

**JOINT CONTRACTING
OPPORTUNITIES INCLUDING AN
OVERVIEW OF
GROUP INTEGRATION AND**

PREPARED FOR

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PHYSICIANS' ORGANIZATION OF WESTERN MICHIGAN



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BIOGRAPHICAL STATEMENT

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GENERAL OVERVIEW

The principal federal statutes that apply to physician networks are the Sherman Act §§ 1 and 2, the Clayton Act § 7, and the Federal Trade Commission (“FTC”) Act § 5. Section 1 of the Sherman Act prohibits contracts, combinations, and conspiracies in restraint of trade. Examples of conduct that could violate Sherman § 1 are:

1. Agreements to fix prices;
2. Agreements to allocate markets or customers;
3. Agreements to engage in group boycotts; and
4. Refusals to deal.

Section 2 of the Sherman Act prohibits:

1. Monopolization;
2. Attempts to monopolize; and
3. Conspiracies to monopolize.

Sources of Guidance to Counsel for Physicians

Case law and FTC decisions, which apply the antitrust laws to physician action through medical societies and physician controlled provider networks are relatively few. Federal enforcement agencies have chosen a number of nonlitigation alternatives to try to shape antitrust policy. Among these are policy statements, consent decrees and business review/advisory opinions. Although these agency approaches to enforcement policy represent the views of the DOJ and FTC, they do not represent the extent to which the courts may apply the federal antitrust laws to physician activities through medical societies and physician controlled provider networks. Because investigations are fact intensive and the consequences of a violation severe, the costs of responding to an investigation, even if the end result is a settlement or a successful defense, can be huge. Therefore, following the guidance provided by the DOJ and FTC is a prudent course to take to minimize the risk of investigation by either agency.

1996 Joint Policy Statements

Perhaps the most important guidance in this area is the joint DOJ and FTC Statements of Antitrust Enforcement Policy in Health Care (the “Policy Statements”) that contain nine policy statements that outline the framework under which the agencies will analyze particular transactions or issues and define safety zones within which transactions or activities will not be challenged by the agencies.

The agencies will also provide antitrust guidance regarding specific proposed conduct through the DOJ business review procedures or the FTC’s advisory opinion process. A business review letter or advisory opinion is prospective, applying only to proposed conduct, not to existing behavior. Thus, the time to ask for one is before engaging in proposed conduct. Either agency may decline to give an opinion and may rescind or revoke an opinion already given. However, if an issued opinion remains in effect, the agencies will not take action against conduct that conforms to the opinion. In the

Policy Statements, the agencies commit to responding to requests for business review or advisory opinions within 90 days from receipt of all information regarding formation of physician joint venture networks (120 days for multi-provider networks). Receipt of one of these opinions provides assurance that a proposed course of conduct will not be challenged. This assurance is particularly valuable if the proposed activity does not clearly fit within one of the Policy Statement's safe zones. Since a March 2002 agreement between the FTC and DOJ, the FTC has the primary responsibility for such healthcare guidance.

Unreasonable Restraint of Trade

There are two basic standards applied to conduct when determining if the conduct unreasonably restrains trade in violation of Sherman Act § 1 - the per se rule and the rule of reason. Courts have found concerted action to be unreasonable per se if it involves:

- (a) Horizontal price fixing (*i.e.*, an agreement among competitors regarding the prices they will charge for their products or services);
- (b) Market division or customer allocation (*i.e.*, an agreement among competitors to allocate among them the geographic or demographic markets in which they will sell their products and services); or
- (c) Group boycotts (*i.e.*, an agreement among competitors not to deal with certain customers or potential customers for the products or services they offer).

An example of the last item would be a situation in which all the doctors in a community refuse to sign contracts with a particular commercial health insurance plan. Conduct that does not fall within a category considered per se unlawful is analyzed under the rule of reason, which requires a balancing of the reduction in competition from the challenged conduct with the competitive benefits flowing from it. Often, this requires a lengthy analysis of the relevant product or service and geographic markets to determine the pro- and anti-competitive effects of a particular conduct.

Application of Sherman Act Section 1 Analysis to Networks

To reduce the imbalance in bargaining power between physicians and insurers, the following have been discussed:

- (a) The maximum prices the physicians will charge;
- (b) The copayment amounts they will charge;
- (c) Whether to grant discounts;
- (d) Whether to participate in a health plan if its physician fee schedule is not increased;

- (e) Whether to adopt and issue to medical society members an advisory fee schedule;
- (f) Whether to formulate and distribute to medical society members a relative value scale and/or a conversion factor or factors to convert the scale to a fee schedule; and
- (g) Whether to appoint an agent to negotiate with commercial health plans on behalf of medical society members.

