ANTITRUST DEVELOPMENTS TO WATCH:
MESSENGER MODELS ASTRAY
AND WHAT ELSE IS NEW

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11th Annual Health Law Institute
Pennsylvania Bar Institute
Philadelphia, Pennsylvania
March 15, 2005
Antitrust basics

• Prohibits
  – agreements in restraint of trade
  – Monopolization

• Enforced by
  – Department of Justice
  – FTC
  – States
  – Private plaintiffs
#1 Value-based purchasing promotes a competitive marketplace
#2 The public should be provided with more information on prices and quality
#3 Barriers to entry in provider markets should be decreased
#4 Mandates (including provider mandates) are anti-competitive
#5 Providers are subject to the antitrust laws – just like everyone else
#6 Agencies will scrutinize mergers and alleged abusive conduct by payors
Coordination among Providers

- Agreement – takes two
- Price fixing and group boycotts
- Exception for bona fide joint ventures – “rule of reason”
- Network avoids joint agreement on price – “messenger model”
Coordination among Payors

- Collusion in reimbursement to providers
- Collusion/customer allocation/bid rigging of customer accounts
Making monopoly

• Unfairly excluding competitors or using market power to prevent customers from benefiting from competition
• Not illegal for monopolist to simply charge high prices
A Cautionary Tale of Realtors

- Annual dinner meeting
- President’s address
- “Costs up; my fees going up to 7%”
Don’ts

• No price fixing -- competitors cannot agree on fees or price terms
  – Price fixing includes agreements on any element of price equation, not just agreement on actual prices
• No group boycotts -- Joint refusals to deal or threats over fees illegal
• Watch out for:
  – “I don’t know about you, but I am …”
  – “Let’s all ‘unilaterally’ refuse to ….”
  – “So long as it’s not in the minutes, it’s OK”.
  – “So long as it’s in the minutes, it’s OK.”
  – “OK, counsel told us the rules, now let’s move on to business [and set prices] . . .”
• Other joint action can be unlawful depending on the specific facts
  – Bona fide joint ventures – “rule of reason”
  – Price fixing cartel is not a joint venture – a budget doesn’t make it “legit”
Perceived imbalance

- Take it or leave it” deals offered by plans
- Few plans enroll high percentage of patients
- 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).
Positive cooperation

• Providers can join together to enhance quality and clinical outcome improvement or be accountable for cost of care
• Joint network contracting may be appropriate where key to success of positive venture;
• Opportunity for brand or product differentiation by interested payor
Risk sharing

- Price negotiation not automatically illegal where providers share together in responsibility for cost or utilization or have significant upside gain potential for staying within realistic budget
- Still illegal if “united front” of too many providers
- Wrong question -- How much “risk sharing” to be able to fix prices?
Clinical integration

• “Per se” price fixing law may not apply if providers are clinically integrated
• Examples -- practice protocols adopted and followed, sharing of clinical information, shared electronic medical records or health risk assessment protocols, oversight, accountability and reporting of performance – slimmed down program not enough
• AND joint price setting must be reasonably necessary to make venture work
  – Are physicians devoting significant time or capital to programs and planning?
  – Would they do so if there was no assurance that network would be contracting as one?
  – Will negotiated fee schedule be adapted to incentivize participation and compliance by physicians in key specialties, central to quality improvement?

• Still subject to “rule of reason” analysis
Pay for Performance

• Combination of risk contract and clinical integration
• Risk element converted to rewards for meeting quality improvement, outcome or clinical integration objectives
• Is price fixing necessary to make pay for performance arrangement work?
• How material are incentives and clinical improvement activity compared to price fixing component?
Model contracts

- IPAs and PPOs can develop “model” contracts or contract language
  - Contracts may illustrate sample provisions and offer choices
  - Frequently seen contract terms can be explained
  - Areas for physician focus may be noted
  - Should not be directive or “hidden message” sent
- Do say “Here is language to consider” or “Note the impact of this provision”
- Do not say “Don’t sign these” or “Use only this language”.
- Must be educational; not centerpiece of boycott campaign
- Avoid price – danger that “suggested” price terms will be viewed as “agreement” on price terms.
Surveys, information sharing and education

