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Health Information

Antitrust Aspects of Health Information Sharing By Public and Private Health Insurers

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Introduction

Antitrust law rests on the philosophy that the economy functions best when markets thrive and when purchasers, armed with information, are able to make decisions that yield both quality and value. Thus, the overarching aim of antitrust law is to advance free and open markets in which competition can flourish. But health care is a market not quite like any other, distinguished by the special relationship that governs patients and health professionals, and the asymmetry of information that has historically characterized this relationship.¹ While consumers are far more knowledgeable today, the roles and duties of health professionals in society remain special ones, not easily amenable to sweeping change, despite ongoing calls for reform.² Thus, antitrust law and health care have had an uneasy relationship for decades. Even though medical care itself represents the single largest part of the economy, it is different from buying televisions, and how to adapt health care buying and selling to the law of markets has proven to be a complex undertaking.³

¹ Arrow KJ, "Reflections on the Reflections," *Journal of Health Politics, Policy and Law*, 26 (5), 2001.

² *A Dose of Competition*, Washington: Federal Trade Commission and U.S. Department of Justice, 2004. http://www.usdoj.gov/atr/public/health_care/204694.htm (accessed June 22, 2009).

³ Rosenblatt R, Law S, and Rosenbaum S, *Law and the American Health Care System*, New York: Foundation Press, 1997; Rosenblatt R, Rosenbaum S, and Frankford D, *Law and the American Health Care System: 2001-2002 Supplement*, New York: Foundation Press, 2001.

This policy brief is the first of two to address antitrust considerations that arise in health system transformation aimed at producing greater clinical integration and greater levels of information about the quality and cost of care. The second policy brief will discuss the implications of several recent Federal Trade Commission rulings on physician joint contracting to achieve clinical integration and greater health information accountability. These rulings have significant implications for growing efforts, as part of health reform, to create entities known as accountable care organizations.

It is evident that information sharing alone is not the culprit—the antitrust problems arise when competitors jointly use the information to attempt to control the price within a particular geographic and product market. Thus, entities that convene stakeholders, provide extensive information about cost and quality outcomes within the market, present information on innovations in health care organization and payment, educate and inform their members, and provide technical support to test payment and delivery innovations would appear to raise no antitrust problems. Nor would efforts on

the part of providers to improve the information flow about the care they are furnishing in order to make payments fairer and more aligned with quality and efficiency contradict antitrust law.

Thus this policy brief focuses on those activities that can be pursued without running afoul of basic antitrust principles and also describes types of conduct that appear to venture into prohibited-conduct territory. Antitrust law is dense, complex and very fact-specific. Therefore it is not possible to give one-size-fits-all answers. For this reason, we follow the general principles set forth in the beginning of the brief with four case scenarios of efforts to advance greater information transparency.

Background

Public and private health insurers and employer-sponsored health plans have a high degree of interest in "value-based purchasing" innovations involving the use of provider performance data to assess quality and develop benefit, pricing and payment policies that reward high performance and incentivize improvements.⁴ Extensive evidence shows high variability in costs and quality among U.S. health care markets.⁵ Most markets contain thousands of individual health plan sponsors (e.g., public and private employers, Medicaid agencies and Medicare) who utilize multiple health benefit service companies to either insure or administer their plans.

⁴ Miller HD, *Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform*, New York: The Commonwealth Fund, 2007, <http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2007/Sep/Creating-Payment-Systems-to-Accelerate-Value-Driven-Health-Care--Issues-and-Options-for-Policy-Reform.aspx> (accessed June 22, 2009); Robinson JC, "Slouching Toward Value-Based Health Care," *Health Affairs*, 27(1): 11-12, January/February 2008; Tompkins C et al., "Measuring Outcomes and Efficiency in Medicare Value-Based Purchasing," *Health Affairs* 28(2): 251-261, March/April 2009; *Theory and Reality of Value-Based Purchasing: Lessons from the Pioneers*, AHCPR Publication No. 98-0004, Rockville, MD: Agency for Health Care Policy and Research, 1997, <http://www.ahrq.gov/qual/meyerrpt.htm> (accessed June 22, 2009).

⁵ Statement of Peter Orszag Before the Senate Finance Committee on the Overuse, Underuse, and Misuse of Health Care (June 17, 2008), http://www.cbo.gov/ftpdocs/95xx/doc9567/07-17-HealthCare_Testimony.pdf (accessed June 22, 2009).

Given the shared interest in raising quality and reducing costs, it makes sense for health plan sponsors, health insurers, providers, and others to collaborate on efforts to set common performance expectations, share information about actual health care performance, costs and pricing, and seek system-wide improvements in quality and efficiency. The concept of "value-based purchasing" has been a formal federal policy focus for several years,⁶ and the United States Department of Health and Human Services (HHS) has attempted to spur value-based purchasing interest.⁷ Special payment initiatives incorporating episode-based payment concepts such as "evidence-informed case rates" also have been undertaken.⁸ These types of payment experiments are designed to improve health care quality while simultaneously increasing the transparency of health care pricing information in order to increase efficiency.⁹

⁶ A Google search of "value-based purchasing" on the HHS website turns up several thousand separate hits with numerous documents regarding value-based purchasing and "how to" guides on the activity (Google search conducted March 25, 2009). The Agency for Health Care Research and Quality defines "value-based purchasing" as the act on the part of buyers of holding health care sellers "accountable for both cost and quality of care." Thus, a value-based purchasing initiative would bring together "information on the quality of health care, including patient outcomes and health status, with data on the dollar outlays going towards health. It focuses on managing the use of the health care system to reduce inappropriate care and to identify and reward the best-performing providers. This strategy can be contrasted with more limited efforts to negotiate price discounts, which reduce costs but do little to ensure that quality of care is improved."

⁷ *Evaluating the Impact of Value-Based Purchasing: A Guide for Purchasers*, Table 1, AHRQ Publication No. 02-0029. Rockville, MD: Agency for Healthcare Research and Quality, 2002, <http://www.ahrq.gov/about/cods/valuebased/vbptab1.htm> (accessed June 22, 2009).

⁸ Gosfield A, *Making Prometheus Payment@ Rates Real: Ya' Gotta Start Somewhere*, Princeton, NJ: The Robert Wood Johnson Foundation, 2008.

