

Complaint

IN THE MATTER OF

PIEDMONT HEALTH ALLIANCE, INC., ET AL.

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

Docket 9314; File No. 0210119

Complaint, December 27, 2003--Decision, October 1, 2004

This consent order, among other things, prohibits Respondent Piedmont Health Alliance, Inc. ("PHA") -- a physician-hospital organization that includes physicians, hospitals, and other licensed health care providers in Alexander, Burke, Caldwell, and Catawba counties in western North Carolina (known as the "Unifour" area) -- and ten individual physician Respondents from entering into, participating in, or facilitating any agreement between or among any physicians: (1) to negotiate with payors on any physician's behalf; (2) to deal, not to deal, or threaten not to deal with payors; (3) on what terms to deal with any payor; or (4) not to deal individually with any payor, or to deal with any payor only through an arrangement involving PHA. The order also prohibits the respondents from exchanging or facilitating exchanges of information between or among physicians concerning whether, or on what terms, including price terms, they are willing to contract with a payor; from attempting to engage in any action prohibited by the order; and from inducing anyone else to engage in any action prohibited by the order. The order permits the individual physician Respondents to participate in activities that solely involve physicians who are part of their own medical group practices, or who are reasonably necessary to form, participate in, or further certain qualified risk-sharing joint arrangements, or certain qualified clinically-integrated joint arrangements. The order also permits Respondent PHA, beginning 30 months after the order becomes final, to participate in activities that are reasonably necessary to form, participate in, or further certain qualified risk-sharing joint arrangements, or certain qualified clinically-integrated joint arrangements, provided that PHA complies with certain requirements regarding prior notification to the Commission. The order also prohibits Respondent PHA, with certain exceptions, from preparing, maintaining, or participating in the preparation of any fee schedule regarding physician services; from collecting or maintaining information, or any summary or compilation of information, about price or other terms under which physicians deal, or are willing to deal, with payors; and from encouraging, facilitating, suggesting, advising, pressuring, inducing, or attempting to induce anyone to engage in such conduct. In addition, the order prohibits Respondent PHA, for 54 months after the order becomes final, from participating in a "Messenger Arrangement," as defined in the order, except that it may participate in a "Limited Messenger Arrangement" as defined in the order, beginning 30 months after the order becomes final. The order also

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requires Respondent PHA to provide payors with a copy of the order; to terminate without penalty any preexisting contract between the payor and Respondent PHA that the payor requests in writing be terminated; and, with certain limited exceptions and time extensions, to terminate within six months after the order becomes final all contracts between payors and Respondent PHA.

Participants

For the Commission: *David M. Narrow, Christi J. Braun, Karen R. Singh, Andrew Ginsburg, John P. DeGeeter, Steven J. Osnowitz, Robert Canterman, Mary Connelly-Draper, Emily Jones, Brian Beall, Jeanna Composti, Markus H. Meier, Jeffrey W. Brennan, Anne R. Schenof, Roberta S. Baruch, Thomas R. Iosso, Louis Silvia, Jr. and Timothy A. Deyak.*

For the Respondents: *Paul L. Yde, Freshfields Bruckhaus Derringer LLP*

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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 (“Commission”), having reason to believe that Piedmont Health Alliance, Inc. (“PHA”), Peter H. Bradshaw, M.D., S. Andrews Deekens, M.D., Daniel C. Dillon, M.D., Sanford D. Guttler, M.D., David L. Harvey, M.D., John W. Kessel, M.D., A. Gregory Rosenfeld, M.D., James R. Thompson, M.D., Robert A. Yapundich, M.D., and William Lee Young III, M.D., herein collectively referred to as “Respondents,” have violated Section 5 of the Federal Trade Commission Act, as amended, 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 a horizontal agreement among approximately 450 physician shareholders and non-shareholder

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subcontracted physicians (collectively, “physician members”) of PHA to agree collectively on the prices they demand for physician services from payors, including health insurance plans, health maintenance organizations, preferred provider organizations, employers directly providing self-funded health care benefits to their employees and their employees’ dependents, and other third-party purchasers of health care benefits. The physicians, with and through PHA, have eliminated price competition to the detriment of payors and consumers in the “Unifour area” of North Carolina, which comprises Alexander, Burke, Caldwell, and Catawba Counties.

RESPONDENTS

2. PHA, a physician-hospital organization (“PHO”), is a for-profit corporation organized, existing, and doing business under and by virtue of the laws of the State of North Carolina, with its principal address at 1899 Tate Boulevard, SE, Suite 2106, Hickory, North Carolina 28602.

3. The following persons (“Physician Respondents”) are physicians licensed to practice medicine in the State of North Carolina, and are shareholders in PHA. Their respective names, principal addresses, and roles in PHA are as follows:

- A. Peter H. Bradshaw, M.D., Hickory Surgical Clinic, 415 North Center Street, Suite 102, Hickory, North Carolina 28601, has been a voting member of the PHA Board of Directors (“PHA Board”);
- B. S. Andrews Deekens, M.D., Morganton Family Medicine, PLLC, 115 Foothills Drive, Morganton, North Carolina 28628, has served on the PHA Board as Chairman, a voting member, and a non-voting advisory member;
- C. Daniel C. Dillon, M.D., P.A., 11 13th Avenue, NE, Suite 102, Hickory, North Carolina 28601, has served on the

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PHA Board as Chairman, a voting member, and a non-voting advisory member;

- D. Sanford D. Guttler, M.D., Crown Health Care, PA, d/b/a Granite Falls Primary Care Physicians, One Trade Street, Granite Falls, North Carolina 28630, has been a voting member of the PHA Board, and has served both as the Chairman and as a member of the PHA Contracts Committee;
- E. David L. Harvey, M.D., Piedmont Nephrology & Hypertension Associates, 1899 Tate Boulevard, SE, Suite 2101, Hickory, North Carolina 28602, has been a voting member of the PHA Board, and was a member of the PHA Contracts Committee;
- F. John W. Kessel, M.D., Fairbrook Medical Clinic, 1985 Startown Road, Hickory, North Carolina 28602, has served both as a voting member and as a non-voting advisory member of the PHA Board;
- G. A. Gregory Rosenfeld, M.D., Piedmont Neurosurgery, P.A., 1899 Tate Boulevard, SE, Suite 2108, Hickory, North Carolina 28602, has been a voting member of the PHA Board, and was a member of the PHA Contracts Committee;
- H. James R. Thompson, M.D., Caldwell Family Care Center, 212 Mulberry Street, SW, Lenoir, North Carolina 28645, has served both as the Chairman and as a voting member of the PHA Board;
- I. Robert A. Yapundich, M.D., Neurology Associates, P.A., 1985 Tate Boulevard, SE, Suite 600, Hickory, North Carolina 28602, has been a voting member of the PHA Board, and was a member of the PHA Contracts Committee; and

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J. William Lee Young III, M.D., Hickory Family Practice Associates, P.A., 52 12th Avenue, NE, Hickory, North Carolina 28601, has served both as a voting member and as a non-voting advisory member of the PHA Board.

JURISDICTION AND INTERSTATE COMMERCE

4. At all times relevant to this Complaint, PHA has been engaged in the business of contracting with payors, on behalf of its physician and hospital members, for the provision of health care services to persons for a fee.

5. The general business practices of PHA, 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. Except to the extent that competition has been restrained as alleged herein, PHA’s physician members, including the Physician Respondents, have been, and are now, in competition with each other for the provision of physician services in the Unifour area to persons for a fee.

7. The general business practices of the Physician Respondents, 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.

BACKGROUND

8. Payors often contract with physicians, hospitals, and other providers of health care services in a geographic area to create a network of health care providers (“provider network”) that have agreed to provide health care services to enrollees covered under the payors’ programs. Those providers may enter into contracts individually and directly with the payor, or through a provider organization, such as a PHO.

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9. To become members of payors' provider networks, physicians often enter into contracts with payors that establish the terms and conditions, including fees and other competitively significant terms, for providing health care services to enrollees under the payors' programs. Physicians entering into such contracts often agree to reductions in their usual compensation in order to obtain access to additional patients made available to them by the payors' contractual relationships with their enrollees. Such reductions in physician fees may permit payors to constrain increases in, or reduce, the premiums they charge to their customers, or to offer broader benefits coverage without increasing premium levels or out-of-pocket expenditures by enrollees.

10. Medicare's Resource Based Relative Value Scale ("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 Unifour area make contract offers to individual physicians or groups at a price level specified as some percentage of the RBRVS fees for a particular year (*e.g.*, "110% of 2003 RBRVS").

11. Absent agreements among competing physicians on the prices and other contract terms on which they will provide services to the payor's enrollees, competing physicians or medical group practices decide unilaterally whether to enter a contract to participate in the payor's provider network on the terms and conditions, including price, offered by the payor.

12. Some self-insured employers contract with other payors to gain access to established provider networks. Payors who are not self-insured employers typically sell their programs to various customers, including employers or other entities that purchase or arrange for (and sometimes pay all or part of the cost of) programs providing health care benefits to their employees and their employees' dependents.

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13. To be marketable and competitive in the Unifour area, a payor's health plan generally must include in its physician network a large number of primary care and specialist physicians, offering services in a sufficient number of practice fields, who are available to customers at convenient or accessible locations, and at affordable prices. Because the substantial majority of the primary care and specialist physicians who practice in the Unifour area are members of PHA, many payors doing business in the Unifour area cannot offer marketable and competitive health plans without having at least a substantial portion of PHA's physician members in their provider networks.

