

**ANTITRUST DEVELOPMENTS IN HEALTH CARE:
2002**

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I. INTRODUCTION

In the 1990s, many of the most significant developments in antitrust health care emanated from the federal government. During those years, the Antitrust Division of the Department of Justice and the Federal Trade Commission developed and refined their statements of enforcement policy in health care.¹ The two agencies provided additional significant guidance through business review letters and staff advisory opinions issued in response to requests for advice from the health care community.² The agencies also pursued a vigorous enforcement agenda – they challenged numerous hospital mergers and filed various other enforcement actions, many of which resulted in consent decrees.³

In the late 1990s, and into the early Bush administration, however, the pace at the federal agencies appeared to slow. Neither agency challenged a hospital merger after the Federal Trade Commission's failed effort in Poplar Bluff, Missouri, in 1997.⁴ The health care enforcement statements, modified three times between 1993 and 1996, were not changed again. Very few advisory letters were issued by the federal antitrust enforcement agencies. While each agency continued to pursue enforcement actions in health care, it began to appear as though important future developments in health care antitrust were more likely to be generated through private litigation than through public enforcement.

In 2002, however, the pendulum began to swing decisively back to increased involvement by the federal agencies in antitrust enforcement in health care. The Federal Trade Commission, in particular, was active and identified health care as an area of primary importance for its antitrust enforcement efforts. The Department of Justice, while signaling a retreat from antitrust enforcement in health care early in the year, also may be re-entering the stage.

Reflecting these developments, the largest part of the following review of antitrust developments in health care consists of a discussion of the activities of the government enforcement agencies. The review focuses on developments that occurred in 2002, but where it is important to reach

¹ The Federal Trade Commission and the Antitrust Division first issued joint statements detailing their antitrust enforcement policies in health care in 1993. *Statements of Antitrust Enforcement Policy in the Health Care Area (1993)*, reprinted in 4 Trade Reg. Rep. (CCH) ¶13,151. These were modified in 1994, *Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust (1994)*, reprinted in 4 Trade Reg. Rep. (CCH) ¶13,152, and again in 1996. *Statements of Antitrust Enforcement Policy in Health Care (1996)*, reprinted in 4 Trade Reg. Rep. (CCH) ¶13,153.

² These are collected at the agencies' websites. See <http://www.ftc.gov/bc/advisory.htm> (for the FTC's staff advisory opinions in health care since 1993) and <http://www.usdoj.gov/atr/public/busreview/letters.htm> (for all of the Department of Justice's business review letters since 1993).

³ Actions taken by the FTC since 1996 are collected at the agency's website at <http://www.ftc.gov/bc/CommissionActions/index.htm>; actions taken by the Department of Justice are summarized at http://www.usdoj.gov/atr/public/health_care/0000.htm.

⁴ *Federal Trade Commission v. Tenet Healthcare Corporation and Poplar Bluff Physicians Group*, 17 F. Supp. 2d 937 (E.D. Mo. 1998), rev'd, *FTC v. Tenet Health Care*, 1999 WL 512108 (8th Cir. 1999).

back to decisions or actions taken in 2001 in order to understand the context of the more recent developments, these earlier matters are reviewed briefly as well.

II. DISCUSSION

A. Government Enforcement.

1. Changes at the Agencies.

2002 saw significant changes at the two federal agencies that enforce the antitrust laws in health care. At the beginning of the year, the Department of Justice announced the abolition of the Antitrust Division's Health Care Task Force.⁵ Then, in early March, the Federal Trade Commission and the Department entered into a memorandum of agreement allocating to the FTC primary responsibility for enforcing the antitrust laws in health care. Primary responsibility for enforcing the antitrust laws in health insurance was given to the Department.⁶

Two months later the agencies scuttled their agreement in the face of opposition from Sen. Hollings, chairman of the appropriations subcommittee.⁷ Since then, the Department has taken various actions in health care and has indicated it has additional matters under review.⁸ The Health Care Task Force has not been re-constituted, however. The question of how active the Department will be in health care the future is still an open one, and grew more difficult to answer in October, when Charles James, the Assistant Attorney General in charge of the Division, announced his resignation after only a little over a year on the job.⁹

Lest anyone grow complacent that antitrust enforcement in health care might slacken as a result of the uncertainty at the Department, the FTC has made clear its interest in vigorous enforcement of the antitrust laws in health care. In August the FTC announced formation of a new Merger Litigation Task Force, to be headed by Michael Cowie, which "will be responsible for reinvigorating the Commission's hospital merger program, which includes a review of, and potential challenge to, consummated transactions that may have resulted in anticompetitive price increases."¹⁰ While the woeful track record compiled by the agencies in hospital mergers is well

⁵ Press release issued January 4, 2002, available at www.usdoj.gov/atr/public/press_releases/2002/9773.htm

⁶ Press release issued March 5, 2002, available at www.usdoj.gov/atr/public/press_releases/2002/10171.htm

⁷ Press release issued May 20, 2002, available at www.usdoj.gov/atr/public/press_releases/2002/11178.htm

⁸ See Remarks of Deborah Platt Majoras, Deputy Assistant Attorney General, before the FTC Health Care Competition Law and Policy Workshop (September 9, 2002), available at <http://www.usdoj.gov/atr/public/speeches/200195.htm>. Ms. Majoras stated that DOJ "is pursuing a number of health care matters focused on provider conduct, including a number that we have opened in recent months."

⁹ Press release issued October 3, 2002, available at www.usdoj.gov/atr/public/press_releases/2002/200287.htm

¹⁰ Press release issued August 28, 2002, available at www.ftc.gov/opa/2002/08/mergerlitigation.htm

known,¹¹ the announcement that the agency was investigating completed hospital mergers – and might mount a challenge to such mergers – came as a surprise, and as a signal of the FTC’s continuing interest in the area.

Soon after, Timothy Muris, Chairman of the FTC, made it known that the agency is spending more on health care antitrust enforcement than in the past and plans to step up its focus, not just on hospital mergers, but on medical groups as well.¹² Finally, in September 2002, the FTC held a two-day workshop with an ambitious agenda that covered subjects ranging from provider integration to health insurance to quality issues and their relation to competition policy.¹³

2. Enforcement Actions.

a. Background: The 1996 Statements of Antitrust Enforcement Policy in Health Care.

The Federal Trade Commission and the Antitrust Division of the Department of Justice first issued statements of their antitrust enforcement policies in health care in 1993; Revised and expanded statements were issued in 1994 and 1996.¹⁴ These guidelines, and in particular Statements 8 and 9 of the 1996 Statements, describe in detail the federal antitrust enforcement agencies’ analytical approach when confronted with a network of otherwise independent health care providers who seek to contract to provide their services to a health care plan.

The 1996 Statements, in addressing physician joint ventures, make a critical distinction between networks that are not integrated and those where “the physicians’ integration through the network is likely to produce significant efficiencies that benefit consumers.”¹⁵ Members of networks that have not integrated in any fashion cannot price jointly without violating the *per se* rule against price fixing. Such networks are relegated to using the so-called “messenger” model if they wish to deal with a health plan on prices. The goal of the messenger model is to ensure that each provider in the network makes independent, non-collusive decisions on prices and other competitive terms. Providers who are sufficiently integrated, on the other hand, may jointly set price without running afoul of the *per se* rule; agreements on price and other terms of competition among providers in an integrated network are subject to the rule of reason.

¹¹ Between them, the FTC and DOJ lost five litigated hospital merger cases in the last half of the 1990s, without a countervailing success. The FTC lost in *FTC v. Tenet Healthcare Corp.*, 186 F.3d 1045 (8th Cir. 1999), *FTC v. Butterworth Health Corp.*, 946 F. Supp. 1285 (W.D. Mich. 1996), *aff’d mem.*, 121 F.3d 708 (6th Cir. 1997) and *FTC v. Freeman Hospital*, 69 F.3d 260 (8th Cir. 1995), while DOJ accumulated losses in *United States v. Long Island Jewish Medical Center*, 983 F. Supp. 121 (E.D.N.Y. 1997) and *United States v. Mercy Health Servs.*, 902 F. Supp. 968 (N.D. Iowa 1995), *vacated as moot*, 107 F.3d 632 (8th Cir. 1997). In early 2000, the State of California lost its own challenge to a hospital merger. *State of California v. Sutter Health System*, ___ F. Supp. 2d ___, 2000 WL 194832 (N.D. Cal. February 17, 2000).

¹² “U.S. to Step Up Antitrust Effort on Health Care,” (August 9, 2002) available at www.nytimes.com/2002/08/09/business/09HOSP.html

¹³ Related documents available at www.ftc.gov/ogc/healthcare/index.htm

¹⁴ See n. 1, *infra*.

