Bureau of Competition
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

August 28, 1986

Cecil M. Cheves, Esquire
Page, Scrantom, Harris,
McGlamry & Chapman, P.C.
1043 Third Avenue
Columbus, Georgia 31994

Re: Association for Quality Health Care, Inc.

Dear Mr. Cheves:

You have requested staff advice concerning a proposed "preferred provider organization" (PPO) program for the provision of health care services to be established by your client, the Association for Quality Health Care, Inc. (the "Association"). According to the information contained in or accompanying your request, the Association is a nonprofit, tax-exempt[1/] corporation, open to membership by any employer in the Columbus, Georgia area. The "service and market areas" for the Association include Muscogee, Stewart, Harris, Talbot, and Chattahoochee counties in Georgia, and Russell County in Alabama. These counties have a total population of about 270,000, of whom about 39,000 (14.4%) potentially could participate in the Association's program if all 15 of the self-insured employers currently in the service and market area joined the Association. About 200 physicians practice in the Association's service and marketing area. You state that the Association was established to address the rising cost of health care by negotiating and entering into contracts with certain local area physicians to provide health care services for the Association's members, and their employees and dependents, pursuant to each member's individual plan or program of employee health care benefits.

The Association is to be governed by a board of directors elected by the Association's members. No more than 25% of the board members "may be physicians or be selected by physician groups such as medical societies, individual practice associations, medical service bureaus, foundations for medical care,

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1/ Under Section 501(c)(4) of the Internal Revenue Code.

medical clinics and hospital medical staffs."[2/] You characterize the Association as "an association of [health care services] users -- not providers."[3/]

Employers wishing to become members of the Association must pay an "initial assessment" of $2,500.00 and an annual membership fee, and execute a Membership Agreement. This Membership Agreement includes numerous provisions relating to the responsibilities and contemplated actions of the member and the Association, respectively, regarding the proposed PPO program. Pursuant to the Membership Agreement, the Association will, among other things, contract with certain health care providers who agree to provide medical services to employees and dependents of the Association's members; prepare and update a list of participating providers for the members and provide educational programs for members, employees, and dependents, on the use of preferred providers and other topics relating to "judicious" and "cost-sensitive" use of health care services; and provide utilization review data to members and arrange for a program of utilization review by an organization selected by the Association. Members agree, among other things, to: provide incentives in their health benefits plans for employees and dependents to use "preferred" physicians who have contracted with the Association; verify coverage of employees and dependents to physicians; ensure prompt payment of charges to preferred physicians for covered services; and provide the Association with data necessary for utilization review.

Physicians who wish to become participating "preferred" physicians of the Association execute a Physicians' Agreement with the Association. Under this Agreement, physicians agree, among other things, to: provide necessary and appropriate medical services to employees of Association members and their dependents; refer covered patients to other participating providers, insofar as possible; employ certain cost-containment measures, such as using outpatient facilities when appropriate; cooperate in the utilization review program and abide by its decisions; accept "usual, customary, and reasonable" (UCR) reimbursement for covered services from Association members as

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2/ Association for Quality Health Care, Inc., Bylaws, Article III, Section 1. (Exhibit A to letter of September 24, 1984).

3/ Letter of September 24, 1984, at 3.

payment in full,[4] and not seek any reimbursement from the employee or beneficiary, other than for any deductibles or copayments provided for under the member's benefits plan.

The Association agrees, among other things, to: negotiate contracts for membership with local employers whereby the latter agree to include in their health benefits programs incentives for employees and beneficiaries to use participating physicians; keep the physicians apprised of membership in the Association and require members' employees to have appropriate identification of their coverage; verify coverage of services for the physician; and prepare and update a directory of participating physicians for use by members and their employees. The Association also will establish a utilization review program, "to be performed by an organization or entity selected by the ASSOCIATION," "which shall seek to avoid unnecessary or unduly costly hospital and medical services while ensuring the delivery of quality health care services for the members, employees and their dependents."

