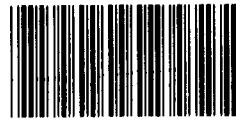
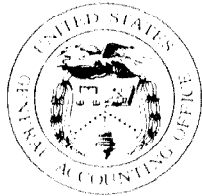


July 1991

HEALTH CARE

Antitrust Issues Relating to Physicians and Third-Party Payers



144417

Office of the General Counsel

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July 10, 1991

The Honorable Lloyd Bentsen
Chairman, Committee on Finance
United States Senate

The Honorable Dan Rostenkowski
Chairman, Committee on Ways and Means
House of Representatives

The Omnibus Budget Reconciliation Act of 1989 requires the General Accounting Office to study physician antitrust issues and to report to the Congress. This report is submitted in satisfaction of that requirement.

Pursuant to the law and discussions with congressional staff, this report addresses: (1) the effect of antitrust laws on the ability of physicians to act in groups to educate and discipline peers so as to reduce and eliminate ineffective practice patterns and inappropriate utilization; and (2) antitrust issues as they relate to the adoption of practice guidelines by third-party payers. See appendix I for a discussion of our objectives, scope, and methodology.

Background

The public policy of the United States, which favors free market competition and opposes unreasonable restraints on trade, is articulated in federal statutes prohibiting practices that are incompatible with competition as an instrument for allocating resources, empowering consumers, and checking private economic power. The federal antitrust statutes¹ most pertinent to medical societies and other professional associations¹ are section 1 of the Sherman Anti-Trust Act² and section 5 of the Federal Trade Commission Act.³

Section 1 of the Sherman Act declares illegal “[e]very contract, combination . . . or conspiracy, in restraint of trade or commerce among the several States . . .” While this prohibition literally encompasses every arrangement in restraint of trade, the courts have construed it as precluding only those contracts or combinations that are unreasonable in

¹American Medical Association (AMA) memorandum, Legal Implications of Practice Parameters, at 28 (1990) (hereafter cited as AMA memorandum on practice parameters).

²July 2, 1890, c.647, 1, 26 Stat. 209, classified to 15 U.S.C. 1.

³Sept. 26, 1914, c.311, 5, 38 Stat. 719, classified to 15 U.S.C. 45.

the sense that, on balance, they restrain rather than promote competition.⁴ The Department of Justice (DOJ) is authorized to bring criminal or civil proceedings to enforce this prohibition.⁵

The Federal Trade Commission (FTC) also has a role in antitrust enforcement. Section 5 of the Federal Trade Commission Act authorizes the Commission to issue cease and desist orders to prohibit “unfair methods of competition.” This has been interpreted to reach activity in restraint of trade that violates the Sherman Act or that, “when full blown,” would violate that act.⁶

In addition, under section 4 of the Clayton Act,⁷ private parties “injured in [their] business or property by reason of anything forbidden in the antitrust laws” are authorized to sue offending parties for treble damages. In this way, private parties may also enforce section 1 of the Sherman Act.

Results in Brief

The antitrust laws need not unduly interfere with the responsible actions of physicians to reduce ineffective practice patterns and inappropriate utilization, or with those of payers to adopt practice guidelines. There appears to be no need at present for legislation providing antitrust immunity to physicians or payers to facilitate these activities.

Basic Antitrust Analysis—Application to Physicians

For many years, the Supreme Court did not decide whether practice of the learned professions constitutes “trade or commerce,” so that it was unclear whether section 1 of the Sherman Act applied to the medical profession.⁸ However, in 1975, the Court ruled that section 1 of the Sherman Act applied to professionals.⁹ Seven years later, the Court confirmed that the provision applies to physicians with the same rigor as to

⁴Northern Pacific Railway Company v. United States, 356 U.S. 1, 4-5 (1958).

⁵15 U.S.C. 1 and 4.

⁶Federal Trade Commission v. Motion Picture Advertising Service Co., 344 U.S. 392, 394-395 (1953); Federal Trade Commission v. Brown Shoe Co., 384 U.S. 316, 321 (1966).

⁷Oct. 15, 1914, c.323, 4, 38 Stat. 731, classified to 15 U.S.C. 15.

⁸American Medical Association v. United States, 317 U.S. 519, 528 (1943); United States v. National Association of Real Estate Boards, 339 U.S. 485, 492 (1950).

⁹Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975).

competitors of other kinds.¹⁰ The Court found that maximum-fee schedules—agreements among competing physicians setting the maximum fee they may claim in full payment for services provided to policyholders of certain insurance plans—violated section 1 of the Sherman Act.

Thus, agreements among competitors—including physicians—and any resulting concerted activity are illegal if they injure consumers by unreasonably restraining competition. Any agreement between competing physicians, whether as members of a medical society or in a less organized context, may therefore trigger section 1 scrutiny to determine if the action unreasonably suppresses competition. Such scrutiny employs two basic modes of analysis.¹¹

Per Se

Certain business arrangements are presumed to restrain trade or commerce unreasonably and, therefore, constitute per se violations of antitrust laws. As set out by the Supreme Court, the per se rule applies to “agreements or practices which because of their pernicious effect on competition and lack of any redeeming virtue are conclusively presumed to be unreasonable and therefore illegal without elaborate inquiry as to precise harm they have caused or the business excuse for their use.”¹² Examples of such agreements cited by the Court include those to fix prices, divide markets, or engage in some forms of boycott activity.¹³

Rule of Reason

Courts have treated antitrust challenges to joint action among competitors to achieve market efficiencies as requiring a more detailed analysis than when a per se violation is found. This analysis is called the rule of reason.¹⁴ The rule of reason doctrine involves a broad inquiry into the nature, purpose, and effect of any challenged practice. The Supreme Court rendered an oft-cited expression of this doctrine in Chicago Board of Trade v. United States:¹⁵

¹⁰Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982).

