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UNITED STATES OF AMERICA
BEFORE FEDERAL TRADE COMMISSION

COMMISSIONERS: **Jon Leibowitz, Chairman**
Pamela Jones Harbour
William E. Kovacic
J. Thomas Rosch
Edith Ramirez

In the Matter of	)	
	)	**Docket No. C- 4288**
Roaring Fork Valley Physicians I. P. A., Inc., a corporation.	)	

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.

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.

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.

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.

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 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.

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.

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 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.

Donald S. Clark
Secretary

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