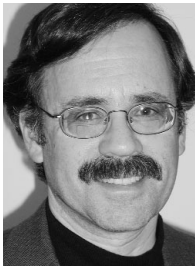


Brown Bag Program

Messed Up Messenger Models and How to Do Them Right

An ABA Section of Antitrust Law “Brown Bag” Conference Call, held March 5, 2003, co-sponsored by the Section’s Sherman Act Section 1 Committee and Health Care Industry Committee.

MODERATOR



Robert F. Leibenluft
Partner, Hogan &
Hartson, LLP

PARTICIPANTS



Denise M. Gunter
Partner, Nelson Mullins
Riley & Scarborough
LLP



John J. Miles
Principal, Ober, Kaler,
Grimes & Shriver



David M. Narrow
Federal Trade
Commission

Editor’s Note: This program covers antitrust analysis of collaborative efforts by firms or individuals to engage in joint contracting. While the focus here rests on physicians, the analysis applies equally to firms or sellers in other industries. For example, the Justice Department has applied the messenger-model analysis to a joint venture among automotive damage appraisers who sell their services to insurance companies.¹

Joint contracting has been the subject of considerable antitrust enforcement activity in the health care sector, particularly among physicians or physician groups. It is well established that price fixing among financially and clinically independent physicians is per se illegal.² What is more complicated is evaluating collaborative arrangements or joint ventures in which the participants attempt to realize transaction efficiencies associated with joint contracting while pricing separately.

The Health Care Guidelines recognize that “[a]rrangements that are designed simply to minimize the costs associated with the contracting process, and that do not result in a collective determination by the competing network providers on prices or price-related terms, are not per se illegal price fixing.”³ The Guidelines further explain that providers may maintain sufficient independence through the use of a third-party agent or “messenger” to convey pricing information.⁴ A joint venture or collaborative arrangement with a third-party agent or messenger “can be organized in a variety of ways,” and determining whether it constitutes illegal price fixing “is a question of fact in each case.”⁵

¹ Independent Automotive Damage Appraisers Ass’n, Dep’t of Justice Business Review Letter (June 27, 1996), available at <http://www.usdoj.gov/atr/public/busreview/iadaa.ltr.html>.

² *Arizona v. Maricopa County Med. Soc’y*, 457 U.S. 332 (1982).

³ Dep’t of Justice and FTC Statements of Antitrust Enforcement Policy in Health Care (1996), Statement 9, available at <http://www.ftc.gov/reports/hlth3s.htm> [hereinafter Health Care Statements].

⁴ *Id.*

⁵ *Id.*

The panelists below discuss common issues or fact patterns that arise in connection with messenger models, including fact patterns discussed in recent government enforcement actions. The FTC will conduct hearings on September 25 focusing on antitrust analysis of messenger models.⁶ Physician collaboration continues to receive attention in private antitrust litigation as well as government enforcement.⁷ Thus, the discussion below is useful in considering government enforcement and private antitrust litigation in the physician sector and more generally the subject of joint marketing or joint sales ventures.

—MIKE COWIE

BOB LEIBENLUFT: Our program today is devoted to health care “messenger-model” arrangements, which are a way for providers—particularly doctors, but other providers as well—to deal with health plans in a way that might save transaction costs but, because there is no agreement among providers on price, there can be no violation of Sherman Act Section 1. The concept was explained in some detail in Statement 9 of the 1996 DOJ/FTC Statements of Antitrust Enforcement Policy in Health Care. Example 4 in Statement 9 lays out several kinds of messenger models, three of which are lawful according to the Policy Statements, and one of which is not.

When you look at messenger models, what’s apparent—and you hear this all the time from people in the field—is that it seems like it’s almost never done right, or at least not done the way that the antitrust agencies have described it should be done. Some business people, in fact, say that it just can’t be done that way, or that it’s simply not worth the effort. The agencies certainly have experience with messenger models where the providers have said that they’ve done a messenger model, but in fact the agencies have concluded that the arrangement just masked “illegal activities” or didn’t conform to a “legitimate messenger model,” to quote from a couple of recent cases that the Antitrust Division has brought.⁸ Indeed, this year the FTC already has brought four cases, one in Dallas⁹ and three in Denver,¹⁰ against physicians claiming that they were doing messenger-model arrangements, but which involved conduct that the Commission staff concluded involved joint negotiations and agreements that violated the antitrust laws.

So, clearly, we have an area that’s controversial. The questions for our panel will include the following: How should the messenger model be implemented? What are the common misperceptions and potential pitfalls in implementing the messenger model? What are the practical issues? And, in the end, is it worth doing?

To begin, we will hear from Denise Gunter, who is a partner with the law firm of Nelson Mullins Riley & Scarborough in Winston-Salem, North Carolina, and has been involved in establishing several messenger-model networks. She will address messenger-model structures and the practical issues that arise in implementing the model and ensuring that providers do not slip into prob-

⁶ FTC and Department of Justice Hearings on Health Care and Competition Law and Policy, Agenda, available at <http://www.ftc.gov/ogc/healthcarehearings/0309agenda.htm>.

⁷ International Healthcare Mgmt. v. Hawaii Coalition for Health, 332 F.3d 600 (9th Cir. 2003) (affirming grant of summary judgment ruling dismissing claims against defendant physicians).

⁸ U.S. v. Federation of Physicians and Dentists, Inc., 2002-2 Trade Cas. (CCH) ¶ 73,868 (D. Del. 2002), available at <http://www.usdoj.gov/atr/cases/indx26.htm>.

⁹ System Health Providers, Inc., FTC Docket No. C-4064 (Oct. 24, 2002), available at <http://www.ftc.gov/os/caselist/c4064.htm>.

¹⁰ Professionals in Women’s Care, FTC Docket No. C-4063 (Oct. 11, 2002), available at <http://www.ftc.gov/os/caselist/c4063.htm>; Aurora Associated Primary Care Physicians, L.L.C., FTC File No. 011 0174 (May 9, 2002), available at <http://www.ftc.gov/os/caselist/0110174.htm>; Physicians Integrated Services of Denver, Inc., FTC File No. 011 0173 (May 9, 2002), available at <http://www.ftc.gov/os/caselist/0110173.htm>.

lematic behavior once the arrangement is up and running. Denise will be followed by Jeff Miles, of Ober, Kaler, Grimes and Shriver in Washington, D.C., who has represented several physician groups whose messenger-model arrangements have been challenged by the enforcement agencies. Based on this experience, Jeff will discuss the pros and cons of the messenger model. Last, we have David Narrow, who has been at the FTC Health Care Division for about twenty-five years and participated in the drafting of the DOJ/FTC Statements of Antitrust Enforcement Policy in Health Care and has worked on numerous investigations involving so-called “messed-up messenger models.” Dave will provide an FTC staff perspective on these issues.

