

Complaint

IN THE MATTER OF

PARTNERS HEALTH NETWORK, INC.CONSENT ORDER, ETC., IN REGARD TO ALLEGED VIOLATIONS OF
SEC. 5 OF THE FEDERAL TRADE COMMISSION ACT*Docket C-4149; File No. 0410100**Complaint, September 19, 2005--Decision, September 19, 2005*

This consent order addresses practices used by Respondent Partners Health Network, Inc., a physician-hospital organization consisting of approximately 225 physicians; Palmetto Health Baptist Medical Center at Easley; and Cannon Memorial Hospital, in South Carolina. The order, among other things, prohibits the respondent from entering into or facilitating any agreement between or among any physicians (1) to negotiate with payors on behalf of any physician; (2) to deal, not to deal, or threaten not to deal with any payor; (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. The order also prohibits the respondent from facilitating exchanges of information between physicians concerning whether, or on what terms, to contract with a payor, and from attempting to engage, or inducing anyone to engage in, any action prohibited by the order. In addition, the order requires the respondent 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, and before participating in contracting with health plans on behalf of a qualified risk-sharing joint arrangement, or a qualified clinically-integrated joint arrangement. The order also requires the respondent, at any payor's request and without penalty, to terminate its current contracts with respect to providing physician services; to distribute payor requests for contract termination to all physicians who participate in Partners Health; and to terminate all current contracts not otherwise terminated no later than one year from the date the order becomes final.

Participants

For the Commission: *Karan Singh, Anne R. Schenof, David R. Pender, Daniel P. Ducore, Louis Silvia, and Mark Frankena.*

For the Respondent: *F. Martin Dajani, DLA Piper Rudnick Gray Cary US LLP*

Complaint

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

Nature of the Case

1. This matter concerns agreements among competing physicians, acting through the Respondent, to fix prices charged to health plans and other third-party payors (“payors”), and to refuse to deal with payors except on collectively agreed upon terms. The Respondent had no legitimate justification for these agreements, which increased consumer health care costs in northwestern South Carolina.

Respondent

2. Partners Health, a physician-hospital organization (“PHO”), is a for-profit corporation, organized, existing, and doing business under and by virtue of the laws of the State of South Carolina, with its principal address at 215 East 1st Avenue, Easley, South Carolina 29640-3038.

3. Partners Health was formed to increase the members’ negotiating leverage concerning payment terms in health contracts. Partners Health contracts with payors on behalf of its member physicians jointly, as well as on behalf of its two member hospitals separately.

Complaint

4. Partners Health members include more than 225 physicians licensed to practice allopathic or osteopathic medicine in South Carolina, and two non-profit hospitals. The hospitals, Palmetto Health Baptist Easley and Cannon Memorial Hospital, are the only two hospitals in Pickens County, located in northwestern South Carolina. About 150 of the Partners Health physician members practice in Pickens County, and they account for approximately 75% of the physicians in the county. To be marketable in the Pickens County area, a payor's health plan must contract with a large number of physicians who are members of Partners Health.

5. Partners Health's eight-member Board of Directors consists of four physicians and four hospital administrators. The physicians on the Board are elected by the Partners Health physician members to represent the members' interests in Partners Health's affairs.

6. On health plan contracting issues, the Board of Directors receives advice from its Advisory Board, which consists of ten representatives of the physician members and two hospital member representatives.

Jurisdiction

7. At all times relevant to this Complaint, Partners Health has been engaged in the business of contracting with payors, on behalf of Partners Health's physician members, for the provision of physician services.

8. Except to the extent that competition has been restrained as alleged herein, a substantial majority of Partners Health physician members have been, and are now, in competition with each other for the provision of physician services in the Pickens County, South Carolina, area.

Complaint

9. Partners Health, a for-profit entity, is a corporation within the meaning of Section 4 of the Federal Trade Commission Act, as amended, 15 U.S.C. § 44.

