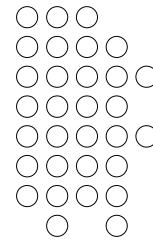


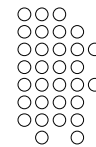
# MANAGED CARE ANTITRUST COMPLIANCE ISSUES

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## MCO Antitrust Issues

1. The Obama administration's stance on health insurers
2. Partial repeal of the McCarran Act
3. Managed Care Mergers
4. Managed Care Exclusive and Selective Contracting
5. Most-Favored-Nations Provisions
6. All-Products Provisions



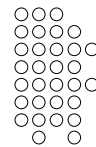
## The Obama Administration



- Even before the election, Obama promised to “reinvigorate” antitrust enforcement
- Specific mention of MCO mergers
  - Grossly excessive concentration and market power in MCO markets
  - Failure of DOJ to do anything about it
- MCOs as Obama’s and Congress’s “whipping boy”
- What’s happened so far?

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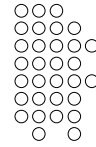
## MCO Concentration



- What’s wrong with concentrated markets?
  - “Seller-side” issues
  - “Buyer-side” issues
- Are MCO markets highly concentrated?
  - Depends on to whom you talk
    - AHA
    - AMA
    - AHIP
  - Government Accountability Office

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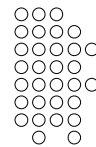
## Partial Repeal of the McCarran Act?



- What's the McCarran Act, when does it apply, and what does it do?
- How important is it to MCOs?
- Proposals for limited repeal
- Are members of Congress liars or just stupid?
- What would the effect of partial repeal be?
  - Can we please focus on issues that matter?

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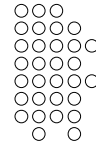
## Managed Care Mergers



- An important issue; a likely major enforcement area
- Although we may disagree about the degree, MCO market concentration has increased substantially over the last 15 years
- What are the bad effects of mergers?
- What are the good effects?
- Need to examine both “seller side” and “buyer side” effects from MCO mergers
- Enforcement responsibility: DOJ Antitrust Division

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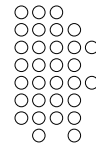
## Analyzing an MCO Merger



1. Define the relevant market
2. From that, identify competitors
3. Compute post-merger market shares
4. Compute post-merger market concentration and degree to which merger increases concentration
5. Determine the likely competitive problem from the merger—“coordinated interaction” or “unilateral effects”

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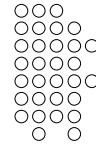
## MCO Merger Analysis, cont'd



6. Compare market share and concentration statistics to enforcement agency benchmarks suggesting a problem
7. Determine whether government has a prima facie case
8. If so, consider “rebuttal” evidence, e.g.:
  - a. Low entry barriers
  - b. Low expansion barriers
  - c. Efficiencies from the merger
  - d. “Failing” or “flailing” firm

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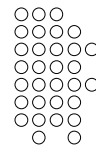
## MCO Merger Analysis, cont'd



- What have the enforcers done so far?
  - Aetna/Prudential
  - UnitedHealth/PacifiCare
  - UnitedHealth/Sierra
- How many investigations?
- Why so few challenges?
- And don't forget about necessary approvals from state insurance commissioners
  - Highmark/Independence Blue Cross

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## MCO Merger Analysis, cont'd What Are the Major Issues?



- Relevant product market definition
  - "Seller-side" analysis
    - What type plans are included? HMOs, POS-HMOs, PPO's, self insurance, government programs, no insurance?
      - Depends on degree of "reasonable interchangeability," or price cross-elasticity of demand, among the different types of products, or those types that constrain the ability of the merged plan to raise premium prices
    - Sales to all types of customers or just to certain types?
    - What the government has said
      - Aetna/Prudential
      - UnitedHealth/PacifiCare
      - United Health/Sierra

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## MCO Merger Analysis, cont'd

### What Are the Major Issues?

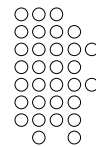


- Relevant geographic market
  - Not a lot of controversy here
    - Geographic markets are usually relatively local, e.g., MSAs
    - Why?
      - Primarily because the MCOs' provider networks are local and members won't travel long distances to providers

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## MCO Merger Analysis, cont'd

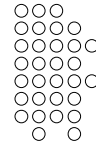
### What Are the Major Issues?



