

**ANTITRUST PATHS AND PITFALLS:  
WHAT'S REALLY THE DEAL WITH THE  
“MESSENGER MODEL”?**

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**ARTHUR LERNER**  
Crowell & Moring LLP  
Pennsylvania Bar Institute  
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# Antitrust law basics

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- Prohibits
  - Agreements in restraint of trade
    - Price fixing
    - Anticompetitive group boycotts
  - Monopolization
- Enforced by
  - Department of Justice
  - FTC
  - States
  - Private plaintiffs

# Antitrust Risk for Networks – PPOs, IPAs, PHOs, etc.

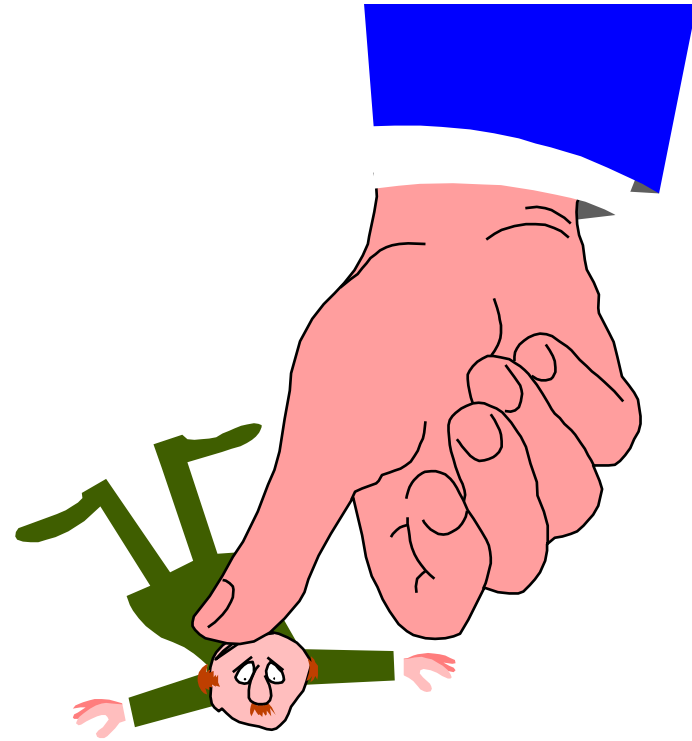
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- Agreement – takes two
- Price fixing and group boycotts
- Avoiding “per se” condemnation for provider network collaboration:
  - where collaboration in pricing is needed for productive joint venture “rule of reason” applies
    - Financial risk sharing
    - Clinical integration
  - network avoids risk by avoiding price collaboration < “messenger model

# Perceived imbalance

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- “Take it or leave it” deals offered by plans
- Few plans may have high percentage of patients
- Information and leverage gap
- Desire to “level the playing field”



# Feel the tension (1)

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“Health care providers who must deal with consumers . . . through [managed care] plans . . . face an unusual situation that may legitimate certain collective actions. Medical plans serve, effectively, as the bargaining agents for large groups of consumers; they use the clout of their consumer base to drive down health care service fees . . .

In light of [the] departures from a normal competitive market, . . . health care providers are entitled to . . . take some joint action

*[... sounding pretty good?]*

## Feel the tension (2)

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(short of price fixing or a group boycott) to level the bargaining imbalance . . . . Providers might . . . band together to negotiate [**non-price** points] . . . such as payment procedures, the type of documentation they must provide, the method of referring patients and the mechanism for adjusting disputes. Such concerted actions . . . must be carefully distinguished from efforts to dictate terms by explicit or implicit threats of mass withdrawals . . . .

*United States v. Alston* (9th Cir. 1992) (emphasis added).



# Positive cooperation

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- Providers can join together to enhance quality and clinical outcomes or to be accountable for cost of care – joint price setting through network might be OK, depending on various market factors
- But price negotiation alone risks antitrust attack
- Is there a role for the “messenger model”?

# Risk sharing

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- Price negotiation not automatically illegal where providers share together in responsibility for cost or utilization or have significant upside gain potential for staying within realistic budget
- May still be illegal if “united front” of too many providers
- Wrong question -- How much “risk sharing” to be able to fix prices?