10. The general business practices of Partners Health, and of its physician members, including the acts and practices herein alleged, are in or affect “commerce” as defined in the Federal Trade Commission Act, as amended, 15 U.S.C. § 44.

Overview of Physician Contracting with Payors

11. Physicians contract with payors to establish the terms and conditions, including price terms, under which they render physician services to the subscribers to the payors’ health 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.

12. Absent agreements among them, otherwise competing physicians unilaterally decide whether to enter into payor contracts to provide services to insureds, and what prices they will accept pursuant to such contracts.

13. The Medicare Resource Based Relative Value Scale (“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. 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”).

Anticompetitive Conduct

14. Partners Health, acting as a combination of its physician members, and in conspiracy with its members, has acted to

Complaint

restrain competition by, among other things, facilitating, entering into, and implementing agreements, express or implied, to fix the prices and other terms at which they would contract with payors; to engage in collective negotiations over terms and conditions of dealing with payors; and to have Partners Health members refrain from negotiating individually with payors or contracting on terms other than those approved by Partners Health.

15. Partners Health physician members have agreed, upon joining Partners Health, to be automatically bound by contracts that Partners Health negotiates on their behalf, unless the member opts out of the contract within 30 days after he or she receives notice of the contract. Physician members also agreed to refer insureds under Partners Health contracts only to other Partners Health physicians, except in medical emergencies.

16. Under the Partners Health contracting system, Partners Health polls its physician members to determine their fee expectations from payor contracts. Partners Health's Executive Director uses the highest of the fees received to formulate a "floor" fee schedule that he presents to payors as Partners Health's "fee expectations." Partners Health then negotiates the fees that the payor will present for the Partners Health members' consideration.

17. Under Partners Health's bylaws, the Board of Directors must approve any fee offer from a payor before the offer may be presented to the Partners Health physician members for their review. In practice, however, the Executive Director consults with the Advisory Board during contract negotiations, and the Board of Directors is merely notified of the offer terms that are to be presented to the physician members.

18. In some cases, a physician member who opts out of a Partners Health contract, or leaves Partners Health, may not individually contract with the payor due to the exclusivity provision Partners Health seeks to include in all of its contracts. Under this contract provision, payors that contract with Partners

Complaint

Health may not contract with individual physicians in Pickens County without the approval of Partners Health.

19. In 2003, after a payor objected to the Partners Health contracting system, Partners Health began referring to its contracting system as a “messenger model.” 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. 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. 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.

20. Despite calling its contracting system a messenger model, Partners Health continued to negotiate with payors the price terms to be offered or paid to the Partners Health physician members.

Contract Negotiations with Beech Street

21. Beech Street had both individual physician contracts with Pickens County physicians, and a letter of agreement with Partners Health for physician services dating to 1996. In November 1996, Partners Health informed Beech Street that it wanted to update the letter of agreement, and sent Beech Street its “physician fee expectations” in a fee schedule. Partners Health’s Executive Director told Beech Street that the Partners Health Board of Directors would need to approve the negotiated contract terms before the terms would be presented to the Partners Health physicians for their acceptance. After negotiating price terms, Partners Health entered into a new contract with Beech Street.

Complaint

22. In 2001, Partners Health approached Beech Street with a request to renegotiate the prices in the contract. Beech Street began negotiations by presenting the standard fee schedule it pays most South Carolina physicians. Partners Health told Beech Street that this offer fell below a “negotiation corridor,” and presented a price list for several hundred procedures that was 18% higher than the Beech Street offer. Partners Health claimed it had developed the list based on its view of what the Partners Health members had considered acceptable in past contract negotiations.

23. Beech Street agreed to the Partners Health fee schedule, with a few modifications. After the parties agreed to the prices and contract language, the final contract was presented to the Partners Health members, who accepted the new contract terms.

