Antitrust and Healthcare

Cory A. Talbot
(4-15)

HOLLAND&HART LLP

What are we going to talk about?

- The (very) basics of antitrust enforcement
- How antitrust enforcement works in the healthcare arena
  - Examples to help identify pitfalls and stay safe

Who is looking at these issues?

- The Federal Trade Commission (FTC)
  - Group specifically to address healthcare
- The Department of Justice (DOJ)
  - Potential to bring criminal actions (very rare in healthcare)
- State attorneys general
- Competitors

What is the agencies' goal?

- The goal of antitrust enforcement is improving consumer welfare by protecting competition
  - This is not the same is protecting a particular competitor
- Competition provides
  - Lower prices
  - Better quality
  - More output

What are the agencies looking at?

- The Sherman Act
  - Prohibits combinations that restrain trade
  - Per se unlawful transactions
    - Price-fixing agreements
    - Agreements not to compete
  - Rule of reason
    - Demonstrate a lack of market power or significant pro-competition benefits

If the agencies use a rule of reason analysis, is the transaction allowed?

- Not automatically – the agency analyzes the transaction under its specific facts and circumstances
- Market share is typically the critical consideration
- The agencies also consider the efficiency of the transaction, *i.e.*, the value added

What else are the agencies looking at?

- The Clayton Act
  - Prohibits acquiring stock or assets that "may" tend to "substantially" lessen competition in a line of commerce
    - The agencies have a lot of latitude here
    - No time limit – challenge can come after the transaction
  - Employment is not an acquisition under the Clayton Act

Anything else?

- Back to the Sherman Act
  - Prohibits monopolization and attempts at monopolization
    - Courts have taken a conservative view of this provision, limiting it to conduct that is "predatory" or "unreasonably exclusionary"
  - FTC thinks courts are too lax in enforcing this provision of the Sherman Act
- The FTC Act?

What types of behavior creates antitrust risk?

- Refusals to deal
  - This is a narrow behavior, only actionable where a party terminates a profitable relationship for the purpose of forcing a competitor out of the market
- Tying
- Bundling
  - Key is whether the product or service is sold below cost
- Exclusive dealing

This is boring, when do we talk about healthcare?

- Now

What transactions are the agencies scrutinizing?

- Healthcare
- Pharmaceuticals
- Energy
- Financial services
- E-commerce

Why is healthcare targeted?

- Healthcare is not especially competitive due to insurance and asymmetrical information, *i.e.*, one side to a transaction has more or better information than the other side
- Twin Goals of the Current Administration:
  - Healthcare reform
  - Antitrust enforcement
- Result: antitrust review in the healthcare arena is vigorous and shows no signs of letting up
  - The chair of the FTC said that antitrust enforcement in the healthcare arena is one of the agency's highest priorities

What's happening in the healthcare industry now?

- Healthcare providers are frequently looking to consolidate or collaborate:
  1. To level the playing field with dominant insurers and
  2. To take advantage of the financial benefits offered by the Affordable Care Act (ACA) to providers that collaborate to reduce Medicare expenditures

What guidance do the agencies provide in the healthcare arena?

- The agencies issued a Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Share Savings Program (Policy Statement)
- The Policy Statement gives guidance to Affordable Care Organizations (ACOs), a network of doctors and hospitals that share the responsibility of providing care to a population of Medicare patients to save Medicare costs and then share in those savings
  - Notably, the agencies apply these principles more broadly to healthcare transactions

What does the Policy Statement do?

- The ACA provides financial incentives to ACOs.
  - The upside is that, done correctly, they can lower health care costs
  - The downside is that, while it's early, they raise the specter of antitrust issues.
- In a recent speech, FTC commissioner Julie Brill rejected the perceived tension between the ACO program and antitrust enforcement
  - "Indeed, the goals of the ACA and antitrust enforcement are aligned and compatible"
    - Is that right?

Is there a safe harbor?

- Yes – the Policy Statement tries to reduce the antitrust risk by providing a safe harbor and additional guidance for other transactions
- An ACO presumptively does not present antitrust risks if it meets three factors and there are no "extraordinary circumstances"

Factor 1 – low market share

- the ACO participants together do not provide more than 30% of a relevant service in any single ACO provider's primary service area
  - Exceptions for rural providers
  - Very difficult to measure and satisfy this factor
    - St. Luke's is a good example

Factor 2 – no exclusivity

- No hospital or ambulatory surgery center (ASC) participating in the ACO is exclusive to the ACO by contract or in practice

Factor 3 – still no exclusivity

- If the ACO includes a "dominant provider," *i.e.*, a provider with more than a 50% market share of any service that no other ACO participant provides, then (1) the dominant provider does not have an exclusive relationship with the ACO and (2) the ACO does not restrict any payer's ability to contract with other networks

What if a transaction is outside the safe harbor?

