

Hot Buttons in Health Care Antitrust

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**Payors, Plans and Managed Care Law Institute
American Health Lawyers Association
Chicago, Illinois
December 6-7, 2011**

2011 Hot Spots

- Exclusionary discounts, and bundling – critical issues in plan-provider contracting
- DOJ “Most Favored Nation” suit against BCBS Michigan and new investigations
- Merger wars – lessons from the enforcers
 - FTC provider merger enforcement
 - Health insurer merger enforcement at DOJ
- Accountable care organizations and antitrust – the smoke clears

Hospital pricing allegedly used as lever to exclude competition

- Courts and enforcers working to develop tools to distinguish aggressive price competition from exclusionary anticompetitive practices
- *PeaceHealth* litigation in 9th Circuit a few years ago focused attention on bundled pricing by hospital linking sale of all its services to sale of tertiary services only it offered in local market area. *Cascade Health Solutions v. PeaceHealth*, 515 F.3d 883 (9th Cir. 2008)
- New DOJ enforcement action focuses on discounting conditioned on exclusion of competing hospital from managed care network

United States v. United Regional Health System

- United States and Texas AG accuse United Regional Health System of monopolizing markets for general acute-care inpatient hospital services and outpatient surgical services sold to commercial health insurers in the Wichita Falls area. [Complaint](#), Case No.: 7:11-cv-00030 (N.D. Tex. 2/25/2011)
- [Final judgment](#) imposes constraints on hospital (9/29/2011)

DOJ allegations of monopoly power

- United Regional formed in 1997 by merger of two hospitals; no other acute-care hospitals in metropolitan area at the time
- Merger had antitrust exemption via Texas Legislature
- 369-bed hospital with trauma, cardiac, and neonatal care services that make it a “must have” hospital for insurers
- Provides 90 percent of inpatient hospital services and 65 percent of outpatient surgical services in Wichita Falls area
- Competitors are Kell West Regional Hospital , a 41-bed acute care hospital that opened shortly after the merger, and an ambulatory surgery center.
- DOJ claims United Regional is one of the most expensive hospitals in Texas, with rates 70 percent higher than Kell West’s

United Regional – challenged conduct

- “Discounts” (up to 25%) off billed charges, but if insurer contracts with a competing facility, discount falls to 5%.
- Provisions adopted within three months of Kell West opening
- Attributing value of the discount difference across all United Regional patients to the rates for patients that might otherwise have gone to Kell West, the net rates for these “contested” patients would not even cover United Regional’s marginal cost
 - Equally efficient competitor could not conceivably compete for payor business
 - Alternative framing is that the 5% discount is not a bona fide alternative. United River was effectively requiring exclusivity as a condition of doing business, knowing payors could not accept the alternate proposal.
- Apart from BCBS Texas, “not one insurer opted for the non-exclusive rate for more than twelve years.” BCBS Tennessee premiums in Wichita Falls are higher than other payors.

United Regional -- remedy

- May not condition any insurer's contract or rates on it not contracting with a competitor
- May not refuse to contract, terminate a contract, or discriminate in contracting terms because an insurer contracts with a competing provider
- May not contract on conditional volume discount basis, except for certain permitted "incremental" volume discounts
- May not bar insurers from encouraging use of other providers

United Regional – more on remedy

- United Regional may offer “incremental volume discount” where ratio of (a) the rates applicable after threshold volume is achieved, divided by (b) billed charges, exceeds the hospital’s cost to charge ratio in its Medicare cost report.
- Note: Allegations dependent on monopoly power; remedy includes “fencing in” language premised on defendant having crossed the line

Possible risk for payors

- United Regional suit brought only against hospital as Sherman Act §2 monopolization claim
- Private plaintiff in similar suit could conceivably bring suit on Sherman Act §1 conspiracy/agreement theory, and bring payors into the case
 - Note that DOJ MFN suit in Michigan claims that plan's agreements with hospitals violated §1, which implies hospitals were co-conspirators with plan dominant party insisting on restrictive language
- Some parallels to cases where new entrant hospital or surgi-center claims that payor(s) conspired with dominant hospital or each other to exclude new entrant provider. See *Heartland Surgical Specialty Hospital LLC v. Midwest Division Inc.*, 527 F.2d 1257 (D.Kan. 2007)

