

TO COMPETE OR REGULATE: WHAT'S RIGHT FOR HEALTH CARE?

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The need to increase the efficiency and reduce the costs of health care has been prominent in the debate over health care reform. From the perspective of many antitrust lawyers and economists, increased competition is the best means to deliver the needed cost savings. However, the Federal Trade Commission's recently proposed consent decree with the Minnesota Rural Health Cooperative demonstrates that there is not unanimity on the appropriate scope of antitrust enforcement in the health care sector. See *In the Matter of Minnesota Rural Health Cooperative*, FTC File No. 051-0199 (consent order proposed June 18).

An otherwise routine FTC enforcement action against collective rate negotiations by the MRHC took on a new twist following the passage of a Minnesota statute intended to immunize the conduct the FTC sought to enjoin as harmful to consumers. While the FTC obtained significant relief through the proposed settlement, the resulting consent order continues to allow for collective negotiations by the MRHC on behalf of its members, a significant departure from typical practice that was driven by the contrasting state and federal views as to the desirability of MRHC's practices.

The MRHC example is just the latest round in a long-running debate as to whether perceived inequality in bargaining power between payors and providers in some circumstances justifies the regulatory-sanctioned use of collective bargaining to "level the playing field." The Minnesota legislature responded to the FTC's investigation of the MRHC by seeking to displace antitrust enforcement with an arguably less restrictive form of regulatory oversight. On the other hand, the recent proposals to repeal the McCarran-Ferguson Act, which partially exempts the insurance industry from the antitrust laws, presume that antitrust enforcement should be broadened to areas where competitive issues currently exist.

Prior FTC/DOJ Actions Against Collaborations Among Providers

In the past decade, the FTC and U.S. Department of Justice have brought over 20 actions against groups of physicians or other health care practitioners that have engaged in collective rate negotiations with health insurers. The legal premise of these cases, which is generally not controversial, is that, absent some economic or clinical integration of the parties involved, the antitrust laws prohibit competitors from jointly negotiating with purchasers of their services. Successfully denying a purchaser the right to negotiate and ultimately contract with individual competitors leads to higher prices and thus harms consumers.

The U.S. Supreme Court has emphasized the per se illegality of collective actions among competitors to establish prices even in cases where public policy reasons arguably support a variation from the competitive norm. In *FTC v. Superior Court Trial Lawyers Association*, 493

U.S. 411 (1990), the Supreme Court upheld an FTC order finding that an agreement among court-appointed defense lawyers not to accept future appointments unless and until the very low hourly compensation was increased was per se illegal.

The Supreme Court's opinion reaffirmed that "the Sherman Act reflects a legislative judgment that ultimately competition will produce not only lower prices, but also better goods and services" and that "the statutory policy underlying the Sherman Act precludes inquiry into whether the competition is good or bad." 493 U.S. at 423-4.

In accordance with that mandate, the FTC and DOJ have vigorously pursued enforcement actions against horizontal agreements among competing health care providers. Similarly, the 2004 DOJ/FTC Healthcare Report specifically recommended that "governments should not enact legislation to permit independent physicians to bargain collectively." See Federal Trade Commission and Department of Justice, *Improving Health Care: A Dose of Competition* at 23 (July 2004) ("2004 Health Care Report"). The 2004 Health Care Report concluded that "physician collective bargaining will harm consumers financially and is unlikely to result in quality improvements. There are numerous ways in which independent physicians can work together to improve quality without violating the antitrust laws."

MRHC and the FTC Investigation

The MRHC website states that its mission is "to develop a cooperative effort of physicians, public health agencies and hospitals to preserve and maintain health care resources and access with local choice and control for member communities." The MRHC has approximately 22 member hospitals and 114 physician members, which the FTC alleged account for the "vast majority" of hospitals in the geographic area in which the MRHC operates and "roughly half of the primary care physicians in southwestern Minnesota." Based on the allegations in the FTC complaint, the core activities of the MRHC do not appear to be substantively different from many of the other provider organizations challenged by the FTC or DOJ.

The FTC alleged that the MRHC negotiated the price terms of contracts for individual members with numerous payors and that those negotiations were conducted on the basis that no individual MRHC member would contract separately. The MRHC appears to have been explicit in informing payors that individual negotiations with MRHC members were not permitted and that the MRHC "expects our group to be accepted or rejected as a group." Absent some economic or clinical integration among MRHC members, which does not appear to have been present in a meaningful form, insisting on such collective negotiations would raise a significant antitrust concern.

Minnesota Seeks to Invoke the State Action Doctrine

The formation of health care cooperatives such as the MRHC had been authorized under Minnesota law since 1994. However, there was no ongoing state oversight over there at the time the FTC investigation began. In May 2009, while the FTC was investigating the activities of the MRHC, the Minnesota legislature passed an amendment to the existing health cooperatives law requiring that the state commissioner of health "review and authorize" contracts entered into by

health care cooperatives. The new legislation appears to have been directly aimed at shielding contracts submitted for state review from liability under the federal antitrust laws.

