notwithstanding the licensing of generic entry following the merger.

The majority statement cites other Commission challenges to restraints as support for picking which consumers will win and which will lose in pharmaceutical markets. However, these challenged restraints were intended to, and did, hinder generic entry, and the thrust in our remedies in these cases is to allow free competition to work. A subtle but important policy perspective is that the free market picked the winners and losers; we only allowed the market to work. The Commission did not manipulate the outcome of these markets.

In reading the majority's statement, I observe though that the majority unfortunately compares market outcomes in its statement instead of evaluating the Commission's appropriate role in providing antitrust protection in American markets. Our Clayton Act, Section 7 mandate is simple: protect markets so that the competitive process provides the market outcomes, such as quantity produced, prices charged, and who wins and loses financially. I disagree with a merger remedy policy that instead embraces manipulating the structure of market competition and trades off recognized (or probable) benefits for one segment of consumers for recognized (or probable) harm to another. As the Supreme Court over 40 years ago established, antitrust policy does not countenance mergers that are anticompetitive but are, ''on some ultimate reckoning of social or economic debits and credits, * * * deemed beneficial.'' [6] This policy principle equally—if not even more so—applies to government-imposed restructurings in merger remedies. Accordingly, I believe that the Commission should refrain from accepting settlements that expressly contemplate benefitting one group of customers at the expense of other customers, especially where challenging a merger would likely be successful and the Commission is able to fulfill its mandate to protect all consumers from antitrust harm. For all of these reasons, I believe that the Commission should have rejected the proposed settlement and challenged this transaction.

As a final note, I recognize that the pharmaceutical industry over the recent past has transformed itself to an industry where larger, established companies refrain from developing the bulk of their products internally and instead often acquire smaller R&D companies as a means of stocking their portfolio of products. This transaction provides the Commission with the opportunity to demonstrate its commitment to aggressively protect pharmaceutical consumers under these changed market dynamics. Instead, I fear that the Commission today may be signaling the industry that dominant firms in pharmaceutical markets now have the antitrust ''green light'' to acquire competitors or potential entrants in exchange for a remedy that restructures markets in ways that trumps the free market decision as to who will benefit from the market and who will be harmed, as well as the extent of these effects on different groups. Accordingly, I believe that the Commission should have rejected the proposed settlement and challenged the transaction in order to protect fully consumers in the BTCP drug market and to signal the Commission's antitrust resolve in both challenging anticompetitive mergers and only accepting remedies that minimize consumer exposure to anticompetitive risk.

[FR Doc. 04–19443 Filed 8–24–04; 8:45 am]

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[6] Setting out the bounds of Section 7 enforcement, the Court further cautions decision makers: ''A value choice of such magnitude is beyond the ordinary limits of judicial competence, and in any event has been made for us already, by Congress when it enacted the amended § 7.'' *United States* v. *Philadelphia National Bank,* 83 S.Ct. 1715, 1745 (1963). The majority statement strains in a failed attempt to distinguish away this Supreme Court case. Regardless of whether customers are within different geographic markets or within different segments of a relevant product market, a reasonable reading of the case is that the Supreme Court does not condone the type of consumer welfare tradeoffs that the majority statement endorses.

FEDERAL TRADE COMMISSION

[Docket No. 9314]

Piedmont Health Alliance, Inc., et al.; Analysis To Aid Public Comment

AGENCY: Federal Trade Commission.

ACTION: Proposed consent agreement.

SUMMARY: The consent agreement in this matter settles alleged violations of federal law prohibiting unfair or deceptive acts or practices or unfair methods of competition. The attached Analysis to Aid Public Comment describes both the allegations in the complaint and the terms of the consent order—embodied in the consent agreement—that would settle these allegations.

DATES: Comments must be received on or before September 10, 2004.

ADDRESSES: Comments should refer to ''Piedmont Health Alliance, Inc., *et al.*, Docket No. 9314,'' to facilitate the organization of comments. A comment filed in paper form should include this reference both in the text and on the envelope, and should be mailed or delivered to the following address: Federal Trade Commission/Office of the Secretary, Room H–159, 600 Pennsylvania Avenue, NW., Washington, DC 20580. Comments containing confidential material must be filed in paper form, as explained in the Supplementary Information section. The FTC is requesting that any comment filed in paper form be sent by courier or overnight service, if possible, because U.S. postal mail in the Washington area and at the Commission is subject to delay due to heightened security precautions. Comments filed in electronic form (except comments containing any confidential material) should be sent to the following e-mail box: *consentagreement@ftc.gov*.