PHA'S FORMATION AND EXPANSION

14. In 1993, the Chief Executive Officer ("CEO") of Frye Regional Medical Center, Inc. ("Frye"), formulated a plan to create a PHO that would include Frye and physicians who practiced at Frye. Frye paid a health care consultant to conduct surveys of physicians practicing at Frye to determine their level of interest in forming a PHO, and the services they would expect the PHO to offer. The consultant told Frye that the surveyed physicians "stated a need to form the group to negotiate with group clout and power" and "maintain[] their income" in anticipation of the arrival of managed care organizations to the Unifour area.

15. Eight physicians practicing at Frye, including Physician Respondents Dillon and Guttler, were recruited to serve on a PHO "steering committee" with Frye's CEO and Chief Operating Officer ("COO"). This committee met periodically, for more than a year, to make decisions about the purpose, form, and organization of the PHO.

16. In 1994, PHA was incorporated and its shareholders elected a Board of Directors, made up of physician and hospital representatives from among the PHA membership. Frye's COO initially directed PHA's operations. In 1995, PHA hired a full-

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time CEO, who was charged with overseeing the day-to-day operations of PHA, subject to approval by the PHA Board.

17. In early 1995, representatives of PHA participated in discussions with Caldwell Memorial Hospital (“Caldwell Memorial”), Grace Hospital (“Grace”), and their medical staffs about the possibility of joining PHA to form a “super PHO.” In 1996, PHA amended its Articles of Incorporation, Bylaws, and Policies and Procedures to permit Grace, Caldwell Memorial, and their respective medical staffs to join PHA and share equally in its governance.

**RESPONDENTS HAVE ENGAGED IN PRICE-FIXING
AND OTHER ANTICOMPETITIVE ACTS**

18. According to its records, PHA was “created to be a contracting entity for its members and serves to negotiate managed health care contracts with [payors].” In 1994, PHA informed potential physician members that “[e]ach [payor] contract will be carefully reviewed to determine advantages and disadvantages (including but not limited to reimbursement issues) to Piedmont Health Alliance participants and only those [contracts] which the directors determine to be favorable on balance to our participants as a whole will be signed.”

19. PHA’s physician members signed agreements that bound them to participate in all contracts that PHA entered, to accept PHA-negotiated prices, and to agree that if PHA entered into a contract with a payor with which the physician had an individual contract, then that physician would terminate the individual contract. PHA agreed to attempt to negotiate contracts with payors that included all PHA physician members.

20. In early 1994, the PHA steering committee established a Contracts Committee to negotiate contracts with payors on behalf of PHA and its physician and hospital members. The PHA Bylaws authorized the Contracts Committee to evaluate and negotiate proposed contracts with payors on behalf of PHA and its

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members. Until 2001, the Contracts Committee met regularly and was actively involved in PHA's contracting activities. Physician Respondents Guttler, Harvey, Rosenfeld, and Yapundich participated in the activities of the Contracts Committee during this period. Over that period, PHA negotiated and entered into more than 50 payor contracts.

21. From 1994 through early 1996, Frye's Chief Financial Officer ("CFO") and COO served as PHA's principal contract negotiators with payors. Beginning in 1996, PHA's CEO and her staff assumed the responsibility for negotiating PHA's payor contracts, and PHA's Board and Contracts Committee advised PHA's CEO regarding the price and other contract terms to demand from payors.

22. PHA's Board must approve PHA contracts with payors before they can take effect. PHA's Board is composed of 14 physician directors and six hospital directors, two representing each hospital (but with only one vote per hospital). Contract approval requires that both a majority of the PHA physician directors and two of the three hospital shareholders approve the contract. The Physician Respondents and the PHA hospitals' representatives on the PHA Board voted on the approval of contracts containing physician fee schedules that PHA collectively negotiated with payors.

23. PHA hired actuaries and other consultants to develop physician fee schedules containing price terms that PHA subsequently demanded from payors as a condition of contracting for the services of PHA's physician members.

24. PHA's most common contracting method has been to enter into a single-signature contract between PHA and a payor that covers the services of all PHA physician members. Payors that failed to reach agreement with PHA on contract terms, including price and price-related terms, were denied access to PHA's physician members for inclusion in their provider networks.

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25. PHA's physician members agreed with each other and with PHA that they would not deal individually, or through any other organization, with any payor with which PHA was attempting to negotiate, or had signed, a contract jointly on behalf of PHA's members. Until 2001, the physicians' participation agreements with PHA expressly included this provision. After 2001, this provision was no longer written into the PHA participation agreements, but PHA physicians nonetheless continued to adhere to it. PHA's physician members also refused to deal directly and individually with payors after PHA terminated its contracts with those payors.

26. By and through PHA, the member physicians and hospitals jointly agreed to require payors, as a condition of dealing with the PHA physicians, to refrain from contracting with non-PHA physicians or physician organizations in the Unifour area.

**PHA'S SO-CALLED "MESSENGER" APPROACH TO
CONTRACTING CONSTITUTES PRICE-FIXING**

27. Competing physicians sometimes use a "messenger" to facilitate their contracting with payors in ways that do not constitute an unlawful agreement on prices and other competitively significant terms. Legitimate messenger arrangements can reduce contracting costs between payors and physicians. A messenger can be an efficient conduit to which a payor submits a contract offer, with the understanding that the messenger will transmit that offer to a group of physicians and inform the payor how many physicians across specialties accept the offer or have a counteroffer. At less cost, payors can thus discern physician willingness to contract at particular prices, and assemble networks, while physicians can market themselves to payors and assess contracting opportunities. A messenger may not negotiate prices or other competitively significant terms, however, and may not facilitate coordination among physicians on their responses to contract offers.

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28. In February 2001, the PHA Board voted to change prospectively PHA's method of contracting with payors for physician services. PHA called its new contracting method the "modified messenger model." PHA told physician members that this contracting method would not apply to existing PHA payor contracts or to contracts then in the final stages of negotiation – all of which contained price and other terms that the PHA physician members had fixed and jointly demanded through PHA. Since the PHA Board's decision to institute its so-called "messenger" method for contracting, many existing PHA payor contracts renewed, and a number of new contracts were finalized, without being processed through PHA's messenger model.

29. In setting up this new contracting method, PHA told its physician members to report to PHA the minimum price levels they would accept under payor contracts. To aid physicians in making these price decisions, PHA informed them of the prices they had been paid for their most common medical procedures under several pre-existing, PHA-negotiated payor contracts. All such contracts contained prices that the physicians had collusively fixed and demanded through PHA. Many PHA physician members used these fixed prices to determine the prices that they would demand under the new "messenger" method.

30. PHA has processed two payor contracts for its physician members pursuant to its "messenger" method for contracting – one with CIGNA HealthCare of North Carolina, Inc. ("CIGNA"), and the other with United HealthCare of North Carolina, Inc. ("United"). PHA and its members engaged in price-fixing in connection with both contracts. PHA negotiated with CIGNA and United, respectively, on the overall average price levels that each would pay to all PHA physicians in the aggregate. PHA engaged in this conduct without transmitting contract offers to its physician members for their unilateral acceptance or rejection. As a result of these negotiations, United and CIGNA each agreed to aggregate payment rates substantially higher than their respective aggregate payment rates for North Carolina physicians.

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31. After fixing the overall average price level that would be paid to all its physician members under each of these two contracts, PHA, through its actuarial consultant, created fee schedules that established different price levels for each medical procedure and for different medical specialties. The actuary calculated these fee schedules such that, in their aggregate, they would total the overall average price level that PHA had negotiated for all PHA physicians to receive under the contract. In effect, the overall average price level was the “pie” that the PHA physicians collectively would share, and the fee schedules were the “pieces of the pie” that individual physicians could earn – depending on their specialty and the procedures they performed. PHA negotiated for United’s and CIGNA’s acceptance of these fee schedules. It did so without transmitting contract offers to its physician members for their unilateral acceptance or rejection.

32. PHA negotiated with United and CIGNA regarding, or collectively agreed on, various other contract terms as well – including pricing terms such as a demand for periodic, across-the-board percentage increases in physician fee levels to occur at certain times under the contract, and cost containment programs – without transmitting contract offers to PHA physician members for their unilateral acceptance or rejection.

33. After PHA had collectively negotiated with United and CIGNA on behalf of its physician members, more than 90% of PHA’s physician members agreed to participate in those contracts.

**THE PHYSICIAN RESPONDENTS PARTICIPATED IN
PRICE-FIXING AND OTHER ANTICOMPETITIVE ACTS**

34. All the Physician Respondents were voting members of the PHA Board. In that capacity, they participated in decisions of the PHA Board to: (a) approve or reject proposed contracts with payors that included fixed prices for PHA’s physician members; (b) authorize negotiations with payors by the PHA Contracts Committee and other PHA representatives aimed at gaining acceptance by the payors of physician fee schedules and prices

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collectively determined by PHA; (c) authorize development of, and approve, physician fee schedules for use by PHA in negotiating and contracting with payors; (d) terminate contracts between PHA and payors; (e) approve recommendations of the PHA Contracts Committee concerning payor contracts and contract terms, including physician prices; and (f) permit or not permit payors to obtain an exception from PHA's requirement that payors agree, as a condition of dealing with PHA, to refuse to deal with non-PHA physicians and physician organizations. The Physician Respondents directly profited from PHA's price-fixed contracts.

