

Chapter 25:

Antitrust and

Consumer Protection

Laws

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Reference Date: The author prepared this chapter from reference materials that were available as of October 30, 2008.

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Acknowledgements

Special thanks to Doug Ross, of Davis Wright Tremaine, for his mentoring and comments.

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25.1 Chapter Summary

This Chapter summarizes federal and state antitrust and consumer protection laws that healthcare practitioners may face on a regular basis. In-depth treatment of these topics is available in other sources.¹ This Chapter provides an overview directed at issue spotting that might help prevent litigation. Thus, this Chapter intentionally omits the details of antitrust litigation that are of interest only after a suit has been filed (e.g., standing, antitrust injury, etc.). This Chapter first provides an overview of federal and state antitrust laws, followed by a brief explanation of the Washington Consumer Protection Act. The Chapter then reviews antitrust areas of concern common to healthcare practitioners, and concludes with a list of questions every administrator should keep in mind to help minimize the risk of antitrust violations.

25.2 Federal and State Antitrust Laws

The federal and state antitrust laws are based on the premise that competitive markets maximize consumer welfare by reducing the prices and increasing the quality of goods and services, while promoting innovation and determining the best allocation of resources. As a result, these laws protect competition itself, not individual competitors from the operation of competitive markets. As one judge noted, “the Sherman Act contemplates some roadkill on the turnpike to Efficiencyville.”² Thus, actions that leave the structure of a market untouched likely will not offend the antitrust laws, even if those actions may have a detrimental impact on particular providers within those markets. For example, replacing one exclusive provider of hospital-based services with another exclusive provider is not an antitrust violation: the market remains the same despite the potentially devastating effect on the ousted incumbent.

The antitrust laws protect competition in markets for both goods and services. Health care has been subject to the prohibitions of the antitrust laws since the United States Supreme Court eliminated the so-called “learned professions” exemption from federal antitrust law in 1975.³ The “entrepreneurial aspects of medicine” are similarly regulated by the Washington Consumer Protection Act and its antitrust provisions.⁴

At the federal level, the Sherman and Clayton Acts codify competition law. The Department of Justice (“DOJ”) and the Federal Trade Commission (“FTC”) have the power to enforce the nation’s antitrust laws, and private plaintiffs may bring private suits based on certain provisions of the laws. While a private plaintiff may only bring an action after a violation has occurred (or is dangerously likely to occur), the powers of the DOJ and the FTC are not so limited. These enforcement agencies may investigate suspected violations without ever filing suit; they must approve proposed mergers of a certain size and may bring actions to derail those mergers; and the DOJ may bring criminal actions. The penalties for violating the antitrust laws can be severe: losing defendants in civil cases face mandatory treble damages and attorney fees, plus the possibility of structural modifications through permanent injunctions.⁵ Criminal defendants face up to ten years in prison and up to \$1 million in fines for individuals and \$100 million for corporations for each count of a conviction.⁶

¹ See ABA SECTION OF ANTITRUST LAW, ANTITRUST LAW DEVELOPMENTS (6th ed. 2007); ABA SECTION OF ANTITRUST LAW, ANTITRUST HEALTH CARE HANDBOOK (3d ed. 2004); WSBA, WASHINGTON ANTITRUST AND CONSUMER PROTECTION HANDBOOK (4th ed. 2008).

² *Freeman v. San Diego Ass’n of Realtors*, 322 F.3d 1133, 1154 (9th Cir. 2003).

³ *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 788 n.17 (1975).

⁴ *Quimby v. Fine*, 45 Wn. App. 175, 182, 724 P.2d 403 (1986) (citing *Short v. Demopolis*, 103 Wn.2d 52, 61, 691 P.2d 163 (1984)). For purposes of the Washington CPA, the “entrepreneurial aspects of medicine” include “how the price of [medical] services is determined, billed, and collected and the way a [provider] obtains, retains and dismisses clients.” *Short*, 103 Wn. 2d at 61.

⁵ 15 U.S.C. §§ 15, 15a, 26.

⁶ 15 U.S.C. § 1.

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Washington's antitrust laws are codified in the Washington Consumer Protection Act ("WCPA"),⁷ and enshrined in the state Constitution.⁸ There is no meaningful distinction between these provisions. The antitrust provisions of the WCPA mirror their federal counterparts in most important respects. The primary distinction is that Washington's antitrust laws reach purely intrastate activities, while the federal laws require something more than a *de minimis* impact on interstate commerce, although in the health care sector—with numerous multi-state payors, as well as goods that travel between the states from manufacturer to end-user—a finding of a sufficient impact on interstate commerce for purposes of federal law is nearly perfunctory. Given the near perfect overlap of the state and federal antitrust laws, there are very few reported cases in any industry addressing solely the antitrust provisions of the WCPA. Private plaintiffs may bring private actions under Washington's laws and the state Attorney General may launch pre-suit investigation and bring enforcement actions. Washington's laws permit awards of treble damages, but they are discretionary with the court and they are limited to \$10,000.⁹ Structural remedies are available through injunctive relief under Washington's laws. Violations of Washington's antitrust laws are not criminal offenses.

25.2.1 Agreements in Restraint of Trade

Section One of the Sherman Act (and Section Three of the WCPA) prohibit agreements in restraint of trade.¹⁰ A finding of an agreement is indispensable for a Section One violation, but the agreement need not be written down or even expressly stated. Instead, it may be inferred from parallel conduct by competitors or other circumstantial evidence. The requirement of an agreement is very real, however, and if an antitrust plaintiff cannot allege facts that tend to rule out the possibility that the defendants were acting independently, the claims will not survive the pleading stage of a lawsuit.¹¹ Defendants may also raise Section One as a defense to a breach of contract claim on the grounds that the contract violates public policy and is therefore unenforceable.

The Supreme Court has long held that the antitrust laws do not prohibit all restraints of trade, but only "unreasonable" restraints. However, the Court has also recognized that some restraints are so pernicious that judges may declare them facially invalid without detailed analysis. Such restraints are "per se" unreasonable and include such obvious antitrust violations as agreements by competitors to fix prices or divide the territories in which they compete. The class of such restraints is narrow and provides a bright line for avoidance: if two competitors overtly agree to limit their competition, the agreement most likely is prohibited and should be avoided.

