THE ANTITRUST LAWS IN DENTISTRY:

A PRIMER OF "DOs, DON'Ts AND HOW TOs" FOR DENTISTS AND DENTAL SOCIETIES

American Dental Association
www.ada.org

PREAMBLE

THE DENTIST'S PROCLAMATION

"If we work together, we can win this battle. We are fighting an economic war where the very survival of our profession is at stake. How long can some of the leaders of dentistry…be so complacent and willing to fall into the trap that is being set for us. If only they would take the time, to see from whence come the arrows that are heading in our direction… The name of the game is money… There is no way a dental service can be rendered cheaper when the third party has to have its share of the dollar. Already we are locked into a fee freeze that could completely control the quality of dental care, if left on long enough."

Sound familiar? Capture the sentiment you've heard in some quarters? Indeed, the statement was made by a former constituent dental society official, who was one of the founders of a break-away federation that opposed the submission of x-rays to insurers. But not recently – not even during the lifetime of some new dentists reading this primer!

THE SUPREME COURT'S POINTED RESPONSE:

In the landmark dental antitrust case Federal Trade Commission v. Indiana Federation of Dentists, 476 U.S. 447, 450 fn. 1 (1986), the Supreme Court of the United States quoted the above language as a plain example of how to violate the antitrust laws. As characterized by the Supreme Court, the quote "is revealing as to the motives underlying the dentists' resistance to the provision of x-rays for use by insurers in making alternative benefits determinations."

So more than two decades ago (1986), the Supreme Court told us that coordinated efforts by dentists and dental societies to thwart cost-containment efforts by insurance companies can readily run afoul of the antitrust laws. Then the tide of managed care and other recent forms of third party payor plans really began to take root in many parts of the country! Had enough dentists listened?

THE CHALLENGE:

To learn enough about antitrust law, including the principles of competition that they support, to pursue what you want wisely and proactively, yet without unduly stepping into legal harm's way.

It can be done and this primer will help you get there!

ACKNOWLEDGEMENTS

The ADA's Division of Legal Affairs is pleased to offer this edition of The Antitrust Laws In Dentistry to dentists and dental societies. The Division serves as ADA's key antitrust resource and compliance advocate, monitoring antitrust issues of interest to dentistry, and providing ongoing antitrust support to dentists and dental societies nationwide. We are hopeful that the material contained in this primer will provide a useful tool to help you achieve your objectives without creating undue antitrust risk.

This edition of The Antitrust Laws In Dentistry was developed by the Division of Legal Affairs, with principal contributions by Mark S. Rubin, J.D., ADA Associate General Counsel. It contains significant new content, including input from tripartite dental societies and member dentists over the past 15 years.[1]

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TABLE OF CONTENTS

INTRODUCTION

Since they were first enacted in 1890, the federal antitrust laws have embodied the national policy of promoting competition in the provision of all manner of products and services in the American economy. In interpreting those laws, the federal agencies charged with enforcing them, as well as the United States Supreme Court, strongly believe that "Competition in health care markets benefits consumers because it helps contain costs, improve quality, and encourage innovation."[2] True, they have consistently rejected the argument that somehow competition among professionals – dentists, physicians, lawyers or engineers – is undesirable. However, they are receptive to the importance of professionals being able to undertake legitimate efforts to reduce costs, increase the quality of patient care, or innovate on services offered and in service delivery systems.

The antitrust laws affect dentists in many ways. Most visibly, they come into play when dentists seek to respond together to what they perceive as the unlevel playing field that exists between dentists and insurance companies. But the list goes on: dental practice, dental-team, dental education, dental society membership and communications issues, ethical rules and restrictions on professional advertising – all these and more can raise antitrust considerations.

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Many dentists perceive that historically, the antitrust laws have been used more against them than for them. Indeed, since the last edition of this book was published over a decade ago, during which time managed care took center stage in health care, federal regulators have aggressively pursued antitrust enforcement actions against health care providers, including dentists; for reasons discussed below, third party payors and others have received relatively much less antitrust scrutiny, largely because their efforts at cost containment are viewed by the agencies as beneficial. In other cases, however, the antitrust laws have been invoked to shield dentists from restrictions imposed on them by insurance providers that limit their ability to lower price, as well as dental society constraints on truthful advertising.

As prudent business people and providers of health care, dentists typically want to set their fees at appropriate market rates and at a level that will allow their patients to afford quality care. They also wish to preserve the right to practice in their chosen mode of practice (e.g., fee-for-service, managed care, etc.). It is important for dentists to have some grounding in the antitrust laws to protect against taking on undue legal risk when it comes to issues such as fee setting and practice mode. Violations of these laws can subject dentists and dental societies to significant financial penalties and even jail time.

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[2] This is how the Federal Trade Commission's current web site begins its overview of antitrust issues in the Health Care industry. See Competition in the Health Care Marketplace – Overview, available at http://www.ftc.gov/bc/healthcare/index.htm.

INTRODUCTION

The good news is that there are positive paths that dentists and their professional societies may safely travel in pursuit of their legitimate interests and the interests of their patients without creating undue antitrust exposure. The ADA has worked diligently for years to promote those interests in aggressive yet legally sound ways. Some of those positive advocacy paths are noted throughout this book and can serve as examples for readers to consider tailoring to their particular circumstances and needs.

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We recognize that due to marketplace realities, the examples of sound ADA advocacy mentioned in this book have not yet produced all of the desired outcomes. At the very least, therefore, it is important that dentists know enough about the antitrust laws to avoid needlessly getting into harms way while trying to achieve their legitimate goals. Playing on an unlevel field is hard enough; trying to do so without knowing the rules of the game can make it orders of magnitude worse. So let's get started. The antitrust laws are sometimes called the rules of the game of competition. Let's learn how to play!

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ANTITRUST 101

Using this Book

It is essential for dentists to gain a basic understanding of antitrust law. This understanding can sensitize them to potential problems and when to seek expert legal advice. This primer explains basic antitrust principles – and how they can both limit dentists but also protect them if they are in fact the victims of anti-competitive practices. Its primary focus is on what dentists and dental societies may and may not do when dealing with fees and reimbursement. It addresses many positive advocacy paths that can be safely undertaken. Finally, in a series of hypothetical questions and answers, it explores numerous situations that dentists could face and assesses the potential antitrust ramifications of each.

Dentists with baseline knowledge of antitrust have an added arrow in their quiver when playing the game of competition: they are empowered to think more clearly about relative levels of risk. In other words, they can begin to consider how to best accomplish their goals, both in terms of end result and degree of legal risk, particularly antitrust exposure. Rather than run with initial, often emotional reactions, which may create undue antitrust risk, they may find that many of their objectives can be achieved in relatively safe ways.

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The Purposes and Scope of the Antitrust Laws

Antitrust is characterized by some commentators as the rules of the game of competition. In particular, the antitrust laws govern what conduct in the marketplace is permissible, because it promotes or is neutral with respect to competition, and what conduct is not permitted because it is anti-competitive.

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The most important antitrust law affecting dentistry is the Sherman Act, and in particular Section 1 of that Act. (Sherman Act Section 2 and other antitrust laws are described later in this publication.)

Section 1 of the Sherman Act prohibits contracts, combinations and conspiracies that unreasonably restrain competition. As discussed more fully below, there are thus always two key questions to keep in mind for antitrust purposes: (1) is there concerted action (a contact, combination or conspiracy) and, if so, (2) does it unreasonably restrain competition?

But what does that mean? Before we get into some of the specifics, it is useful to try and identify the kinds of conduct with which the Sherman Act is concerned. For example, would you object if you learned that the cost of your office or dental supplies had risen because a group of formally competing wholesalers had

agreed to fix uniform and higher prices for their supplies? And what if you learned that your primary wholesaler had just dropped a new and quality brand that you favored, because a dominant, competing supplier no longer permitted the wholesaler to offer the competing brand?

These two examples illustrate how the antitrust laws can work to protect consumers from higher prices. Anti-competitive conduct can happen when a group of rivals: (1) collectively seek directly to suspend competition among themselves by, for example, agreeing on price, terms of sale, product or service characteristics – the kinds of things typically determined through competition; or (2) indirectly, when a single firm or group of firms tries to exclude a rival, especially a rival that is exerting competitive pressures on them. It is important to see the connection between these two, what antitrust enforcers and courts call "collusion" and "exclusion." It is not possible to succeed for very long in directly limiting competition unless you also are attentive to challenges from rivals outside the agreement. So “exclusion” often follows on the heels of “collusion.” In both cases, the market ceases to be responsive to consumer demand (whoever "the consumer" is).

How do these questions surface in the health care arena? A primary factor is that health care professionals are often subjected to pressure from many third party payors to reduce their fees, grant discounts or alter their practices. Dentistry is no exception. Payors that account for a substantial volume of patients often are able to obtain concessions from independently practicing dentists. In some situations payors have a marketplace advantage in these negotiations because of their purchasing power, just as is often said of mega-retailers like WalMart. But with rare exceptions the antitrust laws view the result – cost efficiencies and lower prices – as desirable. That will be the case unless there is some significant evidence that the quality of care has diminished or the prices being demanded are below the actual cost of providing the services and those are hard to prove conditions.

A natural, but sometimes dangerous, reaction of individual dentists is to seek to increase their sense of fairness by joining with their colleagues to deal with payors collectively over reimbursement and fees. Collective conduct by independently practicing dentists might take the form of an understanding to “hold the line” on minimum reimbursement fees, or a collective refusal to accept certain reimbursement rates or other terms from managed care firms. Such action can result in allegations of illegal price fixing or group boycott agreements under the antitrust laws. And even short of those two classic antitrust concerns, the conduct in fact could be anti-competitive and thus unlawful.

For these and other reasons, dentists should avoid discussing their fees or engaging in any group activity that could have an impact on competition without first having obtained competent legal advice. Our first rule of thumb in understanding the antitrust laws, therefore, is "prices up, risk up." If the point of collective conduct is to stabilize or raise price, the antitrust yellow flag is waiving.

Antitrust Enforcement

Why should a dentist care? Stated simply, violation of the antitrust laws can involve severe civil and/or criminal sanctions. Are you thinking about ways you and other dentists in your community can combat insurance companies? About agreeing with other dentists to set fees at certain levels? Or threatening boycotts of managed care plans? Then, you also should be thinking about the cost and embarrassment of years of litigation with the government or private plaintiffs, up to ten years in jail for committing a federal felony, fines for individuals of up to $1,000,000.00 per violation (which can be even higher under alternative fine provisions), and private litigation that could result in paying three times the actual damages you caused, plus the other side's attorneys' fees and costs (in addition to your own). In other words, mega risk, none of which is likely to be covered by your malpractice insurance.

