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Price-Fixing and Provider Networks

The Federal Trade Commission ("FTC") has filed numerous price-fixing complaints since the mid-1990s against physician networks operating as independent physician associations or physician/hospital organizations (together, "Networks") that contract with managed care payors. The FTC's complaints are based on the joint pricing of competing physicians' services by the Networks. The Networks' lack of financial or clinical integration among otherwise competing physicians was alleged to constitute per se price-fixing under the Sherman Act §1. Most of the Networks challenged by the FTC established minimum fee schedules for the negotiation of physicians' services with the payors. The Networks did not employ or at least fully satisfy the FTC's requirements for the so-called "Messenger Model." The FTC's enforcement actions routinely resulted in Consent Decrees with the Networks that prevent the Networks from using minimum fee schedules, negotiating on behalf the physician, and boycotting payors.

In the Matter of North Texas Specialty Physicians

The FTC was able to avoid contested hearings in each of these physician price-fixing cases until it brought an action against North Texas Specialty Physicians ("NTSP"). *In the Matter of North Texas Specialty Physicians* was filed by the FTC alleging that NTSP was:

- A. *facilitating, negotiating, entering into, and implementing agreements among its Participating physicians on price and other competitively significant terms;*
- B. *refusing or threatening to refuse to deal with payors except on collectively Agreed-upon terms; and*
- C. *Negotiating fees and other competitively significant terms in payor contracts for NTSP's participating physicians and refusing to submit payor offers to Participating physicians unless and until price and other competitively significant terms conforming to NTSP's contract standards have been negotiated.*

Since price-fixing may be punished by either or both criminal and civil remedies, there has been a natural reluctance on the part of principal players in Networks to challenge the FTC's price-fixing complaints. NTSP refused to agree with the FTC's complaint, and there was a contested hearing before an administrative law judge. The FTC issued its formal decision based on the facts gathered during this hearing. The importance of this ruling is that a full factual public record was available for the first time, and the public record detailed the exact activities that were undertaken by the Network, including in-depth findings of fact and law by the FTC concerning those activities.

The FTC issued a decision on December 1, 2005, finding that NTSP's contracting activities amounted to horizontal price-fixing. The FTC found that the following NTSP activities violated antitrust laws: (1) improper use of a power of attorney to negotiate prices with payors; (2) the refusal to deal with payors where the payor's offer did not reach a level equal to at least 50% of the fees that NTSP's physicians had previously advised NTSP's messenger that they would accept; and (3) NTSP's right of first negotiation with payors.

The FTC did not find NTSP's poll of its physician members regarding minimum prices as violative of the price-fixing proscriptions. The FTC also did not find that the power of attorney received from some of the NTSP physicians allowing NTSP to enter into contracts with payor on the physician's behalf if the payor's offer met the physician's minimum prices constituted a prohibited activity.

However, the FTC did find that the manner in which NTSP used the polling information and the powers of attorney facilitated a price-fixing scheme. The FTC found that NTSP provided the poll data to the NTSP physicians, established minimum fees for payor contracts and advised the physicians that NTSP would not move forward to negotiate with a payor whose offer did not meet the minimum fee. The FTC concluded that there were no efficiency-enhancing features associated with the way that NTSP gathered and disseminated price information. The FTC also found that providing the aggregated poll data to the physicians would encourage higher prices in subsequent years.

The FTC was particularly concerned by the refusal of NTSP to messenger contracts that fell below the minimum fee schedule. The physicians' contracts with NTSP provided that a physician may opt in or out of a contract NTSP messengered, but only the contracts that met the minimum fees of at least 50% of the NTSP Physicians based on the price poll the minimum fee were messengered. The participating physician agreement required a participating physician forward all offers received directly from payors to NTSP for first consideration. The FTC viewed this provision as a right of first negotiation. The FTC found that the refusal of NTSP to messenger contracts below the minimum fee when tied to the right of first negotiation limited payors to an illegal collective negotiation with NTSP.

The FTC found that NTSP's authority to negotiate on behalf of the physicians did not comply with the messenger model as envisioned by the FTC. The FTC found that NTSP did not have sufficient financial or clinical integration to allow NTSP to negotiate for the physicians as to fee-for-service contracts. The FTC references the advisory letter it issued to MedSouth, Inc., as guidance for a Network seeking to achieve clinical integration through use of a resource management program. The MedSouth letter discusses in detail how that organization proposed to create a program to evaluate and modify clinical practice patterns to control cost and to ensure quality through cooperation between the physicians.

