

ANTI-TRUST GUIDELINES

for Private Purchasers Engaged in Value Purchasing of Health Care

Issued by *Buying Value*

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A Private Purchaser Initiative (“Group” or “PPI”) proposes the creation and adoption of quality-based health care metrics. A guiding principle of this effort is to align, as much as possible, the quality performance metrics used by public and private participants in the health care market. Potentially in conjunction with hospitals (providers), insurers (payors), and the Government¹, the Group’s participants (purchasers of health care) will develop or advance the adoption of these metrics. As a general matter, the development of quality measures will not raise antitrust problems, provided there are some limitations on what information is shared among the participants (discussed below) and no purchaser, provider, or payor is coerced to adopt the measures. The Group’s primary purpose is to encourage and assist private purchasers of all types to change from buying health care on a treatment basis to buying on a value or quality-of-care basis, and its primary activity is educating and assisting private purchasers in this effort. This educational and assistance activity is unlikely to raise antitrust risk, as long as the guidelines discussed below are followed.

We see three potential antitrust problems for the Group to avoid: (i) any exchange of competitively important information must not allow participating payors or providers to identify the pricing or payment practices of their competitors; (ii) it must not act in concert with providers or payors to exclude from a relevant market a purchaser, provider, or payor that does not adopt the quality-based metrics it develops; and, (iii) it must structure appropriately any joint purchasing or attempts to negotiate price contracts as a group. Narrow restrictions on information sharing, and requiring participants of the Group to act unilaterally in their eventual adoption of the quality-based metrics as part of their contracting process with providers and payors, will limit the likelihood of an antitrust challenge to the Group’s activities. The formation of a purchasing joint venture – in which participants of the Group integrate purchasing functions to achieve efficiencies – will be necessary for significant joint purchasing activity.²

1. Information Exchange

Exchanges of competitively sensitive information can support an inference of an agreement in restraint of trade or can make coordination of pricing and service decisions easier. Competitively sensitive information for purchasers of health care includes specific price and service terms of existing or potential contracts with payors or providers. The antitrust agencies, Health Care Statement 6 provides a safe harbor for the collection and dissemination of competitively sensitive information: (i) the collection and dissemination is managed by a third party; (ii) any information that is shared among Group participants (or participating payor and providers) is more than three months old; and (iii) for any information that is shared, there are at least five providers reporting data upon which any disseminated statistic is based, no individual provider’s data may represent more than 25% on a weighted basis of that statistic, and any information disseminated must be sufficiently aggregated such that it would not allow recipients to identify the prices charged by a provider.³

Information exchanges that fall outside of the safety zone may not raise competitive problems, but are subject to a more detailed factual analysis of their possible effect. In Pacific Business

Group on Health, the Antitrust Division of the Department of Justice (“DOJ”) indicated that the creation of a data exchange program for hospital services was not likely to produce any anticompetitive effects.⁴ The data exchange, which fell outside of the safe harbor, was intended to improve transparency with respect to the cost and quality of hospital services, and involved the collection and distribution of cost and care data among hospitals, payors, and group purchasers. The data exchange was unlikely to meet the third prong of the safe harbor; for some cost indices, an individual payor’s data would have accounted for more than 25% of the data, and in other instances, the data might not include five players.⁵ Nevertheless, the DOJ found the proposed plan unlikely to raise competitive concerns because: (i) no participant (hospital, payor or group purchaser) would have access to “raw” data submitted by another participant; (ii) the reports prepared from the data exchange would not disclose the prices that any participating hospital charged for its services; and, (iii) it was unlikely any recipient of the reports would be able to “reverse engineer” the statistics to determine specific rates paid (by a payor) or charged (by a provider).

The exchange of non-competitively sensitive information is unlikely to raise antitrust concerns.⁶ We understand, in conjunction with this initiative, a new website that will house and display the results of a survey of health plans that asks detailed questions about how health plans use payment incentives to try to drive improvement in quality performance among hospitals will be launched. The data to be displayed and shared does not include information on prices paid or the cost or financial terms associated with structuring the incentives. The exchange of this information is unlikely to raise antitrust concerns.

2. Group Boycott

The Group, and its participants, must protect against becoming a participant in an effort to exclude certain payors or providers from participating in a relevant market. While the development of quality-of-care metrics is likely to be considered procompetitive⁷, coordinated exclusion of providers or payors who refuse to adopt the metrics would likely be considered an anticompetitive group boycott (in support of a horizontal conspiracy among participating payors or providers).⁸ Thus, neither the Group nor its participants should be coerced not to deal with providers or payors who have failed to adopt the quality-of-care metrics, or who have failed to provide services at a specific or fixed price, or above or below a specific cost.⁹ If the Group wishes to “partner” with providers who agree to adopt the quality-of-care metrics and agree not to deal with those who do not, integration between provider(s) and the Group will be necessary. The Group, and its partners, should identify and document the efficiency justification for the venture.¹⁰

