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Application of Federal Antitrust Laws to Healthcare Providers

By Mark S. Kopson

To most laymen and many attorneys, the word "antitrust" conjures visions of software superpowers and telecom mega-mergers, not their family physician or local hospital. In recent years, however, the healthcare industry has been the subject of a substantial portion of federal antitrust investigation and enforcement activities. While once of concern to only corporate goliath clients of silk-stocking law firms, antitrust compliance has now become a major concern for healthcare providers of all sizes. As such, neither business attorneys, nor general practitioners can afford ignorance of the antitrust laws if they have physicians or other healthcare providers for clients. This article presents a brief overview of the federal antitrust laws, their recent enforcement against healthcare providers, and a look at what lies ahead.

The Federal Antitrust Laws

The federal antitrust laws include the Sherman Act[i], the Clayton Act[ii], and the Federal Trade Commission ("FTC") Act[iii]. Section 1 of the Sherman Act, enacted in1890 as the first federal antitrust statute, prohibits contracts, combination, and conspiracies in restraint of trade. Agreements by competitors to refuse to deal with particular entities are known as "group boycotts" and are generally deemed to be *per se* violations of Section 1. Section 2 of the Sherman Act prohibits monopolization, attempts to monopolize, and conspiracies to monopolize.

First enacted in 1914, the Clayton Act makes illegal specific actions and practices that may have anticompetitive effects. For example, Section 2 of the Clayton Act (also known as the Robinson-Patman Act) prohibits price discrimination between purchasers of commodities when it might lessen competition. Section 3 prohibits exclusive dealing and tying arrangements when their effect may be to substantially reduce competition. Section 7 of the Clayton Act prohibits mergers, consolidations, and joint ventures when their effect may be to tend to create a monopoly or to substantially lessen competition. Many antitrust issues first appear in the news media as the result of the mandatory notice provisions in Section 7(a) of the Clayton Act. That section requires that companies with assets in excess of certain value thresholds give the FTC thirty days' advance notice of proposed mergers, acquisitions, and tender offers.

The FTC Act, also enacted in 1914, prohibits "unfair methods of competition," including conduct that violates the Sherman Act or Clayton Act and actions that retrain trade in violation of the policy or spirit of those statutes. It also prohibits "unfair or deceptive acts or practices," including misleading advertising or representations. The FTC Act has thus been the bane of the diet-aid industry and is largely responsible for the rapidly-spoken disclaimers at the end of many TV and radio ads.

Enforcement Responsibility and Penalties

In addition to aggrieved private parties, including states, both the Department of Justice (DOJ) and the FTC (collectively, the "Agencies") enforce the federal antitrust laws. The DOJ can proceed criminally or civilly in the case of Sherman Act violations, but is limited to civil actions to enforce the Clayton Act. It

prosecutes both types of action in the federal district courts. The DOJ's investigative tools include not only the grand jury and subpoenas for criminal matters, but also broad civil investigative demand powers under the Antitrust Civil Process Act, 15 USC §1312 (1994). Criminal violations of the Sherman Act can be punished by up to three years in prison, plus fines in amounts up to the greater of twice the violator's pecuniary gain, twice the damaged party's pecuniary loss, or $350,000 (for individuals) or $10 million (for corporations).[iv] In civil actions to enforce the Sherman and Clayton Acts, the DOJ can both recover damages and obtain injunctive relief, while private parties can recover treble damages plus costs and attorney fees.

The FTC enforces the FTC Act and shares with the DOJ enforcement of the Clayton Act. It has civil investigative powers similar to the DOJ's and can seek injunctive relief to enforce both statutes in the federal district courts. Unlike the DOJ, however, the FTC can also commence administrative proceedings before an Administrative Law Judge ("ALJ") who, if she finds the conduct at issue to be illegal, can issue a cease and desist order. Violators of such orders can face civil penalties of $10,000 per violation. Either party can appeal the ALJ's decision to the full FTC, whose decision is binding on the FTC staff. Conversely, an aggrieved respondent can further appeal the FTC's decision to a federal court of appeals.