Now I’m going to turn this over to Denise for a discussion of messenger-model structures.

A messenger model network may seem like an easy thing to develop, but in reality, it can be difficult to implement successfully.

—DENISE GUNTER

DENISE GUNTER: As Bob indicated, I have worked with several messenger-model networks. A messenger model network may seem like an easy thing to develop, but in reality, it can be difficult to implement successfully. There are a variety of structures that one can employ to establish a messenger-model network. I have been able to identify about five different structures, and my co-panelists and those of you participating in today’s program may have seen some others. What I’ve tried to do is arrange the structures from the simplest form to the most complex form. Each of these structures has pros and cons.

The simplest structure is what I would call a “Plain Vanilla” messenger model. In this structure, a network of providers obtains a fee schedule from a payor, such as an insurer or a self-insured employer or from an agent acting for a payor, such as a third-party administrator. Then a messenger—someone appointed in a special role to serve as a “pipeline”—sends that fee schedule out to the providers for their individual decision making. Each provider will decide individually whether or not he or she wants to accept that fee schedule, reject it, or counterpropose other terms back to the payor. That sounds pretty easy to do, and in theory should work just fine. There is at least one major problem with that kind of arrangement, however. If the fee schedule that is proposed by the payor is not accepted by the vast majority of providers and there are a lot of rejections or counterproposals back to the payor, it can take a long time to build a network. In my experience, it’s not unusual for the network building in that scenario to take anywhere from thirty to sixty to ninety days, or sometimes even longer. So that’s a definite drawback to that type of structure.

There is a variation on the “Plain Vanilla” model. This model works according to the same basic principle of the “Plain Vanilla” model, in which a fee schedule is accepted from a payor and is then “messengered” out to the providers in the network for their individual consideration. However, the network will sometimes impose a time limit for the providers to speak up and say whether or not they accept or reject the payor’s offer or wish to counterpropose terms to the payor. I have seen some structures in which the messenger will inform the providers that if the network does not hear from the provider within a certain period of time, for example, twenty-one days, the provider is deemed to have accepted that fee schedule and will therefore be a participating provider for that payor. That speeds things along and in some respects makes it easier for the providers and the payors because it avoids extended back and forth communications. The major drawback, of course, is that if providers haven’t opened up the mail to see what the fee schedule is, they may find themselves in a situation they don’t particularly like. So, while this model offers greater speed, it can create some discord with the providers in the network.

From there, the messenger model becomes a bit more sophisticated in terms of the various structures that could be employed. One of the more common structures is known as the “Standing Offer” messenger model. In contrast to the “Plain Vanilla” models, in which the payors do the work

on the front end, the “Standing Offer” messenger models involve a bit more work on the provider end. There are several variations on the Standing Offer model.

In the first variation of the Standing Offer messenger model, the providers have individually determined the lowest amount that each will accept from a payor.¹¹ Alternatively, the providers may have individually established a range that is acceptable. For example, the provider may state that he is willing to accept between 110 percent and 130 percent of the Medicare fee schedule. The messenger will then try to match payor offers with those pre-authorized or pre-determined rates from each individual provider. This sounds efficient and should speed things along because it could eliminate having to messenger multiple fee schedules for multiple different payors. But this can be difficult to implement from the providers’ perspective because the providers may have trouble determining how to establish their fees. Some providers may not have the time or the staff to go back through their existing contracts and figure out an acceptable rate. So that creates an issue on the provider end. Messenger-model networks may get questions from their providers asking where the providers can go to obtain information on rates. This can create practical problems, because competing providers will not be able to talk to each other about rates, and the messenger is not supposed to tell providers where to set their rates.

The second variation on the “Standing Offer” model is one in which the providers authorize the messenger to accept rates that are equal to or better than the rates contained in contracts that the provider has already accepted.¹² That also sounds good, and could speed things along, but again, there are practical problems. Exactly which contracts will be used in this scenario? Who’s going to do the work to figure out exactly what fees and which contracts are acceptable to the provider? Again, the provider is going to have to do a lot of work in this scenario.

I should mention that for both of these “Standing Offer” models, the 1996 Health Care Enforcement Statements tell us that any offers that do not meet the provider’s pre-determined figure must be messengered back to the provider for his or her individual acceptance or rejection.¹³ The messenger cannot say to the payor: “I’m not passing that offer along.” That would be a big danger sign, and I’m sure Dave and Jeff can comment on the propriety of the messenger screening offers and saying: “I’m not going to send that out to the providers for their individual decisions.”¹⁴ So, something that falls outside the provider’s pre-authorized range is going to have to be sent back out to the provider to allow the provider to make an individual decision.

The last model that I’ve been able to identify is something I call the “Grid Model,” but I’ve also seen it referred to as a “Matrix Model.” In this model, the messenger will collect fee information or fee range information individually from providers and then put that information on a grid, chart, or spreadsheet for the payor.¹⁵ This is useful in situations in which a payor, particularly a self-insured employer, does not know where to start in proposing fee schedules to providers. The grid or matrix

¹¹ See, e.g., Health Care Statements, *supra* note 3, Statement 9, Example 4.

¹² See *id.*

¹³ See *id.*

¹⁴ See, e.g., Professionals in Women’s Care, *supra* note 10 (FTC charged that messenger had a practice of not conveying to network physicians payor offers that the messenger deemed deficient). More recently, in May 2003, the FTC challenged similar conduct in *Carlsbad Physician Association, Inc.*, FTC Docket No. C-4081 (June 20, 2003), available at <http://www.ftc.gov/os/2003/06/carlsbadcmp.htm>. The FTC alleged that the network repeatedly refused to messenger contract offers it deemed deficient and engaged in collective price negotiations and refusals to deal.