35. Physician Respondents Guttler, Harvey, Rosenfeld, and Yapundich were all members of the PHA Contracts Committee. In that capacity, they participated in activities and decisions of that Committee, including: (a) reviewing and deciding on, subject to final approval of the PHA Board, the acceptability of contracts and contract terms, including physician prices, proposed or offered by payors; (b) authorizing negotiations by PHA representatives with payors, and presentation to payors of specific requested contract terms, including price terms, or counteroffers to payors' offers; (c) recommending to the PHA Board that it approve contracts with payors that included collectively negotiated prices for the services of PHA physician members; (d) recommending to the PHA Board that it terminate contracts between PHA and certain payors; (e) approving or rejecting fee schedules, reimbursement terms, price levels, or other proposals or analyses relating to fees to be paid to PHA's physician members for use by PHA in negotiating and contracting with payors; and (f) recommending that the PHA Board approve or adopt fee schedules for reimbursement of PHA physician members in contracts between PHA and payors.

RESPONDENTS' PRICE-FIXING IS NOT JUSTIFIED

36. PHA's collective negotiation of fees and other competitively significant contract terms has not been, and is not,

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reasonably necessary to achieving any efficiency-enhancing integration.

ANTICOMPETITIVE EFFECTS

37. Respondents' actions described in Paragraphs 14 through 35 of this Complaint have had, or have tended to have, the effect of restraining trade unreasonably and hindering competition in the provision of physician services in the Unifour area of North Carolina in the following ways, among others:

- A. price and other forms of competition among PHA's physician members were unreasonably restrained;
- B. prices for physician services in the Unifour area have increased or been maintained at artificially high levels; and
- C. health plans, employers, and individual consumers were deprived of the benefits of competition among physicians.

**VIOLATION OF THE FEDERAL TRADE COMMISSION
ACT**

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

NOTICE

Notice is hereby given to the Respondents that the twenty-second day of March, 2004, at 10:00 a.m., or such later date as determined by an Administrative Law Judge of the Federal Trade Commission, is hereby fixed as the time and Federal Trade Commission offices, 600 Pennsylvania Avenue, N.W., Room 532, Washington, D.C. 20580, as the place when and where a hearing

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will be had before an Administrative Law Judge of the Federal Trade Commission, on the charges set forth in this Complaint, at which time and place you will have the right under the Federal Trade Commission Act to appear and show cause why an order should not be entered requiring you to cease and desist from the violations of law charged in the Complaint.

You are notified that the opportunity is afforded to you to file with the Commission an answer to this Complaint on or before the twentieth (20th) day after service of it upon you. An answer in which the allegations of the Complaint are contested shall contain a concise statement of the facts constituting each ground of defense; and specific admission, denial, or explanation of each fact alleged in the Complaint or, if you are without knowledge thereof, a statement to that effect. Allegations of the Complaint not thus answered shall be deemed to have been admitted.

If you elect not to contest the allegations of fact set forth in the Complaint, the answer shall consist of a statement that you admit all of the material facts to be true. Such an answer shall constitute a waiver of hearings as to the facts alleged in the Complaint and, together with the Complaint, will provide a record basis on which the Administrative Law Judge shall file an initial decision containing appropriate findings and conclusions and an appropriate order disposing of the proceeding. In such answer, you may, however, reserve the right to submit proposed findings and conclusions under § 3.46 of the Commission's Rules of Practice for Adjudicative Proceedings and the right to appeal the initial decision to the Commission under § 3.52 of said Rules.

Failure to answer within the time above provided shall be deemed to constitute a waiver of your right to appear and contest the allegations of the Complaint and shall authorize the Administrative Law Judge, without further notice to you, to find the facts to be as alleged in the Complaint and to enter an initial decision containing such findings, appropriate conclusions, and order.

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The Administrative Law Judge will schedule an initial prehearing scheduling conference to be held not later than 14 days after the last answer is filed by any party named as a Respondent in the Complaint. Unless otherwise directed by the Administrative Law Judge, the scheduling conference and further proceedings will take place at the Federal Trade Commission, 600 Pennsylvania Avenue, N.W., Room 532, Washington, D.C. 20580. Rule 3.21(a) requires a meeting of the parties' counsel as early as practicable before the prehearing scheduling conference, and Rule 3.31(b) obligates counsel for each party, within five (5) days of receiving a Respondent's answer, to make certain initial disclosures without awaiting a formal discovery request.

NOTICE OF CONTEMPLATED RELIEF

Should the Commission conclude from the record developed in any adjudicative proceeding in this matter that Respondents Piedmont Health Alliance, Inc. ("PHA"), Peter H. Bradshaw, M.D., S. Andrews Deekens, M.D., Daniel C. Dillon, M.D., Sanford D. Guttler, M.D., David L. Harvey, M.D., John W. Kessel, M.D., A. Gregory Rosenfeld, M.D., James R. Thompson, M.D., Robert A. Yapundich, M.D., and William Lee Young III, M.D. ("Physician Respondents") are in violation of Section 5 of the Federal Trade Commission Act as alleged in the Complaint, the Commission may order such relief as is supported by the record and is necessary and appropriate, including, but not limited to:

1. An order to cease and desist from entering into, adhering to, participating in, maintaining, organizing, implementing, enforcing, or otherwise facilitating any combination, conspiracy, agreement, or understanding between or among any physicians: (a) to negotiate on behalf of any physician with any payor; (b) to deal, refuse to deal, or threaten to refuse to deal with any payor; (c) 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 (d) not to deal individually with

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any payor, or not to deal with any payor through any arrangement other than PHA.

2. An order to cease and desist from 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.

3. An order to cease and desist from attempting to engage in any action prohibited by Paragraphs 1 or 2, above.

4. An order to cease and desist from encouraging, suggesting, advising, pressuring, inducing, or attempting to induce any person to engage in any action that would be prohibited by Paragraphs 1 through 3, above.

Provided, however, Paragraphs 1 through 3, above, would not prohibit any Physician Respondent from forming, participating in, or taking any action in furtherance 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. Provided further, Paragraphs 1 through 3, above, would not prohibit PHA, following the seven (7) year period specified in Paragraph 6, from forming, participating in, or taking any action in furtherance of a qualified risk-sharing joint arrangement or a qualified clinically-integrated joint arrangement, so long as the arrangement does not restrict the ability, or facilitate the refusal, of physicians who participate in it to deal with payors on an individual basis or through any other arrangement.

5. An order that PHA cease and desist from evaluating or considering, on behalf of any physician, any information, term, condition, or requirement of dealing with any payor, and from advising any PHA physician member to accept or reject any term, condition, or requirement of dealing with any payor.

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6. An order that PHA cease and desist, for a period of seven (7) years, from: (a) acting as a messenger, or as an intermediary or agent, for or on behalf of any physicians, with payors regarding contracts or terms of dealing involving the physicians and payors; (b) participating in, organizing, or facilitating any discussion or understanding with or among any physicians or hospitals, pursuant to a qualified risk-sharing joint arrangement or a qualified clinically-integrated joint arrangement, relating to price or other terms or conditions of dealing with any payor; and (c) contacting a payor, pursuant to a qualified risk-sharing joint arrangement or a qualified clinically-integrated joint arrangement, to negotiate or enter into any agreement relating to price or other terms or conditions of dealing with any payor, on behalf of any physician or hospital in such arrangement.

7. A requirement that, for any pre-existing contract with any payor for the provision of physician services having a termination or renewal date of one (1) year or less after the date the order becomes final, PHA terminate such contract, without penalty or charge and in compliance with any applicable laws, at the earlier of:

(a) receipt by PHA of a written request from a payor to terminate such contract, or

(b) the earliest termination or renewal date (including any automatic renewal date) of such contract.

Provided, however, a preexisting contract may extend beyond any such termination or renewal date no later than one (1) year after the date on which the order becomes final if, prior to such termination or renewal date: (i) the payor submits to PHA a written request to extend such contract to a specific date no later than one (1) year after the order becomes final; and (ii) PHA 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 part (a) of this paragraph, to terminate the contract at any time.

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8. A requirement that, for any pre-existing contract with any payor for the provision of physician services having a termination or renewal date of more than one (1) year after the date this order becomes final, PHA terminate such contract, without penalty or charge and in compliance with any applicable laws, no later than one (1) year after the date on which the order becomes final. Provided, however, that any such payor retains the right, pursuant to part (a) of Paragraph 7, to terminate the contract at any time.

9. A requirement that, for five (5) years following the end of the seven (7) year period specified in Paragraph 6, PHA give notice to the Commission at least sixty (60) days prior to:

(a) participating in, organizing, or facilitating any discussion or understanding with or among any physicians or hospitals relating to price or other terms or conditions of dealing with any payor concerning a clinically-integrated or financial risk-sharing joint arrangement in which PHA participates; (b) contacting a payor, pursuant to any such joint arrangement, to negotiate or enter into any agreement concerning price or other terms or conditions of dealing with any payor on behalf of any physician or hospital participating in such joint arrangement; or (c) acting as a messenger, or as an agent on behalf of any physicians, with payors regarding contracts for physician services.

