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FEDERAL BUREAU OF
ANTITRUST DIVISION

The Honorable Anne K. Bingaman
Assistant Attorney General
Antitrust Division
United States Department of Justice
10th Street and Constitution Avenue, N.W.
Washington, D.C. 20530

Re: HEREIU Welfare Fund/Fund Unit 150 (Las Vegas)--
Request for Business Review Letter

Dear Ms. Bingaman:

The Hotel Employees and Restaurant Employees International Union Welfare Fund (the "Welfare Fund"), Fund Unit 150, respectfully requests the expedited response of the Antitrust Division, pursuant to the Business Review Procedure established in 28 C.F.R. Section 50.6 and the Pilot Business Review Program for information exchanges established in 58 Fed. Reg. 6132-03 (1993), with respect to the Fund's proposed conduct as described in this letter and the enclosed materials. This request is limited to the antitrust implications of the proposed conduct and does not seek the Department's opinion on any other legal issues that the proposed conduct may implicate.

The Welfare Fund is a self-funded Taft-Hartley multiemployer employee welfare benefit trust fund, established pursuant to collective bargaining agreements between labor organizations and employers in the hotel and restaurant industry, in accordance with the provisions of the Employee Retirement Income Security Act ("ERISA") of 1974, as amended, as well as provisions of the Labor-Management Relations Act ("LMRA") of 1947, as amended. The Welfare Fund provides benefits to more than 100,000 participants and their dependents who reside throughout the United States. The Welfare Fund is comprised of various Fund Units, covering eligible participants and beneficiaries in different geographical jurisdictions. The Plans of Benefits in the various Fund Units may differ in some respects; however, the Trustees of the Welfare Fund, in their discretion, design the Plans of Benefits; make eligibility determinations under the Plans; and approve the method of delivering promised benefits.

Fund Unit 150, based in Las Vegas, Nevada, is the single largest Fund Unit comprising the Welfare Fund. This Fund Unit covers over 85,000 participants and dependents, the vast majority of whom reside in the Las Vegas, Clark County, area. The following request is being made in connection with the implementation of a new Trustee-approved provider fee schedule which is based on the Medicare reimbursement approach established by the Health Care Financing Administration ("HCFA").

The Nature of Fund Unit 150

Fund Unit 150 provides health benefits to its participants through a self-insured Plan. However, the Fund Unit is not an insurance company,[1/] does not "compete" with other third-party payers,[2/] and does not "sell" insurance coverage to consumers.[3/] Rather,

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[1/]See ERISA's "deemer clause," ERISA § 514(b)(2)(B) (No employee benefit plan "shall be deemed to be an insurance company . . . or to be engaged in the business of insurance. . . .").

[2/]Fund Unit 150's participant population, like that of the Welfare Fund as a whole, consists almost exclusively of individuals employed in the hotel and restaurant industry. Although the Welfare Fund and its constituent Fund Units provide coverage to some "non-bargaining unit" employees, the vast majority of participants are members of Local Unions affiliated with the Hotel Employees and Restaurant Employees International Union. Under the Labor-Management Relations Act (the "Taft-Hartley Act") of 1947, 29 U.S.C. § 141, et seq., "Taft-Hartley Funds" such as the Welfare Fund are administered by a Board of Trustees consisting of an equal number of Trustees representing labor and management, respectively. See 29 U.S.C. § 186(c)(5)(B). Therefore, a Taft-Hartley welfare fund does not "compete" for health care consumers, except to the coincidental extent that its labor and management trustees, in their separate roles, seek to maximize employment and overall revenues in the industry.

[3/]Benefits are funded by "employer contributions," based on dollar rates per hour or other units worked, negotiated under the applicable collective bargaining agreement between the Labor Union and the employer. These employer contributions essentially represent the "insurance premiums" paid by participants. As these "insurance premiums" constitute part of each employee's collectively bargained compensation, each covered employee is, realistically, removed from the competitive market for health care financing, as his coverage is, essentially, already paid for. Therefore, by its very nature, a self-insured Taft-Hartley welfare fund does not compete with insurance companies or other third-party payers for a share of the consumer market. Rather, the welfare fund more closely resembles a consumer union, purchasing health care services, with interests no different

Fund Unit 150 itself, acting solely in the interests of its participants is the ultimate consumer of health care services, as it has no interest other than that of the consumer.[4/] In this regard, Fund Unit 150's mission is to make available to its participants and their beneficiaries the highest quality of health care coverage possible within the practical constraints of its financial budget. To achieve this objective, Fund Unit 150 has embarked upon an ambitious effort to rationalize its physician payments and control costs without compromising the quality of care.

