

PHYSICIAN ANTITRUST ISSUES

A Day With the Judges

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The focus of this paper is the effect of the antitrust laws on common physician transactions. There are numerous areas in which the antitrust laws play a role in determining the structure and operation of physician practices. This paper will concentrate on issues involving group practices and physician organizations, as well as the legality of restrictive covenants prohibiting certain post-employment conduct.

BACKGROUND

For a time, it was uncertain that the antitrust laws applied to physicians and other professionals. In 1940, the Supreme Court had suggested that professionals might be exempt from the antitrust laws because Congress in passing the Sherman Act was concerned with restraints in “business and commercial transactions.” *Apex Hosiery Co. v. Leader*, 310 U.S. 469, 493, 60 S. Ct. 982, 992 (1940). The *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 95 S. Ct. 2004 (1975) decision settled the argument and rejected the contention by the Virginia Bar Association that its minimum fee schedule was immune from antitrust scrutiny because the fees were being charged for professional services not commercial transactions. Nonetheless, a footnote in the *Goldfarb* Opinion left open the question of whether there were areas in which the application of the antitrust laws to professions might be different from the application of the same laws to other businesses.

The National Society of Engineers argued for an antitrust exception in reliance on this footnote to justify an ethical canon which prohibited engineers from engaging in competitive bidding. The Supreme Court observed that price was the essential

economic term in any business transaction and refused to create an antitrust exemption for the “learned professions.” *Nat’l Soc’y of Prof’l Engineers v. United States*, 435 U.S. 679, 696, 98 S. Ct. 1355, 1367 (1978).

The *Engineers* case concluded almost forty years of speculation about the application of the antitrust laws to professionals.¹ It would take another four years, however, before the *Goldfarb* and *Engineers* principles were applied in the health care context. In *Arizona v. Maricopa County Med. Soc’y*, 457 U.S. 332, 102 S. Ct. 2466 (1982), members of a county medical society formed a foundation to promote fee-for-service medicine and provide a competitive alternative to insurance companies. The members agreed on a maximum fee-for-service schedule they would accept from insurance plans approved by the foundation. The Supreme Court was unpersuaded by the good intentions of those involved to hold down medical costs and improve the quality of medicine. Whether at maximum or minimum levels, an agreement by competitors on the price they will charge, standing alone, violates the Sherman Act.

The *Maricopa County* decision focused on the concept of “naked restraints.” Essentially, the only agreement the foundation doctors made was the price agreement. The fact that such agreements might be well intentioned or could in some circumstances lower costs was immaterial. The Court found that price-fixing

¹ In 1943, the Justice Department had obtained a criminal conviction against the American Medical Association for conspiring with the District of Columbia Medical Society to discipline doctors who participated in or cooperated with a new delivery system being offered in the area. *Am. Med. Ass’n v. United States*, 317 U.S. 519, 63 S. Ct. 326 (1943).

agreements of this kind were treated as *per se* violations in other industries, and there was no reason to reach a different result in the health care area.

However, the door was opened to “clothed” or ancillary restraints, that is, agreements on price which are incidental to and necessary for some new plan or product which, in the final analysis, is beneficial to competition. Interestingly, one of the ancillary restraint examples discussed by the Court at the time was the relatively new concept of an HMO where the insurance risk shifts to and is shared by doctors. Although network doctors agree on price they also agree to provide all required medical services for that price. The resulting new product is distinct from fee-for-service medicine and the price agreement is a necessary part of, but ancillary to, the new HMO product.

Although, there is no longer any doubt about the general applicability of the antitrust laws to the health care industry, what remains uncertain is whether the public service and professional obligations inherent in the physician/patient relationship may require conduct of professionals that would violate the antitrust laws in another context. *Goldfarb*, 421 U.S. at 788 n.17, 95 S. Ct. at 2013 n.17. With that background, it is necessary to understand general antitrust principles used to evaluate the legality of other physician transactions.

ANTITRUST LAW OVERVIEW

There are many antitrust laws potentially applicable to the health care industry, however, the fundamental statute is section I of the Sherman Act, 15 U.S.C. § 1.² That statute, enacted in 1889, provides: “Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal.” The statute was designed to protect competition and was intended to have a broad reach and expansive effect. It has been described as a charter of economic freedom much like the United States Constitution is a charter of political freedom. *Appalachian Coals, Inc. v. United States*, 288 U.S. 344, 359, 53 S. Ct. 471, 474 (1933).

Despite the literal language of the statute, courts almost immediately recognized that every contract restrains trade to some extent. *Bd. of Trade of City of Chicago v. United States*, 246 U.S. 231, 238, 38 S. Ct. 242, 244 (1918). Consequently, the United States Supreme Court first announced in *Standard Oil Co. of N. J. v. United States*, 221 U.S. 1, 60, 31 S. Ct. 502, 516 (1911), that the Sherman Act was to be interpreted pursuant to the “standard of reason which had been applied at common law.” The classic statement of what came to be known as the Rule of Reason is found in that Court’s Chicago Board of Trade case:

² Violation of section I of the Sherman Act is a felony punishable by a maximum fine of \$350,000 and three years in jail for individuals and \$10,000,000 for a corporation. There are few antitrust violations the federal government will pursue on a criminal basis. Price-fixing, however, is one. In addition, private plaintiffs can recover three times the damages they have incurred as well as their attorney fees. Attorney fees are not awarded against an unsuccessful plaintiff. *See* 15 U.S.C. §§ 15 and 16.

The true test of legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition.

