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# Takeaways From the FTC, DOJ Workshop on Health Care Competition

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- All Federal

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The ***Federal Trade Commission*** and ***Department of Justice Antitrust Division*** held their second public workshop on health care competition on February 24-25, 2015. The workshop is part of the FTC and DOJ's commitment to periodically "step back" from the work of day-to-day antitrust enforcement to take in a broader perspective of trends in the health care industry. This workshop was intended to focus on recent developments related to health care provider organizations and payment models that may affect competition. The workshop included panels that brought together representatives from the industry, government, academia, think tanks, and the private bar. The workshop also featured remarks from policymakers, including remarks by the nation's two top antitrust enforcers: FTC *Chairwoman Edith Ramirez and Assistant Attorney General Bill Baer*.

The workshop was held in Washington, D.C. and broadcast live over the Internet; a video recording and transcript of the event will be made available on the FTC website. But for those who can't wait (or who don't have two days to spend watching

video), below is a quick recap of some of the ideas exchanged at the workshop and key takeaways that we see for businesses.

## Day One: Opening Remarks by FTC Chairwoman Ramirez

- Chairwoman Ramirez noted that health care remains one of the top priorities of the FTC's competition agency. She also repeated the common refrain from regulators that federal health care reform does not supplant the antitrust laws. Rather, she explained, the goals of the antitrust laws are complementary with the goals of federal health care reform.

- Chairwoman Ramirez also noted that while the FTC has focused much of its resources on horizontal mergers, there is growing agency concern that "non-overlap" mergers such as downtown, urban hospitals acquiring smaller, suburban hospitals, or vertical acquisitions, may also warrant antitrust attention.

## Presentation by Dr. Ezekiel Emanuel

- Dr. Ezekiel Emanuel, a professor at the University of Pennsylvania, gave a presentation on the state of the health care system in the United States. Dr. Emanuel noted that the health care system in this country is undergoing more structural changes today than at any time in the past century, and that past models used to predict effects may not apply in this new and changing environment.

- Dr. Emanuel noted that 83% of health care costs in the United States relate to the treatment of chronic illnesses, and he suggested that antitrust enforcers should pay particular attention to how provider consolidations will impact the treatment of the chronically ill.

- Dr. Emanuel noted major trends moving forward, including changes in payments to focus more on value and risk.

- Dr. Emanuel said that future consolidation of payors and providers is inevitable to a degree, and also noted ongoing efforts by providers to integrate vertically into the direct taking of patient risk. He commented on the desirability of ensuring that there are multiple, integrated delivery systems left after the dust settles to ensure competitive markets in the future.

## Panel on Network Design and Contracting Practices

- The first panel of the workshop focused primarily on the value and risks to consumers related to the rise of tiered and limited-network plans.

- The panel praised the move towards measuring the true price of health care to include quality. The panel indicated that efforts to incentivize cost-lowering and quality-enhancement by providers—such as network products that steer consumers to lower-cost and higher-quality care—are undoubtedly a positive development, but the effectiveness of those initiatives depends on several

factors.

- One key factor identified to the success of such products is ensuring that consumers feel that they have sufficient choice such that insurance products are appealing and effective. In this respect, it was noted that tiered-network products may have an advantage over older managed care options, as tiered-network products allow consumers to make valuable choices in real time at the point of service, rather than just annually at the point of enrollment.

- The panel also agreed that in order for consumer choice to be meaningful, it needs to be based on good information. That information includes resources as simple as accurate, audited provider directories as well as tools that may be more difficult to design, such as giving consumers the means to evaluate network adequacy.

## Panel on the Health Insurance Exchanges

- The second panel offered early observations on the impacts of the ACA insurance exchanges on competition. Based on two years of data, an estimated 11 to 12 million individuals have purchased insurance through the exchanges as of the start of 2015. Most individuals purchasing policies through the exchanges were previously uninsured, such that the nationwide market for individual insurance plans has doubled in size since 2013.

- Based on two years' experience, insurer participation is broadly up year-after-year. Only three states experienced a decrease in the number of insurers on their exchanges between 2013 and 2014.

- Of all the various exchange models, the lowest premiums have been realized by clearinghouse models, whereby the exchange allows all qualified health plans to participate.

- One study in California suggests that the premium rates on the exchange correlate more closely to the concentration level of providers in any given region (as measured by HHI) than to the concentration level of payors.

## Day Two: Opening Remarks by AAG Baer

- AAG Baer praised innovations that the regulators are seeing in the marketplace to reduce costs, such as narrow networks and tiered networks. But by the same token, he said that efforts to frustrate such innovations—such as anti-tiering and anti-steering provisions—will be a particular area of agency focus going forward.