You indicate that to provide physician services and the utilization review function, the Association will contract with Physicians Group, Inc. ("PGI"), an organization that "the local physicians have agreed among themselves to form . . . in order that collectively they may negotiate with the Association."[5] According to the latest information you have provided, 94 local physicians (out of about 200 in the proposed service/marketing area) in approximately 25 medical specialty and subspecialty areas are members of PGI.

In your correspondence, you have requested staff opinions on several aspects of the Association's proposed structure and operation.

Medical Control

You have asked "[w]hether the PPO is controlled by physicians in a manner which violates the antitrust standards set forth in the Statement of Enforcement Policy [With Respect to Physician Agreements to Control Medical Prepayment Plans] of the Federal

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4/ In your letter of September 24, 1984, you state (at p. 5) that physicians agree to accept their UCR reimbursement "less a ten percent (10%) discount" as full payment for services rendered to persons covered under the Association's programs. The Physicians' Agreement attached as Exhibit C to that letter, however, states (at p. 3) that physicians agree to accept UCR reimbursement, with no mention of any discounting of fees.

5/ Letter of November 3, 1984.

Trade Commission and thus violates the spirit of the Sherman and Clayton Anti-Trust Acts."[6] As the Commission has emphasized:

> The analysis of [physician] control is a practical one, asking whether the plan's lines of authority give the physician group the ability (either "on paper" or in practice) to make overall plan policy. The existence of control will be clearest when a physician group owns the plan. It is also likely when a group selects a majority of the voting members of the plan's governing body. When neither of these conditions is present, de facto control may nevertheless exist. For example, a physician group may be able to dominate a plan's decisionmaking processes through the selection of a minority of members of a plan's governing body. . . . As with factual issues in other areas of antitrust enforcement, substance will govern over form in determining whether control exists. (Footnotes omitted). [7]

Consequently, it is not possible to give you a definitive answer as to whether or not the Association would be medically controlled. While the origin, initial governance, and formal structure of the Association[8] all suggest that it is controlled

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[6] Letter of September 24, 1984, at 8.

[7] Statement of Enforcement Policy with Respect to Physician Agreements to Control Medical Prepayment Plans, 46 Fed. Reg. 48982, 48986 (1981). It is not clear that the Association, an organization of self-insuring employers purchasing medical care for their employees and their dependents, is a "medical prepayment plan" as that term is defined in the Commission's Statement of Enforcement Policy. See 46 Fed. Reg. at 48984 n.1. However, the concept of control, as used in the Statement of Enforcement Policy, would appear to be applicable in other contexts as well.

[8] While such a possibility appears unlikely, even the formal governance structure of the Association does not absolutely rule out medical control of the Association. While Article III, Section 1 of the Association's Bylaws states that no more than 25% of the board members of any time may be physicians or selected by physician groups, Article II, Section 2 states that any employer (including, presumably, a physician who employs office staff, a clinic, or a medical society, for example) may become a member of the Association, and the members, in turn, elect the board (Article III, Section 2). Thus, at least theoretically, physicians could come to dominate the Association's membership, and elect a majority of
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by purchasers of health care services, rather than by providers, only observation of the Association's operations -- which, of course, may vary over time -- would demonstrate whether or not at any particular time it in fact is medically controlled. This, therefore, is not the type of issue that properly can be determined in advance as a matter of law.