10. A requirement that PHA distribute a copy of the order and Complaint, within thirty (30) days after the order becomes final, to: (a) each physician who is participating, or has participated, in PHA; (b) each officer, director, manager, and employee of PHA; and (c) all payors with which PHA has been in contact since January 1, 1994, regarding contracting for the provision of physician or hospital services (including a notice to these payors of their right to terminate any of their existing contracts with PHA).

11. A requirement that for ten (10) years after the order becomes final, PHA: (a) distribute a copy of the order and Complaint to: (i) each payor that contracts with PHA for the provision of physician or hospital services; (ii) each person who

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becomes an officer, director, manager, or employee of PHA; and (iii) each newly participating physician in PHA; and (b) annually publish a copy of the order and Complaint in any official annual report or newsletter sent to all physicians who participate in it, and on its website, with such prominence and identification as is given to regularly featured articles.

12. Requirements that PHA and each Physician Respondent: (a) file periodic compliance reports with the Commission; and (b) notify the Commission of any changes that may affect compliance obligations.

13. Any other provision appropriate to correct or remedy the anticompetitive practices engaged in by PHA and the Physician Respondents.

WHEREFORE, THE PREMISES CONSIDERED, the Federal Trade Commission on this twenty-second day of December, 2003, issues its Complaint against Piedmont Health Alliance, Inc., Peter H. Bradshaw, M.D., S. Andrews Deekens, M.D., Daniel C. Dillon, M.D., Sanford D. Guttler, M.D., David L. Harvey, M.D., John W. Kessel, M.D., A. Gregory Rosenfeld, M.D., James R. Thompson, M.D., Robert A. Yapundich, M.D., and William Lee Young III, M.D.

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DECISION AND ORDER

The Federal Trade Commission (“Commission”), having heretofore issued its Complaint charging Piedmont Health Alliance, Inc. (“PHA”), hereinafter sometimes referred to as “Respondent PHA,” and ten individual physicians (“Physician Respondents”), together collectively hereinafter sometimes referred to as “Respondents,” with violations of Section 5 of the Federal Trade Commission Act, as amended, 15 U.S.C. § 45; and

Respondents, their attorneys, and counsel for the Commission having thereafter executed an Agreement Containing Consent Order to Cease and Desist (“Consent Agreement”), containing an admission by Respondents 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 Respondents that the law has been violated as alleged in such Complaint, or that the facts as alleged in such Complaint, other than jurisdictional facts and the facts admitted in the Respondents’ Answer to the Complaint, are true, and waivers and other provisions as required by the Commission’s Rules; and

The Commission having thereafter withdrawn this matter from adjudication in accordance with Section 3.25 (f) of the Commission’s Rules, 16 C.F.R. § 3.25 (f), and the Commission having considered the matter 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 section 2.34 of its Rules, now in further conformity with the procedure described in Commission Rule 3.25 (f), 16 C.F.R. § 3.25 (f), the Commission makes the following jurisdictional findings and issues the following Order:

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1. Respondent PHA is a for-profit corporation, organized, existing, and doing business under and by virtue of the laws of the State of North Carolina, with its principal address located at 1899 Tate Boulevard, SE, Hickory, North Carolina 28602.
2. The Physician Respondents are persons who are licensed to practice medicine in the State of North Carolina, and are shareholders in PHA. Their respective names and principal addresses are as follows:
 - A. Peter H. Bradshaw, M.D., Hickory Surgical Clinic, 415 North Center Street, Suite 102, Hickory, North Carolina 28601;
 - B. S. Andrews Deekens, M.D., Morganton Family Medicine, PLLC, 115 Foothills Drive, Morganton, North Carolina 28655;
 - C. Daniel C. Dillon, M.D., P.A., 11 13th Avenue, NE, Suite 102, Hickory, North Carolina 28601;
 - D. Sanford D. Guttler, M.D., Crown Health Care, PA, d/b/a Granite Falls Primary Care Physicians, One Trade Street, Granite Falls, North Carolina 28630;
 - E. David L. Harvey, M.D., Piedmont Nephrology & Hypertension Associates, 1899 Tate Boulevard, SE, Suite 2101, Hickory, North Carolina 28602;
 - F. John W. Kessel, M.D., Fairbrook Medical Clinic, 1985 Startown Road, Hickory, North Carolina 28602;
 - G. A. Gregory Rosenfeld, M.D., Piedmont Neurosurgery, P.A., 1899 Tate Boulevard, SE, Suite 2108, Hickory, North Carolina 28602;
 - H. James R. Thompson, M.D., Caldwell Family Care Center, 212 Mulberry Street, SW, Lenoir, North Carolina 28645;

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- I. Robert A. Yapundich, M.D., Neurology Associates, P.A., 1985 Tate Boulevard, SE, Suite 600, Hickory, North Carolina 28602; and
 - J. William Lee Young III, M.D., Hickory Family Practice Associates, P.A., 52 12th Avenue, NE, Hickory, North Carolina 28601.
3. The Federal Trade Commission has jurisdiction of the subject matter of this proceeding and of the Respondents, 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 PHA” means Piedmont Health Alliance, Inc., its officers, directors, employees, agents, attorneys, representatives, successors, and assigns; the subsidiaries, divisions, groups, and affiliates controlled by it, and the respective officers, directors, employees, agents, attorneys, representatives, successors, and assigns of each.
- B. “Physician Respondents” means Peter H. Bradshaw, M.D., S. Andrews Deekens, M.D., Daniel C. Dillon, M.D., Sanford D. Guttler, M.D., David L. Harvey, M.D., John W. Kessel, M.D., A. Gregory Rosenfeld, M.D., James R. Thompson, M.D., Robert A. Yapundich, M.D., and William Lee Young III, M.D.
- C. “Respondents” means Respondent PHA and the Physician Respondents.
- D. “Group practice” means a bona fide, integrated firm in which providers practice together as partners, shareholders,

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owners, members, or employees, or in which only one provider practices.

- E. “Hospital” means a health care facility licensed by any state as a hospital.
- F. “Limited Messenger Arrangement” means an arrangement pursuant to which PHA receives a contract offer from a payor, timely conveys without comment or analysis such offer to some or all of the arrangement’s participants as directed by the payor, receives from each participant his or her independent, unilateral decision to accept or reject the payor’s contract offer, and timely conveys each such response without comment or analysis to the payor.
- G. “Messenger Arrangement” means an arrangement, excluding a Limited Messenger Arrangement, pursuant to which Respondent PHA acts as a messenger, or as an agent for or on behalf of a provider, with payors regarding contracts or terms of dealing involving the providers and payors.
- H. “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.”
- I. “Payor” means any person that pays, or arranges for payment, for all or any part of any provider services or hospital services for itself or for any other person. Payor includes any person that develops, leases, or sells access to networks of providers or hospitals.
- J. “Person” means both natural persons and artificial persons, including, but not limited to, corporations, unincorporated

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entities, and governments.

- K. “Physician” means a doctor of allopathic medicine (“M.D.”) or a doctor of osteopathic medicine (“D.O.”).
- L. “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 Respondent PHA, pursuant to Paragraph VII.A.4 of this Order, of such payor’s right to terminate such contract.
- M. “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.
- N. “Provider” means any licensed health care professional, including, but not limited to, physicians.
- O. “Qualified clinically-integrated joint arrangement” means an arrangement to provide provider services, hospital services, or both provider and hospital services, in which:
 - 1. all providers and hospitals that 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 providers and hospitals that 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.
- P. “Qualified risk-sharing joint arrangement” means an arrangement to provide provider services, hospital services, or

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both provider and hospital services, in which:

1. all providers and hospitals that participate in the arrangement share substantial financial risk through their participation in the arrangement and thereby create incentives for the providers and hospitals that participate jointly to control costs and improve quality by managing the provision of provider services and hospital services, such as risk-sharing involving:
 - a. the provision of provider services and hospital services to payors at a capitated rate,
 - b. the provision of provider services and hospital services for a predetermined percentage of premium or revenue from payors,
 - c. the use of significant financial incentives (*e.g.*, substantial withholds) for providers and hospitals that 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 hospitals and providers 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.

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- Q. “Unifour Area” means the area of North Carolina that comprises Alexander, Burke, Caldwell, and Catawba Counties.

II.