# Clinical integration

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- “Per se” ban may not apply if providers are clinically integrated
- Examples -- practice protocols adopted and followed, sharing of clinical information, shared electronic medical records or health risk assessment protocols, oversight, accountability and reporting of performance – slimmed down program not enough
- AND joint price setting is reasonably necessary to make venture work
  - Are physicians devoting significant time or capital to programs and planning?
  - Would they do so if there was no assurance that network would be contracting as one?
  - Will negotiated fee schedule be adapted to incentivize participation and compliance by physicians in key specialties, central to quality improvement?
- Still subject to “rule of reason” analysis

# Messenger model

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- Provider network negotiates non-price components of managed care contract that network organization will accept
- Acts as “messenger” for price terms, not as cartel
- May circulate payor price terms or use “black box” or “clearinghouse” model
- If joint pricing is avoided, safety zone applies if 30% or less of specialty in network; 20% if doctors are “exclusive

# Second generation

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- Accelerated, black box or clearinghouse model
  - Individual physicians indicate prices they will accept
  - Physicians “locked in” to payors within range
  - Network can likely decline contracts that do not generate widespread physician participation, if not accompanied by likely boycott
  - May include annual screen against physician’s fee specifications to avoid obsolete fees problem
  - May messenger out price proposals that are below a doctor’s submitted range
  - May be accompanied by education

# Messenger model

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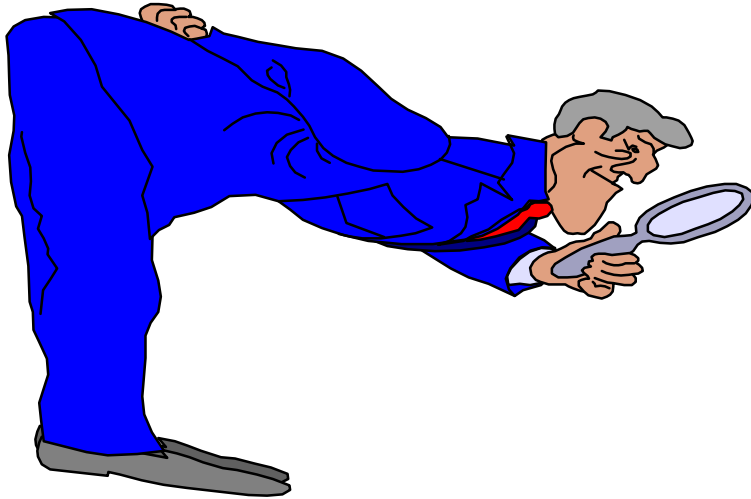
- Can “messenger model” work? Depends what you mean by “work”.
  - Give physicians better information to act on? -- OK
  - Give physicians vehicle for carrying out market-based decisions? -- OK
  - Give physicians automatic re-check of contract terms against acceptable fee parameters – OK
  - Permit efficient contracting process? – OK
  - Give greater voice in non-price contracting terms -- OK
  - Avoid workings of supply and demand? -- No
  - Go back to “good old days” – No

# Enforcement is active

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Some providers go too far. Must avoid “sham” messenger model arrangements

- Repeated enforcement by FTC and DOJ – They’re trying tougher remedies. Suing organizations, doctors AND CONSULTANTS.



Texas physician group’s case now on appeal  
may clarify boundaries.

# Common pitfalls

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- Network negotiates price, but gives latitude to doctors to “opt out” -- still involves collective price negotiation
- Network establishes fee schedule as floor for any price proposal it is willing to “messenger” to members
- Network claims to be using messenger model, but “messenger model” is found only in legal papers, not in behavior
- Network contracts with payors on basis of fee schedule developed by its own hired consultant, which is then messengered to physicians
- Competing groups employ same consultant who coordinates contracting, and acts as “hub” of price fixing understanding

# Model contracts

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- IPAs and PPOs can develop “model” contracts or contract language
  - Contracts may illustrate sample provisions and offer choices
  - Frequently seen contract terms can be explained
  - Areas for physician focus may be noted
  - Should not be directive or “hidden message” sent
- Do say “Here is language to consider” or “Note the impact of this provision”
- Do not say “Don’t sign these” or “Use only this language”.
- Should be educational; not centerpiece of boycott campaign
- Avoid price – danger that “suggested” price terms will be viewed as “agreement” on price terms.

# Surveys, information sharing and education

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- Networks can generally share historical information on fees, shielding identification and using data at least 3 months old
- Fee information can be collected via survey and conveyed to payors
- May convey information to providers to help make them informed marketplace decision-makers, without “call to arms”
- Education  $\neq$  coercion

# Watch out

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- “So long as it’s not in the minutes, it’s OK”.
- “So long as it’s in the minutes, it’s OK.”
- “OK, counsel told us the rules, now let’s move on to business [and set prices] . . .”
- “I don’t know about you, but I am ...”
- “Let’s all ‘unilaterally’ refuse to ....”
- “The meeting with the HMO was just educational” (though member bulletin touted success achieved by “sticking together” and letting payor know physicians were unified and wouldn’t accept its rates)

# A Cautionary Tale of Realtors

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- Annual dinner meeting
- President's address
- “Costs up; my fees going up to 7%”



# Where to get public information

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- Sources of guidance
  - DOJ and FTC 1996 policy statements
  - Agency advice letters
  - Government enforcement actions
  - Court rulings