PRACTICE TIP

Two competitors in the same geographic market should almost never agree—whether expressly or tacitly—to set their prices at the same rates (whether purchasing or sale prices), limit their production, or allocate geographic markets between them. Any healthcare provider considering any agreement with a competitor should consult an antitrust attorney before taking any such action.

⁷ RCW 19.86.030 – 060.

⁸ Wash. Const. art. 12, § 22.

⁹ RCW 19.86.090.

¹⁰ 15 U.S.C. § 1; RCW 19.86.030.

¹¹ *E.g., Bell Atlantic Corp. v. Twombly*, 127 S. Ct. 1955, 1964 (2007).

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Outside of the per se realm, facts matter. The first factual inquiry involves defining the “relevant market” actually at issue. Defining the relevant market involves two dimensions: (1) defining the relevant geographic market and (2) defining the relevant product or service market. Both dimensions turn on questions of “interchangeability”: how far will a customer reasonably travel to obtain a replacement service and what services are reasonably interchangeable with those of the alleged monopolists? Moreover, market definition is not an end in itself, but frames the next factual inquiry: do the defendants have sufficient power in the properly defined market (sensibly enough, do they have “market power”?) such that they could “raise prices above those that would be charged in a competitive market.”¹² As the Supreme Court has noted, “without a definition of the market there is no way to measure the ability to lessen or destroy competition.”¹³ Although market power can be shown through direct evidence of supra-competitive prices, most often it is inferred by proof of the defendants’ market share within the relevant market. This factual inquiry requires identification of the competitors in the relevant market, the relative market shares of the alleged conspirators, and whether or not there are significant barriers to entry in the relevant market that would prevent new competitors from entering the market if the defendants tried to raise prices above competitive levels.

Thus, the fact that a joint venture might involve two providers of radiology services in Western Washington may be irrelevant; specificity is important in market definition and foreclosure analysis, as demonstrated in some possible variations on this hypothetical agreement between radiology providers:

- If the alliance is between mammography providers (service market) in Olympia and Bellingham (geographic markets), there is likely not to be a problem under the antitrust laws even if the conspirators were the only two providers in their respective cities. Because patients are not likely to consider Bellingham and Olympia reasonable geographic substitutes, the providers are not in the same geographic market and are therefore not competitors. Similarly, the numerous mammography providers throughout Puget Sound make the potential for foreclosure of a substantial amount of competition unlikely. Either way, the agreement is not likely to be an unreasonable restraint on trade.
- If the alliance is between a clinic providing only CT scans and another providing only MRI services, there is not likely to be a problem even if the clinics are in the same building. This is because the clinics specializing in different radiology modalities operate in separate service markets; their alliance would not by itself change the number of competitors in their respective service markets.
- A merger between two clinics that between them control only a small percentage of the market for MRIs in a properly defined geographic market would most likely survive scrutiny because the resulting firm would likely not have market power (i.e., the power to raise prices above a competitive level).
- Similarly, a merger between two clinics that between them would control a large portion of the market for MRIs in a well-defined geographic territory might suggest market power, unless there are no real barriers to entry in the market, as may be the case with radiology services.¹⁴

Market analysis is not the last of the factual inquiries into whether a restraint is unreasonable. Even if the agreement appears to foreclose an unreasonable amount of competition in the relevant market, the parties will have the opportunity to demonstrate the reasonable business justifications for the transaction. (There can be no

¹² *NCAA v. Bd. of Regents*, 468 U.S. 85, 109 n. 38 (1984).

¹³ *Walker Process Equip. Co. v. Food Mach. & Chem. Co.*, 382 U.S. 172, 177 (1965).

¹⁴ See, e.g., *East Portland Imaging Center, P.C. v. Providence Health System – Oregon*, No. 06-35394 (9th Cir. May 20, 2008) (unpublished) (affirming summary judgment upon finding that there are no barriers to entry in the diagnostic imaging market).

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justifications for per se violations, so this analysis does not apply to naked violations like price fixing.) Thus, the parties should always take care to document the business case for any agreement between potential or actual competitors, and such documentation should be credible and not just a self-serving exercise. For example, the parties to a joint venture ideally would be able to prove actual economies of scale that they will pass on to their patients in the form of lower prices as a result of the combination. Efficiencies that simply result in increased profits for the joint venture are less persuasive justifications, but still necessary to document. Calling higher prices that will result from greater market share an “economy of scale” is no justification at all.

PRACTICE TIP

To help avoid antitrust scrutiny, the business case for every agreement between competitors should include a section asking, How will this agreement benefit consumers? Answers that help deflect antitrust scrutiny include: lower prices, more available services, better abilities to recruit providers, and increased efficiency.

25.2.2 Unilateral Action

Section Two of the Sherman Act (and section four of the WCPA) prohibits the willful acquisition, maintenance and attempted acquisition of monopoly power through the exercise of predatory or exclusionary conduct.¹⁵ Section Two targets the unilateral actions of single actors, not agreements between competitors. Significantly, Section Two prohibits only “monopolization” and “attempted monopolization”; it does not outlaw monopolies per se or even the charging of monopoly prices through the exercise of monopoly power. Instead, Section Two focuses on willful conduct in acquiring, maintaining or attempting to acquire monopoly power: it prohibits “the willful acquisition or maintenance of monopoly power as distinguished from growth or development as a consequence of a superior product, business acumen, or historical accident.”¹⁶ In other words, Section Two does not prohibit one provider from acquiring a monopoly; after all, certain communities may only support one cardiologist or one neurosurgeon. Section Two prohibits that neurosurgeon from trying to keep other neurosurgeons out of the market through anticompetitive conduct.

This distinction between legitimate and illegitimate conduct (both of which might lead to monopoly) can be as difficult to apply as it is easy to state. The courts have developed relatively clear standards for certain types of unilateral conduct (e.g., “predatory pricing,” where a defendant forsakes short-term profits in the hopes of driving competitors from the market and recouping its losses through the charging of supra-competitive prices).¹⁷ Otherwise, the particular facts are of paramount importance, and one of the key factors in distinguishing legitimate from illegitimate conduct is the business justification for the conduct. Thus, for example, a hospital’s requirement that its employed physicians refer only to other employed physicians may be a perfectly legitimate, efficiency-enhancing practice,¹⁸ while the same hospital’s prohibition on referrals from competing providers to a hospital-owned clinic may be an irrational (and therefore illegitimate) forsaking of immediate profits solely for the purpose of harming a competitor.¹⁹

¹⁵ 15 U.S.C. § 2; RCW 19.86.040.