Why Healthcare?

Why has antitrust become so much of a concern for healthcare providers? In the infamous words erroneously attributed to Willie Sutton, "because that's where the money is."[v] According to the Centers for Medicare & Medicaid Services ("CMS"), from 2000 to 2002, healthcare spending in the U.S. rose from $1.3 trillion to $1.6 trillion, and by 2003, represented over 15% of our Gross Domestic Product ("GDP"). CMS also projects that, by 2014, U.S. healthcare spending will reach $3.6 trillion and nearly 19% of GDP.[vi] There are, perhaps, only two things certain about these staggering healthcare cost increases: (1) any attempt to assign responsibility for them will generate heated debate (witness the current UAW – General Motors discussions), and (2) virtually every industry is both searching for, and demanding, relief from them. A large part of Uncle Sam's response has been to step up antitrust enforcement activities in an effort to eliminate perceived anti-competitive conduct by healthcare providers. The balance of this article addresses the types of conduct at issue, the government's response, and what the future may hold for healthcare providers.

Physicians and Hospitals As Antitrust Enforcement Targets

It must be noted that, for purposes of antitrust analysis, both individual hospitals and independent physicians and physician practices, e.g., professional corporations, in any given specialty are viewed as competitors, each competing against the others for the healthcare dollars of patients, insurers, and other third-party payors, such as Medicare. Inasmuch as neither a single individual, nor the constituent parts of a single entity can conspire with themselves,[vii] independent healthcare providers and legally-organized physician practices are, for the most part, free to set their own prices for the care they provide. Historically, the antitrust laws became of increasing concern when the development and growth of managed care led such otherwise competing healthcare providers to development and join both formal and informal networks.

As part of their efforts to manage healthcare and its cost, health plans (payors) began to move away from letting their insureds or "members" utilize any physician or hospital of their choice, and from paying those providers on the basis of the fees independently set by each provider. Instead, payors began to specify limited groups of "participating" hospitals and physicians at which and from whom their members could receive care as a covered benefit. The payors also began to, themselves, dictate in advance the fees and rates at which they would pay the participating providers for the care they furnished to plan members.

Healthcare providers perceived the health plans' actions as major threats to both their financial well being and their continued exercise of independent professional judgment. Recognizing their rapidly decreasing bargaining power on both counts and hoping to level the playing field in their dealings with the increasingly powerful health plans, healthcare providers banded together in both physician-only networks (physician organizations (POs) and independent practice associations (IPAs)) and combined, physician-hospital organizations (PHOs). In some cases, the aggregation occurred with little or no thought of the potential antitrust implications. In other cases, however, the providers did consider the implications but, for a number of reasons, concluded that network formation would provide legally permissible assistance in their payor contracting efforts. Among those reasons were the revised Statements Of Antitrust Enforcement Policy In Health Care (Policy Statements) issued by the Agencies in 1996.[viii]

The Policy Statements explain the Agencies' antitrust enforcement policies and specify "antitrust safety zones" for certain joint activities by healthcare providers, which, absent extraordinary circumstances, the Agencies will not challenge. Statement 8 addresses "physician network joint ventures," which the Agencies define as a "physician-controlled venture in which the network's physician participants collectively agree on prices or price-related terms and jointly market their services."[ix] Statement 9 addresses "multiprovider networks," which the Agencies, while noting that they vary greatly in terms of their included participants, contracts with payors, and intended efficiencies, generally define as "ventures among providers that jointly market their health care services to health plans and other purchasers."[x] Read together, Policy Statements 8 and 9 delineate three ways in which otherwise competing health care providers can form physician or multiprovider networks and jointly negotiate price terms legally.[xi] They also describe a category of alternative arrangements through which competing health care providers may legally collaborate without jointly negotiating price terms.