Bd. of Trade of City of Chicago, 246 U.S. at 238, 38 S. Ct. at 244. The Oklahoma Supreme Court adopted the Rule of Reason for the interpretation of 79 O.S. § 1,³ Oklahoma's counter-part to section 1 of the Sherman Act, in *Bd. of Regents of the Univ. of Okla. v. NCAA*, 1977 OK 17, ¶ 15, 561 P.2d 499, 506.⁴

However, a rule of reason analysis is not necessary in every case. First, some restraints are so injurious to competition that they are considered unlawful, as a matter of law. *N. Pac. R. Co. v. United States*, 356 U.S. 1, 78 S. Ct. 514 (1958). *Per se* violations “are conclusively presumed to be unreasonable and, therefore, illegal without elaborate inquiry as to the precise harm they cause or the excuse for their use.” *Bd. of Regents of the Univ. of Okla. v. NCAA*, 1977 OK 17, ¶ 15, 561 P.2d at 505. “Once experience with a particular kind of restraint enables the Court to predict with confidence that the rule of reason will condemn it, it has applied a conclusive presumption that the restraint is unreasonable.” *Arizona v. Maricopa County Med. Soc’y*, 457 U.S. at 344, 102 S. Ct. at 2473. Restraints of trade deemed to be illegal, *per se*, include price-fixing and market division agreements by competitors and group boycotts. *N. Pac. R. Co. v. United States*, 356 U.S. at 5, 78 S. Ct. at 518; *United*

³ Now codified at 79 O.S. § 203, as part of Oklahoma's Antitrust Reform Act.

⁴ The Oklahoma Supreme Court has previously established that where Oklahoma's antitrust law is similar to federal law, “interpretation of Federal antitrust legislation provides valuable assistance in interpreting the provisions of the Oklahoma statutes.” *Teleco, Inc. v. Ford Indus., Inc.*, 1978 OK 159, ¶ 3, 587 P.2d 1360, 1362. The Antitrust Reform Act codifies that rule: “The provisions of this act shall be interpreted in a manner consistent with Federal Antitrust Law 15 U.S.C., Section 1 et seq. and the case law applicable thereto.” 79 O.S.2001 § 212.

States v. Trenton Potteries Co., 273 U.S. 392, 47 S. Ct. 377 (1927); *United States v. Topco Assocs.*, 405 U.S. 596, 607, 92 S. Ct. 1126, 1133 (1972).

Second, in other circumstances a complete rule of reason analysis is not necessary to determine the legality of the restraint at issue. If the anticompetitive effect of a particular restraint is obvious, an “abbreviated” relevant market analysis may be appropriate. *Calif. Dental Ass’n v. Fed. Trade Comm’n*, 526 U.S. 756, 778, 119 S. Ct. 1604, 1617 (1999). *See also Nat’l Soc’y of Prof’l Engineers v. United States*, 435 U.S. 679, 692, 98 S. Ct. 1355, 1365 (1978) (footnote omitted) (holding the legality of an agreement among competitors not to discuss prices could be determined without “elaborate industry analysis”); *NCAA v. Bd. of Regents of the Univ. of Okla.*, 468 U.S. 85, 109-10, 104 S. Ct. 2948, 2964 (1984) (finding “detailed market analysis” unnecessary to invalidate a price and output restriction in the absence of “some competitive justification”); *Fed. Trade Comm’n v. Indiana Fed’n of Dentists*, 476 U.S. 447, 106 S. Ct. 2009 (1986) (holding it unnecessary to precisely define the relevant market before finding a horizontal agreement to withhold x-rays from customers an unreasonable restraint of trade).

Nonetheless, absent a *per se* violation,⁵ the rule of reason analysis requires determination of three issues: (1) what is the relevant market,⁶ (2) what is the effect

⁵ If the effect is not “pernicious,” the restraint is “tested by a rule of reason to determine if the activity unduly restricted competition and unreasonably prejudiced public interest.” *Fine Airport Parking, Inc.*, 2003 OK 27, ¶ 13, 71 P.3d 5, 10 (citations omitted).

⁶ *See, e.g.*, the analysis conducted by the Oklahoma Supreme Court in *Teleco, Inc. v. Ford Indus., Inc.*, 1978 OK 159, 587 P.2d 1360, and the federal antitrust cases cited in footnote 11.

of the restraint on competition in that market,⁷ (3) if the effect is anticompetitive, are there any procompetitive benefits that outweigh the anticompetitive effects.⁸ The first step, therefore, is defining the relevant market, which consists of two components, the relevant geographic market⁹ and the relevant product market.¹⁰ Once the relevant market is defined, determining the effect of the restraint in that market often requires an analysis of market power and market concentration. *Cal. Dental Ass'n v. Fed. Trade Comm'n*, 526 U.S. 756, 788-89, 119 S. Ct. 1604, 1621 (1999) (Bryer, J., dissenting). Market or monopoly power is defined in Oklahoma's Antitrust Reform Act as "the power to control market prices or exclude competition." 79 O.S.2001 § 203(D)(2). Federal antitrust law does and Oklahoma law may include a third alternative, the power to reduce output. *NCAA v. Bd. of Regents of Univ. of Okla.*, 468 U.S. 85, 99, 104 S. Ct. 2948, 2959 (1984).

⁷ *Arizona v. Maricopa County Med. Soc'y*, 457 U.S. 332 (1981).

⁸ *Broadcast Music, Inc. v. Columbia Broadcasting Sys., Inc.*, 441 U.S. 1, 18-23, 99 S. Ct. 1551, 1561-64 (1979).

⁹ Generally, geographic markets in the health care industry are considered to be relatively local. Statements of Enforcement Policy in Health Care, 4 Trade Reg. Rep. (CCH) ¶ 13,153, p. 65.

¹⁰ The outer boundaries of a product market are determined by the reasonable interchangeability of use or the cross-elasticity of demand between the product itself and substitutes for it. However, within this broad market, well-defined submarkets may exist which, in themselves, constitute product markets for antitrust purposes. *United States v. E. I. du Pont de Nemours & Co.*, 353 U.S. 586, 593-595, 77 S. Ct. 872, 877 (1957). "The boundaries of such a submarket may be determined by examining such practical indicia as industry or public recognition of the submarket as a separate economic entity, the product's peculiar characteristics and uses, unique production facilities, distinct customers, distinct prices, sensitivity to price changes, and specialized vendors." *Brown Shoe Co. v. United States*, 370 U.S. 294, 325, 82 S. Ct. 1502, 1524 (1962). *Accord, Teleco, Inc. v. Ford Indus., Inc.*, 1978 OK 159, ¶ 13, 587 P.2d 1360, 1364.