¹⁵ See Health Care Statements, *supra* note 3, Statement 9, Example 4.

is not a fee schedule; it simply shows the number of providers who are willing to contract at particular price levels. For example, the chart may show that if a payor proposes 150 percent of the Medicare fee schedule, the payor will get X percent of the network. If the payor proposes 130 percent of the Medicare fee schedule, the payor will get Y percent of the network.

This model may be helpful to the payors in terms of formulating offers, but I will caution that networks that use this model need to make sure that their messengers are properly trained to ensure that it does not appear that the messenger is trying to force a fee schedule onto the payors. In addition, this model is also a pretty labor-intensive operation for most networks.

There is another contracting method that some networks use and believe is a messenger model, but it is not. It's called the "Black Box" method.

There is another contracting method that some networks use and believe is a messenger model, but it is not. It's called the "Black Box" method. In a "Black Box" method, a third party collects fee information from providers. This is generally fine, so long as the information is collected on an individual basis and the providers do not communicate with each other about the fee information. Where the "messenger" in this model goes astray, however, is by taking the fee information and developing a fee schedule.¹⁶ Sometimes the Black Box method is coupled with an opt-in or opt-out procedure in which the providers are permitted to opt in or opt out of that fee schedule. Networks that use this procedure sometimes believe that if the provider makes the decision whether or not to participate, there is no collective decision making on fees. But the enforcement agencies tell us otherwise.¹⁷ If a messenger has created a fee schedule, the opt-in/opt-out method will not save the network from a possible antitrust challenge.

Despite the different structures of a proper messenger model, there are common themes.

First, the messenger does not negotiate fees for the providers.¹⁸

Second, there is no collectively-developed fee schedule for the providers. There may be a payor-created fee schedule, but in a properly created messenger-model network, there will never be a fee schedule that the providers have developed collectively or had developed for them by a consultant.

Third, the messenger does not refuse to pass on offers from payors. The messenger does not just reject offers out of hand from the payor.

Fourth, the messenger doesn't tell the payor what to offer or express an opinion about particular offers. The messenger does not say to the payor: "You know, if I were you, I would sweeten that offer a little bit because you're not going to get anybody in this network with an offer like that." However, the messenger may show the payor factual information about the number of providers who have agreed to contract at different price levels.¹⁹

Fifth, the messenger is not supposed to tell providers how to set their fees or whether they should or should not accept a payor's offer.

—DENISE GUNTER

¹⁶ For example, in *United States v. Mountain Health Care, P.A.*, Civ. No. 1:02CV288-T (W.D.N.C. filed Dec. 13, 2002), available at <http://www.usdoj.gov/atr/cases/mountain.htm>, the DOJ alleged that the defendant IPA "blended" the rates of multiple physician practices to create a uniform fee schedule.

¹⁷ See Health Care Statements, *supra* note 3, Statement 9 n.65, which specifically disapproves of the opt-in/opt-out procedure in this context. More recently, on June 9, 2003, the FTC challenged a Dallas-area network that used the opt-in/opt-out method for its collectively negotiated contracts. See SPA Health Org., Inc., FTC Docket No. C-4088 (July 25, 2003), available at <http://www.ftc.gov/os/2003/07/spahealthcomp.pdf>.

¹⁸ See, e.g., *United States v. Federation of Physicians and Dentists, Inc.*, CA98-475JJF (D. Del. filed Aug. 12, 1998), available at <http://www.usdoj.gov/atr/cases/f1800/1880.htm> (DOJ alleged the messenger negotiated fees on behalf of competing providers).

¹⁹ See Health Care Statements, *supra* note 3, Statement 9 n.4.

And last, but not least, there's no sharing of fee information or contracting decisions by the messenger among the various providers. The messenger does not tell Group A: "Well, this is what Group B did." All of the communications between the messenger and the various provider groups are to remain confidential.

Those are the common themes that emerge in a properly functioning messenger model.

BOB LEIBENLUFT: Thanks, Denise. That's pretty simple, right? So why does everybody screw it up?

JEFF MILES: You're asking me why they screw it up? That's an interesting question that I'm going to ask Dave Narrow when we finish.

Let me go back in history just briefly and note that messenger models are a development that resulted from the *Maricopa County Medical Society* decision back in 1982.²⁰ You might remember that the defendant foundation for medical care's maximum fee schedule in that case was struck down as a per se unlawful price-fixing agreement. And if you're old enough, you'll recall that PPOs were on the rise, and there was much interest in the question of where we go from here in establishing prices for physicians in provider-controlled networks. The purpose for messenger models is to avoid the *Maricopa* provider-controlled network price-fixing problem—as Denise mentioned, to create a type of network in which there are no horizontal agreements about price and therefore no per se violations.

I think 2003 is the 20th anniversary of messenger models. Dave Narrow and I independently went back to our archives and looked for the first mention of messenger models we could find. Independently, both of us discovered the same paper, a September 30, 1983, speech by Art Lerner, who was then Assistant Director in charge of the Health Care shop at the FTC. That's the earliest reference we can find.

Bob mentioned that there is a lot of agency interest in messenger models, and there certainly is. If my memory is correct, last year four of the FTC enforcement actions against physician networks involved messed-up messenger models. On the DOJ side, the court has finally entered the consent decree in the *Federation of Physicians and Dentists* case,²¹ the physician labor union case in which the union claimed it was nothing more than a messenger for orthopedic surgeons in Delaware. I certainly know that the FTC has other messenger-model networks under investigation, and I wouldn't be surprised if the DOJ does, too. There is a lot of interest in messenger models, and the subject is important.

Two other preliminary points are worth mentioning. First, it appears that DOJ is still in the provider health care antitrust enforcement business. If there was a market allocation agreement between the two agencies back in the spring by which the DOJ would not handle provider issues, that agreement has been abrogated, I think, and the DOJ continues to examine provider issues as it did before. Moreover, DOJ has a number of highly competent attorneys from its former Health Care Task Force now in the Litigation I Section to handle this type of work.

Second, when messed-up messenger cases are brought, it's not simply the network that is at risk of being named as a respondent or defendant. A number of the cases have named individual physicians who were deeply involved in negotiation activity as defendants or respondents and,

²⁰ *Arizona v. Maricopa County Med. Soc'y*, 457 U.S. 332 (1982).

