

Complaint

## IN THE MATTER OF

**PREFERRED HEALTH SERVICES, INC.**CONSENT ORDER, ETC., IN REGARD TO ALLEGED VIOLATIONS OF  
SEC. 5 OF THE FEDERAL TRADE COMMISSION ACT*Docket C-4134; File No. 0410099**Complaint, April 13, 2005—Decision, April 13, 2005*

This consent order, among other things, prohibits the respondent from entering into, participating in, implementing, or otherwise facilitating any combination, conspiracy, agreement, or understanding between or among any physicians (1) to negotiate on behalf of any physician with any payor; (2) to deal, refuse to deal, or threaten to refuse to deal with any payor; (3) regarding any term, condition, or requirement upon which any physician deals, or is willing to deal, with any payor, including, but not limited to, price terms; or (4) not to deal individually with any payor, or not to deal with any payor through any arrangement other than the respondent. The order also prohibits the respondent, for three years, from acting as or using a messenger or agent on behalf of any physicians, in dealing with health plans regarding contracts under which physicians would be compensated for the provision of services. In addition, the order requires the respondent, for three years, to notify the Commission at least sixty days before taking certain steps concerning the prices or other terms on which physicians in certain other arrangements deal with any payor.

*Participants*

For the Commission: *Steve Vieux, Melea Greenfeld, Karan Singh, Elizabeth Argeris, David R. Pender, Jeffrey W. Brennan, Daniel P. Ducore, and Louis Silvia.*

For the Respondent: *Michael Cowie, Howrey, Simon, Arnold & White.*

**COMPLAINT**

Pursuant to the provisions of the Federal Trade Commission Act, as amended, 15 U.S.C. § 41 *et seq.*, and by virtue of the authority vested in it by said Act, the Federal Trade Commission (“Commission”), having reason to believe that Preferred Health Services, Inc. (“Preferred Health”), hereinafter sometimes referred

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to as “Respondent,” has violated Section 5 of the Federal Trade Commission Act, 15 U.S.C. § 45, and it appearing to the Commission that a proceeding by it in respect thereof would be in the public interest, hereby issues this Complaint stating its charges in that respect as follows:

**NATURE OF THE CASE**

1. This matter concerns horizontal agreements among competing physicians in the Seneca, South Carolina, area to fix prices charged to health care plans and other third-party payors (“payors”), and to refuse to deal with payors except on collectively agreed upon terms. These physicians, who constitute most of the physicians in the Seneca area, orchestrated these price-fixing agreements and refusals to deal through the Respondent.

**RESPONDENT**

2. Preferred Health, a physician-hospital organization (“PHO”), is a not-for-profit corporation, organized, existing, and doing business under and by virtue of the laws of the State of South Carolina, with its principal address at 301 Memorial Drive, Suite E, Seneca, South Carolina 29672. Preferred Health was formed in 1996, and consists of a non-profit hospital (Oconee Memorial Hospital) and over 100 physicians. Preferred Health’s eight-member Board of Directors (“Board”) consists of four physician members elected by the entire physician membership, and four representatives of the hospital. The Chair and Vice-Chair of the Board are both physicians.

**THE FTC HAS JURISDICTION OVER RESPONDENT**

3. At all times relevant to this Complaint, Preferred Health has been engaged in the business of contracting with payors, on behalf of Preferred Health’s members, for the provision of health care services to persons for a fee.

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4. Except to the extent that competition has been restrained as alleged herein, Preferred Health physician members have been, and are now, in competition with each other for the provision of physician services in the Seneca, South Carolina, area to persons for a fee.

5. Preferred Health was founded in 1996. Its physician members and Oconee Memorial Hospital control Preferred Health. It carries on business for the pecuniary benefit of its physician members. Accordingly, Preferred Health is a corporation within the meaning of Section 4 of the Federal Trade Commission Act, as amended, 15 U.S.C. § 44.

6. Preferred Health's general business practices, including the acts and practices herein alleged, are in or affecting "commerce" as defined in the Federal Trade Commission Act, as amended, 15 U.S.C. § 44.

#### **OVERVIEW OF REGION AND PHYSICIAN CONTRACTING WITH PAYORS**

7. Seneca, located in Oconee County, is in northwest South Carolina. The closest major cities to Seneca are Greenville, South Carolina, approximately 50 miles to the east; Spartanburg, South Carolina, approximately 75 miles to the northeast; Asheville, North Carolina, approximately 100 miles to the north; and Atlanta, Georgia, approximately 120 miles to the southwest.

8. Preferred Health's physician members are licensed to practice allopathic or osteopathic medicine in the State of South Carolina. Preferred Health's physician members account for approximately 70% of the physicians who independently practice in the Seneca area. To be marketable in the Seneca area, a payor's health insurance plan must have access to a large number of physicians who are members of Preferred Health.

