

FEDERAL TRADE COMMISSION DECISIONS

FINDINGS, OPINIONS, AND ORDERS
JULY 1, 2009, TO DECEMBER 31, 2009

IN THE MATTER OF

ALTA BATES MEDICAL GROUP, INC.

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

*Docket No. C-4260; File No. 051 0260
Complaint, July 10, 2009 – Decision, July 10, 2009*

This consent order addresses Alta Bates Medical Group, Inc.'s fixing of prices charged to those offering coverage for health care services in the Berkeley and Oakland, California, areas and refusing to deal with such payors except on a collectively determined basis. Since at least 2001, ABMG, acting as a combination of its physician members, and in conspiracy with its members, has acted to restrain competition with respect to fee-for-service contracts 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 ABMG members refrain from negotiating individually with payors or contracting on terms other than those approved by ABMG. The order prohibits ABMG from entering into or facilitating any agreement between or among any health care providers: (1) to negotiate on behalf of any physician with any payor; (2) to 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 other than through ABMG. The order also prohibits ABMG the from facilitating exchanges of information between health care providers concerning whether, or on what terms, to contract with a payor. However, ABMG is not precluded from engaging in conduct that is reasonably necessary to form or participate in legitimate "qualified risk-sharing" or "qualified clinically-integrated" joint arrangements.

Participants

For the *Commission*: Linda Badger and Sylvia Kundig.

For the *Respondents*: Donald J. Bouey, Bouey & Black LLP.

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COMPLAINT

Pursuant to the provisions of the Federal Trade Commission Act, as amended, 15 U.S.C. § 41 *et seq.* (“FTC Act”), and by virtue of the authority vested in it by said Act, the Federal Trade Commission (“Commission”), having reason to believe that Alta Bates Medical Group, Inc. (“ABMG”), herein sometimes referred to as “Respondent,” has violated Section 5 of the FTC Act, 15 U.S.C. § 45, and it appearing to the Commission that a proceeding by it in respect thereof would be in the public interest, hereby issues this Complaint stating its charges in that respect as follows:

NATURE OF THE CASE

1. This matter concerns horizontal agreements among competing physicians, acting through Respondent, to fix prices charged to health plans, other third-party payors, and third-party networks (“payors”), to refuse to deal with certain payors, and to refuse to deal with payors except on collectively agreed terms.

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2. Alta Bates Medical Group, Inc., an independent practice association (“IPA”), is a for-profit corporation, organized, existing, and doing business under and by virtue of the laws of the State of California, with its principal place of business located at 2000 Powell Street, Suite 830, Emeryville, CA 94608. ABMG consists of multiple, independent medical practices with a total of approximately 600 physician members, of which approximately 200 are devoted to primary care.

THE FTC HAS JURISDICTION OVER RESPONDENT

3. At all times relevant to this Complaint, Respondent has been engaged in the business of negotiating or attempting to negotiate contracts with payors for the provision of physician services on behalf, and for the pecuniary benefit, of its members.

4. Except to the extent that competition has been restrained as alleged herein, ABMG’s physician members have been, and are now, in competition with each other for the provision of physician services in and around Berkeley and Oakland, California.

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5. Respondent is a “person,” “partnership,” or “corporation” within the meaning of Section 5 of the Federal Trade Commission Act, as amended, 15 U.S.C. § 45.

6. The general business practices of Respondent, including the acts and practices alleged herein, affect the interstate movement of patients, the interstate purchase of supplies and products, and the interstate flow of funds, and 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

7. Individual physicians and physician group practices contract with payors, including health maintenance organizations (HMOs), preferred provider organizations (PPOs), self-insured employers, and others, to establish the terms and conditions, including price terms, under which the physicians will render their professional medical services to the payors’ subscribers. Physicians and physician group practices entering into such contracts often agree to accept lower compensation from payors in order to obtain access to additional patients made available by the payors’ relationship with the subscribers. These contracts may reduce payors’ costs and enable them to lower the price of insurance or of providing health benefits, thereby resulting in lower medical costs for subscribers.

8. Physicians and physician group practices sometimes form or participate in financially integrated joint ventures to provide physician services under agreements with payors who seek such arrangements. Under such arrangements, the physicians and physician group practices may share financial risks and rewards in several ways. For example, the physicians may provide services at a “capitated” rate or share rewards/penalties based on their collective success in achieving pre-established targets or goals regarding aggregate utilization and costs of the services provided to covered individuals.

