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Antitrust Enforcement Encourages Health Care Providers to Cooperate Procompetitively

David Marx, Jr.*
Christopher M. Murphy**

In 1993, the federal and state antitrust enforcement agencies openly and unabashedly encouraged the health care industry to engage in cooperative efforts to reduce costs and provide services more efficiently.1 While encouraging the formation of joint ventures among competitors, these same agencies also sent a clear message that they would challenge those arrangements that are formed for an anticompetitive purpose or operated in an anticompetitive manner. Moreover, the significant judicial decisions in 1993 in cases initiated by private plaintiffs were consistent with the agencies’ enforcement philosophy. Thus, in 1993:

- The Department of Justice and Federal Trade Commission jointly issued antitrust enforcement policy statements for the health care field that set out specific “antitrust safety zones” specifying when the federal agencies will not challenge provider conduct, but that also highlight the fact-intensive nature of antitrust analysis

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1. Several states enacted legislation intended to immunize certain health care collaborative activities from the antitrust laws. Because the validity of the scope of protection intended to be afforded by the statutes has not yet been tested, it is too soon to tell whether these legislative efforts will achieve their purpose. For a more detailed discussion of these local “hospital cooperation acts,” see Sarah S. Vance, Immunity for State-Sanctioned Provider Collaboration After Ticor, 62 ANTITRUST L.J. 409 (1994); David Marx, Jr., State Hospital Cooperation Acts: Are They Sufficient Antitrust Shelter for Hospital Collaborations? 10 HEALTHSPAN 3 (1993).
and the need for individual examination of transactions and conduct in specific markets;

- These enforcement agencies spoke greatly about hospital merger enforcement but did little to stem the tide of consolidation among hospitals;

- Courts granted immunity to hospitals and their staffs in staff privileges cases under the Health Care Quality Improvement Act, but construed the language of the Act narrowly and required strict compliance with its notice and hearing requirements; and

- The enforcement agencies encouraged the formation of physician networks and managed care organizations, but expressed their concern with exclusive arrangements and abuse of market power.

A review of developments in 1993 demonstrates that the antitrust laws should not impede innovative, cost-cutting cooperative arrangements among providers, as long as the anticompetitive effects of the arrangements do not outweigh the actual or potential procompetitive benefits.

I. DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION ISSUE ANTITRUST ENFORCEMENT POLICY STATEMENTS IN THE HEALTH CARE AREA

On September 15, 1993, the Justice Department and the Federal Trade Commission (FTC) jointly issued six Statements of Antitrust Enforcement Policy in the Health Care Area, setting forth certain “antitrust safety zones” that describe the circumstances under which the federal antitrust agencies will not challenge provider conduct, “absent extraordinary circumstances.” The policy statements address: 1) hospital mergers; 2) hospital joint ventures with high technology or other expensive medical equipment; 3) information provided by physicians to purchasers (for example, third-party payers or self-insured employers) of health care services; 4) hospital participation in exchanging price and cost information; 5) joint purchasing arrangements among health care providers; and 6) physician network joint

2. 4 Trade Reg. Rep. (CCH) ¶ 13,150, at 20,757 (Sept. 15, 1993).
3. Id. at 20,758.
4. Id. at 20,761.
5. Id. at 20,762.
6. Id. at 20,763.
ventures. The statements also explain the analysis these agencies will use to determine antitrust liability and give examples of situations in which the agencies would not challenge an arrangement that would fall outside an antitrust safety zone. Finally, the agencies commit themselves to responding expeditiously to health care providers' requests for guidance.

A. The Substance of the Policy Statements

1. Hospital mergers

The antitrust safety zone set forth in the statement for hospital mergers applies to any merger between two general acute care hospitals when one of the hospitals, over the three most recent years, 1) has fewer than one hundred licensed beds, and 2) has an average daily inpatient census of fewer than forty patients. This safety zone does not apply if that hospital is less than five years old.

Though they reaffirmed the applicability of the 1992 Horizontal Merger Guidelines to hospital mergers, the agencies identified several situations in which a hospital merger would not be challenged even though the market concentration might otherwise raise an inference of anticompetitive effects. These include mergers 1) after which the merged hospital would still face strong competitors or between merging hospitals sufficiently differentiated from each other (for example, offering more complementary than competitive services); 2) that would allow the hospitals to realize significant cost savings that could not otherwise be achieved; or 3) that would eliminate a hospital that likely would fail resulting in its assets exiting the market.

This safety zone departs significantly from traditional hospital
merger analysis in looking at only one of the merging hospitals. Unlike the analysis under the Merger Guidelines, the safety zone does not take into account the presence or absence (and competitive strength or weakness) of other hospitals in the market. Nevertheless, because the safety zone is limited to hospitals with an average daily census of fewer than forty patients, it is unlikely to apply in many transactions that otherwise would have raised serious antitrust concerns.

2. Hospital medical equipment joint ventures

One policy statement sets forth an antitrust safety zone for any joint venture among hospitals to purchase, operate, and market the services of high technology or other expensive medical equipment if the joint venture includes only the number of hospitals needed to support the equipment. Also, a joint venture that includes additional hospitals will not be challenged if the additional hospitals could not support the equipment on their own or through the formation of a competing joint venture. The joint venture participants will have the burden of justifying with objective evidence both the need for the venture and the number of participants.

This statement provides that joint ventures outside the safety zone will be scrutinized using the traditional four-step rule of reason analysis, which consists of 1) defining the relevant market in which the service produced through the joint venture competes; 2) evaluating the venture’s competitive effects; 3) assessing the procompetitive efficiencies generated by the venture; and 4) reviewing any agreements between the venture partners that are ancillary to the joint venture. The purpose of this analysis is to determine whether the joint venture may reduce competition substantially and, if so, whether it is likely to produce procompetitive efficiencies that outweigh its anticompetitive potential.

The policy statement gives the example of a five-hospital market in which all of the hospitals agree to jointly purchase and maintain a mobile lithotripter that will be available one day per week at each hospital. Although any combination of two of the hospitals could afford to purchase the equipment and recover their costs within the equipment’s useful life, patient vol-

10. Commissioner Owen raised this point in her statement dissenting against the issuance of the policy statements. See Owen Statement, supra note 8.