Options for Networks to Jointly Negotiate Price Terms

The first option for legally permitted joint price negotiation is to meet the requirements of one of the two antitrust safety zones specified in Statement 8 for physician network joint ventures. One applies to only exclusive networks, in which physicians' ability to contract with payors individually and/or affiliate with other networks or plans is restricted; the other applies to non-exclusive networks. Both safety zones limit the percentage of local physicians in each specialty that may participate in the network (generally 20% for exclusive networks and 30% for non-exclusive networks) and require that the involved physicians "share substantial financial risk."[xii] Examples of potentially sufficient risk-sharing include, but are not limited to, accepting capitation payments or all-inclusive case rates, providing services in exchange for a percentage of a plan's revenue or premiums, and withholding a portion of physicians' payments to be paid only if certain performance targets are met.[xiii] (pp 65-66)

The second and third options both entail integration of the network's providers in a manner and to a degree sufficient to qualify for "rule of reason" analysis. Under the antitrust laws, naked agreements among competitors that fix prices are *per se* illegal. In Statement 8, however, the Agencies noted that if the integration of physicians in a network is likely to produce significant economic efficiencies that benefit consumers, agreements on price reasonably necessary to achieve those procompetitive efficiencies will, instead, be analyzed under the "rule of reason."[xiv] "A rule of reason analysis determines whether the formation and operation of the joint venture may have a substantial anticompetitive effect and, if so, whether that potential effect is outweighed by any procompetitive efficiencies resulting from the joint venture."[xv] Two types of integration can qualify a network for rule of reason analysis: (i) financial integration through substantial financial risk-sharing, akin to that required for the Statement 8 safety zones, and (ii) so-called "clinical integration." While determining the existence of either type of integration is extremely fact-dependent, clinical integration has historically been the more difficult to define. In Statement 8, the Agencies noted that it "can be evidenced by the network implementing an active and ongoing program to evaluate and modify practice patterns by the network's physician

participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality."[xvi]

The Messenger Model Alternative to Jointly Negotiating Price Terms

Recognizing the difficulty of qualifying for an antitrust safety zone and the uncertainty inherent in any attempt to be deemed sufficiently integrated to qualify for (and then survive) a rule of reason analysis, many provider networks have, in fact or in theory, elected to forgo joint negotiation of price terms in favor of a "messenger model." The messenger model was recognized in the Policy Statements as a tool through which provider networks might economically facilitate contracting with payors while avoiding price-fixing liability. Although the Agencies acknowledged that messenger models "can be organized and operated in a variety of ways,"[xvii] the two major varieties have become known as the "pure" and "modified" messenger models.

Under the pure messenger model, an independent third party (the "messenger") serves as a mere conduit between the network's providers and payors. The messenger communicates a payor's offer to each of the individual providers and, in turn, conveys each provider's acceptance or rejection of the offer back to the payor. If the provider accepts the offer, the messenger can forward the payor's written contract to the provider for execution. If the provider rejects the original offer, the payor may utilize the same procedure to forward one or more revised offers until either the provider accepts an offer or the payor elects to forgo a contract with the provider.

Under the modified messenger model, the third-party messenger obtains from each provider the lowest price at which he will furnish services (e.g., an actual fee schedule or a rate, such as 135% of Medicare RBRVS) and the provider's authorization to accept on his behalf payor offers that meet or exceed his price floor. The messenger must also forward to the provider for his individual consideration any offer that does not meet that floor. To facilitate contracting, the messenger may also prepare and share with potential payors, but not the network providers, an aggregation of the providers' price floors, from which the payor may ascertain the percentage of the network's members that would participate if offered a particular fee schedule or rate.

Significantly, under either model, the messenger can ***not*** negotiate on behalf of the network's providers, allow member providers access to other members' price information, or engage in any other conduct that "facilitates collective decision-making by network providers, rather than independent, unilateral, decisions" on price or price-related terms.[xviii] Recent enforcement actions suggest, however, that messenger-model networks abiding by those proscriptions may be the exception rather than the rule. Since 2002, in addition to a favorable ALJ decision[xix], the FTC and the DOJ have obtained consent orders from more than twenty targeted networks or groups of healthcare providers. The overwhelming majority of those orders resolved allegations that the network physicians, with or without hospital involvement,[xx] utilized what they claimed to be a legally-permissible messenger model to engage in anticompetitive behavior and restraint of trade namely, group boycotts and/or collusion to fix the prices payable by plans for the providers' healthcare services.