²¹ *U.S. v. Federation of Physicians and Dentists, Inc.*, 2002-2 Trade Cas. (CCH) ¶ 73,868 (D. Del. 2002), available at <http://www.usdoj.gov/atr/cases/indx26.htm>.

even more interesting, the FTC has named the network's consultant as a respondent in several cases because the consultant handled the network's negotiations with payors. Several years ago, the DOJ did the same thing in the *Federation of Certified Surgeons & Specialists* case. Even more interesting, both the FTC and DOJ have investigated situations in which the attorney for competing providers negotiated prices with health plans. So, you need to be careful when you deal with payors on behalf of competing health-care clients.

I'm not a great fan of messenger models. Let me explain why and note what I see as their costs and benefits. If you look at messenger models from the providers' standpoint, I think it's true that messenger models can be used to affirmatively market the physicians' services to payors, which is a plus. And, depending on the messenger-model structure you use, and particularly how the model operates, a messenger model can generate significant transactions-cost efficiencies in contracting. If you use a standing-offer messenger model with a power of attorney—one of the models Denise discussed—the physicians don't have to sign twenty or thirty contracts. Rather, they can just buy into the messenger arrangement, and there will be some sort of master contract. Messenger models can increase physician patient volumes, and that's one thing physicians look for. In somewhat unusual circumstances, messenger models can actually increase physician reimbursement, but not because of any aggregation of market power. I've seen situations, especially in medium and smaller communities, where a standing-offer messenger model was used with self-insured employers, the standing offers were "high," and the employers or their brokers or TPAs either did not know where to get comparative price information or did not want to go through the messenger process and so they just said, "Okay, I'll take all the standing offer fees." In another situation, payors may be willing to pay a small premium for the contracting efficiencies that messenger models can generate for them. Finally, the messenger network can educate its members so they can make more informed contracting decisions and this can lead to better reimbursement.

I do not believe there is any way that a messenger model can legitimately increase the market power of a group of physicians in bargaining with third-party payors.

—JEFF MILES

Now let me mention what I see as the costs or disadvantages of messenger models from the providers' perspective. If I can make one crucial point today that everybody understands and remembers from this program, it is this: I do not believe there is any way that a messenger model can legitimately increase the market power of a group of physicians in bargaining with third-party payors. I just don't know any way this can be done with a messenger model, especially since the purpose for using a messenger model is to keep it from happening. And I believe that if attorneys would tell their provider-network clients this on the front end, then the antitrust problems we see with messenger models today would not occur. If physicians understand that messenger models are not a mechanism they can use to ratchet up reimbursement through aggregating their bargaining strength, then there will be far fewer messenger networks, there will be far fewer physicians with antitrust problems, and physicians will save a ton of money on attorneys and consultants who sell them messed-up messenger models.

A problem with messenger models is that even if they operate properly initially, they are quite difficult to operate lawfully over time. It might be that a messenger model starts out with wonderful pristinely clear legal advice. But as time goes by, these networks seem to start deteriorating, usually for two reasons. First, it is not crystal clear precisely what a messenger can and can't do under the antitrust laws. Second, it is hard for us as attorneys to control the day-to-day actions of the messenger, and messengers have strong incentives to go as far as they can go—maybe up to and over the line—in their actual dealings with third-party payors. Messengers are often put in a somewhat unnatural, uncomfortable situation where payors asks them questions that their antitrust attorneys have warned them not to answer. The payor, for example, might ask the mes-

senger, “Well, what price will it take to get them?” Or the payor may ask, “How do you think they will react to this price?” And it’s somewhat uncomfortable and embarrassing for the messenger to sit there like a potted plant and say, “On advice of counsel, I can’t answer that question.” These are just two of the situations that can arise, and there are many more.

Another disadvantage to messenger models is simply that a lot of customers—health plans, employers, and TPAs—don’t like them. If you have ever been involved in switching a network using a fee schedule to a messenger model, you know there can be total chaos for months because nobody understands what’s going on. In addition, as Denise mentioned, it can take forever to form a network, especially if there are a number of rounds of offers and counter-offers. Another problem can be that the employer, who may be used to having an extremely broad panel of participating providers, has no guarantee of full participation when the network is established under a messenger-model approach. On the front-end of an employer’s discussion with the network about using its providers, the employer has absolutely no idea of which providers will ultimately participate in its network. If an important provider refuses to participate at rates acceptable to the employer or insurer, the employer or health plan may go to the network and say, “We’ve always had Dr. X in the network before, we need him in the network now, and so you do something to make him participate. This is your fault.” But if the messenger-model network is operating properly, there is nothing the network or messenger can do to force Dr. X to participate. Dr. X may have legitimately obtained market power and just wants a price reflecting that power.

Another concern about messenger models I’ve seen small employers raise is the fear that network providers will, as they put it, “discriminate” against them. They fear they are so small that many physicians in the network won’t think it worthwhile to contract with them and so they won’t get the doctors they need.

From the payor’s standpoint, especially if the model is a standing-offer model, administrative problems can arise because the payor may be used to paying all physicians the same price for the same services and its claims-processing infrastructure can’t handle different prices for different physicians. In light of this, many health plans simply ignore the standing offers and present the network with a list of fees that would pay all physicians the same amount for all services (e.g., 120 percent of Medicare) or for the same services (e.g., based on CPT codes).

Denise alluded to another problem, and that is where the customer—usually a TPA or employer—has no idea whether the offers it receives from a standing-offer model are reasonable. Similarly, if the messenger network is not a standing-offer model, the burden is on the payor to come forth with an offer. In some cases, the payor has no idea of what to offer, and there the network needs to look for ways to help the payor obtain the type of price information it needs to play the messenger-model game. But absent care, that too can raise antitrust issues.

And then, finally, there is a cost of the infrastructure of the model—the cost to establish and run the network. In the case of messenger-model networks, especially standing-offer models with a large number of providers, the messengering process needs to be electronic. The network won’t be able to do all the matching of standing offers and payer counteroffers that Denise discussed by hand. The network will need both hardware and software. There are programs for messengering, but the ones I’ve seen are proprietary. So to me, the bottom line from a business standpoint, especially given that most physicians participate in networks to increase reimbursement and messenger-model networks won’t accomplish this, is that I question whether the messenger-model game is really worth playing.

