FTC/DOJ PHO PANEL

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Introduction

Struggling with nationwide cost of providing healthcare to Americans, Congress passed the Federal Health Maintenance Organization Act of 1973 (the "HMO Act")

IPA/PHO Development

- Part of the HMO Act – creation of the Independent Practice Association (the "IPA")
- Legislators recognized the need for physicians to spread risk and to work together to manage care

Since Then

- Congress enacted the Employee Retirement and Income Savings Act ("ERISA"), which effectively preempts a large majority of state law claims that could otherwise be brought against managed care organizations

Managed Care Evolution

- Health plans evolved into forms other than HMOs: PPOs, POS plans, etc. All forms strive to minimize the provision of both unnecessary healthcare and excessive reimbursement

Evolution Continues

- Methods: pre-authorization for care, external determination of medical necessity, ‘gatekeeper’ physicians, capitation / risk-shifting, utilization review, physician credentialing

Provider Response

- Responses: for as long as managed care organizations have existed, patients and physicians have provided congressional leaders, executive branch authorities and courts with a litany of managed care's failures:

Legislators' Response

- mandated disclosure laws
- mandated benefit laws
- patients' bills of rights
- any-willing provider laws
- utilization of 'State Action' exemption to antitrust laws for provider collective negotiation (the most prominent being Texas' law promoted by then-Governor Bush)

Legislators

- efforts to eliminate ‘all products clauses’
- prohibition on managed care organizations’ de-participation’ determinations based on patient advocacy

Attorneys General / DOIs

- investigations and lawsuits alleging billing fraud
- promulgation of industry-wide regulations pertaining to claims adjustment

Court Findings

- denying medically necessary care
- providing sub-standard care
- breaching fiduciary duties
- breaching the duties of good faith and fair dealing (via refusing to disclose fee schedules and reimbursement methodologies to providers)

U.S. Supreme Court

- Most recently, the U.S. Supreme Court held that a health insurer could be liable for violating the Racketeer Influenced and Corrupt Organizations Act ("RICO")

Results

- providers continue to strive to find methods of ensuring managed care's fair dealing with both themselves and their patients

What Happens Next?

- Best case scenario. . .providers continue to develop PHOs, IPAs and OWAs. . .focusing on clinical integration
- Clinical integration. . .the management of disease states through the application of agreed upon protocols, through the use of claims data or data found in electronic patient specific data repositories

Why is this the Best Case?

- Medical management, by networked physicians is the best method to reduce/eliminate overuse, underuse and misuse

What are the challenges to Clinical Integration?

- The refusal of health plans to deal with clinically integrated networks
- The cost of clinical integration

Advocate and Blue Cross

- AHP attempted to take its financially and clinically integrated network of physicians and negotiate with BCBS of Illinois on behalf of 1700 of those physicians
- BCBS refused to negotiate and filed suit claiming price fixing, tying and group boycott

Advocate and Blue Cross

- BCBS stopped making periodic payments to Advocate hospitals
- AHP moved to dismiss the suit on its pleadings and counterclaimed for payment of the periodic payments
- In our opinion, BCBS never really prosecuted the antitrust case

Who was ultimately hurt?

- Advocate and BCBS ultimately arrived at an HMO contract, but AHP's clinically and financially integrated network was not allowed to negotiate a clinically integrated arrangement for its fee-for-service patients
- those patients are not allowed access to state of the art quality/efficiency enhancement techniques