- Relevant product market
  - Buyer-side analysis
    - Mirror image of the seller-side analysis
    - Market includes all reasonably interchangeable alternative buyers of the providers' services
    - Thus, the major issue is whether the market includes only sales of provider services to commercial insurers or sales to all types of customers, including government programs and self-pays

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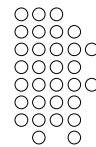
## MCO Merger Analysis What Are the Major Issues?



- Relevant geographic market
  - Buyer side
    - Typically local
    - Why? Because providers typically can't move to more distant locations and their patients tend to be local and don't tend to travel long distances for medical services

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## MCO Merger Analysis, cont'd What Are the Major Issues?

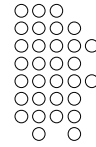


- Post-merger concentration and market share: warning signs:
  - Market share: Roughly speaking, post-merger market share of 35% or more
    - Raises “unilateral effects” issue
  - Concentration: A post-merger HHI of 2,000 or more and an increase in the HHI of 100 or more; or the aggregate market shares of the four largest firms (the CR=4) exceed 70%
    - Raises “coordinated interaction” issue
  - But these are only rough guidelines

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## **MCO Merger Analysis, cont'd**

### **What Are the Major Issues?**

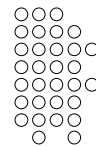


- High entry barriers?
  - For MCO markets, substantial disagreement about this
  - Potential entry barriers:
    - Required capital
    - Reputation
    - Perhaps most important, building the necessary networks

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## **MCO Merger Analysis, cont'd**

### **What Are the Major Issues**

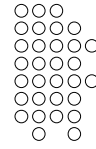


- High expansion barriers?
  - Not much disagreement here
  - Expansion barriers to incumbent MCO firms are low; should be relatively inexpensive to increase capacity and sales

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## **MCO Merger Analysis, cont'd**

### **What Are the Major Issues?**

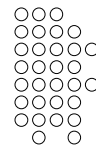


- Efficiencies from the merger
  - Substantial disagreement about this
  - Literature suggests that economies of scale in the MCO industry are maximized at relatively low numbers of subscribers, but is disagreement
  - Maybe all that can be said is that the answer is quite fact specific, depending on the particular merger and how the merging parties intend to integrate their operations

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## **MCO Merger Analysis, cont'd**

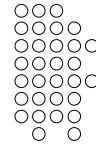
### **What Are the Major Issues?**



- Bottom line on enforcement:
  - All of us expected the Antitrust Division to challenge MCO mergers much more aggressively.
  - It hasn't happened yet, but it's early
  - Jury still out

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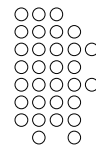
## Exclusive and Selective Contracting



- Can take numerous forms, e.g.:
  - MCO agrees with one hospital that that hospital alone can provide a service or all services to the MCO's members
  - MCO agrees to contract with some, but not all, providers wishing to participate in its network
  - MCO agrees with one or more providers to include plan-benefit inducements for members to use those providers, but members can use other providers at a higher cost
  - MCO and a provider agree that the price the MCO pays the provider depends on the number of other providers that the MCO includes in its network
  - MCO and provider agree that price the MCO pays the provider depends of MCO excluding certain providers determined by participating provider
  - MCO and hospital agree that that price MCO pays hospital depends on MCO excluding physician-owned facilities

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## Exclusive and Selective Contracting, cont'd



- The basic antitrust analysis is the same in all these situations
- What's the competitive concern?
  - Foreclosure of competitors from the market
  - To the extent other providers are excluded from the MCO's network, they're foreclosed from some part of the market, i.e., the MCOs members
  - If a sufficient percentage of all providers are foreclosed from a sufficiently large percentage of the market for a sufficiently long period of time, the "favored provider" may obtain market power

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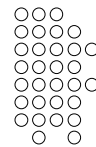
## Exclusive and Selective Contracting, cont'd



- In general:
  - No problem if the MCO acts unilaterally rather than entering into an agreement with the provider or providers
  - In most circumstances, these forms of contracting are procompetitive because they force providers to compete against one another to participate in the network
  - The federal enforcement agencies, in general, smile on these forms of contracting
  - There have been numerous private antitrust actions filed by excluded providers. Most have failed but some have succeeded

