

Antitrust Issues Related to PHOs and IPAs

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Healthcare Financial Management Association  
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Many health care providers protest that their dealings with health insurers and managed care plans are one-sided – that too much power is on one side of the table. Some payors are concerned that in some instances physicians, hospitals or other providers collude to frustrate competition and artificially drive up prices.

Today's health antitrust battlelines reflect these concerns. We focus today on part of this equation -- antitrust treatment of provider joint contracting activity in IPAs and PHOs, including discussion of recent developments involving the messenger model, clinical integration and pay-for-performance contracting.

## **ANTITRUST FUNDAMENTALS**

Antitrust enforcement authority over provider managed care contracting is divided. At the federal level, enforcement authority is shared. The Federal Trade Commission ("FTC") has antitrust enforcement authority under the FTC Act. The Department of Justice ("DOJ") has antitrust enforcement authority under the Sherman Act. Civil relief is generally sought, although criminal prosecution could occur in egregious cases.

States also have antitrust enforcement authority. State attorneys general enforce state and federal antitrust laws. In addition, private plaintiffs can bring civil actions, seeking triple damages. Employers and employer coalitions, consumers, and HMOs and other payors are all potential plaintiffs.

The antitrust laws prohibit agreements in restraint of trade. Agreements necessarily require multiple actors; under the antitrust laws, a single entity cannot agree with itself. Some agreements – such as price fixing, allocation of customers, certain tie-ins or group boycotts – are so inherently anticompetitive that they are deemed illegal on a *per se* basis. Other agreements must be “unreasonable” in terms of their competitive effects. Price-fixing agreements among competitors are *per se* illegal. The rule was applied by the Supreme Court in Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982) (striking down maximum fee schedule agreed to by members of a medical foundation).

## **PROVIDER NEGOTIATIONS**

Physicians, hospitals and other health care providers face increasing marketplace pressures, from managed care, altered reimbursement rules in government programs, and their numerous peers. Some perceive that payors have an unfair advantage and use “take it or leave it” contracting tactics. However, when physicians or other providers seek to join together to better their bargaining position they can run into antitrust trouble.

Courts have expressed some sympathy for health care professionals dealing with payors, but have not relaxed the basic antitrust proscription against price fixing. In a criminal antitrust prosecution, United States v. Alston, 974 F.2d 1206 (9<sup>th</sup> Cir. 1992), dentists were accused of conspiring to force increases in fees payable by health plans. Evidence showed they met to discuss fees, agreed on the higher fees to be sought, and mailed identical letters demanding higher fees. In remanding a case back to the trial court, the Court of Appeals showed some analytical strain, in commenting:

[H]ealth care providers who must deal with consumers indirectly through 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. Uniform fee schedules - anathema in a normal, competitive market - are standard operating procedure when medical plans are involved. In light of these departures from a normal competitive market, individual health care providers are entitled to take some joint action (short of price fixing or a group boycott) to level the bargaining imbalance created by the plans and provide meaningful input into the setting of the fee schedules.

Thus health care providers might pool cost data in justifying a request for an increased fee schedule. . . . Providers might also band together to negotiate various other aspects of their relationship with the plans 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, which would not implicate the per se rule, must be carefully distinguished from efforts to dictate terms by explicit or implicit threats of mass withdrawals from the plans. . . .

974 F.2d at 1214 (emphasis added). Of course, if providers are not allowed to engage in price fixing or group boycotts, what can they do?

The tension between letting providers have a voice in the process and permitting cartel activity can be seen in this language.