¹¹Lawrence A. Sullivan, Handbook of the Law of Antitrust, 59 (1977).

¹²Northern Pacific R. Co. v. United States, 356 U.S. at 4-5.

¹³See, Arizona v. Maricopa County Medical Society, 457 U.S. at 342-355 (price-fixing agreements); Fashion Originators Guild v. FTC, 312 U.S. 457 (1941) (group boycotts).

¹⁴See, Leibenluft and Pollard, Antitrust Scrutiny of the Health Profession: Developing a Framework for Assessing Private Restraints, 34 Vanderbilt L. Rev. 927, 949-950 (1981).

¹⁵246 U.S. 231, 238 (1918).

“The true test of legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition. To determine that question the court must ordinarily consider the facts peculiar to the business to which the restraint is applied; its condition before and after the restraint was imposed; the nature of the restraint and its effect, actual or probable. The history of the restraint, the evil believed to exist, the reason for adopting the particular remedy, the purpose or end sought to be attained, are all relevant facts. This is not because a good intention will save an otherwise objectionable regulation or the reverse; but because knowledge of intent may help the court to interpret facts and to predict consequences.”¹⁶

The application of such a doctrine is fact-intensive, requiring concrete information about the restraint being imposed and culminating in a determination whether the challenged restraint benefits consumers by promoting competition or injures consumers by suppressing competition.¹⁷ Unlike cases involving *per se* offenses that clearly harm competition and are conclusively presumed to be illegal, rule of reason cases involve a “grey area,” requiring a more laborious assessment of the competitive effect of an agreement.¹⁸ The need to assess the effect of each such agreement makes it difficult to generalize regarding the application of the rule of reason doctrine.

¹⁶See, e.g., *Wilk v. A.M.A.*, 719 F.2d 207, 222 (7th Cir. 1983) (*Wilk I*), cert. denied, 467 U.S. 1210 (1984); *Kreuzer, D.M.D. v. American Academy of Periodontology*, 735 F.2d 1479 (D.C. Cir. 1984).

¹⁷*National Society of Professional Engineers v. United States*, 435 U.S. 679, 691 (1978).

¹⁸“Standards and Certification: The Role of Antitrust,” Remarks by Judy Whalley, Deputy Assistant Attorney General, Antitrust Division, Department of Justice, Before the Council on Codes and Standards, American Society of Mechanical Engineers (Mar. 5, 1988) (discussing the antitrust implications of engineering standards).

Effect of Antitrust Laws on the Ability of Physicians to Act Collectively to Educate and Discipline Peers in Order to Reduce and Eliminate Ineffective Practice Patterns and Inappropriate Utilization

Hospital Peer Review

Hospital peer review is subject to antitrust scrutiny but is likely to violate the law only when the process is abused. In fact, peer review is arguably pro-competitive in many situations.

The vast majority of American hospitals have established a medical peer review process whereby physicians review the qualifications of, and appropriateness and quality of care rendered by, other staff physicians.¹⁹ The Supreme Court recently confirmed that such hospital peer review meets the “trade or commerce” requirement for jurisdiction under section 1 of the Sherman Act.²⁰

However, according to federal antitrust enforcement agencies, only in exceptional circumstances—where the peer review process is not used to review individual competence but, rather, is a sham used to exclude a competent practitioner or group of practitioners from the market and thus to restrain competition—would an antitrust violation result from peer review.²¹

¹⁹The Joint Commission on Accreditation of Healthcare Organizations, which accredits approximately 80 percent of American hospitals, maintains standards requiring hospitals to engage in some form of medical staff peer review.

²⁰*Summit Health, Ltd. v. Pinhas*, 59 U.S.L.W. 4493 (U.S. May 28, 1991) (No. 89-1679).

²¹See, e.g., Charles Rule, Assistant Attorney General, DOJ letter to American Medical Association, December 2, 1986; Letter from FTC to the Honorable John Dingell (July 26, 1986); *Health Care Management Corp., et al.*, 107 F.T.C. 285 (1986).

Case law bears out this contention: Patrick v. Burget, one of the few cases where peer review participants have been found liable,²² involved substantial evidence of bad faith conduct that a court characterized as “shabby, unprincipled and unprofessional.”²³

So long as peer review is conducted in good faith and in a manner that provides rights of due process to those reviewed, participants should not have to be concerned about violating antitrust law. Indeed, such review may be seen as promoting competition between groups of physicians by providing a tool by which a particular group may enhance its own reputation for efficiency and quality in relation to the others. Peer review is also essential to the efficient operation of hospitals as competitive enterprises seeking to provide good quality care at low cost.

