No. 05-1000

IN THE

SUPREME COURT OF THE UNITED STATES

ALAN D. GORDON, M.D.; ALAN D. GORDON, M.D., P.C., A CORPORATION; MIFFLIN COUNTY COMMUNITY SURGICAL CENTER, INC., A CORPORATION,

Petitioners,

v.

LEWISTOWN HOSPITAL

Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

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MOTION FOR LEAVE TO FILE BRIEF AS *AMICI CURIAE* AND BRIEF FOR THE AMERICAN ASSOCIATION OF AMBULATORY SURGERY CENTERS AND THE OUTPATIENT OPHTHALMIC SURGERY SOCIETY IN SUPPORT OF THE PETITION

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March 13, 2006

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MOTION OF THE AMERICAN ASSOCIATION OF AMBULATORY SURGERY CENTERS AND THE OUTPATIENT OPHTHALMIC SURGERY SOCIETY FOR LEAVE TO FILE BRIEF AS *AMICI CURIAE* IN SUPPORT OF THE PETITION

Pursuant to Rule 37 of the Rules of this Court, the American Association of Ambulatory Surgery Centers ("AAASC") and the Outpatient Ophthalmic Surgery Society ("OOSS") request leave to file the accompanying brief as *amici curiae* in support of the petition for writ of certiorari.[1]

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[1] Petitioner Mifflin County Community Surgery Center, which is a member of the *amici* organizations AAASC and OOSS, has provided financial support to *amici* to partially defray the cost of this brief, but neither it nor its counsel have otherwise participated in its preparation.

AAASC is one of the premier national non-profit professional associations dedicated to promoting the high quality, lower-cost, patient-centered care provided through ambulatory surgery centers ("ASCs"). AAASC has over 500 members comprising over 1500 ASC locations across the country; these members include individual centers, corporate members, professional organizations, and state associations. ASCs compete with hospitals and frequently provide outpatient surgical procedures at substantially lower cost.

OOSS is the leading ophthalmic ASC non-profit professional society, with membership of roughly 1000 ophthalmic surgeons who offer care through over 200 ophthalmic ASCs nationwide. OOSS's mission is to help ASC owners and ophthalmic surgeons utilizing ASCs to provide high quality, cost-effective surgical care through education, information, and advocacy. Ophthalmic ASCs compete directly with hospitals to provide surgical services related to cataracts, glaucoma, and refractive or vitreoretinal care. They serve as a competitive check on hospitals with respect to cost, standards of care, and patient satisfaction.

As a representative of ASCs, and the physicians who practice in them, *amici* have a vital interest in ensuring that ASCs can continue to provide convenient and patient-friendly alternatives to hospital care. Because ASCs offer many benefits that customers and payors desire, they have become increasingly popular in the past decade, often at the expense of hospital outpatient facilities that compete with ASCs for patient and government funds. At the same time, ASCs depend on hospitals due to federal and state laws requiring ASC physicians to have privileges at nearby hospitals. ASCs are often especially vulnerable in local areas where a single hospital has a strong market position. Thus, ASCs are placed in the challenging position of competing with the very same

hospitals on which they often must rely to become licensed and stay in business.

The Third Circuit's decision leaves ASCs, and the physicians who practice in them, especially vulnerable in two situations: (1) when the physicians face "peer review" performed at a hospital; and (2) in their first stages of operation, when they are still nascent. The court's analysis of both of these questions left ASCs and their related physicians more exposed than ever to anticompetitive behavior from a hospital. Thus, amici seek permission to submit this brief to address these two points of the Third Circuit's opinion.

First, ASC physicians must be able to practice without fearing inappropriate reprisals through the physician peer review process. The Health Care Quality and Improvements Act ("HCQIA") provides protection from antitrust damage suits in legitimate peer review situations. However, it also provides exceptions from that immunity for certain potentially anticompetitive behavior. The Third Circuit applied overly broad immunity to hospitals tasked with performing peer review, in a manner that effectively expunged the exceptions for potential antitrust violations from the statute. If uncorrected, the Third Circuit's decision would allow hospitals and others to engage in *exactly* the type of unchecked behavior that Congress intended its exceptions to prevent. This Court should grant certiorari in order to give effect to the plain language of the statute.