9. Physicians contract with payors to establish the terms and conditions, including price terms, under which they render

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services to the subscribers to the payors' health insurance plans ("insureds"). Physicians entering into such contracts often agree to lower compensation to obtain access to additional patients made available by the payors' relationship with insureds. These contracts may reduce payors' costs and enable them to lower the price of insurance, and thereby result in lower medical care costs for insureds. Competing physicians, absent agreements among them on the terms, including price, on which they will provide services to insureds, decide individually whether to enter into payor contracts to provide services to insureds, and what prices they will accept pursuant to such contracts.

10. 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 counter-offer. 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.

11. The Medicare Resource Based Relative Value Scale ("RBRVS") is a system used by the Centers for Medicare and Medicaid Services ("CMS") to determine the amount to pay physicians for the services they render to Medicare patients. Generally, payors in South Carolina make contract offers to individual physicians or groups at price levels specified by some percentage of the RBRVS fee for a particular year (*e.g.* "110% of 2004 RBRVS").

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**PREFERRED HEALTH NEGOTIATED PAYOR  
CONTRACTS  
ON BEHALF OF ITS MEMBER PHYSICIANS**

12. Preferred Health refers to itself as the “contracting representative” for its members in negotiations with payors. It touts itself to its physician members as a “collective bargaining unit for the negotiation of managed care contracts.” To further collective negotiations of payor contracts on behalf of physician members, Preferred Health’s Executive Director created, and the Board approved, a fee schedule, with fees for some procedures as high as 300% of 2000 RBRVS. Preferred Health negotiates with payors for payment terms under this fee schedule.

13. Physician members of Preferred Health participate in Preferred Health’s payor contracts by entering into a “Physician Participation Agreement” with Preferred Health. The Physician Participation Agreement automatically binds a physician member of Preferred Health to payor contracts that incorporate “the [Preferred Health] fee schedule.” If a contract uses “a Payor’s fee schedule that is at a comparable level to the [Preferred Health] fee schedule,” then the physician member will be given notice of the “comparable” fee schedule and be automatically bound to accept the contract unless he or she rejects it within 30 days. A physician member who rejects such a contract is expected to terminate his or her participation in Preferred Health.

14. When payors reject the Preferred Health fee schedule, Preferred Health’s Executive Director, under the Board’s direction, negotiates “comparable” fee schedules. During negotiations with such payors, the Executive Director transmits payor offers to the Board, which then votes on whether to approve a proposed payor contract, including the fee schedule. Only if the Board approves a contract does the Executive Director transmit it to Preferred Health physicians for their acceptance.

15. Preferred Health physician members have agreed with each other and with Preferred Health not to deal individually, or

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through any organization besides Preferred Health, with any payor with which Preferred Health is attempting to negotiate a contract for physician services. Physician members, at Preferred Health's urging, refuse payor offers made to them individually. This hinders payor efforts to establish competitive physician networks in the Seneca area. Due to Preferred Health's large share of Seneca area physicians and demand for collective negotiation, payors have repeatedly acceded to Preferred Health's price demands.

16. At an August 2002 Board meeting, Preferred Health's Executive Director stated that "there are two kinds of PHOs: (1) **Risk** - where you negotiate and sign on behalf of all the members and (2) **Messenger** - the model we use - no risk involved - a collective bargaining voice" (emphasis in original). Preferred Health repeatedly operated according to this illegitimate, non-risk, concerted contracting method, and unlawfully negotiated payor contracts on the collective behalf of its physician members.

### **CONTRACT NEGOTIATIONS WITH UNITED HEALTHCARE**

17. United Healthcare of South Carolina, Inc. ("United"), is a payor doing business in the Seneca area. United had accessed Preferred Health physician members by contracting with a third party administrator that had contracts with Preferred Health for physician services. United could not obtain a contract directly with Preferred Health because United would not agree to Preferred Health's high prices. In late 2001, United attempted to contract directly with individual Preferred Health physician members and also initiated contract discussions with Preferred Health, offering prices for most procedures at 106% or 108% of 2001 RBRVS. The prices for most procedures on the Preferred Health fee schedule were approximately 10% to 165% higher than United's proposal on prices. Preferred Health discouraged its members from contracting unilaterally with United, by sending a

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memorandum to the entire membership, asking the physicians to “hold off on doing anything with United Health Care until we can complete our discussions.”

