FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

March 26, 1984

William C. Kopit, Esquire
Epstein, Becker, Borsody
and Green, P.C.
1140 19th Street, N.W.
Washington, D.C. 20036

Re: Request for Staff Advisory Opinion,
Kitsap Physicians Service

Dear Mr. Kopit:

By letter of November 4, 1984, you have requested that the Federal Trade Commission staff issue an advisory opinion concerning two practices proposed to be undertaken by your client, Kitsap Physicians Service (hereinafter referred to as "KPS" or the "Plan").[1] Specifically, you have asked:

(1) Whether a nonprofit IPA-type HMO which is physician sponsored may include a clause in its contracts with participating physicians, whereby such physicians agree not to offer any other health plan lower rates than those offered to the Plan; and

(2) Whether such an HMO may deny membership in the plan to all [new] physicians in a specific category in which the physician to enrollee ratio is currently higher than certain specified generally acceptable standards.

Kitsap Physicians Service is a physician-sponsored, nonprofit medical care prepayment plan operating in Kitsap, Jefferson, and

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1 This letter reflects my views as an official of the Commission's Bureau of Competition. It is not binding on the Commission itself. <u>See</u> Section 1.3(c) of the Commission's Rules of Practice.

Mason counties in the State of Washington. It is licensed by the State of Washington as a "health care service contractor," whose operation you describe as that of an independent practice association-type health maintenance organization. KPS competes with the statewide Blue Cross and Blue Shield plans, which operate in its service area, with Group Health Cooperative of Puget Sound (a health maintenance organization), and with commercial health insurers. You state that KPS currently covers about 25 percent of the population of its three-county service area (approximately 44,000 enrollees out of a population of about 175,000). By our estimate from publicly available data, its share of the privately insured population[2] is approximately 33 percent. According to your submission, KPS has a "non-dominant aggregate market share" of area subscribers.

Your submission states that KPS has participation agreements with 201 physicians, representing more than 95 percent of all physicians in the Plan's three-county service area. The number of physicians practicing in KPS's service area has increased by about 50 percent since 1977, a rate "substantially greater" than the rate of increase in the area's population during that period. Participating physicians are not prohibited from participating in any other health plan. Participating physicians also are at risk for cost overruns of the Plan (i.e., where the total costs of services provided exceed the Plan's revenues from subscriber premiums) "through a pro rata system which permits reductions in the amount payable to physicians." As a health maintenance organization, KPS apparently is contractually and legally obligated to provide covered medical services to its subscribers, not merely to pay for such services.

With regard to your first question, concerning KPS's proposed use of a "most favored nation" clause in its participation agreement with member physicians, we are unable to offer an opinion at this time, pursuant to Section 1.1(b) of the Commission's Rules of Practice, since "the same or substantially the same course of action [by another entity] is under investigation . . . ."

With regard to the second question, based on our analysis of the available information, there is cognizable danger that closing off access to participation in KPS for additional physicians in various medical specialties would, on balance, have substantial anticompetitive effects. While we have not, of course, determined that adoption of the proposed restriction would be unlawful, we are not able to provide you with an advisory opinion approving the proposed conduct.

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2 This excludes the uninsured and those persons covered under governmental programs such as Medicare, Medicaid, and CHAMPUS.

KPS is a joint venture of competing fee-for-service physicians that operates an independent practice association-type health maintenance organization. Under the Commission's Enforcement Policy with Respect to Physician Agreements to Control Medical Prepayment Plans" (Sept. 25, 1981) (hereinafter "Enforcement Policy Statement"), KPS's exclusion of new physicians in various specialties would constitute a concerted refusal to deal with competitors by the physicians controlling a "partially integrated plan." Enforcement Policy Statement at 23-24, 27. On its face, a concerted refusal to deal with new entrants by an organization of 95 per cent of a market's participants is inherently suspect, requiring close antitrust scrutiny. Consistent with the Enforcement Policy Statement, we have analyzed the proposed conduct under the antitrust rule of reason, because independent evidence of a predominantly anticompetitive purpose is absent and the exclusion may plausibly be related to the effective operation of the plan.

