

Complaint

IN THE MATTER OF

**MEMORIAL HERMANN HEALTH NETWORK
PROVIDERS**CONSENT ORDER, ETC., IN REGARD TO ALLEGED VIOLATIONS OF
SEC. 5 OF THE FEDERAL TRADE COMMISSION ACT*Docket C-4104; File No. 0310001
Complaint, January 8, 2004--Decision, January 8, 2004*

This consent order addresses practices used by Respondent Memorial Hermann Health Network Providers, a nonprofit corporation that contracts with third-party payors for the provision of medical services on behalf of its approximately 3,000 participating physicians, who are licensed to practice medicine in the State of Texas, and who are engaged in the business of providing medical services to patients in the Houston metropolitan area. The order, among other things, prohibits the respondent from entering into or facilitating agreements among physicians (1) to negotiate on behalf of any physician with any payor; (2) to deal, refuse to deal, or threaten to refuse to deal with any payor; (3) regarding any term upon which any physicians deal, or are willing to deal, with any payor; and (4) not to deal individually with any payor or through any arrangement other than the respondent. The order also prohibits the respondent from exchanging or facilitating the 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. In addition, the order prohibits the Respondent from attempting to engage in – or encouraging, pressuring, inducing, or attempting to induce any person to engage in - any action prohibited by the order. The order also requires the respondent, for three years, to notify the Commission at least 60 days prior to entering into any arrangement under which the respondent will act as a messenger or agent on behalf of physicians with payors regarding contracts. In addition, the order requires the respondent to terminate, without penalty, any payor contracts that it had entered into during the period at issue, at any such payor's request.

Participants

For the Commission: *Alan Loughnan, Barbara Anthony, Anne R. Schenof, Daniel P. Ducore, D. Bruce Hoffman, Thomas R. Iosso, and Louis Silvia, Jr.*

For the Respondent: *Daniel L. Wellington, Fulbright & Jaworski L.L.P.*

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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, having reason to believe that Memorial Hermann Health Network Providers (hereinafter “MHHNP”) 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 matter concerns MHHNP’s actions to orchestrate and implement agreements among competing physicians on the prices they would accept from health plans and other third-party payors (“payors”) in the greater Houston, Texas area. The challenged actions of MHHNP had the purpose and effect of increasing prices paid for physician services in the greater Houston area.

RESPONDENT

2. MHHNP is a non-profit corporation, organized, existing, and doing business under and by virtue of the laws of Texas, with its office and principal address at 9401 Southwest Freeway, Houston, Texas 77074.
3. MHHNP has approximately 3000 participating physician members (hereinafter “physician“members”) who are licensed to practice medicine in the State of Texas and engaged in the business of providing medical services to patients in the Houston metropolitan area (hereinafter “Houston area”).

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4. Except to the extent that competition has been restrained as alleged herein, the physician members of MHHNP have been, and are now, in competition with each other for the provision of physician services.

JURISDICTION

5. MHHNP's general business activities and those of the physician members who utilize MHHNP's services, including the acts and practices herein alleged, are in or affecting "commerce" as defined in Section 4 of the Federal Trade Commission Act, as amended, 15 U.S.C. § 44.
6. MHHNP is a corporation within the meaning of Section 4 of the FTC Act. Although MHHNP's articles of incorporation and by-laws designate Memorial Hermann Healthcare System, a non-profit corporation, as its "sole member" for purposes of Texas corporation law, the physician members of MHHNP are members of the corporation within the meaning of Section 4 of the FTC Act. MHHNP engages in substantial activities for the pecuniary benefit of its for-profit physician members.
7. MHHNP is governed by its Board of Directors, which includes 16 "Voting Directors," all of whom are physician members. These Board members are elected by MHHNP's physician members, subject to the ultimate approval of its sole member.

