INSIDE THE MINDS™

UNDERSTANDING ANTITRUST ISSUES IN HEALTH CARE

LEADING LAWYERS ON ANALYZING THE IMPACT OF HEALTH CARE REFORM, MANAGING ANTITRUST ENFORCEMENT CONCERNS, AND PREPARING CLIENTS FOR CHANGE

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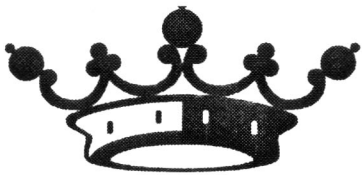
INSIDE THE MINDS

Understanding Antitrust Issues in Health Care

Leading Lawyers on Analyzing the Impact of Health Care Reform, Managing Antitrust Enforcement Concerns, and Preparing Clients for Change



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Antitrust and the PPACA: Reforming Health Care by Realigning Incentives and Introducing Competition

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Introduction

My practice focuses on litigation and counseling on antitrust and competition issues, but also includes advising clients on all types of government investigations. For many years, a substantial part of my practice has been providing antitrust counseling and litigation representation to participants in the health care industry. Consequently, I have had a front-row seat to examine and try to understand the workings of the health care industry and how health care delivery compares to other service markets. For a variety of reasons that will be discussed, health care delivery is different from almost any other market. The key difference is the unaligned incentives of the key market players. The countervailing forces of fee-for-service and managed care place providers, payers, and patients at irreconcilable odds.

Health care reform, embodied as the Patient Protection and Affordable Care Act (PPACA), Pub. L. 111-148, 124 Stat. 119 (2010), seeks to reform health care delivery[1] in the United States. In large part, if it is to be considered a success, the PPACA will reform health care delivery by substantially altering the dynamics between payers, providers, and patients. Congress considered and ultimately rejected including any antitrust exemptions in the PPACA. Consequently, the changes to health care delivery and, by necessity, the changes to the tri-partite relationship that makes up health care delivery, will have to be forged within the parameters of the antitrust laws and other applicable laws and regulations. This includes the provisions in the PPACA that may have the most obvious and long-lasting impact on health care delivery, including changes to patient care models, linking payment to quality of care, changes in reimbursement compensation, and provider consolidation and collaboration.

Since the passage of the PPACA, there has been a great deal of discussion and hand-wringing about whether this industry restructuring can happen within the current enforcement environment. The assumption underlying

[1] As we will discuss, currently, the delivery of health care to an individual is mostly done as a series of "one-offs" and generally with very little communication between and among the various providers who may be treating a single patient. Calling this type of delivery a "system" is misleading. The word "system" conjures up a single, functional, and interdependent entity.

these concerns is that the antitrust laws are a constraint on innovation and the type of collaboration that leads to lower costs and higher quality. This mindset is absolutely wrong. The antitrust laws are not barriers, but rather boundaries. In fact, the rationale underpinning many of the proposed changes to health care delivery in the PPACA is consistent with the rationale for the antitrust laws: competition and transparency tend to lower costs, raise quality, and foster innovation. In short, the antitrust laws are not an impediment to the PPACA reforming the health care delivery system; rather, the antitrust laws are part of the framework for successfully implementing the PPACA.

