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YOUR BOTTOM LINE
Public Interest: Sharing AHLA’s Expertise with Policymakers and the Public

When I introduce myself to other AHLA members at conferences and mention the work of Health Lawyers’ Public Interest Committee, I usually receive one of two responses: (1) “That’s terrific, Elisabeth. Our public interest activities are an important part of AHLA’s mission. Tell the committee to keep up the good work!” or, (2) “Public Interest? Hmmm, that sounds like something worthwhile. What is it?”

Thankfully, more and more members are giving the first response and, increasingly, many are including in their reply examples of Public Interest activities. “Oh yes, the Conversations with Policymakers teleconferences. Those are really interesting.” Or, “Of course, the colloquiums. That report on the medical errors colloquium was very informative. I shared it with our medical director.” Or, “I just downloaded the Emergency Preparedness Checklist from AHLA’s Web site. That’s a timely and important topic. I’m glad AHLA is able to provide it on a complimentary basis as a public interest activity.”

I am pleased to have the opportunity to write this guest column in Health Lawyers News to explain the basis and focus of AHLA’s public interest commitment and to report on the Public Interest Committee’s FY 05 initiatives.

AHLA’s Public Interest Commitment and Role

AHLA’s Public Interest role arises from the closing phrase in our mission statement, which pledges our Association to “...serve as a public resource on selected healthcare legal issues.” In recent years, the “public” in “public resource” has evolved from an emphasis on policy-related projects through which we provide neutral forums for the discussion of major health issues, to our current two-pronged approach through which Health Lawyers shares its expertise with two important outside audiences—the health policymaking community and the public.

Our nonpartisan Public Policy Activities include AHLA’s biannual colloquiums and reports (planning for the 2005 colloquium, Medical Necessity: Current Concerns and Future Challenges, is nearing completion); quarterly Conversations with Policymakers teleconferences; panel discussions and other sessions at Health Lawyers’ in-person programs; and periodic issue briefings for health policy analysts and the press.

The second prong, Public Information/Outreach Initiatives, was developed in FY 04 and includes “public information” projects through which the Association can serve as a resource on health law issues for other non-profit organizations, government agencies, certain legal services agencies, and healthcare consumers. A recent publication, Emergency Preparedness, Response & Recovery Checklist: Beyond the Emergency Management Plan, is one example of this type of activity. A similar publication, A Legal Guide to Life-Limiting Conditions, will soon be released. Additionally, the Public Interest Committee will conduct an educational session relating to Limited English Proficiency (LEP) patients at the 2005 Annual Meeting in San Diego.

The academic community is an important resource to the educational aspects of AHLA’s public interest commitment, and the work of our FY 05 Links with Academia Advisory Group warrants special mention. Current activities include: (i) release of an open-access Web site for members of the academic health law and policy research community; (ii) initiation of a Web-based survey of 670 full-time law professors and adjunct faculty that solicited feedback on ways in which AHLA can assist academicians in their daily teaching of health law; and (iii) development of an FAQ relating to career counseling issues for health law students to be placed on the AHLA Web site in recognition of the importance of reaching out to the next generation of health lawyers.

FY 2005 Public Interest Fundraising Campaign

An encouraging sign of members’ growing awareness of, and support for, Health Lawyers’ public interest activities is the slow but steady increase we are witnessing in member donations to our annual public interest fund. Public interest activities are financed through a combination of operating revenues and donations from members and their firms. These donations are an essential source of funding, both in terms of dollars and, perhaps more important, as an expression of our members’ grass-roots support for the Association’s public interest commitment. Many members generously contribute their time to Health Lawyers’ educational mission. Your financial support also is needed, however, to continue this important part of Health Lawyers’ overall mission. Donations may be made through the $20 Public Interest fund check-off on AHLA’s membership renewal form or through a direct contribution submitted online or by mail.

(Continued on page 22)
Boost Your Privacy Expertise with Web-based Learning!

Whether you are retained as outside counsel for a healthcare facility or work within an organization, the people you advise rely on you to know privacy law and how it pertains to them.

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• Privacy Practices
• Managing Access, Amendment, and Disclosures
• The Organization’s Responsibilities

The face-to-face Privacy Institute (the next one is scheduled for Chicago, in the spring of 2005) offers an opportunity to engage in face-to-face learning and discussion with other professionals who have faced and met the same challenges.

For more information, or to register, visit http://campus.ahima.org or e-mail dawn.bibbs-morrissey@ahima.org

AHIMA, founded in 1928, is the national association of health information management (HIM) professionals. AHIMA’s 50,000 members are dedicated to the effective management of personal health information needed to deliver quality healthcare to the public. For information about the Association, go to www.ahima.org.
Heart and Soul

As the New Year commenced, I had the opportunity to spend an afternoon with Mike Greco, the President-Elect of the American Bar Association. Mike is a litigator from Boston and will become the ABA President in August of this year. One of my partners, Jonathan Cole, is the Immediate Past Chair of the Young Lawyers Division of the ABA. Jonathan was hosting Mike in town for a Leadership Law retreat of the Tennessee Bar Association. In the course of the conversation, Mike was asking about AHLA and telling me about his journey within the ABA. Mike indicated that he had spent most of his ABA tenure in the Individual Rights & Responsibilities Section of the ABA, which in his words has been the “heart and soul” and thus conscience of the ABA for a number of years. He then paused and said, “But now the Young Lawyers Division of the ABA has become that heart and soul.” In some ways it was a compliment to my partner, Jonathan Cole, who had spent his year leading a national One Child, One Lawyer initiative on children’s rights. However, it also provoked me to think about the heart and soul of AHLA.

This past summer, we had the 35th Annual Meeting of AHLA. It prompted us to look back at our history and legacy. Clearly, the foundations of AHLA are found in its educational programs. This year, the Long Term Care Conference will be celebrating its 26th year, and the Medicare/Medicaid conference will be celebrating its 31st year. Many of our other conferences are in double-digit anniversaries and have core audiences and committed leaders. Many of those programs also have the benefit of long-term leadership from the nation’s best health lawyers. Len Homer and J.D. Epstein led the Medicare/Medicaid Institute for 20 years, and Phil Proger led the Antitrust Institute for 19 years. Additionally, Anne Hoover is the AHLA senior staff member, having served with AHLA now for seventeen years, all in the area of educational programs.

Education is also fundamental to our mission. The AHLA mission statement includes a provision to produce the highest quality non-partisan educational programs. The AHLA tax-exempt status is based on Internal Revenue Code § 501(c)(3), which establishes the primacy of education as a fundamental AHLA mission and purpose. Finally, education programs remain our single largest source of revenue, accounting for approximately 40 percent of the revenue of the Association.

Many of the past and current leaders in the AHLA were first attracted to the AHLA because of the excellence of its educational program. They later became faculty members and program leaders and ultimately, Association leaders. We have expanded our leadership opportunities exponentially in recent years with the tremendous work that has been done in practice groups by Mark Kadzielski, Nancy Severson, Al Adelman, and now Joel Hamme. We can now find more Association leaders in our substantive practice group areas than you can find in the program planning committees.

With this rich legacy in education and the emerging one in practice groups, it is hard to have any reflections on how the heart and soul of our Association might be different in the future. As Mike Greco noted, the heart and soul of the ABA may have been the Individual Rights & Responsibilities Section, but now it is the Young Lawyers Division. The role of young AHLA members has been the subject of considerable discussion in leadership levels of AHLA for a number of years. It began a few years ago when Anthea Daniels as Chair of the Membership Committee began to focus much more actively on the recruitment and services to student members of AHLA. We have long considered whether or not a young lawyer section would be beneficial to the Association and have repeatedly concluded that inclusion of young leaders within the program planning groups and practice group leadership structures is important. I believe that we have made advancements in that regard. However, I would also note that David Matyas, the current chairman of the Membership Committee of the AHLA Board is also the youngest member of the AHLA Executive Committee.

David has brought great energy, enthusiasm and imagination to what can otherwise be a very arduous and routine job of recruiting and retaining members. Likewise, Anthea Daniels will be one of the youngest presidents in the history of the AHLA, when she takes office in the summer of 2006. Anthea has brought great enthusiasm and energy to all her endeavors on the AHLA Board. However, when I reflect on the future heart and soul of AHLA, although naturally drawn to the vigor and vision of youth, I am equally drawn to another area, the emerging importance of AHLA’s role in Public Interest.

Public Interest is one of the later additions to the primary roles of AHLA. The Association began its public interest activities in 1986, and established the Public Interest Committee of the board in 1994. It has for the past 10 years focused principally on a bi-annual colloquium to provide intense dialogue and commentary on an emerging issue of health law significance. 2005 is a colloquium year, and on March 31-April 1 we will be holding the 8th AHLA colloquium on the significant subject of “Medical Necessity: Current Concerns and Future Challenges.”
A significant tenant of the next strategic plan of AHLA is to devote more of our time, energy and resources to Public Interest activities beyond the colloquium. Elisabeth Belmont is the current chair of the AHLA Public Interest Committee, and is capable of doing the work of three small law firms. In addition to planning and executing the colloquium, Elisabeth has this year spearheaded the development of our Emergency Preparedness Response and Recovery Checklist, which has been recently released. She has also spearheaded the organizational efforts on legal issues in life-limiting conditions, which is a subject of personal interest that Elisabeth and I share. Under Elisabeth’s able leadership we are making significant advances in the important areas of addressing health law issues of not only health lawyers but also of our nation and particularly its vulnerable citizens and public sectors. Finally, we continue to advance our efforts to assist in the newly formed association of public health lawyers.

Additionally, this month marks the return of Peter Leibold as our Chief Executive Officer. Peter has spent the last several months enmeshed in one of the world’s most acute crises, a 25-year civil war in the Sudan. Peter was originally drawn to Washington by his spirit for public service, and has consistently maintained a hand in public sector activities, such as his recent term of service with the United Nations and the State Department. Peter returns with a renewed vigor and conviction of what AHLA can do to advance not only its core missions of education, information and dialogue, but also its expanded view of how AHLA can make a difference in the development and implementation of effective health policy throughout our nation.

As our Association continues to grow and influence effectiveness, let us hope that one day we will be recognized not only for our excellent education (we are better than our competitors), but also for our service to our nation and to mankind.

Richard G. Cowart
President
Antitrust Issues
Raised in the DOJ’s Investigation of the Anthem-WellPoint and United-Oxford Mergers

By Monica Noether, Sean May and Caterina Nelson, Charles River Associates, Boston, MA

Within the last year, the U.S. Department of Justice (DOJ) has reviewed and approved at least three major health plan transactions. It has been about five years since its last major ruling, in the Aetna-Prudential transaction in 1999. The managed care landscape has changed substantially since, as health plans have responded, first to the “managed care backlash” that fostered more loosely structured, less exclusive networks, and subsequently to increasing employer concern over rising costs that has led to increased patient cost-sharing.

The more recent mergers—those of Anthem, Inc. (Anthem) with WellPoint Health Networks Inc. (WellPoint) and UnitedHealth Group (United) with Oxford Health Plans, Inc. (Oxford)—raised some familiar issues relating to market definition and monopsony power, as well as a novel one stemming from the combination of two of the only three for-profit Blue Cross Blue Shield (BCBS or Blue) plans. Below we discuss the issues that the DOJ considered and its apparent conclusions regarding them. We also provide the economic perspective on these debates.

Anthem-WellPoint Background
On October 27, 2003, Anthem and WellPoint announced their definitive merger agreement, under which Anthem was to purchase WellPoint in a transaction valued at approximately $16.4 billion. This merger combined two for-profit Blue plans that together spanned thirteen states. It resulted in the largest managed care insurer nationwide, with 28 million medical members nationwide when the deal closed on November 30, 2004.

At the time of the announcement, Anthem was the fifth largest publicly traded health benefits company in the U.S., providing healthcare benefits to over 11.8 million people and specialty benefits to 12.1 million people. It was the BCBS licensees for Indiana, Kentucky, Ohio, Connecticut, New Hampshire, Colorado, Nevada, Maine, and Virginia (except for the suburbs of Washington, D.C.), with 2002 revenue of $13.3 billion and assets of $13.2 billion as of September 30, 2003.

WellPoint provided healthcare benefits to more than 14 million members and more than 44 million specialty members nationwide. It held a license for Blue Cross of California and BCBS licenses for Georgia, Missouri, and Wisconsin. WellPoint also provided healthcare benefits through its two non-Blue plans, HealthLink and UniCare.

After a four month investigation, the DOJ announced that it had concluded that the Anthem-WellPoint merger would not have adverse competitive effects in any of four segments that it had considered: the sale of health plans to individuals and employers, the purchase of physician and hospital services, the contract terms under which hospital services are purchased, or the purchase of for-profit Blue plans.

“Traditional” Concerns: Monopoly and Monopsony Power in Health Insurance
Due to the national Blue Cross Blue Shield Association’s (BCBSA’s) regulations, which assign specific geographic territories to each of its licensees and prohibit the use of Blue marks by a licensee outside its assigned geographic...
territory, there was no geographic overlap between the Blue-branded plans offered by Anthem and the Blue plans offered by WellPoint. While WellPoint did offer non-Blue plans in the nine states in which Anthem operated, the DOJ determined that WellPoint’s shares of “health insurance products” in Anthem states were very small and that the plans offered by WellPoint through HealthLink and UniCare were not particularly close substitutes for the Anthem BCBS plans—Healthlink is a provider rental network, while UniCare focused extensively on individual and small group plans. The DOJ also determined that WellPoint’s share of the total revenues earned by healthcare providers in Anthem states was very small. The DOJ therefore also concluded that the merger was unlikely to enable Anthem profitably to reduce payment to providers through monopsonistic behavior.

The DOJ also considered the ability of the Blue plans operated by the merged firm to impose non-price terms in their contracts for the purchase of hospital services that would reduce competition. For the same reasons that monopolistic or monopsonistic power over price did not exist, there was no indication that the merger was likely to affect other contractual terms adversely.