⁹ See e.g., The Robert Wood Johnson Foundation's *Aligning Forces for Quality* initiative, a long-term, comprehensive effort to lift the overall quality of health care in targeted communities, reduce racial and ethnic disparities, and provide models for national reform, <http://www.rwjf.org/qualityequality/af4q> (accessed June 22, 2009).

Although the spotlight has been on payer-driven purchasing innovations, it is also important to stress that certain forms of value-based purchasing are proving attractive to provider groups, as the second issue brief in this series will show. This is because such a strategy might help foster changes in benefit, cost-sharing, and payment design that more appropriately aligns financing with high quality clinical care.¹⁰ Thus, collaboration might include providers, plan sponsors, and companies that insure or administer plans. Antitrust law generally is not implicated when such conduct occurs within single, vertically integrated entities, although there are exceptions.¹¹ On the other hand, important antitrust issues may arise when the conduct involves collective action among competitors.

¹⁰ Federal Trade Commission, In re Greater Rochester Independent Practice Association Advisory Opinion (2007), <http://www.ftc.gov/bc/healthcare/industryguide/advisory.htm> (accessed June 22, 2009).

¹¹ *Kartell v. Blue Shield of Massachusetts*, 749 F. 2d 922 (1st Cir. 1984). But see *Abraham v. Intermountain Health Care, Inc.*, 461 F.3d 1249 (10th Cir. 2006) (illustrating that even single, vertically integrated entities can be subject to antitrust liability under Section 2 of the Sherman Act which extends the law's reach to unilateral conduct that results in a monopolization of any part of trade or commerce. While the court here did not impose antitrust liability under section 2 of the Sherman Act, the court's discussion describes the possible liabilities that vertically integrated entities face).

In a nutshell, although antitrust law prohibits conduct among competitors that seeks to restrain trade, this prohibition certainly does not proscribe all interactions between competitors in a given market. Indeed, carefully crafted forums designed to promote value-based purchasing by providing quality information and technical support to the participants—even if competitors—is perfectly legal under antitrust law, as long as the participants do not collectively set uniform prices, fees, bonus amounts or other competitively sensitive terms.

Thus, while competitors may choose not to collaborate (companies that administer and insure health plans are competitors and may not want to share what they consider to be proprietary information and trade secrets), antitrust law does not bar many helpful types of collaborations. The overarching aim of antitrust law is the advancement of free and open markets in which competition can flourish. To that end, payment initiatives and value-based purchasing innovations actually can promote competition by generating more transparent quality and pricing information in an effort to create a more efficient health care system and antitrust rules appear to allow such initiatives to happen. Indeed, it is probably safe to say that it may be impossible to realize high value in health care without some level of information comparison and collaboration.

Over the years, Congress, federal and state antitrust enforcers, and the courts have considered whether special treatment or even exemptions under the antitrust laws are warranted for certain sectors of the economy where for various reasons it is thought that market competition might not lead to desirable results. While some advocates have sought special antitrust exemptions for health care providers,¹² Congress has resisted efforts to establish special antitrust rules in the health care sector. In the 1990s, however, the United States Department of Justice (DOJ) and the Federal Trade Commission (FTC) (the two federal antitrust enforcement agencies), in an attempt to explain how they intended to enforce the antitrust laws in the health care sector, issued a series of *Statements of Antitrust Enforcement Policy in Health Care* (Statements).¹³

¹² Greaney T, "Whither Antitrust? The Uncertain Future of Competition Law in Health Care," *Health Affairs* 21(2): 185-196, March/April 2009.

¹³ *Statements of Antitrust Enforcement Policy in Health Care*, Washington: Federal Trade Commission and U.S. Department of Justice, 1996, <http://www.ftc.gov/bc/healthcare/industryguide/policy/index.htm> (accessed June 22, 2009).

The Statements do not modify classic antitrust principles. In fact, in recent years the federal

government has vigorously enforced the antitrust laws in the health care sector, particularly with respect to the supply side of the equation. These enforcement activities have taken the form of prosecuting physicians for jointly setting their prices in negotiations with health plans¹⁴ or challenging hospital mergers that the agencies believed would reduce competition.¹⁵ The federal government also has conducted extensive policy analyses examining the effects of limited competition on health care cost and quality.¹⁶

¹⁴ North Texas Specialty Physicians v. F.T.C, 528 F.3d 346 (5th Cir. 2008).

¹⁵ Federal Trade Commission, In re Evanston Northwestern Healthcare Corporation and ENH Medical Group, Inc. (File No. 011 0234, Docket No. 9315).

¹⁶ *A Dose of Competition*, supra note 3, Washington: Federal Trade Commission and U.S. Department of Justice, 2004, http://www.usdoj.gov/atr/public/health_care/204694.htm (accessed June 22, 2009).

Given the expressed interest in using a growing body of health information to advance quality and efficiency in health care, one might think that group efforts to exchange and share information related to quality, price and efficiency would have received a blessing from antitrust enforcers. The FTC and DOJ staff have opined that information exchanges among providers detailing price and insurer reimbursement levels do not violate antitrust law if carefully crafted,¹⁷ but there is no general, express provision in the 1996 Statements addressing the types of expanded collaborations that one might envision in an era in which the expanded use of health information has become a driving national policy goal.¹⁸

¹⁷ Federal Trade Commission, In re Medical Group Management Association Advisory Opinion (2003); Federal Trade Commission, In re PriMed Physicians Advisory Opinion (2003). <http://www.ftc.gov/bc/healthcare/industryguide/advisory.htm> (accessed June 22, 2009). Department of Justice, In re Washington State Medical Association Business Review Letter (2002). <http://www.usdoj.gov/atr/public/busreview/letters.htm> (accessed June 22, 2009).

¹⁸ The American Recovery and Reinvestment Act of 2009 (ARRA), Public Law 111-5, 111th Cong., 1st sess. (2009).