**OVERVIEW OF MARKET AND PHYSICIAN
COMPETITION**

8. MHHNP regularly and in the ordinary course of business classifies its physicians as "physician members," and conducts its business affairs in a manner that demonstrates that the physician members are "members" of MHHNP. To participate in MHHNP's network and utilize MHHNP's contract negotiation and other services, a physician member must complete a MHHNP "Membership Application" and sign a "Network Participation Agreement." MHHNP's "Membership

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and Credentialing Committee,” a 13-member panel of board members and appointees, evaluates the physician’s credentials and recommends to the board the physician’s eligibility for membership.

9. Physician members, through their elected representatives on the board, actively participate in MHHNP’s management and business operations. Among other things, the board develops guidelines for negotiating, reviewing, approving, rejecting, terminating, and renewing payor contracts; approves price terms for dealing with payors; establishes procedures for credentialing MHHNP’s physician members; and establishes certain billing and payment procedures for physician members.
10. MHHNP’s activities substantially advance its physician members’ economic interests. These activities include negotiating payor contracts, including price and price-related terms; group purchasing; continuing medical education; and engaging in marketing on behalf of its physician members.
11. Physicians often contract with payors to establish the terms and conditions, including price terms, under which the physicians will render services to the payors’ subscribers. Physicians entering into such contracts often agree to lower compensation in order to obtain access to additional patients made available by the payors’ relationship with insureds. These contracts may reduce third-party payors’ costs, enable them to lower the price of insurance, and reduce out-of-pocket medical expenditures by subscribers to the payors’ health insurance plans.
12. Absent agreements among competing physicians on the terms, including price, on which they will provide services to enrollees in payors’ health care plans, competing physicians decide individually whether to enter into payor

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contracts to provide services to their subscribers or enrollees, and what prices they will accept pursuant to such contracts.

13. Medicare's Resource Based Relative Value System (hereinafter "RBRVS") is a system used by the United States Centers for Medicare and Medicaid Services to determine the amount to pay physicians for the services they render to Medicare patients. The RBRVS approach provides a method to determine fees for specific services. In general, payors in the Houston area contract with individual physicians or groups at a price level specified in the RBRVS, plus a markup or a discount based on some percentage of that price (*e.g.*, "110% or 95% of 2001 RBRVS").
14. To be competitively marketable in the Houston area, a payor's health insurance plan must include in its physician network a large number of primary care physicians and specialists who practice in the Houston area. Many of the primary care physicians and specialists who practice in the Houston area are physician members of MHHNP.
15. Competing physicians sometimes use a "messenger" to facilitate the establishment of contracts between themselves and payors in ways that do not constitute or facilitate an unlawful agreement on fees and other competitively significant terms. Such an arrangement, however, will not avoid constituting or facilitating a horizontal agreement if the "messenger" or an agent negotiates fees and other competitively significant terms on behalf of the participating physicians, or facilitates the physicians' coordinated responses to contract offers by, for example, electing not to convey a payor's offer to them based on the agent's, or collectively the participants', opinion on the appropriateness, or lack thereof, of the offer.

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FORMATION AND OPERATION OF MHHNP

16. MHHNP was incorporated in 1982 under the name Memorial Healthnet Providers, Inc. In 2000, its name was changed to MHHNP. Before 1999, MHHNP engaged in risk contracting with some payors. In 1999 or 2000, MHHNP terminated all existing risk contracts with payors on behalf of its physician members, and renegotiated such contracts to be non-risk contracts—*i.e.*, contracts that do not involve financial risk sharing by physicians through arrangements such as fee withholds or capitation. MHHNP has not subsequently entered into any risk contracts with any payors. In negotiating non-risk contracts with payors for its physician members, MHHNP has sought, and has often obtained, higher fees and other more advantageous terms than those physician members, negotiating unilaterally, could have obtained.
17. To participate in MHHNP's payor contracts, a physician member enters into a "Network Participation Agreement" with MHHNP, granting MHHNP the authority to arrange for his or her services to be provided to persons covered by payors pursuant to agreements between MHHNP and the payors. Individual physician members may opt into or out of any particular contract negotiated between MHHNP and a particular payor, but each physician member agrees to participate in a reasonable number of payor plans as a condition of continued participation in MHHNP.