Most favored customer clauses

- Provider promises insurer to give it best price given to any other insurer or an even better price
- Government concern -- May drive up prices to smaller competitors when imposed by dominant insurer
- Justifications
 - Helps assure that insurer is paying no more than market price
 - May help insurer's customers reduce shopping time by assuring that insurer's provider discounts are competitive

DOJ and State AG sue BCBS Michigan

- DOJ and Michigan AG sue BCBS Michigan for violating Sherman Act §1 ban on agreements in restraint of trade and parallel state law
- Allegations:
 - BCBSMI has market power, with more than 60% of state’s commercially insured population
 - MFN type agreements with more than half the state’s hospitals, accounting for over 40% of beds
 - Uses both “MFN-plus” and “equal-to” MFNs
 - Traded higher prices for MFN “protection from competition”
 - Caused hospitals to raise prices to competitors (some of whom had contracts at lower prices than BCBSMI), excluded some competitors from the market and likely increased prices for customers of BCBSMI and other plans
 - BCBSMI reports “medical cost advantage, delivered primarily through its facility discounts, is its largest source of competitive advantage”

Claims regarding “MFN-plus” clauses

- 22 hospital contracts, accounting for 45% of state’s tertiary care beds, require other payors to pay more than BCBSMI
- Some require competitors to pay as much as 40% more
- Employed when hospitals have sought significant rate increases

Gov't claims re “Equal-to” MFN clauses

- Used with more than 40 small hospitals that are sole hospitals in their communities
- DOJ claims BCBSMI agreed to pay more to hospitals, increasing its own and customers' costs, in conjunction with adding MFN clause
 - “Blue Cross has purchased protection from competition by causing hospitals to raise the minimum prices they can charge to competitors, but in so doing has increased its own costs. Blue Cross has not sought or used MFNs to lower its own cost of obtaining hospital services.”
- Hospital that declines to add MFN provision would be paid approximately 16% less
- Per government, differences in reimbursement methodologies can cause uncertainty for a hospital comparing BCBSMI's rates to anticipated payment rates from other insurers. To avoid risk of MFN application, hospitals sometimes contract with other payers at higher prices to avoid being penalized if audited for MFN compliance.

Relevant markets

- Product markets = sale of commercial group health insurance, including access to a provider network, and sale of commercial individual health insurance, with network access
- Geographic markets = series of individual local market areas across state

Motion to Dismiss Denied

- BCBSMI argued
 - “State action” immunity protects its MFN agreements
 - Federal court should abstain given role of state insurance department in regulating health insurance
 - Complaint does not plausibly or sufficiently describe product or geographic markets, market power or allege viable theory of harm to competition
 - Conduct exempt from state antitrust law
- Court denies motion to dismiss. [*U.S. v. Blue Cross Blue Shield of Michigan*](#), Case 10-14155 (S.D. Mich. Aug. 12, 2011)



Additional proceedings

- Private follow-on litigation against BCBS MI and some of the hospitals
- DOJ and state attorneys general also investigating other BCBS plans' use of MFNs
 - Investigations at early stage

Most recent health care merger enforcement

- FTC and DOJ track record in court poor from 1990s into first half of last decade in hospital mergers
- FTC pursues cases with renewed vigor since Evanston case, then INOVA hospital in Northern Virginia, and Carilion case in Roanoke, Virginia involving acquisition of outpatient centers, and Universal Health Services (psychiatric hospitals)
- Latest actions in Toledo, Ohio and now Rockford, Illinois