¹⁵ 1996 Statements, Statement 8.B. 1.

Accordingly, unless the formation and operation of such a network may have a substantial anticompetitive effect that is not outweighed by any procompetitive efficiencies, such a venture is lawful under the antitrust laws.

The 1996 Statements provide that the clearest way for a physician network to integrate economically is for the physician members to “share substantial financial risk in providing all the services that are jointly priced through the network.”¹⁶ The agencies provide five examples of what constitutes sharing of substantial financial risk.¹⁷ These are:

- **Capitation.** The agreement to provide defined health care services to an enrollee in return for a fixed, predetermined, regardless of the level of services actually required, shifts the financial risk of paying for those services from the enrollee to the provider.
- **Provision of Services on a Percentage of Premium Basis.** A network that provides services of its participating physicians to a health plan on a percentage of premium basis also is assuming the financial risk of providing these services. As with capitation, providers are paid a fixed amount per patient to provide designated health services.
- **Fee-for-Service With a Risk Withhold.** A network assumes risk if it contracts on a fee-for-service basis but withholds a “substantial amount” from distribution to physician members based on group performance in meeting the cost containment goals of the network as a whole.
- **Establishment of Targets and Financial Penalties.** Some networks establish overall cost or utilization targets for the network as a whole. Participants are rewarded or penalized depending on group performance in meeting the targets. The agencies recognize that such a structure can constitute assumption of risk.
- **Global Rates.** Global rates, or “all-inclusive case rates,” may involve substantial risk sharing if they cover “a complex or extended course of treatment that requires the substantial coordination of care by physicians in different specialties offering a complementary mix of services, for a fixed, predetermined payment, where the costs of that course of treatment for any individual patient can vary greatly due to the individual patient’s condition, the choice, complexity, or length of treatment, or other factors.” Statement 8.A.4.

Capitation and fee-for-service with a risk withhold were included in the 1993 Statements as examples of substantial risk sharing; the other examples made their first appearance in the 1996 Statements. Significantly, the 1996 Statements also recognize that substantial risk sharing is not the only way in which network providers can integrate. According to the agencies, networks “that do not involve the sharing of substantial financial risk” nonetheless lawfully may set prices at which they sell their services if they “involve sufficient integration to demonstrate that the venture is likely to produce significant efficiencies.”¹⁸ Such integration can be evidenced by the

¹⁶ Statement 8.B.2.

¹⁷ Statement 8.A.4.

¹⁸ Statement 8.B.

network implementing an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality. Such a program could include utilization review, evaluation of individual and aggregate performance, efforts to modify behavior where necessary, case management, review of hospital stays, and development of practice standards and protocols.¹⁹

The statements also comment favorably on selective recruitment of efficient providers and significant investment of capital, "both monetary and human," in the venture. This integration without sharing substantial financial risk is frequently referred to as "clinical integration."

Finally, the Statements describe the same two "safety zones" for joint pricing of services by physician networks that were contained in the 1994 Statements.²⁰ These apply to provider networks that "share substantial financial risk." The agencies will not challenge non-exclusive physician networks that account for no more than 30% of the physicians with hospital staff privileges in a geographic market. (Each specialty is considered separately.) A non-exclusive network is one that permits a provider to contract directly with other health plans and to participate in other networks. If a network is "exclusive," that is it does not allow physicians to contract with health plans except through the network, the safety zone is 20%.

b. Developments.

(1) *In re Obstetrics and Gynecology Medical Corporation of Napa Valley, et al.*²¹

The FTC entered a consent order in May 2002 requiring an independent practice association (IPA) composed of OB/GYNs to disband, following charges that the group restrained competition among OB/GYNs in Napa Valley by facilitating collective bargaining and boycotts.

The IPA was formed as a single-specialty IPA after its members became dissatisfied with a local multi-specialty IPA. The members of the new IPA included most of the OB/GYNs in the county. The FTC asserted that these physicians refused to contract individually with the multi-specialty IPA or health plans, and that they agreed on a price schedule and boycotted the multi-specialty IPA in an effort to persuade it meet their fee demands. As a result, the multi-specialty IPA did not have sufficient OB/GYNs to meet its obligations to HMOs, and the multi-specialty group was forced to close. This, in turn, led to the withdrawal of some HMOs from the county.

The consent order entered by the FTC forces the dissolution of the OB/GYN IPA and prevents its members from entering into agreements with other physicians to negotiate or refuse to deal with payers or providers. Physicians are permitted to form a "qualified risk-sharing joint arrangement" or "qualified clinically integrated joint arrangement," however.

A "qualified risk-sharing joint arrangement" must satisfy two conditions. First, all physician participants must share substantial financial risk, thereby creating incentives for the group as a whole to control costs and improve quality. Second, any agreement on fees or other conditions

¹⁹ Statement 8.B.1.

²⁰ Statement 8.A.

²¹ FTC File No. 011-0153 (May 17, 2002) available at www.ftc.gov/os/caselist/0110153.htm

of dealing must be reasonably necessary to obtain significant efficiencies through the joint arrangement.

A “qualified clinically-integrated joint arrangement” also must satisfy two conditions. First, all physicians must participate in active and ongoing programs to evaluate and modify their clinical practice patterns so as to create a high degree of interdependence and cooperation among them to control costs and ensure quality services are provided. Second, as with a “qualified risk-sharing joint arrangement,” any agreement on fees or other conditions of dealing must be reasonably necessary to obtain significant efficiencies through the joint arrangement.

(2) *In re Physician Integrated Services of Denver, Inc.*,²² and *In re Aurora Associated Primary Care Physicians, L.L.C.*²³

Two groups of primary care physicians in Colorado, their physician leadership, and an agent agreed to the entry of consent orders with the FTC. The groups were Physician Integrated Services of Denver, Inc. (“PISD”) and Aurora Associated Primary Care Physicians, L.L.C. (“AAPCP”).

PISD had over 40 members (including internists, pediatricians, family physicians, and general practitioners) located in south Denver, while AAPCP had approximately 45 members in the same specialties in Aurora, Colorado. According to the FTC, the groups jointly negotiated contracts with payers that paid more than individual physicians could have obtained on their own. The two groups used the same non-physician consultant to assist the physician leadership of each group in negotiating contracts with payers. One of the groups retained the consultant “after she had made a board presentation showing how AAPCP could collect fee information from members and use that information to reach a consensus on an initial fee level to demand from payors.”²⁴

The complaints against the two groups provide a laundry list of how not to design a proper messenger model arrangement. The FTC charged:

- The agents negotiated fees and other competitively significant terms on behalf of group members.
- The agents refused to convey contract offers to members that contained price and other terms the negotiators deemed deficient. Instead they “demanded and received contract terms that were more economically advantageous, from the members’ perspective, than the members themselves could have obtained by negotiating individually.”

²² FTC No. 011-0173 (May 13, 2002) available at <http://www.ftc.gov/os/caselist/0110173.htm>

²³ FTC No. 011-0174 (May 13, 2002) available at www.ftc.gov/os/caselist/0110174.htm

²⁴ *Analysis of Agreement Containing Consent Order to Aid Public Comment*, available at <http://www.ftc.gov/os/2002/05/auroraanalysis.pdf>

- The groups “functioned as their members’ *de facto* exclusive contracting representatives with payors.” Each group, through its agents, told payers that it had the authority to negotiate and sign contracts on behalf of its members.
- Physician members sent letters to payers asserting that they would deal with payers only through their groups and their appointed agents.
- The groups advised their members to terminate, or threaten to terminate, their individual contracts so as to coerce payers to deal with the groups. Many physicians followed up by terminating their contracts. This left payers the choice either of either paying more or losing these physicians.

The consent order prohibits such practices in the future, though it allows participation in a “qualified risk-sharing joint arrangement” or a “qualified clinically integrated joint arrangement.”

(3) *Professionals in Women’s Care.*²⁵

Eight OB/GYN practice groups in Denver and their non-physician agent entered into a consent order after they were charged by the FTC with price fixing and refusing to deal with payers except on collectively determined terms. The FTC alleged that the agent organized more than 80 physicians in the eight Denver-area OB/GYN groups so as to facilitate collective negotiations with payers.