9. Physicians and physician group practices may also participate in joint ventures that do not involve financial integration, but involve clinical integration, by implementing an

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active and ongoing program to evaluate and modify practice patterns by the physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality.

10. Other than through their participation in integrated joint ventures, and absent anticompetitive agreements among them, otherwise competing physicians and physician group practices unilaterally decide whether to enter into contracts with payors to provide services to their subscribers, and what prices they will accept as payment for their services pursuant to such contracts.

RESPONDENT'S OPERATION

11. Since its formation, ABMG has entered into contracts with payors for and on behalf of its respective physician members, under which ABMG received capitated payments from the payors in exchange for the medical practices' agreement to provide their professional medical services to subscribers of the contracting payors. The capitated contracts provided to payors, in addition to the physician services, an insurance guarantee component that all covered physician services needed by subscribers of a payor's program would be provided by ABMG's physician members for the predetermined capitation charge, regardless of the actual quantity or type of services needed and provided.

12. The member physicians' participation in ABMG, and their offering of services through ABMG's capitated contracts, was not, however, the member physicians' exclusive method of selling their professional medical services. Rather, the member physicians also continued to sell their medical services individually, on a fee-for-service basis, outside of ABMG to individual patients and through contracts individually and directly entered into with payors.

ANTICOMPETITIVE CONDUCT

13. Since at least 2001, ABMG, acting as a combination of its physician members, and in conspiracy with its members, has acted to restrain competition with respect to fee-for-service contracts by, among other things, facilitating, entering into, and implementing agreements, express or implied, to fix the prices

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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 ABMG members refrain from negotiating individually with payors or contracting on terms other than those approved by ABMG.

Collective Negotiations with Payors

14. ABMG refers to its fee-for-service 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. For example, a payor may submit a contract offer to the messenger, 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. Alternatively, the messenger may receive authority from the individual physicians to accept contract offers that meet certain criteria. A lawful messenger arrangement does not involve negotiation on prices or other competitively significant terms and does not facilitate coordination among physicians on their responses to contract offers. Additionally, a lawful messenger arrangement does not discourage physicians from dealing individually with a payor.

15. As part of its fee-for-service contracting system, approximately 95 percent of ABMG's physicians signed “powers of attorney” (“POA”) granting ABMG authority to contract with PPO health plans on their behalf. The POA states that the individual ABMG physician appoints ABMG:

- a. To facilitate, execute, revise, modify, or amend an agreement (“Agreement”) with PPO networks that is consistent with the financial and other language parameters identified by PHYSICIAN.
- b. To execute the Agreement on PHYSICIAN'S behalf without further consultation with or authority of PHYSICIAN, provided the Agreement meets the PHYSICIAN'S parameters.

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16. Despite the POA provisions, ABMG did not rely on financial and other language parameters identified by its individual physician members regarding what rates and/or terms they would unilaterally accept. Instead, ABMG decided, on behalf of the group, what rates and/or terms it used in its communications with the PPO health plans. Therefore, ABMG did not employ a lawful messenger arrangement as described in Paragraph 14.

17. Rather than employ a lawful messenger arrangement, ABMG, on behalf of its physician members, has orchestrated collective negotiations for fee-for-service contracts with some payors who do business in and around Berkeley and Oakland, California. Since at least 2001, ABMG negotiated with these payors on price, making proposals and counter-proposals, as well as accepting or rejecting offers, without consulting with its individual physician members regarding the prices they would accept, and without transmitting the payors' offers to its individual physician members until ABMG had approved the negotiated prices.