Why should a dental society care? For starters, it would be extremely difficult for a dental society to survive the civil or criminal sanctions that could be imposed – similar to penalties risked by individual dentists, except that fines can be up to $100 million per violation and even more under aggravated circumstances. And beyond that, an antitrust investigation, in addition to its financial cost of defense, has the potential to grind the typical society's day-to-day operations to a virtual halt. Those expenses cannot be recovered, even if no court action is ultimately brought, a settlement is reached, or if the society ultimately prevails after years of litigation.

To understand better what conduct should be avoided, it is thus important to know who enforces the antitrust laws, and what the enforcement agencies are looking for when they conduct an investigation. There are a wide range of effective enforcement mechanisms under the antitrust laws. The United States Department of Justice (DOJ) is authorized to bring civil and criminal actions. In addition, the Federal Trade Commission (FTC) can bring civil antitrust cases. State attorneys general can enforce both state and federal antitrust laws. Finally, private parties injured by an antitrust violation, including competing dentists and insurance companies, may sue for treble damages, injunctive relief, litigation costs, and attorneys' fees. Treble damages means the

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party harmed by the violation can recover three times the amount if its actual damages – so again, the risk can be significant.

Also important is how the enforcement agencies go about investigating violations and looking for evidence of wrongdoing. As with other investigations and lawsuits, there will be the usual array of document production requests, depositions and the like. But welcome to the new Millennium – the age of the internet and e-mail. The most likely way to create a damaging antitrust trail may now be a virtual one. Indeed, in the government's recent antitrust case against Microsoft, the jury reportedly found particularly damning an e-mail sent by none other than Bill Gates. Consider the following possible contenders for People's Exhibit 1 in a dental antitrust case: pages hurriedly put on a society's website without the usual review; postings on a board or council listserv revealing anti-competitive underpinnings for the body's actions; postings to society discussion groups; even a society president or CEO's informal reports or newsletter to the society's board or peers...and the list goes on!

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All of this is important because the enforcement agencies are not shy about prosecuting dentists. Indeed, the first criminal health care antitrust case brought by DOJ in more than 50 years was against dentists in Arizona (non-ADA members, by the way). And even if you are able to successfully defend a charge of antitrust violation, you may do so at substantial financial and emotional cost, not the least of which may be disruption – or even destruction -- of a viable practice.

The enforcement agencies are not shy about prosecuting dentists.

On the other hand, the agencies are not unmindful of the fact that payors often can exert undue market pressure on health care providers. To help level the playing field, in the mid 1990's the DOJ and FTC issued joint Statements Of Antitrust Enforcement Policy In Health Care (http://www.ftc.gov/reports/hlth3s.htm).[3] The DOJ/FTC statements were part of the agencies' efforts "to advise the health care community in a time of tremendous change, and to address, as completely as possible, the problem of

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[3]The DOJ/FTC statements cover the following:
Statement 1 Mergers Among Hospitals
Statement 2 Hospital Joint Ventures Involving High Technology Or Other Expensive Health Care Equipment
Statement 3 Hospital Joint Ventures Involving Specialized Clinical Or Other Expensive Health Care Services
Statement 4 Providers' Collective Provision Of Non-Fee-Related Information To Purchasers Of Health Care Services
Statement 5 Providers' Collective Provision Of Fee-Related Information To Purchasers Of Health Care Services
Statement 6 Provider Participation In Exchanges Of Price And Cost Information
Statement 7 Joint Purchasing Arrangements Among Health Care Providers
Statement 8 Physician Network Joint Ventures
Statement 9 Multiprovider Networks

uncertainty concerning the Agencies' enforcement policy that some had said might deter mergers, joint ventures, or other activities that could lower health care costs." The statements set forth "antitrust safety zones" that describe health care provider activity that is "highly unlikely to raise substantial competitive concerns, and therefore will not be challenged by the Agencies under the antitrust laws, absent extraordinary circumstances." Some of the DOJ/FTC statements – especially those related to sharing fee and cost data, and to provider networks – can be put to good use by dentists and dental societies, as discussed below.

The Sherman Act

Congress enacted the first of the core antitrust laws over 100 years ago to protect the public by promoting competition, including by assuring that each individual or firm competes independently. Among the early targets were oil companies, railroads, tobacco and steel firms that had become so large that, by themselves or in combination with their competitors, they had both increased prices and driven competition out of their marketplaces, to the detriment of the public.

The antitrust law most relevant to dentists is Section 1 of the Sherman Act[4]. That statute prohibits any contracts, combinations or conspiracies ("concerted action") that unreasonably restrains competition. Two elements must be present to establish a violation of this law:

The antitrust law most relevant to dentists is Section 1 of the Sherman Act.

1. concerted action which produces
2. an unreasonable restraint of competitio

Concerted Action

The key to concerted action is that it takes two to tango—truly unilateral activity is not a Sherman 1 risk (although it is addressed under Section 2). The requirement of concerted action reflects an underlying belief that the risk to competition increases when rivals combine forces instead of pursuing their market goals as individual economic actors. That said, a formal written agreement is not necessary to satisfy the concerted action element of the Sherman Act. An informal understanding can be sufficient: even a "wink—wink, nudge—nudge" understanding, between two dentists can establish concerted action. (Indeed, one of the first English common law cases of conspiracy involved two people sneezing at the same time in church).

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[4] Among the other key federal antitrust laws are:

- The Sherman Act, Section 2, which prohibits monopolization, conspiracy to monopolize, and attempt to monopolize
- The Clayton Act, which prohibits conduct such as certain exclusive dealing and tying arrangements, mergers and interlocking corporate directorates

Action by a dental society will almost certainly be considered to satisfy the concerted action element of the Sherman Act. Subject to certain limited exceptions, the laws view dentists as competitors, and deem dentists joined together in a professional association as a combination of competitors (i.e., acting in a concerted manner). For practical purposes, a dental society can be said to amount to "a walking conspiracy" in this respect. It is critical, therefore, that dental societies exercise care so their actions do not unreasonably restrain competition.

Action by a dental society will almost certainly be considered to satisfy the concerted action element of the Sherman Act.

Informal groups of dentists are likewise at risk. A dental study club meeting, and even for informal discussions among dental friends or acquaintances, can constitute concerted action. For example, a price fixing agreement might be inferred if dentists meet, discuss fees, and then begin charging the same fees. Thus, dentists should avoid sharing fee information, or any group activity that could effect competition, without first consulting with legal counsel.

Informal groups of dentists are likewise at risk.

In contrast to concerted action, independent actions by single entities do not constitute agreements for purposes of the Sherman Act. An individual dentist or a professional corporation count as single entities for antitrust purposes. Thus, acting independently, the dentist or corporation can make its own marketplace decisions without antitrust concern – it takes two to tango; without concerted action, conduct undertaken independently by a single entity cannot violate Section 1. Moreover, under a concept called "conscious parallelism," the fact that all or some single entities make the same business decision is still not a problem, provided they truly acted independently. This kind of "leader-follower" behavior may be common in some industries and even reflect vigorous competition. In contrast, if concerted action can be proven or reasonably inferred, and the conduct is anti-competitive, there is an antitrust problem.

Restraint on Competition

Concerted action alone is not an offense unless it is also unreasonably anti-competitive. Reasonableness is tied to whether the restraints materially and adversely affect competition in the relevant market, e.g. by increasing prices or decreasing output.

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- The Federal Trade Commission Act, which in addition to prohibiting practices barred by the Sherman and Clayton Acts, prohibits unfair and deceptive practices, and
- The Robinson-Patman Act, which prohibits certain types of price discrimination and other payments and allowances.

In addition, all 50 states have their own antitrust laws, which while usually similar to the federal laws, may impose even higher legal standards. These state antitrust laws are typically applied to more local activities that may lie beyond the reach of federal antitrust laws and reflect some of the specific concerns of individual states with respect to anti-competitive practices in their local economies.

While the law has evolved a more nuanced set of measures to judge alleged antitrust violations over the last quarter-century, two key landmark standards are still used to assess the competitive consequences of challenged conduct: rule of reason and *per se* analysis. Most conduct is examined under the rule of reason, under which a court examines all relevant facts and weighs the evidence of pro-competitive and anti-competitive effects of the activity. Rule of reason cases are difficult to win for plaintiffs, because they require significant evidence of actual or very likely anti-competitive effects. On the other hand, they can be costly to defend for defendants, who may be required to produce extensive amounts of evidence before it becomes clear that the plaintiffs cannot prevail.

Two key landmark standards are still used to assess the competitive consequences of challenged conduct: rule of reason and per se analysis.

Per se analysis comes into play with certain types of conduct that are considered always to be anti-competitive – they are presumptively unreasonable. The conduct is so egregious that courts do not consider evidence about the purpose, effect, or justifications of such conduct. In legal terms, the presumption is "irrebuttable." These types of conduct are said to be *per se* illegal, regardless of their purpose or their actual effect on competition. It is only the *per se* illegal types of agreements that the Department of Justice prosecutes criminally.

The type of concerted action most likely to be prosecuted criminally is a price fixing agreement, which is simply an agreement or understanding among competitors to fix, stabilize, or change (typically by raising) prices or to charge a particular fee. For example, if two or more dental groups in a town agreed with each other upon the fees they would charge for restorative care, their conduct would be a price fixing agreement and illegal *per se*. It would also be price-fixing for competing dentists to agree not to lower prices, or to agree on a maximum fee.

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Another type of agreement that may be considered *per se* unlawful is a group boycott or concerted refusal to deal. A group boycott is an agreement among competitors to refuse to deal with another competitor, a supplier, or a customer in order to suppress competition. Group boycotts in dentistry have generally involved dentists jointly: (1) refusing to deal with an insurance plan, e.g. until certain contract terms are met and/or (2) refusing to respond to insurance plan requests, e.g., by refusing to submit radiographs in response to third party utilization review requests. Boycotts can also be a means to enforce a price-fixing agreement, as when a group of competitors refuses to sell their services unless the buyer agrees to a specified price or price level.

Another type of agreement that may be considered per se unlawful is a group boycott or concerted refusal to deal.