18. In January 2002, Preferred Health informed its members that contract discussions with United were unsuccessful, because United “showed little interest in meeting the criteria we require of all payors.” A month later, the Board formally rejected United’s offer, stating that United’s payment terms were “very low.” Preferred Health has repeatedly rejected subsequent United contract offers, for the same reason. Preferred Health told United that it “needed better rates in order to move forward” and told its physician members that the “United fee schedule is way off.” United also was unsuccessful in contracting directly with Preferred Health physician members after the physicians received Preferred Health’s criticisms of United’s payment terms.

19. In April 2003, United asked Preferred Health to transmit to its physician members a contract proposal containing rates ranging from 75% to 185% of 2002 RBRVS. The Preferred Health fee schedule included higher prices for almost all procedures – typically in the range of 10% to 30% higher. Preferred Health responded that it could not transmit the United offer “without a Board vote,” and informed United that “if you want to mail [direct contracts] now, the [Preferred Health member] offices will just call us and we’ll tell them to hold on until [the Board members] meet and vote.” Preferred Health also informed United that if the Preferred Health Board voted not to contract with United, then Preferred Health “would not do any form of negotiation.”

20. The minutes of a May 2003 Preferred Health Board meeting report that Preferred Health was unable to agree with United “on the various methods of reimbursement,” and that “the Board agreed to decline their fee schedule offer and inform [Preferred Health] members to contract directly with United should there be any interest.” Preferred Health did not transmit any United offer to the Preferred Health members.

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21. United also has been unable to contract directly with Preferred Health physician members, who refused to deal with United because it would not agree to Preferred Health's price demands. For example, in July 2003, United approached the largest primary care practice in Seneca with an offer to begin contract negotiations. The physicians refused to negotiate with United, because United "did not agree to take the [Preferred Health] fee schedule."

**CONTRACTING WITH CAROLINA CARE PLAN**

22. Carolina Care Plan, Inc. ("Carolina Care"), is a health plan doing business in the Seneca area. Prior to 2000, Carolina Care developed its physician network in the Seneca area through direct contracts with individual physicians. In early 2000, the Preferred Health physician members terminated their Carolina Care contracts and agreed that Preferred Health would negotiate all future payor contracts on their joint behalf.

23. In June 2000, Preferred Health proposed its fee schedule to Carolina Care. Carolina Care counter-proposed its standard price list, which contains the rates that it pays other physicians in South Carolina. These rates – almost all of which were at least 10% to 30% below the Preferred Health fee schedule – were between 100% and 140% of 2000 RBRVS for most procedures and closely matched what Carolina Care was previously paying the Preferred Health members with whom it had direct contracts prior to 2000. By September 2000, the Preferred Health Board rejected Carolina Care's contract offer and demanded that Carolina Care accept the Preferred Health fee schedule.

24. Shortly thereafter, Carolina Care made another contract proposal to Preferred Health, increasing its proposed payment terms for certain procedures by as much as 42%. In October 2000, the Preferred Health Board instructed the Executive Director to reject this proposal as well. Ultimately, Carolina Care met Preferred Health's demand in May 2001, and signed a contract containing Preferred Health's fee schedule. Preferred

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Health never transmitted Carolina Care's various fee proposals to member physicians during the course of negotiations, and never notified members of the Carolina Care contract until after signing it. Carolina Care told Preferred Health that "[the] physician fee schedule is significantly higher than [Carolina Care's] standard" in the rest of South Carolina.

**CONTRACTING WITH CIGNA**

25. Cigna of South Carolina, Inc. ("Cigna"), is a payor doing business in the Seneca area. In early 2000, Preferred Health physician members who had direct contracts with Cigna terminated those contracts, and informed Cigna that Preferred Health would now jointly handle their contract negotiations. In late 2000, Preferred Health proposed its fee schedule to Cigna, which contained rates that were approximately 5% to 40% higher than the rates that Cigna had been paying under direct contracts with Preferred Health physician members. Confronted with Preferred Health's collective demands, and needing Preferred Health's physician members to assemble a marketable health plan in the Seneca area, Cigna, in March 2001, agreed to Preferred Health's price demands. Preferred Health did not notify physician members of the Cigna contract and fee schedule until after Cigna signed the contract.

**CONTRACTING WITH OTHER PAYORS**

26. Preferred Health, on behalf of its physician members, has orchestrated collective negotiations with other payors who do business, or attempted to do business, in the Seneca area, including Private Healthcare Systems, Inc., Premier Health Systems, Inc., and Medcost, LLC. Preferred Health negotiated with these payors on price, making proposals and counter-proposals, as well as accepting or rejecting offers, without transmitting them to members for their individual acceptance or rejection. Preferred Health also facilitated collective refusals to deal and threats of refusals to deal with payors. Preferred Health's members collectively accepted or rejected these payor contracts,

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and refused to deal with these payors individually. Due to Preferred Health's dominant market position in the Seneca area, these coercive tactics have been successful in raising the prices paid to its physician members.

