

Complaint

IN THE MATTER OF

MINNESOTA RURAL HEALTH COOPERATIVECONSENT ORDER, ETC., IN REGARD TO ALLEGED VIOLATION OF
SEC. 5 OF THE FEDERAL TRADE COMMISSION ACT*Docket No. C-4311; File No. 051 0199**Complaint, December 28, 2010 — Decision, December 28, 2010*

The consent order addresses allegations that the Minnesota Rural Health Cooperative (“MRHC”) eliminated competition between individual doctors and hospitals in southwest Minnesota by orchestrating illegal agreements to fix the prices at which they contract with health insurance plans and by refusing to deal with health plans that did not agree to MRHC’s desired reimbursement rates. The consent order prohibits MRHC from using coercive tactics to extract favorable contract terms from health plans and requires MRHC to offer to renegotiate all current contracts with health plans and to submit any revised contracts to the state for approval.

Participants

For the *Commission*: Robert S. Canterman and Randall David Marks.

For the *Respondent*: Mike Hatch, Blackwell Burke; Stephen L. Hill, Blackwell Sanders Peper Martin LLP; David Balto, Law Offices of David Balto; and Jeff Miles and Christie Braun, Ober Kaler.

COMPLAINT

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

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I. NATURE OF THE CASE

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

II. RESPONDENTS AND JURISDICTION

A. Respondent

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

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

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

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B. Jurisdiction

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

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

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

III. OVERVIEW OF HEALTH CARE PROVIDER CONTRACTING

A. Nature of Provider Contracting

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

9. Physicians, hospitals, and pharmacists entering into payer contracts often agree to discount or lower their prices in exchange for access to additional patients made available by the payers' relationship with their subscribers. These contracts with physicians, hospitals, and pharmacies may reduce payers' costs

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and enable payers to lower the price of health insurance and reduce patients' out-of-pocket medical care expenditures.

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

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

B. The Medicare Part D Program

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

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

14. The need to satisfy network access requirements gave pharmacies leverage in their dealings with the third-party payers,

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as well as the incentive to act collectively. If they acted collectively to deny third-party payers enough pharmacies to meet the access standards, they would more easily force third-party payers to raise their reimbursement rates.

IV. ANTICOMPETITIVE CONDUCT

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

A. Agreement among MRHC Members to Negotiate Collectively

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

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

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

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B. Price Agreements on Physician and Hospital Services

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

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

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

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

23. First, the MRHC obtained higher prices from payers. Indeed, the MRHC told its members at the 2005 annual member meeting that improvements in its contract with Preferred One

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would be “worth \$100,000s annually for MRHC members.” Five payers — HealthPartners, Medica, MultiPlan, Preferred One, and America’s PPO — have paid MRHC members more than comparable rural hospitals and/or physicians elsewhere in Minnesota.

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

25. Third, the MRHC has forced payers to reimburse new MRHC members at the higher MRHC rates, even though the members had existing contracts with the payer that paid lower rates. For example, MultiPlan had to increase one hospital’s reimbursement rate from 78 percent of billed charges to a significantly higher percent of billed charges merely because it joined the MRHC. Moreover, Medica told the MRHC that “because of the Co-op relationship all of the clinics and hospitals, except Rice, are being paid higher reimbursement then they were prior to our Medica agreement with the Co-op.”

C. Price Agreements on Pharmacy Services

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

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

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28. By “stand[ing] together and speak[ing] with ONE voice to the PBMs,” the MRHC believed it could leverage the federal access requirements for Part D networks to obtain higher reimbursement rates. The MRHC repeatedly stressed the benefits of standing together and negotiating as a block in letters to members and prospective members. A June 27, 2005, letter explained that:

With our membership in MRHC comes the opportunity to stand together and speak with ONE voice to the PBMs. . . . We have to stand together in this effort or once again the PBMs will intimidate us and pick us off one by one with contracts we don’t want.

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

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

Do NOT sign and return your Medicare Part D PBM contracts. MRHC will review and negotiate these for you during the next few weeks. The contracting deadline is not until later this summer and our best leverage is to take our time to negotiate as a block. The bigger block the better [sic].

