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Antitrust Alert

FTC Issues Favorable Advisory Opinion Permitting Competing Providers to Engage in Joint Contracting Where They are Sufficiently "Clinically Integrated"

On April 13, 2009, the Federal Trade Commission (the "FTC") issued a significant advisory opinion (the "Advisory Opinion") to TriState Health Partners, Inc. ("TriState"), a physician-hospital organization ("PHO") based in Hagerstown, Md. The Advisory Opinion indicates that the FTC has no present intention to challenge TriState's proposed clinical integration program, which would include joint contracting by its members with health plans. In reaching this decision, the FTC concluded that TriState's joint contracting was "reasonably necessary" for TriState to achieve its overarching mission of lowering health care costs and improving the quality of care, and thus the program satisfied the "rule of reason." As such, the Advisory Opinion provides valuable additional guidance on the degree of "clinical integration" required for joint provider contracting with health plans, significantly expanding upon the guidance contained in the 1996 DOJ/FTC *Statements of Antitrust Enforcement Policy in Health Care* and later discussed in the FTC's 2006 Advisory Opinion to Suburban Health Organization, Inc.

As first explained in the DOJ/FTC Statements, absent appropriate justification — for example, financial risk sharing or "clinical integration" — it can constitute a *per se* antitrust violation for a PHO to negotiate contracts provisions with payers on behalf of its competing members. However, *per se* condemnation is replaced by a "rule of reason" examination and found permissible under the antitrust laws "if the providers' integration through the network is likely to produce significant efficiencies that benefit consumers, and any price agreements (or other agreements that would otherwise be *per se* illegal) by the network providers are reasonably necessary to realize those efficiencies." To make such a determination, the FTC analyzes the level of clinical integration achieved by the joint venture and whether the potential anticompetitive effects of a joint venture are subordinate to the primary potential efficiency gains of the joint venture. As the FTC has explained, where a PHO demonstrates that it intends to "implement an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality," an appropriate level of "clinical integration" may exist to justify joint contracting.

In its request to the FTC for guidance, TriState indicated that its proposed program would

Also in this edition:

Questions?

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"offer payers a network of primary care and specialist physicians whose services will be integrated through a formal and stringent medical management program that includes protocol development and implementation, performance reporting, procedures for corrective action when necessary, and aggressive management of high-cost, high-risk patients." TriState further represented that the program will "offer payers a network of coordinated services from physicians committed to improving outcomes by working together to achieve quality improvements not possible by working independently" and that "TriState's physicians will actively collaborate in the development of all facets of the program, ensuring the cooperative delivery of high-quality, cost-effective care." To accomplish its goals, TriState represented that it would utilize an internal health information system, which would allow TriState to identify at-risk patients and facilitate health information exchange within its network of providers, and that it intends to develop clinical practice guidelines and monitor member compliance with such guidelines. Additionally, TriState stated that it would review episodes of care for the purpose of determining the best care protocols, where improvements will have the greatest financial and quality of care benefits, and identifying overutilization and underutilization.

However, perhaps most significantly, TriState pointed to a pilot medical management service program that it had conducted that had achieved measurable efficiency improvements and increased clinical results, and indicated that if its proposed program were permitted — including joint contracting — it intended to expand the size and scope of its medical management services. In short, by being able to point to tangible efficiency improvements and increased clinical results, even on a small scale, TriState was able to get past the sometimes difficult task of persuading the FTC that its form of clinical integration could actually deliver consumer benefits. Instead, the FTC concluded that "integration among the participating physicians in the program ... appears to have the potential to result in significant efficiencies, both in terms of cost and quality, in the delivery of medical services to patients covered under payer contracts for the program."

Having concluded that the TriState program could provide consumer benefit, the FTC next considered whether the efficiency gains and quality improvement gains TriState claimed would be created from such integration could not reasonably be achieved without joint contracting. TriState maintained that "the only way to ensure that all TriState physicians participate in all TriState payer contracts (and thus be able to achieve the benefits of its medical management services) is for TriState to negotiate payer contracts for its complete network." Ultimately, the FTC agreed, stating that "uniform participation will facilitate the program's in-network referral requirement, which is central to the program's success in rationalizing and effectively providing evidence-based care to the program's enrollees." Moreover, "achieving these operational necessities would be far more difficult if different physicians were participating in different payer contracts," because "referral patterns [would have to] be adjusted" and "information on patient treatments and provider behavior [would be] less uniformly available."