The agent and the eight groups named themselves “Professionals in Women’s Care” (“PIWC”) but formed no organization and had no officers or other indicia of a formal entity. The FTC asserted that the agent and the eight groups claimed they were implementing a proper “messenger model” but failed to do so. Instead, the physicians and their agent collectively negotiated fees and “other competitively significant terms.” When the agent and the practice groups considered the terms of a particular offer deficient they did not convey it to PIWC physicians. Moreover, in order to obtain bargaining clout, PIWC physicians terminated their relationships with other IPAs and practice management groups. PIWC physicians then demanded, and obtained, higher fees and more favorable terms from payers. The agent also advised PIWC physicians to terminate, or threaten to terminate, their individual contracts with payers. Many physicians complied. Because access to PIWC physicians was essential to health plans who wanted to have marketable networks, these threats to terminate contracts were successful in raising fees paid to the PWIC physicians above the fees paid to other OB/GYNs in the area.

Under the terms of the consent order entered by the FTC, the groups and their agent are prohibited from negotiating on behalf of physicians with any payer or health care provider and from refusing to deal with any payer or health care provider. The order does not prohibit the respondents from facilitating agreements between physicians, if the physicians are part of the same medical group practice. In addition, the respondents are permitted to participate in a “qualified risk-sharing joint arrangement” or “qualified clinically-integrated joint arrangement.”

²⁵ FTC File No. 011 0175 (October 11, 2002) available at www.ftc.gov/os/caselist/c4063.htm

The order prohibits the agent, for three years, from negotiating with any payer on behalf of any current or past physician in PIWC, and from advising any current or past PIWC physician to accept or reject any term, condition, or requirement of dealing with any payer. The order also requires the eight practice groups to terminate contracts negotiated by the agent if so requested by any payer.

(4) *In the Matter of System Health Providers.*²⁶

Genesis Physicians Group was a multi-specialty association of physicians in the eastern part of the Dallas-Fort Worth area with over 1,250 physician members. According to the FTC, it was not an integrated group of physicians, but included many providers who otherwise competed with each other. System Health Providers (SPS) was a management service organization subsidiary of Genesis. Both organizations entered into a consent order with the FTC after the Commission charged that they unreasonably restrained price and other forms of competition among Genesis's members.

The gravamen of the FTC's complaint was the assertion that SPS acted improperly as the messenger for physicians in Genesis. Rather than acting as a messenger, SHP negotiated with payers on behalf of Genesis physicians, even proposing and counter-proposing fee schedules. SHP also discouraged Genesis physicians from entering into separate agreements with payers and advised physicians that they could increase their bargaining power if they negotiated collectively through SHP. The FTC alleged that many Genesis physicians were unwilling to negotiate on their own, and let payers know this. As a result, according to the FTC, payers who desired access to this large group of physicians were forced to deal with Genesis physicians as a group and this, in turn, caused fees to be higher than they otherwise would have been,

A particular assertion made by the FTC deserves special mention. The Commission charged that SHP did not relay payer offers to members when SHP deemed these deficient. Instead SHP demanded – and often received – more favorable fees and other contract terms as the price of transmitting the offer to its physicians.

As with the consent order entered in the FTC cases discussed above, the order proposed here would prohibit Genesis and SPC from negotiating on behalf of physicians with any payer or health care provider and from refusing to deal with any payer or health care provider. The order also would permit respondents to facilitate agreements among physicians so long as the physicians are part of the same medical group practice and would permit them to facilitate creation of “qualified risk-sharing joint arrangements” and “qualified clinically-integrated joint arrangements.” Payers also would be permitted to terminate without penalty any agreements negotiated with SHP if they so desired.

²⁶ FTC File No. 011 0196 (August 20, 2002) available at www.ftc.gov/os/caselist/0110196.htm

3. FTC Staff Advice.

a. FTC Staff Advisory Opinion on Clinical Integration.²⁷

The FTC staff issued one of the most important staff advisory opinions in many years in February 2002 when – for the first time – the staff reviewed and commented extensively on the competitive consequences of a group of competing physicians who proposed to integrate clinically, but not economically.

In 1996, the FTC and Department of Justice jointly issued their *Statements of Antitrust Enforcement Policy in Health Care*.²⁸ In Statement 8 the agencies set forth how a group of otherwise competing physicians could negotiate collectively with payers by sharing financial risk. The agencies acknowledged that it would be possible to “clinically” integrate to achieve the same end without economically integrating. The Statements provide an example of how such clinical integration might work, but until the advisory opinion discussed here, had never expanded in a meaningful fashion on this hypothetical situation.

MedSouth is a Denver IPA with over 400 competing primary care and specialist physician members. These physicians constitute over half of the physicians on staff at three hospitals in south Denver. MedSouth sought to jointly negotiate contracts on behalf of its members even though it was not economically integrated and did not propose to share risk among the physicians.

MedSouth proposed to coordinate and integrate primary and specialty care through a clinical resource management program in which all physicians would be required to participate. The program would permit sharing of patient information on a web-based clinical data record system. Moreover, MedSouth stated it will develop and implement clinical protocols, and will provide for oversight of physicians and reporting of their performance in relation to protocols and goals. Physicians whose performance is deemed deficient must implement a plan of correction and are subject to expulsion for non-compliance.

The FTC stated that the arrangement is subject to the rule of reason, and not analysis under the *per se* rule, because the clinical integration proposed by MedSouth has the potential to increase quality and reduce the cost of care beyond the level that individual physicians, acting independently, would be likely to achieve. The FTC staff observed, however, that the “crucial question” was the “extent to which collective negotiation of prices is ancillary to this integration.”

Generally speaking, an agreement is ancillary to a competitor collaboration to the extent that it is subordinate to and reasonably necessary to accomplish the goals of the integration, unless the

²⁷ Letter from Jeffrey W. Brennan to John J. Miles on behalf of MedSouth (February 19, 2002), available at www.ftc.gov/bc/adops/medsouth.htm

²⁸ Reprinted in 4 Trade Reg. Rep. (CCH) ¶13,153 (and available at <http://www.ftc.gov/reports/hlth3s.htm>)

parties could have achieved similar efficiencies by practical, significantly less restrictive means.

The FTC concluded that joint negotiation of price was “reasonably necessary for MedSouth to achieve the procompetitive benefits it seeks” because,

In order to establish and maintain the on-going collaboration and interdependence among physicians from which the projected efficiencies flow, the doctors need to be able to rely on the participation of other members of the group in the network and its activities on a continuing basis. This does not appear to be possible if contracting for the sale of services is done individually. The price for professional services rendered under health plan contracts needs to be established, and if it is done through individual negotiation and contracting, then no one can count on the full participation of the group’s members. Whatever value the program has for consumers, beyond what would result from individual doctors computerizing their records and determining to follow particular guidelines, is significantly dependent on the doctors being able to function as a group within which patients are commonly referred.

(Emphasis added; footnotes omitted.) The FTC staff also observed that joint contracting also “may permit the network to allocate the returns among members of the network in a way that creates incentives for the physicians to make appropriate investments of time and effort in setting up and implementing the proposed program.”

The FTC letter is replete with cautions and conditions. The FTC warned that adoption of a patient information system without the clinical protocols and performance standards would be insufficient to establish clinical integration. The FTC also noted that some physicians who do not receive significant referrals from MedSouth members may not conform their practice patterns to the protocols and guidelines and, therefore, may not be considered clinically integrated with the remaining members. The letter also conditioned the advice given on the understanding that the IPA would operate non-exclusively – *i.e.*, that its members could and would contract separately with payers that did not contract with MedSouth. Finally, the FTC observed that MedSouth had represented that its final membership probably would be smaller than the 400 physicians in the organization at the time the request for advice was made.

b. FTC Staff Advisory Opinions on the Application of the Non-Profit Institutions Act to Pharmaceutical Purchases.

The Nonprofit Institutions Act (“NPIA”) provides that the prohibitions on price discrimination found in the Robinson-Patman Act do not apply “to purchases of their supplies for their own use by schools, colleges, universities, public libraries, churches, hospitals, and charitable institutions not operated for profit.”²⁹ In *Abbott Laboratories v. Portland Retail Druggists Association*,³⁰ the

²⁹ 15 U.S.C. § 13c.

Supreme Court held that purchases of drugs by hospitals for dispensing through their pharmacies qualified as purchases for the hospitals' "own use" if they were part of, and promoted, the hospital's intended institutional operation in the care of its patients.³¹ The Court concluded that drugs purchased and dispensed to inpatients, emergency room patients, and outpatients were purchased for the hospital's "own use." The Court held that the renewal of prescriptions (whether for inpatients, former emergency patients, or outpatients) did not qualify as for the hospital's "own use." Similarly, purchases by walk-in patients were not made for the hospital's "own use."

