

# Developments in Antitrust Law

Spring 2007

## FOCUS ON HEALTH CARE

### AVOIDING PRICE-FIXING CHARGES IN NEGOTIATIONS BETWEEN PHYSICIANS' GROUPS AND MANAGED CARE ORGANIZATIONS

#### FTC SHEDS MORE LIGHT ON CLINICAL INTEGRATION STANDARDS

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The Federal Trade Commission provided new guidance on its standards for “clinical integration” in its 2006 Advisory Opinion to *Suburban Health Organization, Inc.*, stating that, if a network of competing physicians meets the FTC’s clinical integration standards, it may negotiate with a managed care organization (MCO) on behalf of its physician members without fear of a federal Antitrust prosecution for price-fixing.

After years of settling physician price-fixing cases, the FTC has started warning that it may bring suit against physicians engaged in price-fixing to disgorge their illegal profits or, in appropriate cases, refer them to the Justice Department for criminal prosecution. Moreover, several health insurers have instituted private antitrust actions against provider networks within the last several years alleging price-fixing and other antitrust violations. These changes in the enforcement climate significantly raise the stakes for physician hospital organizations (PHOs) and independent practice organizations (IPOs) and their members who are engaged in collective contract negotiations with MCOs.

Over the years there have been significant skirmishes between IPOs which are engaged in negotiating with MCOs, and the federal antitrust enforcement agencies, who have attacked these joint negotiations and resulting refusals to deal as violations of the antitrust prohibitions on price-fixing, group boycotts, tying and market allocation. At the same time, the federal regulators have sought to promote



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interdependence and cooperation among independent, competing physicians by developing carefully crafted “safe harbors”. One such harbor exists when physicians form a financially or clinically integrated organization to achieve greater efficiencies and higher quality health care. “Clinical integration” exists where a physician network implements an *active and ongoing* program to *evaluate and modify* practice patterns of participating physicians and to create a high degree of interdependence and cooperation among the physicians in order to reduce costs and ensure quality.

In the *Suburban Health Opinion*, the FTC concluded that there were only limited integration and limited efficiencies. It found the joint pricing and exclusive nature of the network were not “reasonably necessary” (the crucial test) to achieve the projected efficiencies and would unreasonably restrict competition. In its 2002 Advisory Opinion to *MedSouth, Inc.*, the FTC had reached a contrary result, concluding that joint contracting was reasonably necessary for the IPO to achieve partial integration of its physician network and achieve the targeted quality improvements and cost reductions. Taken together, these Opinions provide a good road map as to what is needed to create a clinically integrated organization that can engage in joint contracting activities without violating the antitrust laws. Thus, to pass muster safely from an antitrust standpoint, any clinical integration program should satisfy the following conditions:

- **The physician network should be non-exclusive.** Non-exclusive means that there are other competing networks in the market and that physicians in the network actually participate in and contract with MCOs individually or through such other networks. Where physicians in the network are restricted from individually contracting with MCOs or other networks, the network will be considered exclusive and will have to demonstrate that the restrictions are reasonably necessary to achieve the program efficiencies.

- **No physician specialty in the network should have a market share of more than 30%.** If the network has the ability to exercise significant market power (which it may have if any physician specialty in the network has market share of over 30%) or if the arrangement is exclusive, there may be too great a foreclosure of competition, raising a red flag.
- **A sufficient variety of providers should be in the network to ensure meaningful collaboration.** One of the deficiencies of the Suburban Health network was that it included only hospital-based primary care physicians, and thus there was little opportunity for the physicians to work collaboratively and integrate various specialties.
- **There should be sufficient informational infrastructure and collective investment to implement the program.** Significant investment in new information systems to provide clinical and financial information in the hospital, outpatient facilities and the office is important, because it not only provides the data needed to evaluate and modify physician performance, but also demonstrates that the program could not be undertaken by any single physician group.
- **The program should have specific goals that could not be accomplished by the physicians acting individually and data should be developed to demonstrate these goals are being achieved.** This is crucial.
- **The program should have incentives and other mechanisms to modify physician behavior.** No clinical integration program is likely to achieve efficiencies or improve quality unless there are mechanisms to identify and modify physician behavior, i.e., practice patterns to control costs and ensure quality through interdependence. The mechanisms include meaningful financial incentives, practice oversight, and other carrots and sticks to improve efficiency and quality care.

- Joint contracting should be reasonably necessary to achieve the desired integration and collaboration. In the *MedSouth* opinion, the FTC concluded that the projected efficiencies and cost-savings could only be achieved if contracting with payers was done on a collective basis, because collective contract negotiation permitted allocation of network revenues among the physicians in a manner that would provide financial incentives to improve performance.
- The network should take steps to ensure it does not become a conduit for the exchange of competitively sensitive information among competing physicians and there are other protections against anticompetitive spillover. Counsel's participation in establishing and evaluating the network is essential.