**New Concern: The Purchase of For-Profit Blue Plans**

The DOJ also investigated the novel theory that the merger might harm competition in the “market” for acquisition of for-profit Blue plans. The 40 Blue plans that operate across the country each operate separately, but the development of the national “Blue Card” program in recent years has brought them together in ways that may raise or lower competition. The Blue Card program provides independent Blue plans a mechanism to offer national coverage to large employers and thereby compete more effectively with other national health insurers. On the other hand, various requirements of the BCBSA may be viewed by some as either overly restrictive on their ability to compete, or facilitating the exercise of market power. In this situation, the DOJ was concerned that, because of restrictions by BCBSA on who can purchase Blue plans, the merger could reduce the prices paid for other for-profit Blue plans by reducing competition in the “market” for acquisition of for-profit Blue plans.

This concern stemmed from the consolidation of for-profit Blue plans. In 1980, there were 115 nonprofit Blue plans. After a 1994 change in the BCBSA rules that allowed for-profit organizations to hold BCBS licenses, a number of Blue plans converted to for-profit status. Today, of the 40 remaining plans, only three companies controlled all existing for-profit Blue licenses: Anthem, WellPoint, and WellChoice in New York. As noted above, Anthem and WellPoint collectively controlled the Blue licenses in 13 states. Since WellChoice’s conversion to for-profit status in November 2002, no other Blue plans have successfully convinced state regulators to allow their conversion.

The DOJ considered the possibility that the Anthem-WellPoint combination reflected a 3-2 merger in the “market” for for-profit Blue plans. It worried, therefore, that “the purchase prices of for-profit [Blue] plans sold in the future might decrease, to the detriment of the plans’ shareholders, which would include private charitable health care foundations. Lower purchase prices could reduce the charitable funds available for uninsured and indigent medical care.” Regardless of the validity of this concern in the broader framework of charitable care, it has nothing to do with traditional antitrust considerations, which generally focus on deadweight losses in welfare, rather than wealth transfers. In takeovers, any “underpayment” by the bidder only represents a transfer of value from the target to the bidder, in which any reduction in the welfare of target firm shareholders stemming from a reduction in the acquisition price is exactly offset by the benefit to shareholders of the acquiring firm. Antitrust authorities are not generally concerned about transfers of wealth from one set of shareholders to another or in the implications of for-profit ownership resulting in the formation of charitable healthcare foundations that hold the shares of the newly public company.

In this case, the DOJ’s analysis recognized that WellChoice, the only then-current potential acquisition target, had publicly stated that it planned to remain independent and that the “current political and regulatory climate is hostile to for-profit conversions.” As a result, “the Division could not predict that such competitive harm would result in the foreseeable future, if at all, and therefore concluded this theory did not support a challenge to the transaction.”

**Other Regulatory Approvals not Relating to Antitrust Issues**

After the DOJ closed its investigation, the merger was approved by BCBSA, and by late summer 2004, it had received approval from regulators in Texas, Illinois, Delaware, Virginia, Georgia, Missouri, Oklahoma, West
Virginia, Wisconsin, and Puerto Rico, as well as the California Department of Managed Health Care (DMHC) and the California Attorney General.14

However, on July 23, 2004, the California Insurance Commissioner denied Anthem’s application to acquire control of BC Life and Health Insurance Company, an indirect subsidiary of WellPoint.15 After this denial was announced, the Georgia Insurance Commissioner rescinded its approval and insurance departments in Missouri, Illinois, Virginia, and Wisconsin began “looking at the deal again.”16 On November 9, 2004, the California Insurance Commissioner announced that he would approve the acquisition, based on his obtaining commitments from Anthem to contribute substantial additional funds to California healthcare.17 On November 30, 2004, the Georgia Insurance Commissioner announced that Anthem had agreed to provide $126.5 million to his “Rural Health Initiative.”18 The parties announced the completion of their merger that day.19

United-Oxford Background

United announced in April 2004 that its UnitedHealthcare (UHC) division was to acquire Oxford. United is a Fortune 100 company that offers healthcare services to individuals and businesses nationwide through its UHC, Uniprise, Ovations, and AmeriChoice business units. United’s commercial health insurance business is concentrated in its UHC and Uniprise divisions. The primary business of UHC is the provision of health plans to individuals and small and mid-sized employers, but UHC also offers Medicare Advantage plans in some areas. Uniprise’s customer base consists primarily of large multi-state employers, which purchase self-insured health plans. AmeriChoice and Ovations serve more specialized segments: AmeriChoice offers health plans for beneficiaries of Medicaid and other government-sponsored healthcare programs, and Ovations offers health plans to individuals over the age of 50, including Medicare supplemental insurance offered in conjunction with AARP.

Oxford was a significant regional health insurer, offering plans to employers and individuals located principally in New York City, southern Connecticut, and northern New Jersey, with approximately 1.1 million members in New York State, 340,000 members in New Jersey, and 100,000 members in Connecticut. Relative to United, Oxford’s business customers had fewer employees and were less likely to purchase self-insured health plans. In addition to providing the full variety of fully-insured commercial insurance plan types, Oxford also offered Medicare Advantage plans and some self-funded plans. Combined, in the third quarter of 2004, United and Oxford had approximately 20.3 million medical members: 7.6 million enrolled in fully-insured commercial health plans, 3.2 million enrolled in self-insured commercial health plans, 9.5 million employed by national multi-location employers, and 315,000 Medicare Advantage members, making it the second largest health insurer in the United States after Anthem-WellPoint.

The DOJ closed its investigation of the merger in July 2004 after concluding that the merger would have no adverse competitive impact on the sale of health plans to individuals and employers or on the purchase of healthcare services from physicians and hospitals.

Sale of Health Insurance

Product Market

Although most courts have favored a relatively broad product market definition for health insurance,20 as part of its review of the 1999 Aetna-Prudential merger, the DOJ concluded that a relevant product market consisted only of health maintenance organization (HMO) and HMO-based POS plans, based on information that suggested that purchasers (brokers and employers) did not view the different types of products as substitutes. However, in its more recent investigation of the United-Oxford transaction, the DOJ acknowledged that “the definitions of particular products . . . have blurred,” and that health insurance companies compete more broadly to offer “insurance solutions.” Different health plan products share increasingly similar benefit plan designs in terms of primary care physician gatekeeper and referral requirements, out-of-network benefits, pre-certification, and network size, resulting in a convergence in prices. In addition, mirroring a general trend in consumers’ desire for increased flexibility in health plans, United and Oxford’s HMO enrollment in the tri-state area has been declining, and now accounts for a small fraction of total commercial enrollment.

Although the DOJ did not consider a narrow product market definition based on benefit plan design, the DOJ suggested that there was limited substitutability between fully-insured and self-insured plans. Health plans bear and charge for the risk in a fully-insured plan; these are generally purchased by individuals and small and mid-sized businesses. Self-insured plans are generally purchased by employers that are sufficiently large to internalize the risk. While this appears to be a recent DOJ consideration, it is echoed in the recent Federal Trade Commission-DOJ report on the healthcare hearings.21 Oxford was not a significant competitor with respect to self-insured plans, having only a very small proportion of
its members enrolled in self-insured plans. As a result, the DOJ did not draw a definitive conclusion on this market definition issue. In future transactions, the distinction of plans based on who bears the insurance risk may become more important, at which point it will become necessary to consider what proportion of employers can find a means to self-insure.

United and Oxford also offer Medicaid HMO, Medicare Advantage, and Medicare supplemental plans. While the DOJ’s closing statement focused on the effect of the merger on the sale of health plans to employers (i.e. commercial insurance), its silence on other plans likely only reflects the lack of competitive overlap in these other segments. Consequently, the merger had no competitive effect on the provision of these types of plans in the tri-state area.

Geographic Market

Although United is a large health insurance company with a nationwide presence, Oxford was primarily a regional insurer, offering health plans to individuals and businesses located in the metropolitan tri-state area of New York, northern New Jersey, and southern Connecticut, surrounding New York City. Indeed, a primary benefit of the merger to Oxford customers was their enhanced access to provider networks and benefit programs in other parts of the country. In its review, the DOJ examined the extent to which the merger would affect competition for the provision of health insurance in the overlapping metropolitan statistical areas (MSAs) in the tri-state area. This approach resembles the DOJ’s analysis of the Aetna-Prudential merger, in which the DOJ considered narrow geographic markets that corresponded to MSAs.

Given the local concentration of Oxford’s covered lives, it was not necessary for the DOJ to opine on the precise contours of the geographic market. In fact, there is reason to believe that the geographic market for health insurance may be broader than a MSA: generally, only a single license is needed to operate a health plan in a state, and once a plan is licensed, expanding within the state is simply a matter of developing a provider network. Furthermore, most individuals covered by commercial health insurance obtain that coverage through a plan offered by their employer, and health insurers compete to offer insurance solutions to that employer, covering the territory where its employees reside.

Competitive Effects

Based on the analysis of both product and geographic markets, the DOJ concluded that the relevant product market “was no broader than the market for fully-insured health insurance products sold to employers that are largely located in the tri-state area.” In such markets, the combined share of the two companies did not exceed 25% to 30%.

Regardless of the precise share of the combined company, the DOJ concluded correctly that it is unlikely to possess unilateral market power. First, a large number of substantially sized health plans compete with United and Oxford, which limits the ability of the combined company to raise prices post-merger. Moreover, additional insurance companies already hold HMO or insurance licenses in New York, New Jersey, and Connecticut, and there are no capacity constraints that would make expansion by commercial health plans difficult or untimely. The presence of healthcare provider rental networks and significant subscriber turnover also facilitates entry of new competitors or expansion of existing competitors. Second, the DOJ found that many customers did not believe that United and Oxford were close substitutes, and that the two companies differed in the scope of their provider network, their geographic coverage, and the employers to which they marketed.

Additionally, the DOJ concluded that harm from coordinated effects as a result of the merger was unlikely because the highly differentiated nature of health insurance products and the variety of customers would make it difficult for health insurance companies to coordinate on price or service dimensions of product offerings.

Purchase of Healthcare Services

As in the Anthem-WellPoint transaction, the DOJ also investigated the effect the merger would have on the combined firm’s negotiating leverage with providers who furnish healthcare services to its members. Since the horizontal overlaps were more significant in this transaction and providers were concerned, the DOJ focused on monopsony issues more carefully here, focusing on both hospital and physician services.

Unlike sell-side markets for health insurance, the DOJ recognized that in evaluating the potential for exercise of market power on the buy-side, it is necessary also to consider the importance of government payers, which are significant sources of funds to most providers, in total.
provider revenues. In 2002, for example, government expenditures on hospital and physician services were $286 billion and $115 billion, respectively, while private expenditures on hospital and physician services were $200 billion and $225 billion, respectively.23

In evaluating the ability of a particular purchaser to reduce the price it pays for services below the competitive level, it is necessary to identify the alternative purchasers to which sellers can turn. In the United-Oxford transaction, the DOJ evaluated the share of physician patient revenues that the combined company’s membership would account for in each MSA, on the basis, presumably, that physicians attract patients within fairly narrowly defined areas. For hospitals, the DOJ performed a similar analysis, but also suggested that the combined company might be able to price discriminate by identifying hospitals that may be unusually dependent on the combined company’s membership for patient revenues. As a result, the DOJ also examined the effect of the transaction on individual hospital systems, considering geographic markets as narrow as a particular seller.

An assessment of buyer market power must also consider that many of the combined company’s members are enrolled in plans with out-of-network benefits. Therefore, even if the combined company dropped a provider from its network, that physician or hospital would not be excluded from providing healthcare services to the plan members. In fact, although an out-of-network provider’s patient volume may decline, in the absence of negotiated rates, the provider’s reimbursement for those patients who continue to use the provider on an out-of-network basis would increase. As a result, the aggregate effect on revenues may be small. Additionally, strong consumer preference for broad provider networks should mitigate the effects of increased share of the combined company in contract negotiations with hospitals and physicians.

The state of New Jersey imposed an additional constraint on the combined firm’s negotiation leverage with providers. New Jersey state law provides a waiver from antitrust laws that would otherwise prohibit collective negotiations among competing physicians. This waiver allows independent physicians to bargain collectively with health plans over non-fee related terms of their contracts, including the definition of medical necessity, utilization management, clinical practice guidelines, and patient referral standards and procedures. Furthermore, upon a finding by the New Jersey Attorney General that a health plan has “substantial market power in its service area,” independent physicians are permitted to bargain collectively with health plans over fees and fee-related matters.

Other Parties Involved

In addition to a review by the DOJ, the merger also required regulatory approval from the New York Department of Insurance, New Jersey Department of Banking and Insurance (DOBI), and the Insurance Department of the State of Connecticut, each of whom reviewed the transaction carefully with the assistance of its state’s Attorney General. All approved the transaction. However, in the proceedings before the DOBI, the Medical Society of New Jersey (MSNJ) argued that the merger would significantly increase concentration in northern New Jersey, thereby reducing competition among health plans and harming patients and providers. The MSNJ filed a lawsuit under a New Jersey law that allows an “aggrieved” party to challenge an administrative agency’s regulatory decision by asking a superior court judge to reconsider the agency’s decision in trial. The lawsuit remains pending, despite United’s completed acquisition of Oxford.
Lessons from the DOJ’s Investigation of the Two Transactions

Several lessons can be drawn from the DOJ’s recent investigations of health plan consolidations to guide future merger considerations.

- The DOJ was willing to consider the variety of commercial managed care products (e.g., HMO, PPO, and POS plans) in the same product market in these mergers, in contrast to Aetna-Prudential where it limited the market to HMO and POS plans written on HMO licenses. This change appears to reflect the greater blurring in the last five years of distinctions among plan features and prices.

- The DOJ saw the distinction between fully-insured and ASO products as a relevant dimension when delineating product markets.