Additionally, *amici* seek recognition that ASCs are not required to open their doors before the antitrust laws properly may be applied to shield them against anticompetitive behavior. Despite the fact that the Petitioner in this case had applied for a Certificate of Need to open an ASC, and had taken further steps in pursuit of its license, the Third Circuit determined that Petitioner and Lewistown Hospital which also offered

outpatient care services "were not competitors in the relevant market" and that Petitioner's "competition in the facility services market did not commence until MCCSC opened more than one year later." App. at 41. Such a result conflicts with antitrust cases and principles which recognize that competition in its incipiency is actual competition in the market. Moreover, this result leaves ASCs particularly vulnerable where they either enter a market where a hospital is already entrenched or where their physicians must rely on hospitals for privileges without which ASCs cannot operate under federal or state law. *Amici* support the issuance of a writ of certiorari on this issue to settle this question, as the Third Circuit's erroneous decision contradicts both accepted case law and antitrust analysis.

Accordingly, *amici* respectfully request that their motion for leave to file the accompanying brief as *amici curiae* be granted to address these issues.[2]

Respectfully submitted,

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March 13, 2006

[2] Petitioners have consented to the filing of this *amicus brief*; Respondent Lewistown Hospital has not.

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BRIEF FOR THE AMERICAN ASSOCIATION OF AMBULATORY SURGERY CENTERS AND THE OUTPATIENT OPHTHALMIC SURGERY SOCIETY IN SUPPORT OF THE PETITION

INTEREST OF *AMICI CURIAE*

The American Association of Ambulatory Surgery Centers ("AAASC") and the Outpatient Ophthalmic Surgery Society ("OOSS") request leave to file the attached brief *amici curiae* in support of the petition for writ of certiorari.

Amici are leading professional organizations dedicated to providing high-quality, lower-cost health care through ambulatory surgery centers ("ASCs"). ASCs compete with hospitals in providing outpatient surgical services, and regularly offer these services at substantially reduced costs to patients, private payors, and the government via Medicare and Medicaid. The opening of an ASC will

often result in decreased charges and/or improved standards of care for outpatient surgery at nearby hospitals.[1]

Amici have a strong interest in ensuring that physicians active in the formation or operation of ASCs do not lose their hospital privileges for anticompetitive reasons via restraints masquerading as professional review actions. Specifically, they have an interest in assuring that the federal statute affording qualified immunity from antitrust damage claims for legitimate peer review activity in hospitals is not improperly extended to restraints directed at physicians' competitive acts – restraints outside the scope of statutory immunity by the plain text of the law. They also seek recognition that the antitrust laws protect them against a hospital's anticompetitive acts when they are perhaps most vulnerable, when they are just embarking upon operation. ASCs should be protected from hospitals' anticompetitive actions as soon as they have taken concrete steps toward opening or providing services through an ASC that make them potential or incipient competitors of hospitals, whether or not their doors have yet opened for business.

SUMMARY OF ARGUMENT

Over the last decade, ASCs have become an important source of competition to hospitals for outpatient surgical services. By offering convenient, high-quality, lower-cost options for patients and physicians, ASCs provide an

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[1] Testimony of David Shapiro, M.D., President, AAASC, before the Subcomm. on Health, Comm. on Ways & Means, U.S. House of Representatives regarding the Medicare Payment Advisory Comm'n Report on Medicare Payment Policies for Ambulatory Surgery Center Services, at 2 (Mar. 20, 2003) [hereinafter "Shapiro Testimony"], *available at* http://www.aaasc.org/advocacy/documents/AAASCTestimony2003.pdf.

important alternative to hospital care. At the same time, ASCs and the physicians who staff them are dependent on hospitals for staff privileges without which many cannot operate under federal and state law. This dependence could be abused by hospitals to quash the threat of additional ASC competition.

A physician's peer review action is one potential vehicle for such abuse. The Health Care Quality and Improvement Act, 42 U.S.C. §§ 11101-11152 (1986) ("HCQIA" or "the Act") is designed to set standards for immunity from treble antitrust damages for certain physician peer review actions. Because the statutory language clearly requires satisfaction of a two-part test to confirm that a review was (1) not based on a doctor's competitive behavior, which would fall outside the definition of a "peer review action"; and (2) reasonable, it was error for the Third Circuit to subsume the first test into the reasonableness inquiry of the second. This can only result in an improper broadening of the intended immunity.

The Third Circuit also misapplied applicable precedent in stating that a still nascent ASC could not have been a competitor of an existing hospital. Antitrust law recognizes that potential or incipient competition will often act as a check on the marketplace. ASCs need legal protection from anticompetitive conduct even before they open their doors.