FTC and Ohio AG win injunction in Toledo hospital merger case

- FTC and Ohio AG allege acquisition of St. Luke's Hospital by ProMedica Health System will harm competition in Lucas County, Ohio markets for inpatient obstetric and general acute-care inpatient hospital services.
- Federal district court finds that concentration in the Lucas County market made the proposed acquisition presumptively illegal, and determined that ProMedica's various arguments failed to rebut that presumption.
- Though their corporate affiliation had already occurred, the court grants a preliminary injunction, requiring the parties to continue abiding by an existing Hold Separate Agreement for the duration of the FTC's administrative proceedings.
 - *FTC v. ProMedica Health System, Inc.*
[Case No. 3:11 CV 47 \(N.D. Ohio Mar. 29, 2011\)](#)

Parties' claims

- Government claims ProMedica is Lucas County's "dominant" health system, and further that by eliminating the competition from St. Luke's the acquisition would make ProMedica a "must have" system for commercial medical payers.
- ProMedica countered by arguing (1) acquisition would generate efficiencies and reduce prices to consumers; (2) acquisition would improve the ability of ProMedica and of St. Luke's to take productive advantage of federal health reform's support for Accountable Care Organizations; and (3) St. Luke's was a failing enterprise whose resources would only remain productive if the acquisition prevented the impending failure.

Court analysis

- Court rejects defense arguments:
 - Efficiencies were speculative;
 - St. Luke's was already well positioned to take advantage of opportunities created by health reform; and
 - St. Luke's was neither flailing nor failing, as evidenced by improvements to volume, occupancy, and financials that followed from a recent leadership change.
 - Though new entry or incumbent expansions might mitigate the acquisition's anticompetitive effects, that mitigation will not be timely, likely, or sufficient.
- The case now proceeds before an FTC administrative law judge, whose ruling may be appealed to the Commission itself, unless court of appeals reverses injunction.

FTC challenges proposed hospital transaction in Rockford, Illinois

- In the second antitrust merger challenge to similar mergers in the same city, the FTC on November 18 directed its staff to file suit to enjoin OSF Healthcare System's proposed acquisition of Rockford Health System. The FTC also filed an [administrative complaint](#), charging that the acquisition would reduce competition among hospitals and primary care physicians in Rockford, Illinois
- Twenty years ago, the federal District Court for the Northern District of Illinois, blocked a merger of Rockford hospitals due to similar antitrust concerns

FTC claims

- New FTC complaint alleges OSF would control 64 percent of general acute-care inpatient services in Rockford area, and face only one competitor. OSF and the sole remaining hospital would control 60 percent of the primary care physicians.
- The consolidation would give OSF greater leverage to raise rates to health plans, the complaint alleges
- OSF's proposed acquisition would increase the incentives and ability for the two remaining hospitals in Rockford to engage in coordinated anticompetitive behavior
- Acquisition would also allegedly eliminate non-price competition among the Rockford hospitals, reducing the quality, convenience, and breadth of services provided to local residents.
- Case is notable in its allegation that merger would create added risk of “coordinated” anticompetitive effects and not just “unilateral” anticompetitive effects

Health insurer merger enforcement

- DOJ stakes out aggressive public posture
- Bush Administration Antitrust Division and State of Nevada challenged harm to Medicare Advantage market from acquisition of Sierra Health Services by UnitedHealth Group
 - Consent agreement required divestiture
 - Rest of acquisition permitted to go forward
 - State AG obtained range of additional relief, including MFNs, charitable donations, physicians council, etc.
- 2010 challenge to proposed acquisition of local plan by BCBS Michigan
 - [Merger dropped](#) after DOJ and State AG announced challenge
- Both cases involved alleged market shares above 90%, so not a good indicator of government's approach to other situations
- Other health insurer acquisitions are being investigated closely, including use of “second requests” in circumstances where less investigation may have been likely before
- State insurance departments and State AGs also active