**RESPONDENT'S PRICE-FIXING IS NOT JUSTIFIED**

27. Respondent's joint negotiation of fees and other competitively significant contract terms has not been, and is not, reasonably related to any efficiency-enhancing integration.

**RESPONDENT'S ACTIONS HAVE HAD SUBSTANTIAL ANTICOMPETITIVE EFFECTS**

28. Respondent's actions described in Paragraphs 12 through 26 of this Complaint have had, or tend to have had, the effect of restraining trade unreasonably and hindering competition in the provision of physician services in the Seneca area in the following ways, among others:

- a. price and other forms of competition among physician members of Preferred Health were unreasonably restrained;
- b. prices for physician services were increased; and
- c. health plans, employers, and individual consumers were deprived of the benefits of competition among physicians.

**VIOLATION OF THE FEDERAL TRADE COMMISSION ACT**

29. The combination, conspiracy, acts, and practices described above constitute unfair methods of competition in violation of Section 5 of the Federal Trade Commission Act, 15 U.S.C. § 45.

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Such combination, conspiracy, acts, and practices, or the effects thereof, are continuing and will continue or recur in the absence of the relief herein requested.

**WHEREFORE, THE PREMISES CONSIDERED**, the Federal Trade Commission on this thirteenth day of April, 2005, issues its Complaint against Respondent Preferred Health.

## Decision and Order

**DECISION AND ORDER**

The Federal Trade Commission (“Commission”), having initiated an investigation of certain acts and practices of Preferred Health Services, Inc. (“Preferred Health”), hereinafter sometimes referred to as “Respondent,” and Respondent having been furnished thereafter with a copy of the draft of Complaint that counsel for the Commission proposed to present to the Commission for its consideration and which, if issued, would charge Respondent with violations of Section 5 of the Federal Trade Commission Act, as amended, 15 U.S.C. § 45; and

Respondent, its attorney, and counsel for the Commission having thereafter executed an Agreement Containing Consent Order to Cease and Desist (“Consent Agreement”), containing an admission by Respondent of all the jurisdictional facts set forth in the aforesaid draft of Complaint, a statement that the signing of said Consent Agreement is for settlement purposes only and does not constitute an admission by Respondent that the law has been violated as alleged in such Complaint, or that the facts as alleged in such Complaint, other than jurisdictional facts, are true, and waivers and other provisions as required by the Commission’s Rules; and

The Commission having thereafter considered the matter and having determined that it had reason to believe that Respondent has violated the said Act, and that a Complaint should issue stating its charges in that respect, and having accepted the executed Consent Agreement and placed such Consent Agreement on the public record for a period of thirty (30) days for the receipt and consideration of public comments, and having duly considered the comment received from an interested person pursuant to Commission Rule 2.34, 16 C.F.R. § 2.34, now in further conformity with the procedure described in Commission Rule 2.34, the Commission hereby issues its Complaint, makes the following jurisdictional findings and issues the following Order:

1. Respondent Preferred Health is a not-for-profit corporation, organized, existing, and doing business under and by virtue of the laws of the State of South Carolina, with its principal address at 301 Memorial Drive, Suite E, Seneca, SC 29672.
2. The Federal Trade Commission has jurisdiction of the subject matter of this proceeding and of Respondent, and the proceeding is in the public interest.

## **ORDER**

### **I.**

**IT IS ORDERED** that, as used in this Order, the following definitions shall apply:

- A. “Respondent” means Preferred Health Services, Inc., its officers, directors, employees, agents, attorneys, representatives, successors, and assigns; and the subsidiaries, divisions, groups, and affiliates controlled by Preferred Health Services, Inc., and the respective officers, directors, employees, agents, attorneys, representatives, successors, and assigns of each.
- B. “Medical group practice” means a bona fide, integrated firm in which physicians practice medicine together as partners, shareholders, owners, members, or employees, or in which only one physician practices medicine.
- C. “Participate” in an entity means (1) to be a partner, shareholder, owner, member, or employee of such entity, or (2) to provide services, agree to provide services, or offer to provide services, to a payor through such entity. This definition also applies to all tenses and forms of the word “participate,” including, but not limited to, “participating,” “participated,” and “participation.”