¹⁶ *United States v. Grinnell Corp.*, 384 U.S. 563, 570-71 (1966).

¹⁷ See, e.g., *Weyerhaeuser Co. v. Ross-Simmons Hardwood Lumber Co.*, 127 S. Ct. 1069 (2007).

¹⁸ See *Blue Cross & Blue Shield United of Wisconsin v. Marshfield Clinic*, 65 F.3d 1406 (7th Cir. 1995).

¹⁹ See *MetroNet Servs. Corp. v. Qwest Corp.*, 383 F.3d 1124, 1134 (9th Cir. 2004).

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A defendant's intent is often of limited interest to an analysis under Section Two, despite the emphasis on "willful" acquisition or maintenance. The intent to drive one's competitors out of business is after all the heart of competition. As the Supreme Court has noted, "[t]he opportunity to charge monopoly prices—at least for a short period—is what attracts 'business acumen' in the first place."²⁰ (An important exception is an attempt to monopolize claim under Section Two, which requires a showing of an intent to monopolize a particular market.) As a result, actions generally matter more than words when considering unilateral actions: for example, emails from a hospital administrator expressing a desire to run the doctors who just opened a competing pathology lab out of town will generally be irrelevant without some follow through on those threats. (Even an attempt to monopolize claim requires a showing of anticompetitive actions in support of that attempt.) The embarrassment or rancor such statements might cause when they inevitably find their way to the medical staff or other stakeholders is, of course, a different story.

Section Two claims require the same market definition as Section One claims: the first step is defining what services over what geography are reasonably interchangeable with those offered by the defendant. Market power is also important in Section Two claims; anticompetitive conduct without market power might be many other things, but it is not an antitrust violation. For example, a failed doctor who burns down a rival's clinic is merely an arsonist; when the only doctor in town burns down the newly opened clinic of a competitor, he may be guilty of monopolization (as well as arson). In turn, the alleged monopolist's market share is very significant in determining whether that person has market power. In fact, certain benchmarks have solidified as *prima facie* evidence of market power (or its absence): a 70 percent share of any market tends to be *prima facie* evidence of market power, while a share of less 50 percent tends to be *prima facie* evidence of its absence. Barriers to entry are also relevant, and significant barriers may combine with lower market shares to provide evidence of market power, while insignificant barriers will require a showing of greater market share to prove market power. Or, in plain English: a radiologist accusing another radiologist of monopolization will have to show that the defendant enjoys a large market share because entry into the radiology market is relatively easy, while dialysis providers may need to make less of a showing against their monopolistic competitors due to the significant barriers to entry posed by the Certificate of Need statutes.

The primary distinction between monopolization and attempted monopolization is whether the defendant already has market power or whether there is merely a "dangerous probability" that the defendant will acquire such power if left unchecked in its exclusionary conduct; as a result, a lesser showing of market power (plus intent to monopolize) is required for an attempted monopolization claim.

PRACTICE TIP

Being the only provider in town is not prohibited under the antitrust laws. Nor is being (or becoming) the biggest provider in town. The antitrust laws prohibit protecting or acquiring your bigness or exclusivity through actions that have no rational basis other than to harm your competition. If you are the biggest or only provider in town, ask if your growth plan is based on your own organic growth opportunities, or if it is based on stopping your competitors' growth. If it is the latter, revise your plans and consult an antitrust attorney.

25.2.3 Mergers

Section 7 of the Clayton Act (and Section 6 of the WCPA) prohibits mergers and acquisitions that substantially lessen competition.²¹ Mergers are subject to scrutiny both before and after they are consummated. The

²⁰ *Verizon Commc'ns, Inc. v. Law Offices of Curtis V. Trinko, LLP*, 540 U.S. 398, 407 (2004).

²¹ 15 U.S.C. § 18; RCW 19.86.060.

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notification and waiting periods imposed by the Hart Scott Rodino Act²² permit the Antitrust Division of the DOJ and the FTC to review and take action to block certain mergers before they occur. Mergers can also be challenged retrospectively under Section 7 of the Clayton Act, as well as under Sections One and Two of the Sherman Act. Indeed, in 2007, the FTC concluded that an already completed merger of two hospital systems in Evanston, Illinois allowed the resulting system to exercise market power and increase prices for acute inpatient hospital services.²³ (Fortunately for the system, the FTC reversed the administrative law judge's conclusion that the merger would have to be unwound.) Mergers are subject to the same market analysis and procompetitive justifications as agreements under Section One of the Sherman Act.

25.2.4 Defenses

There are a number of statutory and judicially created exceptions to the federal antitrust laws. As with any exception to a statutory prohibition, these defenses are narrowly construed. Entities attempting to rely upon one of these exceptions to avoid scrutiny (or liability) should take particular care to meet the requirements of the defense.

25.2.4.1 Health Care Quality Improvement Act

The Health Care Quality Improvement Act ("HCQIA") of 1986²⁴ can shield hospitals and other healthcare providers from monetary damages under the antitrust laws (as well as other laws²⁵) for professional review investigations conducted into the competency or professional conduct of physicians, as well as actions taken pursuant to those investigations. There are four requirements for immunity for professional review under the HCQIA: the professional review must have been taken (1) in the reasonable belief that it would further the quality of health care; (2) after a reasonable effort to obtain the facts; (3) with "fair" procedural safeguards; and (4) in the reasonable belief that any disciplinary action is based on the facts. The HCQIA does not block injunctive relief, but its protections against the treble damages of an antitrust claim provide a strong incentive for building adequate safeguards into the peer-review process. It also permits a substantially successful defendant to recover its reasonable attorney fees if the plaintiff's antitrust claim is found to be frivolous.²⁶

PRACTICE TIP

The best way to ensure HCQIA immunity is to design the peer review section of your bylaws or other operating agreement to track the HCQIA's requirements, and then *follow those bylaws*.

