Cost Containment, Alternative Delivery, and the Antitrust Laws

A BASIC GUIDE FOR ANTITRUST COMPLIANCE

By Howard Adler, Jr, Esq. and John A. Francis, Esq.

Soaring medical costs and the mounting pressure for cost containment have inspired departures from traditional methods of delivering health care services. Typically, these new methods entail cooperation among competing providers and the setting of preagreed actual or maximum charges for health care services. While efforts to lower health care costs are in the public interest, they enjoy no antitrust immunity; and the enforcement agencies and courts have delivered some mixed signals.

On one hand, Robert Bloch, who heads up the Justice Department's health care antitrust enforcement, has said that the department encourages "the development of both provider and nonprovider-controlled PPOs and IPAs because generally they bring competition to the market."

At the same time, James Rill, the department's antitrust chief, has said, "The department's enthusiasm for new and innovative forms of alternative delivery systems is matched only by our determination to send a clear message that antitrust violations will not go unchallenged." Rill went on to warn that providers who try to conceal unlawful price-fixing "behind a sham PPO will be subject to criminal prosecution."

The Supreme Court has also sent a mixed message. In a 1982 case involving the Maricopa County, Arizona, Medical Society, the court held that when a group of competing physicians agree on even maximum rates their conduct will be a criminal violation of Section 1 of the Sherman Act. At the same time, the court pointed out that the harsh penalties for price-fixing would not apply to "joint arrangements in which persons who would otherwise be competitors pool their capital and share the risks of loss, as well as the opportunities for profit."

Notwithstanding the lack of antitrust immunity and the ambiguity of the message being delivered, fear of antitrust prosecution should not inhibit efficiency-enhancing cooperation among physicians, hospitals, and other health care entities. The two most critical questions are: (1) How can an IPA, PPO or other provider group set pre-determined charges for its services without facing criminal prosecution for price-fixing? (2) How can such provider groups avoid potential civil antitrust liability as an unreasonable restraint of trade? This article undertakes to answer those questions.

How To Avoid Criminal Liability For Unlawful Price Fixing
In antitrust terminology, the term "per se violation" refers to conduct that is so clearly harmful to competition that it is unlawful without regard to the amount of commerce affected or the existence of possible business justifications. Some examples of per se violations are price-fixing, division of markets or production limitation agreements. Price-fixing and other per se violations are typically prosecuted criminally so that perpetrators are exposed to imprisonment as well as to substantial monetary damages in private treble damage actions. It is the threat of criminal and civil prosecution for price-fixing that is the source of greatest concern for provider groups that wish to set specific or maximum fees to be charged their patients or to be used in negotiating managed care contracts.

Although price-fixing is ordinarily a per se offense, price-setting agreements by parties to a legitimate joint venture are not subject to the per se rule and are usually permissible. This was established by the Supreme Court in its 1979 *Broadcast Music* decision where the court upheld a blanket copyright license even though it involved a price agreement among the composer-members of ASCAP. The court reasoned that to "the extent the blanket license is a different product, ASCAP is not really a joint sales agency offering the individual goods of many sellers, but is a separate seller offering its blanket license, of which the individual compositions are raw material." As the court explained, "Joint ventures and other cooperative arrangements are . . . not usually unlawful, at least not as price fixing schemes, where the agreement on price is necessary to market the product at all."

The defendants in the *Maricopa* case attempted to rely on *Broadcast Music* to defend their maximum fee agreement. The case involved a foundation consisting of approximately 1,750 physicians and podiatrists, representing about 70 percent of the practitioners in Maricopa County. Among other functions, it established a schedule of "maximum fees that participating doctors agree to accept as payment in full for services performed for patients insured under plans approved by the foundation." Finding this fee schedule to be "fundamentally different" from the incidental price agreement upheld in the *Broadcast Music* case, the court held that the foundation's maximum fee agreement was unlawful per se.

Significantly, the court distinguished the foundation from "partnerships or other joint arrangements in which persons who would otherwise be competitors pool their capital and share the risks of loss as well as the opportunities for profit. In such joint ventures, the partnership is regarded as a single firm competing with other sellers in the market." Such a joint arrangement, the court observed, would not constitute "an agreement among hundreds of competing doctors concerning the price at which each will offer his own services to a substantial number of consumers," and it concluded:

> If a clinic offered complete medical coverage for a flat fee, the cooperating doctors would have the type of partnership arrangement in which a price-fixing agreement among the doctors would be perfectly proper. But the fee agreements disclosed by the record in this case are among independent competing entrepreneurs. They fit squarely into the horizontal price-fixing mold.

