

Complaint

IN THE MATTER OF

SAN JUAN IPA, INC.

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

Docket C-4142; File No. 0310181
Complaint, June 30, 2005--Decision, June 30, 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 requires the respondent, for three years, to notify the Commission at least sixty days before entering into any arrangement with any physicians under which the respondent would act as their messenger or agent with payors regarding contracts or terms of dealing. In addition, the order requires the respondent, for three years, to notify the Commission before participating in a qualified risk-sharing arrangement or qualified clinically integrated arrangement.

Participants

For the Commission: *Steve Vieux, Aaron Hewitt, David R. Pender, Daniel P. Ducore, and Louis Silvia.*

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

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 San Juan IPA, Inc. (“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

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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 Farmington, New Mexico, 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 terms. These physicians, who constitute most of the physicians in the Farmington area, orchestrated their price-fixing agreements and joint refusals to deal through Respondent.

RESPONDENT

2. Respondent is a not-for-profit corporation, organized, existing, and doing business under and by virtue of the laws of the State of New Mexico, with its principal address at 2325 East 30th Street, Farmington, NM 87401.

THE FTC HAS JURISDICTION OVER RESPONDENT

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

4. Except to the extent that competition has been restrained as alleged herein, Respondent’s physician members have been, and are now, in competition with each other for the provision of physician services in the Farmington, New Mexico, area to persons for a fee.

5. Respondent was founded by, is controlled by, and carries on business for the pecuniary benefit of its physician members. Accordingly, Respondent is a corporation within the meaning of Section 4 of the Federal Trade Commission Act, as amended, 15 U.S.C. § 44.

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6. Respondent'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 MARKET AND PHYSICIAN COMPETITION

7. Farmington is located in San Juan County, in northwestern New Mexico. The closest major cities to Farmington are Albuquerque, the largest city in New Mexico, 181 miles to the southeast; and Santa Fe, the state capital and second largest city in the state, 205 miles to the southeast.

8. Respondent is an independent physician association ("IPA") with approximately 120 physician members, all of whom are licensed to practice allopathic or osteopathic medicine in the State of New Mexico.

9. To be marketable in the Farmington area, a payor's health insurance plan must include in its physician network a large number of primary care and specialist physicians who practice in that area. Members of Respondent account for approximately 80% of the physicians who independently practice in the Farmington area.

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

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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.

11. 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.

**OVERVIEW OF RESPONDENT’S CONTRACTING ON
BEHALF OF ITS PHYSICIAN MEMBERS**

12. Payors and physicians in the Farmington area agree on physician compensation by using either a percentage discount from the physician’s full billed charges, or a fixed percentage of the Medicare Resource Based Relative Value Scale (“RBRVS”). RBRVS is a system used by the Centers for Medicare and Medicaid Services to determine the amount to pay physicians for the services they render to Medicare patients. Several payors in the Farmington area make contract offers to individual physicians or groups at a price level specified as some percentage of the RBRVS fee for a particular year (*e.g.*, “110% of 2004 RBRVS”). Payors often prefer this method of determining price to discounts off full billed charges, because the former method allows payors

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to know exactly the price they will pay physicians. Contracts that determine price based on a discount off billed charges, in contrast, allow physicians unilaterally to increase their billed charges.

13. Respondent was incorporated in 1986 to help its physician members determine whether to participate in payor contracts. Respondent's physician members participate in Respondent's payor contracts by signing a "Membership Agreement" that requires physician signatories to accept fee schedules specified in the contracts that Respondent signs with payors. Payor contracts include fee schedules that apply to the entire membership. The fee schedules contain either all set prices, all discounts off full billed charges, or both such pricing methods, which vary by physician service.

14. Respondent's physician members agreed to refuse offers payors made to them individually and to demand that payors deal for physician services solely with Respondent – thereby hindering payors' efforts to establish competitive physician networks in the Farmington area. Due to Respondent's large share of Farmington-area physicians, payors have repeatedly acceded to Respondent's price demands for all of its physician members.