The MRHC repeated this message to prospective members:

We are asking all MRHC members NOT to sign and return their Medicare Part D PBM contracts. MRHC will review and negotiate these for them during the next couple of weeks. Our best leverage is to take our time to negotiate as a block, and the bigger block the better. . . . [sic]

Don’t sign contracts but notify the PBMs who will act as your agent – the MRHC!

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

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

V. LACK OF JUSTIFICATION FOR THE CONDUCT

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

33. The MRHC’s physician members do not share significant financial risk in providing physician services under the contracts between the MRHC and payers discussed above. Four of these contracts with commercial insurers have no financial risk-sharing mechanisms whatsoever. The withholding arrangements in the remaining three contracts withhold at most ten percent of physician charges and return money to the MRHC members regardless of whether they achieve cost-containment goals.

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

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Moreover, their price fixing is not reasonably necessary to engage in these activities.

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

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

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

VI. MINNESOTA POLICY CONCERNING HEALTH CARE COOPERATIVES

38. In 1994, Minnesota authorized the formation of health care cooperatives. The enabling legislation provided that, with certain limitations, a cooperative was "not a combination in restraint of trade" and any cooperative contracts or agreements with a payer "are not contracts that unreasonably restrain trade." 2009

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Minnesota Statutes, § 62R.06, subd. 3. Among the limitations, the law declared it “unlawful for any health care provider cooperative to engage in any acts of coercion, intimidation, or boycott of, or any concerted refusal to deal with, any health plan company seeking to contract with the cooperative on a competitive, reasonable, and nonexclusive basis.” 2009 Minnesota Statutes, § 62R.08(d).

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

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

VII. ANTICOMPETITIVE EFFECTS

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

- a. Unreasonably restraining price and other competition among the MRHC hospital members and among the MRHC physician members;
- b. Increasing prices for hospital and physician services; and
- c. Depriving third-party payers and consumers of the benefits of such competition.

42. The MRHC recruited pharmacists to negotiate collectively agreements with PBMs. Their actions had the purpose of unreasonably restraining trade and hindering competition in the

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provision of pharmacy services in Minnesota by unreasonably restraining price and other competition among the MRHC's pharmacy members, and thereby had the potential to harm consumers by depriving them of the benefits of such competition.

VIII. VIOLATION OF THE FTC ACT

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

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

By the Commission.

DECISION AND ORDER

The Federal Trade Commission ("Commission"), having initiated an investigation of the Minnesota Rural Health Cooperative ("MRHC"), hereinafter sometimes collectively 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

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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 an interested person pursuant to Commission Rule 2.34, 16 C.F.R. § 2.34, now in further conformity with the procedure described in Commission Rule 2.34, the Commission hereby issues its Complaint, makes the following jurisdictional findings, and issues the following Order:

1. The Minnesota Rural Health Cooperative is a for-profit corporation organized, existing, and doing business under and by virtue of the laws of the State of Minnesota with its principal address at 190 E.4th Street N, PO Box 155, Cottonwood, Minnesota 56229-9902.
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. "MRHC" shall mean the Minnesota Rural Health Cooperative; its officers, directors, employees, agents,

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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. “Distribute” means to provide a copy of the specified documents by (1) personal delivery, with a signed receipt of confirmation; (2) first-class mail with delivery confirmation or return receipt requested; (3) facsimile with return confirmation; or (4) electronic mail with electronic return confirmation.
- C. “Hospital” means a health care facility licensed by the State of Minnesota as a Hospital.
- 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, Hospital, or Pharmacy services to itself or any other Person, as well as any Person that develops, leases, or sells access to networks of Physicians, Hospitals, or Pharmacies.
- F. “Person” means both natural persons and artificial persons, including, but not limited to corporations, unincorporated entities, and governments.
- G. “Pharmacy” means any Person licensed by the State of Minnesota to dispense pharmaceuticals.
- H. “Physician” means a doctor of allopathic medicine (“M.D.”) or a doctor of osteopathic medicine (“D.O.”).

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- I. “Preexisting Contract” means a contract for the provision of Physician, Hospital, or Pharmacy 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 MRHC pursuant to Paragraph III.A.2 of this Order of such Payor’s right to terminate such contract.
- J. “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.

II.

