Healthcare Antitrust Bootcamp Webinar Series

Part I: Introduction and Antitrust Overview

This webinar series is brought to you by the Antitrust Practice Group

October 16, 2013

Moderator:
Douglas Ross, Davis, Wright Tremaine

Presenters:
Leemore Dafny, Northwestern University and Bates White, LLC
Arthur Lerner, Crowell & Moring LLP
Shawn Johnson, Crowell & Moring LLP

Disclaimer: The written materials for this session were prepared by Dr. Dafny, Mr. Lerner and Mr. Johnson
Basic Antitrust Statutes

- Section 1 Sherman Act, 15 U.S.C. §1
  - Agreements in restraint of trade

- Section 2 Sherman Act, 15 U.S.C. §2
  - Monopolization and attempted monopolization

- Section 7 Clayton Act, 15 U.S.C. §18
  - Anticompetitive mergers and acquisitions

- Section 5 FTC Act, 15 U.S.C. §45
  - Unfair methods of competition

- State antitrust and unfair trade and insurance practice laws
Who enforces?

- U.S. Government – Dept. of Justice and Federal Trade Commission
  - Advisory opinions and business review letters
  - Explanations re law enforcement actions

- State Attorneys General

- Private Plaintiffs

- State Insurance Departments have similar authority over insurers
Risks of Non-Compliance

- Civil fines
- Investigations
- Civil litigation
- Criminal sanctions
- Employment sanctions
- Injunctions and consent decrees
- Merger delays and/or prohibitions
- Treble damages and awards of attorneys fees
Antitrust Penalties

Tougher penalties for criminal antitrust violations:

- 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
Other Risk Factors

- Government enforcers may learn of violations from customers, providers and competitors, including firms trying to get a better deal by self-reporting.

- Ever rising costs and consolidation in the industry is sparking greater enforcement interest.
Background of Antitrust in Health Care

- **AMA v. United States**, 317 U.S. 519 (1943) – boycott of group health plan doctors in District of Columbia unlawful
- **Hospital Bldg. Co. v. Trustees of Rex Hospital**, 425 U.S. 738 (1976) – local hospital’s activities had substantial effect on interstate commerce
- **National Soc’y of Prof. Engineers v. United States**, 435 U.S. 679 (1978) – agreement among competitors to restrain competition not justifiable on ground that competition itself will lower quality
- **Group Life & Health Ins. Co. v. Royal Drug Co.**, 440 U.S. 205 (1979) – agreements between health insurers and providers not part of McCarran-Ferguson Act “business of insurance” antitrust exception
- **AMA v. FTC**, 638 F.2d 443 (CA2 1980), aff'd by an equally divided Court, 455 U.S. 676 (1982) (*per curiam*) – ethical restraints on corporate practice and truthful advertising unlawful
- **Arizona v. Maricopa County Med. Soc’y**, 457 U.S. 332 (1982) – physician network that jointly negotiates rates for participating physicians is per se illegal, absent indicia of integration to which price setting is ancillary
- **FTC v. Phoebe Putney Health System, Inc.**, 133 S.Ct. 1003 (2013) – acquisition of competing hospital by a state-created Hospital Authority not immune under “state action” doctrine
Agreements in Restraint of Trade
(Sherman Act Section 1)
Agreements in Restraint of Trade

- Must involve “restraint of trade”
  - Mere advocacy or recommendations not enough
  - Must agree to DO something that affects conduct in the marketplace

- Requires at least two parties with separate economic identities
  - Distinction between a corporation’s board of directors (still one “person”) and participants in a joint venture or other collaboration (professional association, IPA, ACO, hospital medical staff)
  - *Copperweld* doctrine confirms that parent and wholly owned subsidiaries, and sister corporations, are not capable of conspiring with each other
  - Outer edges of doctrine not clear where there are partially controlled non-profit corporations involved in collaborations or alliance
Per Se v. Rule of Reason

- Some agreements are per se illegal
  - Price fixing, market and customer division, and certain group boycotts and tie-in arrangements. For example:
    - Joint price negotiations and boycotts of health plans have long been targeted
    - Attempts have been made to target hospitals for conspiracy to depress wages of nurses

- Most agreements are subject to “rule of reason” balancing test
  - Only agreements that unreasonably restrain trade are unlawful
  - Reasonableness is assessed in terms of competition: balance procompetitive benefits against anticompetitive effects
  - Market power can be critical to rule of reason analysis

- Some activities also subject to “Quick Look” review
- Otherwise anticompetitive restraint might be permissible if ancillary to bona fide joint venture
Provider Network Negotiations with Health Plans

- For many years, joint provider negotiations with health plans has been a constant focus of antitrust enforcement.

- This is of continuing importance, especially as providers and payors adapt to health reform and public policy goals of greater care coordination and increased efficiency.

- A network that is sufficiently integrated, either financially (via capitation, risk sharing or bonus arrangements) or clinically, will not be subject to per se condemnation.
  
  - This is focus of 1996 Statements of Antitrust Enforcement Policy in Health Care, the agencies’ more recent ACO policy statement, and numerous advisory opinions and enforcement actions.

