

Complaint

IN THE MATTER OF

**ROARING FORK VALLEY
PHYSICIANS I.P.A., INC.**CONSENT ORDER, ETC. IN REGARD TO ALLEGED VIOLATIONS OF
SEC. 5(A) OF THE FEDERAL TRADE COMMISSION ACT

Docket No. C-4288; File No. 061 0172
Filed, April 5, 2010 — Decision, April 5, 2010

This consent order addresses Roaring Fork Valley Physicians I.P.A., Inc.'s orchestrating and implementing price-related agreements and concerted refusals to deal among competing physician members of RFV to maintain and raise the price at which RFV's physician members contract with payers. Since at least 2003 RFV, although purporting to use a messenger model, negotiated price-related terms on behalf of its members for the purpose of increasing and maintaining the rates for services provided by RFV's otherwise competing physician members. Its members also engaged in concerted refusals to deal with payers except upon the collectively-agreed upon contract terms demanded during negotiations. Furthermore, RFV members did not engage in any efficiency-enhancing integration of their practices sufficient to justify the collectively negotiation or the concerted refusals to deal. The order prohibits RFV from entering into or facilitating any agreement between or among any physicians: (1) to negotiate with payers on any physician's behalf; (2) to deal, refuse to deal, or threaten to refuse to deal with payers; (3) on any terms on which a physician is willing to deal with any payer; or (4) not to deal individually with any payer, or not to deal with any payer other than through RFV. RFV is also prohibited from facilitating exchanges of information between physicians concerning any physician's willingness to deal with a payer or the terms or conditions, including price terms, on which the physician is willing to deal with a payer. RFV is not precluded from engaging in conduct that is reasonably necessary to form or participate in legitimate joint contracting arrangements among competing physicians, such as a "qualified risk-sharing joint arrangement" or a "qualified clinically-integrated joint arrangement," however, the arrangement must not restrict the ability of, or facilitate the refusal of, physicians who participate in it to contract with payers outside of the arrangement.

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Participants

For the *Commission*: *Linda Blumenreich* and *Constance M. Salemi*.

For the *Respondents*: *Sharon E. Caulfield, Caplan and Earnest, LLC* and *Mark Horoschak, Womble Carlyle*.

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 Roaring Fork Valley Physicians I.P.A., hereinafter referred to as "Respondent," has 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:

NATURE OF THE CASE

1. This action concerns horizontal agreements among approximately 85 competing independent physicians and physician practice groups ("physician members") acting through Respondent to engage in concerted refusals to deal and to fix prices with payers offering coverage for health care services in the Garfield County, Colorado area. Respondent orchestrated and carried out these illegal agreements, and Respondent's physician members participated in these illegal agreements, which have increased prices for consumers of physician services in the Garfield County area and have no legitimate justification.

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THE RESPONDENT

2. Respondent is a Colorado corporation with a principal place of business at 1906 Blake Avenue, Glenwood Springs, Colorado 81623.

JURISDICTION

3. Respondent is organized for the purpose, among others, of serving the interest of its members. Respondent exists, and operates, and at all times relevant to this Complaint has existed and operated, in substantial part for the pecuniary benefit of its physician members.

4. Respondent is a “corporation” within the meaning of Section 4 of the Federal Trade Commission Act.

5. At all times relevant to the Complaint, Respondent has been engaged in the business of contracting with payers, on behalf of its physician members, for the provision of physician services to persons for a fee.

6. Except to the extent that competition has been restrained as alleged herein, Respondent's physician members have been, and are now, in competition with one another for the provision of physician services in the Garfield County area.

7. The general business practices of Respondent and its physician members, including the acts and practices herein alleged, affect the interstate movement of patients, the interstate purchase of supplies and products, and the interstate flow of funds, and are in or affecting “commerce” as defined in Section 4 of the Federal Trade Commission Act, as amended, 15 U.S.C. § 44.

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**OVERVIEW OF PHYSICIAN CONTRACTING WITH
PAYERS**

8. Respondent is a type of organization commonly referred to in the health care industry as an “independent practice association” because its members consist of independent physicians in solo and small group practices.

9. Physicians often contract with health plans and other third-party payers (“payers”) to establish the terms and conditions, including price and price-related terms, under which they render physician services to the payers’ enrollees. Physicians entering into such contracts often agree to lower compensation to obtain access to additional patients made available by the payers’ relationships with enrollees. These contracts may reduce payers’ costs and enable them to lower the price of insurance, and thereby result in lower medical-care costs for enrollees.

10. Absent agreements among competing physicians on the prices and terms at which they will provide services to payers’ enrollees, competing physicians decide unilaterally whether to participate in the payers’ provider networks based on the price and other terms and conditions offered by the payers.

11. To be marketable and competitive in the Garfield County area, a payer’s health plan must include in its physician network a large number of primary care and specialist physicians offering services to customers in a sufficient number of practice fields at convenient or accessible locations and at affordable prices. Because a substantial number of the primary care and specialist physicians who practice in the Garfield County area are members of Respondent, payers doing business in the Garfield County area have significant difficulty offering marketable and competitive health plans without having at least a substantial portion of Respondent’s physician members in their provider networks.

