UNITED STATES OF AMERICA
BEFORE FEDERAL TRADE COMMISSION

COMMISSIONERS: **Deborah Platt Majoras, Chairman**
Orson Swindle
Thomas B. Leary
Pamela Jones Harbour
Jon Leibowitz

In the Matter of	)	
	)	**Docket No. C-**
PREFERRED HEALTH SERVICES, INC., a corporation.	)	

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 Preferred Health Services, Inc. ("Preferred 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 horizontal agreements among competing physicians in the Seneca, South Carolina, area to fix prices charged to health care plans and other third-party payors ("payors"), and to refuse to deal with payors except on collectively agreed upon terms. These physicians, who constitute most of the physicians in the Seneca area, orchestrated these price-fixing agreements and refusals to deal through the Respondent.

RESPONDENT

2. Preferred Health, a physician-hospital organization ("PHO"), is a not-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 301 Memorial Drive, Suite E, Seneca, South Carolina 29672. Preferred Health was formed in 1996, and consists of a non-profit hospital (Oconee Memorial Hospital) and over 100 physicians. Preferred Health's eight-member Board

of Directors ("Board") consists of four physician members elected by the entire physician membership, and four representatives of the hospital. The Chair and Vice-Chair of the Board are both physicians.

THE FTC HAS JURISDICTION OVER RESPONDENT

3. At all times relevant to this Complaint, Preferred Health has been engaged in the business of contracting with payors, on behalf of Preferred Health's members, for the provision of health care services to persons for a fee.

4. Except to the extent that competition has been restrained as alleged herein, Preferred Health physician members have been, and are now, in competition with each other for the provision of physician services in the Seneca, South Carolina, area to persons for a fee.

5. Preferred Health was founded in 1996. Its physician members and Oconee Memorial Hospital control Preferred Health. It carries on business for the pecuniary benefit of its physician members. Accordingly, Preferred Health is a corporation within the meaning of Section 4 of the Federal Trade Commission Act, as amended, 15 U.S.C. § 44.

6. Preferred Health's general business practices, including the acts and practices herein alleged, are in or affecting "commerce" as defined in the Federal Trade Commission Act, as amended, 15 U.S.C. § 44.

OVERVIEW OF REGION AND PHYSICIAN CONTRACTING WITH PAYORS

7. Seneca, located in Oconee County, is in northwest South Carolina. The closest major cities to Seneca are Greenville, South Carolina, approximately 50 miles to the east; Spartanburg, South Carolina, approximately 75 miles to the northeast; Asheville, North Carolina, approximately 100 miles to the north; and Atlanta, Georgia, approximately 120 miles to the southwest.

8. Preferred Health's physician members are licensed to practice allopathic or osteopathic medicine in the State of South Carolina. Preferred Health's physician members account for approximately 70% of the physicians who independently practice in the Seneca area. To be marketable in the Seneca area, a payor's health insurance plan must have access to a large number of physicians who are members of Preferred Health.

9. Physicians contract with payors to establish the terms and conditions, including price terms, under which they render services to the subscribers to the payors' health insurance 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. Competing physicians, absent agreements among them on the terms, including price, on which they will provide services to

insureds, decide individually whether to enter into payor contracts to provide services to insureds, and what prices they will accept pursuant to such contracts.

10. 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. Legitimate 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 counter-offer. At less cost, payors can thus discern physician willingness to contract at particular prices, and assemble networks, while physicians can market themselves to payors and assess contracting opportunities. 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.

11. The Medicare Resource Based Relative Value Scale ("RBRVS") is a system used by the Centers for Medicare and Medicaid Services ("CMS") 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").

PREFERRED HEALTH NEGOTIATED PAYOR CONTRACTS ON BEHALF OF ITS MEMBER PHYSICIANS

12. Preferred Health refers to itself as the "contracting representative" for its members in negotiations with payors. It touts itself to its physician members as a "collective bargaining unit for the negotiation of managed care contracts." To further collective negotiations of payor contracts on behalf of physician members, Preferred Health's Executive Director created, and the Board approved, a fee schedule, with fees for some procedures as high as 300% of 2000 RBRVS. Preferred Health negotiates with payors for payment terms under this fee schedule.