The distinction drawn in *Maricopa* between horizontal price-fixing among "independent competing" physicians and the legitimate establishment of prices by a medical services joint venture has been relied on in later antitrust cases as well as in speeches by antitrust enforcers.
A leading post-Maricopa case is *Hassan v. Independent Practice Associates*. It involved an HMO known as Health Plus of Michigan (Health Plus) and Independent Practice Associates (IPA), an organization of physicians who provided medical care to the subscribers of Health Plus. Health Plus was funded by subscribers who paid a fixed premium per month. Out of that funding, Health Plus paid IPA members for medical services, primarily on a fee-for-service basis. The amount paid to IPA members was limited by a maximum fee schedule that all IPA members agreed to accept. As in the *Maricopa* case, the issue was whether this maximum fee schedule constituted unlawful price-fixing.

The court held that although there was an agreement on fees among competing physicians, the agreement was related to a legitimate health care joint venture and, therefore, was not price-fixing. The court relied on the following distinctions between the maximum fee agreement in *Maricopa* and the IPA's maximum fee schedule:

1. In *Maricopa*, "the agreement between hundreds of competing doctors concerned the price each would charge to the community." In *Hassan*, the maximum fee agreement only affected "what IPA member physicians can charge Health Plus members," and did "not dictate what those doctors can charge to nonHealth Plus patients."

2. The facts showed "that IPA member physicians share the risks of loss as well as the opportunities for profit by accepting a capitation payment from Health Plus, unlike the physicians in *Maricopa.*" The court noted also that physician-members of IPA accepted the risk of nonpayment of a part of their fees which was withheld to protect IPA against loss if its expenses exceeded the capitation payments received from Health Plus.

3. It was also critical to the court that "Health Plus, unlike the foundations in *Maricopa* . . . underwrites and arranges for a comprehensive range of health services for a fixed premium from the consumer." By doing so, it provided consumers "with a new product: guaranteed comprehensive physician services for a prepaid premium different from fee-for-service physician services." In light of those considerations, the court upheld the maximum fee schedule.

It is important to understand that price agreements made in connection with legitimate joint ventures, while exempt from criminal prosecution as per se violations, may be subject to civil injunction actions by the Justice Department or Federal Trade Commission or to private treble damage actions if they do not pass muster under what is known as a "rule of reason analysis." We define the rule of reason and discuss its implications in the next section of this article; for the purpose of this section, the critical point is that the justice Department has accepted the reasoning of cases like *Broadcast Music, Maricopa*, and *Hassan* and will not condemn legitimate IPAs and PPOs as per se criminal violations.

As Robert Bloch has said, "The majority of joint provider activities we investigate require a rule of reason analysis. Perhaps the most commonly undertaken joint activity in this category is the formation and operation of bona fide provider-controlled PPOs and IPAs."

Antitrust chief, Rill has identified the following factors that distinguish legitimate joint ventures from unlawful price-fixing schemes:
We look for evidence of economic integration or conduct that produces a new product or service. Where there is such evidence, rule of reason rather than per se treatment is appropriate.

The types of business or physical asset integration that antitrust lawyers expect to see in a bona fide joint venture such as risk-sharing, centralized business operations, joint marketing or other forms of organizational integration are evident in varying degrees in alternative delivery systems.

Conceivably, rule of reason treatment may be appropriate even if there is an absence of operational integration when the pooled effort in itself provides a product significantly different from that otherwise offered on an independent basis by the individual providers.

When these conditions are met, price-related agreements among physicians will not be condemned as criminal price-fixing. On the other hand, Rill has stated that if "providers who are members of a legitimate PPO engage in conduct outside the scope of the PPO that satisfies the elements of a per se violation, the conduct would be prosecuted criminally." Furthermore, Bloch has emphasized that any attempt by physicians to "resist competitive pressures to discount fees" to third-party payers must be avoided. Indeed, according to Bloch, concerted "resistance to vigorous third-party payers' demands for lower fees or discounts represents the greatest risk of antitrust exposure."

