051 0199

UNITED STATES OF AMERICA
BEFORE FEDERAL TRADE COMMISSION

COMMISSIONERS: **Jon Leibowitz, Chairman**
William E. Kovacic
J. Thomas Rosch
Edith Ramirez
Julie Brill

In the Matter of	)	
Minnesota Rural Health Cooperative, a corporation.	)	**DOCKET NO. C-4311**

COMPLAINT

Pursuant to the provisions of the Federal Trade Commission Act, as amended, 15 U.S.C. § 41, *et seq.*, and by virtue of the authority vested in it by said Act, the Federal Trade Commission ("Commission"), having reason to believe that Respondent Minnesota Rural Health Cooperative ("MRHC") violated Section 5 of the Federal Trade Commission Act, 15 U.S.C. § 45, and it appearing to the Commission that a proceeding by it in respect thereof would be in the public interest, hereby issues this Complaint, stating its charges in that respect as follows:

I. NATURE OF THE CASE

1. This matter concerns agreements among competing hospitals, physicians, and pharmacies in rural Minnesota to fix prices and collectively negotiate contracts, including price terms, with health insurers and other third-party payers in Minnesota. The hospitals, physicians, and pharmacies orchestrated these agreements through the MRHC. The MRHC, originally composed of hospitals and physicians, has fixed prices of hospital and physician services since 1996. After the Congress enacted the Medicare prescription drug program in 2003, the MRHC recruited pharmacies as members and began to negotiate prices collectively on their behalf. The MRHC has not undertaken any efficiency-enhancing integration that could justify the challenged conduct. By collectively negotiating prices without any legitimate justification, the MRHC has engaged in unfair methods of competition.

II. RESPONDENTS AND JURISDICTION

A. Respondent

2. The Minnesota Rural Health Cooperative is a for-profit corporation that is organized, exists, and does business as a health provider cooperative under and by virtue of the laws of the State of Minnesota with its principal address at 190 E. 4th Street N., PO Box 155, Cottonwood, MN 56229-9902.

3. The MRHC has approximately 22 hospital members and 114 physician members, who practice in approximately 47 clinics. During the relevant time period, the hospital members included most of the hospitals, with two-thirds of hospital beds, in the area of southwestern Minnesota in which the MRHC operates.

4. Between early 2005 and late 2007, the MRHC had approximately 70 pharmacist members. These pharmacists operated in rural Minnesota, outside of the Minneapolis-St. Paul area. The MRHC terminated these pharmacist memberships in November 2007.

B. Jurisdiction

5. The MRHC is a corporation within the meaning of Section 4 of the Federal Trade Commission Act.

6. At all times relevant to the Complaint, the MRHC has been engaged in the business of contracting with payers, on behalf of its members, for the provision of physician, hospital, and pharmacy services to persons for a fee. Except to the extent that competition has been restrained as alleged herein, MRHC's physician, hospital, and pharmacy members have been in competition with one another for the provision of physician, hospital, or pharmacy services.

7. The general business practices of the MRHC, including the acts and practices alleged herein, affect the interstate movement of patients, the interstate purchase of supplies and products, and the interstate flow of funds, and are in or affect "commerce" as defined in Section 4 of the Federal Trade Commission Act.

III. OVERVIEW OF HEALTH CARE PROVIDER CONTRACTING

A. Nature of Provider Contracting

8. Physicians, hospitals, and pharmacists often contract with third-party payers — including health insurers and managed care organizations — to establish the terms and conditions, including price and other competitively significant terms, under which they will provide services to subscribers of health plans. To negotiate for pharmacy services, payers often use pharmacy benefit managers (PBMs) to create networks of pharmacies and administer pharmacy benefit programs.

9. Physicians, hospitals, and pharmacists entering into payer contracts often agree to discount or lower their prices in exchange for access to additional patients made available by the payers' relationship with their subscribers. These contracts with physicians, hospitals, and pharmacies may reduce payers' costs and enable payers to lower the price of health insurance and reduce patients' out-of-pocket medical care expenditures.