18. ABMG's conduct, which constituted unlawful agreements between its individual physician members on the prices and other terms, included, but was not limited to:

- a. Approaching payors and suggesting contract rates and/or terms that it represented the ABMG physician members would accept, without obtaining price and term criteria from its individual physician members;
- b. Expressing its opinion about whether or not the ABMG physicians would likely accept contract rates and/or terms proposed by a payor and suggesting that payors reconsider offers it deemed inadequate, without obtaining price and term criteria from its individual physician members;
- c. Failing to submit payor proposals or counter proposals to its individual physician members to determine if each physician member would unilaterally accept the rates and/or terms being offered;

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- d. Submitting to ABMG physician members, on an opt-out basis, only those payor proposals for which ABMG had accepted the rates and terms; and
- e. Periodically providing its member physicians with a list of payors with which ABMG had negotiated contracts, and cautioned them about dealing individually with payors, because the individual contracts may have less favorable contract rates and/or terms. For example, during one negotiation ABMG sent the following notice to its individual member physicians:

As a general rule of caution, please scrutinize all contract solicitations that are mailed to your office, as many of these contracts do not represent the best interests of physicians. In the event that you may have signed these documents and returned them to [the PPO], you may certainly contact [the PPO] and say that you did not mean to sign the agreement because you should already be participating through ABMG and therefore the Individual Contract is superfluous.

Concerted Refusal to Deal

19. ABMG physicians and the Permanente Medical Group compete in the sale of physician services to consumers in and around Berkeley and Oakland, California. Because the Permanente Medical Group exclusively sells its physicians' services to Kaiser Foundation Health Plans, this competition occurs when a consumer chooses either a Kaiser Foundation Health Plan HMO, which allows the subscriber to access only the Permanente Medical Group, or an open-panel payor.

20. In 2006, a payor, Kaiser Permanente Insurance Corporation ("KPIC"), co-owned by the Permanente Medical Group and Kaiser Foundation Health Plans, began actively marketing an open-panel PPO. KPIC's PPO subscribers would access physician services through a third-party network. With

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this development, the Kaiser system could offer one-stop shopping to employers who want to offer their employees a choice between an open-panel PPO product (one that would allow subscribers to access physicians who are not members of the Permanente Medical Group), and Kaiser's traditional closed-panel HMO. This would result in more competition between ABMG physicians and the Permanente Medical Group in the sale of physician services through employers.

21. Under a prior contract with the third-party network referenced in Paragraph 20, the ABMG physicians had agreed to sell their physician services at a discount to payors who contract to access that network. In response to KPIC's initiative, however, ABMG decided, on behalf of the group, that ABMG physicians would not be available to KPIC's subscribers through the third-party network.

22. In furtherance of this decision, ABMG provided notice to the third-party network that its prior contract "is hereby amended to state that the physicians who are participating physicians of [ABMG] shall not provide services to members of Kaiser Health Plans" Although ultimately unsuccessful, the sole purpose of this action was to impede competition in the provision of physician services in and around Berkeley and Oakland, California.

**RESPONDENT'S CONDUCT IS NOT LEGALLY
JUSTIFIED**

23. Respondent's negotiation of fees and other competitively significant terms and concerted refusal to deal on behalf of its competing member physicians, and the agreements, acts, and practices described above, have not been, and are not, reasonably related to any efficiency-enhancing integration among the physician members of ABMG.

**RESPONDENT'S ACTIONS HAVE HAD, OR COULD BE
EXPECTED TO HAVE, SUBSTANTIAL
ANTICOMPETITIVE EFFECTS**

24. Respondent's actions described in Paragraphs 12 through 20 of this Complaint have had, have tended to have, or if

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successful would have had, the effect of restraining trade unreasonably and hindering competition in the provision of physician services in and around Berkeley and Oakland, California, in the following ways, among others:

- a. unreasonably restraining price and other forms of competition among physicians who are members of ABMG;
- b. increasing prices for physician services;
- c. depriving payors, including insurers and employers, and individual consumers, of the benefits of competition among physicians; and
- d. depriving consumers of the benefits of competition among payors.

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, as amended, 15 U.S.C. § 45. Such combination, conspiracy, acts, and practices, or the effects thereof, are continuing and will continue or recur in the absence of the relief herein requested.

WHEREFORE, THE PREMISES CONSIDERED, the Federal Trade Commission on this tenth day of July, 2009, issues its Complaint against Respondent Alta Bates Medical Group, Inc.

By the Commission.

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The Federal Trade Commission (“Commission”), having initiated an investigation of certain acts and practices of Alta Bates Medical Group, Inc., herein sometimes referred to as “Respondent,” and Respondent having been furnished thereafter

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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 (“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 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 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 Alta Bates Medical Group, Inc. is a for-profit corporation, organized, existing, and doing business under and by virtue of the laws of the State of California, with its principal place of business located at 2000 Powell Street, Suite 830, Emeryville, CA 94608.
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.

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ORDER**I.**

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

- A. “Respondent” means Alta Bates Medical Group, Inc., its officers, directors, employees, agents, attorneys, representatives, successors, and assigns; and the subsidiaries, divisions, groups, and affiliates controlled by it, 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, as well as 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.”).

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- G. “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 Alta Bates Medical Group, Inc., pursuant to Paragraph VII.A.2 of this Order of such Payor’s right to terminate such contract.
- H. “Principal Address” means either (1) the primary business address, if there is a business address, or (2) the primary residential address, if there is no business address.
- I. “Qualified Clinically-Integrated Joint Arrangement” means an arrangement to provide Physician services in which:
1. all Physicians who Participate in the arrangement Participate in active and ongoing programs of the arrangement to evaluate and modify the practice patterns of, and create a high degree of interdependence and cooperation among, the Physicians who Participate in the arrangement, in order to control costs and ensure the quality of services provided through the arrangement; and
 2. any agreement concerning price or other terms or conditions of dealing entered into by or within the arrangement is reasonably necessary to obtain significant efficiencies that result from such integration through the arrangement.
- J. “Qualified Risk-Sharing Joint Arrangement” means an arrangement to provide Physician services in which:
1. all Physicians who Participate in the arrangement share substantial financial risk through their Participation in the arrangement and thereby create incentives for the Physicians who Participate jointly to control costs and improve quality by managing the provision of Physician services such as risk-sharing involving:

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- a. the provision of Physician services at a capitated rate,
 - b. the provision of Physician services for a predetermined percentage of premium or revenue from Payors,
 - c. the use of significant financial incentives (e.g., substantial withholds) for Physicians who Participate to achieve, as a group, specified cost-containment goals, or
 - d. the provision of a complex or extended course of treatment that requires the substantial coordination of care by Physicians in different specialties offering a complementary mix of services, for a fixed, predetermined price, when 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 that result from such integration through the arrangement.
- K. "Qualified Arrangement" means a Qualified Clinically-Integrated Joint Arrangement or a Qualified Risk-Sharing 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:

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- 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 with respect to their provision of Physician services:
1. To negotiate on behalf of any Physician with any Payor;
 2. To refuse to deal, or threaten to refuse to deal, with any Payor, in furtherance of any conduct or agreement that is prohibited by any other provision of Paragraph II of this Order;
 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 other than through 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 with a Payor;
- C. Attempting to engage in any action prohibited by Paragraphs II.A or II.B above; and
- D. Encouraging, suggesting, advising, pressuring, inducing, or attempting to induce any Person to engage in any action that would be prohibited by Paragraphs II.A through II.C above.

Provided, however, that nothing in this Paragraph II shall prohibit any agreement or conduct involving Respondent that, subject to the requirements of

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Paragraph IV of this Order, is reasonably necessary to form, Participate in, or take any action in furtherance of, a Qualified Arrangement.

III.

IT IS FURTHER ORDERED that, for three (3) years from the date this Order becomes final, for any arrangement under which Respondent would act as an agent, or as a messenger, on behalf of any Physician or any Medical Group Practice with any Payor regarding contracts, except for those contracts under which Respondent is, or will be, paid on a capitated (per member per month) rate by the Payor, Respondent shall notify the Commission in writing (“Paragraph III Notification”) at least sixty (60) days prior to entering into the arrangement for which Paragraph III Notification is required. The Paragraph III Notification shall include the number of proposed Physician Participants in the proposed arrangement; the proposed geographic area in which the proposed arrangement would 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 proposed arrangement; and a description of procedures to be implemented to limit possible anticompetitive effects of the proposed arrangement, such as those prohibited by this Order.

IV.

IT IS FURTHER ORDERED that:

- A. If, within sixty (60) days from the date of the Commission’s receipt of the Paragraph III Notification, a representative of the Commission makes a written request to the Respondent providing such notification for additional information, then that Respondent shall not participate in the proposed arrangement prior to the expiration of thirty (30) days after substantially complying with such request, or such shorter waiting period as may be granted in writing from the Bureau of Competition;

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- B. 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 the proposed arrangement does or does not violate this Order or any law enforced by the Commission;
- C. The absence of notice that the proposed arrangement has been rejected, regardless of a request for additional information, shall not be construed as a determination by the Commission, or its staff, that the proposed arrangement has been approved;
- D. Receipt by the Commission of any Paragraph III Notification is not to be construed as a determination by the Commission, or its staff, that the proposed arrangement does or does not violate this Order or any law enforced by the Commission; and
- E. Paragraph III Notification shall not be required prior to participating in any arrangement for which Paragraph III Notification has previously been given.

V.

IT IS FURTHER ORDERED that for three (3) years from the date this Order becomes final, pursuant to each Qualified Arrangement in which Respondent is a Participant, except for those contracts under which Respondent is, or will be, paid on a capitated (per member per month) rate by the Payor, (“Paragraph V Arrangement”), Respondent shall notify the Commission in writing (“Paragraph V 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 terms or conditions of dealing with any Payor; or

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- B. 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 or Medical Group Practice in such Arrangement.

VI.**IT IS FURTHER ORDERED** that:

- A. Paragraph V Notification shall include the following information regarding the Qualified Arrangement pursuant to which the Respondent intends to engage in the above identified conduct:
1. the total number of Physicians and the number of Physicians in each specialty participating in the Qualified Arrangement;
 2. a description of the Qualified Arrangement, including its purpose and geographic area of operation;
 3. a description of the nature and extent of the integration and the efficiencies resulting from the Qualified 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 Qualified Arrangement;
 5. a description of any procedures proposed to be implemented to limit possible anticompetitive effects resulting from the Qualified 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 any relevant market, including, but not limited to, the market share of Physician services in any relevant market.

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- B. If, within sixty (60) days from the Commission's receipt of the Paragraph V Notification, a representative of the Commission makes a written request to Respondent for additional information, then Respondent shall not participate in any arrangement described in Paragraph V.A or Paragraph V.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;
- C. 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 the proposed Qualified Arrangement does or does not violate this Order or any law enforced by the Commission;
- D. The absence of notice that the proposed Qualified Arrangement has been rejected, regardless of a request for additional information, shall not be construed as a determination by the Commission, or its staff, that the proposed Qualified Arrangement has been approved;
- E. Receipt by the Commission of any Paragraph V Notification regarding participation pursuant to a proposed Qualified Arrangement is not to be construed as a determination by the Commission that any such proposed Qualified Arrangement does or does not violate this Order or any law enforced by the Commission; and
- F. Paragraph V Notification shall not be required prior to participating in any Qualified Arrangement for which Paragraph V Notification has previously been given.

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VII.

IT IS FURTHER ORDERED that Respondent shall:

- A. Within thirty (30) days from the date on which this Order becomes final:
 - 1. send by first-class mail with delivery confirmation or return receipt requested, or electronic mail with return confirmation, a copy of this Order and the Complaint to:
 - a. every Physician who Participates, or has Participated, in Respondent at any time since January 1, 2001; and
 - b. each current officer, director, manager, and employee of Respondent; and
 - 2. send by first-class mail, return receipt requested, a copy of this Order, the Complaint, and the letter attached as Appendix A to this Order to the chief executive officer of each Payor that has contracted with Respondent for the provision of Physician services at any time since January 1, 2001 regarding contracting for the provision of Physician services, except for those contracts under which Respondent is, or will be, paid a capitated (per member per month) rate by the Payor;
- B. Terminate, without penalty or charge, and in compliance with any applicable laws, any Preexisting Contract with any Payor who is sent the letter required by Paragraph VII.A.2 of this Order, at the earlier of: (1) receipt by Respondent Alta Bates Medical Group, Inc. of a written request to terminate such contract from any Payor that is a party to the contract, or (2) the earliest termination date, renewal date (including any automatic renewal date), or the anniversary date of such contract.

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Provided, however, a Preexisting Contract for Physician services 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 Alta Bates Medical Group, Inc. 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 Alta Bates Medical Group, Inc. 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 Paragraph VII.B of this Order, to terminate the Preexisting Contract at any time.

- C. Within ten (10) days of receiving a written request to terminate from a Payor, pursuant to Paragraph VII.B of this Order, distribute, by first-class mail, return receipt requested, or electronic mail with return confirmation, a copy of that request to each Physician Participating in such contract as of the date that Respondent Alta Bates Medical Group, Inc. receives such request to terminate.
- D. For three (3) years from the date this Order becomes final:
1. Distribute by first-class mail, return receipt requested, or electronic mail with return confirmation, a copy of this Order and the Complaint to:
 - a. each Physician who begins Participating in Respondent, and who did not previously receive a copy of this Order and the Complaint from Respondent, within thirty (30) days of the time that such Participation begins;

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- b. each payor who contracts with Respondent for the provision of Physician services, except for those Payors who contract with Respondent solely for Physician services that are, or will be, paid on a capitated (per member per month) rate by the Payor, and who did not previously receive a copy of this Order and the Complaint from Respondent, within thirty (30) days of the time that such Payor enters into such contract; and
 - c. Each Person who becomes an officer, director, manager, or employee of Respondent, and who did not previously receive a copy of this Order and the Complaint from Respondent, within thirty (30) days of the time that he or she assumes such position with Respondent; and
 - 2. Annually publish in an official annual report or newsletter and/or on the physician-access portion of Respondent's website, a copy of this Order and the Complaint with such prominence as is given to regularly featured articles, and send the report or newsletter to, or notify by electronic mail that such report or newsletter is published on the website, all Physicians who participate in Respondent.
- E. File verified written reports within sixty (60) days from the date this Order becomes final, annually thereafter for three (3) years on the anniversary of the date this Order becomes final, and at such other times as the Commission may by written notice require. Each report shall include:
- 1. a detailed description of the manner and form in which the Respondent has complied and is complying with this Order;
 - 2. the name, address, and telephone number of each Payor with which the Respondent has had any contact, during the one (1) year period preceding the date for filing such report, except for Payors

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whose sole contacts with Respondent relate to contracts under which Respondent is, or will be, paid a capitated (per member per month) rate by the Payor;

3. The identity of each Payor sent a copy of the letter attached as Appendix A, the response of each Payor to that letter, and the status of each contract to be terminated pursuant to that letter; and
4. copies of the delivery confirmations, signed return receipts, or electronic mail with return confirmations required by Paragraph VII.A.I, and copies of the signed return receipts required by Paragraphs VII.A.2, VII.C, and VII.D.

VIII.

IT IS FURTHER ORDERED that Respondent shall notify the Commission:

- A. of any change in its Principal Address within twenty (20) days of such change in address; and
- B. 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 including, but not limited to, assignment and the creation or dissolution of subsidiaries, if such change might affect compliance obligations arising out of this Order.

IX.

IT IS FURTHER ORDERED that, for the purpose of determining or securing compliance with this Order, and subject to any legally recognized privilege, and upon written request and upon five (5) days notice to Respondent, Respondent shall, without restraint or interference, permit any duly authorized representative of the Commission:

Decision and Order

- A. Access, during office hours of Respondent, and in the presence of counsel, to all facilities and access to inspect and copy all books, ledgers, accounts, correspondence, memoranda, and all other records and documents in the possession, or under the control, of Respondent relating to compliance with this Order, which copying services shall be provided by Respondent at its expense; and
- B. To interview officers, directors, or employees of Respondent, who may have counsel present, regarding such matters.

X.

IT IS FURTHER ORDERED that this Order shall terminate on July 10, 2029.

By the Commission.

Decision and Order

Appendix A

[Respondent's letterhead]

[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 Alta Bates Medical Group, Inc.

Pursuant to Paragraph V.B of the Order, Alta Bates Medical Group, Inc. must allow you to terminate, upon your written request without any penalty or charge, any contracts with Alta Bates Medical Group, Inc. for the provision of physician services 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 your contract, the contract will terminate at the earlier of [date one year from the date the Order becomes final] or its earliest termination or renewal date (including any automatic renewal date). If the termination or renewal date occurs prior to [date one year from the date the Order becomes final], you may request Alta Bates Medical Group, Inc. to extend that date to a date no later than [date one year from the date the Order becomes final]. If you choose to extend the term of the contract, you may nevertheless still terminate the contract at any time.

