Health Care Antitrust Alert

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DOJ Reaches Settlement Prohibiting Hospital from Entering into Anticompetitive Contracts with Health Insurers

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The Obama Administration's DOJ Antitrust Division has highlighted reinvigorated enforcement of Section 2 of the Sherman Act and strong antitrust enforcement in health care markets as two of its priorities. Christine Varney, Assistant Attorney General for the Antitrust Division, withdrew the controversial Section 2 enforcement policy report issued during the Bush Administration as one of her first official actions.[1] Likewise, one of Ms. Varney's major policy speeches, delivered almost a year ago, focused on health care antitrust enforcement.[2]

On February 25, 2011, those two enforcement priorities converged as the Antitrust Division and the Texas Attorney General's Office filed a complaint against, and proposed settlement with, United Regional Health Care System of Wichita Falls, Texas. *U.S. and State of Texas v. United Regional Health Care System*, No. 7:11-cv-00030-O (N.D. Tex, Feb. 25, 2011). The complaint alleged that United Regional had violated Section 2 by entering into contracts that improperly inhibited commercial health insurers from contracting with United Regional's competitors. This is the first case brought by the DOJ since 1999 alleging that a monopolist has engaged in traditional unilateral anticompetitive conduct.

Since the case will not be litigated, it will not reset the law on Section 2, which after recent Supreme Court opinions like *Trinko*[3] raised the bar significantly on Section 2 claims. However, the complaint, the relief ordered, and particularly the Antitrust Division's analysis revealed in its Competitive Impact Statement provide significant insights into the DOJ's current thinking.

The Complaint

United Regional, formed by a 1997 merger, is by far the largest hospital in Wichita Falls, Texas. The complaint alleges that the relevant geographic market is no larger than the Wichita Falls Metropolitan Statistical Area (MSA). The complaint alleges two distinct relevant product markets: (1) the market for general acute-care inpatient hospital services sold to commercial health insurers, and (2) the market for outpatient surgical services sold to commercial health insurers.

The complaint further alleges that United Regional has monopoly power and asserts that there is strong direct and circumstantial evidence of that fact. First, the complaint claims that United Regional has charged supracompetitive prices for a sustained period of time and that as a "must have" hospital in the Wichita Falls MSA, it is one of the most expensive hospitals in Texas. Allegedly, United Regional is paid almost 70% more than Dallas-Fort Worth hospitals for inpatient hospital services, and about 70% more than competitors in Wichita Falls.

Second, the complaint offers market share data as evidence of monopoly power. United Regional's

share of general acute-care inpatient hospital services is approximately 90% and its share of outpatient surgical services sold to commercial health insurers is more than 65%.

Importantly, possession of monopoly power alone does not violate Section 2—Section 2 makes it unlawful to *maintain* monopoly power through exclusionary conduct. In this case, the complaint alleged that United Regional systematically required most commercial health insurers to enter into contracts that effectively prohibited them from contracting with United Regional's competitors. United Regional adopted the exclusionary contracts in direct response to the competitive threat presented by inpatient and outpatient surgical facility competitors.

As alleged in the complaint:

> All of United Regional's exclusionary contracts share the same anticompetitive feature: a pricing penalty ranging from 13% to 27% if an insurer contracts with [competing facilities]. Specifically, the contracts provide for a higher discount off billed charges (e.g. 25%) if United Regional is the only local hospital or outpatient surgical provider in the insurer's network. The contracts provide for a much smaller discount (e.g. 5% off billed charges) if the commercial health insurer adds another competing local health care facility…. A penalty that reduces an insurer's discount from 25% to 5% (for adding a rival facility) increases the insurer's price from 75% to 95% of billed charges—a 27% increase over the discounted price.

In its Competitive Impact Statement, the DOJ spells out its analysis as to why the contracts reduced competition and enabled United Regional to improperly maintain its monopoly by foreclosing its rivals from many of the most profitable health-insurance contracts in Wichita Falls. Citing *U.S. v. Dentsply Int'l, Inc.* 399 F.3rd 181 (3rd Cir. 2005), the DOJ argues that a competitor is "foreclosed" from competition when it is denied or disadvantaged in its access to significant sources of input or distribution. Here, according to the government, a foreclosure analysis properly focuses on the profitability of various payment sources available to health care providers.