Denise mentioned a number of the practices that raise antitrust problems for messenger models. I want to emphasize those and add a few others. But first, I think it worth emphasizing that it

. . . it is not clear to me that everything the government seems to object to in complaints and consent decrees is necessarily unlawful conduct.

—JEFF MILES

is not clear to me that everything the government seems to object to in complaints and consent decrees is necessarily unlawful conduct. I think we sometimes put ourselves into a mind-set where we accept as gospel all of the government advice, guidelines, and speeches without much in-depth independent thought ourselves. I would urge you to think very carefully about specific network conduct and whether that conduct amounts to price fixing, facilitates price fixing, has any affect on prices, or otherwise unreasonably restrains competition based on the specific facts of the situation.

Denise mentioned that messenger models cannot develop and use agreed-upon fee schedules. A messenger in a standing-offer messenger arrangement, however, may take all the standing offers and prepare a matrix, schedule, or grid of fees, as she mentioned, and provide it to the payor. Some messenger models refer to this type of document as a “fee schedule.” I would suggest when networks use this methodology, they not use the term “fee schedule” because of the negative connotation it has that raises the antennae of David Narrow and the agencies.

Denise also mentioned the “black box” concept, where an outsider develops a fee schedule that participants then accept or reject. The relevant point is that it doesn’t matter who develops the fee schedule; it doesn’t do any good to get some third-party to develop a fee schedule and it doesn’t do any good to have a third-party develop the fee schedule and then messenger it to participants for their individual acceptance or rejection. This is one of the most frequent misconceptions I see in working with messenger models. The agencies’ view is that the requisite agreement results from the network decision to have the party create a fee schedule. The problem is particularly acute where the messenger then uses that fee schedule, which all the providers have accepted, to negotiate prices with payors. Be sure to review footnote 65 in Statement 9 of the agencies’ Health Care Guidelines, which addresses this issue. Related to the use of a fee schedule, the use of contract parameters—that is, where the network develops a range of acceptable fees it seeks to obtain—raises a problem also.

Provider or physician collusion in establishing their standing offers is also an obvious “no-no,” as is provider collusion regarding whether to accept particular offers or network decisions to terminate contracts because they believe the reimbursement is too low. Denise mentioned the problem with the messenger’s refusal to messenger all offers, although if you look at some of the consent decrees, there are exceptions to this rule under narrow circumstances. Problems arise where offers are negotiated and then go to the network’s “contract committee” for its review and approval. In some cases, if the contract committee doesn’t like the price offer, it sends the messenger back to the payor to improve it. That’s obviously a “no-no,” as is the situation where the contract committee rejects the contract and tells the messenger not to messenger it.

Denise also alluded to problems that can arise when the messenger makes recommendations regarding prices to either network participants or payers. Although the messenger should be able to provide objective information to participants, he or she should not suggest how the participant should react to the offer or discuss the merits of the contract.

These are “no-nos.” Messenger models can present a number of interesting questions that I just want to mention but don’t have time to discuss today. First, one of the most interesting questions is, what constitutes negotiation? Where do you draw the line, for example, between discussion and suggestion on one hand and threats and coercion on the other hand. The former may be procompetitive; the latter are not.

Second, how does the network handle non-price terms—these are some of the most important terms in any contract. What is a non-price term? I think you’ll find that the agencies define “price term” much more broadly than you might. For example, they would argue that a most-favored-

nation's clause is a price term; the same is true about a time-of-payment provision, since "time is money." When you think about it, there are a lot of terms in provider agreements that affect prices, but which, at first glance, we might look at and think are non-price terms. Can a network negotiate non-price terms and, if so, to what extent?²² Can a messenger network develop a model contract without price terms and use it in discussions with third-party payors?

Do the participation percentages matter in a messenger network? Theoretically, they shouldn't. Does exclusivity matter in a messenger network or, by definition, is a messenger network non-exclusive? Can a messenger network demand that its providers use a uniform price universe—for example, can the network tell the providers in its standing offer model to send it not 8,000 CPT codes with prices, but rather one Medicare, RBRVS percentage? Doing so clearly simplifies the network's administrative burden, but there is case authority that this would constitute a price-fixing agreement. Perhaps the efficiencies from using a single price universe are such that the agreement to do so is ancillary.

Denise mentioned the necessity for messenger networks to limit the rounds of offers and counter-offers. From a practical standpoint, doing so is absolutely essential. If you don't, the network formation process can go on forever, and it can take a year to establish a network. Related to this, it is important to provide physicians with a relatively short time in which to respond to offers or to make counter-offers.

These are only some of the more obvious issues that messenger-model networks can raise. There are a multitude of others, many of which arise from the characteristics of the particular network under examination and the types of customers they serve. The good news is that none of the cases filed thus far raise such detailed issues. In each of the cases brought by the government thus far, assuming the allegations were true, there were clear allegations of coercion to increase prices. It doesn't appear to me that the cases involved conduct close to the line, and this provides me with some solace.

Finally, it's worth noting that payors don't seem to be as shy as they used to be about filing private treble-damage actions against their providers. They're certainly not shy about complaining to both federal and state antitrust authorities. In sum, messenger networks are risky.

BOB LEIBENLUFT: Jeff has mentioned some problems in implementing the messenger model. Now I am going to turn back to Denise to have her address how she has dealt with some of those issues in practice, and particularly how she has gone about educating physicians as to how to do it right.

DENISE GUNTER: Jeff indicated that for a messenger-model network to operate correctly over time, it's not reasonable to believe that a lawyer can just come in one time, tell the client what the law is, and then say "see you later" and hope for the best. In order to make the messenger model work, counsel needs to be involved from the start, and needs to have ongoing involvement. I know we are not always blessed with the situation in which we can come in on the front end and troubleshoot. If we are fortunate enough to start working with the client on the front end before the network really is up and running, one of the first things that we as counsel need to do is put on our "teacher" hat and help our clients work through all the various scenarios and problems that they are likely to encounter.

²² For a recently decided decision evaluating alleged collaboration by physicians over nonprice terms, see *International Healthcare Mgmt. v. Hawaii Coalition for Health*, 332 F.3d 600 (9th Cir. 2003) (affirming grant of summary judgment ruling dismissing claims against defendant physicians).

