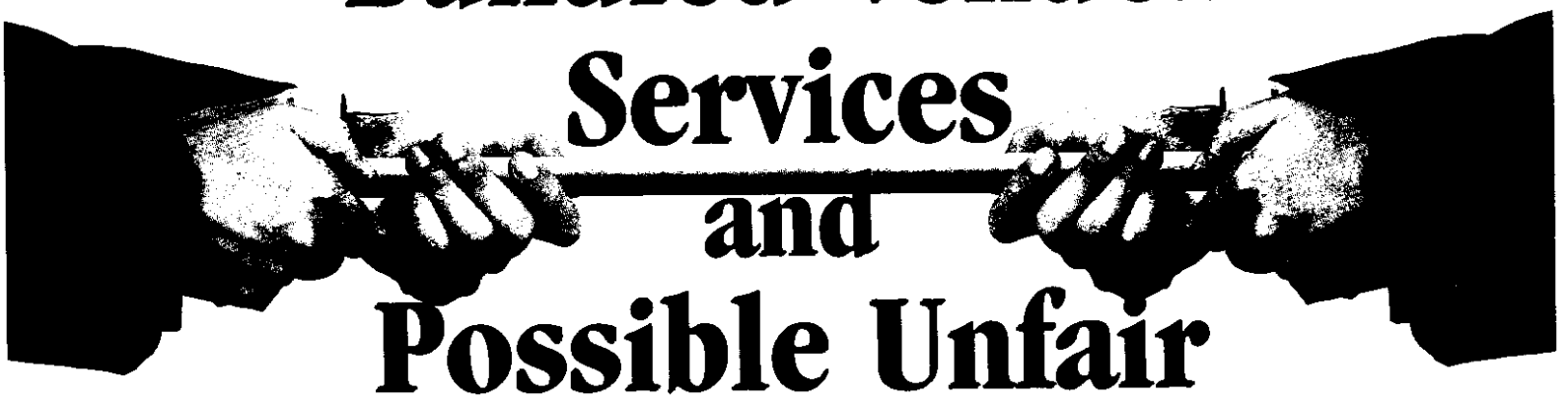
Bundled Vendor Services and Possible Unfair Methods of Competition



By Carlton Harker

Introduction

This brief critique examines the federal unfair methods of competition issues with respect to bundled, or combined, vendor services that might possibly be in violation of certain federal or state laws. The concern of the writer is that such possibility might become a reality thereby offering proponents of a single-payer health system an additional argument. A relatively simple solution to such a potential problem is suggested; i.e., a special-purpose audit, selectively made, which would demonstrate compliance with both the spirit and letter of applicable federal and state laws. This critique is limited to general asset self-funded plans where the only claims under scrutiny are hospital-related.

The critique is in these parts:

Problem
Discussion
Solution
Exhibits
A – Definitions
B – Illustration of Possible Infractions

Italicized words are defined in Exhibit A

Problem

When any of the four *vendor*-provided functions to a self-funded health *plan* are provided in *combination* (i.e., *bundled* there exists the *possibility* of *unfair competition* as contemplated by *state* or *federal laws*. Potential unfair methods competition exists because of the presence of *conflicted interest* (disclosed or otherwise) with such combined vendors. Where the four vendors are each freestanding, no conflicted interest is deemed possible.

If a *special-purpose audit* is made of the activities of the combined vendors, it may well be demonstrated that, as a result of the conflicted-interest of the vendors, an unfair method of competition did, in fact occur. If such is shown to be the case, an FTC investigation might be made at the instigation of: (a) interested parties (*regulators*, e.g.); (b) aggrieved parties (*providers*, e.g.) (c) any of the four vendors not involved with, but harmed by, such alleged discrimination and (d) *plan sponsors*. It is important to note that plan *beneficiaries* are not involved in that the unfair methods of competition under discussion do not typically afflict plan benefits. Examples of infractions which arise from conflicted interest and which may likely be unfairly competitive are illustrated in Exhibit B, attached.

The infractions alleged to be unfair methods competition which are set forth in Exhibit B may or may not be found by the FTC to be such depending on facts and circumstances. These are the Type B infractions shown in the Definitions-Federal Laws. Such infractions may be corrected by the FTC without civil or criminal penalties to the miscreant(s). However, an act may be a Type B and also a Type A infraction in which event the miscreant(s) may have to face the draconian antitrust penalties (most particularly the treble damage award where the damages are usually the creations of hired economists).

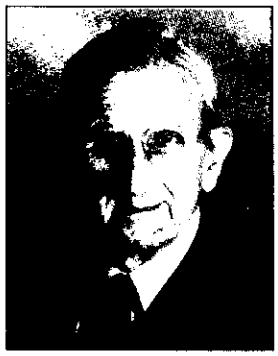
Discussion

Additional topic-related comments are as following:

1. *Producers*, while significant to the care and upkeep of the plans, do not have sufficient impact on the unfair competition aspects thereof to be a factor and therefore do not enter the critique.
2. Central to the writer's thesis is the following assertion:
   - With an *oligopolistic* economic environment such as hospital services...

- Any significant unfair competition infraction...
- That does not have an economic justification...
- Might be deemed a violation of certain federal laws...
- Unless otherwise shown to be pro-competitive by applying the rule of reason test.