If the restraint has an adverse effect on competition, it may nonetheless be justified if the overall effect of the conduct promotes or enhances competition in the relevant market. With respect to this issue, it is important to note that the “true test of legality” pursuant to a rule of reason analysis is whether the restraint “merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition.” *Bd. of Trade of City of Chicago v. United States*, 246 U.S. 231, 238, 38 S. Ct. 242, 244 (1918). “[T]he antitrust laws were passed ‘for the protection of competition, not competitors.’” *Brooke Group Ltd. v. Brown & Williamson Tobacco Corp.*, 509 U.S. 209, 224, 113 S. Ct. 2578, 2588 (1993) (quoting *Brown Shoe Co. v. United States*, 370 U.S. 294, 320, 82 S. Ct. 1502, 1521 (1962)). Consequently, it is not enough to show that a particular restraint adversely affected a competitor, some “antitrust injury” or harm to consumers must be shown.

Who can violate the antitrust laws? In limiting restraints to “contracts, combinations and conspiracies,” Section 1 of the Sherman Act requires concerted action. The statute “does not reach conduct that is ‘wholly unilateral.’” *Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752, 768, 104 S. Ct. 2731, 2740 (1984). The prohibited contract, combination or conspiracy can be between competitors in the relevant market (horizontal restraints) or, in some circumstances, between entities that do not directly compete, such as manufacturers and their retailers (vertical restraints). *Id.* See also *Leegin Creative Leather Products, Inc. v. PSKS, Inc.*, 551 U.S. 877, 886-87, 127 S. Ct. 2705, 2712-2713 (2007). In either circumstance, at least two economic

entities are required. “The officers of a single firm are not separate economic actors pursuing separate economic interests,” *Copperweld*, 467 U.S. at 769, 104 S. Ct. at 2740; “there can be little doubt that the operations of a corporate enterprise organized into divisions must be judged as the conduct of a single actor.” *Id.*, 467 U.S. at 770, 104 S. Ct. at 2741; “the coordinated activity of a parent and its wholly owned subsidiary must be viewed as that of a single enterprise for purposes of § 1 of the Sherman Act.” *Id.*, 467 U.S. at 771, 104 S. Ct. at 2741.

There is exception to this concerted action requirement in Oklahoma. Oklahoma’s version of the Sherman Act section 1, 79 O.S.2001 § 203(A), provides: “Every act, agreement, contract, or combination in the form of a trust, or otherwise, or conspiracy in restraint of trade or commerce within this state is hereby declared to be against public policy and illegal.” Although the two are almost identical, there is a difference between the language of section 203(A) and its federal counterpart, section 1 of the Sherman Act. As interpreted by the United States Court of Appeals for the 10th Circuit:

Although Okla. Stat. tit. 79, § 1 [now Section 203(A)] is “similar to federal antitrust legislation,” *Oakridge Invs., Inc.*, 719 P.2d at 850, it is not identical to § 1 of the Sherman Act. Significantly, Okla. Stat. tit. 79, § 1 prohibits “[e]very act . . . in restraint of trade.” *Id.* Section 1 of the Sherman Act does not prohibit “every act” in restraint of trade, but proscribes “[e]very contract, combination . . . or conspiracy in restraint of trade,” 15 U.S.C. § 1, all words that denote agreement or concerted action between at least two entities. Simply put, it takes two to tango under § 1 of the Sherman Act, while the plain language of § 1 of the Oklahoma Antitrust Act reaches unilateral conduct in restraint of trade.

Harolds Stores, Inc. v. Dillard Dep’t Stores, Inc., 82 F.3d 1533, 1550 (10th Cir. 1996).

Even though Oklahoma’s antitrust law reaches the conduct of a single actor, to be

actionable the challenged conduct must cause some “detriment to the public of the nature our antitrust legislation was intended to prevent.” *Krebsbach v. Henley*, 1986 OK 58, ¶ 31, 725 P.2d 852, 859. In the Harold’s case, the Court found that Dillard’s theft of dress patterns raised a barrier to entry into that market by other potential competitors. As previously discussed, the power to exclude competitors is evidence of market power and results in injury to competition in the relevant market.

Finally, it does not take a smoke-filled room and an express agreement to form a conspiracy which violates the antitrust laws. Tacit agreements are just as illegal although there was no meeting, no conversation or no exchange of any more than the competitors’ future plans joined with an invitation to follow. A wink of the eye or a nod of the head may establish “a conscious commitment to a common scheme designed to achieve an unlawful objective”. *Monsanto Co. v. Spray-Rite Serv. Corp.*, 465 U.S. 752, 764, 104 S. Ct. 1464, 1471 (1984). And, if a co-conspirator brings a civil suit claiming an antitrust violation, it is no defense that he was also involved in the antitrust violation. *Perma Life Mufflers, Inc. v. Int’l Parts Corp.*, 392 U.S. 134, 88 S. Ct. 1981 (1968). Likewise, it is no defense that the plaintiff is guilty of some unrelated antitrust violation. *Kiefer-Stewart Co. v. Joseph E. Seagram & Sons, Inc.*, 340 U.S. 211, 71 S. Ct. 259 (1951).

PHYSICIAN ORGANIZATIONS AND MERGERS

Whether the issue is the merger of existing group practices or the formation of physician networks, the initial antitrust inquiry is determining the relevant market. The

United States Department of Justice and the Federal Trade Commission issued Enforcement Statements in 1993, later revised on several occasions, to aid practitioners in applying the antitrust laws to the health care industry because the determination of the relevant market in the health care area has been particularly difficult.

Pursuant to the Enforcement Statements, geographic markets are defined by a process of starting at the central point where a particular agreement will have an impact and moving out in all directions until the products at issue are no longer considered reasonable substitutes for the products available. For example, if patients will travel 25 miles to a hospital but not 50, hospitals within a 25 mile radius providing the same range of services would be within the same geographic market.