- The DOJ’s position on geographic markets was unclear. The limited geographic overlap between Anthem and WellPoint limited the importance of traditional questions regarding horizontal market power in the sale of health plans or the purchase of healthcare services. United-Oxford had more significant geographic overlap. Although the DOJ evaluated sell-side and buy-side shares at the MSA level, statements in their opinion on United-Oxford suggest that it may consider the market to be as broad as the tri-state area in which Oxford’s customer base was located.

- The DOJ recognized the importance of the varying business focuses of United and Oxford on the likely effect of the transaction. United was focused on large customers and ASO services, while Oxford primarily served fully-insured and smaller businesses. As a result, while horizontal overlaps were noticeable, the companies’ varying focuses and the differentiated nature of the health insurance product limited the traditional horizontal concerns.

- In both transactions, the DOJ focused on the buy-side aspect of the merger, perhaps because of complaints from physicians and hospitals that managed care consolidation is decreasing reimbursement rates and making it more difficult to practice medicine. Given the important role of government programs in provider revenues, buy-side concerns were even less significant than those on the sell-side.

- While, in Anthem-WellPoint, the DOJ advanced a novel theory concerning shareholders as customers, in the end, it recognized that because of the paucity of for-profit Blue plans, such harm was unlikely. As a result it is difficult to ascertain what the DOJ would have concluded had the likelihood of future acquisitions of for-profit plans been higher.

Thanks go to the Antitrust Practice Group for sponsoring this feature.

End Notes

3 Blue plans have exclusive territories to provide Blue-branded products. They are permitted, by the Blue Cross Blue Shield Association to offer non-Blue products in other areas of the country, however, a substantial majority of their total revenues must be earned from branded products sold within their granted territory.
4 “Department of Justice Antitrust Division Statement on the Closing of its Investigation of Anthem, Inc.’s Acquisition of WellPoint Health Networks, Inc.,” March 9, 2004 (DOJ closing statement).
5 Ibid.
6 Ibid. The Department also stated that it retains the right to investigate any such enhancement of monopsony power should it become necessary.
7 Their concern was echoed in a November 2003 article, which stated, “Because Anthem and WellPoint in the past frequently
upped bids to beat out each other in making acquisitions, prices of Blue Cross plans were often inflated. Now that the two are combining their businesses into a single company, however, acquisition prices could fall.” (See Investment Dealers Digest, “Lowering Blue Cross Acquisition Costs,” November 19, 2003.)

8 Blue plans in 15 states had converted to for-profit status by 2003. (See Best’s Review, “Applying the Brakes,” March 1, 2004.)


10DOJ closing statement.

11 For example, according to the 424B4 filed by WellChoice on November 8, 2002, “The Fund was established under the Conversion Legislation to hold 95% of the fair market value of HealthChoice and its subsidiaries on the effective date of the conversion. The Fund is responsible for maximizing the value of the assets in the Fund and making disbursements to fund various health care initiatives of the State of New York, in accordance with the direction of the Director of the Division of the Budget.”

12DOJ closing statement.


20 See, for example, Blue Cross & Blue Shield United of Wisconsin v. Marshfield Clinic, 65 F.3d 1406 (7th Cir. 1995) (amended on denial of rehearing), cert. denied, 516 U.S. 1184 (1996) in §2 case (and §1 case): court held that HMOs compete with various types of fee-for-service providers, including PPOs; U.S. Healthcare v. Healthsource, 986 F.2d 589, 591 (1st Cir. 1993) in §2 case (and §1 case): court held that plaintiffs failed to establish a separate HMO market, and affirmed a market definition that included all forms of healthcare financing; Ball Mem’l Hosp., Inc. v. Mutual Hosp. Ins., Inc., 784 F.2d 1325 (7th Cir. 1986): in §2 case (and §1 case), court affirmed a market definition that included all forms of health care financing, including HMOs, PPOs and self-insuring employers; Coventry Health Care of Kansas v. Via Christi Health Sys., Inc., 176 F. Supp.2d 1207 (D. Kan. 2001): in §2 case (and §1 case), court held that HMOs, PPOs, and PP0s are alternative forms of the same product—health insurance—rather than separate products.

21 The report notes that the issue of whether self-insurance is part of the same product market as fully insured plans is “highly fact specific.” (Federal Trade Commission and Department of Justice. Improving Health Care: A Dose of Competition, Chapter 6, page 5)

22 United offers Medicare supplemental plans (through an arrangement with between its Ovations division and AARP) and Medicaid HMO plans (through its AmeriChoice division) in the tri-state area, but Oxford offers neither type of plan. While United and Oxford both offer Medicare Advantage plans in the tri-state area, the combined company had an insignificant number of members relative to total enrollment in Medicare and total enrollment in Medicare Advantage plans in the area.

Poll Identifies Healthcare Costs and Medicare Solvency as Voters’ Top Health Priorities for Washington Lawmakers

A post-election poll conducted by the Kaiser Family Foundation and the Harvard School of Public Health identifies reducing healthcare costs and ensuring the future of Medicare as the public’s top healthcare priorities for Congress and President Bush in 2005. Reducing jury awards in malpractice lawsuits, an element of the Bush administration’s proposal for medical liability reform, ranked eleventh on a list of twelve health initiatives, just ahead of increasing federal funding for stem cell research. Overall, healthcare was the third highest ranked issue for respondents at 10%, trailing the economy (17%) and the war in Iraq (27%).

The poll of 1,396 respondents age 18 or older was conducted between November 4 and November 28, 2004. Findings on the top health priorities for 2005 are presented in the table below:

Recognizing the prominence of medical liability reform on Congress’ 2005 agenda, the poll results include detailed information on respondents’ views on this issue. Key findings include:

- Asked to select from a list what they regard as “very important” contributors to rising medical malpractice insurance costs, respondents answered:
  - Too many lawyers are filing unwarranted lawsuits (60%);
  - Too many patients are making unwarranted claims against physicians (53%);
  - Malpractice insurance companies’ profits are too high (49%);
  - Too many doctors are making mistakes in treating patients (43%);
  - Too many juries are approving larger awards than are justified (42%).

- With respect to limiting awards for patients’ pain and suffering.

### 2005 Healthcare Priorities for the President and Congress

<table>
<thead>
<tr>
<th>Percent of respondents indicating that each of the following should be a top priority for the President and Congress in 2005.</th>
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<tbody>
<tr>
<td><strong>1</strong> Lowering the cost of healthcare and insurance</td>
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<tr>
<td><strong>2</strong> Making Medicare more financially sound for the future</td>
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<tr>
<td><strong>3</strong> Increasing the number of Americans with health insurance</td>
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<tr>
<td><strong>4</strong> Improving quality of care/reducing medical errors</td>
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<tr>
<td><strong>5</strong> Improving the nation’s ability to respond to bioterrorism</td>
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<tr>
<td><strong>6</strong> Protecting patients’ rights in HMOs/managed care</td>
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<tr>
<td><strong>7</strong> Improving the Medicare prescription drug law</td>
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<tr>
<td><strong>8</strong> Allowing Rx drugs to be imported from Canada</td>
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<tr>
<td><strong>9</strong> Spending more on medical research</td>
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<td><strong>10</strong> Strengthening the system that provides flu vaccines</td>
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<tr>
<td><strong>11</strong> Reducing jury awards in malpractice lawsuits</td>
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<tr>
<td><strong>12</strong> Increasing federal funding for stem cell research</td>
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</table>

Source: Kaiser Family Foundation/Harvard School of Public Health Health Care Agenda for the New Congress (conducted November 4–28, 2004)
(noneconomic damages), 63% said they favored such a cap and 33% opposed a cap. Among those who favored a cap on noneconomic damages, 30% favor a cap of $1 million or higher, 23% favor a $500,000 cap, 16% favor a $250,000 cap, 15% favor a cap of less than $250,000, and 17% answered “don’t know” or did not respond. The Bush administration’s plan would limit awards for noneconomic damages to $250,000.  

- A large majority of respondents (72%) said they would favor legislation to prohibit people from filing medical malpractice lawsuits unless a qualified independent medical specialist reviewed the claim and judged it reasonable.  
- Most respondents also believe that damage caps and requiring independent medical review both would have some impact on lowering healthcare costs. Sixty-nine percent believe that a law limiting noneconomic damages would help a lot (32%) or some (37%) in reducing the overall cost of healthcare, while 25% believe such a law would be of little or no value.  
- More Republicans (37%) than Democrats (17%) believe that reducing jury awards in malpractice lawsuits should be a top priority in 2005. Respondents who identified themselves as Republicans also are more likely to favor various malpractice reforms and to believe these reforms would help in reducing the overall cost of healthcare in the United States.

A news release with Internet links to detailed findings of the poll, Health Agenda for the New Congress, may be accessed at www.kff.org/kaiser-polls/pomr011105pkg.cfm.

Community Benefit Reporting Guidelines Are Published by the Catholic Health Association and VHA Inc.

A new publication jointly issued in December 2004 by the Catholic Health Association of the United States (CHA) and VHA Inc. is designed to help nonprofit hospitals and other facilities better identify and quantify benefits they provide to their local communities that, along with charity care, may be cited as justification for tax-exempt status. CHA and VHA indicated that Community Benefit Reporting: Guidelines and Standard Definitions for the Community Benefit Inventory of Social Accountability has been under development for more than a year and is designed to “create standardized community benefit categories, definitions, and reporting guidelines in an effort to achieve a national standardized approach for not-for-profit health care organizations.”

The report acknowledges the timeliness of the guidance on community benefit in view of recent developments, stating, “Across the nation, local and state government, consumer advocacy groups, and other constituents have challenged whether not-for-profit health care organizations deserve tax exemption.” In the summer of 2004, several congressional committees held oversight hearings on healthcare tax-exempt status, and further scrutiny is anticipated in 2005. Last year also witnessed the filing of a host of class action lawsuits on behalf of the uninsured against tax-exempt hospitals.

The guidelines are the latest development in a fifteen-year effort by the Catholic health ministry to better standardize community benefit definitions and reporting. In 1989, CHA released a “Social Accountability Budget” to assist facilities in planning and reporting community benefits. Over the years additional community benefit planning resources were developed in conjunction with VHA and other groups, and a companion software tool was developed in collaboration with Lyon Software. The latest report includes a revised set of community benefit categories with specific examples of community benefits for each category. Topics that are addressed include:

- Guidelines on accounting and calculating costs;
- Community benefit categories and reporting guidelines (covering such subjects as community health services, health professions education, and subsidized health services such as emergency care, neonatal intensive care, and burn units);
- Research activities;
- Donations and fund-raising activities; and
- Community-building activities (including economic development, environmental improvements, and coalition activities).

CHA is the national leadership organization of the Catholic health ministry, engaged in strategic directions of mission, ethics, and advocacy. CHA’s more than 2,000 members form the nation’s largest group of not-for-profit healthcare sponsors, systems, facilities, health plans, and related organizations. VHA, founded in 1977, is an alliance of not-for-profit hospitals, health systems, and their affiliates.

To read or download Community Benefit Reporting: Guidelines and Standard Definitions for the Community Benefit Inventory of Social Accountability, visit www.chausa.org/sab/commbenguidelines.pdf. The link will open a .PDF file.
CMS Says Healthcare Spending Slowed In 2003

Healthcare spending grew at its slowest pace in seven years in 2003, the Centers for Medicare and Medicaid Services (CMS) reported in a new study published in Health Affairs. Medicaid spending growth was down from 12.1% in 2002 to 7.1% in 2003—its first decline in growth since 1997. According to CMS, states were able to reduce Medicaid spending by tightening eligibility and restricting benefits. In addition, the report found that Medicare spending reached $283.1 billion in 2003, an increase of 5.7% over 2002 and 4.3% per enrollee. This compares to rates of 10.8% in 2001 and 7.6% in 2002. The slowdown in 2003 “was due to the expiration of key provisions of a budget law, which enabled hospitals, nursing homes, and home health agencies to temporarily recoup Medicare payments lost via the Balanced Budget Act,” said a Health Affairs press release. To read an abstract of the report, go to www.healthaffairs.org/press/janfeb0501.htm. To read CMS’ press release, go to www.cms.hhs.gov/media/press/release.asp?Counter=1314.

Waxman Requests Investigation Of Medicare Prescription Drug Discount Card Program

House Committee on Government Reform Ranking Minority Member Henry A. Waxman (D-CA) sent a letter January 10 to the Government Accountability Office (GAO) requesting that GAO investigate three aspects of the Medicare prescription drug discount card program. Waxman asked GAO to examine policies for selecting drug card sponsors, contracting with companies involved in the program, and monitoring and evaluating the services offered by drug card sponsors. Waxman specifically requested a detailed evaluation of the selection of drug card sponsors, the approval process, and oversight of card sponsors including enforcement efforts. Second, Waxman asked GAO to examine what value the programs provide to Medicare beneficiaries and whether some cards provide a greater value than others. As part of the evaluation Waxman asked GAO to examine drug card sponsors’ contracting practices with drug manufacturers and pharmacies. Third, Waxman requested that GAO examine CMS’ responsibilities for educating Medicare beneficiaries on the drug discount cards. To read Waxman’s letter to GAO, go to democrats.reform.house.gov/Documents/20050110140926-38329.pdf.

Survey Shows Covering Uninsured, Improving Safety Among Policy Experts’ Top Priorities

Covering the uninsured should be Congress’ top healthcare priority over the next five years, according to 87% of respondents to a survey released by the Commonwealth Fund January 7. Most respondents also agreed on the ways to accomplish expansion of coverage to the uninsured: allowing individuals and small businesses to buy into the Federal Employees Health Benefits Program or similar federal group program; and expanding existing state-based public insurance programs like Medicaid and the State Children’s Health Insurance Program (SCHIP). The Commonwealth Fund Health Care Opinion Leaders survey, a survey of more than 300 widely-recognized experts in healthcare practice and policy, revealed that improving quality and safety of care, including increased use of information technology (69%) and reforms to ensure Medicare’s long term solvency (50%), were also important policy objectives. To read the survey results, go to www.cmwf.org/surveys/surveys_show.htm?doc_id=254281.