- Even where network offers efficiency benefits and is not per se illegal, it may pose Section 1 restraint of trade or Section 2 monopolization issues if market power concerns are raised by breadth of network and exclusivity features.
Proving an Antitrust Conspiracy

- In order to prove that a conspiracy existed, the evidence must show:
  - The alleged members of the conspiracy
  - *In some way*
  - Came to an agreement or *mutual understanding*
  - To accomplish a *common purpose*
Proving an Antitrust Conspiracy, cont’d

- However, the evidence need not show that:
  - Its members entered into any *express, formal, or written agreement*;
  - They *met together*; or
  - They *directly stated their purpose, the details of the plan*, or the *means* by which they would accomplish their purpose

- The agreement itself may have been entirely unspoken
How Do Bad Things Happen to Good People?

- Not usually just a rogue individual
- Well-meaning individuals get carried away/rationalize
- Activity that led to enforcement included:
  - Sharing (too much) information with competitors
  - Discussing a common justification to resist discounting
  - Joint negotiations to “level the playing field”
  - “Sham” joint ventures that appear to government to be nothing more than vehicles to facilitate price fixing
Case Study: Puerto Rico Nephrologists

- Eight independent doctors comprised 90 percent of the nephrologists in southwest Puerto Rico

- FTC complaint alleged illegal collective bargaining with insurers and refusal to treat patients when price demands were not met in violation of Section 5 of the FTC Act

- May 2013: Final Consent Agreement approved
  - Doctors prohibited from:
    - Jointly negotiating prices
    - Jointly refusing to treat patients
    - Jointly refusing to deal with any insurer
Collusion and Associations

- Associations are the “incubators of cartels”
  - US antitrust litigation often involves an association
  - Post-*Twombly*, plaintiffs have turned to associations to meet the “plausibility” test, leading to even greater exposure
  - In health care, this focus may be on professional associations, medical staff, and organizations such as physician-hospital organizations and individual practice associations

- Preventative measures include:
  - Internal policies regarding participation and attendance
  - Compliance training and audits
Monopolization
(Sherman Act Section 2)
Monopolization

- Principal focus: Abuse of “monopoly power” or “dominant position” to exclude competitors

- Two critical elements:
  - Market power (typically evidenced by high market share)
  - Exclusionary conduct (a/k/a “bad acts”)

- Other key issues:
  - Impact on competitors
  - Legitimate (pro-competitive) rationale for conduct
Legal Commercial Success v. Illegal Monopolization

- Excellent products, prices, and service may yield a 95% market share
- An illegal monopolization scheme may also yield a 95% market share
- The difference: What you do to get there or stay there

Trinko: “To safeguard the incentive to innovate, the possession of monopoly power will not be found unlawful unless it is accompanied by an element of anticompetitive conduct.”

Dentsply: “[T]here must be proof that competition, and not merely competitors, has been harmed.”
Exclusionary Conduct

- Potentially suspect behavior
  - Tying and (certain) bundling of multiple products/services
  - Refusing to deal with competitors (in certain situations)
  - Exclusive dealing (in certain situations)
  - Predatory/Below-Cost Pricing
  - Most Favored Nation clauses

- Court balances anticompetitive effect (degree of market foreclosure) v. legitimate business justification
Case Study: Cascade vs. PeaceHealth

- Cascade and PeaceHealth are the only two hospitals in Lane County, Oregon
  - Cascade offered primary and secondary care services
  - PeaceHealth offered primary, secondary and tertiary care services
- PeaceHealth discounted its tertiary care services to insurance companies that made PeaceHealth their sole preferred provider of all services
- Cascade sued, alleging that PeaceHealth had engaged in “predatory” discounting and attempted to monopolize the market for primary and secondary care services
- Jury awarded $5.4 million (trebled to $16.2 million)
Anticompetitive Transactions
(Clayton Act Section 7)
Mergers & Acquisitions

- Clayton Act §7 prohibits mergers that will result in “market power” and increased prices
- Impact assessed in specific relevant product and geographic markets
- Agencies use market shares as a key diagnostic tool, but not definitive
- Barriers to entry among many factors that can affect outcome
- Federal authorities give weight to verifiable merger-specific efficiencies
Hart-Scott-Rodino Act

- Acquisitions valued above statutory threshold (currently $70.9 million) require advance notification to FTC and DOJ under HSR Act

- Purpose:
  - To avoid the difficulty and expense of challenging anticompetitive mergers and acquisitions after they have occurred, and
  - To allow the agencies to preserve, as opposed to try to restore the state of competition
HSR Act (cont.)

- Parties must observe “waiting period” before closing
  - Agencies generally have 30 days to review transaction
  - At expiration of waiting period, agencies may seek additional information ("second request")
  - If second request issued, parties may not close until 30 days after substantial compliance

- If agency ultimately has competitive concerns, can seek injunction

- Consent agreement is a possible outcome, where divestiture of some operations is sufficient to restore competition. Non-structural relief also possible, but less likely to be found sufficient by itself.