IT IS FURTHER ORDERED that each Respondent, directly or indirectly, or through any corporate or other device, in connection with the provision of provider 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 providers:
1. to negotiate on behalf of any provider 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 provider 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 PHA;
- B. Exchanging or facilitating in any manner the exchange or transfer of information between or among providers concerning any provider’s willingness to deal with a payor, or the terms or conditions, including any price terms, on which the provider is willing to deal with a payor;
- C. Attempting to engage in any action prohibited by Paragraphs II.A and II.B above; and

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- 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 any conduct by:

1. Respondent PHA or any Physician Respondents to the extent necessary to continue to participate in the bonus plan contracts with the payors listed in Confidential Appendix A of this Order;
2. Any Physician Respondent that is reasonably necessary to form, participate in, or take any action in furtherance of a qualified risk-sharing joint arrangement or a qualified clinically-integrated joint arrangement, or that solely involves providers in the same medical group practice;
3. Respondent PHA, beginning thirty (30) months after the date this Order becomes final, and subject to the provisions of Paragraph IV of this Order, that is reasonably necessary to form, participate in, or take any action in furtherance of a qualified risk-sharing joint arrangement or a qualified clinically-integrated joint arrangement that in any way restricts the ability, or facilitates the refusal, of providers who participate in it to deal with payors on an individual basis or through any other arrangement (“exclusive qualified joint arrangement”), so long as the provider participants constitute twenty (20) percent or less of the providers in each provider specialty with active hospital staff privileges who practice in:
 - a. Catawba County, North Carolina; and
 - b. the Unifour Area;

provided further that, if Respondent PHA forms an exclusive qualified joint arrangement pursuant to proviso 3

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of Paragraph II of this Order, and if any provider specialty has fewer than five providers in that provider specialty, then that exclusive qualified joint arrangement may include one group practice that includes one or more providers in that specialty, on a non-exclusive basis; or

4. Respondent PHA, beginning thirty (30) months after the date this Order becomes final, and subject to the provisions of Paragraph IV of this Order, that is reasonably necessary to form, participate in, or take any action in furtherance of a qualified risk-sharing joint arrangement or a qualified clinically-integrated joint arrangement that does not restrict the ability, or facilitate the refusal, of providers who participate in it to deal with payors on an individual basis or through any other arrangement (“non-exclusive qualified joint arrangement”), so long as the provider participants constitute thirty (30) percent or less of the providers in each provider specialty with active hospital staff privileges who practice in:

- a. Catawba County, North Carolina; and

- b. the Unifour Area;

provided further that, if Respondent PHA forms a non-exclusive qualified joint arrangement pursuant to proviso 4 of Paragraph II of this Order, and if any provider specialty has fewer than four providers in that provider specialty, then that non-exclusive qualified joint arrangement may include one group practice that includes one or more providers in that specialty;

Provided, however, that beginning ten (10) years after the date this Order becomes final, provisos 3 and 4 of Paragraph II of this Order shall no longer apply, and thereafter nothing in Paragraph II shall prohibit any agreement involving, or any conduct by, Respondent PHA that is reasonably necessary to form, participate in, or take any action in furtherance of a

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qualified risk-sharing joint arrangement or a qualified clinically-integrated joint arrangement.

III.

IT IS FURTHER ORDERED that Respondent PHA, directly or indirectly, or through any corporate or other device, in connection with provider 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. Preparing, maintaining, or participating in the development or preparation of any provider fee schedule;
- B. Collecting, soliciting, maintaining, or otherwise accumulating any information relating to the terms, conditions, or requirements upon which any provider deals, or is willing to deal, with a payor, including, but not limited to, price terms;
- C. Preparing or maintaining any summary or other compilation relating to the terms, conditions, or requirements upon which any provider deals, or is willing to deal, with a payor, including, but not limited to, price terms; and
- D. Encouraging, facilitating, suggesting, advising, pressuring, inducing, or attempting to induce any person to engage in any action that would be prohibited by Paragraphs III.A through III.C above, if Respondent PHA were to engage in such action.

PROVIDED, HOWEVER, that Paragraph III of this Order shall not apply, to the extent such conduct is reasonably necessary:

1. for Respondent PHA to continue the bonus plan contracts with payors listed in Confidential Appendix A of this Order;

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2. to the formation or operation of an exclusive qualified joint arrangement or a non-exclusive qualified joint arrangement pursuant to the provisos to Paragraph II of this Order;

PROVIDED FURTHER that Paragraph III.B and Paragraph III.C of this Order shall not apply to the extent that such conduct is necessary for, and undertaken solely for the purpose of:

- (1) entering into a Messenger Arrangement pursuant to Paragraph V of this Order; or
- (2) implementing information technology services in the form of practice management and electronic medical record software to group practices, and medical management services for payors.

IV.

IT IS FURTHER ORDERED that, pursuant to each exclusive qualified joint arrangement or non-exclusive qualified joint arrangement (“Arrangement”) in which Respondent PHA is a participant, Respondent PHA, for five (5) years after the date on which PHA is permitted to begin to enter into such Arrangements pursuant to provisos 3 and 4 of Paragraph II of this Order, shall notify the Secretary of the Commission in writing (“Notification”) at least sixty (60) but not more than ninety (90) days prior to:

- A. Participating in, organizing, or facilitating any discussion or understanding with or among any providers in such Arrangement relating to price or other terms or conditions of dealing with any payor; or
- B. Contacting a payor, pursuant to an Arrangement, to negotiate or enter into any agreement relating to price or other terms or conditions of dealing with any payor, on behalf of any provider in such Arrangement;

PROVIDED, HOWEVER, that Notification shall not be required for subsequent contacts with any payor pursuant to any Arrangement for which Notification has been given pursuant to Paragraph IV.A or Paragraph IV.B of this Order;

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PROVIDED FURTHER:

1. that with respect to any Notification, Respondent PHA shall include the following information:
 - a. for each provider participant, the name, address, telephone number, medical or other provider specialty, group practice, if applicable, and the name of each hospital where the provider has privileges;
 - b. a description of the Arrangement and its purpose, function, and geographic area of operation;
 - c. a description of the nature and extent of the integration and the efficiencies resulting from the Arrangement;
 - d. an explanation of how any agreement on prices, or on contract terms related to price, furthers the integration and achievement of the efficiencies resulting from the Arrangement;
 - e. a description of any procedures proposed to be implemented to limit possible anticompetitive effects resulting from the Arrangement or its activities; and
 - f. all studies, analyses, and reports that were prepared for the purpose of evaluating or analyzing competition for provider services in the Unifour Area or specifically in Catawba County, North Carolina, including, but not limited to, the market share of provider services in such market(s); and
2. if, within sixty (60) days from the Commission's receipt of the Notification, a representative of the Commission makes a written request for additional information to the Respondent PHA, then Respondent PHA shall not engage in any conduct described in Paragraph IV.A. or Paragraph IV.B of this Order prior to the expiration of thirty (30) days

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after substantially complying with such request for additional information, or such shorter waiting period as may be granted in writing from the Bureau of Competition. The expiration of any waiting period described herein without a request for additional information or without the initiation of an enforcement proceeding shall not be construed as a determination by the Commission, or its staff, that a violation of the law, or of this Order, may not have occurred. Further, receipt by the Commission from Respondent PHA of any Notification, pursuant to Paragraph IV of this Order, is not to be construed as a determination by the Commission that any such Arrangement does or does not violate this Order or any law enforced by the Commission.

V.

IT IS FURTHER ORDERED that Respondent PHA, directly or indirectly, or through any corporate or other device, cease and desist:

- A. for thirty (30) months after the date that this Order becomes final from entering into any Limited Messenger Arrangement; and
- B. for fifty-four (54) months after the date that this Order becomes final, from:
 - 1. evaluating, advising, or giving any opinion relating to contracts or terms of dealing involving providers and payors; or
 - 2. entering into any Messenger Arrangement.

PROVIDED, HOWEVER, that, subject to the provisions of Paragraph VI of this Order, nothing in Paragraph V of this Order shall prohibit Respondent PHA from entering into a Limited Messenger Arrangement on behalf of providers with regard to

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direct employer contracts with payors listed in Confidential Appendix B of this Order.

VI.

IT IS FURTHER ORDERED that, for three (3) years after the date that Respondent PHA enters into any Messenger Arrangement or Limited Messenger Arrangement pursuant to Paragraph V of this Order, Respondent PHA shall notify the Secretary of the Commission in writing (“Messenger Notification”) at least sixty (60) days, but no more than ninety (90) days, prior to entering into any such arrangement. The Messenger Notification shall include the identity of each proposed provider participant; the proposed geographic area in which the proposed arrangement will operate; a copy of any proposed provider 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 the procedures to be implemented to limit possible anticompetitive effects. Messenger Notification is not required for Respondent PHA’s subsequent acts pursuant to any Messenger Arrangement or Limited Messenger Arrangement for which this Messenger Notification has been given. Receipt by the Commission from Respondent PHA of any Messenger Notification, pursuant to Paragraph VI of the Order, is not to be construed as a determination by the Commission that any action described in such Messenger Notification does or does not violate this Order or any law enforced by the Commission.

VII.