With respect to physicians, the product market is initially defined by recognized medical specialty. Therefore, all cardiologists within a relevant geographic market are considered competitors in that market. This is an oversimplified approach, but, to reduce the time and expense required, at least, for the initial analysis, it serves a legitimate purpose. The Enforcement Statements establish “safety zones” which they consider unlikely to create antitrust issues. For example, the safety zone for exclusive physician networks is set at 20% of the physicians in the relevant market, 30% if the network is non-exclusive. But, exceeding the safety zone does not necessarily mean that an antitrust violation will result. Attached is the Justice Department’s review of the provider network proposed by ProOklahoma Care, Inc., for its HMO. The Oklahoma Physicians Network letter is cited in footnote 24 of the 1996 Enforcement Statements as an example of a network which “substantially” exceeded the 30% safety zone but was

approved by the Justice Department. The rule of reason analysis concluded that despite the large size of the network it would not have market power and was, on balance, likely to be pro-competitive.

This safety zone applies only to physician joint ventures and networks. If the physicians intend to merge into a fully integrated group practice the agencies may apply a traditional merger analysis using the agencies' 1992 Horizontal Merger Guidelines. These Guidelines define market power according to the level of concentration after the proposed merger. The method selected to measure concentration is the Herfindahl-Hirschman Index where 10,000 represents a complete monopoly and zero is the lowest level of concentration achievable. If the post-merger score exceeds 1,800 and the increase in concentration is more than 100, the agencies presume that the merger will be "likely to create or enhance market power or facilitate its exercise." 1992 Horizontal Merger Guidelines, 4 Trade Reg. Rep. (CCH) ¶ 13, 104, at ¶ 1.51(c). Case law considering the same issue has approved post-merger concentrations approaching seventy percent of the market.

A Justice Department review of a proposed merger of Albuquerque Pulmonologists illustrates this point. If analyzed pursuant to the 1992 Merger Guidelines, it is likely that the increased concentration would have been too high for the merger to have been approved. However, the Justice Department followed the Enforcement Statement approach instead. Pulmonologists were initially defined as the relevant product market, and, because health care markets are usually local, the City of Albuquerque was determined to be the relevant geographic market. There were 21

pulmonologists in Albuquerque, 10 of whom asked the Department of Justice to review their proposed merger. The resulting group's fifty (50) percent of all pulmonologists exceeds the 20% safety zone established by the agencies for physician network joint ventures. However, analyzing what pulmonologists actually do, the Department found that pulmonologists did not constitute a separate product market. Pulmonologists place patients on ventilators like general and cardiovascular surgeons, they perform thoracentesis like internists and thoracic surgeons, and so on. Consequently, there were more competitors in the pulmonology product market than board certified pulmonologists and the merger was approved.

COVENANTS NOT TO COMPETE

The specific statute governing restrictive covenants in employment agreements is section 217 of Title 15 of the Oklahoma statutes:

Every contract by which any one is restrained from exercising a lawful profession, trade or business of any kind, otherwise than as provided by Sections 218 and 219 of this title, . . . is to that extent void.

The language of section 217 was enacted by the first state Legislature, and remained unchanged until amended in 2001. The original statute was identical to the statute in effect in the Oklahoma Territory immediately prior to statehood. Wilson's Rev. & Ann. St. 1903, Chapter XV, Art. 4, section 819; *see also Hulen v. Earl*, 13 OK 246, 73 P. 927 (1903). It is not without significance that the "restraint of trade" language was included in section 217 at the same time Congress was passing the Sherman Act

prohibiting concerted conduct “in restraint of trade.”¹¹ Construction and interpretation of section 217 is, therefore, informed by the common law and decisions of the Territorial Courts.

It is often observed that all contracts restricting an individual’s ability to practice a lawful trade or profession were illegal at common law. *See, e.g., Standard Oil Co. v. United States*, 221 U.S. 1, 51, 31 S. Ct. 502, 512 (1911). The observation has reference to the reaction to and eventual ban on English monopolies during the reign of Elizabeth I, during which time the Guild system governed England’s employer/employee relationships. An early English legal commentator, Sir William Blackstone wrote: “At common law every man might use what trade he pleased [until the passage of Stat. 5 Eliz, c. 4, § 31 granting anyone serving as an apprentice for seven years the exclusive right to exercise that trade, which] statute restrains that liberty to such as have served as apprentices.” Blackstone, Bk I, Of Masters and Servants, Ch. XIV, § II, p. 426. Blackstone describes apprentices as a class of servants usually bound for a term of years “to serve their masters, and be maintained and instructed by them,” and that all servants except apprentices were entitled to wages. *Id.* at § III, p. 429. In exchange for this maintenance and instruction, the interest of masters of the Guild was protected by the service rules during which the master enjoyed the benefits of the servant’s labor. The interest of apprentices was

¹¹ “[W]here words are employed in a statute which had at the time a well-known meaning at common law or in the law of this country, they are presumed to have been used in that sense unless the context compels to the contrary.” *Standard Oil*, 221 U.S. at 59, 31 S. Ct. at 515. *Cf., Cooper v. Tanaka*, 1978 OK CIV APP 12, ¶7, 591 P.2d 1181, 1183 (explaining that “we believe that the concept ‘restraint of trade’ as used in 79 O.S. 1971 § 1 was used by our legislature in its common law context and thus declares illegal only contracts unreasonably in restraint of trade”).

protected by preventing competition from anyone who had not served an apprenticeship. “[N]o one would be induced to undergo a seven years’ servitude, if others, though equally skillful, were allowed the same advantages without having undergone the same discipline.” *Id.* at p. 428. The Oklahoma Supreme Court described this mercantile economy as one in which trade was localized and craftsmen and tradesmen were required to follow their trade. *Wesley v. Chandler*, 1931 OK 477, ¶ 6, 3 P. 720, 722. However, once the apprenticeship was completed, the master’s right to the services of his former apprentice was terminated.

