

Avoid Antitrust Enforcement: How to Deal with Private Payers Without Government Crackdowns

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- Prohibits
 - Agreements in restraint of trade
 - Monopolization
- Enforced by
 - Department of Justice
 - FTC
 - States
 - Private plaintiffs



- Takes two
- Mutual understanding to accomplish a common purpose.
- Does NOT require: written or formal agreements or any meetings

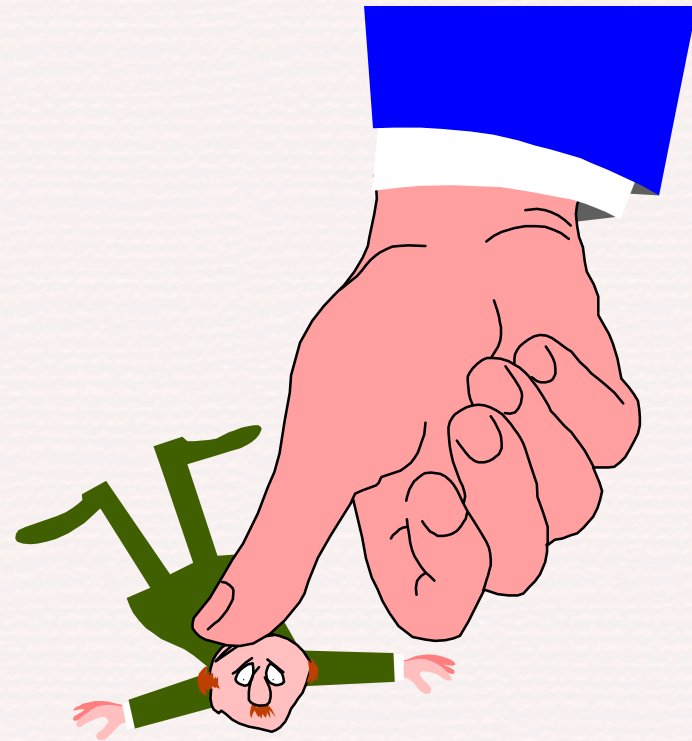
- Criminal
 - Maximum prison sentences are now ten years, rather than three
 - Maximum fines for individuals are now \$1 million, up from \$350,000
 - Maximum fines for corporations are now \$100 million, up from \$10 million
- Civil
 - Triple damages
 - Payment of plaintiff's attorneys fees

- 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”

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



- “Take it or leave it” deals offered by plans
- A few plans enroll high percentage of patients
- Information and leverage gap
- Desire to “level the playing field”



Feel the tension (1)

“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 [. . .]

Feel the tension (2)

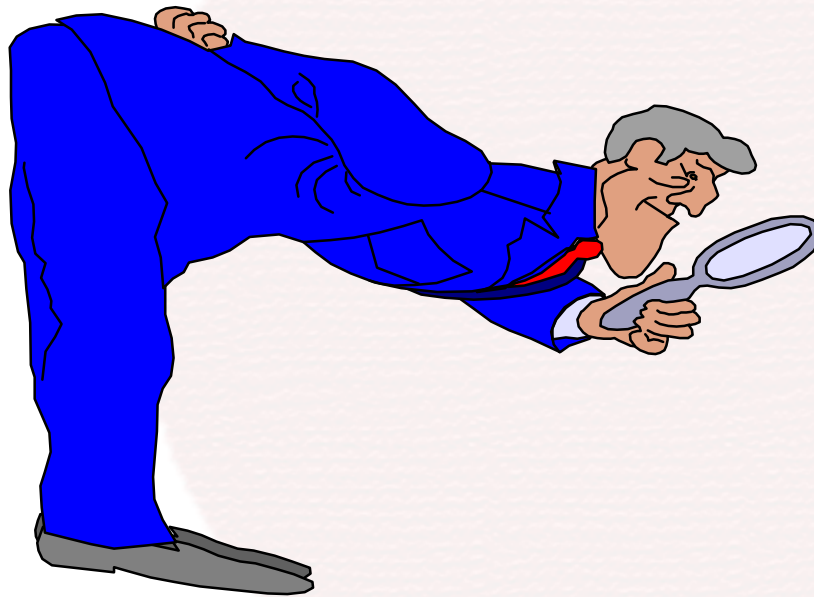
(short of price fixing or a group boycott) to level the bargaining imbalance Providers might . . . band together to negotiate [non-price points] . . . such as payment procedures, the type of documentation they must provide, the method of referring patients and the mechanism for adjusting disputes. Such 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).



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
- Physicians 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

Common problems (2)

- 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.

Positive cooperation

- Providers can join together to enhance quality and clinical outcome improvement or to 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

- 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?

- “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

- 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?
- Agencies likely to give room to let market evolve, but not for bogus schemes

- 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”

- 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

- 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

- 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 \neq coercion

- 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

Questions to ask to set rules of the road

- Are you trying to make the market work better, or to stop the market from working?
- Are you offering a better service or are you combining to stop someone from trying out an alternative?
- Is a consultant offering pie in the sky? Does anything sound like a gimmick?
- Can your plan be a win- win for all?

- Objectives
 - Meet patient needs
 - Respond to customer and market demand
 - Improve patient health outcomes
 - Be responsive to payor concerns
 - Is it really about fees?
- Steps
 - Assure maintenance of choice
 - Avoid agreements outside scope of legitimate venture
 - Determine approach to “price” collusion problem,
AND ADHERE TO ADOPTED SOLUTION