FOR FURTHER INFORMATION CONTACT: David Narrow, FTC, Bureau of Competition, 600 Pennsylvania Avenue, NW., Washington, DC 20580, (202) 326–2744.

SUPPLEMENTARY INFORMATION: Pursuant to Section 6(f) of the Federal Trade Commission Act, 38 Stat. 721, 15 U.S.C. 46(f), and Section 3.25(f) of the Commission's Rules of Practice, 16 CFR 3.25(f), notice is hereby given that the above-captioned consent agreement containing a consent order to cease and desist, having been filed with and accepted, subject to final approval, by the Commission, has been placed on the public record for a period of thirty (30) days. The following Analysis to Aid Public Comment describes the terms of the consent agreement, and the allegations in the complaint. An electronic copy of the full text of the consent agreement package can be obtained from the FTC Home Page (for August 11, 2004), on the World Wide Web, at *http://www.ftc.gov/os/2004/08/index.htm.* A paper copy can be obtained from the FTC Public Reference Room, Room 130–H, 600 Pennsylvania Avenue, NW., Washington, DC 20580, either in person or by calling (202) 326–2222.

Public comments are invited, and may be filed with the Commission in either paper or electronic form. Written comments must be submitted on or before September 10, 2004. Comments should refer to ''Piedmont Health Alliance, Inc., *et al.*, Docket No. 9314,'' to facilitate the organization of comments. A comment filed in paper form should include this reference both in the text and on the envelope, and should be mailed or delivered to the following address: Federal Trade Commission/Office of the Secretary,

Room H–159, 600 Pennsylvania Avenue, NW., Washington, DC 20580. If the comment contains any material for which confidential treatment is requested, it must be filed in paper (rather than electronic) form, and the first page of the document must be clearly labeled ''Confidential.'' [1] The FTC is requesting that any comment filed in paper form be sent by courier or overnight service, if possible, because U.S. postal mail in the Washington area and at the Commission is subject to delay due to heightened security precautions. Comments filed in electronic form should be sent to the following e-mail box: *consentagreement@ftc.gov*.

The FTC Act and other laws the Commission administers permit the collection of public comments to consider and use in this proceeding as appropriate. All timely and responsive public comments, whether filed in paper or electronic form, will be considered by the Commission, and will be available to the public on the FTC Web site, to the extent practicable, at *www.ftc.gov*. As a matter of discretion, the FTC makes every effort to remove home contact information for individuals from the public comments it receives before placing those comments on the FTC Web site. More information, including routine uses permitted by the Privacy Act, may be found in the FTC's privacy policy, at *http://www.ftc.gov/ftc/privacy.htm*.

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 Piedmont Health Alliance, Inc. (''PHA''), and ten individual physicians who are named as Respondents (''Physician Respondents'') in the complaint issued by the Commission on December 22, 2003.[1] The agreement settles charges that PHA and the ten Physician Respondents (together ''Respondents'') violated Section 5 of the Federal Trade Commission Act, 15 U.S.C. 45, by orchestrating and facilitating agreements among PHA's physician members to fix prices and other terms on which the physicians would deal with health plans and other purchasers of physician services (''payors''), and to refuse to deal with payors except on collectively-determined terms. On July 2, 2004, the case was withdrawn from adjudication, so that the Commission could consider a proposed consent agreement and decision and order. 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 any comments and decide whether to withdraw from the agreement or make the proposed order final.

The purpose of this analysis is to facilitate comment on the proposed order. The analysis does not constitute an official interpretation of the agreement and proposed order and does not modify their terms in any way. The proposed consent order has been entered into for settlement purposes only and does not constitute an admission by Respondents that they violated the law or that the complaint's alleged facts—other than jurisdictional facts and facts admitted in the Respondents' answer to the complaint—are true.

The Complaint Allegations

PHA, a for-profit corporation, is a physician-hospital organization (''PHO'') that includes physicians, hospitals, and other licensed health care providers in Alexander, Burke, Caldwell, and Catawba counties in western North Carolina (known as the ''Unifour'' area). PHA includes approximately 450 physicians, representing the substantial majority of physicians in the Unifour area, and three of the five Unifour area hospitals, including Frye Regional Medical Center (''Frye''), Caldwell Memorial Hospital (''Caldwell Memorial''), and Grace Hospital (''Grace'').[2]

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 (but with only one vote per hospital member). A majority of PHA physician directors and two of the three voting hospital directors must approve each payor contract entered into on behalf of PHA's members. Since 1994, the Board voted to approve more than 50 contracts containing physician fee schedules that PHA collectively negotiated with payors.