10. Absent agreements among physicians, hospitals, or pharmacists on prices and other contract terms on which they will provide services to subscribers of health plans, competing physicians, competing hospitals, and competing pharmacists decide individually whether to enter into contracts with payers, and at what prices they will accept payment for services rendered pursuant to such contracts.

11. To be competitively marketable in southwestern Minnesota, a payer's health plan must include in its provider network a large number of primary care physicians and hospitals at accessible locations and at affordable prices. Because so many physicians and hospitals in southwestern Minnesota are MRHC members, any payer doing business there cannot offer competitive health plans serving patients without having at least a substantial portion of MRHC members in its provider network.

B. The Medicare Part D Program

12. Medicare is the federal government health insurance program for senior citizens. In 2003, Congress created the Medicare Part D program to provide coverage for prescription drugs. In establishing the Medicare Part D program, Congress decided to rely on competing third-party payers to provide pharmacy benefits for senior citizens, rather than having the federal government run the program directly.

13. To participate in the Medicare Part D program, a third-party payer must submit a network of pharmacies willing to dispense pharmaceuticals to its Part D clients. Each pharmacy network must contain enough pharmacies to meet a specified level of access for beneficiaries, depending on their urban, suburban, or rural location. For example, the access standard applicable to rural areas requires each network to include enough pharmacies so that 70 percent of rural beneficiaries live no more than 15 miles from at least one participating pharmacy.

14. The need to satisfy network access requirements gave pharmacies leverage in their dealings with the third-party payers, as well as the incentive to act collectively. If they acted collectively to deny third-party payers enough pharmacies to meet the access standards, they would more easily force third-party payers to raise their reimbursement rates.

IV. ANTICOMPETITIVE CONDUCT

15. The MRHC, acting as a combination of its members, and in conspiracy with them, has acted to restrain competition by, among other things, negotiating, entering into, and implementing agreements to fix the prices on which their members contract with payers and threatening to terminate contracts with payers who refuse to deal with the MRHC on the terms it

demands. Moreover, in furtherance of this conduct, members of the MRHC have refrained from negotiating individually with payers.

A. Agreement among MRHC Members to Negotiate Collectively

16. Pursuant to the MRHC by-laws, MRHC members elect physicians and hospital representatives to serve on the MRHC's Board of Directors and manage the MRHC's operations. The Board oversees all contract negotiations and approves all contracts between the MRHC and third-party payers.

17. MRHC members, in joining MRHC, agree to participate in the MRHC's contracts with payers. In accordance with their MRHC membership and provider participation agreements, MRHC members grant MRHC the authority to contract on their behalf and they agree to accept payment for their services according to the terms that the MRHC negotiates with payers.

18. MRHC committees have handled these contract negotiations. Its contracting committee, which is composed of physician clinic and hospital administrators and the MRHC's executive director, negotiates contracts with third-party payers for hospital and physician services. The pharmacy contracting committee, which was composed of pharmacists and its executive director, negotiated contracts with payers for pharmacy services. The Board of Directors oversees all contract negotiations and approves all contracts between the MRHC and third-party payers.

B. Price Agreements on Physician and Hospital Services

19. Since at least 1996, the MRHC, acting through its contracting committee and executive director, has negotiated prices and other competitively significant terms, on behalf of MRHC physician and/or hospital members, with the major payers in Minnesota, including BlueCross BlueShield of Minnesota, HealthPartners, Medica Health Plans, MultiPlan, Inc., Preferred One, and America's PPO. Upon completion of contract negotiations with each of these payers, the MRHC Board of Directors approved each contract and the MRHC entered into and administered each contract.

20. When negotiating new rates, the MRHC threatened to terminate contracts with payers to pressure them to increase prices for physician and hospital services. For example, during its 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 MRHC hospital members ten percent more than comparable non-MRHC hospitals. A similar tactic forced Preferred One to pay MRHC members higher rates.

21. To further its bargaining leverage in contact negotiations, MRHC informed payers that the MRHC "expect[s] our group to be accepted or rejected as a group" and, as recently as March 2009, that payers would be unable to negotiate individually with MRHC members. When

payers attempted to negotiate separately with particular members, the members rebuffed these efforts.