MHHNP'S ILLEGAL ACTS AND PRACTICES

18. MHHNP has regularly negotiated with payors the fees and other terms relating to the medical care its physician members offer to persons covered by the payors. At the direction of its Board, MHHNP has actively bargained with payors, often proposing and counter-proposing applicable fee schedules, among other terms.

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19. MHHNP periodically has polled its physician members, asking each to disclose the minimum fee, typically stated in terms of a percentage of RBRVS, that he or she would accept in return for providing medical services pursuant to future MHHNP-payor agreements. The Board then has calculated minimum acceptable fees for use in payor negotiations, based in part on the information received from physician members concerning their future pricing intentions. The Board has generally set minimum fees at levels which at least 40% of the physician members have indicated would be acceptable to them. Often, MHHNP has begun discussions with a payor regarding a possible contract for physician services by informing the payor that its physician members have minimum fees, which MHHNP provides. MHHNP has then stated that it will not enter into or otherwise forward to its physician members any payor offer that does not satisfy those fee minimums. In some instances, payors have reformulated or revised their planned or proposed fee schedules to satisfy MHHNP's stated fee minimums, thereby resulting in payor fee offers that exceed the fees that would have been offered absent the participating physicians' agreement and MHHNP negotiations with payors on behalf of its physician members.
20. In other instances, MHHNP has responded to payor proposals that included fee schedules that did not meet MHHNP physician members' minimum fees for services to be provided, by advising the payors of the established fee minimums and instructing them to resubmit the proposals with fee schedules satisfying those minimums. At other times, MHHNP has rejected the payors' proposed offers, and counter-proposed fee schedules at prices at or above its physician members' agreed-to minimums, and otherwise actively bargained with payors as to fees to be paid MHHNP's physician members. As a result, payors

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sometimes have either submitted new offers with higher fees or accepted the higher fees counter-proposed by MHHNP on behalf of its physician members.

21. In at least one instance, at the direction of its Board, MHHNP solicited from its physician members the response they wanted MHHNP to give a payor, who had approached MHHNP with an offer. The physician members were told that the Board already had rejected the payor's offer because it was below the minimum threshold level previously set pursuant to physician member surveys. Although the payor had asked MHHNP to messenger its latest offer to MHHNP's physician members for individual opt-in/opt-out decisions, MHHNP instead polled each of its physician members to determine whether or not the Board should accept the latest payor offer. A large majority of physician members voted to agree with the Board's decision to reject the offer. MHHNP then rejected the payor's offer and explicitly refused to forward the offer to any of its physician members, whether or not the proposed fees were above any given physician's stated minimum acceptable fees. Following that refusal and numerous communications between MHHNP, its physician members, and others attacking the payor's fee proposal as "below market," the payor increased proposed fees to the MHHNP fee minimums. Only then did MHHNP enter into a contract and forward the agreement to its physician members, affording them the option to participate (or not) in the payor's offer.
22. In addition, while seeking to negotiate fees on behalf of its physician members, MHHNP has discouraged and prevented payors and participating physicians from negotiating directly with one another. In at least one instance, after MHHNP fee negotiations with a payor broke down, MHHNP discouraged individual physician members from signing individual participation agreements with the payor. This increased the pressure on the payor to contract

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for the services of MHHNP's physician members through MHHNP, at higher proposed fees. The payor ultimately yielded to that pressure and contracted with MHHNP and its physician members at increased fee levels.

23. MHHNP has on occasion prior to 2000 entered into contracts with payors for physician services that contain a term prohibiting the payor from negotiating individual contracts with MHHNP physician members for a period of several months after either MHHNP or the payor terminates the contract that provided for reimbursement for the services of MHHNP physician members. On other occasions, MHHNP has sought the agreement of other payors to a contract term of this sort. Such a contract term interferes with the ability of a payor to terminate a contract with MHHNP and seek individual agreements with its physician members at lower fee levels.