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ANTICOMPETITIVE CONDUCT

12. Respondent, acting as a combination and in conspiracy with its physician members, has acted to maintain and increase the rates at which Respondent's physician members contract with payers by (1) facilitating, coordinating, and implementing agreements to refuse to deal with payers except on collectively agreed-upon terms; and (2) facilitating, coordinating, negotiating, entering into, and implementing agreements on price-related terms.

**RESPONDENT'S PHYSICIAN MEMBERS AGREE TO
ABIDE BY THE CONTRACTING RULES AND POLICIES
APPROVED BY RESPONDENT**

13. Respondent was formed in 1994 for the purpose of entering into contracts with health maintenance organizations, insurance companies, and other entities to provide a panel of physicians to perform the physician services covered by the contracts. Under Respondent's by-laws, Respondent's Board of Directors manages its affairs. Board members are elected by the general membership at Respondent's annual meeting.

14. To join Respondent, physicians sign a "Physicians Professional Services Agreement" in which they agree to comply with the contracts that Respondent enters into and to which they opt in or accept; the bylaws, rules, and regulations of Respondent; and any policies and procedures established by Respondent. By signing the "Physicians Professional Services Agreement," Respondent's members agree to refuse and refused to enter into contracts except on Respondent's collectively agreed-upon terms. The collectively agreed-upon terms include, but are not limited to, terms in the "Bona Fide Offer Criteria" and the "Best Practices" formally adopted by Respondent's Board of Directors in mid-2003.

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15. The Bona Fide Offer Criteria states, among other things, that Respondent will not consider any Medicare-based proposal to be a bona fide offer. Respondent would not messenger offers with Medicare-based rates to its members because the offer did not meet the Bona Fide Offer Criteria. The Best Practices identify a cost of living increase (“COLA”) as a term that should be in Respondent’s payer contracts.

16. After a payer’s offer was found to comply with Respondent’s Bona Fide Offer Criteria, Respondent would hold lengthy bargaining sessions during which Respondent pressed payers to use a COLA, other Best Practice terms, and other terms in their contracts. Respondent messengered the negotiated contract to its members at the conclusion of those bargaining sessions.

17. Respondent represented itself to some prospective members as the “group which does the bargaining” with payers on the Best Practices that they should include in their proposed contracts.

**RESPONDENT, WITH ITS MEMBERS, ENGAGED IN
CONCERTED REFUSALS TO DEAL**

18. In order to collectively maintain and increase rates, Respondent’s members agreed to refuse and refused to enter into individual contracts with payers. The payers with whom Respondent’s members refused to deal, included, but were not limited to, United Healthcare, CIGNA, Government Employee Hospital Association Inc., Humana Inc., and Anthem Blue Cross and Blue Shield. When approached by payers asking them to sign individual contracts, members often referred the payers to Respondent for contracting. For example, one member told Respondent that the payer’s “contract agreements are filed in the local landfill. We will wait for them to go back to the IPA.”

19. By adopting the ban on Medicare-based rates, Respondent and its members agreed to refuse to deal and refused to deal with

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any payer using Medicare-based rates in a proposed contract. In a 2004 newsletter, Respondent told its members that it banned Medicare-based rates because any physician who has Medicare-based rates in a payer contract would face “declining reimbursements.”

20. Respondent formally adopted a restrictive network adequacy rule in 2004. The network adequacy rule states that Respondent would only sign and administer messengered contracts that at least 80 percent of all of its members and 50 percent of each specialty accepted.

21. By adopting its restrictive network adequacy rule, Respondent and its physician members again agreed to refuse to deal and refused to deal with any payer except on Respondent’s collectively agreed-upon contract terms. According to a member of the Board of Directors, the network adequacy rule was a mechanism to allow for “a consensus among the community” on the contract terms that should be accepted.

22. Respondent and its members used its restrictive network adequacy rule as a mechanism to facilitate a boycott of national payers. None of the national payers satisfied Respondent’s network adequacy rule. Only one of the national payers eventually satisfied the network adequacy rule after a second messengering attempt, and only after Respondent advised the payer to increase the offered reimbursement level to induce members to accept the contract.

23. Respondent and its members refused to provide payers who had failed to meet the network adequacy rule with the identities of the members who accepted their contracts. This further impeded the ability of the payers to contract individually with physicians and reinforced Respondent’s collective refusals to deal with national payers.

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24. Respondent also reinforced the concerted refusals to deal with payers except on its collectively agreed-upon terms by repeatedly reminding members in newsletters and other documents that Medicare-based rates banned by the Bona Fide Offer Criteria would lead to declining reimbursement, and that Respondent's role was to "keep [members] informed of best practices," and the extent to which payers used its Best Practices in their contracts.

**RESPONDENT COORDINATED AGREEMENT ON
PRICE-RELATED TERMS**

25. Respondent's formal adoption of a ban on Medicare-based rates was designed to maintain reimbursement levels in payer contracts.

26. Respondent's adoption of a COLA term in the "Best Practices," was designed to insure, among other things, that reimbursement in its payer contracts would increase.