Negotiations with CCN & First Health

24. In the summer of 2001, the Partners Health Board of Directors ordered the renegotiation of the CCN contract to get higher prices. In July 2001, Partners Health sent CCN a list of higher fees for the existing contract’s fee schedule. In response, CCN offered to pay a percentage of the Partners Health members’ billed charges. Partners Health rejected the offer and countered with rates 5-15% higher than CCN’s offer, still as a percentage of the members’ billed charges, depending on specialty.

25. CCN responded by offering fee terms of a flat percentage of 2001 Medicare RBRVS for all procedures, which Partners Health told CCN was “completely unacceptable.” Partners Health stated that it “can only agree to two different payment methodologies”: either a percentage of members’ billed charges, or a fee schedule that Partners Health sent CCN. Partners Health rejected the CCN offer without submitting it to the Partners Health physician members.

26. Partners Health terminated the CCN contract, effective February 2002, because “CCN will not agree to renegotiate with

Complaint

Partners Health based on Partners Health's historical payment expectations and methodology."

27. Following the contract termination, Partners Health organized its members' refusal to deal with CCN so as "to strengthen Partners Health Network's position." In December 2001, Partners Health members were instructed that "[i]f CCN makes any attempt to contact your hospital or office in the next two months then please do what you have previously done - refer them to the [Partners Health] office." In February 2002, Partners Health's Executive Director told the Partners Health physicians to continue to refuse to deal with CCN, terminate any direct contracts they may have with CCN, and steer CCN to Partners Health.

28. CCN's attempts at direct contracts with Partners Health members during this period resulted in the physicians directing CCN to Partners Health. Meanwhile, CCN merged with First Health and sought to combine the two companies' contracts with Partners Health into a single joint agreement that still distinguished between the two companies' brand names.

29. First Health sent direct contracts to Pickens County physicians in early 2003, but the physicians either referred First Health to Partners Health or sent First Health's contracting offer materials straight to Partners Health.

30. After receiving the forwarded offers for the First Health portion of the contract, Partners Health contacted First Health and demanded that any First Health portion of the combined contract have the same percentage-of-billed-charges arrangement as in the CCN portion of the contract. First Health refused, and offered Partners Health up to four different fee schedules for the First Health portion of the contract. Partners Health rejected each one, insisted on a discount-off-billed-charges arrangement, and never sent the fee schedules to the Partners Health members.

Complaint

31. In June of 2003, First Health agreed to take the “Partners Fee Schedule” for the First Health portion of the contract. Partners Health then presented the First Health fee offer to the Partners Health members, and they accepted it.

32. Eventually Partners Health reached a joint First Health/CCN agreement in December 2003. The CCN portion of the contract contained payment terms that were 17% higher than the original CCN offer.

Contract Negotiations with Premier Health Systems

33. Premier Health Systems ("Premier") has contracted with Partners since 1995. Contract renegotiations began in October 2000, when the Partners Health Executive Director told Premier that “general expectations” for a new contract included Premier’s acceptance of an attached fee schedule. Partners Health negotiated fee terms with Premier over the next ten months, ending when Premier accepted Partners Health’s fee expectations, which were 17% higher than Premier’s initial offer.

34. The Partners Health Executive Director informed the Partners Health members of Premier’s agreement to the fees in August 2001, telling them: "As customary regarding physician payment, PHN has negotiated specialized pricing for over 600 [procedures].”

35. In December 2003, Partners Health polled its members to learn what fees they would accept for a new Premier contract. The individual member practices responded with their fee requests, which varied by practice. However, Partners Health presented Premier with a single fee schedule that listed the highest requested rate among the Partners Health practices.

36. On March 10, 2004, Partners Health sent Premier an email: “Bottom line . . . [the attached fee schedule] represent[s] Partners Health’s expectation,” which averaged 12% higher than the currently contracted rates. Premier countered with a 6%

Complaint

increase over the current rates. Partners Health sent the Premier increase to its members in May 2004, and they accepted the contract.

