Bureau of Competition
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

March 26, 1986

Jonathan E. Gaines, Esquire
Vice President and Counsel
The Equitable Life Assurance Society
1285 Avenue of the Americas
New York, New York 10019

Dear Mr. Gaines:

This letter is in response to your request on behalf of The Equitable Life Assurance Society of the United States ("Equitable") for an advisory opinion concerning Equitable's plan to negotiate with individual hospitals the rates to be charged for certain services rendered to patients covered by Equitable's insurance policies or by health benefit plans established by Equitable's customers.

I understand from your letter of January 21, 1986, and telephone conversations supplementing that letter that Equitable issues to employers, and others, group health insurance policies that obligate Equitable to pay a portion of the cost of certain medical and hospital services rendered to covered individuals. In addition, Equitable offers an Administrative Claims Service ("ACS") for self-insured health benefit plans. As of the end of 1985, Equitable covered approximately four million individuals under insurance contracts, and approximately four million more persons were covered in connection with ACS arrangements. Equitable believes that in most geographic areas, its insurance and ASC contracts cover less than 5% of the population.

Claims, including hospital claims, constitute the largest cost of health insurance. In an effort to reduce the amount that Equitable and its customers must pay for hospital services, Equitable proposes to negotiate with individual hospitals agreements that establish a predetermined fee to be charged for each episode of hospitalization. These fees would replace the hospitals' usual practice of charging separately for each service provided to patients. The negotiated fees would be based on the Diagnosis Related Groups ("DRG's") currently used by Medicare.

Equitable intends to negotiate DRG payment rates individually with selected hospitals in local geographic areas, and rates may vary from hospital to hospital. The rate for each of the various diagnostic groups would be based on each hospital's historical costs for treating patients with that

diagnosis. Identifying such costs requires analysis of claims data for the services associated with each DRG. Equitable has developed a methodology for collecting and analyzing the necessary claims data and has begun to collect the data.[1]

Equitable intends to negotiate DRG rates for claims covered by the insurance policies it underwrites. In addition, Equitable proposes to offer a "DRG service" that would make available to employers that subscribe to the service the DRG rates that Equitable had negotiated and provide a means by which each hospital and the DRG service subscribers could agree to be bound by the negotiated rates. Hospitals and the DRG service subscribers could also agree in advance to be bound for a period not to exceed 12 or 18 months by rates to be negotiated by Equitable in the future. For this service Equitable may receive a fee paid by the DRG service's subscribers.

The DRG service would be available to Equitable's ACS customers and to employers that are not otherwise its customers. While the service may include as subscribers employers who purchases health insurance or ACS services from competing firms, Equitable will not deal directly with the competitor insurers in such cases or participate in any negotiations between the employers and their insurers regarding the impact of the negotiated hospitial rates on the insurance premiums to be paid by the employer. Indeed, Equitable may seek to obtain the insurance or ACS business of employer-subscribers to the DRG service who are not currently its insurance or ACS customers. In addition, Equitable does not intend to make the DRG service available to groups composed principally of employers who are competitors or in situations where it has reason to

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[1] In order to obtain a valid sample of claims relating to each DRG, Equitable may need to supplement its own claims data with data obtained from major employers in an area. When it uses data obtained from others, Equitable intends to share the statistical analysis of the data with cooperating employers and their insurers or ACS providers, and with cooperating hospitals. Since Equitable has not requested approval of its data collection and dissemination activities, this letter does not cover that aspect of the proposal. However, it should be noted that sharing by competing hospitals and insurers of aggregate information regarding the use and costs of health care services does not appear to raise antitrust issues unless the arrangement is used to further an anticompetitive boycott or collusive price-fixing. See, e.g., Letter from James C. Miller III, Chairman, Federal Trade Commission, to Senate Committee on the Judiciary at 6-7 (May 21, 1985); Department of Justice business review letter to Joseph J. Feltes, Esquire, concerning Stark County Health Care Coalition, Inc. (Aug. 30, 1985).

believe that competitors have reached agreements respecting use of the service for the purpose of restricting competition among them.

The DRG rate would apply only to persons covered by health benefit plans established by Equitable and its DRG service customers, and would not determine the prices that hospitals charge to other payers. DRG service subscribers would be free to use other hospitals or to participate in competing DRG arrangements. Equitable and its customers may offer financial incentives to encourage covered individuals to use hospitals with which a DRG rate has been negotiated. Equitable currently intends to limit the number of subscribers to its DRG service so that the population covered by the negotiated rates will not exceed 15% to 20% of the population of any local geographic area.

