ANALYSIS OF AGREEMENT CONTAINING
CONSENT ORDER TO AID PUBLIC COMMENT
In the Matter of Memorial Hermann Health Network Providers
File No. 031 0001

The Federal Trade Commission has accepted, subject to final approval, an agreement containing a proposed consent order with Memorial Hermann Health Network Providers ("Respondent" or "MHHNP"). The agreement settles charges that Respondent violated Section 5 of the Federal Trade Commission Act, 15 U.S.C. § 45, by facilitating and implementing agreements among MHHNP members on price and other competitively significant terms; refusing to deal with payors except on collectively agreed-upon terms; and negotiating uniform fees and other competitively significant terms in payor contracts and refusing to submit to members payor offers that do not conform to Respondent's standards for contracts.

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 Respondent that it violated the law or that the facts alleged in the complaint (other than jurisdictional facts) are true. The allegations in the Commission's proposed complaint are summarized below.

The Complaint

Respondent MHHNP is a nonprofit corporation that contracts with third-party payors for the provision of medical services on behalf of its approximately 3,000 participating physicians. MHHNP is organized and operated to further the pecuniary interests of those physicians, who are licensed to practice medicine in the State of Texas and who are engaged in the business of providing medical services to patients in the Houston metropolitan area (hereinafter "Houston area").

Physicians often contract with third-party payors, such as insurance companies and preferred provider organizations. The contracts typically establish the price and other terms under which the physicians will render services to the payors' subscribers. Contracting physicians often agree to accept lower-than-customary compensation from these third-party payors to gain access to additional patients through the payor. Thus, these contracts may reduce payor costs, and may result in lower medical care costs to the payor's subscribers.

Absent agreements among competing physicians, each competing physician decides for him or herself whether, and on what price and other terms, the physician will contract with third-party payors to provide medical services to the payors' subscribers. To be competitively marketable in the Houston area, a payor must include in its physician network a large number of primary care physicians (PCPs) and specialists who practice in the Houston area. Many of the

PCPs and specialists who practice in the Houston area are members of MHHNP. Accordingly, many payors concluded that they could not establish a viable physician network in areas in which MHHNP physicians are concentrated without including a large number of MHHNP physicians in that network.

Sometimes a network of competing physicians uses an agent to convey to payors information, obtained from each of its participating physicians individually, about fees and other significant contract terms that the physicians are willing to accept. In other instances, the agent may convey all payor contract offers to network physicians, with each physician then unilaterally deciding whether to accept or reject each offer. These "messenger model" arrangements, which are 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 (see http://www.ftc.gov/reports/hlth3s.htm), can facilitate contracting between physicians and payors and minimize the costs of providing medical care, without fostering agreements among competing physicians on fees and other competitively sensitive terms. The messenger may not, consistent with the competitive model, negotiate fees and other competitively significant terms on behalf of the participating physicians, nor facilitate the physicians' coordinated responses to contract offers, for example, by electing not to convey a payor's offer to the physicians based on the messenger's opinion of the acceptability or appropriateness of the offer.

Rather than acting simply as a "messenger," MHHNP engaged in collective negotiations on its members' behalf with third party payors. MHHNP's improper collective negotiations included actively bargaining with third-party payors by proposing and counter-proposing fee schedules (among other terms), gathering fee information from its members and using that information to negotiate prices, refusing to messenger proposals it deemed unacceptable on price and other terms, and, to maintain its bargaining power, on occasion discouraging its participating physicians from entering into unilateral agreements with third-party payors. For example, MHHNP periodically polled its physician members, asking each to disclose the minimum fee that he or she would accept in return for providing medical services pursuant to future MHHNP-payor agreements. MHHNP would then calculate minimum acceptable fees for use in payor negotiations, based in part on the information received from physician members concerning their future pricing intentions, and would often begin discussions regarding a possible contract for physician services by informing the payor of these minimum fees, and stating that it would not enter into or otherwise forward to its physician members any payor offer that did not satisfy those fee minimums.

