ANALYSIS OF AGREEMENT CONTAINING CONSENT ORDER TO AID PUBLIC COMMENT

***In the Matter of Minnesota Rural Health Cooperative, File No.* 051-0199**

The Federal Trade Commission has accepted, subject to final approval, an agreement containing a proposed consent order with the Minnesota Rural Health Cooperative (MRHC). The proposed consent order has been placed on the public record for 30 days to receive comments from interested persons. Comments received during this period will become part of the public record. After 30 days, the Commission will review the agreement and the comments received and decide whether to withdraw from the agreement or make the proposed order final.

The purpose of this analysis is to facilitate public comment on the proposed order. The analysis is not intended to constitute an official interpretation of the agreement and proposed order or to modify their terms in any way. Further, the proposed order has been entered into for the settlement purposes only and does not constitute an admission by MRHC that it violated the law or that the facts alleged in the complaint (other than jurisdictional facts) are true.

I. The Complaint

The MRHC is a for-profit corporation of physicians and hospitals located in southwestern Minnesota. In addition, between early 2005 and late 2007, the MRHC also had pharmacy members. The complaint charges that the MRHC has violated Section 5 of the Federal Trade Commission Act, 15 U.S.C. § 45, by, among other things, orchestrating and implementing agreements among competing MRHC members to fix the price at which they contract with

A. ***Price fixing for hospital and physician services***

The MRHC has approximately 25 hospital members, which constitute the vast majority of hospitals in the area of southwestern Minnesota in which the MRHC operates. The organization has approximately 70 physician members practicing in 41 clinics, who represent roughly half of the primary care physicians in southwestern Minnesota. The MRHC is controlled by a Board of Directors composed of physicians and hospitals elected by the members.

When providers join MRHC, they agree that MRHC will negotiate and contract with health plans on their behalf and agree to participate in all MRHC contracts. The Board oversees contract negotiations undertaken by a contracting committee of physician and hospital representatives and approves all contracts between MRHC and health plans.

The MRHC has negotiated prices and other competitively significant terms, on behalf of MRHC physician and hospital members, with numerous payers in Minnesota, including Blue Cross Blue Shield of Minnesota, HealthPartners, Medica Health Plans, MultiPlan, Inc., Preferred One, and America's PPO. After its Board of Directors approved, the MRHC entered into and administered each contract.

The MRHC has threatened to terminate these group contracts with payers to pressure them to increase prices for physician and hospital services. For example, during 2003 contract renewal negotiations with HealthPartners, the MRHC notified HealthPartners that it would terminate the contract unless HealthPartners agreed to higher reimbursement rates. HealthPartners acceded to the MRHC's demands, eventually agreeing to pay MRHC physician members 27 percent more than comparable non-MRHC physicians and to pay MRHC hospital members ten percent more than comparable non-MRHC hospitals. A similar tactic forced

Preferred One to pay MRHC members higher rates than it paid comparable non-MRHC providers.

The MRHC informed payers that the MRHC “ex

Co-op relationship all of the clinics and hospitals, except Rice, are being paid higher reimbursement then they were prior to our Medica agreement with the Co-op."

B. Price fixing for pharmacy services

In 2004, after being approached by pharmacies, MRHC expanded its membership to include pharmacies and began recruiting pharmacists for the purpose of collectively negotiating agreements with pharmacy benefit managers (PBMs). The MRHC encouraged pharmacies to join to increase the reimbursement levels they would receive under the new Medicare Part D prescription drug program. Between early 2005 and late 2007, the MRHC had approximately 70 pharmacist members.

The MRHC urged pharmacies not to deal individually with PBMs and instead to act together through MRHC. The MRHC repeatedly reminded pharmacies of the benefits of acting collectively, advising them to "stand together and speak with ONE voice to the PBMs." For example, in letters to members and prospective members, MRHC stated:

- "We have to stand together in this effort or once again the PBMs will intimidate us and pick us off one by one with contracts we don't want."
- "Do NOT sign and return your Medicare Part D PBM contracts. MRHC will review and negotiate these for you during the next few weeks. The contracting deadline is not until later this summer and our best leverage is to take our time to negotiate as a block. The bigger block the better [sic]."
- "We are asking all MRHC members NOT to sign and return their Medicare Part D PBM contracts. MRHC will review and negotiate these for them during the next couple of weeks. Our best leverage is to take our time to negotiate as a block, and the bigger block the better [sic]. . . . Don't sign contracts but notify the PBMs who will act as your agent – the MRHC!"

