In 1993, Frye's Chief Executive Officer ("CEO") developed a plan for a PHO that would include Frye and the physicians practicing at Frye. He hired a consultant to survey the physicians regarding what they would expect from a PHO. The consultant reported that the physicians "stated a need to form the group to negotiate with group clout and power" and "maintain their income" in anticipation of the arrival of managed care organizations in the Unifour area. Frye's CEO and Chief Operating Officer, along with eight physicians practicing at Frye, formed a steering committee responsible for establishing and organizing the PHO.

PHA was established in 1994 to facilitate physician collective bargaining with payors and obtain more favorable fees and other terms than PHA's physician members could obtain by dealing individually with payors. PHA established a Contracts Committee to negotiate contracts with payors on behalf of PHA's physician members, subject to approval by PHA's Board of Directors. In 1996, PHA expanded to include Caldwell Memorial and Grace, both nonprofit hospitals, and their respective medical staffs.

The Board manages and controls PHA. The Board has 14 physician directors elected by PHA's physician members, and six hospital directors – two representing each hospital member

In 2001, PHA prospectively adopted a new contracting method that it called a "modified messenger model." This contracting method did not affect existing contracts between PHA and payors or contracts in final stages of negotiation. Since 2001, PHA renewed or entered several payor contracts without using the "messenger model." The complaint alleges that, in setting up

Prompting this prohibition is, as the complaint alleges, PHA's previous use of a self-described "messenger" contracting mechanism that failed to eliminate collective price setting and

proposed order becomes final, PHA may engage in conduct that is reasonably necessary to form or participate in such joint arrangements, subject to certain size and other limitations.

The size limitations for these allowable arrangements correspond to the safety zones for physician network joint ventures that are set forth in the joint Department of Justice and Federal Trade Commission Statements of Antitrust Enforcement Policy in Health Care,[3] and provide for different sizes depending on whether physicians' participation in the joint venture is exclusive or non-exclusive.[4] These size restrictions are intended to assure that any such joint arrangements involving PHA – which, as presently constituted, includes approximately three-fourths of the area's physicians – do not obtain or exercise

[3]U.S. Department of Justice and the Federal Trade Commission, Statements of Antitrust Enforcement Policy in Health Care at Statement 8, Part A (August 1996) (safety zones for physician network joint ventures) (available at http://www.ftc.gov/reports/hlth3s.htm).

[4]Permissible joint ventures by PHA, where the physicians participate in the arrangement on a non-exclusive basis, are generally limited to having no more than 30% of the physicians in any medical specialty practicing either in Catawba County or in the Unifour area. Permissible joint ventures by PHA, where the physicians participate in the arrangement on an exclusive basis, are generally limited to having no more than 20% of the physicians in any medical specialty practicing either in Catawba County or in the Unifour area. Catawba County contains the substantial majority of PHA's physician members, and is where most of the Unifour area's large employers, and the largest concentration of the area's population, are located. Applying the percentage limitations to both areas – Catawba County and the Unifour – avoids the possibility that a joint arrangement by PHA could have a higher percentage of Catawba County physicians, while still meeting the allowable percentage limitations for the Unifour as a whole. Despite the general size limitations, in either exclusive or non-exclusive arrangements, PHA is permitted to have non-exclusive participation by physicians in medical specialties where the limited number of such local specialists otherwise would not permit their participation within the proposed order's percentage limitations.

[5]The safety zones in the Statements of Antitrust Enforcement Policy in Health Care do not establish upper size limits on lawful arrangements, but restricting PHA to size limits is appropriate in light of the complaint's allegations of PHA's unlawful conduct and the resulting anticompetitive effects. The size limits for qualified joint arrangements in the proposed order apply for 10 years after the order becomes final, rather than for the 20 years that apply to Paragraph II's general prohibitions.

terms of dealing with a payor. Neither PHA nor the Physician Respondents are precluded from engaging in conduct that is necessary to continue PHA's preexisting "bonus plan" contracts with certain self-insured employers, which appear to involve the sharing of some financial risk among PHA's physician members. This exception does not necessarily mean that the bonus plan contracts are qualified joint arrangements as defined in the proposed order.

As defined in the proposed order, a "qualified risk-sharing joint arrangement" must satisfy two conditions. All physician and hospital participants must share substantial financial risk through the arrangement and thereby create incentives for the physician and/or hospital participants jointly to control costs and improve quality by managing the provision of services. Also, any agreement concerning price or other terms or conditions of dealing must be reasonably necessary to obtain significant efficiencies through the joint arrangement.

As defined in the proposed order, a "qualified clinically-integrated joint arrangement" also must satisfy two conditions. All physician and hospital participants must participate in active and ongoing programs to evaluate and modify their clinical practice patterns, creating a high degree of interdependence and cooperation among physicians and/or hospitals, to control costs and ensure the quality of services provided. Also, any agreement concerning price or other terms or conditions of dealing must be reasonably necessary to obtain significant efficiencies through the joint arrangement.

In the event that PHA forms a qualified risk-sharing joint arrangement or a qualified clinically-integrated joint arrangement, Paragraph IV of the proposed order requires PHA, for five years, to notify the Commission at least 60 days prior to initially contacting, negotiating, or entering into agreements with payors concerning the arrangement. Notification is not required for subsequent contacts, negotiations, or agreements with payors pursuant to any arrangement for which notice was already given under Paragraph IV. Paragraph IV sets out the information necessary to make the notification complete, and also provides the Commission with the right to obtain additional information regarding the arrangement before PHA enters into the arrangement.