As a result, some health care purchasers may feel uncertain about the antitrust risks that arise if a group of buyers and sellers within one geographic region—or focusing on one particular health care product (e.g., hospital services)—collectively share and use the results of information to make health care purchasing decisions. Furthermore, to the extent such uncertainty is widespread, entities may be reluctant to engage in information-enabled buying and selling of health care. Some of the questions that arise include the following: What can entities that exchange health information do besides merely produce data for isolated use by individual payers and providers? Can these entities actually convene health care buyers and sellers to actively engage in value purchasing, that is, understanding and acting on pricing variation in relation to quality, testing new mechanisms for paying for health care, or sharing information about the results?

It is important to note that in the current health care environment, different levels of health information exchange are taking place. These activities can range from the very basic exchange of information between an information entity and one or more participants in the exchange, to active efforts to affirmatively gather certain types of information among participants and examine the information for quality and cost, to efforts to use information to actually design new ways of paying for certain types of health care in order to achieve certain outcomes.

Overview of Federal Antitrust Law and Actions Among Competitors

Antitrust laws (the Sherman Act, the Clayton Act and the Federal Trade Commission Act)¹⁹ exist to safeguard free and open market competition both within geographic regions and in relation to certain types of products or services. The basic objective of antitrust law is to eliminate or prevent those practices that interfere with free competition. These laws are designed to benefit the consumer by encouraging vigorous competition in an environment in which business entities have the full opportunity to compete for consumers on the basis of quality, service and price. As noted above, the primary federal antitrust laws are the Sherman Act, the Clayton Act and the Federal Trade Commission Act; in the context of establishing innovative payment reform models, however, Section 1

of the Sherman Act is most relevant.

¹⁹ 15 U.S.C §1 (2009); 15 U.S.C §12 (2009); 15 U.S.C §45 (2009).

The Sherman Act's Prohibition Against Agreements that Restrain Trade

Section 1 states that “[e]very contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several states, or with foreign nations, is declared illegal.”

²⁰ The Supreme Court has interpreted this provision to render unlawful only those restraints of trade that unreasonably restrain competition, ²¹ and three elements are required for a violation: (1) the existence of a contract, combination, or conspiracy among two or more separate entities that (2) unreasonably restrains trade and (3) affects interstate or foreign commerce. ²² Because Section 1 of the Act does not prohibit independent action by a single entity regardless of its purpose or effect on competition, ²³ an agreement between separate entities is essential to establish liability. ²⁴ An agreement has been defined by the Supreme Court of the United States as “a unity of purpose or a common design and understanding, or a meeting of the minds in an unlawful arrangement,” ²⁵ and such an illegal contract or conspiracy need not require any formal agreement but can be inferred from circumstantial evidence. ²⁶

²⁰ 15 USC §1 (2009).

²¹ *Standard Oil Co. v. United States*, 221 U.S. 1, 5 (1911).

²² *Maric v. St. Agnes Hospital Corp.*, 65 F.3d 310, 313 (2nd Cir. 1995).

²³ However, Section 2 of the Sherman Act and parts of the Clayton Act do reach and prohibit certain types of monopolistic practices by single entities, such as the willful acquisition or maintenance of monopoly or market power with the ability to control market prices or exclude competition in a given market. Conduct amounting to refusals to deal, agreements to foreclose competition, leveraging power in one market to gain power in another market, tying arrangements, and predatory pricing are examples of the types of behaviors that may violate antitrust law's monopoly prohibitions.

²⁴ *Monsanto Co. v. Spray-Rite Service Corp.*, 465 U.S. 752, 761 (1984); *Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752, 767-68 (1984).

²⁵ *American Tobacco Co. v. United States*, 328 U.S. 781, 810 (1946).

²⁶ *Monsanto Co. v. Spray-Rite Service Corp.*, 465 U.S. 752 (1984).

The most common antitrust violations result from “horizontal” arrangements that involve concerted or collusive activities by competitors in a given market, either product or geographic. Whether litigation is brought by the government or private litigants, a plaintiff must prove not only that the defendants are legally capable of conspiring (i.e., the alleged collusive activity did not occur between a parent company and its subsidiary), but also that they actually did so. In the absence of a formal agreement to collude, the Supreme Court has placed reasonable limitations on the range of permissible inferences from ambiguous evidence of an agreement or conspiracy. Thus, the relevant inquiry focuses on, among other things, whether the defendant had any rational motive to conspire, and whether the defendant's conduct was consistent with its own independent interest. ²⁷

²⁷ *Matsushita Electric Industrial Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986).

Thus, to the extent that separate competing health care entities—whether insurers, companies that administer health insurance products, or community providers—agree tacitly or otherwise to operationalize new payment models through provider participation contracts with network physicians, then Sherman Act Section 1 could be implicated. In the same vein, were competing providers to jointly agree to value-based purchasing bargaining strategies, that action may violate the Sherman Act. Indeed, it was concerted provider action related to the pricing of quality health care that led to the Supreme Court's seminal decision in *Arizona v. Maricopa County Medical Society*, ²⁸ in which the Court found pricing efforts among horizontal health care competitors, even where ostensibly linked to the advancement of health care quality goals, to constitute a *per se* violation of Section 1 of the Sherman Act.

²⁸ *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982).

Per se Versus Rule of Reason

Once it has been determined that the defendants have the legal capacity to conspire and that an unlawful agreement exists, the effect of that agreement must be considered to determine whether it restrains competition unreasonably. The sharing of information about price and quality in and of itself is not the problem; it is what is done with the information.

The courts generally use one of two methods to make this determination, depending on the nature of the agreement at issue. Certain categories of restraints, such as horizontal price-fixing, group boycotts, bid rigging, and market-allocation agreements are considered *per se* illegal. That means that these activities have been conclusively presumed to restrain competition unreasonably even without a study of the market in which they occurred, or an analysis of their actual effect on competition, or their purpose. ²⁹ Antitrust cases are replete with examples of agreements that were determined to be price-fixing arrangements, such as establishing minimum or maximum prices, ³⁰ creating pressure to increase prices, ³¹ stabilizing prices, ³² interfering with a competitor's freedom to make price changes independently, or establishing uniform terms of sale, discount policies, or otherwise establishing an agreed-upon approach to an underlying element of the price charged. ³³

²⁹ ABA Section of Antitrust Law, *Antitrust Law Developments* ch. I.B.3. (6th ed. 2007); *Arizona v. Maricopa Medical Society*, 457 U.S. 332 (1982).