In December 2001, FTC staff issued two advisory opinions that clarify the scope of the "own use" exception. In the most significant of the letters, the staff found that the NPIA applied to protect purchases of drugs by a multi-specialty medical clinic which dispensed those drugs to its patients through pharmacies situated at different clinic locations.³² The clinic, Harvard Vanguard, was a nonprofit, tax exempt clinic composed of practitioners who provided services at 14 clinic locations. While most of the patients seen by the Vanguard practitioners were members of Harvard Pilgrim, a nonprofit, tax-exempt HMO, Harvard Vanguard also provided services to enrollees of other health plans. Initially, Harvard Pilgrim owned the clinics and the pharmacies located on them. Harvard Vanguard sought the advisory opinion from the FTC when it entered into an agreement to acquire the real estate on which the clinics (and the pharmacies) were located. Harvard Vanguard informed the FTC that it intended to "purchase pharmaceuticals directly from manufacturers and dispense them, through the clinic pharmacies, to all patients who are under the care of a physician employed by Harvard Vanguard or under contract to practice at the clinics." Harvard Vanguard indicated that the clinic pharmacies would not "dispense pharmaceuticals to walk-in customers who are not patients of the clinic physicians." Harvard Vanguard asked the FTC whether the purchase of pharmaceuticals for the clinics at discounted prices, for subsequent dispensing to all its patients, would be exempt from the Robinson-Patman Act under the NPIA.

In deciding whether the proposed pharmaceutical purchases were for Vanguard's "own use," and thereby exempt under the NPIA, the FTC observed that the basic function of the institution determines the scope of the "own use" exception. Referring to the Ninth Circuit's opinion in *DeModena v. Kaiser Foundation Health Plan*,³³ the FTC wrote, "all drugs dispensed to enrollees were purchased for the HMO's 'own use' because providing continuing care to members was part of the broad institutional function of an HMO (as opposed to a hospital's core function of providing temporary and episodic care)." Turning to Harvard Vanguard, the FTC noted, its "stated purposes include providing comprehensive medical services to patients, educating medical students and others, participating in health service research projects, and developing programs to meet the needs of medically underserved and economically disadvantaged individuals." The FTC then posed the "central question" as whether Harvard Vanguard's dispensing of pharmaceuticals "furthers ... Harvard Vanguard's core institutional functions in the care of its patients."

³⁰ 425 U.S. 1 (1976).

³¹ *Id.* at 14.

³² Letter from Jeffrey W. Brennan to David Marx, Jr., on behalf of Harvard Vanguard Medical Associates, Inc., (December 18, 2001) available at www.ftc.gov/bc/adops/harvardvma.htm

³³ 743 F.2d 1388 (9th Cir. 1984).

To answer this question the FTC first considered those Vanguard patients who were covered by contracts under which Vanguard bore some financial risk for pharmaceuticals. The FTC concluded that the purchase of drugs for these patients clearly was exempt under the NPIA. The FTC relied on an earlier analysis in which it found that patients of a health care system who were covered by a risk contract with an HMO were “patients of the health system for all their needs.”³⁴ The FTC noted that this was “not the end of the inquiry, however, because Harvard Vanguard seeks to dispense to all of its patients, including those who are not covered by risk contracts.” The FTC then found,

Harvard Vanguard’s central institutional function, within the meaning of *Abbott Labs*, is to deliver comprehensive and continuing health care services, including pharmaceuticals, to all its patients. Having the clinics’ pharmacies dispense to clinic patients contributes directly to the ability of the clinics to deliver comprehensive care. Prescriptions can be transmitted electronically from the doctors to the pharmacy, thereby minimizing errors due to handwritten orders; the pharmacy’s electronic dispensing system is connected to the patient’s medical record, which improves the quality of the medical record and allows the professional staff to check the accuracy of the prescription more easily; and the close proximity of the pharmacy to the staff enhances the ability of doctors and pharmacists to communicate easily with one another about appropriate treatment.

Accordingly, the FTC concluded, “the clinic pharmacies may dispense products purchased under the NPIA to all patients who are treated at clinics staffed by employed physicians or physicians under contract with Harvard Vanguard, and who are under the continuing care of such a physician.”

In a second letter, issued two days later, the FTC staff opined that not-for-profit member hospitals of the Connecticut Hospital Association could sell pharmaceuticals to active employees and retirees with vested retirement or pension benefits under the NPIA.³⁵ Though the FTC earlier had concluded that hospital sales to retired employees were not covered by the NPIA,³⁶ the FTC agreed that in this situation, where discounted pharmaceuticals had been offered as a retirement benefit, the NNPIA applied because the program promoted patient care by allowing member hospitals to attract and retain qualified employees.

³⁴ See Letter from Richard A. Feinstein to Gary Senner re: BJC Health System (November 9, 1999).

³⁵ Letter from Jeffrey W. Brennan to Robert M. Langer on behalf of Connecticut Hospital Association (December 20, 2001) available at www.ftc.gov/bc/adops/harvardvma.htm

³⁶ Letter from Michael J. McNeely to Bruce Toppin on behalf of North Mississippi Health Services (October 3, 1996) available at www.ftc.gov/bc/adops/nmhs.htm

4. Department of Justice Business Review Letters.

a. Review of Proposed Survey by the Washington State Medical Association.³⁷

The Department of Justice wrote to the Washington State Medical Association to notify it that the agency would not object to a WSMA survey that would collect and publish two categories of statistics: the average amount charged for particular services by Washington physicians and the average reimbursement paid by particular insurers.

The Department noted that WSMA proposed to collect fee and reimbursement information from physicians and make the results available to its members. WSMA stated it would “to the extent possible ... structure the Survey to conform with the criteria of the Safety Zone found in Statement 6 of the DOJ/FTC Health Care Guidelines.” In compliance with those guidelines, WSMA promised it would not publish provider-specific information.

Statement 6 of the *Statements of Antitrust Enforcement Policy in Health Care*,³⁸ describes exchanges of price and cost information among providers that will not be challenged by the federal agencies. Moreover, Statement 6 indicates that a survey falls within a “safety zone,” and is presumptively lawful, if the survey is managed by a third party, the information provided by survey participants is more than three months old, and “there are at least five providers reporting data upon which each disseminated statistic is based, no individual provider’s data represents more than 25 percent on a weighted basis of that statistic, and any information disseminated is sufficiently aggregated such that it would not allow recipients to identify the prices charged or compensation paid by any particular provider.” The Department found that the proposed survey of provider charges by CPT codes, “resulting in statistics showing an average charge for each such CPT,” would fall within the safety zone as WSMA had indicated its intention to comply with the three conditions set forth therein.

The second proposal, to publish the average reimbursement paid by particular insurers, caused the Department more concern. This proposal did not fall within the safety zone set forward in Statement 6 because it involved dissemination of information collected from providers on insurer reimbursement, rather than on provider prices. The Department noted that the fact that a proposal falls outside a safety zone does not mean the conduct is illegal, however. The Department observed that the proposed survey “raises the possibility of anticompetitive effects in the sale of physician services. . . . The identification of average reimbursement paid by individual insurers, as opposed to more aggregated data, could more readily lead to physician boycotts of the insurer(s) offering the lowest reimbursement rates. Another concern is that the dissemination of the average reimbursement paid by an insurer could, explicitly or implicitly, serve to facilitate an agreement among physicians on a starting point for negotiations with insurers.”

WSMA allayed the Department’s concerns, however, by arguing that publication of the information could lead to more, not less competition, “because it will allow a better and less

³⁷ Letter from Charles A. James to Jerry Edmonds on behalf of the Washington State Medical Association (September 23, 2003) www.usdoj.gov/atr/public/busreview/200260.htm

³⁸ 4 Trade Reg. Rep. (CCH) ¶13,153, available at <http://www.ftc.gov/reports/hlth3s.htm>

costly comparison of the insurers' fee schedules" which, WSMA represented, often were not sent to Washington physicians. Furthermore, the availability of the information to other insurers, employers, and academic researchers was viewed as a positive factor. WSMA also represented that the market for physician services in Washington is relatively unconcentrated; that it would obtain data that was at least three months old; that no provider-specific information would be disseminated; that there would at least five providers reporting data upon which each disseminated statistic is based; that no individual provider's data would constitute more than 25% of any statistic; and that only the average reimbursement data for each service would be provided for each payer.

Based on these facts and representations, the Department stated it had no current intention to challenge the proposal.

b. Review of Network of Seven Community Hospitals in Michigan.³⁹

Seven small, community hospitals in Michigan proposed to form a contract negotiation group. The Department of Justice determined it would not challenge the group primarily because the member hospitals did not compete with each other, given their geographic location. Moreover, the Department found, the network likely would create efficiencies that would ensure that hospital services would continue to be offered to rural communities.