Antitrust Division challenges Montana plan's deal with hospitals

- DOJ and the State of Montana challenged agreement between Blue Cross Blue Shield of Montana and five of the six Montana hospitals that own New West Health Services health plan.
- Key components of the agreement were:
 - For six years, hospital defendants would cease purchasing health coverage from New West and would instead purchase coverage from BCBSM;
 - The hospital defendants would gain two seats on the board of BCBSM; and
 - BCBSM would pay the hospital defendants \$26.3M

DOJ allegations

- DOJ alleges that because the agreement would effectively deprive New West of the third of its enrollment represented by its owners.
- This would create the perception that New West would fold, and it follows that New West would in fact fold ("The Agreement effectively eliminates New West as a viable competitor in the sale of commercial health insurance.").
- Although complaint does not expressly explain what "acquisition" is technically effected by the parties' dealings, it characterizes the agreement as an acquisition unlawful under horizontal merger standards
- Complaint: (11/8/2011)
www.justice.gov/atr/cases/f277100/277177.pdf

Requirements of Montana settlement

- New West and hospital defendants to offer to sell New West's assets to PacifiSource – unless PacifiSource refuses, in which case sellers have a month to find other buyer before assets are taken into receivership by trustee to sell
- Hospital defendants to contract with the non-BCBSM acquirer for three years on substantially the same terms as are currently provided under existing contracts with New West
- BCBSM prohibited for six years from conditioning its contracts with providers on pricing or participation with other payors
- Competitive Impact Statement :
www.justice.gov/atr/cases/f277100/277173.pdf
- Proposed Final Judgment:
www.justice.gov/atr/cases/f277100/277165.pdf

Failed health plan merger challenge in NY

- *City of New York v. Group Health Incorporated, HIP Foundation, Inc., and Health Insurance Plan of Greater New York*
No. 10-2286-cv (2d Cir. Aug. 18, 2011) (upholding summary judgment against plaintiff New York City's challenge to health plan merger that would allegedly harm competition in "low-cost municipal health benefits market" and district court's refusal to permit amendment of complaint to present an alternative theory of antitrust injury not dependent upon a particular market definition, based on antitrust merger guidelines of FTC and Department of Justice)

Accountable Care Organizations (“ACOs”)

- Health reform law provides for provider-sponsored ACOs in Shared Savings Program (“SSP”) under fee for service Medicare program
- CMS originally proposed antitrust pre-screening mechanism to deny participation to ACOs hitting antitrust risk threshold that do not get favorable advance review from FTC or DOJ
- FTC and DOJ proposed new policy guidance
- CMS [final rule](#) abandons mandatory prior antitrust review. 76 *Fed. Reg.* 67,806 (Nov. 2, 2011)
- Antitrust agencies issue [revised final guidance](#), including new “safety zone” -- *Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program*, 76 *Fed. Reg.* 67,026 (Oct. 28 , 2011)
- CMS will give antitrust agencies aggregate claims data on allowed charges and fee-for-service payments for ACOs accepted into the SSP and copies of SSP applications of ACOs formed after March 23, 2010.

New FTC-DOJ enforcement policy on ACOs

- FTC-DOJ guidance applies to all Medicare ACOs, including those that wish to contract with commercial payers, regardless of date of formation
- New “safety zone” for ACOs meeting specific standards
- Safety zone applicability tied to provider membership relative to provider participation thresholds in defined “Primary Service Areas” (“PSAs”).

Antitrust Issues – Clinical Integration

- Prior antitrust guidance indicated that providers could avoid application of “*per se*” rule against price-fixing for joint negotiations with payers if they are (1) financially integrated via risk sharing or (2) clinically integrated and price negotiation by the provider network is reasonably necessary for venture to work.
 - Under 1996 policy statement, clinical integration is shown by implementing an ongoing program to evaluate and modify practice patterns by provider participants and creating a high degree of interdependence and cooperation among providers to control costs and ensure quality.
- New Enforcement Policy confirms that satisfaction of CMS’s requirements to be an ACO under the SSP would be sufficient to defeat *per se* pricing treatment of joint price negotiations by the ACO with commercial payers:
 - [I]f a CMS-approved ACO provides the same or essentially the same services in the commercial market, . . . [t]he [CMS] integration criteria are sufficiently rigorous that joint negotiations with private-sector payers will be treated as subordinate and reasonably related to the ACO’s primary purpose of improving health care services. . . . [T]he Agencies will provide rule of reason treatment to an ACO if, in the commercial market, the ACO uses the same governance and leadership structure and the same clinical and administrative processes.