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- D. “Payor” means any person that pays, or arranges for the payment, for all or any part of any physician services for itself or for any other person. Payor includes any person that develops, leases, or sells access to networks of physicians.
- E. “Person” means both natural persons and artificial persons, including, but not limited to, corporations, unincorporated entities, and governments.
- F. “Physician” means a doctor of allopathic medicine (“M.D.”) or a doctor of osteopathic medicine (“D.O.”).
- G. “Preexisting contract” means a contract that was in effect on the date of the receipt by a payor that is a party to such contract of notice sent by Respondent, pursuant to Paragraph V.B of this Order, of such payor’s right to terminate such contract.
- H. “Principal address” means either (1) primary business address, if there is a business address, or (2) primary residential address, if there is no business address.
- I. “Qualified clinically-integrated joint arrangement” means an arrangement to provide physician services in which:
  - 1. all physicians 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 physicians who participate in the arrangement, in order to control costs and ensure the quality of services provided through the arrangement; and
  - 2. any agreement concerning price or other terms or conditions of dealing entered into by or within the arrangement is reasonably necessary to obtain significant efficiencies through the joint arrangement.

- J. “Qualified risk-sharing joint arrangement” means an arrangement to provide physician services in which:
1. all physicians who participate in the arrangement share substantial financial risk through their participation in the arrangement and thereby create incentives for the physicians who participate jointly to control costs and improve quality by managing the provision of physician services, such as risk-sharing involving:
    - a. the provision of physician services for a capitated rate from payors;
    - b. the provision of physician services for a predetermined percentage of premium or revenue from payors;
    - c. the use of significant financial incentives (*e.g.*, substantial withholds) for physicians who participate to achieve, as a group, specified cost-containment goals; or
    - d. the provision of a complex or extended course of treatment that requires the substantial coordination of care by physicians in different specialties offering a complementary mix of services, for a fixed, predetermined price, where the costs of that course of treatment for any individual patient can vary greatly due to the individual patient’s condition, the choice, complexity, or length of treatment, or other factors; and
  2. any agreement concerning price or other terms or conditions of dealing entered into by or within the arrangement is reasonably necessary to obtain significant efficiencies through the joint arrangement.

## II.

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

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with the provision of physician services in or affecting commerce, as “commerce” is defined in Section 4 of the Federal Trade Commission Act, 15 U.S.C. § 44, cease and desist from:

- A. Entering into, adhering to, participating in, maintaining, organizing, implementing, enforcing, or otherwise facilitating any combination, conspiracy, agreement, or understanding between or among any physicians:
  - 1. To negotiate on behalf of any physician with any payor,
  - 2. To deal, refuse to deal, or threaten to refuse to deal with any payor,
  - 3. Regarding any term, condition, or requirement upon which any physician deals, or is willing to deal, with any payor, including, but not limited to, price terms, or
  - 4. Not to deal individually with any payor, or not to deal with any payor through any arrangement other than Respondent;
- B. Exchanging or facilitating in any manner the exchange or transfer of information among physicians concerning any physician’s willingness to deal with a payor, or the terms or conditions, including price terms, on which the physician is willing to deal;
- C. Attempting to engage in any action prohibited by Paragraph II.A or II.B, above;
- 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; and
- E. For a period of three (3) years after the date this Order becomes final, acting as or using a messenger or agent on behalf of any physicians, in dealing with health plans

regarding contracts under which physicians would be compensated for the provision of services.

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

### III.

**IT IS FURTHER ORDERED** that:

- A. Respondent shall, pursuant to each purported qualified risk-sharing joint arrangement or purported qualified clinically-integrated joint arrangement (“Arrangement”), for three (3) years from the date this Order becomes final, notify the Secretary of the Commission in writing (“Qualified Arrangement Notification”) at least sixty (60) days prior to:
  - 1. Participating in, organizing, or facilitating any discussion or understanding with or among any physicians in such Arrangement relating to price or other terms or conditions of dealing with any payor; or
  - 2. Contacting a payor, pursuant to an 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 in such Arrangement.

**PROVIDED, HOWEVER,** that the Qualified Arrangement Notification required by this Paragraph III.A is not required for negotiations or agreements with subsequent payors pursuant to any Arrangement for which the Qualified Arrangement Notification was given.

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- B. Respondent shall include the following information in the Qualified Arrangement Notification:
1. for each physician participant, his or her name, address, telephone number, medical specialty, medical practice group, if applicable, and the name of each hospital where he or she has privileges;
  2. a description of the Arrangement, its purpose, function, and area of operation;
  3. a description of the nature and extent of the integration and the efficiencies resulting from the Arrangement;
  4. an explanation of the relationship of any agreement on prices, or contract terms related to price, to furthering the integration and achieving the efficiencies of the Arrangement;
  5. a description of any procedures proposed to be implemented to limit possible anticompetitive effects resulting from the Arrangement or its activities; and
  6. all studies, analyses, and reports, that were prepared for the purpose of evaluating or analyzing competition for physician services in the Seneca, South Carolina, area, including, but not limited to, the market share of physician services.
- C. If, within sixty (60) days from the Commission's receipt of the Qualified Arrangement Notification, a representative of the Commission makes a written request for additional information to the Respondent, then Respondent shall not engage in any conduct described in Paragraph III.A.1 or Paragraph III.A.2 of this Order prior to the expiration of thirty (30) days 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 of any Qualified Arrangement Notification, pursuant to Paragraph III 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.