13. Physician members of Preferred Health participate in Preferred Health's payor contracts by entering into a "Physician Participation Agreement" with Preferred Health. The Physician Participation Agreement automatically binds a physician member of Preferred Health to payor contracts that incorporate "the [Preferred Health] fee schedule." If a contract uses "a Payor's fee schedule that is at a comparable level to the [Preferred Health] fee schedule," then the physician member will be given notice of the "comparable" fee schedule and be automatically bound to accept the contract unless he or she rejects it within 30 days. A physician member who rejects such a contract is expected to terminate his or her participation in Preferred Health.

14. When payors reject the Preferred Health fee schedule, Preferred Health's Executive Director, under the Board's direction, negotiates "comparable" fee schedules. During

negotiations with such payors, the Executive Director transmits payor offers to the Board, which then votes on whether to approve a proposed payor contract, including the fee schedule. Only if the Board approves a contract does the Executive Director transmit it to Preferred Health physicians for their acceptance.

15. Preferred Health physician members have agreed with each other and with Preferred Health not to deal individually, or through any organization besides Preferred Health, with any payor with which Preferred Health is attempting to negotiate a contract for physician services. Physician members, at Preferred Health's urging, refuse payor offers made to them individually. This hinders payor efforts to establish competitive physician networks in the Seneca area. Due to Preferred Health's large share of Seneca area physicians and demand for collective negotiation, payors have repeatedly acceded to Preferred Health's price demands.

16. At an August 2002 Board meeting, Preferred Health's Executive Director stated that "there are two kinds of PHOs: (1) **Risk -** where you negotiate and sign on behalf of all the members and (2) **Messenger -** the model we use - no risk involved - a collective bargaining voice" (emphasis in original). Preferred Health repeatedly operated according to this illegitimate, non-risk, concerted contracting method, and unlawfully negotiated payor contracts on the collective behalf of its physician members.

CONTRACT NEGOTIATIONS WITH UNITED HEALTHCARE

17. United Healthcare of South Carolina, Inc. ("United"), is a payor doing business in the Seneca area. United had accessed Preferred Health physician members by contracting with a third party administrator that had contracts with Preferred Health for physician services. United could not obtain a contract directly with Preferred Health because United would not agree to Preferred Health's high prices. In late 2001, United attempted to contract directly with individual Preferred Health physician members and also initiated contract discussions with Preferred Health, offering prices for most procedures at 106% or 108% of 2001 RBRVS. The prices for most procedures on the Preferred Health fee schedule were approximately 10% to 165% higher than United's proposal on prices. Preferred Health discouraged its members from contracting unilaterally with United, by sending a memorandum to the entire membership, asking the physicians to "hold off on doing anything with United Health Care until we can complete our discussions."

18. In January 2002, Preferred Health informed its members that contract discussions with United were unsuccessful, because United "showed little interest in meeting the criteria we require of all payors." A month later, the Board formally rejected United's offer, stating that United's payment terms were "very low." Preferred Health has repeatedly rejected subsequent United contract offers, for the same reason. Preferred Health told United that it "needed better rates in order to move forward" and told its physician members that the "United fee schedule is way off." United also was unsuccessful in contracting directly with Preferred Health physician members after the physicians received Preferred Health's criticisms of United's payment terms.

19. In April 2003, United asked Preferred Health to transmit to its physician members a contract proposal containing rates ranging from 75% to 185% of 2002 RBRVS. The Preferred Health fee schedule included higher prices for almost all procedures – typically in the range of 10% to 30% higher. Preferred Health responded that it could not transmit the United offer "without a Board vote," and informed United that "if you want to mail [direct contracts] now, the [Preferred Health member] offices will just call us and we'll tell them to hold on until [the Board members] meet and vote." Preferred Health also informed United that if the Preferred Health Board voted not to contract with United, then Preferred Health "would not do any form of negotiation."

20. The minutes of a May 2003 Preferred Health Board meeting report that Preferred Health was unable to agree with United "on the various methods of reimbursement," and that "the Board agreed to decline their fee schedule offer and inform [Preferred Health] members to contract directly with United should there be any interest." Preferred Health did not transmit any United offer to the Preferred Health members.