The seven hospitals ranged in size from 33 beds to 127 beds, and had average daily patient counts between 15 and 70 patients. The two closest hospitals were more than 50 miles apart. Significantly, the network would be non-exclusive: member hospitals could negotiate with payers outside the group. Based on these facts, the Department indicated its lack of opposition.

5. FTC Testimony.

The staff of the FTC during 2002 opposed bills pending in the Alaska,⁴⁰ Washington,⁴¹ and Ohio⁴² legislatures that would have authorized collective bargaining by physicians. In each case the FTC asserted that the proposed antitrust immunity for collective negotiations by physicians would increase health care costs and reduce access to health care. The FTC also cautioned that neither bill satisfied the stringent requirements established by the Supreme Court for state action immunity.

³⁹ Letter from Charles A. James to Clifton Johnson on behalf of the Michigan Hospital Group, Inc. (April 3, 2002) available at <http://www.usdoj.gov/atr/public/busreview/10933.htm>

⁴⁰ For the testimony on the Alaska bill, see www.ftc.gov/opa/2002/03/alaskaphysicians.htm. For the letter written in opposition to the Washington bill, see www.ftc.gov/opa/2002/02/washphys.htm

⁴¹ Washington House Bill 2360 (January 16, 2002) available at www.leg.wa.gov/pub/billinfo/2001-02/House/2350-2374/2360_01162002.txt

⁴² Letter from Joseph J. Simons, Jeffrey W. Brennan, R. Ted Cruz and John T. Delacourt to Dennis Stapleton (October 16, 2002) available at www.ftc.gov/os/2002/10/ohb325.htm

The Alaska bill later was signed into law.⁴³ Although it was amended, the final version did not increase the level of state supervision. The Washington bill was not enacted.

B. Private Litigation.

1. Antitrust Injury: *Vangala v. St. Mary's Regional Medical Center*.⁴⁴

A urologist charged that a hospital and its medical staff refused to refer patients to him in violation of Section 1 of the Sherman Act. The Ninth Circuit affirmed dismissal of his antitrust claims on grounds that he did not sufficiently allege antitrust injury. Plaintiff had alleged only that the refusal to refer patients to him damaged his ability to compete and thereby harmed competition. The court found that the allegation in the complaint that defendants' conduct had a "material impact on competition" was conclusory and insufficient to survive a motion to dismiss.

One judge dissented, observing that although the elimination of one competitor typically does not injure competition, the complaining urologist should have been given the opportunity to prove that such injury occurred in this case.

2. Relevant Geographic Market: *Villalobos v. Llorens*.⁴⁵

An anesthesiologist sued after she was denied medical staff privileges at a hospital in the Arecibo region of Puerto Rico. Her complaint was dismissed for failure properly to allege a relevant geographic market. The anesthesiologist had claimed that the market consisted of the "Arecibo region," which could consist of just one hospital. The court ruled that this definition was insufficient. The complaint did not detail what was meant by the "Arecibo region" and did not explain why patients could not go outside this region for health care. Relying on *Brader v. Allegheny General Hospital*,⁴⁶ the court also warned that a market confined to one hospital generally is "too narrow" to constitute a relevant geographic market for antitrust purposes. The court also observed that plaintiff had failed properly to plead antitrust injury as loss of staff privileges, without more, typically is insufficient to establish antitrust injury.

3. No Conspiracy, No Antitrust Injury, and Immunity under the Local Government Antitrust Act of 1984: *Patel v. Midland Memorial Hospital and Medical Center*.⁴⁷

Dr. Patel was an interventional cardiologist on staff at Midland Memorial Hospital in Midland, Texas. After an outside reviewer found that Dr. Patel was operating without clear indications, using poor procedures, and in vessels that were poorly suited for the procedures chosen, the Medical Executive Committee summarily suspended his privileges. Dr. Patel asked for, and received, a hearing. At the conclusion of the hearing the hearing panel found he was not a danger to patients but that his documentation was poor. The panel recommended restoration of

⁴³ Alaska Senate Bill 37 (Jun. 20, 2002) available at www.legis.state.ak.us/pdf/22/Bills/SB0037G.pdf

⁴⁴ 2002-1 Trade Cas. (CCH) ¶ 73,674 (9th Cir. Mar. 19, 2002).

⁴⁵ 137 F. Supp. 2d 44 (D.P.R. Mar. 31, 2002).

⁴⁶ 64 F.3d 869, 879-80 (3rd Cir. 1995).

⁴⁷ 2002-2 Trade Cas. (CCH) ¶ 73,739 (5th Cir. July 10, 2002).

his privileges subject to a six-month probation to ensure that his documentation would improve. The panel specifically found that the physicians involved in the suspension had acted reasonably and in good faith. Following the hearing, Dr. Patel's privileges were restored.

Dr. Patel promptly filed a lawsuit against the hospital and various individual physicians who had participated in the peer review. The district court granted summary judgment for defendants on all claims and on appeal the Fifth Circuit Court of Appeals affirmed. Dr. Patel's antitrust claims were grounded on his contention that Midland Hospital and the individual defendants competed with him and conspired to deprive him of his ability to practice. Dr. Patel, in the past, had engaged in various ventures that were competitive with the hospital, such as opening a cardiac catheterization laboratory and an imaging center, and he was involved in an effort to open a new hospital that would compete with Midland Hospital.

The Fifth Circuit was not impressed with Dr. Patel's claims. It noted that there was insufficient evidence from which a fact finder could conclude that his privileges were suspended as a result of a conspiracy rather than as a result of genuine concerns about his competence. The court also found that the participation of direct competitors in the peer review process was "of little concern here" because it was "inevitable" that competitors be involved in a proper peer review. "[O]nly specialists from the same field can fairly assess a physician's cases." In order to minimize the possibility that competitors would act improperly in the peer review process the hospital had sent the cases out for an independent review and no competitor voted on the committees that recommended his suspension.

The court of appeals also held that plaintiff's antitrust claims failed as a matter of law because he had not alleged a cognizable antitrust injury. During the suspension of his privileges Dr. Patel was able to treat his patients at another hospital in Midland.

Finally the court recognized that the hospital, as a public hospital was a political subdivision of the state and thus protected by the Local Government Antitrust Act of 1984.⁴⁸ This statute bars recovery of damages or fees under the antitrust laws "in any claim against a person based on any official action directed by a local government, or official or employee thereof acting in an official capacity." The court held that this statute provided defendants with antitrust immunity.⁴⁹

Because the court affirmed the grant of summary judgment for defendants on substantive grounds, it did not reach their argument that they were immune from antitrust attack under the Health Care Quality Improvement Act of 1986.⁵⁰

⁴⁸ 15 U.S.C. §§ 34-36.

⁴⁹ In fact, the statute protects local governments and their officials and employees from liability for damages and fees only – it does not completely immunize them from antitrust liability. Only if Dr. Patel had sought damages, and no injunctive relief, would the statute would have provided complete protection to the claims asserted.

⁵⁰ 42 U.S.C. §11101.

4. No Antitrust Injury: *Volm v. Legacy Health System, Inc.*⁵¹

Volm was a “lactation consultant” who worked at Legacy Meridian Park Hospital and other hospitals in Portland, Oregon. Volm practiced under the supervision of a physician. After a number of incidents her supervising physician refused to supervise her further. An application by another physician to supervise Volm was denied by the hospital. Volm then brought suit against Legacy and various additional defendants asserting federal and state antitrust claims, as well as state law non-antitrust claims. She argued that she lost her privilege to see patients as a result of a conspiracy among her competitors.

The district court noted that “there are numerous other hospitals in the Portland area in which a mother can give birth” and that “if a patient felt strongly enough about using Volm’s services, she could have asked her doctor to attend to the birth at a different hospital.” Volm already practiced at another hospital in the area (Providence St. Vincent) and had not showed that she could not obtain privileges at still more hospitals. Accordingly, the court held, Volm had failed to raise a factual issue that “she has suffered an antitrust injury of the type required for standing.” The court then granted summary judgment on the antitrust claims.

5. *Noerr-Pennington Doctrine: In re Buspirone Patent Litigation.*⁵²

Bristol-Myers Squibb, which holds a patent (the “‘763 Patent”) covering the use of buspirone for the treatment of anxiety, has sold this drug since 1986. A day before its patent was to expire, in November 2000, Bristol-Myers listed a newly-obtained patent (the “‘365 Patent”) in the Food and Drug Administration’s “Orange Book.” The Orange Book lists approved drugs with therapeutic equivalence evaluations. Listing confers a number of valuable benefits on the owner of a patent including, in some situations, the ability to delay generic entry.

