HEALTH PLAN POWER AND PRACTICES

Arthur Lerner
Crowell & Moring LLP

Antitrust in Healthcare
American Health Lawyers Association
American Bar Association
Sections of Antitrust Law and Health Law
May 12-13, 2005
Washington, D.C.
Providers’ perceived imbalance

- A few plans have high percentage of covered lives
- “Take it or leave it” deals offered by plans
- Information and leverage gap
- Desire to “level the playing field”
“Health care providers who must deal with consumers . . . through [managed care] plans . . . face an unusual situation that may legitimate certain collective actions. . . . In light of [the] departures from a normal competitive market, . . . health care providers are entitled to . . . take some joint action . . .
(short of price fixing or a group boycott) to level the bargaining imbalance . . . . Providers might . . . band together to negotiate [non-price points] . . . such as payment procedures, the type of documentation they must provide, the method of referring patients and the mechanism for adjusting disputes. Such concerted actions . . . must be carefully distinguished from efforts to dictate terms by explicit or implicit threats of mass withdrawals . . . .

*United States v. Alston* (9th Cir. 1992) (emphasis added)
High shares of what?

A market is a product or group of products for which a hypothetical profit-maximizing firm, not subject to price regulation, that was the only present and future producer or seller of those products likely would impose at least a "small but significant and nontransitory" increase in price, assuming the terms of sale of all other products are held constant.

FTC-DOJ Merger Guidelines
Market definition focuses on customers

-- “Customers” could be viewed either as purchasers of services from MCOs or as providers selling services to MCOs

-- Market definition focuses solely on demand substitution factors -- i.e., possible consumer responses.

-- Supply substitution factors -- i.e., possible production responses – are considered in the identification of firms that participate in the relevant market and the analysis of entry.
Alternate configurations

All inclusive:  
- HMO
- Proprietary insured PPO

Modular:  
- Insured rental PPO
- TPA/rental PPO/stop-loss carrier

Employers can mix and match
Market definition – What product?

- Case law -- broad definition
  - Blue Cross & Blue Shield United v. Marshfield Clinic
  - Ball Memorial Hospital v. Mutual Hospital Ins.
  - Reazin v. Blue Cross & Blue Shield
  - Coventry Health Care v. Via Christi Health System
  - Hassan v. Independent Practice Ass’n
    -- Gateway Contracting Services v. Sagamore Health Network

DOJ
  -- HMO and HMO-like POS products (Aetna/Pru)
    -- All managed care, but not service to self-insured? (recent United/Oxford review)
## Convergence on product spectrum

<table>
<thead>
<tr>
<th></th>
<th>Insured</th>
<th>Network</th>
<th>Gatekeeper</th>
<th>UM/QA</th>
<th>OON</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO</td>
<td>Usually</td>
<td>Yes</td>
<td>Usually</td>
<td>Yes</td>
<td>Often</td>
</tr>
<tr>
<td>POS</td>
<td>Very often</td>
<td>Yes</td>
<td>Often</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>PPO</td>
<td>Often</td>
<td>Yes</td>
<td>Rarely</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
– Medicare Advantage?
– Medicaid managed care?
– Small business?
– Individual market?
Monopoly / Monopsony

• Plan with 50% of local commercial health insurance business may only represent 20% of “purchases” of health services
• Plan with 50% of local Medicare Advantage business may only represent 2% of purchases of health services
• Leverage over particular providers/dependence of particular providers may not reflect “monopsony” power
  – E.g., if a law firm’s biggest customer gets discount, is that an exercise of monopsony power
If data show provider reimbursement levels are lower in one metropolitan area than in a similar one, does that suggest:

- Monopsony power by payors in the first market?
- Collusion by payors in the first market?
  - Lawsuits in Kansas, Missouri, Kentucky and Ohio have included such allegations
- Market power by providers in the second market?
- Differences in supply and demand?
- Bad data?
What about monopsony power?

- Monopsony power is not illegal
  - But antitrust law disfavors mergers that would create it
  - Antitrust would proscribe agreements that unreasonably restrain competition to enable its exercise
Are there barriers to entry?

- Need for strong provider network?
- Need for full range of health products?
- Know-how and infrastructure demanded by employers?
- Sales force
- Licensure requirements?
What follows from suspicions of payor power?

• Benefit of the doubt to provider networks claiming to be “clinically integrated”?
• Tough time for govt. in challenges to hospital mergers?
• Scrutiny of health insurer mergers
• Search for antitrust theory for challenges to “all product clauses”?
• Judicial tolerance for broad-based provider RICO challenges to alleged Standard Operating Procedures of managed care?
• Allegations of conspiracy?