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HEALTH CARE

EXCLUSIVITY

Antitrust Ramifications of Exclusivity in Health Care

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I. THE ISSUE

Health care providers seek to serve as many patients as they safely and economically can to ensure continued profitability and expansion. Sometimes, to gain additional patient volume, a physician practice will agree to accept a lower reimbursement rate from an insurer in exchange for obtaining the exclusive right to serve the insurer's members in a given service area. Such exclusive arrangements can have substantial competitive consequences and, therefore, may run afoul of antitrust law.

This article identifies the potential procompetitive impacts and anticompetitive effects that can be caused by such provider/insurer exclusivity. It also highlights criteria that should be used when determining whether the exclusive may constitute an unreasonable restraint of trade or act of monopolization.

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II. Procompetitive Benefits That Can Be Achieved Through Exclusivity

Many exclusive arrangements between providers and insurance companies will have competitively neutral, if not procompetitive, effects.[1] This is because providers will likely accept a lower reimbursement rate from the insurer (potentially leading to lower rates for consumers) in exchange for the exclusivity and, thus, higher volume of patients promised by the insurer.

Insurers will generally not want to limit physician options for their members, particularly where they are in heated competition with other insurers, unless they receive a financial incentive to do so. Accordingly, to convince an insurer to grant an exclusive, a provider will likely have to agree to accept lower reimbursements for the medical services it offers. The insurer can then either choose to book the savings from lower reimbursement as profits or pass such lower reimbursements on to subscriber/members in the form of lower insurance premiums. (Under the Affordable Care Act, the insurer may be required to pass on at least some of these savings: the ACA limits the percentage of premium that can be retained by insurers as profit.)[2] In a competitive market for insurance subscribers, it is likely that some of the lower costs achieved by the exclusive will be passed on to the insurer's members.

To the extent that these savings are passed on to members in the forms of lower premiums and the exclusive does not bar consumers from receiving superior quality medical services, overall consumer welfare will be enhanced by the exclusive. Such an exclusive would thus be procompetitive. It would also contribute towards achieving our national goal of reducing health

[1] ABA, *Antitrust Law Developments,* (7th Ed. 2012) at 210 (Exclusive ''arrangements may have procompetitive effects and may be motivated by goals that are not anticompetitive.'')

[2] *See* Section 2718 of the Public Health Service Act, 42 U.S.C. § 300gg-18, as amended by the ACA.

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care costs – costs that now account for approximately $8000 per American per year.[3]

III. Anticompetitive Harms That Can Be Caused By Exclusivity

While exclusive provider/insurer relationships can and likely will either enhance, or not substantially impact consumer welfare, it must be recognized that certain provider/insurer relationships can cause anticompetitive harm. These relationships have the potential of causing anticompetitive harm where they effectively bar significant numbers of patient-consumers from getting the healthcare services that they need or want.

For instance, exclusives could prevent patients from accessing innovative medical treatment. This could occur where the provider to the exclusive does not offer an innovative treatment desired by the patient that is offered by his excluded competitor as most patient-consumers that are covered by commercial insurance generally forego paying substantial ''out of pocket'' costs to visit ''out of network'' providers for procedures or treatment.[4]

Consider a simplified example. An exclusive arrangement exists between an insurer and a provider of orthopedic services. This arrangement requires members of the insurance plan living in the orthopedist's service area to (1) use this physician for orthopedic services or (2) face paying substantial out of pocket costs (i.e., hundreds of dollars) to use a competitor orthopedic practice. Now let's say that the excluded orthopedist offers an innovative technique that helps heal injuries sustained to Achilles tendons quickly. And let's say that the orthopedist that is a party to the exclusive does not offer this treatment. In this paradigm, patient-consumers covered by the plan will not be able to take advantage of these specialized Achilles tendon-healing services unless they pay substantially more to go ''out of network'' — something that they likely will not do.

Here, patient-consumers have effectively been precluded from accessing a medical innovation. If the plan at issue covers substantial amounts of members who desire the excluded provider's Achilles tendon-healing services, it can be said that consumer welfare has been reduced as a result of the exclusive.

The anticompetitive harms of this arrangement become particularly apparent when one considers that it is not economically rational for most patient-consumers to switch insurance plans. That is because most patient-consumers have their commercial insurance selected and subsidized (to some extent) by their employers. Accordingly, switching away from a plan that limits their healthcare choices to a plan that covers the innovative medical procedures they want would likely impose a substantial switching cost on patient-consumers by causing them to forego employer subsidies. This renders it unlikely that they will make such a switch.

