

Developments in Antitrust Law and the Impact on Health Care Providers

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Carolinas Healthcare Case

- ▶ Carolinas Healthcare System
 - Owns 10 hospitals in Charlotte, NC area
 - 50% market share
 - Next competitor is less than half its size

Carolinas Healthcare Case

- ▶ Hospitals compete to be in payor networks
- ▶ Once in-network, hospitals compete for patients
- ▶ Payor trades steerage for discount
- ▶ DOJ alleges that Carolinas offers “modest concessions on its market-power driven, premium prices” to enter networks

Carolinas Healthcare Case

- ▶ DOJ theory:
 - Section 1 of the Sherman Act Rule of Reason
 - No claim under Section 2
 - Product market: inpatient hospital services reimbursed by commercial payors
 - Alleged conduct also applies to outpatient, ancillary, and physician services but DOJ claim does not cover them
 - Geographic market: No larger than the Charlotte Combined Statistical Area, as defined by the U.S. Office of Management and Budget
 - “An insurer selling health insurance plans to individuals and employers in the Charlotte area must have CHS as a participant in at least some of its provider networks, in order to have a viable health insurance business in the Charlotte area” (DOJ Complaint)

Carolinas HealthCare Case

▶ DOJ Theory:

- Carolinas suppressed competition with anti-steering contract clauses with payors
 - Steering either prohibited, carries a financial penalty (increased reimbursement) or triggers early termination right
- No narrow networks excluding Carolinas
- No adverse tiering of Carolinas
- Eliminates the reward for Carolinas competitors discounting for better steerage
- Restrictions in contracts impede payors from providing truthful information to consumers about the value (cost and quality) of services

Carolinas Healthcare Case

- ▶ Relief Sought by DOJ
 - No monetary relief requested
 - “[E]njoin CHS . . . from seeking, agreeing to, or enforcing any provision in any agreement that prohibits or restricts an insurer from engaging, or attempting to engage, in steering towards any healthcare provider” (DOJ Complaint)
 - “[E]njoin CHS from retaliating, or threatening to retaliate, against any insurer for engaging or attempting to engage in steering” (DOJ Complaint)

Carolinas Healthcare Case

- ▶ Carolinas Motion for Judgment on the Pleadings:
 - Carolinas offers discounts to be in-network
 - Expected volumes are key to rates because higher volumes offset significant fixed costs
 - Payors use Carolinas participation to market their products
 - Carolinas protecting against bait and switch of being cut out of volume after granting discounts and giving payors marketing advantage

Carolinas Healthcare Case

- ▶ Carolinas Motion for Judgment on the Pleadings continued:
 - No allegation of actual anticompetitive effect (price/quality/output), just “competitive process”
 - Anti-steering clauses much softer in reality than alleged and market power exaggerated
 - BCBS-NC established narrow network without Carolinas
 - United Healthcare terminated contract in 2015
 - Challenged clauses vary by payor, not uniform terms imposed by hospital system

Payor Mergers

- ▶ In 2015, there was a scramble among large healthcare payors to consolidate
 - July 2, 2015: Aetna enters agreement to buy Humana for \$37 billion
 - July 23, 2015: Anthem enters agreement to buy Cigna for \$54 billion
- ▶ In July 2016, DOJ, in conjunction with various state attorneys general, filed complaints in the U.S. District Court for the District of Columbia to permanently enjoin both acquisitions
 - Each complaint alleges that the respective payor combination will substantially lessen competition in violation of Clayton Act Section 7
- ▶ Trials November - January

U.S. v. Anthem, et al.

▶ Anthem

- Part of the BCBS Association that controls the Blues license in 14 states (covering 39% of the US population)
- Outside of Anthem Territory
 - Other Blues can cede right to account to Anthem
 - Anthem receives “BlueCard fees”
- 39 million members nationwide and \$78 billion in revenue in 2015

▶ Cigna

- Operates in all 50 states and DC
- 13 million members and \$38 billion in revenue in 2015
- 13% compound revenue growth annually over the past 6 years

U.S. v. Anthem, et al.

- ▶ DOJ alleged that the Anthem-Cigna acquisition will substantially lessen competition in numerous markets:
 - National Accounts*
 - Local commercial markets – large group employers in 35 metropolitan areas
 - Individual public exchanges – St. Louis and Denver
 - Abandoned this allegation pursuant to stipulation
 - Purchase of healthcare services by commercial payors*
- ▶ Other notable allegations
 - Reputation of Anthem vs. Cigna
 - Conflict of interest with other Blues

U.S. v. Anthem, et al.

- ▶ DOJ theory re: National Accounts
 - Three to four players
 - Combined market share of at least 50% (excluding slice payors)
 - Documents/testimony show Defendants as close rivals for national account clients
 - E.g., bounty program, win/loss reports, etc.
- ▶ Defendants' Response
 - Prevalence of slicing – regional payors compete with Defendants
 - Blues compete with one another
 - Hundreds of TPAs compete for large, self-insured accounts

U.S. v. Anthem, et al.

- ▶ DOJ theory re: purchase of healthcare from providers
 - Combined payor can leverage large number of covered lives to receive lower reimbursement rates from providers
 - These lower rates lead to reduced quality, less access to medical care, and fewer value-based collaborations between providers and payors
- ▶ Defendants' Response
 - Lower rates are an efficiency of the transaction – savings are passed through to consumers
- ▶ In late December, court requests further briefing on this issue
 - DOJ: only need to show that combination will likely increase market power that risks harm to providers through lower rates
 - Defendants: DOJ needs to show that combination will push reimbursement rates below providers' long-run marginal costs
- ▶ On last day of trial, court asked further questions of counsel

U.S. v. Aetna, et al.