11. A lithotripter is an instrument that crushes calculi in the bladder.
volume from all five hospitals is required to maximize the efficient use of the machine. The agreement does not provide for joint marketing of lithotripsy services and each hospital establishes its own price for the service. This joint venture does not fall within the antitrust safety zone because smaller groups of hospitals could afford to purchase and operate lithotripters and recover their costs. In these circumstances where the joint venture falls outside the safety zone, the agencies would apply the rule of reason analysis and would not challenge the venture because it is limited to the purchase of the equipment and would not eliminate competition among the hospitals in the provision of lithotripsy services. The joint venture participants would not agree on the prices at which each would market the lithotripsy services provided by the jointly-owned equipment.

3. Physicians’ provision of information to purchasers

An antitrust safety zone is established to allow physicians collectively to provide to purchasers of health care services underlying medical data (for example, outcome data or suggested practice parameters) that may improve purchasers’ resolution of issues related to the mode, quality or efficiency of treatment. The collective provision of fee information is expressly excluded from the safety zone, as are implied or threatened boycotts.

4. Exchange of price and cost information by hospitals

Hospitals are now permitted to exchange certain price and cost information within the following antitrust safety zone: Hospitals may participate in written surveys of a) prices for hospital services or b) wages, salaries, or benefits of hospital personnel if the following conditions are satisfied:

- the survey is managed by a third party (for example, a purchaser, government agency, health care consultant, academic institution, or trade association);
- the information provided by survey participants is based on data more than three months old; and
- there are at least five hospitals reporting data upon which each disseminated statistic is based, no individual hospital’s data represents more than twenty-five 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 hospital.
The statement warns that exchanges of future prices for hospital services or future compensation of employees are likely to be considered anticompetitive. It also warns that if an exchange of information among competing hospitals of price or cost information results in an agreement among competitors as to the prices for hospital services or the wages to be paid hospital employees, that agreement will be considered per se unlawful.

5. Joint purchasing arrangements

A joint purchasing arrangement among health care providers (hereinafter participants) falls within an antitrust safety zone if: 1) the amount of the total purchases accounts for less than thirty-five percent of all sales of that product or service in the relevant market; and 2) the total cost to the participants of the products and services jointly purchased amounts to less than twenty percent of each participant's total revenues from all products or services sold by that participant.

To the extent that a joint purchasing arrangement does not fall within the safety zone, the policy statement identifies several safeguards that can minimize antitrust risks. For example, a joint purchasing arrangement that does not require members to purchase all of their requirements for a product or service through the arrangement is less likely to raise concerns than one that does. Similarly, the antitrust risk is lessened when joint purchasing arrangements use an employee or agent independent of its members to negotiate purchases and where communications between the joint purchasing organization and each of its members are kept confidential.

6. Physician network joint ventures

An antitrust safety zone is established for physician network joint ventures (for example, independent practice associations (IPAs) or preferred provider organizations (PPOs)) that 1) are comprised of twenty percent or less of the physicians in each physician specialty who have active hospital staff privileges and who practice in the relevant geographic market and 2) in which the participating physicians share substantial financial risk. The statement gives two examples of situations in which substantial financial risk is shared by members of a physician network joint venture:

- an agreement that services will be provided to a health insurance plan at a capitated (per subscriber) rate; or
financial incentives for the joint venture's members to achieve cost-containment goals, for example, withholding a substantial amount (e.g., twenty percent) of the members' compensation, with that amount distributed to the members only if the cost-containment goals are met.

The statement notes that the antitrust safety zone applies to both exclusive and nonexclusive IPAs and PPOs.12 The factors most likely to affect the federal agencies' assessment of the formation of a physician network joint venture outside the safety zone are the ability of payers to contract with physicians individually, the availability of a sufficient number of nonparticipating physicians for another network to be formed, and the perception by payers that the network will be procompetitive.

The threshold of twenty percent of the physicians in the market for the safety zone is quite conservative, particularly for nonexclusive arrangements. Thus, the safety zone merely confirms that such a limited percentage of providers is an easy case, without giving much additional certainty to physicians interested in forming a network.

7. Expedited issuance of business review letters and advisory opinions

For many years, the Justice Department and FTC have had a procedure for handling requests for guidance. The Justice Department issues business review letters and the FTC issues advisory opinions describing their enforcement intentions in connection with proposed conduct or transactions.13 In practice, however, there was often a delay of many months between a request and a response.

The policy statements now commit the agencies to responding to requests for business reviews or advisory opinions from the health care community no later than 90 days after all necessary information is received regarding any matter addressed in the

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12. For an explanation of the difference between exclusive and nonexclusive IPAs and PPOs, see U.S. HealthCare, Inc. v. HealthSource, Inc., 1992-1 Trade Cas. (CCH) ¶ 69,697 (D.N.H. Jan. 30, 1992), aff'd, 986 F.2d 589 (1st Cir. 1993).


The Justice Department business review letters and the FTC's advisory opinions are summarized in BNA's Antitrust & Trade Regulation Reporter and are available in their entirety from the respective agencies. In addition, the Justice Department's business review letters are available in Westlaw.
statements, except requests relating to hospital mergers outside the antitrust safety zone. The agencies commit to providing a response to business review or advisory opinion requests regarding other nonmerger health care matters within 120 days after all necessary information is received.

B. Applications of the Policy Statements

Although the policy statements were issued in September, both the Department of Justice and the FTC already have applied them in responding to requests for guidance by health care providers. In its first application of the policy statements, the Department of Justice announced its intention to not challenge a proposal by the National Cardiovascular Network (NCN) to establish a national network of cardiologists, cardiovascular surgeons, and acute care hospitals because the network qualified for the antitrust safety zone set forth in the policy statement relating to physician network joint ventures.\(^{14}\) Subsequently, both the Department of Justice and the FTC applied the traditional rule of reason analysis in endorsing the formation of two managed care organizations to contract with third-party payers where neither network fell within any of the policy statements' antitrust safety zones. The Department of Justice approved a proposal by the California Chiropractic Association (CCA) to form a statewide chiropractic managed care organization to contract with third-party payers at a capitated rate;\(^{15}\) the FTC approved a similar proposal on behalf of radiologists by California Managed Care Imaging Medical Group (CMI).