[3] *See* Steve Brill, ''Better Pill: Why Medical Bills Are Killing Us,'' *Time*, March 9, 2013.

[4] *See Palmyra Park Hosp. v. Phoebe Putting Mem'l Hosp.*, 604 F.3d 1291, 1304 (''the costs of paying out-of-pocket for medical services is high enough that a rational . . . policy holder would not usually select an out-of-network provider . . .'')

IV. Factors To Consider When Adjudging Exclusive Health Care Relationships

To adjudge whether an exclusive provider-insurer relationship may violate competition laws, counsel and/or enforcers should consider, among other things, whether (A) there is a horizontal aspect to the relationship, (B) one (or both) of the parties in the relationship possess ''market power,'' and (C) the relationship precludes patients from received desired, even prescribed, goods or services.

A. Is there a horizontal aspect to the relationship?

A horizontal aspect to a healthcare exclusive can indicate that the relationship offends antitrust norms. Consider a group of providers that have agreed with an insurer to limit participation in an insurance network to themselves. Such a relationship can be characterized as a group boycott – a type of horizontal arrangement that is judged more harshly under antitrust law than a purely vertical exclusive deal. These arrangements are generally deemed more problematic because they can create marketplace distortions that could not be achieved by any individual.

In our example, providers combine to achieve a desired collective end rather than enter into individual deal to do so. Arguably, providers have only sought to do this on a collective basis in order to force an exclusive upon the insurer and, by doing so, harm their competitors – something that no provider in our example could do on its own.

When a wholly vertical exclusive is being examined, even by one who has already achieved market power (in a legal manner), there is no concern that the relationship is allowing providers to act in a manner that they could not achieve on their own.

B. Does one of the parties to the relationship possess market power?

Neither a provider nor an insurer can substantially harm competitors in a healthcare market unless one of them wields so-called market power. Market power is the power to impact competition such as by increasing price over, or reducing price below, a competitive level for a significant period of time in a profitable manner. It is also defined as the power to exclude competition or impact the quality of products or services available.[5]

Often, parties show that healthcare players have market power by pointing to market share. In the context of an insurance provider, one can try to demonstrate its market power by estimating the number of commercially insured lives its products cover in a particular region.

Health care provider market power can also be measured by estimating the providers' size and share of patients relative to its competitors in a given specialty in a given area. To measure provider share, one must identify (1) the number of doctors that the specialty practice accounts for in the relevant area, (2) the number of procedures that the provider accounts for in the area, or (3)

[5] *See*, e.g., *United States v. Visa*, 344 F.3d 229, 239 (2d Cir. 2003).

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the number of patients that frequent the provider in a given area over competitors in its medical field.[6]

C. Are any patients being hindered from receiving desired medical services or goods as a result of the exclusive relationship?

Most importantly, to adjudge whether an exclusive is anticompetitive, one must examine its impact on patients. To the extent that the exclusive precludes a significant quantum of patients from accessing desired or necessary medical services, even if the exclusive has resulted in lower health insurance premiums, it may be anticompetitive.[7] In the very least and under antitrust law, if evidence is provided by a plaintiff challenging an exclusive which plausibly shows an anticompetitive impact, it will be up to a trier of fact (i.e., a jury) to determine whether the anticompetitive impact of the arrangement outweighs any claimed efficiencies or lower prices that it achieves. This determination will rely, to some extent, on the demand that patients or their referring physicians have for the desired services.

V. Conclusion

Providers and insurers will likely consider exclusivity as a means of achieving our national goal of lowering healthcare costs. In doing so, they must consider whether contemplated exclusive arrangement will likely offend antitrust principles.

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[6] *See* e.g., 1996 Department of Justice and Federal Trade Commission Statements of Antitrust Enforcement Policy in HealthCare (setting antitrust safety zones based on number of patients serviced or number of physicians in a network).

[7] *See* Competitive Impact Statement in *United States v. United Regional Health Care System*, CV 7:11-cv-0300, (N.D. Tex.) (''without the exclusionary contracts . . . United Regional and its competitors would have increased incentives to make additional quality improvements, and the overall level of quality of health care in [relevant market] would be higher.'')