AMA
AMERICAN
MEDICAL
ASSOCIATION

Michael D. Maves, MD, MBA, Executive Vice President, CEO

May 13, 2009

The Honorable Jon Leibowitz
Chairman
Federal Trade Commission
600 Pennsylvania Avenue, NW
Washington, DC 20580

Re: *Boulder Valley IPA*, FTC File No. 0510252 ("*Boulder Valley*")

Dear Chairman Leibowitz:

In June 2008, the American Medical Association (AMA) submitted to the Federal Trade Commission (FTC) a white paper that outlines modifications to the FTC-Department of Justice (DOJ) Health Care Guidelines that would provide greater flexibility for physicians to engage in procompetitive joint arrangements. One of the proposed modifications is that non-exclusive physician networks—those in which physicians are genuinely available to contract with payers separately from the network—should almost always be found lawful under the rule of reason. Non-exclusive physician networks offer payers the advantage of choosing whether they want to negotiate directly with the network or with the network's individual physician members. We wish to confirm here that when a non-exclusive physician network's offer of a joint contract arrangement is approved by payers, the network will not have to fear that it may be subjected to price-fixing charges.

A. Enforcement Issues Presented by the FTC Boulder Valley IPA Pleadings

In the *Boulder Valley* case, the FTC alleges that the Boulder Valley IPA (BVIPA) had an exclusive dealing arrangement with its physician members. BVIPA denies this allegation and says that it gave payers several options with respect to contract negotiations. First, payers could present and negotiate their own fee-for-service contracts with the individual physicians on BVIPA's panel. Second, payers could use the messenger arrangement offered by BVIPA. Finally, payers could negotiate directly with BVIPA. Under this last option, the payer would effectively ask BVIPA to provide an offer on behalf of its members. The payer was then free to accept or reject BVIPA's joint offer. The AMA has examined several affidavits payers have submitted that substantiate BVIPA's claim that payers chose to negotiate either directly with BVIPA or with its individual member physicians.

When payers *ask* a physician network to jointly negotiate on behalf of its members, it is because payers realize substantial efficiencies through these negotiations, such as transaction cost savings, that outweigh any pricing power created by the joint negotiations. Yet, based upon the FTC's pleadings in *Boulder Valley*, it appears that the agency has elected to apply the *per se* liability rule. Under these circumstances, the FTC's proposed consent decree would seemingly prevent payers from getting a service from a physician network that they considered valuable—they would be forced to negotiate separately.

Therefore, the AMA respectively requests that the FTC clarify its enforcement policy by confirming that even in the absence of financial or clinical integration, a non-exclusive physician network is not subject to summary condemnation when payers request that the non-exclusive network jointly negotiates its physician fees and the network complies.

It is our understanding that the FTC also views the recent messengering efforts of BVIPA's executive director as an orchestration of a *de facto* exclusive ("hub and spoke") conspiracy, evidenced by the similar fees the physicians offered. We believe, however, that it is not unlikely that physicians practicing under very similar market conditions in a localized rural or semi-rural area may reach similar conclusions about the merits of a proposed agreement without the existence of a price-fixing agreement. The AMA respectively requests that the FTC clarify that if a physician network is non-exclusive and payers have a choice as to how they want to approach the negotiation process, the FTC should not infer a price-fixing conspiracy from parallel conduct by physicians in these situations. Otherwise, the FTC will make it next to impossible for physician networks to operate in small or isolated communities.

B. Legal Analysis

Since the FTC-DOJ Health Care Guidelines were enacted, the Supreme Court has repeatedly questioned the rigid application of *per se* condemnation. Underlying the Supreme Court's concern with the excessive use of *per se* labels is the recognition that antitrust laws should not prohibit business arrangements that are possibly procompetitive. For identical reasons, the Supreme Court has also taken the position that summary condemnation under a quick-look analysis is limited to blatantly anticompetitive arrangements with no plausible procompetitive efficiencies. When payers request that a network negotiate on behalf of its physician members, they are acknowledging that substantial efficiencies are created by joint negotiations.

Providing the option of a "one-stop-shopping" source to smaller payers may allow them to enter markets in a manner that will let them effectively compete against larger and entrenched competitors. The ability of smaller payers to directly negotiate with a physician network makes it unnecessary for them to create their own networks or to put in place the administrative structures needed to negotiate hundreds of individual contracts.

