
Legal Briefs

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One more battle in the competitive struggle

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Any lawyer practicing in the healthcare industry cannot help but notice the turf wars between competing specialties of healthcare professionals: physicians vs chiropractors, orthopedists vs osteopaths, psychiatrists vs psychologists and other mental health professionals, physicians vs podiatrists, and anesthesiologists vs nurse anesthetists. Some of the foremost antitrust cases in the healthcare arena have witnessed providers in these specialties playing out these competitive struggles. The turf wars become even more heated by declining reimbursement from Medicare, private health plans, and other third-party payers.

The competitive struggle between anesthesiologists and nurse anesthetists became sharper during the past decade in the face of an influx of recent medical graduates into anesthesia, declining reimbursement for anesthesia services, as well as changes in Medicare regulations designed to address billing irregularities by anesthesiologists and to afford direct billing rights to nurse anesthetists under Medicare Part B. At the same time, physicians faced a climate of increasing public concern about rising healthcare costs, universal care, and Hillary Clinton's healthcare reform, which in turn led to proposals to strengthen managed care and growing uncertainty among physicians about how to deal with a marketplace in which their supremacy was being challenged.

The struggle to "keep control" in Minnesota

The recent antitrust case in *Minnesota, Minnesota Association of Nurse Anesthetists v Unity Hospital, et al*, 208 F. 3rd 655 (8th Cir. 2000), presented an illustration of these struggles and the desire of physicians to "keep control." In that case, the Minnesota Association of Nurse Anesthetists (MANA) alleged that 3 hospitals and their staffs of anesthesiologists conspired to terminate nurse anesthetists from the employ of the hospitals for whom they had worked and to put the nurse anesthetists to the Hobson's choice of either working for their competitors—the anesthesiologist groups at the hospitals—or ceasing to work at the hospitals. The conduct of the anesthesiologists stemmed from the above-described changes in healthcare reimbursement and the sudden new competition in anesthesia generated by declining reimbursement, increasing numbers of practitioners, and more aggressive regulation. This competition posed a real threat to the defendant anesthesiologists, who had not been accustomed to it in the Twin Cities/St. Cloud areas.

Faced with these changes, the anesthesiologists were quoted as expressing grave concern about the approaching new, direct, cost-driven competition for anesthesia dollars—and the clear threat to their incomes it posed. In the words of their leadership, they vowed to the CRNAs (according to the evidence) that they were not going to "lose one thin dime," "a single dollar," or

“power and control.” Indeed, in early 1990 the president of the American Society of Anesthesiologists (ASA) sounded the following alarm over this threatened competition:

“We know this intolerable situation has arisen because of claims being submitted by CRNAs for anesthesia services, which has led these carriers to issue new policies recognizing only the CRNA claim.... Failure to recognize and properly reimburse for medical direction may well be the overriding battle for ASA and all of its members this year.”

This threat was not lost on the anesthesiologists in the Twin Cities/St. Cloud area. An influential local anesthesiologist reportedly cited “several instances of payment refusal or drastic reductions for [anesthesiologists’] services.”

The anesthesiologists, MANA claimed in the Minnesota antitrust litigation, tried to deal with reduced anesthesia reimbursement by continuing to use CRNAs, putting in little or no time of their own in the operating room but billing as if they were personally present and working there. This phenomenon led to “whistle-blowing” by several nurse anesthetists and to allegations of false claims submissions that were ultimately part of a companion *qui tam* case brought by MANA in federal district court in Minnesota. “*Qui tam*,” which literally means “in the place of the King,” is a vehicle for private individuals to bring actions on behalf of the government against those allegedly defrauding the government. (The *qui tam* claims are currently pending before the 8th Circuit Court of Appeals.)

The anesthesiologists’ solution

When the anesthesiologists realized that their solution would not work, MANA alleged, the Minnesota anesthesiologists devised a plan to enter into what were purportedly “single-source” or “exclusive” contracts that would result in the provision of all anesthesia services by anesthesiologist groups. The anesthesiologist groups would correspondingly seek to eliminate direct employment of CRNAs by the defendant hospitals. The CRNAs would work, instead, for the anesthesiologist groups. This goal was echoed in the plan enunciated by one of the anesthesiologists:

“We have a way to take care of the CRNAs in Minnesota...without worrying about antitrust. We will get the hospitals to fire the CRNAs and force them to work for us...”

This intent, coupled with the anesthesiologists expressed anticompetitive motivations (not to lose control or even “one thin dime”), was

believed to supply ample evidence of the anticompetitive intent of the anesthesiologists underlying the revised anesthesia structure at the 3 defendant hospitals. But antitrust cases are not proved by motive alone. The antitrust laws do not prohibit individual action. An unlawful *conspiracy* to restrain trade that has an *adverse impact on competition* also must be demonstrated. On these issues there was evidence on both sides. MANA argued that there was enough evidence supporting the existence of an unlawful conspiracy to restrain trade to send the case to trial. The district court dismissed the case by a summary judgment (a pretrial judgment based on the facts developed through pretrial discovery and applicable law). The decision was appealed to the US 8th Circuit Court of Appeals by MANA.

Evidence of an unlawful conspiracy

The first task for MANA was to prove the existence of an *unlawful conspiracy*. Proving this under the antitrust laws has been difficult historically, and even more so in the last 20 years, as courts pulled in the reins in antitrust cases in several different ways. Increasingly, if conduct is as consistent with individual action as it is with conspiratorial behavior, courts will tend to dismiss conspiracy claims.

Another difficulty for MANA was the seemingly routine custom in the delivery of anesthesia services to sole source those services through exclusive contracts. Hence, at the oral argument of the case in St. Paul, the first question from the 8th Circuit judge who ended up writing the opinion dismissing MANA’s claims was: “Haven’t these types of arrangements to sole source anesthesia services been undertaken elsewhere?”

If the Minnesota case had involved simply the decision of a hospital and its exclusive anesthesia group to sole source the provision of anesthesia, it would have been a very different case—one that probably would not have been brought in the first place. However, MANA believed that the evidence it had discovered during the litigation contained various indications that the hospitals and the anesthesiologist groups were not making individual decisions but had conspired among themselves to impose these arrangements at all 3 defendant hospitals. There was evidence that the anesthesiologists had taken advantage of their close relationships to act in concert, proceeded in accordance with a “blueprint” for action supplied under the guise of legal advice by the attorney for the Minnesota Society of Anesthesiologists, exchanged

confidential information about the negotiations of the sole-source contracts at each hospital, shared information among hospital officials about how they implemented the sole-source arrangements, and undertaken suspiciously similar steps in the way the hospitals and anesthesiologist groups went about executing these arrangements—even to the point of doing so through the same consultants and negotiating the termination of the nurse anesthetists' employment on very similar terms.

But the 8th Circuit Court of Appeals rejected the notion that a conspiracy had been proved, partly because it did not find convincing several of the events MANA had alleged to be indicative of a conspiracy. There was no "smoking gun" to prove conspiracy. For example, the court labeled the Minnesota Society of Anesthesiologists' attorney's alleged "blueprint" for the conspiracy as simple "counseling," and the interhospital exchange of information as a "procompetitive" exchange designed to enable the hospitals to accomplish efficiencies in sole-source contracting. The opinion accepted without much scrutiny the defendants' explanations for their conduct, even as it arguably gave short shrift to competing inferences of conspiracy to be drawn from the behavior of the hospitals and anesthesiologists.

Reasoning underlying dismissal

This underlying view of the conduct as an attempt by hospitals to implement legitimate sole-source contracting arrangements—ie, as a common, but not necessarily conspiratorial, approach to the difficult problem of how to achieve efficiencies in a changing healthcare marketplace and reimbursement system—underlie the 8th Circuit opinion that there also was no *unreasonable adverse impact on competition*. The court thought that it was not unreasonable for a hospital to react to complicated and changing medical reimbursement regulations by getting rid of its own anesthesia department and letting physicians be solely responsible for providing and billing for anesthesia.

The court also believed that the record failed to demonstrate how, in the Twin Cities and St. Cloud, the sole-source contracts had an adverse impact on competition. There was insufficient evidence, according to the court, of the exercise of any "market power" by the defendants in an identifiable relevant geographic market. Nurse anesthetists continued to work at the hospitals (albeit as employees of the anesthesiologists); while there were no independent CRNAs to compete in the

Twin Cities or St. Cloud after the contracts were granted, there had not been any before the alleged antitrust activity either. Moreover, the alleged antitrust activities had had no visible impact on anesthesia prices, the ultimate test of an antitrust violation.

MANA claimed that the elimination of direct billing by potentially independent CRNAs, capable of competing on a high-quality, lower-cost basis, inevitably injured competition, as did the requirement, in essence, that they work for their competitors if they wanted to stay at the hospital. The hospitals claimed that they simply wanted to reduce cost, provide more efficient service, and get out of the business of billing for anesthesia services. The court drew a balance among this competing evidence by finding essentially that the hospitals' actions were equally consistent with lawful as with unlawful behavior and dismissed the antitrust claims just as the lower court (the federal district court) had done.

The federal district court also has dismissed the *qui tam* case brought by MANA on behalf of the "whistle-blowing" CRNAs based on the alleged false claims submitted by anesthesiologists to Medicare. One of the reasons the court did so was that the CRNAs had not provided direct or new evidence after the antitrust claim had already been filed. Currently, MANA is appealing this vigorously on factual grounds, as well as on the basis that the legal underpinnings for this decision differ from the case law as it has developed in a number of other courts.

Indeed, courts do disagree. MANA and its counsel believed that there was enough evidence in the antitrust case to warrant a trial of the case, rather than a dismissal by summary judgment. It is conceivable that, in another jurisdiction that might be more hospitable to antitrust plaintiffs, the case would have been allowed to proceed to trial.

Implications for the present and future

The Minnesota cases are emblematic of the increasingly intense struggle between the anesthesia specialties. Although the antitrust case was lost, it demonstrated the resolve of the community of nurse anesthetists to take action when forced to challenge the conduct of anesthesiologists seeking to exclude nurse anesthetists unfairly from their vital role in the healthcare system. The case probably served as a deterrent to similar, if not more egregious, anticompetitive conduct that might have developed without the case. Indeed, it may be that, *on those facts*, the hospitals and anesthesiologists did

not violate the antitrust laws. But other healthcare professionals have succeeded in challenging unlawful concerted action that led to the exclusion of a class of healthcare professionals, including chiropractors (against physicians), osteopaths (against orthopedists), podiatrists (against physicians), psychologists (against psychiatrists), and, of course, the nurse anesthetist in the *Oltz* case [*Oltz v St. Peter's Community Hospital*, 861 F.2d 1440 (CA9 (Mont.), 1988)], which invalidated an exclusive contract excluding the nurse anesthetists in a market in which the hospital had market power and in a situation where there were insufficient procompetitive virtues behind the arrangement.

So the result in the Minnesota case does *not* give unrestricted opportunity to anesthesiologists, or the associations that represent them, to engage in anticompetitive arrangements to exclude nurse anesthetists. The court does not say that excluding nurse anesthetists from the market is legal. All the case stands for is that a hospital may make an individual choice to have an anesthesiologist-directed anesthesia department without violating the antitrust laws. The ASA and other organized efforts of anesthesiologists must remain mindful of antitrust constraints, notwithstanding the result in this one case.

In addition, of course, the Minnesota cases supply but 1 relatively local example of the competitive struggle. In Florida, the Florida Association of Nurse Anesthetists is challenging vigorously the state Board of Medicine's questionable requirement in new regulations of anesthesiologist supervision of nurse anesthetists in office settings. Evidence of the competitive struggle is found in many other states where nurse anesthetists remain vigilant toward their practice rights. This struggle is hardly new in the now more than 100-year history of nurse anesthesia. Of course, HCFA's recent ruling on the physician supervision requirement looms much larger as a victory than the Minnesota case does as a defeat in maintaining and augmenting the role of nurse anesthetists in the healthcare system.

Conclusion

As the competitive struggle continues, nurse anesthetists must continue to be not only vigilant, but also unafraid to mount political and legal challenges to unwarranted attempts by their competitors to distort the truth about anesthesia services and exclude nurse anesthetists from their place as vital, cost-effective, and high-quality providers of those services.