Thus, medical staff of a hospital may engage in peer review without undue antitrust exposure by establishing procedures to ensure that medical peer review activities are conducted in good faith with safeguards for the rights of those subject to review and competitors of the doctors under review do not wield the ultimate power. For example, with respect to the last point, the hospital management, not the medical staff, could ultimately make the staffing or privileges decision: unlike the medical staff, the hospital cannot be said generally to be a competitor of the physician who is the subject of peer review.²⁴

During the early 1980s, in response to antitrust challenges to the peer review process, lower federal courts in Illinois and Oregon ruled that the process was exempt from federal antitrust laws under the “state-action immunity doctrine.”²⁵ This doctrine recognizes that the Sherman Act was intended to regulate private practices and not to prohibit states

²²486 U.S. 94 (1988), reh'g. denied, 487 U.S. 1243 (1988); See e.g., American Medical Association memorandum, Litigation Over Hospital Peer Review Decisions, at 8 (hereinafter cited as AMA memorandum on peer review litigation).

²³486 U.S. at 98 n.3 (quoting the Court of Appeals, 800 F.2d 1498, 1509 (9th Cir. 1986)). For example, one member of the peer review panel chaired a state investigation into the practice of the doctor who was sanctioned by the panel without revealing his conflict of interest. In addition, there was substantial evidence indicating that the peer review panel had treated that doctor's cases differently from those of other doctors.

²⁴See, Havighurst, Doctors and Hospitals: An Antitrust Perspective in Traditional Relationships, 1984 Duke L.J. 1071, 1121, 1124-1125.

²⁵AMA memorandum on peer review litigation, *supra* note 22, at 9 (citing Marrese v. Interqual, Inc., 748 F.2d 373 (7th Cir. 1984), cert. denied, 472 U.S. 1027 (1985) and Patrick, 800 F.2d 1498, rev'd, 486 U.S. 94 (1988)).

from imposing commercial restraints as acts of government.²⁶ These rulings were regarded as significant since most states have policies clearly articulated by statutes requiring hospitals to engage in peer reviews²⁷ and providing some form of civil immunity for physicians serving in that capacity.²⁸

In *Patrick*, the Supreme Court clarified the degree of state supervision necessary for the state-action exemption to protect hospital peer review. The Court held that, for state-action immunity to apply, the state must engage in such active supervision of the challenged conduct, that it exercises "ultimate control" over peer review decisions.²⁹ Since many states do not engage in such active supervision of the peer review process,³⁰ some feared that this ruling would result in increased litigation seeking to hold peer review participants liable for antitrust violations.³¹

Through the Health Care Quality Improvement Act of 1986, the Congress attempted to ameliorate these fears and thus to encourage physicians to engage in peer review. The act provides, for persons participating in professional review of physicians, an exemption from antitrust liability for money damages when that review conforms to specified criteria.³² The professional review must relate to the competence or professional conduct of a physician being reviewed, and any action against a physician must be taken:

- "(1) in the reasonable belief that the action was in the furtherance of quality of 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

²⁶*Parker v. Brown*, 317 U.S. 341 (1943).

²⁷AMA memorandum on peer review litigation, *supra* note 22, at 4.

²⁸See, *The Legal Liability of Peer Review Participants for Revocation of Hospital Staff Privileges*, 28 *Drake L. Rev.* 692, 694 (1978).

²⁹486 U.S. at 101.

³⁰See, e.g., AMA memorandum on peer review litigation, *supra* note 22, at 9-10.

³¹See, e.g., Koska, *Peer Review Privileges: MDs Fear Legal Tangles*, *Hospitals*, Dec. 5, 1989, at 28.

³²Pub. L. No. 99-660, Title IV, 100 Stat. 3784 (1986). Physicians exercising due care in their employment by peer review organizations in the Medicare program were already specifically accorded criminal and civil immunity. 42 U.S.C. 1320c-6(b).

such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).³³

This law was recently held by a U.S. District Court in California to immunize the participants in a challenged peer review decision.³⁴

Practice Guidelines

Physician Efforts at Self-Education, Including Informational Guidelines

Seldom would any physician effort for the purpose of self-education result in a restraint of trade. This remains true, even if the effort involved the promulgation by competing physicians of voluntary informational guidelines.³⁵ Physician self-education may be seen as promoting competition by informing physicians of alternative and potentially more effective and efficient ways to practice medicine. For example, informational practice guidelines would be expected to promote competition by establishing some form of consensus for treating certain conditions.³⁶ Physicians may independently gauge their decision-making accordingly, and insurers and patients may use such information to become better-informed consumers. Therefore, if physician groups produce guidelines for purely informational purposes, there is little chance of an antitrust problem.³⁷

The American Medical Association has suggested that a physician group wishing to adopt informational guidelines could take certain common sense steps to minimize antitrust liability risks, such as: (1) basing the guidelines on objective, scientific judgment; (2) using the guidelines to recommend what should be done as opposed to who should do it; and

³³ 412(a), 100 Stat. 3786, classified to 42 U.S.C. 11112(a).

³⁴ Austin v. McNamara, 731 F. Supp. 934 (C.D. Cal. 1990); See also Stitzell v. York Memorial Osteopathic Hospital, 754 F.Supp. 1061 (M.D. Pa. 1991).

³⁵ See, e.g., Whalley remarks, supra note 18.