The initial antagonism to post-employment restraints was founded on two grounds. First, unable to work, the tradesman could become a public charge and the community would be deprived of his services. Second, enforcement of such covenants would concentrate the benefits of a monopoly in the trade in one or a few masters. *See United States v. Addyston Pipe and Steel Co.*, 85 F. 271, 279 (6th Cir. 1898). These restraints were also contrary to the developing public policy in England favoring free trade in developing market based economies. *East India Co. v. Sandys*, Skinner, 165, at 169. In a market economy, the English courts recognized the benefit in permitting the buyer of a business to elicit an agreement from the seller not to compete with the business being sold. *See Mitchel v. Reynolds*, 1 P.Wms. 181, 24 Eng. Rep. 347 (1711), enforcing an agreement not to compete against the seller of a bakery business because the buyer was buying not only the location but also the existing trade.

By the end of the nineteenth century additional exceptions to early common law prohibition were recognized as the mercantile economy transitioned to a free market

economy. Without the monopoly protection of the guild system, it was, nonetheless, important that businesses and professionals be able to protect against the unjust use of confidential knowledge acquired by assistants during their employment in order to encourage them to employ the “ablest assistants, and to instruct them thoroughly.” *Addyston Pipe*, 85 F. at 281. To be enforceable, however, such agreements had to be no more restrictive than necessary to protect the legitimate interest of the employer and not otherwise injurious to the public interest. *Horner v. Graves*, 7 Bing. 735. Stated differently, if the restraint was ancillary to the main purpose of an otherwise legitimate contract and did not tend to achieve the adverse economic impact resulting from common law monopolies, it was enforceable. *Addyston Pipe*, 85 F. at 282-83.

What is evident from this history is that as economic conditions change, so does the conception of what benefits the public and what does not.¹²

[C]ontracts or acts . . . at one time deemed to be of such a character as to justify the inference of [competitive harm] . . . were at another period thought not to be of that character.

Standard Oil, 221 U.S. at 58-59, 31 S. Ct. at 515. Nonetheless, the rule of reason previously discussed provides an analytical framework for consistent application of uniform legal principles regardless of the current nuances and particularities of the marketplace at issue.

Rule of reason analysis was applied by the Oklahoma Supreme Court to a post-employment restraint in *Tatum v. Colonial Life & Accident Ins. Co. of Am.*, 1970 OK

¹² For example, the Court in *Standard Oil* observed that in the span of less than 100 years, market practices deemed harmful at common law had become pro-competitive in the changing economic environment. 221 U.S. at 55, 31 S. Ct. at 513-14.

27, 465 P.2d 448, resulting in the enforcement of a narrowly drawn restrictive covenant in an employment agreement. The Court determined that the relevant product market consisted of the lines of insurance sold by the departed employee while employed and the geographic market was defined as those customers of the employer previously serviced by the departing employee.¹³ The covenant did not prevent the employee from selling other lines of insurance to existing customers of the former employer; it did not prohibit the sale of any line of insurance, including those sold while employed, to any client who was not a customer of the former employer; and it did not prevent the employee from accepting unsolicited business from customers of the former employer. Given these limitations, the Court concluded that the agreement was intended to prevent the former employee from using company information disclosed to him during his employment and customer relationships developed during his employment for a limited period of time after his employment terminated but not otherwise prevent competition by the employee. As a result, the covenant was not likely to achieve the “evils” of a monopoly with which the common law “restraints of trade” were concerned and, therefore, did “not come within the purview of 15 O.S. 1961 § 217.” *Tatum*, at ¶ 12, 465 P.2d at 452.

The Oklahoma Supreme Court recently considered section 217 in *Cardiovascular Surgical Specialists, Corp. v. Mammana*, 2002 OK 27, ¶ 14, 61 P.3d 210, 213. The restrictive covenant was signed when Dr. Mammana joined an existing

¹³ “Geographic,” in this sense is determined by the location of the customers rather than a geographic area and, therefore, did not prohibit solicitation of a potential client who was not a customer of the employer even if located next door to a customer of the employer. A similar relevant market analysis is conducted in *Bayly*.

cardiovascular and thoracic surgery practice but prevented him from soliciting or accepting referrals of patients needing cardiovascular or thoracic surgery for nine months following termination.¹⁴ The parties apparently agreed that cardiovascular and thoracic surgery was the relevant product market. The Court analyzed the effect of the referral prohibition within that market finding that patients in need of those services normally seek less specialized treatment in the first instance and are then referred by their treating physician for surgery. Consequently, cardiovascular and thoracic surgeons are “dependent on referrals from other physicians” for their medical practice. *Mammana* at ¶ 3, 61 P.3d at 212.

The relevant market analysis in the *Mammana* case disclosed that surgical specialists generally do not have a long-term relationship with those who eventually become their patients. A specialist’s patients are, in essence, the patients of other doctors and are referred to the specialist for surgery. Consequently, Dr. Mammana was dependent on referrals from other doctors for his surgical patients. The Court found that prohibiting him from accepting those referrals from doctors who were not parties to the contract at issue would effectively eliminate him as a competitor in the relevant surgical market. Monopsony, controlling the sources of supply, is equally injurious to competition as a monopoly, controlling the market in which goods or

¹⁴ The covenant at issue also prevented the departing employee from (1) practicing cardiovascular or thoracic surgery within twenty miles of the former employer’s office, and (2) soliciting patients of the former employer for one year following termination. The employer admitted that the first provision effectively precluded Mammana from being able to practice in his specialty. The Court was unpersuaded by the employer’s argument that the restriction was, nonetheless, reasonable because Mammana was not prevented from practicing some other specialty. The Court found the second provision enforceable pursuant to *Tatum*.

services are sold. *See Been v. O.K. Indus., Inc.*, 495 F.3d 1217, 1231-32 (10th Cir. 2007). Understandably, therefore, the *Mammana* Court refused to enforce the referral prohibition. Nonetheless, the Court did find that Dr. Mammana's agreement not to actively solicit his former employer's patients for one year following termination of his employment was enforceable.