27. Even before adopting the COLA term as an official "Best Practice," Respondent reported the benefits of an annual automatic COLA to the members in a 2002 newsletter. The newsletter stated: "Your IPA Board has been unusually inactive this year. The IPA has a Cost of Living Adjustment (COLA) built into all of our contracts so that we don't have to waste time renegotiating every year."

28. Respondent was highly effective in imposing the ban on Medicare-based rates and including the COLA term in payer contracts. None of Respondent's current contracts has rates based on Medicare and all of its contracts have a COLA.

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RESPONDENT'S CONDUCT IS NOT JUSTIFIED

29. Respondent and its physician members have not undertaken any programs or activities that create any integration among their members in the delivery of physician services sufficient to justify their acts or practices described in the foregoing paragraphs. Respondent's members do not share any financial risk in providing physician services, do not collaborate in a program to monitor and modify their clinical practice patterns to control costs or ensure quality, or otherwise integrate their delivery of care to patients.

RESPONDENT'S ACTIONS HAVE HAD SUBSTANTIAL ANTICOMPETITIVE EFFECTS

30. Respondent's actions have had, or tend to have had, the effect of unreasonably restraining trade and hindering competition in the provision of physician services in the Garfield County, Colorado area, in the following ways, among others:

- a. unreasonably restraining price and other forms of competition among physicians;
- b. increasing prices for physician services; and
- c. depriving health plans, employers, and individual consumers of the benefits of competition among physicians.

VIOLATION OF THE FEDERAL TRADE COMMISSION ACT

31. The combination, conspiracy, acts, and practices described above constitute unfair methods of competition in violation of Section 5 of the Federal Trade Commission Act, 15 U.S.C. § 45. Such combination, conspiracy, acts, and practices, or the effects

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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 fifth day of April, issues its Complaint against Respondent.

By the Commission, Commissioner Ramirez not participating.

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DECISION AND ORDER

The Federal Trade Commission ("Commission"), having initiated an investigation of certain acts and practices of Roaring Fork Valley Physicians I. P. A., Inc., hereinafter referred to as "Respondent," and Respondent having been furnished thereafter with a copy of the draft Complaint that counsel for the Commission proposed to present to the Commission for its consideration and which, if issued, would charge Respondent with violations of Section 5 of the Federal Trade Commission Act, as amended, 15 U.S.C. § 45; and

Respondent, its attorney, and counsel for the Commission having thereafter executed an Agreement Containing Consent Order to Cease and Desist ("Consent Agreement"), containing an admission by Respondent of all the jurisdictional facts set forth in the aforesaid draft Complaint, a statement that the signing of said Consent Agreement is for settlement purposes only and does not constitute an admission by Respondent that the law has been violated as alleged in such Complaint, or that the facts as alleged in such Complaint, other than jurisdictional facts, are true, and waivers and other provisions as required by the Commission's Rules; and

The Commission having thereafter considered the matter and having determined that it had reason to believe that Respondent has violated said Act, and that a Complaint should issue stating its charges in that respect, and having accepted the executed Consent Agreement and placed such Consent Agreement on the public record for a period of thirty (30) days for the receipt and consideration of public comments, and having duly considered the comments received from interested persons pursuant to section 2.34 of its Rules, now in further conformity with the procedure described in Commission Rule 2.34, 16 C.F.R. § 2.34, the Commission hereby issues its Complaint, makes the following jurisdictional findings, and issues the following Order:

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1. Respondent is a not-for-profit corporation, organized, existing, and doing business under and by virtue of the laws of the State of Colorado, with its principal address at 1906 Blake Avenue, Glenwood Springs, CO 81601.
2. The Federal Trade Commission has jurisdiction of the subject matter of this proceeding and of the Respondent, and the proceeding is in the public interest.

ORDER**I.**

IT IS ORDERED that, as used in this Order, the following definitions shall apply:

- A. "Respondent" means Roaring Fork Valley Physicians I. P. A, Inc. ("RFVIPA"), its officers, directors, employees, agents, attorneys, representatives, successors, and assigns; and the subsidiaries, divisions, groups, and affiliates controlled by it, and the respective officers, directors, employees, agents, attorneys, representatives, successors, and assigns of each.
- B. "Medical Group Practice" means a bona fide, integrated firm in which Physicians practice medicine together as partners, shareholders, owners, or employees, or in which only one Physician practices medicine.
- C. "Non-exclusive Arrangement" means an arrangement that does not restrict the ability of, or facilitate the refusal of, Physicians who participate in it to deal with payors on an individual basis or through any other arrangement.

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- D. “Participate” in an entity or an arrangement means (1) to be a partner, shareholder, owner, member, or employee of such entity or arrangement, or (2) to provide services, agree to provide services, or offer to provide services to a Payor through such entity or arrangement. This definition applies to all tenses and forms of the word “participate,” including, but not limited to, “participating,” “participated,” and “participation.”
- E. “Payor” means any person that pays, or arranges for payment, for all or any part of any Physician services for itself or for any other person, as well as any person that develops, leases, or sells access to networks of Physicians.
- F. “Person” means both natural persons and artificial persons, including, but not limited to, corporations, unincorporated entities, and governments.
- G. “Physician” means a doctor of allopathic medicine (“M.D.”), a doctor of osteopathic medicine (“D.O.”), or a doctor of podiatric medicine (“D.P.M.”).
- H. “Preexisting Contract” means a contract for the provision of Physician services that was in effect on the date of the receipt by a Payor that is a party to such contract of notice sent by Respondent RFVIPA pursuant to Paragraphs VII.A.2 of this Order of such Payor’s right to terminate such contract.
- I. “Principal Address” means either (1) primary business address, if there is a business address, or (2) primary residential address, if there is no business address.