³⁶ Practice guidelines may affect more than treatment decisions. For example, in a recent report, examining the methods for the development of guidelines, we used the following definition:

"guidance—by whatever name—that aids practicing physicians and others in the medical community (and consumers, if included) in day-to-day decisions by describing the degree of appropriateness and the relative effectiveness of alternate approaches to detecting, diagnosing, and/or managing selected health conditions."

GAO, Practice Guidelines: The Experience of Medical Specialty Societies at 2 (PEMD-91-1).

³⁷ See, AMA memorandum on practice parameters, supra note 1 at 33; See also, Schachar v. American Academy of Ophthalmology, Inc., 870 F.2d 397, 399 (7th Cir. 1989); Consolidated Metal Products, Inc. v. American Petroleum Institute, 846 F.2d 284 (5th Cir. 1988).

(3) adhering to fair procedures in the development of the guidelines, such as permitting interested parties to comment on draft guidelines and attempting to incorporate suggestions in the final version.³⁸

Mandatory Guidelines

If physician groups make adherence to practice guidelines the basis for membership or agree with payers to make them the basis for reimbursement,³⁹ antitrust issues may arise, depending on the nature of the group. Physician groups organized for the specific purpose of delivering services competitively can and do use mandatory guidelines. An example of this kind of group would be a health maintenance organization.⁴⁰ In such a situation, the physicians in the group may argue plausibly that adherence to the guidelines is ancillary to the operation of a legitimate joint venture that enhances competition in the health care market.

However, if the physician group—for example, a professional association—is not organized specifically to deliver services, the use of mandatory guidelines becomes more difficult to justify. This is because guidelines binding on association members who compete among themselves increase the likelihood that consumers may be prevented from obtaining a service they desire.

Probably the best competitive justification for mandatory guidelines by a group such as a professional association is that maintaining and enforcing certain standards allows a nondominant group of competing physicians to differentiate themselves from other physicians, thereby affording consumers clearer choices and enhancing competition.⁴¹ If a physician group using a mandatory guideline does not dominate its field of practice, competitors have the option of practicing under different guidelines and consumers are not denied access to alternative styles of practice.

³⁸AMA memorandum on practice parameters, *supra* note 1, at 42.

³⁹Physician groups recommending that payers make group guidelines the basis for reimbursement are unlikely to be found liable but may increase their risk of being sued under the Sherman Act. See *e.g.*, *Schachar*, 870 F.2d at 398 (*dicta* indicating that one reason the American Academy of Ophthalmology's characterization of a new surgical procedure as "experimental" did not violate antitrust law was that the Academy did not directly attempt to influence insurers); *Virginia Academy, Etc. v. Blue Shield of Va.*, 469 F. Supp. 552 (E.D. Va. 1979) (professional association of clinical psychologists in Virginia unsuccessfully brought action against payer, alleging conspiracy with Neuropsychiatric Society of Virginia based on consultations between the two).

⁴⁰See, *e.g.*, *Antitrust Enforcement and the Medical Profession: No Special Treatment*, Remarks by Charles F. Rule, Assistant Attorney General, Antitrust Division, Department of Justice, Before the Interim Meeting of the AMA House of Delegates (Dec. 6, 1988).

⁴¹*Koefoot v. American College of Surgeons*, 652 F. Supp. 882, 904 (N.D. Ill. 1986).

The FTC has indicated that physician groups making agreements to operate medical prepayment plans under their control can minimize potential antitrust problems by establishing that: (1) the physician members have no anti-competitive intent in making the agreements; (2) the collective market share affected is not so large as to foreclose competition; and (3) adherence to the agreements will achieve a pro-competitive efficiency that outweighs any reduction in competition between the physicians.⁴² Although applied to prepayment plans, the FTC does not limit these suggestions to physician groups engaging in the "business of insurance."⁴³ Physician groups contemplating agreeing to mandatory guidelines may find these FTC suggestions, as well as the relevant suggestions pertaining to the establishment of voluntary guidelines, to be valuable guidance.

Even with these precautions, it may be difficult, outside the context of a legitimate joint venture specifically organized to deliver health care, to establish a competitive justification for certain mandatory guidelines.⁴⁴ Further, a court will almost certainly consider such a case in the context of a rule of reason analysis,⁴⁵ necessarily involving extensive and time-consuming gathering of facts and analysis. Thus, in general, a physician group incurs more risk of antitrust problems by using mandatory guidelines as opposed to informational guidelines.

⁴²See Federal Trade Commission Enforcement Policy With Respect to Physician Agreements to Control Medical Prepayment Plans, at 13-21, 46 Fed. Reg. 48,982 (1981) (hereafter cited as FTC enforcement policy).

⁴³Id. at 4.

⁴⁴See, e.g., Wilk v. American Medical Association, 895 F.2d 352 (7th Cir. 1990) (Wilk II) (Court rejected AMA argument that physician "boycott" of chiropractors based on AMA ethical principles had a pro-competitive effect: Court found that "boycott" restricted consumers' ability to obtain a lawful service that they wanted); A.M.A. v. F.T.C. 638 F.2d 443 (2d Cir. 1980), affirmed by an equally divided Court, 455 U.S. 676 (1982) (AMA restraints on truthful physician advertising and solicitation violated antitrust law because restraints made it more difficult for consumers to obtain information about available services).