Health Care Reform and Antitrust

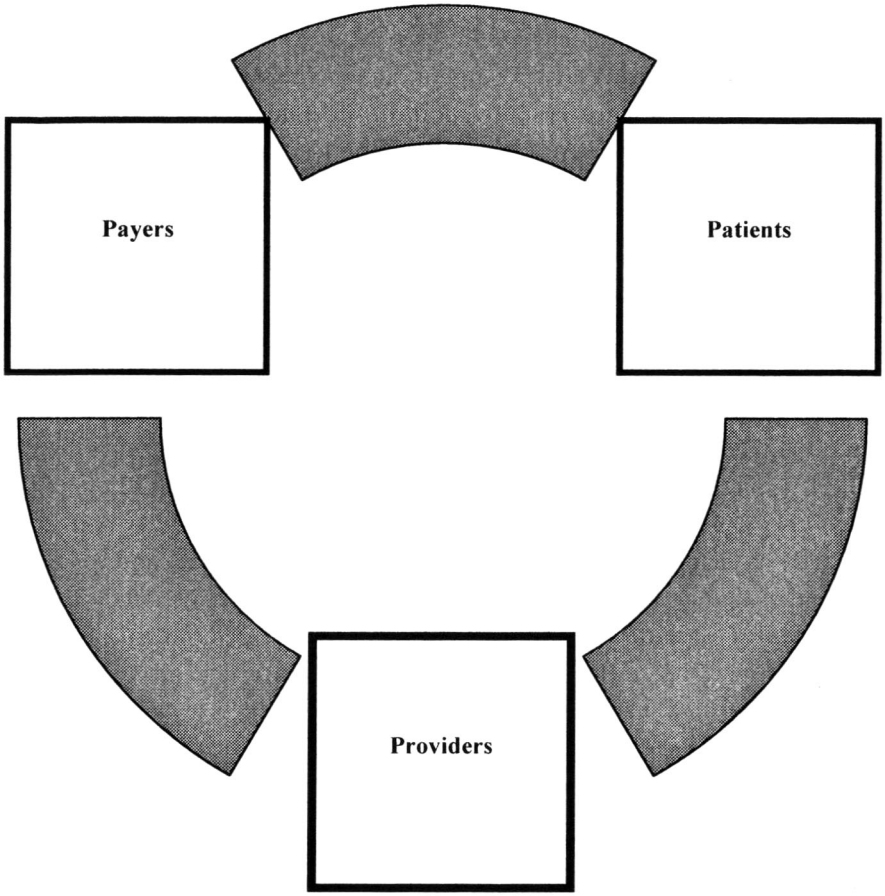
The most significant development in the health care industry is the passage of the PPACA. Several provisions of the PPACA seek to restructure the market interactions between providers, payers, and patients. *See, e.g.*, §§ 1311-1313, 124 Stat. 119, 120; §§ 2704-2706, 124 Stat. 119, 122; §§ 3001-3015, 124 Stat. 119, 122. Importantly, the provisions of the PPACA that are directed at changing the delivery model for patient care and provider payment are limited to the government health care programs, Medicare and Medicaid. It is assumed, however, that because these government programs constitute such a significant share of the health care delivery market, the PPACA reforms will spread into the commercial markets as well, similar to the way the Medicaid/Medicare fee-for-service model became the norm in the commercial markets after being introduced.

The Current Health Care Delivery Market: A Case of Unaligned Incentives

In most markets, the entity that pays for the product or service is the entity that receives the value from the product or service. This direct pay-benefit relationship conforms to the commonly understood economic incentives—that consumers as payers will seek out the optimum price-quality mix they can afford.

The U.S. market for health care delivery is fundamentally different, as every patient in America could attest to. In the health care market, payers,

providers, and patients operate in what is often referred to as a "bilateral" or two-sided network market.[2]



Payers and Providers

In the commercial market, payers try to anticipate which provider characteristics will be attractive to patients and then seek out providers with those characteristics with whom to negotiate reimbursement compensation. If the provider and payer reach agreement, the provider becomes part of the

[2] While there are significant differences in the way reimbursement compensation is determined as between government payers and commercial payers, this two-sided relationship exists in both markets.

payers' network. Notably, while payers negotiate reimbursement compensation with providers, there are generally little, if any, compensation adjustments for quality or outcome.

Patients and Payers

There are several assumptions made regarding the relationship between patients and payers. First, that patients have a choice about which health care plan they subscribe to and that patients choose a health plan based upon which providers are in the network. Whether either or both of these assumptions are accurate is highly questionable. In many geographic markets, there is a single dominant insurer. Further, while employers may comparison shop among payers when choosing an employee health plan, an individual has little, if any, choice (except for, example, federal workers) in choosing between health plans and networks. Thus, the employer acts as proxy for its employees in identifying the characteristics of the provider network of choice, and may or may not utilize the same selection criteria as the individual employee in identifying a preferred network of providers.

Commercial health insurance companies operate in a starkly different marketplace than, for example, homeowner or car insurance companies. Health insurance utilizes a network model. This model essentially inserts the insurer into the economic relationship between provider and patient. There is nothing inherently bad about this, and the existence of health insurance has enabled many people to have access to health care. Nevertheless, this third party has changed the normal behavioral assumptions of the market.

