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

August 28, 1986

Richard C. Greenberg, Esq.
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Dear Mr. Greenberg:

This letter responds to your request for an informal advisory opinion letter regarding the legality, under the laws enforced by the Federal Trade Commission, of the formation and operation of your client, a preferred provider organization ("PPO") to be known as Pacific International Health, Inc.

According to the information contained in your written submission and supplemented in several telephone conversations, Pacific International Health would be a for-profit corporation operating in the Los Angeles area. It would be particularly designed to serve the health care needs of Japanese and Japanese-Americans which, according to your client, are not being adequately served by existing plans, but it would offer services to individuals of all demographic groups. Its service area would include communities with significant oriental populations in the Los Angeles/Long Beach and Anaheim/Santa Ana primary metropolitan statistical areas (PMSA's). In 1980, those two PMSA's had a total population of 9.4 million, including 39,000 persons with Japanese surnames.

Pacific International Health would be owned by 150 or fewer physician "members." Each member would pay the PPO an annual enrollment fee of $500. In addition, each member would pay the PPO a percentage (set by the PPO at between 5% and 15%) of any fees received for providing health care services to beneficiaries of any of the PPO's third-party payors. If the PPO's expenses exceeded its revenues, each member would be assessed an additional amount. If the PPO's revenues exceeded its expenses, the PPO could decide to refund all or part of the excess to its members in proportion to their contributions. Each member would be on Pacific International Health's provider panel. The provider panel would also include "contract physicians" who would not have an ownership interest in the PPO. The contract physicians would pay the PPO the same percentage that members would pay of fees received for providing health care services to beneficiaries of any of the PPO's third-party payors. They would pay no annual enrollment fee, however, and they would not be liable for any additional assessment or entitled to share in any excess of the PPO's revenues over expenses. Pacific International Health anticipates that there will be no more than 100 contract physicians at any time.

Pacific International Health expects that its provider panel of members and contract physicians will be about 65% primary care physicians and 35% specialists. The panel would comprise about 1% of all physicians in the PMSA's in which Pacific International Health will operate. Panel physicians would not comprise a majority of practicing physicians in the area, nor a majority of any significant physician specialty. In addition, the PPO anticipates that it will provide less than 1% of the overall health services in the PMSA's and less than 10% of such services in the Japanese communities in the service area.

Pacific International Health would enter into contracts with third-party payors (such as employers and insurers) that offer group health benefit plans. Under these contracts, the PPO would provide a third-party payor with a list of physicians on its provider panel. In addition, Pacific International Health would perform peer and utilization review to aid third-party payors in quality and cost controls. Initially, the third-party payors would not pay Pacific International Health directly for any services. In the future, the third-party payors might agree to reimburse Pacific International Health for peer and utilization review.

Pacific International Health would not be a party to any price agreements with physicians or third-party payors. Rather, each third-party payor would contract directly with some or all of the physicians on the PPO's provider panel. Each physician would determine whether and on what conditions to contract with each third-party payor. The third-party payors would pay the physician directly for services rendered to their beneficiaries. The physician would then pay Pacific International Health the appropriate percentage of fees received. Pacific International Health would use these fees for operating expenses, contingencies, or expansion of services. Unneeded funds from any fiscal year could be returned to members in proportion to their contributions.

According to your submissions, Pacific International Health would be a "non-exclusive" plan; it would permit participating physician providers to affiliate with other plans. In addition, third-party payors could permit their beneficiaries to seek care from non-participating providers (although beneficiaries' out-of-pocket expenses might be higher when non-participating providers are used).

Based on the above description of Pacific International Health, it does not appear likely that formation and operation of the PPO would violate the Federal Trade Commission Act or any provision of the antitrust laws enforced by the Commission.[1]

In general, PPOs may be procompetitive by stimulating price, quality and service competition among physicians and third-party payors. Nonetheless, PPOs, particularly PPOs such as Pacific International Health that are established and operated by a group of providers, can raise several potential antitrust issues. Appropriate antitrust analysis of these issues seeks to determine whether the PPO would ultimately serve significantly to lessen competition in relevant markets rather than to stimulate it.