Survey Finds Most Employers Keeping Retiree Drug Coverage After Medicare Benefit Becomes Available

A new survey about the Medicare Part D prescription drug benefit found that 90% of employers that currently offer their retirees prescription drug coverage intend to continue offering drug coverage after the new Medicare benefit goes into effect in 2006. The survey by Deloitte Consulting’s Human Capital practice examines the response of employers to the new Part D benefit. Employers that continue to provide a prescription drug plan to their retirees will receive a 28% subsidy from the government for providing the benefit. The survey revealed that 80% of respondents have begun evaluating the effects of the Part D benefit on their own plans. Of the surveyed employers, 55% said they have either decided on or are leaning toward continuing prescription drug benefits and receiving the subsidy. To read a press release about the survey, go to www.deloitte.com/dtt/press_release/0,1014,sid%253D2283%2526cid%253D70311,00.html.
Bush Renews Push For Medical Liability Reform

In a January 5 speech at Gateway Center in Collinsville, Illinois, President Bush talked about the “need to fix a broken medical liability system” and urged Congress to pass “real” reform this year. According to Bush, “lawyers are filing baseless suits against hospitals and doctors” because they “know the medical liability system is tilted in their favor.” In order to solve the problem of these “junk” lawsuits, Bush expressed his support for a cap on non-economic damages of $250,000. According to Senator Byron Dorgan (D-ND) the President’s plan would also shield large drug companies from liability for their own negligence. “In its zeal to support the big drug companies, the Bush Administration is seriously overreaching with this proposal. It will not stand,” Dorgan said. To read the text of Bush’s speech, go to www.whitehouse.gov/news/releases/2005/01/20050105-4.html. To read Sen. Dorgan’s statement, go to http://dorgan.senate.gov/newsroom/record.cfm?id=230431.

Group Recommends Ways To Increase Participation In Medicare Low-Income Drug Subsidy

Although the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) contains substantial financial subsidies for low-income beneficiaries, the record of enrolling eligible beneficiaries in existing Medicare subsidy programs is poor, the Medicare Rights Center said in a recent report. Accordingly, the group recommends several strategies in order to maximize participation in the MMA’s subsidies. The “best way to maximize enrollment in health insurance programs” according to the report, “is to automatically enroll as many persons as possible.” To read the report, go to www.medicarerights.org/lowincomeissuebriefframeset.html.

USP Submits Medicare Prescription Drug Benefit Model Guidelines To CMS

The United States Pharmacopeia (USP) December 31 submitted its Medicare Prescription Drug Benefit Model Guidelines to the Centers for Medicare and Medicaid Services (CMS). The Model Guidelines consist of a list of therapeutic drug categories and associated pharmacologic classes that create a framework that plans offering the Medicare drug benefit can use in developing their drug plan formulary. “We will use USP’s work to make sure that beneficiaries will have access to the prescription drugs they need at the most affordable price,” said CMS Administrator Mark B. McClellan, M.D., Ph.D. To read USP’s press release about the Model Guidelines, go to www.onlinepressroom.net/uspharm/. To read McClellan’s statement, go to www.cms.hhs.gov/media/press/release.asp?Counter=1303.
In Advisory Opinion No. 04-19 released on January 6, the Department of Health and Human Services Office of Inspector General (OIG) said a proposal by a hospital to subsidize malpractice insurance premiums for two neurosurgeons on the hospital’s staff could potentially generate prohibited remuneration under the Anti-Kickback Statute, but that it would not impose administrative sanctions in connection with the arrangement. Two neurosurgeons had medical malpractice insurance that was set to expire in May 2003. The insurance carrier informed the physicians that their coverage would not be renewed. The insurance carrier offered to provide tail coverage for free if the physicians retired from medical practice. The hospital represented to the OIG that it depends on the two physicians to provide critical neurosurgery services in the community and for emergency services and proposed to subsidize the insurance premiums. The OIG determined that the arrangement was implemented as a temporary measure to assure that neurological services are available in the community, and is limited to a period of two years. The arrangement is structured to prevent a significant financial windfall for the physicians. The physicians will also be required to provide call coverage, serve on hospital committees, and furnish Medicaid and indigent care to further reduce any financial benefit from the subsidy. The OIG concluded that under the totality of the circumstances the arrangement minimized the risk of fraud and abuse under the Anti-Kickback Statute. To read the Advisory Opinion, go to www.healthlawyers.org/docs/ask2005/AO_0419.pdf.

DHHS OIG Approves Hospital’s Proposal To Subsidize Physicians’ Medical Malpractice Premiums

In Advisory Opinion No. 04-19 released on January 6, the Department of Health and Human Services Office of Inspector General (OIG) said a proposal by a hospital to subsidize malpractice insurance premiums for two neurosurgeons on the hospital’s staff could potentially generate prohibited remuneration under the Anti-Kickback Statute, but that it would not impose administrative sanctions in connection with the arrangement. Two neurosurgeons had medical malpractice insurance that was set to expire in May 2003. The insurance carrier informed the physicians that their coverage would not be renewed. The insurance carrier offered to provide tail coverage for free if the physicians retired from medical practice. The hospital represented to the OIG that it depends on the two physicians to provide critical neurosurgery services in the community and for emergency services and proposed to subsidize the insurance premiums. The OIG determined that the arrangement was implemented as a temporary measure to assure that neurological services are available in the community, and is limited to a period of two years. The arrangement is structured to prevent a significant financial windfall for the physicians. The physicians will also be required to provide call coverage, serve on hospital committees, and furnish Medicaid and indigent care to further reduce any financial benefit from the subsidy. The OIG concluded that under the totality of the circumstances the arrangement minimized the risk of fraud and abuse under the Anti-Kickback Statute. To read the Advisory Opinion, go to www.healthlawyers.org/docs/ask2005/AO_0419.pdf.

DHHS OIG OKs Cash Donations To Hospice From Foundation Affiliated With Health System

In Advisory Opinion 04-18, issued December 29, the DHHS Office of Inspector General (OIG) said it would not impose administrative sanctions in relation to proposed donations from a foundation affiliated with a health system to a local hospice. The OIG concluded that the donations are unlikely to result in fraud or abuse under the Anti-Kickback Statute. First, said the OIG, patient referrals from the hospice to the health system will be limited “because patients electing Medicare hospice services are required to relinquish their rights to curative care for their terminal illnesses.” Second, the foundation will not restrict in any way the use of the funds by the hospice. Third, the OIG said that the foundation’s donations will be subject to an annual cap and a fixed duration. Accordingly, based on the “totality of facts and circumstances,” the OIG concluded that it would not impose administrative sanctions under the Anti-Kickback Statute. To read Advisory Opinion 04-18, go to www.healthlawyers.org/docs/ask2004/AO_0418.pdf.

DHHS Task Force Report Recommends Against Personal Prescription Drug Importation

The Department of Health and Human Services (DHHS) Task Force on Drug Importation released December 21 its “Report on Prescription Drug Importation.” According to the 145-page report, the safety of imported drugs cannot be assured and “significant risks” are associated with the way individuals are currently importing prescription drugs. The report concluded that it would be “extraordinarily difficult and costly for ‘personal’ importation to be implemented in a way that ensures the safety and effectiveness of the imported drugs.” Individuals making purchases from Internet drug stores was identified specifically by the report as a risky activity and one that would be nearly impossible to regulate. To read the report, go to www.hhs.gov/importtaskforce/Report1220.pdf.
FDA Issues New Drug Warnings, Energy And Commerce Committee Looks Into Celebrex Safety

House Energy and Commerce Committee Chairman Joe Barton (R-TX) and ranking member John Dingell (D-MI) sent a letter December 17 to Hank McKinnell, chairman and CEO of Pfizer Inc. requesting information regarding what Pfizer knew about the safety issues associated with its drug Celebrex and when it had that information. The letter was sent in response to Pfizer’s announcement that two long term trials of Celebrex were halted after an increased risk of heart attacks was observed in one of the trials. The Food and Drug Administration (FDA), also reacting to Pfizer’s December 17 announcement, asked the company to voluntarily suspend direct-to-consumer marketing of Celebrex while FDA is “obtaining and evaluating the new and conflicting scientific data on adverse events associated with the drug.” Another drug study was halted by the National Institutes of Health (NIH) December 20. This time the non-steroidal anti-inflammatory drug Aleve (Naproxen) was suspected of increasing the risk of adverse cardiovascular events. FDA advised consumers taking the over-the-counter medication “to carefully follow the instructions on the label.” To read the letter to McKinnell, go to http://energy-commerce.house.gov/108/News/12172004_1418.htm. To read NIH’s press release, go to www.nih.gov/news/pr/dec2004/od-20.htm. To read FDA’s statement on Naproxen, go to www.fda.gov/bbs/topics/news/2004/NEW01148.html.

GAO Releases Report On Medicare Power Wheelchair Benefit Abuses

Over a six-year period beginning in 1997, contractors repeatedly told the Centers for Medicare and Medicaid Services (CMS) about escalating spending for power wheelchairs and that they were conducting program safeguards to respond to improper payments, but CMS did not lead a coordinated effort to address the underlying problem, the Government Accountability Office (GAO) found in a new report. In the report, “Medicare: CMS’s Program Safeguards Did Not Deter Growth in Spending for Power Wheelchairs” (GAO-05-43), GAO determined that spending growth for power wheelchairs has increased faster than Medicare spending in the last few years, but that CMS was unconcerned with the increase. GAO concluded that, although CMS has made progress, it has not implemented a revised form to collect better information for power wheelchair claims review, clarified guidance for suppliers on appropriate marketing, or required contractors to conduct less predictable site visits. To read GAO’s report, go to www.healthlawyers.org/docs/ask2004/GAO_05_43.pdf.
CBO Issues New Report On Medicaid Reimbursements To Pharmacies For Prescription Drugs

The Congressional Budget Office (CBO) released December 17 a new report that examines recent trends in markups on prescription drugs that were paid by state Medicaid programs to wholesalers and pharmacies to distribute and dispense the drugs. In the report, “Medicaid’s Reimbursements to Pharmacies for Prescription Drugs” CBO found that Medicaid payments for distributing and dispensing prescription drugs have increased markedly in recent years, adding significantly to the overall cost of the program. Between 1997 and 2002, Medicaid payments for distributing and dispensing services increased an average of 18%, from $10.2 billion to $23.4 billion. The “markup” that Medicaid pays is the difference between the price Medicaid pays for a prescription and the price the pharmacy or wholesaler pays the manufacturer of the drug. The average markup increased 9.7% a year between 1997 and 2002. The CBO concluded that the markup Medicaid paid for new generic drugs, about $32 per prescription, significantly exceeded the average markup for older generic as well as brand name drugs in 2002. To read the CBO’s report, go to www.cbo.gov/showdoc.cfm?index=6038&sequence=0.

CMS Issues Draft Decision Memos On Expansion Of Medicare Coverage For Cancer Drug And Carotid Artery Stenting, Requests Comments

The Centers for Medicare and Medicaid Services (CMS) released December 17 draft decision memos to expand Medicare coverage for carotid artery stenting and the use of the drug abarelix for the treatment of prostate cancer. CMS also released a final decision memo expanding Medicare coverage for insulin infusion pumps to treat diabetes. CMS determined there was sufficient evidence to conclude that continuous subcutaneous insulin infusion is reasonable and necessary for the treatment of Medicare beneficiaries with diabetes, and will consider not only patients who meet the updated fasting C-peptide testing requirement, but also those who are beta cell autoantibody positive. In its draft decision memo on carotid artery stenting CMS determined there was sufficient evidence to conclude that carotid artery stenting with embolic protection is reasonable and necessary for Medicare beneficiaries who are at high risk for carotid endarterectomy and who also have symptomatic carotid artery stenosis greater than 70%. CMS is also seeking comment on a draft decision memo to expand Medicare coverage for the use of the drug abarelix to treat prostate cancer. CMS said there was sufficient evidence to conclude that abarelix is reasonable and necessary as a palliative treatment for Medicare beneficiaries with advanced symptomatic prostate cancer. Comments on both draft decision memos are due by January 17, 2005. To read the decision memo on insulin pumps, go to www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=109. To read the draft decision memo on carotid artery stenting, go to www.cms.hhs.gov/mcd/viewdraftdecisionmemo.asp?id=128. To read the draft decision memo on the use of abarelix for the treatment of prostate cancer, go to www.cms.hhs.gov/mcd/viewdraftdecisionmemo.asp?id=129.

Employers, Retirees See Double-Digit Healthcare Cost Increases

Employers providing retiree health benefits saw a 12.7% average cost increase in 2004, according to a new survey conducted by the Kaiser Family Foundation and Hewitt Associates. Among surveyed employers, the total employer and retiree cost of providing health benefits for both pre-sixty-five and age sixty-five and over retirees and their dependents was an estimated $15.5 billion in 2003, the report said. Most employers (79%) said they had increased retirees’ premiums in the past year to deal with the large cost increases and 85% said they would do so in the coming year. In addition, 53% of surveyed employers increased copayments or coinsurance for prescription drugs in the past year and 49% expect to do so in the coming year. For more information, go to www.kff.org/medicare/med121404pkg.cfm.

DHHS Issues Semiannual Regulatory Agenda

DHHS issued in the December 13 Federal Register (69 Fed. Reg. 73119) its Semiannual Regulatory Agenda. Improving Medicare tops the list of DHHS’ regulatory priorities for 2005. Among the actions identified in the agenda as in the final rule stage are: revisions to the Medicare appeals process; implementation of the Medicare drug benefit; and modifications to managed care rules. In addition, a number of rules are in the works related to adverse event reporting in an effort to improve patient safety and quality of care. To read DHHS’ semiannual agenda, go to www.healthlawyers.org/docs/ask2004/69FR_73119.pdf.
Congressional Aides Preview 2005 Health Debate

AHLa concluded its Fall 2004 Conversations with Policymakers teleconference series with “Congress and Health 2005,” held on Wednesday, December 15, 2004. The speakers were:

Cybele Bjorklund, Democratic staff director for the Ways and Means Health Subcommittee in the United States House of Representatives, Washington, DC; Mark Hayes, Health Policy Advisor to Senate Finance Committee Chairman Chuck Grassley (R-IA), Washington, DC; and Eugene M. Tillman, Partner and Director of Legal Personnel, Reed Smith, LLP, Washington, DC (moderator).