Boycotts of this type are very likely to be found illegal either as *per se* violations or under a rule of reason analysis.[5]

Not all potentially anti-competitive conduct falls squarely within the *per se* or rule of reason categories, and in practice these categories can be more flexible. In fact, two of the most well-known antitrust cases involving conduct in the dental care industry illustrate that flexibility. For example, when dentists collectively refused to provide x-rays to third party payors in the *Indiana Federation* case, the Supreme Court declined to apply the *per se* rule, because it was plausible that the dentists had some legitimate reasons for doing so. The Court noted, however, that nothing more than a "quick look" was needed to determine that the conduct was anti-competitive, because it was so likely to thwart cost-containment efforts of the payors. This "quick look" approach is an abbreviated version of the rule of reason. On the other hand, the Supreme Court rejected the FTC's effort to prosecute the California Dental Association for certain restrictions on dentist advertising using a "quick look," because the FTC failed to produce any hard evidence that the restrictions in fact led to anti-competitive effects, such as higher prices.[6] In lieu of such evidence, the FTC sought to rely on studies of advertising in other areas and argued that restrictions on advertising should be viewed as inherently suspect. The Court appeared to hold that use of the "quick look" should be reserved for cases of hard evidence of anti-competitive effect.

[5] A third type of agreement that may be *per se* unlawful is a market allocation arrangement. Examples of such an arrangement include agreements among competing dental groups regarding the geographic area that each group serves or the managed care plans with which they will deal. In practice, market allocation agreements involving dentists are highly unusual. A restrictive covenant between a dentist practice owner and an associate is a narrow type of market allocation agreement, but it is almost always viewed today as reasonable, provided the terms are not more expansive than necessary. Most such agreements, which apply at the termination of an employment contract are ancillary to an employment agreement that enables the employer to hire additional professionals and to compete more effectively. Accordingly, a covenant not to compete is judged under the rule of reason. Most courts will uphold the validity of such agreements, when challenged, if the geographic scope of the covenant and its duration are narrowly drawn. A minority of courts, however, believe such agreements, which by their nature can restrain trade, are void as against public policy.

[6] The case and its significance is discussed more fully below.

Choice and Competition

As noted above, every dentist may independently decide whether to contract with an insurance plan. Independent choice is a cornerstone to safe action: your personal choice about whether to participate in managed care; your personal choice in establishing your fees and terms of payment; your patients' choice of dentist; your ability to talk with your patients about these choices. All of these things can be done safely, legally. Ultimately, deciding whether to join a managed care plan can be viewed as a business twist on informed consent: What's really at issue is your consent, your individual informed choice, based on what's right for you, personally and professionally. An illegal restraint of competition can arise only when the dentist makes this decision as part of a group of otherwise independent, competing dentists. Even when acting independently, dentists must be careful not to use the threat of a group boycott in negotiations with third party payors or in other ways. For example, the enforcement agencies may infer a boycott if a third party is telling dentists not to sign with a particular plan, and a significant percentage of dentists in the market decide not to sign. A reasonable inference is enough to establish concerted action.

Independent choice is a cornerstone to safe action.

In sum, the touchstone of Section 1 of the Sherman Act is competition. Neither the courts nor the enforcement agencies will look favorably at agreements which suppress competition, unless perhaps there is a pro-competitive justification. On the other hand, they will respect appropriate competitive activity, such as the normal operation of integrated dental practices, appropriate niche marketing of insurance free practices, or legitimate discussions with patients about practice decisions and proper promotion of fee-for-service dentistry, including Direct Reimbursement. Dentists and dental societies should secure competent legal advice concerning whether a proposed course of conduct constitutes concerted action and, if so, whether the conduct may be unreasonably anti-competitive.

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Exceptions

There are a number of exceptions (some of which are statutory exemptions) to the antitrust laws. Four are of particular relevance to dentistry: two because they can be used proactively to help level the playing field, and two because their effect on the playing field seems too often to be misunderstood.

1. Lobbying and Lawsuits

Perhaps the most important exception for dentists arises out of the right to petition the government. The right, as protected by the First Amendment to the United States Constitution, extends to petitioning the government through the executive branch, the legislature, administrative agencies and the courts. As captured under the so-called Noerr-Pennington doctrine (as a result of court decisions by those two names), this protection permits individuals and others, including dentists and dental societies, to collectively advocate government action even if that action would harm competition, provided that the advocacy is in good faith. A classic example is that while dentists may not threaten to boycott state's Medicaid program unless reimbursement rates are increased, they may lobby the legislature or insurance commissioner for changes in the law or regulations to raise reimbursement levels. Likewise, good faith lobbying on Any Willing Provider or Assignment of Benefits legislation is permissible.

Perhaps the most important exception for dentists arises out of the right to petition the government.

The good faith requirement to this lobbying exception is important. "Sham" efforts to secure legislation or to secure court action, as through filing law suits, are not protected. But to establish that petitioning activity is a sham, a challenger has to demonstrate that the petitioning activity was "objectively baseless," i.e. that no reasonable person could realistically have expected to achieve success, and, if it meets that standard, that the petitioner intended solely to burden competition. Lobbying that focuses on patient care is usually safer than lobbying about marketplace effect. In the prior example, good faith may be more readily established if the tie between an increase in reimbursement rates and enhanced patient care is advanced as part of the equation.

The good faith requirement to this lobbying exception is important.

It is critical to note that by inviting communication among other dentists or dental societies, even good faith efforts can create very significant risks of the protected lobbying activity "spilling over" to the marketplace and creating obvious antitrust risks; e.g. through efforts to secure passage of a patient protection bill to rein in insurance company abuses, rival dentists illicitly agree to a "code" that dentists should not join plans that are believed to engage in the practices objected to in the legislation.

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As dentistry becomes increasingly sophisticated in its use of Noerr-Pennington, consideration about spillover takes on even more importance. For example, caution should be taken to protect a wonderful public affairs program promoting a legislative agenda from creating an antitrust nightmare. Efforts to promote the legislation to legislators and to both media and members should focus narrowly on the lobbying component, taking pains to avoid calling for inappropriate marketplace activity.

Worthy of note is that the FTC in recent years has undertaken well-publicized efforts to limit the scope of this exception, in part in response to a trend in the courts appearing to expand it and the FTC's view that anti-competitive legislation cloaked in Noerr-Pennington protections can be costly for consumers. This should suggest the value of the exception to dentistry, and the importance of securing timely advice from competent antitrust counsel before relying on it. Three great examples are ADA's class action lawsuits against insurance carriers to rein in abuses and protect the doctor-patient relationship: they were filed when the courts began accepting such suits under the then current interpretation of Noerr-Pennington.

2. State Action

Another important exception to antitrust laws flows from the states' immunity from suit under the Sherman Act. Under the "state action exemption," states cannot be sued for their own anti-competitive acts under the Sherman Act. As an extension of that immunity, individual states also can immunize the actions of private parties through legislation, provided two conditions are satisfied: the state must clearly articulate its desire to displace competition and it must actively supervise the activity it wishes to make exempt. For example, a state can pass legislation exempting dentistry – or, more realistically, certain types of behavior by dentists, potentially even fee sharing -- from both federal and state antitrust laws.

Another important exception to antitrust laws flows from the states' immunity from suit under the Sherman Act.

Whether any particular state law satisfies the active supervision requirement depends on the specifics of the laws and its implementation: the more active the state's oversight, the more likely that the intended antitrust relief will be created. The state cannot leave implementation to private parties. In contrast, paying mere lip service to the active supervision requirement will not create the intended relief. Obviously, the decision to seek such legislation will raise questions about the relative desirability of state regulation.

Whether any particular state law satisfies the active supervision requirement depends on the specifics of the laws and its implementation.

It should also be noted that the state action doctrine may provide only a defense to liability, not immunity from being sued. The difference is illustrated by a case brought in 2003 by the FTC against the South Carolina State Board of Dentistry. The administrative complaint accuses the Board of unlawfully restricting competition when it adopted a regulation that barred dental hygienists from providing certain kinds of preventive dental care services to school children unless the child had first been examined by a dentist. In the FTC's view, the Board's claim of state action immunity was invalid, because in generally authorizing the Board to regulate various aspects of dentistry, the state did not express a policy to displace competition. One possible lesson from the case, which is still being litigated, is that

it may take a Board or Society years of litigation to establish whether it has a valid defense based on the assertion of the state action doctrine.

3. The Insurance Exemption

Many dentists are aware that the insurance industry enjoys a limited exemption to the antitrust laws, meaning that some insurance industry activities will be protected from antitrust scrutiny. The exemption, known as the McCarran-Ferguson Act, applies to the extent state law regulates the "business of insurance," and allows for activities such as joint data collection and sharing. Would eliminating this exemption level the playing field?

It may take a Board or Society years of litigation to establish whether it has a valid defense based on the assertion of the state action doctrine.

There have been a number of Supreme Court cases defining the meaning of the "business of insurance," and thereby limiting the scope of the exemption. Another important limitation is found in the Act: McCarran-Ferguson establishes that agreements to boycott, coerce or intimidate, or acts of boycott, coercion or intimidation, are not exempt from the antitrust laws. The Supreme Court has broadly construed the term "boycott" under McCarran-Ferguson, thereby further limiting the exemption.

While this exemption gives insurance companies some antitrust latitude, it does not confer upon them the right to create or benefit from the oft-criticized unlevel playing field. Indeed, in most cases that dentists believe to be problematic because of the McCarran-Ferguson Act, the real culprit turns out to be the economics of managed care, and the limited scope of the Sherman Act or related laws concerning unfair competition. McCarran-Ferguson addresses insurance companies sharing information, not the usual complaint that a particular insurance company is abusing excessive market power. Eliminating McCarran-Ferguson would thus not truly level the playing field.

In most cases that dentists believe to be problematic because of the McCarran-Ferguson Act, the real culprit turns out to be the economics of managed care, and the limited scope of the Sherman Act.

However inequitable it may seem, under the antitrust laws an individual dentist and an insurance company are each viewed as a single entity. The only solutions in that regard would be a repeal or modification of the Sherman Act to allow dentists to band together in order to more effectively compete with dental plans. That, however, is not the law, or in any credible antitrust crystal ball.

4. The Labor Exemption (Unionization)

Another approach that sometimes surfaces as a potential counterbalance to managed care is unionization of health care practitioners. The nation's antitrust laws would apply fully to the activities of any dentist union. Indeed, in the *Indiana Federation* case discussed above, the Supreme Court upheld findings of antitrust violation by a union of dentists.

The unionization theme persists due to misinterpretation of certain labor exemptions to the antitrust laws. The exemptions essentially immunize from antitrust scrutiny otherwise unlawful restraints resulting from a collective bargaining relationship between a union and employer, on the premise that those mainly affected by the agreement have consented to such restraints. The key point is the exemption applies only to nonsupervisory employees in collective bargaining with their employers – for example, salaried dentists employed by a hospital clinic.[7]

Some health care professional unions have suggested that the terms and conditions of managed care companies make practitioners *de facto* employees of the plan. But there is no case law supporting a right to bargain collectively on this basis. Claims by health care provider unions that their members are exempt from, or receive more lenient treatment under, the antitrust laws should be viewed with caution.