RESTRAINT OF TRADE

24. The conduct of MHHNP constitutes combined or concerted action by its physician members. MHHNP, acting as a combination of competing physicians, has acted to restrain competition by, among other things:
- A. facilitating, negotiating, entering into, and implementing agreements among its physician members on price and other competitively significant terms;
 - B. refusing to deal with payors except on collectively agreed-upon terms;
 - C. seeking or entering into contracts with third-party payors that restrict the payors' freedom to enter into contracts with individual physicians following termination of a group contract with MHHNP; and

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- D. negotiating prices and other competitively significant terms in payor contracts for MHHNP's physician members, and refusing to submit payor offers to its physician members that do not conform to MHHNP's standards for contracts.

LACK OF SIGNIFICANT EFFICIENCIES

- 25. The acts and practices described in Paragraphs 18 through 23, including MHHNP's negotiation of fees and other competitively significant terms of contracts, have not been and are not, reasonably related to any efficiency-enhancing integration.

ANTICOMPETITIVE EFFECTS

- 26. Respondent MHHNP's actions as described in Paragraphs 18 through 23 of this Complaint have had, or tend to have, the effect of restraining trade unreasonably and hindering competition in the provision of physician services in the Houston area in the following ways, among others:
 - A. price and other forms of competition among Respondent MHHNP's physician members were unreasonably restrained;
 - B. prices for physician services were increased; and
 - C. health plans, employers, and individual consumers were deprived of the benefits of competition among physicians.
- 27. The combination, conspiracy, 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 combination, conspiracy, acts, and practices, or the effects thereof, are continuing and

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will continue or recur in the absence of the relief herein requested.

WHEREFORE, THE PREMISES CONSIDERED, the Federal Trade Commission on this eighth day of January, 2004, issues its Complaint against Respondent MHHNP.

Decision and Order

DECISION AND ORDER

The Federal Trade Commission (“Commission”), having initiated an investigation of certain acts and practices of Memorial Hermann Health Network Providers (“MHHNP”), hereinafter referred to as Respondent, and Respondent having been furnished thereafter with a copy of the draft of 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 of 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 comment 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:

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1. Respondent Memorial Hermann Health Network Providers is a not-for-profit corporation, organized, existing, and doing business under and by virtue of the laws of the State of Texas, with its principal address at 9401 Southwest Freeway, Houston, Texas 77074.
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 Memorial Hermann Health Network Providers, its officers, directors, employees, agents, representatives, successors, and assigns; and the subsidiaries, divisions, groups, and affiliates controlled by it, and the respective officers, directors, employees, agents, 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, members, or employees, or in which only one physician practices medicine.
- C. "Participate" in an entity means (1) to be a partner, shareholder, owner, member, or employee of such entity, or (2) to provide services, agree to provide services, or offer to provide services, to a payor through such entity. This definition applies to all tenses and forms of the word "participate," including, but not limited to, "participating," "participated," and "participation."

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- D. “Payor” means any person that pays, or arranges for payment, for all or any part of any physician or hospital services for itself or for any other person. Payor includes any person that develops, leases, or sells access to networks of physicians or hospitals.
- E. “Person” means both natural persons and artificial persons, including, but not limited to, corporations, unincorporated entities, and governments.
- F. “Physician” means a doctor of allopathic medicine (“M.D.”) or a doctor of osteopathic medicine (“D.O.”).
- G. “Preexisting contract” means a contract that was in effect on the date of the receipt by a payor that is a party to such contract of notice sent by a Respondent, pursuant to Paragraph IV.B. of this Order, of such payor’s right to terminate such contract.
- H. “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.
- I. “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 through the arrangement.

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- J. “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 to jointly control costs and improve quality by managing the provision of physician services such as risk-sharing involving:
 - a. the provision of physician services to payors at a capitated rate;
 - b. the provision of physician services for a predetermined percentage of premium or revenue from payors;
 - 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, where 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 through the arrangement.