Tillman (pictured), engaged Bjorklund and Hayes in a dialogue about Congress’ 2005 health policy agenda, addressing such topics as coverage of the uninsured, medical liability reform, technical amendments to the Medicare prescription drug benefit statute, patient safety, healthcare spending reductions, and encouragement of health information technology. At the conclusion of their moderated discussion, the speakers responded to questions from teleconference participants.

Thank you to our Sponsors!
The modest registration fee for each Conversations with Policymakers teleconference is made possible through the generous support of several health law organizations. Health Lawyers sincerely thanks the following sponsors of the Fall 2004 Conversations with Policymakers teleconference series:

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Donor Newsletter Reports on FY 2005 Public Interest Activities

The Fall/Winter 2004 issue of Your Public Interest Donations at Work, published in December, provides a snapshot of FY 2005 Public Interest activities that are supported by generous donations from AHLA members and others. Developments reported in the recent issue include:

• Publication of Emergency Preparedness, Response & Recovery Checklist: Beyond the Emergency Management Plan, the first publication in AHLA’s Public Information Series;
• An update on planning for AHLA’s eighth Public Interest Colloquium, Medical Necessity: Current Concerns and Future Challenges;
• Activities of AHLA’s 2004-2005 Links with Academia Advisory Group;
• “Corporate Responsibility: Roles of the General Counsel and Compliance Officer,” the first in AHLA’s Fall 2004 Conversations with Policymakers teleconference series; and

Your Public Interest Donations at Work is a semiannual report to contributors to AHLA’s annual Public Interest fundraising campaign. The latest issue may be read at www.healthlawyers.org/docs/pi_donation.pdf. The link will open a PDF file.
Meet the AHLA Public Interest Committee

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<tr>
<th>Name</th>
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<th>Contact Information</th>
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<tbody>
<tr>
<td>Elisabeth Belmont, Esquire</td>
<td>Chair</td>
<td>(Chair) Corporate Counsel MaineHealth Portland, ME (207) 775-7010 <a href="mailto:belmoe@mail.mmc.org">belmoe@mail.mmc.org</a></td>
</tr>
<tr>
<td>Almeta E. Cooper, Esquire</td>
<td>General Counsel</td>
<td>Ohio State Medical Association Hilliard, OH (614) 527-6762 <a href="mailto:aecooper@osma.org">aecooper@osma.org</a></td>
</tr>
<tr>
<td>Timothy P. Blanchard, Esquire</td>
<td></td>
<td>McDermott Will &amp; Emery Los Angeles, CA (310) 551-9320 <a href="mailto:tblanchard@mwe.com">tblanchard@mwe.com</a></td>
</tr>
<tr>
<td>Adele A. Waller, Esquire</td>
<td></td>
<td>Barnes &amp; Thornburg LLP Chicago, IL (312) 214-4835 <a href="mailto:adele.waller@btlaw.com">adele.waller@btlaw.com</a></td>
</tr>
<tr>
<td>Elise Dunitz Brennan, Esquire</td>
<td></td>
<td>Doerner Saunders Daniel &amp; Anderson, LLP Tulsa, OK (918) 582-1211 <a href="mailto:ebrennan@dsda.com">ebrennan@dsda.com</a></td>
</tr>
<tr>
<td>Donna Z. Eden, Esquire</td>
<td></td>
<td>Owings Mills (410) 581-9692 <a href="mailto:dze@comcast.net">dze@comcast.net</a></td>
</tr>
<tr>
<td>Philip L. Pomerance, Esquire</td>
<td></td>
<td>Arnstein &amp; Lehr Chicago, IL (312) 876-7804 <a href="mailto:plpomerance@arnstein.com">plpomerance@arnstein.com</a></td>
</tr>
<tr>
<td>Richard L. Shackelford, Esquire</td>
<td></td>
<td>King &amp; Spalding Atlanta, GA (404) 572-4995 <a href="mailto:rshackelford@klslaw.com">rshackelford@klslaw.com</a></td>
</tr>
<tr>
<td>Joseph A. Kuchler</td>
<td></td>
<td>Staff Liaison Director of Public Interest and Public Affairs American Health Lawyers Association (202) 833-0787 <a href="mailto:jkuchler@healthlawyers.org">jkuchler@healthlawyers.org</a></td>
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**AHLA’s Public Interest Committee**

I have the privilege of working with an extremely dedicated Public Interest Committee. These members deserve special recognition for their continuing commitment and their many valuable contributions to advance the Public Interest mission. Health Lawyers could not conduct its many Public Interest initiatives without the support of its Department of Public Interest and Public Affairs, headed by Joseph A. Kuchler and supported by its Administrative Assistant, Ana R. Mayer.

In closing, Public Interest activities help Health Lawyers fulfill its nonpartisan educational mission by sharing its expertise with health policymakers and the public. AHLA members also benefit by increasing their understanding of the broader health policy context in which the decisions that affect their clients or organizations occur. If you have suggestions for future Public Interest initiatives, please contact me at (207) 775-7010 or belmoe@mmc.org.

**PUBLIC INTEREST: “... to serve as a public resource on selected healthcare legal issues”— From AHLA’s Mission Statement**

The Committee Notes column by Elisabeth Belmont (see page 2 and continuation above) explained the basis of AHLA’s public interest commitment and reported on the Public Interest Committee’s FY 2005 initiatives. *Health Lawyers News* is pleased to introduce the members of the 2004-2005 Public Interest Committee and AHLA’s Public Interest Department.
*Correction from 2005 Resource Guide. Wellspring Partners Ltd, and Wellspring Valuation Ltd listings should appear as the following:

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On July 23, 2004, the Department of Justice (DOJ) Antitrust Division and the Federal Trade Commission (FTC) issued their long-awaited Report concerning the joint hearings on healthcare and competition law and policy held during 2003. Significantly, the Report marks the agencies’ first comprehensive guidance in the healthcare arena since the 1996 DOJ & FTC Statements of Antitrust Enforcement Policy in Healthcare (Healthcare Policy Statements). If the FTC’s healthcare workshop is included, the joint hearings encompassed more than fifty sessions held on twenty-seven days in September 2002, and from February to September 2003. The Report is based on testimony and written comments from over 300 participants, as well as independent research by the agencies. While most of the hearings focused on the “big three” players in healthcare—hospitals, physicians, and health plans—participants included not only representatives of those groups but also federal and state government officials, employers, attorneys, patient advocates, economists, and academics, and the hearings also covered topics pertaining to group purchasing organizations (GPOs), allied health professionals, and pharmaceutical companies. The resulting record contains almost 6000 pages of transcripts, presentations, written submissions, and agendas from the hearings.

What, if any, are the Report’s practical implications for hospitals and physicians? Does the Report identify specific “do’s and don’ts” for providers, or only general observations and recommendations? This article is a sequel to an earlier paper written in February, 2004, which sought to draw conclusions from the joint hearings’ voluminous record before the Report was issued. Now that the agencies have published their own take on those findings, we can revisit the earlier paper’s conclusions in light of the Report’s stated recommendations and observations, as well as subsequent public comments by officials from both DOJ and the FTC elaborating on the Report. These subsequent comments provide a gloss and additional insight on the Report’s more guarded commentary.

I. THE REPORT’S SCOPE AND ITS BROAD LESSONS

The Report addresses issues extending far beyond those pertaining to hospitals and physicians, and certainly addresses more topics than can or will be evaluated in any detail here. Much of the Report is devoted to discussing general “observations” on competition in the healthcare arena, and aspirational goals such as improving measures of price and quality, giving consumers more information on prices and quality, and giving consumers greater incentives to use such information. Few would argue with these statements. But while they may appear to offer little in the way of practical guidance to hospitals or physicians, the discussion provides several general principles that are important to providers.

First, the Report makes clear that open competition and consumer choice maximizes consumer welfare, even in the healthcare sector involving complex products and services. More specifically, the Report makes clear that the antitrust laws apply to healthcare actors. While this may seem unremarkable, and it should be, there are still...
individuals and groups of healthcare providers who do not believe the antitrust laws should be enforced against them. The Report should disable them of that notion. Second, the Report is itself tangible evidence of both the DOJ Antitrust Division’s and the FTC’s continued commitment to policing the healthcare sector. Third, and more specifically, the Report demonstrates that the 1996 Healthcare Policy Statements are flexible guidelines, and the agencies are willing to consider new ideas within the framework of the Policy Statements. And the Report contains a surprising amount (even for someone who was involved in the hearings) of specific guidance for hospitals and physicians, and a relatively clear indication of the agencies’ enforcement agenda.

II. HOSPITALS: SIGNALS OF NEW OR RENEWED ENFORCEMENT TRENDS?

For the most part, the Report’s discussion and stated perspectives on hospital-related issues focus on merger enforcement. One must turn to comments on the Report by agency officials after it was issued to find statements on the agencies’ enforcement priorities relating to hospital contracting practices.

A. Hospital Mergers

The considerable attention devoted to hospital mergers in the Report, as well as the FTC’s recently completed retrospective review of consummated hospital mergers and DOJ official’s acknowledgment that they too have retrospectively reviewed at least one merger and are currently reviewing a prospective hospital merger, makes clear that neither the FTC nor DOJ are abdicating their enforcement responsibilities in this area, despite predictions to the contrary based on their losing all six merger challenges brought between 1994 and 2000. In fact, agency officials have stated that they do not view their merger enforcement record in the 1990s as a losing streak. They disclaim the need to change their approach to analyzing mergers; instead, according to agency officials, their record in public as well as non-public merger challenges confirm that merger enforcement is having an effect. For example, they point to three mergers evaluated by DOJ (including one merger challenged but not enjoined after trial) that were abandoned at various points prior to being consummated, others that were never pursued because of agency scrutiny, and still others were structured differently or the hospitals’ own analysis (e.g., potential merger-specific, cognizable efficiencies) was sharpened by the specter of agency enforcement.

Consistent with this view, the Report states that the agencies will continue to use the analytical framework set forth in the 1992 Horizontal Merger Guidelines to evaluate hospital mergers. The Report contains lengthy discussions of the myriad issues surrounding geographic and product market definition, which will not be repeated in detail here. In general, the Report reaffirms the importance of data in merger analysis, especially to define geographic and product markets. The Report criticizes certain methods, specifically the Elzinga-Hogarty test, and endorses others, such as properly-applied critical loss analysis to implement the “hypothetical monopolist” paradigm, for using data to define markets.

The Report also encourages courts to use the same types of evidence in analyzing hospital mergers as is used in any other merger cases, such as the parties’ strategic planning documents and customer testimony and documents. Finally, agency officials state that their retrospective merger reviews will inform and educate the agencies’ prospective analysis in future merger investigations.

Two additional points pertaining to hospital mergers made by the Report bear mentioning. First, the Report emphatically states that the agencies will not accept, and recommends that state attorneys general should not accept, “community commitments” from merging hospitals to resolve hospital merger challenges. Community commitments—agreements to pass on to consumers a specified amount of money resulting from the merger efficiencies or not to raise prices for a specified period—were a device much in vogue during the hospital merger boom in the mid to late 1990s. Second, the Report also clearly rejects treating merging hospitals differently or more leniently based their non-profit status—which many commentators believe was one factor influencing courts and contributing to the agencies’ losses in merger cases in the 1990s.

In sum, although the Report indicates that the agencies will vigorously enforce the antitrust laws as they apply to hospital mergers, we will have to wait until the next cycle of increased hospital merger activity to evaluate whether the agencies follow through on their promise to do so.

B. Hospital Contracting Practices

Although not really addressed by the Report itself, agency officials highlighted three areas of concern regarding hospital contracting practices that will receive scrutiny by the FTC and DOJ going forward.

The first contracting practice raising potential antitrust concern is bundling, also known as full-system contracting, “forcing,” or all-or-nothing contracting, where a hospital system demands that a payor include all system hospitals in the payor’s network. The Report states only that the agencies will challenge unilateral bundled contracting practices “where appropriate.” While this practice does not always or even usually violate the antitrust laws, agency officials’ comments after the Report signal that
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this practice will receive increased attention, and that it is more likely to raise concern where a hospital system with market power uses that power to both demand inclusion of all its hospitals and resist tiering or other mechanisms to incentivize patients to use lower cost hospitals. Tiering allows a payor to include a “must have” hospital and maintain a broad network, while at the same time steering consumers to lower cost facilities by applying different copayments to different hospitals. It also should be noted that the Report recognizes that there are legitimate reasons why hospitals may resist tiering, such as fear of low cost facilities being labeled as low quality and high cost facilities labeled as inefficient, difficulty in maintaining expensive services such as burn units, trauma services and emergency “stand by” capability, and jeopardizing indigent care, teaching functions, and innovative research by hospitals.

A second area of concern addressed by my earlier paper and discussed at length in the Report, but without a clear statement of its enforcement priority, is conduct by a dominant hospital to exclude entry by “single specialty hospitals” (SSHs) or ambulatory surgery centers (ASCs). This conduct includes not only contracting practices through which the hospital excludes the SSH or ASC, but also “economic credentialing” whereby the hospital refuses or terminates privileges to physicians who are investors in the competing facility and other actions by hospitals in response to competition from ASC’s or SSHs. The Report concludes that the antitrust laws do not prohibit individual hospitals from unilaterally terminating physicians’ privileges or lobbying state governments in connection with certificate of need (CON) proceedings to oppose entry by these competitors. The conduct includes not only contracting practices through which the hospital excludes the SSH or ASC, but also “economic credentialing” whereby the hospital refuses or terminates privileges to physicians who are investors in the competing facility and other actions by hospitals in response to competition from ASC’s or SSHs. The Report concludes that the antitrust laws do not prohibit individual hospitals from unilaterally terminating physicians’ privileges or lobbying state governments in connection with certificate of need (CON) proceedings to oppose entry by these competitors. The conduct includes not only contracting practices through which the hospital excludes the SSH or ASC, but also “economic credentialing” whereby the hospital refuses or terminates privileges to physicians who are investors in the competing facility and other actions by hospitals in response to competition from ASC’s or SSHs. The Report concludes that the antitrust laws do not prohibit individual hospitals from unilaterally terminating physicians’ privileges or lobbying state governments in connection with certificate of need (CON) proceedings to oppose entry by these competitors. The conduct includes not only contracting practices through which the hospital excludes the SSH or ASC, but also “economic credentialing” whereby the hospital refuses or terminates privileges to physicians who are investors in the competing facility and other actions by hospitals in response to competition from ASC’s or SSHs.

