PRESENTATION TO DOJ/FTC
ON REMEDIAL ISSUES IN
ANTITRUST ENFORCEMENT IN HEALTH CARE

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I have been asked to address two remedial issues relating to application of the federal antitrust laws in health care:

1. The propriety of criminal enforcement; and

2. The propriety of structural relief in non-merger cases.

These are important topics, and I am honored to have the opportunity to discuss each of them.

At the outset, I should say that my views have developed over more than a quarter of a century of representing providers – generally physicians and their associations – in antitrust proceedings. I served as counsel to the American Medical Association in the first foray of the Federal Trade Commission into health care – its 1975 Complaint challenging the Association's ethical rules on physician advertising and on contractual relationships between physicians and third parties. Subsequently, I have been involved in the defense of FTC proceedings, such as Southbank IPA, in which structural relief has been an issue. I have also been involved in numerous DOJ investigations, including criminal investigations of allergists in Massachusetts and of obstetricians in Georgia. And I met on several occasions with representatives of the agencies as they were formulating both the 1994 Joint Statements on Enforcement of the Antitrust Laws in Health Care as well as subsequent revisions.

There is no question that my thoughts have been shaped by my experience in representing physicians and other providers. But I am not here today on behalf of any client, and I will try to speak as impartially as I can. In this connection, I should note that I teach Health Law and Policy at the University of Chicago Law School and at the Harris School of Public Policy. In that capacity, I have given a good deal of consideration to the matters which we will be discussing.

A. Criminal Enforcement

Let me begin by saying that I do not believe that criminal antitrust enforcement in health care is never appropriate. In my judgment, however, criminal enforcement of the Sherman Act should be limited to situations in which each of two elements are present:

1. The challenged conduct should involve a clear and well-established violation of the antitrust laws; and

2. There should be unambiguous proof that those who engaged in the conduct did so knowing that conduct to be unlawful.

Unless both elements are present, criminal sanctions should not be sought.

I want to emphasize that I am not putting forward a special rule for health care. Rather, this rule should govern all sectors of our economy. The rule is, in my view, necessary to harmonize two fundamental but competing policies: (1) effective enforcement of the antitrust laws; and (2) the basic premise of our Anglo-American system of jurisprudence that, except for certain conduct which poses risk to human health or safety, criminal punishment should be limited to conscious and calculated wrongdoing.

In advocating a very circumscribed role for criminal prosecution, I readily acknowledge that criminal proceedings are a very effective means of antitrust enforcement. There is nothing like a criminal conviction, or even a prosecution, to get the attention of those to whom the Antitrust Division is trying to deliver a message.

And criminal proceedings are effective in another sense as well. On this point, I speak from experience. Several years ago, I served as coordinating counsel for a number of obstetricians in Savannah, Georgia who were the targets of a serious criminal antitrust investigation. Well into the investigation, the Antitrust Division offered to drop its request for criminal sanctions if the obstetricians signed a civil consent decree. That decree is reported as United States v. Burgstiner, 56 Fed. Reg. 6681 (Feb. 19, 1991).

I advised my clients that the proffered decree was overbroad, prohibited lawful conduct, and imposed unduly burdensome procedural requirements. But once the prospect of criminality was lifted, these physicians fell over themselves to sign – before the Division might change its mind and return to the criminal approach. The dread of criminal sanctions is so great that the physicians couldn't wait to sign a decree to which they otherwise would have objected.

So if criminal enforcement is so effective, why should its use be very carefully circumscribed. In my view, there are two basic reasons. Both of these reasons ultimately derive from two facts:

1. The Sherman Act, unlike most traditional criminal statutes, does not precisely identify the conduct which it proscribes. Rather, its broad prohibition against contracts, combinations, or conspiracies in restraint of trade covers a panoply of conduct whose competitive consequences are often difficult to predict.

Consequently, well-meaning individuals may engage in conduct that violates the Act without having any understanding that their conduct is unlawful.

2. The Sherman Act, unlike modern statutes that impose criminal liability without intent, does not regulate conduct that threatens the health or safety of the population.

From these two facts emerge two powerful arguments against any but the most limited criminal enforcement of the antitrust laws. I will call the first "the fairness rationale" and the second "the efficiency rationale." Both of these were recognized by the Supreme Court in its seminal decision in United States v. United States Gypsum Co., 438 U.S. 422 (1978).

a. The Fairness Rationale

At bottom, the fairness argument is that, outside the context of regulation of health and safety, it is unfair and inconsistent with the generally accepted functions of criminal law to punish someone for engaging in conduct which he or she did not know to be wrong. On this issue, the Supreme Court was quite clear: The criminal laws should not be used "simply to regulate business practices regardless of the intent with which they were undertaken." Id. at 442. Instead, they should be reserved only to punish "conscious and calculated wrongdoing . . . ." Id.