21. United also has been unable to contract directly with Preferred Health physician members, who refused to deal with United because it would not agree to Preferred Health's price demands. For example, in July 2003, United approached the largest primary care practice in Seneca with an offer to begin contract negotiations. The physicians refused to negotiate with United, because United "did not agree to take the [Preferred Health] fee schedule."

CONTRACTING WITH CAROLINA CARE PLAN

22. Carolina Care Plan, Inc. ("Carolina Care"), is a health plan doing business in the Seneca area. Prior to 2000, Carolina Care developed its physician network in the Seneca area through direct contracts with individual physicians. In early 2000, the Preferred Health physician members terminated their Carolina Care contracts and agreed that Preferred Health would negotiate all future payor contracts on their joint behalf.

23. In June 2000, Preferred Health proposed its fee schedule to Carolina Care. Carolina Care counter-proposed its standard price list, which contains the rates that it pays other physicians in South Carolina. These rates – almost all of which were at least 10% to 30% below the Preferred Health fee schedule – were between 100% and 140% of 2000 RBRVS for most procedures and closely matched what Carolina Care was previously paying the Preferred Health members with whom it had direct contracts prior to 2000. By September 2000, the Preferred Health Board rejected Carolina Care's contract offer and demanded that Carolina Care accept the Preferred Health fee schedule.

24. Shortly thereafter, Carolina Care made another contract proposal to Preferred Health, increasing its proposed payment terms for certain procedures by as much as 42%. In October 2000, the Preferred Health Board instructed the Executive Director to reject this

proposal as well. Ultimately, Carolina Care met Preferred Health's demand in May 2001, and signed a contract containing Preferred Health's fee schedule. Preferred Health never transmitted Carolina Care's various fee proposals to member physicians during the course of negotiations, and never notified members of the Carolina Care contract until after signing it. Carolina Care told Preferred Health that "[the] physician fee schedule is significantly higher than [Carolina Care's] standard" in the rest of South Carolina.

CONTRACTING WITH CIGNA

25. Cigna of South Carolina, Inc. ("Cigna"), is a payor doing business in the Seneca area. In early 2000, Preferred Health physician members who had direct contracts with Cigna terminated those contracts, and informed Cigna that Preferred Health would now jointly handle their contract negotiations. In late 2000, Preferred Health proposed its fee schedule to Cigna, which contained rates that were approximately 5% to 40% higher than the rates that Cigna had been paying under direct contracts with Preferred Health physician members. Confronted with Preferred Health's collective demands, and needing Preferred Health's physician members to assemble a marketable health plan in the Seneca area, Cigna, in March 2001, agreed to Preferred Health's price demands. Preferred Health did not notify physician members of the Cigna contract and fee schedule until after Cigna signed the contract.

CONTRACTING WITH OTHER PAYORS

26. Preferred Health, on behalf of its physician members, has orchestrated collective negotiations with other payors who do business, or attempted to do business, in the Seneca area, including Private Healthcare Systems, Inc., Premier Health Systems, Inc., and Medcost, LLC. Preferred 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. Preferred Health also facilitated collective refusals to deal and threats of refusals to deal with payors. Preferred Health's members collectively accepted or rejected these payor contracts, and refused to deal with these payors individually. Due to Preferred Health's dominant market position in the Seneca area, these coercive tactics have been successful in raising the prices paid to its physician members.

RESPONDENT'S PRICE-FIXING IS NOT JUSTIFIED

27. Respondent's joint negotiation of fees and other competitively significant contract terms has not been, and is not, reasonably related to any efficiency-enhancing integration.

RESPONDENT'S ACTIONS HAVE HAD SUBSTANTIAL ANTICOMPETITIVE EFFECTS

28. Respondent's actions described in Paragraphs 12 through 26 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 Seneca area in the following ways, among others:

a. price and other forms of competition among physician members of Preferred 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

29. 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 _____ day of _____, 2005, issues its Complaint against Respondent Preferred Health.

By the Commission.

Donald S. Clark
Secretary

SEAL