• Physicians can share historical information on fees, shielding identification and using data at least 3 months old
• Fee information can be collected via survey and conveyed to payors
• May convey information to providers to help make them informed marketplace decision-makers, without “call to arms”
• Education ≠ coercion
Messenger model

- Provider network negotiates non-price components of managed care contract
- Acts as “messenger” for price terms, not as cartel
  - May use “drop box” or “clearinghouse” model
  - Creates clearinghouse with lock-in
  - Individual physicians indicate prices they would accept
  - Network can likely decline contracts that do not generate widespread physician participation
  - May include annual screen against physician’s fee specifications
- Must avoid “sham” messenger model arrangements
  - There’s lots of them. Led to lots of FTC cases.
- Safety zone applies if 30% or less of specialty in network; 20% if doctors are “exclusive”
Messenger model

• Does “messenger model” work? Depends what you mean by “work”.
  – Give physician better information to act on? -- OK
  – Give physician vehicle for carrying out market-based decisions? -- OK
  – Give physician automatic re-check of contract terms against acceptable fee parameters – OK
  – Go back to 1975 – not OK
Enforcement is active

Some providers go too far. Repeated enforcement by FTC and DOJ – They’re trying tougher remedies. Suing organizations, doctors AND CONSULTANTS.
• Competing groups employ same consultant who coordinates contracting, and acts as “hub” of price fixing understanding

• Providers collectively obstruct “pay for performance” or other programs basing compensation on quality measures

• Association of physicians claims to be “messenger” only, but actually coordinates price fixing scheme
• Hospitals or doctors try to justify price fixing by unsupported claims they are “clinically integrated”
• PHO operates as joint venture accepting limited risk for enrollee costs, but has most area providers tied up under de facto exclusive contracts, and threatens boycott to force higher rates
• Key hospital agrees that it will only do managed care contracts through PHO that demands above market rates for physician services.
• Messenger model IPA or PHO won’t “messenger” arrangements that don’t pay high enough prices and tells members what the floor is.
Powerful provider system uses “must have status” -- from size, availability of specialty services or products, or location -- to force contract concessions by health plans using bundling, tie-ins, forced exclusivity, or suppression of choices creating cost transparency.

This may be legal, but the provider system may be crossing an antitrust line, depending on the facts.

How does conduct affect competition? Legitimate efficiency justification?
Examples

• “All or none” contracting
  – Forced inclusion of higher priced or lower quality hospitals, ancillary providers, or physicians
• No discounts at any facility if “tiering” against any provider in system
• Ban on “consumer directed” plan designs that include greater transparency in cost to consumer
• Hospital system requires health plan to prevent MD steering incentives to other hospitals
• Hospital conditions discounts on exclusion of competing new ASC
Hospital based physicians

- Exclusive contract at hospital –
  - May not be unlawful
- Pressure on hospital not to permit competition
- Mergers to lock up specialty at multiple hospitals in local market
Other enforcement developments to watch

- “Retrospective” hospital merger case in Illinois
- Clinical cooperation as purported basis for price fixing”
- All or none” and other “bossy” contracting by dominant hospital systems
- Exclusionary conduct by hospital-based physicians
- Payor misbehavior -- e.g., conspiring re provider rates, MFNs by dominant plans, or anticompetitive mergers
- Messenger models “at the edge”
- Product market allocations by hospitals, particularly in conjunction with CON laws
Group practice

- Doctors in a single group practice cannot “conspire” with themselves in violation of the antitrust laws
- Combination of doctors into a group is legal unless it would provide market power
- Combination in a “sham” group can result in price fixing charges
Most favored nation clauses

• Normally, a “promise to give me your best deal” requirement is not illegal
• Department of Justice has sued dominant health insurers where the impact is to stifle competition from smaller plans, and set floor on fees.
• MFN adopted by physician network on its members’ dealings with plans is very risky.
• Some state insurance law bar them