⁴⁵See, e.g., F.T.C. v. Indiana Federation of Dentists, 476 U.S. 447, 458 (1986); National Society of Professional Engineers, 435 U.S. at 696; Koefoot, 652 F. Supp. at 885-889.

Effect of Antitrust Laws on Physician Response to Medicare Implementation of a Statutory Fee Schedule

Under recent legislation, beginning in 1992, physicians serving Medicare patients will receive payment for physician services based on actual charges or a statutory fee schedule, whichever is less. The fee schedule is the product of three factors: (1) the relative value of the service performed, (2) a monetary conversion factor, and (3) a geographic adjustment.⁴⁶

The monetary conversion factor appears to provide an incentive for physicians to limit current Medicare expenditures in order to maintain the rate of reimbursement in subsequent years. The conversion factor will be weighted to reflect, among other things, actual expenditures for physicians' services in relation to expenditures that had been projected for those services. If actual expenditures are less than projected, future reimbursements for physicians will tend to increase. Conversely, if actual expenditures are greater than projected, future reimbursements will tend to decrease.

The incentive created by the conversion factor might encourage physicians to influence each other in order to reduce unnecessary or ineffective care. However, this would pose antitrust problems only if it results from an agreement between independently competing physicians and has the effect of restraining competition. Such a situation might arise if competing physicians agreed to follow particular practice guidelines.

Similarly, local physicians might agree not to refer patients to another particularly inefficient or uncooperative physician so as not to affect negatively future Medicare payments. Such agreements would present antitrust issues and would be difficult to defend as pro-competitive undertakings.

However, these agreements are unlikely to occur, for several reasons. Because the conversion factor is indirectly weighted to reflect cost efficiency and applies uniformly to all physicians providing services in particular categories or groups nationwide, isolated attempts by physicians to limit expenditures are unlikely to result in a significant return to them. Although national organizations might try to standardize physician practices to curb opportunistic or inefficient behavior, we are aware of no signs as yet that this is contemplated. Further, it will take 2 years for the statutory fee schedule to reflect a failure to meet an

⁴⁶Omnibus Budget Reconciliation Act of 1989 (OBRA 1989), Pub. L. No. 101-239, 6102, 103 Stat. 2169-2180, classified to 42 U.S.C. 1395w-4.

expenditure target. Because the Congress itself may intervene during that time, there will be only a limited incentive to conspire in this way.

Under another part of the same 1989 Medicare amendment, the chance of anti-competitive behavior may be somewhat greater. The law requires the Secretary of Health and Human Services to develop a plan under which, on or after October 1, 1991, qualified physician groups may elect to use separate group-specific reimbursement rates. These rates would be determined by a monetary conversion factor calculated specifically for each such group.⁴⁷ Depending on the nature of the group, the number of physicians, and their geographic distribution, there may be some potential for agreements that raise antitrust concerns.

If the group is small enough, one inefficient physician may increase actual expenditures of the group enough to affect future rate determinations significantly. Enforceable agreements to adhere to practice guidelines might be the easiest way for physicians to ensure that a few aberrant competitors do not raise costs and trigger future reductions in payment levels. Further, if the area of group distribution is compact enough, the chance is greater that group members will have established patterns of referring patients to each other. Consequently, physicians may enter into agreements not to refer patients to a particularly inefficient member of the group.

Since there is currently no evidence that even direct economic incentives would actually result in anti-competitive behavior by physicians, the extent of risk of such behavior as a result of the amendment is unpredictable. If a physician group constitutes a joint venture formed to deliver services more competitively, such as a staff or independent practice association health maintenance organization, then an agreement by the members of that group to enforce certain standards of efficiency would be justified as ancillary to the overriding competitive purpose.⁴⁸ But if the physician group is not organized specifically to deliver services more competitively, the same conduct jointly, as opposed to individually, would be difficult to justify. It should be noted that implementation of the Secretary's plan for separate group-specific reimbursement rates is contingent on specific approval by the Congress.⁴⁹

⁴⁷Id. at 6102(f)(4)(A), 103 Stat. 2180.

⁴⁸See FTC enforcement policy, *supra* note 41, at 13-17.

⁴⁹OBRA 1989, *supra* note 45, at 6102(f)(4)(B), 103 Stat. 2189.

Effect of Antitrust Laws on Physicians Complaining to Peer Review Organizations and Carriers About Violations of Medicare Guidelines by Other Physicians

A judicially created doctrine called the Noerr-Pennington Doctrine protects from antitrust liability efforts by private entities to obtain or influence government legislation or regulation, even where motivated by anti-competitive intent.⁵⁰ This doctrine has been extended to protect petitioners to government agencies,⁵¹ including a quasi-governmental health systems agency.⁵²

It seems likely that physician complaints to peer review organizations and carriers regarding potential violations of the Medicare program, so long as they are not a mere sham to disguise anti-competitive activities,⁵³ would be seen as, in essence, directed to the government, and would therefore be protected from antitrust liability by the Noerr-Pennington doctrine. Both peer review organizations (PROs) and carriers have distinct and essential responsibilities under the Medicare law. PROs contract with the federal government to promote “the effective, efficient, and economical delivery of health care services and . . . the quality of services of the type for which payment may be made.”⁵⁴ Carriers contract with the federal government to “make determinations of the rates and amounts of payments required pursuant to [Part B of Medicare]” and to make such payments and audit them “to assure that proper payments are made.”⁵⁵ It is settled that PROs and carriers, in administering the Medicare program, act as agents of the federal government.⁵⁶

Further, through the Health Care Quality Improvement Act of 1986, the Congress has provided immunity from damages for any person providing information in good faith, regarding the competence or professional conduct of a physician, to a “professional review body.”⁵⁷ The

⁵⁰Eastern Railroad Presidents' Conference v. Noerr, 365 U.S. 127 (1961); United Mine Workers v. Pennington, 381 U.S. 657 (1965).