Using rule-of-reason analysis, we have attempted to assess any likely anticompetitive effects of the policy in light of the nature of the restraint and the degree, if any, of KPS's market power. Under the KPS proposal, non-member physicians in various specialties -- especially those considering entry, and new entrants in the KPS market area -- would be foreclosed from access to patients covered by KPS. As noted above, these patients reportedly represent approximately 25 percent of the area's population and, by our estimate, approximately one-third of the area's residents with private health insurance.[3]

You state in your letter that KPS is "non-dominant" in its market. Although the available information does not clearly establish either the existence or absence of market power, it does suggest that participation in KPS may be sufficiently important or essential that barring new physicians from KPS would effectively discourage or prevent entry by many of them into the market.[4] If so, the effect of the proposed policy would be to protect the physicians who now participate in KPS from competition by new

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3 KPS's market share in recent years has been much higher, but has fallen in the last few years.

4 In October, 1981, a federal district court concluded in an antitrust lawsuit that "KPS is the dominant health care insurer" in its service area, that it had an "entrenched position," and that "[t]he financial benefits of KPS membership are substantial." Blue Cross v. Kitsap Physicians Service, 1982-1 Trade Cas. (CCH) ¶64,588 at 73,205, 73,208 (W.D. Wash. 1981). Anticompetitive effects could be very substantial if KPS has market power. See Enforcement Policy Statement at 27; Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia, 624 F.2d 476 (4th Cir. 1980), cert. denied, 450 U.S. 916 (1981).

entrant physicians not only for KPS patients, but for all the patients in the market. By deterring new entry, the rule could also limit the supply of physicians available to participate in competing health care organizations that face difficulty in attracting adequate numbers of physicians in the area into their programs. In particular, these plans may have difficulty recruiting physicians to the area because they probably cannot generate for their participating specialists sufficient patient volume for a full practice, if these practitioners are not allowed to join KPS.[5]

Because the proposed restraint may be substantially anticompetitive in some respects, we have attempted under the rule of reason to assess its countervailing justifications. In that regard, a restraint may be justified, notwithstanding its anticompetitive aspects, if it is capable of increasing the effectiveness of KPS as a competitor and is no broader than necessary for that purpose.

One stated justification is that the restriction addresses problems of management and physician commitment to Plan objectives caused by an "excessive" number of participating physicians. You state that having too many physicians makes it difficult for the Plan to perform effective utilization review or to demonstrate to physicians that their economic interests are commensurate with those of KPS. This justification has some plausibility as to health plans in general. It is difficult, however, to give substantial weight to this rationale when proffered by a plan that apparently will continue to represent and permit participation by virtually all of the current market participants, but plans to exclude all -- and only -- new entrants in various specialties. Although it cannot conclusively be determined by us on the information presented, the proposed policy may be both overbroad, in its discriminatory treatment of new entrants, and underinclusive, insofar as the Plan is seeking to promote effective utilization review and less costly practice patterns. Specifically, the proposal will exclude all new physicians, regardless of their individual cost consciousness, utilization patterns or other practice characteristics, without necessarily strengthening utilization controls regarding those physicians already participating in the Plan nor conditioning their continued participation in the Plan on adherence to stricter utilization controls. Nor does the Plan appear to be taking other steps that will reduce participation so as to achieve a material difference in Plan operations. Under the circumstances, we do not believe that this argument could justify the proposed exclusionary policy.

The key stated justification for the proposed policy is that reducing the number of participating physicians available to KPS

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5 <u>See</u> Blue Cross v. Kitsap Physicians Service, <u>supra</u>, note 4 at 73,208; Enforcement Policy Statement at 25.

patients to an "appropriate" ratio will result in lower utilization and thus lower premiums. You explain that the Graduate Medical Education National Advisory Committee study ("GMENAC")[6] indicates that 84 is the "appropriate" number of physicians, drawn from various specialties, for a community of 44,000 people. Applying this doctor-patient ratio to KPS's 44,000 person enrollment makes 84 the "appropriate" size for its panel of participating physicians, you submit, rather than the 201 that KPS now has. However, KPS's proposed application of the figures you state are drawn from the GMENAC study seems questionable, even assuming that the GMENAC study recommendations are sound.[7]

First, the GMENAC study's conclusions relate to the physician to population ratios and utilization rates within geographic market areas, and not to such ratios or rates within a particular insurance or prepayment program. KPS's transfer of these conclusions from one context to another is questionable both in concept and application. Second, even if they are generally useful for the kind of purpose contemplated by KPS, it does not appear that the GMENAC recommendations provide support for, or even are consistent with, implementation of the proposed restraint on the facts here.