#### IV.

**IT IS FURTHER ORDERED** that, for three (3) years from the date Respondent is permitted to enter into an arrangement with any physician to act as or use a messenger or agent in dealing with health plans regarding contracts or terms of dealing with payors, Respondent shall notify the Secretary of the Commission in writing ("Messenger Notification") at least sixty (60) days prior to entering into any arrangement with any physicians under which Respondent would act as a messenger, or an agent on behalf of those physicians, with payors regarding contracts or terms of dealing. The Messenger Notification shall include the identity of each proposed physician participant, the proposed geographic area of operation, a copy of any proposed physician participation agreement (including a copy of each form intended to be used to communicate with physician participants regarding contracts or terms of dealing with payors), a description of the proposed arrangement's purpose and function, a description of any resulting efficiencies expected to be obtained through the arrangement, and a description of procedures to be implemented to limit possible anticompetitive effects, such as those prohibited by this Order. Messenger Notification is not required for Respondent's subsequent acts as a messenger pursuant to an arrangement for which the Messenger Notification has been given. Receipt by the Commission from Respondent of any Messenger Notification, pursuant to Paragraph IV of this Order, is not to be construed as a determination by the Commission that any action described in

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such Messenger Notification does or does not violate this Order or any law enforced by the Commission.

**V.**

**IT IS FURTHER ORDERED** that Respondent shall:

- A. Within thirty (30) days after the date on which this Order becomes final, send by electronic mail with electronic return receipt, a copy of this Order and the Complaint to:
  - 1. each physician who participates, or has participated, since January 1, 2003, in Respondent; and
  - 2. each officer, director, manager, and employee of Respondent;
- B. Within thirty (30) days after the date on which this Order becomes final, send by first-class mail, return receipt requested, a copy of this Order and the Complaint to the chief executive officer of each payor with which Respondent has a record of having been in contact since January 1, 2003, regarding contracting for the provision of physician services, and include in such mailing the notice specified in Appendix A to this Order;
- C. Terminate, without penalty or charge, and in compliance with any applicable laws, any preexisting contract with any payor for the provision of physician services, at the earlier of: (1) receipt by Respondent of a written request from a payor to terminate such contract, or (2) the earliest termination or renewal date (including any automatic renewal date) of such contract; *provided, however*, a preexisting contract 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, (a) the payor submits to Respondent a written request to extend such contract to a

specific date no later than one (1) year after the date this Order becomes final, and (b) Respondent 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 (1) of Paragraph V.C of this Order, to terminate the contract at any time;

- D. Within ten (10) days after receiving a written request from a payor, pursuant to Paragraph V.C(1) of this Order, distribute, by first-class mail, return receipt requested, a copy of that request to each physician participating in Respondent as of the date Respondent receives such request;
- E. For a period of three (3) 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 physician who begins participating in Respondent, and who did not previously receive a copy of this Order and the Complaint from Respondent, within thirty (30) days of the time that such participation begins;
    - b. each payor that contracts with Respondent for the provision of physician services, and that did not previously receive a copy of this Order and the Complaint from Respondent, within thirty (30) days of the time that such payor enters into such contract; and
    - c. each person who becomes an officer, director, manager, or employee of Respondent, and who did not previously receive a copy of this Order and the Complaint from Respondent, within thirty (30) days of the time that he or she assumes such responsibility with Respondent; and
  - 2. annually publish a copy of this Order and the Complaint in an official annual report or newsletter sent to all physicians

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who participate in Respondent, with such prominence as is given to regularly featured articles;

- F. File a verified written report within sixty (60) days after the date this Order becomes final, annually thereafter for three (3) years on the anniversary of the date this Order becomes final, and at such other 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 has complied and is complying with this Order; and
  2. copies of the return receipts required by Paragraphs V.A, V.B, V.D, and V.E.1 of this Order; and
- G. Notify the Commission at least thirty (30) days prior to any proposed (1) dissolution of Respondent, (2) acquisition, merger or consolidation of Respondent, or (3) any other change in Respondent that may affect compliance obligations arising out of this Order, including but not limited to assignment, the creation or dissolution of subsidiaries, or any other change in Respondent.

**VI.**

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

**VII.**

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

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

### VIII.

**IT IS FURTHER ORDERED** that this Order shall terminate on April 13, 2025.

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**Appendix A**

[letterhead of Preferred Health]

[name of payor's CEO]

[address]

Dear \_\_\_\_\_:

Enclosed is a copy of a complaint and a consent order ("Order") issued by the Federal Trade Commission against Preferred Health Services, Inc. ("Preferred Health").