Meeting Rule of Reason Requirements

Rill has made it clear that if a health care joint venture "passes the 'sham' test or otherwise is characterized as conduct not subject to the per se rule . . .," the justice Department still must test it under the rule of reason. As a general proposition, the basic inquiry under the rule of reason is whether the restraint in question "is one that promotes competition or one that suppresses competition." In conducting that inquiry, the fact finder must weigh a restraint's benefits to competition against its adverse effects. If there is no substantial net anticompetitive effect, there will be no violation.

In applying the rule of reason to provider groups, the department is "most concerned about over-inclusive provider-controlled PPOs and IPAs, and PPOs and IPAs with market power that engage in exclusionary practices to prevent, exclude or eliminate the development of competing alternative delivery systems." At one time the department believed it should "not be concerned with a PPO that has less than 35 percent of all providers in a community." Now, however, it applies a more sophisticated analysis using the methodology of the Merger Guidelines issued by the department in 1984.

In applying the Merger Guidelines, the starting point is market definition. "In the PPO context," according to Bloch, "the relevant product markets are likely to be defined around particular specialty practice areas demanded by consumers." The relevant geographic market will be the area to which patients can reasonably look in seeking medical care. That area is likely to be more extensive for sophisticated specialty care than for routine medical treatment.
Once the relevant product and geographic market has been defined, the department applies its horizontal merger criteria based on the Herfindahl-Hirschman Index (HHI). (The HHI is a measure of market concentration which uses the sum of the squares of the market shares instead of simply adding the market shares of the top four or top eight firms.) If the post-transaction HHI is less than 1000, the merger or joint venture will not be challenged; between 1000 and 1800, the merger or joint venture is in a gray area and may be challenged depending on consideration of a variety of economic factors. If the post-transaction HHI is above 1800, the division is likely to challenge the transaction in the absence of ease of entry or other compelling procompetitive factors.

The department would be looking for combinations of health care providers that collectively hold market power. If the PPO, IPA or other provider group controls 30 percent or so of the pertinent market, there is not likely to be a significant competitive problem unless the remaining 70 percent is tightly held by a small number of providers or provider groups. It is important to understand that the department does not rigidly or mechanically apply its HHI-based enforcement tests. Therefore, each case must be considered on its individual facts.

Even if the health care joint venture is not overly-inclusive, there can still be an antitrust problem if there are unduly restrictive ancillary provisions, in particular, provisions that create exclusivity arrangements between individual physicians and the IPA or its affiliated HMO. According to Rill, such arrangements can "have serious anticompetitive effects where they exclude competing alternative delivery systems and significantly constrict fee-for-service options."

Bloch has identified some problem provisions. For example, the department has questioned a provision that prohibited an IPA's members from dealing individually with third-party payers "unless the IPA first reaches an impasse with the payer . . ." Likewise, it has disapproved of an HMO's paying a premium to doctors to obtain their exclusive affiliation with the HMO on the ground that this "could discourage the HMO's providers from joining competing HMOs or [could] prevent new HMOs from entering the market to the detriment of consumers." Bloch has also expressed concern with "price information exchange programs among different groups of competing providers."

With full understanding of the applicable concepts and careful structuring and implementation there should be little risk of antitrust liability in forming and operating alternative health care delivery systems. It is particularly important that the entity be a legitimate joint venture that provides a health care product different from the fee-for-service product individually offered by the participating practitioners. Once that requirement is satisfied, the rule of reason will apply. There will then be no criminal liability and civil liability will exist only if the venture controls an undue share of the market or if there are unreasonably restrictive ancillary provisions.

In the final analysis, antitrust looks to substance not to form. If the cooperative venture is truly intended and designed to promote the cost effective delivery of health care services, then careful attention to structure and implementation should ensure compliance with the antitrust laws. If the true purpose is to eliminate competition or to ensure higher fees (or lower discounts), then skilled lawyering and creative cosmetics are unlikely to save the venture and its members from significant antitrust liability.

Howard Adler is the senior antitrust partner in the Washington, D.C. office of the Denver firm of Davis,
Graham & Stubbs. **John Francis** is an associate in the firm's Washington, D.C. office. Both are members of the firm's Health Care Practice Group.

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