentistry for committing an unfair method of competition by adopting an emergency regulation prohibiting dental hygienists from providing services to school children without a prior clinical examination by a dentist to determine the need for hygienist's treatment. *South Carolina State Board of Dentistry*, Dkt. No. 9311 (July 28, 2004).  
<http://www.ftc.gov/os/adjpro/d9311/040728commissionopinion.pdf>

The board is South Carolina's regulatory authority for dentists and dental hygienists. Six of its eight members are elected by the state's licensed dentists. The Commission ruled that, on the basis of the allegations of the complaint, and applicable law, there was insufficient basis to dismiss the case on state action grounds. The Commission said that, on the information pled, the board's action contradicted state law, and did not impose a restraint that was a foreseeable result of the board's authority. The Commission also ruled the case was not moot.

- The Department of Justice has filed a complaint and proposed consent order to resolve allegations that two hospitals in West Virginia entered into an anticompetitive market allocation agreement in connection with applications for certificates of need under the state's hospital regulatory scheme. *United States v. Bluefield Regional Medical Center, Inc. and Princeton Community Hospital*, Civil Action No. 1:05-0234 (March 2005).  
<http://www.usdoj.gov/atr/cases/f208200/208263.htm>

After the state denied a certificate of need for a new cardiac program by the Bluefield hospital and encouraged a cooperative approach to the CON process, the two hospitals entered into agreements calling for joint applications for cardiac and cancer programs, with Bluefield to operate the cardiac program, and Princeton the cancer program, the arrangements including sale of a linear accelerator to Princeton by Bluefield and covenants not to compete in relation to the planned programs. The state approved the joint CON application for the heart program to be located at Bluefield and the cancer CON application remained pending. DOJ alleged that the agreements were not protected by the state action doctrine, notwithstanding the CON law and the State's hospital rate regulatory scheme, because the state's Health Care Authority lacked the power to authorize private anticompetitive agreements and it had not approved the actual agreements between the parties. The Health Care Authority filed a comment on the proposed consent order asserting that the state action doctrine protected the hospitals' actions, but

---

<sup>2</sup> This section was inadvertently omitted from the version distributed at the AHILA Annual Meeting.

DOJ has rejected that view in a response filed with the district court. Final action on the consent order is pending.

### **VIII. Hospital-based Physicians**

Hospitals often have exclusive contracts with physicians in certain specialties, such as anesthesia, radiology and pathology. Concerns of anticompetitive effects may be met with the response that if such exclusive relationships are not efficient, the hospitals would change them or payors as customers would shop among hospitals, thereby disciplining attempts by hospital based physicians to exercise market power.

In practice, though, efforts to engender competition for practice opportunities in these specialties, and to maintain a competitive level of market performance, can be contentious and may raise material antitrust issues.

- A hospital in Defiance, Ohio won partial summary judgment against a defendant anesthesia clinical practice for monopolization and attempted monopolization claims premised on the theory that it forced the hospital, which had rejected an exclusive arrangement, to compete at a loss in providing anesthesia services. *Defiance Hospital, Inc. v. Fauster-Cameron, Inc.*, 344 F. Supp. 2d 1097 (N.D. Ohio 2004). The sole remaining element to be resolved is whether the defendant had acted with anticompetitive intent or for legitimate business reasons. After the hospital declined to grant the anesthesia clinical group an exclusive contract, the clinic solicited and secured agreements with independent physicians in the area to use the clinic's CRNAs as their "primary source" for anesthesia services. The Clinic then refused to provide anesthesia services for patients of non-signing physicians, and forced them all to agree. When the hospital recruited its own anesthesiologist, the defendant clinic would not share call coverage, requiring him to be on call seven days a week, 24 hours a day. In order to create competition in the provision of anesthesia at all, the hospital was effectively forced to create an entire anesthesia delivery system, capable of serving the entire community's needs.

### **IX. Payor Prospects**

- DOJ issued a statement after it closed its investigation into UnitedHealth Group's acquisition of Oxford Health Plans, saying the facts did not support a conclusion that the merger would create market power or monopsony (buyer) power in markets where the companies competed. DOJ indicated that in this particular case an HMO-only market definition was not supported.
- A health plan that used affiliated ophthalmologists to provide all eye care services to its enrollees, whether the care is surgical or nonsurgical, to the exclusion of optometrists, does not offend federal antitrust law. *Abraham v. Intermountain Health Care Inc.*, 2005 U.S. Dist. LEXIS 3998; 2005-1 Trade Cas. (CCH) P74,723 (D.Utah Feb. 10. 2005) The plaintiff optometrists lacked standing to assert a claim that IHC had unfairly used market power in the

private health plan market to increase its market power in the hospital and surgical facilities market, the court ruled. The court rejected claims that IHC tied health insurance coverage to use of its designated physicians finding that the health plan and its making available a defined network of providers, was a single product.