Clinical integration programs are not easy to develop and implement. They require committed physician leadership and broad financial support to achieve the desired results lawfully. However, in view of the difficulties of financial risk sharing and the limitations of the alternative "messenger" model (in which agents convey information from the providers to purchasers), clinical integration seems to be the best way forward for IPOs and other physician networks. ▲

## UPDATES: ANTITRUST HEALTH CARE BRIEFS

### PRICE-FIXING

Joint action among doctors that did not pass the *MedSouth/Suburban Health* test is exemplified in the FTC's *Advocate Health Partners* case.

Groups representing more than 2,900 independent Chicago-area physicians have just resolved FTC price-fixing charges by consent decree. The organizations, Advocate Health Partners (AHP) and related parties, agreed to cease fixing prices and refusing to deal with various health plans on collectively determined terms.

AHP is a "super physician- hospital organization," whose members consist of the nonprofit Advocate Health Care Network (AHCN) hospital system and eight physician-hospital organizations organized at AHCN hospital sites. The FTC charged AHP with acting as the collective bargaining agent for member-physicians in contracts with health plans, and that, for ten years until 2004, the respondents collectively negotiated the prices and other contract terms at which their otherwise competing member-physicians would provide services to health plan subscribers, without any efficiency-enhancing integration of their practices sufficient to justify their conduct. The proposed consent order prohibits the respondents from entering into or facilitating agreements between or among physicians: (1) to negotiate with payors on any physician's behalf; (2) to deal, refuse to deal, or threaten to refuse to deal with any payor; (3) to designate the terms upon which any physician deals or is willing to deal with any payors; and (4) not to deal individually with any payor, or to deal with any payor only through any arrangement involving the respondents.

## FTC VIEWS ON PHYSICIAN GROUP PRICING

David Wales, Deputy Director of the FTC's Bureau of Competition, recently provided the agency's perspective during a hearing that examined competition in group health care. Wales outlined the agency's broad and proactive effort to inform and educate health care providers.

Challenged arrangements generally involve "otherwise competing physicians jointly setting their prices and collectively agreeing to withhold their services if health care payers do not meet their fee demands." This conduct, he stressed, harms competition and consumers by "raising prices for health care services and health care insurance coverage and reducing consumers' choices." However, he acknowledged, not all joint conduct by physicians is improper; some physician network joint ventures "can yield impressive efficiencies."

Wales emphasized that "collective setting of prices and negotiation with health plans by physicians does not assure quality health care" and that "there is no inherent inconsistency between vigorous competition and the delivery of high quality health care services. . . . When vigorous competition occurs, consumer welfare is increased in health care, as in other sectors of the economy."

## PRICE DISCRIMINATION:

### HOSPITAL-OWNED PHARMACIES

The FTC Bureau of Competition has cleared a plan to provide pharmaceuticals to patients of a health system's affiliated hospital and its affiliated clinic through three hospital-owned pharmacies in an Advisory Opinion, *St. John's Health System*.

St. John's Health System is a non-profit corporation in Missouri that operates an integrated health services

delivery system. It offers medical services through two wholly-owned subsidiaries, that also are non-profit Missouri corporations: St. John's Regional Health Center (hospital); and St. John's Clinic (clinic).

St. John's Health System enjoys preferential prices for purchases of pharmaceuticals used to treat Hospital inpatients, as permitted under the Non-Profit Institutions Act (NPIA). The proposal cleared by the FTC involves a plan to provide the preferentially priced pharmaceuticals to clinic patients and hospital outpatients.

The FTC explained that the proposed program falls within the NPIA, which exempts from liability for price discrimination under the Robinson-Patman Act "purchases of . . . supplies for their own use by schools, colleges, universities, public libraries, churches, hospitals, and charitable institutions not operated for profit." Under the NPIA, an institution that is eligible for the NPIA exemption must purchase the discounted pharmaceuticals for its "own use."

The Assistant Director of the FTC's Health Care Division concluded that the information about the proposed program provided sufficient evidence to satisfy the "own use" requirement. More than 90 percent of the prescriptions filled and dispensed at three hospital-owned pharmacies are written by the clinic's physicians for their patients; the other 10 percent filled at the three hospital-owned pharmacies are for non-St. John's patients. The plan avoids any improper sales of the discounted pharmaceuticals to a non-exempt entity or for a non-exempt use by establishing a separate accounting mechanism.