In 2001, 15 O.S. § 219A was added creating a third exception to the contracts prohibited by section 217:¹⁵

A. A person who makes an agreement with an employer, whether in writing or verbally, not to compete with the employer after the employment relationship has been terminated, shall be permitted to engage in the same business as that conducted by the former employer or in a similar business as that conducted by the former employer as long as the former employee does not directly solicit the sale of goods, services or a combination of goods and services from the established customers of the former employer.

B. Any provision in a contract between an employer and an employee in conflict with the provisions of this section shall be void and unenforceable.

Prior to the enactment of section 219A, the enforceability of a customer non-solicitation agreement was determined pursuant to a rule of reason analysis.¹⁶

¹⁵ The other two exceptions, section 218, exempting agreements involving the sale of goodwill of a business, and section 219, relating to agreements which dissolve a partnership, are not discussed in this paper.

¹⁶ *Bayly*, 1989 OK 122 at ¶ 11, 780 P.2d at 1171 ("Although the rule of reason which requires that in order to be valid, a covenant must be deemed reasonable by the court, had been incorporated as a matter of law into agreements falling within the parameters of 79 O.S.1981 § 1, its application to § 217 was questionable before the *Crown Paint* and *NCAA* decisions.") (footnotes omitted).

Although the “*Tatum Rule*” has been consistently followed, *Cardiovascular Surgical Specialists, Corp. v. Mammana*, 2002 OK 27, ¶ 14, 61 P.3d 210, 213; *Bayly, Martin & Fay, Inc. v. Pickard*, 1989 OK 122, 780 P.2d 1168; *Thayne A. Hedges Reg’l Speech and Hearing Ctr., Inc. v. Baughman*, 1998 OK CIV APP 122, 996 P.2d 939; *Key Temporary Personnel, Inc. v. Cox*, 1994 OK CIV APP 123, 884 P.2d 1213, section 219A brings legislative permanency to this issue. Section 219A addresses the third part of the rule of reason analysis, *i.e.*, whether the procompetitive effects of a non-solicitation agreement limited to established customers of the former employer outweigh the inherent anticompetitive effects of that agreement. Section 219A does not eliminate the rule of reason analysis.

What the statute does eliminate is the need for part of the analysis. In section 219A the Legislature has determined that the pro-competitive benefits of an agreement between an employer and an employee preventing the employee from “directly solicit[ing] the sale of goods, services or a combination of goods and services from the established customers of the former employer” after termination of the employment outweigh the anti-competitive effects of that agreement. Beyond that, the Legislature left the parties free to negotiate the terms of post-employment restraints within the constraints of established legal principles.

Inergy Propane, LLC v. Lundy, 2009 OK CIV APP 8, ¶ 28, 219 P.3d 547, 557. Those legal principles address the length of time the restriction may be enforced, and the relevant product and geographic markets in which the employee may be restrained.

CONCLUSION

In the health care industry, physicians are both producers and consumers of health care products. Antitrust analysis of these transactions is often fact intensive. Slight variations in market structure can produce different results. The antitrust laws are unique in this respect. Most criminal statutes proscribe defined conduct. The antitrust laws are concerned with the effect of certain conduct. If the effect is procompetitive, the conduct will be permitted. If it is not, the same conduct will result in an antitrust violation. The ultimate focus of the antitrust laws is the protection of competition for the benefit of consumers.

ATTACHMENT I

Summary of 1996 Statements of Antitrust Enforcement Policy In Health Care

I.

HOSPITAL MERGERS

The first safety zone relates to hospital mergers. The guidelines provide that mergers involving hospitals having fewer than 100 beds, an average daily census of less than 40 patients and which are more than five years old will not ordinarily be challenged. Outside this safety zone, the merger will be analyzed according to the 1992 Merger Guidelines.

II.

HIGH TECHNOLOGY VENTURES

The second policy statement permits joint ventures among hospitals to purchase expensive high technology health care equipment. Even though the hospitals compete in providing the services related to the equipment, a safety zone is provided in terms of the minimum number of hospitals necessary to purchase or support the equipment. The safety zone includes purchases of new equipment as well as ventures formed to support already purchased equipment.

Finally, the safety zone permits hospitals, in addition to those required to support or purchase the equipment, to join the venture if on their own they cannot support, purchase or form another venture to support or purchase the equipment.

III.

HOSPITAL JOINT VENTURES RELATED TO SPECIALIZED OR EXPENSIVE HEALTH CARE

The Statements do not create a safety zone for this area but point out they have never challenged an integrated joint venture among hospitals to provide specialized clinical or expensive health care. The traditional Rule of Reason analysis is utilized to evaluate these joint ventures.

IV.

PROVIDER PROVISION OF NON-FEE RELATED INFORMATION

This statement deals with competing providers who provide underlying medical data which may improve the mode, quality or efficiency of treatment. It establishes a safety zone for medical societies who collect outcome data and for providers who jointly develop practice parameters and treatment protocols.

V.

PROVIDER PROVISION OF FEE RELATED INFORMATION

This statement relates to the manner in which fee information may be collected and provided by competitors. The safety zone is very detailed in defining the requirements imposed for this kind of information exchange. The safety zone is designed to permit the exchange of useful, historical information, but prevent a mechanism through which the providers could engage in price-fixing.

VI.

PROVIDER SURVEYS

Statement 6 recognizes that surveys of prices for health care services, salaries, benefits and so forth do not necessary raise antitrust concerns. This Statement creates a safety zone imposing the same requirements as Statement 5 regarding the collection of this information.

VII.

JOINT PURCHASING

Joint purchasing agreements outside the health care industry have long been recognized as having potential pro-competitive effects. Essentially the same rules developed in these areas are applied in defining the safety zone for joint purchasing arrangements among health care providers. Commonly referred to as the 35/20 Rule, the safety zone exempts joint purchasing agreements among health care providers who account for less than 35 percent of the total market of the purchased items. If the providers are direct competitors, the costs of the purchased items must account for less than 20% of the total revenues of each purchaser.