Paragraph III of the proposed order prohibits PHA from preparing, maintaining, or participating in the preparation of any fee schedule regarding physician services. This requirement is a response to PHA's alleged history, as set forth in the complaint, of having agents and consultants prepare fee schedules and using the fee schedules in negotiations with payors.

Paragraph III also prohibits PHA from collecting or maintaining information about price and other terms under which physicians deal, or are willing to deal, with payors. This addresses PHA's alleged practices in collecting and using such information as part of its so-called "modified messenger model." Paragraph III excepts from these prohibitions activities necessary to maintain preexisting bonus plan contracts or to form or operate a qualified joint arrangement permitted under Paragraph II. Paragraph III also excepts actions necessary for, and undertaken solely for the purpose of, entering messenger arrangements as permitted in Paragraph V (discussed below) or implementing information technology services (for practice management

and electronic medical records software for physician practices, or for medical management services provided to payors). Implementing information technology services, which involves activities that PHA already has begun, may have significant potential for efficiency and quality enhancement for medical services, and itself does not appear to present a significant risk of being used in anticompetitive ways, particularly in light of the proposed order's other provisions.

Paragraph V of the proposed order prohibits PHA from acting as an agent for physicians, or from entering into any type of messenger arrangement between physicians and payors, for thirty (30) months after the proposed order becomes final. It also prohibits PHA from entering into any type of messenger arrangement, other than acting as a simple transmitter of offers and responses between payors and individual physician practices, for an additional twenty-four (24) months -- *i.e.*, until fifty-four (54) months after the proposed order becomes final.[6]

The first "cooling off" period – of 30 months – eliminates PHA involvement between physicians and payors, to facilitate payors' ability to deal directly with individual physician practices and increase physicians' incentive to deal directly with payors (or deal through other arrangements that do not have PHA's alleged history of fostering anticompetitive agreements). The second, 24-month-long prohibition on all but strictly limited-in-form messenger arrangements – *i.e,* the prohibition on arrangements that might involve, for example, PHA's collection and maintenance of price and other information on physicians' terms of dealing – is intended to permit PHA to re-enter the physician contracting business, but with additional safeguards against recurrence of the abuses, under the guise of "modified messenger model," that the complaint alleges. Should PHA ultimately engage in a standing offer or similar messenger arrangement, the physician services market will have had at least four and one-half years to restore -- with little or no PHA involvement -- the competitive balance allegedly lost due to the conduct charged in the complaint.

Paragraph VI of the proposed order requires PHA to provide the Commission with prior

[6]The time periods for these prohibitions are based on the requirement in Paragraph VII.D of the proposed order that all of PHA's contracts, with the identified exceptions, be terminated no later than six (6) months after the date the order becomes final.

termination of the contracts, which, according to the complaint, embody price-fixed physician fees. Paragraph VII.A requires PHA to provide the payors with which it has a contract with a copy of the order and complaint, as well as a notification letter apprising the payors of certain contract termination rights regarding their contracts with PHA. For payors that have preexisting "bonus plan" contracts with PHA, which are listed in Confidential Appendix A to the proposed order, the notification letter informs the payors that they may terminate their existing contracts with PHA, upon written request, without any penalty or charge. With regard to payors holding contracts with PHA, other than the payors with bonus plan contracts, the notification letter likewise informs the payors that they may terminate their contracts without penalty, upon providing written request. However, the letter also apprises payors with non-bonus-plan contracts that, if they do not voluntarily terminate their contracts within six months after the order becomes final (or the contract does not reach its scheduled termination date by that time), then the contract will terminate as of six months after the order becomes final. With regard to certain employers that have preexisting, non-bonus-plan direct contracts with PHA, and which are identified in Confidential Appendix B of the proposed order, in order to help minimize any possible disruption to their health benefits programs, Paragraph V of the proposed order permits PHA to serve as a simple messenger for any subsequent contract offers by these payors to PHA's physician members.

Termination of the contracts between PHA and payors for the provision of physician services is required to eliminate the payment to PHA's physician members of what the complaint alleges are collectively negotiated, price-fixed fee levels. The provision allowing payors six months during which they may request voluntary termination of their contracts with PHA is intended to provide them with flexibility and facilitate their making alternative arrangements to provide the services now provided through their contracts with PHA.

The mandatory termination date also obviates the risk that any payor would face competitive disadvantage by voluntarily terminating a PHA contract – and not have a physician network in place – before rival payors have terminated their contracts. Establishing a mandatory termination date provides an incentive for all payors to act promptly to make alternative arrangements for a physician network before the termination date, makes clear to PHA's physician members that they promptly must begin to deal directly (or outside of PHA) with the payors if they wish to continue being in the payors' networks, and eliminates the possible disincentive for a payor to be the first to voluntarily terminate its contract with PHA because it would be the first payor in the market not to have a contracted network of physicians.

Paragraph VII also requires PHA, for five years, annually to publish a copy of the order and complaint in a report or newsletter sent to its participating providers, and file certain compliance reports with the Commission. Paragraphs VIII, IX, and X provide for various compliance reports and notifications by PHA and the Physician Respondents. Paragraph XI obligates the Respondents to cooperate in certain ways with any Commission inquiry into their compliance with the order.

The proposed order will expire in 20 years.