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We've all heard the cliché about “working smarter, not harder.” But what happens when “smarter” becomes collusion via computer code?

That was the subject of Monday's blog post, **An Algorithmic Conspiracy? DOJ Weighs In on MultiPlan Case**. You can follow the link to read the post online, or just keep reading.

The company formerly known as MultiPlan, now “Claritev”, presents itself as a technology, data, and insights company focused on making healthcare transparent, affordable and fair for all. Multiple plaintiffs in federal court litigation against Multiplan and its insurance company clients including UnitedHealthcare, Cigna, and Aetna, allege that it's anything but.

The plaintiffs, a collection of medical groups, hospitals, and other healthcare providers, allege that MultiPlan and the insurers conspired to suppress out-of-network reimbursement rates.

Although it's easy for most to understand the illegality inherent in competitors meeting in a secret, smoke-filled room to determine pricing, here the issue is both more complex and far more relevant to the age of AI and algorithms: do health insurers violate antitrust law, the Sherman Act, by collectively using a common pricing algorithm to determine provider reimbursement rates?

The U.S. Department of Justice has now weighed in, filing a “Statement of Interest”, a brief, in the case, which rebuts the defendants' core argument: that the insurers' use of MultiPlan's pricing tool can't support a conspiracy claim because each insurer allegedly used the tool differently.

The DOJ disagrees. In its view, the law doesn't require identical conduct or uniform pricing outcomes. If competitors jointly rely on a third-party algorithm to set reimbursement benchmarks or influence pricing strategies, that's enough to allege "concerted action"—a violation of the law—even if they don't end up at the same final number.

Citing long-standing precedent, the DOJ emphasizes that coordination on the starting point or method of pricing can restrain competition just as much as fixing final prices. Agreements on formulas, benchmarks, or pricing inputs are not immunized simply because some discretion is left at the margins.

Information Exchange—Old Wine, New Bottles

The defendants argue there's no direct exchange of pricing data among insurers. But the DOJ notes that the Sherman Act doesn't require direct communication between competitors. Exchanging competitively sensitive information through a common intermediary, like an algorithm vendor, can be just as unlawful. When an intermediary aggregates and shares strategic data to help competitors "avoid competition," that's a problem.

"But reimbursement to providers aren't prices!"

One of the more curious defenses raised in the case is that reimbursement rates to out-of-network providers don't count as "prices," and thus can't be "fixed."

But saying that healthcare reimbursement paid by an insurer to a provider isn't a price is like saying a co-pay isn't cash. Cute, but no, and the DOJ's position is that when insurers directly pay providers for services, they are purchasers in the market—and agreements among competitors to suppress those rates are price-fixing in the classic sense, in fact, they are per se unlawful under antitrust law.

A Warning Shot for Algorithmic Coordination

The DOJ's filing sends a strong signal that the government's position is that algorithmic coordination is not beyond the reach of antitrust law. The form of coordination might be new, but the function—suppressing competition—is familiar.

As healthcare payers, tech platforms, and pricing vendors increasingly collaborate through sophisticated analytics, this case is a clear reminder: if you're coordinating decisions that competitors used to make independently, you may be coordinating antitrust liability as well.

And, note carefully that that concept doesn't simply apply to prices paid by insurers, it also applies to prices charged by providers.

The Latest on H.R. 2191 Revising Stark's Prohibitions on Physician Ownership of Hospitals

Here's the latest on H.R. 2191, the legislation to amend the Stark Law in regard to physician investment in or ownership of hospitals.

The resolution's text was just released. It's not as broad as I had hoped, but some relief from discrimination against physician investment in and ownership of hospitals is better than none.

If H.R. 2191 were to be enacted in its present form, we'd see a liberalization of the Stark Law's restrictions in two key ways:

First, rural hospitals would be carved out from Stark's self-referral ban.

And, second, there would no longer be a prohibition on the expansion of an existing physician-owned hospitals' capacity in terms of the number of operating rooms, procedure rooms, and beds.

Together, this could make physician investment in rural hospitals more feasible, allow existing physician-owned hospitals to expand, and, in general, revive the debate over singling out physicians in terms of prohibitions on hospital ownership and investment.

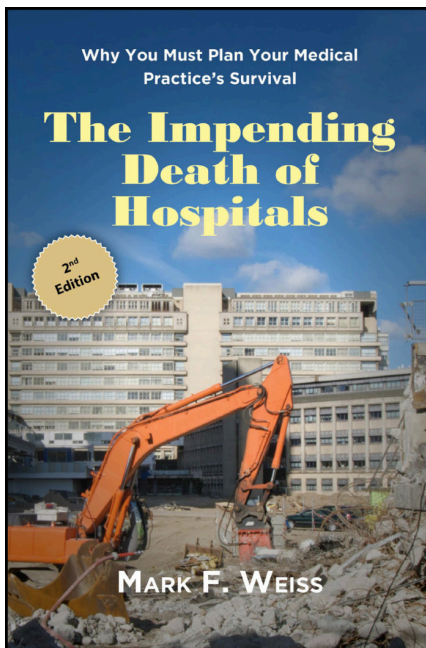
After all, Stark doesn't prohibit hospitals from essentially owning physicians. But even with the changes envisioned by H.R. 2191, there would still be restrictions on physician ownership of hospitals. That emperor has no clothes and to pretend it has is just some bullshit.

Keep an eye on blog.weisspc.com for updates as H.R. 2191 makes its way through the legislative process.



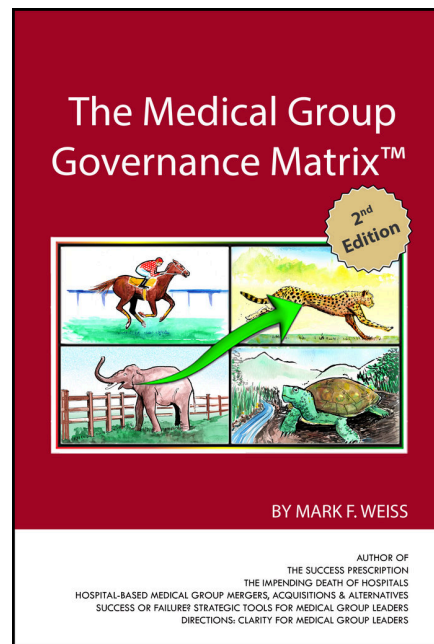
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