IN SEARCH OF THE MESSENGER MODEL

FTC/DOJ HEARINGS ON HEALTH CARE AND COMPETITION LAW AND POLICY

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Recently I pulled out my copy of Section One of the Sherman Act and discovered to my amazement that it made no mention of the messenger model. So I looked through the cases, and couldn't find any reference to the messenger model there either. Finally, I got to the *Statements of Antitrust Enforcement Policy in Health Care*, and there it was, in Statement 9.[1]

Of course, the messenger model and its variations have also been illuminated in scads of agency advisory letters, consent orders, and speeches.[2] And there is also a vast non-public literature of lawyers' advice explaining the serious risks of doing network contracting on a fee-for-service basis *without* following the messenger model.

One thing I have never found, though, is a business person, administrator, or health care professional in any segment of the industry who advocates the use of the messenger model for any *business purpose*. Let me qualify that last statement: The few people I *have* heard promote the messenger model have all had a false conception of what the messenger model really requires. Some of them have ended up signing consent orders with one or the other of our co-hosts at today's hearing.

Of course, the messenger model was never intended to achieve a business purpose, so perhaps it shouldn't be measured by that standard. The messenger model was devised by antitrust lawyers solely as a vehicle to permit network contracting while avoiding any agreement on price among the network participants.

The phrase "devised by antitrust lawyers" ought to raise a red flag, because devising things is not something we antitrust lawyers usually do. What we do is pass upon the

legality of things devised by others, or defend them after the fact. But we rarely *devise* a business model. When we do – as with the messenger model – we ought to face a heavy burden of justifying to our clients why an arrangement with such a dubious lineage ought to be abided.

I'd like to suggest, for purposes of discussion today, a return to first principles. Let's suppose that we did not have twenty-five years or more of health care antitrust law and lore, and that we were able to write on a clean slate – clean, that is, except for the same principles of antitrust law applicable to participants in any industry. And then let's consider whether the messenger model is really necessary to avoid harm to competition posed by a physician network seeking payer contracts on a fee-for-service basis.

Now you might say that "harm to competition" is not the right standard, because a failure to follow the messenger model represents a *per se* violation under *Maricopa*,[3] so harm to competition doesn't matter. I think most antitrust lawyers would find that response unsatisfying. An application of the *per se* rule that condemns business conduct that does not harm competition is one that deserves to be re-examined.

Even apart from that, we all know that agreements on price by competitors may be sustained in certain circumstances. In particular, price agreements that are ancillary to a legitimate joint venture are examined under the rule of reason. And the antitrust agencies have recognized that when a physician network meets the standards of so-called "financial integration" or "clinical integration," the physicians' use of a fee schedule to price their joint product is not price-fixing, precisely because the joint pricing is ancillary to a potentially efficiency-enhancing venture.[4]

"Financial integration" and "clinical integration" are concepts that are a bit like the messenger model itself – *i.e.*, they are *doctrinal* concepts that have been devised to fit the health care context. But for purposes of our thought experiment today we are returning to first principles, so we're going to set these concepts aside.

Let's consider a not-so-hypothetical example. Suppose a network of independent physicians wants to offer the physicians' services to self-insured employers in a community. The network intends to provide some administrative services such as credentialing and soft-core

utilization review, but not to accept financial risk. The principal function of the network's administrative office is to analyze contracts, collect information and the like, and to lease office space and purchase office equipment for those employees – but not to establish the sort of "virtual group practice" that appears to be called for by the concept of clinical integration.[5]

Now let's suppose that the network is approached by a payer for a price quote, and the network representative responds that the physicians will accept the Medicare fee schedule. That, my friends, is a *per se* violation. If a physician organization asked me what to do in that situation, I would strongly counsel them not to go there. I would tell them that, under these facts, their only choice is to have the network representative act as a messenger who carries offers and responses back and forth until a series of bilateral agreements are reached between the payer and the individual network members.

But I'm not at all sure that that is the *right* advice from an antitrust standpoint. What really is the threat to competition here? I think we would all agree that there are some payers and self-insured employers who are interested in contracting with a network of this type if the price is right. But the messenger model is based on the premise that this network may not, *must* not establish a network price. A network price – a fee schedule – even one based on an existing schedule offered by a payer in the market – is deemed to be the product of a group agreement, and thus a form of price-fixing; hence, the need for the messenger model's unique brand of shuttle diplomacy, in which some unfortunate soul ferries offers back and forth between the payer and each individual physician's office, all the while remaining mute on the merits of the payer's proposal.

Returning to our hypothetical, let's make it perhaps a bit more realistic and say that the network representative says to the payer that its members will accept 140% of the Medicare fee schedule. If the payer accepts – and there are no additional facts out there suggesting a threat of boycott by the physicians – presumably the payer is accepting the proposal because it views the proposal as competitive and appropriate. If the payer rejects the proposal, it can still pursue other options for getting a network, either by building its own or contracting with another network in the market.

Has competition been harmed in this scenario? I see only two potential threats to competition, neither of which necessarily calls for the strong preventive medicine of the messenger model.