The labor exemption does not extend to collective bargaining by independent practitioners. Accordingly, dentists participating in managed care programs are not likely to qualify as "employees" entitled to protection under the labor exemption, particularly when their contracts typically specify that they are independent contractors, not employees. In light of the potential antitrust consequences, nonemployee dentists should not be misled that unionization is the answer to their questions about managed care.

The labor exemption does not extend to collective bargaining by independent practitioners.

Banding Together

As noted above the antitrust laws do not prohibit conduct by an individual dentist or corporate practice, including a refusal to participate in any third party payor's program, as long as the conduct represents an individual decision based on the dentist's or corporate practice's independent judgment and is not based on any understanding with other dentists about whether to participate. In addition, it is highly unlikely that the competitive decisions of a fully integrated group practice would result in an unreasonable restraint of trade. Fully integrated practices should feel free to set their fees and make decisions about participation in managed care programs. A merger of two dental practices into a single practice is full integration.

[7] The definition of "employee" under labor law does not include "any individual having the status of independent contractor, or any individual employed as a supervisor." In addition, the term "supervisor" is defined as "any individual having authority, in the interest of the employer, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward or discipline other employees, or responsibly to direct them, or to adjust their grievances, or effectively to recommend such action, if in connection with the foregoing the exercise of such authority."

Sometimes dentists who remain competitors for some purposes will form a joint venture to practice more efficiently or to offer a service that they could not offer as effectively without the venture. Ventures of this nature involve partial integration of the dental practices. In dentistry, this occurs in Individual Practice Associations (IPAs), which are loosely bound entities formed to allow dentists to collectively negotiate contract terms such as fees.

Most agreements involving partially integrated ventures are not naked restraints of trade, and are thus analyzed under the rule of reason. Among the usual fact questions are whether the venture: 1) is truly integrated; 2) is formed for legitimate purposes; 3) does not include too many competing dentists in an area; 4) prevents the formation and operation of similar entities; and 5) adopts any restrictions on competition that are not reasonably related to the achievement of their legitimate purposes or are greater than necessary to do so.

As discussed above, the DOJ/FTC statements issued in the mid-1990's created "antitrust safety zones" to help level the playing field. Two approaches that come into play relative to banding together are "Physician Network Joint Ventures" and the "Messenger Model." While each has received favorable opinion letters from the enforcement side, each carries its own limitations and risks:

The DOJ/FTC statements issued in the mid-1990's created "antitrust safety zones" to help level the playing field. Two approaches that come into play relative to banding together are "Physician Network Joint Ventures" and the "Messenger Model."

- The principle behind Physician Network Joint Ventures applies in dentistry in the form of Individual Practice Associations. In essence, the agencies are not likely to challenge exclusive IPAs with up to 20% of the number of providers in the relevant market, or non-exclusive IPAs with up to 30% participation. As set forth in the statement, "[i]n an 'exclusive' venture, the network's physician participants are restricted in their ability to, or do not in practice, individually contract or affiliate with other network joint ventures or health plans. In a 'non-exclusive' venture, on the other hand, the physician participants in fact do, or are available to, affiliate with other networks or contract individually with health plans." The agencies will be open to even larger percentages provided that they have a pro-competitive effect.

  There must be significant risk sharing by the IPA providers. This can be achieved by means such as an agreement by the providers to accept capitation payments, or to withholds of an agreed percentage of reimbursement tied to cost containment measures.

  Whether an existing or proposed IPA will fall into the "safety zones" should be assessed by competent antitrust counsel, who can also consider risks associated with improper use or characterization of the IPA.

- Unlike the IPA approach, the Messenger Model is not limited with respect to the number of dentists who might participate. Theoretically, the model can be safely used by providers to exchange information with prospective purchasers of their services about acceptable fees while avoiding unlawful price agreements, and thereby facilitate fee negotiations by acting as a messenger between individual doctors and an insurance company. In essence, providers wishing to use this model would employ a messenger, who would act as their agent to funnel fee or non-fee information back and forth between them and the prospective purchaser.[8] Using this model for only non-fee activities might be one way to lessen any potential exposure.

  While the messenger model can provide a useful tool as a go-between providers and insurers, it is imperative that the providers in question do not share their information with one another; in other words, they can communicate with the messenger, but not each other. Further, the messenger is there to facilitate the flow of information, but cannot share the information received from individual providers with other providers, and is also precluded from negotiating price-related terms on behalf of the network. If any of these lines is crossed, the providers and the messenger could be at substantial antitrust risk – indeed, even a good faith violation could lead to *per se* antitrust liability.

  If you consider using a messenger model, it would be prudent to review recent DOJ and/or FTC opinion letters, and consider seeking an opinion in advance from one of those agencies about your plans. Keep in mind that being blessed by the agencies in advance is not a guarantee about the future. Indeed, provider groups that have misused the Messenger Model have found themselves in the clutches of antitrust enforcement. Competent counsel is needed if considering the model.

[8] Providers can advise the messenger – on an individual basis -- about the fees they would be willing to accept. They can also empower the messenger to agree to certain price terms on their individual behalf's if the purchaser is willing to pay at certain levels. Based on the information supplied by individual providers, for example, the messenger could be empowered to advise the purchaser that X% of the dentists are willing to participate if the provider pays at Level 1, but that the percentage would go up to Y% if the provider were to pay at the higher Level 2. In this way, the messenger can facilitate the flow of information back and forth between providers and purchasers.

Dental Society Action

Dentists sometimes ask what their societies can do to stop insurance plans from gaining a foothold in their markets. Dental societies are not in the business of trying to stop insurance companies – indeed, to do so could create substantial antitrust risk for the society and those involved. Whether and how to participate in insurance plans, including managed care or any particular plan, is an individual decision each dentist must make.

Dental societies must recognize that the antitrust laws view them as a "walking conspiracy." In other words while dentists members think of themselves as colleagues, the law views them as competitors. And when a society acts on their behalf, the "concerted action" element of Sherman 1 is met.

Sensitivities

What can a dental society do on behalf of its members in this arena without restraining competition?[9] Dental societies should be particularly sensitive to discussions about refusal to participate, negotiation of terms, and discussion of fee levels. These can serve as useful leverage in dealing with third party payors. But, any activity of this nature must not be concerted and must be conducted only with the assistance of experienced antitrust counsel. Dentists should be vigilant to assure that the discussions do not stray to agreements as to appropriate fee levels. And, groups of dentists should never threaten a payor with group nonparticipation if the payor refuses to accept dentist demands. As discussed below, dental societies should also remain cautious about expansive regulation of advertising, especially in the absence of documented areas of abuse from deception.

What can a dental society do on behalf of its members in this arena without restraining competition?

Opportunities

That said, dental societies are in a unique position to safely address third party payor issues, provided they do not restrain trade in the process. Dental societies represent dentists on all issues economic, educational and ethical. Dental societies have continuing relationships with the groups most responsible for the issues facing dentists today: the legislatures, government agencies, and payors. There are many examples of what dental societies can do without risking antitrust liability, including the following that you may wish to discuss with your counsel:

Dental societies are in a unique position to safely address third party payor issues, provided they do not restrain trade in the process.

[9] For reasons set forth above, much of this discussion would apply to informal groups of dentists, such as study clubs, as well.

1. *Dental societies may ask legislatures, courts and other government agencies in good faith for any actions, as long as there is no threat that the dentists as a group will refuse to participate if their requests are denied. As noted above, good faith in this context typically means that there is a legitimate basis for making such requests, and a genuinely desired outcome.*

   Examples: The ADA is at the forefront of advocacy efforts to rein in managed care and insurance company abuses, so that dentists will be able to best serve their patients. Recent examples: ADA's three class action suits against insurance companies; ADA's lobbying for patient protection legislation.

2. *Dental societies may evaluate the meaning and effects of dental provider contract proposals, provided that the analysis is neutral and leaves the decision whether to accept particular proposals is left to individual dentists or group practices. Dentists are permitted to learn whatever they need to know to make an informed decision about whether to participate in a third party plan, and their societies can help supply needed information. There should not, however, be a suggestion, even if hidden or implied, that dentists should not participate in a plan.*

   Examples: ADA Division of Legal Affairs' Contract Analysis Service, including documents such as What Every Dentist Should Know before Signing A Dental Provider Agreement and the Model Contract for Third Party Dental Service Agreements. The ADA also offers members information about practice options, including managed care, to help members make informed individual decisions about how to practice.

3. *Dental societies may express concerns of their members about proposals to third party payors and even submit recommended changes, provided there is no threat of concerted action if the recommended changes are rejected, and that no such action takes place.*

   Examples: ADA has ongoing discussions with national third party carriers (e.g. Delta and Aetna) and carrier groups (e.g. the National Association of Dental Plans) on an array of issues of concern to our members and the patients they serve

4. *Dental societies may, either directly or through a consultant, express to payors the views of their members on issues not relating to fees. Among acceptable topics are the procedures and services covered, the claim forms required, and utilization and peer review procedures. The society can effectively present the views of its members on such non-fee issues, as long as it avoids implied or direct threats of boycotts.*

Examples: ADA has given direct, often written critique to specific payor practices not related to fees, ranging from complaints about payors' processing policies, to commenting on unfair EOB language.

5. *Dental societies may collect and release price and cost data – including about fees and staff compensation – provided they do so properly. The DOJ/FTC Statements provide a "safety zone" for exchanges of such data, meaning that societies can take on that role if they do so properly. The "safety zone" is subject to specific conditions, including that the data be at least 3 months old and that it be aggregated in specified ways. Perhaps most importantly, the data must not be used by providers for discussion or coordination of prices or costs. Using an independent data collector can help protect against this risk.*

   Examples: ADA collects and releases substantial survey data for individual member use, including information about fees and costs. ADA data is also readily used to facilitate public policy development, e.g. a study of the economic aspects of independent hygiene practice, as it relates to affecting access to care for the underserved.

6. *Dental societies may properly express the views of their members that particular fees and reimbursement levels should be raised. A dental society may not suggest, imply or threaten that its members will refuse to participate in the plan unless reimbursement is increased. Moreover, a society runs a substantial risk by suggesting specific fee levels if the members subsequently demand that fee or threaten to p articipate if it is not met.*

   Examples: ADA has released fee data to support hikes in reimbursement rates, particularly in support of Medicaid litigation intended to address access to care issues.

Payor Market Power: Monopoly and Monopsony (Sherman 2)

Health care providers often very understandably feel that the playing field must be leveled because the practices of certain large insurance companies, due to their dominant market power, are virtually by definition anti-competitive. This takes us from Sherman 1 to Sherman 2, which prohibits monopolizing, conspiring to monopolize, or attempting to monopolize through anti-competitive means.