IT IS FURTHER ORDERED that Respondent PHA shall:

- A. Within thirty (30) days after the date on which this Order becomes final, send a copy of this Order and the Complaint by first-class mail:

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1. with delivery confirmation, to each provider and hospital that participates in Respondent PHA;
 2. with return receipt requested, to each present officer, director, manager, and employee of Respondent PHA;
 3. with return receipt requested, to the chief executive officer of each payor with which Respondent PHA has no current contract, but with which Respondent PHA has a record of being in contact, since January 1, 1997, regarding contracting for the provision of provider services; and
 4. with delivery confirmation, and with an enclosed copy of the notice specified in:
 - a. Appendix C to this Order, to the chief executive officer of each payor with which Respondent PHA has a contract for the provision of provider services;
 - b. Appendix C to this Order, to each payor with a direct employer contract, listed at Confidential Appendix B of this Order; and
 - c. Appendix D to this Order, to each payor with a bonus plan contract, listed at Confidential Appendix A of this Order;
- B. For a period of five (5) years after the date this Order becomes final:
1. Distribute by first-class mail, return receipt requested, a copy of this Order and the Complaint to:
 - a. each provider and hospital that begins participating in Respondent PHA, and that did not previously receive a copy of this Order and the Complaint from Respondent PHA, within thirty (30) days of the day that such participation begins;

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b. each payor that contracts with Respondent PHA for the provision of provider services, and that did not previously receive a copy of this Order and the Complaint from Respondent PHA, within thirty (30) days of the day that such payor enters into such contract; and

c. each person who becomes an officer, director, manager, or employee of Respondent PHA, and who did not previously receive a copy of this Order and the Complaint from Respondent PHA, within thirty (30)

days of the day that he or she assumes such responsibility with Respondent PHA; and

2. Annually publish a copy of this Order and the Complaint in an official annual report or newsletter sent to all providers who participate in Respondent PHA, with such prominence as is given to regularly featured articles;

C. File a verified written report within sixty (60) days after the date on which this Order becomes final, annually thereafter for five (5) years on the anniversary of the date this Order becomes final, and at such other times as the Commission may by written notice require. Each such report shall include:

1. A detailed description of the manner and form in which Respondent PHA has complied and is complying with this Order;

2. The name, address, and telephone number of each payor with which Respondent PHA has had any contact; and

3. Copies of the delivery confirmations required by Paragraphs VII.A.1 and VII.A.4 of this Order, and copies of the signed return receipts required by Paragraphs VII.A.2, VII.A.3, and VII.B.1 of this Order; and

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- D. Terminate, without penalty or charge, and in compliance with any applicable laws, any preexisting contract with any payor for the provision of provider services, at the earlier of: (1) receipt by Respondent PHA of a written request from a payor to terminate such contract, or (2) six (6) months after the day the Order becomes final; *provided, however*, that the automatic termination requirement of part (2) of Paragraph VII.D of this Order does not apply to the bonus plan contracts entered into by Respondent PHA with payors listed in Confidential Appendix A of this Order; *provided further* that any payor holding a contract with Respondent PHA, other than a bonus plan contract entered into by Respondent PHA with payors listed in Confidential Appendix A of this Order, may, upon written request to Respondent PHA, extend the termination date of such contract for a period not to exceed six (6) months after the date this Order becomes final; *provided further* that any payor making such request to extend a contract retains the right, pursuant to part (1) of Paragraph VII.D of this Order, to terminate the contract at any time.

VIII.

IT IS FURTHER ORDERED that each Physician Respondent shall file a verified written report within sixty (60) days after the date on which this Order becomes final, annually thereafter for three (3) years on the anniversary of the date this Order becomes final, and at such other times as the Commission may by written notice require. Each such report shall include a detailed description of the manner and form in which each Physician Respondent has complied and is complying with this Order. Such details shall include, but are not limited to, a description of any exclusive qualified joint arrangement or any qualified joint arrangement entered into by the Physician Respondent during the reporting period.

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IX.

IT IS FURTHER ORDERED that Respondent PHA shall notify the Commission at least thirty (30) days prior to any proposed (1) dissolution of Respondent PHA, (2) acquisition, merger or consolidation of Respondent PHA, or (3) other change in Respondent PHA that may affect compliance obligations arising out of the order, including but not limited to assignment, the creation or dissolution of subsidiaries, or any other change in Respondent PHA.

X.

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

XI.

IT IS FURTHER ORDERED that, for the purpose of determining or securing compliance with this Order, each 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 his or its possession, or under his or its control, relating to any matter contained in this Order; and
- B. Upon five (5) days' notice, and in the presence of counsel, and without restraint or interference from it, to interview officers, directors, or employees of the Respondent.

XII.

IT IS FURTHER ORDERED that this Order shall terminate on October 1, 2024.

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Appendix A

**[Redacted From Public Record Version But Incorporated By
Reference]**

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Appendix B

**[Redacted From Public Record Version But Incorporated By
Reference]**

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Appendix C

**Letter to payors with whom PHA currently has a contract,
other than a bonus plan contract**

[letterhead of Respondent PHA]
[name of payor's CEO]
[address]

Dear _____:

Enclosed is a copy of a complaint and a decision and order ("Order") issued by the Federal Trade Commission against Piedmont Health Alliance, Inc. ("PHA"), and ten individual physicians.

Pursuant to Paragraph VII.D of the Order, PHA must allow you to terminate, upon your written request, without any penalty or charge, any contracts with PHA that are in effect at the time of your receipt of this letter.

Paragraph VII.D of the Order also provides that, if you do not terminate a contract currently in effect with PHA, the contract will terminate on the earlier of its termination or renewal date (including any automatic renewal date) or six (6) months after the date the enclosed Order becomes final. The Order became final on [appropriate date to be filled in by PHA]. However, if the contract terminates on a date prior to [appropriate date six months after Order became final to be filled in by PHA], the contract may be extended at your written request to a date no later than [appropriate date six months after Order became final to be filled in by PHA]. If you choose to extend the term of the contract, you may later terminate the contract at any time prior to [appropriate date six months after Order became final to be filled in by PHA].

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,

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Appendix D
Letter to payors with bonus plan contracts

[letterhead of Respondent PHA]

[name of payor's CEO]

[address]

Dear _____:

Enclosed is a copy of a complaint and a decision and order ("Order") issued by the Federal Trade Commission against Piedmont Health Alliance, Inc. ("PHA"), and ten individual physicians.

Pursuant to Paragraph VII.D of the Order, PHA must allow you to terminate, upon your written request, without any penalty or charge, any contracts with PHA that are in effect at the time of your receipt of this letter.

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

Sincerely,

Analysis

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

The Federal Trade Commission has accepted, subject to final approval, an agreement containing a proposed consent order with Piedmont Health Alliance, Inc. (“PHA”), and ten individual physicians who are named as Respondents (“Physician Respondents”) in the complaint issued by the Commission on December 22, 2003.¹ The agreement settles charges that PHA and the ten Physician Respondents (together “Respondents”) violated Section 5 of the Federal Trade Commission Act, 15 U.S.C. § 45, by orchestrating and facilitating agreements among PHA’s physician members to fix prices and other terms on which the physicians would deal with health plans and other purchasers of physician services (“payors”), and to refuse to deal with payors except on collectively-determined terms. On July 2, 2004, the case was withdrawn from adjudication, so that the Commission could consider a proposed consent agreement and decision and order. 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 any comments and decide whether to withdraw from the agreement or make the proposed order final.

The purpose of this analysis is to facilitate comment on the proposed order. The analysis does not constitute an official interpretation of the agreement and proposed order and does not modify their terms in any way. The proposed consent order has been entered into for settlement purposes only and does not constitute an admission by Respondents that they violated the law

¹ The ten Physician Respondents (all M.D.s) are: Peter H. Bradshaw, S. Andrews Deekens, Daniel C. Dillon, Sanford D. Guttler, David L. Harvey, John W. Kessel, A. Gregory Rosenfeld, James R. Thompson, Robert A. Yapundich, and William Lee Young III.

Analysis

or that the complaint's alleged facts – other than jurisdictional facts and facts admitted in the Respondents' answer to the complaint – are true.

The Complaint Allegations

PHA, a for-profit corporation, is a physician-hospital organization (“PHO”) that includes physicians, hospitals, and other licensed health care providers in Alexander, Burke, Caldwell, and Catawba counties in western North Carolina (known as the “Unifour” area). PHA includes approximately 450 physicians, representing the substantial majority of physicians in the Unifour area, and three of the five Unifour area hospitals, including Frye Regional Medical Center (“Frye”), Caldwell Memorial Hospital (“Caldwell Memorial”), and Grace Hospital (“Grace”).²

In 1993, Frye's Chief Executive Officer (“CEO”) developed a plan for a PHO that would include Frye and the physicians practicing at Frye. He hired a consultant to survey the physicians regarding what they would expect from a PHO. The consultant reported that the physicians “stated a need to form the group to negotiate with group clout and power” and “maintain their income” in anticipation of the arrival of managed care organizations in the Unifour area. Frye's CEO and Chief Operating Officer, along with eight physicians practicing at Frye, formed a steering committee responsible for establishing and organizing the PHO.

PHA was established in 1994 to facilitate physician collective

² The Commission previously issued a separate consent order related to this case against Frye and its parent corporation, Tenet Healthcare Corporation, both of which are for-profit corporations. *In the Matter of Tenet Healthcare Corporation and Frye Regional Medical Center, Inc.*, Dkt. No. C-4106 (consent order issued January 29, 2004).

Analysis

bargaining with payors and obtain more favorable fees and other terms than PHA's physician members could obtain by dealing individually with payors. PHA established a Contracts Committee to negotiate contracts with payors on behalf of PHA's physician members, subject to approval by PHA's Board of Directors. In 1996, PHA expanded to include Caldwell Memorial and Grace, both nonprofit hospitals, and their respective medical staffs.

The Board manages and controls PHA. The Board has 14 physician directors elected by PHA's physician members, and six hospital directors – two representing each hospital member (but with only one vote per hospital member). A majority of PHA physician directors and two of the three voting hospital directors must approve each payor contract entered into on behalf of PHA's members. Since 1994, the Board voted to approve more than 50 contracts containing physician fee schedules that PHA collectively negotiated with payors.