As is the case with hospital enforcement, the Report’s discussion of physician issues, comments by agency officials on the Report after it was released, the sheer number of cases recently filed (and usually simultaneously settled) against provider networks, and the increasing severity of remedies obtained in those cases demonstrate the agencies’ continued if not heightened antitrust enforcement agenda relating to physicians. At the same time, the Report endorses new financial integration mechanisms and increased flexibility in recognizing clinical integration in analyzing the legality of provider network joint ventures.

Finally, the Report’s recommendations are not limited to private parties. The Report prominently concludes that state CON programs more often than not hinder desirable open competition by creating barriers to entry and expansion by potential competitors. It remains to be seen whether individual states with existing CON programs will heed the agencies’ advice, but to the extent any state does, the modification or elimination of CON requirements will have a significant impact on hospital competition.

III. PHYSICIANS: CONTINUED ENFORCEMENT PRIORITIES AND NEW INTEGRATION GUIDANCE

A. Provider Network Joint Ventures

In his remarks at the press conference announcing the release of the report, then-FTC Chairman Timothy Muris commented on the “audacity” and “large-scale” of provider networks engaging in naked price fixing two years ago. Echoing those comments, the head of the FTC’s healthcare enforcement section stated that the number of networks violating the antitrust laws was “striking.” In the two years since then, the FTC has filed suit and/or entered into consent decrees in nineteen provider network cases. Although the use, or more accurately the misuse or abuse, of the messenger model (an arrangement that allows contracting between payors and un-integrated providers while avoiding price-fixing by those competing providers) was the source of the antitrust violation in most of those cases, the Report provides no new guidance on this issue.

B. Increasingly Severe Remedies

Instead, the Report focuses primarily on the remedies for this and other antitrust violations resulting from provider networks. The Report states that “much more stringent measures” are necessary for flagrant or repeated violations, and also for those who facilitate violations by oth-
ers. Assistant Attorney General Hew Pate highlighted this aspect of the Report in his comments at the same press conference mentioned previously, warning that DOJ would not hesitate to pursue criminal remedies in the healthcare arena where warranted in cases of egregious conduct. In later presentations, DOJ officials have stated that the Antitrust Division does not have any set guidelines but will evaluate whether to apply criminal remedies in healthcare matters on a case-by-case basis. The same official took pains to dispel the notion that criminal remedies are never appropriate in healthcare matters, and noted that DOJ has considered criminal action in several recent matters but ultimately decided to pursue only civil relief.

Additionally, the Report states that disgorgement and/or dissolution will be sought in appropriate healthcare cases. Subsequent comments by agency officials explain that dissolution will be appropriate where there is “no procompetitive justification whatsoever” for the violative conduct, and that disgorgement or restitution will be sought where the violation is clear, there is a reasonable basis to calculate the amount of the defendant’s “unjust enrichment,” and this remedy will be valuable because other remedies including criminal prosecution or private actions are unlikely.

C. Provider Responses to Payor Monopsony Power

Another question addressed in my earlier paper was whether payors possess monopsony power in healthcare markets in the United States, and if so, what can physicians legally and effectively do to “level the playing field.” Several days of testimony at the hearings were devoted to the monopsony power issue. The Report unambiguously summarizes those findings by stating that “the available evidence does not indicate that there is a monopsony power problem in most health care markets.”

The Report also clearly rejects (or, more accurately reaffirms the agencies’ prior rejection of) countervailing market power as a tool for physicians to combat real or perceived payor market power. Countervailing market power is the aggregation of market power through otherwise unlawful collusion by physicians. In fact, agency officials stated that “leveling the playing field” is never a justification for price fixing. They explained that it is impossible to determine the degree of countervailing power that would be proper, and even if possible, there is danger of “spill-over” from the market power theoretically proper to balance the payor’s market power to additional market power unreasonably restraining competition. And the agencies take a particularly dim view of physician (or, for that matter, hospital) collusion to impede perceived
in innovative contracting practices discussed elsewhere in this paper such as pay-for-performance arrangements or tiering mechanisms.29

This section of the Report concludes that “[t]o the extent monopsony power exists in some markets, the Agencies and state Attorneys General should address such matters on a case by case basis.”30 The Report explains that it is preferable to use antitrust enforcement to address monopsony power rather than to allow physicians to accumulate countervailing market power. Following its own advice, DOJ scrutinized potential health plan monopsony power resulting from two recent health plan mergers. Although neither merger was ultimately challenged, the DOJ’s statements on the closing of each merger investigation (one issued only three days before the Report) highlighted the respective investigations’ focus on whether the merger between two plans would create market or monopsony power.31

The Report and comments by agency officials also emphasized that not only the acquisition through mergers, but also the improper use or abuse of monopsony power (i.e., monopsony conduct) is a concern. The Report indicates that this can be a competitive concern where, for example, a health plan with monopsony power imposes a most-favored-nations (MFN) contract provision to deter hospitals or other providers from granting discounts to competing health insurers. An MFN is a contractual agreement between a plan and provider that requires the provider to sell to the plan on pricing terms at least as favorable as the pricing terms under which that provider sells to any other plan. A monopsonist health plan’s imposing an MFN can create a barrier to entry by new competing health plans or increase their costs thus making the rival plan a less effective competitor.32 The agencies, and particularly the DOJ, have brought several cases challenging insurers’ imposition of MFNs (although none since 1999). Agency officials caution, however, that it is not a violation for a health plan simply to pay providers less than they seek in contract negotiations.

As is the case regarding hospital issues, the Report’s guidance on responses to health plan bargaining or monopsony power is not limited to private parties. In the context of addressing mechanisms to “level the playing field” between physicians and payors, the Report concludes that state governments (or for that matter, the federal government) should not enact legislation permitting collective bargaining by independent physicians. According to the agencies, collective bargaining leads to higher prices and is unlikely to result in higher quality care.33 Finally, in the Report, the agencies encourage physician information sharing provided that it is conducted pursuant to the analytical framework of Healthcare Policy Statement 6 to provide adequate safeguards ensuring the information is not used for anticompetitive ends.34 As noted in my earlier paper, the Statement 6 conditions are very specific and may be hard to meet, so information sharing may not be an effective mechanism for many physicians to “level the playing field” in negotiating with payors.

D. Financial and Clinical Integration

On the bright side for physicians, the Report specifically identifies another form of financial integration that the agencies will recognize in conducting joint venture analysis of provider networks under the antitrust laws, and also promises increased flexibility in analyzing clinical integration arrangements by provider networks.

Healthcare Policy Statement 8, last revised in 1996, describes how the agencies evaluate physician network joint ventures, and in outlining the analysis that will be applied to joint ventures, Statement 8 notes that “physicians’ integration through the network is likely to produce significant efficiencies that benefit consumers, and any price agreements . . . by the network physicians [that] are reasonably necessary to realize those efficiencies” will be evaluated under the antitrust rule of reason (which balances those efficiencies against anticompetitive effects) rather than summarily condemned as per se illegal.35 Statement 8 provides examples of acceptable, substantial financial integration through risk-sharing such as capitation, global fee arrangements, fee-withholds, and cost or utilization based bonuses or penalties.

In keeping with the Report’s emphasis on improving measures of price and quality, giving consumers more information on prices and quality, and giving consumers and providers greater incentives to use such information, the Report recognizes that payment for performance (P4P) arrangements among physicians may constitute a form of financial risk sharing in addition to those mechanisms outlined in Statement 8.36 P4P arrangements generally “align financial incentives with the implementation of care processes based on best practices and the achievement of better patient outcomes,” rewarding physicians for achieving “increasingly higher levels of safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity.”37

Statement 8 also acknowledged that certain clinical integration arrangements could produce sufficient efficiencies to justify joint negotiation by providers; however, Statement 8 has been criticized for failing to provide ade-
quate guidance and detail specifying the parameters of acceptable clinical integration. The Report expressly seeks to fill that void, and contains considerable discussion of the indicia and applicable analytical framework the agencies will apply in evaluating clinical integration arrangements.38 The four primary indicia of clinical integration identified in the Report are: (1) the use of common information technology to ensure exchange of all relevant patient data; (2) the development and adoption of clinical protocols; (3) care review based on the implementation of protocols; and (4) mechanisms to ensure adherence to protocols.39 The Report also contains a broad outline of the types of inquiries the agencies are likely to make when analyzing the competitive implications of a clinical integration arrangement. Those questions merit repeating here:

1. What do the physicians plan to do together from a clinical standpoint?
   - What specific activities will (and should) be undertaken?
   - How does this differ from what each physician already does individually?
   - What ends are these collective activities designed to achieve?

2. How do the physicians expect actually to accomplish these goals?
   - What infrastructure and investment is needed?
   - What specific mechanisms will be put in place to make the program work?
   - What specific measures will there be to determine whether the program is in fact working?

3. What basis is there to think that the individual physicians will actually attempt to accomplish these goals?
   - How are individual incentives being changed and re-aligned?
   - What specific mechanisms will be used to change and re-align the individual incentives?

4. What results can reasonably be expected from undertaking these goals?
   - Is there any evidence to support these expectations, in terms of empirical support from the literature or actual experience?
   - To what extent is the potential for success related to the group’s size and range of specialties?

5. How does joint contracting with payors contribute to accomplishing the program’s clinical goals?
   - Is joint pricing reasonably necessary to accomplish the goals?
   - In what ways?

6. To accomplish the group’s goals, is it necessary (or desirable) for physicians to affiliate exclusively with one IPA or can they effectively participate in multiple entities and continue to contract outside the group?
   - Why or why not? 40

Finally, the Report and particularly subsequent comments by agency officials emphasize that they do not endorse any particular model for financing and delivering healthcare or any particular structure with which to achieve clinical integration for fear that this would channel market behavior. Instead, the agencies encourage market participants to develop innovative arrangements on their own that are responsive to their own efficiency goals and market conditions. In turn, the agencies will flexibly apply Statement 8 to those integration arrangements. Agency officials noted, however, that they have seen very few P4P arrangements, and few clinically integrated provider networks (although there have been more in the last year). Agency officials and the Report also emphasize that an important overarching question in their analysis of both financial and clinical integration (reflected in the inquiries enumerated above) is the extent to which joint contracting is reasonably necessary to achieve efficient financial or clinical integration—i.e., why do the providers need to jointly negotiate prices in order to integrate? An arrangement that fails this inquiry will not pass muster.

IV. CONCLUSION

The Report clearly has practical implications for physicians and hospitals. Although those providers may not like all of the agencies’ findings and conclusions based on the testimony and commentary adduced at the joint hearings, the Report and subsequent elaboration by officials provide specific guidance on issues such as contract’s and DOJ’s enforce-
Bill Berlin is a principal in Ober/Kaler’s Washington, DC office. He devotes his practice to counseling, representing clients in government investigations by the Antitrust Division of the United States Department of Justice, Federal Trade Commission, and state Attorneys General, and in private as well as government litigation. Formerly a Trial Attorney with the Health Care Task Force and later the Litigation I Section of the Antitrust Division (1995 to 2003), Mr. Berlin has been involved in investigations and litigation of both merger and non-merger civil antitrust cases in healthcare and other market sectors. In addition, he also managed the Joint DOJ/FTC Hearings on Healthcare and Competition Law and Policy on behalf of the Department of Justice in 2003 and was a moderator for several sessions during the Hearings, and is a frequent guest speaker at healthcare association conferences and meetings.

