Analysis of Agreement Containing
Consent Order to Aid Public Comment
In the Matter of Preferred Health Services, Inc.
File No. 041 0099

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

Preferred Health is a physician-hospital organization consisting of over 100 physicians and Oconee Memorial Hospital. Preferred Health does business in the Seneca, South Carolina, area, which is located in northwestern South Carolina. Preferred Health acts as a "contracting representative" for its physician members in negotiations with health plans, and a "collective bargaining unit for the negotiation of managed care contracts."

Preferred Health's physician members account for approximately 70% of the physicians independently practicing (that is, those not employed by area hospitals) in and around the Seneca area. To be marketable in the Seneca area, a health plan must have access to a large number of physicians who are members of Preferred Health.

Although Preferred 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. In contract negotiations with payors, Preferred Health uses a physician fee schedule created by its Executive Director and approved by its Board of Directors. Preferred Health's membership agreement automatically binds physician members to contracts using the Preferred Health fee schedule. Whenever a health plan rejects the Preferred Health fee schedule, Preferred Health's Executive Director negotiates, under the Board's direction, a contract with a "comparable" fee schedule. The Executive Director transmits these contracts to the Board, and then to the physician members if the Board approves it. If a contract contains a Board-approved "comparable" fee schedule, physician members have 30 days to reject the contract. The only recourse available to a physician member who rejects a contract with a "comparable" fee schedule is to terminate his or her membership in Preferred Health.

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

---

[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.

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

Paragraph II.E contains certain additional "fencing-in" relief, which is imposed for three years. Under this provision, Preferred Health may not, in connection with physician health plan contracting, either (1) act as an agent for any physicians; or (2) use an agent with respect to contracting. Such relief, designed to assure that Preferred Health does not seek to use other arrangements to continue the challenged conduct, is warranted in light of the complaint charges that Preferred Health engaged in overt price-fixing behavior, and its assertion that its conduct was legitimate "messengering" of health plan contract offers.

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

Paragraph IV, for three years after the bar on messengering ends, requires Preferred 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 IV also sets out the information necessary to make the notification complete.

Paragraph V requires Preferred Health to distribute the complaint and order to all physicians who have participated in Preferred Health, and to payors that negotiated contracts with Preferred Health or indicated an interest in contracting with Preferred Health. Paragraph V.C requires Preferred Health, at any payor's request and without penalty, or within one year after the Order is made final, to terminate its current contracts with respect to providing physician services. Paragraph V.D requires Preferred Health to distribute payor requests for contract termination to all physicians who participate in Preferred Health. Paragraph V.E.1.b requires Preferred Health to distribute the complaint and order to any payors that negotiate contracts with Preferred Health in the next three years.

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

The proposed order will expire in 20 years.