IT IS FURTHER ORDERED that MRHC, directly or indirectly, or through any corporate or other device, in connection with the provision of Physician, Hospital, or Pharmacy 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, agreement, or understanding between or among any Physicians, Hospitals, or Pharmacies with respect to the provision of Physician, Hospital, or Pharmacy services:
 - 1. to refuse to deal, or threaten to refuse to deal with any Payor regarding any term, condition, or requirement upon which any Physician, Hospital, or Pharmacy deals, or is willing to deal with any Payor, including, but not limited to, price terms; or
 - 2. not to deal individually with any Payor, or not to deal with any Payor other than through MRHC;
- B. Submitting to the Minnesota Department of Health for approval any agreement with any Payor if the MRHC or any of its officers, directors, members, or employees engaged in any acts of coercion, intimidation, or

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boycott of, or any concerted refusal to deal with, any Payor seeking to contract with the MRHC;

- C. Exchanging or facilitating in any manner the exchange or transfer of information to facilitate any action prohibited by Paragraphs II.A and II.B;
- D. Attempting to engage in any action prohibited by Paragraphs II.A through II.C above; and
- E. 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.D above.

Provided, however, that it shall not of itself constitute a violation of Paragraph II of this Order for MRHC, when negotiating with any Payor in compliance with Minnesota Annotated Code § 62R.01, *et seq.*, to:

- (1) reject any offer or counter-offer or refuse to contract; or
- (2) exchange such information as is reasonably necessary to contract pursuant to negotiating or contracting with any Payor.

III.

IT IS FURTHER ORDERED that MRHC shall:

- A. Within thirty (30) days from the date this Order becomes final:
 - 1. Distribute this Order and the Complaint to each current officer, director, member, or employee of MRHC; and
 - 2. Send by first-class mail, with return receipt requested, with the letter attached as the Appendix, to the chief executive officer of each Payor with

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which MRHC has contracted at any time since January 1, 2005.

- B. Terminate, without penalty or charge, and in compliance with any applicable laws, any Preexisting Contract with any Payor, at the earlier of: (1) receipt by MRHC of a written request from a Payor to terminate such contract, or (2) the earliest termination or renewal date (including any automatic renewal date) of such contract.

Provided, however, a Preexisting Contract for Physician services or Hospital services 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:

1. the Payor submits to MRHC 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
2. MRHC 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 III.B of this Order, to terminate the Preexisting Contract at any time.

- C. Within ten (10) days of receiving notification from a Payor to terminate, pursuant to Paragraph III.B of the Order, notify in writing, by first class mail with return receipt requested, each Physician, Hospital, or Pharmacy that provides services through that contract to be terminated.
- D. For three (3) years after the date on which this Order becomes final:

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1. Distribute this Order and the Complaint to each person who becomes an officer, director, member, or employee of MRHC, and who did not previously receive a copy of this Order and the Complaint, within thirty (30) days of the time that he or she becomes an officer, director, member, or employee;
2. send by first class mail, return receipt requested, a copy of this Order and the Complaint to each Payor who contracts with MRHC for the provision of Physician services or Hospital services and who did not previously receive a copy of this Order and the Complaint, within thirty (30) days of the time that such Payor enters into such contract; and
3. annually publish in the MRHC Newsletter, or any successor publication sent to all Physician and Hospital members of MRHC, this Order and the Complaint with such prominence as is given to regularly featured articles.

IV.

IT IS FURTHER ORDERED that MRHC shall file a verified written report 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.

- A. Each report shall include, among other information that may be necessary:
 1. a detailed description of the manner and form in which MRHC has complied and is complying with this Order;
 2. the name, address, and telephone number of each Payor with which each MRHC has had any contact during the one (1) year period preceding the date for filing such report; and

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3. the status of each contract required to be terminated.
- B. The sixty day report shall also include, in addition to the information required by Paragraph IV.A:
1. the identity of each Payor sent a copy of the letter in the Appendix to the Order and the response of each Payor to that letter;
 2. a copy of each verification of Distribution required by Paragraph III.A.1; and
 3. a copy of each return receipt required by Paragraph III.A.2 and Paragraph III.C
- C. Each annual report shall also include, in addition to the information required by Paragraph IV.A:
1. a copy of each verification of Distribution required by Paragraph III.D.1;
 2. a copy of each return receipt required by Paragraph III.D.2; and
 3. evidence that the copy of the Order and Complaint has been published, as required by Paragraph III.D.3.

V.