³⁰ *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982); *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975).

³¹ *Minnesota v. Mid-West Minnesota Associated Physicians*, 1991-1992 Trade Cas. (CCH) §69,531 (Douglas County Dist. Ct. July 2, 1991) (consent decree).

³² *United States v. Container Corp. of America*, 393 U.S. 333 (1969).

³³ *Catalano, Inc. v. Target Sales, Inc.*, 446 U.S. 643 (1980); *Vandervelde v. Put & Call Brokers Association*, 344 F. Supp. 118, 136 (S.D.N.Y. 1972).

However, the prevailing standard for assessing the effect on competition of most categories of restraints is the *rule of reason*, which requires an analysis of the challenged restraint's effect on competition in a relevant market. ³⁴ The rule of reason is applied in situations "where the economic impact of certain practices is not immediately obvious." ³⁵ Of course, defendants in antitrust actions would much prefer that in evaluating a claim, a court use a *rule of reason* analysis, as opposed to a *per se* analysis, because it gives the defendant the chance to justify its actions by offering facts that are viewed as demonstrating a pro-competitive effect as a result of the agreement. While some health care providers have argued that their pricing policies can only be judged under a rule of reason test because of the special considerations of quality and professionalism on which pricing rests, such assertions have been rejected by the courts, and "naked" price-fixing by physicians or other health care providers will be condemned as *per se* illegal.

³⁴ *Chicago Board of Trade v. United States*, 246 U.S. 231 (1918); *NCAA v. Board of Regents of Univ. of Okla.*, 468 U.S. 85 (1984).

³⁵ *FTC v. Indiana Federation of Dentists*, 476 U.S. 447 (1986).

Yet, even under a *rule of reason* analysis, courts have prohibited information exchanges in industries whose structural characteristics indicate that exchanging price information is likely to have an anticompetitive effect. That is, courts can at some point view the exchange of information as suspicious in its own right, underscoring the need for further clarity and certainty in the field. Thus, an exchange of price information that is not part of a price-fixing scheme may be legal if its value for quality purposes (e.g., improving the quality of health care) outweighs any likely anticompetitive effects. At the same time, the very nature of a *rule of reason* analysis—a case by case review of the facts—suggests the inherent challenges in applying antitrust law to a fast-evolving field of health care.

Of most concern for plan sponsors and companies that insure or administer plans that are engaged in the effort to develop new pricing models is the danger that these new models will be considered price-fixing under the Sherman Act. As discussed above, price-fixing allegations are subject to a *per se*

unreasonable restraint analysis which offers the defense very little chance to defend its actions. For example, once a plaintiff can show that two or more managed care entities have agreed—either explicitly or implicitly—to implement a payment model with agreed-upon prices for provider services, it is likely that a court will view this as price-fixing, and impose liability under the *per se* rule. Therefore, understanding how to avoid a *per se* determination is critical.

Avoiding Antitrust Liability

Entities that exchange competitively-sensitive information can avoid *per se* antitrust liability in several ways. The doctrine known as “conscious parallelism,” the antitrust safety-zones in the FTC/DOJ statements, and the “state action” doctrine all provide specific defenses for certain types of information exchanges and are discussed below.

“Conscious Parallelism”

“Conscious parallelism” can provide a defense for entities that, while not actually agreeing on price, have engaged in an information exchange from which one could reasonably infer that a price agreement had been reached. The doctrine provides that a pattern of uniform business conduct among competitors does not, standing alone, run afoul of the antitrust laws. Parallel behavior by itself does not prove a conspiracy; plaintiffs must offer several “plus factors” in combination with conscious parallelism to prove an inference of coordinated action. These “plus factors” are often other facts and circumstances that support the claim that a conspiracy has occurred.³⁶

³⁶ *Theatre Enterprises v. Paramount Film Distribution Corp.*, 346 U.S. 537 (1954);
Twombly v. Bell Atlantic Corp., 425 F.3d 99, 114 (2nd Cir. 2005).

Thus if payers of health care services adopt new pricing models—even the exact same model—they might claim conscious parallelism without an antitrust violation. The crux of this defense will hinge on whether, in these multi-stakeholder collaborations to develop new pricing mechanisms, any meeting of the minds occurred with regard to actual implementation and roll-out related to the setting of price or other competitively-sensitive terms. Again, for this defense to work, there must be adequate safeguards built into the structure of the collaboration itself to assure that there is no agreement on price terms. Put another way, meeting to exchange information and gain knowledge about innovation is not the problem; using the information to then develop a joint approach to pricing is the issue.

Antitrust Safety Zones

The DOJ and FTC have addressed the issue of information exchanges among health care providers in their *1996 Statements of Antitrust Enforcement Policy in Health Care*, and among horizontal competitors in general in their “Antitrust Guidelines for Collaborations Among Competitors.” Through these documents, the agencies have recognized the pro-competitive potential of information exchanges, but also warn that such exchanges may in certain cases increase the likelihood of collusion on matters such as price, output, or other competitively sensitive variables. These statements create antitrust safety-zones for certain categories of information exchange, and conduct that falls within a safety-zone will avoid an agency finding of *per se* antitrust liability. Several statements are applicable here.

Statement 4 addresses the government’s “[e]nforcement policy on providers’ collective provision of non-fee-related information to purchasers of health care services.” The antitrust safety zone provided by this Statement allows providers to collectively give to purchasers “underlying medical data that may improve purchasers’ resolution of issues relating to the mode, quality, or efficiency of treatment.” The collection of outcome data from independent physicians about a particular procedure that the providers believe should be covered, and the provision of that information to purchasers, falls within the safety zone and is not a *per se* violation of antitrust law. In addition, the antitrust enforcement agencies will not challenge “providers’ development of suggested practice parameters—standards for patient management developed to assist providers in clinical decision-making—that also may provide useful information to patients, providers, and purchasers.” The agencies believe that this type of concerted conduct by physicians poses little risk of restraining competition and in fact has the potential to increase quality and efficiency, thereby promoting competition. Statement 4 warns, however, that the safety-zone does not apply to the extent that this activity is used by providers to coerce purchasers’ decision-making by threatening to boycott a plan that does not adhere to the providers’ joint recommendation.