Generic drug makers who wished to enter the buspirone market, direct purchasers, consumer protection organizations, and 30 states brought suit. They claimed that Bristol-Myers fraudulently represented to the FDA in the Orange book listing that the ‘365 Patent covered uses of buspirone and that a reasonable claim of patent infringement could be asserted against generic producers of the drug. Plaintiffs asserted Bristol-Myers knew the use of buspirone would be in the public domain after expiration of the ‘763 Patent. Plaintiffs also asserted that Bristol-Myers brought patent infringement suits against generic competitors who were seeking to enter the buspirone market, which triggered an automatic stay of the FDA’s approval of these generic products for up to 30 months under the Hatch-Waxman Amendments.⁵³

Bristol-Myers moved to dismiss all claims, arguing that its conduct was protected under the *Noerr-Pennington* doctrine.⁵⁴ The court disagreed. It held that *Noerr-Pennington* does not apply

⁵¹ 2002-1 Trade Cas. (CCH) ¶ 73,655 (D. Ore. Mar. 7, 2002).

⁵² 185 F. Supp. 2d 363 (S.D.N.Y. Feb. 14, 2002).

⁵³ 21 U.S.C. § 355(j)(5)(B)(iii).

⁵⁴ The *Noerr-Pennington* doctrine protects from antitrust liability persons who petition any branch of the state or federal government for relief, so long as a favorable result legitimately is sought. The doctrine is named for *Eastern Railroad Presidents Conference v. Noerr Motor Freight*, 365 U.S. 127 (1961) and *United Mine Workers v. Pennington*, 381 U.S. 657 (1965).

where the government performs no independent review of the statements made by private parties, and exercises no intervening judgment, but instead acts in a purely ministerial function. Pioneer drug companies are required by law to submit the information Bristol-Myers submitted and the FDA is required to publish the information. The court also rejected Bristol-Myers's contention that the listing of the '365 Patent was immunized because it was inextricably bound up with its subsequent patent infringement suits which, the company argued, "are paradigmatic instances of petitioning activity." The court found, however, that Bristol-Myers could have listed the information in the Orange Book without filing subsequent patent infringement suits – and it could have brought those suits without relying on the Orange Book listing.

The court then held that even if Bristol-Myers' actions were protected by *Noerr-Pennington*, two generic manufacturer plaintiffs had pled sufficient facts to come within the so-called *Walker Process* exception to *Noerr* immunity.⁵⁵ Under *Walker Process*, Bristol-Myers would lose its petitioning immunity if it engaged in fraud on the FDA by submitting information it knew to be false.

6. Relevant Geographic Market and Exclusive Dealing: *Surgical Care Center of Hammond, L.C. v. Hospital Service District No. 1 Tangipahoa*.⁵⁶

After North Oaks Hospital purchased the only other acute care hospital in Hammond, Louisiana, and converted it into a rehab facility, a group of physicians on the hospital's staff formed an outpatient facility (Surgical Care Center). North Oaks then negotiated contracts with payers under which it promised a 25% discount on billed charges if they designated the hospital as their sole provider for certain services, including outpatient services. As the court characterized these arrangements, a payer had to agree to use the hospital for outpatient surgery in order to obtain a discount on inpatient services. Surgical Care Center filed an antitrust action, alleging that the hospital had monopolized, or attempted to monopolize, the outpatient surgery market by leveraging its market power over inpatient services into outpatient services. Alternatively, plaintiff complained that the hospital had tied the two services together, all in violation of Section 2 of the Sherman Act.

To prove an attempt to monopolize a plaintiff must show that the defendant engaged in predatory or exclusionary conduct, with a specific intent to gain monopoly power in a relevant market, and that the defendant had a dangerous probability of achieving monopoly power. The lower court granted summary judgment for the hospital and the Fifth Circuit affirmed.

The court of appeals found that to succeed on a Section 2 claim a plaintiff must first define a relevant geographic market. This it was unable to do. Borrowing from the Eighth Circuit's analysis in *Minnesota Association of Nurse Anesthetists v. Unity Hospital*,⁵⁷ the court observed that "a hospital's 'trade area is not necessarily the relevant geographic market for purposes of the antitrust analysis' because geographic market evidence must take into account 'where consumers could practicably go, not on where they actually go.'" Plaintiff's expert argued that the

⁵⁵ *Walker Process Equipment, Inc. v. Food Machinery & Chemical Corp.*, 382 U.S. 172 (1965).

⁵⁶ No. 01-30971 (5th Cir. October 6, 2002), *affirming*, No. Civ.A.97-1840, 2001 WL, 8586 (E.D. La. Jan. 3, 2001).

⁵⁷ 208 F.3d 665, 662 (8th Cir. 2001).

hospital's service area (*i.e.*, the area from which it drew its patients) constituted the relevant geographic market. Because such an analysis failed to take into account where patients could go, however, it failed to establish the relevant geographic market.

Plaintiff also claimed that the hospital and Quorum Health Resources, the management company that ran the hospital, had conspired to restrain competition. The court gave short shrift to this argument noting that as a matter of law a corporation and its agent cannot conspire in violation of the antitrust laws. Under *Copperweld Corp. v. Independence Tube Corp.*,⁵⁸ there was no basis for finding any independent liability on the part of Quorum.

Finally, the court held that the district court had abused its discretion by failing to permit plaintiff to amend its complaint shortly before trial to add tying and exclusive dealing claims under Section 1 of the Sherman Act. The appellate court did not remand the matter for trial, however, finding that the Section 1 claims would fail as well because under each plaintiff would have to define a relevant geographic market – and this it had been unable to do.

7. Post-Hospital Merger Antitrust Claims.

In *Health America Pennsylvania, Inc. v. Susquehanna Health System*,⁵⁹ two managed care entities and a third-party administrator brought suit against the Susquehanna Health System (“SHS”) and the Susquehanna Physician Services (“SPS”).⁶⁰ The lawsuit flows followed the merger, in 1994, of the two major hospital systems in the north central Pennsylvania region, which combined the two hospitals in Williamsport, Pennsylvania, and a nearby hospital. The merger was allowed by the Pennsylvania Attorney General under a consent decree that required certain savings from the increased efficiencies passed on to consumers over a five year period, which expired in July, 1999. The complaint alleged that after July, 1999, SHS successfully demanded significant price increases for hospital services, and illegally tied the negotiation of physician services and hospital service contracts. The plaintiffs alleged that SHS renegotiated its prices and obtained a 21 percent increase in hospital rates and forced the plaintiffs to pay higher rates for SPS physicians than for non-SPS physicians.

Plaintiffs made three antitrust claims:

- First, plaintiffs challenged the hospital merger under Section 7 of the Clayton Act and Section 1 of the Sherman Act.
- Second, plaintiffs asserted that SPS illegally acquired physician practices resulting in SPS's employing over 40 percent of the primary care physicians in the county.
- Finally, plaintiffs asserted that defendants unlawfully tied the provision of hospital services to physician services.

⁵⁸ 467 U.S. 752 (1984).

⁵⁹ 2001 WL 395420 (M.D. Pa., April 17, 2001).

⁶⁰ See also Leo T. Crowley, *Tying Arrangements: Hospital and Physician Services*, NEW YORK LAW JOURNAL, Health Law, p.3 (June 18, 2001) (discussing *HealthAmerica Pennsylvania Inc. v. Susquehanna Health System*).

Defendants moved to dismiss the third claim on the grounds that an illegal tying arrangement was not properly alleged, or was inconsistently alleged, and that the mere joint negotiation of physician and hospital contracts did not constitute any illegal tying arrangement.

The court denied defendants' motion to dismiss, finding that inconsistent pleadings are permissible under the federal rules. Furthermore, the court noted, the tying claim was not necessarily in conflict with the claim that SPS unlawfully acquired a monopoly in physician services. According to the court, if a seller has monopoly power over both the tying and tied product, then that merely enhances its ability to maximize its profits regarding the tying arrangement. The court also found that plaintiffs adequately alleged antitrust damages.

The case is significant because it is one of the first cases to spring from controversial hospital mergers that were approved by state agencies under a condition requiring the hospitals to pass on the savings and efficiencies to consumers for a finite period of time, but which made no provision as to the effect on consumers after the time period in the agreement expired. The case raises interesting issues, particularly the potential remedies if a court were to find that the merger was anticompetitive.