- The agencies look to the facts and circumstances and to "suspect behavior"
- Suspect behavior
  - "Anti-steering" and "anti-tiering" requirements
  - Tying ACO services to services from providers outside the ACO
  - Exclusive contracts
  - Restrictions on information
  - Price-sharing among ACO providers

Good News

- Under the FTC/DOJ's jointly issued Policy Statement, providers can get an expedited review of the proposed ACO formation so long as they are not yet participating in the Medicare Share Savings Program.

How does this work in real life?

- The FTC issued a February 2013 “advisory opinion” regarding a Norman, Oklahoma physician hospital organization (PHO) that sheds some light on the FTC’s recent approach to healthcare collaboration

What was happening in Norman?

- The PHO included the Norman Regional Hospital and 238 physicians
- The PHO had been in operation since 1994 using a messenger model, *i.e.*, no agreement between competitors
- The PHO wanted to move to a clinically integrated model
- Analyzed under the rule of reason

How did the Norman PHO avoid the per se analysis?

- Even though agreements on prices/price levels for patients are per se illegal, joint price negotiations by competing health care providers may be evaluated under the rule of reason if
  - The providers are "financially integrated" or "clinically integrated" and the agreement is reasonably necessary to accomplish the pro-competitive benefits of the integration
  - Messenger model: no agreement between competitors

How are financial and clinical integration achieved?

- Financially integrated
  - Providers share a "significant" risk of financial performance
- Clinically integrated
  - Providers share the risk of clinical performance
  - How much risk is enough?
    - Nobody knows

What was the Norman PHO doing to achieve clinical integration?

- Put in place procedures to oversee and control costs while maintaining quality of care
- Using an electronic platform to monitor the participating physicians compliance with standards set by the Norman PHO
- Participating Practitioner Agreement committing each physician to implement the Norman PHO's clinical practice guidelines
- Investments of time and money by the Norman PHO and its physicians to realize efficiencies
  - The capital investment was very minimal

How did the Norman PHO show the need for joint contracting?

- Consistent panel of like-minded physicians with shared commitment to participating in all aspects of the clinical integration program for all patients under network contracts.
  - Otherwise, physician panels might vary from contract to contract.
- Incentive to participate in PHO clinical integration projects.

The FTC's Analysis

- The network was not expected to affect the number of contracting alternatives because PHO was non-exclusive
- The FTC was concerned that a substantial portion of physicians in the area would be in the network
- Mitigation of this concern:
  - Representations that customers could bypass the PHO and contract directly with providers;
  - Representations that the network would not force payers to contract with the PHO; and
  - Representations that the network would not use its monopoly power (it was the only hospital in the area) to limit competition in other areas (e.g., requiring patients to use PHO physicians).
- The Norman PHO was offering counseling and guidance to avoid "spillover."

What if . . . ?

- The Norman PHO included 100% of area physicians?

Takeaways

- Interesting that many points not even finalized when the Advisory Opinion was issued
- Not clear if all steps necessary for approval
- FTC left open the door if "serious concerns" arose out of the PHO to reevaluate the PHO
- FTC supported though not linked to a Medicare Shared Savings Program
- Integration does not eliminate antitrust risk
  - Example – negotiations

How do ACOs minimize risk?

- Non-exclusivity is key
- Do not prohibit carve-outs of services

Vertical Acquisitions

- Historically, this has not been a key focus for the agencies
- Vertical combinations are generally less of an antitrust concern then horizontal combinations
  - Competition is the key
  - For example, hospitals and physicians do not typically compete with each other
  - Multiple acquisitions raise concerns

St. Luke's

- St. Luke's acquired Saltzer, an independent physician group
- The FTC alleged that this acquisition included the right to negotiate health plan contracts and to establish rates and charges
- St. Alphonsus alleged that this would give St. Luke's a dominant market share and allow St. Luke's to block referrals to St. Alphonsus

St. Luke's, continued

- The trial court determined that the transaction threatened competition and ordered divestiture of the acquired physician group
  - This is the first case the FTC has litigated through trial challenging a physician acquisition
- The Ninth Circuit affirmed
  - The relevant geographic market was key
  - Divestiture was the preferred remedy

St. Luke's – what was important?

- Note the difference in focus:
  - St. Alphonsus: acquisition would foreclose competition
    - Competition implicated by eliminating incentive to refer patients outside the acquiring group
  - FTC: acquisition gave St. Luke's the ability to extract higher rates from commercial payers

Takeaways

- The FTC is concerned about costs
  - Some hospital groups view this focus as hostile to hospitals when simplistically applied
- The FTC is concerned about reduced competition in the hospital services market
  - Generally, this appears to be central to the FTC's enforcement analysis
- The relevant market is critical to antitrust analysis.

Conclusions

- Antitrust analysis does not lend itself well to bright lines
- The agencies want to protect and encourage competition
- For the foreseeable future, the agencies will focus on healthcare

Cory A. Talbot
Holland & Hart LLP
801.799.5971
catalbot@hollandhart.com
222 South Main Street , Suite 2200
Salt Lake City, Utah 84101

HOLLAND&HART LLP