The FTC staff appeared to be satisfied with these assurances, and it concluded that the pharmaceutical purchase and distribution program proposed by St. John's would fall within the NPIA exemption to the Robinson-Patman Act. ▲

## STAFF PRIVILEGES AND EXCLUSIONS

### A. Doctor's Claim Survives Early Test

In *C.V.R. Reddy v. Joseph Puma*, the United States District Court in New York City considered one of the innumerable cases brought by physicians over the past twenty years claiming antitrust violations flowing from their exclusion from hospital privileges or staff positions. In this case, ruling on a motion to dismiss the claim, the Court decided cardiologists had standing (the right) to assert a claim that they suffered antitrust injury as a result of a group of physicians' attempted anticompetitive behavior to displace him and his associate from treating patients at New York Methodist Hospital in Brooklyn. The Court ruled the displacement of the two cardiologists could have resulted in the decline of quality patient care, where they treated over 35 percent of the patients in the cardiology division. At this early stage of the case – the defense sought immediate dismissal before any discovery – the Court ruled the cardiologists' alleged market share was substantial enough that their elimination from the relevant market could have an impact on the quality and output of services in the relevant market as a whole. The Court recognized that the relevant market – the geographic area in which an appreciable number of patients would turn to the hospital for cardiology services – might be far too large for the exclusion of the two doctors to constitute a sufficient adverse effect on overall competition (a finding that often dooms plaintiffs in these cases). But it was premature to decide that.

The court also ruled on whether there could even be a conspiracy. It found that the exclusion of two physicians specializing in cardiovascular surgery from the market by discouraging hospital personnel from referring patients to the cardiologists, if proven, would have constituted a conspiracy to restrain trade in violation of Sec. 1 of the Sherman Act. The complaining cardiologists' claims did not fail under the "intraenterprise conspiracy" doctrine, which would have immunized the defendants. That doctrine did not

apply because the cardiologists sufficiently alleged an agreement between two "economically distinct" actors; while the defendant physicians were employed by the same hospital, the complaint specifically stated that each had "independent and competing economic interests" from the hospital. Such competing interests were quite common for doctors working a hospital, and the complaining cardiologists' assertion of these competing interests was enough for the complaint to survive, at least at this earliest stage. Absent two distinct actors, there can be no "contract combination or conspiracy" however, to violate §1 of the Sherman Act, 15 U.S.C. 1.

### B. Fifth Circuit Upholds Dismissal Of Physician's Exclusion Claim

An allegation that a gastroenterologist's removal from the staff of a hospital "was [an] injury to the competitive market in that it reduced the public's choice of providers who could effectively treat them" does not sufficiently allege harm to competition to state a Sherman Act Section 1 claim, according to an opinion by the United States Court of Appeals in Dallas in *Taylor v. Christus St. Joseph Health Systems*, issued on February 6, 2007.

The Court observed that the plaintiff, a gastroenterologist, actually alleged only one fact – that he was removed from practice at St. Joseph. "This fact," the court states, "only shows harm to [Dr.] Taylor, not to competition as required to allege a Sherman Act claim.

To adequately allege harm to competition, the Fifth Circuit said, Dr. Taylor would have had to allege "that there was a rise in the price of gastroenterology services above a competitive level, a decrease in the supply of gastroenterologists in the relevant market, or a decrease in the quality of gastroenterology service provided."

Dr. Taylor's complaint did not allege any of these injuries, the court observed. Dr. Taylor claimed "only that he was ejected from working at St. Joseph's, not that he was somehow prevented from serving patients

in the Paris, Texas area. He alleged only that his ejection might have ‘allowed the remaining doctors . . . to engage in monopoly pricing.’ He also stated that ‘the remaining market providers could now easily reduce services.’”

None of these statements, the Court held, amounted to a factual allegation sufficient to withstand a motion to dismiss the case at the beginning. ▲

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*For more information on these cases or other antitrust matters, please contact a member of the Shipman & Goodwin Antitrust Group.*

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## SHIPMAN & GOODWIN<sup>LLP</sup>

COUNSELORS AT LAW

One Constitution Plaza  
Hartford, CT 06103-1919  
(860) 251-5000

300 Atlantic Street      289 Greenwich Avenue  
Stamford, CT 06901-3522      Greenwich, CT 06830  
(203) 324-8100      (203) 869-5600

[www.shipmangoodwin.com](http://www.shipmangoodwin.com)

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### ANTITRUST GROUP

#### James Bergenn

jbergenn@goodwin.com  
(860) 251-5639

#### Ross Garber

rgarber@goodwin.com  
(860) 251-5901

#### Fred Gold

fgold@goodwin.com  
(203) 324-8110

#### Allan Hillman,

Newsletter Editor  
ahillman@goodwin.com  
(860) 251-5037

#### Sheila Huddleston

shuddleston@goodwin.com  
(860) 251-5723

#### Paul Sanson

psanson@goodwin.com  
(860) 251-5721

#### Thomas Tresselt

ttresselt@goodwin.com  
(860) 251-5810



## SHIPMAN & GOODWIN<sup>LLP</sup>

COUNSELORS AT LAW

One Constitution Plaza  
Hartford, CT 06103-1919