Background Information

Consistent with current trends in the industry, Fund Unit 150 has implemented a "managed care" program, utilizing a "preferred provider" network. These preferred providers, consisting of physicians, chiropractors, laboratories, hospital organizations, and a capitated dental program, charge discounted rates to plan participants in exchange for the anticipated high-patient volume made possible through participation in the network. Because the plan pays a much higher percentage of the medical bill where a "preferred provider" is used, participants naturally seek preferred providers whenever possible. These discounted rates are implemented through individual bilateral contracts negotiated between each provider and the Preferred Provider Organization (the "PPO"). The Fund Unit contracts separately with the PPO, whereby the PPO promises to implement a provider network with certain specified characteristics to best serve the needs of the Fund Unit's participants.

The Welfare Fund's Trustees recently authorized the retention of the independent consulting firm of Deloitte & Touche ("Deloitte") to assist the Fund in implementing a "Resource-Based Relative Value Scale" ("RBRVS") for physician reimbursement in Fund Unit 150. (See Exhibit 1.)[5/] After studying the Fund's physician claims experience, the

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from the consuming public as a whole.

[4/]ERISA § 404 requires the Fund, through its Trustees, to act "solely in the interest of the participants and beneficiaries."

[5/]The concept of RBRVS was established by the HCFA pursuant to the Omnibus Budget Reconciliation Act ("OBRA") of 1989, which authorized the HCFA to develop and implement a national, uniform medicare reimbursement schedule. The RBRVS is designed to provide a rational payment methodology for physician and related services, by reimbursing providers based on the actual, relative value of work performed. Each physician procedure is assigned a specific relative value unit or weight, based on the physician resource input required for the service. These weights reflect three components

consultants concluded that the implementation of an RBRVS-based fee schedule, with the application of an appropriate conversion factor, has the potential to result in a 10 percent reduction in payments for PPO physician services, based on the actual mix and volume of allowed charges for physician services related to the PPO coverage from September 1, 1991, through August 31, 1992.

Proposed Conduct

Following the above-described study, the Welfare Fund's Board of Trustees passed a resolution authorizing Fund Unit 150 to implement an RBRVS-based fee schedule, designed to achieve a 10 percent reduction in payments for PPO physician charges, based on the actual mix and volume of allowed charges incurred from September 1, 1991, through August 31, 1992, conditioned upon compliance with the antitrust laws. Implementation of this resolution would require information exchanges between the Fund Unit and its PPO, Silver State Medical Administrators ("SSMA"). Such information exchanges would be facilitated both by Fund Unit employees and Deloitte. The information exchange primarily includes detailed historical claims data of SSMA PPO physicians, for Fund Unit 150 participants, and comparisons of actual costs with hypothetical RBRVS-computed costs, to assist SSMA in achieving the desired savings for the Fund Unit. (See Exhibit 4.)[6/]

Under Fund Unit 150's existing arrangements, Fund Unit 150 contracts with SSMA to achieve a desired result, and SSMA, in turn, contracts with individual providers. However, Fund Unit 150 currently maintains direct contracts, outside of the SSMA PPO, with the seven major hospitals in the Las Vegas area. All existing provider contracts include termination provisions entitling either party, upon providing 60 days' written notice, to terminate the contract. As part of its ongoing efforts to control costs, the Fund

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of relative value--physician work, practice expense, and malpractice costs. Indices are then applied to adjust for geographic variations in costs. The resulting product is then multiplied by a dollar rate conversion factor to arrive at the total reimbursement amount per procedure. (See Exhibit 2.)

[6/]The results of the Deloitte study, shown in Exhibit 4, contain a "simulation run" which, although specifying individual providers, limits disclosure of specific provider data to aggregate costs paid to each provider. Due to the extremely minimal likelihood, under applicable legal precedent, that such an exchange of volume data could facilitate price-fixing or otherwise cause anticompetitive effects, Fund Counsel has authorized the exchange of this preliminary information between Fund Unit 150 and SSMA.

with the seven major hospitals in the Las Vegas area. All existing provider contracts include termination provisions entitling either party, upon providing 60 days' written notice, to terminate the contract. As part of its ongoing efforts to control costs, the Fund Unit maintains a rigorous "Utilization Review" program by contracting with a utilization review service, which reviews hospitalizations, surgical procedures, and specified outpatient medical services, for determinations of medical necessity. Fund Unit 150 intends to continue this review program as an effective method for controlling costs.