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—DENISE GUNTER

One of the first things that counsel and client need to address is who the messenger is going to be. The messenger needs to be somebody who is strong and is going to be able to stand up not only to the providers in the network, who will probably ask some tough questions, but also to the payors and self-insured employers and third-party administrators. As Jeff mentioned, it's likely that there will be some very interesting conversations when the messenger walks in for the first time, and the payor asks, "Where is your fee schedule?" How is the messenger going to answer that question? The network needs to find somebody who is fast on their feet, will be able to think through these issues, and is tough enough to stand up to some of the pressures.

The messenger cannot be one of the providers in the network. You may have encountered situations in which one of the doctors in the network offered to be the messenger or volunteered to have his office manager serve as the messenger. This will not work; providers and their office staff cannot serve as the messenger. The reason that would not work is that the messenger is likely going to obtain confidential fee information from various competing providers.

So to whom do we turn to fill the role of messenger? Sometimes, the network will hire somebody to act as messenger. Sometimes consultants are employed for this purpose, although this can produce mixed results.²³ Sometimes attorneys have been used as messengers.

I think one of the best things that counsel can do is start educating the providers who are going to be in the network. For some providers, the messenger-model environment is going to be a completely different world. They may not have worked with it before, they may not understand it, and they may not understand why they cannot hire somebody to negotiate fees for them. They may not understand why somebody in the next town or the next state may be negotiating fees for providers, while you've told your client that they are not allowed to do that. They may not understand why they cannot adopt a fee schedule as a group. So those are issues that you need to work through with your clients to get them to understand how this process is going to work. What is expected of the provider? What is the messenger going to do for you? How are relations with payors going to work?

What I have found helpful is to get providers in the network together for a meeting so that the rules can be explained. This may entail multiple meetings so that you can explain the rules to as many providers in the network as possible. I don't think that simply writing a letter to somebody in the network is sufficient. I think it makes a difference when counsel actually meets with the providers who will be involved in the network and answers as many questions as possible. Many of the questions that the providers are going to ask are the same questions that the messenger is going to get from potential customers. They'll ask, "Well, what good is the messenger model? Why are we doing this? Why can't we collectively negotiate? And you, as counsel, are going to have to explain the reason why the providers cannot collectively negotiate, and how the messenger process is going to work, depending on the type of messenger-model structure the group decides to use.

One thing that may be helpful in these meetings is to have a list of "do's and don'ts" that are distributed to members of the provider network so they know the "off limits" topics if they have

²³ See, e.g., U.S. v. Federation of Certified Surgeons and Specialists, Inc., Case No. 99-167-CIV-T-17F (M.D. Fla. filed Jan. 26, 1999), available at <http://www.usdoj.gov/atr/cases/f2200/2202.htm>. The DOJ alleged that a consulting firm, which had been retained as a "messenger," in fact served as the joint negotiating agent for the providers in the network. See also Physician Consulting Network, LLC (FTC obtained a consent order in July 2003 against a network and its consultant). FTC File No. 021 0178 (Aug. 29, 2003), available at <http://www.ftc.gov/os/2003/07/physiciananalysis.htm>. In the complaint, the FTC alleged that the consultant negotiated higher reimbursement rates on behalf of large group of orthopedic surgeons in Baton Rouge, Louisiana.

group meetings and you, as counsel, cannot be there to troubleshoot and cut off what may be inappropriate discussions about prices or their opinions on various managed care payors or various managed care contracts.

Now comes what I think is probably the most difficult part, the part that requires ongoing work: the training of the messenger. I don't think it's reasonable to simply put somebody in that role without training because it's a terribly difficult position for some people to be in, given the questions that they're going to be asked by various payors. For example, the first time a messenger walks in to see a self-insured employer, the self-insured employer may have no idea how the messenger model is supposed to function and may ask, "Where is your fee schedule"? The messenger will respond, "We don't have a fee schedule." The employer may ask, "Why don't you have a fee schedule? What good is your network if it doesn't have a fee schedule?" So, right from the start, there may be a very contentious dialogue going on between messenger and payor.

I think what has been helpful is to do some role-play with the person who is going to be the messenger. The lawyer can act as the payor and the messenger will field questions. The lawyer can work with the client on how they're going to answer the questions, so when the messenger is asked, "Why don't you have a fee schedule," the messenger has an answer. The messenger will have to explain to the payor the value the network has even if it does not have a fee schedule and may not be able to promise the payor that in thirty days the payor is going to have a complete panel of providers. The messenger needs to have worked through these issues. Counsel can give the messenger some pointers on how to stand up to those kinds of questions and answer them correctly and in a way that we hope is not going to alienate potential customers.

Common questions that providers will ask the messenger include: "How do my fees compare to other providers? What are other groups doing in response to this payor's offer?" The messenger is not supposed to disclose to competing providers what others are doing, so that's an issue that needs to be thought through as well. I think this training is essential, and sometimes may get overlooked in the process, but we, as counsel, should try to help our clients with that.

Another thing that I think is helpful is a written antitrust policy. Obviously a policy that is put in a desk drawer and never followed is not going to amount to anything in the long run if the network runs into trouble. But I do think that it is valuable to establish a policy in writing about how the organization is going to operate about what is and is not acceptable conduct, and get the providers and the messenger and any other employees who may be involved in messenger types of functions to sign that policy. I think signing your name to something actually does have some value, but again, if the paper gets put in a desk drawer and isn't followed, what good is it? That's where ongoing training and maintenance comes in. That is obviously expensive for the client, but I think that this is important. As Jeff has mentioned, sometimes after the network is up and running, time passes, and people forget. It's human nature. We, as counsel, really ought to try to continue to work with our clients that are using messenger models to do ongoing training. How often the training is done will depend on people's schedules and what the client can afford, but it is valuable to go back in and periodically assess the situation. Have things really worked? Are there any adjustments that need to be made in the way this network is operating? Are there problems that have cropped up in terms of discussions with potential customers that we simply didn't see on the front end when we were setting up the network up? Is the structure that the network adopted working well? Perhaps the network started off with a "Plain Vanilla" model where it was simply taking in offers from payors and then sending them out. Is it time for the network to move to a different structure, such as a "Standing Offer" approach? Those are areas where counsel can continue to be involved and evaluate and, we hope, troubleshoot some issues before an investigation or lawsuit happens.