REASONS FOR GRANTING THE PETITION

I. This Court Should Examine The Third Circuit's Rewriting Of The Test For HCQIA Immunity.

A. ASCs Provide Vital, Innovative, Lower-Cost Health Care Services That Merit Federal Protection From Anticompetitive Conduct.

ASCs play an increasingly important role in the provision of quality health care at reasonable cost to patients

throughout the country. In that role, they often pose a serious competitive threat to hospitals. These facilities, often owned by physician investors, provide surgical procedures to patients who do not require overnight care by physicians or other health care professionals.[2] As such, they compete directly with hospitals that provide similar services in either an inpatient or outpatient setting, often taking business away from them. Recognizing ASCs' potential to reign in health care spending by offering low-risk surgeries in a lower-cost and patient-friendly environment, Congress provided in the early 1980s that Medicare should cover the facility costs of ASCs for certain services as it did for hospital services. *See* Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, § 934, 94 Stat. 2599 (1980). Since then, with advances in technology, the range of services safely provided in ASCs and covered by Medicare and other payers has greatly expanded.

Since the 1980s, the number of ASCs has grown rapidly, doubling in the past decade and now totaling over 4,400.[3] There are many reasons for this growth. First, ASCs ensure benefits to patients and physicians alike. They offer consumers more convenient locations, briefer wait times on-site, shorter delays in scheduling surgery, and often lower

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[2] *See* Medicare Payment Advisory Comm'n, *Report to the Congress: Medicare Payment Policy*, § 2F, at 136, 140 (2003) [hereinafter "MedPAC 2003], *available at* http://www.medpac.gov/publications/congressional_reports/Mar03_Entire_report.pdf.

[3] *See* Fed. Trade Comm'n & Dep't of Justice, Improving Health Care: A Dose of Competition (July 2004), at Chapter 3, at 24, (July 2004) [hereinafter "FTC/DOJ Report"] *available at* http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf; Am. Soc'y of Anesthesiologists Newsletter, Vol. 69, "Hospital Contracts Survey: 2004 Data," (April 2005), *available at* http://www.asahq.org/Newsletters/2005/04-05/pracMgmt04_05.html.

coinsurance payments than hospital outpatient departments.[4] Their concentration in specialized procedures, using state-of-the-art medical technology in facilities staffed by specially trained personnel, enables them to provide better care at greater satisfaction to patients than more generalized care providers.[5] Physicians in turn benefit from the increased efficiencies of using facilities designed for specific outpatient procedures. *See* MedPAC 2003*, supra* note 2, at 140. Because physicians retain control over the surgical calendar at ASCs, they may schedule more surgeries per day, which increases their fee generation ability, improves productivity, and decreases downtime. *See* Casalino, "Focused Factories," *supra* note 5, at 5; Shapiro Testimony, *supra* note 1, at 4.

Second, innovations in technology have allowed ASCs to offer an increasing range of services as outpatient procedures, transforming the way some maladies are treated. In the late 1990s in particular, physicians began performing several high-volume procedures in an ambulatory care rather

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[4] *See* MedPac 2003, *supra* note 2, at 140 (noting ASC copayments of 20 percent as compared with hospital outpatient copayments of up to 55 percent). *See also* Medicare Payment Advisory Comm'n, *Report to the Congress: Medicare Payment Policy*, Table 3F-1, at 187 (2004) [hereinafter "MedPac 2004"], *available at* http://www.medpac.gov/publications/congressional reports/June04_Entire_Report.pdf (noting ASC coinsurance tended to be 10 to 60 percent lower than hospital outpatient coinsurance).

[5] *See* Lawrence P. Casalino *et al*, "Focused Factories? Physician-Owned Specialty Facilities," *Health Affairs*, Vol. 22, No. 6 (Nov./Dec. 2003) at 5-6, *available at* http://aaasc.org/advocacy/ documents/FocusedFactoriesHealthAffairs1103.pdf; Richard P. Kusserow, Inspector General, Dept. of Health & Human Servs., "Patient Satisfaction with Outpatient Surgery: A National Survey of Medicare Beneficiaries," at 3-4, (1989), *available at* http://oig.hhs. gov/oei/reports/oei-09-88-01002.pdf.

than inpatient setting. *See* MedPAC 2003, *supra* note 2, at 139. For example, advances in microsurgery and ultrasound techniques have permitted better cataract lens replacements to be performed safely and more frequently in ASC settings. *Id.*, at 140. Migrating services from the inpatient hospital environment to lower-risk, lower-cost outpatient settings allows patients and payors alike to reap these benefits and encourages further technological advances.