The "cost" of care to the patient is a function, in part, of whether the patient is treated by a provider within a payer's network. For example, if my kids see an in-network pediatrician, the payer will cover all of my costs for routine child visits. Notably, I am provided no information about, nor do I have any role in determining, the provider's compensation for those services. If my kids, however, see an out-of-network pediatrician, my health plan tells me it will reimburse me for 80 percent of my out-of-pocket costs (in other words, 80 percent of the provider's actual cost of providing the service). If the provider requires payment of 100 percent of the fees, I am responsible for paying the provider the balance of the amount owed (or, in this case, 20

percent). In this example, I as the direct payer of the fees am very much aware of the cost of the services my child received. Having this information and knowing the true cost may affect whether I take my child to the doctor for routine health care. Given these financial dynamics, a provider might be financially better off to not be in a network. This choice may, however, lessen demand for the provider's services because there will be many fewer patients willing to pay out of pocket.

Compare that scenario to home insurance or car insurance where there is no network. An insured in these markets usually does not have to go to certain repair shops to reduce out-of-pocket costs. Rather, when an insured suffers a loss, it is reimbursed on a flat basis. For example, if heavy snowfall causes the gutters on my house to fall down, assuming such a loss is covered by my homeowners' policy, my insurance company will write a check based upon its adjuster's estimated cost of repair. I get the same amount no matter which contractor I engage to do the repairs. One might reasonably infer that part of the reason health care costs have risen so dramatically is that very often, in both the government payer and commercial payer markets, the person paying is not the person receiving the services. If I go to the doctor and fill out the forms, somewhere off in the distance money is exchanged and, other than an increase in my insurance premiums, I feel no connection between the services I am receiving and the cost of those services.

Patients and Providers

Notably, unlike other markets that have direct pay-benefit relationships, patients and providers do not. While patients pay premiums and co-pays, the patients are generally not responsible for the majority of the cost of the health care they receive. Because of the asymmetrical nature of the information sharing between provider and patient, it is often difficult for the patient to make informed decisions about care; and because the patient is not usually paying the "list price" but rather is paying some smaller percentage of the actual cost of the service, the patient has less incentive to shop around.

The bottom line is that the normal and predictable directional incentives of the competitive marketplace are not present in the market for provision of health care services.

Healthcare reform and the various provider pilot projects within it may alter this currently skewed pay-benefit incentive mix by realigning the incentives in the health care markets to look more like the pay-benefit incentives in other markets.

PPACA Programs That May Change Incentives in the Health Care Delivery System

Several provisions in the PPACA contemplate the public reporting of outcomes and effectiveness. *See, e.g.*, §§ 3002, 3003 and 3013, 124 Stat. 119, 122. Patients and payers will have more quality and price information with which to make choices. Providers will be able to take control of costs and economically benefit from reduced costs and higher quality in the same way that other service providers do in other markets where there is more competition based on price and quality. *See, e.g.*, §§ 1311-1313, 124 Stat. 119, 120; §§ 2704-2706, 124 Stat. 119, 122; §§ 3001-3015, 124 Stat. 119, 122. In short, the goals of health care reform are aligned with the goals of antitrust—lower costs, higher quality, better service.

These provisions provide means for experimentation in the way health care is delivered and the way services are paid for. The goal of these experiments is to ultimately identify new models for providing health care (whether medicine-based or alternative) and paying for it. The PPACA contains pilot programs for concepts such as accountable care organizations, medical homes, centers for excellence, and bundled payments. While each of these ideas has unique aspects, the premise behind all of them is the efficient and effective delivery and utilization of health care resources. Notwithstanding the potential that each of these new models has for improving care and driving down costs, each of the these models raise, or more accurately could raise, manageable—but potentially significant—antitrust issues.

Changing How Providers Care for Patients by Changing How Providers Are Paid

As has been discussed at length, one of the primary reasons health care costs have skyrocketed is that the normal restraints on costs are not present in the current health care delivery system. Medicare currently reimburses health care providers based on the volume of care they provide rather than the value of care. For each test, scan, or procedure conducted, Medicare provides a separate payment, rewarding those who do more (and the more

complicated, the better) regardless of whether the test or treatment contributes to helping a patient recover. The PPACA includes a number of proposals that move away from the "a la carte" Medicare fee-for-service system toward paying for quality and value. The pilot program proposals including accountable care organizations, medical homes, and bundled payments could make the provision of health care more system-like, in that they each require integrated care by providers.

