

Health Care Industry
Emerging Legal
Issues Webinar Series

Health Care Antitrust Update: Accountable, Coordinated, and Reformed, So What's New?

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The webinar will begin shortly, please stand by. The materials and a recording will be sent to you after the event.

Agenda

- U.S. agency update
- Challenges to provider mergers
- Challenges to health plan mergers
- Problematic contract language imposed by powerful players
- Provider collaboration initiatives
- Health plan and provider vertical integration
- “State Action” developments

Enforcement Update

- DOJ takes lead in health insurer matters and conduct investigations concerning non-profit hospitals
- FTC takes lead in provider mergers, provider conduct (other than non-profit hospitals), PBM, and pharmaceutical company matters
- Agencies success batting average in court is up from prior years
- Many state attorneys general are also actively enforcing
- Health reform environment pushing more integration that brings antitrust to the fore

Key takeaway: DOJ and FTC actively looking for cases, will not accept rote recitations of reform justifications, and ready and willing to litigate

Recent Challenges to Provider Mergers

- *Saint Alphonsus Medical Center-Nampa Inc. et al. v. St. Luke's Health System* (9th Cir. Feb. 10, 2015) (upholding divestiture order and rejecting defense based on alleged facilitation of integrated care from medical group acquisition)
- *Commonwealth of Massachusetts v. Partners Healthcare System* (June 24, 2014) (complaint for injunctive relief and joint motion for entry of final judgment by consent); (Jan. 29, 2015) (order denying approval of consent judgment in light of deficiencies in remedial order and withdrawal of support by Attorney General); (February 2015) (parties terminate proposed transaction)
- *FTC and State of Ohio v. ProMedica Health System* (N.D. Ohio Jan. 7, 2011); *Pro Medica Health System v. FTC* (6th Cir. April 22, 2014) (affirming order requiring divestiture), *cert. denied* (U.S. May 4, 2015)
- OSF/Rockford – complaint against hospital merger filed 2011; district court opinion granted preliminary injunction 2012 (deal abandoned thereafter)
- *In re Reading Health System* (Nov. 16, 2012) (FTC administrative complaint) (deal abandoned)
- *In re Omnicare* (FTC complaint) (Jan. 27, 2012) (long term care pharmacy deal abandoned after challenge alleging putative impact on Medicare Part D plans nationally)

Key Takeaways

- **Principal focus:** Impact on price negotiations with health plans concerned about network marketability and sufficiency
- **Concern:** Whether combining providers are close substitutes, or at least one is an important potential substitute for the other
- **Emerging issue:** Even if the merging providers are not head to head competitors for patients, will leverage with payors still be enhanced
- **Efficiency/ “deal needed for health reform/integrated care” claims scrutinized:**
 - Is merger necessary to achieve benefits?
 - Will benefits be passed through to consumers and payors?
 - Do benefits outweigh foreseeable anticompetitive effects?

Health Plan Merger Challenges

- DOJ investigates health insurer mergers. Competition reviews also by state attorneys general and insurance departments
 - Aetna/Coventry (consummated 2013 with state required Medicaid managed care program divestiture in Missouri)
 - Humana/Arcadian (consummated 2012 with Medicare Advantage divestitures)
 - Anthem/Amerigroup (consummated 2012 with Medicaid managed care plan divestiture in Virginia)
- Key Issues:
 - Geographic market
 - Product market definition (large vs. small group; individual; Medicare Advantage; exchange?)
 - Impact of new health care exchanges on market
 - Procompetitive rationale? Need for scale?

Problematic Contracting Practices by Powerful Players

Recent cases and guidance address conduct that can raise anticompetitive concerns:

- Use of “anti-steering,” “anti-tiering,” “guaranteed inclusion,” “most-favored-nation,” or similar clauses to discourage payors from directing or incentivizing patients to choose certain providers
- Certain tying, expressly or via pricing policies, of services to a payor's purchase of other services
- Network contracting on an exclusive basis with providers
- Restricting a payor's ability to make cost, quality, efficiency, and performance information available to enrollees
- Powerful payor insistence on market-blanketing MFN clauses that have the effect of blocking price reductions to competitors rather than assuring competitiveness of plan seeking MFN protection