The question is when do such activities become unlawful price fixing, market allocation or group boycott activities, which are per se unlawful. First, if the conduct amounts to a “naked” agreement to fix prices, allocate markets, or boycott a payer or payers, then it is per se unlawful. Such an agreement is naked if it is unrelated to the parties economically integrating their business functions to achieve efficiencies in the joint marketing of their services, but instead was created to affect the prices that the physicians

The Supreme Court employed this analysis to conclude that the Maricopa County Medical Society suggested maximum prices was a per se price fixing arrangement in violation of Sherman Act § 1. Advisory fee schedules have been upheld by some courts absent a showing of an understanding among competing providers to use them, but stricken as per se violations in other cases that concluded that the understanding to use them may be inferred from the circumstances. Both the FTC and the DOJ have challenged the formulation and dissemination of relative-value scales by physician groups. The agencies’ concern is that publication of the relative-value scales by provider groups to their members would facilitate price fixing agreements among members of the groups.

Where discussions among physician groups have led to refusals to participate in commercial health plans unless reimbursement demands or goals of the physicians are met, courts have found per se unlawful group boycotts. It is unclear, however, where courts will draw the line when an IPA provides information to a commercial health plan about fees or other matters, if the element of an obvious refusal to deal except on those terms is absent.

Three of the nine 1996 Policy Statements focus on the agencies’ views of when provider information sharing is “safe” and when it risks violating the antitrust laws. Statement 4 discusses Providers’ Collective Provision of Non-Fee-Related Information to Purchasers of Health Care Services; Statement 5 discusses Providers’ Collective Provision of Fee-Related Information to Purchasers of Health Care Services; and Statement 6 discusses Provider Participation in Exchanges of Price and Cost Information. The safety zone for non-fee-related information is fairly broad and protects collective provision of underlying medical data that may improve a health plan’s resolution of issues about the mode, quality or efficiency of treatment. One example is outcome data provided by network physicians that are used by the medical society to recommend that a health plan cover a particular procedure. The Policy Statement warns, however, against attempts to coerce health plan decision-making on these non-fee-related terms through implied threats of group boycotts.

The safety zones for fee-related information sharing with purchasers of healthcare services and for physician participation in price and cost surveys that are shared among survey participants require the following three standards be met: (a) the collection of the information should be managed by a third party; (b) any information available to the physician members of the medical society or group must be more than three months old; and (c) there must be at least five providers reporting data for each statistic that is published to the membership, no more than 25% of any statistic may be represented by a single provider's data, and the data published to the physician members must be aggregated to prevent participants from identifying the prices charged by any individual physician or medical group.

Physician-Controlled Provider Networks

Some IPAs have been investigated as shams, triggering per se rule violations of Sherman Act Section 1 because they operated simply to keep prices high. But, if an IPA is economically or clinically integrated, its agreements on price and other significant terms for participating physicians will be analyzed under the rule of reason. If a network is not economically or clinically integrated, then it must use a messenger as a conduit between the physicians and the health plans to discuss price and other competitively significant terms.

Economic Integration

Economic integration is found where physicians and other providers participating in the network share the risk of costs from overuse of network services by individuals who are covered by the health plans with which the network contracts. The Policy Statements describe the following five types of procompetitive risk sharing:

1. Capitated contracts between the network and the health plans;
2. Where the network creates significant financial incentives for its providers to meet cost containment goals;
3. Where provider reimbursement is based on a percentage of health plan premiums or revenues;
4. Where overall cost or utilization goals are established and subsequent financial rewards or penalties apply to those goals; and
5. Where the network has global or all inclusive case rates.

Substantial Clinical Integration

The Policy Statements indicate that substantial clinical integration consists of an ongoing program to evaluate and modify the practice patterns of network participants to create a high degree of interdependence and cooperation among them. According to the Policy Statements, such a program may include:

- (i) Establishing mechanisms to manage utilization and to control costs and ensure quality;
- (ii) Selectively choosing network participants who are likely to further efficiency objectives; and
- (iii) Investments in resources needed to realize the network's efficiencies.

Substantial clinical integration permits networks to negotiate fee-for-service reimbursement and other nonrisk-sharing pricing arrangements without fear of a per se violation of Sherman Act Section 1.

Messenger Model Operations

Another alternative to financial and clinical integration is for a physician controlled provider network to use a messenger mode approach to contracts with health plans. The Policy Statements specifically recommend use of this approach and have established guidelines for its implementation. In the messenger model approach, an independent third party "messenger" serves as a conduit for communications between the network physicians and the health plans with whom they wish to contract. To avoid price fixing concerns, the messenger must not communicate information among the physicians in the network. The messenger's role is strictly limited to communications between the payers and individual physicians who participate in the network. Further, the messenger must refrain from negotiating on behalf of the network physicians. Each physician or medical group must decide on their own whether or not to agree to the health plan terms and conditions communicated by the messenger.