25.2.4.2 State Action Immunity

The Supreme Court has held that the antitrust laws do not apply to states and their subdivisions where a targeted action is taken pursuant to the official policy of the state. This immunity applies most obviously to the laws passed by state legislatures, but it can also extend to private actors acting pursuant to official state policy. Specifically, private actors must demonstrate (1) that their actions were taken pursuant to a clearly

²² Hart-Scott-Rodino Antitrust Improvements Act of 1976, Pub. L. No. 94-435, § 201, 90 Stat. 1390 (codified as amended at 15 U.S.C. § 18a).

²³ *In re Evanston NW Healthcare Corp.*, FTC Dkt. No. 9315 (Aug. 6, 2007).

²⁴ 42 U.S.C. §§ 11,101-11,152.

²⁵ See *Morgan v. Peacehealth, Inc.*, 101 Wn. App. 750, 774 (2000) (affirming HCQIA immunity from claims under Washington Consumer Protection Act and other laws).

²⁶ 42 U.S.C. § 11,113.

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articulated state policy to displace competition and (2) that their actions are supervised by a state agency vested with the authority to supervise the activity at issue. Certificate of need programs are an obvious example of restraints on trade protected by the state action doctrine. Members of peer review panels at public hospitals may also enjoy immunity from the antitrust laws under the state action doctrine.²⁷

Public hospital districts in particular need to distinguish the state action doctrine from public entities acting as market participants. A public hospital district acting as a competitor, purchaser, or supplier is subject to the same restrictions under the federal antitrust laws as a private hospital. (Not-for-profit hospitals are also subject to the antitrust laws.) The mere fact of a public hospital district's public charter is not sufficient to satisfy the two requirements of the public action doctrine.

The Local Government Antitrust Act ("LGAA") of 1984 grants local governments—including public hospitals—and their officers and agents acting in their official capacity immunity from damages for antitrust claims.²⁸ The test for immunity under this act is the same as the state action doctrine. Whether the immunity applies to public hospital districts depends on the character of those districts under state law.²⁹ While this question has not been addressed under Washington law, the public nature of hospital districts in this state should support immunity under the LGAA. The act does not preclude injunctive relief.

PRACTICE TIP

Practitioners should never presume that immunity from the antitrust laws will be available under the state-action doctrine. Practitioners seeking to rely on this immunity should always seek the advice of an antitrust attorney.

25.2.4.3 Soliciting Government Action

Under the Noerr-Pennington doctrine (not to mention the First Amendment), parties are free to solicit government action without fear of liability under the antitrust laws. Generally, the character of the solicitation is irrelevant: a provider may lobby for the most anticompetitive laws, and may lobby in the most unscrupulous manner, without fear of retribution under the antitrust laws. (Other laws, of course, are a separate matter.) There is an exception for "sham petitioning," which is essentially bad faith or baseless litigation used as an anticompetitive weapon, but it is narrow. Thus, for example, one clinic may aggressively fight a competing clinic's request for a certificate of need without fear of liability under the antitrust laws.³⁰

25.2.4.4 Labor Unions

In the Norris-LaGuardia Act, Congress created an express exemption from the antitrust laws for collective bargaining activities by labor unions (which would be naked agreements to set prices collectively in the absence of such an exemption—as the Supreme Court stated several times before the passage of Norris-LaGuardia). Moreover, the Supreme Court has created the so-called "nonstatutory labor exemption" for the employers who negotiate collectively with the group's employees and enter collective bargaining agreements with labor unions. This exemption does not protect agreements between employers outside of

²⁷ *Crosby v. Hosp. Auth.*, 93 F.3d 1515, 1532 (11th Cir. 1996).

²⁸ 15 U.S.C. § 36.

²⁹ *Tarabishi v. McAlester Reg'l Hosp.*, 951 F.2d 1558, 1566-67 (10th Cir. 1991) (holding that public trust hospital was not entitled to immunity).

³⁰ *Kottle v. Northwest Kidney Centers*, 146 F.3d 1056, 1059 (9th Cir. 1998).

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the collective bargaining context, as several hospitals learned when defending against antitrust claims by nurses in 2006 and 2007.³¹

PRACTICE TIP

While unionized hospitals may be permitted to share wage information with other unionized hospitals during collective bargaining with labor unions, unionized hospitals should not share such wage information with non-unionized hospitals, even during the course of collective bargaining.

25.3 The Washington Consumer Protection Act

Overshadowing its antitrust provisions, the WCPA is also a robust consumer protection statute. The most familiar section of the WCPA, Section Two, prohibits “unfair or deceptive acts or practices in the conduct of trade or commerce.”³² This section is less concerned with preserving competitive markets than it is with policing individual transactions. As one court noted, Section Two intended to “eliminate the ‘gamesmanship’ formerly attendant to the tradition of caveat emptor and in so doing has helped equalize the bargaining position of consumers.”³³ Unfortunately, the WCPA nowhere defines what constitutes an “unfair or deceptive” act or practice, and instead leaves it to courts to give meaning to this phrase on a case-by-case basis, much like Justice Stewart’s approach to pornography. Fortunately, where the Legislature giveth, the Supreme Court taketh away: Section Two makes the determination of whether a particular act is unfair or deceptive, a question of law for the judge to make, not a jury.

Section Two of the WCPA applies to the “entrepreneurial aspects of medicine,”³⁴ but not the clinical aspects.³⁵ This line is not as clear as it may seem. At one end of the spectrum lie billing and collections practices, which are undoubtedly governed by Section Two of the WCPA.³⁶ At the other end, are personal injury claims based on medical negligence, which are not.³⁷ In between, the courts have held that some practices are “entrepreneurial” that might otherwise seem to be simply the exercise of clinical judgment. For example, one court has held that a dentist committed a deceptive practice for purposes of the WCPA by substituting cow bone for human bone in a bone graft procedure.³⁸ Another court held that the failure to obtain informed consent may be a CPA violation where it is motivated by “entrepreneurial” considerations like “promot[ing] an operation or service to increase profits and the volume of patients.”³⁹ Another court has held that the dispensing of suspect diet drugs was subject to a CPA

³¹ Memorandum Opinion, *Reed v. Advocate Health Care*, No. 06 C 3337, 2007 WL 967932, at *5 (N.D. Ill. Mar. 28, 2007); Transcript of Oral Ruling Denying Motion to Dismiss, *Unger v. Albany Med. Ctr.*, No. 06-CV-765-TJM-DRH (N.D.N.Y. Dec. 11, 2006).