Statement 5 addresses the government’s “[e]nforcement policy on providers’ collective provision of fee-related information to purchasers of health care services.” Regardless of the structure of the

provider organization, competing providers can collectively give payers information about price or other aspects of reimbursement—such as episode-of-care cost determinations—without raising significant antitrust implications. The agencies acknowledge that “such factual information can help purchasers efficiently develop reimbursement terms to be offered to providers and may be useful to a purchaser when provided in response to a request from the purchaser or at the initiative of the providers.”³⁷ The agencies provide a detailed antitrust safety zone for this type of scenario if providers satisfy the following conditions: (1) the pricing information is collected by a third-party; (2) while the payers can secure newer pricing data, any information that is shared among the providers must be at least three months old and the pricing data must reflect pricing data from at least five providers with no one provider's data representing more than 25 percent of that statistic; and (3) the information must be aggregated so that the recipients cannot identify the prices charged by any single physician.³⁸ Thus Statement 5 allows aggregated data sharing of price-relevant data by physicians collectively to purchasers, under certain limited conditions.

³⁷ U.S. Department of Justice & Federal Trade Commission, Statements of Antitrust Enforcement Policy in Health Care (1996), Statement 5.
<http://www.ftc.gov/bc/healthcare/industryguide/policy/index.htm> (accessed June 22, 2009).

³⁸ *Id.*

Statement 6 addresses the government's “[e]nforcement policy on provider participation in exchanges of price and cost information.” Here, the antitrust enforcement agencies have created a safety-zone for “participation by competing providers in surveys of prices for health care services, or surveys of salaries, wages or benefits of personnel.” The agencies believe that this information can increase competition because providers can use this information to price their services more competitively, and purchasers can use the survey data to make informed decisions about what they will buy. Specifically, to fall within the safety-zone and thereby avoid *per se* antitrust liability, several elements must be present: (1) the survey is managed by a third party; (2) the information provided by survey participants is based on data more than 3 months old; and (3) there are at least five providers reporting data upon which each disseminated statistic is based, no individual provider's data represents more than 25 percent on a weighted basis of that statistic, and any information disseminated is sufficiently aggregated such that it would not allow recipients to identify the prices charged or compensation paid by any particular provider.³⁹ Statement 6 therefore allows, under certain circumstances, competing providers to share among themselves—or publish for public use—specific provider price and cost information.

³⁹ U.S. Department of Justice & Federal Trade Commission, Statements of Antitrust Enforcement Policy in Health Care (1996), Statement 6.
<http://www.ftc.gov/bc/healthcare/industryguide/policy/index.htm> (accessed June 22, 2009).

Statement 8 addresses the government's “[e]nforcement policy on physician network joint ventures” and sets forth the circumstances under which physicians may collectively agree on price or price-related terms and jointly market their services to purchasers. This Statement provides an antitrust safety-zone for such joint negotiation of price when the physician joint venture is sufficiently financially integrated (i.e. the member providers share significant financial risk). Moreover, Statement 8 further explains that certain types of clinical integration, even when there is no sharing of financial risk among providers, may justify physician joint contracting with purchasers when the joint contracting is necessary to achieve pro-competitive efficiencies.

While clinical integration does not have a specific safety-zone like the one created for financial integration, in a 2007 opinion involving the Greater Rochester Independent Practice Association (IPA), the FTC determined that despite the absence of financial risk, the integrated structure of the IPA, coupled with its proposal to incorporate evidence-based quality reporting and practice management into its structure, eliminated the need for assumption of financial risk. Likewise, in a 2009 opinion, the FTC did not challenge Tristate Health Partners' attempt to clinically integrate its 200 physician members and one hospital member in order to collectively negotiate contracts with payers because, in part, of the new entity's “potential to produce significant efficiencies, including both improved quality and more cost-effective care.”⁴⁰ These decisions and their effect on the creation and use of accountable care organizations are the focus of the second brief in this series.

⁴⁰ Federal Trade Commission, In re TriState Health Partners, Inc. Advisory Opinion (2009), <http://www.ftc.gov/bc/healthcare/industryguide/advisory.htm> (accessed June 23, 2009).

On the payer side, the agencies' "Antitrust Guidelines for Collaborations among Competitors" are most applicable here. This document discusses the framework for evaluating agreements among competitors that might withstand antitrust scrutiny, because the agreement is reasonably necessary to achieve pro-competitive benefits from an integration of economic activity. Here, the more factually driven *rule of reason* analysis would be employed to determine whether the pro-competitive benefits outweigh anticompetitive harms. The guidelines specifically mention several types of collaborative agreements that tend to limit independent decision-making or combine financial interests and thus harm competition: production collaborations, marketing collaborations, buying collaborations and research and development collaborations. At the same time, the fact that in-depth *rule of reason* analysis is appropriate in the agencies' view is extremely important in guiding payer actions.⁴¹

⁴¹ U.S. Department of Justice & Federal Trade Commission, Antitrust Guidelines for Collaborations Among Competitors, §3.31(a). <http://www.ftc.gov/os/2000/04/ftcdojguidelines.pdf> (accessed June 23, 2009).

The State Action Doctrine

Under certain circumstances, defendants in federal antitrust cases can avoid liability under the doctrine of state action. Long ago the United States Supreme Court recognized the authority of the several states to adopt alternative competition regimes tailored to peculiar local conditions, and thus entities that adhere to these state regimes are immune from what otherwise would be considered illegal behavior under federal antitrust law.⁴² This defense, however, comes with significant limitations.

⁴² *Parker v. Brown*, 317 U.S. 341 (1943).

This so-called "Parker immunity" only applies when the challenged activity has been undertaken pursuant to a clearly articulated state policy, such as a law passed by the state legislature or a policy approved by the state supreme court.⁴³ However, a broad grant of statutory authority will not satisfy the clear articulation requirement unless the state clearly intended to displace competition.⁴⁴ On the other hand, a state statute expressly permitting collective rate-making, for example, did render the litigant's rate-making activities immune from the federal antitrust laws.⁴⁵

⁴³ *Southern Motor Carriers Rate Conference, Inc. v. United States*, 471 U.S. 48 (1985).