With regard to the first point, the GMENAC report estimates appear to reflect an assessment of the effects of physician behavior in an entire market area, which might differ substantially from physician behavior within a partially integrated prepaid medical care plan with some utilization controls and some assumption of risk by participating physicians. Thus, it seems wholly speculative to assume that reducing physician participation in KPS will affect their practice patterns so as to reduce KPS's costs. Moreover, on average, a KPS doctor presumably spends only about 25 percent of his or her time taking care of KPS patients, since virtually all the area's current doctors participate in KPS and it covers about 25 percent of the area population. Thus, unless KPS envisions its physicians serving KPS enrollees almost exclusively and not treating many other patients (and you have indicated no such plans), it would appear that if 84 physicians, working full-time, are, by GMENAC's computations, "appropriate" for a community with a population of 44,000, then the "appropriate" number of participating physicians spending about a fourth of their time with KPS patients and the rest of their time with other

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6 <u>See generally</u> Report of the Graduate Medical Education National Advisory Committee to the Secretary, U.S. Department of Health and Human Services (1980).

7 The GMENAC study recommendations were generally tentative in nature and their accuracy and usefulness has been questioned. You do not cite to particular references in the GMENAC study as the source for the planned KPS physician-population ratios.

patients would be well over 200 and could be as many as four times 84, or 336 -- far more doctors than KPS now has. Or, from another perspective, contrary to your assertion that there is a problem of "over-concentration of physicians in the KPS service area,"[8] the population of 175,000 in that three-county area apparently would need an increase in physician supply, perhaps to well over 300, in order to achieve the "appropriate" physician-patient ratio under the tentative GMENAC guidelines as you describe them. Consequently, it is not clear why reducing, in the way KPS proposes, the number of physicians treating KPS patients would result in utilization by KPS enrollees at a lesser, "appropriate" rate under the GMENAC study, so long as the participating doctors continue to compete in the broader market.

As to the second point noted above, KPS may be assuming, in adopting the GMENAC study's suggested physician to patient ratios for communities, that KPS enrollees and physicians make up a separate community so that their utilization behavior occurs apart from, and unaffected by the rest of the medical care market in KPS's service area. This could be true to some extent if KPS enrollees were restricted to using only KPS participating physicians and KPS participating physicians treated only or almost only KPS enrollees. You have indicated no such plans. Viewed this way, moreoever, to achieve KPS's stated goals of utilization reduction and cost control, it presumably would have to reduce its complement of participating physicians to 84 or at least to that general range, assuming the accuracy and usefulness of the GMENAC study's figures for KPS's purposes. A participation freeze or relatively small reduction in the number of participating physicians would leave substantial "excess capacity" in the KPS system, presumably resulting in the same overutilization problem KPS hopes to address by its proposal. The proposal to close membership in KPS to new physicians, absent a program to rapidly and radically reduce participation among current members, appears incapable of advancing significantly KPS's stated goal of reducing participation so as to reduce any associated excess utilization of services.

As to KPS' stated justifications, therefore, while cost-containment is a legitimate, efficiency enhancing function of KPS, the proposed "restraint" -- the closing of membership to new physicians -- does not appear capable of achieving such efficiency to any meaningful degree, and in what it does do, seems broader and more restrictive in its treatment of new physicians than is necessary in order to promote KPS's stated long-term goal.

There is, we emphasize, no inherent likelihood of antitrust illegality in limitations on physician participation in health

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8 Letter from William G. Kopit to Mr. Timothy J. Muris, Director, Bureau of Competition, Federal Trade Commission (November 4, 1983) at 7 n.12.

plans. There is, however, a striking difference between KPS and a health maintenance organization or other plan that is not provider-controlled, that has always had a limited physician panel, or that has a much smaller market share. Antitrust analysis of membership limitations by such a group is very likely to have quite different results with regard to the likelihood that the restraint would predominantly serve a legitimate business purpose without undue exclusionary effect.

In sum, based on the available facts in this particular situation, there appears to be a realistic possibility that substantial anticompetitive effects could result from imposition of the proposed freeze on physician participation in KPS for various medical specialties. Moreover, it is uncertain whether the restraint would have offsetting procompetitive effects, because it does not appear reasonably related to the achievement of substantial cost savings nor does it appear that the restraint is no broader than necessary to promote legitimate cost-containment objectives of the plan. We are, therefore, unable to provide you with an advisory opinion that the proposed participation restriction would not violate the antitrust laws.

Sincerely,

Arthur N. Lerner
Assistant Director