Healthcare Antitrust & Innovation and Efficiency in Health Care Delivery

What is the role of antitrust in promoting innovation and efficiency in health care delivery? According to the government, there can be no doubt that vigorous yet responsible antitrust enforcement is crucial if we are to benefit from innovation and efficiency in our health care delivery system and reduce rising health care costs in both the public and private sectors.

The U.S. population is aging, with the baby boomers once again transforming the demographic landscape as they reach 65. These changing demographics demand that we devise ways to treat even greater numbers of increasingly sick patients more efficiently and affordably. Unquestionably, that will lead to additional interest in integrating what most observers say is now a fragmented health care delivery system.

There does not seem to be serious dispute that clinical integration and coordinated care have the potential to decrease costs and improve quality. The key is whether we can gain those benefits without sacrificing meaningful competition.

The answer to that question should be undoubtedly “yes.” The Health Care Policy Statements and business reviews of the federal antitrust enforcement agencies make clear that antitrust is not an impediment to the formation of innovative, integrated health care delivery systems and genuine increases in provider efficiency. There are many ways under the federal antitrust laws for providers to form joint ventures to control costs and improve quality without unduly inhibiting competition. They can financially integrate, or they can clinically integrate, or, indeed, they can do both. As was said in 1996, the federal antitrust enforcement agencies should be receptive to new and innovative forms of provider arrangements that do not necessarily involve financial risk sharing. As the Policy Statements emphasize, antitrust’s ultimate objective is that there be sufficient network integration—whatever that integration may be—for the network to achieve significant, material efficiencies that will benefit consumers.

The Policy Statements (Statements of Antitrust Enforcement Policy in Health Care, Statement 8 (1996), available at http://www.justice.gov/atr/public/guidelines/1791.pdf) discuss what can constitute sufficient clinical integration. They note the role, and import, of establishing mechanisms to monitor and control utilization of health care services that are designed to control costs and assure quality of care; selectively choosing network providers who are likely to further these efficiency objectives; and making significant investments in network infrastructure and capability so as to realize these claimed efficiencies.

The Federal Trade Commission has applied this analysis in a number of advisory opinions involving questions of clinical integration. The advisory opinions confirm that the touchstone of clinical integration analysis is the adoption of a comprehensive, coordinated program of care management designed, and likely, to improve quality and cost-effective care. Only that kind of program—with its emphasis on realizing benefits for consumers—justifies rule-of-reason treatment for price setting or other agreements that might otherwise be per se illegal.

For example, the FTC’s 2009 TriState Health Partners advisory opinion involved a proposal by a physician-hospital organization to clinically integrate its members’ provision of health care services and to contract jointly with health plans and other payers on a fee-for-service basis. Similarly, the FTC’s 2007 Greater Rochester Independent Practice Association advisory opinion involved a physician association’s proposal to negotiate contracts with payers in connection with its integrated services program. In both of these matters,
providers, through the use of IT systems, practice guidelines, care protocols, referral policies, and quality benchmarks, sought closely to align their efforts to improve their patients’ health and delivery of services. In both ventures, the participating providers substantially integrated their activities in order to establish a comprehensive, aggressive program of care management that would increase efficiency and improve quality of care.

The Policy Statements also provide numerous examples of sufficient financial integration. There can be, among other things, an agreement to provide services at a capitated rate, or to provide particular services for a predetermined percentage of the premium or a predetermined revenue stream. There also could be, for instance, the use of significant financial incentives to achieve specific cost-containment goals, or the agreement to treat complex cases for a fixed, predetermined fee. The point is that, however it is to be achieved, it is incumbent upon the group to share financial risk in such a way that each member has an economic incentive to ensure that the group as a whole produces material efficiencies that will benefit consumers.

It is important to keep in mind that not all provider networks involve sufficient financial, clinical, or other economic integration to apply the rule of reason to joint price negotiations with payers. For example, an arrangement among competing providers simply to engage in joint billing, joint collection services, or even joint purchasing of medical supplies or services is generally not the type of economic integration needed to allow providers jointly to set their reimbursement rates under the rule of reason. Rather, such steps simply reflect an effort to coordinate and share some administrative expenses or to receive volume purchasing discounts.

The economic integration that justifies application of the rule of reason to joint price negotiations with payers requires the sharing of some form of financial risk, such as an agreement by providers to accept a capitated rate, a predetermined percentage of revenue from a health plan, or sufficient clinical integration to induce the group’s members to improve the quality and efficiency of the care they provide. While there is no particular formula that can cover all types of legitimate clinical integration, the key is that there must be sufficient clinical integration to motivate the kinds of changes that can achieve real cost-containment or other performance benchmarks. For example, indicia of clinical integration may include: adequate infrastructure; an adequate number of meaningful protocols for diagnoses and treatment of diseases; enforceable performance standards; and proof of physician commitment to the program. However, where purported efforts to integrate are principally a vehicle for obtaining and exploiting market power or simply a subterfuge for price fixing, then antitrust is there, as it should be, to protect competition and consumers.

The Affordable Care Act’s development of ACOs is a good example of how providers might work together to deliver more efficient, high-quality care without inhibiting competition, so long as their collaborations are properly constructed. For example, the ACO encourages competing physicians, and possibly other providers, to coordinate care for a defined Medicare population through redesigning care protocols, utilizing health IT, investing in infrastructure, and meeting quality targets. If the ACO meets quality-of-care and cost targets, it can share the savings with HHS.

Properly constructed, ACOs have the potential to improve health care delivery and drive down costs. Thus, as reform moves forward, the Justice Department will work closely with HHS and providers to offer whatever guidance may be needed to ensure that providers pursue beneficial integrated ACOs without running afoul of the antitrust laws.
The government, according to CHRISTINE A. VARNEY, the Assistant Attorney General of the Justice Department’s Antitrust Division, wants to see if there are additional, or better, ways to reach out to clinical-integration stakeholders and convey the important message that antitrust is not an impediment to legitimate clinical integration and should not be a concern to those contemplating such efforts. The government also wants to see if it can improve, streamline, and make more transparent our review of integrated provider networks. The ultimate goal is to ensure that health care providers have the necessary guidance to form innovative, integrated health care delivery systems without unduly confining providers to any particular delivery model.