PHA hired actuaries and other consultants to develop physician fee schedules containing price terms that PHA demanded from payors as a condition of contracting with PHA for physician services. PHA generally negotiated single-signature contracts with payors for the services of all PHA's physician members, and committed to attempt to negotiate contracts with payors that included all PHA physician members. Payors that failed to accede to PHA on price and other contract terms were denied access to PHA's physician members for inclusion in the payors' provider networks. PHA's physician members agreed to participate in all PHA's payor contracts, to accept the prices for their services that PHA negotiated on their behalf, and to terminate any individual contracts they had with a payor once PHA entered into a contract with that payor. PHA's physician members also agreed not to deal individually or through any other organization with any payor with which PHA was attempting to negotiate, or had signed, a contract jointly on behalf of PHA's members.

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The Physician Respondents are PHA shareholders. All have been voting Board members and participated in Board decisions to approve or reject payor contracts containing fixed physician prices, authorize negotiations over the prices payors must pay for PHA physician services, authorize development of physician fee schedules for PHA's use in contracting with payors, terminate contracts between PHA and payors, and approve Contracts Committee recommendations concerning price and other payor contract terms. In addition to serving on the PHA Board, four Physician Respondents were members of the Contracts Committee, which more directly negotiated with payors over physician prices and other contract terms. The Physician Respondents and all PHA physician members are compensated for their professional medical services under fee schedules contained in PHA-negotiated contracts with payors.

In 2001, PHA prospectively adopted a new contracting method that it called a "modified messenger model." This contracting method did not affect existing contracts between PHA and payors or contracts in final stages of negotiation. Since 2001, PHA renewed or entered several payor contracts without using the "messenger model." The complaint alleges that, in setting up the "modified messenger model," PHA physician members reported to PHA the minimum price terms – *i.e.*, standing offers or "targets" – each would accept if offered by a payor. To help the physicians set their individual target fees, PHA provided each practice group with specific information about the fees that practice was receiving from several payors under existing PHA-negotiated payor contracts. PHA's physicians used these previously fixed prices in determining the prices to demand under contracts processed under PHA's new contracting method.

PHA used this contracting method with two health plans: United HealthCare of North Carolina, Inc., and Cigna HealthCare of North Carolina, Inc. PHA negotiated with each health plan over the aggregate level of payments the health plan would pay for physician services – stated as a percentage of Medicare's reimbursement for the same services. PHA also negotiated and

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agreed with United and Cigna on other price-related contract terms, such as periodic percentage increases in physician fee levels to occur at certain times. To compel the payor to accept PHA's terms, PHA confronted each payor with actual or threatened contract termination, and thus loss of its provider network, during the negotiation process. Once aggregate payment levels and terms were determined, PHA had its actuary develop fee schedules to be used under each contract. This determined how much each PHA physician would receive for specific medical procedures – in effect, dividing the “pie” that was the negotiated aggregate reimbursement amount. Only after the payor agreed to both the aggregate payment level and the fee schedule did PHA determine which physician practices “matched” the payor’s “offer” and thus would be included in the payor’s provider network under the PHA contract.

The complaint alleges that, as a result of Respondents’ conduct, prices for physician services in the Unifour area were maintained at, or increased to, artificially high prices in the Unifour area, and consumers have been deprived of the benefits of competition among physicians. By facilitating agreements among PHA member physicians to deal only on collectively-determined terms, and through PHA’s and its members’ actual or threatened refusals to deal with health plans that would not meet those terms, PHA and the Physician Respondents are alleged to have violated Section 5 of the FTC Act. PHA’s collective negotiation of fees and other competitively significant terms of dealing has not been, and is not, reasonably necessary to achieving any efficiency-enhancing integration.

The Proposed Consent Order

The proposed consent order is designed to prevent continuation or recurrence of the illegal conduct charged in the complaint, and to facilitate readjustment of the market for physician services in the relevant area to one where physicians competitively determine the prices they charge to payors for medical services – without PHA’s involvement on the physicians’ behalf. The proposed

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order prohibits PHA for a period of time from operating a “messenger model” or any other arrangement for physicians in their dealings with payors. Prompting this prohibition is, as the complaint alleges, PHA’s previous use of a self-described “messenger” contracting mechanism that failed to eliminate collective price setting and negotiation with payors over physician fees. The prohibition should enable payors to deal with physician practices, and establish prices for physician services, without the risk of cartelization through PHA. Such a period, which likely will involve multiple contracting cycles between payors and physicians, will help assure that any price information that physicians later use in participating in any messenger arrangement will reflect competitive price levels, rather than collectively negotiated prices – as allegedly was the case in PHA’s “modified messenger model.”

The proposed order allows Respondents to engage in various forms of legitimate conduct that do not improperly impair competition and that will not interfere with effective remedial relief through the proposed order. For example, the proposed order does not prohibit the Physician Respondents from participating in any legitimate financially integrated or clinically integrated joint arrangements with other physicians. PHA also is not prohibited from participating in arrangements that involve solely hospital services, or certain activities involving physician services, as specified in the proposed order. The proposed order also permits PHA to undertake activities necessary to operate certain programs, such as its information technology and medical management programs, that have procompetitive potential and do not involve physicians’ fees or other contracting terms between physicians and payors. Other parts of the proposed order are similar to orders that the Commission has issued to settle charges relating to allegedly unlawful agreements to eliminate physician competition and raise the prices of physician services.

The proposed order’s specific provisions are as follows:

The core prohibitions are contained in Paragraphs II, III, V,

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and VII. Paragraph II.A prohibits PHA and the Physician Respondents from entering into, participating in, or facilitating any agreement between or among any physicians: (1) to negotiate with payors on any physician's behalf; (2) to deal, not to deal, or threaten not to deal with payors; (3) on what terms to deal with any payor; or (4) not to deal individually with any payor, or to deal with any payor only through an arrangement involving PHA. Other parts of Paragraph II reinforce these general prohibitions. Paragraph II.B prohibits the Respondents from facilitating exchanges of information between or among physicians concerning whether, or on what terms, including price terms, they are willing to contract with a payor. Paragraph II.C bans them from attempting to engage in any action prohibited by Paragraph II.A or II.B. Paragraph II.D prohibits Respondents from inducing anyone else to engage in any action prohibited by Paragraphs II.A through II.C.

As in other Commission orders addressing health care providers' alleged collective bargaining with payors, certain kinds of potentially procompetitive agreements are excluded from the general prohibition on joint negotiations. The Physician Respondents are not prohibited from engaging in conduct that involves only physicians in their own group practice, or that is reasonably necessary to form or participate in a "qualified risk-sharing joint arrangement" or a "qualified clinically-integrated joint arrangement," as these terms are defined and have been used in prior Commission orders. Beginning no sooner than thirty (30) months after the proposed order becomes final, PHA may engage in conduct that is reasonably necessary to form or participate in such joint arrangements, subject to certain size and other limitations.

The size limitations for these allowable arrangements correspond to the safety zones for physician network joint ventures that are set forth in the joint Department of Justice and Federal Trade Commission Statements of Antitrust Enforcement

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Policy in Health Care,³ and provide for different sizes depending on whether physicians' participation in the joint venture is exclusive or non-exclusive.⁴ These size restrictions are intended to assure that any such joint arrangements involving PHA – which, as presently constituted, includes approximately three-fourths of the area's physicians – do not obtain or exercise substantial market power by involving an unduly large number of

³ U.S. Department of Justice and the Federal Trade Commission, Statements of Antitrust Enforcement Policy in Health Care at Statement 8, Part A (August 1996) (safety zones for physician network joint ventures) (available at <http://www.ftc.gov/reports/hlth3s.htm>).

⁴ Permissible joint ventures by PHA, where the physicians participate in the arrangement on a non-exclusive basis, are generally limited to having no more than 30% of the physicians in any medical specialty practicing either in Catawba County or in the Unifour area. Permissible joint ventures by PHA, where the physicians participate in the arrangement on an exclusive basis, are generally limited to having no more than 20% of the physicians in any medical specialty practicing either in Catawba County or in the Unifour area. Catawba County contains the substantial majority of PHA's physician members, and is where most of the Unifour area's large employers, and the largest concentration of the area's population, are located. Applying the percentage limitations to both areas – Catawba County and the Unifour – avoids the possibility that a joint arrangement by PHA could have a higher percentage of Catawba County physicians, while still meeting the allowable percentage limitations for the Unifour as a whole. Despite the general size limitations, in either exclusive or non-exclusive arrangements, PHA is permitted to have non-exclusive participation by physicians in medical specialties where the limited number of such local specialists otherwise would not permit their participation within the proposed order's percentage limitations.

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area physicians.⁵ The size restrictions apply only to physician network joint ventures undertaken by PHA. The proposed order does not affect any joint ventures undertaken by area physicians outside of PHA, or restrict the Physician Respondents or any other PHA physician members from participating in qualified risk-sharing or clinically-integrated joint arrangements outside of PHA that are larger than those that PHA is allowed to undertake.

Paragraph IV requires PHA to notify the Commission about such arrangements prior to negotiating on behalf of the arrangement's members or before those members jointly discuss any terms of dealing with a payor. Neither PHA nor the Physician Respondents are precluded from engaging in conduct that is necessary to continue PHA's preexisting "bonus plan" contracts with certain self-insured employers, which appear to involve the sharing of some financial risk among PHA's physician members. This exception does not necessarily mean that the bonus plan contracts are qualified joint arrangements as defined in the proposed order.