In terms of economic analysis, the economies of scale, volume discounts and so forth, that can be achieved through the cooperative purchasing effort should translate into lower prices to the consumer and foster competition. Smaller competitors can join together to achieve the same costs from suppliers received by individual but larger competitors.

Outside the safety zone, the joint purchasing agreement will be tested under the Rule of Reason. Factors that will enhance the likelihood that the agreement will not be challenged are (1) membership rules which permit the members to utilize the service or to freely purchase the same goods and services outside of the joint arrangement; (2) negotiations on behalf of the joint arrangement which are conducted by independent agents and not members of the joint group; (3) confidentiality provisions which apply to any communications between individual members and the independent negotiator. Finally, the joint purchasing arrangement need not be open to all competitors in the market. However, the policy statement notes that agreements among purchasers that simply fix the price they will pay for a particular product or service are not legitimate joint purchasing activities and constitute a *per se* violation of the antitrust laws. The independent negotiator is an important insulating factor to prevent a legitimate joint purchasing arrangement from creating antitrust problems.

VIII.

PHYSICIAN NETWORKS

The safety zone for physician networks is defined in terms of percentage of physicians in a given specialty. If less than 20% of the physicians in a specialty with active hospital privileges who regularly practice in the relevant geographic market form an exclusive network, it is not likely to be challenged if the physicians share substantial financial risk. The financial risk requirement can be satisfied through either a capitation payment system or a compensation system which withholds a

substantial amount as a financial incentive to achieve cost containment goals. Financial risk sharing is not required if the network accomplishes sufficient clinical integration likely to produce significant efficiencies. For non-exclusive networks the safety zone was increased in 1994 to 30%.

IX.

MULTI-PROVIDER NETWORKS

Multi-provider networks are described in this statement as joint ventures between all types of health care providers that joint market their services. Except where the multi-provider network engages in per se price fixing or market allocation, the Rule of Reason analysis will be utilized to evaluate these ventures. Because the agencies did not feel they had sufficient experience in this area no safety zones were created. Most of the discussion relates to the need for economic integration and notes that the relevant market definitions will follow the analysis provided in the 1992 Horizontal Merger Guidelines. The 1996 Enforcement Statements further determine the approved use of "messenger models" and discuss the Qualified Managed Care Plan as well.



DEPARTMENT OF JUSTICE
Antitrust Division

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January 17, 1996

Mr. John F. Fischer, Esquire
Andrews, Davis, Legg, Bixler, Milsten & Price
500 West Main
Oklahoma City, OK 73102-2275

Dear Mr. Fischer:

This letter responds to your request on behalf of Oklahoma Physicians Network-IPA, Inc. ("OPN") and PROklahoma Care, Inc. ("PROklahoma") for a statement, pursuant to the Department of Justice Business Review Procedure, 28 C.F.R. § 50.6, of the Department's present enforcement intentions regarding OPN/PROklahoma's proposal to set up a health care provider network. For the reasons set forth below, the Department does not currently intend to challenge OPN/PROklahoma's proposed activities under the antitrust laws.

You have explained that OPN will be a statewide physician network, or independent practice association ("IPA"). You have also indicated that the initial membership of OPN will likely include under 1,000 participating physicians. As of mid-May, 1995, 916 physicians, in 51 of Oklahoma's 77 counties, had agreed to become OPN members.

PROklahoma will be a health maintenance organization ("HMO") capitalized by physicians in OPN.¹ Initially, the OPN network will contract with PROklahoma on a capitated basis. You have told us that, in the future, OPN may contract with other

¹ Your initial plan called for PROklahoma to be capitalized with a \$3,000 contribution by each OPN physician-member. You subsequently informed us that, due to lower than expected physician participation, PROklahoma would also sell additional stock to OPN physician-members.

third-party payers on a fee-for-service basis with a "risk pool" or on a capitated basis. With the risk pool, OPN will negotiate utilization and cost containment goals with each of its network customers, and it will withhold 20% of each participating physician's billing. If the cost containment and utilization goals are not met, no physician will receive any withheld amount and the entire withheld fund will be returned by OPN to (or retained by) the payer. When OPN enters into a capitated fee arrangement with PROklahoma or any other payer, it will undertake the risk of providing medical coverage to such payers and distribute the proceeds to OPN's participating physicians.

Based on the information set forth above, it appears that the OPN network will be a bona fide joint venture in which the participating physicians will assume significant, shared financial risk for the achievement of specific cost-containment goals by the group. Thus, OPN's proposed provider network is not engaged in any *per se* illegal activity and will be analyzed, under the antitrust laws, pursuant to rule of reason analysis. See Statement 8 of the 1994 Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust ("Statement 8"). 4 Trade Reg. Rept. (CCH) ¶ 13,152 at p. 20,788.

You have represented that the OPN network will be a nonexclusive network. That is, participating physicians will be free to contract directly with other third party payers, or to participate in other provider-controlled and non-provider-controlled network organizations, without any requirement of notification to, or approval by, OPN. Moreover, you have represented that the vast majority of the physicians who are likely to participate in the OPN network already participate in competing non-provider-controlled networks, or contract directly with managed care plans, and you have stated that OPN expects its participating physicians to continue to do so at competitive rates. This suggests that the OPN network will be nonexclusive in practice, not just in name. See *Id.* (listing indicia of non-exclusivity).

When we assess a physician network joint venture under the rule of reason, our analysis focuses on whether the proposed network will create or facilitate the exercise of market power (the ability to impose supracompetitive prices or to prevent the formation of competing networks). *Id.* at p. 20,789. As described in Statement 8, this analysis involves four steps: defining the relevant market, evaluating the competitive effect of the physician joint venture, evaluating the impact of procompetitive efficiencies and evaluating collateral agreements. *Id.*

You have not provided sufficient information from which we can ascertain precisely the relevant markets that will be involved in the operation of the OPN network. However, it is clear that most of the physicians participating in the network will compete in local markets that generally will be no larger than a single county and

in some areas -- particularly urban centers -- will likely be smaller. You have submitted information about the numbers of physicians in particular medical specialties practicing in fifteen rural or semi-urban counties of the state. The conclusions in this letter assume that this information is accurate and, based on your representations, that these counties contain the majority of OPN's physicians in rural and semi-urban markets and most of the instances in which OPN has high percentages of physicians in certain specialties. Obviously, to the extent that actual percentages in appropriately defined relevant markets are higher than the information now before us discloses, our concerns about the proposed operations of the network might increase.