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- J. “Qualified Clinically-Integrated Joint Arrangement” means an arrangement to provide Physician services in which:
1. all Physicians who participate in the arrangement Participate in active and ongoing programs of the arrangement to evaluate and modify the practice patterns of, and create a high degree of interdependence and cooperation among, the Physicians who Participate in the arrangement, in order to control costs and ensure the quality of services provided through the arrangement; and
 2. any agreement concerning price or other terms or conditions of dealing entered into by or within the arrangement is reasonably necessary to obtain significant efficiencies that result from such integration through the arrangement.
- K. “Qualified Risk-Sharing Joint Arrangement” means an arrangement to provide Physician services in which:
1. all Physicians who Participate in the arrangement share substantial financial risk through their Participation in the arrangement and thereby create incentives for the Physicians who Participate jointly to control costs and improve quality by managing the provision of Physician services such as risk-sharing involving:
 - a. the provision of Physician services at a capitated rate,
 - b. the provision of Physician services for a predetermined percentage of premium or revenue from Payors,

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- c. the use of significant financial incentives (*e.g.*, substantial withholds) for Physicians who Participate to achieve, as a group, specified cost-containment goals, or
 - d. the provision of a complex or extended course of treatment that requires the substantial coordination of care by Physicians in different specialties offering a complementary mix of services, for a fixed, predetermined price, when the costs of that course of treatment for any individual patient can vary greatly due to the individual patient's condition, the choice, complexity, or length of treatment, or other factors; and
 - 2. any agreement concerning price or other terms or conditions of dealing entered into by or within the arrangement is reasonably necessary to obtain significant efficiencies that result from such integration through the arrangement.
- L. "Qualified Arrangement" means a Qualified Clinically-Integrated Joint Arrangement or a Qualified Risk-Sharing Joint Arrangement.

II.

IT IS FURTHER ORDERED that Respondent, directly or indirectly, or through any corporate or other device, in connection with the provision of Physician services in or affecting commerce, as "commerce" is defined in Section 4 of the Federal Trade Commission Act, 15 U.S.C. § 44, cease and desist from:

- A. Entering into, adhering to, Participating in, maintaining, organizing, implementing, enforcing, or otherwise facilitating any combination, conspiracy,

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agreement, or understanding between or among any Physicians with respect to their provision of Physician services:

1. to negotiate on behalf of any Physician with any Payor;
 2. to refuse to deal, or threaten to refuse to deal with any Payor, in furtherance of any conduct or agreement that is prohibited by any other provision of Paragraph II of this Order;
 3. regarding any term, condition, or requirement upon which any Physician deals, or is willing to deal, with any Payor, including, but not limited to, price terms; or
 4. not to deal individually with any Payor, or not to deal with any Payor other than through any Respondent;
- B. Exchanging or facilitating in any manner the exchange or transfer of information among Physicians concerning any Physician's willingness to deal with a Payor, or the terms or conditions, including price terms, on which the Physician is willing to deal with a Payor;
- C. Attempting to engage in any action prohibited by Paragraphs II.A or II.B above; and
- D. Encouraging, suggesting, advising, pressuring, inducing, or attempting to induce any Person to engage in any action that would be prohibited by Paragraphs II.A through II.C above.

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Provided, however, that nothing in this Paragraph II shall prohibit any agreement or conduct involving Respondent that, subject to the requirements of Paragraphs V and VI of this Order, is reasonably necessary to form, Participate in, or take any action in furtherance of, a Qualified Arrangement, so long as such Qualified Arrangement is a Non-exclusive Arrangement.

III.

IT IS FURTHER ORDERED that, for three (3) years from the date this Order becomes final, for any arrangement under which Respondent would act as an agent or messenger, on behalf of any Physician or any Medical Group Practice with any Payor, Respondent shall notify the Commission in writing ("Paragraph III Notification") at least sixty (60) days before acting as an agent or messenger for the first time under the arrangement. Respondent shall also provide Paragraph III Notification for any modifications to an arrangement previously reported to the Commission under this Paragraph. The Paragraph III Notification shall include:

- A. the number of proposed Physician Participants in the proposed arrangement;
- B. the proposed geographic area in which the proposed arrangement would operate;
- C. a copy of any proposed Physician Participation agreement;
- D. a description of the proposed arrangement's purpose and function;
- E. a copy of any rules, best practices or guidance to providers or payers regarding contracting provisions or the contracting process;

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- F. a copy of any rule or requirement regarding participation levels;
- G. a description of any resulting efficiencies expected to be obtained through the proposed arrangement; and
- H. a description of procedures to be implemented to limit possible anticompetitive effects of the proposed arrangement, such as those prohibited by this Order.