Based on the description of Equitable's proposed negotiation of DRG rates as detailed in your submission and outlined above, I am of the opinion that the proposed conduct is not likely to violate Section 5 of the FTC Act.[2] Equitable's negotiation of the prices to be paid to individual hospitals for services rendered to patients covered by its insurance policies does not appear to raise any serious antitrust issues. It has been held in a number of cases that an insurer may bargain over the prices that it is obligated to pay for services rendered to covered individuals. See, e.g., Pennsylvania Dental Ass'n v. Medical Service Ass'n of Pennsylvania, 745 F.2d 248 (3d Cir. 1984), cert. denied, 105 S. Ct. 2021 (1985); Royal Drug Co. v. Group Life & Health Insurance Co., 737 F.2d 1433 (5th Cir. 1984), cert. denied, 105 S. Ct. 912 (1985).

With respect to negotiation of DRG rates on behalf of employers with self-funded health benefit plans or other customers, Equitable's proposal resembles in many respects the Cooperating Provider Program that was the subject of the Commission's advisory opinion letter to Health Care Management Associates ("HCMA"), 3 Trade Reg. Rep. (CCH) ¶ 22,036 (June 8, 1983). Like HCMA, Equitable proposes to act as an intermediary between sellers of services -- hospitals -- and purchasers of those services -- the employer groups and their members. Equitable will identify the hospitals willing to enter into agreements to accept DRG reimbursement, will negotiate the specific DRG rates, and will provide a mechanism through which the hospitals and the employer groups can agree on the rates to be paid. It will not negotiate with hospitals collectively.

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2 This opinion letter is limited to the proposed program described above, as explained in your letter of January 21, 1986, and in telephone conversations supplementing that letter. It does not constitute approval for actions that are different from those described, or that are not specified in your letter.

Viewed in this light, Equitable's proposal does not appear on its face to restrain competition in any market. First, the proposed DRG service does not appear to involve unlawful price-fixing in the hospital services market. The DRG service will set only the prices to be paid to individual hospitals by Equitable and its customers. The program does not involve price-related agreements among hospitals, and it does not determine the amount that the hospitals may charge to patients who are not covered by the DRG service.

Second, the proposal does not appear to involve any unlawful horizontal agreements among buyers of hospital services. The DRG service, as described, would not appear to involve any agreements among Equitable's customers. Moreover, even if the operation of the program were to involve some agreement among purchasers regarding prices to be paid for hospital services, it does not appear that the proposed DRG service would operate as an unlawful joint purchasing arrangement. There is no indication that Equitable or its customers intend to use the DRG service to restrain competition. Nor does it appear likely that subscribers to the DRG service will obtain market power in any geographic market, since Equitable intends to limit enrollment under the DRG plan to 15% to 20% of the population in any geographic area. Because Equitable's customers will be employers that generally are not competitors in the markets in which they sell, the DRG service is unlikely to facilitate collusion among them with respect to prices or output or other anticompetitive agreements.[3] Finally, the proposal does not involve any agreements among Equitable or its customers not to use hospitals with which a DRG rate is not negotiated. Equitable, its customers, and, in all likelihood, the individual patients, will remain free to patronize non-DRG hospitals, even though there may be financial incentives for them to use DRG hospitals.

Third, Equitable's proposal would not appear to pose a danger to competition in the insurance industry. Since the proposal as described above does not involve agreements among competing insurers or ACS providers, no questions of unlawful collusion in the marketing or sale of insurance or ACS services are raised. In addition, it does not appear that the DRG service will permit Equitable to deny other insurers or prepaid health plans access to an input necessary for them to compete in the market. The hospitals that contract with Equitable and its customers will be free to offer equally favorable or more favorable terms to other insurance companies or health benefit plans. See Travelers Insurance Co. v. Blue Cross of Western Pennsylvania, 481 F.2d 80 (3d Cir.), cert. denied, 414 U.S. 1093 (1973).

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[3] However, agreements among the employer-subscribers to standardize benefit packages for their employees could raise antitrust issues.

In sum, it does not appear likely that Equitable's proposal to establish a DRG service will unreasonably restrain competition in any market. Moreover, Equitable's proposal may be procompetitive by generating hospital price competition for the business of Equitable's customers. In addition, the proposed DRG service could generate beneficial competition among third-party payers and claims administrators for ways to reduce the costs of hospital and other health care services. Therefore, the proposed conduct does not appear likely to violate Section 5 of the Federal Trade Commission Act or any provision of antitrust law the Commission enforces.

The above advice is an informal staff opinion. Under the Commission's Rules of Practice § 1.3(c), the Commission is not bound by this advice and reserves the right to rescind it at a later time. In addition, this office retains the right to reconsider the questions involved and, with notice to the requesting party, to rescind or revoke its opinion if implementation of the proposed program results in substantial anticompetitive effects, if the program is used for improper purposes, or if it would be in the public interest to do so.

Sincerely yours,

M. Elizabeth Gee

M. Elizabeth Gee
Assistant Director