Profits from the government plans are not an adequate substitute for the profits from the excluded insurers. With the exception of Blue Cross, the largest payer who pays the lowest rates due to its size, United Regional had exclusionary contracts with all the other commercial payers in the market. Even though they represented only about 8% of United Regional's total patient volume, they accounted for approximately 35 to 40% of all payments United Regional received from commercial health insurers and approximately 30 to 35% of the profits that United Regional earns from all payers. This makes the excluded payers "significant sources of input or distribution."

According to the government, these exclusionary contracts have increased prices and reduced quality competition in three ways. First, they have likely delayed and prevented the expansion and entry of United Regional's competitors. Second, they have limited price competition for price-sensitive patients. Third, they have likely reduced quality competition between United Regional and its competitors; without the exclusionary contracts, United Regional and its competitors would have increased incentives to make additional quality improvements.

The DOJ also reasoned that the exclusionary contracts here closely resemble *de facto* exclusive dealing arrangements, since in reality the nonexclusive (higher) rates were not a commercially feasible option for insurers. While discounts tied to exclusivity can be procompetitive if they result from "competition on the merits," they can be anticompetitive if they prevent equally or more efficient rivals from attracting additional customers.

To analyze United Regional's discounted prices, the DOJ argued that the discounted prices should be put through a price-cost test. The test the DOJ applied was to attribute the entire discount to only the patients that United Regional would actually be at risk of losing if an insurer were to choose nonexclusivity (the "contestable volume"). Using as proxies patient usage patterns from Blue Cross and Medicare, two major payers not subject to exclusivity, the DOJ concluded that the likely contestable volume is approximately 10% of the patient volume that United Regional receives from the payers that have signed exclusionary contracts. When applying the entire discount to the contestable volume, the

DOJ found that the resulting price is below any plausible measure of United Regional's incremental costs. As such, United Regional's discounts would likely exclude an equally-efficient competitor.

Proposed Relief

The proposed Final Judgment prohibits United Regional from (1) conditioning the prices or discounts that it offers to commercial health insurers on whether those insurers contract with other health care providers, and (2) preventing insurers from entering into agreements with United Regional's rivals. United Regional must honor its current contracts unless or until such contracts are renegotiated (for at least 270 days during renegotiation) or terminated.

In addition, the proposed Final Judgment prohibits United Regional from offering other types of "conditional volume discounts," defined as discounts offered on condition that the volume of that insurer's purchases from United Regional meets or exceeds a specified threshold. United Regional can offer above-cost incremental volume discounts, which the DOJ believes is unlikely to cause anticompetitive harm and permits United Regional to engage in procompetitive efforts for additional patient volume. The Competitive Impact Statement offers an example of how an above-cost incremental volume discount would work:

> For example, United Regional may offer to accept payments equal to 75% of billed charges for the first $10 million of gross charges from a particular insurer, and 40% of billed charges for any charges in excess of $10 million. In 2009, United Regional reported total charges of approximately $807 million, and total costs of approximately $207 million, implying a Cost-to-Charge Ratio of approximately 26%. Because the discounted prices for each service line (40% of billed charges) exceed the hospital's Cost-to-Charge Ratio (26% of billed charges), this offer would be above cost and permitted under the proposed Final Judgment.

The proposed Final Judgment would remain effective for seven years.

In announcing the settlement, Ms. Varney stated, "Unfettered competition among hospitals is vital to ensuring that patients receive high-quality, low-cost health care. Today's settlement prevents a dominant hospital from using its market power to harm consumers by undermining its competitors' ability to compete in the marketplace."

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Endnotes

1 Christine A. Varney, Remarks as Prepared for the Center for American Progress, *Vigorous Antitrust Enforcement in This Challenging Era* (May 11, 2009).

2 Christine A. Varney, Remarks as Prepared for the American Bar Association/American Health Lawyers Association Antitrust in Healthcare Conference (May 24, 2010). For a summary of the speech, please see our Health Care Antitrust Advisory, (May 26, 2010).

3 *Law Offices of Curtis V. Trinko v. Verizon Communications Inc.*, 123 F. Supp. 2d 738 (S.D.N.Y. 2000).

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