As defined in the proposed order, a "qualified risk-sharing joint arrangement" must satisfy two conditions. All physician and hospital participants must share substantial financial risk through the arrangement and thereby create incentives for the physician and/or hospital participants jointly to control costs and improve quality by managing the provision of services. Also, any agreement concerning price or other terms or conditions of dealing must be reasonably necessary to obtain significant

⁵ The safety zones in the Statements of Antitrust Enforcement Policy in Health Care do not establish upper size limits on lawful arrangements, but restricting PHA to size limits is appropriate in light of the complaint's allegations of PHA's unlawful conduct and the resulting anticompetitive effects. The size limits for qualified joint arrangements in the proposed order apply for 10 years after the order becomes final, rather than for the 20 years that apply to Paragraph II's general prohibitions.

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efficiencies through the joint arrangement.

As defined in the proposed order, a “qualified clinically-integrated joint arrangement” also must satisfy two conditions. All physician and hospital participants must participate in active and ongoing programs to evaluate and modify their clinical practice patterns, creating a high degree of interdependence and cooperation among physicians and/or hospitals, to control costs and ensure the quality of services provided. Also, any agreement concerning price or other terms or conditions of dealing must be reasonably necessary to obtain significant efficiencies through the joint arrangement.

In the event that PHA forms a qualified risk-sharing joint arrangement or a qualified clinically-integrated joint arrangement, Paragraph IV of the proposed order requires PHA, for five years, to notify the Commission at least 60 days prior to initially contacting, negotiating, or entering into agreements with payors concerning the arrangement. Notification is not required for subsequent contacts, negotiations, or agreements with payors pursuant to any arrangement for which notice was already given under Paragraph IV. Paragraph IV sets out the information necessary to make the notification complete, and also provides the Commission with the right to obtain additional information regarding the arrangement before PHA enters into the arrangement.

Paragraph III of the proposed order prohibits PHA from preparing, maintaining, or participating in the preparation of any fee schedule regarding physician services. This requirement is a response to PHA’s alleged history, as set forth in the complaint, of having agents and consultants prepare fee schedules and using the fee schedules in negotiations with payors.

Paragraph III also prohibits PHA from collecting or maintaining information about price and other terms under which physicians deal, or are willing to deal, with payors. This addresses PHA’s alleged practices in collecting and using such

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information as part of its so-called “modified messenger model.” Paragraph III excepts from these prohibitions activities necessary to maintain preexisting bonus plan contracts or to form or operate a qualified joint arrangement permitted under Paragraph II. Paragraph III also excepts actions necessary for, and undertaken solely for the purpose of, entering messenger arrangements as permitted in Paragraph V (discussed below) or implementing information technology services (for practice management and electronic medical records software for physician practices, or for medical management services provided to payors). Implementing information technology services, which involves activities that PHA already has begun, may have significant potential for efficiency and quality enhancement for medical services, and itself does not appear to present a significant risk of being used in anticompetitive ways, particularly in light of the proposed order’s other provisions.

Paragraph V of the proposed order prohibits PHA from acting as an agent for physicians, or from entering into any type of messenger arrangement between physicians and payors, for thirty (30) months after the proposed order becomes final. It also prohibits PHA from entering into any type of messenger arrangement, other than acting as a simple transmitter of offers and responses between payors and individual physician practices, for an additional twenty-four (24) months -- *i.e.*, until fifty-four (54) months after the proposed order becomes final.⁶

The first “cooling off” period – of 30 months – eliminates PHA involvement between physicians and payors, to facilitate payors’ ability to deal directly with individual physician practices and increase physicians’ incentive to deal directly with payors (or deal through other arrangements that do not have PHA’s alleged

⁶ The time periods for these prohibitions are based on the requirement in Paragraph VII.D of the proposed order that all of PHA’s contracts, with the identified exceptions, be terminated no later than six (6) months after the date the order becomes final.

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history of fostering anticompetitive agreements). The second, 24-month-long prohibition on all but strictly limited-in-form messenger arrangements – *i.e.*, the prohibition on arrangements that might involve, for example, PHA’s collection and maintenance of price and other information on physicians’ terms of dealing – is intended to permit PHA to re-enter the physician contracting business, but with additional safeguards against recurrence of the abuses, under the guise of “modified messenger model,” that the complaint alleges. Should PHA ultimately engage in a standing offer or similar messenger arrangement, the physician services market will have had at least four and one-half years to restore -- with little or no PHA involvement -- the competitive balance allegedly lost due to the conduct charged in the complaint.

Paragraph VI of the proposed order requires PHA to provide the Commission with prior notice before entering into any messenger arrangement permitted by Paragraph V of the proposed order.

Paragraph VII requires PHA to distribute the complaint and order, within 30 days after the order becomes final: to every hospital, physician, or other provider that participates in PHA; to each officer, director, manager, and employee of PHA; and to each payor with which PHA has had any contact since January 1, 1997, but with which PHA does not currently have a contract. For a period of five years after the order becomes final, PHA also must distribute a copy of the order and complaint to new members and officials of PHA, and any new payors with which it commences doing business.

With regard to payors with which PHA currently has a contract for the provision of physician services, Paragraph VII of the proposed order contains provisions concerning the termination of the contracts, which, according to the complaint, embody price-fixed physician fees. Paragraph VII.A requires PHA to provide the payors with which it has a contract with a copy of the order and complaint, as well as a notification letter apprising the payors

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of certain contract termination rights regarding their contracts with PHA. For payors that have preexisting “bonus plan” contracts with PHA, which are listed in Confidential Appendix A to the proposed order, the notification letter informs the payors that they may terminate their existing contracts with PHA, upon written request, without any penalty or charge. With regard to payors holding contracts with PHA, other than the payors with bonus plan contracts, the notification letter likewise informs the payors that they may terminate their contracts without penalty, upon providing written request. However, the letter also apprises payors with non-bonus-plan contracts that, if they do not voluntarily terminate their contracts within six months after the order becomes final (or the contract does not reach its scheduled termination date by that time), then the contract will terminate as of six months after the order becomes final. With regard to certain employers that have preexisting, non-bonus-plan direct contracts with PHA, and which are identified in Confidential Appendix B of the proposed order, in order to help minimize any possible disruption to their health benefits programs, Paragraph V of the proposed order permits PHA to serve as a simple messenger for any subsequent contract offers by these payors to PHA’s physician members.

Termination of the contracts between PHA and payors for the provision of physician services is required to eliminate the payment to PHA’s physician members of what the complaint alleges are collectively negotiated, price-fixed fee levels. The provision allowing payors six months during which they may request voluntary termination of their contracts with PHA is intended to provide them with flexibility and facilitate their making alternative arrangements to provide the services now provided through their contracts with PHA.

The mandatory termination date also obviates the risk that any payor would face competitive disadvantage by voluntarily terminating a PHA contract – and not have a physician network in place – before rival payors have terminated their contracts. Establishing a mandatory termination date provides an incentive

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for all payors to act promptly to make alternative arrangements for a physician network before the termination date, makes clear to PHA's physician members that they promptly must begin to deal directly (or outside of PHA) with the payors if they wish to continue being in the payors' networks, and eliminates the possible disincentive for a payor to be the first to voluntarily terminate its contract with PHA because it would be the first payor in the market not to have a contracted network of physicians.

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Paragraph VII also requires PHA, for five years, annually to publish a copy of the order and complaint in a report or newsletter sent to its participating providers, and file certain compliance reports with the Commission. Paragraphs VIII, IX, and X provide for various compliance reports and notifications by PHA and the Physician Respondents. Paragraph XI obligates the Respondents to cooperate in certain ways with any Commission inquiry into their compliance with the order.

The proposed order will expire in 20 years.

Complaint

IN THE MATTER OF

APPLIED CARD SYSTEMS, INC., ET AL.CONSENT ORDER, ETC., IN REGARD TO ALLEGED VIOLATIONS OF
SEC. 5 OF THE FEDERAL TRADE COMMISSION ACT*Docket C-4125; File No. 0323040*
Complaint, October 6, 2004--Decision, October 6, 2004

This consent order, among other things, prohibits Respondents Applied Card Systems, Inc., and Applied Card Systems of Pennsylvania, Inc., both debt collection firms, from communicating with any third party -- for the purpose of acquiring credit or debit cardholder location information -- more than once without a request by the third party for subsequent calls or a reasonable belief that the third party has complete or correct location information for the debtor. The order also prohibits the respondents from engaging in abusive conduct such as continued calls and the use of abusive language. In addition, the order prohibits the respondents from (1) placing collection calls after 9 p.m. and before 8 a.m. (defined as the local time of the person called); (2) placing calls to a consumer's place of employment if they have reason to know that such calls are employer-prohibited; (3) using false, deceptive, or misleading representations in collection calls; (4) collecting amounts from consumers that are not legally due; and (5) applying payments received to those accounts except as designated by consumers.

Participants

For the Commission: *Jessica D. Gray, Barbara E. Bolton, Shibani Baski, Cindy A. Liebes, Andrea L. Foster, and Andrew Smith.*

For the Respondents: *Richard M. Alexander, Arnold & Porter*

COMPLAINT

The Federal Trade Commission, having reason to believe that Applied Card Systems, Inc. and Applied Card Systems of Pennsylvania, Inc. (collectively "Respondents") have violated the provisions of the Federal Trade Commission Act, and it appearing to the Commission that this proceeding is in the public interest, alleges: