New Jersey District Court Derails Plaintiffs' Antitrust Claims in Ingenix Case

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In 2008, the New York Attorney General launched an investigation into the manner in which Ingenix, a data collection subsidiary of UnitedHealth that calculated "usual and customary" ("UCR") provider charges for many insurers, operated. Amid claims that Ingenix had improperly calculated the UCRs to reduce insurer reimbursements to providers, UnitedHealth ultimately settled the matter with the Attorney General by agreeing to pay a significant civil fine and agreeing to spin off Ingenix into a separate entity that was no longer controlled by the insurer.

As is often the case, the New York Attorney General's investigation spawned a private class action proceeding, *Franco v. Connecticut General Life Insurance Co.* (D. N.J.). The plaintiffs -- both out of network providers and insureds -- alleged that, the defendants (Connecticut General, United Health Group and Ingenix) had agreed to use improperly calculated UCRs in determining what the insurers would pay for out of network services, and that this agreement resulted in the underpayment of fees to the out of network provider plaintiffs and an overpayment of co-pays by the insureds. Plaintiffs alleged that this conduct violated the antitrust laws, ERISA and various civil RICO provisions. On September 23, however, District Judge Stanley Chesler delivered a significant victory to the defendants, dismissing all of plaintiffs' antitrust claims and reducing the scope of plaintiffs' RICO and ERISA claims as well.

With respect to the plaintiffs' antitrust claims, Judge Chesler first concluded that the provider plaintiffs lacked standing to assert their claims. Judge Chesler noted that the insureds had not expressly assigned their antitrust claims to the providers, and that the provider plaintiffs "cite no authority to the Court that supports the pursuit of antitrust claims based [solely] on a party's status as a third party beneficiary." In addition, the providers' contention that they had standing because the alleged depression in UCRs targeted them as much as it did the insureds was, according to the Court, a "superficial and underdeveloped" argument "unsupported by reference to the factual allegations in the complaint." Accordingly, the providers' antitrust claims were dismissed for lack of standing.

The Court then turned to the insureds' antitrust claims, and, while these claims focused on different issues, the insured plaintiffs were no more successful in preserving their claims than the providers. The insured plaintiffs first argued that the insurers' conduct constituted *per se* price fixing. The Court, however, disagreed. As explained by the Court: "Assuming the defendants engaged in concerted action to cap out of network reimbursements, their agreement would pertain to one component of the product sold, not to the price at which the policy is made available for purchase," and thus, because out-of-network reimbursements are only "one aspect of the product sold," and not a distinct product itself, the insured plaintiffs' had failed to state a plausible *per se* claim of price fixing.

The Court then turned to whether the insureds' antitrust claim might still survive as a rule of reason claim. Focusing on the fact that the market that had allegedly been restrained by the defendants' conduct was the data market for UCR rates, the Court noted that the plaintiffs "do not participate in the data market; they are neither competitors engaged in the business of supplying prevailing fee schedules nor direct purchasers of the products sold by Ingenix." As the Court further noted, this circumstance is fatal to a plaintiff's antitrust claim unless, under the Supreme Court's decision in *Blue Shield of Virginia v. McCready,* a plaintiff can credibly maintain that it is the direct victim of the anticompetitive conduct. The Court, however, found that plaintiffs' allegations did not fit within the contours of *McCready*.

Specifically, the Court stated, "Insofar as the Complaint could be read to allege that defendants manipulated insurance benefits to the detriment of [insureds] as part of a scheme which had the purpose or effect of inhibiting competition among health care providers, plaintiffs' antitrust claims would appear on the surface to be similar to *McCready.*" Here, however, the Court concluded that "Plaintiffs' antitrust theory posits that [the insurers] inhibited competition among health care providers by incentivizing [insureds] to utilize providers in their preferred provider network rather than providers who are not," and "there is nothing anticompetitive about the complained-of scheme of shifting business to in-network providers." Accordingly, the Court held that while "the alleged misconduct may state a claim for relief under other legal theories, it does not confer antitrust standing upon plaintiffs." In summary, because "the injury of which plaintiffs complain - receiving lower out of network benefits than they would have received had accurate prevailing fee schedules been employed by [the insurers] - is not one which flows from defendants' alleged efforts to reduce competition, the insured plaintiffs failed to plead any plausible antitrust injury," and their antitrust claims had to be dismissed.

With Judge Chesler's dismissal of all of plaintiffs' antitrust claims, the case now proceeds into discovery on the ERISA and other claims that Judge Chesler concluded the plaintiffs had adequately pled.

FTC/DOJ Issue Policy Statement on Accountable Care Organization Antitrust Issues

On October 20, the Federal Trade Commission and the Department of Justice issued their long-awaited joint policy statement concerning how Accountable Care Organizations (ACOs) would be treated under the federal antitrust laws. ACOs, of course, are a creation of the Affordable Care Act, and are organizations of health care providers that jointly offer their services in a manner designed to reduce costs and improve the quality of patient care. While such organizations are principally intended to provide such services to medicare beneficiaries under the Medicare Shared Savings program, ACOs are also permitted, and expected, to operate in the private insurance arena as well. Accordingly, in recognition that the degree of collaboration among otherwise competing health care providers necessary to form and operate a successful ACO also has the potential, in some circumstances, to have adverse impacts on competition, the FTC and the DOJ have been hard at work crafting guidance on these issues in advance of the 2012 launch date for ACOs. To that end, in March of this year the FTC/DOJ issued a draft policy statement on this subject, inviting comments from the public. The October 20 pronouncement constitutes the agencies' final guidance, issued just in time for providers interested in forming ACOs to assess the antitrust risks associated with their plans before many ACOs become operational.

While the final policy statement tracks the FTC/DOJ's March draft statement in almost all respects - despite the agencies' receipt of over 100 comments urging modifications to virtually every aspect of the draft statement - it does contain one extremely significant modification. In recognition of the concerns expressed about the cost and burden that would be created by the mandatory, pre-operation antitrust reviews of ACOs called for in the draft policy statement (a process similar in concept to the Hart-Scott-Rodino Act pre-consummation approval process for mergers), and the suggestion that

such a process might chill the creation of ACOs altogether (thus eliminating the potential for cost savings for which they are designed), the FTC/DOJ have decided to scrap the idea of mandatory pre-operation antitrust reviews.

Rather than subjecting ACOs to mandatory antitrust reviews, the final policy statement provides that an ACO may seek a voluntary review from the agencies, if it chooses to do so. The agencies commit to "expedite" such reviews, reaching a decision as to whether the ACO's structure and proposed activities pass antitrust muster within 90 days of submission. Alternatively, an ACO that is approved by the Center for Medicare and Medicaid Services ("CMS") as to its non-antitrust attributes may simply commence operations without any such review, subject, of course, to FTC/DOJ oversight and enforcement activity should the agencies subsequently conclude that the ACO has engaged in anticompetitive conduct (in much the same way that health care provider collaborations generally have been addressed since the FTC/DOJ Statements of Antitrust Enforcement Policy in Health Care were issued in 1996). Given these options, it seems highly unlikely that many ACOs will go to the time, trouble and expense of seeking a voluntary review, but only time will tell.

With respect to the remainder of the final policy statement, it remains virtually unchanged from the draft guidance issued in March. Accordingly, the final policy statement provides that legitimately formed ACOs will, in almost all circumstances, be judged under the antitrust "rule of reason," balancing the procompetitive benefits of the collaboration against its potential for anticompetitive harm in assessing its lawfulness, and will not simply be condemned as a *per se* unlawful combination of competitors. In addition, the final guidance preserves the antitrust "safety zone" that was set forth in the draft guidance. As such, where an ACO's participants providing a common service have a combined share of 30 percent or less in each participant's "primary service area," absent unusual circumstances the ACO's activities will be deemed not to be anticompetitive. The final policy statement also provides examples of conduct that can raise competitive concerns, including guidance on avoiding conduct that may facilitate collusion among ACO participants in the sale of competing services outside of the ACO and other activities that may prevent private insurers from obtaining lower prices and better quality services for their members.

New Study Blames Large Hospitals, Not Large Health Insurers, For Rising Health care Costs

Over the last several years, most of the blame for the dramatic increase in health care costs has been directed towards the health insurance industry. Proponents of this view claim that unchecked consolidation in the health insurance industry has created "dominant" insurers in many states, resulting in a decrease in insurer competition that has permitted insurers to increase insurance premiums to insureds. A recent Rand Corporation study, however, takes a different view. The principal cause of the increase in health care costs has been dominant hospitals, not dominant insurers, the report claims, and large insurers have been able to act as a check on the ability of large hospitals to increase their charges for covered services.

Examining hospital cost data from the period 2001-2004, the Rand report suggests that insurer consolidations have had a positive effect for consumers, because larger insurers have been more successful at thwarting hospital price increases. Specifically, the report indicates that in cities in which the fewest number of health insurers operate, insurers pay, on average, 12 percent less for hospital services than those in cities in which many insurers operate. Based upon this data, the report's author, economist Glenn Melnick, concludes that "As long as there is enough competition to keep health plans honest, the consolidation [of health insurers] has a good result on [hospital] prices" for consumers. On the other hand, Melnick finds that where a hospital is "dominant," the hospital is more likely to have successfully pushed through price increases for its services.

Accordingly, in a press release accompanying the report, Melnick concludes that "If policymakers are interested in

lowering costs they should find a way to restore competition among hospitals," and that permitting providers (hospitals, physicians, etc.) to act collectively, as contemplated by the Affordable Care Act, may actually increase, rather than decrease, health care costs. Melnick's views are clearly not in the majority at the moment. Indeed, a September 9 hearing of the House Ways and Means Health subcommittee on health care costs focused almost exclusively on the impact of health insurer consolidation on costs, not on the impact of provider consolidation. That being the case, whether Melnick's report will gain much attention, or have an impact on this debate, remains to be seen. Stay tuned.

Antitrust Regulators Around the Globe Giving More Attention to Insurer Practices

While the insurance industry in the United States has been the subject of considerable antitrust attention recently, there has been a marked increase in antitrust regulator scrutiny of insurer practices outside the United States as well. And with over one hundred countries now having antitrust laws, and increasingly active antitrust enforcers, the risks insurers face if they are engaged in anticompetitive conduct have never been greater.

In the last two months alone, South Korean, Italian and United Kingdom antitrust enforcers have all either announced investigations into insurer activity or announced the imposition of fines against insurers for anticompetitive conduct. On October 14, for example, the Korean Fair Trade Commission announced that it had fined twelve life insurers a total of over $300 million for colluding to fix interest rates on insurance products. The fines conclude an investigation into anticompetitive conduct that was alleged to have begun in 2001 and continued through 2006. The largest fine imposed, against Samsung Life, was for approximately $150 million. Only days later, the Italian Antitrust Authority announced that it had imposed fines on three health insurers, and an insurance broker, for anticompetitive conduct. The fines, which total $13 million euros, address bid rigging in the pursuit of health care contracts, which resulted in an increase in premiums.

In the meantime, in September the U.K.'s Office of Fair Trading announced that it was commencing a wide-ranging investigation into auto insurance premiums. The investigation follows a 40% increase in auto insurance premiums in the U.K. in the last year and a request by the Consumer Council of Northern Ireland that the OFT investigate why auto insurance rates in Northern Ireland are considerably higher than they are in the rest of the U.K. As part of its investigation, the OFT announced that it will examine whether price comparison websites in the U.K. have had an anticompetitive, rather than a procompetitive, impact on auto premiums and on whether insurer use of preferred repairer programs has increased, rather than decreased, costs. The use by insurers of preferred repairer programs has also given rise to antitrust issues in the United States, but rarely have such programs been found to be anticompetitive. *See, e.g., Harner v. Allstate Insurance Co.,* Case No. 11-CV-2933 (S.D.N.Y.)

The OFT plans to publish its findings by the end of the year, and to take any further action, should it be required, early next year. Stay tuned.

For more information about this topic, please contact the author or any member of the Williams Mullen Antitrust Team.

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