II.

IT IS FURTHER ORDERED that Respondent, directly or indirectly, or through any corporate or other device, in connection

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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, agreement, or understanding between or among any physicians:
 - 1. To negotiate on behalf of any physician with any payor;
 - 2. To deal, refuse to deal, or threaten to refuse to deal with any payor;
 - 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 through any arrangement other than Respondent’s arrangements;
- 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.

PROVIDED HOWEVER, that nothing in this Paragraph II shall prohibit any agreement involving, or conduct by,

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Respondent, that is reasonably necessary to form, participate in, or take any action in furtherance of a qualified risk-sharing joint arrangement or qualified clinically integrated joint arrangement, or that solely involves physicians in the same medical group practice.

III.

IT IS FURTHER ORDERED that, for three (3) years from the date this Order becomes final, Respondent shall notify the Secretary of the Commission in writing (“Notification”) at least sixty (60) days prior to entering into any arrangement with any physicians that provides the terms or conditions pursuant to which the Respondent is to act as a messenger, or as an agent on behalf of any physicians with any payor regarding contracts. The Notification shall include the identity of each proposed physician participant; the proposed geographic area in which the proposed arrangement will operate; a copy of any proposed physician participation agreement; a description of the proposed arrangement’s purpose and function; a description of any resulting efficiencies expected to be obtained through the arrangement; and a description of procedures to be implemented to limit possible anticompetitive effects, such as those prohibited by this Order. Notification is not required for Respondent’s subsequent acts as a messenger pursuant to an arrangement for which such Notification has been given. Notification also is not required for changes in the number or identity of the physicians participating in an arrangement for which such Notification has been given. Receipt by the Commission from Respondent of any Notification, pursuant to this Paragraph III, is not to be construed as a determination by the Commission that any action described in such Notification does or does not violate this Order or any law enforced by the Commission.

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IV.

IT IS FURTHER ORDERED that Respondent shall:

- A. Within thirty (30) days after the date on which this Order becomes final, send by first-class mail, with delivery confirmation, a copy of this Order and the Complaint to:
 - 1. each physician who participates, or has participated at any time since January 1, 1999, in Respondent, and
 - 2. each officer, director, manager, and employee of Respondent;
- B. Within thirty (30) days after the date on which this Order becomes final, send by first-class mail, with delivery confirmation, copies of this Order, the Complaint, and the notice specified in Appendix A to this Order, to the chief executive officer of each payor that Respondent has been in contact with since January 1, 1999, regarding contracting for the provision of physician services;
- C. Terminate, without penalty or charge, and in compliance with any applicable laws, any preexisting contract with any payor for the provision of physician services, upon receipt by Respondent of a written request to terminate such contract from any payor that is a party to the contract or that pays for the physician services provided through the contract. Provided, however, that nothing contained herein shall affect the operation of any preexisting contract provision pertaining to continuation of patient care for patients undergoing a course of treatment, or payment therefor, following termination of the preexisting contract.
- D. For a period of three (3) years after the date this Order becomes final:

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1. Distribute by first class mail, with delivery confirmation, a copy of this Order and the Complaint to:
 - a. each physician who begins participating in Respondent, and who did not previously receive a copy of this Order and the Complaint, within thirty (30) days of the time that such participation begins;
 - b. each payor that contracts with Respondent for the provision of physician services, and that 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
 - 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, within thirty (30) days of the time that he or she assumes such responsibility;
2. Annually publish in an official annual 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.
3. Notify the Commission at least thirty (30) days prior to any proposed change in Respondent, such as dissolution, assignment, sale resulting in the emergence of a successor company or corporation or the creation or dissolution of subsidiaries or any other change in Respondent that may affect compliance obligations arising out of this Order.

V.

