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
Collusion

-- Takes two
-- Mutual understanding to accomplish a common purpose.
-- Does NOT require: written or formal agreements or any meetings
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
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”
A Cautionary Tale of Realtors

- Annual dinner meeting
- President’s address
- “Costs up; my fees going up to 7%”
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”
“Health care providers who must deal with consumers . . . through [managed care] plans . . . face an unusual situation that may legitimize 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).
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
• 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.
• 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
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?
- 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”
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
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
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
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
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?
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