IT IS FURTHER ORDERED that MRHC 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: (1) any proposed dissolution of MRHC; (2) any proposed acquisition, merger, or consolidation of MRHC; or (3) any other change in MRCH including, but not limited to,

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assignment and the creation or dissolution of subsidiaries, if such change might affect compliance obligations arising out of this Order.

VI.

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 MRHC, that MRHC shall, without restraint or interference, permit any duly authorized representative of the Commission:

- A. Access, during office hours of MRHC 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 MRHC relating to compliance with this Order, which copying services shall be provided by MRHC at its expense; and
- B. To interview officers, directors, or employees of MRHC, who may have counsel present, regarding such matters.

VII.

IT IS FURTHER ORDERED that this Order shall terminate on December 28, 2030.

By the Commission.

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APPENDIX

[letterhead of MRHC]

[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 Minnesota Rural Health Cooperative ("MRHC").

Pursuant to Paragraph III.B. of the Order, MRHC must allow you to terminate, upon your written request, without any penalty or charge, any contracts with MRHC 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 III.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 MRHC 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.

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,

[MRHC to fill in information in brackets]

Analysis to Aid Public Comment

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

The Federal Trade Commission has accepted, subject to final approval, an agreement containing a proposed consent order with the Minnesota Rural Health Cooperative (MRHC).

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

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

I. The Complaint

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

A. Price Fixing For Hospital And Physician Services

The MRHC has approximately 25 hospital members, which constitute the vast majority of hospitals in the area of southwestern Minnesota in which the MRHC operates. The organization has approximately 70 physician members practicing

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in 41 clinics, who represent roughly half of the primary care physicians in southwestern Minnesota. The MRHC is controlled by a Board of Directors composed of physicians and hospitals elected by the members.

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

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

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

The MRHC informed payers that the MRHC "expect[s] our group to be accepted or rejected as a group." It told payers that resisted the MRHC's price demands that they would be unable to negotiate individually with MRHC members. When these payers attempted to contract directly with individual MRHC hospitals or physicians, the members referred the payers back to MRHC.

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Through its collective negotiations and coercive tactics, the MRHC succeeded in obtaining higher payments to MRHC members by obtaining higher reimbursement rates than comparable providers, more favorable payment methods, and increased reimbursements for new MRHC members.

(1) Higher Rates: Five payers — HealthPartners, Medica, MultiPlan, Preferred One, and America’s PPO — paid MRHC members more than they paid comparable rural hospitals and physicians elsewhere in Minnesota. Indeed, the MRHC told its members at the 2005 annual member meeting that improvements in its contract with Preferred One would be “worth \$100,000s annually for MRHC members.”

(2) Favorable Payment Methods: Two payers — Medica and Preferred One — pay MRHC hospital and physician members based on a percentage of billed charges, rather than a fixed fee for each service. This mechanism allows MRHC members to increase unilaterally their reimbursement, by increasing their billed charges up to the maximum specified in the contract. (3) Increased New Member Reimbursements: The MRHC has forced payers to reimburse new MRHC members at the higher MRHC rates, even though these new members had existing contracts with the payer at lower rates. For example, Medica told the MRHC that “because of the Co-op relationship all of the clinics and hospitals, except Rice, are being paid higher reimbursement than they were prior to our Medica agreement with the Co-op.”

B. Price Fixing For Pharmacy Services

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

The MRHC urged pharmacies not to deal individually with PBMs and instead to act together through MRHC. The MRHC repeatedly reminded pharmacies of the benefits of acting

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collectively, advising them to “stand together and speak with ONE voice to the PBMs.” For example, in letters to members and prospective members, MRHC stated:

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

To “speed up” the PBMs’ acceptance of the MRHC as the pharmacies’ bargaining agent, the MRHC provided each pharmacy member with pre-printed labels stating that MRHC would act as the pharmacy’s contracting agent. Many member pharmacies followed the MRHC’s instructions to return contract offers from PBMs with these labels attached.

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

C. Lack Of Justification

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

1. Hospital And Physician Services

One form of efficiency-enhancing integration among otherwise competing health care providers involves arrangements in which the participants share with one another substantial financial risk for the services provided through the network. Such risk sharing occurs when mechanisms are in place that make the network providers as a group accountable for the total cost of defined services delivered to a group of covered individuals, so that the providers have incentives to cooperate in controlling costs and improving quality by managing the provision of services. The Statements of Antitrust Enforcement Policy in Health Care issued by the FTC and the Department of Justice provide several examples of types of arrangements through which participants can potentially share substantial financial risk.