In the present case, BVIPA took steps to make this option attractive. Payers that cannot efficiently recreate the organizational structures and services created by a non-exclusive physician network, such as BVIPA, can negotiate with the network for access to those organizational structures and services. By paying for such services, smaller payers have the ability to access the market more efficiently. Thus, BVIPA's negotiating arrangement was procompetitive.

While larger payers may not need to jointly negotiate with non-exclusive networks, such as BVIPA, this does not mean they would necessarily reject such an option. If a payer truly has the choice to negotiate with a non-exclusive physician network or its individual physician members, the payer will choose the arrangement that is the most efficient and that does not put the payer into an adverse negotiating position. For example, a payer that has substantial market share may not have any concerns that a non-exclusive network could extract monopoly rents if joint negotiations were pursued.

The FTC's recent letter to TriState Health Partners echoes these points.[1] In the TriState letter, the FTC observed that TriState informed payers that they were free to negotiate with the network or with the physicians individually. The FTC then correctly opined that this "non-exclusivity in practice is of critical importance to our conclusion that TriState's proposed program is unlikely to create or allow it to exercise market power on behalf of its member participants or to result in anticompetitive effects."

A large payer may, however, threaten antitrust actions if joint contracting creates additional competitive pressures for the payer from smaller rivals. In this situation, we believe that the FTC should carefully scrutinize whether the payer is genuinely concerned about a price-fixing arrangement or if it is trying to use the antitrust laws to limit the competition it faces. The FTC apparently saw BVIPA's arrangement as either *per se* unlawful or subject to summary condemnation under a quick-look analysis. Applying a *per se* analysis would compel the FTC to ignore any potential procompetitive benefits created by the negotiating options offered by BVIPA. The Supreme Court, however, has repeatedly stated that the *per se* rule should not be applied to arrangements that have plausible procompetitive effects. More importantly, even if the FTC applied a quick-look analysis, we believe that the procompetitive effects generated by BVIPA should have required the FTC to conduct some form of market power analysis.

Further, we do not think that the FTC should have put significant weight on the common negotiation positions of some or most independent physicians in the Boulder area without proof that a naked horizontal *agreement* existed. It is black letter law that neither the FTC nor a private litigant can presume the existence of an antitrust conspiracy from parallel conduct by market participants. Parallel conduct often occurs because markets are operating efficiently. Presuming an antitrust agreement from parallel conduct alone would wreak havoc in many markets. This is certainly true in physician markets. In many localized physician markets, inferring price-fixing from parallel conduct would make it impossible for physicians to form any type of IPA or collaborative organization. The network would face price-fixing charges simply because the physician market is operating in a manner predicted by economic theory.

Aside from the substantive efficiency argument described above, the AMA does not believe that a non-exclusive physician network's negotiating on behalf of its members constitutes concerted conduct when the payers ask for such a joint offer. In *Tunica Web Advertising v. Tunica Casino Operators Association, Inc.*, 496 F.3d 403 (5th Cir. 2007), the plaintiff had accused a casino trade association and it members of collectively refusing to deal with the plaintiff. The plaintiff alleged that this refusal to deal with them was an unlawful group boycott under the antitrust laws. The plaintiff, however, had made an offer to the association and its members and requested a joint response to its offer. The Fifth Circuit held that under these circumstances, the joint refusal to accept the offer did not constitute concerted conduct by the casino association and its members under the antitrust laws. The *Tunica* case is applicable to the BVIPA situation. When BVIPA was asked by a payer to provide a joint offer, the IPA had to either ignore its customer or provide an offer. *Tunica* stands for the proposition that the antitrust laws do not prevent a group response to an offer that expressly requests a group response.

Overall, the FTC's consent decree could have the perverse effect of making the health care market in the Boulder area function less efficiently and less competitively. Based on the affidavits submitted by some payers, the FTC's action will make it impossible for small payers to get a service they want and which they think is valuable. The rules against price-fixing were designed to protect consumers from

[1] *In re TriState Health Partners, Inc*. (April 2009), available at http://www.ftc.gov/os/closings/staff/090413tristateaoletter.pdf

concerted conduct that would limit their options and cause an involuntary wealth transfer from consumers to sellers. However, in this case, the FTC's enforcement actions are limiting the options available to consumers and making it impossible for consumers to receive a service they desire.

We urge the FTC to re-examine its position on non-exclusive physician networks in light of the above arguments, and we look forward to further discussions with the FTC on its application of the FTC-DOJ Health Care Guidelines.

Sincerely,

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cc: Pamela Jones Harbour
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