BOB LEIBENLUFT: Now we're going to turn to Dave Narrow.

DAVID NARROW: I was asked to give a little bit of the history of the messenger model. Jeff pretty much covered that, and I only want to follow up with one or two comments, and then give the FTC's perspective on messenger models. The first thing I'm going to do, however, is to give the standard disclaimer that the views that I express are not necessarily those of the Federal Trade Commission or of any of the Commissioners or of the Bureau of Competition.

... the most important lesson that you can draw from those decisions is that the analysis is very fact-specific in every instance, and you need to look at each situation. You can have fairly similar situations that fall on opposite sides of the line of legality.

—DAVID NARROW

With regard to the history of the messenger model, I agree with Jeff's characterization that this idea arose in the context of preferred provider organizations, and what they could do and couldn't do lawfully under the *Maricopa* standards in the early 1980s. I'm not sure exactly where the idea of using a messenger, which was how it was first discussed,²⁴ turned into some form of construct called "the messenger model," and then subsequently "pure" messenger models and "modified" messenger models, and all the other kinds of terms. I think that the use of those terms has been a disservice, because it has distracted attention from focusing on the initial underlying concept, which was to have an arrangement that did not involve agreements among competitors on price and price-related terms. The idea of using messenger-model structures has, in practice at least, come to focus more on the question of what type of structure is to be put up that will then allow "us physicians" collectively to negotiate, which is fundamentally inconsistent with the underlying concept of a messenger arrangement. We frequently see references to networks "negotiating through the messenger model." It very much seems to me to be the more recent analogue of the question—"How much do we have to integrate before we can fix prices?"—that also has been raised in the context of physician networks.

With regard to the Federal Trade Commission perspective on messenger models, I would direct you to the Commission's formal statement in that regard, particularly the 1996 Joint FTC and Department of Justice Health Care Policy Statements,²⁵ which have been mentioned before. I would note that those Guidelines are not some independent legal standard that the agencies came up with. The Guidelines articulate the agencies' best understanding of how traditional, standard antitrust laws and principles apply in certain situations.

The second place to which I would direct you would be the FTC's decisions, particularly the consent decrees,²⁶ of which there were four in the past year involving messenger-model issues: three related to physician practices in Denver, and one in Texas.²⁷ They all involve groups of competing physicians purporting to operate as messenger models, at least in part, but really not doing so in the sense that they all involved some degree of agreement among competitors or facilitating practices in that regard. I think the most important lesson that you can draw from those decisions is that the analysis is very fact-specific in every instance, and you need to look at each situation. You can have fairly similar situations that fall on opposite sides of the line of legality.

²⁴ Arthur N. Lerner, Assistant Director for Health Care, FTC Bureau of Competition, Remarks Before the Washington Health Letters and Business Week Conference on Preferred Provider Organizations 12 (Sept. 30, 1983); see also Arthur N. Lerner & David M. Narrow, PPO Programs and the Antitrust Laws in THE NEW HEALTHCARE MARKET: A GUIDE TO PPOs FOR PURCHASERS, PAYORS AND PROVIDERS 852–63, 858 (Peter Boland ed., 1985).

²⁵ Health Care Statements, *supra* note 3, at 125–27, 138–40.

²⁶ FTC Index of Health Care Antitrust Issues, available at <http://www.ftc.gov/bc/healthindex.htm>.

²⁷ System Health Providers, *supra* note 9; Professionals in Women's Care, *supra* note 10; Aurora Associated Primary Care Physicians, L.L.C., *supra* note 10; Physicians Integrated Services of Denver, Inc., *supra* note 10.

An additional place to look for some guidance is in FTC staff advisory opinions.²⁸ Again, these are staff opinions; they are not generally officially approved by the Commission and therefore do not represent official Commission policy or positions. Nevertheless, I would suggest that they are generally consistent with the Commission's views. Many of them are not terribly enlightening; most of the advisory opinions occur between 1995 and 1997, around the time of the Guidelines. Both the opinion letters and the incoming requests for opinions were fairly sketchy as to specifics, other than to make clear the intention to have no form of horizontal agreement among the participants with regard to price or price-related terms.

Similarly, the Department of Justice has issued a large number of business review letters, a number of which have dealt with messenger models. Again, most of those occur during the period 1995–1997, although I have seen one from as far back as 1983, not using the term, but talking about, in that case, a network involving HCA and how it would be doing individual negotiation of the price terms concerning the hospitals that were involved in the network.²⁹

I do want to mention the Department of Justice business review letter regarding Midwest Behavioral Health Care.³⁰ Again, this was a letter that evaluated the “messaging” of price terms, but it also mentioned joint negotiations by the messenger at the payor’s request of “non-price issues such as utilization reviews, credentialing quality assurance standards indemnity and hold harmless provisions payment and billing arrangements and termination procedures.”³¹ There were caveats concerning negotiations not being on an exclusive basis, assuring that payors were free to negotiate terms individually, and that there was no boycott or coercion involved. Perhaps the most important point to note is that, while the Commission has not taken any position with regard to what constitutes “non-price” terms, I would not necessarily accept, on its face, that all of the things that were mentioned in that letter would be accepted by the Commission in all instances as being non-price terms that are permissible subjects of collective negotiation.

I now would like to make a couple of general points, which may pull together some of the ideas that have been mentioned. First of all, focus on substance, not labels. Again, does the operation of the network involve or facilitate joint price agreements, does it interfere with, or influence, individual determinations?

Second, as I mentioned, that assessment is going to be very much a fact-specific determination. Another way to look at these arrangements is to ask whether the network adds an alternative to the market that wasn't there without the network, as opposed to restricting access to what was in the market beforehand. And does it involve coercion in any way, shape, or form concerning the terms of dealing with providers that payors are required to accept, or terms about which payors are unable to get providers to agree?

Next question: does the network create efficiency? We've talked about the transactions-costs efficiencies approach, and that is the primary justification for messenger model-type networks. There are a number of things that these networks do that can be valuable to payors. They can assemble a geographically diverse network of providers that covers a broad range of specialties; they can do credentialing. Those are efficiencies that are real and that are valuable to payors. But

²⁸ FTC Index of Health Care Antitrust Issues, *supra* note 26.