Health care providers often very understandably feel that the playing field must be leveled because the practices of certain large insurance companies, due to their dominant market power, are virtually by definition anti-competitive.

First, it is important to understand that mere size alone is not an offense under the antitrust laws. To safeguard the incentive to compete legitimately and win, monopolists who succeed through their skill, as through producing better products at lower prices, are not subject to liability. For any firm to violate Section 2, it must not only be big, but it must also be "bad" – i.e., it must undertake some kind of conduct that is deemed "exclusionary."

To be subject to a serious allegation of monopolization under Section 2, an insurer would have to have "monopoly power" (typically thought of as requiring a share in excess of 70% of the relevant geographic and product market), or, for a claim of attempted monopolization, significant "market power" (often inferred from a 50-60% share of the relevant product and geographic market). This would be a rare occurrence, however, given marketplace conditions around the country, not to mention the definition of relevant market used by the federal courts and enforcement agencies.

But establishing a firm's size would only mark the beginning of the inquiry. A challenge would also have to demonstrate that the insurance company was engaged in some kind of predatory or exclusionary conduct, which is also defined very narrowly. Merely utilizing "bargaining power" would not satisfy the standard, unless it could be shown, for example, that the reimbursement rates were below dentists' costs.

Monopsony purchasing as an exercise of market power assembled through carrier concentration...is difficult to prove to the satisfaction of the courts or agencies.

Given the limits of the monopoly argument, some opponents of managed care turned to a related theme, with a twist: monopsony purchasing as an exercise of market power assembled through carrier concentration. Monopsony theory is a buyer-side application of monopoly theory that is designed to explain the consequences of one buyer in a market with multiple sellers. This too, however, is difficult to prove to the satisfaction of the courts or agencies, which tend to demand hard data and, if they get it, offset the data with arguments about pro-competitive effects, such as cost efficiencies, that the companies are said to be having in the marketplace.[10]

[10] A thoughtful paper suggesting the presence of monopsony in select dental markets did not lead to action by the agencies. An Examination of Dentists' Fee Discounts and Prepayment Carrier Concentrations, D. House, http://www.ada.org/ada/prod/survey/publications_health.asp

The larger problem confronting dentists in interactions with third party payors and managed care firms can be viewed as more a function of the economics of the health care industry today than any specific feature of the antitrust laws. First, there are economic asymmetries that explain why dentists are poorly situated to bargain with third party payors. There are enormous economies of scale that come from spreading risk and insuring large numbers of patients, but relatively modest economies of scale that come from integrating practice groups. As a consequence, for the foreseeable future third party payors will remain large relative to dental groups. This is true in many other industries as well. For example, Wal-Mart's suppliers frequently are heard to complain that it is pressuring them to reduce price to unreasonably low levels.

Second, a major reason why the federal government agencies don't go after the "big guys" is that the typical complaint about them is that they are pressuring prices DOWN. As long as that pressure is not driving dentists below cost and hence out of business, or is demonstrably impairing the quality of dental care, it is likely to be viewed by courts and antitrust enforcers as positive from the point of view of competition. In contrast, when physicians, dentists and other professionals have been prosecuted, it is frequently based on the accusation that they are trying to respond to downward pressures on price by driving prices UP. Remember our first rule of thumb: "prices up; antitrust risk up."

A major reason why the federal government agencies don't go after the "big guys" is that the typical complaint about them is that they are pressuring prices DOWN.

Advertising Restrictions and Codes of Ethics

One of the areas of professional conduct that has been subjected to a great deal of antitrust scrutiny involves restrictions on professional advertising, often in the context of codes of ethics. It is important at the outset to understand that the agencies and Courts have long rejected the idea that competition can somehow be viewed as inherently "unethical" among professionals. One of the foundation cases involved a ban on competitive bidding adopted as part of the code of ethics of the National Society of Professional Engineers. The Society argued that engineers should be selected based on their qualifications and the quality of their proposed work, not price. In its view, competitive bidding was inherently imprecise, would lead to cutting corners and deceptively low bids, and ultimately to sub-standard specifications that would threaten public safety – in essence, that price competition in the context of engineering services was harmful and hence unethical. These arguments could just as easily be made in the context of any other kind of professional services, including the provision of dental care. But the Supreme Court roundly rejected the Society's position as a "frontal assault on the basic policy of the Sherman Act." The statutory policy in favor of competition, it reasoned, "precludes inquiry into the question whether

competition is good or bad." And the fact that the restrictions were cloaked in a code of ethics could not insulate them from scrutiny.

Similarly, there have been a significant number of antitrust cases involving challenges to restrictions on advertising contained in professional codes of ethics. It is not difficult to understand why they have attracted so much attention. First, as discussed above, the conduct of societies or other groups are "walking conspiracies" that will almost always satisfy the first requirement for a Sherman Act Section 1 claim, "agreement." This is especially true when a society adopts an advertising ban that is express and is included in the professional code of ethics of the group. Also clear is that advertising is a form of competition. So restrictions on advertising by their nature are restrictions on competition that may touch on the ever-sensitive issue of price. For these reasons, the antitrust agencies continue to scrutinize agreements by rivals that limit advertising, through codes of ethics or otherwise. The primary issue, therefore, is whether any given ban is a reasonable restraint on competition or an unreasonable one.

As a general matter, there is little antitrust risk involved in prohibiting "deceptive" or untruthful advertising, provided there are workable definitions of deception and they are reasonably and consistently enforced. The more challenging cases arise when professionals go further and try to ban all or substantially all advertising, or specific kinds of advertising, on the ground that it is inherently deceptive or otherwise "unethical."

The *California Dental Association* case, referred to above, was a groundbreaking case in the area. In *CDA*, the FTC unsuccessfully challenged regulations on certain kinds of advertising. In lieu of specific evidence that the restrictions had an actual anti-competitive effect, such as raising price, the FTC relied on its view that advertising restrictions adopted by rivals are inherently anti-competitive. The Supreme Court concluded that the FTC could not simply rely on its expertise and advertising studies from other industries to make its case – it had to present specific evidence that the *CDA*'s restrictions had anti-competitive effects. Otherwise, it was not necessary for the *CDA* to present evidence of the restrictions' pro-competitive effects.

CDA was a very significant victory for professional regulation of advertising – but not without limitations. It makes clear that the FTC will not be permitted to argue simply that restrictions on advertising are somehow automatically anti-competitive. Dental societies, therefore, may have some leeway in regulating dentist advertising. However, when restrictions on advertising in fact lead to demonstrably higher prices or fewer kinds of alternate dental

procedures, *CDA* may not present a significant hurdle for the FTC or private challengers. In such cases, if the FTC presents evidence of the restrictions' adverse effects, the society may be required to justify its actions in competitive terms.

Recent post *CDA* cases open the question of how much case specific evidence the FTC would need to present to shift the burden of proof. How courts interpret the "rebuttable presumption of illegality" in cases where an alleged restraint is "inherently suspect" should be carefully considered with counsel. Antitrust cases can be lengthy, time consuming and expensive to defend. Continue to watch how the *CDA* case is interpreted by the courts.

Compliance Programs

As noted above, the antitrust laws certainly do not prohibit a dental society from educating its members about the law in general or antitrust law in particular. Indeed, it is prudent that every society consider how it will ensure antitrust compliance.

The needs of any particular society in this regard will vary according to its size, staffing, access to legal counsel (in-house or otherwise), operations, meeting opportunities, use of electronic communications, location, marketplace conditions, the society's culture and willingness to take risk, the composition of its membership, and many other factors. Accordingly, there is no one-size fits all antitrust compliance program for dental societies. Some will rely extensively on their legal counsel and have them present both before and during key meetings, others have no lawyer on call; some will have antitrust compliance requirements read at the beginning of meetings, others may prefer to conduct ongoing antitrust training. Some may do nothing at all.

There is no one-size fits all antitrust compliance program for dental societies.

While needs and resources vary, there are some sensible steps that all dental societies can benefit from considering, as appropriate, as set forth in the following chart:

ANTITRUST COMPLIANCE CONSIDERATIONS
FOR DENTAL SOCIETIES

- Educate your leadership and staff about the antitrust laws. One good step in that process? Have your leadership and staff read this book!
- Have your leadership and staff certify in writing whatever your policy requires, e.g., reviewing the policy, reading this book, etc.
- Conduct ongoing leadership and staff training.
- Consider identifying an antitrust compliance officer – a "go to" person on antitrust issues, who can respond to inquiries and provide some ongoing guidance when questions that trigger antitrust concerns arise.
- Use your lawyer wisely and well: require clearance by counsel before embarking on potentially risky path(s) of action (e.g., meetings and/or products or services addressing perceived third party carrier abuses), have your counsel at key meetings that appear to pose meaningful risk, and after the fact if there is a charge of an antitrust violation.
- In particular, consult with counsel about what types of compliance efforts make sense for your society, e.g., how extensive, how formal, etc. (A quick internet search on antitrust compliance polices will provide numerous things to think about and discuss with your attorney – looking at the policies of professional societies other than dentistry can be particularly illuminating!)
- Always have someone available to answer questions from individuals covered by your antitrust protocols.
- Coordinate your antitrust compliance efforts, protocols and/or policies with your other policies, e.g., Sarbanes-Oxley Act compliance policy.
- Audit your progress, both via internal checks and, if necessary, an external antitrust audit.

THE ANTITRUST LAWS IN PRACTICAL TERMS

Below are several examples of situations that dentists may experience, primarily involving fees and reimbursement, together with a brief explanation of their probable antitrust ramifications.

Antitrust analysis is highly fact-intensive. All the facts of a particular situation, including facts that may appear on the surface not to be relevant, can be very important. Small changes in facts can lead to different results. So, these examples are presented only to give a basic idea of how the antitrust laws work in practical terms. A dentist or dental society always should consult a lawyer concentrating in healthcare antitrust law before undertaking specific conduct with potentially significant competitive consequences, especially conduct involving competitors and fees.

In reading through these examples, it may be helpful to think about the dentist's or society's goals, and to consider whether they might be achieved without taking on as much risk as may be implicit in the example. A number of effective, safer approaches are offered in the text below, to stir your thinking about relative levels of risk.

1. *Ten independently practicing dentists in a city of over 350 dentists agree to increase the price of an office visit by 10%.*

   This is a naked price fixing agreement that is *per se* illegal. It does not matter that only ten of 350 dentists participated. Indeed, even two would constitute concerted action.

2. *The same ten dentists agree to form a professional dental corporation, fully integrate their offices, and practice together for all purposes. They then agree to charge $75 for an office visit.*

   Assuming the group does not include all or most of the dentists or members of a particular specialty or type of practice in the area, this arrangement raises no antitrust problem. Because the dentists have fully integrated their practices through the professional corporation and thus are a single dental practice, their agreement about fees would not violate Section 1 of the Sherman Act. However, dentists must be careful not to include too large a percentage of the dentists in an area within the integrated practice. In that case, the creation of the integrated practice itself could raise antitrust concerns.