PHA hired actuaries and other consultants to develop physician fee schedules containing price terms that PHA demanded from payors as a condition of contracting with PHA for physician services. PHA generally negotiated single-signature contracts with payors for the services of all PHA's physician members, and committed to attempt to negotiate contracts with payors that included all PHA physician members. Payors that failed to accede to PHA on price and other contract terms were denied access to PHA's physician members for inclusion in the payors' provider networks. PHA's physician members agreed to participate in all PHA's payor contracts, to accept the prices for their services that PHA negotiated on their behalf, and to terminate any individual contracts they had with a payor once PHA entered into a contract with that payor. PHA's physician members also agreed not to deal individually or through any other organization with any payor with which PHA was attempting to negotiate, or had signed, a contract jointly on behalf of PHA's members.

[1] Commission Rule 4.2(d), 16 CFR 4.2(d). The comment must be accompanied by an explicit request for confidential treatment, including the factual and legal basis for the request, and must identify the specific portions of the comment to be withheld from the public record. The request will be granted or denied by the Commission's General Counsel, consistent with applicable law and the public interest. *See* Commission Rule 4.9(c), 16 CFR 4.9(c).

[1] The ten Physician Respondents (all M.D.s) are: Peter H. Bradshaw, S. Andrews Deekens, Daniel C. Dillon, Sanford D. Guttler, David L. Harvey, John W. Kessel, A. Gregory Rosenfeld, James R. Thompson, Robert A. Yapundich, and William Lee Young III.

[2] The Commission previously issued a separate consent order related to this case against Frye and its parent corporation, Tenet Healthcare Corporation, both of which are for-profit corporations. *In the Matter of Tenet Healthcare Corporation and Frye Regional Medical Center, Inc.*, Dkt. No. C–4106 (consent order issued January 29, 2004).

The Physician Respondents are PHA shareholders. All have been voting Board members and participated in Board decisions to approve or reject payor contracts containing fixed physician prices, authorize negotiations over the prices payors must pay for PHA physician services, authorize development of physician fee schedules for PHA's use in contracting with payors, terminate contracts between PHA and payors, and approve Contracts Committee recommendations concerning price and other payor contract terms. In addition to serving on the PHA Board, four Physician Respondents were members of the Contracts Committee, which more directly negotiated with payors over physician prices and other contract terms. The Physician Respondents and all PHA physician members are compensated for their professional medical services under fee schedules contained in PHA-negotiated contracts with payors.

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 the ''modified messenger model,'' PHA physician members reported to PHA the minimum price terms—*i.e.*, standing offers or ''targets''—each would accept if offered by a payor. To help the physicians set their individual target fees, PHA provided each practice group with specific information about the fees that practice was receiving from several payors under existing PHA-negotiated payor contracts. PHA's physicians used these previously fixed prices in determining the prices to demand under contracts processed under PHA's new contracting method.

PHA used this contracting method with two health plans: United HealthCare of North Carolina, Inc., and Cigna HealthCare of North Carolina, Inc. PHA negotiated with each health plan over the aggregate level of payments the health plan would pay for physician services—stated as a percentage of Medicare's reimbursement for the same services. PHA also negotiated and agreed with United and Cigna on other price-related contract terms, such as periodic percentage increases in physician fee levels to occur at certain times. To compel the payor to accept PHA's terms, PHA confronted each payor with actual or threatened contract termination, and thus loss of its provider network, during the negotiation process. Once aggregate payment levels and terms were determined, PHA had its actuary develop fee schedules to be used under each contract. This determined how much each PHA physician would receive for specific medical procedures—in effect, dividing the ''pie'' that was the negotiated aggregate reimbursement amount. Only after the payor agreed to both the aggregate payment level and the fee schedule did PHA determine which physician practices ''matched'' the payor's ''offer'' and thus would be included in the payor's provider network under the PHA contract.

The complaint alleges that, as a result of Respondents' conduct, prices for physician services in the Unifour area were maintained at, or increased to, artificially high prices in the Unifour area, and consumers have been deprived of the benefits of competition among physicians. By facilitating agreements among PHA member physicians to deal only on collectively-determined terms, and through PHA's and its members' actual or threatened refusals to deal with health plans that would not meet those terms, PHA and the Physician Respondents are alleged to have violated Section 5 of the FTC Act. PHA's collective negotiation of fees and other competitively significant terms of dealing has not been, and is not, reasonably necessary to achieving any efficiency-enhancing integration.

