



Antitrust and Collective Action by Social Workers

What's Safe and What's Not

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Purpose of Antitrust Laws

- Federal and state antitrust laws are designed to prevent conduct which would result in anti-competitive effects in a particular market, which may be geographically limited and/or limited by product or services
- This material discusses federal law, but New York's Attorney General has an Antitrust Bureau.

Sherman Act § 1

- Sherman Act 1 prohibits contracts, combinations and conspiracies in unreasonable restraint of trade
- Agreements among competitors to
 - fix prices
 - allocate markets or customers
 - engage in group boycotts
 - refuse to deal



Sherman Act 1 Analysis

- Requires there actually is a contract combination or conspiracy to take the prohibited actions
- Circumstantial evidence, since as email, that creates a reasonable inference of competitors' commitment to a common scheme may be enough

Enforcement



- Joint enforcement responsibility at the Antitrust Division of US Department of Justice and the Federal Trade Commission (criminal ad civil) and possible private actions seeking to enjoin the conduct and obtain damages
- Society-wide discussions re: prices, “advisory fee schedules”, whether to participate in a plan, common negotiation of contract terms are all risky

Per Se Analysis vs. Rule of Reason

- Some conduct is *per se* illegal; other conduct is less clearly anti-competitive and will be analyzed by a court under the “rule of reason,” which requires a “facts and circumstances” analysis of the *negative* effects of the conduct in the relevant **market** weighed against any *pro-competitive* outcome or increased efficiencies that result from the conduct

What's a Market for Goods or Services?

- Generally a geographic area in which the goods or services can be obtained, e.g., New York State/outpatient counseling for behavioral health issues or the narrower Manhattan/private practice clinical social workers
- The measure of a market is how easily other players can enter the marketplace, how many choices consumers have and at what additional cost, how far consumers would have to travel to obtain the item or service from an alternate source, etc.

What's Market Power?

Market power is the ability of a seller or purchaser to alter the price of a good or service. In perfectly competitive markets, market participants have no market power.

A firm with market power can raise prices without losing its customers to competitors.

Market participants that have market power are referred to as "price makers," while those without are sometimes called "price takers."

Market Power

Market power gives firms the ability to engage in anti competitive behavior

Some managed care companies clearly have market power and use it. They are price makers.

They have an antitrust exemption



Why Isn't There Enforcement Against Payors?

- The McCarran-Ferguson Act antitrust exemption covers anything that falls within “the business of insurance,” including premium pricing and market allocations.
- It's outdated and was almost stripped away in health care reform.
- The government's top antitrust lawyer testified that as a result of the exemption “anticompetitive claims, such as naked agreements fixing price or reducing coverage, are virtually always found immune.”

Market Power

Social workers in private practice in NYC have limited market power--they are price takers. Why?

Because the market is saturated with different kinds of clinicians in private practice.

Because they are perceived by payors and consumers as somewhat interchangeable.

Because solo practitioners have no clout—it is inefficient for payors to contract with them except on a “take it or leave it” basis.

DOJ/FTC Policy Statements on Antitrust Enforcement in Healthcare

- Of the nine statements, several are relevant to collective actions by competitors
- Most statements create “safety zones” of conduct against which there will be *no* antitrust enforcement
- Statements provide guidance as to what is “kosher” and “non-kosher” conduct

Statement 4: Collective Provision of Non-Fee-Related Information to Purchasers

- Providers may collectively compile and give payors data on treatment costs, mode or outcome, so surveys/research/white papers are OK—advocacy
- **No safety zone** for “provider attempts to coerce a purchaser's decision-making” by implying or threatening a boycott because of provider objections to contract terms

Statement 5: Collective Submission of Fee-Related Information to Purchasers

- Providers may supply purchasers/payors with information on their historic or current fees or alternative reimbursement methods accepted (capitation, risk-withhold, case rates) without risk provided this is done properly.

The Right Way



- Information collection must be managed by a third party (e.g., a purchaser, health care consultant, academic institution, or trade association)
- any information that is shared among competitors must be more than three months old (and should not be provider-identifiable)
- at least 5 providers/ no provider's may represent more than 25% of the reported data/impossible to identify a provider's rates

The Wrong Way



- Data collection and aggregation by a third party is NOT collective negotiation.
- **Un-integrated** providers may not collectively
 - negotiate fees or other aspects of reimbursement
 - agree to set prices
 - threaten, boycott or coerce
 - **provide information or views concerning fee- related matters, as this suggests providers shared their fee information with each other and are attempting to fix prices**

Statement 8: Enforcement Policy on Physician Network Joint Ventures

- Although statement 8 is about *physician* networks, we can draw a parallel to any licensed healthcare professionals who wish to integrate sufficiently to be within an antitrust safety zone.
- The sharing of substantial **financial** risk among a network's participants is necessary for a network to come within the safety zones—e.g., capitation, upside/downside risk, withholds, case rates