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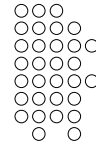
## Exclusive and Selective Contracting, cont'd



- What are the important variables:
  - The percentage of the market foreclosed by the contract to competitors of the provider with the contract
    - Depends to a large extent on the MCOs market share
  - The percentage of providers foreclosed from the market because of the contract
    - Depends on whether the contracting is exclusive or selective
  - The duration of the contract
    - Longer the duration, the less permissible foreclosure
  - The extent to which the provider with the contract has similar contracts with other MCOs
    - Because they increase the percentage of the market foreclosed
  - And, related to that, the market power of the provider with the contract

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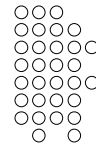
## Exclusive and Selective Contracting, cont'd



- Percentage of foreclosure is, by far, the most important variable
  - How do you calculate it? In particular, does the denominator of the fraction include only that MCO's members, all commercial members, beneficiaries of government programs, and self-pays, or some combination of these?
  - In general, the denominator includes all the above, which, of course, reduces the foreclosure percentage (although this depends on some facts not discussed here)
  - What percentage of foreclosure begins to raise concern?
    - Courts say between 30 and 40%
  - Other variables become important if foreclosure is high

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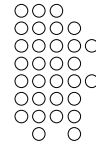
## Selective and Exclusive Contracting, cont'd



- Watch out for one situation:
  - Becoming a pawn in the efforts of general acute-care hospitals to thwart the development and growth of physician-owned single-specialty hospitals or physician-owned outpatient facilities
  - A common problem:
    - MCO enters into an arrangement with a general acute-care hospital not to contract with the physician-owned facility
    - Physician-owned facilities often sue both the hospital and the MCOs with agreements with the hospital
    - If the arrangement drives the physician-owned facility out of business or significantly harms it, a serious antitrust problem can arise
    - Of course, the MCO may decide unilaterally not to add the physician facility to its network, but
      - Don't discuss the decision with the hospital
      - Paper-up the unilateral decision carefully

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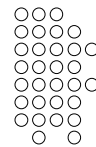
## Exclusive and Selective Contracting, cont'd



- Bottom lines:
  - Selective and exclusive contracting arrangements raise significant antitrust risk in only limited circumstances
  - But the risk of private treble-damage suits by excluded providers is high, even if the suit is meritless, because the MCO may be an important part of their business
  - Arrangements of these types should be scrutinized carefully before implementation

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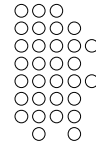
## Most-Favored-Nations Provisions



- Antitrust Division went on a rampage between 1995 and 1999
  - Antitrust Division brought five cases; FTC brought one
- Antitrust Division staff says the Division is still very interested in MFNs implemented by MCOs with significant market share

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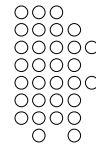
## Most-Favored-Nations Provisions, cont'd



- What's the competitive problem?
  - In limited circumstances, MFNs can constitute an entry barrier into the market, prevent incumbent MCOs from expanding, and result in oligopolistic pricing
  - But the situations in which these problems can arise are infrequent. In general, two factors must be present:
    - The MCO must be so important to area providers that all or most believe that they must participate in its network
    - The MCO must account for a sufficiently large percentage of the participating providers' revenues that it would be unprofitable for them to lose their contract with (or lower their price to) the MCO by contracting with another plan at a lower price

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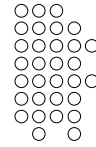
## Most-Favored-Nations Provisions, cont'd



- General rule of thumb:
  - The MCO instituting the provision must account for 35% or more of the revenues of providers in the market.

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## All-Products Provisions



- Few things physicians hate worse
- Look somewhat like tying provisions (which can raise serious antitrust issues), but aren't
- Very little antitrust risk because they don't adversely affect competition except in one very narrow circumstance I've never seen:
  - When the provision takes up so much physician capacity that other plans can't obtain needed physician services
- Antitrust Division has investigated several and closed the investigations with no action
- And, the provisions result in efficiencies in delivery of services