**RESPONDENT FIXED PRICES BY DEMANDING A SET
DISCOUNT OFF BILLED CHARGES**

15. From 1998 until 2001, Respondent was a one-third owner in a joint venture called Lifecourse Management Services ("LMS"). LMS designated certain seats on its Board of Directors specifically for Respondent's members. LMS had a Contracts Committee, half of whose members were Respondent's representatives. This committee adopted a policy of demanding payment from payors for physician services at full billed charges less a fixed 10% discount, and refusing to contract with payors that did not meet LMS's demand. LMS contracted with payors under this policy until LMS dissolved in July 2001. Respondent estimated that these contracts increased physician prices by a range of 10% to 62%.

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16. Since July 2001, Respondent maintained at least three such pre-existing LMS contracts – all of which automatically renewed every year.

17. After LMS dissolved, Respondent signed contracts with at least nine payors. As to each contract, Respondent adopted LMS's pricing policy. It successfully bargained on its members behalf for full billed charges less a fixed 10% discount. These contracts automatically renewed every year. Respondent's negotiations with Admar Corporation ("Admar") and Southwest HeathNet, Inc. ("Southwest") exemplify Respondent's tactic of joint price-setting.

18. In January 2001, LMS demanded that Admar, a preferred provider organization, pay LMS's physician members at full billed charges less 10%. The following month, while LMS and Respondent were preparing for LMS's dissolution, Admar offered individual physician members of Respondent a contract with prices at 145% of RBRVS for medicine and surgery codes. Respondent's Executive Director instructed its physician members to disregard Admar's direct contract proposals, because Respondent was in the process of negotiating a contract with Admar. Admar was thereafter unable to contract directly with any of Respondent's physician members, increasing the pressure on Admar to contract with Respondent. In September 2001, Admar agreed to pay Respondent's physician members at full billed charges less 10%.

19. Southwest is a physician-hospital organization in Cortez, Colorado. In early 2001, Southwest contacted LMS, seeking to gain access to Respondent's physician members in the Farmington, New Mexico area, for payors with which Southwest had contracts. LMS insisted that the payors dealing with Southwest could have access to Respondent's members only by agreeing to pay them their full billed charges less 10%. After LMS dissolved, Southwest dealt directly with Respondent, which adopted LMS's bargaining position and was successful in negotiating contracts with Southwest's payors on these terms.

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Respondent estimated that these contracts increased prices for its member physicians by as much as 60%.

RESPONDENT ALSO NEGOTIATED OTHER FIXED-PRICE PAYOR CONTRACTS

20. During its negotiations with other payors, including Blue Cross & Blue Shield of New Mexico (“Blue Cross”) and Molina Healthcare of New Mexico (“Molina”) (formerly known as Cimarron Health Plan), Respondent purported to be a legitimate messenger, but did not act accordingly. Instead, Respondent coordinated its physician members’ responses to these payors’ price offers, by not transmitting certain offers to its physician members for their unilateral consideration and demanding prices from these payors on the collective behalf of its physician members.

21. In May 2001, Blue Cross made a price offer to Respondent for transmission to its members. Respondent did not transmit this offer to its physician members. Instead, in August 2001, Respondent demanded from Blue Cross, on behalf of its physician members, prices for non-surgical codes that were approximately 17% to 19% higher than Blue Cross’s offer. Later that month, Blue Cross increased its price offer to Respondent’s physician members by 2% to 14% more than the initial Blue Cross offer. Respondent again did not transmit this offer to its physician members. In October 2001, Blue Cross again increased its offer to Respondent’s physician members, to prices ranging from 10% to 16% higher than the initial Blue Cross offer. Only at that point did Respondent transmit this offer to its physician members, who accepted it.

