Antitrust Challenges to Provider Network Exclusion

By Richard D. Raskin and Brad Robertson

Introduction

For as long as there have been provider networks that engage in managed care contracting—whether HMOs, PPOs, IPAs, PHOs, or now ACOs—there have been antitrust lawsuits challenging exclusion from those networks.

These suits tend to share a core set of facts. An excluded provider group contends that the denial of its application for admission to the network was the product of a conspiracy among all or some of the network’s members. The provider contends that its admission to the network would benefit competition by allowing it to compete more effectively with other network participants. The network responds that the excluded provider has other avenues of competition available outside the network, and that the network cannot take all applicants without losing the ability to manage the quality of services and to negotiate discounts on provider fees. Most of these suits also share a common outcome—the excluded provider loses, generally because it cannot establish harm to competition as opposed to harm to itself as an individual competitor.

A recent set of cases involving a radiology benefits management company (RBM) follows the classic pattern, except in one key respect—so far, the plaintiffs have not definitively lost.1 And while no plaintiff has definitively won either, the cases have multiplied and spawned an enforcement action by the New York attorney general.2

In an era of consolidation among providers both through mergers and the creation of network entities such as ACOs, the RBM suits provide a note of caution worth heeding. Just as a network that includes too many providers in a particular specialty may face enforcement risk, a network that selectively includes providers may face treble damages lawsuits from providers whose applications are denied. Those responsible for overseeing network operations need to strike a careful balance in order to successfully manage antitrust risk.

This article begins by reviewing the case law on provider network exclusion. It then describes the recent string of RBM litigations and focuses, in particular, on the unique theory of “one-stop shopping” by which plaintiffs in these suits have tried to establish harm to competition and damages.

I. Antitrust Principles Governing Provider Network Exclusion

The law on network exclusion can be summed up in a few words: The denial of a provider’s application to participate in a legitimate network venture that engages in managed care contracting is not per se unlawful and, absent extraordinary circumstances, is highly unlikely to violate the rule of reason. If the network is not provider-controlled, its decisions about network participation are even less likely to be found unlawful. Absent agreement with one of the network members or a third party, the decision of a non-provider-controlled network is reviewable only under Sherman Act Section 2.

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A. DOJ/FTC Perspective

The Department of Justice (DOJ) and Federal Trade Commission (FTC) addressed the principles governing provider network exclusion in their 1996 Statements of Antitrust Enforcement Policy in Health Care as follows:

A rule of reason analysis usually is applied in judging the legality of a multiprovider network’s exclusion of providers or classes of providers from the network, or its policies on referring enrollees to network providers. The focus of the analysis is not on whether a particular provider has been harmed by the exclusion or referral policies, but rather whether the conduct reduces competition among providers in the market and thereby harms consumers. Where other networks offering the same types of services exist or could be formed, there are not likely to be significant competitive concerns associated with the exclusion of particular providers by particular networks.3

The sole situation in which the Statements appear to recognize a potential for competitive concern is when the network wields market power such that “providers or classes of providers are unable to compete effectively without access to the network.”4 Even then, the agencies “will consider whether there are procompetitive reasons for the exclusion or referral policies.”5

According to the Statements, the principal antitrust risk of physician-owned networks is not that they will exclude some physicians, but that they will be overly inclusive and thereby gain inappropriate negotiating leverage with payers.6 The agencies recently have reiterated this concern in their enforcement policy statement on ACOs.7 Likewise, in its policy advocacy role, the FTC has opposed state legislation requiring health plans to admit “any willing provider,” stating that “such laws appear to protect competitors, not competition or consumers.”8 The agencies have never brought an enforcement action focusing on the exclusion of a particular provider from a contracting network.

B. Case Law

Courts, too, have been generally unsympathetic to antitrust claims brought by providers excluded from contracting networks, even when the network is provider controlled.