Since a physician-controlled PPO typically contains physicians who offer similar medical services and are competitors in the same geographic area, its operation involves some horizontal agreements among competitors. The nature of such agreements and their likely effects can determine whether the plan will operate anticompetitively.

The first concern in the antitrust analysis of a provider-owned PPO is the extent to which the PPO arrangement involves horizontal agreements among competing physicians to fix or set the price at which they will sell their services to beneficiaries of plans that have contracted that the PPO. Such agreements may violate the antitrust laws. See Arizona v. Maricopa County Medical Society, 457 U.S. 332 (1982).[2] However, Pacific International Health has been structured to avoid agreements among physicians on price or price-related terms. Instead, there will be individual negotiations between each third-party payor and each physician provider.

Second, other agreements among PPO physicians that restrain competition among them and are broader than necessary to assure efficient operation of the PPO would be likely to violate the antitrust laws. For example, agreements among otherwise

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1 This advisory opinion is limited to the proposed program described above. It does not apply to actions that are different from those described.

2 For a discussion of the analyses applicable to price-related agreements among physicians members of a PPO, see letter from M. Elizabeth Gee, Assistant Director, Federal Trade Commission, to Michael A. Duncheon, March 17, 1986.

competing PPO physicians regarding the terms on which they would deal with patients not covered by the PPO or with other PPOs would be unlawful. There is no indication that such agreements are contemplated by or will be involved in the proposal to establish the PPO. A third antitrust concern involves agreements that could foreclose competition from other PPOs or other alternative delivery plans such as health maintenance organizations (HMOs). For example, exclusive arrangements between physicians and the PPO could unreasonably restrict competition in the market in which the PPO competes. A PPO could exclude competition by using exclusive contracts if so many physicians in a given market affiliated exclusively with one PPO that it became difficult or impossible for other PPOs or HMOs to enlist physicians and to compete for payors and enrollees. Based on your representations, however, it appears unlikely that Pacific International Health will be structured to or otherwise be able to foreclose entry and competition by other PPOs and by HMOs. As a non-exclusive plan, the PPO would permit physicians to participate in competing PPOs and in HMOs. Thus, the extent to which physicians agree to contract with the PPO should not serve to foreclose competition from other plans. In addition, it does not appear likely that the PPO will include such a large proportion of physicians in any market that competing organizations would be unable to recruit enough physicians to establish their own panels.

You have asked specifically whether organization and operation of a PPO targeting persons of Japanese descent would raise significant antitrust questions. Unless health care services provided to people of Japanese descent could be considered a separate relevant product market, no new antitrust issues are raised by this aspect of the proposal. Absent a showing of special difficulty in providing services to such persons (including geographic considerations), it is unlikely that services sold to one demographic group would be considered a separate product market from services sold to the rest of the population. To the extent that persons of Japanese ancestry have access to prepaid health care plans available to others, and absent any other indication that the products are distinct, it seems likely that the relevant product market would not be limited to sales of health care services to those persons.

Even if the product market could be so narrowly defined, no antitrust problem would arise, so long as the competition for patients by other groups of physicians was not precluded. If physicians have access to other organizations that can compete for patients' business, or can sell their services directly to

patients without being a member of the PPO, then competition among PPO physicians and others will not be impaired by the operation of the PPO, even if the PPO were to obtain a very large share of the market. Moreover, you estimate that the PPO will obtain less than a 10% share of the services rendered in the Japanese communities in the service area.

For the reasons discussed above, it does not appear that the formation and operation of Pacific International Health in the manner described above would violate any law enforced by the Federal Trade Commission.

You should be aware that the above advice does not bind either the Commission or the Bureau of Competition. Both the Commission and the Bureau of Competition retain the right to reconsider the questions involved. If implementation of the proposed program results in substantial anticompetitive effects, or if the program is used for improper purposes, the Bureau or the Commission may take such action as would be in the public interest.

Sincerely,

M. Elizabeth Gee
Assistant Director

BC/MEGee/MStraight/rm/8/25/86