- Agencies also challenge consummated transactions, including those below the HSR thresholds and those that receive HSR clearance
FTC and DOJ Guidance

- *Horizontal Merger Guidelines* issued jointly by the agencies explain how they evaluate horizontal combinations
  - Adverse Effects: Unilateral Effects and Coordinated Effects
  - Market Definition (Product and Geographic) and the Hypothetical Monopolist Test
  - Counteracting Effects: Entry and Efficiencies

- 1996 *Statements of Antitrust Enforcement Policy in Health Care* discuss enforcement issues in the healthcare sector
  - Mergers that involve small (less than 100 beds) general acute care hospitals are not challenged absent extraordinary circumstances
Merger Track Record

- Agencies have long focused on hospital mergers. FTC has had success recently in a number of matters:
  - April 2012: In Illinois, OSF Healthcare and Rockford Health abandoned merger after FTC challenge and federal court preliminary injunction
  - March 2012: FTC required ProMedica to divest St. Luke’s Hospital in Toledo area, following favorable decision for FTC in court; under appeal to 6th circuit
- FTC has also challenged hospital acquisitions of non-general acute care hospital entities
  - September 2013: Idaho trial to prevent major health system from acquiring independent physician practice
- FTC has also focused on other health services mergers
  - May 2012: FTC required divestiture of 60 outpatient dialysis clinics in 43 local markets as condition to settling charges in merger of two of the largest outpatient dialysis providers
  - December 2012: FTC required health system to release cardiologist employees from non-compete clauses following acquisition of two Reno cardiology groups
- DOJ primary federal forum for investigation of health insurance mergers
  - More focus last few years as concerns have grown about concentration and increased public attention
Case Study: Reading Health System

- Proposed merger of Reading Health System (737 beds) and Surgical Institute of Reading (physician-owned specialty hospital, 15 beds)
- FTC alleged combined market share of 49-71 percent in four product markets
- FTC sued, alleging potential loss of head-to-head competition, resulting in higher costs and lower quality
- Reading Health System dropped its proposed acquisition following FTC and State AG announcement of intent to challenge the merger
Case Study: Humana/Arcadian

- Humana announced agreement to acquire Arcadian
- DOJ challenged combination of two providers of Medicare Advantage (“MA”) plans in 45 counties and parishes
- Complaint alleged the combination would harm competition in the MA business, potentially leading to higher prices and reductions in quality or breadth of benefits available to MA enrollees
- In order to remedy those concerns, Humana and Arcadian agreed to divest MA plans for individuals in 51 counties and parishes in Arizona, Arkansas, Louisiana, Oklahoma, and Texas
- October 2012: Final Judgment entered
Affirmative Defenses/Immunity

- “State action” doctrine where the challenged restraint reflects a clearly articulated and affirmatively expressed state policy, and that policy is actively supervised by the state (*FTC v. Phoebe Putney Health System, Inc.*, 133 S.Ct. 1003 (2013) (acquisition of competing hospital by state-created Hospital Authority was not immune under state action doctrine))

- Noerr-Pennington Act – protects petitioning government for action, except for sham activities where petitioning activity itself imposes harm to competition without regard to eventual outcome of government process

- Health Care Quality Improvement Act – bars damages suits for peer review activities meeting specified standards. 42 U.S.C. §§ 11101 et seq.

- McCarran-Ferguson Act – exempts “business of insurance” where subject to state regulation and activity is not boycott, coercion or intimidation. 15 U.S.C. §§ 1011 – 1014
Discussion: Antitrust “Hot” Issues in Health Care Delivery and Insurance Markets

- What factors are driving trends towards consolidation -- of hospitals, physicians and other providers?
  - Is there a conflict between antitrust principles (concerns about collusion and the aggregation of market power) and the Affordable Care Act’s push for greater care coordination and integration?
  - Do existing antitrust laws provide enforcers with appropriate tools to block problematic provider consolidations?
    - E.g., Are markets harmed by health systems’ “vertical consolidations” of physicians and ancillary providers or “horizontal” consolidations across contiguous geographic “markets”?

Discussion: Antitrust “Hot” Issues in Health Care Delivery and Insurance Markets

- What factors are driving trends towards payor consolidations?
  - To what extent do payors’ “vertical” acquisitions of provider entities raise antitrust concerns? Their “horizontal” acquisitions of payors in contiguous geographic “markets”?
- To what extent are ACOs generating antitrust scrutiny?
- The ACO Statements identify certain conduct that dominant providers may wish to avoid to minimize antitrust risk (e.g., exclusive contracts, bundled pricing, “anti-steering,” and Most Favored Nation provisions in managed care contracts). Are there circumstances under which this conduct is more or less likely to generate antitrust concern?
Any views or advice offered in this publication are those of its authors and should not be construed as the position of the American Health Lawyers Association.

“This publication is designed to provide accurate and authoritative information in regard to the subject matter covered. It is provided with the understanding that the publisher is not engaged in rendering legal or other professional services. If legal advice or other expert assistance is required, the services of a competent professional person should be sought”—from a declaration of the American Bar Association