NCN proposed to create a PPO of cardiac care specialists in forty-one metropolitan areas to provide cardiac care services to payers' beneficiaries for an all-inclusive, global price that would cover all hospitalization and physician expenses. In thirty-eight of the forty-one cities, NCN did not plan to contract with competing cardiologists, cardiovascular surgeons, or acute care hospitals; in the other three cities, NCN would not contract with more than twenty percent of the cardiologists or cardiovascular surgeons with active admitting privileges at hospitals in the relevant geographic market. Thus, the proposed network clearly fell within the physician network joint venture safety zone.

\(^{14}\) The proposed transaction was described in a Department of Justice business review letter dated September 28, 1993. 7 Trade Reg. Rep. (CCH) ¶ 50,118.

\(^{15}\) See Letter from Anne K. Bingaman, Assistant Attorney General, to George Miron, Esq., dated December 8, 1993, 1993 WL 517169 (D.O.J.).
The Department of Justice emphasized that the PPO's contracts with third-party payers and providers would be nonexclusive; in other words both payers and providers would remain free to contract with any other PPO, health maintenance organization, independent practice association, or alternative delivery system. The Department also indicated that it would be concerned if the formation or operation of the PPO could raise the prices for physician services above competitive levels or prevent the formation of other physician joint ventures that would compete with the proposed PPO. However, the Department of Justice concluded that NCN's proposal was unlikely to facilitate or result in such anticompetitive conduct.

In contrast, the CCA proposal did not fall within the antitrust safety zone established in the physician network joint venture policy statement. Consistent with the policy statement, however, the Department of Justice applied the traditional rule of reason analysis to conclude that the joint venture was not likely to be anticompetitive. This determination was premised upon several factors, particularly that the proposed managed care organization would be a bona fide joint venture in which the participating chiropractors would assume significant financial risk; the venture would not include more than fifty percent of the chiropractors in any local market; the network would be nonexclusive in nature; and there were a variety of competing alternatives available to payers if the chiropractors attempted to exercise market power.

In a November 17, 1993 staff advisory opinion by the FTC's Bureau of Competition, the FTC approved the formation and operation of CMI, a preferred provider organization that was created to facilitate radiological service arrangements between payers and providers on a statewide or regional basis. The organization would not preclude its members from forming or participating in other physician networks or prevent payers from dealing with radiologists individually rather than through CMI. CMI would offer a uniform price for all providers covered under a regional or statewide contract and develop a capitated fee structure within two years. To reduce the potential antitrust risk of being charged with a boycott by the excluded radiologists, CMI asserted that it would exclude physicians only to increase efficiencies and competitiveness. It projected a two percent

market share. The FTC concluded that CMI was unlikely to attain market power and that its exclusion of physicians would not constitute an unlawful boycott.

C. Conclusion

By issuing the policy statements, the federal antitrust enforcement agencies provided more detailed guidance concerning their enforcement policies in the health care field than is available to any other industry. However, the policy statements highlight the fact-intensive nature of antitrust analysis and the need for individual examination of transactions and conduct in specific markets. This was illustrated by the agencies’ careful scrutiny and discussion of the NCN, CCA, and CMI ventures.

Nevertheless, the policy statements provide basic frameworks that providers can use to develop cooperative arrangements that are less likely to be challenged by the enforcement agencies. Also, the policy statements publicly affirm what knowledgeable antitrust practitioners have known all along—that the federal antitrust enforcement agencies will not invoke the antitrust laws to impede the development of innovative, efficiency-enhancing arrangements by health care providers.

II. THE ANTITRUST ENFORCEMENT AGENCIES FREQUENTLY DISCUSS MERGER ENFORCEMENT BUT RARELY CHALLENGE ONE

The prospect of health care reform and complaints by hospitals (and their trade associations) that the 1992 Horizontal Merger Guidelines provide inadequate guidance have intensified the debate over the need for special hospital-specific antitrust exemptions from the general merger laws.17 In response, the federal enforcement agencies cite historical enforcement statistics as evidence that their enforcement activities have not inhibited hospital consolidation. For example, the FTC and Department of Justice counted at least 229 hospital mergers between 1987 and 1991, during which time they formally investigated only 27 transactions and challenged only 5.18

18. See Chief Robert E. Bloch, Professions and Intellectual Property Section, De-
Antitrust Enforcement

In most respects, merger enforcement in 1993 was no different than in prior years—hospital consolidation continued unabated and virtually unchallenged. The few hospital merger cases filed by the enforcement agencies in 1993 typically arose in connection with multi-hospital transactions between two or more national hospital systems that owned competing hospitals in isolated locations where there was only one other competitor. In one case, the FTC objected to a consummated transaction but, instead of requiring divestiture, merely ordered the offending party to seek prior approval of future acquisitions, a slap on the hand at best.

A. Government Challenges to Hospital Mergers in 1993

In *Dominican Santa Cruz Hospital*, the FTC alleged that the 1990 acquisition of AMI-Community Hospital (AMI) by Catholic Healthcare West (CHW) and its local affiliate, Dominican Santa Cruz Hospital (Dominican), increased the market share of Dominican and CHW in Santa Cruz County from sixty-two percent to seventy-six percent. Prior to the acquisition, there was only one other hospital in the county besides Dominican and AMI. Nevertheless, the FTC did not require CHW and Dominican to divest AMI. Pursuant to the FTC consent order settling the matter, Dominican and CHW will have to obtain FTC approval before acquiring all or any significant part of an acute care hospital in Santa Cruz County, California during the next ten years. The consent order also prohibits Dominican and CHW from selling any hospital in Santa Cruz County unless the acquirer agrees to be bound by the FTC order.

