II. In-Depth

HEALTH INSURER DEFEATS ATTEMPTED MONOPOLIZATION CHALLENGE

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The December 19, 2001 decision in *Coventry Health Care of Kansas, Inc. v. Via Christi Health System, Inc.,*[1] exonerated a large, local HMO from charges that it had monopolized the local HMO market. *Via Christi* was a battle between competing health plans. Coventry Health Care of Kansas, Inc. (the local operating subsidiary of Coventry Health Care, Inc.) charged that Preferred Health Systems, Inc. (PHS) was attempting to monopolize the local health plan market. In support, Coventry alleged that PHS engaged in predatory pricing in connection with its bid for Raytheon Aircraft Company's health insurance business. Coventry complained that an affiliate of PHS, Via Christi Regional Medical Center, Inc., gave PHS a price for inpatient hospital services lower than the price Via Christi offered to Coventry, thereby allowing PHS to submit the winning bid for the Raytheon contract. In analyzing the market and the conduct of the parties, the court made several findings that will be useful for health plans with large market shares when defending or prosecuting future cases.

The *Via Christi* decision illustrates that a health insurer asserting an antitrust claim against a competitor has the burden of establishing a properly defined product market supported with credible factual evidence. In this regard, *Via Christi* represents another reported decision refusing to adopt a narrow definition of the market for health insurance when the evidence demonstrated that various forms of health insurance competed in the market. While the *Via Christi* court rejected a particular antitrust challenge by a health insurer in a local market, other antitrust claims remain available to a health insurer which can be used offensively if warranted by market conditions.

The Product Market – An Essential and Often Dispositive Element of Proof

A properly defined "relevant market" is a threshold requirement for any attempt to monopolize claim. For antitrust purposes, the "relevant market" includes both a "product market" and "geographic market" component. A plaintiff will generally define the "relevant market" narrowly. By contrast, a defendant will generally propose a broader market definition – thereby including additional products or services in "the market." The defendant will contend that these additional products or services are reasonable substitutes for the product or service in the plaintiff's proposed product market. When these additional products or services are included in the market, according to the defendant, the allegedly anticompetitive impact of the challenged conduct is diminished or even eliminated. Thus, the determination of the proper scope of the product market can be dispositive of plaintiff's claims because,

absent proof of anticompetitive effect in the relevant market, an attempt to monopolize claim cannot be sustained.

In the context of a monopolization claim against a managed care company, the plaintiff may seek to define a product market consisting of a single type of benefit plan, *e.g.*, HMO or HMO/POS benefit plans. If the court accepts this proposed product market, the analysis of whether the defendant's conduct creates anticompetitive effects will be limited to assessing competition among HMO/POS benefit plans, to the exclusion of PPO benefit plans and other forms of health insurance. One element of this analysis will be an assessment of the number of members enrolled in defendant's HMO/POS benefit plan compared to the enrollment in the HMO/POS benefit plans offered by its competitors.

A product market definition limited to HMO/POS benefit plans may raise concerns for health insurers with a large share of all managed care lives enrolled in HMO/POS benefit plans. A managed care company that has 80% of all HMO/POS members in the relevant geographic area enrolled in its HMO/POS plans may be perceived as the dominant firm. A dramatically different picture may emerge, however, when PPO enrollment is included in the analysis. For example, managed care company "X" may have 60,000 members enrolled in its HMO/POS plan and only 5,000 members in its PPO plan. Conversely, managed care company "Y" may have only 5,000 members enrolled in its HMO/POS plan but 60,000 members enrolled in its PPO plan. If PPO benefit plans are excluded from the product market, one might infer that company X is the dominant firm. However, company X and Y may actually be evenly matched competitors when PPO health plans are included in the product market. This example illustrates that "product market" definition is critical in health care monopolization claims.

Via Christi – A Recent Illustration

Via Christi involved antitrust litigation between competing managed care companies in Wichita, Kansas. Coventry Health Care of Kansas, Inc. (Coventry) filed suit in August 2001, seeking to enjoin Preferred Health Systems, Inc. (PHS) from replacing Coventry as the health insurer for employees of Raytheon Aircraft Company (Raytheon) commencing on January 1, 2002. Coventry's complaint asserted various claims under the federal antitrust laws as well as a tort claim under state law. As its principal claim, Coventry charged PHS with attempting to monopolize the market for HMO/POS benefit plans in the Wichita area.

Coventry alleged that PHS had almost twice the number of members enrolled in its HMO/POS benefit plans in the Wichita area compared to Coventry. Urging that the court adopt a product market consisting of only HMO and HMO/POS benefit plans, Coventry claimed that PHS held a dominant share of the HMO and HMO/POS managed care lives in the Wichita market and was attempting to monopolize this product market. However, this market definition excluded those persons enrolled in PPO plans, including PPO plans offered by Coventry and Blue Cross and Blue Shield of Kansas, Inc. This market definition also excluded persons who purchased other forms of health insurance such as indemnity insurance. To justify its proposed market definition, Coventry argued that PPOs and indemnity insurance were not reasonable substitutes for HMO and HMO/POS benefit plans in the Wichita market.

Following a week-long preliminary injunction hearing, U.S. District Judge J. Thomas Marten ruled that Coventry failed to establish a legally cognizable product market – a threshold

requirement for its attempt to monopolize claim. The court expressly rejected Coventry's claim that the evidence showed that PPO benefit plans were a product market distinct from HMO and HMO/POS benefit plans. To the contrary, the court found that HMO benefit plans competed with POS plans, PPO plans, and other forms of health insurance in the Wichita market, noting "cross migration" between and among these various forms of health insurance throughout the Wichita area. The court specifically noted that at least one employer in Wichita had selected an indemnity insurance plan for its employees when presented with the option of selecting a managed care plan or an indemnity plan.

The court also rejected Coventry's claim of separate product markets based on pricing differentials between the plans, instead finding that HMO, POS, and PPO benefit plans could be priced the same. In fact, the court noted that Coventry had combined its various benefit plans into a single marketing package and offered employers the option of selecting an HMO, POS, or PPO plan at the same premium cost. Further undermining Coventry's claim of a distinct PPO product market, the court found that an HMO-type plan could be designed with benefits identical to a PPO plan. The court noted evidence that the principal distinction between a POS benefit plan with benefits comparable to a PPO plan is simply the method of accessing benefits. Based on this record, the court rejected Coventry's proposed product market consisting of only HMO/POS plans.

Additional Case Authority Addressing the Product Market for Health Insurance

The holding in *Via Christi* is consistent with the opinions in *Blue Cross & Blue Shield of Wisconsin v. Marshfield Clinic*[2] and *U.S. Healthcare v. Healthsource*.[3] Both courts declined to recognize an HMO product market on the record presented.

In *Marshfield Clinic*, Blue Cross & Blue Shield of Wisconsin and its HMO subsidiary (Compcare) sued a physician-owned clinic located in rural Wisconsin (Marshfield Clinic) and its HMO subsidiary (Security Health). Compcare alleged that Marshfield Clinic had monopoly power and used that power to exclude Compcare from the "HMO market" in north central Wisconsin. Specifically, Compcare alleged that Security Health had contracted with such a large percentage of the physicians in the north central region of Wisconsin that Compcare was unable to offer HMO services to compete with the HMO plan offered by Security Health. The Seventh Circuit noted that, assuming the truth of Compcare's allegation, such allegation "has monopolistic significance only if HMOs constitute a market separate from other contractual forms in which many of the same physicians sell their services."[4]

In reversing a jury verdict in favor of Compcare, the court found insufficient evidence to support a finding that HMO benefit plans constituted a separate product market. The court noted that the record revealed that individuals, employers, and health insurers all regarded HMO benefit plans as competing with PPO benefit plans and various other fee-for-service health plan alternatives. The Seventh Circuit thus concluded that Compare had not demonstrated the existence of a separate HMO market, and its monopolization claim therefore could not stand.

The court in *U.S. Healthcare* similarly declined to recognize a product market defined as HMO benefit plans. In *U.S. Healthcare*, a health maintenance organization (U.S. Healthcare) sued its competitor (Healthsource) challenging certain exclusivity agreements between Healthsource and its physician providers. U.S. Healthcare alleged that the exclusive dealing agreements constituted anticompetitive conduct in furtherance of an attempt to monopolize

the HMO market. The court dismissed this claim based on U.S. Healthcare's failure to define an appropriate product market.

U.S. Healthcare sought to define a product market consisting solely of HMO benefit plans. U.S. Healthcare argued that differences in cost and quality between various forms of health insurance supported its HMO product market definition. But the court noted that these factors created only "the possibility" that HMOs and PPOs comprised separate markets. The court held that the appropriate product market consisted of all forms of health care financing. The court noted, "[s]o defined, Healthsource had a share of that market too small to support an attempt charge, let alone one of actual monopolization." [5]

Potential Claims Against Providers Under Section 2 of the Sherman Act

Coventry's unsuccessful challenge to the Via Christi-PHS reimbursement arrangement should not be interpreted to mean that health plans cannot successfully challenge conduct by providers that deprive health plans of competitive markets. *Via Christi* demonstrates, however, that certain types of anticompetitive conduct are more likely to survive scrutiny under Section 2. In *Via Christi*, Coventry alleged that the price of hospital services Via Christi extended to PHS constituted predatory pricing. As noted in *Via Christi*, predatory pricing claims "are rarely tried, and even more rarely successful." [6] Among other elements, a plaintiff alleging a claim of attempted monopolization by predatory pricing must establish both (1) that the defendant priced its product below an appropriate measure of cost and (2) that the defendant enjoyed a realistic prospect of recouping its losses by supra-competitive pricing. Given the presence of several "strong" competing managed care companies in the Wichita market, and the fact that the court found that the barriers to entry into the health insurance market are "extremely low," the court concluded that any attempt to charge supra-competitive pricing would not be successful in the Wichita market.

Via Christi demonstrates that a variety of obstacles exist to proving a claim of predatory pricing. Nonetheless, a number of other claims may be available to a health insurer and ultimately prove successful depending on the particular market conditions. A challenge to a provider network that is overly inclusive in terms of the number of providers is one possible claim. Provider networks that fail to achieve true integration or fail to share sufficient risk are other examples. Monopolization claims remain viable, but alleging monopolization of an "HMO market" would require circumstances not evident in any of the cases that have so far considered the markets in which health benefit plans compete. A thorough investigation of the relevant facts and circumstances will determine whether any of these potential claims are viable.

Conclusion

Via Christi is another decision refusing to recognize HMO/POS benefit plans as a separate product market based on the record before the court. The opinion demonstrates that evidence of competition between various forms of health insurance in the relevant geographic area will militate against a finding that one particular form of health insurance is a distinct product market. This precedent has significant value for health insurers with large market shares when facing scrutiny under the antitrust laws. *Via Christi* also demonstrates the difficulty of proving a claim of predatory pricing under Section 2 of the Sherman Act. A

health insurer seeking to challenge the conduct of providers should explore other potential causes of action under the Sherman Act.

NOTES

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** Gardner, Carton & Douglas attorneys Thomas Campbell, John J. D'Attomo, and Steven S. Shonder served as lead trial counsel for the defendants in *Via Christi*.

1 176 F. Supp. 2d 1207 (D. Kan. 2001).

2 65 F.3d 1406 (7th Cir. 1995), *cert. denied*, 516 U.S. 1184 (1996).

3 986 F.2d 589 (1st Cir. 1993).

4 65 F.3d at 1410.

5 986 F.2d at 597.

6 176 F. Supp. 2d at 1228 (quoting *Brooke Group Ltd. v. Brown & Williamson Tobacco Corp.*, 509 U.S. 209 (1993)).