8. Exclusive Dealing: *Jersey Dental Laboratories v. Dentsply International, Inc.*,⁶¹ *United States v. Dentsply International, Inc.*⁶²

In January 1999, the government brought suit against Dentsply International, a manufacturer and seller of artificial teeth, charging that the company's exclusive dealing arrangements with dental laboratories violated the antitrust laws.⁶³ Several private plaintiffs also filed companion suits.

In March 2001, the district court denied Dentsply's motion for summary judgment on the merits of the antitrust causes of action, while granting in part its motion for summary judgment with respect to certain of the private plaintiffs on standing grounds.⁶⁴

Dentsply uses dental laboratory dealers to sell its artificial teeth to dental laboratories, who use the teeth to make dentures. Dentsply and its dealers have no written contractual agreement, but Dentsply publishes "Dealer Criteria" that prohibit Dentsply dealers from adding competing tooth lines. The private plaintiffs are dental laboratories and consumers who purchased dentures made with artificial teeth. Plaintiffs alleged that through its Dealer Criteria and other conduct, Dentsply entered into restrictive dealing arrangements with dental laboratory dealers who, collectively, constituted 80 percent of the dealers distributing artificial teeth. According to plaintiffs, this arrangement thwarted attempts by competitors to build a dealer network and thus compete effectively in the U.S. Plaintiffs argued that this resulted in artificially high teeth prices. Plaintiffs also alleged the exclusive dealing policy undermined the efforts of competitors to

⁶¹ 180 F. Supp. 2d 541 (D. Del. Dec. 19, 2001).

⁶² 2001-1 Trade Cas. (CCH) ¶ 73,247 (D. Del. March 30, 2001).

⁶³ *United States v. Dentsply Int'l, Inc.*, No. 99-005-SLR (D. Del.), <http://www.usdoj.gov/atr/cases/f2100/2164.htm> (complaint).

⁶⁴ 2001-1 Trade Cas. (CCH) ¶ 73,247 (D. Del. March 30, 2001). See also *Howard Hess Dental Labs. Inc. v. Dentsply Int'l, Inc.*, No. 99-255-SLR (D. Del. March 30, 2001); *Kaminer v. Dentsply Int'l, Inc.*, No. 99-854-SLR (D. Del. March 30, 2001).

maintain and recruit dental laboratory dealers and induced some dealers to stop distributing competitors' teeth.

The government sought injunctive relief and costs. The laboratory plaintiffs sought injunctive relief and compensatory and treble damages. The consumer plaintiffs sought compensatory and treble damages for alleged violations of the antitrust laws of 16 states and the District of Columbia, which allow statutes permit recovery by indirect purchasers.

Dentsply argued that its exclusive dealing policy did not foreclose competitors because rivals had alternative channels of distribution. They could use other dealers, sell directly to dental laboratories (thus allowing them to reach end users without hindrance), or stop selling Dentsply and switch to a competing line at any time. The court agreed that the existence of alternative channels of distribution to end users lessened the likelihood that an exclusive dealing policy foreclosed competition. However, noting that almost all of the cases that Dentsply cited in support of its argument were decided not at the summary judgment stage but after trial on the merits, the court determined that Dentsply had not met its burden of showing that it was entitled to summary judgment as a matter of law. Specifically, the court held, a genuine issue of material fact existed as to whether selling directly to the end users is a viable option for manufacturers of artificial teeth. The court also held that a genuine issue of material fact existed as to the rate of foreclosure in the defined market – the sale of prefabricated artificial teeth the United States. While Dentsply argued that it controlled only 30 of the 300 total “dental dealers,” the government maintained that the rate of foreclosure was much higher than 10 percent because Dentsply’s list of total “dental dealers” was inflated, as it included “operatorial dealers” who sold supplies to dentists, not dental laboratories. The court held that a genuine issue of material fact existed as to whether the pro-competitive effects that Dentsply alleged precluded plaintiffs from establishing that Dentsply’s exclusive dealing policy foreclosed its rivals from the relevant market. According to the court, Dentsply’s justification for its exclusive dealing arrangement (that it needed to recoup its investment expenses in promotion and marketing) did not show that plaintiffs could not meet their burden regarding establishing foreclosure of the market.

Relying on *Illinois Brick Co. v. Illinois*,⁶⁵ the court granted Dentsply’s motion for summary judgment to the extent the private plaintiffs sought damages, but permitted plaintiffs to proceed with their claims for injunctive relief.

Thereafter, some of the plaintiffs refiled their complaint, this time alleging that Dentsply conspired with dealers in violation of the antitrust laws.⁶⁶ On a motion to dismiss, the court dismissed the complaint, holding that the labs were indirect purchasers and that there was no “co-conspirator” exception to the indirect purchaser doctrine.

The court observed that that the Third Circuit has not adopted a “co-conspirator” exception to the indirect purchaser rule. The policies underlying *Illinois Brick* militated in favor of dismissal, regardless of whether “co-conspirators” were involved.

⁶⁵ 431 U.S. 720 (1977) (treble damage relief in antitrust cases is confined to direct purchasers).

⁶⁶ *Jersey Dental Laboratories, v. Dentsply International, Inc.* 180 F. Supp. 2d 541 (D. Del. Dec. 19, 2001).

9. Peer Review Litigation: *Singh v. Blue Cross/Blue Shield of Massachusetts, Inc.*⁶⁷

After Blue Cross/Blue Shield acquired Baystate, another health care insurer, it wrote to Dr. Singh, a specialist in internal medicine, to state it would not offer him a position on the Baystate panel (with the right to provide care to its subscribers) because of the “excessive utilization rates” he evidenced as a Baystate provider before Blue Cross merged with the plan. Blue Cross and Dr. Singh agreed that a selection of his cases would be reviewed by a physician auditor and that Blue Cross would re-evaluate its decision when the audit was complete. The auditor reviewed the case and reported that Dr. Singh had rendered care “somewhat below the recognized standard of care.” As a result, Blue Cross decided not to offer Dr. Singh a position on the Baystate panel. At the same time, Blue Cross determined to conduct a second audit to determine whether to continue Dr. Singh as a provider on panels for two different products offered directly by Blue Cross itself.

The second audit, conducted by a different physician, was highly critical of Dr. Singh, concluding that “[c]ompetent expert care is rarely seen” and that substandard care had been provided in the overwhelming majority of cases reviewed. Blue Cross then determined to terminate his participation in all its plans. Dr. Singh requested a “fair hearing,” as permitted by Blue Cross. Pending the outcome of the hearing he continued to participate in the Blue Cross plans.

A hearing panel, consisting of two physicians and a lawyer heard evidence from Blue Cross and Dr. Singh and reversed the initial Blue Cross decision to terminate Dr. Singh. Blue Cross took no further action on the matter and he remained as a Blue Cross provider. Dr. Singh then sued, claiming state and federal antitrust violations, as well as pleading various state law causes of action.

The district court granted summary judgment for Blue Cross on all of Dr. Singh’s claims for damages under the Health Care Quality Improvement Act of 1986 (the “HCQIA”). 42 U.S.C. § 11101, *et. seq.* This statute provides immunity to health care entities and individuals who take a “professional review action,” (defined as an action based on the competence or professional conduct of a physician that adversely affects that physician’s clinical privileges or membership in a professional society), so long as the action was taken (1) in the reasonable belief that it furthered quality health care, (2) after a reasonable effort to obtain the facts of the matter, (3) after affording the physician adequate notice and hearing procedures, and (4) in the reasonable belief that the action was warranted by the facts.

On appeal, the First Circuit affirmed the entry of summary judgment by the district court. The appellate court noted that the HCQIA establishes a “rebuttable presumption” that immunity attaches to a professional review action. Dr. Singh claimed that in a summary judgment context this presumption deprived him of his Seventh Amendment right to a jury trial. As a result of the presumption, unlike in the typical summary judgment situation, a movant need not come forward with evidence to support his position in order to shift the burden to the non-moving party. The presumption serves immediately to shift to the non-moving party the burden to come forward

⁶⁷ No. 01-2586 (1st Cir. 2002).

with evidence that defendants' actions are not protected by the four-prong test of immunity, or suffer entry of summary judgment. The appellate court observed that while the presumption had the effect described, this did not preclude a plaintiff from defeating summary judgment (and thereby obtaining a jury trial) if he were to introduce evidence sufficient to overcome the presumption. Consequently, the interplay of the presumption and summary judgment standards did not operate to deprive Dr. Singh of his right to a jury trial.

Dr. Singh also argued that resolution on summary judgment of the issues of whether Blue Cross acted reasonably, as required for HCQIA immunity, deprived him of his right to a jury trial on those issues as well. Following the lead of other circuits that have considered the issue, the court rejected this claim, noting that determination of a qualified immunity typically involves legal issues and that Congress, when it enacted the HCQIA, expressed its desire that the immunity question be resolved in summary proceedings prior to trial where possible.