The antitrust enforcement agencies have attempted to find this balance. They have continued to bring antitrust cases against conduct that they find to run seriously afoul of the antitrust laws, as they have for more than twenty years. Indeed, in the last year or two, there has been an upswing in enforcement activity, particularly at the FTC. Numerous consent agreements and complaints target alleged provider combinations to suppress price competition and raise prices that lack plausible joint venture or other legal rationales.<sup>1</sup> At the same

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<sup>1</sup> See, e.g., *R.T. Welter and Associates, Inc.*, FTC File No. 011 0175 (August 20, 2002) (consent agreement); *System Health Providers*, FTC No. 011 0196 (Aug. 20, 2002) (complaint and proposed consent order); *Obstetrics and Gynecology Medical Corporation of Napa Valley*, FTC File No. 011 0153 (2002), <http://www.ftc.gov/os/caselist/0110153.htm>; *System Health Providers, Inc.*, Dkt. C- 4064 (FTC Nov. 2002), <http://www.ftc.gov/os/caselist/c4064.htm>; *United States v. Mountain Health Care*, <http://www.usdoj.gov/atr/cases/mountain.htm>; *Aurora Associated Primary Care Physicians, L.L.C.* (FTC Dkt. C-4055 July 2002). and *Physician Integrated Services of Denver, Inc.* (FTC Dkt. C-4054 July 2002), <http://www.ftc.gov/bc/CommissionActions/2002.htm>; *Professionals in Women's Care*, FTC File No. 0110175 (Aug. 20, 2002), <http://www.ftc.gov/os/2002/08/profwomendo.pdf>

time, the agencies have issued policy statements, as well as advisory opinions, to help clarify application of the antitrust laws to health care industry activities. This guidance has stressed the joint price-setting by competitors is not necessarily illegal where it is ancillary to a bona fide and competitively meaningful joint venture or other productive collaborative activity.

They also conducted lengthy public hearings in 2003 on health care competition and antitrust which resulted in publication of a report. The report provides an in-depth summary of competition in health care and the application of the antitrust laws. It contains a number of recommendations for policy makers, but relatively little substantive clue to any change in the enforcement direction of the agencies. The executive summary of the report is a very good introduction to some of the issues we are discussing today, but we'll begin our closer look with the 1996 joint statement put out by the DOJ and the FTC on physician network contracting.

### **SAFETY ZONE FOR FINANCIALLY INTEGRATED PHYSICIAN NETWORKS**

In their 1996 statements of health care enforcement policy, <http://www.ftc.gov/reports/hlth3s.htm>, the agencies specifically addressed physician network joint ventures. The agencies explained that a physician controlled network organization would have "safety zone" protection where it involves no more than 30% of physicians in any single specialty in a geographic market and physicians are integrated, such as through financial risk sharing;

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there is a 20% safety zone limit where physicians are exclusive with network entity.

Indicia of non-exclusivity:

(1) that viable competing networks or plans with adequate provider participation currently exist in the market;

(2) that providers in the network actually participate in other networks or contract individually with health benefits plans, or there is other evidence of their willingness and incentive to do so;

(3) that providers in the network earn substantial revenue outside the network;

(4) the absence of any indications of significant departicipation from other networks in the market;

(5) the absence of any indications of coordination among the providers in the network regarding price or other competitively significant terms of participation in other networks or plans.

Where the percentage of doctors in network exceeds the safety zone threshold, legality depends on market impact, including assessment whether the

network serves as a competitive stimulus to the market, or a blockade against competing networks or penetration by managed care.<sup>2</sup>

What constitutes sufficient “integration”? The agencies have provided examples of risk-sharing payment arrangements, such as percentage of premium revenue or global case rate methodologies, in addition to capitation and withhold arrangements.<sup>3</sup>

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<sup>2</sup> The guidelines also provide helpful clarification to provider networks that enter into risk-sharing arrangements but also would like the flexibility to enter into some non-risk sharing arrangements without strictly adhering to the so-called “messenger model.” The guidelines basically conclude that rule of reason analysis is appropriate for a network's fee-for-service payer arrangements, provided that a “substantial majority” of the network's contracting arrangements with payors include risk sharing and the network actively seeks to manage the provision of provider services in its fee-for-service contracts, using the same types of quality and cost management for its fee-for-service enrollees as it does for its risk-based enrollees.

On the other hand, problems can arise where a joint venture network is set up, anticipating widespread risk contracting, and a little fee for service business “on the side”. Counsel should be alert to the possibility that fee-for-service business, and the size of the provider panel may expand greatly, while the risk business is a non-starter, and quality improvement and case management programs remain inchoate or “on paper only”.