The FTC has aggressively pursued price-fixing cases, challenging the use of messengers in negotiations by physician networks that also lacked financial and clinical integration sufficient to permit joint negotiations regarding price and other competitive terms. From 2002 until the present time, there have been more than a dozen consent decrees. A number of common elements appear in most of the consent agreements such as:

- (i) Little clinical or financial integration among the physicians;
- (ii) The messenger's refusal to communicate to the physicians offers deemed insufficient;
- (iii) The messenger's substantive involvement in evaluating the offers;
- (iv) A pattern of offering participating physicians an opportunity to "opt in or out" of the agreement once it was negotiated; and
- (v) Participating physician ownership or control of the network that retained the messenger.

On November 29, 2005, the FTC issued an opinion finding that an IPA engaged in unlawful horizontal price-fixing.

Background

The North Texas Specialty Physicians Corporation (“NTSP”) is an IPA with approximately 500 members in 26 medical specialties. NTSP’s physicians practice primarily in Tarrant County, Texas, surrounding the City of Fort Worth. Many members of NTSP compete with one another.

NTSP’s physicians executed a participation agreement (the “Agreement”) granting NTSP the right to receive all payor offers on behalf of its members, and requiring physicians to forward all offers received individually to NTSP. NTSP also received a right of first negotiation with payors that wished to contract with its physicians. Under the Agreement physicians could not individually entertain payor offers until NTSP had permanently discontinued negotiations with that payor. NTSP agreed to forward all economic provisions of any non-risk offer to its members promptly. If more than 50% of NTSP’s members accepted those economic terms, the Agreement empowered NTSP to negotiate the final contract with the payor. NTSP maintained powers of attorney for its physicians to conduct such negotiations

NTSP periodically polled its members to determine minimum reimbursement rates its physicians would accept under fee-for-service HMO or PPO agreements. NTSP then calculated the mean, median, and mode of the minimum acceptable fees, using these calculations to establish minimum contract prices. NTSP reported these calculations to its members. In its polling form, NTSP expressly stated that it “utilizes these minimums when negotiating managed care contracts on behalf of its participants.”

The vast majority of contracts negotiated by NTSP were non-risk contracts. NTSP acknowledged that risk contracting “is a small part of the business.” Indeed, NTSP had only one risk contract outstanding, with roughly one-half of its physicians participating thereunder. Thus, the majority of NTSP’s activities related to non-risk contracting.

Through the administrative trial, the ALJ adduced a number of key facts illuminating NTSP’s conduct relating to NTSP’s market restraints:

Despite the requirements in the Agreement, NTSP actually messengered only those non-risk contract proposals in which reimbursement fees exceeded NTSP’s minimum reimbursement schedule based upon its poll of members.

NTSP notified payors that it would not forward offers that did not satisfy its minimum price.

NTSP actively encouraged its members to reject offers less than the minimum fees developed through the poll.

NTSP furnished members with a sample letter refusing contract assignment and directing payors to negotiate with NTSP as their agent.

NTSP terminated or threatened to terminate its contracts with several payors, including United Healthcare, CIGNA, and Aetna.

NTSP claimed in a letter to its members that it achieved a victory over United Health Care after it lobbied the City of Fort Worth and terminated a group contract with United.

NTSP sent Aetna 180 physicians' powers of attorney appointing NTSP as their bargaining agent for any direct contracting with Aetna.

NTSP described itself as a "gorilla network" with 124 PCPs and 528 specialists.

NTSP cautioned members not to undermine its pricing consensus in letters to the members.

NTSP warned its physicians in writing that its fees would decline unless "NTSP or someone can provide a unifying voice for physicians."

NTSP was not financially integrated.

NTSP acknowledged that its contracting minimums were not necessary for NTSP to achieve clinical integration, but rather clinical integration was necessary to justify the minimums that the members authorized NTSR to negotiate.

On review of the ALJ Decision, the FTC determined that these facts, in addition to the terms of the Agreement, demonstrated that NTSP fixed prices and enforced its price structure in restraint of trade.