Turning to the merits of the HCQIA defense, the court of appeals separately examined whether each of the audits of Dr. Singh's practice met the requirements of the HCQIA. Dr. Singh argued that Blue Cross's actions could not have been in furtherance of quality health care, or warranted by the facts known, because there was no demonstrated harm to patients from his practice and less drastic measures might have been taken before he was terminated. The court rejected both claims. The HCQIA "was designed to prevent harm, not to assure an adequate response after it has occurred." The court gave similar short shrift to Dr. Singh's claim that Blue Cross was not motivated by concern over the quality of care he provided his patients but rather took action because it believed Dr. Singh's practice was not cost efficient. The court criticized this as "a false dichotomy between furthering quality health care and overutilization of medical procedures and tests." Because unnecessary procedures have both economic and medical consequences Blue Cross could well have terminated him for overutilization and still have taken the action to further quality health care. Finally, acting in accord with *Austin v. McNamara*, 979 F.2d 728 (9th Cir. 1992), the court found that the mere fact that the hearing panel had reversed Blue Cross's initial decision to expel Dr. Singh from the Blue Cross panels did not indicate that the initial decision was made without a reasonable belief that it would further quality health care.

The court then found that Blue Cross took its action after a reasonable effort to obtain the facts of the matter as it engaged expert reviewers to audit his cases. While one of the auditors made some mistakes in his audit, the court held that a physician is entitled only to a "reasonable investigation," not a perfect one.

The court then considered, and rejected, claims Dr. Singh made that he was not afforded adequate notice and procedure before the actions at issue were taken. Dr. Singh complained that the first audit was not fair as he did not agree to the auditor selected. The court found, however, that he had been given an opportunity to object the auditor (after an earlier auditor he had proposed withdrew) and had failed to object. Under the circumstances he was at least as responsible for the auditor selected as was Blue Cross. Similarly, the court found no merit in Dr. Singh's complaint that under the HCQIA he should have been permitted to discuss the results of the audits with the physician auditors.

As the court found that Dr. Singh had failed to rebut the presumption that Blue Cross's actions

were immunized, it entered summary judgment for the company on plaintiff's claims for damages under the antitrust laws.

C. Recent Developments in the Movement for Antitrust Immunity for Physicians.

1. Proposed Federal Legislation.

a. The Quality Health-Care Coalition Act of 1999.

In 1999, then-Representative Tom Campbell of California introduced H.R. 1304, the so-called "Quality Health Care Coalition Act of 1999." This legislation sought to grant collective bargaining rights to physicians and other health care professionals currently excluded from collective bargaining units because they are not "employees" under the National Labor Relations Act (NLRA). On June 30, 2000, the House passed H.R. 1304 by a vote of 276-136 and the bill went to the Senate. The bill failed to reach the Senate floor before the end of the 106th Congress, however.

b. The Health Care Antitrust Improvements Act of 2001.

In February 2002, Reps. Barr and Conyers introduced the "Health Care Antitrust Improvements Act of 2001," H.R. 3897. This bill is far more complex, though far less sweeping, than the Campbell bill. The Barr-Conyers bill would provide special treatment under the antitrust laws to health care providers engaged in joint negotiation with health care plans.

- The bill would apply the rule of reason, rather than the *per se* rule, to lawsuits challenging the efforts of two or more physicians or other health care professionals to negotiate with a health plan.
- In lawsuits against physicians grounded on their joint negotiations with a payer, a substantially prevailing plaintiff would receive an award of attorney's fees only if defendants' conduct in the litigation was frivolous, unreasonable, without foundation, or in bad faith.
- The bill would make any rule or policy of a payer that requires health care professionals to participate in a product or all products offered by the plan in order to participate in a particular product an unlawful tying arrangement, unless the payer could show it lacked market power.

The bill also would create a registration process under which a "health care cooperative venture" (*i.e.*, a group of otherwise competing providers) could register with the Attorney General. Thereafter, such health care cooperative ventures could not be subjected to treble damages for Clayton Act violations. They would only be liable for single damages. Finally the bill would seek to establish various demonstration projects in different states.

2. State Efforts to Provide Immunity for Physicians.

a. Texas.

Many states have considered legislation that would allow physicians to collectively bargain with managed care plans.⁶⁸ Perhaps the first state to enact such legislation was Texas. Under the law adopted there, before a physician group can receive immunity it must show that it accounts for no more than 10 percent of the physicians in a health plan's geographic service area, that the plan has substantial market power, and that the benefits that would flow from joint negotiation outweigh the disadvantages, including harm to competition.⁶⁹ Reports indicate that at least two applications were filed the Texas Attorney General after passage of the law to obtain immunity.⁷⁰ One application later was withdrawn.⁷¹ The other was granted by the Attorney General in August 2001.⁷²

The petition that was granted shows the limitations of the program, however. The petition was filed by 11 physicians in Henderson, Texas – three family physicians, two pediatricians, an internist, an ophthalmologist, a general surgeon, a podiatrist, a pediatrician and an orthopedist. These physicians requested and received immunity to bargain collectively with Blue Cross and Blue Shield of Texas.⁷³ News reports suggest, however, that the physicians have been frustrated by Blue Cross's refusal to negotiate collectively with them – a right Blue Cross retains under the law.⁷⁴ One physician was quoted saying that obtaining the right to bargain collectively with Blue Cross was a “hollow victory” and asked, “What good has it done?”⁷⁵

b. Other State Efforts to Provide Immunity for Physicians.

In addition to the legislation passed in Texas, and the efforts of the Washington, Alaska and Ohio legislatures to provide exemption for physicians (reported above), in early 2002 New Jersey enacted a bill that purported to exempt physicians and dentists from the antitrust laws for their collective negotiations.⁷⁶ The negotiations must be conducted through a representative approved by the New Jersey Attorney General's office and joint negotiation of fees can take place only if the Attorney General finds that the health plan has substantial market power in its service area.

⁶⁸ See *Collective Bargaining by Physicians*, stating that such legislation was introduced in 18 state legislatures as well as the District of Columbia in 2000. In the 1980s and 1990s, of course, a number of states passed legislation that provides a degree of immunity for certain health care transactions. See generally Douglas Ross, *Innovative Remedies in Merger and Network Cases*, in ANTITRUST AND HEALTH CARE: NEW APPROACHES AND CHALLENGES, (ABA, 1998).

⁶⁹ See *An Analysis of Physician Antitrust Exemption Legislation*.

⁷⁰ *Id.*

⁷¹ *Id.*

⁷² See “11 Texas physicians given green light to bargain collectively” in [amednews.com](http://www.ama-assn.org/sci-pubs/amnews/pick_01/prsb0924.htm) (September 24, 2001) (at http://www.ama-assn.org/sci-pubs/amnews/pick_01/prsb0924.htm).

⁷³ *Id.*

⁷⁴ *Id.*

⁷⁵ *Id.*

⁷⁶ S. 1033, effective April 8, 2002.

3. The Potential Effect of Immunizing Health Care from the Antitrust Laws.

The question of what effect granting antitrust immunity to health care providers would have on the economy and the provision of health care has been the subject of much debate.⁷⁷ Two different research groups – one public and one private – have published interesting papers asserting that antitrust immunity for physicians would raise the cost of health care in the United States. Charles River Associates, a private consulting group, estimated that the Campbell bill would raise private health insurance premiums between 4.7 and 13.2 percent and would increase total health care costs from 2.5 to 8.3 percent (which translates into an increase of \$29 to \$95 billion).⁷⁸ The Congressional Budget Office estimated that such immunity would drive private health insurance premiums up, but not by as much – it estimated an increase of 1.9 percent annually.⁷⁹

⁷⁷ A comprehensive discussion of physician antitrust exemption issues is found in Fred J. Hellinger, Gary J. Young, *An Analysis of Physician Antitrust Exemption Legislation, Adjusting the Balance of Power*, JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, Vol. 286, No. 1 (July 4, 2001). An even more recent discussion of the same issues is found in Sujit Choudhry, Troyden A. Brennan, *Collective Bargaining by Physicians – Labor Law, Antitrust Law, and Organized Medicine*, NEW ENGLAND JOURNAL OF MEDICINE, Vol. 345, No. 15 (October 11, 2001).

⁷⁸ The results of the Charles River study are reported in *Collective Bargaining by Physicians* at 1144 n.41. Slightly different figures are given in *An Analysis of Physician Antitrust Exemption Legislation*.

⁷⁹ *Id.*