³² RCW 19.86.020.

³³ *Testo v. Russ Dunmire Oldsmobile, Inc.*, 16 Wn. App. 39, 51, 554 P.2d 349 (1976).

³⁴ *Quimby v. Fine*, 45 Wn. App. 175, 724 P.2d 403 (1986).

³⁵ *Howell v. Spokane & Inland Empire Blood Bank*, 114 Wn.2d 42, 58, 785 P.2d 815 (1990).

³⁶ *See Jaramillo v. Morris*, 50 Wn. App. 822, 827, 750 P.2d 1301 (1988).

³⁷ *Quimby*, 45 Wn. App. at 181.

³⁸ *Michael v. Mosquera-Lacy*, 140 Wn. App. 139, 149, 165 P.3d 43 (2007), *rev. granted* 163 Wn.2d 1033 (2008).

³⁹ *Quimby*, 45 Wn. App. at 181.

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claim.⁴⁰ Yet another case held that practicing medicine without a license can be a CPA violation, but only if the defendant holds itself out as a doctor and patients are thereby deceived.⁴¹

PRACTICE TIP

Very few healthcare activities are beyond the reach of the WCPA. Providers should assume that anything they do to promote or sell their services is the source of a potential WCPA claim, and should ask, “Is this something that has the capacity to deceive a substantial portion of the public”?

Successful plaintiffs under the WCPA are entitled to actual damages and attorney fees. Courts may also award successful plaintiffs three times their actual damages, but only up to a total of \$10,000. Plaintiffs and the Washington Attorney General may also obtain injunctive relief prohibiting practices in violation of the WCPA. There are no criminal penalties for violation of the WCPA.

One significant difference between the WCPA and federal antitrust law is that the state and its political subdivisions are not “persons” for purposes of the WCPA.⁴² This exception clearly protects public hospital districts from Section Two of the WCPA (whereas publicly chartered entities—like public hospital districts—are subject to the federal antitrust laws). What is not clear is whether this exception also provides immunity to public hospital districts from the antitrust provisions of the WCPA; no court has resolved this question.

The WCPA also includes an exception that is similar to the “state action” exemption under federal antitrust law. Under section 17 of the WCPA, actions that are “specifically permitted” by the state or federal governments are immune from the WCPA.⁴³ However, this exception is narrowly construed and in practice provides very little protection unless a state or federal agency has expressly approved a particular defendant’s particular action. Courts will not infer permission and mere acquiescence is insufficient to support this defense.

Finally, the WCPA states that it is not intended to prohibit actions that are “reasonable in relation to the development and preservation of business.”⁴⁴ Despite its apparent sympathy for business realities, this exception provides cold comfort: the “reasonableness” of a defendant’s actions is a question of fact left to a jury to decide unless no reasonable juror could rule in plaintiff’s favor on the question. It is better to try to avoid the challenge in the first place.

25.4 Specific Areas of Concern

The health care industry has been the source of a significant amount of antitrust litigation. Below are some of the recurring topics.

25.4.1 Staffing and Privileges

If a hospital acts in accordance with its medical staff bylaws or the HCQIA when taking action against a doctor’s clinical privileges, it should be able to defeat any antitrust claim the disgruntled physician might bring. Many doctors have brought such claims and almost all of them have lost, at least where the hospital complies with whatever peer review procedures might exist in its medical staff bylaws. One of the primary hurdles such

⁴⁰ *Wright v. Jeckle*, 104 Wn. App. 478, 16 P.3d 1268 (2001).

⁴¹ *State v. Pacific Health Ctr. Inc.*, 135 Wn. App. 149, 143 P.3d 618 (2006).

⁴² *Williamson v. Grant County Pub. Hosp. Dist. No. 1*, 65 Wn.2d 245, 396 P.2d 879 (1964).

⁴³ RCW 19.86.170.

⁴⁴ RCW 19.86.920.

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plaintiffs face is that the medical staff that conducts the peer review is merely an agent of the hospital; as a result, most courts have held that the medical staff cannot conspire with the hospital in making recommendations on privileges.⁴⁵ Moreover, the medical staff generally only makes recommendations to the board concerning privileges, and courts have held that mere recommendations are not agreements for purposes of Section One of the Sherman Act.⁴⁶ One exception is where members of the medical staff who are direct competitors of the targeted physician and exert an undue influence on the peer review process.⁴⁷ Thus, it is wise to exclude any direct competitors from the peer review process whenever possible.

PRACTICE TIP

Hospitals and medical staffs that promote the fiction that they are separate, independent entities run the risk of turning routine peer review decisions into antitrust violations. These risks increase exponentially where competitors are permitted to participate in the peer review process. To minimize antitrust risks, medical staff bylaws should reflect that the medical staff is the hospital's agent responsible for making recommendations based on quality of care concerns.

Physicians challenging the revocation of their privileges under the antitrust laws also face the challenge of proving an adverse effect on competition through the discipline of a single provider,⁴⁸ as well as the well-recognized justification for peer review actions based on quality of patient care.⁴⁹ Thus, in the only reported case in Washington to address antitrust claims based on a revocation or denial of privileges, a federal district court granted a motion to dismiss because “the allegations in Plaintiffs' Complaint [were] concerned [only] with the impact on [plaintiff] of the alleged agreement, combination or conspiracy by the Defendants, rather than with injury to competition in general.”⁵⁰

Challenges to privilege decisions under Section Two of the Sherman Act (monopolization or attempted monopolization by a single actor) have met a similar lack of success. Most frequently, the defendant hospital is held not to be a competitor in the relevant market and therefore any claim for monopolization must fail.⁵¹ The results might be different if the hospital employs physicians who compete with the terminated physician, but even then questions of market definition and pro-competitive justifications will most likely insulate a hospital from antitrust claims based on its legitimate privilege decisions.