The Challenged Restraints

In its Opinion, the FTC challenged NTSP's use of a fee schedule to set prices for non-risk managed care payor contracts, and its enforcement of its fee schedule through refusals to deal and contract termination on behalf of NTSP's members. The FTC findings include:

- * An agreement to fix prices existed among NTSP's members although there was no evidence of any direct communication between and among the members although there was no evidence of any direct communications between and among the members.
- * An agreement among physicians to fix prices can exist without a finding that the competing physicians agreed directly with each other. Rather, the IPA itself acts as the physicians' collective agent, through which the physicians exert the bargaining leverage of their total numbers through a classic "hub-and-spoke" conspiracy theory.
- * Because NTSP was controlled by competing physicians, and because NTSP negotiated prices for services that the members would provide, the FTC held that NTSP's conduct was that of a conspiracy or combination of its members, rather than

unilateral action of NTSP itself.

- * Even if NTSP failed to obtain its desired price, the starting point in fee negotiations was set artificially high by use of a collectively developed minimum schedule. Consequently, payors were required to begin negotiations at a higher level than they would have absent the collective bargaining.
- * The use of a minimum fee schedule, coupled with NTSP's right of first negotiation under the Agreement, hindered payors' ability to contract directly with physicians.
- * Because NTSP communicated the results of its fee polls back to its members, the polls were a means for physicians to communicate indirectly to their competitors what they would like to obtain for their services in the future, and not what they had received for their services in the past or what they might settle for individually. The FTC viewed the poll as the physicians "cast[ing] a vote on the desired minimum price" that NTSP would charge for all physician services, and by doing so the physicians were "telegraphing their intentions about future prices."

NTSP argued that the polls did not further a conspiracy to fix prices because each physician in its group had the individual right to opt out of the contract, and was not bound to his or her poll response. Indeed, NTSP observed that the poll did not require physicians to act at all. Notably, only 34% of NTSP's physicians responded to the poll, and NTSP's actions with regard to poll results were non-binding on any individual physician.

Despite the low participation rate, the FTC held that NTSP's communication of poll results to all members influenced each physician's decisions regarding contracts, regardless whether they participated in the poll. The FTC noted that the challenged restraints were not dependent upon whether the physicians discussed price among one another, but rather that NTSP negotiated fees on their collective behalf. As noted above, the hub-and-spoke conspiracy does not require physicians to speak to one another about the prices they will charge, because they all speak to a common agent who negotiates on their collective behalf.

Although NTSP purported to operate a messenger model network, the FTC found that NTSP's approach deviated from the permissible conduct of a true messenger. For example, Healthcare Statement 9c condemns a messenger's refusal to forward contracts to its members based on price. Although a messenger can charge a payor an administrative fee to messenger offers that fall below the majority of its members' minimum acceptable fees, NTSP refused to messenger those contracts at all. Moreover, NTSP's minimum price was not based upon an acceptable standing offer messenger model, but rather upon a fee schedule developed by collectively bargaining competitors. As the FTC noted, the antitrust laws would permit NTSP to gather minimum fees and to communicate information regarding those fees to payors, but would not allow the messenger to share such survey results with its members.

The FTC concluded that NTSP was able to exert collective bargaining power and fix prices because it did not messenger contracts below its minimum price requirements. Instead, NTSP rejected those contracts outright on behalf of all physicians in NTSP,

exerting its negotiation leverage before any individual physician had the right to opt in or opt out of an offer.

The FTC noted that NTSP's conduct would not be deemed anticompetitive if the "integrated venture were likely to enhance efficiencies," and the network's conduct was reasonably related to the overall agreement and reasonably necessary to achieve the noted efficiencies. To reach this conclusion, the FTC needed to go beyond the per se label and make some initial inquiries about whether there was integration, the likely effects of the integration, and the reasonableness of the specific restraints in this case.

The FTC also noted that it has taken a position to encourage healthcare providers to engage in efficiency-enhancing collaborative activity. Referencing the FTC's advisory opinion in the MedSouth matter, the FTC noted that "we do not want to chill consideration of this activity by use of terminology that could be misunderstood."

The FTC found that NTSP's restraints constituted unlawful horizontal price-fixing. The FTC cited not only the collective agreement on a minimum fee, but also the specific enforcement of the participation agreement through powers of attorney and collective withdrawal from payor networks to coerce agreement from payors. According to the FTC, "this is not really a close case." The FTC stated that the conduct NTSP exhibited was not significantly different from that it has seen in many other cases it has decided in recent years. Given the complete record in this case, however, the FTC found it worthwhile of a more complete analysis as an opportunity to provide guidance to the industry.

If you have any questions about the issues raised in this Article, please contact Mr. Christopherson at christopherson@ddc-law.com or 231-929-0500.

The opinions expressed in these materials are intended for general guidance only. They are not intended as recommendations for specific situations. The laws, rules, regulations and statutes are subject to change. As always, please consult a qualified attorney for specific legal guidance.