One point of clarification about this issue is in order, however. The question, as phrased in your letter, suggests that the existence of physician control itself amounts to a violation of antitrust standards set forth in the Commission's Statement of Enforcement Policy, "and thus violates the spirit of the Sherman and Clayton Anti-Trust Acts." In the Commission's opinion, as explained in detail in the Statement of Enforcement Policy with Respect to Physician Agreements to Control Medical Prepayment Plans, the mere existence of physician control of medical prepayment plans is not automatically illegal under the antitrust laws, and is not necessarily indicative that the controlled plan is anticompetitive. Physician control means merely that such plans involve horizontal agreement among the competing physicians controlling the plan. Whether such agreement is lawful or illegal in a particular case, however, depends upon a careful analysis of the nature and purposes of the agreement and "joint" activities, and their competitive effects which, in turn, may depend on the plan's market power. In short, a finding of physician control only begins the inquiry into a medical prepayment plan's lawfulness; it does not resolve that issue.[9/]

Interstate Commerce

You have asked whether the PPO "substantially affects interstate commerce,"[10/] presumably to ascertain whether the Association's activities would be subject to the federal antitrust laws. Given that the Association's proposed service and marketing area includes parts of two states, its activities would likely be in or affecting interstate commerce, and it therefore appears that interstate commerce jurisdiction over the Association and its activities could be established under the federal antitrust laws.[11/]

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the board, thereby structurally controlling the Association.

9/ But see Addino v. Genesee Valley Medical Care, Inc., 593 F. Supp. 892 (W.D. N.Y. 1984).

10/ Letter of September 24, 1984, at 8.

11/ Certain types of restraints involving aspects of the medical care system have been held to meet the test of effect on interstate commerce despite their appearance as intrastate activities. Thus, for example, while the provision of medical care may be largely a local activity, "[i]nterfer-
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Joint Contracting Through PGI

You have asked whether the Association may contract with the physician group, PGI, rather than with individual physicians, to provide medical services to persons covered under the Association's program.[12] As explained below, such contracting may raise serious antitrust concerns.[13]

In considering the legality of an agreement between the Association and PGI, it is necessary first to analyze the arrangement among PGI's member physicians. Insofar as we are able to discern from the materials and information you have provided, PGI appears to be an organization of independent, otherwise competing physicians who have formed PGI to jointly market their services to PPOs or other purchasers, such as the Association, including negotiating jointly through PGI as to the prices at which the individual physicians will sell their services to those purchasers. PGI also will perform utilization review services for the Association.

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ences with the interstate travel of patients, the interstate payment of fees, and the interstate purchase of medication are well-recognized methods for demonstrating an effect on interstate commerce in antitrust litigation." Cardio-Medical Associates, Ltd. v. Crozer-Chester Medical Center, 721 F.2d 68, 76 (3d Cir. 1983) (citations omitted). See also Weiss v. York Hospital, 745 F.2d 786, 824 n.65 (3d Cir. 1984), cert. denied, 105 S. Ct. 1777 (1985); United States v. Hospital Affiliates Int'l, Inc., 1980-81 Trade Cas. (CCH) ¶ 63,721 at 77,853 (E.D. La. 1980); Michigan State Medical Society, 101 F.T.C. at 212, 250 (initial decision).

12/ Letter of October 31, 1984, at 2.

13/ These antitrust concerns arise even if the Association is not controlled by physicians or physician organizations, but rather is an organization of purchasers of physician services. If the Association is a physician-controlled organization, an even greater risk of antitrust problems exists. With a provider controlled organization, its decisions likely would be viewed under the antitrust laws as being agreements among the competing, controlling physicians to take those actions. If those decisions had anticompetitive effects, they could be held to be illegal agreements in restraint of trade, and could even be held to be per se illegal. See, e.g., Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia, 624 F.2d 476, 479-81 (4th Cir. 1980), cert. denied, 450 U.S. 916 (1981); Addino v. Genesee Valley Medical Care, Inc., 593 F. Supp. 892 (W.D. N.Y. 1984). See also Federal Trade Commission, Enforcement Policy With Respect to Physician Agreements to Control Medical Prepayment Plans, 46 Fed. Reg. 48982 (1981).