22. Throughout 2002, Molina attempted to contract directly with individual physician members of Respondent for its commercial product. Virtually every member of Respondent insisted on contracting with Molina only through Respondent, however, and rejected Molina’s direct contract proposals. In January 2003, Molina proposed 140% of RBRVS to Respondent

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for all physician services. Respondent did not transmit this proposal to its physician members, and, without having asked its members for their individual price terms, told Molina that the physicians would require higher prices for surgical codes. In March 2003, Molina increased its price offer by more than 10% over its initial proposal for surgical codes, and Respondent transmitted this offer to its physician members – the majority of whom refused it. Molina requested the names of the minority of physicians who indicated their willingness to accept Molina's price terms, but Respondent refused to comply – thus bolstering the group's collective leverage by stifling Molina's ability to enter individual with certain members. To date, Molina has not entered into a commercial contract with the Respondent, and as a result Molina has been unable to obtain a viable network of physicians in the Farmington area for its commercial product.

RESPONDENT'S PRICE FIXING IS NOT JUSTIFIED

23. Respondent's joint negotiation of fees has not been, and is not, reasonably related to any efficiency-enhancing integration.

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

24. Respondent's actions described in Paragraphs 13 through 22 of this Complaint have had, or tend to have, the effect of restraining trade unreasonably and hindering competition in the provision of physician services in the Farmington area in the following ways, among others:

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

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**RESPONDENT'S CONDUCT CONSTITUTES A
VIOLATION OF THE
FEDERAL TRADE COMMISSION ACT**

25. The combination, conspiracy, acts, and practices described above constitute unfair methods of competition in violation of Section 5 of the Federal Trade Commission Act, 15 U.S.C. § 45. Such combination, conspiracy, acts, and practices, or the effects thereof, are continuing and will continue or recur in the absence of the relief herein requested.

WHEREFORE, THE PREMISES CONSIDERED, the Federal Trade Commission on this thirtieth day of June, 2005, issues its complaint against Respondent.

DECISION AND ORDER

The Federal Trade Commission (“Commission”), having initiated an investigation of certain acts and practices of the San Juan IPA, Inc. (“San Juan IPA”), 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 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 2.34, 16 C.F.R. § 2.34, the Commission hereby issues its Complaint, makes the following jurisdictional findings and issues the following Order:

1. Respondent San Juan IPA is a not-for-profit corporation, organized, existing, and doing business under and by virtue

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of the laws of the State of New Mexico, with its principal address at 2325 East 30th Street, Farmington, NM 87401.

2. The Federal Trade Commission has jurisdiction of the subject matter of this proceeding and of Respondent, and this 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 San Juan IPA, Inc., its officers, directors, employees, agents, attorneys, representatives, successors, and assigns; and the subsidiaries, divisions, groups, and affiliates controlled by San Juan IPA, 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.”
- 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, pursuant to Paragraph V.A.3 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:

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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 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 Paragraphs II.A or II.B, above; and
- D. Encouraging, suggesting, advising, pressuring, inducing, or attempting to induce any person to engage in any action that would be prohibited by Paragraphs II.A through II.C above.

PROVIDED, HOWEVER, that nothing in 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,

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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.

- 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 Farmington, New Mexico, 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

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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 a period of three (3) years from the date this Order becomes final, 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 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 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 from the date that this Order becomes final, send by first-class mail, return receipt requested, a copy of this Order and the Complaint to:

1. each physician who participates, or has participated, in Respondent since January 1, 2003;
 2. each officer, director, manager, and employee of Respondent; and
 3. 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;
- B. 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) the termination date specified in a written request from a payor to Respondent 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 from the date that 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 from the date that 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.B of this Order, to terminate the contract at any time;
- C. Within ten (10) days of receiving a written request from a payor, pursuant to Paragraph V.B(1) of the 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;

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- D. For a period of three (3) years from the date that 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, within thirty (30) days of the time that such participation begins;
 - b. each payor that contracts with Respondent for the provision of physician services, and that did not previously receive a copy of this Order and the Complaint, within thirty (30) days of the time that such payor enters into such contract; and
 - c. each person who becomes an officer, director, manager, or employee of Respondent, and who did not previously receive a copy of this Order and the Complaint, within thirty (30) days of the time that he or she assumes such responsibility 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 who participate in Respondent, with such prominence as is given to regularly featured articles;
- E. File a verified written report within sixty (60) days from the date that 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.C, and V.D.1 of this Order; and
- F. 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 the 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 officers, directors, or employees of Respondent.