<sup>3</sup> How much integration is enough? When are providers sufficiently integrated that price-related activities will not be viewed as per se illegal, or where potential anticompetitive aspects of price agreements will be outweighed by potential efficiency or other competitive benefits? No clear boundaries. Focus can be on whether risk sharing features are likely to engender change in provider behavior -- greater focus on cost containment, or improved quality of care within defined budgets, for example.

To evaluate a particular undertaking, one has to be prepared to assess the overall competitive character of the conduct -- whether the program is an effort to beat or keep up with the competition, or to establish an innovative delivery or financing vehicle, or, in contrast, to create a blockade to prevent competition or to forge a “united front” scheme.

Mere existence of withholds or bonus provisions not enough. Sometimes risk features seem “stapled” on by lawyers to justify price fixing. Inquiry might be whether price setting activity is incidental to joint venture, or whether “joint venture” features are mere appendages to price fixing arrangement.

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A risk sharing formulation, in and of itself, might not definitively establish the legitimacy of a joint undertaking, either in terms of per se applicability or outcome of rule of reason analysis. Have structures been created through which the participating physicians can jointly respond to the incentives for cost consciousness created by the withhold and bonus provisions? Are there quality improvement or practice protocol programs? Involvement of physician network in oversight of utilization patterns? If such integration or collaborative activity is lacking, it may be less apparent that joint venture is more than a dressed up price agreement or that the arrangement's benefits outweigh potential anticompetitive effects. Collateral restraints in the arrangement, such as "rights of first refusal" requiring physicians to bring all managed care contracting opportunities to the venture first, may also tip the balance towards a potential antitrust violation.

## **CLINICAL INTEGRATION**

The guidelines explain that a provider network that achieves significant clinical coordination and integration among its members might also be able to negotiate managed care rates, even in the absence of capitation or another risk-sharing payment mechanism, under the antitrust "rule of reason."<sup>4</sup> This does not, however, open the doors to price fixing agreements by loosely organized networks that function as contracting entities without significant clinical or other operational integration among the members.

Significant integration can generally be evidenced by "the network implementing an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and

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<sup>4</sup> The statements also explain how the agencies analyze network ventures that are subject to "rule of reason" treatment. First, the agencies define the relevant geographic market and the relevant "product" market, and the market "concentration" of the joint venture activities. Second, the agencies evaluate the competitive effects of the physician joint venture, such as whether the joint venture will have the market position to raise prices, or whether the venture is likely to have "spillover" effects in the physicians' non-venture activities.

Third, the agencies will evaluate the impact of any procompetitive efficiencies that result from the network joint venture, and weigh them against the likely anticompetitive effects. However, the guidelines stress that claims of efficiency, even if substantiated, will not be justified if they could be achieved by less restrictive means that are practical and feasible under the market conditions faced by the providers. Likewise, if anticompetitive effects are unlikely to result from the venture, the agencies will not require the same degree of proof of efficiencies that they might with a more restrictive venture.

Finally, the agencies will evaluate any "collateral agreements," such as an agreement among participating physicians to give the network the right of first refusal to contract with any managed care plan that seeks an agreement with a participating physician, and other similar restraints. Normally, such collateral agreements must be necessary to the success of the venture in order to be considered defensible.

ensure quality." Those provider network entities that do not undertake significant operational activity, beyond credentialing, participation in peer review, and marketing, likely would not meet the rule of reason integration threshold described in the statements.

A credentialing program and a peer review-upon-complaint program also likely are not enough. The focus would be on whether there is substantial activity to manage, and improve the quality and efficiency of the care being provided, and that there is a logical connection between the program's ability to succeed and the venture's having to be able to establish the price terms on which the network's services will be sold.

Are practice protocols being developed and applied? Is there is a common case management or management information system being put in place? Can the network demonstrate changes in practice patterns resulting from its oversight programs?