3. *After the formation of their professional corporation, the corporation's business manager meets with the business manager of another group practice, and they agree to increase*

the groups' fees by 5%. Other practices, concerned about antitrust scrutiny, decide simply to share fee data, but based on that data, they tend to increase prices at the same times and in similar amounts.

The agreement to increase fees is a naked price fixing agreement that is *per se* illegal. The business manager and the corporation could be indicted. If the business managers were acting at the direction or with the approval of the dentist share holders, the dentists could be indicted, also.

Sharing fee data without an express agreement to set fees can also expose a dentist to a charge of *per se* violation of the antitrust laws, but it is not necessarily a violation in and of itself if certain safeguards are maintained. In this example, the fact that the dentists sharing data later altered their rates in similar ways is significant, and could be used in conjunction with the data sharing to infer an agreement to fix prices.

Sharing fee data without an express agreement to set fees can also expose a dentist to a charge of per se violation of the antitrust laws.

To avoid creating significant legal risk — both criminal and potentially expensive civil liability exposure — sole practitioners should set their own fees individually. This determination of the market value of their services need not occur in a vacuum: in deciding what to charge, a dentist is free to look at appropriate fee surveys, which may be commercially available, public documentation, such as competitors' newspaper advertisements, and other means that would not constitute concerted action or allow an agreement to price fix to be inferred. When dentists undertake themselves to gather fee data from rival dentists, however, antitrust risks increase.

To avoid creating significant legal risk — both criminal and potentially expensive civil liability exposure — sole practitioners should set their own fees individually.

(Exceptions are made for dentists within integrated group practices. Such dentists may freely share fee data and set their fees. This would also be true for properly structured networks of dentists that share financial risks, which may be viewed on balance as pro-competitive. These and other exceptions, and the way to properly conduct and use fee surveys, are addressed in the DOJ/FTC Guidelines.)

4. *Members of the local dental society agree that they will not participate in an insurance plan unless the plan increases reimbursement rates by 10%.*

   This is a group boycott to enforce a price fixing agreement and is *per se* illegal.

5. *During a discussion of a proposed managed care plan agreement at a dental society meeting, four dentists separately say that they don't care what the others do but that they will not*

participate unless the payor increases reimbursement. Subsequently only five members of the dental society's 120 members sign agreements with the plan.

This raises group boycott and price fixing concerns. Both the dental society and its members could be sued. A jury could (but would not be required to) find that the dentists agreed not to participate unless reimbursement was increased. It might also conclude that the boycott was undertaken as a means of implementing an underlying agreement to fix prices. If an agreement was found or concerted action could be inferred, it could be viewed as *per se* illegal. Even if a jury did not hold the group liable, the defense of this type of case could be very expensive.

If an agreement was found or concerted action could be inferred, it could be viewed as per se illegal. Even if a jury did not hold the group liable, the defense of this type of case could be very expensive.

6. *After its members receive a proposal from a dental plan, the local dental society hires a consultant to analyze the meaning of contractual provisions and provide a written analysis to the members without recommending whether they should participate. After studying the report and without discussing among themselves their intent to participate, no member participates.*

   There should be no antitrust violation on these facts because there is no express agreement to refuse participation and seemingly no basis to infer one. A plaintiff could, however, argue there was not individual action and ask a jury to infer that the dentists agreed not to participate at a dental society meeting or elsewhere, or that the consultant signaled the dentists not to participate through the nature of his analysis. In order to state such a claim, however, the plaintiff would probably need more than the facts presented here. The defense could present witnesses to testify that the proposal was simply economically unattractive to the individuals and should be able to terminate the litigation short of trial, provided nothing more than the above facts come to light. This case while significantly less troublesome than five above, could also prove costly and disruptive to defend, especially if the assumption of individual action becomes ambiguous in any way.

7. *Same as six except that the consultant recommends, in very precise advice but without reference to specific fees, what changes the dental society should seek.*

   The answer is the same: no liability as long as there is no recommendation or threat of a boycott by the dental society or its members, and no agreement can be inferred. An even safer approach would be for the consultant to frame issues for each individual dentist to consider when making the personal decision about whether to participate. Offering neutral tools to facilitate sound individual choice is invariably sound practice.

THE ANTITRUST LAWS IN PRACTICAL TERMS

8. *Same as six except that the consultant advises the members not to sign the contracts, and only a few sign.*

   Recommendations not to participate from anyone other than the dentist's own privately retained counsel and/or practice/financial advisor(s) can be very risky, because they can provide a basis for inferring conspiracy. Each dentist should make his or her decision independently and not base that decision solely on the recommendation of advisors who are also advising rival dentists or on whether other dentists intend to participate. It can be helpful in ambiguous situations to secure legal counsel, who can assist in documenting the independent reasons for refusing to participate.

Recommendations not to participate from anyone other than the dentist's own privately retained counsel and/or practice/financial advisor(s) can be very risky.

9. *Same as six except that the dental society authorizes the consultant to present the report to and discuss it with the managed care plan with the hope of increasing reimbursement.*

   Here the antitrust risk depends on what the consultant does, and it may be hard for the consultant to do what the dentists want without crossing the antitrust line. For example, if the consultant states or suggests to the Plan that dental society members might not participate unless reimbursement is increased, an agreement among the members to fix price and/or not to participate could be inferred.

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   The society could consider using a "messenger model," whereby a consultant could be advised by individual dentists of the reimbursement rate at which they would participate, and then tells the Plan how many dentists would join at a specified or higher rate. There are many restrictions on this model, not the least of which is that the dentists cannot share their individual acceptance terms with each other, nor can the consultant share information about the dentists' fees, even though they are paying for the consultant's services. The bottom line is that notwithstanding the natural urge to share the data, it cannot be shared or used to set fees. Obviously such activities should not be undertaken without the sound advice of counsel.

10. *After reviewing an insurer's proposal, members of a dental society object to it because the claim forms would be burdensome to complete and the utilization review program would involve too much "red tape." They do not wish to participate unless these problems are solved.*

    Communicating these concerns to the insurer on behalf of the members is completely legitimate activity. Threatening a group boycott by the members as a means of changing the

insurer's proposal, however, would pose substantial antitrust risk. The dentists' concerns probably could be addressed in a way that would present little antitrust risk by explaining the problem to the insurance company, perhaps even focusing on any negative impact the program might have on patient care. Legal advice should be sought.

11. *Because of increased costs to meet new state requirements for using amalgam separators, several independently practicing dentists in town agree to raise their fees by 5%.*

    Like Example 1, this is probably a naked price fixing agreement. Remember, there is no permitted justification for a naked price fixing agreement. An agreement as to reasonable fees is just as illegal as an agreement as to outrageously high fees. A purely individual decision to raise fees to manage increased costs is fine.

12. *Several dentists in town agree to discount their fees by 20% to indigent patients as a public service.*

    Technically, this is a *per se* illegal price fixing agreement – even though it is an agreement to decrease prices. Theoretically, such an agreement could keep prices from going even lower. However, because of its public service aspects, the government may be less likely to challenge this agreement. The society may wish to obtain an advisory opinion in which the government indicates its intention not to sue, keeping in mind the review process can involve some significant cost, take time and is not a guarantee against private lawsuits. The opinion could point out pro-competition aspects of the proposed agreement, e.g. that it helps ensure that care to indigent patients is provided. However public service measures alone do not assure legality.

13. *To circumvent the antitrust law prohibitions of price fixing a dental society establishes itself as a "union" and then attempts to bargain collectively with third party payors.*

    Although there is a "labor exemption" to the antitrust laws, the exemption applies only to collective bargaining by employees and not to collective bargaining by independently practicing professionals. Thus, forming a union will not protect a dental society or its members from antitrust liability. That a dentist has signed an employment contract with a professional dental corporation or a participating agreement with a third party does not mean that the dentist is an "employee" of an HMO, PPO, IPA or insurance company for purposes of the labor exemption. If the dentists were to "strike" or to threaten some

Forming a union will not protect a dental society or its members from antitrust liability.

"joint action" unless reimbursement were increased, a *per se* violation could result.

14. *A number of competing dentists in town agree to charge 8% interest on bills not paid within 90 days of the date services are rendered.*

    This is a *per se* illegal price fixing agreement. "Price," for purposes of the antitrust laws, includes any factor relating to the final cost of the service to the patient. For example, "price" includes discounts, terms of credit, relative value guides and their conversion factors, balance billing, co-payment amounts, interest rates on unpaid bills, and the like. Once again, what can be done safely on an individual basis or within an integrated group practice becomes problematic from an antitrust perspective once collective group activity is involved.

What can be done safely on an individual basis or within an integrated group practice becomes problematic from an antitrust perspective once collective group activity is involved.

15. *A number of dentists in town who previously had seen patients on Saturdays and some evenings agree not to open their practices at these times.*

    Because the hours a business is open is a competitive factor, this sort of agreement raises antitrust concerns. An agreement among competitors to close at certain times can be an antitrust violation. Of course, any dentist or dental practice is free independently to determine its hours of practice.

16. *Because of several conflicts among dentists, third parties and patients about the reasonableness of fees charged by its members, the state dental society establishes a peer review program to assess the reasonableness of particular fees charged by its members.*

    Peer review programs to review the reasonableness of individual fees are lawful under the antitrust laws if they have certain characteristics. The ADA applied for and received an advisory opinion letter from the FTC which provides guidelines on the proper manner to conduct such a program. Most importantly, decisions as to what constitutes a reasonable fee in particular situations should not be disseminated to other society members. In addition, any attempt to discipline members whose fees it thinks are too high increases the level of antitrust risk. Any peer review activities of this nature should not be undertaken without the advice of counsel; given the risks involved, understand that your counsel may recommend against this path in order to protect you.

Peer review programs to review the reasonableness of individual fees are lawful under the antitrust laws if they have certain characteristics.

17. *An insurance company approaches the local dental society and asks it to develop a fee schedule that the company might use in*

reimbursing society members for services rendered to the PPO's subscribers.

The dental society should be extremely cautious about this request and probably should not undertake this activity. The PPO should negotiate a fee arrangement with each dentist individually or develop a fee schedule (with the assistance of a consultant, if necessary) to be offered to dentists. The dentists should then individually decide whether to participate on the basis of the proposed fee schedule. Alternatively, the Messenger Model (see question 9 above) could be employed.

