ANALYSIS OF AGREEMENT CONTAINING
CONSENT ORDER TO AID PUBLIC COMMENT

The Federal Trade Commission has accepted, subject to final approval, an agreement containing a proposed consent order with Genesis Physicians Group, Inc. ("GPG") and System Health Providers, Inc. ("SHP") ("Respondents"). The agreement settles charges that Respondents violated Section 5 of the Federal Trade Commission Act, 15 U.S.C. § 45, by facilitating and implementing agreements among GPG 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 SHP'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 any Respondent that said Respondent violated the law or that the facts alleged in the complaint (other than jurisdictional facts) are true.

The Complaint

The allegations in the Commission's proposed complaint are summarized below.

Respondent GPG has approximately 1,250 members, almost all of whom are physicians licensed to practice medicine in the State of Texas and engaged in the business of providing professional services to patients in the eastern part of the Dallas-Fort Worth metropolitan area ("Dallas area").

Respondent SHP is a management services organization, the voting stock of which is wholly owned by GPG.

Physicians often contract with health insurance firms and other third-party payors, such as preferred provider organizations. Such contracts typically establish the terms and conditions, including price terms, under which the physicians will render services to the payors' subscribers. Physicians entering into such contracts often agree to lower compensation in order to obtain access to additional patients made available by the payors' relationship with insureds. These contracts may reduce payor costs and enable payors to lower the price of insurance, and thereby result in lower medical care costs for subscribers to the payors' health insurance plans.

Absent agreements among competing physicians on the terms, including price, on which they will provide services to subscribers or enrollees in health care plans offered or provided by third-party payors, competing physicians decide individually whether to enter into contracts with third-party payors to provide services to their subscribers or enrollees, and what prices they will accept pursuant to such contracts.

In order to be competitively marketable in the Dallas area, a payor's health insurance plan must include in its physician network a large number of primary care physicians (PCPs) and specialists who practice in the Dallas area. Many of the PCPs and specialists who practice in the Dallas area are members of GPG. In particular, GPG members include a large number of PCPs and specialists located near and associated with the two highly-regarded hospitals comprising the Presbyterian Health System. Accordingly, many payors concluded that they could not establish a viable physician network, particularly in areas in which GPG physicians are concentrated, without including a large number of GPG physicians in that network.

Sometimes a network of competing physicians uses an agent to convey to payors information obtained individually from the physicians about fees or other significant contract terms that the physicians are willing to accept. The agent also may convey all payor contract offers to the physicians, which the physicians then unilaterally decide whether to accept or reject. Such a "messenger model" arrangement, which 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 (see http://www.ftc.gov/reports/hlth3s.htm), can facilitate contracting between physicians and payors and minimize the costs involved, without fostering an agreement among competing physicians on fees or fee-related terms. Such a messenger may not, however, consistent with a competitive model, negotiate fees and other competitively significant terms on behalf of the participating physicians, or facilitate the physicians' coordinated responses to contract offers by, for example, electing not to convey a payor's offer to the physicians based on the messenger's opinion on the appropriateness, or lack thereof, of the offer.

Rather than acting simply as a "messenger," SHP actively bargained with payors, often proposing and counter-proposing fee schedules to be applied, among other terms. To maintain its bargaining power, SHP discouraged GPG members from entering into unilateral agreements with payors. SHP communicated to GPG members the bargaining advantage gained by negotiating with payors collectively through SHP, in general, and SHP's determinations that specific fees and other contract terms being offered by payors were "not comparable to market standards" or otherwise were inadequate. Many GPG members have been unwilling to negotiate with payors apart from SHP, and communicated that fact to payors seeking to resist SHP's collective demands.

SHP had a practice – inconsistent with a messenger model arrangement – of not conveying to GPG members payor offers that SHP deemed deficient, including offers that provide for fees that do not satisfy criteria adopted by SHP's Contracting Committee, which was comprised of 21 GPG

members. SHP instead demanded, and often received, more favorable fee and other contract terms–terms that payors would not have offered to GPG's members had those members engaged in unilateral, rather than collective, negotiations with the payors. Only after the payor acceded to fee and other contract terms acceptable to SHP, would SHP convey the payor's proposed contract to GPG members for their consideration.