To "speed up" the PBMs' acceptance of the MRHC as the pharmacies' bargaining agent, the MRHC provided each pharmacy member with pre-printed labels stating that MRHC would

act as the pharmacy's contracting agent. Many member pharmacies followed the MRHC's instructions to return contract offers from PBMs with these labels attached.

The MRHC negotiated with at least eight PBMs over Medicare Part D reimbursement levels and reached agreements on behalf of the MRHC establishing prices and other competitively significant terms with six of them. The MRHC terminated the pharmacist memberships in November 2007 and transferred management of these agreements to a pharmacy services administration organization in early 2008.

C. Lack of justification

Price agreements among competing sellers, as a general rule, are price fixing and are summarily condemned by the antitrust laws as *per se* illegal. But joint price setting by provider networks is not *per se* illegal if: (1) the participants have integrated their activities through the network (whether financially, clinically, or otherwise) in a way that is likely to produce significant efficiencies that benefit consumers; and (2) the price agreements are reasonably necessary to realize those efficiencies. The MRHC's price fixing for hospital, physician, and pharmacy services, however, was unrelated to any efficiency-enhancing integration of its members' clinical services.

1. Hospital and physician services

One form of efficiency-enhancing integration among otherwise competing health care providers involves arrangements in which the participants share with one another substantial financial risk for the services provided through the network. Such risk sharing occurs when mechanisms are in place that make the network providers as a group accountable for the total cost of defined services delivered to a group of covered individuals, so that the providers have incentives to cooperate in controlling costs and improving quality by managing the provision of

services. The *Statements of Antitrust Enforcement Policy in Health Care* issued by the FTC and the Department of Justice provide several examples of types of arrangements through which participants can potentially share substantial financial risk.

MRHC's hospital and physician members have not shared, and do not share, substantial financial risk in the provision of patient care. MRHC considers only three of its contracts with payers to be "risk" contracts, and these contracts pertain only to physician services. Moreover, these contracts do not provide significant financial incentives for members to collaborate to improve the performance of the group as a whole.[1] For example, under two of the three "risk" contracts, the payers withheld a relatively modest portion of the payments owed to participating physicians (typically no more than 10 percent), and return of these sums did not depend on the group meeting cost containment or quality improvement performance targets. Instead, physicians merely had to participate in a quality improvement project in which they reported their compliance with clinical practice guidelines for treatment of a few specific conditions. These arrangements, while perhaps benefitting some physicians' individual delivery of health care, would thus be unlikely to create incentives to motivate MRHC physicians to work together to improve significantly group-wide care to patients. *Health Care Statements* at 68.

Arrangements among competing health care providers that do not involve the sharing of financial risk may also involve integration that has the potential to create significant efficiencies in the provision of health care services. The *Health Care Statements* discuss an example of such integration: a "clinically integrated" program, which involves "an active and ongoing program

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[1] Even if MRHC were financially integrated for some contracts, that fact alone would not justify their jointly negotiating on behalf of their physicians for contracts where there was no financial integration. *See, e.g., North Texas Specialty Physicians v. FTC,* 528 F.3d 346, 368-70 (5th Cir. 2008) (existence of risk contract did not justify physician group's joint price setting for non-risk contracts).

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 ensure quality." *Health Care Statements* at 72-73.

The MRHC has not undertaken any integration regarding its members' provision of services, clinical or otherwise, that might justify its members' jointly negotiated fees with health plans. It verifies the qualifications of its members, conducts patient satisfaction surveys, collects patient complaints, and organizes meetings to discuss quality of care issues. In addition, it has a few programs that relate solely to physicians: quality improvement projects involving diabetes and preventative services and inspections of physician clinics. Although these activities may

regulation can immunize private parties from federal antitrust liability, states may not simply authorize private parties to violate the antitrust laws.[4] Instead, a state must substitute its own control for that of the market. Thus, as the Supreme Court explained in *California Retail Liquor Dealers Assen v. Midcal Aluminum, Inc.*, private parties claiming the protection of the state action doctrine must demonstrate that their challenged conduct was both (1) undertaken pursuant to a clearly articulated state policy to displace competition with regulation and (2) actively supervised by state officials.[5]

First, it is undisputed that state officials did not supervise the MRHC's anticompetitive conduct. Active state supervision requires that state officials "exercise ultimate control over the challenged anticompetitive conduct."[6] A private party must therefore demonstrate that state officials have "exercised sufficient independent judgment and control so that the details of the rates or prices have been established as a product of deliberate state intervention, not simply by agreement among private parties."[7] But, until recently, Minnesota law did not provide for state review and approval of health care provider cooperative contracting.[8] No review or approval of

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[4] *Federal Trade Commission v. Ticor Title Ins. Co.*, 504 U.S.621, 633 (1992) ("a State may not confer antitrust immunity on private persons by fiat"); *Parker v. Brown*, 341 U.S. 351 (1943) ("a state does not give immunity to those who violate the Sherman Act by authorizing them to violate it, or declaring that their action is lawful").