Contract Negotiations with United Healthcare

37. For years, United Healthcare of South Carolina, Inc. (“United”), accessed Partners Health physician members by contracting with third-party administrator Medcost, which had contracts with Partners Health for physician services.

38. United told Partners Health in March 2003 that it wanted to contract with Partners Health directly, instead of accessing the Partners Health physician members through Medcost. United included a fee schedule for 50 procedures. Partners Health responded with a list of “payment expectations for a contract,” including a fee schedule that listed hundreds of procedures with an overall average price almost double United’s proposal. United responded with a more comprehensive counteroffer of fees than it had submitted on March 5, on average 39% higher than its original offer.

39. After receiving United’s offer, Partners Health suspended negotiations. In May 2003, Partners Health sent its members a memo detailing its decision to cease negotiations with United. Partners Health explained that the two deal-breakers were that United only wanted Partners Health to facilitate individual physician contracts, and that United would “only offer a standard/universal fee schedule (no negotiating flexibility) at rates significantly lower than Medcost.” The memo continued by stating that United’s requests “are unacceptable to Partners Health because facilitating individual agreements achieves no future clout and defensive strength . . . and accepting rates so much lower is inappropriate in a climate of increasing overhead costs.”

40. In July 2003, United sent an antitrust article on messenger arrangements to the Partners Health physician practices, and at the same time it asked Partners Health to messenger the United

Complaint

physician fee schedule to the Partners Health members. In the August 15, 2003, Advisory Board meeting, after discussing the antitrust issues raised by United's article, the Advisory Board decided to send the first United offer to the Partners Health members, and ask them to communicate their fee expectations to the Executive Director, "who will then messenger back [to United] a comprehensive offer" for the entire membership. The Advisory Board agreed that "[i]f a majority of [Partners Health] members do not want to contract with United at all then Partners Health will suspend negotiations again."

41. On September 24, 2003, Partners Health forwarded United's original offer to its members for the first time. Along with the offer, Partners Health "polled" its members by asking them to identify their preferences for contracting with United -- either through Partners Health, another PHO, directly, or not at all. If the members wanted to contract through Partners Health, they were told to return a list of fee counteroffers for United.

42. An October 15, 2003, follow-up memo to the Partners Health members stressed that Partners Health needed 40 out of the 49 practices to choose to contract through Partners Health "to develop a credible contracting position with [United]." The memo stated "[t]he majority of [Partners Health] members . . . will only contract through Partners Health with [United] as verified by the responses already received." The memo concluded by emphasizing that Partners Health "[has] the market completely on our side in terms of access," and that "[e]mployers will drop [United] like a stone come January if there is not a full network in place as a result of severing ties with Medcost without contracting to develop [United's] own [network]."

43. Partners Health then sent its members a memorandum naming the practices that returned the polling form and fee requests, along with a list of practices that chose to contract directly with United. This memorandum bolstered the members' resolve to refuse to deal with United, and targeted the practices

Complaint

choosing to directly contract for peer pressure to conform to the group's wishes to jointly contract.

44. In February 2004, Partners Health told United that it messengered United's offers to the Partners Health members, and included what it called the "members aggregated fee expectations," in the form of a single fee schedule.

45. United has been unable to contract with Partners Health, and is still unable to contract with enough physicians to have a viable network in the Pickens County area. Moreover, Partners Health successfully pressured MedCost, through the threat of network termination, to end United's access to the Partners Health members through MedCost, effective as of July 1, 2004.

Contracting with Other Payors

46. Partners Health, on behalf of its physician members, has orchestrated collective negotiations with other payors who do business, or have attempted to do business, in the Pickens County area, including Aetna, Great-West Healthcare, MedCost, Private Health Care Systems, Southcare, United Payors/United Providers, and USA Managed Care, Inc. Partners 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. Partners Health also facilitated collective refusals to deal and threats of refusals to deal with payors. Partners Health's members collectively accepted or rejected these payor contracts, and refused to deal with these payors individually. Due to Partners Health's dominant position in the Pickens area, these coercive tactics have been successful in raising the prices paid to its physician members.