MRHC's hospital and physician members have not shared, and do not share, substantial financial risk in the provision of patient care. MRHC considers only three of its contracts with payers to be "risk" contracts, and these contracts pertain only to physician services. Moreover, these contracts do not provide significant financial incentives for members to collaborate to improve the performance of the group as a whole. For example, under two of the three "risk" contracts, the payers withheld a relatively modest portion of the payments owed to participating physicians (typically no more than 10 percent), and return of these sums did not depend on the group meeting cost containment or quality improvement performance targets. Instead, physicians

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merely had to participate in a quality improvement project in which they reported their compliance with clinical practice guidelines for treatment of a few specific conditions. These arrangements, while perhaps benefitting some physicians' individual delivery of health care, would thus be unlikely to create incentives to motivate MRHC physicians to work together to improve significantly group-wide care to patients. Health Care Statements at 68.

Arrangements among competing health care providers that do not involve the sharing of financial risk may also involve integration that has the potential to create significant efficiencies in the provision of health care services. The Health Care Statements discuss an example of such integration: a "clinically integrated" program, which involves "an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality." Health Care Statements at 72-73.

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

First, the scope of these activities is very limited. The clinical programs most likely to improve the quality of patient care do not involve the hospital members at all, and the activities involving physicians are limited to just a few of the many medical conditions the physicians treat. Moreover, even in these limited areas, the programs do not create any collaborative activity or interdependence among the physician members. Although the activities may lead individual physicians to modify their behavior,

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none of the programs creates enforceable obligations for physicians to improve their clinical operations or provides members with a shared stake in the performance of the group as a whole. Indeed, all of these activities are essentially informational and each physician clinic could engage in them on its own without any involvement from the other clinics. Finally, the challenged conduct — jointly negotiating with payors and agreeing on prices and other competitively sensitive terms — is unnecessary for members to engage in any of these activities.

2. Pharmacy Services

Similarly, the MRHC's joint price setting for pharmacy services was not related to any integration among its members. The MRHC recruited pharmacies for the purpose of increasing the pharmacies' bargaining leverage in negotiations with PBMs. Aside from inviting pharmacists to attend continuing education programs that it was already providing for its non-pharmacist members, the MRHC's sole activity relating to its pharmacy members was negotiating and administering contracts.

In sum, MRHC's horizontal price fixing does not plausibly promote any efficiency-enhancing integration of its members services and so violates Section 5 of the FTC Act.

D. Lack Of Protection From The State Action Doctrine

The MRHC's anticompetitive conduct is not shielded by the state action doctrine because there was no active supervision of MRHC's conduct and Minnesota does not appear to have articulated a policy to immunize concerted refusals to deal or other forms of coercive conduct.

Since 1999, Minnesota law has authorized health care provider cooperatives to contract with purchasers on a fee-for-service basis and specified that, with certain limitations, such contracts "are not contracts that unreasonably restrain trade." Although state economic regulation can immunize private parties from federal antitrust liability, states may not simply authorize private parties to violate the antitrust laws. Instead, a state must substitute its own control for that of the market. Thus, as the Supreme Court explained in *California Retail Liquor Dealers*

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Assen v. Midcal Aluminum, Inc., private parties claiming the protection of the state action doctrine must demonstrate that their challenged conduct was both (1) undertaken pursuant to a clearly articulated state policy to displace competition with regulation and (2) actively supervised by state officials.

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

In 2009, Minnesota enacted a law establishing a process by which the state Department of Health is to review and approve or disapprove health care provider contracts with third-party payers. The prospect of state review of MRHC's contracts in the future does not provide antitrust immunity for MRHC's prior unsupervised conduct, and the absence of state supervision by itself establishes that the conduct challenged in the complaint is not protected by the state action doctrine.

Second, the Minnesota statute does not appear to articulate a policy to protect MRHC's activities insofar as they involved concerted refusals to deal or other forms of coercive conduct. The statutory provision declaring that health care provider cooperative contracts are not unreasonable restraints of trade is expressly limited, for it is made "[s]ubject to Section 62R.08," a provision entitled "Prohibited Practices" that bars certain types of conduct by provider cooperatives. That provision, among other things, states:

It shall be unlawful for any health care provider cooperative to engage in any acts of coercion, intimidation, or boycott of, or any

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concerted refusal to deal with, any health plan company seeking to contract with the cooperative on a competitive, reasonable, and nonexclusive basis.