⁵¹California Motor Transport Co. v. Trucking Unlimited, 404 U.S. 508, 510-511 (1972).

⁵²Garst v. Stoco, 604 F. Supp. 326 (E.D. Ark. 1985) (antitrust immunity accorded to, among others, physicians petitioning a local Health Systems Agency, a nonprofit, private corporation established pursuant to federal law, in opposition to an application for a certificate of need).

⁵³Noerr, 365 U.S. at 144.

⁵⁴42 U.S.C. 1395y(g).

⁵⁵42 U.S.C. 1395u(a)(1).

⁵⁶E.g., Kwoun v. Southeast Mo. Prof. Standards Rev. Org'n., 811 F.2d 401 (8th Cir. 1987) (PROs); Bushman v. Seiler, 755 F.2d 653 (8th Cir. 1985) (carriers).

⁵⁷Pub. L. No. 99-660, Title IV, 411(a)(2), 110 Stat. 3785 (1986), classified to 42 U.S.C. 11111(a)(2). Persons providing relevant information in good faith to a Medicare PRO are also specifically accorded civil and criminal immunity under the Medicare law. 42 U.S.C. 1320c-6(a).

term “professional review body” encompasses any health care entity and any governing body or committee of a health care entity, including hospitals and professional societies that follow a formal peer review process.⁵⁸

Antitrust Issues Relating to the Adoption of Practice Guidelines by Third- Party Payers

It is difficult to predict whether medical insurers (so-called third-party payers) adopting practice guidelines to determine which claims they will reimburse would qualify under the law that exempts the state-regulated business of insurance from the Sherman Act. However, insurers could safely adopt guidelines as long as they acted independently.

It was not until 1944 that the Supreme Court determined that the business of insurance was part of interstate commerce and subject to the Sherman Act.⁵⁹ The Congress responded with the McCarran-Ferguson Act, which provided persons engaged in the business of insurance regulated by state law with an exemption from application of the Sherman Act.⁶⁰ In order to qualify for the McCarran-Ferguson exemption, a challenged activity must: (1) constitute the business of insurance; (2) be subject to the regulation of state law; and (3) not amount to a boycott, coercion, or intimidation.⁶¹ The Supreme Court has identified three criteria for determining whether an activity is part of the business of insurance. The activity should: (1) have the effect of transferring or spreading a policyholder’s risk; (2) constitute an integral part of the policy relationship between the insurer and the insured; and (3) be limited to entities within the insurance industry.⁶²

Applying those criteria, the Court concluded that an insurance company’s use of a peer review committee to determine the reasonableness of certain charges failed to qualify as the business of insurance on all three counts.⁶³ Likewise, an agreement among insurers to adopt practice

⁵⁸ 431(4)(A) and (11), 110 Stat. 3792-3793, classified to 42 U.S.C. 11151.

⁵⁹ United States v. South-Eastern Underwriters Assn., 322 U.S. 533 (1944).

⁶⁰ 59 Stat. 33, classified to 15 U.S.C. 1011-1915.

⁶¹ 15 U.S.C. 1012(a) and (b), 1013(b); See, e.g., Borsody, The Antitrust Law and the Health Industry, 12 Akron L. Rev., 417, 440-447 (1979).

⁶² Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119, 129 (1982) (construing Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205, 211-217 (1978)).

⁶³ Id. at 128.

guidelines for reimbursement—no matter how logical a business practice—might be construed as outside the business of insurance and therefore not protected by the McCarran-Ferguson antitrust exemption.

However, subjecting insurers acting in this area to antitrust scrutiny would not preclude them from unilaterally adopting practice guidelines for reimbursement. If one party acts alone, there is no combination or conspiracy for the purpose of applying section 1 of the Sherman Act.⁶⁴

Thus, if one insurer independently establishes a policy that it will reimburse for physician services performed only in accordance with certain guidelines, there should be no antitrust problem. Those consumers and physicians adversely affected by the insurer's guidelines would remain free to negotiate with other insurers operating under different rules. Identical guidelines for treating the same conditions are not necessary or even desirable. Just as there are a diversity of medically appropriate ways to deal with certain conditions, there can be a diversity of medical procedures for which insurers may be willing to pay. It is possible to envision a situation where insurers separately adopt different medical practice guidelines.⁶⁵

If more than one insurer should adopt reimbursement policies using identical or substantially similar guidelines, the potential for antitrust difficulty arises, but insurers would be liable only if it can be shown that they agreed to act in concert. Insurers contemplating such agreements would have to weigh the convenience of working with others against the potential for antitrust exposure.