25.4.2 Exclusive Contracts

Numerous doctors around the country have challenged hospitals' staffing decisions under the antitrust laws — particularly decisions to close a department to all but employed physicians or award an exclusive contract in a

⁴⁵ E.g., *Muzquiz v. W.A. Foote Mem'l Hosp.*, 70 F.3d 422, 429 (6th Cir. 1995). *But see Crosby v. Hosp. Auth.*, 93 F.3d 1515, 1528-29 (11th Cir. 1996) (holding that hospital and staff may conspire).

⁴⁶ E.g., *County of Tolumne v. Sonora Cmty. Hosp.*, 236 F.3d 1148, 1156 (9th Cir. 2001).

⁴⁷ E.g., *Oltz v. St. Peter's Cmty. Hosp.*, 861 F.2d 1440, 1451 (9th Cir. 1988).

⁴⁸ E.g., *Lie v. St. Joseph Hosp.*, 964 F.2d 567, 569 (6th Cir. 1992).

⁴⁹ E.g., *Patel v. Midland Mem'l Hosp.*, 298 F.3d 333, 345-46 (5th Cir. 2002); cf., *Rao v. Auburn Gen'l Hosp.*, 19 Wn. App. 124, 127 (1978) (noting hospital's legitimate interests in ensuring the quality of its medical staff).

⁵⁰ *Perry v. Rado*, 504 F. Supp. 2d 1043, 1047 (E.D. Wash. 2007).

⁵¹ E.g., *Beard v. Parkview Hosp.*, 912 F.2d 138, 144-45 (6th Cir. 1990).

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hospital-based specialty. Nearly all of these claims have failed. The economic reality of most of these cases—which is what the antitrust laws are concerned with—is that the exclusive arrangement merely replaces an existing exclusive arrangement, even if the incumbent provider is only a *de facto* exclusive provider. Replacing one exclusive provider or group with another exclusive provider or group merely “reshuffles the deck” without any net impact on competition: consumers nearly always have the same choices after the exclusive contract as they did before.⁵² As a result, there is no impact on competition for purposes of the antitrust laws. Courts have even recognized the pro-competitive benefits of exclusive contracts in the hospital setting.⁵³

25.4.3 Joint Negotiations with Payors

When competing providers agree to the prices at which they will offer services to purchasers, the result is horizontal price fixing, which is per se illegal under the antitrust laws. Numerous independent physician groups have learned this lesson the hard way and have faced action by the enforcement agencies because of their efforts to negotiate collectively with payors. For example, the FTC targeted physicians in Yakima who refused to negotiate with payors on an individual basis and instead would negotiate only through their independent practice association (“IPA”), refused to deal with payors except on the terms set by their IPA, and whose actions resulted in an increase in the cost of medical services.⁵⁴ Similarly, the FTC went after an IPA in Fairbanks, Alaska that represented 60 percent of the physicians at the only private acute care hospital in town. This IPA adopted a fee schedule and model contract based on contractual information gathered from its members, became the *de facto* exclusive representative of its members in negotiations, and refused to transmit payors’ offers unless the payors agreed to the IPA’s minimum terms.⁵⁵ The fact that almost all of these and similar arrangements involved naked price restraints has meant that all but one have been resolved through consent decrees lasting for 10 or 20 years. (The one group that chose to fight might have saved itself the effort and expense: an IPA in Texas was found to have negotiated minimum prices on behalf of its members by polling members about their preferred prices, sending those results to members, and refusing to send offers from payors to members unless the offers surpassed minimums approved by at least 50 percent of its members. The FTC found a violation of the antitrust laws, and a federal court of appeals affirmed the FTC’s findings and conclusions in their entirety, changing only the remedy that the FTC sought.⁵⁶) The frequency with which providers violate the Sherman Act in jointly negotiating with payors is so high that in 2005, the Chairman of the FTC anecdotally estimated that 20 percent of physicians were under consent decrees.

Not all joint negotiation by competitors is prohibited, however. True “messenger” models are acceptable: the IPA transmits offers and counteroffers between individual payors and providers without conveying any competitors’ pricing information to other providers and without negotiating on behalf of the providers.⁵⁷ Many consent decrees, however, have resulted where messenger models become collective negotiation and the “messenger” aggregates the providers’ contract terms into minimum price schedules and form contracts.⁵⁸ In

⁵² E.g., *BCB Anesthesia Care Ltd. v. Passavant Mem’l Hosp. Ass’n*, 36 F.3d 664, 667 (7th Cir. 1994) (noting that “thousands of pages of federal reporters ... [have] almost always come to the same conclusion: A staffing decision at a single hospital based on exclusive contracts is not violative of the antitrust laws.”).

⁵³ E.g., *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2, 43-44 (1984) (O’Connor, J., concurring).

⁵⁴ *In re Surgical Specialists of Yakima*, FTC Dkt. No. C-4101 (Nov. 18, 2003).

⁵⁵ *In re Alaska Healthcare Network, Inc.*, FTC Dkt. No. C-4007 (Apr. 28, 2001).

⁵⁶ *North Texas Specialty Physicians v. Fed. Trade Comm’n*, 528 F.3d 346 (5th Cir. 2008).

⁵⁷ U.S. Dep’t of Justice & Fed. Trade Comm’n, *Statements of Antitrust Enforcement Policy in Health Care*, Statement No. 9 (1996).

⁵⁸ See, e.g., *North Texas Specialty Physicians*, 528 F.3d at 352 (noting NTSP’s migration from a messenger-based, “risk” model to a negotiator-based “non-risk” model).

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addition, the enforcement agencies have indicated that where provider members of a network share financial risk (whether through capitated prices, financial incentives that drive cost containment, or other payment arrangements that shift the burden of seeking efficiencies to the provider), agreements on prices can be acceptable. The rationale is that such “qualified risk-sharing joint arrangements” create both the mechanism and the incentive for creating efficiencies and that joint rate-setting is reasonably necessary to the operation of those incentives.⁵⁹ Similarly, the enforcement agencies recognize that “qualified clinically-integrated joint arrangements,” in which providers create a degree of interdependence and cooperation to control costs and elevate quality, may permit agreement on rates among competing providers, so long as collective negotiation is reasonably necessary for the achievements of the network’s clinical benefits.⁶⁰

PRACTICE TIP

The safest form of independent practice association or other group through which competing providers will interact with payors is a pure “messenger” model in which the IPA merely transmits offers from payors to providers without negotiating on their behalf, does not share pricing information amongst competing providers, and the providers accept risk-sharing contracts. Deviation from these guidelines increases the likelihood of antitrust scrutiny. Providers considering such an arrangement should obtain antitrust counsel.