Pursuant to Paragraph V.C of the Order, Preferred Health must allow you to terminate, upon your written request, without any penalty or charge, any contracts with Preferred Health that were in effect prior to your receipt of this letter.

Paragraph V.C of the Order also provides that, if you do not terminate a contract, the contract will terminate on its earliest termination or renewal date (including any automatic renewal date). However, at your request, the contract may be extended to a date no later than [appropriate date, pursuant to the Order, to be filled in by Preferred Health]. If you choose to extend the term of the contract, you may later terminate the contract at any time.

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

Sincerely,

### **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 Preferred Health Services, Inc. (Preferred Health). The agreement settles charges that Preferred Health violated Section 5 of the Federal Trade Commission Act, 15 U.S.C. § 45, by orchestrating and implementing agreements among members of Preferred Health to fix prices and other terms on which they would deal with health plans, and to refuse to deal with such purchasers except on collectively-determined terms. The proposed consent order has been placed on the public record for 30 days to receive comments from interested persons. Comments received during this period will become part of the public record. After 30 days, the Commission will review the agreement and the comments received, and will decide whether it should withdraw from the agreement or make the proposed order final.

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

### **The Complaint**

The allegations of the complaint are summarized below.

Preferred Health is a physician-hospital organization consisting of over 100 physicians and Oconee Memorial Hospital. Preferred Health does business in the Seneca, South Carolina, area, which is located in northwestern South Carolina. Preferred Health acts as a “contracting representative” for its physician members in

## Analysis

negotiations with health plans, and a “collective bargaining unit for the negotiation of managed care contracts.”

Preferred Health’s physician members account for approximately 70% of the physicians independently practicing (that is, those not employed by area hospitals) in and around the Seneca area. To be marketable in the Seneca area, a health plan must have access to a large number of physicians who are members of Preferred Health.

Although Preferred Health purports to operate as a “messenger model”<sup>1</sup> – that is, an arrangement that does not facilitate horizontal agreements on price – it orchestrated such price agreements. In contract negotiations with payors, Preferred Health uses a physician fee schedule created by its Executive Director and approved by its Board of Directors. Preferred Health’s membership agreement automatically binds physician members to contracts using the Preferred Health fee schedule. Whenever a health plan rejects the Preferred Health fee schedule, Preferred Health’s Executive Director negotiates, under the Board’s direction, a contract with a “comparable” fee schedule. The Executive Director transmits these contracts to the Board, and then to the physician members if the Board approves it. If a contract contains a Board-approved “comparable” fee schedule, physician members have 30 days to reject the contract. The only recourse available to a physician member who rejects a contract with a “comparable” fee schedule is to terminate his or her membership in Preferred Health.

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<sup>1</sup> Some arrangements can facilitate contracting between health care providers and payors without fostering an illegal agreement among competing physicians on fees or fee-related terms. One such approach, sometimes referred to as a “messenger model” arrangement, is described in the 1996 Statements of Antitrust Enforcement Policy in Health Care jointly issued by the Federal Trade Commission and U.S. Department of Justice, at 125. See <http://www.ftc.gov/reports/hlth3s.htm#9>.

Preferred Health has orchestrated collective agreements on fees and other terms of dealing with health plans, carried out collective negotiations with health plans, fostered refusals to deal, and threatened to refuse to deal with health plans that resisted Respondent's desired terms. Respondent succeeded in forcing numerous health plans to raise the fees paid to Preferred Health physician members, and thereby raised the cost of medical care in the Seneca area. Preferred Health engaged in no efficiency-enhancing integration sufficient to justify joint negotiation of fees. By the acts set forth in the Complaint, Respondent violated Section 5 of the FTC Act.

### **The Proposed Consent Order**

The proposed order is designed to remedy the illegal conduct charged in the complaint and prevent its recurrence. It is similar to recent consent orders that the Commission has issued to settle charges that physician groups engaged in unlawful agreements to raise fees they receive from health plans.

The proposed order's specific provisions are as follows:

Paragraph II.A prohibits Respondent from entering into 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 the Respondent.

Other parts of Paragraph II reinforce these general prohibitions. Paragraph II.B prohibits the Respondent from facilitating exchanges of information between physicians concerning whether, or on what terms, to contract with a payor. Paragraph II.C bars attempts to engage in any action prohibited by Paragraph II.A or II.B, and Paragraph II.D proscribes Respondent from inducing anyone to engage in any action prohibited by Paragraphs II.A through II.C.