The Proposed Consent Order

The proposed consent order is designed to prevent continuation or recurrence of the illegal conduct charged in the complaint, and to facilitate readjustment of the market for physician services in the relevant area to one where physicians competitively determine the prices they charge to payors for medical services—without PHA's involvement on the physicians' behalf. The proposed order prohibits PHA for a period of time from operating a ''messenger model'' or any other arrangement for physicians in their dealings with payors. 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 negotiation with payors over physician fees. The prohibition should enable payors to deal with physician practices, and establish prices for physician services, without the risk of cartelization through PHA. Such a period, which likely will involve multiple contracting cycles between payors and physicians, will help assure that any price information that physicians later use in participating in any messenger arrangement will reflect competitive price levels, rather than collectively negotiated prices—as allegedly was the case in PHA's ''modified messenger model.''

The proposed order allows Respondents to engage in various forms of legitimate conduct that do not improperly impair competition and that will not interfere with effective remedial relief through the proposed order. For example, the proposed order does not prohibit the Physician Respondents from participating in any legitimate financially integrated or clinically integrated joint arrangements with other physicians. PHA also is not prohibited from participating in arrangements that involve solely hospital services, or certain activities involving physician services, as specified in the proposed order. The proposed order also permits PHA to undertake activities necessary to operate certain programs, such as its information technology and medical management programs, that have procompetitive potential and do not involve physicians' fees or other contracting terms between physicians and payors. Other parts of the proposed order are similar to orders that the Commission has issued to settle charges relating to allegedly unlawful agreements to eliminate physician competition and raise the prices of physician services.

The proposed order's specific provisions are as follows:

The core prohibitions are contained in Paragraphs II, III, V, and VII. Paragraph II.A prohibits PHA and the Physician Respondents from entering into, participating in, 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 PHA. Other parts of Paragraph II reinforce these general prohibitions. Paragraph II.B prohibits the Respondents from facilitating exchanges of information between or among physicians concerning whether, or on what terms, including price terms, they are willing to contract with a payor. Paragraph II.C bans them from attempting to engage in any action prohibited by Paragraph II.A or II.B. Paragraph II.D prohibits Respondents from inducing anyone else to engage in any action prohibited by Paragraphs II.A through II.C.

As in other Commission orders addressing health care providers' alleged collective bargaining with payors, certain kinds of potentially procompetitive agreements are excluded from the general prohibition on joint negotiations. The Physician Respondents are not prohibited from engaging in conduct that involves only physicians in their own group practice, or that is reasonably necessary to form or participate in a ''qualified risk-sharing joint arrangement'' or a ''qualified clinically-integrated joint arrangement,'' as these terms are defined and have been used in prior Commission orders. Beginning no sooner than thirty (30) months after the 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 substantial market power by involving an unduly large number of area physicians.[5] The size restrictions apply only to physician network joint ventures undertaken by PHA. The proposed order does not affect any joint ventures undertaken by area physicians outside of PHA, or restrict the Physician Respondents or any other PHA physician members from participating in qualified risk-sharing or clinically-integrated joint arrangements outside of PHA that are larger than those that PHA is allowed to undertake.

Paragraph IV requires PHA to notify the Commission about such arrangements prior to negotiating on behalf of the arrangement's members or before those members jointly discuss any 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.

[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.

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 notice before entering into any messenger arrangement permitted by Paragraph V of the proposed order.

Paragraph VII requires PHA to distribute the complaint and order, within 30 days after the order becomes final: to every hospital, physician, or other provider that participates in PHA; to each officer, director, manager, and employee of PHA; and to each payor with which PHA has had any contact since January 1, 1997, but with which PHA does not currently have a contract. For a period of five years after the order becomes final, PHA also must distribute a copy of the order and complaint to new members and officials of PHA, and any new payors with which it commences doing business.

With regard to payors with which PHA currently has a contract for the provision of physician services, Paragraph VII of the proposed order contains provisions concerning the 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.

By direction of the Commission.

Donald S. Clark,

Secretary.

[FR Doc. 04–19444 Filed 8–24–04; 8:45 am]

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[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.

FEDERAL TRADE COMMISSION

[File No. 041 0014]

Virginia Board of Funeral Directors and Embalmers; Analysis To Aid Public Comment

AGENCY: Federal Trade Commission.

ACTION: Proposed consent agreement.

SUMMARY: The consent agreement in this matter settles alleged violations of federal law prohibiting unfair or deceptive acts or practices or unfair methods of competition. The attached Analysis to Aid Public Comment describes both the allegations in the draft complaint that accompanies the consent agreement and the terms of the consent order—embodied in the consent agreement—that would settle these allegations.

DATES: Comments must be received on or before September 13, 2004.