The clinical integration approach is exemplified in the FTC staff advisory opinion issued to the Medsouth multispecialty physician IPA in Colorado. The FTC Bureau of Competition staff advised MedSouth that it would not challenge MedSouth's proposed collective negotiation of payor contracts on behalf of members who participate in its clinical resource management program. (Feb. 19, 2002).

The MedSouth advisory opinion is and remains the first written guidance issued by the FTC addressing in depth the amount and nature of clinical integration necessary to permit otherwise independent physician practices to

collectively negotiate fees without violating federal price fixing prohibitions since the 1996 update to the Statements of Antitrust Enforcement Policy in Health Care issued jointly by the FTC and the Antitrust Division of the U.S. Department of Justice.

Under MedSouth's proposal, all physicians who were members of MedSouth physician practices would be required to participate in MedSouth's proposed clinical integration program. The program would have two major components. First, the physicians will use an electronic data record system that will permit them to access and share clinical data related to their patients, such as patient records, lab reports, treatment plans and prescription information. Second, MedSouth will monitor and analyze physician performance according to clinical practice guidelines and performance goals related to the quality and appropriate use of services. MedSouth maintains that the program will permit MedSouth physicians to improve patient care and outcomes, reduce medical errors, increase efficiency in the provision of services and reduce medical costs, and that it will discipline and terminate physicians who do not fully participate in the program and adhere to the program's standards.

Once its clinical program is operational, MedSouth proposed to market the services of its practice members to commercial third party payors, and to negotiate and execute contracts under which MedSouth members would provide services to health plan enrollees. All MedSouth members would be required to provide services under those contracts, and could not opt out. The physicians

would not be precluded from participating in other networks or from contracting with payors independently if the payors did not contract with MedSouth.

The FTC staff opinion letter concluded that, based on the information provided by MedSouth, the group's proposed collective negotiation and contracting with payors on behalf of its members should not be deemed per se illegal price fixing. The letter stated that the proposed program appears to be capable of creating substantial partial integration of the MedSouth physicians' practices, and to have the potential to produce efficiencies in the form of higher quality or reduced costs for health care services provided by MedSouth physicians.

The letter also concluded that the collective negotiation of payor contracts appeared to be reasonably related to the integration, and to be reasonably necessary to the accomplishment of the program's objectives. On the facts presented, absent the assurance that the full panel of doctors would be involved in the network's contracts, physicians were not likely to be willing to support integration activities on which efficiencies depended. Also, the opinion letter said, "joint contracting may permit the network to allocate the returns among members of the network in a way that creates incentives for the physicians to make appropriate investments of time and effort in setting up and implementing the proposed program."

The opinion warned, though, that "mere adoption of a common clinical information system by itself, without the other programs that MedSouth intends to implement, would not suffice to establish that otherwise competing members of a

physician network have integrated their practices in a manner or to an extent that joint negotiation of prices could be deemed ancillary to an efficiency-enhancing joint venture.”

The staff letter warned that the MedSouth network would be closely monitored, and that absent a demonstration that the network had achieved significant efficiencies outweighing anti-competitive effects, enforcement action would likely be recommended if MedSouth's physicians were able to use their collective power to force payors to contract with the network or to pay higher fees.

The letter relied on MedSouth's representation that its physicians have been and will continue to contract individually with payors that wish to contract separately. If that were not to remain the case, the staff said, enforcement action could result, given the relatively high proportion of MedSouth physicians on the medical staffs of important hospitals in the Denver area.

A copy of the advisory opinion is available at <http://www.ftc.gov/bc/adops/medsouth.htm>.

Two recent FTC cases could have provided more guidance on clinical integration and joint price negotiation. However, one was resolved by consent agreement before trial, and an initial decision has been given in the other that finds the physician network liable for violating the antitrust laws, but does not give notable attention to any clinical integration arguments. In [California Pacific Medical Group, Inc.](#) FTC Dkt. 9306 (Feb. 9, 2004) (consent agreement), the Commission issued a complaint against California Pacific Medical Group, dba

Brown & Toland Medical Group, and then reached a settlement with the IPA, barring it from jointly negotiating managed care contracts on behalf of its physician network, except in risk-sharing arrangement or where the group could show the action were part of a clinically integrated initiative where joint contracting was key to the venture's success. The case is notable because it involved a challenge to the non-risk contracting activity of a physician network organization that had a large capitation (at risk) business as well. The Commission complaint rejected the proposition that the fee for service non-risk contracting was protected as incidental to the risk contracting activity, or that the fee-for service contracting came with efficient practice management initiatives that could justify joint price contracting. The case is making a number of physician groups and IPAs in California review their existing contracting practices.