IV.**IT IS FURTHER ORDERED** that:

- A. If, within sixty (60) days from the date of the Commission's receipt of the Paragraph III Notification, a representative of the Commission makes a written request to Respondent providing such notification for additional information, then Respondent shall not Participate in the proposed arrangement prior to the expiration of thirty (30) days after substantially complying with such request, or such shorter waiting period as may be granted in writing from the Bureau of Competition;
- B. The expiration of any waiting period described herein without a request for additional information, or without the initiation of an enforcement proceeding, shall not be construed as a determination by the Commission, or its staff, that the proposed arrangement does or does not violate this Order or any law enforced by the Commission;
- C. The absence of notice that the proposed arrangement has been rejected, regardless of a request for additional information, shall not be construed as a determination

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by the Commission, or its staff, that the proposed arrangement has been approved;

- D. Receipt by the Commission of any Paragraph III Notification is not to be construed as a determination by the Commission, or its staff, that the proposed arrangement does or does not violate this Order or any law enforced by the Commission; and
- E. Paragraph III Notification shall not be required prior to Participating in any arrangement for which Paragraph III Notification has previously been given.

V.

IT IS FURTHER ORDERED that for three (3) years from the date this Order becomes final, pursuant to each Qualified Arrangement in which Respondent is a Participant, Respondent shall notify the Commission in writing ("Paragraph V Notification") at least sixty (60) days prior to:

- A. Participating in, organizing, or facilitating any discussion or understanding with or among any Physicians or Medical Group Practices in such Qualified Arrangement relating to price or other terms or conditions of dealing with any Payor; or
- B. Contacting a Payor, pursuant to a Qualified Arrangement to negotiate or enter into any agreement concerning price or other terms or conditions of dealing with any Payor, on behalf of any Physician or Medical Group Practice in such Qualified Arrangement.

VI.**IT IS FURTHER ORDERED** that:

- A. Paragraph V Notification shall include the following information regarding the Qualified Arrangement pursuant to which Respondent intends to engage in the above identified conduct:
1. the total number of Physicians and the number of Physicians in each specialty Participating in the Qualified Arrangement;
 2. a description of the Qualified Arrangement, including its purpose and geographic area of operation;
 3. a description of the nature and extent of the integration and the efficiencies resulting from the Qualified Arrangement;
 4. an explanation of the relationship of any agreement on prices, or contract terms related to price, to furthering the integration and achieving the efficiencies of the Qualified Arrangement;
 5. a description of any procedures proposed to be implemented to limit possible anticompetitive effects resulting from the Qualified Arrangement or its activities; and
 6. all studies, analyses, and reports that were prepared for the purpose of evaluating or analyzing competition for Physician services in any relevant market, including, but not limited to, the market share of Physician services in any relevant market.

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- B. If, within sixty (60) days from the Commission's receipt of the Paragraph V Notification, a representative of the Commission makes a written request to Respondent for additional information, then Respondent shall not Participate in any arrangement described in Paragraph V.A or Paragraph V.B of this Order prior to the expiration of thirty (30) days after substantially complying with such request for additional information, or such shorter waiting period as may be granted in writing from the Bureau of Competition;
- C. The expiration of any waiting period described herein without a request for additional information, or without the initiation of an enforcement proceeding, shall not be construed as a determination by the Commission, or its staff, that the proposed Qualified Arrangement does or does not violate this Order or any law enforced by the Commission;
- D. The absence of notice that the proposed Qualified Arrangement has been rejected, regardless of a request for additional information, shall not be construed as a determination by the Commission, or its staff, that the proposed Qualified Arrangement has been approved;
- E. Receipt by the Commission of any Paragraph V Notification regarding Participation pursuant to a proposed Qualified Arrangement is not to be construed as a determination by the Commission that any such proposed Qualified Arrangement does or does not violate this Order or any law enforced by the Commission; and
- F. Paragraph V Notification shall not be required prior to Participating in any Qualified Arrangement for which Paragraph V Notification has previously been given.

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VII.

IT IS FURTHER ORDERED that Respondent shall:

- A. Within thirty (30) days after the date on which this Order becomes final:
 - 1. send a copy of this Order and the Complaint by first-class mail with delivery confirmation or electronic mail with return confirmation and a letter in Attachment B explaining the Order to:
 - a. every Physician who Participates, or has Participated, in Respondent at any time since January 1, 2001; and
 - b. each current officer, director, manager, and employee of Respondent;
 - 2. send by first-class mail, return receipt requested to the chief executive officer of each Payor with whom Respondent has record of being in contact since January 1, 2001, regarding contracting for the provision of Physician services:
 - a. a copy of this Order and the Complaint; and
 - b. the letter attached as Appendix A to this Order.
- B. Terminate, without penalty or charge, and in compliance with any applicable laws any Preexisting Contract or Contracts with any Payor who is sent the letter attached as Appendix A to this Order, at the earlier of: (1) receipt by Respondent of a written request to terminate such contract from any Payor that is a party to the contract, or (2) the earliest termination

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date, renewal date (including any automatic renewal date), or the anniversary date of such contract.