²⁹ Hospital Corp. of Am., Department of Justice Business Review Letter (Sept. 21, 1983).

³⁰ Midwest Behavioral Healthcare LLC, Department of Justice Business Review Letter (Feb. 4, 2000), available at <http://www.usdoj.gov/atr/public/busreview/8670.pdf>.

³¹ *Id.* at 5.

again, as with transactions-costs efficiencies, it is difficult to see any justification for price agreements on the part of the participating physicians in the network as being reasonably necessary to achieving those efficiencies, and that is crucial to the legal analysis. Moreover, with regard to efficiencies, I'd note that we've seen a number of relatively small networks involving few participants and, while those are not necessarily problematic, the transactions-costs efficiencies of a network involving only a handful of providers is, concomitantly, a lot less than it would be in a broader network.

The next point would be that you cannot do indirectly what you can't do directly. That is the old black box problem. I frequently suggest that when people have an agent, they ask the questions: Who hired the agent? Who can fire the agent if they don't like what the agent does on your behalf? Who pays the agent? Those questions will tell you how independent any "independent" agent is in acting on behalf of the network.

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Finally, I would point out that even the collective negotiation of competitively significant non-price terms may be illegal if the network has market power. What we have been focusing on is the analysis of price agreements by competing physicians in networks using the messenger model. However, even if you put aside the issue of price agreements so that you don't have a problem of per se illegality for price fixing, you nevertheless may have situations where networks that have market power may still violate the antitrust laws, even when limiting negotiations to non-price terms.

Jeff was mentioning that it can be a very awkward situation when you are in the room with a payor and the payor asks what it will take to get a contract. How do you react to this? I would respond that coming prepared with factual information as to the range of fees charged by providers—what they have indicated that they would accept individually, the number and types of providers who are likely to respond "yes" to certain offers—is the type of factual information that effectively answers those questions. Jeff also mentioned situations that involve coercion, and how you distinguish between the situation where there are merely discussions, versus agreements or refusals to deal. Long ago in the *Michigan State Medical Society* case, the Commission addressed what "negotiation" was—bargaining in an attempt to reach an agreement.³² The Commission pointed out that the power to agree implies the power to say "no," which also is inherently coercive.³³ I think that provides just a little bit of context for these types of "discussions."

Denise was talking about educating doctors, and I agree with the importance of that, although I also agree with Jeff that the value of messenger model-type networks may be a good deal less than many people believe. I believe that is largely due to the fact that, like it or not, we have seen that most messenger model networks have been set up by providers in an effort to protect their fees and incomes, which is something that, as Jeff has pointed out both today and in his article, is inherently inconsistent with the concept of the messenger model. Therefore, I suspect that the more physicians are, in fact, educated about properly operating messenger models, the less interest they are going to have in them.

—DAVID NARROW

BOB LEIBENLUFT: I have just one question for Jeff, who in a provocative statement said not to assume that everything that the government says is necessarily right or must be followed. I was just wondering if Jeff had anything in mind that he can elaborate on.

³² *Michigan State Med. Soc'y*, 101 F.T.C. 191, 284–89 (1983).

³³ *Id.* at 296 n.32.

JEFF MILES: I did not have anything specific in mind but I think the fault comes from looking at both the complaints and the consent decrees and assuming, perhaps subconsciously, that each activity they allege or prevent would constitute, by itself, a violation of Section 1 or Section 5 (of the FTC Act). Now, I simply stop as I read and ask myself whether particular activities constitute price fixing. Obviously there is fencing in.

DAVID NARROW: In many instances the consent decrees include fencing-in provisions regarding types of conduct which, in and of itself, might be lawful, but in the context of the unlawful conduct that has occurred, it is necessary to make sure the parties don't step over the line in the future. Frequently, we have had instances where the parties are asserting that they are operating a lawful messenger model when, in fact, their conduct indicates that they are not, or that they don't understand what is required under that type of a model, and such fencing-in is necessary to avoid a recurrence of unlawful activity by the same parties.

JEFF MILES: I understand that but I think a lot of people read the decrees and immediately think, "This must be something that the FTC or the Department of Justice is independently telling me I can't do." The only point I was trying to make was that's not necessarily the case.

DAVID NARROW: We do consider the direct effect on competition as well as the extent of integration. I will say that in all of these cases we felt that there were clear effects on competition. Whether that was directly measured in terms of price effects may not have always been possible; however, it was clear that negotiations were aimed at increasing prices, not decreasing them.

That probably seems to be okay. The one caveat I have is that we've seen comparisons to the fees that are accepted under other contracts by the providers, and in some instances those can be selective information that may skew the providers' responses to an offer. If, for example, the messenger only sends information on the highest priced contracts, which may be factually true, this nonetheless tends to be misleading in terms of affecting the likely response of the providers to the offer that is on the table. So again, the devil is in the details.

DENISE GUNTER: Another issue concerns the use of power of attorney, which I understand to be a standing offer methodology—this is how I regard it—where the providers have authorized or given standing offers of fees that are acceptable to them or ranges of fees that are acceptable to them. When I have seen that done, it varies in terms of what effect it has had. It does not always work very well with physicians simply because they often will say that they don't have the kind of resources or even the information to ascertain what the fee should be. It tends to be a little bit more successful in my experience with hospital networks simply because they may have more resources and more technology.

JEFF MILES: Let me just say my feeling is that if you are going to use a messenger arrangement I think the standing offer model with power of attorney is probably the best model to use. I think probably it is the simplest and the most efficient.

DAVID NARROW: On a separate issue, sometimes the argument is made that the payors are happy and therefore the conduct at issue is acceptable. I disagree with the statement that, even if the payor is happy, there is no coercion. We have seen any number of instances where payors enter into agreements because they think that is the best they can get under the circumstances, and

those are the result of collective negotiations and coercion. I can tell you, the fact that a payor is *unhappy* is a signal, although is not itself sufficient to demonstrate a problem. Likewise, the fact that the payor is happy does not necessarily mean that there is no problem. As stated, we do consider the direct effect on competition. The Commission, as a matter of simple use of enforcement resources, is looking for situations where there is the most benefit to the public of using our resources, which generally means that there was some cognizable harm, as opposed to a technical violation. ●