Finally, ASCs can offer cost benefits not just to patients who have smaller copays, but to the government as well. For example, cataract removal or lens insertion makes up about half of the Medicare funds received by ASCs, yet ASCs' Medicare reimbursement rates for these services are at least 19 percent lower than those charged by hospital outpatient departments. *See* MedPAC 2003, *supra* note 2, at 140 & Table 2F-2; FTC/DOJ Report, *supra* note 3, at 26.[6] Comparing Medicare reimbursement rates generally, the government pays higher rates to hospitals for 2,267 procedures, and higher rates to ASCs for only 280 procedures.[7] Recent legislation, effective January 1, 2007, brings all higher ASC reimbursements down to the level of those paid to hospital outpatient departments. *See* Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 5103, 120

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[6] In 2006, the rate gap between ASCs and hospitals for this procedure became even more disparate. *Compare* 70 Fed. Reg. 68734 (Nov. 10, 2005) (listing hospital reimbursement rate for cataract procedures with IOL insert at $1,387.71) *with* U.S. Dep't of Health & Human Srvs., Medicare Claims Process Manual, CMS 100-04, Change Request 4075 (Sept. 30, 2005) (noting 2006 ASC reimbursement rates for the procedure were unchanged at $973).

[7] *See* Lena Robins *et al.*, "Deficit Reduction Act of 2005 Enacts Sweeping Medicare & Medicaid Changes," *Mondaq*, Feb. 17, 2006, *available at* http://www.mondaq.com/i_article.asp_Q_articleid_ E_37888.

Stat. 4, 40 (2006). In this way, ASCs are fulfilling the purpose for which they were intended by applying increasing pressure against hemorrhaging health care costs.

For all of these reasons, ASCs have become increasingly popular with both patients and physicians. Congress has increased the services for which ASCs can receive Medicare reimbursement, and those payments to ASCs have more than tripled between 1992 and 2002, with total Medicare payments of $1.9 billion to ASCs in 2002. *See* MedPAC 2004, *supra* note 4, § 3F, at 186.[8] These results have affected and will continue to impact the bottom line at hospitals, because hospitals would otherwise perform and receive facility fees for these services.

Despite – and in some ways because of – the success of ASCs, physicians who desire to work at or open an ASC sometimes face hurdles imposed by hospitals, particularly in local areas where a single hospital has a dominant market position. Medicare currently does not offer facility reimbursement for all surgical procedures, and some individual patients may have conditions requiring inpatient admission. Doctors whose practice depends on their ability to also perform procedures on a hospital inpatient basis must retain their hospital privileges in order to practice effectively. This dependence is especially keen where the law requires physicians practicing at an ASC to have hospital staff privileges and/or transfer agreements with hospitals. *See* App. at 83; U.S. Dep't. of Health & Human Srvs., Medicare

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[8] The Department of Health and Human Services announced that in 2008, Medicare will significantly expand the list of services for which ASCs receive facility reimbursement. *See* AAASC release, "Medicare Commits to Significantly Expand Coverage of Services Within ASC," *available at* http://www.aaasc.org/advocacy/MedicareCommitstoSignificantlyExpandCoverageofServicesWithinASC.htm.

State Operations Manual, App. L, § 416.41 (2004), *available at* http://www.cms.hhs.gov/manuals/downloads/som107_Appendicestoc.pdf.

A 2004 joint Federal Trade Commission and Department of Justice Antitrust Division report, produced after extensive hearings and submissions, records panelists' observations of the various ways in which hospitals have tried to thwart further ASC entry. *See* FTC/DOJ Report, *supra* note 3, Chapter 3, at 27.[9] Such practices included "revok[ing] privileges of physician-investors in ASCs, and us[ing] state certificate of need (CON) laws to inhibit ASC entry." *Id.* Because physicians often remain dependent on hospitals due to the hospital's position in the marketplace, they are vulnerable to such attacks and require the full protection provided to them by the federal antitrust laws.

B. HCQIA's Clear Language Limits Antitrust Immunity Where Hospitals Use The Peer Review Process In Certain Specified Respects.

The courts below granted Lewistown Hospital (the "Hospital") immunity from antitrust damages on the basis of HCQIA, enacted in 1986. HCQIA was designed to provide hospitals with legal protection from damage claims in connection with *bona fide* peer review of physician competence and professional conduct, while preserving full application of the antitrust and other laws to hospital actions based on enumerated competitive acts by physicians. Congress was concerned that absent immunity, physicians who were aggrieved by adverse peer review decisions would

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[9] *See id.* at 22 n.111 (discussing "economic credentialing" whereby hospitals facing competition from specialty providers revoke the admitting privileges of physicians involved with those providers).

bring non-meritorious but costly challenges to their peer reviews. *See id.*, § 11101.