18. *A PPO approaches the dental society and requests that it collect fee information from its dentists and dental society members and provide the PPO with its members' average charges (or other statistical measures) for particular services.*

This activity can be undertaken within the antitrust laws if the DOJ/FTC "Safety Zone" concerning collection of fee data is satisfied. The information should be collected and the statistics computed by someone other than a competing dentist (e.g., outside accountant). It must also meet DOJ/FTC criteria regarding statistical significance and age (e.g., data on previous as opposed to future prices are far less suspect). The society will want to help ensure that the data is not used by providers for discussion or coordination of prices. It can thus be prudent not to give dental society members access to information relating to the fees charged by their competitors except as allowed by the DOJ/FTC Statement. Advice of counsel is especially important when fees are involved.

19. *Thirty percent of the dentists in a town form an IPA, but continue to practice independently with respect to their private patients. They invest start up capital and market the services of the IPA to area HMOs, employers and insurance companies. In marketing the practice, they develop a fee schedule.*

IPAs are covered under the DOJ/FTC safety zone for physician joint ventures.

IPAs are covered under the DOJ/FTC safety zone for physician joint ventures. Assuming this IPA is non-exclusive, properly structured and appropriately operated, it could safely include members up to the 30% threshold, provided it requires substantial risk sharing among dentists. If the IPA has a greater market share, the dentists might wish to seek a letter from the agencies approving the IPA based on any pro-competitive aspects of this partially integrated venture. Legal advice should be sought to ensure it satisfies the safety zone and is indeed pro-competitive.

20. *The dentists in Example 19 charge all of their patients and payors, including those not associated with the IPA, according to the fee schedule they developed.*

    This is a *per se* illegal price fixing agreement, if there is an agreement among the dentists to do this. The fact that the charges to those not associated with the IPA are now identical where prior to the IPA formation they were varied would be very strong evidence of price fixing.

21. *To preempt the entry of an HMO that plans to enter the area, the local dental society forms a PPO that will include about 70% of area dentists. Each participating dentist must agree not to participate in other managed care plans.*

    The PPO's formation and operation could lead to an antitrust investigation and would likely involve an antitrust violation. The problem here is the dental society's intent to preempt competition and the anti-competitive impact of the agreement of participating dentists not to provide services to other plans.

22. *After a third party payor sends a proposed contract to the dentists in a town, the local dental society meets to discuss its strengths and weaknesses. Several dentists state that they believe the proposed reimbursement is too low because it is lower than other third party payors are currently paying. No dentist suggests, at the meeting or in private conversations with other dentists, whether he or she intends to participate. Ultimately, only two dentists sign contracts.*

    There is not necessarily a violation of the antitrust laws on the facts stated. However, the facts might be viewed as sufficiently suspect to invite investigation and possibly a law suit. A jury could infer that there was an agreement to boycott the payor. Slight changes in the facts, however, could result in a naked group boycott.

23. *The dental society in Example 22 approaches the payor following the meeting of its members. The society reports that some of its members consider the proposed reimbursement to be too low, and explains why. The dental society does not threaten that its members will boycott the payor and in fact affirmatively states that each dentist will independently decide whether to participate. It is exploring the safest way to manage this process.*

    An action such as this carries substantial antitrust risk, but is lawful if done properly. It is absolutely essential that

competent counsel be involved in every step of this process, including possible consideration of whether the Messenger Model might be a viable way to safely achieve a similar result.

24. *The dental society in Example 23 decided that the best way to combat third-party intrusion is to promote Direct Reimbursement. It sends its members an invitation to a "very important meeting to learn how DR can slay the Managed Care Dragon."*

Direct Reimbursement promotional activities, if undertaken inappropriately, could potentially violate antitrust laws and also open the door to actions for libel, slander, or commercial torts. For example, a DR promotion that is no more than a call for an unlawful boycott of an insurance plan is problematic. When DR or other fee-for-services plans are promoted as a means to combat managed care plans, this can present substantial antitrust risk. And even if you win, it takes time and money. In one case, a dental society had to identify and produce voluminous documents to the FTC and expend attorney's fees, simply to establish that its DR promotion was geared toward helping dentists to make informed individual choices about plan participation, and not a boycott.

Direct Reimbursement promotional activities, if undertaken inappropriately, could potentially violate antitrust laws.

Direct Reimbursement can be safely promoted, provided that the promotion is conducted appropriately. Some good rules of thumb are: (1) it is always safest to promote what you or your dental society is for, rather than what some dentists may be against; (2) DR promotions should avoid linkage to inappropriate criticism of other benefit plans; and (3) promotional activities should not be a means of covering up boycott or price fixing activities. In order to avoid legal problems with DR promotions, and because such promotional efforts occur in the context of other dental society activities and not in a vacuum, an attorney should review the materials to be used in the promotional campaign, including seminars and educational programs for members and employers, as appropriate.

Direct Reimbursement can be safely promoted, provided that the promotion is conducted appropriately.

25. *Unhappy that a third party payor's proposal would not provide reimbursement for sealants, a pediatric dentist writes a letter to all other pediatric dentists in an area urging them not to sign participation agreements unless sealants are reimbursed. No pediatric dentist signs a participation agreement.*

Depending on all the facts, a jury could find an agreement among the dentists not to participate. Any such agreement not to participate because of payors' business requirements is likely to violate the antitrust laws.

26. *A constituent dental society and its component dental societies lobby the state to increase dental Medicaid reimbursements by speaking with legislators and presenting testimony at legislative hearings. As a direct result of these efforts, the state increases Medicaid reimbursement.*

Regardless of their effect, good faith lobbying activities are exempt from antitrust liability. There are limits, however, to this exemption as the next two examples show.

Good faith lobbying activities are exempt from antitrust liability.

27. *At first the dentists' lobbying efforts fail. The constituent dental society, after obtaining authority from its members, then writes the state, telling it that its members will "departicipate" from the Medicaid program if reimbursement is not increased. The state increases Medicaid reimbursement.*

The U.S. Supreme Court has held that this type of activity was *per se* illegal. The boycott was a means to implement an agreement to fix prices. The case involved an association of lawyers representing indigent defendants in criminal cases under a government funded program. The Court rejected contentions that the statements made were protected by the First Amendment. It also rejected the contention that the action was justified out of concern for the poor quality of services that would result from the low level of reimbursement.

28. *The constituent dental society learns that the state intends to decrease Medicaid reimbursement. It decides that a suit challenging the decrease has a reasonable but not probable likelihood of success. However, knowing that filing a suit may delay the decrease, it files suit anyway.*

The agreement to file this suit is protected by the First Amendment to the United States Constitution. Indeed, dental societies have filed suits against the states that have led to increases in Medical reimbursement. However, "sham" litigation conducted in bad faith for anti-competitive reasons is not protected and could be subject to antitrust challenge.

29. *A component society peer review committee receives a complaint from a patient of a large closed panel capitated dental practice concerning the quality of treatment. The peer review committee determines not to process the complaint and to recommend that the patient file a formal complaint with the state dental board. Possible reasons for this course of action might be that the complaint indicated gross mistreatment, or that the dental practice had a history of not cooperating with the peer review committee, or that the dental practice had a record of an inordinate number of patient complaints.*

Misuse of the peer review system can constitute an antitrust violation.

As long as peer review decisions are made in good faith for objective reasons, there is little antitrust risk involved. However, analogous to the example in Example 28 concerning sham litigation, the peer review process, like the court system, also can be abused for anti-competitive reasons, such as to exclude or hamper a dentist or third party. Misuse of the peer review system can constitute an antitrust violation. Dental societies should assure they can demonstrate that any activity in these circumstances is pursuant to previously established procedures which have been fairly and objectively applied to all society members. Peer review procedures should be reviewed by health antitrust legal counsel to assure that the procedures are appropriate and being properly and safely implemented. Seeking sound legal advice through the entire process can also help insulate properly conducted peer review from claims of bad faith.

30. *A dental society's ethics committee receives a complaint alleging that an advertisement by a large group dental practice is false and misleading in a material respect. It initiates a disciplinary proceeding which could result in the dentist or dentists responsible for the ad being censured or suspended or expelled from membership.*

    There is strong and clear judicial precedent that a professional society of health care practitioners has the right to review advertisements of its members under an ethical provision which prohibits advertising that is false or misleading in any material respect. However, the cautions and considerations with respect to appropriate procedures and use of legal counsel discussed in reference to dental peer review are entirely applicable to ethics proceedings because, like peer review, ethics proceedings are also subject to antitrust challenge when misused for anti-competitive reasons.

31. *A dental society refuses to grant membership to a dentist who forms an HMO with large market representation and another dentist who starts a dental managed services organization.*

    These dentists could claim that the membership exclusions were anti-competitive and an agreement by society members to unlawfully discriminate against dentists who do not practice in traditional fee-for-service settings. Their claims could carry special weight if the society separately promotes membership as an additional element of a successful practice.

32. *A dentist sees a referral patient for the purpose of providing a second opinion. The patient asks this dentist to replace his or her prior dentist. The second dentist declines.*

Every dentist has the right to choose the patients he or she will treat, subject to applicable laws, particularly those prohibiting discrimination. However, if a dentist declines to accept a patient because of an agreement, no matter how silent or informal, that dentists in an area will not "steal" each others' patients, then an antitrust violation may be present. Such conduct could be viewed as “dividing customers” or “dividing markets,” which in some circumstances has been viewed as *per se* illegal. Dentists are safest when they independently decide whether to accept a particular patient without any "agreement" with competing dentists.

33. *A number of members have complained to their society about receiving letters from insurance companies seeking to audit their records. Many who have allowed audits are complaining even more loudly – some have been asked by the carriers to pay back in excess of hundreds of thousands of dollars. To combat such audits, the society enacts a policy opposing audits and contracts that allow them.*

    This poses an obvious antitrust problem, particularly if the opposition amounts to a boycott threat. Dentists are free individually to enter into or reject any contract of their choice. Freedom of choice extends to the freedom to choose whether to enter managed care plans. To steer dentists away from doing so opens the antitrust risk door. The better path is to help educate members to help them make informed choices. The education should be informational and not designed to sway members against joining. If neutral information results in their avoiding such contracts, there is probably little or no antitrust risk.

34. *Instead, the society in Example 33 enacts a policy urging members to consult with counsel before signing contracts containing audit provisions.*

    This is probably OK – after all, how could anyone argue about recommending that a member get legal advice? That said, the society should help protect against the policy being translated as a signal to not sign contracts allowing audits. To avoid a finding or inference that this is a conspiracy, the society might consider these options: the society can make sure communicating any such policy to the members is done as neutrally as possible; or, it could consider broadening the policy so it calls for legal advice generally, as appropriate, and not just about audits.

35. *The society in Example 33 begins to lobby for legislation prohibiting audits.*

Good faith lobbying is a classic exception to the antitrust laws... Don't let the lobbying exception lead you to do things that are unlawful in the marketplace.