In a case involving the merger of two multi-hospital systems, Columbia Hospital Corporation (Columbia) and Galen Health Care Corporation (Galen), the FTC required Columbia and Galen to obtain FTC approval before acquiring another hospital in Osceola County, Florida during the next ten years. This case differed from *Dominican Santa Cruz*, however, in that the con-
sent order also required Columbia to divest Kissimmee Memorial Hospital, in Osceola County, before proceeding with its acquisition of Galen. Absent the divestiture, the merger of Columbia and Galen would have combined the owners of two competing hospitals in Osceola County, both located in Kissimmee. The FTC alleged that the Osceola market is highly concentrated and entry by new firms is difficult because of state regulatory requirements and the substantial lead time required to establish new hospitals.

In a related case, at the FTC's request, a federal district court enjoined Columbia from acquiring Medical Center Hospital in Charlotte County, Florida, because Columbia already owned a hospital in the county. According to the FTC complaint, there was only one hospital in Charlotte County other than Medical Center Hospital and Fawcett Memorial Hospital, the hospital owned by Columbia. As in the Columbia/Galen case, the FTC alleged that in addition to market concentration, state regulation and the long lead time needed to open a hospital created barriers to entry by new competitors. The preliminary injunction entered by the district court enjoined the acquisition until the conclusion of administrative proceedings.

Two recent announcements by the Department of Justice and the FTC demonstrate why hospitals have complained about the predictability of the federal agencies' merger enforcement policy. On January 24, 1994, the Department of Justice raised no objection to the merger of Catholic Medical Center and Elliot Hospital in Manchester, New Hampshire. The Department of Justice concluded that the six remaining hospitals serving the same area as the merging hospitals provided adequate alternatives to payers. The agency also credited the strong community support for the merger and the planned reduction of excess

23. Columbia and the FTC settled this case on February 8, 1994, in an agreement in which Columbia agreed not to acquire Medical Center and to seek FTC approval before attempting to acquire or transfer any part of any general acute care hospital in the Charlotte County, Florida area for the next ten years. Interestingly, Columbia will also have to give the FTC prior notice before "consummating a joint venture with any other acute-care hospital in the area to establish any new hospital or hospital-based service or facility (unless Columbia's contribution to the venture is less than $1 million)." 5 Trade Reg. Rep. (CCH) ¶ 23,548, at 23,223 (Feb. 8, 1994).
25. The relevant geographic market evaluated in this merger included not only the town of Manchester, but also Concord, Nashua, Derry, and Exeter.
capacity, which is expected to lower costs by $150 million over 10 years. In contrast, one week later, the FTC voted to challenge the merger of St. Mary-Corwin Regional Medical Center and Parkview Episcopal Medical Center in Pueblo. Like the Manchester, New Hampshire merger, the Pueblo merger involved the consolidation of the only two hospitals in a small town of approximately 100,000 inhabitants. Although the hospitals expected the merger to generate substantial cost savings, the FTC nevertheless decided to challenge the transaction.

The paucity of complaints filed by the federal antitrust agencies in 1993 indicates that the agencies have not stepped up enforcement simply because the number of hospital mergers has increased. Rather, the government continues to engage in selective enforcement, challenging only those mergers (or parts of larger transactions) where the anticompetitive effects appear to outweigh the provable potential procompetitive benefits.

B. Private Challenges to Hospital Acquisitions

In Askew v. DCH Regional Health Care Authority, the Eleventh Circuit held that an Alabama health care authority’s acquisition of a privately owned hospital was immunized from the antitrust laws under the state action doctrine. The court held that an Alabama health care authority such as DCH constituted a political subdivision of the state. It then found that the Alabama Health Care Authorities Act of 1982 clearly expressed the State’s policy to displace competition in the field of health care and that the Act specifically granted Alabama health care authorities the powers to acquire, own, and operate health care facilities. As a result, DCH’s acquisition of the privately-

26. 995 F.2d 1033 (11th Cir. 1993).
28. 995 F.2d 1033. In Parker v. Brown, 317 U.S. 341 (1943), the Supreme Court created the “state action” doctrine when it held that the Sherman Act does not apply to the anticompetitive conduct of states acting as sovereigns. In California Retail Liquor Dealers Ass’n v. Midcal Aluminum, Inc., 445 U.S. 97, 105-06 (1980), the Supreme Court held that private parties seeking antitrust immunity under the Parker doctrine must satisfy the following two-prong test: 1) there must be a “clearly articulated and affirmatively expressed” state policy authorizing the challenged conduct; and 2) there must be active state supervision of the private parties as part of the regulatory scheme. In Town of Hallie v. City of Eau Claire, 471 U.S. 34, 46-47 (1985), the Supreme Court applied the state action doctrine to municipalities, but held that the state did not have to actively supervise the conduct of municipalities as long as the municipality could prove that it was acting pursuant to state policy.
29. 995 F.2d at 1039-40.
owned hospital was immune from the application of the anti-trust laws. 30

III. EXCLUDED PHYSICIANS CONTINUE TO TRY, AND GENERALLY FAIL, IN THEIR USE OF THE ANTITRUST LAWS TO OBTAIN OR KEEP STAFF PRIVILEGES

In 1986, Congress passed the Health Care Quality Improvement Act (HCQIA) 31 to curb claims by physicians that the peer review process, which had resulted in the suspension of physicians' hospital privileges, was anticompetitive and violated federal antitrust laws. In the few reported 1993 decisions interpreting HCQIA, courts began to grant immunity to hospitals and their staffs. However, courts construed HCQIA's language narrowly and demanded strict compliance with its notice and hearing requirements. In staff privileges cases that did not involve HCQIA, the courts remained unsympathetic to plaintiffs seeking to invoke the antitrust laws to regain their suspended privileges.

A. The Use of HCQIA to Immunize Peer Review Participants

With regard to a peer review that meets specific standards, HCQIA grants immunity from damages to the peer review body and its members, staff, and contractors, and "any person who participates with or assists the body" for peer review action. 32 The specific standards are set forth in § 11112(a), which states:

For the purposes set forth in § 11111(a) of this title, a professional review action must be taken-
(1) in the reasonable belief that the action was in the furtherance of quality health care,
(2) after a reasonable effort to obtain the facts of the matter,
(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirements of Paragraph (3).
A professional review action shall be presumed to have met

30. Id. at 1040-41.
the preceding standards necessary for the protection set out in section 11111(a) of this title unless the presumption is rebutted by a preponderance of the evidence.