Most groups cannot meet the stringent requirements of clinical integration necessary to meet the MedSouth guidance from the FTC. The decline of capitation contracts has further complicated a Network's ability to establish financial integration. By combining these two facts, it is easy to see why failure to follow the messenger model in fee-for-service negotiations by competitors that are not clinically integrated can lead to an expensive FTC investigation. It is important to note that NTSP had one capitated contract and the FTC found that NTSP could negotiate for its physicians' services on a joint basis for that contract. The FTC restated in its findings that the presence of a capitation contract did not excuse the use of minimum fee schedules by the group in negotiations for fee-for-service contracts.

Suburban Health Organization, Inc.

The FTC staff issued an Advisory Letter on March 28, 2006, in the Suburban Health Organization, Inc. (“SHO”) matter. The Advisory Letter discusses the antitrust requirement that a Network not only establish that its clinical integration program will create efficiencies, but that it also establish that the joint pricing of physicians’ services is reasonably necessary to achieve those efficiencies.

The FTC found that while the SHO program “appears to have the potential to improve quality and efficiency” that the program was too limited to justify the joint pricing of the physicians’ services by the Network. The FTC staff also found that the SHO did not establish that the joint pricing of its physicians’ services was reasonably necessary to achieve the limited clinical integration program. There are eight separate Networks included in the SHO Network, and the FTC found that there was no reasonable connection either financially or clinically between the separate Networks to justify the joint pricing for the services of the SHO physicians.

Advocate Health System v. United Healthcare

Another recent decision of note involved Advocate HealthPartners (“Advocate”), a super PHO Network in the Chicago area. Advocate is a part of the Advocate Health System (“System”). Advocate negotiated a capitated contract in 2000 with United Healthcare (“United”) that included both Advocate-employed physicians and Advocate-affiliated physicians. Advocate terminated the contract as to its employed physicians in 2003. United sought to negotiate a new contract individually with the affiliated physicians. Advocate insisted on negotiating a joint contract that contained a common physician fee schedule. Advocate asserted that it was clinically integrated and was therefore able to negotiate and contract on this basis.

The parties did not reach an agreement, and United filed for arbitration under the prior contracts alleging that Advocate’s actions amounted to, among other things, illegal price-fixing. United sought \$256,925,922 in damages.

There are several notable points about United’s action in addition to the super-sized damages it claimed. United used the arbitration clause in the expired contract to allege violations of the antitrust laws. United successfully joined the System, which was not a signatory to the contract but which was the parent entity of the Network hospitals and the physician group that were the signatories to the contract. A Federal District Judge ruled that the System was properly joined in the arbitration even though it was not a signatory to the contract because it was the parent of the provider/physician parties to the contract.

The arbitration was lengthy and expensive. The arbitration panel ruled for Advocate because of the doctrine of *in pari delicto* or “equal responsibility.” Essentially, the arbitration panel found that United and Advocate were of equal bargaining positions, and therefore, both were able to take care of themselves in the negotiation. The panel further agreed that United had previously taken the benefit of the jointly-negotiated prices and could not now object.

The finding of equal responsibility is outlined in a few pages of the arbitration award. The arbitration panel, however, goes on at length to analyze the other claims made by United concerning whether Advocates' network violated antitrust law. The panel found that United had not proven its case as to these theories.

There are several provisos to be considered with regard to the Advocate case, the most important being that the findings in the arbitration are simply those of a private arbitration panel in a private contract dispute. The panel's findings do not constitute case law that has precedential effect on either the courts or the FTC.

The fact that the System itself was brought into the arbitration even though it was not a signatory to the contract is important for hospitals and hospital systems that serve as corporate members of Networks. The Advocate arbitration was extremely expensive. The parent company was forced to defend itself. A corporate member may be joined in a similar arbitration, or even a lawsuit, even though it did not sign the underlying payor contract. Under Texas law, a corporate member is not responsible for the debts of the corporation for which it is a corporate member. This does, however, highlight the importance of paying attention to the so-called "boiler plate" language in contracts. Limitations of the subject matter that may be arbitrated are a way of protecting a Network from arbitration like the one Advocate faced.

The costs associated with an FTC investigation are significant. Provider and physician groups that contract on a joint basis with managed care payors must be particularly mindful of the manner in which negotiations occur. The FTC has shown no reluctance to pursue Networks.

Deciding the appropriate manner in which a Network establishes competitive physicians' prices is difficult because of the complex legal and factual analysis necessary to determine whether the Network is clinically or financially integrated. The reduction in the number of capitated contracts has led to a loss of financial integration for many Networks. Networks should periodically seek a review by knowledgeable antitrust counsel to determine their compliance with antitrust laws.