Such claims are viewed under the rule of reason, not the per se rule. For example, in Levine v. Central Florida Medical Affiliates9 an excluded internist brought Section 1 and 2 claims against a hospital-owned PPO and the affiliated physician’s advocacy group that provided the main source of the PPO’s network membership. The court rejected the application of the per se rule to the plaintiff’s alleged exclusion from the defendant’s network because such exclusion was “not a naked restraint of trade with no purpose except stifling competition.”10 In Capital Imaging Associates PC v. Mohawk Valley Medical Associates Inc.,11 a radiology practice sued a physician-owned IPA that provided a physician network for a health plan, alleging that its exclusion from the IPA’s physician network violated Sherman Act Section 1. The U.S. Court of Appeals for the Second Circuit found that the per se rule did not apply given “the recognized procompetitive virtues of independent practice association forms of HMOs.”12 The U.S. District Court for the Western District of New York later interpreted the Capital Imaging decision as definitively “rejecting” the application of the per se rule to exclusive health provider networks.13

In Doctor’s Hospital of Jefferson Inc. v. Southeast Medical Alliance Inc.,14 the U.S. Court of Appeals for the Fifth Circuit agreed with the lower court that per se treatment was not appropriate treatment for a hospital’s claims of exclusion from a PPO owned by competitor hospitals. In contrast, the Fifth Circuit previously found in St. Bernard General Hospital v. Hospital Service Association of New Orleans,15 that the plaintiff, an excluded hospital, made a prima facie showing of a per se price fixing violation where it brought a Section 1 claim against a hospital-controlled health plan where the plan set reimbursement differently for the nine hospitals participating on its board than for other contracted hospitals.

Under the rule of reason, exclusion of a particular provider or provider group almost always has been found not to be actionable. Such exclusion does not cause a detrimental effect on competition, even if it harms a particular competitor. For example, in Doctor’s Hospital, an excluded hospital sued a PPO owned by competitor hospitals alleging that its exclusion resulted from a group boycott that harmed competition. At the outset, the Fifth Circuit noted that “although a provider-controlled PPO generally embodies elements of a horizontal restraint of trade simply by ‘preferring’ the members which are its providers, no adverse antitrust consequences follow from this characteristic alone.”16 The court also noted the importance of competition at the network level, stating both that “[c]ompetition among managed-care plans checks any anticompetitive effects of market power achievable from aggregating providers of hospital services,” and “restricting the number of health care providers affiliated with a PPO can simultaneously reduce competition among them and stimulate competition between health service networks.”17 Likewise, in Capital Imaging, the Second Circuit found that plaintiff had “not shown that defendants’ activities have had any adverse impact on price, quality, or output of medical services in the relevant market.”18 And in Hassan v. Independent Prac-

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3 Statement 9, at 122-23.
4 Id.
5 Id.
6 Statement 8, at 74.
8 See letter from FTC staff to Patrick J. Lynch, Rhode Island AG, and Juan M. Pichardo, Rhode Island State Senate, at 5-6 (April 8, 2004), http://www.ftc.gov/os/2004/04/ribills.pdf.
9 72 F. 3d 1538 (11th Cir. 1996).
10 Id. at 1550.
11 996 F.2d 537 (2d Cir. 1993).
12 Id. at 545.
14 123 F.3d 301, 307 n.12 (5th Cir. 1997).
15 712 F.2d 978 (5th Cir. 1983).
16 123 F.3d at 308.
17 Id.
18 Capital Imaging, 996 F.2d at 547.
the U.S. District Court for the Eastern District of Michigan found that the plaintiff allergists failed to satisfy the rule of reason’s requirement of showing injury to overall competition, where the defendants—a provider-controlled health plan and IPA—did not have significant market power and operated in an industry with other large competitors and no significant barriers to entry.

To the extent that the exclusion of a single provider has any anticompetitive effects, those are likely to be outweighed by procompetitive benefits. The Fifth Circuit recognized the procompetitive benefits of exclusive networks in *Doctor’s Hospital*, stating “it is generally recognized that PPOs can, in the proper circumstances, lower the cost of medical care to consumers by allowing negotiation of lower prices through consumers’ representatives, such as employers or insurance companies.”

As mentioned above, the Second Circuit in *Capital Imaging* noted the “recognized procompetitive virtues” of IPA forms of HMOs. In *Stop & Shop Supermarket Co. v. Blue Cross & Blue Shield of Rhode Island*, the First Circuit similarly extolled the procompetitive benefits of a closed network formed by a joint venture among pharmacy chains to enter into exclusive contracts with health plans because it “should lower cost to [the health plan] of supplying drugs to consumers (because most suppliers will cut prices in exchange for increased volume).”