Accordingly, for these reasons, the FTC concluded that "TriState's proposed program, while still in the relatively early stages of development in certain respects, nevertheless appears to involve substantial integration by its physician participants that has the potential to result in the achievement of significant efficiencies that may benefit consumers." Accordingly, TriState's program was approved.

Representative Ron Paul Introduces Legislation Permitting Providers to Negotiate Jointly with Health Insurers

On March 12, Rep. Ron Paul (R-Texas) introduced legislation that would permit providers to negotiate jointly with Health Maintenance Organizations ("HMOs") regarding all aspects of their relationships, including reimbursement rates. Specifically, the "Quality Health Care Coalition Act," H.R. 1493, would exempt providers from the federal antitrust laws with respect to any aspects of their contract negotiations with a health plan. Absent a statutory exemption, joint negotiations by independent providers, particularly concerning the rates they will accept from health plans, can constitute a per se violation of Section 1 of the Sherman Act, and the DOJ Antitrust Division and the FTC have taken enforcement action against providers that have "banded together" to negotiate jointly with health insurers.

Notably, similar legislation has been repeatedly introduced, at both the state and federal levels, over the last several years, but rarely enacted (with the notable exception being a Texas bill that was passed in 1999). Whenever and wherever introduced, the FTC has affirmatively opposed such legislation, contending that joint negotiating by providers would invariably lead to higher prices for health care services and lower levels of insurance coverage. Coincidentally, less than two weeks after H.R. 1493 was introduced, the FTC was provided with a new opportunity to express these views, sending comments on a recently introduced Minnesota bill (H.F. 120/S.F. 203) to the Minnesota legislature. Echoing its long-held views on such legislation, the FTC stated that "[b]ecause they are likely to harm consumers, the Commission has long opposed federal and state legislative proposals that would create antitrust exemptions for collective bargaining by health care providers." The FTC continued that "The Commission's experience investigating numerous cases of collective bargaining by competing health care providers has shown that an antitrust exemption for such joint negotiations would cause consumers and employers, as well as federal, state and local governments, to pay higher prices

for health care." Moreover, "such higher prices will make it more difficult for consumers to gain access to needed services," and "higher payments to health care provider members [will not] provide any assurance of improved quality."

While the FTC has not yet provided its views on H.R. 1493, they will undoubtedly be consistent with the views expressed about the Minnesota bill. While FTC opposition to the bill would, in the past, have likely ensured its swift demise, President Obama's campaign pledge to level the playing field between providers and health plans may enhance the bill's prospects for passage. In any event, the legislation has been sent to the House Judiciary Committee for further action, and on April 27 it was referred to the Subcommittee on Courts and Competition Policy. Stay tuned.

Health System Files Antitrust Case Against Rival System and Insurer Alleging Antitrust Conspiracy

On April 21, West Penn Allegheny Health System filed a complaint in the U.S. District Court for the Western District of Pennsylvania, against UPMC, Pittsburgh's largest hospital system, and Highmark Blue Cross, accusing them of conspiring to restrain trade in the provider and insurer markets in Western Pennsylvania.

In announcing the lawsuit, West Penn Allegheny Chairman David McClenahan asserted that "We believe that for several years UPMC and Highmark have engaged in mutual back-scratching designed to preserve Highmark's monopoly in health insurance and to permit UPMC to build a monopoly in sophisticated tertiary and quaternary healthcare in the region." The private lawsuit follows West Penn Allegheny's complaint to the DOJ Antitrust Division in 2006 regarding the UPMC/Highmark conduct.

Specifically, the lawsuit alleges that UPMC and Highmark reached an unlawful agreement whereby UPMC would contract with Highmark's competitors at higher rates than those charged to Highmark, and in return, Highmark agreed to reimburse UPMC's provider competitors at lower rates, causing them competitive harm. The complaint requests that UPMC and Highmark be enjoined from "further predatory and anticompetitive conduct" and that "Highmark be ordered to contract with West Penn on fair and equitable terms, including the end of any discrimination in reimbursement (both direct and indirect) between UPMC and West Penn."

Both UPMC and Highmark have denied West Penn's charges, claiming that the action is merely an attempt by West Penn to divert attention away from and/or justify its financial difficulties.

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