Networks



- Networks that *do not involve the sharing of substantial financial risk* may be sufficiently **clinically integrated** to demonstrate that the venture is likely to produce significant efficiencies. Substantial clinical integration permits bona fide networks to negotiate fee-for-service reimbursement.
- Such organizations make a “significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies”, such as: implementing an ongoing program to (i) evaluate and modify practice patterns (ii) to monitor and control utilization of health care services (iii) to control costs and assure quality; and (iv) to selectively choose network members likely to further these efficiency objectives (and reject or eliminate others)

Networks that Don't Fly

- “Sham” networks whose purpose is to impede competitive forces from operating in the market will be treated as unlawful cartels, whose price agreements are *per se* illegal. A network may be deemed anticompetitive based on statements; a recent history of anticompetitive behavior or collusion in the market, **including efforts to obstruct or undermine the development of managed care**, a disproportionate percentage of providers in the network on an exclusive basis, no real effort to promote cost control, quality and obtain efficiencies.

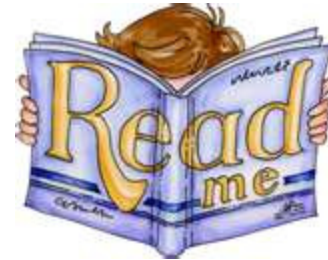
Financial Integration

- Means all involved in service delivery have common financial incentives and submit themselves to common standards for management of treatment costs
- Want to consider? Review Statement 8 carefully
- <http://www.ftc.gov/bc/healthcare/industryguide/policy/statement8.htm> Statement 8
- One can obtain an advance “business advisory”

Using Listservs: what's the risk?

- Society has a listserv of 660 people, a perfect vehicle for communicating rates and organizing protests against payors and offered contract terms.
- **THIS IS EXTREMELY DANGEROUS**
Website should carry a warning

Listserv Warning



Messages should not be posted that encourage or facilitate an agreement among members that expressly or impliedly leads to (i) price fixing (ii) a boycott (iii) or other conduct that may constitute a violation of antitrust laws.

Messages that encourage or facilitate an agreement about these subjects are inappropriate: fees, discounts, reimbursement; salaries; profits, profit margins, or cost data; allocation of clients or geographic service areas; or selection, rejection, negotiation or termination of contracts with payors or other purchasers of members' services.

The Society does not actively monitor the site for inappropriate postings and does not on its own undertake editorial control of postings. The Society may terminate access to any user who does not abide by these guidelines.

WHAT CAN THE SOCIETY DO

- Advocate to Payors
- Market/Educate Public
- Lobby Government



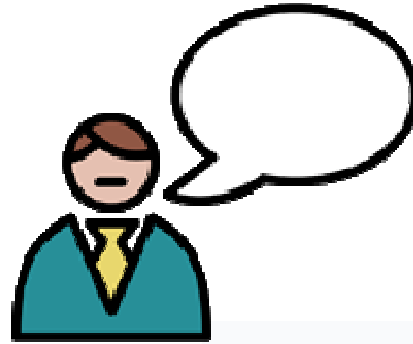
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DO NOT



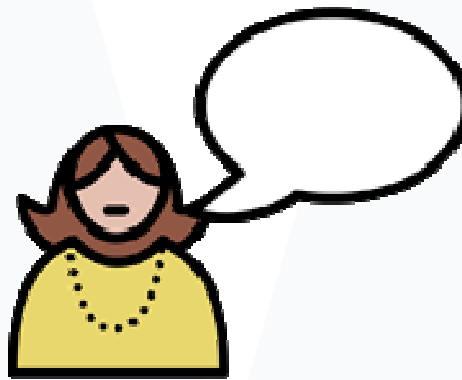
- Collectively exchange rates information with your competitors
- Collectively negotiate rates or terms
- Use Society meetings or listserv to organize boycotts or fix prices, although you may tell others what you intend personally to do

Do



- Use the Society as a vehicle for professional advocacy, state and federal lobbying, input into legislative drafting of social work favorable provisions, including managed care statutes, communication with state agencies on non-rate related payor conduct

Questions?





A 1971 Graduate of Columbia University School of Social Work, Ms. Neuwirth is a New York licensed clinical social worker with postgraduate certificates in psychotherapy. Before becoming an attorney, Ms. Neuwirth was in private practice in Manhattan. She later spent eight years as part of the senior management team of a behavioral health managed care company and understands how the industry views necessity and manages outpatient care.

After graduating from Columbia University Law school in 1996 she devoted herself exclusively to the practice of healthcare law with a particular focus on federal and state regulatory matters. Ms. Neuwirth has extensive experience in devising physician and hospital financial relationships that will comply with the Stark and Anti-kickback statutes. She also handles the defense of psychotherapists in professional discipline matters. She is general counsel to a New York hospital, and compliance counsel to a Connecticut hospital and has broad knowledge of hospital risk management and clinical issues. Ms. Neuwirth is admitted to the bar in New York, Connecticut and Massachusetts. She is a member of the American Health Lawyers Association and is an adjunct professor at Quinnipiac Law School.

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