To benefit from the statutory grant of immunity, defendants must 1) be persons covered under § 11111(a), and 2) have participated in a professional review action meeting the standards of § 11112(a).

In *Farr v. Healtheast, Inc.*, a district court applied HCQIA to dismiss an obstetrician/gynecologist's claim that a hospital revoked his staff privileges in violation of federal antitrust laws. The defendants included the hospital, its parent corporation, its board of directors, and other hospital-related entities involved in the peer review process, as well as various hospital staff members. They denied liability stating that the plaintiff physician continued to perform ovarian biopsies to diagnose Stein-Leventhal syndrome even though he was repeatedly warned that an ovarian biopsy was not an acceptable procedure for diagnosing the syndrome and that if he continued to perform them disciplinary action would result. The hospital peer review committee's suspension of the physician was approved by the hospital's board of directors. An appeals committee reviewed the peer review proceedings and found the suspension to be justified.

The district court concluded that all of the defendants satisfied the requirements of HCQIA §§ 11111(a) and 11112(a). Particularly, the court found that the plaintiff was afforded notice and was requested to support his position at each step in the review process. The court further found that the plaintiff refused to follow the hospital's guidelines and continued to perform surgical procedures reasonably believed to present a real danger to patients.

In contrast, in *Islami v. Covenant Medical Center, Inc.*, the court stated the general principle that a hospital that suspended a surgeon's staff privileges would not be immune from antitrust liability under HCQIA if that hospital did not comply with the notice and hearing provisions of the hospital's bylaws or HCQIA. The plaintiff, a board-certified cardiovascular and thoracic surgeon, maintained staff privileges at the defendant hospital from 1984 until his suspension on May 14, 1990. In 1988, he

34. Id. at 70,520.
set up a vascular testing laboratory in his office, which competed with the hospital’s radiology laboratory. On or about May 16 or 17, 1990, plaintiff was notified of his suspension, which was upheld in August, 1990.

Plaintiff alleged that his suspension by the defendants violated the antitrust laws. The court denied defendants’ motion for summary judgment, which was founded on its claim of immunity, because the hospital did not follow its own bylaws, which closely tracked HCQIA’s adequate notice and hearing provisions. The court also ruled that there was a genuine issue of material fact as to whether the procedures that the hospital followed in suspending the surgeon were fair given the entire factual circumstances of the case. The court emphasized that the hospital’s board of directors had specific notice of the deficiencies in the peer review process but chose to affirm the decision to suspend the physician’s privileges.36

The court also concluded that the hospital and its physicians were legally capable of conspiring in violation of the antitrust laws because the physicians and the hospital could have personally benefited from the plaintiff’s suspension. The physicians on the peer review committee competed with the surgeon in the area of thoracic surgery and, by suspending the plaintiff, the hospital achieved a monopoly on diagnostic testing in the relevant market.37

In a decision with potentially significant ramifications for the viability of HCQIA as a defense in peer review cases, the Sixth Circuit in Manion v. Evans38 held that peer review participants cannot immediately appeal a district court order denying them summary judgment under HCQIA.39 As a general rule, denial of summary judgment is not an appealable final order. However, the collateral order exception of 28 U.S.C. § 1291 permits immediate appeal from orders that would conclusively determine the disputed question, resolve an important issue separate from the merits of the action, and be effectively unreviewable on appeal from a final judgment. Thus, courts have held that immunity from suit or the right not to stand trial is immediately reviewable. In Manion, however, the Sixth Circuit found that HCQIA’s legislative history indicates that its immunity extends

36. Id. at 1377-79.
37. Id. at 1383.
38. 986 F.2d 1036 (6th Cir. 1993).
39. Id. at 1042.
only to liability for damages, not total immunity from suit. Thus, a trial court’s finding that a hospital and its staff are not entitled to immunity under HCQIA is not immediately appealable.\footnote{Id. at 1041-42. See also Decker v IHC Hosp., Inc., 982 F.2d 433 (10th Cir. 1992) (denial of immunity to professional peer review body under HCQIA was not immediately appealable because HCQIA immunizes peer review participants from damages liability only, not liability from suit).} This decision, like \textit{Decker v IHC Hospital} last year, effectively undermines one of the primary anticipated benefits of HCQIA—the ability of peer review participants to promptly and relatively inexpensively obtain dismissal of antitrust claims arising out of peer review actions taken in compliance with HCQIA.

\textbf{B. The Defense of Staff Privileges Cases on the Merits}

Even when HCQIA was not invoked as a defense, courts have found alternate grounds to summarily dismiss complaints against hospitals and their staff arising out of peer review proceedings. In this respect, hospitals continued their long run of successfully defeating antitrust claims made by physicians whose privileges were revoked or denied in the first place.

In \textit{Balaklaw v. Lovell},\footnote{1994-1 Trade Cas. (CCH) ¶ 70,497 (2d Cir. Jan. 26, 1994).} the Second Circuit held that the plaintiff lacked standing to assert his antitrust claims because his alleged injuries were personal in nature, not the type that the antitrust laws were intended to prevent. The plaintiff, the former chief of the anesthesiology department at defendant Cortland Memorial Hospital (CMH) in New York, lost his privileges when CMH awarded an exclusive contract to a competing anesthesiology group that submitted a lower bid. The plaintiff alleged that CMH and others engaged in a group boycott and unreasonably restrained trade by preventing him from practicing anesthesiology at CMH.