IT IS FURTHER ORDERED that Respondent shall file a verified written report within sixty (60) days after 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

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times as the Commission may by written notice require, setting forth:

- A. In detail, the manner and form in which Respondent has complied and is complying with this Order;
- B. The name, address, and telephone number of each physician, medical group practice, and other group of physicians that Respondent has represented or advised with respect to their dealings with any payor in connection with the provision of physician services;
- C. The name, address, and telephone number of each payor with which Respondent has a contract.

VI.

IT IS FURTHER ORDERED that Respondent shall notify the Commission of any change in its principal address within twenty (20) days of such change in address.

VII.

IT IS FURTHER ORDERED that, for the purpose of determining or securing compliance with this Order, Respondent shall permit any duly authorized representative of the Commission:

- A. Access, during office hours and in the presence of counsel, to inspect and copy all books, ledgers, accounts, correspondence, memoranda, calendars, and other records and documents in its possession, or under its control, relating to any matter contained in this Order; and
- B. Upon five (5) days' notice to Respondent, and in the presence of counsel, and without restraint or interference from it, to interview officers, directors, or employees of Respondent.

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VIII.

IT IS FURTHER ORDERED that this Order shall terminate on January 8, 2024.

Analysis

**Analysis of Agreement Containing Consent Orders to Aid
Public Comment**

The Federal Trade Commission has accepted, subject to final approval, an agreement containing a proposed consent order with Memorial Hermann Health Network Providers (“Respondent” or “MHHNP”). The agreement settles charges that Respondent violated Section 5 of the Federal Trade Commission Act, 15 U.S.C. § 45, by facilitating and implementing agreements among MHHNP members on price and other competitively significant terms; refusing to deal with payors except on collectively agreed-upon terms; and negotiating uniform fees and other competitively significant terms in payor contracts and refusing to submit to members payor offers that do not conform to Respondent’s standards for contracts.

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 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 consent order has been entered into for settlement purposes only and does not constitute an admission by Respondent that it violated the law or that the facts alleged in the complaint (other than jurisdictional facts) are true. The allegations in the Commission’s proposed complaint are summarized below.

The Complaint

Respondent MHHNP is a nonprofit corporation that contracts with third-party payors for the provision of medical services on behalf of its approximately 3,000 participating physicians. MHHNP is organized and operated to further the pecuniary

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interests of those physicians, who are licensed to practice medicine in the State of Texas and who are engaged in the business of providing medical services to patients in the Houston metropolitan area (hereinafter "Houston area").

Physicians often contract with third-party payors, such as insurance companies and preferred provider organizations. The contracts typically establish the price and other terms under which the physicians will render services to the payors' subscribers. Contracting physicians often agree to accept lower-than-customary compensation from these third-party payors to gain access to additional patients through the payor. Thus, these contracts may reduce payor costs, and may result in lower medical care costs to the payor's subscribers.

Absent agreements among competing physicians, each competing physician decides for him or herself whether, and on what price and other terms, the physician will contract with third-party payors to provide medical services to the payors' subscribers. To be competitively marketable in the Houston area, a payor must include in its physician network a large number of primary care physicians (PCPs) and specialists who practice in the Houston area. Many of the PCPs and specialists who practice in the Houston area are members of MHHNP. Accordingly, many payors concluded that they could not establish a viable physician network in areas in which MHHNP physicians are concentrated without including a large number of MHHNP physicians in that network.

Sometimes a network of competing physicians uses an agent to convey to payors information, obtained from each of its participating physicians individually, about fees and other significant contract terms that the physicians are willing to accept. In other instances, the agent may convey all payor contract offers to network physicians, with each physician then unilaterally deciding whether to accept or reject each offer. These "messenger model" arrangements, which are described in the 1996 Statements of Antitrust Enforcement Policy in Health Care jointly issued by

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the Federal Trade Commission and U.S. Department of Justice (see <http://www.ftc.gov/reports/hlth3s.htm>), can facilitate contracting between physicians and payors and minimize the costs of providing medical care, without fostering agreements among competing physicians on fees and other competitively sensitive terms. The messenger may not, consistent with the competitive model, negotiate fees and other competitively significant terms on behalf of the participating physicians, nor facilitate the physicians' coordinated responses to contract offers, for example, by electing not to convey a payor's offer to the physicians based on the messenger's opinion of the acceptability or appropriateness of the offer.