- AAG Baer also noted that vertical combinations between hospitals and physician groups is an area of current agency focus. While such arrangements do, in some cases, result in better care and lower costs, AAG Baer expressed concerns that these arrangements can also create "conglomerates" with bargaining leverage over payors.

- Finally, when the agencies do bring enforcement actions, AAG Baer reiterated

the agencies' strong preference to obtain "structural" remedies such as divestitures, rather than "conduct" remedies like negotiated price caps, which require supervision and policing to implement.

## Panel on Accountable Care Organizations

- The first panel of Day Two focused on the perceived successes and failures of ACOs in achieving cost savings and improving the quality of care.
- It was broadly agreed that ACOs are a valuable innovation, but it also was agreed that true capitation should be the ultimate goal of reform. In other words, ACOs are best viewed as a bridge, rather than a destination.
- Panelists expressed the view that there needs to be a real effort to ensure that small, provider-based practices get the necessary capital investments to successfully build the infrastructure that they currently lack, and that these small practices are especially useful because they have the advantage of highly motivated and engaged practitioners. Without this investment in small practices, some panelists expressed a concern that the overall system will devolve into a small number of large systems that already have the necessary infrastructure but lack engaged practitioners.
- From a regulatory perspective, it was observed that the government can play a role in piecing ACOs together. Government-developed ACOs have served as a magnet for similar models for commercially insured patients.

## Panel on Alternatives to Fee-for-Service Payment Models

- The next panel discussed the shift towards pay-for-performance reimbursement. A number of experiences with different models were discussed. On one extreme was disconnecting oncologist reimbursement from drug payments, which resulted in $33 million in savings across just 810 patients. On the other extreme was a per-member-per-month incentive payment tied to meeting process measures, which resulted in meeting the process measures but had no measurable (short-term) effect on outcome improvements or medical expenditure savings.
- It was observed that the industry-wide shift to pay-for-performance needs to be tied to methods that have a demonstrable connection to improving quality. Otherwise the entire process might be a very large effort with no actual effect.
- The panel discussed what role transparency should play in moving the industry to pay-for-performance. It was broadly agreed that pay-for-performance reimbursement models are inherently complicated, and they do not tell patients the information they really need. Rather, it was noted that the key to furthering quality competition is to make quality data more transparent for patients, to enable patients to choose the best providers and thereby reward performance through volume rather than through price.

## Panel on Provider Consolidation

- The next panel discussed consolidations involving providers. The panel covered not only horizontal mergers between competing providers, but also vertical mergers, cross-market mergers, and transactions between payors and providers.

- Several panelists expressed the view that there is a mounting body of evidence that costs tend to increase with provider consolidations, and there appeared to be consensus that tracking price competition in health care markets will continue to be important and complex, especially as the relevant metric shifts from prices of individual services to more risk-based measures.

- The panel also discussed new research purporting to show that consolidation across non-overlapping service and geographic markets may be followed by higher prices. The panel also discussed the rising trend of non-exclusive affiliations among systems in non-adjacent geographic markets, noting that it will be interesting to see whether efficiencies can be generated in these cases through the consolidation of back-office or administrative functions.

## Roundtable on Antitrust Perspectives

- The final session of the workshop was a roundtable discussion about the antitrust implications of the changes being seen in the health care industry. The panel began by discussing ACOs. The early indications are that ACOs have not caused antitrust problems, although there is relatively little data on this point either way. This might also be a function of the fact that the first ACOs were relatively small.

- The panel discussed what role efficiencies should play in merger analysis, especially in the wake of a recent decision by the Ninth Circuit that cast doubt on the efficiencies defense. Although the panel did not go as far as the Ninth Circuit, it was noted that efficiencies are rarely (if ever) dispositive on their own in a merger analysis. It was also broadly agreed that efficiencies defenses require evidence of forward-looking effects that are very difficult to project or calculate with precision.

- The panel agreed with earlier sessions that the insurance exchanges are facilitating the development of narrow-network plans. The panelists believe that the growth of such networks can translate into increased competition between providers.

- In closing, several panelists commented that the health care industry is in the midst of a period of rapid change. Therefore, while antitrust enforcement is necessary to protect competition, such enforcement should not come at the expense of stifling new, innovative models of care delivery or plan design.

## Closing Remarks by DOJ Chief of Legal Policy Bob Potter

- In closing the workshop, the Chief of Legal Policy for the DOJ thanked the many panelists for their contributions. He noted that the more the agencies learn from the industry about changes, the more the agencies need to learn about effects. In other words, there is not enough evidence or data yet to draw

conclusions and the agencies need to keep educating themselves to better understand health care markets, especially in this period of transition.

The workshop provided useful insights into the views of the federal antitrust regulators, and the perspectives and ideas exchanged will help inform the agencies as they continue to enforce the antitrust laws going forward.

Parties interested in submitting written comments to the DOJ and FTC relating to the workshop may do so until April 30th.