[5] 445 U.S. 97, 105 (1980).

[6] *Patrick v. Burget,* 486 U.S. 94, 100 (1988).

[7] *Ticor,* 504 U.S. at 634-35.

[8] From its inception, the Health Care Cooperative Act has required provider network cooperatives to file contracts with the state health department (*see* Minn. Stat.§ 62R.06), but until the 2009 amendments, the law did not require state officials to review and approve the contracts.

Minn. Laws 2009, c

[13] *Ticor*, 504 U.S. at 634-35; *see also Kentucky Household Good Carriers Assn*, 139 F.T.C. 404, 426 (2005), *aff'd 801(,)Tjd0000 TD(,)Tj6.0000 9*

Although it is too early to assess the state's implementation of the new statute, the Commission believes the circumstances here make it appropriate to defer to Minnesota's expressed intention to actively supervise the contracts that result from the MRHC's price fixing.[14] The Commission has in the past taken a different remedial approach where state officials had authority to actively supervise private conduct but failed to exercise it.[15] Here Minnesota officials have only been recently granted that authority, and it is appropriate to allow them an opportunity to utilize that authority.

As a result, the proposed order does not bar collective price negotiations. At the same time, there is certain anticompetitive activity that the state will not supervise and would not be protected under the state action doctrine and the order prohibits such activity. The key prohibitions in the proposed order are aimed at preventing MRHC from using concerted refusals to deal or other coercive tactics to extract favorable contract terms from payers. This relief is appropriate because the new statute only authorizes the Department of Health to supervise the final contracts, not the negotiating process itself, which is where coercive tactics would occur. Further, the new statute does not authorize the Department of Health to reject a contract on the ground that it is the product of coercion. Thus the order is drafted to protect consumers from coercion by the MRHC. In addition, the proposed order provides a remedy for past conduct by requiring renegotiation of all existing contracts and their submission for state approval consistent with the recently enacted Minnesota statute.

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[14] Engrossed version of SF 203, Section 2, Subdivision 1, (b)(1), *available at* https://www.revisor.mn.gov/laws/?id=97&doctype=chapter&year=2009&type=0.

[15] *See Kentucky Household Good Carriers Assn*, at 26 (order prohibiting collective rate-making to remain in effect until the respondent demonstrates to the Commission that the state has implemented a program of active supervision).

agreement between the MRHC and any of its members that the members refuse to deal individually with the payor whose contract the MRHC rejected, or that the members will only deal with that payor through the MRHC. Additionally, the order does not address any actions taken by any individual MRHC member, acting alone in exercising its business judgment. Thus, for example, the order does not bar any member from unilaterally declining to contract with any payer.

Paragraph III.A requires MRHC to send a copy of the complaint and consent order to its members, its management and staff, and any payers who communicated with MRHC, or with whom MRHC communicated, with regard to any interest in contracting for physician services, at any time since January 1, 2001.

Paragraph III.B requires MRHC to terminate, without penalty, pre-existing payer contracts that it had entered into since 2001, at the earlier of (1) receipt by MRHC of a written request for termination by the payer; or (2) the termination date, renewal date, or anniversary date of the contract. This provision is intended to eliminate the effects of MRHC's past alleged illegal collective behavior. The payer can delay the termination for up to one year by making a written request to MRHC.

Paragraph III.D contains notification provisions relating to future contact with members, payers, management and staff. For three years after the date on which the consent order becomes final, MRHC is required to distribute a copy of the complaint and consent order to each member who begins participating in MRHC; each payer who contacts MRHC regarding the provision of member services; and each person who becomes an officer, director, manager, or employee. In addition, Paragraph III.D requires MRHC to publish a copy of

the complaint and consent order, annually for three years, in any official publication that it sends to its participating members.

Paragraphs IV, V, and VI impose various obligations on MRHC to report or provide access to information to the Commission to facilitate the monitoring of compliance with the order.

Finally, Paragraph VII provides that the proposed order will expire in 20 years.