3. Joint Purchasing

Section 1 of the Sherman Act prohibits agreements between firms that unreasonably restrain competition. Antitrust agencies and the courts use different types of analyses to determine if a specific agreement between two or more firms is an unreasonable restraint on competition.¹¹ Some types of agreements are viewed as so likely to harm competition and so unlikely to generate precompetitive benefit that they are considered *per se* illegal. Agreements that are not so clearly harmful to competition are evaluated under the full rule of reason. Such analysis requires a fact-based analysis of an agreement’s overall competitive impact. In this evaluation, the agencies consider potential precompetitive benefits, such as efficiencies not achievable by a single firm. At the same time, the agencies and courts consider how collaborations may harm

consumers by increasing the ability of a firm profitably to raise prices or reduce output, quality, service, or innovation levels.¹²

Agreements between buyers in the purchase of products or services raise serious antitrust issues if the Agreement is not in furtherance of an accepted efficiency benefit. Common antitrust concerns with group purchasing programs are (i) whether the program results in an unlawful price fixing agreement among participating purchasers – e.g., a refusal to purchase services except on specific price or service terms; (ii) whether the program provides the participants with monopsony power (purchaser power over price);¹³ (iii) whether the program facilitates the stabilization of prices at which the participants sell their own products or services; or (iv) whether the purchasing program is used to exclude competitors – an unlawful group boycott. The Group's activities are unlikely to raise concerns about stabilization of prices among its participants because they are not, generally, competitors in the same relevant product markets, and, because their health care costs do not materially vary with marginal variations in their output, they are not likely to affect the price of each member's output. The Group must be sensitive to the other three concerns, however.

Agreements among the Group's participants to fix the price (or service terms, including quality of care metrics) of their health care purchases will raise antitrust issues.¹⁴ To avoid allegations of price fixing agreements by purchasers, the Group's participants should be careful to evaluate individually the merits of particular actions. An agreement to engage in joint purchasing of services is generally not a problem when the group had integrated to some substantial degree its purchasing activity to achieve efficiencies (e.g., lower transactions costs) unless the group has market power.

Market power on the purchaser side of the market is not a significant concern if suppliers – in this case providers and insurers – have numerous other purchasers to which they can sell their products or services. The antitrust agencies have adopted safe harbors for the group purchase of products or services: Statement 7 of the Health Care Statements establishes an antitrust safety zone for group purchasing arrangements where (i) the participants' purchases account for less than 35% of the total sales of the purchased product or service in the relevant market and (ii) the cost of the products and services purchased through the program, in the aggregate, accounts for less than 20% of the total revenues from all products or services sold by each participant.¹⁵

4. Guidelines for Limiting Antitrust Risk

The following guidelines will help limit the antitrust risk associated with the effort to create quality-based health care metrics:

- Participants, on an individual basis, should decide whether to use or require providers to use any report card the Group develops. Absent significant integration via a joint venture involving the participation of health care providers and potentially payors, any collective decision by PPI participants to require adherence by participants to a standard report card or reporting metric would likely run afoul of antitrust laws prohibiting group boycotts.
- A third party, such as an accounting firm or a health care consulting firm, should oversee and conduct the collection and analysis of competitively sensitive data. PPI participants may share competitively-sensitive data such as pricing or the specific payment methods individual participants or providers are using, but competitively sensitive pricing and cost data should be shared through the third party.

- PPI participants can contribute information on treatment/protocol outcomes, metrics that can be used to evaluate provider performance, and other similar information, to assist the group in developing standardized quality-based report card; if these data will be analyzed in conjunction with competitively sensitive pricing or fee data, they should be shared only through the third party. Given that the boundary between competitively sensitive information and non-competitively sensitive information may be unclear in some circumstances, a third party should be responsible for all data collection and analyses efforts for the Group.
- Before the third party provides purchasing information to PPI participants, including the structure and level of performance-based payments, Antitrust counsel should be consulted to ensure that the level of detail being provided is appropriate and does not run afoul of the antitrust laws. In particular, Antitrust counsel and economists should be consulted to identify relevant markets in which the Group may have monopsony (buyer) power (e.g., regions in which PPI participants collectively have more than 20%-35% of employees). Collective action in such markets raises significant antitrust risk.
- Jointly purchasing health care on an ad hoc basis (i.e., without forming an entity and receiving antitrust agency pre-approval) can lead to significant antitrust penalties if the market participants have a high collective market share in a relevant market or have failed substantially to integrate purchasing assets or financial interests. If the Group desires to make joint purchasing decisions, it should establish a formal joint venture.
- As a general rule, provider and payor agreements should be individually negotiated and details should not be shared with other PPI participants, absent antitrust counsel advice to the contrary.

Conclusion

PPI's proposal to share information among its participants, providers, and payors in support of developing quality-of-care metrics can be accomplished without raising antitrust concerns, if the guidelines we propose are followed. For the Group collectively to limit its dealings to only those providers that adopt these quality-of-care metrics as a pricing or service tool will require substantial integration between the Group and those providers. For the Group collectively to negotiate pricing or service particulars with providers will require integration of the purchasing functions to achieve efficiency and an inquiry into whether the Group has buy power in any relevant market for its purchases. These options are likely available to the Group because they hold out the promise of significant efficiencies – including quality improvements – but as each involves collective action and may exclude competitors, additional analysis will be necessary if the Group proceeds with these alternatives. Although not necessary, it may be useful to seek Department of Justice review of either alternative through the DOJ's Business Review Letter process.