Thus, to successfully assert a state action defense, MRHC would have to demonstrate not only active state supervision, but also that the Minnesota Legislature expressed a policy to supplant competition with regulation with respect to all of MRHC's challenged conduct, including acts of "coercion." Given the express limitations placed on the state policy regarding health care provider contracting, the Minnesota legislature does not appear to have expressed such a broad policy.

II. The Proposed Order

The proposed order takes into account the change in Minnesota law that occurred during the pendency of the investigation.

A. Impact Of The New Statute

As noted above, the Minnesota Legislature in 2009 enacted legislation designed to provide state supervision of the contracts that health care provider cooperatives enter into with health plans. The Commission cannot, at this time, determine whether this new law will result in that state engaging in the detailed, substantive review that the Supreme Court has held is required for "active supervision." Determining whether the active supervision prong of the state action doctrine has been met will require a factual inquiry into the Departments of Health's actual implementation of its new authority in specific instances. Although there is no single prescribed method for a state to conduct an adequate review of private anticompetitive conduct, such as the price fixing by the MRHC, such review must include an assessment of the substantive merits of the pricing conduct, based on a factual record that enables the state to exercise "sufficient independent judgment and control so that the details of the rates or prices have been established as a product of deliberate state intervention."

Although it is too early to assess the state's implementation of the new statute, the Commission believes the circumstances here make it appropriate to defer to Minnesota's expressed intention to

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actively supervise the contracts that result from the MRHC's price fixing. The Commission has in the past taken a different remedial approach where state officials had authority to actively supervise private conduct but failed to exercise it. Here Minnesota officials have only been recently granted that authority, and it is appropriate to allow them an opportunity to utilize that authority.

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

B. Order Provisions

Paragraph II.A bars MRHC from organizing or implementing agreements to refuse to deal, or to threaten to refuse to deal, with a payer over contract terms, as well as agreements not to deal individually with payers, or to deal only through the MRHC. Paragraph II.B prohibits the MRHC from submitting for state approval any payer contract that it negotiated using acts of coercion, intimidation, or boycott, or any concerted refusal to deal. The prohibitions apply to agreements for hospital, physician, or pharmacy services.

The remaining portions of Paragraph II prohibit conduct that would facilitate a violation of Paragraph II.A. Paragraph II.C bars information exchanges to further conduct that violates the core

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prohibitions of Paragraph II. Paragraphs II.D and II.E ban attempts and encouragement of such violations.

The order also includes a proviso designed to clarify the scope of the prohibitions in Paragraph II. First, it provides that the provisions of Paragraph II do not prohibit the MRHC, in exercising its business judgment, from rejecting a contract on behalf of its members, so long as there is no agreement between the MRHC and any of its members that the member will refuse to deal individually (or will deal only through the MRHC), with a payer whose contract the MRHC rejects. Second, the order does not prevent the MRHC from exchanging information when necessary to conduct joint payer contract negotiations on behalf of its members. Such information would not, however, ordinarily include whether an individual member is participating in a particular contract or the terms on which it is negotiating with a payer independently of the MRHC.

As this proviso reflects, nothing in the order prohibits the MRHC, in the exercise of its business judgment, from rejecting a contract on behalf of its members, so long as there is no agreement between the MRHC and any of its members that the members refuse to deal individually with the payor whose contract the MRHC rejected, or that the members will only deal with that payor through the MRHC. Additionally, the order does not address any actions taken by any individual MRHC member, acting alone in exercising its business judgment. Thus, for example, the order does not bar any member from unilaterally declining to contract with any payer.

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

Paragraph III.B requires MRHC to terminate, without penalty, pre-existing payer contracts that it had entered into since 2001, at the earlier of (1) receipt by MRHC of a written request for termination by the payer; or (2) the termination date, renewal date, or anniversary date of the contract. This provision is

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intended to eliminate the effects of MRHC's past alleged illegal collective behavior. The payer can delay the termination for up to one year by making a written request to MRHC.

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

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

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