Suspect Conduct and Conditions

Attorneys evaluating proposed or existing contracting arrangements for their physician and hospital clients should consider any of the following items to be a red flag requiring more in-depth scrutiny, as each was cited in one or more of the Agencies' complaints that resulted in antitrust consent orders: (i) outright refusal to messenger or otherwise communicate some payor offers to the network's membership; (ii) requiring that payor contract offers be approved by a committee or board before they will be communicated to the network's membership; (iii) threats to terminate existing payor contracts if specified

terms are not met in a new or amended contract; (iv) adoption or internal publication of a network-wide fee schedule or "acceptable" range of fees or a maximum discount that members will grant to payors; (v) providers' refusal to negotiate with payors except through the network; (vi) prohibiting individual providers from negotiating directly with payors or encouraging them not to do so and/or punishing them for doing so; (vii) encouraging member providers to either terminate existing contacts or to refuse new contract proposals; (viii) conditioning network contracts on a plan's agreement to not contract with non-network providers; or (ix) promotional documents or internal communication that include terms such as "solidarity," "leverage," or "clout and power."

Not surprisingly, many antitrust enforcement actions involving such problematic conduct originate from, or are bolstered by, complaints to the Agencies by aggrieved payors, both those unable to obtain contracts with the subject providers and those that believe the network's conduct increased their cost of contracting with the providers in question.[xxi] As such, attorneys should carefully evaluate all proposed written and verbal communications with payors on behalf of their healthcare provider clients.

Attorneys are also cautioned that non-provider participants, including consultants and contract negotiators, have been targeted in recent antitrust enforcement actions and resulting consent orders.[xxii] A good working knowledge of the antitrust laws and enforcement agency policies should thus be deemed a prerequisite to accepting any engagement to represent a healthcare provider in contract negotiations with a payor or to draft a provider participation agreement.[xxiii]

The Future

Recent written and verbal pronouncements from Washington suggest that the number of healthcare antitrust enforcement actions will continue to rise and that the resulting sanctions against providers and their advisors will become more severe. In their July 2004 report on competition in healthcare, the Agencies discussed the numerous antitrust enforcement actions against messenger-model participants and warned that "much more stringent measures are necessary against those who violate the antitrust laws repeatedly or flagrantly and those who facilitate anticompetitive conduct by multiple parties. The Division will also pursue criminal sanctions in appropriate cases. Disgorgement and/or dissolution will be sought in appropriate cases."[xxiv]

While prefaced by the usual caveat that the opinions expressed were his own and not necessarily those of the FTC or any individual Commissioner, the following May 2005 statement by FTC Commissioner, Jon Liebowitz, was equally ominous:

> In future cases, we should be aggressive in identifying ring leaders and, where we find them, we should name them. This includes doctors and their consultants - both lawyers and non-lawyers - who propose models to physicians which simply dress up price-fixing as something else. If individuals face a greater risk that they may be named - and that adverse publicity is likely to follow - they will be less likely to undertake such conduct.[xxv]

Commissioner Liebowitz also called for industry-wide "sweeps," in which multiple cases of physician price-fixing are packaged together and prosecuted simultaneously, warning that the FTC's "Health Care Division is continuing to look at doctor's groups: you may see a sweep at some point down the road."[xxvi]

Conclusion

Attorneys for healthcare providers must be cognizant of the applicability of the federal antitrust laws to a wide variety of provider conduct. Given the serious consequences that their violation poses for both attorney and client, prudence dictates that the impact of the antitrust laws be considered when evaluating and planning the client's formal and informal communications and contractual dealings with both health plans and colleagues alike.