END NOTES

1 The Report is on the FTC’s Web site at www.ftc.gov/reports/healthcare/040729healthcarecrpt.pdf.
3 Prior to joining Ober/Kaler, the author was involved in managing and conducting the Joint Hearings on behalf of the Department of Justice, and was the moderator for several sessions.
4 The agendas, transcripts, presentations, and written comments from each of the sessions, including those topics addressed in more detail in this paper, are available at www.ftc.gov/ogc/healthcarehearings/index.htm.
5 The earlier paper, Antitrust Issues Affecting Physicians and Physicians Organizations, was originally presented at Health Lawyers’ Physicians and Physician Organization Institute in February 2004, and was then republished in HEALTH LAWYERS WEEKLY (June 11, 2004).
6 All four “observations” identified under “Hospital-Related Issues” in the Executive Summary of the Report pertain to hospital merger-related issues. See REPORT, Executive Summary at pp. 26-27.
7 Similarly, the chapter addressing “Competition Law: Hospitals” devotes only a single paragraph among its forty-seven pages to hospital contracting practices (other than those pertaining to group purchasing organizations). See REPORT, Chapter 4 at p. 47.
8 The FTC’s retrospective merger review has thus far resulted in one complaint being filed in administrative litigation. In the matter of Evanston Northwestern Healthcare Corp. and ENH Medical Group, Inc., Docket No. 9353, File No. 011 0234 (Feb. 10, 2004), available at www.ftc.gov/os/caselist/0110234/0110234.htm.
10 See REPORT, Chapter 4 at pp. 4-25.
11 The Elzinga-Hogarty test has been used extensively in hospital mergers despite being a tool originally designed to analyze commodity movements, such as coal. It is described in detail in the REPORT, Chapter 4 at p. 5-10. The report notes that critical loss analysis has the potential to provide a useful way to define markets, but must be applied with great care. It is described in detail in the REPORT, Chapter 4 at pp. 10-14.
12 See REPORT, Chapter 4 at pp. 15-19.
13 See id. at pp. 28-29.
14 See id. at pp. 29-33.
15 See id. at p. 47.
16 For a discussion of bundling and tiering, see REPORT, Chapter 3 at pp. 31-35.
17 See REPORT, Chapter 3 at pp. 34-35.
18 See REPORT, Chapter 3 at pp. 17-27. In addition, the Report states in the context of hospital product market definition that “the Agencies encourage further research into the competitive significance of SSH’s, including whether payors can discipline general acute care hospitals by shifting a larger percentage of patients to SSHs.” See REPORT, Executive Summary at p. 26. For a discussion of the issue, including the testimony on SSH’s at the hearings, prior to release of the Report, see Antitrust Issues Affecting Physicians and Physicians Organizations, supra note 5, at pp. 18-25.
19 See REPORT, Chapter 3 at p. 27.
20 See id.
21 The transcript and materials from the May 7, 2003 session of the hearings on Hospital Joint Ventures and Joint Operating Agreements, is available at www.ftc.gov/ogc/healthcarehearings/030410ftctrans.pdf.
22 For a description of the messenger model and hearing panelists’ testimony on whether such arrangements even are a useful business model, see REPORT, Chapter 2 at pp. 14-17.
23 See REPORT, Executive Summary at p. 28.
25 See Antitrust Issues Affecting Physicians and Physicians Organizations, supra note 5, at pp. 28.
26 The transcripts and materials from the April 24-25, and May 7, 2003 sessions devoted to monopsony issues are available at www.ftc.gov/ogc/healthcarehearings.
27 See REPORT, Executive Summary at p. 27; Chapter 2 at p. 21; see generally Chapter 6.
28 See REPORT, Chapter 2 at pp. 20-22.
29 See REPORT, Chapter 4 at p. 47.
30 See REPORT, Chapter 2 at p. 22.
31 The two health plan mergers were Anthem, Inc.’s acquisition of WellPoint Health Networks, Inc. and UnitedHealth Group’s acquisition of Oxford Health Plans. The reasons identified by the DOJ for closing each merger investigation included the fact that the merging plans were not particularly close competitors, consumers would have a number of other choices after the merger, and one of the plans had a small share in the markets in which the parties overlapped. The DOJ’s public statements on the two mergers’ closing are available at www.usdoj.gov/atr/public/press_releases/2004/204674.htm and www.usdoj.gov/atr/public/press_releases/2004/202738.htm.
32 See REPORT, Chapter 6 at pp. 22-25.
33 See id., Chapter 2 at pp. 25-26.
34 See id. at p. 41.
35 See HEALTHCARE POLICY STATEMENT 8, supra note 2.
36 See REPORT, Executive Summary at p. 25; Chapter 1 at pp. 8.
37 See id., Chapter 1 at p. 8, n. 36.
38 See id., Chapter 2 at pp. 36-41.
39 See id., Chapter 2 at p. 57.
40 See id., Chapter 2 at pp. 40-41.
Upcoming Practice Group Luncheon Meetings

Physicians and Hospitals Programs
Westin La Paloma Resort and Spa, Tucson, AZ

Physician Organizations Practice Group
Wednesday, February 9
• From the Trenches: HIPAA War Stories

Hospitals and Health Systems Practice Group
Thursday, February 10
• Corporate Governance: Best Practices vs. the Reality of Implementation

Healthcare Liability and Litigation Practice Group
Thursday, February 10
• Expanding the Scope of Provider Liability: Debating the Pros and Cons
  Moderator: Robert Feinberg, Snell & Wilmer LLP, Phoenix, AZ and Speaker: Karen L. Lugosi, Karen L. Lugosi PC, Phoenix, AZ

Medical Staff, Credentialing, and Peer Review Practice Group
Friday, February 11
• Peer Review Privileges in Federal Courts
  Moderator: Ann O’Connell, McDonough Holland & Allen PC, Sacramento, CA

Antitrust Practice Group
Friday, February 11
• Recent Litigation Involving Exclusive Agreements in Healthcare
  Speaker: Douglas C. Ross, Davis Wright Tremaine LLP, Seattle, WA

Long Term Care and the Law Program
Hotel Del Coronado, San Diego, CA

Long Term Care Practice Group
Thursday, February 24
• The Impact of Electronic Medicine and Technology on Long Term Care Providers
  Speaker: David Brailer, MD, PhD, DHHS (Invited), Department of Health and Human Services, Washington DC

President Bush established a national goal of assuring that most Americans have electronic health records within 10 years. HHS has been aggressively moving the nation closer to a national, interoperable health information infrastructure that would allow quick, reliable, and secure access to information needed for patient care, while protecting patient privacy. Dr. David Brailer will speak about the impact of electronic medical records and technology on long term care. Brailer is well qualified to speak on this topic, as he was appointed on May 6, 2004 as the nation’s first National Health Information Technology Coordinator for HHS.

Labor and Employment Practice Group
Friday, February 25
• Union Organizing and Collective Bargaining in Long Term Care
  Speaker: Douglas Topolsk, McGuire Woods, Baltimore, MD

An in-depth discussion of labor issues facing both unionized and non-unionized long term care facilities.
• Discover which Unions are active in organizing in the industry, and what are the most recent organizational trends;
• Learn about union tactics and the issues upon which Unions focus in campaigns;
• Find out what issues are most important to Unions at the bargaining table;
• Hear about the bargaining tactics unions use to try to get what they want.

To register for the program and/or luncheon, go to www.healthlawyers.org/programs/prog_main.cfm.

Upcoming Practice Group Sponsored Teleconferences
Implementation of the Part D Drug Benefit
Monday, February 7
Sponsored by HMOs and Health Plans; Hospitals and Health Systems; and Regulation, Accreditation, and Payment Practice Groups

Implementation of the Medicare Advantage Program
Tuesday, February 8
Sponsored by HMOs and Health Plans; Hospitals and Health Systems; and Regulation, Accreditation, and Payment Practice Groups

March 2005
Interoperable Electronic Health Records 5-Part Teleconference Series
Part III: Anti-kickback, Stark, and Non-profit Tax Issues
Tuesday, March 1
Sponsored by Health Information and Technology Practice Group

Unless otherwise noted, teleconferences held from 1:00 - 2:30 pm Eastern.
For more information and to register, go to www.healthlawyers.org/teleconferences.cfm.
The Fraud & Abuse Practice Group is pleased to announce the formation of the Voluntary Disclosure Task Force. This Task Force will study voluntary disclosures to the government by persons or entities in the healthcare industry. The goal is to examine whether the various methods of voluntary disclosure are achieving their purpose, including encouraging compliance and voluntarily bringing forward problems for prompt, fair resolution. The Task Force hopes to gather data on the overall frequency of voluntary disclosures, to which government entity the disclosures were made (the Fiscal Intermediary, Carrier, OIG, local US Attorney, or Justice Department), and the result or effect of disclosure on the resolution of the matter. The Task Force members include:

**Thomas S. Crane, Chair**
Mintz Levin Cohn Ferris Glovsky & Popeo PC, Boston, MA
(617) 348-1676
tcrane@mintz.com

**John T. Brennan Jr.**
Crowell & Moring LLP, Washington, DC
(202) 624-2760
jbrennan@crowell.com

**Robert G. Homchick**
Davis Wright Tremaine LLP, Seattle, WA
(206) 628-7676
roberthomchick@dwt.com

**Kathleen McDermott**
Blank Rome LLP, Washington, DC
(202) 772-5813
Mcdermott-k@blankrome.com

**Todd A. Rodriguez**
Fox Rothschild LLP, Exton, PA
(610) 458-4978
trodriguez@foxrothschild.com

**Howard J. Young**
Sonnenschein Nath & Rosenthal, Washington, DC
(202) 408-9210
hyoung@sonnenschein.com

**Heather Zimmerman**
Reed Smith LLP, Washington, DC
(202) 414-9262
hzimmerman@reedsmith.com

Health Lawyers commends this new publication to all health attorneys and others in the healthcare field who need to understand the complexities of security standards as they apply to healthcare organizations, as well as those charged with developing prudent policies to address information-security risk management and regulatory compliance in the emerging environment of overlapping obligations.

**Overview of Contents**
- Introduction and Summary
- Concepts and Terminology of Information Security
- A Brief History of Information Security
- Information Security at the Start of the Twenty-First Century: Risk Management
- General Legal Standards in the Era of Risk Management
- Security Standards and Healthcare Organizations Information Systems in Healthcare
- Conclusion: Integrating HIPAA and Other Healthcare Information Security Obligations and Liabilities
- Appendix A: COBIT Principles
- Appendix B: Generally Accepted Systems Security Principles
- Appendix C: ISO 17799 Principles
- Appendix E: Legislation
- Appendix F: Regulations
- Appendix G: Cases
- Appendix H: Bibliography

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Members $85/Non-Members $115
Item WB200402

To order, go to www.healthlawyers.org or call AHLA’s Member Service Center at (202) 833-0766.
CALL FOR SPEAKERS & WORKSHOP TOPICS

If you would like to be considered as a speaker for the 2005 Fraud and Compliance Forum, please complete this form and attach the information requested below. If you would like to submit topic suggestions, please fill out sections I and II only. All forms and supporting documentation should be submitted to Anne H. Hoover, Director of Programs, American Health Lawyers Association, 1025 Connecticut Avenue NW, Suite 600, Washington, DC 20036-5405 or fax it to her attention at (202) 833-1105.

 Fraud and Compliance Forum
   September 2005 – Proposals due March 18, 2005

If selected as a speaker, the information you provide will be used in the program brochure. Please be sure the spelling is correct and all relevant titles, information about degrees, and credentials are included.

I. PRESENTER

Name: ________________________________________________ Title: ________________________________________

Firm/Organization: __________________________________________________________________________________

Street Address:________________________________________________________________________________________

City: __________________________________________________State:_________ZIP+4: ________________________

Phone: (_____) ________________________________________ ☐ Direct Dial ☐ General Office

Fax: (_____) ________________________________________ E-mail: ________________________________________

☐ I belong to the following Practice Groups: ____________________________________________________________

____________________________________________________________________________________________________

Please note: If you wish to submit a proposal with a co-presenter, the co-presenter must also submit the materials requested above. AHLA does not encourage co-presentations unless the speakers will offer differing perspectives (i.e., private practitioner and enforcement official, compliance officer and attorney, or in-house and outside counsel).

II. WORKSHOP TOPIC

Topic: ____________________________________________________________________________________________

On an attached sheet, please provide the following:
(a) a short paragraph describing the audience for whom your session is intended and why the subject area is of importance, and
(b) a list of four to six bullet points that describes the specific issues you plan to cover. (Please note that sessions are one hour in length.)

Please also send a resumé or curriculum vitae that includes a list of previous presentations.
You’re invited to attend…

Physicians and Physician Organizations Law Institute
February 9-10, 2005 • Westin La Paloma Resort and Spa • Tucson, AZ

Sessions at the Physicians program will provide a focused analysis of the legal challenges faced by physicians and their counsel. The program will also include a joint plenary session with the Hospitals program on Thursday, February 10, which includes speakers from the Federal Trade Commission and DHHS Office of General Counsel. Attendees can register for just the Physicians program or “add-on” the Hospitals and Health Systems Law Institute and attend three days of programming (February 9-11) for a more comprehensive look at both the intertwined and the distinct legal issues facing two of the most important components of the healthcare community.

The Physician Organizations Practice Group will sponsor a luncheon on Wednesday, February 9. Come prepared with your HIPAA war stories. The person with the best story will win the Physicians Practice Group Bronze Bomber Award.

All attendees are welcome to register for this luncheon presentation and networking opportunity. There is an additional fee and attendance is limited.

Horne LLP has provided sponsorship in support of this program.

Hospitals and Health Systems Law Institute
February 10-11, 2005 • Westin La Paloma Resort and Spa • Tucson, AZ

Sessions at the Hospitals and Health Systems Law Institute will provide a focused analysis of the legal challenges faced by hospitals and their counsel. The program will also include a joint plenary session with the Physicians program on Thursday, February 10, which includes speakers from the Federal Trade Commission and DHHS Office of General Counsel. Attendees can register for just the Hospitals program or “add-on” the Physicians and Physicians Law Institute and attend three days of programming (February 9-11) for a more comprehensive look at both the intertwined and the distinct legal issues facing two of the most important components of the healthcare community.

The Healthcare Liability and Litigation Practice Group and the Hospitals and Health Systems Practice Group will both sponsor luncheons on Thursday, February 10. The Medical Staff, Credentialing, and Peer Review Practice Group and the Antitrust Practice Group will both sponsor luncheons on Friday, February 11. All attendees are welcome to register for these luncheon presentation and networking opportunities. There is an additional fee and attendance is limited.

Long Term Care and the Law
February 23-25, 2005 • Hotel del Coronado • Coronado, CA

In-house and outside counsel, administrators, accountants and others who advise nursing homes, home health agencies, assisted living facilities and other long term care providers will not want to miss this important program. This year’s program will include sessions on: Medicaid Funding and Payment; Medicare Appeals after MMA; Enforcement Trends in Abuse and Neglect; Contracting with Ancillary Providers and Vendors; Survey and Certification; Developments in Home Care and Hospice; SNF Prospective Payment and more.

The Long Term Care Practice Group will sponsor a luncheon on Thursday, February 24. The Labor and Employment Practice Group will sponsor a luncheon presentation on union organizing and collective bargaining in long term care Friday, February 25. All attendees are welcome to register. There is an additional fee and attendance is limited.
Institute on Medicare and Medicaid Payment Issues
March 16-18, 2005 • Baltimore Marriott Waterfront Hotel • Baltimore, MD

For the most comprehensive program available on legal issues related to reimbursement, attend Health Lawyers’ Institute on Medicare and Medicaid Payment Issues. As in the past, one of the features of the program is the involvement by CMS officials. They will host outreach sessions on hospital and physician issues to answer your questions, and participate in many of the breakout sessions.