22. Through its collective negotiations and coercive tactics, the MRHC succeeded in extracting increased payments to MRHC members in at least three forms: higher reimbursement rates than comparable providers, more favorable payment methods, and increased reimbursements for new MRHC members.

23. *First,* the MRHC obtained higher prices from payers. Indeed, the MRHC told its members at the 2005 annual member meeting that improvements in its contract with Preferred One would be "worth $100,000s annually for MRHC members." Five payers — HealthPartners, Medica, MultiPlan, Preferred One, and America's PPO — have paid MRHC members more than comparable rural hospitals and/or physicians elsewhere in Minnesota.

24. *Second,* the MRHC's agreements with two payers — Medica and Preferred One — require them to pay MRHC hospital and physician members based on a percentage of billed charges, rather than a fixed fee for each service. Payers generally prefer a fixed fee schedule because it prevents providers from increasing their billed charges at will. By obtaining reimbursement rates based on a percent of billed charges, MRHC providers can unilaterally increase their reimbursement, by increasing their billed charges up to the maximum specified in the contract.

25. *Third*, the MRHC has forced payers to reimburse new MRHC members at the higher MRHC rates, even though the members had existing contracts with the payer that paid lower rates. For example, MultiPlan had to increase one hospital's reimbursement rate from 78 percent of billed charges to a significantly higher percent of billed charges merely because it joined the MRHC. Moreover, Medica told the MRHC that "because of the 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."

C. Price Agreements on Pharmacy Services

26. After pharmacists approached it, the MRHC recruited pharmacies by offering to increase Medicare prescription drug program (Part D) reimbursement levels, urged pharmacies not to deal individually with PBMs, and negotiated collectively and contracted with at least six PBMs.

27. To participate in the new Medicare Part D program, each PBM or other payer had to find enough pharmacies to meet the "Tricare access standard." This standard required that each network include a sufficient number of pharmacies to ensure that 70 percent of rural beneficiaries lived no more than 15 miles from at least one participating pharmacy.

28. By "stand[ing] together and speak[ing] with ONE voice to the PBMs," the MRHC believed it could leverage the federal access requirements for Part D networks to obtain higher reimbursement rates. The MRHC repeatedly stressed the benefits of standing together and

negotiating as a block in letters to members and prospective members. A June 27, 2005, letter explained that:

> With our membership in MRHC comes the opportunity to stand together and speak with ONE voice to the PBMs. . . . 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.

The letter included the precise reimbursement levels that the MRHC would seek from PBMs, which were above the levels that PBMs were offering.

29. To maximize the pharmacies' negotiating leverage, the MRHC urged its pharmacy members not to deal individually with PBMs:

> 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].

The MRHC repeated this message to prospective members:

> 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!

30. To "speed up" the PBMs' acceptance of the MRHC as the pharmacies' bargaining agent, the MRHC provided each pharmacy member with labels that referred the PBM to MRHC to attach to offers that PBMs sent them. Many member pharmacies followed the MRHC's instructions to return the offers to the PBMs with such labels attached.

31. The MRHC negotiated with at least eight PBMs over 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 transferred management of these agreements to a pharmacy services administration organization in early 2008.

V. LACK OF JUSTIFICATION FOR THE CONDUCT

32. The MRHC and its physician members have not undertaken any programs or activities that create integration in the delivery of physician services and thus cannot justify the acts and practices described in the foregoing paragraphs.

33. The MRHC's physician members do not share significant financial risk in providing physician services under the contracts between the MRHC and payers discussed above. Four of these contracts with commercial insurers have no financial risk-sharing mechanisms whatsoever.

The withholding arrangements in the remaining three contracts withhold at most ten percent of physician charges and return money to the MRHC members regardless of whether they achieve cost-containment goals.

34. Nor have the MRHC and its physician members undertaken any clinical programs or activities that create any significant integration among its members' clinical practices. The MRHC provides its physician members with certain practice management programs (including two quality improvement projects, clinic inspections, and quarterly quality council meetings) and support services (including delegated credentialing, patient satisfaction surveys, and collection of patient complaints). These activities, however, do not involve collaboration to monitor and modify clinical practice patterns to control costs and ensure quality or otherwise integrate their delivery of care to patients. Moreover, their price fixing is not reasonably necessary to engage in these activities.