Sincerely,

[Alta Bates Medical Group, Inc. to fill in information in brackets]

Analysis to Aid Public Comment

ANALYSIS OF CONSENT ORDER TO AID PUBLIC COMMENT

The Federal Trade Commission has accepted, subject to final approval, an agreement containing a proposed Consent Order with Alta Bates Medical Group, Inc., (“ABMG” or “Respondent”). The agreement settles charges that ABMG violated Section 5 of the Federal Trade Commission Act, 15 U.S.C. § 45, by fixing prices charged to those offering coverage for health care services (“payors”) in the Berkeley and Oakland, California, area and refusing to deal with payors except on a collectively determined basis. 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 Consent Order final.

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

Alta Bates Medical Group, Inc.

ABMG is a multi-specialty independent practice association (“IPA”) comprised of multiple, independent medical practices serving the Berkeley and Oakland, California area. It has a total of approximately 600 physician members, of which approximately 200 are devoted to primary care. Since its formation, ABMG has negotiated group contracts with payors under which it receives capitated (per member per month) payments. These contracts shift the risk of patient illness to the IPA by specifying that the health plan will pay the IPA a flat monthly fee for each enrollee, with almost no regard for patient utilization. This type of contracting is a form of financial integration, so for antitrust purposes, the IPA is treated as a single

Analysis to Aid Public Comment

entity for purposes of these contract negotiations, and not as a group of competing physicians. The complaint does not challenge ABMG's activities concerning these contracts.

ABMG, however, also contracts on behalf of its member physicians with health plans to provide fee-for-service medical care. Under these arrangements, the payor compensates physicians or group practices for services actually rendered pursuant to agreed-upon fee schedules. In the absence of financial risk-sharing or clinical integration on the part of providers, the IPA members are competitors for purposes of antitrust analysis. It is ABMG's negotiation of fee-for-service contracts that is the subject of the allegations in the Commission's Complaint.

The Complaint

Since at least 2001, ABMG, acting as a combination of its physician members, and in conspiracy with its members, has acted to restrain competition with respect to fee-for-service contracts 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 ABMG members refrain from negotiating individually with payors or contracting on terms other than those approved by ABMG. This type of collective conduct by competitors is inherently suspect under the antitrust laws.

At times, however, IPAs will act as a conduit between physician members and health plans regarding fee-for-service contracts to facilitate the contracting process. Under this model, the IPA merely acts as a messenger and does not negotiate the terms of the contract.

Although claiming to employ a lawful messenger arrangement, ABMG, on behalf of its physician members, instead orchestrated collective negotiations for fee-for-service contracts. Specific acts by ABMG that are alleged in the complaint are: making proposals and counter-proposals, as well as accepting or rejecting offers, without consulting with its individual physician members regarding the prices they unilaterally would accept, and

Analysis to Aid Public Comment

without transmitting the payors' offers to its individual physician members until ABMG had approved the negotiated prices.

The complaint also alleged a concerted refusal to deal intended to impede competition by one of ABMG's major competitors, the Permanente Medical Group, which provides physician services exclusively to Kaiser Foundation Health Plan, Inc. In 2006, Kaiser¹ was expanding a fee-for-service product, under which covered individuals could access physician services through a national third-party network that included ABMG physicians. This expansion by Kaiser threatened ultimately to reduce ABMG's business under its capitated contracts, by giving Kaiser the ability to offer employers both a capitated and fee-for-service health plan option. To impede this expansion, ABMG attempted a concerted refusal to serve Kaiser fee-for-service enrollees. Although ABMG's refusal to deal was ultimately unsuccessful, the sole purpose of this action was to impede competition in the provision of physician services in and around Berkeley and Oakland, California.

ABMG did not engage in any activity that might justify collective agreements on the prices its members would accept for their services. For example, the physicians in ABMG have not clinically or financially integrated their practices to create efficiencies sufficient to justify their acts and practices. As a consequence, the Respondent's actions have restrained price and other forms of competition among physicians in the Berkeley and Oakland, California, area and thereby harmed consumers (including health plans, employers, and individual consumers) by increasing the prices for physician services.

The Proposed Consent Order

The proposed Consent Order is designed to prevent the continuance and recurrence of the illegal conduct alleged in the complaint while it allows ABMG to engage in legitimate, joint conduct. The proposed Consent Order does not affect ABMG's activities in contracting with the payors on a capitated basis.