Respondent's Price-fixing Is Not Justified

47. The physician members of Partners Health have not integrated their practices in any economically significant way, nor

Complaint

have they created efficiencies sufficient to justify their acts or practices described in paragraphs 14 through 46.

Respondent's Actions Have Had Substantial Anticompetitive Effects

48. Respondent's actions described in Paragraphs 14 through 46 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 Pickens County area in the following ways, among others:

- a. price and other forms of competition among physician members of Partners 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

49. 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 19th day of September, 2005, issues its Complaint against Respondent Partners Health.

Decision and Order

DECISION AND ORDER

The Federal Trade Commission (“Commission”), having initiated an investigation of certain acts and practices of the Partners Health Network, Inc. (“Partners Health”), hereinafter sometimes referred to as “Respondent,” and Partners Health having been furnished with a copy of the draft 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 this 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, 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 Partners Health is a for-profit corporation, organized, existing, and doing business under and by virtue of the laws of the State of South Carolina, with its principal

Decision and Order

address located at 215 East 1st Avenue, Easley, South Carolina 29640-3038.

2. The Federal Trade Commission has jurisdiction of the subject matter of this proceeding and of the Respondent, and the proceeding is in the public interest.

ORDER**I.**

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

- A. “Respondent Partners Health” means Partners Health Network, Inc., its officers, directors, employees, agents, attorneys, representatives, successors, and assigns; the subsidiaries, divisions, groups, and affiliates controlled by it, and the respective officers, directors, employees, agents, attorneys, representatives, successors, and assigns of each.
- B. “Hospital” means a health care facility licensed by any state as a hospital, including, but not limited to, Cannon Memorial Hospital and Palmetto Health Baptist Medical Center at Easley.
- C. “Medical Group Practice” means a bona fide, integrated firm in which physicians practice together as partners, shareholders, owners, or employees, or in which only one physician practices.
- D. “Participate” in an entity means (1) to be a partner, shareholder, owner, member, or employee of such entity, or (2) to provide services, agree to provide services, or offer to provide services, to a payor through such entity. This definition applies to all tenses and forms of the word “participate,” including, but not limited to, “participating,” “participated,” and “participation.”

Decision and Order

- E. “Payor” means any person that pays, or arranges for 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.
- F. “Person” means both natural persons and artificial persons, including, but not limited to, corporations, unincorporated entities, and governments.
- G. “Physician” means a doctor of allopathic medicine (“M.D.”) or a doctor of osteopathic medicine (“D.O.”).
- H. “Preexisting contract” means a contract for the provision of physician services 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 Partners Health, pursuant to Paragraph V.A.3 of this Order, of such payor’s right to terminate such contract.
- I. “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.
- J. “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 that participate in the arrangement, in order to control costs and ensure the quality of services provided through the arrangement; and
 - 2. any agreement concerning price or other terms or conditions of dealing entered into by or within the arrangement is reasonably necessary to obtain significant efficiencies through the arrangement.

Decision and Order

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

Decision and Order

II.

IT IS FURTHER ORDERED that Respondent Partners Health, 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 Partners Health;
- B. Exchanging or facilitating in any manner the exchange or transfer of information between or among physicians concerning any physician’s willingness to deal with a payor, or the terms or conditions, including any price terms, on which the physician is willing to deal with a payor;
- C. Attempting to engage in any action prohibited by Paragraphs II.A or II.B above; and

Decision and Order

- 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, subject to the requirements of Paragraph IV of this Order, nothing in this Paragraph II shall prohibit any agreement involving, or any conduct that is reasonably necessary to form, participate in, or take any action in furtherance of a qualified risk-sharing joint arrangement or a qualified clinically-integrated joint arrangement that does not restrict the ability, or facilitate the refusal, of physicians who participate in it to deal with payors on an individual basis or through any other arrangement, or that solely involves physicians in the same medical group practice.