Rather than acting simply as a "messenger," MHHNP engaged in collective negotiations on its members' behalf with third party payors. MHHNP's improper collective negotiations included actively bargaining with third-party payors by proposing and counter-proposing fee schedules (among other terms), gathering fee information from its members and using that information to negotiate prices, refusing to messenger proposals it deemed unacceptable on price and other terms, and, to maintain its bargaining power, on occasion discouraging its participating physicians from entering into unilateral agreements with third-party payors. For example, MHHNP periodically polled its physician members, asking each to disclose the minimum fee that he or she would accept in return for providing medical services pursuant to future MHHNP-payor agreements. MHHNP would then calculate minimum acceptable fees for use in payor negotiations, based in part on the information received from physician members concerning their future pricing intentions, and would often begin discussions regarding a possible contract for physician services by informing the payor of these minimum fees, and stating that it would not enter into or otherwise forward to its physician members any payor offer that did not satisfy those fee minimums.

In the course of its collective price negotiations with payors, MHHNP in fact often did not convey to its physician members

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payor offers that provided for fees that did not satisfy MHHNP's Board of Directors. MHHNP instead demanded, and often received, more favorable fee and other contract terms—terms that third-party payors would not have offered to MHHNP's participating physicians had those physicians engaged in unilateral, rather than collective, negotiations with the payors. Only after the third-party payor acceded to fee and other contract terms acceptable to MHHNP, would MHHNP convey the payor's proposed contract to MHHNP's participating physicians for their consideration. For example, in one instance MHHNP refused a payor's request to messenger an offer MHHNP's Board deemed unacceptable. Instead, MHHNP notified its members that it had rejected the offer because it was below the minimum acceptable fee level previously set pursuant to physician member surveys, and then "polled" its members to determine whether or not they agreed with the Board's decision to reject the offer. A majority of physician members voted to agree with the Board's decision, and MHHNP then again rejected the payor's offer and explicitly refused to forward the offer to any of its physician members. Subsequently, the payor increased its proposed fees to the MHHNP fee minimums, and MHHNP then entered into a contract with the payor and messengered the agreement to its physician members, affording them the option to participate (or not) in the payor's offer.

Since the end of 2000, MHHNP and its members have entered only into fee-for-service agreements with payors, pursuant to which MHHNP and its members did not undertake financial risk-sharing. Further, MHHNP members have not integrated their practices to create significant potential efficiencies. MHHNP's joint negotiation of fees and other competitively significant terms has not been, and is not, reasonably related to any efficiency-enhancing integration. Instead, MHHNP's acts and practices have restrained trade unreasonably and hindered competition in the provision of physician services in the Houston area in the following ways, among others: price and other forms of competition among MHHNP's members were unreasonably restrained; prices for physician services were increased; and health

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plans, employers, and individual consumers were deprived of the benefits of competition among physicians. Thus, MHHNP's conduct has harmed patients and other purchasers of medical services by restricting choice of providers and increasing the price of medical services.

The Proposed Consent Order

The proposed consent order is designed to prevent recurrence of the illegal concerted actions alleged in the complaint while allowing Respondent and its members to engage in legitimate joint conduct.

Paragraph II.A prohibits Respondent from entering into or facilitating agreements among physicians: (1) to negotiate on behalf of any physician with any payor; (2) to deal, refuse to deal, or threaten to refuse to deal with any payor; (3) regarding any term upon which any physicians deal, or are willing to deal, with any payor; and (4) not to deal individually with any payor or through any arrangement other than MHHNP.

Paragraph II.B prohibits Respondent from exchanging or facilitating the 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.