In affirming the district court’s grant of summary judgment in favor of CMH, the Second Circuit concluded that competition was not foreclosed in either of the two relevant markets. In the market for \textit{consumers} of anesthesiology services, the only change was the identity of the group providing the exclusive services. In the market for \textit{providers} of anesthesiology services, the geographic scope of the market could be multi-state or even...
nationwide as evidenced by the hospital’s solicitation of proposals from anesthesiology groups in seven states.\(^\text{42}\)

In *Flegel v. Christian Hospital Northeast-Northwest*,\(^\text{43}\) the Eighth Circuit affirmed a grant of summary judgment in favor of the defendants based upon the plaintiffs’ failure to present sufficient evidence of anticompetitive effects. Plaintiffs, two osteopathic doctors who were denied privileges at Christian Hospital Northeast-Northwest (Christian), had applied to be the first osteopathic urologists on Christian’s staff. They relied on the affidavits of osteopathic doctors in general practice at Christian who asserted that their patients would receive better care if treated by the plaintiffs than by medical doctor urologists. However, the court found no evidence that the allegedly lower quality of care had caused the affiants to move a patient out of Christian for treatment by the plaintiffs.\(^\text{44}\) The court also held that the plaintiffs failed to prove that the relevant market was limited to urologists’ services at Christian rather than in the St. Louis metropolitan area.\(^\text{45}\)

In *Willman v. Heartland Hospital East*,\(^\text{46}\) the court granted summary judgment in favor of a hospital and the physicians who participated in the peer review process at issue. The plaintiff alleged that his competitors participated in the peer review process as a “sham” to cover up their intent to drive him from the market. The court rejected plaintiff’s claim that the defendants committed a per se violation of the Sherman Act. Citing *Flegel*, the court stated that the exclusion from staff privileges fell within the category of “industry self-regulation,” which was not appropriate for per se analysis.\(^\text{47}\) The court also rejected plaintiff’s claim under the rule of reason analysis. The court ruled that the insignificant competitive advantage to be gained by the

\(^{42}\) Id. at 71,699.

\(^{43}\) 4 F.3d 682 (8th Cir. 1993).

\(^{44}\) Id. at 689.

\(^{45}\) Id. at 690-91. The Eighth Circuit also rejected the plaintiffs’ argument that the defendants’ actions that led the hospital to deny them privileges amounted to a group boycott subject to per se analysis under the Sherman Act. The court stated that the practice of excluding nonphysicians in favor of physicians was not one that would always have an anticompetitive effect; therefore, it was appropriate to apply the rule of reason analysis. The court also stated that the exclusion from staff privileges constitutes “industry self-regulation,” which is not appropriate for per se analysis. Id. at 687.


\(^{47}\) Id. at 1527.
forty-three physicians alleged to be competitors rendered the plaintiff's conspiracy claim implausible.\(^ {48}\)

Other courts have invoked the state action doctrine to insulate hospitals and their staffs from potential antitrust liability. In *Bolt v. Halifax Hospital Medical Center*,\(^ {49}\) the Eleventh Circuit held that Halifax Hospital Medical Center was entitled to summary judgment on plaintiff's claim that it conspired with its peer review committee in violation of the antitrust laws. The Eleventh Circuit previously had held in the same case that the hospital should be treated as a municipality subject to the state action doctrine, but denied the hospital immunity because plaintiff had alleged that the hospital conspired with its peer review board to deny him staff privileges.\(^ {50}\) After the United States Supreme Court held that there was no conspiracy exception to the state action immunity doctrine in *City of Columbia v. Omni Outdoor Advertising, Inc.*,\(^ {51}\) the *Bolt* court granted the hospital summary judgment.

In *Scara v. Bradley Memorial Hospital*,\(^ {52}\) two licensed anesthesiologists alleged that the exclusive contract of Bradley Memorial Hospital, a public hospital, with Cleveland Anesthesiologists was an unlawful tying arrangement and established a monopoly in favor of Cleveland Anesthesiologists. The court held that the defendants were subject to the state action immunity doctrine because Tennessee law vested the hospital with the authority to enter into contracts for the employment of all personnel and the hospital actively supervised Cleveland Anesthesiologists' performance under the contract.\(^ {53}\)

Other courts ruled in favor of hospitals and their staffs on the grounds that a hospital is legally incapable of conspiring with its medical staff in violation of the antitrust laws during the peer review process. In *Pudlo v. Adamski*, the Seventh Circuit dismissed a physician's complaint alleging that a hospital violated the antitrust laws when it terminated his staff privileges.\(^ {54}\) The court held that a hospital is legally incapable of conspiring with its medical staff during the peer review process where the medical staff has been delegated the authority to recommend action
to the hospital’s board. In reaching its decision, the Seventh Circuit followed similar decisions in the Third and Fourth Circuits and rejected the contrary reasoning of the Ninth and Eleventh Circuits.55

Plaintiffs were not shut out entirely in 1993. In a decision driven by the case’s unsavory facts, the Eleventh Circuit (which previously held that a hospital can conspire with its staff) reinstated a verdict of $450,000 against a hospital in a staff privileges case in Boczar v. Manatee Hospitals & Health Systems.56 The court reversed a judgment notwithstanding the verdict in favor of the defendant Manatee Memorial Hospital (Manatee), which had terminated the plaintiff’s staff privileges. The district court had granted Manatee’s motion for judgment notwithstanding the verdict after the individual defendants on the peer review committee were dismissed, holding that the verdict against the hospital for conspiring in violation of the antitrust laws was inconsistent with the dismissal of the individual defendants. The appellate court reversed, holding that the hospital could have conspired with members of the hospital staff other than the individual defendants or even with the named defendants, who could have been found not liable by the jury because they were either not the proximate cause of the plaintiff’s injuries or were immune from liability.57

The court found sufficient evidence that Manatee conspired with others to restrain the plaintiff’s practice of medicine. First, the court held that the hospital had an economic incentive to terminate the plaintiff. When the plaintiff first joined the medical staff, several competing members of the obstetrics/gynecology staff defected to a competing hospital. Manatee feared further defections because the plaintiff’s prices were significantly lower than those of competing physicians at Manatee. Also, the plaintiff had reported numerous errors made by the hospital’s staff.58 Second, Manatee’s alleged reason for suspending the plaintiff proved to be false. Although the hospital alleged that the plaintiff had abandoned a patient, the patient

56. 993 F.2d 1514 (11th Cir. 1993).
57. Id. at 1516-17 & n.5.
58. Id. at 1517-18.
testified at trial that she was not the plaintiff’s patient and that the hospital had tricked her into signing a misleading affidavit.\textsuperscript{59}

Because of its unique facts, \textit{Manatee} should not be of great concern to hospitals or participants in the peer review process. It does show, however, that once a hospital grants a physician staff privileges, it must act prudently in revoking them.