⁴⁴ *Patrick v. Burget*, 486 U.S. 92 (1988); *Southern Motor Carriers Rate Conference, Inc. v. United States*, 471 U.S. 48 (1985).

⁴⁵ *Southern Motor Carriers Rate Conference, Inc. v. United States*, 471 U.S. 48 (1985).

The test to determine whether Parker immunity is a viable defense to an antitrust allegation contains two parts: the private party must prove that it was (1) acting pursuant to a clearly articulated and affirmatively expressed state policy and (2) that the state is engaged in the active supervision of the conduct.⁴⁶ This type of explicit, state-sanctioned activity with ongoing accountability essentially gives the imprimatur of state action to private conduct by regulating it. Not only must the law authorize the arrangement, but there also must be ongoing oversight of the process and the output of the conduct.⁴⁷ Our review of state laws that could potentially provide some level of federal antitrust protection under the state action doctrine is discussed below.

⁴⁶ *California Retail Liquor Dealers Association v. Midcal Aluminum, Inc.*, 445 U.S. 97 (1980).

⁴⁷ *Id.* at 105.

Specific Forms of State Action: Through laws (frequently developed at the state level, where health care quality regulation takes place) that address specific matters, such as health care quality improvement and reporting or licensure and certification of health care facilities and entities, the legal

system may grant specific antitrust immunity for certain types of conduct that would otherwise be considered anticompetitive. For example, state law may explicitly authorize collective bargaining, data sharing or referral agreements between providers, as shown in the chart below. Aside from specific antitrust exemptions stated in law, legal involvement in the area of health care pricing runs the gamut from merely allowing the publication of prices to actively restructuring payment systems. Many states have laws mandating or facilitating the exchange of information regarding the price health care providers charge for various services.⁴⁸ Price information for certain providers (usually hospitals) is collected by the state and used for analysis of health care spending trends. Sometimes this information is available to the public in its entirety, and in other cases, the state generates public reports showing average prices for certain services in the state or prices by facility for certain services. This level of state action, however, would not be sufficient to create Parker immunity.

⁴⁸ See Arizona Revised Stat. 36-125.05 (2009); California Health & Safety Code §1339.56 (2009); Ohio Rev. Code §3727.12 (2009); South Dakota Codified Laws §34-12E-11 (2009); 35 P.S. §§449.5-449.7 (2009); Utah Code §26-33a-104 (2009).

In recognition of the need for health care cost control and improved efficiency, some states have established councils or commissions to collect and analyze price data and develop policies to improve cost effectiveness, such as quality and efficiency measures. Additionally, a handful of states are actively pursuing efforts to restructure health care payment systems by incentivizing payment structures that are more efficient or effective than others. This type of state action may help create antitrust immunity if the state clearly articulates a policy to displace market competition with regulation of health care prices and services and actively supervises the marketplace affected by its action. The chart below shows some state laws involving health care pricing. The reporting of charges tends to be the focus of these laws, rather than the reporting of actual contracted payment rates, which may be the greater focus of interest. At the same time, the laws underscore growing state interest in actual intervention to increase the provision of information.

Level of State Action	State	Law	Activity
	Arizona	Arizona Revised Stat. 36-125.05	Requires uniform reporting system for all hospitals, outpatient surgical centers and emergency departments, including average charge per patient, average charge per physician and publication of public report of average patient charges.
LIMITED (data gathering and reporting)	California	CA Health & Safety Code §1339.56	Requires hospitals to report prices for the top 25 most common outpatient services or procedures.
	Ohio	Ohio Rev. Code §3727.12	Requires reporting of hospital charges for the top 100 diagnosis related groups (DRGs) and certain other procedures.
	South Dakota	S.D. Codified Laws §34-12E-11 (2009); Senate Bill 182 (2008)	Hospitals must report charges for 25 most common inpatient DRGs, to be published online in 2009.
	Pennsylvania	35 P.S. §§449.5-449.7	Requires the Health Care Cost Containment Council to develop a computerized system for the collection, analysis and dissemination of health care quality and cost information; to collect patient data (including total charges); and to publicize services and provide comparisons.
MODERATE (analysis and development of cost and efficiency)	Utah	Utah Code §26-33a-104 (2009) (data collection); H R 9 (2007)	Health Data Committee instructed to "collect, analyze, and distribute health care data to facilitate the promotion and accessibility of quality and cost-effective health care." Committee instructed to develop plan to measure and compare costs of

measures)	(episodes of care)	episodes of care and authorized to collect data regarding fees, contract terms, reimbursement arrangements, etc.
	Vermont 2006 Health Care Affordability Act (H. 861)	Requires data collection and reporting of expenditures and creates a chronic care management program, which includes studying "payment methodologies to align reimbursements and create financial incentives and rewards for health care professionals to establish management systems for chronic conditions, to improve health outcomes, and to improve the quality of care, including case management fees, pay for performance ... "
EXTENSIVE (developing payment structures and incentivizing certain types of care)	Massachusetts Senate, No. 2863 (2008)	Commission will investigate reforming and restructuring the health care system and will recommend a plan for "the implementation of the common payment methodology across all public and private payers in the commonwealth."
	Minnesota S.F.No. 3780 (2008)	Payment system reform for both public and private sectors, including provider pricing for "baskets" of care, care coordination fees for medical homes, requiring health plans to use cost and quality data.
SPECIFIC ANTITRUST IMMUNITY	Washington Rev. Code Wash. §43.72.310 (2008)	Provides that action pursuant to the chapter (re: cost-control measures, cooperative arrangements, effective health care delivery systems, etc.) to be exempt from state and federal antitrust laws; defines actions which will not be exempt.
	Nebraska R.R.S. Neb. §71-7709 (2008)	Provides antitrust immunity to any party to a cooperative agreement approved by the department for actions based on the agreement.
	South Carolina S.C. Code Ann. §44-7-520 (2007)	Exempts from state antitrust laws providers and purchasers acting subject to an approved cooperative agreement.