In [North Texas Specialty Physicians](#), FTC Dkt 9312 (Sept. 17, 2003) (complaint), the FTC challenged a network's non-risk contracting as unlawfully restraining price competition among physicians. The initial decision of the FTC's administrative law judge, now on appeal, finds that the group engaged in improper joint pricing activity, and does not give much attention to any clinical integration defense contentions. Similarly, in [Surgical Specialists of Yakima, P.L.L.C.; Cascade Surgical Partners, Inc., P.S.; and Yakima Surgical Associates, Inc., P.S.](#), FTC Dkt No. C-4101 (Nov. 18, 2003) (complaint and consent order), the Commission settled allegations that two surgery organizations had combined unlawfully to negotiate with managed care plans. The Commission enforcement

action rejected any contention by the groups that they had integrated their practices to a degree that justified joint contracting actions. The order also required that a combined venture of the groups terminate its affiliation with one of the groups.

Right now, the New York Attorney General's Office is investigating the joint contracting and price fixing activities of the hospital members of the Long Island Health Network. The participants in the venture claim that they're use of jointly developed clinical pathways justifies their price collaboration. The state is reportedly considering whether to initiate a law enforcement action.

Finally, the existence of sufficient integration so that a network is not engaged in "per se" illegal price fixing does not provide an absolute defense. If the net effect overall of the venture is to frustrate competition, through the aggregation of market power, and the creation of a "united front," the antitrust laws may still be violated.

## **PAY FOR PERFORMANCE**

Many managed care and provider organizations are moving away from the capitation and cost-based withhold reimbursement systems that became prevalent in the 1989s and early 1990s. With great attention being given to ways to improve the quality of care to patients, and to improve the consistency with which quality care is provided, payors and provider organizations are exploring pay for performance payment methods. Observers have noted, for example, that in the current American health care economic model the same price is paid for

care by providers of varying levels of quality. Lots of groups are trying to perfect ways to provide incentives and recognition for better care, which can also depend, of course, on being able to identify, measure and track which care actually is better.

Pay for performance payment models are basically a variant on the risk and clinical integration models. Payments to providers may vary based on performance against various performance measures. The provider networks may utilize tools for clinical integration or quality improvement, and negotiate collectively for compensation arrangements that recognize their performance. The FTC and the Department of Justice completed lengthy hearings and a public report in 2004. One of the findings of the report is that the agencies would be interested in recognizing initiatives that pursue quality improvement through pay for performance approaches. Again, though, the substantiality of the activity, and the existence of a solid nexus between the initiative's success and the providers' having to jointly negotiate over price, will be critical.

### **MESSENGER MODEL**

Where there no or minimal risk-sharing or inadequate clinical integration or quality improvement activity, a physician network has the option of using the so-called "messenger model" to ameliorate risk of "price-fixing" problems. Under the messenger model, a network entity works out the basic content of a managed care contract, but does not negotiate or agree to price or price-related terms of

dealing.<sup>5</sup> That decision is left to individual providers, to be effectuated through any number of contracting models.

DOJ has stated that a “properly implemented third-party messenger system, with adequate safeguards against collusion, should not lead to a messenger’s negotiating on behalf of competing independent physicians or enhance the bargaining leverage of such physicians.” A proper messenger model arrangement can “facilitate the contracting process, reduce transaction costs, and thus ultimately benefit consumers.” See *U.S. v. Federation of Physicians and Dentists, Inc.*, Civ. A. No. 98-475 (D. Del. Aug. 12, 1998) (complaint).