HCQIA provides that "[i]f a professional review action (as defined in section 11151(9) of this title) of a professional review body meets all the standards specified in section 11112(a) of this title," it shall not be liable for damages related to that action. *Id.*, § 11111(a)(1). Thus, the plain language of the Act requires an action to satisfy two tests to obtain immunity from damages: first, it must meet the definition set out in Section 11151(9), and second it must comply with additional standards in Section 11112(a).

The first test, Section 11151(9), defines a "professional review action" as "an action or recommendation of a professional review body which is taken . . . based on the competence or professional conduct of an individual physician." *Id.*, § 11151(9). Section 11151(9) further provides, however, that an action will not be deemed to be based on the competence or professional conduct of a physician – and therefore will not be a "professional review action" – if the action is primarily based on one of five exceptions, including "the physician's fees or the physician's advertising or engaging in other competitive acts intended to solicit or retain business." *Id.*, § 11151(9)(B).[10] These limits

[10] The four other exceptions are: "the physician's association, or lack of association, with a professional society or association," "the physician's participation in prepaid group health plans, salaried employment, or any other manner of delivering health services whether on a fee-for-service or other basis," "a physician's association with, supervision of, delegation of authority to, support for, training of, or participation in a private group practice with, a member or members of a particular class of health care practitioner or professional," and "any other matter that does not relate to the competence or professional conduct of a physician." 42 U.S.C. §§ 11151(9)(A), (C)-(E). These exceptions were inserted because

(continued....)

on the definition of "professional review action" are explicit and critical.

The second test, Section 11112(a), sets out additional standards necessary for a professional review action to qualify for immunity, including the reviewing body's "reasonable belief that the action was in the furtherance of quality health care." *Id.*, § 11112(a)(1).[11]

Contrary to the plain language of the Act, the Third Circuit effectively held that so long as an action meets the second test, the action or recommendation of a hospital's professional review body will automatically pass the first test and will be deemed a "professional review action" based on a physician's competence or professional conduct. Thus, according to the Third Circuit, "even when the solicitation exception [to the definition of professional review action] is in play, immunity will be judged by applying the objective standard [of the second test] regarding whether the Hospital based its actions upon the reasonable belief that they are in furtherance of quality healthcare." App. at 31-32. The Third Circuit's holding therefore eviscerates Congress's decision to categorically limit the range of actions entitled to immunity, while applying a presumptively reasonable

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(continued) . . .

"this area presented the greatest potential for abuse of the professional review process for economic or other reasons under the guise of improving the quality of health care." H.R. Rep. No. 99-903, pt. 1, at 6404 (1986).

[11] Section 11112(a) further states that "[a] professional review action shall be presumed to have met the preceding standards necessary for [immunity from damages] unless the presumption is rebutted by a preponderance of the evidence." Accordingly, Section 11112(a) will not even apply unless the act in question has already satisfied the definition of a "professional review action."

standard to a hospital's determination. The result expands the range of physician conduct that can be the basis for adverse action that qualifies for immunity and broader protection for anticompetitive behavior than the law provides.

In addition to defeating the plain language of the Act, this holding confounds the longstanding Supreme Court teaching that exemptions to the antitrust laws are to be construed narrowly. *See Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 126 (1982); *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 231 (1979).

By subsuming the categorical exclusion of five specific exceptions in the test for reasonableness, the Third Circuit created a split with the Fifth Circuit, which had previously affirmed the separate application of both tests in their proper order. *See Rogers v. Columbia/HCA*, 971 F. Supp. 229, 234 (W.D.La. 1997) (determining act was a professional review action not fitting any exceptions set out in § 11151(9)(A)-(E) before proceeding to second test of § 11112(a)), *aff'd*, 140 F.3d 1038 (5th Cir. 1998) (mem). As such, the holding is appropriate for certiorari under Supreme Court Rule 10(a).

C. The Evisceration Of The Exceptions From HCQIA Immunity Conflicts With The Policies Underlying HCQIA And The Antitrust Laws.