The fairness rationale is particularly strong in the physician context – where the potential defendants are not sophisticated business persons with knowledgeable counsel on the payroll. I can say unequivocally that in all of the criminal antitrust matters with which I have been involved, none of the physicians had a clue at the time in which they engaged in the conduct for which they were investigated that that conduct was unlawful.

Specifically, I wrote a brief amicus curiae in the Ninth Circuit on behalf of the American Dental Association and the American Medical Association in United States v. Alston, 974 F.2d 1206 (9th Cir. 1992). In the course of preparing that brief, I spoke with A. Lanoy Alston, D.D.S. I can fairly say that Dr. Alston had no idea that it was unlawful to seek the same co-payment amounts for dentists in Tucson as their colleagues in Phoenix were receiving.

Similarly, I represented an allergist who was one of the targets of the investigation in U.S. v. Mass. Allergy Society, 1992-1 Trade Cases ¶69,846 (D. Mass. 1992). He was an extremely decent individual who never would have knowingly acted in an unlawful manner. He happened to be a member of an IPA that was insufficiently integrated economically to satisfy antitrust requirements that would have permitted the IPA to set fees. He simply did not recognize that there was anything wrong with having that IPA suggest fees to various payors and to bargain over those fees. And as for the Savannah obstetricians, it just did not dawn on them that having a meeting to discuss a proposed two year contract proffered by a managed care company – with no agreement regarding specific fees to offer to that company – might be deemed to contravene the Sherman Act.

Of course, as counsel for DOJ has repeatedly told me, everyone knows that price fixing is unlawful. But the problem is that even sophisticated antitrust counsel – to say nothing of physicians and health care providers – cannot agree on precisely what constitutes price fixing. It comes as quite a surprise to physicians that agreeing on fees to recommend to a payor, discussing the economic implications of a proposed contract among themselves, or negotiating with an insurance company, might constitute price fixing – given that the ultimate decision regarding payment is made by the payor, not by the physicians.

One clear indication of a lack of criminal intent is that almost all antitrust violations by health care providers occur in the open. These are not covert operations performed in secrecy or in code. Rather, the conduct in cases like Alston is carried out in the public eye. I would submit to you that very few criminals commit their crimes overtly – with no attempt to cover up in some way. The non-clandestine nature of the actions of health care providers which raise antitrust concerns bespeaks a lack of criminal intent.

In this connection, I would point out that it is a somewhat peculiar feature of Section 1 that antitrust violations are predicated on agreement rather than on market power. Most individual physicians and small physician groups feel themselves powerless against payors which control any substantial percentage of their patients. They do not see it as inherently evil to band together to try to achieve countervailing bargaining power that will put them in a position to negotiate on an equal footing. And as Congressional enactments such as the federal labor laws and the Capper-Volstead Act attest, atomistic sellers banding together to give themselves some negotiating leverage is not inherently evil.

To prosecute people for engaging in conduct that they reasonably do not see as wrong-doing is unfair. It also breeds hostility to, and distrust of, the legal system on the part of those regulated. For these reasons too, it should be avoided.

b. The Efficiency Rationale

Quite apart from fairness considerations, it is not sound antitrust policy to invoke criminal sanctions against conduct which is not a blatant violation of law. Please note that I am not making a distinction between per se and rule of reason cases. For, as the decision of the Supreme Court in Arizona v. Maricopa County Medical Society, 4457 U.S. 332 (1982) well

illustrates, the competitive implications of conduct that is technically a per se violation can be quite ambiguous. Thus, I believe that the distinction should be between unambiguously clear violations and all other conduct.

The efficiency rationale for limiting criminal enforcement to well understood and egregious violations of law is that salutary and procompetitive conduct in the antitrust area lies close to the borderline of impermissible conduct. As the Court noted in Gypsum, "salutary and procompetitive conduct lying close to the borderline of impermissible conduct might be shunned by businessmen who chose to be excessively cautious in the face of uncertainty regarding possible exposure to criminal punishment for even a good faith error of judgment." Id. at 441. This observation holds true across-the-board. However, it is particularly true for physicians – for whom an antitrust conviction can mean not only all of the sanctions associated with antitrust violations generally but also loss of the physician's most precious possession – the license to practice medicine.

Once again, there are numerous examples of procompetitive conduct that may well be deterred if criminal sanctions are invoked too liberally. Some of these were catalogued in Alston itself – the one relatively recent criminal antitrust prosecution in health care that has been litigated. As Judge Kozinski noted, it is lawful for individual health care providers to come together "to level the bargaining imbalance created by [managed care] plans and provide meaningful input into the setting of . . . fee schedules." 974 F.2d at 1214. Similarly, it is lawful for health care providers to "pool cost data in justifying a request for an increased fee schedule." Id. And it is lawful for providers to collectively "negotiate various other aspects of their relationship" with managed care plans "such as payment procedures, the type of documentation

they must provide, the method of referring patients and the mechanism for adjusting disputes." Id.