III.

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

Decision and Order

is not to be construed as a determination by the Commission that any action described in such Paragraph III Notification 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 this Order becomes final, pursuant to each qualified clinically-integrated joint arrangement or qualified risk-sharing joint arrangement (“Arrangement”) in which Respondent Partners Health is a participant, Respondent Partners Health shall notify the Secretary of the Commission in writing (“Paragraph IV Notification”) at least sixty (60) days prior to:

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

PROVIDED, HOWEVER, that Paragraph IV Notification shall not be required for an Arrangement whenever such Notification has been previously given for that Arrangement.

PROVIDED FURTHER:

- 1. that with respect to any Paragraph IV Notification, Respondent Partners Health shall include the following information:

Decision and Order

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

Decision and Order

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 Partners Health of any Paragraph IV Notification, pursuant to Paragraph IV of this Order, is not to be construed as a determination by the Commission that any such Arrangement does or does not violate this Order or any law enforced by the Commission.

V.

IT IS FURTHER ORDERED that Respondent Partners Health shall:

- A. Within thirty (30) days after the date on which this Order becomes final, send a copy of this Order and the Complaint by first-class mail:
 1. with delivery confirmation, to each physician and hospital that participates in Respondent Partners Health;
 2. with return receipt requested, to each present officer, director, manager, and employee of Respondent Partners Health; and
 3. with return receipt requested, and with the letter attached as Appendix A to this Order, to the chief executive officer of each payor with whom Respondent Partners Health has a record of being in contact since January 1, 2001, regarding contracting for the provision of physician services; *provided, however*, that a copy of Exhibit A need not be included in the mailings to those payors with whom Respondent Partners Health has not entered into or renewed (including any automatic renewal of) a contract since January 1, 2001.

Decision and Order

- B. 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 and hospital that begins participating in Respondent Partners Health, and that did not previously receive a copy of this Order and the Complaint from Respondent Partners Health, within thirty (30) days of the day that such participation begins;
 - b. each payor that contracts with Respondent Partners Health for the provision of physician services, and that did not previously receive a copy of this Order and the Complaint from Respondent Partners Health, within thirty (30) days of the day that such payor enters into such contract; and
 - c. each person who becomes an officer, director, manager, or employee of Respondent Partners Health, and who did not previously receive a copy of this Order and the Complaint from Respondent Partners Health, within thirty (30) days of the day that he or she assumes such responsibility with Respondent Partners Health; 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 Partners Health, with such prominence as is given to regularly featured articles;
- C. File a verified written report within sixty (60) days after the date on which this Order becomes final, annually thereafter for 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:

Decision and Order

1. A detailed description of the manner and form in which Respondent Partners Health has complied and is complying with this Order;
 2. The name, address, and telephone number of each payor with which Respondent Partners Health has had any contact; and
 3. Copies of the delivery confirmations required by Paragraph V.A.1 of this Order, and copies of the signed return receipts required by Paragraphs V.A.2, V.A.3, V.B.1, and V.E of this Order;
- D. 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 earliest of:
1. the termination date specified in a written request from a payor to Respondent Partners Health to terminate such contract;
 2. the earliest termination or renewal date (including any automatic renewal date) of such contract; or
 3. one year from the date this Order becomes final.

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 Partners Health 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 Partners Health 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

Decision and Order

Paragraph V.D of this Order, to terminate the contract at any time; and

- E. Within ten (10) days of receiving a written request from a payor, pursuant to Paragraph V.D (1) of this Order, distribute, by first-class mail, return receipt requested, a copy of that request to each physician and hospital participating in Respondent Partners Health as of the date Respondent Partners Health receives such request.

VI.