SHP refused to convey payors' proposed fee and other contract terms to GPG members even where the payor explicitly has requested that it do so. SHP's discouraging of physicians' contracting directly with payors and its unwillingness to convey payors' proposed contracts to GPG members unless and until those offers satisfy SHP's criteria have rendered it less likely and more costly for payors to establish competitive physician networks in the Dallas area without first coming to terms with SHP. As a result, payors often have offered or acceded to SHP demands for supracompetitive fees for all GPG members.

Since July of 1999, GPG, its members, and SHP have entered only into fee-for-service agreements with payors, pursuant to which GPG, its members, and SHP did not undertake financial risk-sharing. Further, GPG members have not integrated their practices to create significant potential efficiencies. Respondents' joint negotiation of fees and other competitively significant terms has not been, and is not, reasonably related to any efficiency-enhancing integration. Instead, the Respondents' acts and practices have restrained trade unreasonably and hindered competition in the provision of physician services in the Dallas area in the following ways, among others: prices and other forms of competition among Respondent GPG's members were unreasonably restrained; prices for physician services were increased; and competition in the purchase of physician services was restrained to the detriment of health plans, employers, and individual consumers. Thus, Respondents' 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 Respondents and member-Providers to engage in legitimate joint conduct.

Paragraph II.A prohibits Respondents from entering into or facilitating agreements among providers: (1) to negotiate on behalf of any provider 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 providers deal, or are willing to deal, with any payor; and (4) not to deal individually with any payor or through any arrangement other than SHP or GPG. Use of the term "Provider" in the proposed order, rather than the narrower term "physician," reflects SHP's inclusion of non-physician providers of ancillary medical services in its contracting arrangements.

Paragraph II.B prohibits Respondents from exchanging or facilitating the transfer of information among Providers concerning any Provider's willingness to deal with a payor, or the terms or conditions, including price terms, on which the Provider is willing to deal.

Paragraph II.C prohibits Respondents from attempting to engage in any action prohibited by Paragraph II.A or II.B. Paragraph II.D prohibits Respondents from encouraging, pressuring, 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 Respondents 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," so long as the arrangement does not restrict the ability, or facilitate the refusal, of participating providers to deal with payors on an individual basis or through any other arrangement. To be a "qualified risk-sharing joint arrangement," an arrangement must satisfy two conditions. First, all participating Providers must share substantial financial risk through the arrangement and thereby create incentives for the 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. To be a "qualified clinically-integrated joint arrangement," an arrangement must satisfy two other conditions. First, all participants must join in active and ongoing programs to evaluate and modify their clinical practice patterns, creating a high degree of interdependence and cooperation among Providers to control costs and ensure the quality of services provided. Second, any agreement concerning reimbursement or other terms or conditions of dealing must be reasonably necessary to obtain significant efficiencies through the joint arrangement. Both definitions reflect the analyses contained in the 1996 FTC/DOJ Statements of Antitrust Enforcement Policy in Health Care.

Paragraphs III.A and III. B require SHP to distribute the complaint and order to its members, payors with which it previously contracted, and specified others. Paragraph III.C requires SHP to terminate, without penalty, 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 Respondents' joint price-setting. Paragraph III 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. This proviso was implicit in the "termination upon request" provision of the recent Commission Order in *Physicians Integrated Services of Denver*. To avoid any risk of confusion among affected persons and the public-at-large, the proviso is made explicit here.

The remaining provisions of the proposed order impose complaint and order distribution, reporting, and other compliance-related provisions. For example, Paragraph III. D requires SHP to distribute copies of the Complaint and Order to incoming SHP Providers, payors that contract with SHP or GPG for the provision of Provider services, and incoming SHP and GPG officers, directors,

and employees. Further, Paragraph III.F requires SHP to file periodic reports with the Commission detailing how SHP and GPG have complied with the Order. Paragraph V. authorizes Commission staff to obtain access to Respondents' 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.