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REMARKS OF

J. PAUL McGRATH
ASSISTANT ATTORNEY GENERAL
ANTITRUST DIVISION

BEFORE THE

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CONCERNING PREFERRED PROVIDER ORGANIZATIONS AND THE ANTITRUST LAWS

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I welcome the opportunity to address this topic at such a fortuitous time--a time when the health care industry is experiencing an unprecedented surge of competition and innovation and when cost containment finally seems to be on everyone's agenda. This new interest in competition has been spurred in part by an increasingly cost-aware public and in part by recent Supreme Court recognition that professional service industries are indeed subject to the competitive mandates of the antitrust laws. At the same time, both the Antitrust Division and the Federal Trade Commission have begun to devote substantial resources to maintaining and promoting competition in the health care field. Therefore, sensible competition policies and sound antitrust counselling should be foremost in the minds of your clients and employers.

I will focus my remarks today on an area of enormous potential significance to the growth of competitive health care markets: that is, contracting for the provision of health care services through preferred provider organizations and other alternative health care delivery systems. I hope to do two things: first, to dispel some of the uncertainty that may inhibit the development of efficient, procompetitive arrangements of this kind and, second, to warn against certain anticompetitive types of concerted behavior that would thwart their growth.

The methods we use to pay our health care bills--including government programs and private insurance plans--significantly affect the entire workings of our health care delivery system.

If you will allow me to borrow a medical metaphor from the Supreme Court, health care financing is the "central nervous system" of the health care industry. Thus, most of the faults that we may find with our health care providers can be traced to the faults and inefficiency of our financing system.

You probably are all familiar with the conventional economic analysis of the cost-based reimbursement practices of third-party payers. Cost-based reimbursement has significantly distorted marketplace incentives. It has perversely rewarded hospitals and doctors who increase costs and consume greater resources. It is not an exaggeration to say that cost-based reimbursement has been the major culprit fueling inflation and creating economic inefficiency in our health care industry. In short, it is by now clear that if we want an efficient health care industry, we must have competitive bargaining between the buyers and sellers of health care services.

By providing this crucial bargaining link between buyers and sellers, preferred provider organizations--or PPOs--and similar arrangements should help to revolutionize the dynamics of the health care marketplace. First, they place price and utilization controls squarely on the bargaining table, where they belong, subjecting them to "normal" marketplace incentives. Second, health insurers will begin to compete on premium levels, service, and other competitive variables, giving consumers the opportunity to shop for the mix of price, service, quality, and convenience they prefer. Third, hospitals and physicians will be motivated to contain costs by

controlling utilization and by pricing competitively. And, finally, an often-overlooked but very important benefit of PPOs is the spur they give to non-participating physicians and hospitals to contain costs and lower prices.

Given the procompetitive potential of these contractual arrangements, it should come as no surprise that we have encouraged their development. In business review letters, we repeatedly have stressed the potential procompetitive benefits that may arise from appropriately structured PPOs and similar arrangements. In general, it seems clear that PPOs controlled by insurance companies, third-party administrators, or independent contractors have real procompetitive potential and in most cases pose little risk of anticompetitive harm. Moreover, although PPOs created and controlled by <u>providers</u> present somewhat more of an antitrust risk, and thus are subject to somewhat greater scrutiny, we recognize that they too generally provide significant competitive benefits. Indeed, provider initiative and entrepreneurship are exactly what is needed to inject competition into the market.

Therefore, I think we need to remove regulatory barriers to the formation of competitive PPOs. I agree with those who question the wisdom of unnecessarily restrictive, so-called free choice statutes that prohibit groups of physicians or hospitals from selectively negotiating with health care consumers and third party-payers. By requiring either that insurance programs permit all health care providers to participate or that they pay the same rates to all providers,

these statutes prevent the development of competing systems of doctors and hospitals. Most or all of such statutes predate programs such as PPOs and their restrictive effects on the development of PPOs and similar arrangements very likely were neither intended nor anticipated.

We should also encourage the free flow of information concerning health care providers and utilization patterns. Access to such information is essential both to third-party payers purchasing PPO services and to those seeking to put together PPO panels made up of cost-conscious providers. It was for this reason that the Division recently urged the Health Care Financing Administration of HHS to make public dataprofiles collected by Peer Review Organizations concerning specific hospitals and physicians.