In the 1970s and early 1980s, following the Supreme Court's decision in *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975), antitrust law began to be applied actively in the health care field and in the professions. The litigation that followed challenged longstanding practices and premises in the professions and in the health field. The courts and antitrust enforcement agencies regularly confronted claims that restraints were justified because the competition engendered by otherwise professionally-proscribed market conduct would be harmful to patients or consumers – in

effect, that competition itself was unreasonable. Such restraints were often directed at advertising and solicitation activities; discounting; physicians practicing or cooperating with non-physician health care providers who compete with some physicians, such as nurse midwives, podiatrists, or chiropractors; affiliating with health maintenance organizations ("HMOs") or prepaid group health plans; and engaging in the salaried "corporate" practice of medicine. Numerous antitrust cases successfully challenged many of these restraints.[12] As the Supreme Court reemphasized in *National Society of Professional Engineers v. United States*, 435 U.S. 679, 695 (1978), an attempt to justify a restraint under the rule of reason "on the basis of the potential threat that competition poses to the public safety and the ethics of its profession is nothing less than a frontal assault on the basic policy of the Sherman Act."

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[12] *FTC v. Ind. Fed'n of Dentists*, 476 U.S. 447, 463-64 (1986) (rejecting claim that "an unrestrained market in which consumers are given access to the information they believe to be relevant to their choices will lead them to make unwise and even dangerous choices"); *Am. Med. Ass'n v. FTC*, 94 F.T.C. 701, 1037-39 (1979) (striking association's ethics code-based restrictions on advertising, corporate practice of medicine, and affiliation with prepaid group health plans), *aff'd as modified*, 638 F.2d 443 (2d Cir. 1980), *aff'd per curiam by an equally divided Court*, 455 U.S. 676 (1982); *In re Mem'l Med. Ctr.*, 110 F.T.C. 541, 546-47 (1988) (consent order prohibiting medical center staff from denying or restricting hospital privileges to nurse midwives without basis); *Wilk v. Am. Med. Ass'n*, 719 F.2d 207, 211, 222-29 (7th Cir. 1983) (reversing jury verdict where jury instructions suggested that defendants' boycott of chiropractors was lawful if boycotting doctors sincerely believed chiropractics to be "dangerous quackery"); *In re State Volunteer Mut. Ins. Co.*, 102 F.T.C. 1232, 1236-37 (1983) (consent order prohibiting insurance company from applying different underwriting criteria to physicians affiliated with nurse midwives).

At the same time, physicians began using the antitrust laws to challenge individual peer review actions to which they objected, even where the action was based solely on their competence or professional conduct, unrelated to their pricing practices or other competitive activities. These cases generally failed – but not without exception. *See, e.g.*, *Patrick v. Burget*, 486 U.S. 94, 105 & n.8 (1988).[13] Congress, therefore, sought to provide qualified immunity to traditional peer review actions directed at a physician's competence or professional conduct, while being careful to exclude from immunity actions that suppress competitive activity by physicians, regardless of the belief of those imposing the discipline that the disciplinary action would further patient welfare and the quality of care provided.

HCQIA reflects careful line-drawing by Congress. Congress sought, on the one hand, to protect *bona fide* peer review focused on the competence or professional conduct of physicians. On the other hand, Congress recognized that restraints on certain types of physician activity were not appropriate for immunity. Among these activities were professional association memberships; fees; advertising and competitive acts intended to solicit or retain business; participation in HMOs or other health plans; and association with non-physician health care practitioners. Congress declined to extend immunity to restraints imposed to prevent a harm emanating from acts of competition themselves. Congress's approach tracks basic principles of antitrust law.

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[13] Bernard D. Reams, Health Care Quality Improvement Act of 1986: A Legislative History of Publ. L. No. 99-660 [hereinafter "HCQIA Hearings"], 101-02 (1990) (testimony of Arthur N. Lerner) (noting reaction to successful cases).

As a result, a "professional review action" can qualify for antitrust damages immunity if it meets specified standards, including fair process and a reasonable belief that the action furthers quality health care. But irrespective of the hospital's belief to the contrary, if the action is based primarily on the enumerated types of competitive acts by physicians, no immunity is provided. Disciplinary actions based on such conduct are fully subject to the antitrust laws. The plaintiff still may not win a suit -- after all, actions not immune under HCQIA are not presumed to violate the antitrust laws. *See* HCQIA Hearings, *supra* note 13, at 6393 ("failure to meet the standards of [the Act] creates no presumption with respect to the liability or lack of liability of a health care entity"). Many hospital peer review decisions, even though not exempt, have no harmful impact on competition or may actually foster it. Rather, where there is no immunity, plaintiffs merely get their day in court.