\section*{IV. The Agencies Encourage the Formation of Physician Networks but Discourage Them From Operating Anticompetitively}

The federal antitrust enforcement agencies have actively encouraged physician networks and joint ventures formed to negotiate risk-sharing contracts with managed care payers. However, when these networks act anticompetitively, the agencies have not hesitated to challenge their conduct. Thus, the agencies have signaled that they will not challenge physician networks that do not wield market power and operate nonexclusively—that is, when the network members are free to negotiate and contract with payers independently from the group. In contrast, if a provider organization is formed to engage in price fixing without risk sharing or to prevent the development of managed care by engaging in a concerted refusal to deal, the agencies will intercede to protect competition.

In a January 7, 1993 business review letter, the Department of Justice stated its intent not to challenge a proposal by Case Western Reserve University School of Medicine and University Hospitals of Cleveland to use a single agent to negotiate contract terms and fees with third-party payers on behalf of nineteen separate, noncompeting physician practice groups that provide medical care at the hospitals.\textsuperscript{60} The agent was to advise third-party payers that they could negotiate directly with any practice group, and each practice group was free to accept or reject an agent-negotiated contract. Moreover, all practice group contracts would be independent from each other. The Department of Justice concluded that the proposal was unlikely to increase the availability of fee and cost information among competing providers and thus unlikely to facilitate collusion. The Department of Justice also noted that the arrangement

\textsuperscript{59} Id. at 1518-19.

\textsuperscript{60} 64 Antitrust & Trade Reg. Rep. (BNA) No. 1597, at 11-12 (Jan. 14, 1993) (the full text of the business review letter is available in Westlaw, at 1993 WL 4171 (D.O.J.)).
would expedite negotiations and facilitate the bargaining process, thereby lowering the costs associated with contracting.

Similarly, in a November 8, 1993 business review letter, the Department of Justice announced that it would not challenge a proposal by St. Anthony Medical Center in Rockford, Illinois to offer preferred provider contracts to employers and other third-party payers.\textsuperscript{61} St. Anthony proposed to enter into multiple, nonexclusive subcontracts with physicians and/or another hospital, and then offer managed care contracts that would combine St. Anthony and the subcontracting providers as joint preferred providers. Its goal was to compete more vigorously for managed care contracts. The subcontract between St. Anthony and the other hospital would include overflow services (services that St. Anthony would be unable to provide) as well as patient-choice services (services that St. Anthony provides but that the patient would prefer to receive from the other hospital). However, referrals for both overflow and patient-choice services would be limited to an amount equal to twenty percent of St. Anthony admissions. The Department of Justice concluded that the nonexclusivity provision and the referral limitation would protect against any anticompetitive behavior. Moreover, the proposal would increase competition for managed care plans and help drive down costs for consumers.

In contrast, when an independent practice association (IPA) served as a vehicle for competing physicians to engage in a boycott of a health maintenance organization (HMO), the Department of Justice intervened to prohibit the unlawful, anticompetitive conduct. In \textit{United States v. Greater Bridgeport Individual Practice Association, Inc.},\textsuperscript{62} an IPA and its members, who constituted about ninety percent of the physicians in the Bridgeport, Connecticut area, were prohibited by a consent decree from entering into any agreements whereby the members would \textit{not} contract individually with an HMO. The IPA was also required to establish an antitrust compliance program.\textsuperscript{63}

\textsuperscript{61} 65 Antitrust & Trade Reg. Rep. (BNA) No. 1640, at 652 (Nov. 18, 1993) (the full text of the business review letter is available in Westlaw, 1993 WL 482071 (D.O.J.)).

\textsuperscript{62} 1993-2 Trade Cas. (CCH) ¶ 70,389 (D. Conn. Jan. 1, 1993).

\textsuperscript{63} The FTC took similar action against the McLean County Chiropractic Association, a group representing thirteen competing chiropractors in the Bloomington/Normal, Illinois area, which had set and then periodically voted to raise the maximum fees its members could charge patients and third-party payers for their services. \textit{In re McLean County Chiropractic Ass'n}, 5 Trade Reg. Rep. (CCH) ¶ 23,524 (Jan. 5, 1994).
In one of the first cases to emerge from the FTC’s investigation of physician referrals to self-owned firms, two San Francisco Bay Area home medical equipment firms and their twenty-eight investing physicians agreed to reduce the number of physician partners in each company to resolve FTC charges that the firms violated antitrust laws in obtaining high market shares. According to the FTC complaint, the joint ventures permitted groups of specialists to control the market for an ancillary service by controlling patient access to that service. In each case, the ancillary service was the provision of oxygen systems prescribed for home use by patients with lung, heart, or other diseases who cannot obtain sufficient oxygen through normal breathing. In general, patients who require oxygen systems receive the services of pulmonologists or of hospital staff members who are supervised by pulmonologists. As a result, pulmonologists can influence the choice of which oxygen systems supplier will service their patients. According to the FTC complaints, sixty percent of the pulmonologists in the areas served by the two medical equipment firms became affiliated in one or the other of the two firms. Furthermore, several of the pulmonologists partners were medical directors of the respiratory therapy departments of hospitals in the firms’ service areas. Under the proposed consent agreements between the firms and the FTC, the pulmonologists in each partnership would be required to reduce their collective ownership so that twenty-five percent or less of the pulmonologists in the relevant geographic market are affiliated with the partnership.

V. COURTS REFUSE TO INTERFERE WITH THE PROCOMPETITIVE OPERATION OF MANAGED CARE ORGANIZATIONS

There has been a paucity of private litigation involving the operation of managed care organizations. In two important cases in 1993, however, the courts upheld the conduct of health maintenance organizations against challenges by excluded com-

The FTC prohibited the Association from entering into any agreement with any chiropractor to 1) discuss or collectively determine fees, or 2) deal with payers on collectively determined terms. For an explanation of maximum fee price fixing, see Arizona v. Maricopa County Medical Soc’y, 457 U.S. 332 (1982).

peting physicians in one case and by a competing managed care organization in the other.

