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

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Antitrust basics

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

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Collusion

-- Takes two

-- Mutual understanding to accomplish a common purpose.

-- Does NOT require: written or formal agreements or any meetings

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Penalties

- 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

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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”

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A Cautionary Tale of Realtors

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

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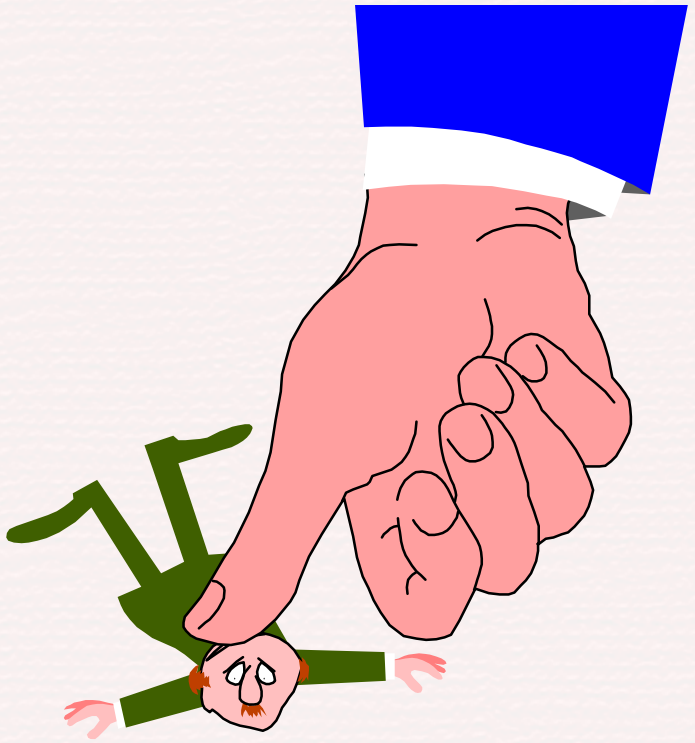
Perceived imbalance

- "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"



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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 [. . .]

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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).

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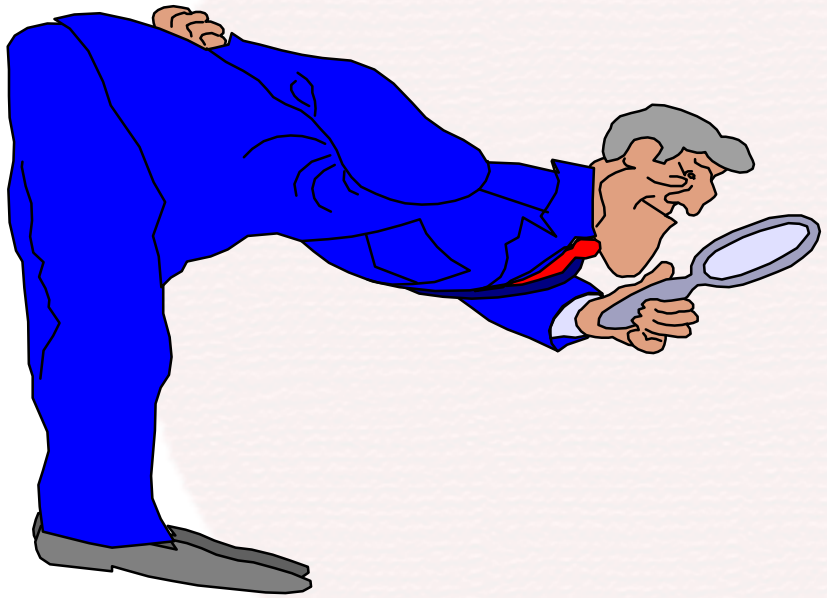
Enforcement is active

Some providers go too far. Repeated enforcement by FTC and DOJ – They're trying tougher remedies. Suing organizations, doctors AND CONSULTANTS.



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Common problems

- 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

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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.

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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

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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?

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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

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

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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"

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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

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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

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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.

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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

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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

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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?

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Moving forward

- 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