In the course of its collective price negotiations with payors, MHHNP in fact often did not convey to its physician members payor offers that provided for fees that did not satisfy MHHNP's Board of Directors. MHHNP instead demanded, and often received, more favorable fee and other contract terms–terms that third-party payors would not have offered to MHHNP's participating physicians had those physicians engaged in unilateral, rather than collective, negotiations with the payors. Only after the third-party payor acceded to fee and other contract terms acceptable to MHHNP, would MHHNP convey the payor's proposed contract to MHHNP's participating physicians for their consideration. For example, in one instance

MHHNP refused a payor's request to messenger an offer MHHNP's Board deemed unacceptable. Instead, MHHNP notified its members that it had rejected the offer because it was below the minimum acceptable fee level previously set pursuant to physician member surveys, and then "polled" its members to determine whether or not they agreed with the Board's decision to reject the offer. A majority of physician members voted to agree with the Board's decision, and MHHNP then again rejected the payor's offer and explicitly refused to forward the offer to any of its physician members. Subsequently, the payor increased its proposed fees to the MHHNP fee minimums, and MHHNP then entered into a contract with the payor and messengered the agreement to its physician members, affording them the option to participate (or not) in the payor's offer.

Since the end of 2000, MHHNP and its members have entered only into fee-for-service agreements with payors, pursuant to which MHHNP and its members did not undertake financial risk-sharing. Further, MHHNP members have not integrated their practices to create significant potential efficiencies. MHHNP's joint negotiation of fees and other competitively significant terms has not been, and is not, reasonably related to any efficiency-enhancing integration. Instead, MHHNP's acts and practices have restrained trade unreasonably and hindered competition in the provision of physician services in the Houston area in the following ways, among others: price and other forms of competition among MHHNP's members were unreasonably restrained; prices for physician services were increased; and health plans, employers, and individual consumers were deprived of the benefits of competition among physicians. Thus, MHHNP's conduct has harmed patients and other purchasers of medical services by restricting choice of providers and increasing the price of medical services.

The Proposed Consent Order

The proposed consent order is designed to prevent recurrence of the illegal concerted actions alleged in the complaint while allowing Respondent and its members to engage in legitimate joint conduct.

Paragraph II.A prohibits Respondent from entering into or facilitating agreements among 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 upon which any physicians deal, or are willing to deal, with any payor; and (4) not to deal individually with any payor or through any arrangement other than MHHNP.

Paragraph II.B prohibits Respondent from exchanging or facilitating the 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.

Paragraph II.C prohibits Respondent from attempting to engage in any action prohibited by Paragraph II.A or II.B. Paragraph II.D prohibits Respondent from encouraging, pressuring, inducing, or attempting to induce any person to engage in any action that would be prohibited by Paragraphs II.A through II.C. Paragraph II contains a proviso that allows Respondent to engage in conduct that is reasonably necessary to the formation or operation of a "qualified risk-sharing joint arrangement" or a "qualified clinically-integrated joint arrangement," or that solely involves physicians in the same medical group practice.

Paragraph III requires MHHNP, for a period of three years after the order becomes final, to notify the Commission at least 60 days prior to entering into any arrangement under which MHHNP will act as a messenger or agent on behalf of physicians with payors regarding contracts. This provision will allow the Commission to review any future MHHNP policy or practice that MHHNP plans to implement with payors before such a policy or practice is implemented with respect to any particular payor.

Paragraphs IV.A and IV. B require MHHNP to distribute the complaint and order to its members, payors with which it previously contracted, and specified others. Paragraph IV.C requires MHHNP to terminate, without penalty, any payor contracts that it had entered into during the collusive period, at any such payor's request. This provision is intended to eliminate the effects of Respondent's joint price setting. Paragraph IV.C also contains a proviso to preserve payor contract provisions defining post-termination obligations relating to continuity of care during a previously begun course of treatment.

The remaining provisions of the proposed order impose complaint and order distribution, reporting, and other compliance-related provisions. For example, Paragraph IV. D requires MHHNP to distribute copies of the Complaint and Order to incoming MHHNP members, payors that contract with MHHNP for the provision of physician services, and incoming MHHNP officers, directors, and employees. Further, Paragraph V requires MHHNP to file periodic reports with the Commission detailing how MHHNP has complied with the Order. Paragraph VII authorizes Commission staff to obtain access to Respondent's records and officers, directors, and employees for the purpose of determining or securing compliance with the Order. The proposed order will expire in 20 years.