The FTC and DOJ Multiprovider Network Enforcement Policy Statement discusses the messenger model as follows (at pp. 125-27):

Messenger models can be organized and operate in a variety of ways. For example, network providers may use an agent or third party to convey to purchasers information obtained individually from the providers about the prices or price-related terms that the providers are willing to accept. In some cases, the agent may convey to the providers all contract offers made by purchasers, and each provider then makes an

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<sup>5</sup> The network should be able to negotiate non-price and non-price related terms of a contract, unless the network poses a danger of exercise of market power in working out those terms. Cf. FTC and DOJ Statement of Enforcement Policy on Providers’ Collective Provision of Non-Fee-Related Information to Purchasers of Health Care Services (at 42)(“Providers who collectively threaten to or actually refuse to deal with a purchaser because they object to the purchaser’s administrative, clinical, or other terms governing the provision of services run a substantial antitrust risk.”) Note that an agreement on what some might consider to be a “non-price” term could be considered a “price” agreement in antitrust parlance, risking per se condemnation. See Catalano, Inc. v. Target Sales, Inc., 446 U.S. 643 (1980)(per se price fixing rule applies to agreement among competitors to require advance or cash payment, and not to permit short term credit).

independent, unilateral decision to accept or reject the contract offers. In others, the agent may have received from individual providers some authority to accept contract offers on their behalf. The agent also may help providers understand the contracts offered, for example by providing objective or empirical information about the terms of an offer (such as a comparison of the offered terms to other contracts agreed to by network participants).

The key issue in any messenger model arrangement is whether the arrangement creates or facilitates an agreement among competitors on prices or price-related terms. Determining whether there is such an agreement is a question of fact in each case. The Agencies will examine whether the agent facilitates collective decision-making by network providers, rather than independent, unilateral, decisions. In particular, the Agencies will examine whether the agent coordinates the providers' responses to a particular proposal, disseminates to network providers the views or intentions of other network providers as to the proposal, expresses an opinion on the terms offered, collectively negotiates for the providers, or decides whether or not to convey an offer based on the agent's judgment about the attractiveness of the prices or price-related terms. If the agent engages in such activities, the arrangement may amount to a per se illegal price-fixing agreement.

Specific models for messenger model operation recognized in the policy statements are:

-- Messenger conveys payor's proposed price terms to network providers for their acceptance or rejection – contract could provide that provider will be deemed to have accepted or to have rejected if no response within specified time, or could require signature on terms.

-- Messenger uses “single signature” authority to “lock in” providers to payor contracts where price terms fall within price parameters individual providers have communicated to network – known sometimes as “accelerated messenger model” or “black box”. While the policy statements do not squarely address the possibility, there also appears to be room for an arrangement that lets the messenger make a judgment whether proposed price terms are substantially within parameters set by the provider in his or her private submission, for

example, if provider has set out fees for ten common procedure codes and payor price schedule is within range for nine out of ten.<sup>6</sup>

-- The network organization may properly help providers understand the contracts offered, for example by providing objective or empirical information about the terms of an offer, including a comparison of the offered terms to other contracts in the marketplace.

-- Messenger simply informs payors of individual price information provided by member providers. Messenger does not contract with payor.

On September 23, 2003, the FTC staff issued an advisory opinion approving a messenger model arrangement in California for the Bay Area Preferred Physicians organization. <http://www.ftc.gov/bc/adops/bapp030923.htm>

The arrangement was set up on an advance survey/physician commitment

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<sup>6</sup> This can be contrasted with the allegations in [Memorial Hermann Health Network Providers](#), FTC Dkt. C-4104 (Jan. 13, 2004) (complaint and consent order). Confronting another allegedly “messed up” messenger model, the Commission settled charges that a 3000 physician Houston-area physician organization had improperly negotiated physician pricing and other terms with payors. The FTC alleged that the physician organization polled its members, asking each to disclose the minimum fee he or she would accept in return for providing medical services. This conduct alone is not objectionable. However, the Commission claimed that the organization then calculated minimum acceptable fees for use in payor negotiations based on the results of the poll. The FTC claimed that the physician group told payors that it would not even forward to its physician members any offer that did not satisfy the fee minimums.

model.<sup>7</sup> The guidance letter demonstrates that creativity and a desire to make the messenger model viable may have utility.<sup>8</sup>

Some network organizations and consultants may have missed key limitations on messenger model contracting prior to 1996 and in some instances overreacted to the clarifications and flexibility afforded by the 1996 policy statements giving more explicit recognition to messenger model operations.