In addition, an excluded provider may not have standing to bring an antitrust action, as its exclusion from a contracting network may not represent antitrust injury, as opposed to harm resulting from competition itself. In *Abraham v. Intermountain Health Care Inc.*, the court affirmed summary judgment for a managed care network in a case brought by excluded optometrists. Among other reasons, the court found that plaintiffs failed to show antitrust injury to establish standing to assert their Section 2 claims. In contrast, the court in *Doctor’s Hospital* found the hospital’s allegations of losses and competitive disadvantage from its exclusion from a PPO owned by competitor hospitals to be a sufficient allegation of antitrust injury to establish standing. Notably, the court then proceeded to affirm dismissal of plaintiff’s Section 1 claims on summary judgment because competition had not been harmed.

### II. RBM ANTITRUST LITIGATION

In a series of cases filed in federal courts in New York over the past six years, imaging centers have alleged that an RBM unlawfully excluded them from a contracting network for outpatient diagnostic imaging services. The cases all arise from a common factual background.

#### A. Allegations

In the mid-1990s, a number of radiologists and their affiliated outpatient imaging centers came together to form the RBM to oversee and manage the provision of imaging services paid for by HMOs, PPOs, and other third party payers. The RBM developed a network of radiology providers and contracts with payers to manage radiology benefits under the payers’ health plans. The network included all of the RBM’s owners and some additional radiologists and imaging centers, but it did not admit any willing provider—it engaged in selective contracting in order to negotiate discounted rates. Some third party payers reimbursed the network on an at-risk, capitated basis. Others reimbursed the network for administrative services only and paid radiology providers directly. Other payers chose not to deal with the RBM at all. Instead, these payers used competing RBMs or performed these services in-house.

Each of the complaints in the RBM litigation is brought by an excluded radiologist or outpatient diagnostic imaging entity. The complaints allege that the RBM is by its nature a conspiracy among the radiologists who own or control it, and that the plaintiffs’ exclusion from the network is anticompetitive. In some cases, a particular competing radiology practice or physician that owns shares of the RBM also is named as a defendant and alleged to have entered into discrete conspiracies with the RBM. The complaints claim that the alleged conduct by the RBM and its owners violates Sherman Act Section 1 by excluding potential competitors and thereby reducing competition. Some of the complaints also allege a violation of Sherman Act Section 2 for alleged monopolization, attempted monopolization, and conspiracy to monopolize.

#### B. Market Power

A major issue in the suits to date is whether the RBM has sufficient market power to even raise a potential antitrust issue as to anticompetitive foreclosure. Market power generally is thought to be a necessary but not sufficient prerequisite for a network to inflict competitive harm through exclusion.

The alleged product market in each of the RBM cases is the market for outpatient diagnostic imaging. Plaintiffs and defendants differ, however, as to whether to include governmental programs within that market. Leasing government payers out of the market increases the RBM’s total market share and makes exclusion from the RBM seem more significant. Plaintiffs and defendants also disagree on whether market share should be measured by total sales of outpatient radiological ser-

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20 123 F.3d at 308.
21 996 F.2d at 545.
22 373 F.2d 57, 62 (1st Cir. 2004).
23 461 F.3d 1249 (10th Cir. 2006).
24 Id. at 1267-68.
25 123 F.3d at 305.
26 Id.
28 See, e.g., *Stop & Shop*, 373 F.3d at 29-30 (noting that “low numbers make dismissal easy,” and that “foreclosure levels are unlikely to be of concern where they are less than 30 or 40 percent”).
services or by covered lives. Total sales data can be more difficult to obtain but provides a more direct measure of the market than covered lives, at least where most payments are made on a fee-for-service basis. The geographic market at issue varies from case to case, depending on the specific region in which the plaintiff does business.