Provided, however, a Preexisting Contract with a Payor to be terminated pursuant to Paragraph VII.B may extend beyond any such termination or renewal date no later than one (1) year from the date that the Order becomes final if, prior to such termination or renewal date:

- a. the Payor submits to Respondent a written request to extend such contract to a specific date no later than one (1) year from the date that this Order becomes final, and
- b. Respondent has determined not to exercise any right to terminate.

Provided further, that any Payor making such request to extend a contract retains the right, pursuant to Paragraph VII.B. of this Order, to terminate the Preexisting Contract at any time.

- C. Within ten (10) days of receiving a written request to terminate from a Payor, pursuant to Paragraph VII.B of this Order, distribute, by first-class mail, return receipt requested, a copy of that request to each Physician Participating in such contract as of the date that Respondent receives such request to terminate; and
- D. For three (3) years from the date this Order becomes final:
 1. Distribute by first-class mail, return receipt requested, a copy of this Order and the Complaint to:

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- a. each Physician who begins Participating in Respondent, and who did not previously receive a copy of this Order and the Complaint from Respondent within thirty (30) days of the time that such Participation begins;
 - b. each Payor who contracts with Respondent for the provision of Physician services, and who did not previously receive a copy of this Order and the Complaint from Respondent, within thirty (30) days of the time that such Payor enters into such contract; and
 - c. each Person who becomes an officer, director, manager, or employee of Respondent, and who did not previously receive a copy of this Order and the Complaint from Respondent, within thirty (30) days of the time that he or she assumes such position;
2. Annually publish in any official report or newsletter sent to all Physicians who Participate in Respondent a copy of this Order and the Complaint with such prominence as is given to regularly featured articles.

VIII.

IT IS FURTHER ORDERED that Respondent shall file verified written reports within sixty (60) days from the date this Order becomes final, annually thereafter for three (3) years on the anniversary of the date this Order becomes final, and at such other times as the Commission may by written notice require. Each report shall include, among other information that may be necessary:

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- A. The name, address, and telephone number of each Payor with which Respondent has had any contact during the one (1) year period preceding the date for filing such report;
- B. The identity of each Payor sent a copy of the letter attached as Appendix A, the response of each Payor to that letter, and the status of each contract to be terminated pursuant to that letter;
- C. Copies of the delivery confirmations or electronic mail with return confirmations required by Paragraph VII.A.1, and copies of the signed return receipts required by Paragraphs VII.A.2, VII.C, and VII.D; and
- D. A detailed description of the manner and form in which Respondent has complied and is complying with this Order.

IX.

IT IS FURTHER ORDERED that Respondent shall notify the Commission:

- A. Of any change in its Principal Address within twenty (20) days of such change in address; and
- B. At least thirty (30) days prior to any proposed: (a) dissolution of Respondent; (b) acquisition, merger, or consolidation of Respondent; or (c) any other change in Respondent including, but not limited to, assignment and the creation or dissolution of subsidiaries, if such change might affect compliance obligations arising out of this Order.

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X.

IT IS FURTHER ORDERED that, for the purpose of determining or securing compliance with this Order, and subject to any legally recognized privilege, and upon written request and upon five (5) days notice to Respondent, Respondent shall, without restraint or interference, permit any duly authorized representative of the Commission:

- A. Access, during office hours of Respondent, and in the presence of counsel, to all facilities and access to inspect and copy all books, ledgers, accounts, correspondence, memoranda, and all other records and documents in the possession, or under the control, of Respondent relating to compliance with this Order, which copying services shall be provided by Respondent at its expense; and
- B. To interview officers, directors, or employees of Respondent, who may have counsel present, regarding such matters.

XI.

IT IS FURTHER ORDERED that this Order shall terminate on April 5, 2030.

By the Commission, Commissioner Ramirez not participating.

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APPENDIX A

[letterhead of RFVIPA]

[name of payor's CEO]

[address]

Dear _____:

Enclosed is a copy of a complaint and a consent order ("Order") issued by the Federal Trade Commission against Roaring Fork Valley Physicians I.P.A., Inc. ("Roaring Fork").

Pursuant to Paragraph VII.B of the Order, Roaring Fork must allow you to terminate, upon your written request, without any penalty or charge, any contracts with Roaring Fork that are in effect as of the date you receive this letter.

If you do not make a written request to terminate the contract, Paragraph VII.B. further provides that the contract will terminate on the earlier of the contract's termination date, renewal date (including any automatic renewal date), or anniversary date, which is [date].

You may, however, ask Roaring Fork to extend the contract beyond [date], the termination, renewal, or anniversary date, to any date no later than [date], one (1) year after the date the Order becomes final.

If you choose to extend the term of the contract, you may later terminate the contract at any time.

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Any request either to terminate or to extend the contract should be made in writing, and sent to me at the following address: [address].

Sincerely,

[Roaring Fork to fill in information in brackets]

APPENDIX B

[Letterhead of Roaring Fork Valley Physicians I.P.A.]

Dear Member:

The Federal Trade Commission has ordered the Roaring Fork Valley Physicians I. P. A., Inc. ("Roaring Fork"), to cease and desist its collective contracting activities. A copy of the Commission's Complaint and Order is enclosed.