The Department of Health and Human Services, through the Agency for Health Care Policy and Research, is in the process of developing medical practice guidelines in connection with the Medicare program.⁶⁶ Insurers may find it convenient to adopt these Medicare guidelines, or some variation thereof, for their own use. If this happened, the circumstances would tend to explain the timing and substance of the insurers' simultaneous adoption of the Medicare guidelines and would not support any inference of an agreement among insurers.

⁶⁴Sullivan, *supra*, note 11, at 59.

⁶⁵See e.g., Havighurst, *Practice Guidelines for Medical Care: The Policy Rationale*, 34 St. Louis U. L. J. 737 (1990).

⁶⁶42 U.S.C. 1320b-12(a), as added by Pub. L. No. 101-239, 6103(b), 103 Stat. 2195 (1989).

Conclusions

It is impossible to predict exactly what actions physicians might take to eliminate ineffective practice patterns and inappropriate utilization or how payers might go about adopting practice guidelines. Similarly, there is no way to know for sure how courts might rule on antitrust challenges to these activities.

However, the antitrust laws should not unduly interfere with responsible actions by physicians or payers to achieve either end. Moreover, the risk of anti-competitive effects should be considered before deciding that a further legislative exemption from antitrust scrutiny is warranted. Hospital-based peer review is already exempt to a large extent.

Accordingly, there appears to be no need at present for legislation providing antitrust immunity to physicians or payers to facilitate these activities. If, in the future, it becomes apparent that the adoption of guidelines is being hindered unduly, the Congress may consider providing antitrust immunity at that time.

Agency Comments

The Federal Trade Commission and the Department of Justice reviewed drafts of this report. Where appropriate, their comments have been incorporated. Both agencies have submitted written statements generally supporting the conclusions reached herein. The FTC's statement is included in appendix II, and DOJ's in appendix III.

The FTC took issue with us on one significant point. In commenting on the draft, FTC staff disagreed with our statements that physician groups recommending that payers adopt their guidelines for reimbursement purposes and payers adopting identical or substantially similar guidelines for reimbursement would almost certainly experience antitrust problems. The FTC views such activities as the mere communication of information or expression of policy and hence not as antitrust violations.

We agree. The draft was intended to reflect our view that physicians or insurers acting in these areas could be challenged on antitrust grounds, and not to imply that such suits would be successful. We have modified the report to correct any impression that antitrust suits are likely to succeed in these instances.

We also submitted a draft of this report to Clark C. Havighurst, William Neal Reynolds Professor of Law at Duke University, the author of a number of papers dealing with the application of antitrust law in the

area of health care. Where appropriate, his comments have also been incorporated in the text of the report.

Copies of this report are being sent to appropriate congressional committees; the Federal Trade Commission; the Attorney General; and other interested parties. This report was prepared under my direction by staff of the Office of the General Counsel of the General Accounting Office. If you have any questions about this report, please call me at (202) 275-5881. Other major contributors are listed in appendix IV.



Barry R. Bedrick
Associate General Counsel

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Abbreviations

AMA	American Medical Association
DOJ	Department of Justice
FTC	Federal Trade Commission
OBRA 1989	Omnibus Budget Reconciliation Act of 1989
PRO	peer review organization

Objectives, Scope, and Methodology

The Omnibus Budget Reconciliation Act of 1989 (OBRA 1989) requires the General Accounting Office to study physician and third-party payer antitrust issues:

“The Comptroller General shall conduct a study of the effect of anti-trust laws on the ability of physicians to act in groups to educate and discipline peers of such physicians in order to reduce and eliminate ineffective practice patterns and inappropriate utilization. The study shall further address anti-trust issues as they relate to the adoption of practice guidelines by third-party payers and the role that practice guidelines might play as a defense in malpractice cases. . . .”¹

This report addresses the antitrust questions posed by the statute and discusses how antitrust law may constrain physicians and third-party payers in addressing quality-of-care and utilization problems in various contexts. It specifically discusses physician antitrust issues pertaining to: hospital peer review; practice guidelines, both informational and mandatory; the antitrust implications of various collective responses by physicians to the Medicare statutory fee schedule; and physicians’ complaints to Medicare peer review organizations and carriers regarding the practice of other physicians. We have also examined the antitrust implications of the adoption of practice guidelines by third-party payers.

In preliminary investigation of the issue of malpractice and practice guidelines, we found that any discussion would have had to be based mainly on conjecture, and as a result would not have been very useful. Few if any data were available on how courts had dealt with the issue. We could have speculated on what courts might do in the future but, given that malpractice cases are largely heard in state courts, it would have been difficult and perhaps misleading to attempt to generalize about what may happen.²

We discussed the issue of the role of practice guidelines in malpractice cases with staff from the Senate Committee on Finance’s Subcommittee on Long Term Care. It was agreed that, in lieu of including that issue in this report, we would address instead the antitrust implications of the Medicare statutory fee schedule provisions.

¹Pub. L. No. 101-239, 6102(d)(9), 103 Stat. 2187 (1989).