In *Capital Imaging Associates, P.C. v. Mohawk Valley Medical Associates, Inc.*, the Second Circuit affirmed summary judgment in favor of member physicians of an IPA model HMO against allegations that it denied the plaintiff's application for membership into the IPA in violation of the antitrust laws. Plaintiff Capital Imaging Associates, P.C. (Capital) was a private radiology group in Albany County, New York, offering diagnostic imaging services. Defendant Mohawk Valley Medical Associates, Inc. (Mohawk) was an independent physician practice association providing medical care to enrollees in defendant Mohawk Valley Physicians Health Plan (the Plan). The Plan purchased medical services from Mohawk at a fixed capitated rate per individual enrollee and did not permit price competition among the doctors. The court held that Capital failed to prove any anticompetitive effects on the relevant market because the radiology service fees would remain the same irrespective of whether the plaintiff was admitted into Mohawk. The court also held that Capital failed to establish the defendant's market power—the Plan's 100,500 enrollees represented only 2.3 percent of the region's HMO subscribers and Mohawk's membership included only 6.75 percent of the region's physicians. The court noted that Mohawk's market share was even lower, 1.15 percent, if the market was defined as including competition from non-HMO sources.

In *U.S. HealthCare, Inc. v. HealthSource, Inc.*, plaintiff, one of the largest providers of HMO services in the country, alleged that the defendant HMO entered into an unlawful exclusive dealing arrangement with its primary care physicians. Prior to the filing of the complaint, defendant Healthsource was the only nonstaff model HMO in New Hampshire. In the Fall of 1989, Healthsource notified its panel of doctors that they would receive greater compensation if they agreed not to contract with any other HMO. A doctor who accepted Healthsource's offer remained free to serve non-HMO patients and could revert to nonexclusive participation in Healthsource by giving adequate notice.

65. 996 F.2d 537 (2d Cir. 1993).
66. *Id.* at 546.
67. *Id.* at 547.
68. 986 F.2d 589 (1st Cir. 1993).
Plaintiff challenged the exclusivity clause as both a group boycott and an attempt to monopolize. On the boycott claim, the court held that an exclusivity clause that was terminable on thirty days' notice posed only a de minimis constraint and, despite the fact that Healthsource had exclusive contracts with twenty-five percent of the primary care physicians in the relevant market, competing HMOs were not precluded from entering the market and contracting with the remaining doctors. 69

On the monopolization claim, the court found that plaintiff failed to properly define the relevant product and geographic markets. The court stated that there was an issue whether the product market consisted only of HMOs or constituted the broader market of health care financing, which would include indemnity insurers, staff model HMOs, and preferred provider organizations. The court stated that the geographic market could have been southern New Hampshire or the whole state. 70

VI. TRADE ASSOCIATION ACTIVITIES CONTINUE TO RECEIVE CLOSE SCRUTINY BY THE FEDERAL ANTITRUST ENFORCEMENT AGENCIES

Trade associations can be procompetitive or, in some cases, they can serve as a vehicle for their members to engage in anticompetitive behavior. As the antitrust enforcement policy statements indicate, the exchange of competitively sensitive price and cost data by trade associations can create antitrust concerns.

For example, in an October 1, 1993 business review letter, the Department of Justice stated it would challenge a proposal submitted on behalf of the Pharmaceutical Manufacturers Association (PMA) to implement a program whereby its member companies would commit to limit their price increases on their entire line of prescription drug products in any calendar year to an amount not to exceed the increase in the Consumer Price Index. 71 According to the PMA, it developed the proposed program in response to concerns about controlling health care costs, including the cost of prescription drugs, pending implementation of comprehensive health care reform. Each PMA member company would decide unilaterally whether to participate in the program and was free to withdraw at any time.
Department of Justice characterized the PMA proposal as an arrangement among competitors that limits individual pricing decisions—a per se Sherman Act Section 1 violation. The Department of Justice emphasized that the antitrust laws do not prohibit individual firms from adopting and announcing pricing policies that are intended to contain or limit increases in the prices of their products.\textsuperscript{72}

In contrast, in an October 13, 1993 business review letter, the Department of Justice announced that it would not challenge a voluntary data exchange program by a health care trade association for transporting products commonly sold in drugstores.\textsuperscript{73} The Health and Personal Care Distribution Conference (HPCDC), a trade association comprised of seventy-five members that distribute drugs, medicines, toilet preparations, and related articles to wholesale and retail customers, proposed to survey its members periodically regarding their actual experience with general freight motor carriers. A third party would compile the information and publish the results. The published report would not identify any of the survey results with any particular member of HPCDC participating in the survey. The Department of Justice stated that the proposed information exchange could be potentially anticompetitive if it resulted in the exercise of monopsony power over transportation rates, but that HPCDC could not negotiate transportation rates collectively on behalf of any of its members. The Department of Justice also concluded that the information exchange would not facilitate price collusion or otherwise reduce competition for the purchase or sale of the members’ products; the members’ products have relatively high selling prices, with the transportation cost representing less than two percent of the total price. Since the transportation cost component of the selling price was so low, HPCDC’s members would be unable to use the information exchange as a vehicle by which to collude on the prices of their products.

\textsuperscript{72} The Sherman Act proscribes concerted action to unreasonably restrain trade. It does not reach conduct that is “wholly unilateral.” Copperweld Corp. v. Independence Tube Corp., 467 U.S. 752, 768 (1984).

\textsuperscript{73} 65 Antitrust & Trade Reg. Rep. (BNA) No. 1635, at 491 (Oct. 14, 1993) (the full text of the business review letter is available in Westlaw, 1993 WL 421017 (D.O.J.)).
CONCLUSION

The fundamental purpose of the antitrust laws is to promote competition, not to protect any individual competitor or select group of individuals. During 1993, the enforcement agencies construed and the courts applied the antitrust laws to the health care field with that objective firmly in mind by encouraging cooperation among providers to reduce costs or increase efficiency and challenging those arrangements formed or operated for anticompetitive purposes.