Good faith lobbying is a classic exception to the antitrust laws. Keep in mind the words "good faith." Sound, patient-focused lobbying will typically meet this standard; purely dentist-pocketbook lobbying masquerading as patient care advocacy may not. In addition, be very careful not to let legitimate lobbying slip over into problematic marketplace activity. To avoid this particular risk, don't let the lobbying exception lead you to do things that are unlawful in the marketplace. If a lobbying effort against audit provisions is communicated to the members as a call not to sign contracts containing them, all bets are off, and you should be prepared to put your antitrust gloves on.

36. *The society in Example 33 considers suing the insurance companies on behalf of the affected members.*

The society recognizes that filing a lawsuit avoids the risks associated with advising dentists to avoid participation or to sever ties with an insurance company or other company market participants, because legitimate petitioning of the courts is exempt from the antitrust laws. However, the suit must not be objectively baseless to merit that protection. So among other things, there must be a good theory of suit. This may be hard to come by if carriers are simply exercising their contractual rights. It might be easier if the affected dentists were non-par, and are arguably not bound by the contract terms. Also, the spill over issues in the prior hypothetical come into play.

37. *The society in Example 33 runs a story about the horrors of insurance company audits, and in subsequent issues runs letters to the editor chastising insurance companies for this practice.*

A single story alone need not produce antitrust risk. However, if a story is one sided against insurance company policies or procedures, it could create exposure. The risk, of course, lies in the effect in the marketplace – will it cause dentists to boycott? Moreover, the story does not exist in a vacuum. Even a balanced story can be tainted if the only letters published amount to "piling on" against the insurance company – unless of course those are the only letters that were received.

The bottom line: the risk would increase if it turned into an exhortation to action AND there was action. In such a case, the article could be viewed as an invitation to collude and the action an acceptance of the invitation. The newsletter in essence would have become a conduit through which the members had reached agreement.

A society wishing to avoid this risk may wish to keep in mind that the story with the least amount of antitrust risk is one that tells both (or all!) sides; asks questions instead of advocating answers; uses softening words such as "might" or "may" unless stronger words are indicated, and uses the language only in the context of legislation and lobbying. And keep in mind that even that type of exempt status requires good faith, and can quickly be lost without it, or if the protected activity spills over inappropriately into the marketplace.

38. *All of the letters in Example 37 prompt the editor to write an editorial proclaiming the audits to be unwarranted and unreasonable. This then leads the society president to write a "MyView" column broadening the discourse and using phrases such as "managed care and capitation termites have been chewing away at the framework of our profession…we are in a state of war with these outside forces that require constant vigilance." The column concludes "just say no to PPO."*

This is exactly the type of "call to arms" that the Supreme Court cautioned against in the *Indiana Federation* case (see Preamble). As suggested in Example 37, the concern is whether such an exhortation leads to action that will constitute a violation, in which case the exhortation will become important evidence in an antitrust action.

Does it make a difference whether it was the editor rather than a high placed volunteer that spoke so passionately? While the editor is arguably an independent agent able to speak his or her mind freely, the journal is an arm of the society, so the editor should take care not to encourage readers to violate the antitrust laws. And the president, of course, like all of the society's officers and board members, must always be vigilant about antitrust.

The words in the president's column may sound familiar from the 1990s when managed care reached its peak. But there has been reason for concern about such language long before the advent of managed care. Consider the quote seized upon by the U.S. Supreme Court in *Indiana Federation* as having been strong evidence of antitrust violation (behind the cover of this book). The "state of war" language remains problematic today. And the cute "just say no" would seem far less cute if the enforcement agencies used it as Peoples Exhibit 1 to establish an unlawful call for collective action in restraint of competition.

"State of war" language remains problematic today.

If published today, the editorial and the my view column would pose a significant problem for the society, have the potential to be seen as reflective of the leadership's underlying world view and purpose, and potentially taint other products and services that may have been appropriately developed.

39. *At the urging of its members, a dental society gears up to stop a new dental school from being built, since it will be privately funded and require its students, who can attend for free, to spend five years after graduation working as employees in practices owned by the company that wants to build the school.*

    The society needs to be very careful. If students want free dental education in exchange for five years of paid employment after they graduate, they are free to make that choice. Any attempt to directly interfere with it could be viewed as an effort to restrain competition. Educating the potential student body about the merits of this path is fine – including about the practice and legal aspects of signing such an agreement. And of course lobbying against the proposed school might be an option, if the society has a good faith basis to argue against it, e.g., because of possible adverse public health effects, if indeed that could reasonably be contended.

40. *A dental society's governing body is charged by its members to find ways to restrict the rights of allied team members, and to stop legislation that would allow team members to provide dental care in remote locations independently.*

    The portion of this question regarding state legislation is fine, provided the society's Board proceeds in good faith and the lobbying is not a sham. However, great care needs to be taken to prevent "spillover" in the marketplace. This is the case regardless of whether the issue is hygienists applying sealants at school based programs, hygienists practicing independently in remote parts of a state, and even individuals with training as oral health therapists augmenting the treatment team and performing invasive procedures. In each case, a dental society would risk being viewed as trying to raise the cost of dental services for a public needing access to low cost dental care. Again, a sound approach is to keep the main objectives in mind, and consider whether there are any proactive approaches that can address them with relatively less risk than a blatant showing of market power that would likely be seen as pocketbook driven. And to wrap it all into the legislative arena, if appropriate.

41. *Pleased that it has been highly proactive in advocacy and member service initiatives, without attracting antitrust*

scrutiny, a society wants to promote this and other good news to members and prospective members. Part of its recruitment and retention efforts include a chart listing the value of different portions of membership, and totaling those numbers in order to show that belonging to organized dentistry creates significant value. The chart's punch line is that by paying $x in dues, the member benefits $3x or more, and that a dentist has to join to have a successful practice.

Dental societies have every right to trumpet their good works, perhaps especially when their successes have been proactive, but were thought through carefully in advance and structured to avoid antitrust and other legal exposure. But this is not the most prudent way to do so.

Dental societies have every right to trumpet their good works, perhaps especially when their successes have been proactive.

As a framework for understanding why this is so, consider that a dentist who has been denied membership in the society might cite to these very statements to demonstrate that exclusion from the society impaired that dentist's ability to practice and therefore that the denial was anti-competitive. Overselling the benefits of membership carries a similar risk. A key teaching in one of the classic antitrust cases in dentistry, the *Boddicker* decision (see final question for more on this case), is that steering clear of claims that a dentist must join a society to have a successful practice can help avoid antitrust liability. Showing the savings by individual member benefit is probably the safest place to be in this direction. Tallying them up to a grand total in order to conclude or imply that a dentist must join to achieve success, can needlessly raise antitrust risk. If scrutinized, the claims may also be deemed to be overstated, since very few members will likely use every benefit. Again, the key is to consider relative levels of risk when making the business decision – is a total tally needed, or can the reader draw the desired conclusion and join up without the society taking on undue exposure?

42. *A society hopes to add a big push to make its products and services available to its members only.*

Products and services deemed to be competitively significant may be made available to members only if nonmembers can obtain similar resources elsewhere. For example, ADA Division of Legal Affair's recent publication *Frequently Asked Legal Questions* is available to members only. We'd like to think our perspectives and answers to the questions on our members' minds will be the best, but it's no secret that they can get legal information elsewhere!

43. *The society decides that instead of selling products on a members only basis, it will make them available to nonmembers at a premium.*

There is nothing wrong with an appropriate price differential. However, charging a non-member so much more that the society is effectively forcing the dentist to join, in order to get the information at a fair price, may be problematic. Typically, price differentials in the 50% surcharge range are fine. But when the differential for any one product or service approaches or exceeds 100% of the member price, it's a good time to get the society's lawyer involved, to assure that anyone opposing the policy could not successfully argue that membership is necessary to compete. These common sense rules of thumb are not set in stone, and legal counsel can look at all of the facts. The goal, of course, is to help guide the society to a decision that will promote non-dues revenue without creating undue antitrust risk.

It is important to emphasize that in both Examples 42 and 43, the complaining dentist would have to show that the unavailability of the benefit so significantly raised costs that the dentist was placed at a significant competitive disadvantage, and that would be hard to do.

44. *A dentist calls to complain about one level of the tripartite, and says that while he will gladly pay dues to the other two, he feels its an antitrust violation for dentistry to force him to join at all three levels – local, state and national.*

The tripartite requirement that a dentist must join all three levels was upheld in the landmark *Boddicker* case decades ago. Among the key reasons: the complaining dentist could successfully practice without being a member, 25% of the local dentists were not members, and nonmembers could purchase products and services. For these and other reasons, the tripartite remains sound from an antitrust perspective today.

The tripartite requirement that a dentist must join all three levels was upheld in the landmark Boddicker case decades ago.

CONCLUSION

As the variety of examples above indicate, potential antitrust violations relating to anti competitive agreements among dentists can arise in many different contexts. Moreover, seemingly small and insignificant changes in facts can lead to different and sometimes opposite results. Finally, antitrust problems can arise quite innocently, without the dentists involved realizing a problem exists until it is too late to solve it. Because of this and the substantial time and expense of antitrust investigations and litigation, dentists should exercise great care before participating in any activities with other dentists regarding fees, reimbursement or competition.

Sound legal advice is critical before action is taken. The cost, publicity and time alone in any antitrust action can be a severe strain on an individual dentist, family, the dental practice, or a dental society. Especially in light of the enforcement agencies' histories of aggressively enforcing the antitrust laws in health care, including by prosecuting dentists criminally for price fixing violations, the American Dental Association is making a strenuous affirmative effort to ensure that dentists learn as much as possible about permissible and prohibited activities under the antitrust laws.

With good support from your dental society and your counsel, there is not only hope, there is opportunity. True, dentist often initially perceive the antitrust laws as posing high hurdles making it unduly difficult for the typical private practitioner to compete effectively in the marketplace. But the playing field need not be as unlevel as it seems. With awareness about the antitrust laws, dentists and their societies have the benefit of being able to assess relative levels of risk, and make safe choices about "how to" achieve their objectives without taking on undue antitrust exposure.

Note: Dentists and dental societies who desire additional information regarding the antitrust laws may contact the ADA Division of Legal Affairs for additional information. The legal staff can be reached at the ADA Member "800" number, or by dialing direct to 312-440-2874. Specific legal advice always should be sought from the individual's or group's own attorney.

The playing field need not be as unlevel as it seems. With awareness about the antitrust laws, dentists and their societies have the benefit of being able to assess relative levels of risk, and make safe choices about "how to" achieve their objectives without taking on undue antitrust exposure.

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