Seemingly common adaptations, risking antitrust dangers, have been:

- ◆ Applying “messenger model” label to arrangements where the network organization negotiates price, but then permits individual physician to “opt out”.
- ◆ Applying “messenger model” label where network organization establishes fee schedule as floor for any price proposal to be acceptable for presentation to network participants (Recent case against [North Texas Specialty Physicians](#), FTC Dkt 9312 (Sept. 17, 2003) (complaint) may be an example of this. The complaint outlines alleged transgression of “messenger model” boundaries. For

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<sup>7</sup> The PPO plans to execute and administer a managed care contract if 50 percent or more of its physicians are willing to accept a particular payor's offer based on prior submission of acceptable contract terms by the physicians, or if the payor bears contract administration costs. A payor whose offer would not be accepted by 50 percent of the doctors may elect to approach physicians directly to negotiate individual contracts. In that case, the PPO would provide the payor with the names of the physicians who were willing to accept the contract offer. The staff's approval of this model does not mean that to be an acceptable “messenger model,” a PPO must operate on this particular protocol.

<sup>8</sup> The Department of Justice and Federal Trade Commission Bureau of Competition have each issued business advice letters giving a green light to provider groups seeking to conduct fee surveys. One planned to survey its members' fee schedules and the other prices paid by payors, and both planned to publish the results. They each got favorable guidance, along with warnings to adhere to proper antitrust precautions to avoid boycotts and price fixing risks. Letter to Jerry B. Edmonds (re Washington State Medical Association), Sept. 23, 2002 <http://www.usdoj.gov/atr/public/busreview/200260.htm> and FTC Bureau of Competition Letter to Greg Binford (re PriMed Physicians), Feb. 6, 2003, <http://www.ftc.gov/bc/adops/030206dayton.htm>.

example, FTC claims that the physician organization polls its participating physicians to determine the minimum fee that they would accept for medical services provided pursuant to a network agreement. Once this information is collected, the network then calculates the averages of the reported minimum acceptable fees and reports these measures to its participating physicians, confirming to the participating physicians that these will be the minimum fees that the network will entertain when negotiating any contract with a payor.

- ◆ Applying “messenger model” label to arrangements where network organization says it is not negotiating price with payor, but is actually is.<sup>9</sup> Network entity is hub of price conspiracy.
- ◆ Network contracts with payors on the basis of a fee schedule or reimbursement formula produced by its hired consultant. Where parties to a joint venture could not lawfully agree among themselves on the prices they will charge to contracting payors, it does not solve antitrust issue to delegate decision on fees to "agent." Cartel cannot avoid antitrust risk by assigning price setting function to hireling.
- ◆ Having "network" of providers approve contract, while individual providers must enter into separate contracts. If panel of individual physicians have effective voting rights to veto compensation terms proposed to individual doctors, price fixing risks can be significant. See Glen Eden Hospital v. Blue Cross and Blue Shield of Michigan, 740 F.2d 423 (6th Cir. 1984).

## **PHO's TOO**

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<sup>9</sup> See U.S. v. Federation of Physicians and Dentists, Inc., No. 98-475 (D.Del. Aug. 12, 1998) (complaint alleging that “union” fostered price collusion and concerted refusal to deal); United States v. Federation of Certified Surgeons and Specialists, Inc., and Pershing Yoakley & Associates, Case No. 99-167-CIV-T-17F (M.D. Fla. Jan. 26, 1999)(consent agreement against physician organization and consulting firm); See United States v. Massachusetts Allergy Society, Inc., 1992-1 Trade Cas. (CCH) ¶ 69,846 (D.Mass. 1992); United States v. Burgstiner, 1991-1 Trade Cas. (CCH) ¶ 69,422 (S.D.Ga. 1991) (consent agreement settling charge that obstetrician/ gynecologists, among other things, reached mutual understanding as to range of fees they would submit to purchasing organization).