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[i] 15 USC §§1-7 (2004).
[ii] 15 USC §§12-27 (2004).
[iii] 15 USC §§41-58 (2004).
[iv] 15 USC §§1, 2 (2004); 18 USC §3571(d).
[v] For an interesting history of Willie and "the quote," see Cocheo, *"The bank robber, THE QUOTE, and the final irony,"* ABA Banking Journal Online (March 1997), *available at* www.banking.com/aba/ profile_0397. htm.
[vi] CMS Office of Public Affairs Press Release, *Health Care Spending Reaches $1.6 Trillion In 2002* (January 08, 2004), *available at* http://www.cms.hhs.gov/media/press/release.asp?Counter=935; CMS Office of Public Affairs Press Release, *Overall Health Care Cost Growth Projections Slow From 2003 Medicare Drug Coverage Expected To Lower Prices* (February 23, 2005), *available at* http://www.cms.hhs.gov/media/press/ release.asp?Counter=1356.
[vii] *Copperweld Corp v Independence Tube Corp*, 467 US 752 (1984).
[viii] Dep't of Justice & Federal Trade Comm *Statements of Antitrust Enforcement Policy in Health Care* (1996), available *at* www.usdoj.gov/atr/public/guidelines/1791.pdf (hereafter, "*Policy Statements*").
[ix] *Policy Statements* at 59.
[x] *Id.* at 103.
[xi] This article uses "price terms" to refer to both actual price terms, e.g., specific fees and fee schedules, and price-related terms. The latter include items such as late-payment penalties and, arguably, even the time period within which payments for covered services must be made.
[xii] *Policy Statements* at 61-62.
[xiii] *Id.* at 65-66.
[xiv] *Id.* at 68.
[xv] *Id.* at 71.
[xvi] *Id.* at 69. *See also FTC Staff Advis Op Ltr regarding MedSouth, Inc* (Feb 19, 2002)(discussing facts and circumstances deemed sufficient to qualify as clinical integration), *available at* www.ftc.gov/bc/ adops/medsouth.htm; Dep't of Justice & Federal Trade Comm, *Improving Health Care: A Dose of Competition*, Ch 2, pp 36-41 (2004), *available at* www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf (hereafter "*A Dose of Competition"*).
[xvii] *Policy Statements* at 122.
[xviii] *Id* at 123.
[xix] *In Re North Texas Specialty Physicians*, FTC Docket No 9312 (currently on appeal). The pleadings and orders for all cited FTC enforcement actions are available on the FTC's web site at www.ftc.gov/ftc/ antitrust.htm through the link entitled "Commission Actions (Health Care Antitrust Issues)."
[xx] A third of the fifteen most recent consent orders involved networks of both hospitals and physicians.
[xxi] *See, e.g., In Re San Juan, IPA*, FTC File No 031 0181 (Molina Healthcare of New Mexico unable to obtain contract; Blue Cross & Blue Shield of New Mexico able to obtain contract only at rates 10-16% above original offer).
[xxii] *E.g., In Re Physician Network Consulting, LLC*, FTC Docket No C-4094; *In Re White Sands Healthcare System, LLC and Alamagordo Physicians Cooperative, Inc*, FTC Docket No C-4130.
[xxiii] Attorneys undertaking such matters would be well-served by a careful review of both the Agencies' *Antitrust Guidelines for Collaborations Among Competitors* (2000), *available at* www.ftc.gov/os/2000/ 04/ftcdojguidelines.pdf and the complaints in the FTC enforcement actions cited herein.
[xxiv] *A Dose of Competition* at 320.
[xxv] Jon Liebowitz, Commissioner FTC, *Health Care and the FTC: The Agency as Prosecutor and Policy Wonk (Health Care as the New Cement; and Actions Against the Pharmaceutical Industry as a Game of Whack-a-Mole)*, remarks before the American Bar Association/American Health Lawyers Association *Antitrust in Healthcare Conference*, Washington, D.C. (May 12, 2005), at 12, *available at* www.ftc.gov/speeches/leibowitz/050512 healthcare.pdf.
[xxvi] *Id.*