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# 'Independent Practice,' Collective Enforcement

*Law360, New York (February 14, 2012, 1:55 PM ET)* -- Independent health care providers such as doctors and pharmacists occasionally form independent practice associations (IPAs) to cooperate in providing services to patients. At times, these IPAs attempt to collectively negotiate reimbursement rates with third-party payers. This type of collective negotiation often leads to antitrust enforcement actions.

Since 2001, the Federal Trade Commission (FTC) and the U.S. Department of Justice have brought 36 cases against IPAs, with 35 ending in consent decrees banning future rate negotiation.

In the one remaining case, North Texas Specialty Physicians v. FTC (NTSP), the FTC found, and the U.S. Court of Appeal for the Fifth Circuit affirmed, that collective rate negotiation was illegal under an "inherently suspect" analysis.

Since that decision, the FTC has entered into six consent decrees with IPAs, which treat collective negotiation by IPAs as essentially illegal per se. The FTC's continued tough stance against IPAs provides fertile ground for payers to receive meaningful relief from the FTC if they suspect collective negotiation.

This article surveys NTSP and subsequent consent decrees, highlighting common themes that emerge from these enforcement actions.

## North Texas Specialty Physicians v. FTC Affirms Liability Under an Inherently Suspect Analysis

North Texas Specialty Physicians formed in 1995 to provide contracts with health care payers such as insurance companies and health-maintenance organizations (HMOs ) on a fee-per-patient — often referred to as capitated — basis. Under capitated contracts, the providers promise to treat all of a plan's patients for a per-patient fee, while sharing the risk of profit and loss.

By 2001, however, payers' interest in capitated contracts waned, and NTSP transitioned to negotiating fee-for-service contracts, which do not entail risk sharing among providers. By that time, NTSP had only one capitated contract remaining.

NTSP negotiated nonrisk contracts pursuant to agreements with each of its members. Under these agreements, NTSP "messengered" or relayed payer-reimbursement offers to its members. If half of the membership indicated that it would accept the contract, NTSP negotiated a nonrisk contract on behalf of the membership.

The agreements contemplated that the physicians would negotiate independently only if NTSP did not negotiate collectively — that is, that fewer than half of the member physicians accepted the original terms.

NTSP also polled its members annually, asking the minimum rate that each would accept in a nonrisk contract. It used data from the responses to calculate the mean, median and mode of the minimum-acceptable fees. NTSP published these data to members and used them in its negotiations with payers on behalf of its members.

In an administrative procceding, the FTC charged that NTSP's conduct constituted illegal horizontal price fixing. NTSP defended its practices by arguing that the pro-competitive effects of its single risk contract "spilled over" onto its nonrisk business.

An administrative law judge, and later the full FTC, disagreed and ruled that the nonrisk contracts were illegal under an "inherently suspect" analysis, under which practices that "judicial experience and current economic learning have shown to warrant summary condemnation," are declared illegal unless the defendant can present empirical evidence of procompetitive effects.[1]

The "inherently suspect" analysis is a close cousin of the truncated or "quick look" rule of reason that the FTC has relied upon in courts of appeals with some success since the U.S. Supreme Court questioned its use of the quick-look analysis in California Dental.[2]

The Fifth Circuit affirmed. The court agreed with the FTC's conclusion that an "inherently suspect" analysis was appropriate because "the great likelihood of anti-competitive effects is obivous"[3] when competitors negotiate collectively in a manner that closely resembles horizontal price fixing.[4]

The court then assessed the justifications that NTSP proffered, including its argument that the efficiencies of risk contracts spilled over into its nonrisk business. While the court acknowledged the theoretical possibility of spillover effects, it rejected NTSP's claims as a factual matter because a large number of physicians did not participate in risk contracts and therefore the polling and joint negotiating that NTSP conducted was based in large part on fee-for-service business.[5]

The court also rejected two other justifications that NTSP proffered — that relaying only acceptable contracts saved administrative expenses and that their practices promoted patient health. The court credited these as laudible goals but concluded that they were unrelated to price fixing.[6]

Because NTSP could not justify its "inherently suspect" conduct, the court affirmed the FTC's ruling and largely upheld its remedy that provided for cancellation of all nonrisk contracts with payers and banned NTSP from collectively negotiating on behalf of its members.

Since NTSP, the FTC has continued its aggressive stance against IPA joint negotiation, which resulted in six consent decrees against physicians alone since the Fifth Circuit's decision.[7] A few common themes emerge from these consent decrees and the NTSP case.

## The FTC Treats Collective Negotiations by IPAs as Per Se Illegal

The FTC in NTSP took the position that collective negotiation could be condemned as per se illegal, even though it analyzed the conduct under the marginally more lenient "inherently suspect" standard.[8]

While unlitigated consent decrees may not paint an accurate picture of the state of the law, the decrees that followed NTSP appear to take the more aggressive per se approach.

In Minnesota Rural Health Cooperative (MRHC), for example, the FTC stated that it was per se illegal for a group of physicians and hospitals to jointly negotiate with payers. While the FTC's analysis to aid public comment in that case does cite some evidence of harm to competition — higher rates compared with other regions, more favorable payment methods and increased reimbursements for new members — the thrust of its reasoning is that joint negotiation by itself is illegal.[9]

The justifications that the FTC did address related only to the degree to which the providers had clinically integrated their practices, which it concluded was factually unsupported.

In two other consent decrees, Southwest Health Alliances and Higgins, the FTC declared that its consent decrees were in the public interest because joint negotiation — by an IPA and a director of an IPA respectively — was inherently anti-competitive.

Recent enforcement actions demonstrate that the FTC takes allegations of provider collusion seriously, even when a group is smaller or more dispersed than NTSP. Some of the investigated IPAs were quite small, in fact — Southwest Health Alliances consisted of 84 members in rural Colorado, while the Minnesota Rural Health Cooperative had 70 physician and 25 hospital members.