Yet these activities are not far from implicit threats of mass withdrawals from managed care plans – which would implicate the antitrust laws. If we don't want to intimidate health care providers from engaging in these lawful activities – activities which generally promote both competition and, perhaps even more importantly, patient care – the Antitrust Division needs to be extremely judicious about any criminal enforcement activities that it might undertake.

Finally, I would like to turn to the argument that criminal enforcement is needed as a deterrent because civil remedies are inadequate. It is worth recalling that, in addition to government actions, private treble damage actions are available. As you know, defendants who lose such actions get to pay, not only treble damages, but also the plaintiffs' attorneys fees – even if only injunctive relief is granted. There have been many such cases, e.g. Intl. Healthcare Mgmt. v. Hawaii Coalition for Health, 332 F.3d 600, 605 (9th Cir. 2003), decided just this year. There are plaintiffs' antitrust attorneys and class action attorneys ready to move in if an arguable antitrust violation has occurred. Moreover, managed care plans and others who feel that providers are acting anticompetitively are not shy about threatening antitrust litigation. The threat of private treble damage actions is deterrent enough for those who would ignore antitrust requirements.

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In sum, I submit that the Attorney General's National Committee to Study the Antitrust Laws got it right nearly 50 years ago in 1955 when it concluded that:

> ". . . criminal process should be used only where the law is clear and the facts reveal a flagrant offense and plain intent to restrain trade."

Report, at 349. The Division should not deviate now from that wise conclusion.

B. Structural Relief

At the outset, it is important to recognize that there are various forms of possible structural relief in non-merger cases. I'm going to confine my remarks this morning to two forms of such relief – (a) dissolution and (b) break up of large IPAs. But I'd like to begin with the words of the Federal Trade Commission in Indiana Federation of Dentists, 101 F.T.C. 57, 186-187 (1983):

> "Only in circumstances where there is no significant function remaining for an organization other than to repeat antitrust violations, or in which a conduct order would not reasonably be expected to prevent repeating such violations or to restore competition, would a dissolution order be appropriate."

In that case, the Commission rejected the recommendation of the ALJ to dissolve the Indiana Federation of Dentists because the Commission concluded that the Federation did serve some legitimate purposes and because the antitrust violation at issue could effectively be addressed by a conduct order.

In my judgment, the approach to dissolution taken by the Commission twenty years ago in IFD was correct. Dissolution should be ordered only if one of two conditions is present:

1. A conduct order is inadequate to halt the antitrust violation; or

2. The respondent has no substantial legitimate function or is a sham designed to perpetrate unlawful conduct.

Where, as in IFD, neither is present, dissolution should not be ordered.

To be sure, there won't be many cases in which either of these conditions is exists. In most instances, a well-drafted conduct order should suffice to enjoin the violation. And not many organizations are created as a sham or with no substantial lawful purpose. So cases in which dissolution is ordered will be very few. But that is as it should be because dissolution is basically corporate capital punishment.

Finally, I'd like to discuss the break up of IPA and similar organizations. Here, there are two very important distinctions from dissolution.

1. Unlike dissolution, break up is a complex remedy. It may sound easy to divide one IPA into 2 or 3. But it is not. How does one decide which physician or physician group goes into which new IPA? This is very difficult as a practical matter. Indeed, it was congressional recognition that it is difficult to unscramble mergers between two previously separate companies that led to enactment of the Hart-Scott-Rodino Act. How much more difficult is it to break apart entities that have evolved organically and that are not the result of a merger? The practical problems in splitting apart IPAs are quite significant.

2. Unlike dissolution (which by definition involves an entity with no substantial legitimate purpose), break up of an IPA generally involves an organization with a lawful, procompetitive purpose. Antitrust agencies need to recognize that break

up may well result in the loss of efficiencies such as economies of scale or the ability to serve a large geographic area effectively. The loss of these efficiencies – and, most importantly, the impact on quality of care, needs to be carefully considered before a break up is sought.

Based on these considerations and my effort to apply Indiana Federation of Dentists in this context, I would submit that break up should be considered only if each of three conditions is present:

1. It is clear that a conduct order will not suffice to remedy the violation;

2. The break up can be effectuated without substantial administrative costs; and

3. The break up will not result in a loss of significant efficiencies or a reduction in quality of care.

Unless each of these conditions exists, break up of an IPA would be inappropriate.

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Thank you for the opportunity to be part of this panel. I hope that my remarks have been useful.