## **X. Pharmaceutical Cases Take New Turns**

- The FTC's attack on allegedly collusive "reverse" patent settlements between brand and generic drug manufacturers took a hit in the Schering Plough litigation. *Schering Plough v. FTC*, 402 F.3d 1056 (11<sup>th</sup> Cir. 2005). The Court of Appeals ruled that absent evidence that Schering-Plough's patent was in fact invalid, there could not be an anticompetitive effect when it agrees to make payments to an allegedly infringing generic drug maker to secure its abandonment of the patent dispute litigation and its generic competition. The Commission filed a petition for rehearing en banc on April 22, 2005.

- The trial court in the consolidated CIPRO antitrust case rejected the remaining antitrust claims of plaintiffs challenging another brand-generic patent settlement. *In re Ciprofloxacin Hydrochloride Antitrust Litigation*, 363 F.Supp. 3rd 563 (E.D.N.Y. 2005). [http://op.bna.com/hl.nsf/id/sfak-6b2mqh/\\$File/barrcipro.pdf](http://op.bna.com/hl.nsf/id/sfak-6b2mqh/$File/barrcipro.pdf). The court ruled that it is inappropriate for an antitrust court, in determining the reasonableness of a patent settlement agreement, to conduct an after-the-fact inquiry into the validity of the underlying patent, that there is no duty to settle legitimate patent disputes on terms that maximize consumer welfare, and that the settlement at issue had not constrained competition beyond the scope of the brand manufacturer's patent claims. These conclusions resulted in summary judgment for the defendants.

- Pharmaceutical merger enforcement continues:

*Genzyme Corporation and Ilex Oncology*, C-4128 (consent order issued January 31, 2005) resolving allegations of anticompetitive effects in the market for immunosuppressant drugs used in solid organ transplants.

*Sanofi-Synt and Aventis*, C-4112 (consent order issued September 20, 2004) -- resolving allegations that merger would lessen competition in Factor Xa Inhibitor e anticoagulants used to treat conditions related to excessive blood clot formation, cytotoxic colorectal cancer drugs, and prescription anti-insomnia drugs.

*Cima Labs and Cephalon, Inc.*, C-4121 (consent order issued September 24, 2004) -- resolving allegations that merger would lessen competition in market for treatment of breakthrough cancer pain.

## **XI. Privilege Battles Still Tough Sledding for Plaintiffs**

- Hospital peer review action upheld by 8<sup>th</sup> Circuit against money damage antitrust claim under the Health Care Quality Improvement Act. *Lee v. Trinity Lutheran Hospital*, 2005 U.S. App. LEXIS 9444 (8<sup>th</sup> Cir. 2005).
- Hospital wins summary judgment against cardiac surgeon's antitrust complaint concerning termination of his employment contract and the hospital's subsequent decision to limit hospital privileges to employed physicians (*Clinch v. Heartland Health*, No. 03CV72021 (Mo. Cir. Ct. Oct. 29, 2004). Judge rules that doctor lacks antitrust standing because he has not suffered cognizable antitrust injury.
- The Sixth Circuit ruled that the alleged fear of witnesses to testify against a hospital with market power was not a sufficient basis for granting the plaintiff physicians more time for discovery. The additional time would not solve the alleged problem, the court ruled, and would likely be "further wasted time." *Eastern Kentucky Cardiothoracic Surgery, P.S.C. v. Ashland Hospital Corp.*, 119 Fed. Appx. 715; 2004 U.S. App. LEXIS 27210; 2004-2 Trade Cas. (CCH) P74,660 (6<sup>th</sup> Cir. 2004).

## **XII. "Resident Match" Lawsuit Runs into Post-Legislation Wall**

The Sherman Act class action alleging a conspiracy to impose anticompetitive restraints on medical residency hiring and salaries was dismissed after enactment of a special amendment the antitrust laws protecting the match program. *Jung v. Ass'n of American Medical Colleges*, 339 F.Supp. 2d 26 (D.D.C. Aug. 12, 2004).

## **XIII. 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?
- Challenge to monopoly hospital "economic credentialing" against physicians who establish ambulatory or specialty facilities in competition with hospital?
- Agency look at exclusionary practices by hospital-based physician groups?