PROVIDER POWER: USES AND ABUSES

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Recent cases such as *United States v. United Regional Health System* and *West Penn Allegheny Health System Inc. v. UPMC,* address alleged exercise of market power by providers acting alone and in conjunction with payors. In addition, restrictions on plans' disclosure of cost and quality information to enrollees and referring practitioners, contracting practices in relation to tiered benefit plans, and "all or nothing" contracting may also be the focus of antitrust scrutiny. This panel, which includes leading federal antitrust enforcement officials, will explore these antitrust topics, including discussion of the accountable care organization ("ACO") policy statement from the FTC and DOJ.

I. *United States v. United Regional Health System* -- Hospital pricing allegedly used as lever to exclude competition

Antitrust courts and the antitrust enforcement agencies have long sought to develop tools to distinguish aggressive price competition from exclusionary anticompetitive practices. Price reductions are normally viewed favorably by the antitrust laws. For decades, antitrust law has given attention to defining or clarifying the narrow circumstances in which prices

may be set so low that, in conjunction with other factors, a claim of monopolization or attempted monopolization for predatory pricing might be made out. Focus has long been given to assessments of "below cost" pricing and to appropriate "cost" benchmarks -- e.g., average cost, variable cost, marginal cost, etc. – in this analysis. In health care, because pricing for services is so often negotiated in the context of managed care contracting in which prices are set across a range or "bundle" of services and types of providers, even more complex issues can arise.

The *PeaceHealth* litigation in the Ninth Circuit a few years ago focused attention on bundled pricing. That case involved a hospital organization linking sale of all its services to pricing in the sale of tertiary services that only it offered in a local market area. See *Cascade Health Solutions v. PeaceHealth, 515 F.3d 883 (9th Cir.* 2008). A recent Department of Justice and Texas Attorney General antitrust enforcement action has again focused attention on discounting conditioned on exclusion of a competing hospital from managed care networks. In *United States v. United Regional Health System,* the United States and the Texas Attorney General accused 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, Texas area. Complaint, Case No.: 7:11-cv-00030 (N.D. Tex. 2/25/2011). A negotiated final judgment imposes constraints on the hospital (9/29/2011).

What are the lessons of this case? Do hospitals need to fear engaging in aggressive price competition? Do hospitals have to hire antitrust economists and lawyers for every managed care contract negotiation? Are there legal risks for payors in dealings with hospitals that offer price terms that are contingent on narrow provider network configurations?

A. Complaint allegations of monopoly power

The complaint first makes a series of allegations to support the assertion that United Regional has 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;
- United Regional is a 369-bed hospital with trauma, cardiac, and neonatal care services that make it a "must have" hospital for insurers;
- United Regional provides 90 percent of inpatient hospital services and 65 percent of outpatient surgical services in the Wichita Falls area;
- Competitors are Kell West Regional Hospital, a small 41-bed acute care hospital that opened shortly after the 1997 merger, and an ambulatory surgery center; and

- Complaint alleges United Regional is one of the most expensive hospitals in Texas, with rates 70 percent higher than Kell West's.

B. Challenged conduct

The core allegation is that United Regional offered "discounts" (up to 25%) off billed charges, but that the discount would fall to 5% if the insurer contracts with a competing facility. The notion that a provider would give a payor a better deal for inclusion in a narrower provider network is not unusual. Indeed, it is the underpinning of managed care contracting that has been prevalent in health care markets over the last 30 years. Were it generally proscribed we would seemingly return to the days when insurers contracted with all providers, had little if any ability to negotiate for improved rates and there was little if any downward market pressure on provider pricing. DOJ and the State Attorney General presumably have no intention of interfering with the typical dynamics of managed care contracting. So what did they think was so special in United Regional? And was it really special?

The complaint alleged the following:

First, according to DOJ and the AG, attributing the value of the discount difference (25% compared to 5%) <u>across all United Regional patients</u> to the rates for patients that might otherwise have gone to Kell West, the net rates that would actually be received by United Regional for

these “contested” patients would not even cover United Regional’s marginal cost. There is a lot packed in this one sentence. The gist is that for those patients who would come to United Regional no matter what, there was no competitive reason for United Regional to drop its prices for services to them. The government claims therefore that the dollar value of ALL THE PRICE REDUCTIONS should be netted against the prices charged by United Regional for the patients in competitive play. The resulting net price for services to those patients should be compared to the costs of providing those services, the government claims, as part of determining if the pricing is unreasonably exclusionary and not just tough competition. In this case, the government claims, the equation results in a conclusion that the services for the “contested” patients were way below cost. As a result, it would follow, an equally efficient competitor could not conceivably compete for payor business so long as United Regional were the only available source for the other lines of services, since for it to lower its prices enough to convince the payor to qualify for only the 5% discount from United Regional, it would have to reduce its costs way below its costs, and it would not have any other lines of service in which to make up the difference.

An alternative prism is to view the 5% discount option as not being a bona fide alternative, compared to the 25% discount offer conditioned on exclusion of Kell West. Viewed this way, United River was effectively

requiring exclusivity as a condition of doing business, knowing payors could not accept the alternate proposal.