The state action doctrine immunizes actions taken by a state and conduct by private parties expressly authorized and supervised by a state from federal antitrust liability. A defendant seeking to invoke the state action doctrine must establish two elements. First, the challenged conduct must have occurred in furtherance of a “clearly articulated and affirmatively expressed” state policy. Second, the state must “actively supervise” the policy that gave rise to the challenged conduct. See *California Retail Liquor Dealers Ass’n v. Midcal Aluminum Inc.*, 445 U.S. 97, 105 (1980).

With respect to the review of rates established by private parties, the Supreme Court has held that the “active supervision” prong requires the exercise of “sufficient independent judgment and control so that the details of the rates or prices have been established as a product of deliberate state intervention.” *Federal Trade Commission v. Ticor Title Ins. Co.*, 504 U.S. 621, 634-35 (1992).

Both the FTC and the Antitrust Modernization Commission have expressed concern over the potential for the state action doctrine to immunize conduct not within the Supreme Court’s formulation of the doctrine. The 2005 AMC Report, building on the similar recommendations of a 2003 FTC staff report, recommended that “courts should apply the state action doctrine more precisely and with greater attention to both Supreme Court precedents and possible consumer harm from immunized conduct.” AMC Report at 344.

The FTC staff submitted a nine-page comment regarding the proposed Minnesota legislation. Consistent with the views expressed in the 2004 Health Care Report and other advocacy filings, the FTC staff vigorously opposed the legislation, while noting that the MRHC was currently the subject of an FTC investigation and was the “main proponent” of the bill. See March 18, 2009 Letter from David P. Wales et al to Rep. Tom Emmer (available on the FTC website).

The FTC staff argued that collective bargaining by health care providers would raise health care costs and harm consumers. With respect to the impact of the legislation on its investigation, the FTC staff argued that the limited review process and presumption in favor of approval of contracts submitted for review might not satisfy the active supervision requirement.

Notwithstanding the FTC staff’s objections, the proposed legislation became law on May 16, 2009. The FTC and MRHC ultimately reached a proposed consent order resolving the FTC investigation, which was released for public comment on June 18.

The Proposed Consent Order

The proposed FTC consent order attempts to craft a compromise between its long-standing opposition to collective rate negotiations by provider groups and the clear endorsement by the state of Minnesota of the MRHC’s activities. Unlike the majority of consent orders entered in similar situations, the proposed consent order expressly acknowledges that the MRHC may continue to negotiate contracts with payors on behalf of its members (although it does prohibit explicit agreements among the MRHC and its members to refuse to contract individually). The proposed consent order further prohibits the MRHC from seeking state approval of contracts

resulting from “acts of coercion, intimidation, or boycott of, or any concerted refusal to deal with, any payor seeking to contract with the MRHC.” See Decision and Order at Paragraph II. The language of the proposed consent order does not give further guidance as to how the line between unlawful “acts of coercion, intimidation or boycott” and lawful joint negotiations, which necessarily imply the threat of a boycott, will be drawn. As the FTC staff’s own comments opposing the recent Minnesota legislation argued, “[c]ollective negotiations by their very nature can convey an implicit threat that, if the health plan does not agree to terms acceptable to the physician group, the plan will be unable to obtain agreements with group members.” FTC Comments at 7.

The proposed consent order does impose significant monitoring obligations on the MRHC and requires that it terminate existing payor contracts upon their expiration or upon the request of any payor. Nevertheless, in light of the continued ability of the MRHC to “reject any offer or counter-offer or refuse to contract” and to “exchange such information as is reasonably necessary to contract pursuant to negotiating or contracting with any payor” it is questionable whether the consent order would adequately remedy on a going-forward basis the harms the FTC identified from the MRHC’s previous conduct.

The FTC’s analysis to aid public comment acknowledges that in prior circumstances the FTC has prohibited state-sanctioned collective bargaining absent proof of the active supervision required by the state action doctrine. However, given the recent passage of the Minnesota statute and lack of experience with it, the commission determined that “the circumstances here make it appropriate to defer to Minnesota’s expressed intention to actively supervise the contracts that result from the MRHC’s price fixing.” Analysis to Aid Public Comment at 12.

Conclusions

While affecting a relatively small part of the massive health care sector, the differing approaches of the FTC and the state of Minnesota illustrate the continuing tension as to how to fix the perceived crisis in health care. The FTC and DOJ have acknowledged that certain features of health care markets limit the type of competition that is relied upon in other markets. Nevertheless, their preferred approach is typically to remove or limit those barriers to competition wherever possible.

State authorities and many market participants, however, often take the view that such an idealized view of competition as a “cure-all” is not practical in the messy world of health care and that practices that would normally be deemed anti-competitive should be allowed or even furthered to promote other policy goals.

The MRHC action and a separate proceeding filed by the FTC against the North Carolina Board of Dental Examiners on June 17 demonstrate that the FTC remains interested in the contours of the state action doctrine, which establishes the border between the antitrust and regulatory spheres described above. The periodic disagreements between federal antitrust enforcers and state health care officials and legislators may result in further guidance from the courts as health care reform continues to develop.