ANALYSIS OF AGREEMENT CONTAINING
CONSENT ORDER TO AID PUBLIC COMMENT
In the Matter of Advocate Health Partners, et al., File No. 031 0021

The Federal Trade Commission has accepted, subject to final approval, an agreement containing a proposed consent order with Advocate Health Partners ("AHP") and other related parties. The agreement settles charges that the proposed respondents violated Section 5 of the Federal Trade Commission Act, 15 U.S.C. § 45, by orchestrating, implementing, and participating in agreements among physician practices to fix prices and other terms on which they would deal with health plans and to refuse to deal with certain health plans 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 the proposed respondents that they 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.

AHP is a "super physician-hospital organization" whose members consist of the non-profit Advocate Health Care Network ("AHCN") hospital system and eight physician-hospital organizations organized at each of the AHCN hospital sites (the "PHO Respondents"). Each PHO Respondent, in turn, consists of a hospital member (a non-profit subsidiary of AHCN) and a portion of physicians on staff at the hospital. Approximately 2,600 independently practicing physicians in the Chicago metropolitan area belong to the PHO Respondents. In addition, two AHCN for-profit subsidiaries named in the complaint (the "Advocate System Respondents") contract with health plans, often through AHP, to provide the services of approximately 300 physicians who are employed by or under contract to provide services exclusively to the Advocate System Respondents.

The complaint challenges conduct during the period 1995 to 2004, during which the respondents negotiated the prices and other terms at which their otherwise competing member physicians would provide services to the subscribers of health plans without any efficiency-enhancing integration of their practices sufficient to justify their conduct. Between 1995 and 2001, AHP staff negotiated contracts on behalf of each PHO Respondent, with each

PHO Respondent retaining authority to approve offers and counteroffers. Ultimately, each PHO Respondent would approve a negotiated contract on behalf of its member physicians, who could then opt in or opt out of the negotiated contract. In 2001, the respondents centralized contract approval at the super-PHO level. AHP staff continued to negotiate contracts, but AHP (rather than each PHO Respondent) had the authority to approve offers and counteroffers and, ultimately, to approve negotiated contracts on behalf of the AHP physicians, who could then opt in or opt out of the negotiated contract. At various times, the Advocate System Respondents participated in these collective negotiations by utilizing AHP to negotiate on their behalf, jointly with AHP's independent physicians. Under both approaches, AHP acted as the collective bargaining agent for physician practices that would otherwise compete.

By 2002, AHP had served as the collective bargaining agent for member physicians in numerous contracts with health plans. Blue Cross Blue Shield of Illinois, however, was one of a few payors that had not contracted with AHP. Instead, Blue Cross contracted directly with the vast majority of AHP physicians. In early 2002, AHP began developing a strategy to force Blue Cross to replace those individual contracts with a group AHP contract, at higher rates than Blue Cross was paying AHP physicians under their individual contracts.

To carry out its strategy to increase the prices Blue Cross paid to AHP physicians, AHP requested that all of its physicians submit what it termed "Agency Agreements," which authorized AHP to terminate the physicians' existing individual contracts with Blue Cross, and to collectively negotiate new contract terms on their behalf. In seeking this authority, AHP reminded its physicians that "[a] major part" of the value AHP offers "has been your access to the favorable rates negotiated by AHP for many of your fee-for-service managed care contracts." Moreover, AHP's President instructed AHP staff to warn physicians attempting to rescind their Agency Agreement that "if they rescind there is no hope of getting increases going forward and it will impact everyone's ability to get increases from other payors as [other payors] won't be able to compete [with Blue Cross]." AHP obtained signed Agency Agreements from approximately 1,700 physicians and, on October 1, 2002, terminated the physicians' individual contracts with Blue Cross, effective January 1, 2003.

AHP ultimately abandoned its plan to coerce Blue Cross to negotiate a group contract on price terms set by AHP, but only after Blue Cross sued AHP for violating the antitrust laws and agreed to make certain payments to AHP as part of the settlement of that dispute. Although Blue Cross's payments to AHP were supposed to be used by AHP to "encourage outcome-based reimbursement" and to support efforts to implement electronic-claim-submission capabilities for all AHP physicians, in fact AHP distributed the money only to physicians that had collectively threatened not to deal with Blue Cross.