New Safety Zone

- The Agencies will not challenge Medicare ACOs that fall within a new “safety zone,” absent extraordinary circumstances.
- To qualify, every independent ACO participant (e.g., *each* physician group, individual practitioner, or hospital) that provides the same service (“common service”) must have a combined share of 30% or less of each common service in each participant’s Primary Service Area, wherever two or more ACO participants provide that service to patients from that PSA.
 - PSA is the “lowest number of contiguous postal zip codes from which the [ACO participant] draws at least 75 percent of its patients.”
 - PSA to be score separately for each independent provider in ACO. CMS to make Medicare data available for calculations.

New Safety Zone

- Hospitals and ambulatory surgery centers must be “non-exclusive” to the ACO to be in the safety zone, regardless of PSA share.
 - To be non-exclusive, the provider must be allowed to contract individually or affiliate with other ACOs or commercial payers.
 - Exclusivity will be assessed based on practical realities, rather than simply by nominal phrasing of organizational documents or contracts.
- “Dominant provider limitation” if an individual provider in the ACO has a share in a PSA greater than 50% of any service that no other ACO participant provides to patients in the PSA.
 - Where the limitation applies, the provider must be non-exclusive to the ACO in order to qualify for the safety zone.
- Rural exception permits inclusion of one physician or group in any specialty regardless of share

Suspect behavior?

- Agencies flag four types of conduct that may be OK, but where present could raise potential competition concerns:
 - Use of “anti-steering,” “anti-tiering,” “guaranteed inclusion,” “most-favored-nation,” or similar clauses to discourage payers from directing or incentivizing patients to choose certain providers
 - Tying, expressly or via pricing policies, ACO’s services to payer’s purchase of other services from providers outside the ACO venture (and vice versa)
 - Contracting on an exclusive basis with providers
 - Restricting a payer’s ability to make cost, quality, efficiency, and performance information available to enrollees, if it is similar to information used in Medicare Shared Savings Program
- When might any of these actions itself be an antitrust violation?

Review process

- Agencies will provide process for expedited voluntary requests for review
- For ACOs that do not qualify for safety zone, agencies will consider a range of information suggesting that PSA shares may not reflect actual market power
- They will also consider pro-competitive justifications

Determining PSA share levels

- To perform the PSA calculations, an ACO must: (1) identify each service provided by two or more independent ACO participants; (2) collect patient zip code data from those participants; (3) collect coding or billing data from those participants (which may or may not be in the same computer file as the zip code data); and (4) match the zip codes to the Medicare Specialty Codes (“MSCs”) (in the case of physicians), outpatient treatment categories (in the case of outpatient facilities), or Major Diagnostic Categories (“MDCs”) (in the case of hospitals).
- Then the ACO must match Medicare fee-for-service allowed charges (physicians), Medicare fee-for-service payments (outpatient facilities), or inpatient discharges (hospitals) to the zip codes and specialty codes or categories.

Old wine in new bottles

- Some providers may seek to employ new health reform lingo to try out familiar “united front” managed care contracting strategies, with lip service to integration
- Enforcement agencies will likely pierce the rhetoric, where integration claims are empty, to challenge price fixing activities. Cf. *North Texas Speciality Physicians v. FTC*, No. 06-60023 (5th Cir. 2008); *Southwest Health Alliances, dba BSA Provider Network* (FTC complaint/consent agreement (May 10, 2011))
- FTC and DOJ may not, though, press to the limit where there is a legitimate quality improvement and clinical integration argument