- ▶ Aetna
 - 23.5 million enrollees and revenues of \$60 billion in 2015
 - “Major, growing” Medicare Advantage competitor
- ▶ Humana
 - 14.2 million enrollees and revenues of \$54 billion in 2015
 - Second largest Medicare Advantage payor with 3.1 million enrollees

U.S. v. Aetna, et al.

- ▶ DOJ alleged that the combined entity will lessen competition in two markets:
 - Medicare Advantage*
 - Individual public exchanges – Florida, Georgia, Missouri
- ▶ Aetna's proposed divestiture insufficient to restore competition

U.S. v. Aetna, et al.

- ▶ DOJ theory re: Medicare Advantage:
 - Medicare Advantage is its own market
 - Costs less and offers more benefits than traditional Medicare
 - In 364 counties, combined entity would have market share of at least 35%, and in 70 of those counties, the share would be 100%
 - Documents/testimony show intensity of head-to-head competition
 - Divestiture candidate (Molina Healthcare) unlikely to preserve competition
 - Currently operates in only 41 of the 364 counties and has less than 500 enrollees
- ▶ Defendants' Response
 - Medicare Advantage competes with traditional Medicare
 - Combined entity will remain subject to CMS's regulatory oversight
 - Compete with many other MAOs and no evidence that Defendants are particularly close competitors
 - E.g., Texas (16 MAOs), North Carolina (8 MAOs)
 - Ease and prevalence of entry
 - Molina Healthcare will effectively compete
 - Divestitures provide Molina 290K enrollees in 21 states

U.S. v. Aetna, et al. – The Decision

- ▶ January 23, 2017 – District Court blocks merger
- ▶ Agreed with DOJ that traditional Medicare is not included in market with Medicare Advantage
 - Medicare Advantage has distinct characteristics and use
 - Documents and testimony revealed “industry and public recognition” of distinct markets
 - E.g., detailed assessments of competition among Medicare Advantage plans ubiquitous
 - Medicare Advantage enrollees rarely switch, but if do, go to another Medicare Advantage plan
 - Based on Defendants’ expert’s data, DOJ’s expert determined that hypothetical monopolist could profitably impose small but significant and non-transitory increase in price without losing customers to traditional Medicare

U.S. v. Aetna, et al. – The Decision

- ▶ Concluded that DOJ established prima facie case that combination will have anticompetitive effects
 - Based on market share concentration calculations, the combination presumptively enhances market power
 - Combination results in elimination of aggressive competitor
 - Head-to-head analyses revealed that Aetna's presence decreases Humana's market share
 - Regression analysis performed by DOJ's expert predicts 60% increase in premiums as result of acquisition
 - \$500 million/year harm to seniors and taxpayers

U.S. v. Aetna, et al. – The Decision

- ▶ Determined that Defendants' arguments did not rebut presumption of anticompetitive effects
 - CMS will not deter or remedy anticompetitive conduct
 - Entry into Medicare Advantage Market not timely, likely, or sufficient
- ▶ Molina not adequate divestiture candidate
 - Contemporaneously-prepared business documents from Molina's Board and executives undermine argument that it can successfully compete
 - Low purchase price raises concern
 - Molina has not succeeded in Medicare Advantage in past

U.S. v. Aetna, et al. – The Decision

- ▶ Concluded that Combination will substantially lessen competition on public exchanges in three Florida counties
 - Contemporaneously-prepared documents show that Aetna left markets in 17 complaint counties to improve litigation position
 - Evidence presented that Aetna would offer plans in some of those 17 counties in the future
 - Market share concentration calculations and evidence of head-to-head competition establish prima facie case of anticompetitive effects in Florida counties that Defendants were unable to rebut

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- ▶ National chair of the Health Care practice.
- ▶ Work includes government regulatory investigations, contracting issues, credentialing, peer review, licensing, medical staff bylaws, joint commission accreditation and Medicare certification.
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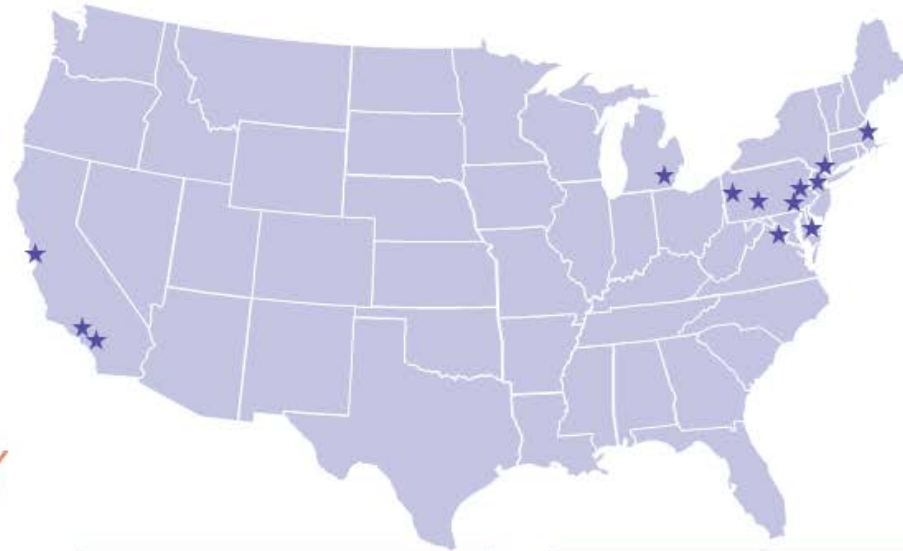
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