State Action and Provider Collaboration: What if groups of health care providers were to work together to offer a "value package" to payers, acting under state supervision? A recent FTC advisory opinion to the Minnesota legislature regarding a piece of proposed Minnesota legislation aimed at exempting certain health care cooperatives from charges of price-fixing sheds some light on the types of laws that the FTC finds insufficient to find state action immunity. (Bear in mind, of course, that there has been no official judicial ruling on the state law). Senate Bill S.F. No. 203 would establish health care cooperatives to collectively negotiate on behalf of their members in order to promote rural health care delivery. The legislation, aimed at improving rural health care, requires certain health care cooperatives to operate under state supervision to assure that their contracts advance lawful interests. The bill provides for submission of contracts to the state for review and approval; failure to act or seek additional information on the part of the state results in approval, making the system potentially one of passive review. The bill provides that contracts are to be deemed lawful in the absence of findings by the state that the anticompetitive effects of the contract exceed pro-competitive effects or efficiencies, or that the price agreements are not necessary to achieve efficiencies. Therefore, the measure places the burden of proof on the state to find arrangements anticompetitive.

In the view of the FTC, the Minnesota law "would deprive health care consumers of the protections of

the antitrust laws and the benefits of competition ... If the bills ... were to become law, all consumers—patients, employers, insurers, and federal, state, and local health programs—likely would pay more for medical care.”⁴⁹ The FTC found that “like...other health care provider collective bargaining bills...” the measure is designed to confer authority on competitors to agree to “prices and other terms they will accept from health plans and to bargain jointly to obtain these collectively determined contract terms.”⁵⁰ The FTC determined that “although the bills set up a scheme for state review, the nature of that review is limited. Indeed, [the] bills effectively establish a presumption in favor of approval.”⁵¹

⁴⁹ Federal Trade Commission, In re Minnesota House Bill H.F. No. 120 & Senate Bill S.F. No. 203 Advisory Opinion (March 18, 2009).
<http://www.ftc.gov/opp/advocacy/V090003.pdf> (accessed June 23, 2009).

⁵⁰ *Id.*, p. 3.

⁵¹ *Id.*

According to the FTC, under the bill, “as long as the applicant provides the information requested by the Commissioner, within a very limited time, the Commissioner must evaluate the potential competitive effects of the application, the potential efficiencies of the application, and determine which of these effects exceeds the other.”⁵² Finding that this type of collective bargaining by providers does not serve the public interest and would likely raise health care costs, the FTC concluded that the measure was tantamount to state-sanctioned price-fixing and pointed to cost estimates prepared by the United States Congressional Budget Office, which found that similar federal measures would lead to higher private insurance premiums.⁵³ The FTC found inadequate state oversight given the limited time accorded to the state for review, as well as the presumption of legality built into the process. In other words, the type of active supervision that goes to the heart of the state action doctrine was missing in the view of the FTC (a court might, of course, find otherwise), not only because it was not expressly called for, but because the bill itself was structured to effectively prevent active oversight from happening.

⁵² *Id.*

⁵³ *Id.*, p. 8.

The FTC also determined that by encouraging higher prices, the measure would advance neither health care access nor quality, even though its ostensible purpose was to stabilize health care in rural areas. The FTC also noted that since antitrust law already allows collective action among horizontal competitors through the creation of integrated systems that (typically) bear risk and are empowered to act as an integrated unified entity, the bill was unnecessary to achieve legitimate aims. In other words, were providers to form a corporation to sell medical care products and to negotiate integrated delivery arrangements with payers, their conduct would be lawful (provided the entity lacked market power) without the need for state action.

Whether a court would agree with the legal conclusions reached by the FTC is a matter of conjecture, and a court might conclude that the state’s intervention was sufficiently strong to pass muster. In part, the FTC letter goes to the policy wisdom (or lack thereof) of granting a state action exemption, a matter that a legislature might well consider important, particularly in rural areas (or medically underserved urban areas for that matter) in which countervailing policy considerations regarding matters of access and stability and health care quality are particularly important.

Four Case Scenarios

It is evident that information sharing alone is not the culprit—the antitrust problems arise when competitors jointly use the information to attempt to control the price within a particular geographic or product market. Thus, entities that convene stakeholders, provide extensive information about historic cost and quality outcomes within the market, present information on innovations in health care organization and payment, educate and inform their members, and provide technical support to test payment and delivery innovations would appear to raise no antitrust problems. Nor would efforts on the part of providers to improve the information flow about the care they are furnishing in order to enable purchasers to make more informed buying decisions contradict antitrust law. We offer four hypothetical situations that illustrate possible collaborative activities.

Scenario 1

A regional health care collaboration convenes several insurers and employer group health plan sponsors, as well as the medical society and hospital association in its service area. The purpose is to share (appropriately de-identified) information comparing the prices paid across the market for certain types of surgery, as well as readmission and health outcome data related to the surgery. The group also wants to discuss the potential to move toward a different payment structure for this type of surgery that would entail a single payment to health care facilities for surgery and aftercare as a means of reducing readmissions and improving health. The general outlines of “bundled” pricing are discussed and past successes or challenges are reviewed. At the same time, there is no exchange of information regarding how any particular insurer or plan in the room will in fact price the surgery and aftercare or whether the physicians in the room would agree to move to a modified aftercare payment system or how much they would charge. (Of course the hospitals and physicians may subsequently decide to come together to form a new integrated entity just for the purpose of managing the payment and practice associated with surgery and aftercare, but this is another matter.)

Is this legal? It would appear to be. The exchange is merely convening and providing information and technical support for the stakeholders to act independently. The exchange is offering a key service by promoting value-based purchasing to encourage a new approach to covering and paying for surgery and aftercare. The outcome hopefully might be a bundled case rate that prices and pays for an integrated treatment approach over an entire episode of care. Payment would be based upon clinical practice evidence linked to health care quality. Individual insurers and plans are free to adopt or not adopt the model. Individual providers are free to participate or not participate in the model. There may be general discussion of how payment is structured under this type of approach, but the insurers in the room are making no agreements, and neither are the physicians. If everyone agrees to move forward, the exchange might continue to work with the insurers, plans and providers to implement the changes and report back to the group about the results.