3. Miscreant practices are primarily unfair methods of competition or unfair or deceptive practices in nature; they are secondarily (if at all) monopolistic on trade restraining in nature. Rules of interpretation used with infractions of the *Clayton Act* will usually be used with unfair methods of competition infractions, however.
4. *MGUs* do not gain a place in the critique because they are an extension (or alter ego) of the stop-loss carrier.



About the Author:
Carlton Harker, FSA, MAAA is a well known and respected member of the self-funding community and has been an active participant in the Self-Insurance Institute of America's educational programs for many years. In addition to authoring numerous books on a diversity of subjects related to self-funded health care, Carlton has appeared as a speaker and panel member at various industry educational functions. Harker has appeared as an expert witness in many hearings and trials. Mr. Harker is the Principal of Self-Funding Actuarial Services, 8025 North Point Blvd., Suite 207 W., Winston-Salem, NC 27106. (tel) 336-759-2035, (fax) (336)892-0392, or via e-mail at harker2@earthlink.net He maintains a web site at www.self-fundhealth.com

Solution

The vendors, who are bundled or in combination for plan services, have a choice between the following two options as regards the acquisition of a special-purpose audit:

- Do not acquire such audit and rely on their actions being immune from any challenge.
- Acquire an audit, correct/amend any instances of unfair methods of competition to the extent possible, and enjoy the comfort of a likely legal safe harbor.

Facts and circumstances will dictate the more prudent course of action in each instance.

It is the assertion of the writer that, while Exhibit B shows instances where conflicted interests might lead to indefensible unfair methods of competition and/or unfair/deceptive practices which would probably fail the rule of reason test, the majority of such vendor combinations are likely above reproach as respects such activities.

(see page 14)

Exhibit B

Illustration of Possible Infractions

We consider four employers:

- Each has a medical plan with identical benefits.
- Each plan uses a set of four vendors (stop-loss, MCO, UR and TPA) with each set consisting of different vendors.
- Each of the employers has a covered person who intends to use ABC Mercy Hospital; the four covered persons are identical in all particulars and have identical health problems.
- The stop-loss terms for each of the four plans are the same.
- ABC has posted a $125,000 chargemaster fee for the Medicaid procedure and offers a 20% discount to all four plans.
- The plans are all single-employer, self-funded general asset, ERISA-governed medical plans.

The only difference is that for Employer A, the vendors are totally independent, while for Employer B-D, the vendors are tied together either by ownership or by contract in some significant way.

Analysis of Cost Distributions

	Plan A	Plan B	Plan C	Plan D
Hospital Charge				
Gross Charge	$125,000	$150,000	$125,000	$100,000
Discount	25,000	0	25,000	20,000
Balance Billing	0	0	0	20,000
Net Charge	100,000	150,000	100,000	100,000
Financed as Follows				
Employer	$75,000	$75,000	$28,000	$75,000
Participant	2,000	2,000	2,000	2,000
Stop-loss Carrier	23,000	73,000	0	3,000
Total	100,000	150,000	100,000	80,000

Notes

The net charge is the legal liability of the covered person as contemplated by IRC §105.

Plan Differences

A-All four vendors are independent.
B-MCO, UR and TPA are combined.
C-Stop-loss and TPA are combined.
D-MCO and UR are combined.

Explanation of Why Cost Distribution Varies

Plan A

With all four vendors being independent, this is the correct distribution of costs.

Plan B

With the MCO, UR and TPA acting in concert, ABC agrees with the MCO and the UR that the case is best provided in another hospital. Therefore, the covered person is sent to another with the consent of such person being obtained in some manner.

Plan C

The stop-loss carrier and the TPA ***claims game*** so that the paid claims straddle the plan year so that the $98,000 benefit is paid in such a manner that the employer has to meet the two specifics and not the one specific. Depending on numerous factors, this activity may or may not gain the McCarran-Ferguson safe harbor. Even if such safe harbor is available, there is the likelihood that the state's fair trade practices would apply.

Plan D

The UR, MCO and stop-loss carrier are connected so that ABC will necessarily acquiesce to the accepted charges by the reasonable and customary provisions of the plan, which will be $100,000 and not $125,000. ABC is presumed to insist on balance billing to the covered person. Such person has no recourse but to accept such balance billing because of the terms of the consent to treatment agreement executed by the covered person.

Commentary to Exhibit B

It is the assertion of the writer that the infractions above-sited have the potential for being FTC-determined violations of the "unfair methods of competition and for unfair acts and deceptive practices" provisions of the FTCAct (15USC ch.2§45) depending on the facts and circumstances surrounding such activities. It is also the assertion of the writer that such activities might also be in restraint of trade or monopolistic but leaves that issue for others to ponder.

Of interest in that analysis are the following comments:

- As far as the writer can discern the three infractions, above-cited, do not violate any state insurance statutes or ERISA. Nor have such infractions, been acknowledged to exist by any regulatory body (state or federal).
- With each of the three infractions cited, there exists a conflicted interest on the part of the vendors. While not dispositive of a wrongdoing, the presence of such conflicted interest is a danger-signal to possible trouble.
- The Exhibit cites three infractions; there are, of course, numerous instances of other infractions but are not discussed because of space limitations.