In holding that these categorical exceptions were subsumed by a reasonableness test focused on furtherance of quality health care, the Third Circuit undermined Congress's approach. Under that court's analysis, a hospital and its medical staff would be immune from antitrust damages for revoking the hospital privileges of a doctor who, for example, discounts his or her fees, joins an HMO, advertises, or collaborates with a nurse midwife, if the hospital reasonably believed that its actions furthered quality health care. This must be wrong. It was not Congress's intent to immunize a hospital that enforced a price-fixing or boycott scheme through peer review if it proffers a reasonable argument that it seeks to further quality health care.

Similarly, the Third Circuit's approach would extend antitrust damages immunity to hospitals that excluded physicians who advertised or otherwise communicated the relative cost, convenience or service advantages of ASC

services to prospective patients, so long as the reasonableness standards were met. Such a result could be devastating for non-hospital affiliated ASCs across the country, since doctors would have to, in effect, re-litigate in each instance whether the competition they sought to foster, and the hospital to restrain, would further quality health care or not. Such restraints do not qualify as professional review actions in the first place, and should enjoy no immunity.

The specific activity by Dr. Gordon that was the primary basis for the Hospital's disciplinary action is a fact issue, and whether that activity fits within any of the enumerated exceptions to the definition of "professional review action" is similarly a fact issue. Those issues are not properly resolved, however, by inquiries into whether the Hospital believed it was furthering quality health care and into the reasonableness of such a belief.

D. Legislative History Supports Application Of The Antitrust Exceptions From HCQIA Immunity.

The legislative history of the Act is compiled in HCQIA Hearings, *supra* note 13. The House's Committee Report on HCQIA confirms that "[t]o qualify for the [immunity] protection, the professional review action must meet the standards specified in section 102(a) [§ 11112(a)] and must be an action as defined in section 301(9) [§ 11151(9)]." *Id.* at 6391 (emphasis added). Other sections of the history concur that the immunity sections of Section 11112(a) were not meant to subsume the exceptions to professional review actions defined in Section 11151(9).[14] The Third Circuit's holding is to the contrary.

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[14] *See, e.g.*, HCQIA Hearings, *supra* note 13, at 47-49 (statement of Henry A. Waxman, Chairman, House Subcommittee on

(continued....)

II. This Court Should Consider Whether A Restraint Imposed On A Potential Or Incipient Competitor Can Be Horizontal In Nature Even If The Competitor Has Not Yet Commenced Operations.

The Third Circuit held that the restrictive "Conditions of Reappointment" that Dr. Gordon entered into with the Hospital on November 14, 1996 in order to be reinstated did not unlawfully restrain trade under the rule of reason. The court applied a "full" rather than a "quick look" rule of reason analysis, categorizing the relationship between Dr. Gordon and the Hospital as a "vertical" relationship between a single hospital and a single physician. In support, the court relied on a conclusion that "Gordon and the Hospital were not competitors in the relevant market in November 199[6][15] when he agreed to the Conditions. His competition in the facility services market did not commence until MCCSC opened more than one year later [in 1998]." App. at 41. In essence, the court found that to the extent proper analysis of an allegedly anticompetitive restraint depends on the existence of a relationship of competition between two

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(continued) . . .

Health and Environment) ("as *redrafted*, our bill applies *only* to professional review actions based on the competence or conduct of an *individual* physician. We completely *exclude* from the protections of the bill, any disciplinary action based on a doctor's membership or lack of membership in a medical society . . ."); *id.*, at 103, (statement of Arthur N. Lerner) (noting that the exclusions prevent application of immunity); *see also id.*, at 6404 (quoted *supra* at n.10, noting that antitrust exceptions were inserted due to concern for abuse for economic and related reasons).

[15] We note from Dr. Gordon's petition for certiorari that the Third Circuit's opinion makes a typographical error in listing the date of Dr. Gordon's agreement as November 1995 rather than 1996. *See* Pet. for Cert. at 24 n.2.

parties, no competitive relationship will be found when the new entrant has yet to open for business. The court erred and the implications of this error are grave. The court's error is starkly inconsistent with this Court's precedents, with decisions of other circuits, and with accepted antitrust analysis, importantly undermining a significant aspect of antitrust analysis in this field.