Precisely because the antitrust-sensitive aspects of this endeavor—data collection, quality assessment, and setting of the case rate—would occur independently among the entities, the activities would not appear to implicate federal antitrust law. No state action doctrine needs to be invoked. Nor does antitrust law stop any of the stakeholders from making information about their own experiences public.

Scenario 2

Insurers and physicians, working with a collaborative in a given market, agree to test a “medical home” model of care that utilizes a specified approach to physician payment (e.g., the basic clinical fees plus a monthly care coordination fee for certain types of cases). The insurers agree that they will provide a “care coordination fee” to their network physicians and that they will send data on clinical care outcomes to the exchange for analysis. Everyone agrees on the outcomes over time they will monitor (reduced admission and emergency room use, stable or improved measures of health status, better adherence to certain treatment regimens, total costs, as well as the cost of each component of the model). The group agrees to pursue the effort for a year and use the exchange to collect and report on the results. Does this activity violate federal antitrust law?

Again, this type of activity would not violate antitrust law because the agreement between the insurers stops short of collectively setting the fee or bonus amount. There is nothing illegal about horizontal competitors discussing and agreeing to try a general approach to improving the quality of care, the cost of care, and health outcomes. However, if the insurers want to use the same method to price and pay for the underlying care and case management fee, they would need to operate within an antitrust safety zone or pursuant to the state action doctrine. That is, the law would specifically govern the setting of the rate, the use of the rate to pay for the care, and oversight of the results.

Scenario 3

Three hospitals in a given market develop and publish standard definitions of billing codes for emergency care and urgent care provided in the emergency department, as well as guidance for hospitals on how to bill under those codes for different services. The local hospitals all agree to use these definitions to ensure that they are billing for their services appropriately and uniformly. Is this activity legal?

Yes, this activity would appear to be lawful, since the purpose is to improve the quality and appropriateness of emergency room use by allowing hospitals and payers to more clearly understand and distinguish between health conditions that are judged following an initial examination to be true medical emergencies and those that can be more appropriately treated in alternative settings and that require a different payment structure and different incentives. This information may not only facilitate

more informed purchasing but, over time, can help shed light on serious health care access gaps, as hospitals, physicians, and insurers gain a better understanding of health care access and use patterns in the community. The hospitals essentially are collaborating to produce better information about health care in their community, which in turn, should allow for a more efficient payment structure. (Were the hospitals to use this information to bargain collectively as a group with insurers over what they should be paid, the conduct would likely be condemned as per se illegal absent a state action exemption whereby the state expressly sanctions and regulates the activity.)

Scenario 4

Five health insurers serving a specific community have come together to collaborate and establish a uniform set of practice guidelines and performance measures. For each practice, performance on a designated measure set is estimated using all patient data, regardless of payer. The health insurers all agree to use the guidelines and performance measures to make coverage determinations, and they agree to make incentive payments only to those practices that meet performance standards. The health insurers all agree on the amount of the incentive payments to be paid when the performance measures are met.

This level of joint conduct, in the absence of state action or a specific antitrust safe harbor, would appear to violate antitrust law, because there has been a meeting of the minds among the competing insurance companies regarding both the uniform coverage determinations based on satisfying the clinical guidelines, and the setting of the amount of the incentive payment to be made when the guidelines are followed. Where the focus is on common practice guidelines—rather than an agreement to only cover services that meet these common guidelines—by which quality will be measured, the activity remains one of quality improvement and should fall within the rule of reason. But at the point at which the quality measures start to be translated into payment structures, levels of payment, and collective coverage determinations, the activity moves into restricted territory because it is collective action to control the price of care.

Conclusion

The results of this analysis suggest that collaboration around key information exchange activities aimed at quality improvement, cost containment, and information transparency are all consistent with antitrust doctrine, whether undertaken with the formal guidance and support of an entity created specifically to undertake health information exchange or through more informal collaboration.

At the same time, with the capacity to generate health information now growing at relative warp speed as the process of HIT adoption unfolds, this analysis suggests the potential need for an updating and expansion of the 1996 Statements of Antitrust Enforcement Policy in Health Care. As useful as these statements are, they were drafted nearly 15 years ago, well before the transformation to an information-driven health care system got seriously under way. Now that the sharing and exchange of extensive information regarding cost and quality has become a serious and formal health system goal in its own right, an important consideration is whether to accompany this evolution in health information technology with an expanded list of scenarios and activities that either raise no antitrust problems or that can proceed either under a safety zone or through a state action doctrine exemption.

In our view, enabling an appropriate interaction between antitrust law with the aims of an information-driven health care system merits attention in an era of national health reform. The U.S. health care system rests on basic concepts of competitive markets. At the same time, achieving greater value and efficiency in health care demands the ability to use and exchange information regarding price and quality within a variety of markets. Convincing competitors that it is not only desirable but legally safe to exchange information and work together to share and learn from information on price and quality may pose a challenge in the absence of clear safety zones permitting such conduct. While the state action doctrine may be of use in this regard, the very desire to keep health care competitive may defeat legislative efforts to bring greater transparency to quality and price within a health care market. For this reason, incentives, in the form of more explicit safety zones may produce progress.

Advancing the actual use of health information is a goal that could be pursued through a comprehensive effort such as that undertaken in the development of the health care safety zones initially. Such an effort might entail the convening of experts in health care quality improvement and disparities reduction, cost containment, and health information, to create national goals regarding information creation, exchange, and access. These goals could, in turn, serve as the basis for a revision or expansion of the Statements to assure that the aims of more, better, and more transparent

information are reflected in the range of activities legally sanctioned under the Statements. Such an initiative would seem particularly germane, not only to the transformation of health care, but to vigorous and targeted antitrust enforcement policy.⁵⁴ The provision of transparent, comprehensive, and high quality information about how much health care costs and which types of health care appear to be valuable investments for society would appear to be worthy of incentives, and any doubts about the legality of producing and sharing such information—particularly when such information is made public—could be erased through the policy development process.

⁵⁴ Labaton S, "Administration Plans to Strengthen Antitrust Rules," *New York Times*, Section A1, May 11, 2009, <http://www.nytimes.com/2009/05/11/business/11antitrust.html?scp=2&sq=antitrust&st=cse> (accessed June 23, 2009).

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