According to the information you submitted, OPN has a low percentage of primary physicians in the two urban parts of the state, including only 4% and 6% of the primary physicians in Tulsa County and Oklahoma County, respectively, which are the largest population centers in the state.² Approximately 480 of OPN's physicians practice in Oklahoma County or in Tulsa County. Primary care participation is not as low in rural and semi-urban parts of the state, but it is generally below 30%. Where OPN's percentage of primary care physicians is below 30% in a properly defined market, it falls within the safety zone for non-exclusive joint ventures described in Statement 8. Id at 20,788.

Similarly, you claim that OPN has fewer than 30% of the physicians in most specialties in urban areas. Again, the safety zone of Statement 8 for non-exclusive joint ventures covers OPN's operations in any properly defined local market in which OPN has fewer than 30% of the physicians in each specialty. Id.

In a number of putative local markets in rural and semi-urban areas, however, OPN appears to have substantially more than 30% of the physicians in several specialties. In some of these, all of the physicians in specialties contracting with OPN already practice together in an integrated physician group. Since OPN's operations will not increase concentration in these specialties in these markets, OPN raises no concerns. For some putative local markets, however, OPN has more than 30% of the physicians in particular specialties, and the specialists do not practice together in a group. For example, OPN has 100% of the available otorhinolaryngologists in Lawton, Muskogee and Norman, and there are multiple otorhinolaryngologist practices in each of these areas. Substantial percentages of some specialties persist even when the

² Roughly 1.2 million of Oklahoma's 3.1 million citizens live in Oklahoma County or in Tulsa County.

possible market areas are broadened to include two or three counties.³ In all, only about 10% of OPN's physicians are in specialties in putative local markets where OPN appears to exceed the safety zone provided in Statement 8.

The substantial percentage of physicians contracting with OPN in certain specialties in these markets raises the possibility that OPN could lead to the creation and exercise of market power in these specialties, particularly in view of the incipient state of HMOs and the limited number of other managed care organizations in many rural and semi-urban parts of Oklahoma. This is particularly the case in markets such as Norman and McAlester in which, some managed care payers have told us, physicians have been reluctant to participate in the payers' managed care networks.⁴

However, several factors allay our concerns that OPN will exercise market power in rural and semi-urban markets. First, OPN has been designed to be non-exclusive, and information you have provided suggests that OPN will be non-exclusive in fact. For example, many OPN physician-members contract with PPOs that have entered their markets. It also appears that, even after OPN is launched, its physicians will continue to earn substantial revenue from these PPOs and from other sources outside of the network.

Second, most of the instances in which a substantial percentage of a market's physicians are participating in OPN are in rural or semi-urban markets. Because of the small number of physicians that practice in these markets, it appears that OPN needs higher percentages of the limited number of physicians in some specialties in order to provide adequate choice and coverage to OPN customers.

Third, it does not appear that the overall structure of OPN will facilitate the exercise of market power. Thus, although physicians in urban areas and primary physicians in all areas are a majority of OPN's membership, these physicians constitute only small portions of the markets in which they participate. Consequently, these urban and primary physicians will have an incentive to ensure that OPN's physician services are priced competitively. This is likely to provide some counter to any incentives among OPN members in more rural areas to attempt to exercise market

³ Though we have not determined the boundaries of relevant local markets in various health care services in these areas, we have examined OPN's percentage of physicians in: arguably the smallest local markets in these areas (hospital staffs), intermediate local markets (counties) and large local markets (two to three county areas).

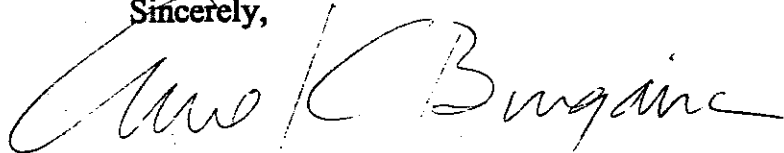
⁴ We note, however, that most of OPN's physician-members in Norman appear to contract with at least three PPOs.

power and charge supracompetitive prices. This is particularly likely since the instances in which OPN physicians constitute a high percentage of the specialists in a local area do not appear to be concentrated in any particular specialty or geographic market.

For these reasons, the Department has no present intention to challenge the proposed operations of OPN or PROklahoma. However, this conclusion is based on our assumption that OPN and PROklahoma will operate in fact in the competitive manner described in this letter. Of course, we reserve the right to bring an enforcement action if the actual operation of OPN or PROklahoma proves anticompetitive in effect. For example, we would view the situation differently if OPN proved to be exclusive in practice and its members were able to raise prices to supracompetitive levels or prevent the entry of managed care plans into rural and semi-urban markets of Oklahoma. Similarly, we would be concerned if OPN, even though non-exclusive in practice, were to create or facilitate the exercise of market power in these markets, or if the activities of OPN or PROklahoma were to cause anticompetitive effects in any other manner.

This statement of the Department's enforcement intentions is made in accordance with the Department's Business Review Procedure, 28 C.F.R. § 50.6, a copy of which is enclosed. Pursuant to its terms, your business review request, as supplemented, and this letter will be made available to the public immediately. Any supporting documents not deemed confidential pursuant to your request in accordance with Paragraph 10(c) of the Business Review Procedure will be publicly available within 30 days of the date of this letter.

Sincerely,

A handwritten signature in cursive script, reading "Anne K. Bingaman". The signature is written in black ink and is positioned above the typed name and title.

Anne K. Bingaman
Assistant Attorney General