Certain activities of PGI, particularly those relating to the prices charged by member physicians, may constitute agreements that restrain trade, and absent sufficient productive integration of those competing physicians' businesses through the joint arrangement, may face condemnation as per se illegal price fixing. See Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982). See also Michigan State Medical Society, 101 F.T.C. 191 (1983); Jose F. Calimlim, et al., FTC Dkt. No. 9199 (complaint issued Sept. 30, 1985).[14] A more detailed analysis of how such joint activity would be analyzed under the antitrust laws recently was provided in another staff advice letter, to Michael A. Duncheon, Esquire, a copy of which is enclosed. Antitrust concerns could also be raised if PGI, which has about half of the local area physicians as members, were to prohibit or limit its members' participation in third-party payment programs other than through PGI. Such a prohibition or limitation might prevent other PPO programs unwilling to deal with PGI from entering the market by precluding them from access to local physicians, whose services would be necessary for any such program.

Assuming that PGI's activities did constitute unlawful agreements, the Association, as a result of contracting with PGI, also could be party to illegal conduct. A purchaser who, by contract or agreement, facilitates an illegal conspiracy among providers might be viewed as a co-conspirator rather than a victim of the conspiracy. See Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia, 624 F.2d 476, 483 (4th Cir. 1980), cert. denied, 450 U.S. 916 (1981). Even if the purchaser's role is one of victim of a provider conspiracy, it might be regarded as a participant, albeit an unwilling one, in illegal conduct.[15]

14/ Certain of PGI's activities, such as its performance of utilization review services, appear to be the type of joint activity by competing physicians that often may be allowable under the antitrust laws, assuming that the utilization review program is not used for the anticompetitive purpose of disadvantaging competitors or otherwise to further some anticompetitive agreement among PGI's member physicians.

15/ Of course, depending on the facts, the Association might not be named in an action challenging the illegal conduct. For example, in several cases the Federal Trade Commission has not charged as co-conspirators purchasers of professional health services coerced into agreeing to anticompetitive arrangements by unlawful concerted action on the part of health care providers. See, e.g., Michigan State Medical Society, 101 F.T.C. 191 (1983); Indiana Federation of Dentists, 101 F.T.C. 57 (1983), rev'd, 745 F.2d 1124 (7th Cir. 1984), rev'd, ___ U.S. ___, 106 S. Ct. 2009 (1986); Indiana Dental Ass'n, 93 F.T.C. 392 (1979) (consent order);
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Antitrust risks also potentially exist with regard to exclusionary agreements between the Association and outside parties like PGI where those agreements may have anticompetitive effects. For example, your question regarding the legality of the Association agreeing with PGI on the definition of a preferred provider organization, whereby the Association would not contract with any individual physicians or PPO consisting of less than five physicians, references an area of antitrust concerns. The Association itself may lawfully decide that it is in its own best interest not to contract with individual physicians or small groups, but rather to require that any "preferred provider organization" with which it contracts be comprised of at least five physicians. However, an agreement with PGI to that effect, for the purpose, or with the effect, of primarily serving the economic interests of the PGI physicians, could be anticompetitive and violate the antitrust laws.[16] This is particularly true where, as you have indicated, the Association itself has no legitimate business reason to want such a restrictive policy and, as you have suggested, in fact may prefer to have the option of signing participation agreements with individual physicians.[17]

Texas Dental Association, 100 F.T.C. 536 (1982) (consent order); Association of Independent Dentists, 100 F.T.C. 518 (1982) (consent order); Jose F. Calimlim et al., FTC Dkt. No. 9199 (complaint issued Sept. 30, 1985).

16/ Such a finding might result, for example, where the Association adopted the policy in response to coercion by PGI.

17/ While it might be necessary for a plaintiff to show that the Association benefitted from the challenged restraint (see Harold Friedman, Inc. v. Kroger Co., 581 F.2d 1068 (3d Cir. 1978)), this requirement might be met by the Association having obtained the medical and utilization review services for its PPO program via the contract with PGI. But see American Society of Mechanical Engineers, Inc. v. Hydrolevel Corp., 456 U.S. 556 (1982), where a nonprofit standard-setting organization was held liable for treble damages under the Sherman Act for the antitrust violations of agents acting within the scope of their apparent authority. In Hydrolevel, the Supreme Court specifically rejected the argument that ASME should not be held liable unless its agents acted with an intent to benefit the organization. Id. at 573-74.

