



Current Trends in FTC/DOJ Antitrust Enforcement in the Health Care Industry

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Antitrust Regulation Background

- The antitrust laws encompass a series of federal statutes that prohibit anticompetitive behavior, including the Sherman Act, the Clayton Act, the FTC Act, etc.
- The Federal Trade Commission (“FTC”) and the Department of Justice (“DOJ”) have overlapping authority to enforce the antitrust laws.
- The theory behind the antitrust laws is that competition allows for a proper allocation of resources, the lowest prices, and the highest quality of product.
- “Antitrust enforcement can improve health care in two ways. First, by preventing or stopping anticompetitive agreements to raise prices, antitrust enforcement saves money that consumers, employers, and governments otherwise would spend on health care. Second, competition spurs innovation that improves care and expands access.”
 - » Richard Feinstein, Director of the Bureau of Competition at the FTC, December 1, 2010, Statement before the House Representatives Subcommittee on Courts and Competition Policy

Critical FTC/DOJ Guidance Applicable to Antitrust Enforcement in Health Care

- 1996 Federal Trade Commission and Department of Justice Statements of Antitrust Enforcement Policy in Health Care.
- 2000 Antitrust Guidelines for Collaborations Among Competitors, issued by the FTC and Antitrust Division, DOJ.
- 2010 Horizontal Merger Guidelines of the DOJ and FTC.
- 2011 Statement of Antitrust Policy Regarding Accountable Care Organizations, issued by the FTC and DOJ.

The Obama Administration Antitrust Regulation of the Health Care Industry

- Implications of PPACA – reflect DOJ/FTC concerns about health care industry
- For example, the DOJ’s Antitrust Division has recently investigated the barriers to entry new insurers face in new markets.
 - They found that a concentrated market presence by a dominant insurer presented significant barriers (as compared to less concentrated markets) due to the difficulty in negotiating provider discounts
 - This directly led to the DOJ’s lawsuit against BCBS of Michigan’s use of MFN clauses (discussed later).
- In a statement to Congress, DOJ has identified two key enforcement areas as a result of health care reform: (1) “ensuring that coordination and integration amount health care providers encourages innovation and efficiency without harming competition” and (2) the “importance of measured and responsible antitrust enforcement in the health care insurance market.”

DOJ/FTC Enforcement Priorities

- Integration between health care providers
 - Balance - competitive benefits v. harm
 - DOJ Antitrust Division recognizes the value of ACOs in this area.
- Mergers between health care providers
 - 2010 Merger Guidelines
 - Focus on hospitals and health care mergers
- Health care insurers
 - BCBS case
 - Division supports amendment to McCarran-Ferguson Act.
- “Pay to Delay”

DOJ Enforcement Highlight: Action Against BCBS of Michigan

- October 2010: DOJ and Michigan filed a claim against BCBS based upon use of MFN clauses.
- Key allegations:
 - MFN Plus and equal to MFN eliminate entry of competitors
 - Higher premiums
 - Separate geographic markets throughout Michigan – covering 60% of non-Medicare residents.
 - Rule of Reason applies

DOJ Enforcement Highlight: Action Against BCBS of Michigan (Cont'd)

- October 2010 – first private action filed (The Shane Group v. BCBS of Michigan)
- The district court dismissed BCBS' early dismissal motion
 - Rejected application of state action doctrine – “quasi-public” institution
 - Local, not “national” market
 - Sufficient theory of harm
 - Refused to engage in pre-discovery cost-benefit analysis
- March 2011 – DOJ serves subpoenas on BCBS in 8 other jurisdictions (D.C., Kansas, Missouri, North Carolina, Ohio, South Carolina, West Virginia).
- “Any time a dominant provider uses anticompetitive agreements, the market suffers. . . . Let me be clear, we will challenge similar anticompetitive behavior anywhere else in the United States.”
 - Christine Varney, DOJ, October 18, 2010

Impact of BCBS of Michigan

- This case is being carefully watched
 - District Court's Order on MFN clause opens door for cognizable legal theory on harm of MFN clauses. Cf., Ocean State Physician's Plan v. BCBS of Rhode Island (1st Cir. 1989) (finding that use of MFN clause not a violation of the Sherman Act)
 - State action doctrine?