And because the FTC treats joint negotiation as per se illegal, it follows that none of these enforcement actions considered the market power of the providers or the payers who were affected by the joint negotiation.

## The FTC Maintains High Standards for Clinicial Integration to Avoid Presumed Illegality

IPAs have a narrow opening to escape per se liability for joint negotiation. The FTC and the DOJ's statements of health care antitrust enforcement policy provide that providers can escape per se illegality by clinically integrating in ways that are "likely to produce significant efficiencies that benefit consumers."[10]

According to one observer, the FTC approved two clinically integrated networks between 1996 and 2006, however.[11] NTSP and recent enforcement actions continue this trend.

In NTSP, the FTC and later the Fifth Circuit did not accept the defendants' spillover claim at face value, and instead dug into the details of NTSP's practice to refute it.[12]

Similarly, the FTC disputed MRHC's label of some of its contracts as "risk" contracts because only a small portion of the physician reimbursement in those was withheld to attain care-related goals and the care-improvement work that it conducted consisted of inspections and preventative services that were unrelated to risk sharing.[13]

## The FTC's Remedies Provide Meaningful Relief for Payers

FTC enforcement actions against IPAs contain standard provisions intended to provide quick and meaningful relief for payers that believe they were harmed by collective negotiation.

First, consent decrees routinely prevent the IPA from negotiating future fee-for-service reimbursement rates with payers and from collectively dealing or refusing to deal with payers. Although a prohibition on collective dealing was struck down by the Fifth Circuit in NTSP as "overly broad and internally inconsistent," the FTC continues to insert similar prohibitions in its consent decrees.[14]

Of even greater importance to payers, the FTC's consent orders allow payers to terminate previously collectively negotiated contracts at will and without penalty.[15]

In NTSP, the commission added that the contracts be automatically terminated at their next termination or renewal date, in order to alleviate fears that the group would retaliate against payers who terminated.[16] The Fifth Circuit upheld that provision over NTSP's challenge, accepting the FTC's justification that they were necessary to prevent reprisal.

Finally, in order to guarantee that payers receive notification of the FTC's action, consent decrees typically require that the IPA forward the complaint and judgment to affected payers and member providers.[17]

## Conclusion

The enforcement actions after NTSP clearly indicate that the FTC continues to take seriously and aggressively prosecute charges of collusion among competing health care providers. If a payer runs into difficulty negotiating with individual members of IPAs or otherwise suspects collusion, a complaint to the FTC is likely to be taken seriously and result in effective relief at significantly less burden and expense than a private action.

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[1] F.T.C. v. N. Tex. Specialty Physicians, 2005-2 Trade Cas. (CCH) ¶75,032 at 103 (quoting Polygram Holding, Inc. v. F.T.C., 5 Trade Reg. Rep. (CCH) ¶ 15,453 (F.T.C. 2003)).

[2] N. Texas Specialty Physicians v. F.T.C., 528 F.3d 346, 362 (5th Cir. 2008); Polygram Holding Inc. v. F.T.C., 416 F.3d 29, 36 (D.C. Cir. 2005); But see Realcomp II v. F.T.C., 635 F.3d 815, 826 (6th Cir. 2011) (upholding FTC's judgment under full rule of reason without deciding whether "inherently suspect" analysis is appropriate). The FTC is also arguing that so-called "reverse payment" or "pay-for-delay" pharmaceutical patent settlements are inherently suspect as well. Brief of the Federal Trade Commission as Amicus Curiae Supporting Appellants and Urging Reversal at 22-25, In re K-Dur Antitrust Litig., Nos. 10-2077, -2078, -2079 & - 4571 (3d Cir. May 18, 2011).

[3] N. Tex. Specialty Physicians, 528 F.3d at 362 (quoting Cal. Dental Ass'n v. F.T.C., 526 U.S. 756, 778 (1999)).

[4] Id.

[5] Id. at 368.

[6] Id. at 369-70.

[7] A full list of FTC enforcement actions is available on the FTC's website at www.ftc.gov/bc/caselist/industry/cases/healthcare/HealthCareProfessionals.pdf.

[8] N. Tex. Specialty Physicians, 2005-2 Trade Cas. (CCH) ¶75,032 at 103, 460.

[9] Analysis of Agreement Containing Consent Or. to Aid Public Cmt. at 3-4, In the Matter of Minn. Rural Health Cooperative (No. 051-0199), available at www.ftc.gov/os/caselist/0510199/100618ruralhealthanal.pdf (Jun. 18, 2010).

[10] FTC & Antitrust Division, Dep't of Justice, Statements of Health Care Antitrust Enforcement Policy at 70 (1996).

[11] The Federal Trade Commission, Clinical Integration, and the Organization of Physician Practice, Lawrence P. Casalino University of Chicago Journal of Health Politics, Policy and Law, Vol. 31 No.3 June 2006 Duke University Press.

[12] N. Tex. Specialty Physicians, 528 F.3d at 368-70.

[13] Analysis of Agreement Containing Consent Or. to Aid Public Cmt. at 5-7, In the Matter of Minn. Rural Health Cooperative

[14] See, e.g., Analysis of Agreement Containing Consent Or. to Aid Public Cmt., S.W. Health Alliances, Inc (No. C-4327), at 2-3 (May 10, 2011); Analysis of Agreement Containing Consent Or. to Aid Public Cmt., In the Matter of Roaring Fork Valley Physicians I.P.A., Inc., (No. C-0610172) at 3 (Feb. 4, 2010).

[15] See id.

[16] N. Tex. Specialty Physicians, 528 F.3d at 371-72.

[17] See supra n. 14.