25.4.4 Refusals to Deal

Competitors need not agree on price to run afoul of the antitrust laws. “Group boycotts,” or agreements between competitors not to deal with some third party (typically, but not always, a payor), can be anticompetitive if the conspirators have sufficient market power in a particular line of services and if, in refusing to deal with the third party, their boycott places the third party at a competitive disadvantage. Thus, one Washington court enjoined an IPA from refusing membership to physicians who provided services within the plaintiff HMO’s network.⁶¹ The boycott was likely an effort by the physician members of the IPA to keep the HMO from entering their market. Similarly, the Washington Supreme Court found a violation of the antitrust provisions of Washington’s Constitution where hospitals in King County conspired with the King County Medical Society to block Group Health Cooperative and its contract-medicine model from entering the market.⁶²

PRACTICE TIP

Competitors’ group boycotts are very different from a single entity’s refusal to deal with its competitors. Even monopolists generally have no obligation to assist their rivals, and can usually refuse to cooperate with competitors even if it places the competitor at a disadvantage in the market. When competitors refuse to deal with a third party,

⁵⁹ U.S. Dep’t of Justice & Fed. Trade Comm’n, *Statements of Antitrust Enforcement Policy in Health Care*, Statement Nos. 8-9 (1996).

⁶⁰ *Id.*

⁶¹ *Blue Cross of Washington & Alaska v. Kitsap Physician Servs.*, 1981 WL 2198 (W.D. Wash. Oct. 28, 1981); see also *In re Montana Associated Physicians, Inc.*, FTC Dkt. No. C-3704 (Jan. 24, 1997) (entering consent decree where 80% of independent physicians in Billings, Montana used IPA to attempt to keep managed care plans out of Billings).

⁶² *Group Health Cooperative of Puget Sound v. King County Med. Soc’y*, 39 Wn.2d 586, 237 P.2d 737 (1951).

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however, the structure of the market can be distorted in violation of the antitrust laws.

25.4.5 Information Sharing

Purchasers of services (e.g., hospitals negotiating nursing contracts) are often interested in what their competitors are paying for similar services. While the sharing of non-public price information is not by itself a per se violation of the antitrust laws, it is fraught with danger: “sharing” can easily become “agreeing,” particularly if it occurs over a long period of time or involves any quid pro quo.

The DOJ and FTC have developed a set of guidelines that create a presumptive safe harbor for sharing wage or price information.⁶³ Specifically, wage surveys should be managed by a third party not controlled by any of the competitors; the wage information should be more than three months old; at least five providers should participate; no one provider’s data should represent more than 25 percent of any one statistic (on a weighted basis); and the wage data should be reported back to participants only in a way that does not allow those receiving the survey results to identify any particular participant’s wage rates.

PRACTICE TIP

In order to avoid the appearance of agreements on wages or prices (and resulting inquiries from enforcement agencies), competitors should avoid any direct exchanges of non-public wage or price information, particularly future wage or price information (historical data is more benign). Administrators (especially of hospitals) should also counsel their human resources staff to avoid discussing wage or price information or plans with their competitors’ human resources staff at meetings, job fairs or other trade gatherings, regardless of their informality. What may start as a seemingly innocent “off the record” discussion, can snowball into a full-blown price fixing conspiracy.

25.4.6 Group Purchasing

The DOJ and the FTC have also established a safety zone for group purchasing. To fall within it, the purchases must account for less than 35 percent of the total sales of the purchased product or service in the relevant market and the cost of the products or services purchased jointly must account for no more than 20 percent of the total revenues from all products or services sold by each participant in the group.⁶⁴ Even outside of this safety zone, however, group purchasing organizations (“GPOs”) are not automatically condemned. In order to avoid antitrust scrutiny, the GPO should not require members to make all their purchases of the relevant good or service through the GPO; an independent agent or employee not employed by a member should conduct negotiations on behalf of the GPO; and communications between the GPO and individual members should be kept confidential from other members.

Hospitals need to be particularly sensitive to the risks of group purchasing where the safety zone is not applicable. Indeed, in 2007, several hospitals in Arizona learned this lesson the hard way when they had to submit to a consent decree with the DOJ over their use of a GPO for temporary nursing staffing: what started as a legitimate standard-setting “registry” for ensuring that itinerant nurses met relevant qualitative criteria (e.g., credentialing, insurance and background checks), transformed over time into full-blown price collusion that

⁶³ U.S. Dep’t of Justice & Fed. Trade Comm’n, *Statements of Antitrust Enforcement Policy in Health Care*, Statement Nos. 5-6 (1996).

⁶⁴ U.S. Dep’t of Justice & Fed. Trade Comm’n, *Statements of Antitrust Enforcement Policy in Health Care*, Statement No. 7 (1996).

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began imposing uniform rates on all nurse staffing agencies that wished to participate in the registry.⁶⁵ Given that the vast majority of hospitals in the relevant geographic markets participated in the registry, a finding of an antitrust violation was seemingly a foregone conclusion.

PRACTICE TIP

A group purchasing organization should organize it self as follows: do not impose uniform purchasing rates on sellers; each member should contract individually with sellers; contracts should include early termination clauses; members should not exchange pricing information; the GPO should not impose minimum purchasing requirements on members; and the GPO should try to comply with the DOJ/FTC safe harbors. Antitrust counsel is nearly essential in setting up a compliant GPO.

25.4.7 Standard Setting/Quality Exchanges

The Supreme Court and the enforcement agencies have recognized that standard setting and the sharing of quality and other non-price related data serves an important public purpose and can enhance competition.⁶⁶ The DOJ and FTC have stated that they will not challenge the collection, sharing or dissemination of quality-related data.⁶⁷ Thus, they will not challenge a medical society's collection of outcome data from its members and provision of that data to payors in the hope the payors will cover a particular procedure. Similarly, they will not challenge the establishment of clinical protocols even though such protocols may be agreements by competing physicians. There are important caveats to this rule. Quality standards must be objective and reasonably related to their purpose, and they cannot be used to coerce a purchaser's decision making.