²One potentially significant source of data on malpractice and practice guidelines is a not-yet-implemented demonstration project in Maine. Participating physicians in that state in certain medical specialties that are frequent targets of malpractice claims will be permitted to use compliance with state-sanctioned practice parameters as a defense to malpractice charges. However, data will not be available for some time. The right to use the defense will begin next year (provided that at least 50 percent of the physicians in each eligible specialty agree to participate).

We agree that the impact of malpractice claims and insurance on efforts to control the costs of medical care deserves our attention. We are planning work in this area that will explore alternatives to the current system.

In preparing this study, we reviewed applicable court decisions, surveyed literature pertaining to physician antitrust issues and the development and use of practice guidelines, and met with representatives of interested organizations and governmental entities charged with enforcing antitrust laws. We conducted our work from January 1990 through May 1991. We performed our work in accordance with generally accepted government auditing standards.

Comments From the Federal Trade Commission



OFFICE OF THE SECRETARY

UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

June 17, 1991

Barry R. Bedrick
Associate General Counsel
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Bedrick:

Thank you for providing the Commission with an opportunity to review the General Accounting Office's draft report to Congress on the applicability of the antitrust laws to efforts by professional groups and by third party payers to develop and apply guidelines for effective medical practice.¹ As you know, the Commission's staff has discussed with GAO staff the application of antitrust analysis to health care markets and the Commission's activities in that area.

The Commission agrees with the report's conclusion that the federal antitrust laws, including the Federal Trade Commission Act, do not impede desirable efforts by professional groups or third-party payers to establish guidelines for medical practice designed to improve the quality and cost-effectiveness of medical care delivered to patients. In particular, the report accurately reflects court decisions and Commission policy and precedent on the following points:

1. Hospital-based peer review of physicians' practices is generally both legitimate and procompetitive, raising antitrust issues primarily when abused to restrict competition by excluding practitioners or categories of practitioners from the market for reasons not grounded in the hospital's interest in the efficient delivery of high-quality services;

¹ This letter is based upon a review of the draft report. While the final report was not available for review prior to the date specified for Commission comment, FTC staff members have provided the GAO with detailed comments on the draft report, and the Commission understands that these comments may be reflected in the final report submitted to Congress.

Appendix II
Comments From the Federal
Trade Commission

Barry R. Bedrick
Page 2

2. Advisory practice standards and other educational programs are highly unlikely to cause antitrust concerns;


3. Mandatory practice standards are likely to be procompetitive if adopted by integrated joint ventures and may be procompetitive in other circumstances depending on their effects;

4. Insurers' unilateral adoption of practice guidelines to govern their payment decisions does not violate the antitrust laws.

While portions of the draft report could create a mistaken impression that certain kinds of conduct are likely to raise significant antitrust problems, the Commission's staff has discussed these matters with a representative from your office, and it is the Commission's understanding that GAO staff is attempting to address these concerns in the final report.

The Commission appreciates the opportunity to comment and looks forward to working with you in the future on issues of mutual concern.

By direction of the Commission.


Donald S. Clark
Secretary

Comments From the Department of Justice



U. S. Department of Justice

Antitrust Division

*Judiciary Center Building
555 Fourth Street, N.W.
Washington, DC 20001*

June 26, 1991

Mr. Barry R. Bedrick
Associate General Counsel
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Bedrick:

The Antitrust Division of the Department of Justice has reviewed the General Accounting Office's (GAO's) draft report on the antitrust implications of actions by physicians and payers to reduce inefficient practice patterns and inappropriate utilization. We thank you for the opportunity to review this report, and to discuss these issues with the GAO staff who formulated the report. The cost and availability of quality health care services in this country is a significant national concern, and we believe that it is important to clarify the impact of the antitrust laws on legitimate efforts by physicians and payers to improve the quality and efficiency of health care services.

The report concludes that additional statutory antitrust immunities are not necessary because the antitrust laws are unlikely to significantly interfere with physicians' abilities to engage in activities such as peer review and the development of clinical practice guidelines. The report reaches the same conclusion as to payers who develop practice guidelines. We agree.

Most of the actions upon which the report focuses do not raise significant antitrust concerns, because they are rarely anticompetitive and can be very beneficial. They can provide consumers and payers with additional information that enables them to make better decisions about purchasing and using health care services, and they encourage providers to compete more vigorously on the basis of cost-effectiveness and quality. Most consumers of health care do not have the knowledge or experience to allow them to determine the quality or appropriateness of services being provided to them. Peer review and practice

Appendix III
Comments From the Department of Justice

guidelines, when properly developed and implemented, give payers and consumers a standard to use in evaluating providers and thus increase competition as providers seek to establish that they offer quality care in an efficient manner.

Legitimate peer review actions and the promulgation of advisory guidelines are generally unlikely to be found to violate the antitrust laws. Other actions such as mandatory guidelines, if challenged, will usually be subject to a full analysis under the antitrust laws weighing both the procompetitive benefits and likely harm to competition. If, on balance, these activities injure consumers by limiting price and/or quality, they would be invalidated. The only exception to the usual full analysis would be in instances where mandatory guidelines involve or result in agreements that are generally regarded as per se illegal such as price fixing.

We have informally provided detailed comments on the draft report to the GAO staff, and we continue to work with them to clarify portions of the report for its final version. Thank you again for the opportunity to comment on and review this report.

Sincerely yours,



Robert E. Bloch, Chief
Professions & Intellectual
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