The complaint also discusses AHP's dealings with United Healthcare of Illinois, Inc. in 2001, as an example of AHP's collective bargaining on behalf of its member physicians. In order to establish a minimum acceptable rate for the United negotiations, AHP obtained input from each PHO Respondent's Board of Directors and established a single benchmark for the entire

group that was higher than the minimum rate that some PHO Respondent's Boards were willing to accept. Ten days after United failed to agree to AHP's benchmark price for physician services, AHP terminated United's contracts not only with the AHP physicians, but also with the AHCN hospitals. After United attempted to enter into direct contracts with AHP physicians, AHP threatened that United would be unable to contract for AHCN hospital services unless United agreed to a group contract for AHP physician services. United ultimately agreed to a group contract containing fees for physician services that were 20 to 30 percent higher than United's direct contracts with individual physicians in the Chicago area.

As the complaint alleges, the respondents engaged in no efficiency-enhancing integration sufficient to justify the conduct challenged in the complaint. Accordingly, the complaint alleges that they violated Section 5 of the FTC Act.

The Proposed Consent Order

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

The proposed order's specific provisions are as follows:

Paragraph II.A. prohibits the respondents from entering into or facilitating any agreement between or among any physicians: (1) to negotiate with payors on any physician's behalf; (2) to deal, not to deal, or threaten not to deal with payors; (3) on what terms to deal with any payor; or (4) not to deal individually with any payor, or to deal with any payor only through an arrangement involving the respondents.

Other parts of Paragraph II. reinforce these general prohibitions. Paragraph II.B. prohibits the respondents 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 the respondents 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, Paragraph II excludes certain kinds of agreements from its prohibitions. First, the respondents are not 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, for three years, restrict the ability of, or facilitate the refusal of, physicians who participate in it to contract with payors outside of the arrangement.

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

A "qualified clinically-integrated joint arrangement," on the other hand, need not involve any sharing of financial risk. Instead, as defined in the proposed order, physician participants must participate in active and ongoing programs to evaluate and modify their clinical practice patterns in order to control costs and ensure the quality of services provided, and the arrangement must create a high degree of interdependence and cooperation among physicians. As with qualified risk-sharing arrangements, any agreement concerning price or other terms of dealing must be reasonably necessary to achieve the efficiency goals of the joint arrangement.

Second, the respondents are not precluded by Paragraph II. from engaging in conduct that solely involves the Advocate System Respondents, which are subsidiaries of the AHCN hospital system, and other physicians employed by AHCN because they are all part of a single entity.

Finally, the order does not prohibit the respondents from engaging in conduct solely related to their participation in a program that AHP refers to as its "Clinical Integration Program" (the "Program"). The complaint does not allege a violation of the FTC Act with respect to that conduct, and the Commission has made no determination with respect to its legality. The order, while not prohibiting conduct related to the Program, ensures that the illegal conduct charged in the complaint does not continue or recur. In addition, Paragraph VI.D. provides certain mechanisms designed to allow the Commission to monitor the further development, implementation, and results of the Program. The Commission retains the ability to challenge conduct related to the Program if it later determines that such a challenge is warranted and would be in the public interest.

Paragraph III., for three years, requires the respondents 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 the respondents 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 AHP and health plans. Paragraph IV. also sets out the information necessary to satisfy the notification requirement.

Paragraph V. imposes certain notification obligations on AHP and requires the termination of contracts that were entered into illegally. Paragraphs V.A. and V.D. require AHP to distribute the complaint and order to (1) physicians who have participated in AHP and the PHO Respondents in the past or who do so within the next three years; (2) to various past and future personnel of the respondents and AHCN subsidiaries that offer physician services to payors; and (3) to payors with whom the respondents have dealt in the past or deal with in the next three years. Paragraph V.B. requires AHP, at any payor's request and without penalty, or, at the latest, within one year after the order is made final, to terminate its existing contracts for the provision of physician services to payors, other than those contracts covering the program which AHP refers to as its Clinical Integration Program. Paragraph V.B. also allows any such contract currently in effect to be extended, upon mutual consent of AHP 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.C. requires AHP to distribute payor requests for contract termination to physicians who participate in the respondents. Paragraph V.E. requires AHP to notify the Commission of certain organizational changes to any respondent or other changes that may affect compliance with the order.

Paragraphs VI., VIII., and IX. impose various obligations on the respondents to report or provide access to information to the Commission to facilitate the monitoring of compliance with the order. Because Paragraphs V. and VI. impose on AHP, in the first instance, obligations to provide notice and reporting on behalf of all respondents, Paragraph VII. requires that any respondents for which AHP has not acted fulfill those obligations.

Finally, Paragraph X. provides that the order will expire in 20 years.