25.4.8 Package Pricing: Bundled Discounts and Tying Arrangements

One of the primary antitrust issues that health care providers face for their unilateral actions is packaging their separate services for sale together. Such packages can take the form of either bundled discounts or tying arrangements. The danger with both from an antitrust standpoint is when they exclude competing providers.

Bundled discounts are ubiquitous, and not just in health care; as the Ninth Circuit has explained, “[s]eason tickets, fast food value meals, all-in-one home theater systems – all are bundled discounts.”⁶⁸ Since lower prices are one of the primary goals of the antitrust laws, the courts are particularly solicitous of bundled discounts. The problem that courts seek to prevent is the use of a bundled discount to drive a more efficient producer of a single product from the market.⁶⁹ The test is whether “the discounts result in prices that are below an appropriate measure of the defendant's costs.”⁷⁰ The appropriate measure of the defendant's costs is the “discount attribution role,” at least in the Ninth Circuit: the full amount of the discounts for the entire bundle is to be allocated to the competitive product, and if the resulting price of the competitive product is

⁶⁵ *United States v. Arizona Hospital & Healthcare Ass'n*, No. CV07-1030-PHX (D. Ariz. May 5, 2007).

⁶⁶ *E.g., California Dental Ass'n v. FTC*, 526 U.S. 756, 771-72 (1999).

⁶⁷ U.S. Dep't of Justice & Fed. Trade Comm'n, *Statements of Antitrust Enforcement Policy in Health Care*, Statement No. 4 (1996).

⁶⁸ *Cascade Health Solutions v. Peacehealth*, 515 F.3d 883, 894 (9th Cir. 2008).

⁶⁹ *Id.* at 896.

⁷⁰ *Id.* at 903.

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below the defendant's incremental costs of production, the trier of fact may conclude that the discount is exclusionary.⁷¹

A tying arrangement can be more blatantly anticompetitive. A tying arrangement exists where a provider conditions the purchase of one product (the “tying product”) on another, generally less desired product (the “tied product”). Thus, for example, a provider of chest x-rays might provide those services to an insurer only if the insurer agrees to purchase that provider's CT services as well. A tying arrangement is illegal when the provider has sufficient market power in the market for the tying product to coerce customers into purchasing the tied product.⁷² Coercion need not be express, but can be inferred. Thus, in *Cascade Health Solutions v. PeaceHealth*, the Ninth Circuit held that the tying product was the defendant's tertiary service line (where it faced little or no competition), while the tied products were its primary and secondary service lines (where it faced competition from the plaintiff), and found a question of fact as to whether purchasers were coerced into purchasing the tied products based on evidence that the defendants' prices were higher and only 14 percent of insurers purchased the defendant's services separately (while the others purchased the package). The point is, if purchasers have economically viable options for purchasing the tying product (e.g., the market is flooded with providers of chest x-rays), there will be no coercion and providers are free to try to encourage insurers to purchase their entire service lines.

PRACTICE TIP

If bundling your products or services does not make any economic sense other than to harm your competitors, you might want to rethink them.

25.5 Ten Questions Every Administrator Should Keep in Mind to Help Spot Antitrust Issues

1. Who are you negotiating with?

Negotiations with competitors should always raise concerns. If the subject is prices, the negotiations should come to a stop.

2. Who is on your side in negotiations?

Any time competitors collectively negotiate with a third-party purchaser or supplier, there is a high risk of collusion in violation of the antitrust laws. While certain safe harbors might apply, they are technical and require close scrutiny to make sure you stay within them.

3. Who are you sharing your price/wage information with and why?

There are very specific ways for competitors to share price and wage information without running afoul of the antitrust laws. Exchanging salary rates at a private meeting of human resources professionals is not one of them. The more nonpublic and current your data is, the less likely you are able to share it with competitors.

4. Are there other competitors in the market?

The more competitors in the marketplace, the more likely you can take your contemplated course of action. Whether the issue is a merger or a unilateral price increase, if there are other providers

⁷¹ *Id.* at 906. This test is far more easily stated than applied, particularly for hospitals. For example, in the *Cascade Health Solutions* case the bundling involved entire service lines: insurers who purchased PeaceHealth's primary, secondary and tertiary service lines paid lower reimbursement rates than insurers who purchased its competitor's primary and secondary service lines, while purchasing tertiary services from Peacehealth. *Id.* at 893. The Ninth Circuit remanded application of the test to the district court.

⁷² *Id.* at 913.

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in the market who can offer the same services at a lower price if they choose to, the antitrust concerns are diminished.

5. Will this action change the competitive make-up of the market?

Replacing one exclusive provider of services with another exclusive provider has no effect on competition. Combining all of the providers of one specialty into one group does, and the resulting group needs to be administered carefully so as not to use its market power unreasonably (if it can be combined at all). If there will be a reduction in competition as a result of your actions, it would be wise to consult an antitrust advisor.

6. What is the procompetitive justification for this activity?

Unless the proposed course of action is blatant price pricing or market division, the antitrust laws permit actions that are reasonable under the circumstances. Therefore, the more legitimate business justifications an action has in its favor, the more likely it is to pass antitrust scrutiny. Note, however, that the projected efficiencies and cost savings should be real, not just euphemisms for higher prices through increased leverage.

7. Is this merger/joint venture simply a means to gain leverage to increase prices?

Hopefully, not. But if it is, you should consult an antitrust advisor for a determination of whether it makes sense to go through with a transaction that might lead to litigation down the road.

8. Is your pricing structure forcing consumers or payors to purchase services they might not otherwise want to purchase?

If so, and if you have a significant market share in the particular service that is forcing the unwanted purchases, you might be guilty of a tying violation.

9. Are any of your services priced below your marginal costs?

If so, and if you already have significant market share in those services, you might be guilty of predatory pricing.

10. Are you taking an action solely for the purpose of harming your competition?

If so, and if you have significant market share in a service area affected by that action, you might be guilty of monopolization.