IT IS FURTHER ORDERED that Respondent Partners Health shall notify the Commission at least thirty (30) days prior to any proposed (1) dissolution of Respondent Partners Health, (2) acquisition, merger or consolidation of Respondent Partners Health, or (3) other change in Respondent Partners Health 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 Partners Health.

VII.

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

VIII.

IT IS FURTHER ORDERED that, for the purpose of determining or securing compliance with this Order, Respondent Partners Health 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

Decision and Order

and documents in its possession, or under its control,
relating to any matter contained in this Order; and

- B. Upon five (5) days' notice, and in the presence of counsel, and without restraint or interference from it, to interview officers, directors, or employees of the Respondent.

IX.

IT IS FURTHER ORDERED that this Order shall terminate twenty (20) years from the date it is issued.

Decision and Order

Appendix A

[letterhead of Respondent Partners Health]

[date]

[name and address of payor's CEO]

Dear [CEO]:

Enclosed is a copy of a complaint and a decision and order ("Order") issued by the Federal Trade Commission against Partners Health Network, Inc. ("Partners Health").

Pursuant to Paragraph V.D of the Order, Partners Health must allow you to terminate, upon your written request, without any penalty or charge, any contracts with Partners Health for the provision of physician services that are in effect as of the date you receive this letter.

If you do not make such written request to terminate the contract, Paragraph V.D further provides that the contract will terminate on the earlier of:

1. [date], the contract's termination or renewal date; or
2. [date], one year from the date the Order becomes final.

You may, however, ask Partners Health to extend the contract beyond [date], the termination or renewal date, to any date no later than [date], one (1) year after the date the Order becomes final.

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

Decision and Order

be made in writing, and sent to me at the following address:
[address].

Sincerely,

[signatory]

[Partners Health to fill in applicable dates]

Analysis

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

The Federal Trade Commission has accepted, subject to final approval, an agreement containing a proposed consent order with Partners Health Network, Inc. The agreement settles charges that Partners Health violated Section 5 of the Federal Trade Commission Act, 15 U.S.C. § 45, by orchestrating and implementing agreements among members of Partners 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 Partners 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.

Partners Health is a physician-hospital organization consisting of approximately 225 physicians, Palmetto Health Baptist Medical Center at Easley, and Cannon Memorial Hospital. Partners Health does business in the Pickens, South Carolina, area, which is located in northwestern South Carolina. Partners Health was “created to develop, negotiate, enter into, and administer

Analysis

contracts” for its physician members, and its “primary function” is described as “centralized managed care contracting.”

Partners Health’s physician members account for approximately 75% of the physicians independently practicing (that is, those not employed by area hospitals) in and around the Pickens County area. To be marketable in this area, a health plan must have access to a large number of physicians who are members of Partners Health.

Although Partners Health purports to operate as a “messenger model”¹ – that is, an arrangement that does not facilitate horizontal agreements on price – it orchestrated such price agreements. The Partners Health Executive Director negotiates physician contracts with payors using a physician fee schedule that he created with input from the Partners Health physician members. This contracting process is overseen from start to finish by the Advisory Board and the Board of Directors. The Advisory Board is a 12-member committee that provides consultation to both the Board of Directors and the Executive Director during contract negotiations.

The Executive Director creates the Partners Health fee schedule by first polling the Partners Health physician practices to determine what prices they would like to receive in managed care contracts. The Executive Director then takes the highest prices he receives from among the physicians’ responses for a given medical procedure, and assembles those highest prices into

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>.

Analysis

a single fee schedule. The Executive Director uses this fee schedule to negotiate contract terms with health plans. Whenever a health plan rejects the Partners Health fee schedule, Partners Health's Executive Director negotiates, in consultation with the Advisory Board, a contract with a "comparable" fee schedule. After notifying the Board of Directors, the Executive Director transmits these contract terms to the Partners Health member practices for their review. Physician members are automatically bound by the contract unless they specifically opt out within 30 days of receiving the offer.