Antitrust law recognizes the centrality of new entry and incipient competition to the vitality of the marketplace; this Court's precedents apply the antitrust laws to protect such competition. In *United States v. El Paso Natural Gas Co.*, 376 U.S. 651, 662 (1964), the Court ordered El Paso Natural Gas to divest Pacific Northwest, which it had acquired. The Court found that the acquisition lessened competition even though Pacific Northwest had not yet sold any natural gas in competition with El Paso in the California relevant market. Pacific Northwest had been on the verge of doing so, and had entered into negotiations and a tentative agreement for a supply contract with a prospective customer. *Id.*, at 660-61. In *United States v. Marine Bancorporation*, 418 U.S. 602, 623-25 & n.24 (1974), the Court discussed the El Paso ruling, and, notably, described El Paso as an "actual competition rather than a potential competition case."[16]

In Sherman Act Section 1 cases, courts often apply strict scrutiny to restraints directed at the actions of firms in

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[16] See also *In re Brunswick Corp.*, 94 F.T.C. 11 (F.T.C. 1979) (Pitofsky, C.), *aff'd on other grounds sub nom*, *Yamaha Motor Co. v. FTC*, 657 F.2d 971, 980-81 (8th Cir. 1981), *cert. denied*, 456 U.S. 915 (1982). The FTC had determined that Brunswick's venture with Yamaha unlawfully lessened "actual competition" in the United States outboard motor market, even though Yamaha had made no sales into the country. The Eighth Circuit held that the joint venture unlawfully lessened "actual potential competition."

potential competition, recognizing that such restraints can be horizontal in character, even though actual competition, in the sense of commercial business operations in the same relevant market, has not yet occurred. For example, in *Palmer v. BRG*, 498 U.S. 46 (1990) (per curiam), defendants argued that vertical analysis was appropriate because they were only potential and not current competitors, and because the challenged dealings between them were vertical. The Eleventh Circuit agreed, but this Court reversed, finding the challenged covenant to be "illegal on its face." *Id.*, at 50.[17] *See also United States v. Reicher*, 983 F.2d 168, 170 (10th Cir. 1992) (applying horizontal *per se* standard although one of the two competitors did not have the capacity to perform the contract); *United States v. MMR Corp.*, 907 F.2d 489, 498 (5th Cir. 1990) (affirming decision that company lacking capacity to enter the market was a competitor, because it "was a competitive threat"); *Engine Specialties, Inc. v. Bombardier Ltd.*, 605 F.2d 1, 11 (1st Cir. 1979) (holding that a contract not to compete between a manufacturer and potentially competing distributor was *per se* illegal).

The Third Circuit's notion that two facilities are not competitors for purposes of antitrust analysis until the second facility opens its doors is peculiar and contrary to past decisions and common sense. The antitrust laws must protect doctors desiring to affiliate with ASCs against a dominant hospital's anticompetitive acts as soon, for example, as the physician's definite steps toward opening or providing services through an ASC makes him or her a potential or incipient competitor. As the Court explained in

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[17] *See also Palmer v. BRG*, 874 F.2d 1417, 1432-33 (11th Cir. 1989) (Clark J., dissenting) ("It is firmly established that entities in a seemingly vertical relationship may be capable of horizontal restraints if they are actual or potential competitors.").

El Paso, a firm's competitive significance in a market "is determined by the nature or extent of that market and by the nearness of the absorbed company to it, that company's eagerness to enter that market, its resourcefulness, and so on." 376 U.S. at 660. Under this analysis, "Pacific Northwest's position as a competitive factor in California was not disproved by the fact that it had never sold gas there." *Id.* By any measure, Dr. Gordon was a competitor of the Hospital when the challenged restraints occurred.

Opening an ASC can be an arduous process. The CON procedure in some states, such as Pennsylvania's during the time in question, was highly regulated, costly, and time-consuming. Hospitals often hold the key for ASC entry, as the federal government and many state regulatory agencies require physicians who seek to open or work at an ASC to have privileges at a hospital. In this way, ASCs are particularly vulnerable when they are still nascent, and the doctors who support them are then most in need of antitrust protection. A finding that antitrust protections for ASCs and doctors who work with them do not fully ripen until their doors are actually open for business poses severe risks for ASCs, for competition, and for consumers.

Appropriate antitrust analysis of hospital-physician interactions can be complicated. Questions regarding applicability of the *per se* rule and of "quick look," "sliding scale" or full-blown rule of reason standards can arise. The answer to these questions may depend on a variety of factors, and the mere fact that parties are in some regards competitors does not condemn any and all agreements between them necessarily to *per se* or "quick look" treatment. It is equally evident, though, that to the extent an agreement's horizontal character makes a difference in antitrust analysis, it is wholly unsound to decide that question by application of an all-or-none "are they

competitors" test that turns on whether the target of the restraint has yet opened his or her doors.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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March 13, 2006