Case Law

- *Cascade Health Solutions v. PeaceHealth* (9th Cir. 2008) (challenge to bundled pricing by a hospital linking its primary and secondary care services to the sale of tertiary services in which it was the sole hospital provider in the local market; court applied discount attribution test.)
- *United States v. United Regional Health System* (N. D. Tex. 2011) (DOJ consent order resolves challenge to exclusionary discounting practice that had the effect of forcing exclusive contracting); *see also Methodist Health Services Corp. v. OSF Healthcare System* (C.D. Ill. Mar. 25, 2015) (complaint)
- *UFCW & Employer Benefit Trust v. Sutter Health* (Sup'r Ct. S.F. Cal. April 14, 2014) (complaint challenging contract provisions)
- *United States and State of Michigan v. Blue Cross Blue Shield of Michigan* (E.D. Mich. 2010) (DOJ and state challenged use of MFN clauses where insurer allegedly had +60% market share and MFN terms allegedly created spread from rates to smaller competitors)
- *Cf. Mueller v. Wellmark* (Iowa Sup. Ct. Feb. 27, 2015) (confirming that health insurer's negotiation of provider rates on behalf of self-insured customers does not constitute price fixing or unreasonable restraint of trade)

Key Takeaway

Where one of the contracting parties has “market power” and demands inclusion of potentially anticompetitive language into an agreement, antitrust liability can go in both directions if the arrangement is deemed an agreement in restraint of trade.

Provider Collaborations and Networks¹

Agreements on price: “Per Se” or “Rule of Reason”?

- Is there real integration that provides efficiencies - clinical, financial, or otherwise?
- Is joint price setting needed to make the initiative work?
- Will the venture block competition or cause competitive harms that outweigh benefits – too much market power?
- Exclusivity commitments by providers that create a bottleneck or united front?

¹ See DOJ/FTC Statements of Antitrust Enforcement Policy in Health Care, August 1996, Statements 8 and 9

<https://www.ftc.gov/sites/default/files/documents/reports/revised-federal-trade-commission-justice-department-policy-statements-health-care-anitrust/hlth3s.pdf>

Department of Justice and Federal Trade Commission Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 *Fed. Reg.* 67,026 (Oct. 28, 2011). <http://www.gpo.gov/fdsys/pkg/FR-2011-10-28/pdf/2011-27944.pdf>

Key Takeaways

- Even where there is clinical or financial integration, an antitrust violation can still occur if the combined enterprise will be able to wield market power via exclusivity with providers and, in some instances, over-inclusiveness.
- Some providers may be tempted to employ health reform lingo to try out familiar “united front” managed care contracting strategies, but with only lip service to real integration, or its deferral to a later date. The enforcement agencies will pierce the rhetoric, where integration claims are empty, to challenge price fixing activity.²
- The antitrust agencies are not likely to press to the limit where there is some real effort toward legitimate quality improvement and clinical integration and no “market power” problem.
- Where there is real integration, but there might also be a market power problem, agencies sometimes have to make a tough call.

²Cf. *North Texas Speciality Physicians v. FTC*, (5th Cir. 2008); *Southwest Health Alliances, dba BSA Provider Network* (FTC complaint/consent agreement (May 10, 2011))

Health Plan/Provider Integration

- Health care reform driving integration in care, and closer collaboration between payors and providers
 - Health plans acquiring providers of health care services or doing joint ventures with providers
 - Providers taking risk and arranging care for defined population
- Vertical mergers do not usually pose serious antitrust risk
 - See Department of Justice statement re closing of investigation of acquisition of West Penn Allegheny Health System by Highmark (April 12, 2012)
 - Could raise issues where via acquisition a dominant firm (whether health plan or provider) forecloses competitor access to services or needed network participation (similar issues arise in context of ACOs/clinical integration)
- Exclusivity terms in collaborations potentially problematic if, due to market share, they create bottleneck or seriously foreclose other payors from access to viable provider network or block other providers access to essential payor customers

“State Action” Immunity

- Supreme Court clarifies state action immunity:
 - In *North Carolina Board of Dental Examiners v. FTC*, the Supreme Court on February 25, 2015 denied antitrust immunity to a state licensing board dominated by practicing professionals where the board’s actions were not subject to active state supervision.
 - In 2013, the Supreme Court in *FTC v. Phoebe Putney Health System* held that a local public hospital authority lacked antitrust immunity because the hospital authority statute did not demonstrate legislative intent to displace competition either through regulation or monopoly service. The Court contrasted the language in the Georgia statute with that in other cases where the displacement of competition was the inherent, logical, or ordinary result of the exercise of authority delegated by the state legislature.
- State action immunity comes up frequently in health care context
 - Public hospitals
 - State efforts to immunize certain conduct
 - Licensing boards and other state-based credentialing
 - *Teladoc, Inc. v. Texas Medical Board* (W.D. Tex. 2015)(antitrust lawsuit alleging Texas Medical Board rule requiring physicians to meet in person with a new patient violates the Sherman Act and should be enjoined)

Conclusion & Speakers



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- *Privacy & Cybersecurity: Evolving Risks and Liability Trends*: September 29 – Robin Campbell, Elliot Golding
- *How to Survive a Subpoena/CID*: November 17 - John Brennan, David O'Brien