Plaintiffs have made some attempt to establish market power through evidence of so-called “direct effects” rather than market share data. Some courts have admonished that “such direct proof is only rarely available.” Nevertheless, plaintiffs have asserted, for example, that wait times for radiology services at in-network providers are longer than the plaintiffs’ wait times, or that the RBM network does not include some specialized service (e.g., stand-up MRI machines) that plaintiffs provide.

C. One-Stop Shopping

One of the unique features of the RBM suits is the plaintiffs’ theory of “one-stop shopping.” According to plaintiffs, one-stop shopping is a phenomenon by which an imaging provider excluded from the RBM’s network may lose business not only from health plans that contract to use that network, but also other health plans that have no relationship whatsoever with the RBM.

The theory holds that referring physicians wish to avoid the administrative burden of determining which imaging providers are in network for a particular health plan. Given the choice, they will send all of their cases to a provider that is in network for all plans. As a result, a physician will choose not to refer any patients to an imaging provider who is not in network for all plans. Such a provider can therefore argue that because it was excluded from an RBM accounting for only a small percentage of the market, it lost substantial business from health plans from which it was never excluded.

One-stop shopping is a bit like the domino theory of the Cold War era: It posits that a single lost opportunity, even one seemingly insignificant in itself, could trigger a chain reaction of collapses that lead to ruin. But does the theory align with reality? Ultimately, the predictive value of the theory is a question of fact—either referring physicians stop sending patients to excluded providers, or they do not. But no decision to date has squarely decided whether this dynamic actually plays out in reality. Plaintiffs have offered the testimony of an economist who supports the theory. Defendants have argued to the contrary, based on economist testimony as well as testimony of referring physicians that they make referrals based on factors other than mere administrative convenience (such as quality, service, and location).

If true, the one-stop shopping theory has sweeping implications. There is no apparent reason why referring physicians would treat their referrals for outpatient imaging services substantially differently from referrals for other specialty services. If referring physicians are only willing to send patients requiring imaging services to “one-stop” imaging providers who participate in every health plan, why would they act differently with respect to referrals for any other medical specialty service? Consider what the one-stop shopping theory could have meant for the plaintiffs in prior network exclusion cases:

- In Capital Imaging, the defendants had 2.3 percent of the region’s HMO subscribers and 1.15 percent of the total insured patient population. The court called this a de minimis market share and determined that foreclosure from this segment of the market did not represent an injury to competition. But did the plaintiffs also lose business from other health plans from which they were not excluded due to one-stop shopping by referring physicians? And would such a loss have represented a cognizable antitrust injury?

- In Hassan, the defendants covered 20 percent of the patients in the geographic area, which the court found not to constitute sufficient market power to support a potential to cause injury to competition. But, again, did the plaintiff physician also lose business from plans he belonged to as a result of one-stop shopping and, if so, would such a loss be actionable?

- In Levine, the plaintiff’s claim failed because he presented no evidence proving the defendants’ had sufficient market power to affect competition. Might the court have ruled differently if the plaintiff presented evidence addressing the possibility of one-stop shopping?

If one-stop shopping is a reality, these plaintiffs may have each missed an opportunity to demonstrate substantial harm resulting from their exclusion. Of course, it also is possible that these courts would have rejected the one-stop shopping theory. These courts may have found as a factual matter that it is not a significant inconvenience for a referring physician’s office staff to determine which imaging centers are in network for a particular health plan. They also may have found that the administrative burden of determining which centers are in-network does not actually trump other factors—such as quality, service and location—in driving referral decisions. They also may have rejected the theory on the grounds that any injuries resulting from “one-stop shopping” are too causally remote from the alleged network exclusion to be actionable.

CONCLUSION

With health care reform under way, network contracting arrangements are as important as ever, if not more so. Despite a daunting set of precedents establishing the generally procompetitive nature of selective contracting, plaintiffs continue to bring suits directed at establishing that the exclusion of a single competitor from a network may be actionable under the antitrust laws. The fate of the one-stop shopping theory in the RBM litigation may affect whether plaintiffs can prevail in future network exclusion cases.

30 United States v. Microsoft, 253 F.3d 34, 51 (D.C. Cir. 2001) (en banc).
31 996 F.2d at 547.
32 698 F. Supp. at 694.
33 72 F.3d at 1553.