Healthcare Antitrust Bootcamp Webinar Series

Part I: Introduction and Antitrust Overview

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

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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
  - *Statements of Antitrust Enforcement Policy in Health Care* (1996)
  - *Antitrust Guidelines for Collaborations Among Competitors* (2000)
  - *Improving Health Care: A Dose of Competition* (2004)
  - *Statement of Antitrust Enforcement Policy Regarding ACOs Participating in the Medicare Shared Savings Program* (2011)
  - 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
- *Goldfarb v. Va. State Bar*, 421 U.S. 773 (1975) – end of "learned professions" exception
- *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
- *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982) (agreement among health care professionals via peer review under insurance company arrangement not within McCarran-Ferguson Act immunity for "business of insurance"
- *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. Indiana Fed'n of Dentists*, 476 U.S. 447 (1986) – collective refusal to cooperate in utilization review unlawfully restrained competition
- *Patrick v. Burget*, 486 U.S. 94 (1988) – anticompetitive abuse of hospital privileges process not protected by "state action" immunity
- *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

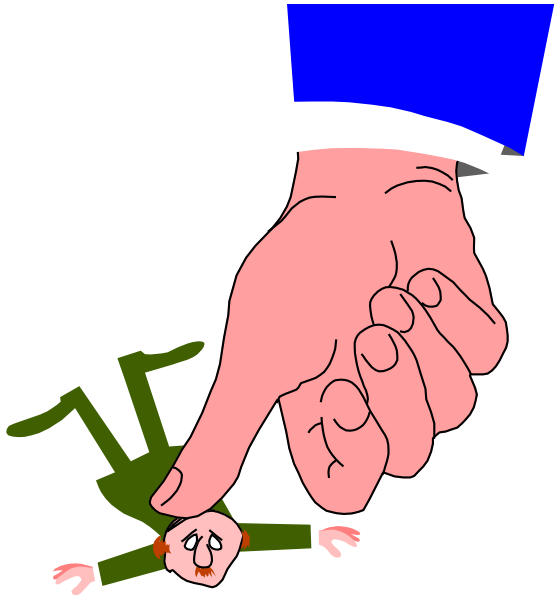
Case Study: Puerto Rico Nephrologists

- 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 case 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?