VIII.

IT IS FURTHER ORDERED that this Order shall terminate on June 30, 2025.

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Appendix A

[letterhead of San Juan IPA]

[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 San Juan IPA, Inc. ("San Juan IPA").

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

Paragraph V.B 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 San Juan IPA]. 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 San Juan IPA, Inc. (San Juan IPA). The agreement settles charges that San Juan IPA violated Section 5 of the Federal Trade Commission Act, 15 U.S.C. § 45, by orchestrating and implementing agreements among physician members of San Juan IPA 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 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 San Juan IPA 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.

San Juan IPA is an independent physician association (IPA) with approximately 120 physician members. San Juan IPA does business in the Farmington, New Mexico, area, which is located in the northwestern corner of New Mexico.

Analysis

San Juan IPA's physician members account for approximately 80% of the physicians independently practicing (that is, those not employed by area hospitals) in and around the Farmington area. To be marketable in the Farmington area, a payor's health insurance plan must have access to a large number of physicians who are members of San Juan IPA.

Although San Juan IPA purported to operate as a "messenger model"¹-- that is, an arrangement that does not facilitate horizontal agreements on price -- it engaged in various actions that demonstrated or orchestrated such agreements. San Juan IPA coordinated joint pricing among its physician members in three ways. First, San Juan IPA was a party to contracts that a joint venture, in which San Juan IPA participated, collectively negotiated on behalf of San Juan IPA's members. Second, San Juan IPA, on behalf of its physician members, collectively negotiated contracts for payment of physician services at full billed charges less a 10% discount, made collective demands, and refused to deal with payors. Finally, San Juan IPA coordinated its members' responses to payor offers for fixed-price contracts, by not transmitting certain offers to its physician members and collectively demanding prices, on behalf of its physician members, from these payors.

San Juan IPA succeeded in forcing numerous health plans to raise the fees paid to its physician members, and thereby raised the cost of medical care in the Farmington area. San Juan IPA engaged in no efficiency-enhancing integration sufficient to justify

¹ 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>.

joint negotiation of fees. By orchestrating agreements among its members to deal only on collectively-determined terms, and actual or threatened refusals to deal with health plans that would not agree to those terms, San Juan IPA 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 San Juan IPA 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 San Juan IPA.

Other parts of Paragraph II reinforce these general prohibitions. Paragraph II.B prohibits San Juan IPA 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 inducing anyone to engage in any action prohibited by Paragraphs II.A through II.C.

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. San Juan IPA would not be precluded from engaging in conduct that is reasonably necessary to form or participate in legitimate joint contracting arrangements among

Analysis

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 San Juan IPA to notify the Commission before participating in contracting with health plans on behalf of a qualified risk-sharing joint arrangement or a qualified clinically-integrated joint arrangement. Paragraph III also sets out the information necessary to make the notification complete.

Paragraph IV, for three years, requires San Juan IPA 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.A requires San Juan IPA to distribute the complaint and order to all physicians who have participated in San Juan IPA, and to payors that negotiated contracts with San Juan IPA or indicated an interest in contracting with San Juan IPA. Paragraph V.B requires San Juan IPA, at any payor's request and without penalty, or, at the latest, within one year after the order is made final, to terminate its current contracts. Paragraph V.C requires San Juan IPA to distribute payor requests for contract termination to all physicians who participate in San Juan IPA. Paragraph V.D.1.b requires San Juan IPA to distribute the complaint and order to any payors that negotiate contracts with San Juan IPA in the next three years.

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

The proposed order will expire in 20 years.

Order

IN THE MATTER OF

TELEBRANDS CORP.

ORDER

IT IS HEREBY ORDERED THAT Complaint Counsel's December 17, 2004 Motion for Leave to Substitute an Amended Version of Answering Brief and Cross Appeal Brief and Errata Sheet, as supplemented by Complaint Counsel's January 7, 2005 filing, is granted.