Contracting by a Joint Purchasing Organization

Several questions raised in your request[18] relate to essentially the same general question; i.e., what are the limitations imposed by the antitrust laws on the activities of an organization like the Association that is a combination of purchasers, with respect to its ability to limit with whom, or set the terms under which, it will contract with physicians to provide services under the PPO program.[19]

Organizations of purchasers, such as cooperative buying associations, can serve legitimate, procompetitive purposes and, in many cases, may be expected to facilitate rather than to impair competition. For example, such arrangements may allow the participants to benefit from economies of scale in their purchases, facilitate dissemination of information about price and quality of services or products to be purchased, reduce transaction costs, and encourage competition among sellers to obtain sales contracts. However, in some circumstances, these organizations may engage in conduct, or attain a degree of market power, that raises concerns under the antitrust laws.

A cooperative buying arrangement may raise antitrust concerns if it represents a sufficient proportion of buyers in a market so that it can exercise monopsony power, and thereby force prices of the goods and services it purchases below competitive levels, reduce output, and thus result in a misallocation of resources.[20] While the Association's potential market share of

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18/ See letter of September 24, 1984, at 8; letter of October 31, 1984, at 2, 3.

19/ These questions include whether the Association may refuse to contract with certain physicians, whether it may agree with PGI on the definition of a preferred provider organization for the purpose of defining with whom the Association may contract for the provision of physician services, and whether it may have multiple contracts containing different terms for PGI and non-PGI physicians.

20/ A cooperative buying arrangement also may raise antitrust concerns by facilitating price fixing or other anticompetitive collusion among its members in the markets in which they are sellers. Since the Association apparently is not made up of competing businesses in the same industry, this would not appear to be a concern in this instance. Cooperative buying associations also potentially may raise antitrust issues under the Robinson-Patman Act. However, that Act only applies to transactions involving "commodities," and is not pertinent here since your request for advice only relates to the purchase of services -- i.e., medical care services -- by the Association.

purchasers of medical services, no more than 14.4% of the area's population, appears to preclude the possibility that the Association has or could obtain market power, the Association should be aware of the potential application of the antitrust laws to its activities should its plan of operation change so that it did obtain market power.[21] However, absent such market power, or an anticompetitive purpose, the Association generally may decide which providers or categories of providers it chooses to contract with, and on what terms, without raising antitrust concerns. This would include the freedom to contract with PGI or individual physicians, or with both (except to the extent that such contracting is part of an anticompetitive provider conspiracy, as discussed above), and the Association would be permitted to contract on different terms with different categories of providers.

This letter sets out the views of the staff of the Bureau of Competition, as authorized by the Commission's rules. It has not been reviewed or approved by the Commission. As the Commission's Rules (§ 1.3(c)) explain, the staff's advice is rendered "without prejudice to the right of the Commission later to rescind the advice and, where appropriate, to commence an enforcement proceeding."

Sincerely,

M. Elizabeth Gee

M. Elizabeth Gee
Assistant Director

Enclosure

21/ See Mandeville Island Farms, Inc. v. American Crystal Sugar Co., 334 U.S. 219 (1948); United States v. Socony-Vacuum Oil Co., 310 U.S. 150 (1940). See also National Macaroni Mfrs. Ass'n v. FTC, 345 F.2d 421 (7th Cir. 1965) (prices of purchased goods unreasonably depressed by combination of all or the dominant purchasers in a market). While the courts have not previously applied the antitrust laws to combinations of ultimate consumers jointly purchasing goods or services, as opposed to combinations of manufacturers or sellers who purchased inputs and later sold products that used those inputs, such an application has not been precluded by the courts.