Antitrust Concerns

The first antitrust consideration involves market share. Fund Unit 150's market share is approximately 10 percent, as the Fund Unit's total participants and dependents number approximately 85,000, while the population of Clark County, Nevada (encompassing Las Vegas), is approximately 850,000. Fund Unit 150 believes that its relatively insignificant market share precludes it from potential liability, under Sections 1 and 2 of the Sherman Act, as a purchaser of health care services. Although the SSMA PPO serves other third-party payer plans besides the Fund Unit,[7/] the aggregate market share of all SSMA subscribers combined is also unlikely to be found high enough to indicate an ability to restrict output, control prices, or extract "predatory" prices from providers. Furthermore, while the Fund Unit is aware that SSMA may attempt to implement the RBRVS-based fee schedule for all plans in its PPO, Fund Unit 150 will not conspire with these other plans to exercise consolidated market power.

A second issue concerns "group boycott" liability. In this regard, Fund Unit 150 believes that the inevitable exclusion of certain providers from the PPO network should not expose it to potential "group boycott" liability, as any such exclusions will have procompetitive, as opposed to anticompetitive, effects. (See Exhibit 5c, Memorandum of Law-Potential Group Boycott Liability.) The potential concern in this area arises from the effect of RBRVS on certain types of providers. A fundamental predicate of the federal government's medicare reimbursement methodology is the conclusion that certain provider services, primarily radiology, pathology, anesthesiology, and specialized surgical procedures are overcompensated, while primary care services are somewhat undercompensated. (See Exhibit 3, p. 31). The implementation of RBRVS for Fund Unit 150 could result in fees to these overcompensated providers being cut by as much as 30 percent or more, while primary care providers would enjoy a slight fee increase.

[7/]It is our understanding that all third-party payer plans subscribing to the SSMA PPO cover, in the aggregate, approximately 20 to 25 percent of the total population of Clark County, Nevada.

Unit 150 believes that no antitrust violations will result, as: (1) the Fund's market share is insufficient to establish anticompetitive effects through an ability to restrict output or control prices; (2) notwithstanding the slight increase in fees to primary care providers, the implementation of RBRVS with an appropriate conversion factor will decrease overall costs substantially; and, (3) the anticipated new fee schedule will not constitute an artificially low predatory price, but rather, will result in fairer reimbursement rates based on the actual relative values of services rendered.

Another concern of Fund Unit 150 is the potential claim that the Fund, by contracting with SSMA to implement an RBRVS-based fee schedule, is inducing SSMA and its related entities to violate the antitrust laws. This potential claim could be exacerbated by SSMA's corporate structure. SSMA is a wholly owned division of Mega, Inc., a Nevada corporation. Mega, Inc., is 100 percent owned by Elias F. Ghanem, M.D. Dr. Ghanem, through various corporate and partnership entities (See Exhibit 6), holds a controlling ownership interest in Las Vegas Medical Centers, a primary care provider to Fund Unit 150. As SSMA is a provider-controlled PPO, price-fixing claims might be raised by competing providers. (See Exhibit 5a, Memorandum of Law.) However, these claims should not be imputable to Fund Unit 150, which represents the final consumer of health care services and, therefore, has no interest in inducing anticompetitive behavior by providers.

A final potential concern arises from the fact that the Fund's utilization review service, C.U.R.B. Associates, is a wholly owned division of Mega, Inc. This relationship raises a potential likelihood of group boycott complaints from excluded providers. However, the function of utilization review, as related to the Fund Unit's proposed conduct, is limited to the approval or denial of particular physician services, based on determinations of medical necessity using standard criteria. Therefore, the relationship of utilization review to the exclusion of providers from the network is too tenuous and remote to raise group boycott or other antitrust concerns.

In sharing data between the Fund and SSMA, no specific pricing information on specific providers for specific procedures will be exchanged, nor will information be exchanged from which such specifics could be determined, except to the extent SSMA, in negotiating existing fee schedules, was already privy to such information. Any benefit to Las Vegas Medical Centers, as a primary care provider, would be purely incidental to the implementation of RBRVS, and in no way would result directly from the information exchanges between the Fund Unit and SSMA. Furthermore, the mission and purpose of the Fund Unit's proposed conduct is inimical to any price-fixing or anticompetitive behavior by sellers of health care services (i.e., providers), as the Fund Unit represents the consumers of health care services.

Conclusion

On the advice of Fund Counsel, Fund Unit 150 and the Welfare Fund have adopted detailed antitrust guidelines to safeguard against activities that might raise antitrust concerns (See Antitrust Guidelines, Exhibit 7). By following these Guidelines in the implementation of the RBRVS-based fee schedule, no unfair or anticompetitive behavior will result. Instead, the new fee schedule will result in procompetitive behavior by substantially reducing amounts paid to overcompensated providers, excluding from the network low-quality/high-cost providers, and improving the availability, quality, and affordability of health care to consumers.

Should you require any additional information, please feel free to contact the undersigned.

Sincerely,

Gerald M. Feder
Fund Counsel

Enclosures (Addressee Only)

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