In order that you may readily understand the terms of the Order, we have set forth its essential provisions and describe its application to Roaring Fork's contracting activities, although you must realize that the Order itself is controlling, rather than the following explanation of its provisions.

(1) Roaring Fork, on behalf of its members, is prohibited from engaging in any collective contracting activities affecting rates in payer contracts. Roaring Fork is prohibited under the Order from:

(i) collectively refusing to accept proposed contracts for messengering with Medicare-based rates,

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- (ii) collectively asking payers to include a cost of living adjustment in the contract to be messengered, and
- (iii) directing payers seeking information on the rates acceptable to members to look at collectively-negotiated I. P. A. contracts;

The Order prohibits the adoption and enforcement of any new rule or guidance affecting the rates of its members in payer contracts.

(2) Roaring Fork, with and on behalf of its members, is further prohibited from adopting or implementing any rule or guideline or engaging in other conduct that promotes members' collective refusals to deal with payers that do not conform to Roaring Fork's bona fide offer criteria, best practices or other contracting guidance. Examples of the prohibited conduct include:

- (i) the network adequacy rule stating that 80 percent of the members and 50 percent of the specialists must accept a contract before Roaring Fork agrees to administer it; and
- (ii) the rule preventing Roaring Fork from providing payers with the identity of members who wish to contract with the payer.

(3) All Roaring Fork contracts currently in effect with payers must be canceled no later than one year after the Order becomes final.

Sincerely yours,

[appropriate RFV officer]

Analysis to Aid Public Comment

**ANALYSIS OF AGREEMENT CONTAINING CONSENT
ORDER TO AID PUBLIC COMMENT**

The Federal Trade Commission has accepted, subject to final approval, an agreement containing a proposed consent order (“proposed order”) with Roaring Fork Valley Physicians I.P.A., Inc., (“RFV”). The agreement settles charges by the Federal Trade Commission that RFV violated Section 5 of the Federal Trade Commission Act, 15 U.S.C. § 45, by, among other things, orchestrating and implementing price-related agreements and concerted refusals to deal among competing physician members of RFV to maintain and raise the price at which RFV’s physician members contract with payers.

The proposed order has been placed on the public record for 30 days to receive comments from interested persons. Comments received during this period will become part of the public record. After 30 days, the Commission will review the agreement and the comments received, and will decide whether it should withdraw from the agreement or make the proposed order final.

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

The Complaint

The allegations of the complaint are summarized below.

RFV is a type of organization commonly referred to in the health care industry as an “independent practice association” because its members consist of independent physicians in solo and small group practices. RFV is controlled by and organized in

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substantial part for the pecuniary benefit of its approximately 85 physician members. RFV is located in Garfield County, Colorado.

The complaint alleges that since at least 2003 RFV, although purporting to use a messenger model, negotiated price-related terms on behalf of its members for the purpose of increasing and maintaining the rates for services provided by RFV's otherwise competing physician members. RFV increased rates by demanding that payers include automatic annual cost of living adjustments (COLAs) in their contracts. RFV held lengthy bargaining sessions with payers to pressure them into including COLAs and other terms in their contracts. To protect the automatic increases, RFV refused to messenger contracts with Medicare-based rates because of their potential to decline. RFV feared Medicare-based rates would decline over time.

The complaint also alleges that since at least 2003 RFV and its members engaged in concerted refusals to deal with payers except upon the collectively-agreed upon contract terms demanded during negotiations. RFV organized concerted refusals to deal by requiring payers contracting with RFV to persuade 80 percent of all RFV members and 50 percent of each RFV specialty ("80/50 rule") to accept their contracts. After a payer satisfied the 80/50 rule, RFV signed, administered and bound all the members to the payer's contract. RFV refused to messenger the contract of a payer who failed to satisfy the 80/50 rule. RFV reinforced the 80/50 rule by refusing to provide unsuccessful payers with the identity of the members willing to accept their contracts. RFV's refusal prevented the unsuccessful payers from contracting directly with individual physicians willing to accept the proposed contract terms. RFV also reinforced its concerted refusals to deal by encouraging members to only use the IPA for their contracting. RFV targeted its concerted refusals at national payers and warned members against contracting with them. Most national payers attempting to contract with RFV could not satisfy the 80/50 rule. RFV members did not engage in any efficiency-enhancing

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integration of their practices sufficient to justify the collectively negotiation or the concerted refusals to deal. Accordingly, the complaint alleges that RFV violated Section 5 of the FTC Act.

The Proposed Order

The proposed order is designed to remedy the illegal conduct charged in the complaint and prevent its recurrence. It is similar to recent consent orders that the Commission has issued to settle charges that physician groups engaged in unlawful agreements to raise fees they receive from health plans.

The proposed order's specific provisions are as follows:

Paragraph II.A prohibits RFV from entering into or facilitating any agreement between or among any physicians: (1) to negotiate with payers on any physician's behalf; (2) to deal, refuse to deal, or threaten to refuse to deal with payers; (3) on any terms on which a physician is willing to deal with any payer; or (4) not to deal individually with any payer, or not to deal with any payer other than through RFV.