Endnotes

¹ Working with the government does not, in itself, prevent antitrust challenges to the Group's efforts to develop or advance the adoption of quality-based health care metrics, however, the adoption of certain metrics by state governments can provide antitrust immunity for conduct in accord with the adopted law or regulations, and the collective petitioning to support such adoption can be consistent with the antitrust laws. Under the state action doctrine, the courts have permitted state governments and certain private actors to show that compliance with a state regulatory scheme precludes antitrust liability. The Noerr-Pennington doctrine allows for the collective petitioning by competitors (or any parties) for the advancement of certain legislative or regulatory policies. Neither doctrine precludes an antitrust challenge to conduct required by the state, or to activities undertaken in support of collective petitioning, but both doctrines can provide significant protection from antitrust liability.

² This joint venture can be contractual, not structural.

³ U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE, Statement 6 (1996). While this statement provides an analysis of the conduct of health care providers, the analysis and principles are applicable to the Group's activities in health care markets. See, e.g. April 26, 2010 Letter of Christine Varney, Assistant Attorney General, to Mit Spears, Response to Pacific Business Groups on Health, available at <http://www.justice.gov/atr/public/busreview/258013.pdf>, at n. 7 (applying Statement 6 to proposal involving data exchange between payors and providers).

⁴ Response to Pacific Business Group on Health at 7-8.

⁵ Id.

⁶ U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE, Statement 4 (1996) ("Providers collective provision of underlying medical data that may improve purchasers' resolution of issues relating to the mode, quality or efficiency of treatment is unlikely to raise any significant antitrust concerns and will not be challenged by the Agencies, absent extraordinary circumstance.")

⁷ Letter of June 20, 1994 from Anne Bingaman to David Johnson, Response to Birmingham Cooperative Clinical Benchmarking Demonstration Project ("collaboration between these purchasers [of hospital services] and providers of hospital services ... has the potential of allowing businesses to make better informed purchasing decisions and should also promote hospital effectiveness and efficiency").

⁸ A group boycott is an agreement among two or more competitors not to deal in some respect with another party. In a "classic group boycott" the target of the boycott is a competitor to one or more of the parties engaging in or organizing the boycott, where the purpose of the boycott is to put the target at a competitive disadvantage.

⁹ November 2, 1995 Letter of Anne K. Bingaman to A. Michael Ferril, *Response to Southwest Oncology Group's Request for Business Review Letter* (that there is no agreement among members to approach or collectively negotiate with insurance companies or to coerce concessions from them by taking a unified position in separate negotiations was a factor in deciding that a data exchange of cost and price data was unlikely to be anticompetitive); U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE, Statement 4 (1996) ("the antitrust safety zone excludes any attempt by providers to coerce a purchaser's decisionmaking by implying or threatening a boycott of any plan that does not follow the providers' joint recommendation").

¹⁰ See *Northwest Wholesale Stationers v. Pacific Stationery & Printing Co.*, 472 U.S. 284,294 (1985) (whether a refusal to deal is a violation will depend on various factors, including whether the purpose is to disadvantage competitors, whether the participating firms have market power or exclusive access to an element essential to effective competition, and whether the refusal to deal can be justified by plausible arguments that it was "intended to enhance overall efficiency and make markets more competitive").

¹¹ U.S. DEP'T OF JUSTICE AND FED. TRADE COMM'N ANTITRUST GUIDELINES FOR COLLABORATIONS AMONG COMPETITORS (hereinafter, "Collaboration Guidelines") (April 2000), at 3.

¹² COLLABORATION GUIDELINES, at 6.

¹³ Where monopoly power relates to a single seller of a product or service, monopsony power involves a single buyer of a product or service. From an economic perspective, monopoly and monopsony power have similar effects by reducing output and harming consumer welfare.

¹⁴ Several cases have alleged that pharmacy-benefit managers engage in per se unlawful price-fixing arrangements when they negotiate, on behalf of their customers, the prices those customers will pay pharmacies for prescriptions. *N.Jackson Pharmacy v. Express Scripts, Inc.*, 345 F. Supp. 2d 1279 (N.D. Ala. 2004); later decision, 385 F. Supp. 2d 740 (N.D. Ill. 2005); *Bellevue Drug Co. v. Advance PCS*, 2004 WL 724490 (E.D. Pa. 2004).

¹⁵ U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE, Statement 7 (1996). The Competitor Collaboration Guidelines provide a lower safety zone for group purchasing activity – 20% instead of 35% - but this is a general threshold for application across all industries and for both sale and purchase activity. Although the issue is hardly free from doubt, we believe the market share threshold of Statement 7 is the more appropriate benchmark for identifying a safe harbor for the Group's potential group purchasing of health care services. The economics literature generally avoids these types of bright-line thresholds. The logic is that economists have shown anticompetitive effects from buyer cooperatives with market shares less than 35% (because the ultimate economic effects depend on more factors than just market share).