According to the complaint, apart from Blue Cross Blue Shield of Texas, "not one insurer opted for the non-exclusive rate for more than twelve years." BCBS Texas premiums in Wichita Falls are higher than other payors, the complaint says.

Thus, according to DOJ, the discount offered by United Regional was not just hard ball competition, it was actually a form of predatory pricing the amounted to monopolization. It is not clear whether the government viewed it as critical to its case to show that United Regional would recoup the reduced pricing through increased prices once its competition were vanquished.

C. The remedy in *United Regional*.

Under the negotiated final judgment reached via settlement, United Regional may not condition any insurer's contract or rates on the insurer it not contracting with a competitor of United Regional. United Regional may not refuse to contract, terminate a contract, or discriminate in contracting terms because an insurer contracts with a competing provider. It also may not contract on a conditional volume discount basis, except for certain permitted "incremental" volume discounts, outlined below. An additional

constraint is that United Regional may not bar health insurers from encouraging use of other providers.

The final judgment does permit United Regional to offer an "incremental volume discount" where the ratio of (a) the rates applicable after the threshold volume is achieved, divided by (b) billed charges, exceeds the hospital's cost to charge ratio in its Medicare cost report.

Note that the requirements in the final judgment are intended to prevent antitrust violations and remedy harm to competition by a competitor the government has claimed has taken unlawful steps to maintain and extend a monopoly. The final judgment presumably contains "fencing in" language premised on the defendant having crossed the line. The case, though, does raise questions about finding the line separating legitimate competition from monopolistic behavior.

D. Possible risk for payors

The *United Regional* suit was brought only against the hospital as Sherman Act §2 monopolization claim. A private plaintiff in a similar suit could conceivably bring file on a Sherman Act §1 conspiracy/agreement theory, as well, and bring payors into the case. Note that the Department of Justice's complaint against Blue Cross Blue Shield of Michigan concerning use of "most favored nation" clauses was also brought only against one defendant, and not against the hospitals who had contracted with the health

insurer on those terms. However, that complaint alleged that the plan's agreements with hospitals violated Section 1 of the Sherman act, which implies that the hospitals were co-conspirators with the allegedly dominant health insurer that was supposedly insisting on the MFN language. By analogy, a complainant in a future suit involving issues similar to United Regional could attack not only the hospital offering price reductions conditioned on exclusion of a competitor from a managed care network, but also against any health plan that accepted such an offer.

There are some parallels to cases where a new entrant hospital or surgi-center claims that one or more payors conspired with a dominant hospital or with each other to exclude the plaintiff new entrant provider. See *Heartland Surgical Specialty Hospital LLC v. Midwest Division, Inc.,* 527 F.Supp.2d 1257 (D.Kan. 2007).

II. ***West Penn Allegheny Health System Inc. v. UPMC*** **-- Reciprocal undertakings between allegedly dominant provider and payor as potential obstacle to competition**

West Penn Allegheny Health System (Allegheny), the second largest hospital system in the Pittsburgh area, sued the dominant hospital system (UPMC) and the dominant health insurer (Highmark) for conspiring to "protect one another from competition." Allegheny alleged that UPMC agreed to use its power in the provider market to insulate Highmark from competition in the health insurance market by refusing to contract with

Highmark's rivals and by gutting a competing insurance company UPMC had established. In return, Highmark allegedly agreed to protect UPMC from competition by providing artificially depressed reimbursement rates to Allegheny while paying UPMC supracompetitive rates, by removing its "low-cost" insurance plan from the market, and by engaging in other acts to harm Allegheny. Allegheny also alleged that Highmark increased its premiums to afford the higher rates paid to UPMC, which it was able to do because UPMC had insulated it from competition. Finally, Allegheny alleged that UPMC attempted to monopolize the Pittsburgh-area market for specialized hospital services by soliciting physicians away from Allegheny, pressuring community hospitals to refer all patients to UPMC, and making defamatory statements about Allegheny.

The federal district court dismissed the complaint, holding that Allegheny: (1) failed to allege a "conspiracy"; (2) had not suffered an "antitrust injury" caused by the conspiracy; and (3) had failed to show UPMC engaged in "anticompetitive conduct" necessary to support an attempted monopolization claim. On appeal, the Third Circuit reversed, criticizing the district court for apparently imposing a heightened pleading requirement due to the complexity of the case. No. 09-4468 (3d Cir. Nov. 29, 2010). With respect to the conspiracy claims, the Third Circuit held that the complaint contained sufficient allegations to establish a conspiracy that caused anticompetitive effects in the market.

The court found that Highmark did not cause an antitrust injury when it allegedly removed the low cost insurance plan from the market, explaining that a "supplier" such as Allegheny cannot suffer an antitrust injury "when competition is reduced in the downstream market [i.e., the insurance market] in which it sells goods or services." Similarly, the court held that Highmark's alleged refusal to refinance a loan it had made to Allegheny did not cause an antitrust injury. The Third Circuit concluded, however, that Highmark's alleged payment of artificially depressed reimbursement rates pursuant to the conspiracy did cause an antitrust injury because, even if this resulted in lower premiums to subscribers (which it did not), it might still have caused other anticompetitive effects such as "suboptimal output, reduced quality, allocative inefficiencies, and (given the reductions in output) higher prices for consumers in the long run."

Finally, the court held that UPMC's alleged conduct – engaging in a conspiracy to drive Allegheny out of business, hiring away employees to injure Allegheny, pressuring other hospitals to refer patients exclusively to UPMC, and making false statements – at least when viewed as a whole, plausibly suggested UPMC engaged in anticompetitive conduct sufficient to sustain an attempted monopolization claim. Accordingly, the court reversed dismissal of the complaint.

Since then, the Pittsburgh area health care environment has shifted radically. Highmark has announced its plans to form an affiliation with the financially troubled Allegheny health system, under which a new nonprofit parent company will hold all the corporate membership rights in both Highmark and the Allegheny system. Highmark has agreed to make a financial commitment of up to $475 million to Allegheny. UPMC, in turn, has announced that it would no longer contract to be a participating provider in the Highmark network if Highmark became UPMC's competitor via acquisition of Allegheny.

The Department of Justice on April 10, 2012 announced that it was closing an investigation into Highmark's affiliation agreement with West Penn Allegheny Health System.[1] DOJ said, "The proposed [vertical] affiliation holds the promise of bringing increased competition to western Pennsylvania's health care markets by providing WPAHS with a significant infusion of capital and increases the incentives of market participants to compete vigorously. . . . Finally, the affiliation agreement likely will not facilitate horizontal collusion by health plans because new entrant national insurers are for the first time in many years aggressively attempting to reduce Highmark's dominant market share." According to DOJ, some

[1] Statement of the Department of Justice's Antitrust Division on Its Decision to Close Its Investigation of Highmark's Affiliation Agreement with West Penn Allegheny Health System, April 10, 2012.
http://www.justice.gov/atr/public/press_releases/2012/282076.htm

national insurers recently obtained contracts from UPMC that are significantly more competitive than their prior arrangements, improving their prospects of bringing increased competition to the area's health insurance markets.

The DOJ statement also contains a somewhat startling comment suggesting that long-term contracts (i.e., with fixed multi-year financial terms, where the contract is not subject to a ninety day notice or similar termination clause) between dominant hospitals and insurers are problematic from an antitrust standpoint, even if they contain no facially exclusionary provisions:

> Long-term contracts between dominant hospitals and insurers can dull their incentives to compete, leading to higher prices and fewer services. If a dominant hospital is guaranteed a predictable revenue stream for many years from a dominant insurer, then the hospital may be less likely to promote the growth of new insurers by offering them competitive rates. Similarly, if a dominant health insurer is guaranteed rates from a dominant hospital for an extended period, then the insurer may be less likely to promote competition in the hospital market by investing in more affordable hospitals. Not all contracts between dominant hospitals and insurers are anticompetitive. Contracts with shorter terms can provide significant benefits to consumers by providing consumers with more options, while at the same time encouraging dominant hospitals to promote competition among health insurers, and encouraging dominant health insurers to promote competition among hospitals. The foreseeable expiration of the contracts increases the need for both the dominant hospital and the insurer to have alternatives to their dominant counterparts.

III. Selected "provider power" considerations in Accountable Care Organization analysis.

A. Background.

The health reform law provides for provider-sponsored ACOs in Shared Savings Program ("SSP") under fee for service Medicare program. CMS originally proposed an antitrust pre-screening mechanism to deny participation to ACOs hitting an antitrust risk threshold that do not get favorable advance review from FTC or DOJ. The FTC and DOJ then proposed new policy guidance. The CMS final rule abandons mandatory prior antitrust review. 76 *Fed. Reg.* 67,806 (Nov. 2, 2011). The Department of Justice Antitrust Division and the Federal Trade Commission then issued a revised final enforcement policy, including a 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).

B. New FTC-DOJ enforcement policy statement on ACOs

The new FTC-DOJ guidance applies to all Medicare ACOs, including those that wish to contract with commercial payers, and regardless of the date of their formation. The statement creates a new "safety zone" for ACOs meeting specific standards. Safety zone applicability is tied to provider

membership relative to provider participation thresholds in defined "Primary Service Areas" ("PSAs").

a. Clinical Integration

Prior antitrust agency guidance had indicated that providers could avoid application of the "*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 their 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.

The new enforcement policy statement 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.

b. 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. The PSA is the "lowest number of postal zip codes from which the [ACO participant] draws at least 75 percent of its patients." The PSA to be score separately for each independent provider in ACO. CMS will make certain Medicare data available for calculations.

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.

A so-called “dominant provider limitation” applies 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.

A rural exception permits inclusion of one physician or group in any specialty regardless of share.

c. 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.

d. Suspect behavior?

The agencies flag four types of conduct that, though they may be unobjectionable, could raise potential competition concerns:

> An ACO with high PSA shares or other possible indicia of market power may wish to avoid the conduct set forth in (1) through (4) below. Depending on the circumstances, the conduct identified below may prevent private payers from obtaining lower prices and better quality service for their enrollees (76 Fed. Reg. at 67,030) --
>
> - 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?

e. Review process

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