Health Care Provider Mergers

- A series of challenges to hospital mergers that (allegedly) lessen competition, reduce quality of care, and drive up prices
 - Providence Health & Services (Toledo OH, Jan. 2011)
 - Phoebe Putney-Palmyra Park Hospital, Inc. (Albany GA, April 2011)
 - Cardinal Health-Biotech (requiring reconstitution and divestiture of pharmacies) (October 2011)
 - OSF Healthcare – Rockford Health System (Rockford IL, November 2011)
- Physician Group Collaborations
 - Roaring Fork (settled claim of price fixing through collective price negotiations)
 - Minnesota Rural Health Care (same)

Health Care Provider Mergers (cont'd)

- Integration of Physician Services
 - Although typically analyzed under the rule of reason, FTC has made clear that collaborations must show cost savings and health improvement
 - Tri-State agency opinion

FTC Enforcement Blow – Phoebe Putney

- FTC filed claim to enjoin potential acquisition by Phoebe Putney Health System, Inc. of Palmyra Park Hospital
 - Focused on acute care services
 - Argued that involvement of Hospital Authority of Albany-Dougherty County was a “straw man” to invoke state action doctrine
 - Joint Hospital would have 85% of market share
- Eleventh Circuit just affirmed dismissal
 - Rejected inquiry into intent of government
 - Phoebe Putney and municipal authority relied on “clearly articulated” state policy authorizing anticompetitive conduct
 - inference from GA’s Hospital Acquisition Act
 - FTC intends to press on.



Update on New CMS Accountable Care Rules and Antitrust Exemptions

Background

- Section 3022 of PPACA
- Based upon theory that fee for service payment system does not maximize coordination of care; better care can be delivered for less with better coordination of care.
- Regulatory Activity:
 - On March 31, 2011, CMS issued proposed regulations.
 - On October 20, 2011, CMS issued final rules, which included substantial changes, including
 - No mandatory Antitrust Review
 - Simplified Quality Review and the ACO's mandatory governance structure.
 - Limits the scope of downside risk, and expands the potential for upside reward
 - Expanded list of potential participants
 - DOJ and FTC followed with antitrust regulations for ACOs – including those that serve both Medicare and non-Medicare patients.
 - IRS issued guidance on ACO tax issues.

Feature of ACO Rules

- How an ACO works.
 - An ACO is a group of providers and suppliers of services that work together to coordinate care for Medicare fees for service beneficiaries they serve.
 - Disclosure Obligations [Participants must be notified that the provider is an ACO; that the entity can receive additional payments; and that data can be shared among other providers.]
 - Free to elect services – how will they be measured?
 - Each ACO must have a governing board, and it must monitor and report the care it delivers.
 - An ACO must have 5,000 Medicare Fee-For-Service beneficiaries to be eligible to participate in the program, and it must deliver an application identifying how it will deliver the improved care.
 - The contract must be for at least three years.

Features of ACO Rules (cont'd)

- Who can form an ACO?
 - Health care professionals in group and individual practice arrangements
 - Partnership or joint venture arrangements between hospitals and professionals
 - Hospitals employing ACO professionals
 - Other Medicare providers and suppliers as determined by CMS (including rural clinics, critical care hospitals, and certain health centers)

Features of the ACO Rules

- Monitoring ACO Performance
 - The final rule sets forth a methodology by which CMS will monitor compliance with the program requirements, including claims data, financial data, along with site visits, and beneficiary surveys.
 - CMS retains the right to terminate the contract [including for failure to comply with quality performance standards, and refusal to accept high-risk beneficiaries].

Features of the ACO Rules

- Measuring care and providing payment
 - CMS first creates a benchmark cost point at which the ACO will start to realize cost sharing savings.
 - The final payment will depend upon the cost savings along with achieving quality care.
 - The rules allow ACOs to elect one of two cost sharing paths.

Antitrust Exemptions

- FTC/DOJ also issued their own antitrust enforcement standard.
- It drops the requirement of mandatory antitrust review by federal regulators.
- Indicates that CMS-approved ACOs will receive rule of reason review – even if serving non-Medicare participants.
- Creates a series of carefully described “safe zones” for ACOs, which the regulators will not challenge absent “extraordinary circumstances.”



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