Paragraph II.C prohibits Respondent from attempting to engage in any action prohibited by Paragraph II.A or II.B. Paragraph II.D prohibits Respondent from encouraging, pressuring, inducing, or attempting to induce any person to engage in any action that would be prohibited by Paragraphs II.A through II.C. Paragraph II contains a proviso that allows Respondent to engage in conduct that is reasonably necessary to the formation or operation of a "qualified risk-sharing joint arrangement" or a "qualified clinically-integrated joint arrangement," or that solely involves physicians in the same medical group practice.

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Paragraph III requires MHHNP, for a period of three years after the order becomes final, to notify the Commission at least 60 days prior to entering into any arrangement under which MHHNP will act as a messenger or agent on behalf of physicians with payors regarding contracts. This provision will allow the Commission to review any future MHHNP policy or practice that MHHNP plans to implement with payors before such a policy or practice is implemented with respect to any particular payor.

Paragraphs IV.A and IV. B require MHHNP to distribute the complaint and order to its members, payors with which it previously contracted, and specified others. Paragraph IV.C requires MHHNP to terminate, without penalty, any payor contracts that it had entered into during the collusive period, at any such payor's request. This provision is intended to eliminate the effects of Respondent's joint price setting. Paragraph IV.C also contains a proviso to preserve payor contract provisions defining post-termination obligations relating to continuity of care during a previously begun course of treatment.

The remaining provisions of the proposed order impose complaint and order distribution, reporting, and other compliance-related provisions. For example, Paragraph IV. D requires MHHNP to distribute copies of the Complaint and Order to incoming MHHNP members, payors that contract with MHHNP for the provision of physician services, and incoming MHHNP officers, directors, and employees. Further, Paragraph V requires MHHNP to file periodic reports with the Commission detailing how MHHNP has complied with the Order. Paragraph VII authorizes Commission staff to obtain access to Respondent's records and officers, directors, and employees for the purpose of determining or securing compliance with the Order. The proposed order will expire in 20 years.

Complaint

IN THE MATTER OF

AMERICA ONLINE, INC., ET AL.

CONSENT ORDER, ETC., IN REGARD TO ALLEGED VIOLATIONS OF
SEC. 5 OF THE FEDERAL TRADE COMMISSION ACT

Docket C-4105; File No. 0023000

Complaint, January 28, 2004--Decision, January 28, 2004

This consent order addresses the manner in which Respondents America Online, Inc. ("AOL") – and its wholly owned subsidiary, CompuServe Interactive Services, Inc. – handled requests from subscribers to AOL's Internet access service who wanted to cancel their Internet access service, and operated the "CompuServe \$400 Rebate program," under which consumers received a \$400 cash rebate toward the purchase of an eligible computer if they contracted for three years of CompuServe Internet service. The order, among other things, requires the respondents to establish and maintain appropriate measures for ensuring that consumer requests to cancel any such online service or continuity program are promptly processed, and that billing will cease prior to the next billing cycle. The order also prohibits the respondents from continuing to charge any subscriber who has requested cancellation of any covered service or continuity program, unless respondents first obtain the subscriber's express informed consent, preceded by clear and conspicuous disclosure of certain specified information, including the pricing plan to which the subscriber is agreeing. In addition, the order requires the respondents to mail confirmation notices and cancellation request forms to subscribers who request the cancellation of any internet or online service and who are then recorded as having agreed to continue their subscriptions. The order also prohibits the respondents from making any representation about the time in which certain rebates will be mailed, or otherwise provided to purchasers – unless they have a reasonable basis for the representation at the time it is made – and from failing to provide any such rebate within the time specified or, if no time is specified, within thirty days.

Participants

For the Commission: *Michael Ostheimer, Laura Sullivan, Sydney Knight, Heather Hippsley, Mary Koelbel Engle, Louis Silversin, Gerard R. Butters and Paul A. Pautler.*

For the Respondents: *William C. MacLeod and John E. Villafranco, Collier Shannon Scott, PLLC.*