35. The MRHC and its hospital members have not undertaken any programs or activities that create integration in the delivery of hospital services and thus cannot justify their acts and practices described in the foregoing paragraphs. Hospital members do not share any financial risk in providing hospital services. Further, they do not collaborate in programs to monitor and modify their clinical practice patterns, to control costs and ensure quality, or to integrate otherwise their delivery of care to patients. Indeed, the only services that the MRHC provides to its hospital members are certain practice support services (including delegated credentialing, patient satisfaction surveys, and collection of patient complaints) and attending quality council meetings. Moreover, their price fixing is not reasonably necessary to engage in these activities.

36. The MRHC did not undertake any programs or activities to create integration in the delivery of pharmacy services and thus cannot justify their acts and practices described in the foregoing paragraphs. Pharmacist members did not share any financial risk in providing pharmacy services, collaborate in programs to monitor and modify their clinical practice patterns, to control costs and ensure quality, or to integrate otherwise their delivery of care to patients. Indeed, aside from inviting pharmacists to attend continuing education programs it already provided for its non-pharmacist members, the MRHC's *sole* service for its pharmacy members was jointly negotiating and administering contracts.

37. The MRHC's conduct has not been, and is not, reasonably related to any efficiency-enhancing integration among its members.

VI. MINNESOTA POLICY CONCERNING HEALTH CARE COOPERATIVES

38. In 1994, Minnesota authorized the formation of health care cooperatives. The enabling legislation provided that, with certain limitations, a cooperative was "not a combination in restraint of trade" and any cooperative contracts or agreements with a payer "are not contracts that unreasonably restrain trade." 2009 Minnesota Statutes, § 62R.06, subd. 3. Among the limitations, the law declared it "unlawful for any health care provider cooperative to engage in any acts of coercion, intimidation, or boycott of, or any concerted refusal to deal with, any health plan company seeking to contract with the cooperative on a competitive, reasonable, and nonexclusive basis." 2009 Minnesota Statutes, § 62R.08(d).

39. As alleged above, the MRHC and its members engaged in acts of coercion and intimidation, boycotts, and concerted refusals to deal in response to payers' offers of terms identical or similar to terms the payers were offering to comparable rural providers in other parts of Minnesota.

40. Prior to May 16, 2009, when Minnesota enacted new legislation concerning health care cooperatives, Minnesota officials did not have the power to approve or disapprove contacts between health care cooperatives and payers. At least until then, state officials neither reviewed nor approved any MRHC contracts with payers.

VII. ANTICOMPETITIVE EFFECTS

41. The MRHC's actions have the purpose and/or had, or tended to have, the effect of unreasonably restraining trade and hindering competition in the provision of hospital and physician services in Minnesota in the following ways, among others:

a. Unreasonably restraining price and other competition among the MRHC hospital members and among the MRHC physician members;

b. Increasing prices for hospital and physician services; and

c. Depriving third-party payers and consumers of the benefits of such competition.

42. The MRHC recruited pharmacists to negotiate collectively agreements with PBMs. Their actions had the purpose of unreasonably restraining trade and hindering competition in the provision of pharmacy services in Minnesota by unreasonably restraining price and other competition among the MRHC's pharmacy members, and thereby had the potential to harm consumers by depriving them of the benefits of such competition.

VIII. VIOLATION OF THE FTC ACT

43. The acts and practices described above constitute unfair methods of competition in violation of Section 5 of the Federal Trade Commission Act, as amended, 15 U.S.C. § 45. Such acts and practices, or the effects thereof, are continuing and will continue or recur in the absence of the relief herein requested.

WHEREFORE, THE PREMISES CONSIDERED, the Federal Trade Commission on this twenty-eighth day of December, 2010, issues its Complaint against the Minnesota Rural Health Cooperative.

By the Commission.

Donald S. Clark
Secretary

SEAL