The program will include sessions on more than 50 topics, some of which include Advanced Stark; Hospital Outpatient PPS; Medicare Billing and Payment Issues for Physicians; Workshop on PRRB Practice Issues; Medicare Rules on Uniformity of Charges, Charge Levels, and Discounts; Medicare Bad Debt; When, Whether and How to Make Repayments and Disclosures; Reassignment and Receivables Financing; Medicare DSH Adjustments; and many others.

The Regulation, Accreditation, and Payment Practice Group will sponsor a luncheon on Wednesday, March 16. The In-House Counsel Practice Group will sponsor a luncheon on Thursday, March 17. All attendees are welcome to register for these luncheon presentations and networking opportunities. There is an additional fee and attendance is limited.

For hotel reservations, please call the Baltimore Marriott Waterfront Hotel at (800) 228-9290. Indicate you are attending the Health Lawyers program in order to be eligible for the special group rate of $204 single/double. The room rate expires on February 16, 2005.

Pharmaceutical and Device Law Institute
March 15, 2005 • Baltimore Marriott Waterfront Hotel • Baltimore, MD

This one-day program is designed to address the unique issues faced by in-house and outside counsel for pharmaceutical companies and device manufacturers. Sessions will address advanced emerging issues in pharmaceutical and device compliance. Medicare Part D, state issues, pharmaceutical relationships with institutional providers, relationships between PBMs and manufacturers, and price control.

For hotel reservations, please call the Baltimore Marriott Waterfront Hotel at (800) 228-9290. Indicate you are attending the Health Lawyers program in order to be eligible for the special group rate of $204 single/double. The room rate expires on February 16, 2005.

Wellspring Partners Ltd. has provided sponsorship in support of this program.

Cancellations must be received in writing. If the cancellation is received before the specified cut-off date, registration fees, less a $125 administrative fee, will be refunded following the program.

The cancellation cut-off dates for these programs are: Physicians and Physician Organizations and Hospitals and Health Systems – February 1; Long Term Care – February 16; Pharmaceutical and Device Law Institute – March 7; and Medicare and Medicaid – March 7.
2005 Program Registration Form

To register: Remit payment and completed registration form by mail to the American Health Lawyers Association, PO Box 79340, Baltimore, MD 21279-0340, by fax with credit card information to (202) 775-2482, or by phone at (202) 833-0766. To avoid duplicate charges, please do not mail this form if you have already faxed it to us.

Name:__________________________________ Member ID #: __________________________
First Name on badge (if different than above) ____________________ Title: ______________________
Organization: ________________________________________________________________________________________________
Address: ________________________________________________________________________________________________
City: __________________________________________ State: ________________ ZIP: ________________
Telephone: (_____)____________________ Fax: (_____)________________________ E-mail: ____________________________

By providing my signature and fax number, I consent to receive faxes sent by/or on behalf of American Health Lawyers Association (AHLA).

Signature: ________________________________________________________________________________________________

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<tr>
<th>Program Name</th>
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<th>Non-Member Rate*</th>
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For registration fee information, see calendar on inside back cover

*If you are not a member of Health Lawyers but join when you register for the program, you will be eligible for the member registration fee!

Payment Information

Please fill in applicable amount

(Make check payable to Health Lawyers, U.S. dollars)

Registration Fee(s): $ __________
Membership Dues (see box below): $ __________
Practice Group Lunch Fee: $ __________
Total Enclosed: $ __________

Check enclosed

Bill my credit card: □ □ □ □
Card Number: __________
Exp. Date: __________
Name of Cardholder: __________
Signature of Cardholder: __________

Attorney □ In-House Counsel □ Health Professional/Non-lawyer

Date of Admission to the Bar/Graduated from College ___________

Less than four years ago ...............................................................$165
Four to eight years ago .................................................................$285
More than eight years ago ..............................................................$325
Academician (full-time faculty) .......................................................$150
Government Attorney .................................................................$150
Public Interest Attorney ..............................................................$100
Student ..................................................................................$25

501(C)(3) FED ID No. 23-7333380 HLN
In-House Counsel Program — June 26, 2005
San Diego Marriott Hotel and Marina
San Diego, CA

Program Highlights
Designed to address the unique issues faced by in-house counsel, this year’s In-House Counsel program will include sessions on:
- Risk Management Issues
- Medical Staff Relations
- A Day in the Life of an In-House Counsel
- Stark and Physician Recruitment

The Golden Ferret Returns
The In-House Counsel Practice Group will hold a business meeting and the Golden Ferret Award will be presented to the attendee with the best too-weird-to-be-true story. The lunch is included in the registration fee and all attendees are welcome to attend.

Register Now
Fees for the program are $305 for AHLA members and $480 for non-members. To register, go online to www.healthlawyers.org/programs/prog_05annual.cfm or call the Member Service Center at (202) 833-0766.

Annual Meeting — June 27-29, 2005
San Diego Marriott Hotel and Marina
San Diego, CA

Program Highlights
This year’s Annual Meeting will include a keynote address, the always popular Year in Review, and breakout sessions on 40 different topics that will analyze the important cutting-edge issues facing all segments of the health industry and those who serve as counsel. Your attendance is crucial to the success of the peer-to-peer learning forum that also provides unique opportunities for networking, interaction and information exchange. In addition to the high quality of education, the program will include a number of social and networking opportunities so attendees can relax with family and friends.

Register Early and Save
Register by June 7 and pay just $950 for AHLA members, $875 for member group, and $1,125 for non-members. To register, go online to www.healthlawyers.org/programs/prog_05annual.cfm or call the Member Service Center at (202) 833-0766.

Where to Stay
California’s second largest city, San Diego boasts a near-idyllic climate, seventy miles of pristine beaches and dazzling array of world-class family attractions, including the world-famous San Diego Zoo and Wild Animal Park, SeaWorld San Diego, and LEGOLAND California. The most difficult decision to make regarding a trip to San Diego is determining what to do and see among the region’s vast and diverse variety of offerings. San Diego offers a vacation experience for everyone.

The San Diego Marriott Hotel & Marina is located on San Diego Bay and offers travelers five award-winning restaurants and lounges, a 446 slip marina, two outdoor heated pools, health club, sauna and six lighted tennis courts. The Marriott is convenient to Mission Bay, Old Town, Balboa Park, Tijuana and Coronado Island, as well as many museums, parks, attractions and beaches.

For reservations, call the San Diego Marriott Hotel and Marina at (800) 266-9432 and indicate you are attending the American Health Lawyers Association’s meeting to be eligible for the special discounted group rates we have arranged for AHLA members.

CLE Information
AHLA is an approved sponsor of continuing legal education credits in most states. Additional information on CLE credits will be available soon.

Sponsorship Opportunities
If you are interested in our sponsorship opportunities, please contact Valerie Eshleman, Manager of Programs, at (202) 833-0784 or veshleman@healthlawyers.org. Join your colleagues in helping to support your Association.
POSITIONS AVAILABLE

CALIFORNIA

Oakland, CA: Health Care Attorney: McDonough Holland & Allen PC, a prominent law firm with offices in Sacramento, Oakland and Yuba City, CA, is seeking a health care attorney with significant transactional and regulatory health law experience to join the Oakland office. Extensive experience with federal and state health care laws and regulations, health care contracts, medical foundations, medical staff issues, etc. Excellent writing skills and strong academic credentials are required. Please submit cover letter, resume, writing sample and references to: Brenda Deckwa, Recruiting & Professional Development Coordinator, McDonough Holland & Allen PC, 555 Capitol Mall, Sacramento, CA 95814; bdeckwa@mhalaw.com; www.mhalaw.com.

CONNECTICUT

Hartford, CT: Health Care Associate: Shipman & Goodwin LLP, a full-service law firm with over 140 attorneys, represents a wide spectrum of health care providers and is looking for an experienced health law attorney to join the Hartford office. Qualified applicants must have three to four years of health care regulatory and transactional experience. We require superior research and writing skills. Competitive salary and benefits package. Please submit a cover letter and resume to Sandra G. Olearcek, Director of Legal Recruiting, Shipman & Goodwin LLP, One Constitution Plaza, Hartford, CT 06103-1919.

Classified Advertising
ASSISTANT/ASSOCIATE UNIVERSITY COUNSEL

WEILL MEDICAL COLLEGE OF CORNELL UNIVERSITY

Cornell University’s Office of University Counsel is seeking an experienced lawyer at its branch office at Weill Medical College in New York City. Principal assignments: legal advice and counsel on the wide range of business issues affecting a university and academic medical center, including corporate transactions, contract preparation and review, real estate, corporate and government compliance, sponsored research and related issues. Must have at least 5 years experience. Additional related experience in technology transfer and complex corporate transactions is preferred. Must be admitted or eligible for admission to the New York State Bar. The position requires the candidate to have superior academic credentials and demonstrated ability to work with and communicate with a disparate client group. Please forward letter of application and accompanying resume to: James J. Mingle, University Counsel, Office of University Counsel, Cornell University, 445 East 69th Street, Room 432, New York 10021. For electronic submission, e-mail to jjm19@cornell.edu.

PROFESSIONAL SERVICES

Long Term Care Expert (Nursing Homes, Assisted Living, ICF-MR, Group Homes)


Lance R. Youles
Office: (516) 715-48-1228 / lyoules@jul.com
www.nursinghomeinsider.com
September 2004
Fraud and Compliance Forum
Co-sponsored with Health Care Compliance Association
September 26-28, 2004
Baltimore, MD

October 2004
Tax Issues for Healthcare Organizations
October 21-22, 2004
Washington, DC

November 2004
Fundamentals of Health Law
November 10-12, 2004
Palmer House Hilton
Chicago, IL

One-Day Advanced Mediation Training
November 11, 2004
Chicago, IL

Arbitration Training – The Essentials of Arbitrating a Healthcare Dispute
November 12, 2004
Palmer House Hilton
Chicago, IL

January 2005
Legal Issues Affecting Academic Medical Centers and Other Teaching Institutions
January 27-28, 2005
Ritz-Carlton Pentagon City
Arlington, VA

February 2005
Physicians and Physician Organizations Law Institute
February 9-10, 2005
Westin La Paloma Resort
Tucson, AZ

Registration Fees paid by Jan. 19, 2005**
Member: $705
Group Member: $630
Non-Member: $880

*Practice Group Luncheons:
Physician Organizations – February 9
Healthcare Liability and Litigation – February 10
Hospitals and Health Systems – February 10

Hospitals and Health Systems Law Institute
February 10-11, 2005
Westin La Paloma Resort
Tucson, AZ

Registration Fees paid by Jan. 19, 2005**
Member: $775

March 2005
Pharmaceutical and Device Law Institute
March 15, 2005
Baltimore Marriott Waterfront Hotel
Baltimore, MD

Registration Fees paid by Feb. 23, 2005
Member: $395
Group Member: $350
Non-Member: $520

Institute on Medicare and Medicaid Payment Issues
March 16-18, 2005
Baltimore Marriott Waterfront Hotel
Baltimore, MD

Registration Fees paid by Feb. 23, 2005**
Member: $820
Group Member: $745
Non-Member: $995

*Practice Group Luncheons:
Regulation, Accreditation, and Payment – March 16
In-House Counsel – March 17

May 2005
Law Conference on Health Insurance Plans and Providers
Co-sponsored with America’s Health Insurance Plans
May 2-4, 2005
Broadmoor Hotel
Colorado Springs, CO

*Practice Group Meeting:
HMOs and Health Plans

Antitrust in Healthcare
May 12-13, 2005
Hotel Monaco
Washington, DC

Co-sponsored with the ABA Health Law Section and the ABA Section of Antitrust Law

June 2005
In-House Counsel Program
June 26, 2005
San Diego Marriott Hotel and Marina
San Diego, CA

Registration Fees:
Member: $505
Non-Member: $680

Practice Group Luncheon (included in the registration fee):
In-House Counsel

Annual Meeting
June 27-29, 2005
San Diego Marriott Hotel and Marina
San Diego, CA

Registration Fees paid by June 7, 2005
Member: $875
Group Member: $800
Non-Member: $1,125

*Practice Group Luncheons:
Monday, June 27
Antitrust

Fraud and Abuse, Self-Referrals, and False Claims
Healthcare Liability and Litigation
Tax and Finance
Teaching Hospitals and Academic Medical Centers

Tuesday, June 28
Health Information and Technology and Hospitals and Health Systems
HMOs and Health Plans
Long Term Care
Physician Organizations

Wednesday, June 29
Medical Staff, Credentialing, and Peer Review
Labor and Employment
Regulation, Accreditation, and Payment

*Practice Group Luncheons:
Arbitration Training
June 30, 2005
San Diego Marriott Hotel and Marina
San Diego, CA (to register, call (202) 387-4176)

* Practice Group functions are an additional $38 for members of the Practice Group that is sponsoring the meeting and $43 for non-members of the Practice Group.
** Registration fees increase $75 after this date.
“BNA drills down to the important issues.”

“We have a leading health care practice at our firm because we provide seamless, single-point access to comprehensive legal services that focus on our clients’ business needs. This type of client service requires immediate access to the latest industry developments and analyses provided by BNA online publications.

“BNA drills down to the important legal and business issues, presenting them concisely and precisely. I find the resources provided by BNA invaluable to my practice as a health care business and transactional lawyer.”

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Why do so many legal professionals trust CCH to deliver the accurate, timely Medicare and Medicaid information they need for their most important decisions? For starters, it’s the expert analysis and insights of our experienced editorial board that always get to the heart of the issue. Plus, with CCH, professionals can access the most up-to-date government policies, rulings and regulations in their own office through our exclusive Medicare and Medicaid Resource Library. Not to mention tapping into online support for breaking news and policy changes as they happen. And because we’ve been covering these issues since the inception of Medicare and Medicaid in 1965, our depth of experience and industry perspective are truly unique.

See for yourself. Put a CCH Medicare and Medicaid resource to work for you by calling 888 224 7377 or visiting health.cch.com.