When they join Partners Health, the physician members agree to refer the patients they see under Partners Health contracts only to other Partners Health physicians, except in medical emergencies. This requirement stands even if non-Partners Health physicians are in the contracted payor's network.

Partners 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 Partners Health's desired terms. Partners Health succeeded in forcing numerous health plans to raise the fees paid to Partners Health physician members, and thereby raised the cost of medical care in the Pickens County area. Partners Health engaged in no efficiency-enhancing integration sufficient to justify joint negotiation of fees. By the acts set forth in the Complaint, Partners Health 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.

Analysis

The proposed order's specific provisions are as follows:

Paragraph II.A prohibits Partners Health 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 Partners Health.

Other parts of Paragraph II reinforce these general prohibitions. Paragraph II.B prohibits Partners Health 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 Partners Health from 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. Partners Health 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

Analysis

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 Partners 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 III also sets out the information necessary to make the notification complete.

Paragraph IV, for three years, requires Partners Health 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. The contracting discussions that trigger the notice provision may be either among physicians, or between Partners Health and health plans. Paragraph IV also sets out the information necessary to satisfy the notification requirement.

Paragraph V requires Partners Health to distribute the complaint and order to all physicians who have participated in Partners Health, and to payors that negotiated contracts with Partners Health or indicated an interest in contracting with Partners Health. Paragraph V.D requires Partners Health, 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 with respect to providing physician services. Paragraph V.D. also

Analysis

allows any contract currently in effect to be extended, upon mutual consent of Partners Health and the contracted payor, to any date no later than one year from when the order became final. This extension allows both parties to negotiate a termination date that would equitably enable them to prepare for the impending contract termination. Paragraph V.E requires Partners Health to distribute payor requests for contract termination to all physicians who participate in Partners Health.

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

The proposed order will expire in 20 years.

Commission Opinion

IN THE MATTER OF

**TELEBRANDS CORP., TV SAVINGS, LLC, AND AJIT
KHUBANI**OPINION OF THE COMMISSION AND FINAL ORDER IN REGARD TO
ALLEGED VIOLATIONS OF SEC. 5 OF THE
FEDERAL TRADE COMMISSION ACT*Docket 9313; File No. 0223279**Complaint, Sept. 30, 2003--Opinion and Final Order, Sept. 19, 2005*

In a unanimous Opinion, the Commission addressed advertising practices used by Respondents Telebrands Corporation and TV Savings, L.L.C. – and their principal, Respondent Ajit Khubani – for the Ab Force, a belt-like device that uses electronic stimulation (“EMS”) to cause involuntary contraction of the muscles of the abdominal wall, and determined that certain of these practices violated Section 5 of the Federal Trade Commission Act. The Final Order, among other things, prohibits the respondents – in connection with the manufacturing, labeling, advertising, promotion, offering for sale, sale, or distribution of the Ab Force EMS device or any substantially similar device – from representing (1) that any such device causes or promotes loss of weight, inches, or fat; (2) that any such device causes or promotes well-defined abdominal muscles; (3) that use of any such device for any period of time is an effective alternative to regular exercise; or (4) that any such device makes a material contribution to any system, program, or plan that produces the results described in the first three clauses. The Order also prohibits the respondents from misrepresenting – in connection with the manufacturing or marketing of any EMS device – (1) that any such device causes or promotes loss of weight, inches, or fat; (2) that any such device causes or promotes well-defined abdominal muscles; (3) that use of any such device for any period of time is an effective alternative to regular exercise; or (4) that any such device makes a material contribution to any system, program, or plan that produces the results described in the first three clauses.

Participants

For the Commission: *Constance M. Vecellio, Walter C. Gross, III, Joshua S. Millard, Amy M. Lloyd, James Reilly Dolan, Elaine D. Kolish, James A. Kohm, Russell Porter, Susan P. Braman, and Gerard R. Butters.*

For the Respondent: *Edward F. Glynn, Jr. and Theodore W. Atkinson, Venable LLP.*