Antitrust laws and enforcement will have a major influence on this whole process, just as they have on the current delivery model. Assuming that health care will not be the recipient of an antitrust exemption, there will be considerable attention paid to the implementation of the provider pilot programs in the PPACA. The two issues that are likely to be of greatest concern to enforcers are (1) the accumulation and exercise of market power by provider groups, and (2) the use of the provider group models to facilitate collusion among otherwise competing providers. These are the same issues the Department of Justice (DOJ) and the Federal Trade Commission (FTC) highlighted as concerns in their "Statements of Antitrust Enforcement Policy in Health Care" and "Antitrust Guidelines for Collaborations Among Competitors."[3]

Concerns within the Legal Community

The most significant antitrust issue raised by the PPACA is whether accountable care organizations, medical homes, and other new types of provider organizations, and the bundling of payments for a range of services, are going to create providers that will have the ability to demand and receive substantial increases in reimbursement compensation (i.e., whether they will have "market power"). That is the big unknown. Changes to health care delivery have never been tried on such a large scale, and many are wondering what these organizations are going to look like ten years from now. The concern that antitrust lawyers and government enforcement staffers share is that we may be exchanging one challenge for another—we have an inefficient system now, but what will be the effect of potentially Goliath-sized provider groups?

[3] These guidance documents, along with others, can be found at www.ftc.gov/bc/healthcare/industryguide/policy/index.htm.

The DOJ and the FTC, the primary enforcers on the federal level of the antitrust laws, are very much aware of the role their enforcement decisions are likely to play in the implementation of health care reform. In letters responding to inquiries from the U.S. Senate, both the DOJ and the FTC highlighted the guidance each has already provided to providers who are seeking to collaborate, and stated that each agency would review their programs and initiate additional ones as appropriate.

Given the congressional intent in favor of provider collaborations and new forms of provider/payer relationships, it seems likely that the FTC and the DOJ will approach formation and operation of the pilot programs with a wait-and-see approach, and not reflexively attempt to quash such programs before there is an opportunity to determine their competitive effects. Additionally, both agencies are likely to be involved in the drafting of the regulations that operationalize the PPACA programs. Christine Varney, assistant attorney general for antitrust, confirmed that this will be the approach of at least the DOJ when she stated:

> There can be no doubt that vigorous yet responsible antitrust enforcement is crucial if we are to benefit from innovation and efficiency in our health care delivery system and reduce rising health care costs in both public and private sectors.
>
> The key question is whether we can gain those benefits without sacrificing meaningful competition. The answer to that question is undoubtedly "yes." ... [A]ntitrust is not an impediment to formatting [an] innovative, integrated health care delivery system and genuine increases in provider efficiency.[4]

See Appendix B for the complete remarks.

[4] Christine Varney, Remarks as Prepared for the ABA/AHLA Antitrust in Healthcare Conference, Arlington, Virginia, May 24, 2010

Fundamentals of FTC and DOJ Health Care Antitrust Enforcement

The FTC

The FTC's Bureau of Competition contains several groups, or in FTC parlance "shops," that play a role in policing the health care industry. The FTC has a "Health Care Shop" that investigates the business activities of physicians and other health care professionals, pharmaceutical companies, institutional providers, and insurers, and reviews mergers involving health care products and services.

The "Merger 1 Shop" is responsible for mergers in health care-related industries, including the areas of medical devices, branded and generic pharmaceuticals, and consumer health products. The "Merger IV Shop" looks at mergers and other competitor collaborations in the provider area. For example, attorneys from Mergers IV successfully challenged the proposed transaction between Inova Health System and Prince William Health System. *See* F.T.C v. Inova Health Sys. Found., No. 1:08CV460 (E.D. Va. Jun. 12, 2008)(order granting joint motion to dismiss).

The DOJ

The DOJ is divided into sections, with each section taking responsibility for antitrust oversight of various industries. Generally, the Litigation I Section at looks at provider collaborations that may run afoul of the antitrust laws. Additionally, the DOJ reviews health plan mergers.

Antitrust Complaints Brought Against Health Care Companies

During the past ten yrs, the FTC and the DOJ have brought more than forty complaints against providers. In these cases, the agencies have alleged that independent providers got together and jointly negotiated with insurance companies in violation of Section 1 of the Sherman Act, 15 U.S.C. § 1 (2004), and/or Section 5 of the FTC Act, 15 U.S.C. § 45 (2006). Section 1 prohibits competitors from entering into unreasonable agreements; if two competitors agree to negotiate jointly against an insurance company, that is unlawful citation.