It is important to recognize that these concerns apply not only to physician-only organizations and hospital-only organizations, but also to combined physician-hospital entities, such as PHOs. In [South Georgia Health Partners, LLC](#), FTC Dkt. C-4100 (Nov. 4, 2003), the FTC settled charges that a large “super-PHO” and its five owner PHOs and three physician organizations had joined together to improperly negotiate for 15 hospitals and approximately 500 physicians.

Some years ago already, the DOJ settled two separate investigations of physician-hospital joint ventures, one in Danbury, Connecticut, and the other in Buchanan County, Missouri. [U.S. v. HealthCare Partners, Inc.](#), No. 395-CV-01946RNC (D. Conn. 9/13/95); [U.S. v. Health Choice of Northwest Missouri, Inc.](#), No. 95-6171-CVSJ6 (W.D. Mo. 9/13/95). DOJ alleged that both PHOs had a high percentage of physicians as members (98% of physicians on the staff of the Danbury hospital and 85% of physicians practicing in Buchanan County), and required all managed care contracting by member physicians to be through the PHO. Because of their alleged market power, they were able to require higher fee schedules and more liberal utilization review policies from managed care organizations, without sharing any meaningful risk associated with higher utilization, DOJ claimed.

DOJ entered into consent decrees with both PHOs. Orders prohibited them from, among other things, discouraging physicians from contracting with payors, obtaining rights of first refusal from providers for contracting with payors, and disclosing commercially sensitive information about one physician to any

other physician except in limited circumstances. In the Danbury settlement, the order barred physicians from owning an interest in any organization that sets, negotiates, or expresses views on competitive terms and conditions for competing physicians. Limited exceptions were included for bona fide integrated delivery system joint ventures, which would need to include risk sharing features. If physician participation is to surpass specified levels, then certain physicians would have to be contracting providers without being members of the joint venture entity itself, in an arrangement that preserved the entity's incentive to bargain hard with the additional contracting providers.

Also, the agencies have also focused their attention on hospitals that participated in improper collusion – sometimes with other hospitals, and in other instances by joining in and facilitating price fixing activities by their medical staff physicians. This can be a risk in PHO programs. See, e.g.. So, for example, where a hospital has some measure of clout in its local market, and it establishes a policy that it will not contract with HMOs other than through an affiliated PHO, it may be throwing its weight behind the efforts of staff physicians to engage in cartel-type behavior. In [Tenet Healthcare Corporation and Frye Regional Medical Center, Inc.](#), FTC Dkt. C-4106 (Feb. 3, 2004) (complaint and consent order) and [Piedmont Health Alliance](#), FTC Dkt. 9314 (Dec. 23, 2003) (complaint), the Commission charges addressed the Frye hospital and its parent Tenet. The case represented the first time the FTC named a hospital as a participant in an alleged physician price-fixing conspiracy. The complaint

alleged that the hospital played a central role setting up and facilitating price fixing activities by a hospital-physician organization in a four county area in North Carolina.

In [Maine Health Alliance](#), FTC Dkt. C-4095 (Aug. 27, 2003), the Commission settled charges with a network of doctors and hospitals in northeast Maine, barring the organization from negotiating jointly on behalf of its members with third-party payors. The case, which also included charges against the organization's executive director, was the first brought by the FTC involving charges that a provider organization engaged in price-fixing and other anticompetitive collusive conduct in the provision of hospital services.

### **WHOSE IDEA WAS THIS ANYWAY?**

The FTC and DOJ have been increasingly inclined to sue not only provider organizations that have violated the law, but also consultants or negotiating agents who have advised or represented the providers. See, e.g., [Physician Network Consulting, L.L.C.](#), FTC Dkt. C-4094 (Aug. 27, 2003).