But, equally important, we must vigilantly police collective actions by health care providers that are designed only to inhibit competition. Unfortunately, we have witnessed incidents in which health care providers have greeted competitive contracting with cartel activity.

Of course, concerted action by health care providers seeking to obtain higher levels of payment from third-party payers is not new to the antitrust enforcement agencies. In two cases, the Antitrust Division challenged attempts by nursing home trade associations to increase the level of their reimbursement from state Medicaid programs by refusing to deal with those agencies except under terms mutually agreed upon through the associations. More recently, the Division filed

suit in federal district court in North Dakota alleging that the state hospital trade association and 14 member hospitals engaged in per se illegal price fixing by agreeing that each would refuse to discount their charges for services in their individual negotiations with the Indian Health Service. That case is still pending.

Recently, we have begun to see similar concerted activity involving PPOs. Last October, the Division announced that it would challenge a physician-organized PPO in Stanislaus County, California as a violation of Section 1 of the Sherman Act. The Stanislaus PPO was created in 1982 ostensibly to offer PPO physician services to third-party payers. The organization's membership comprised over 50% of the physicians in one market and over 90% of the physicians in another market. In addition, there was substantial direct evidence that the PPO was expressly formed to eliminate or reduce competitive pressures on physicians in the relevant markets to discount their fees. The PPO required members to agree not to participate in any other PPO or HMO without the express approval of, or without contracting through, the Stanislaus PPO. Because of the PPO's apparent anticompetitive intent and the likely anticompetitive effects that would result from its rules and structures, we informed the PPO that we were prepared to file a civil suit alleging a restraint of trade under Section 1. The PPO elected to disband. Although the result of this investigation does not signal that the Division considers all provider-sponsored PPOs to be restraints of trade, I hope this incident will make clear

that provider activity designed to thwart competitive bidding by hindering the development of competing provider panels will be challenged.

In another matter, both the Antitrust Division and the State of Maryland recently investigated an apparent attempt by physicians in Allegany County, Maryland to organize a concerted refusal to deal with a PPO. Among other things, physician leaders of the county medical society and others in the area circulated a memorandum urging physicians not to participate in the Blue Shield of Maryland PPO because of its proposed fee discounts and utilization review standards. Activities such as this, when plainly designed to thwart the price discounting and cost control objectives of PPOs, are per se illegal under Section 1 as price fixing and a group boycott. We chose not to pursue the matter further because the parties took prompt, voluntary action to correct their activities and because the State of Maryland had itself admonished the Medical Society.

It should be clear from these examples that concerted action to tamper with competitive price mechanisms for physician or hospital services will be vigorously prosecuted. Having said that, let me now outline the Division's general approach to analyzing provider-sponsored PPOs. This analysis generally would apply only to PPOs controlled by health care providers, and not to PPOs operated by third-party payers, employers, and independent contractors unless such PPOs were

created or serve to conceal horizontal restraints among providers. 1/

It is appropriate to analyze provider-sponsored PPOs under principles similar to that applicable to joint ventures generally. Under many circumstances, joint activity by competitors is legal under the antitrust laws where it enhances efficiency and promotes competition even though it may entail some horizontal agreements among its members. Under this analysis, at least three elements must be satisfied for a joint venture among competitors to pass muster under the antitrust law: (1) the horizontal agreements that are part of the venture must be ancillary to a cooperative activity that promotes competition; (2) the collective market share of the participating venturers must not be so large that it forecloses effective competition; and (3) the parties must have no anticompetitive purpose.

To avoid the rule set forth in Maricopa, the provider-controlled PPO must show that the horizontal aspects of its operations (e.g., an agreement between physicians setting price and utilization standards) are reasonably related and ancillary to a new competitive venture. Where a PPO can make the showing that it offers economic integration and efficiency advantages and that those advantages outweigh harms

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1/ PPOs operated by third parties may, of course, be subject to antitrust scrutiny for reasons other than the risks associated with provider cartels, e.g., where they engage in collusion with other PPOs or where they possess and exercise monopsony power.

from lessening competition among participating providers, it should pass antitrust muster.