¹ Kaiser is a trade name for an association of three entities: Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Hospitals; and the Permanente Medical Groups.

Analysis to Aid Public Comment

Paragraph II.A prohibits Respondent from entering into or facilitating any agreement between or among any health care providers: (1) to negotiate on behalf of any physician with any payor; (2) to 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 other than through ABMG.

The other parts of Paragraph II reinforce these general prohibitions. Paragraph II.B prohibits the Respondent from facilitating exchanges of information between health care providers 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 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.

As in other Commission orders addressing health care providers' collective bargaining with health care payors, certain kinds of agreements are excluded from the general bar on joint negotiations. Paragraph II does not preclude ABMG from engaging in conduct that is reasonably necessary to form or participate in legitimate "qualified risk-sharing" or "qualified clinically-integrated" joint arrangements, as defined in the proposed Consent Order. Also, Paragraph II would not bar agreements that only involve physicians who are part of the same medical group practice, defined in Paragraph I.B, because it is intended to reach agreements between and among independent competitors.

Paragraphs III through VI require ABMG to notify the Commission before it initiates certain contacts regarding contracts with payors. Paragraphs III and IV apply to arrangements under which ABMG would be acting as a messenger on behalf of its member physicians. Paragraphs V and VI discuss arrangements under which ABMG plans to achieve financial or clinical integration.

Analysis to Aid Public Comment

Paragraph VII.A requires ABMG to send a copy of the Complaint and Consent Order to its physician members, its management and staff, and any payors who communicated with ABMG, or with whom ABMG communicated, with regard to any interest in contracting for physician services, at any time since January 1, 2001.

Paragraph VII.B requires ABMG to terminate, without penalty, pre-existing payer contracts that it had entered into since 2001, at the earlier of (1) receipt by ABMG of a written request for termination by the payer; or (2) the termination date, renewal date, or anniversary date of the contract. This provision is intended to eliminate the effects of ABMG's illegal collective behavior. The payer can delay the termination for up to one year by making a written request to ABMG.

Paragraph VII.D contains three-year notification provisions relating to future contact with physicians, payors, management and staff. This provision requires ABMG to distribute a copy of the Complaint and Consent Order to each physician who begins participating in ABMG; each payor who contacts ABMG regarding the provision of physician services; and each person who becomes an officer, director, manager, or employee for five years after the date on which the Consent Order becomes final. In addition, Paragraph VII.D requires ABMG to publish a copy of the Complaint and Consent Order, annually, in any official publication that it sends to its participating physicians.

Paragraphs VII.E and VIII-IX impose various obligations on ABMG to report or to provide access to information to the Commission to facilitate monitoring its compliance with the Consent Order.

Pursuant to Paragraph X, the proposed Consent Order will expire in 20 years from the date it is issued.

Complaint

IN THE MATTER OF

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

Docket No. C-4261; File No. 082 3188
Complaint, July 13, 2009 - Decision, July 13, 2009

This consent order addresses Tender Corporation's marketing and sale of "Fresh Bath" brand moist hand and body wipes. The complaint alleges that respondent violated Section 5 of the FTC Act by making false and misleading representations that its products and packaging were "biodegradable," when in fact, customary disposal methods do not allow for respondent's products or packaging to break down completely and return to nature. The complaint further alleges that respondent failed to substantiate its "biodegradable" claim. The consent order prohibits respondent from engaging in similar acts and practices by prohibiting respondent from making representations its products are biodegradable or environmentally beneficial unless substantiated by competent and reliable scientific evidence. Additionally, the order requires respondent to specify whether its biodegradability claim applies to the product, package, or components and to keep copies of relevant advertisements and their materials substantiating the claim.

Participants

For the *Commission*: Michael J. Davis and Laura Schneider.

For the *Respondents*: Rebecca Dandeker and Lawrence Lanpher, K&L Gates.

COMPLAINT

The Federal Trade Commission, having reason to believe that Tender Corporation ("respondent"), has violated provisions of the Federal Trade Commission Act, 15 U.S.C. § 41 *et seq.*, and it appearing to the Commission that this proceeding is in the public interest, alleges:

1. Respondent Tender Corporation is a Delaware corporation with its principal office or place of business at 106 Burndy Road, Littleton, New Hampshire 03561.