First, there is the possibility of a boycott to guard against – *i.e.*, a scenario in which the individual network members all refuse to contract with the payer except at the agreed-on network level. This is a legitimate concern, but one that antitrust law has long dealt with based on the *facts*. If a trier of fact finds the network members to have made a collective decision to refuse to deal with the payer, they may be found to have engaged in a group boycott and dealt with accordingly. But the facts also may lead to the conclusion that the members each independently decided that the payer's proposal was inadequate. Rather than relying on the specific facts of the case, the messenger model doctrine in effect builds in a presumption that a price-fixing boycott *will* occur if certain procedures are not followed. Why not approach the question as antitrust law usually does and examine the specific facts of the case, rather than relying on a presumption?

Second, there is the so-called "spill-over" problem. In other words, the network physicians might adopt the network fee schedule in their individual practices, causing a general stabilization in prices across the market. While the potential for this scenario to unfold has often been discussed,[6] to my knowledge it has never been shown to have occurred. Even if it did occur, it is far from clear whether this scenario should be viewed as an anticompetitive result, particularly since billed charges often have little relationship to what payers pay. To put it another way, even if some physicians followed the network fee schedule to determine billed charges for their individual practices, that might have little or no impact on actual transaction prices.

One problem with the *per se* approach is that it moots all discussion of the more subtle questions that might be considered under the rule of reason. And it leaves antitrust counselors and enforcers uninformed as to what the competitive effects of different types of physician networks really are.

Last year, Commissioner Thomas Leary gave a speech in which he discussed the *MedSouth* advisory letter in some detail.[7] He noted that, in the health care field, the Commission

has little experience in applying the rule of reason. With all the dozens of consent orders, advisory letters, and policy statements that have been issued, the rule of reason has only rarely been employed. Most arrangements have either been alleged to be *per se* unlawful, or they have not been challenged. I would suggest that, with a re-invigorated rule of reason in health care, the awkward machinations of the messenger model would simply not be necessary.

The messenger model represents a prophylactic, fencing-in approach designed for an era in which network activity by physicians was assumed to be inherently suspect. It provides a form of safety zone for actors who are viewed as likely to be conniving toward bad ends. But it is also an odd construct in the world of antitrust: If you meet its strictures, the agencies as a practical matter will likely consider your network lawful; but if you fall outside of it, you have fixed prices, the highest form of antitrust offense. There is no middle ground, no rule of reason, to fall back on.

If I had my way, the messenger model would be reserved for precisely two situations. The first is where a network already has been subject to an investigation, complaint, and consent order. In that situation, the fencing-in aspect of the messenger model makes sense as an enforcement device. The second situation in which the messenger model may have some utility is when a network is exceptionally conservative and wants to eliminate as much risk of antitrust exposure as it conceivably can. Such networks should be cautioned, however, against buying a pig in a poke: Even the best intentioned may have difficulty implementing the messenger model according to its rules. Jeff Miles has made this point more effectively than I possibly can, so I refer you back to his remarks at this hearing.

Other than these two limited situations, I'd be inclined to stick with first principles – and shoot the messenger.

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[1] U.S. Department of Justice & Federal Trade Commission, *Statements of Antitrust Enforcement Policy in Health Care*, Stmt. 9 (Sept. 27, 1994), *available at* http://www.ftc.gov/reports/hlth3s.htm [hereinafter "*Health Care Policy Statements*"].

[2] *See, e.g.*, FTC Staff Letter to Martin J. Thompson (Sept. 23, 2003) (Bay Area Preferred Physicians), *available at* http://www.ftc.gov/bc/advisory.htm); FTC Staff Letter to J. Bert Morgan (Nov. 17, 1993) (California Managed Imaging Medical Group), *available at* http://www.ftc.gov/bc/advisory.htm); *United States v. Health Choice of Northwest Missouri, Inc.*, Case No. 95-6171-CV-SJ-6 (W.D. Mo., filed Sept. 13, 1995) (competitive impact statement); Remarks of William Baer, Director, Bureau of Competition,

FTC, "Current Issues in Health Care Antitrust Enforcement at the Federal Trade Commission," Oct. 24, 1996.

[3] *Arizona v. Maricopa County Med. Society,* 457 U.S. 332 (1982).

[4] *Health Care Policy Statements*, Stmt. 9.

[5] *See* FTC Staff Letter to John J. Miles (Feb. 19, 2002) (MedSouth, Inc.), *available at* http://www.ftc.gov/bc/adops/medsouth.htm.

[6] *See, e.g., Health Care Policy Statements*, Stmts. 8-9; FTC Staff Letter to William Kopit, Esq. (Apr. 19, 1985) (American Society of Internal Medicine) (on file with the Federal Trade Commission).

[7] Commissioner Leary's remarks were subsequently expanded into an article. *See* Thomas B. Leary, *The Antitrust Implications of "Clinical Integration:" An Analysis of FTC Staff's Advisory Opinion to MedSouth*, 47 St. Louis U. L.J. 223 (Spring 2003).