As a threshold matter, physician-controlled PPOs entail some degree of integration to produce efficiencies. Although providers typically do not share risk, there are a number of aspects of PPO agreements that militate in favor of concluding that an efficiency-enhancing integration may be present. These may include: an agreement to treat patients on a fee-for-service basis at reduced or discounted levels or pursuant to some fee schedule with no balance-billing; an agreement to abide by some limitation on their practice in the form of utilization review; an agreement to administer claims and jointly market their venture; and an agreement to select a group of limited size to engage in "bidding" for contracts against other panels. For small employers or insurance companies unable to organize their own provider panels, a provider-sponsored PPO may provide a ready-made vehicle for competitive bargaining that might not otherwise be available. In short, a PPO of limited size can make a plausible showing that it is an integrated activity enhancing efficiency and competition despite price or other horizontal agreements necessary for and ancillary to its operations.

Second, the membership of a provider-sponsored PPO must not be so inclusive that it prevents the formation of effectively competing PPOs, such as in the Stanislaus matter. General joint venture principles are relevant to planning in this

area. 2/ Our analysis of typical health care markets to date indicates that we will likely have no reason to challenge the size of a provider-sponsored PPO with fewer than 20% of the physicians in active private practice in a market. Moreover, as I have said on other occasions, we will not be mesmerized by market share statistics. As the proportion of physicians increases above this 20% benchmark, we will apply a market-specific analysis to assess the PPO's likely competitive effects in the market in which it competes. Among other things, we will consider the minimum size panel needed to compete efficiently given an area's particular demographic characteristics and consumers' demand for services, the nature of the particular PPO, the efficiencies achieved, the extent to which participating physicians are willing and able to participate in competing PPOs, and the actual and potential competing alternative health care delivery systems in the market.

Finally, we will look closely at evidence of anticompetitive intent and at any collateral agreements that bear no relationship to the PPO's success and that may pose competitive problems. Certainly, any effort to influence the prices charged by participating doctors or hospitals to payers

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2/ In the context of research joint ventures, for example, we have stated that combinations of competitors with less than 20% of the market are unlikely to raise competitive concerns and that levels somewhat above the general merger standards applicable to concentrated markets should apply to production joint ventures. See Remarks of J. Paul McGrath at the 18th Annual New England Antitrust Conference, November 2, 1984.

not covered by the PPO will raise antitrust questions. Likewise, efforts to inhibit the freedom of providers to associate with other health plans or to discourage providers from granting similar or greater price concessions to other PPOs will be closely examined. In short, consistent with conventional analysis of ancillary restraints, the PPO agreement must be no broader than necessary to promote the legitimate purposes of the venture.

Let me offer a few corollaries to these general principles. First, from an antitrust perspective, at least, PPOs need not be overly concerned about excluding physicians or hospitals as participants. The essential feature of a PPO is its selectivity, and the primary competitive risks associated with PPO formation--as with most joint ventures--are of over-inclusiveness rather than exclusion. Thus, the exclusion of some interested physicians and hospitals will likely promote competition among panels, and is a necessary part of the process.

Second, an employer or insurer seeking to obtain favorable terms from providers should feel free to conduct hard-nosed negotiations, seeking out discounts and utilization controls that will meet its needs. A PPO's involvement in hard bargaining reflects the market process at work.

Finally, given the significant increase in competition among providers that may be fostered by competitive contracting, it is very important to assure that competitive conditions exist in provider markets. In particular, mergers

that reduce options for competitive contracting and anticompetitive restrictions on non-physician providers will be scrutinized closely.

In closing, let me say that I've noted that as competition has grown in health care markets, the pressures for a return to a regulated environment also have intensified. For example, a number of states are considering greater reliance on rate regulation, "all payers proposals," controls on capital expenditures, and other regulatory alternatives. My belief is that where reliance is placed on the competitive marketplace, real reductions in costs and greater efficiency will be realized. That outcome provides the most persuasive argument in the debate between competition and regulation. The antitrust enforcement program and competition policy I have outlined are essential to assuring that the competition agenda is given a fair chance to realize the goals of cost containment and efficiency.