Other parts of Paragraph II reinforce these general prohibitions. Paragraph II.B prohibits RFV from facilitating exchanges of information between physicians concerning any physician's willingness to deal with a payer or the terms or conditions, including price terms, on which the physician is willing to deal with a payer. Paragraph II.C bars attempts to engage in any action prohibited by Paragraph II.A or II.B, and Paragraph II.D proscribes RFV from inducing anyone to engage in any action prohibited by Paragraphs II.A through II.C.

As in other Commission orders addressing providers' collective conduct with health-care purchasers, Paragraph II excludes certain kinds of agreements from its prohibitions. First, RFV is not precluded from engaging in conduct that is reasonably necessary to form or participate in legitimate joint contracting arrangements among competing physicians, such as a "qualified

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risk-sharing joint arrangement” or a “qualified clinically-integrated joint arrangement.” The arrangement, however, must not restrict the ability of, or facilitate the refusal of, physicians who participate in it to contract with payers outside of the arrangement.

As defined in the proposed order, a “qualified risk-sharing joint arrangement” possesses two characteristics. First, all physician participants must share substantial financial risks through the arrangement, such that the arrangement creates incentives for the physician participants jointly to control costs and improve quality by managing the provision of services. Second, any agreement concerning reimbursement or other terms or conditions of dealing must be reasonably necessary to obtain significant efficiencies through the joint arrangement.

A “qualified clinically-integrated joint arrangement,” on the other hand, need not involve any sharing of financial risk. Instead, as defined in the proposed order, physician participants must participate in active and ongoing programs to evaluate and modify their clinical practice patterns in order to control costs and ensure the quality of services provided, and the arrangement must create a high degree of interdependence and cooperation among physicians. As with qualified risk-sharing arrangements, any agreement concerning price or other terms of dealing must be reasonably necessary to achieve the efficiency goals of the joint arrangement.

Paragraph III, for three years, requires RFV to notify the Commission before it enters into any arrangements to act as a messenger or an agent on behalf of any physicians, with payers regarding contracts. Paragraph IV sets out the information necessary to make the notification complete.

Paragraph V, for three years, requires RFV to notify the Commission before participating in contracting with health plans on behalf of either a qualified risk-sharing or a qualified

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clinically-integrated joint arrangement. Paragraph VI sets out the information necessary to satisfy the notification requirement.

Paragraph VII imposes other notification obligations on RFV and requires the termination of certain contracts that were entered into illegally. Paragraph VII.A require RFV to distribute the complaint and order to (1) physicians who have participated in RFV since 2001; (2) to various past and current personnel of RFV; and (3) to payers with whom RFV has dealt since 2001. Paragraph VII.B requires RFV, at any payer's request and without penalty, to terminate its existing contracts with the payer for the provision of physician services. Paragraph VII.B allows certain contracts currently in effect to be extended at the written request of the payer no longer than one year from the date that the order becomes final. Paragraph VII.C requires RFV to distribute payer requests for contract termination to physicians who participate in the contract Paragraph VII.D requires RFV for three years, to provide new members, personnel, and payers not previously receiving a copy, a copy of the Order and the Complaint. Paragraph VII.D also requires RFV to publish annually a copy of the Order and the Complaint in its newsletter.

Paragraphs VIII, IX, and X impose various obligations on RFV to report or provide access to information to the Commission to facilitate the monitoring of compliance with the order. Finally, Paragraph XI provides that the order will expire in 20 years.

Complaint

IN THE MATTER OF

RICHARD J. STANTONCONSENT ORDER, ETC. IN REGARD TO ALLEGED VIOLATIONS OF
SEC. 5(A) OF THE FEDERAL TRADE COMMISSION ACT

Docket No. C-4287; File No. 072 3165
Filed, April 5, 2010 — Decision, April 5, 2010

This consent order addresses Richard J. Stanton's marketing and distribution of a variety of online seal certification marks ("website seals" or "seals") for companies to display on their websites. Mr. Stanton falsely represented to consumers that his company, Controlscan, had verified the privacy and security protections offered by a company displaying ControlScan's Business Background Reviewed, Registered Member, Privacy Protected, and Privacy Reviewed seals, and falsely represented how frequently ControlScan reviewed a company's fitness to display each of these seals, as well as an additional seal, the Verified Secure seal. The complaint describes, with specificity, the claims respondent made regarding its verification of a company displaying each of the challenged seals, as well as the verification that ControlScan in fact conducted in connection with each seal. The consent order prohibits respondent from misrepresenting: 1) the verification that is conducted concerning the protection that a company provides for the privacy and/or security of consumer information or the steps a company has taken to provide such protection; or 2) the frequency of such verification. Mr. Stanton was required to pay to the Commission \$102,000 in equitable monetary relief.

Participants

For the *Commission*: *Laura Berger, Katie Race Brin, and Kristin Krause Cohen.*

For the *Respondents*: *Steven D. Cooper, Stites & Harbison, PLLC.*

COMPLAINT

The Federal Trade Commission, having reason to believe that Richard Stanton, through his direction, control, and ownership of