## Analysis

Paragraph II.E contains certain additional “fencing-in” relief, which is imposed for three years. Under this provision, Preferred Health may not, in connection with physician health plan contracting, either (1) act as an agent for any physicians; or (2) use an agent with respect to contracting. Such relief, designed to assure that Preferred Health does not seek to use other arrangements to continue the challenged conduct, is warranted in light of the complaint charges that Preferred Health engaged in overt price-fixing behavior, and its assertion that its conduct was legitimate “messengering” of health plan contract offers.

As in other Commission orders addressing providers’ collective bargaining with health care purchasers, certain kinds of agreements are excluded from the general bar on joint negotiations. Respondent would not be precluded from engaging in conduct that is reasonably necessary to form or participate in legitimate joint contracting arrangements among competing physicians in a “qualified risk-sharing joint arrangement” or a “qualified clinically-integrated joint arrangement.” The arrangement, however, must not facilitate the refusal of, or restrict, physicians in contracting with payors outside of the arrangement.

As defined in the proposed order, a “qualified risk-sharing joint arrangement” possesses two key characteristics. First, all physician participants must share substantial financial risk through the arrangement, such that the arrangement creates incentives for the physician participants jointly to control costs and improve quality by managing the provision of services. Second, any agreement concerning reimbursement or other terms or conditions of dealing must be reasonably necessary to obtain significant efficiencies through the joint arrangement.

A “qualified clinically-integrated joint arrangement,” on the other hand, need not involve any sharing of financial risk. Instead, as defined in the proposed order, physician participants must participate in active and ongoing programs to evaluate and modify their clinical practice patterns in order to control costs and

ensure the quality of services provided, and the arrangement must create a high degree of interdependence and cooperation among physicians. As with qualified risk-sharing arrangements, any agreement concerning price or other terms of dealing must be reasonably necessary to achieve the efficiency goals of the joint arrangement.

Paragraph III, for three years, requires Preferred Health to notify the Commission before participating in contracting with health plans on behalf of a qualified risk-sharing joint arrangement or qualified clinically-integrated joint arrangement. Paragraph III sets out the information necessary to make the notification complete.

Paragraph IV, for three years after the bar on messengering ends, requires Preferred Health to notify the Commission before entering into any arrangement to act as a messenger, or as an agent on behalf of any physicians, with payors regarding contracts. Paragraph IV also sets out the information necessary to make the notification complete.

Paragraph V requires Preferred Health to distribute the complaint and order to all physicians who have participated in Preferred Health, and to payors that negotiated contracts with Preferred Health or indicated an interest in contracting with Preferred Health. Paragraph V.C requires Preferred Health, at any payor's request and without penalty, or within one year after the Order is made final, to terminate its current contracts with respect to providing physician services. Paragraph V.D requires Preferred Health to distribute payor requests for contract termination to all physicians who participate in Preferred Health. Paragraph V.E.1.b requires Preferred Health to distribute the complaint and order to any payors that negotiate contracts with Preferred Health in the next three years.

## Analysis

Paragraphs VI and VII of the proposed order impose various obligations on Respondent to report or provide access to information to the Commission to facilitate monitoring Respondent's compliance with the order.

The proposed order will expire in 20 years.

Complaint

## IN THE MATTER OF

**VISION I PROPERTIES, LLC, doing business as  
CARTMANAGER INTERNATIONAL**CONSENT ORDER, ETC., IN REGARD TO ALLEGED VIOLATIONS OF  
SEC. 5 OF THE FEDERAL TRADE COMMISSION ACT*Docket C-4135; File No. 0423068  
Complaint, April 19, 2005—Decision, April 19, 2005*

This consent order, among other things, prohibits the respondent from making, expressly or by implication, any false or misleading representation regarding the collection, use, or disclosure of personally identifiable information (“PII”). The order also prohibits the respondent from selling, renting, or disclosing to any third party for marketing purposes any PII collected from consumers -- through shopping cart software used at a merchant customer’s Web site -- before the order became effective. In addition, the order prohibits the respondent from selling, renting or disclosing to any third party for marketing purposes any PII collected from consumers -- through shopping cart or other software used at a merchant customer’s Web site -- after the order became effective, without taking certain steps to ensure that consumers receive advance notice that the information they provide may be sold, rented, or disclosed to third parties. The order also requires the respondent to disgorge to the United States Treasury the fees it received from renting consumer information.

*Participants*

For the Commission: *Loretta H. Garrison, Laura Mazzarella, Jessica L. Rich, Joel Winston, Louis Silversin, and Gerard R. Butters.*

For the Respondent: *Joseph Emig.*

**COMPLAINT**

The Federal Trade Commission, having reason to believe that Vision I Properties, LLC, doing business as CartManager International, a corporation (“Vision One” or “Respondent”) has violated the provisions of the Federal Trade Commission Act, and it appearing to the Commission that this proceeding is in the public interest, alleges: