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MINIMIZING ANTITRUST RISKS OF BLUE CROSS AND BLUE SHIELD PLANS

Charles J. Steele*

INTRODUCTION

In Becker v. Blue Cross and Blue Shield of Southwestern Virginia, Inc.,¹ Johnson v. New Mexico Blue Cross and Blue Shield,² General Hospitals of Humana, Inc. v. Baptist Medical System, Inc.,³ and perhaps other cases, plaintiffs charged Blue Cross and Blue Shield plans and some or all of their trustees⁴ with violations of Section 1 of the Sherman Act.⁵ While in none of these cases did plaintiffs obtain judgments against the individual trustees, they highlight the fact that trustees as well as plans are antitrust targets. For that and other reasons, it obviously is important to minimize antitrust risks, especially in this era of rampant antitrust activity in the field of health care financing.

Becker was an alleged boycott case brought by chiropractors in southwestern Virginia against the Roanoke, Richmond and District of Columbia plans.⁶ Also named as defendants were the physician trustees of the three plans. The theory behind naming only the physicians apparently was that they were competitors of chiropractors and they had their own economic stake in maintaining the boycott. At last word, the case was still pending.⁷

Johnson is also an alleged boycott case, but in Johnson the plaintiff chiro-

* Partner, Pierson, Ball & Dowd, Washington, D.C.
2. 1987-2 Trade Cas. (CCH) ¶ 67,737 (D.N.M. 1987).
4. While plans generally use the term “trustees” rather than directors, the plan boards of trustees act as boards of directors. The fiduciary duties of plan trustees have been held to be the duties of corporate directors rather than the higher duties of trustees. Christiansen v. National Savings and Trust Co., 683 F.2d 520 (D.C. Cir. 1982).
6. Subsequent to the complaint being filed, the Richmond and Roanoke plans merged their operations.
7. The plaintiffs voluntarily dismissed the D.C. plan and its trustees.
practors named all trustees, including the plan's CEO, as defendants. Following a change in counsel, plaintiffs voluntarily dismissed the individual defendants, leaving only the plan and the state medical society as defendants.

In *Humana*, the plaintiff proprietary hospital chain alleged a conspiracy among two Little Rock hospitals, the Arkansas plan, and others to keep Humana out of the Little Rock market. Among "the others" were two executives of the defendant hospitals who sat on the plan board. In a series of four separate orders and opinions, the court granted summary judgment in favor of all defendants, both corporate and individual.

In *Copperweld Corp. v. Independence Tube Corp.*, the Supreme Court held that a corporation and its wholly owned subsidiaries are incapable of conspiring with each other for purposes of Section 1 of the Sherman Act. In so doing the Court expressly held, "officers or employees of the same firm do not provide the plurality of actors imperative for a § 1 conspiracy." If a corporation is incapable of conspiring with its employees, why are plan trustees being named defendants in Section 1 Sherman Act suits? The answer is found in the "independent stake exception," alluded to by the Court in *Copperweld* when it said "many courts have created an exception for corporate officers acting on their own behalf."

In *Weiss v. York Hospital*, the Third Circuit held that "the medical staff [of a hospital] is a combination" as a matter of law. Can the same be said for the board of trustees of a plan? At least in the absence of provider control of the board, the answer is no; but as was held in *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, the board can be a combination as a matter of fact. The Weiss holding that the medical staff was a "walking conspiracy" and not a single entity rested on the premise that "[e]ach staff member . . . [had] an economic interest separate from and in many cases in competition with the interests of other medical staff members." The same requirement should exist with respect to plan boards, for example, unless the trustees have an economic interest separate from and in competition with the interests of other trustees, the board should be considered a single entity incapable of a Section 1 conspiracy.

So, how do a plan and its trustees minimize their risk of being sued in

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9. Id. at 769.
10. Id. at 769-70, n.15. (The Court cited, in support of its proposition, H & B Equipment Co. v. International Harvester Co., 577 F.2d 239, 244 (5th Cir. 1978); Greenville Publishing Co. v. Daily Reflector, Inc., 496 F.2d 391, 399 (4th Cir. 1974) (dictum); and Johnston v. Baker, 445 F.2d 424, 427 (3rd Cir. 1971).
12. 624 F.2d 476 (4th Cir. 1980).
13. 745 F.2d at 815.
antitrust cases? The answer is not easy. The plans have won a large majority of the antitrust suits brought against them, an indication of the fact that it is not possible to prevent bad antitrust suits from being filed. One approach is to examine the kind of suits that have been filed and the kind of plaintiffs who filed them. One conclusion to be drawn from this approach is that the plans can not change all the policies that led to the filing of the suits. To do so would not only change the nature of the plans, it would cripple their operations. This effect would result because those suits have attacked, among other things, provider differentials, the usual, customary and reasonable reimbursement formula, peer review of the reasonableness of provider charges, bans on balance billing, exclusive service areas under the plan license agreements with Blue Cross Blue Shield Association ("BCBSA"), participation in health care planning, the operation of Preferred Provider Organizations ("PPOs") and the right not to contract with every type of health care provider.

I. THE DIFFERENTIAL

The manner in which plans reimburse hospitals for care rendered to subscribers has changed over the years, but many plans still enjoy a differential or, as others call it, a discount. Even in Maryland, where the Health Services Cost Review Commission sets rates for hospitals, the plans operating in that state receive a six percent differential.\(^{14}\) The differential was the subject of the first major antitrust case involving a Blue Cross plan.

In *Travelers Insurance Co. v. Blue Cross of Western Pennsylvania*,\(^{15}\) Travelers charged the plan with restraining trade in violation of Section 1 of the Sherman Act and with monopolizing and attempting to monopolize in violation of Section 2. The district court found that the plan's conduct was immunized by the McCarran-Ferguson Act and that even if it were not, there was no violation of the Sherman Act. The Third Circuit agreed.\(^{16}\)

14. See, Blue Cross of Maryland, Inc. v. Franklin Square Hospital, 277 Md. 793, 352 A.2d 798 (1976); and Health Services Cost Review Commission v. Franklin Square Hospital, 372 A.2d 1051 (Md. 1977) for an explanation of the method of operation of the Commission and its relationship with Blue Cross plans.


16. In finding the McCarran-Ferguson Act applicable, the court said:

In the present case, the district court found that the interrelationship of hospital payments and subscribers' rates was such that Blue Cross' arrangement with hospitals should be considered part of the "business of insurance." This conclusion is a sound construction of the law and is amply supported by the evidence.

481 F.2d at 83. The Supreme Court subsequently disagreed that the plans' provider contracts were part of the business of insurance and fell within the McCarran-Ferguson Act exemption in *Group Life & Health Ins. Co. v. Royal Drug Co., Inc.*, 440 U.S. 205 (1979). See also, *Union
In *Travelers*, the plan provided hospitalization coverage for fifty-one percent of the population in its twenty-nine county service area. The plan accounted for sixty-two percent of all patient days covered by insurance other than Medicare and Medicaid. It had contracts with 101 hospitals under which it reimbursed the hospitals only for audited costs, subject to a ceiling and not including expenses of capital construction, free services to indigents and bad debts. This resulted in a fourteen to fifteen percent differential. It also subsidized poor risk subscribers to the tune of $27,000,000 in the year 1960, and its hospital contracts were approved by the State Insurance Department.

On the merits, the court held that even if the plan had "monopoly power," an issue the court did not reach, "Blue Cross's arrangement with hospitals neither illegally restrains trade in violation of Section 1 of the Sherman Act nor constitutes, in violation of Section 2, 'the willful acquisition or maintenance of that power as distinguished from growth or development as a consequence of a superior product, business acumen, or historic accident,'" applying the criteria set forth in *United States v. Grinnell Corp.*

The court went on to say that the case did not fit into any of the "garden variety" vertical restraints such as tie-ins and exclusive dealing arrangements and had to be looked at on its own facts in order to reveal whether any restraint of trade it caused was reasonable. In language that makes one long for the good old days the court found the plans conduct reasonable, saying:

In its negotiating with hospitals, Blue Cross has done no more than conduct its business as every rational enterprise does, *i.e.*, get the best deal possible. This pressure encourages hospitals to keep their costs down; and, for its own competitive advantage, Blue Cross passes along the saving thus realized to consumers. To be sure, Blue Cross's initiative makes life harder for commercial competitors such as Travelers. The antitrust laws, however, protect competition, not competitors; and stiff competition is encouraged, not condemned. It must be pointed out that the size of its competitors does not give Blue Cross the freedom to conduct other than fair competition for business. The dependence of the community on health facilities requires that anti-competitive practices not be tolerated.

As for Section 2: The district court found, on ample evidence, that Blue Cross owes its success to the completeness of its coverage. From the time of its organization in the late 1930's, Blue

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18. 481 F.2d at 84.
Cross has reimbursed hospitals for all covered services rendered its subscribers. Private companies, on the other hand, have, until relatively recently, provided only that their policyholders would be indemnified up to a set dollar ceiling. Blue Cross thus has exposed itself to considerably greater risk because of the possibility that treatment would be extensive and because of the probability that hospital costs would rise. By shouldering the risk, Blue Cross has made itself considerably more attractive to consumers. The antitrust laws were not intended to condemn such conduct.  

II. PRICE FIXING AND USUAL, CUSTOMARY AND REASONABLE; PEER REVIEW OF REASONABLENESS; THE BANON BALANCE BILLING

In Arizona v. Maricopa County Medical Society, physicians belonging to a "foundation for medical care" agreed to charge no more than agreed upon maximum fee schedules as payment in full for their services to policyholders of certain insurance companies. The physicians could charge less than the scheduled amount and charges to uninsured patients were unrestricted. The foundation, to which most area physicians belonged, formulated the fee schedules and submitted them for approval to the membership. The membership was composed of competing physicians. The Supreme Court found the scheme to be horizontal price fixing, pure and simple, and a per se violation of section 1 of the Sherman Act.

Dr. John Ratino contended that the usual, customary and reasonable reimbursement formula used by the District of Columbia Blue Shield plan, especially when coupled with peer review of the reasonableness of contested fees by a committee of the Montgomery County, Maryland Medical Society, fell within the proscriptions of Maricopa. The result was Ratino v. Medical Service of the District of Columbia.

Dr. Ratino, a plastic surgeon, belonged to the Montgomery County [Maryland] Medical Society. At one time, he was a participating physician with Medical Service of the District of Columbia ("MSDC"), the Blue Shield plan for the metropolitan Washington area. He resigned in 1974.

MSDC reimbursed physicians for most of the care rendered to its subscribers under a usual, customary and reasonable ("UCR") formula. Under UCR, MSDC would pay the treating physician's usual fee, provided the fee was within the customary range of area fees for that service, or, in the event of unusual circumstances, was otherwise reasonable. The "customary" com-

19. Id. at 85.
ponent, known as the maximum customary allowance or MCA, was derived by ascertaining the ninetieth percentile of charges through a computer check of all charges submitted in a given year. The MCA was fixed at that ninetieth percentile. Unlike Maricopa, physicians did not vote on the maximum fee for a given procedure.

A patient or treating physician could challenge the MCA in a given case, either by claiming that the MCA did not in fact accurately reflect the ninetieth percentile or that because of the circumstances of the particular case a fee higher than the MCA was reasonable. In the event of such a challenge, MSDC would send the case to the medical society to which the physician belonged, in Dr. Ratino's case the Montgomery County Medical Society ("MCMS"). The fee review committee of MCMS, after removing the name of patient and physician, would submit a summary of the case to physicians in the same specialty as the treating physician. In turn, the physicians polled would advise the committee of what they considered to be a reasonable fee or reasonable range of fees. The committee would then determine the reasonable fee and advise MSDC and the physician. The committee and medical society considered the fee thus arrived at to be advisory only. The participating physician and MSDC agreed, however, that it would be binding as to them. As noted, Dr. Ratino was not a participating physician and so was bound by no such agreement. Most significantly, the fee arrived at was limited to the case at hand. It created no new maximum customary allowance. It did not become a component of a maximum customary allowance. It was never used again.

At first the district court did not reach the legality of this reimbursement system. It granted summary judgment on McCarran-Ferguson grounds. Dr. Ratino appealed and between the time of the ruling below and the oral argument before the Fourth Circuit the Supreme Court decided Union Labor Life Insurance Co. v. Pireno.\(^\text{22}\) In Pireno the Supreme Court held that agreements between insurers and peer review committees dealing with the reasonableness of fees were not part of the business of insurance and thus did not fall within the McCarran-Ferguson Act exemption. The Fourth Circuit, therefore, reversed and remanded Ratino to the District Court for trial. In doing so, it set forth certain guidelines, saying:

Ratino raised a number of allegations in his complaint which if proved could be indicative of a conspiracy to fix the customary fee:

(1) He alleged that Blue Shield's Board of Trustees, which is responsible for establishing the UCR fee schedule, is controlled by

\(^{22}\) 458 U.S. 119 (1982).
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physicians, and thus physicians effectively control the determination of the fee schedule.

(2) He alleged that physicians control the fee schedule in that Blue Shield's agreement with participating physicians provides that: (a) it will not change any of the mechanics "without the approval of the participating physicians by mail ballot for the life of the UCR program;" and (b) "the UCR . . . plan will be reviewed biannually by the medical advisory council and the Board of Trustees and submitted to the participating physicians to vote on continuation or cancellation of the program on renewal dates."

(3) He alleged that the customary fee ceiling — arrived at by taking the 90th percentile of usual fees submitted for particular services — is a system whereby physicians collectively exert control on what the maximum fee schedule should be through submitting their bills to Blue Shield. Ratino alleged that participating physicians, in effect conspire without necessarily directly communicating — that through various means they individually obtain information concerning how the system works from Blue Shield, which is the central collector and user of the information employed in the alleged price-fixing scheme. He alleges that each individual physician obtains the information concerning the maximum fees through submission of higher fees until they exceed the customary ones. Once obtaining information as to the maximum allowable fees, he contends that physicians adjust their fees to obtain the maximum price allowed by the Blue Shield system for each service and, at the same time, act to continually escalate the maximum allowable fee.

(4) Ratino alleged that the peer review committees act as a policing mechanism aimed at intimidating participating as well as non-participating physicians into conformity with the customary fee schedule; and alleged numerous instances of the fee review committee attempts to dictate his fees through coercion. We cannot predict whether Ratino will be able to prove these allegations. It no doubt will be difficult, but the scenarios he alleges are not so improbable that he should not have an opportunity to resolve the allegations as primary issues of fact. If the district court finds that in effect the physicians control the customary fee, under Maricopa it must find such practice per se illegal.

Upon remand a two and one-half week jury trial took place. The jury was out one hour and returned a verdict on behalf of all five defendants, the plan, the medical society and the three physician members of the fee review committee. The Fourth Circuit's four guidelines had the following result at trial:

23. 718 F.2d at 1270, 1271 (footnotes omitted).
(1) There was no evidence that physicians controlled the plan board. One exhibit introduced by plaintiff was a memo signed by the president of the Medical Society of the District of Columbia calling for a mass meeting of physicians at the plan's office to protest reimbursement policies. The jury may well have found that is not the way control is normally exercised. In addition, there was no evidence of how physicians voted on particular issues. Also, the assumption that the board was responsible for establishing the UCR fee schedule was erroneous. It was true that prompted by the Civil Service Commission, which wanted full service benefits for federal employees, the board had voted to adopt a UCR reimbursement system, but the maximum customary allowances had never even been disclosed to the board let alone set by it.

(2) The facts that the mechanics of UCR could not be changed without the approval of the participating physicians and that the continuation of UCR was voted on by the participating physicians every other year turned out to be non-issues at trial, as they should have. If UCR did not fix or stabilize prices or otherwise restrain trade, what difference should it make if participating physicians had a veto power over its modification or termination.

(3) The allegation that the participating physicians individually learned the maximum customary allowances and set their fees so as to obtain the same maximum payment from the plan received considerable attention at trial. The plan introduced bar graphs for over seventy surgical procedures, including some customarily performed by plastic surgeons, Dr. Ratino's specialty. A red bar showed the maximum customary allowance. Blue bars showed the actual fees charged. The fees did not come close to clustering around the MCA. Most fees charged were less than the MCA; some were more. If UCR was a conspiracy to allow physicians to charge the maximum fee which the plan would pay then the bar graphs indicated, as was argued to the jury, that the physician conspirators were the gang that couldn't shoot straight.

(4) The allegation that the medical society peer review committee acted as an enforcer to coerce physicians to charge no more than the MCA died for lack of proof.

There were two bottom lines in Ratino. With respect to the facts, the jury obviously did not believe that the combination of UCR and peer review was part of a conspiracy to stabilize prices. With respect to the law, neither the district court nor the Fourth Circuit found UCR to constitute a per se violation. Maricopa was not imposed on the Blue Shield reimbursement system.

Ratino also involved a prohibition against the balance billing of subscribers by participating physicians. That issue was more central to Kartell v.
Blue Shield of Massachusetts. To quote the First Circuit:

Blue Shield pays doctors for treating patients who are Blue Shield health insurance subscribers, but only if each doctor promises not to make any additional charge to the subscriber. The basic issue in this case is whether this Blue Shield practice — called a "ban on balance billing" — violates either Sherman Act § 1 forbidding agreements "in restraint of trade," . . . or Sherman Act § 2 forbidding "monopolization" and "attempts to monopolize."

The district court had found a Section 1 violation. The First Circuit reversed.

Kartell involved a typical UCR - no balance billing formula. What was atypical was that Massachusetts Blue Shield's market share consisted of about seventy-four percent of privately insured residents of Massachusetts. "Virtually all" Massachusetts physicians participated and agreed not to balance bill.

The district court found that the effect of this system, when combined with Blue Shield's size and buying power, produced an unreasonably rigid and unjustifiably low set of prices. It interfered with the physician's freedom to set higher prices for more expensive services and discouraged them from developing and offering patients better services. Therefore, the district court reasoned, the ban against balance billing unreasonably restrained trade.

In reversing, the First Circuit observed:

To find an unlawful restraint, one would have to look at Blue Shield as if it were a "third force," intervening in the marketplace in a manner that prevents willing buyers and sellers from independently coming together to strike price/quality bargains.

That, however, was not the case. Blue Shield was, the First Circuit observed, not an inhibitory "third force" but rather was itself the purchaser of the physicians' services, albeit for the account of others. A purchaser is free to strike whatever bargain it can, including a ban on balance billing.

Physicians might argue that they sell their services only to their patients, but "[t]he relevant antitrust facts are that Blue Shield pays the bill and seeks to set the amount of the charge."

25. Id. at 923.
26. Id. at 924.
28. 749 F.2d at 926.
But, the plaintiffs argued, in no other case did a buyer have the market power of Massachusetts Blue Shield. Again the First Circuit disagreed. There was no lower seller output. On the contrary, the number of physicians in Massachusetts had increased over the past decade.

Even assuming, arguendo, that Massachusetts Blue Shield did have market power and in addition used that market power to obtain "lower than competitive prices" the result would not be different. As explained by the court:

We [must] ask whether Blue Shield's assumed market power makes a significant legal difference. As a matter of pure logic, to distinguish the examples previously mentioned one must accept at least one of the following three propositions: One must believe either (1) that the law forbids a buyer with market power to bargain for "uncompetitive" or "unreasonable" prices, or (2) that such a buyer cannot buy for the account of others, or (3) that there is some relevant difference between obtaining such price for oneself and obtaining that price for others for whom one can lawfully buy. In our view, each of these propositions is false, as a matter either of law or of logic.\(^{29}\)

As in *Travelers*, the court found nothing illegal about a buyer of medical services driving a hard bargain.

The court then expressly considered the ban on balance billing. The plaintiff physicians had made several arguments similar to some of those made by Dr. Ratino, including:

1. Price competition among physicians was "virtually eliminated by the ban."
2. Doctors' prices have tended to cluster around Blue Shield's "maximum price levels."
3. Doctors wanting to compete by offering innovative or "premium" services were inhibited from doing so.

The court responded:

The short — and conclusive — answer to these arguments is that normally the choice of what to buy and what to offer to pay is the buyer's. And, even if the buyer has monopoly power, an antitrust court (which might, in appropriate circumstances, restructure the market) will not interfere with a buyer's (nonpredatory) determination of price.\(^{30}\)

The Court closed with some additional observations:

1. Unlike the situation in *Virginia Academy of Clinical Psycholo-
2. Courts should be reluctant to condemn an arrangement to bring low prices to consumers.
3. The price system at issue is supervised by state regulators.
4. Blue Shield has a right, so long as it acts unilaterally, not to deal with physicians who decline to become participating physicians.
5. Insufficient evidence existed to support plaintiffs' predatory pricing claim.
6. The charge of conspiracy between the Shield plan and the Cross plan fails because the objective of the alleged conspiracy — a ban on balance billing — is lawful.

Provider control over, or substantial influence over, the prices which Blue Cross and Blue Shield plans pay for services rendered to subscribers creates serious antitrust problems. It is an invitation to litigation. Absent such provider influence or control, plans have wide latitude in arriving at the prices they will pay.

III. EXCLUSIVE SERVICE AREAS UNDER BCBSA’S LICENSE AGREEMENT

Let us begin by acknowledging that the topic of exclusive service areas under BCBSA’s license agreements is a delicate subject. This is so because suits involving the plans’ exclusive service areas have been brought by, including but not limited to, the Maryland and Ohio Attorney Generals. A number of plans also have been on opposite sides in lawsuits involving this issue. What follows is an effort to present an objective, hopefully clear, exposition of the legal issues involved.

For purposes of this discussion, the operative document is the 1972 Blue Cross Association (“BCA”) license agreement. This agreement provides that each plan shall have as its exclusive service area the area that the plan was servicing on June 30, 1972.33

BCBSA is the licensor. One of BCBSA’s predecessor corporations, BCA, licensed the Cincinnati plan exclusively to use the Blue Cross name and logo in certain counties in eastern and western Ohio that the plan serviced in 1972. Another of its predecessor corporations, Blue Shield Association

31. 624 F.2d 476 (4th Cir. 1980).
33. There is a relatively limited exception for service areas that overlapped at the time. The Blue Cross Association license agreement, or “pooling agreement,” contains no exclusivity provision but is generally treated as if it does.
("BSA") or (National Association of Blue Shield Plans "NABSP"), licensed it, or a predecessor corporation, to use the Blue Shield name and logo. The plan used the Blue Shield name and logo in all but five counties in Ohio.

In *Blue Cross and Blue Shield Association v. Community Mutual Insurance Corp.*, BCBSA sued the Cincinnati plan for injunctive relief to enforce the exclusive service area provisions of the license agreement. The facts set forth are as found by the Court in the slip opinion. Judge John W. Potter of the United States District Court for the Northern District of Ohio found that in August of 1985 the Cleveland and Toledo plans announced that they would (1) merge and (2) "market under the Blue Shield name and ... convert to their own account" the Cincinnati plan's Toledo area Blue Shield business. Judge Potter also found that:

BCBSA's top officials were aware of [the Cleveland plan's] Akron area Blue Shield activities in late 1984 or early 1985. No action was taken by BCBSA to restore [the Cincinnati plan's] business or to arrest further conversions of [the Cincinnati Plan's] Blue Shield business in the six county region.

The court further found that on September 16, 1985, the Cincinnati plan notified BCBSA that it planned to operate statewide using the names and logos. Two days later BCBSA filed this suit against the Cincinnati plan seeking an injunction to enforce the exclusive service area provisions in the license agreement.

The Ohio Attorney General intervened in the litigation, taking the position that the exclusive service area provision of the license agreement violated Section 1 of the Sherman Act and that the injunction should not be issued. The Cincinnati plan also argued that "the licensing agreements constitute horizontal market allocations under Section 1 of the Sherman Act ... and that BCBSA is guilty of unclean hands' in that it failed to take legal action against others allegedly encroaching upon [its] marketing area." The antitrust issue was, therefore, squarely before the court.

In refusing to issue the injunction the court arrived at some thought provoking conclusions of law, including the following:

As to the aspect of likelihood of confusion among consumers, the Court finds that due to the multiplicity of various plans in any given area and cardholders of such plans, and sophistication of

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35. *Id.* at 5 (findings of fact and conclusions of law for preliminary injunction).
36. *Id.*
37. *Id.*
38. *Id.* at 6.
coverage procurers, i.e., employers, there is little likelihood of added confusion.

* * *

Since approximately 80 percent of Blue Cross/Blue Shield cardholders do not directly contract with an underwriter, but instead subscribe to their insurance plan through an employer or other source, the need or the desire of the individual cardholder to know which company underwrites the policy is of little consequence. The Court is also not convinced that hospital clerks or doctor office personnel who might have to process insurance claims from competing Blue Cross or Blue Shield plans will be faced with undue confusion, or will place the responsibility of deciding level coverage back in the hands of the cardholder. Plaintiff admitted that even without competition from other plans, these clerks have to already make these decisions. Within a service plan area, many levels of coverage are offered.

* * *

BCBSA has permitted other plans to compete against CMIC, yet BCBSA has not permitted CMIC to compete against its competitors. This, the Court views as a substantial hardship for CMIC, a factor the Court uses to balance with the other factors considered. The parties have argued the doctrine of unclean hands and its availability. The Court has considered the fact that the plaintiff has failed to take legal action against the actions or proposed actions of the Cleveland, Akron and Toledo Plans as it relates to the balancing of harm on a preliminary injunction proceeding. The defenses of unclean hands and/or antitrust have a logical connection "between the right plaintiff asserts" and the conduct of the defendant. As to the antitrust allegation, the State of Ohio is also presenting this proposition and advances the proposition that the plaintiff is using its trademark licensing to permit competition among the member plans. The Court has balanced this contention and the evidence adduced in the weighting process as to likelihood of success on the merits.

For the purpose of this preliminary injunction, BCBSA has failed to show a likelihood of success on the merits. Further, BCBSA will not suffer irreparable harm as a result of this denial and serious injury will result to the enjoined party. Finally, the public interest will be furthered if this Court denies plaintiff's motion.39

The Maryland allocation of territory litigation had a different genesis. In Maryland v. Blue Cross and Blue Shield Association40 the Maryland Attor-

39. Id. at 7-8 (citations omitted).
ney General filed a Section 1 Sherman Act suit against BCBSA, the Maryland plan and the District of Columbia plan attacking the exclusive service areas of the Maryland and District of Columbia plans in that state on two bases: 1) The license agreement; and 2) An agreement between the two plans as to the line dividing their service areas.41

After much discovery and shortly before the court was scheduled to rule on whether the case should be tried under a per se theory or a rule of reason analysis, the case was settled. This settlement is effective until the later of January 1, 1991 or the completion of the Assembly of Plans. The key paragraph in the settlement agreement reads as follows:

The parties agree that in regard to Blue Cross and Blue Shield health care financing, the licensing agreements between the Defendant Plans and the Blue Cross and Blue Shield Association remain in full force and effect. Defendants agree that each Defendant Plan may enroll a Maryland headquartered group or individual located within the traditional service area of the other Plan, provided that such enrollment is otherwise consistent with: (i) the ownership, enforcement, and administration of the BLUE CROSS and BLUE SHIELD trade names and service marks by the Blue Cross and Blue Shield Association; (ii) the rights and obligations of the Defendant Plans as licensees of such trade names and service marks; and (iii) the independent business judgment of the enrolling Defendant Plan. (emphasis added).

The first sentence appears to be a capitulation by the Attorney General. The underlined clause of the second sentence, however, abrogates the license agreement in that both the Maryland and District of Columbia plans can sell throughout each other's service areas. Subparagraph (ii) appears to reinstate the exclusive service area provision of the license agreement because marketing outside the exclusive service areas must be consistent with “the rights and obligations of the Defendant plans as licensees of such trade names and service marks.”

The Attorney General issued a press release which clearly sets forth his interpretation. It reads in part:

According to the settlement agreement, each Blue Cross and Blue Shield Plan may market its traditional Blue Cross and Blue Shield health insurance, health maintenance organizations, preferred-provider plans, third party administration services, and other insurance products throughout the state. Consistent with the antitrust laws, the settlement agreement provides that each plan will use its independent business judgment in deciding where it will sell its

41. Id.
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health insurance. "The settlement promotes the purpose of the antitrust laws by ensuring that the business decisions of potential competitors are made independently and without regard to artificial marketing barriers," [Attorney General] Curran said.

Prior to the settlement, according to the lawsuit, the Washington, D.C. Plan was restricted to offering its traditional Blue Cross and Blue Shield insurance only in certain areas of Maryland in the Washington metropolitan area. The Maryland Blue Cross and Blue Shield Plan was able to market its Blue Cross and Blue Shield products only in the remainder of the state and could not offer them in the restricted Washington suburban areas. This alleged agreement between the two Blue Cross and Blue Shield Plans was implemented by the trademark licensing agreements between the national Blue Cross and Blue Shield Association and the local plans.

According to the settlement agreement, the trademark licensing agreements remain in full force and effect but each of the Blue Cross and Blue Shield Plans may now, exercising independent business judgment, sell its products outside its traditional marketing areas.42

The legal basis for the Ohio and Maryland Attorney Generals' cases rests on the Supreme Court's opinion in United States v. Topco Associates, Inc.43 Topco was a cooperative association of independent regional supermarket chains. It was formed to act as a purchasing agent and to develop a private label merchandise program for its members. Each Topco member was granted a license to sell trademarked Topco brand products only in an exclusive territory, and each was generally prohibited from selling such goods to other retailers. The district court, refusing to apply a per se rule, determined that the territorial and customer restrictions, although eliminating intrabrand competition in Topco products, were reasonable as they promoted and enhanced interbrand competition with national supermarket chains. The Supreme Court rejected the rule of reason approach and stated: "One of the classic examples of a per se violation of Section 1 is an agreement between competitors at the same level of the market structure to allocate territories in order to minimize competition."44

After remand, the Supreme Court summarily affirmed a final judgment permitting Topco to utilize areas of primary responsibility, designate warehouse locations, determine the locations of places of business for trademark licensees, terminate the membership of businesses not adequately promoting

43. 405 U.S. 596 (1972).
44. Id. at 608.
Topco products, and formulate and implement profit passovers, unless such practices directly or indirectly achieved or maintained territorial exclusivity.

In Topco, the Supreme Court also expressly struck down Topco's customer restrictions preventing members from selling Topco's private label goods to wholesalers, thereby treating customer allocation among competitors, as well as market division as a per se violation of Section 1.

The Ohio and Maryland Attorney Generals argued that BCBSA stands in the same position as Topco, i.e., that it is a trade association controlled by its members who are potential horizontal competitors.

The plans involved in the Maryland litigation relied upon the fact that the doctrine that the Supreme Court enunciated in Topco has been eroded over the years. Indeed, in Rothery Storage & Van Co. v. Atlas Van Lines, Inc., Judge Bork wrote for the court:

*If Topco and Sealy . . . state the law of horizontal restraints, the restraints imposed by Atlas [Van Lines] would appear to be a per se violation of the Sherman Act. An examination of more recent Supreme Court decisions, however, demonstrates that to the extent that Topco and Sealy stand for the proposition that all horizontal restraints are illegal per se, they must be regarded as effectively overruled.*

The "more recent Supreme Court decisions" relied upon by Judge Bork were Broadcast Music, Inc. v. Columbia Broadcasting System; National Collegiate Athletic Association v. Board of Regents; and Northern Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co. If in the Maryland case the court held that the rule of reason was the proper standard, counsel for the defendant plans hoped to persuade the court that the exclusive service areas were more pro-competitive than anti-competitive and were therefore lawful.

**IV. PARTICIPATION IN HEALTH PLANNING**

In National Gerimedical Hospital and Gerontology Center v. Blue Cross of Kansas City, the Supreme Court refused to exempt from antitrust scrutiny the decision of the Kansas plan not to accept the plaintiff as a participating provider despite the fact that the decision was made in furtherance of a health care planning scheme mandated and funded under the National

46. Id. at 226.
Minimizing Antitrust Risks

Health Planning and Resources Development Act of 1974. The statute provided for "health systems agencies" ("HSA"), i.e., private, nonprofit advisory groups receiving federal funding. Each HSA was mandated to develop and promote health care planning in its local area and to implement the plan "to the extent practicable . . . with the assistance of individuals and public and private entities in its health service area." The HSA with responsibility for Kansas City determined that the area was not in need of additional hospital beds and that it would therefore not approve any additional acute care beds. The plaintiff, who was planning the construction of a hospital, did not seek the approval of the HSA. Plaintiff's application to Blue Cross to become a participating member provider was rejected on the ground that plaintiff failed to obtain the approval of the HSA.

The Supreme Court held that Blue Cross' decision was not immune from antitrust liability because: (1) it was a private response to the advisory opinion of a private body, neither compelled nor approved by a government agency; (2) the application of the antitrust laws to the particular action would not conflict with any particular statutory provision or regulatory order; (3) the statute did not clearly contemplate enforcement by private providers of insurance; and (4) the statute was not in such conflict with the antitrust laws as to create a "blanket exemption" for all activity undertaken in response to planning recommendations.

National Gerimedical did not hold that the plan violated the Sherman Act, only that its activities did not fall within an exemption of it. Health planning is considered by many plans to constitute cost containment as well as a public service and they continue to play a part in the Act. This caused the Arkansas plan to be named a defendant in General Hospitals of Humana, Inc. v. Baptist Medical System, Inc.

Among the defendants in Humana were the Blue Cross plan, Baptist Medical System, Inc., which operated two hospitals in the Little Rock metropolitan area, St. Vincent Infirmary, a large tertiary care hospital in Little Rock, and an official of Baptist and an official of St. Vincent who were also trustees on the plan board. The primary allegation was that the defendants had conspired to exclude Humana from the Little Rock area by preventing it from obtaining the necessary certificate of need ("CON").

Discovery produced no evidence that the plan had done anything other

52. Id. at § 3001-2(c)(1).
53. ABA ANTITRUST SECTION, ANTITRUST LAW DEVS. 602 (2d ed. 1984).
54. 1986-1 Trade Cas. (CCH), ¶ 66,996 (E.D. Ark. 1986). Only one of the four orders and opinions issued by the court were published. The order and opinion granting the plan's motion for summary judgment were not published.
than oppose the CON before the Central Arkansas Health Systems Agency ("CAHSA") and the Statewide Health Coordinating Council ("SHCC"). The plan filed an affidavit stating that the decision to oppose Humana's application was made at the staff level and was not presented to the board. Humana was able to discover no evidence to controvert the affidavit but argued that it had a right to additional discovery to attempt to find it. The court disagreed, saying "[a] party should have a factual basis for its suit at the time it brings the suit ... [D]iscovery is to be used only to support a case, not to create a case."\(^{55}\)

A year after granting summary judgment to the plan the court granted summary judgment to Baptist.\(^{56}\) In that opinion the court made several interesting rulings, including:

1) The actions of the defendant hospitals in obtaining CONs allegedly to use up all new bed slots in the area were protected by the state action doctrine enunciated in *Parker v. Brown.*\(^{57}\)

2) The Fourth Circuit was incorrect in *North Carolina v. P.I.A. Asheville,*\(^{58}\) in requiring "wholesale regulation of an entire industry" in order to trigger the "active state regulation" requirement of the state action doctrine.\(^{59}\)

3) Health systems agencies are government agencies within the meaning of the Noerr-Pennington doctrine.\(^{60}\) In arriving at this conclusion the court relied on its earlier decision in *Garst v. Stoco, Inc.*\(^{61}\)

*National Gerimedical* and *Humana* stand for the propositions that (1) active engagement in planning will probably be held lawful, and (2) it is not possible to prevent the institutional providers who are being opposed from filing suit.\(^{62}\)

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56. 1986-1 Trade Cas. (CCH) ¶ 66,996 (E.D. Ark. 1986).
60. The doctrine can be summarized as holding that a party's efforts to procure government actions, even when motivated by anticompetitive intent, are protected from antitrust scrutiny by the Constitutional right to petition the government. It was enunciated in Eastern Railroad Presidents Conference v. Noerr Motor Freight, Inc., 365 U.S. 127 (1961) and United Mine Workers v. Pennington, 381 U.S. 657 (1965).
62. In this connection, the court seriously considered, but denied, the Arkansas plan's petition for attorneys' fees in *Gen. Hospitals of Humana.*
V. PREFERRED PROVIDER ORGANIZATIONS ("PPOs")

PPOs have been with us a relatively short period of time. They have, nonetheless, had two antitrust cases before courts of appeal and have induced an unusually large number of advisory opinions from the Antitrust Division of the Department of Justice and from the Federal Trade Commission. Because they involve issues of pricing and of exclusion of providers, PPOs are naturals for antitrust activity.

Unlike Health Maintenance Organizations ("HMOs"), PPOs can be imposed on the present network of hospitals and doctors without having to build clinics or convert doctors into employees. Instead, PPOs operate on the basis of an agreement between health care providers (hospitals, physicians, pharmacies, etc.) and third party payers (insurance companies and self-insured employers), whereby the providers agree to utilization review and in some cases to discounted fees. In exchange, the payers offer a higher reimbursement rate for the fees of such participating providers than for those of nonparticipants. Higher reimbursement encourages the payor's subscribers to patronize participating providers, thus increasing their patient volume and permitting further discounts.

PPOs fall into two basic categories: provider controlled and nonprovider controlled. Health care providers themselves establish and administer the former organizations. Nonprovider PPOs are developed and run under the auspices of an insurer, self-insured employer or intermediary corporation.

The arrangements between providers and payers are subject to numerous variations. Some PPOs require provider or payor exclusivity (i.e., providers can care only for PPO patients or PPO patients can only consult participating providers). Certain PPOs individually negotiate prices with each provider. Others offer either a basic fee for specific services or a flat discounted rate. Exclusivity and price discounts are only two of the characteristics which may differ from one PPO to the next.

In a number of business review letters written to sponsors of proposed or existing PPOs, the Federal Trade Commission ("FTC") and the Department of Justice ("DOJ"), Antitrust Division, have acknowledged that PPOs confer many benefits on consumers of health care. Nonetheless, the FTC

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63. The PPO portion of this paper is based on a memorandum to the author from Stephanie Thier, a 1987 summer associate at Pierson, Ball & Dowd and a student at Columbia Law School.

64. 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" market place/incentives. Second, health insurers will begin to compete on premium levels, service, and other competitive variables, giving consumers the opportunity to shop for the
and DOJ, as well as the courts, emphasize that many antitrust issues are raised by these organizations.

A. PPO Antitrust Issues

Sherman Antitrust Act violations for which PPOs may be liable include monopolization, price-fixing, and boycotting or concerted refusal to deal. Whether a PPO violates federal antitrust law, specifically depends on:

1) whether a PPO (a) creates a monopoly, or (b) constitutes an attempt to monopolize, or (c) a conspiracy to monopolize in violation of Section 2 of the Sherman Act;

2) whether a PPO, in developing a reimbursement plan for provider fees and services, engages in illegal price fixing in violation of Section 1 of the Sherman Act; and

3) whether a PPO, by limiting its membership, engages in an illegal boycott or concerted refusal to deal in violation of Section 1 of the Sherman Act which proscribes conspiracies in restraint of trade.

1. Monopoly; Attempt to Monopolize; Conspiracy to Monopolize

a. Monopoly

Possession of monopoly power, by itself, is not a violation of Section 2 of the Sherman Act, which provides in part:

Every person who shall monopolize, or attempt to monopolize or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several states . . . shall be deemed guilty of a felony.\(^6\)

More than acquisition and retention of a dominant market share must exist for a finding of illegal monopoly. It must further be demonstrated that market power was not obtained or maintained lawfully through the marketing of a superior product or service, but rather unlawfully, through restraints on trade such as those proscribed by Section 1 of the Act.

Market or monopoly power is defined as “the power to control prices in 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 nonparticipating physicians and hospitals to contain costs and lower prices.


the relevant market and exclude competition.\textsuperscript{66, 67} This element of control is often inferred from a large market share but, as explained in \textit{Ball Memorial Hospital Inc. v. Mutual Hospital Insurance, Inc.},\textsuperscript{68} "[m]arket share is just a way of estimating market power, which is the ultimate consideration. When there are better ways to estimate market power, the court should use them." These other factors are based on the nature of the relevant market and involve inquiries into the barriers to market entry, the geographic scope of the relevant market and submarkets, and the elasticity of demand.\textsuperscript{69}

In \textit{Ball}, the court held that a Blue Cross/Blue Shield PPO in Indiana did not have market power, despite possession of a large market share, because the relevant market of health care financing remained competitive. The court found few barriers to entry. It deemed that only start-up capital and a license are needed to enter the field and found that customers readily switched allegiance to the plan offering the lowest cost. The court also indicated that other companies wishing to develop PPOs could "divert production into the market from outside," as no capital asset such as a building or facility is necessary to enter the insurance or PPO business.\textsuperscript{70} The court concluded that market share was not synonymous with market power in this instance.\textsuperscript{71}

Despite the desirability of weighing other factors, market share remains an important criterion in deciding whether market power exists. The courts have not been clear as to what share of the market will render a company or organization suspect. However, the cases suggest that control of fifty percent or greater is sufficient to raise doubts.\textsuperscript{72}

Most of the plans analyzed in FTC and DOJ business letters controlled less than fifty percent of the market and therefore were not suspect on grounds of monopoly. The letters suggest, however, that antitrust challenges might be made to proposed or existing PPOs which subsequently acquire an excessive market share.

One plan that did encounter antitrust attack from the DOJ was the Stanislaus PPO ("SPPO").\textsuperscript{73} SPPO, which dissolved after the DOJ threatened to file suit, was a plan controlled by 230 physicians practicing in and around

\textsuperscript{67} There are those who would say market power is the power to control prices in the relevant market or exclude competition.
\textsuperscript{68} 784 F.2d 1325, 1336 (7th Cir. 1986).
\textsuperscript{69} \textit{Id.} at 1332.
\textsuperscript{70} \textit{Id.} at 1335.
\textsuperscript{71} \textit{Id.}
\textsuperscript{73} U.S. Dep't of Justice Press Release (Oct. 12, 1983).
Stanislaus County, California. The DOJ concluded that SPPO had been organized to discourage the establishment of competing PPOs and to eliminate price competition among doctors. Although SPPO had a membership of fifty percent of the physicians in one market area and ninety percent in another, the DOJ focused not solely on the scope of membership but on the fact that broad enrollment was compounded by the plan's provider exclusivity requirement. Participating physicians were prohibited from contracting with any other PPOs, HMOs or alternative delivery systems not associated with SPPO. The obvious result of this exclusivity would be to deprive potentially competing PPOs access to a large number of physicians in the market occupied by SPPO. That the exclusivity provision was the deciding factor inducing the DOJ's antitrust challenge is evident when SPPO is compared with cases upholding similarly broad but nonexclusive plans. In *Kartell*,\textsuperscript{74} for example, the court upheld the legality of a Blue Shield plan which contracted with ninety-nine percent of area physicians. The Kartell plan did not restrict the outside affiliations of participating providers. Thus, no productive asset was denied to competing PPOs. In the same vein, *Ball* warned that "[w]hen a firm (or group of firms) controls a significant percentage of the productive assets in the market, the remaining firms may not have the capacity to increase their sales quickly to make up for any reduction by the dominant firm or group of firms."\textsuperscript{75}

Another example in which a large market share was determined not to constitute a monopoly is found in a DOJ Letter to Franklin A. Sanchez.\textsuperscript{76} The DOJ explained that it had no intention of challenging a pharmaceutical network, "Service for You" ("SFY"), even though SFY planned to permit enrollment of pharmacies with up to a fifty percent market share in remote rural areas. The DOJ emphasized that sizable enrollment in underdeveloped areas was essential to a workable plan and it further stressed that, in all market areas, SFY did not prohibit member pharmacies from contracting with other organizations.\textsuperscript{77}

In yet another letter,\textsuperscript{78} the FTC approved a PPO in which twelve percent of the population was enrolled and sixty percent of area doctors participated nonexclusively. The Commission nevertheless cautioned against the dangers of exclusive contracts in this instance where provider membership was high.

\textsuperscript{74} 749 F.2d 922 (1st Cir. 1984).
\textsuperscript{75} 784 F.2d at 1335.
\textsuperscript{76} Letter from Charles F. Rule, Acting Asst. Att'y Gen., Antitrust Div., Dep't. of Justice to Frank Sanchez, Coordinator Pro Forma Committee to Create a Joint Venture (Oct. 3, 1986).
\textsuperscript{77} Id. at 3-4.
\textsuperscript{78} Letter from Bureau of Competition, Federal Trade Commision, to Gilbert M. Frimet, Esq. (Mar. 6, 1984).
An FTC letter to David A. Gates\(^7\) similarly denounced long-term, exclusive contracts where many doctors or other providers were included in the PPO. That letter, however, did not summarily prohibit all exclusive contracts but instead indicated that exclusive contracts would be valid if on a short-term basis and/or with fewer providers. Apparently, the FTC wishes not to discourage the potentially positive, procompetitive effects of provider exclusivity — loyalty, closer cooperation and dedication to offering superior, lower cost services to PPO beneficiaries.

The DOJ Letter to Donald W. Fish\(^8\) stated that a PPO which enlists the services of a majority of area physicians, even on a nonexclusive basis, may lead to an illegal monopoly if the size of the dominant PPO creates an incentive for providers to join only that particular organization.

If a PPO is deemed to possess market power, the next matter to be explored is whether such power has been acquired or maintained through illegal conduct such as the restraints of trade discussed below. Reliance on anticompetitive practices to dominate the market may lead to a finding of monopolization in violation of Section 2 of the Sherman Act.

\(b. \text{ Attempt to Monopolize}\)

An attempt to monopolize exists when the accused firm or firms (1) have a specific intent to monopolize, (2) engage in anticompetitive conduct manifesting that intent, and (3) have a dangerous probability of success for dominating the market.\(^9\) While the FTC and DOJ letters do not address this potential form of antitrust violation, some of the case law has considered attempt claims. A showing of attempt to monopolize closely tracks the requirements for a finding of illegal monopoly; however, a finding of specific intent on the part of the actors is required whereas proof of a monopoly demands only a finding of general intent.

A “dangerous probability” of successful domination of the relevant market may be shown, in part, by a substantial market share. According to Vakerics, a forty percent or larger market share will usually be necessary to find a “dangerous probability.”\(^10\) As mentioned above, however, market power analysis is most accurate when based on consideration of additional factors such as market trends, strength of competitors and barriers to entry.

\(^7\) Letter from Jeffrey I. Zuckerman, Director, Bureau of Competition, Federal Trade Commission, to David A. Gates, Commissioner of Insurance (Nov. 5, 1986).
\(^8\) Letter from William F. Baxter, Asst. Att’y. Gen., Antitrust Div., Dep’t. of Justice, to Donald W. Fish, Senior Vice Pres. and General Counsel, Hospital Corp. of America (Sept. 21, 1983).
\(^9\) T. Vakerics, supra note 72.
\(^10\) Id.
c. **Conspiracy to Monopolize**

A conspiracy to monopolize is shown through (1) an agreement to monopolize, (2) actions in furtherance of the agreement (i.e., not purely inchoate action), and 3) an intent to monopolize.\(^8\) Market power or substantial market share need not be demonstrated for a finding of conspiracy, as the violation centers around the illegal agreement or understanding between parties with the aim to eliminate competition from the market.

In relation to all claims of monopoly under Section 2 of the Sherman Act, it bears reiteration that market power alone is insufficient ground for finding a violation.\(^8\)\(^4\) It is not enough that a company intends to harm rivals or to do all the business that it can. To penalize this intent is to penalize competition.\(^8\)\(^5\) The monopolist must intend to eliminate competition on grounds unrelated to efficiency. Some courts have phrased the monopoly inquiry as "whether the large firm intended to 'transfer' power from one market to another or to do something smaller firms could not do."\(^8\)\(^6\) Another proposed inquiry is whether the large company can, and plans to, raise its rivals’ business costs.\(^8\)\(^7\) These inquiries are subject, however, to qualifications. For example, an incidental, yet legitimate, effect of a well run PPO is the attraction of customers away from higher priced competitors. Consequently, the dominant PPO may offer lower rates while the less efficient and smaller competing PPO will be required to raise the fees charged to its dwindling pool of patients. A monopoly will be found in the presence of market power only when rivals’ costs of doing business are increased because of the dominant company's predatory practices.

PPOs with nonexclusive provider agreements, even when they enroll fifty percent or more of providers in the relevant market, do not abolish opportunities for competition but, rather, may actually foster such opportunities. When exclusive contracts are used, the enrollment of a large percentage of providers may be monopolistic because competitors are denied access to a necessary productive asset. PPOs which employ nonexclusive contracts are probably free from Section 2 liability even when enlisting a large number of providers because these PPOs do not usually deter market entry by competing health plans.\(^8\)\(^8\)

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\(^{83}\) Instructional Systems Dev. Corp. v. Aetna Casualty and Surety Co., 787 F.2d 1395, 1402 (10th Cir. 1986).

\(^{84}\) Kartell, 749 F.2d at 927.

\(^{85}\) Ball, 784 F.2d at 1339.

\(^{86}\) Id.

\(^{87}\) Id.

\(^{88}\) Cf. Letter from William F. Baxter, Asst. Att'y. Gen., Antitrust Div., Dep't. of Justice, to Donald W. Fish (Sept. 21, 1983) (discussing nonexclusive contracts and the need for
2. Price Fixing

Price fixing among competitors (i.e., horizontal) has long been held to be a per se violation of Section 1 of the Sherman Act. Nonetheless, recent cases, as well as FTC and DOJ business review letters to PPOs, have carved out exceptions to the per se rule against price-fixing agreements. These cases hold that a rule of reason analysis should be employed in exploring price-fixing agreements when the price-fixing is "incidental to some otherwise valid business goal," rather than a scheme "whose predominant purpose is the suppression of price competition."

In Broadcast Music, Inc. v. CBS ("BMI") the Supreme Court refused to apply a per se analysis to a price-fixing arrangement when it determined that "agreement on price [was] necessary to market the product [an ASCAP blanket license] at all." The Court emphasized that the "literal approach does not alone establish that [a] . . . practice is . . . plainly anticompetitive." The Court concluded that, although a per se rule might still be appropriate in cases of "naked price-fixing," a rule of reason is necessary where, as in BMI, "the challenged practice may have redeeming competitive virtues and . . . the search for those values is not almost sure to be in vain."

A rule of reason analysis involves an exploration and balancing of the procompetitive and anticompetitive effects of the challenged practice. Some of the factors to explore when applying the rule of reason to PPO activities have been outlined by the FTC. These include:

- Proportions of the hospital and physician services markets involved in the contract, the purposes of the contract, its duration, the extent to which it deters entry, the benefits the hospital and the public derive from it, and the extent of competition for the

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89. National Collegiate Athletic Ass'n. v. Board of Regents, 468 U.S. 85 (1984); Broadcast Music, Inc. v. CBS, 441 U.S. 1 (1979); Rothery Storage & Van Co. v. Atlas Van Lines, Inc., 792 F.2d 210, 226 (D.C. Cir. 1986) ("the extent that Topco and Sealy [1972 and 1967 Supreme Court decisions] stand for the proposition that all horizontal restraints are illegal per se, they must be regarded as effectively overruled.").


91. Id.
92. 441 U.S. 1 (1979).
93. Id. at 23.
94. Id. at 9.
95. Id. at 13.
96. For the classic articulation of the "rule of reason, see Chicago Board of Trade v. United States, 246 U.S. 231, 238 (1918).
contract.97

The PPO Task Force, at the April 2, 1987 Spring Meeting of the American Bar Association ("ABA") Antitrust Section, suggested that the strict rule of Maricopa98 may no longer apply.99 Nonetheless, a study of the FTC and DOJ business review letters does lead to the conclusion that although legitimate price-fixing between competing practitioners does not require that joint venturers pool capital and share risk, it does require that establishment of prices be ancillary to an otherwise procompetitive joint enterprise which creates a new product or permits new efficiencies.100

Nonprovider PPOs are less likely to be attacked for price-fixing, but they may be subject to challenge upon allegations that providers in fact control the PPO's decision-making process on reimbursement determinations. In Barry v. Blue Cross of California,101 for example, the plaintiffs, two doctors, alleged that a Blue Cross PPO was actually controlled by the Physicians Relations Committee ("PRC") which the plan had established to serve as an advisory panel. In the alternative, the plaintiffs claimed that the PPO was created through conscious parallelism between participating physicians. The court found no evidence that the PRC review influenced or had authority over the PPO and, in fact, evidence existed to the contrary.102 The court also found no tacit agreement or parallelism between physicians as no economic interdependence existed among them and participation in the PPO was not contrary to the physicians' self-interests. Rather, each physician had an independent economic reason for joining the PPO.103

Several other cases explore the problem of tacit provider control of PPOs which may subject such organizations to liability for price-fixing and other horizontal restraints. In Pennsylvania Dental Association v. Medical Service Association of Pennsylvania,104 the court stated that "[t]o the extent that Blue Shield's establishment of the UCR [usual, customary, reasonable] reimbursement system might disguise or embody an agreement among competing providers, its actions would come within the purview of Section 1 of the Sherman Antitrust Act."105 Hence, overt agreement between providers is not essential to a finding of horizontal price-fixing. The court stated that

97. FTC Complaints and Orders (CCH) ¶ 22,005 (Feb. 24, 1983).
99. PPO Task Force Presentation at Spring Meeting, 1 ABA ANTITRUST HEALTH CARE CHRONICLE 5, 6 (1987).
100. J.P. McGrath, supra note 64; 468 U.S. at 113.
101. 805 F.2d 866 (9th Cir. 1986).
102. Id. at 869.
103. Id. at 869-70.
105. Id. at 257.
majority provider membership on review and policy committees "without
more, does not make out a prima facie case of structural horizontal conspir-
acy." Rather, the nature and power of these committees must be ex-
plored on a case-by-case basis to determine whether they are authoritative
or merely advisory to a nonprovider dominated decision-making body.

A number of nonprovider plans examined in the FTC and DOJ business
review letters also contained physician or provider dominated Utilization
Review Committees which advised specifically on nonprice matters. In
some programs, prices were individually negotiated with, or offered to, each
provider. In another instance the intermediary, Health Care Management
Associates ("HCMA"), offered contracting providers two payment options:
(1) the lesser of the provider’s charges or a maximum fee schedule deter-
mined by HCMA, or (2) a payor established flat discount rate on the usual,
customary and reasonable fee of the provider. In some cases, an interme-
diary solicits prices or discount rates from third party payers and submits
them to individual providers for acceptance or rejection.

If providers do unduly influence the price schedules of ostensibly nonpro-
vider controlled PPOs, the court may explore whether such agreements are
"naked" price restraints per Maricopa, or are necessary ancillary mea-
sures in furtherance of a procompetitive business venture. No FTC, DOJ or
judicial statement has been issued as to what type of analysis would apply to
payor-PPOs which mask provider price agreements. However, it is possible
that, although no risk-sharing is involved when a payor or other corporation
controls the PPO, physician price agreements will be considered necessary to
offer the product at all or to promote efficiency. Nonetheless, one view is
that "where the providers play no part in the establishment of the PPO ... fee
setting by the providers may be viewed as per se illegal .... In this
situation the price setting is not necessary for the establishment and opera-
tion of the PPO; the prices can just as well be set by the nonproviders who
sponsor the PPO."

Although a unilaterally established price is immune from antitrust attack,

106. Id. at 258.
107. Letter from Arthur N. Lerner, Asst. Director, Bureau of Competition, Federal Trade
Commission, to Michael L. Denger, Esq. (Sept. 21, 1983); Letter from Antitrust Div., DOJ to
Donald W. Fish, supra note 80.
108. Letter from Emily H. Rock, Secretary, Federal Trade Commission, to Irwin S. Smith,
M.D. (June 7, 1983).
Div., Dept. of Justice (Dec.12, 1984).
111. 1984-1 Trade Cas. (CCH) ¶ 7,307 (opinion of the Attorney General of Ohio) ( cita-
tions omitted).
Payor controlled PPOs could incur price-fixing liability as buyers if several insurers combine to form the PPO. Kartell explained that "[a]ntitrust law rarely stops the buyer of a service from trying to determine the price . . . of the product . . . . Thus, the more closely Blue Shield's activities resemble, in essence, those of a purchaser, the less likely they are unlawful."\textsuperscript{112} Although the court acknowledged that horizontal price-fixing between purchasers has been held per se illegal, it explained that cases which found such conspiracies between buyers generally involved "sham" organizations whose only purpose was to join independent buyers so as to suppress the "competitive instinct to bid up price."\textsuperscript{113}

3. Boycott or Concerted Refusal to Deal

A classic group boycott or concerted refusal to deal involves agreement by a group of competing persons or firms to exclude other competitors so as to gain advantage by forcing them out of business or forcing acceptance of certain terms.\textsuperscript{114} While typical horizontal group boycotts have been accorded per se treatment when "directly aimed at excluding or limiting competitors . . . not all concerted refusals to deal can be classified so simply."\textsuperscript{115} The FTC emphasizes that concerted exclusion of certain providers does not usually constitute a boycott when exclusion is incidental to the establishment of an effective PPO and the PPO does not possess market power.

Exclusion by provider controlled PPOs involves horizontal agreement among competing providers. These PPOs are therefore subject to antitrust attack when exclusionary practices are interpreted as a boycott. When provider PPOs constitute a joint venture, as described in the discussion of price-fixing, the PPOs may avoid liability for boycottting provided the DOJ or FTC standards for judging legitimate horizontal restraints are met. A combination of these two sets of standards provides a helpful analysis for either exposing or immunizing a joint venture with respect to an attack for boycottting. The relevant inquiries would be:

1) whether the horizontal restraint, boycott, or concerted refusal to deal, is incidental and necessary to a procompetitive business venture; 
2) whether the joint venture's market share is so large as to be anticompetitive;

\textsuperscript{112} Kartell, 749 F.2d at 925.
\textsuperscript{113} Id.
\textsuperscript{114} T. Vakerics, \textit{supra} note 71, at 6.03 (1987).
\textsuperscript{115} 1984-1 Trade Cas. (CCH) ¶ 7,307 (Nov. 17, 1983)(opinion of the Attorney General of Ohio).
3) whether there is an anticompetitive purpose behind the venture; and
4) whether the venture's procompetitive effects outweigh its anticompetitive consequences.

Even when a joint venture is not found, St. Bernard General Hospital v. Hospital Service Association\(^{116}\) states that three factors must exist for a refusal to deal to fall within a per se analysis. These are:

1) an anticompetitive motive for the concerted action, \(i.e.,\) the agreement not to deal;
2) a commercial purpose underlying the agreement, "rather than... an attempt at industry self regulation;" and
3) coercive economic pressure.\(^{117}\)

\(St. \text{ Bernard}\) also stated that an affirmative defense exists when "the restrictions were reasonable, or were the least restrictive methods to achieve a legitimate business goal."\(^{118}\)

It is apparent that the FTC has emphasized that a concerted refusal to deal, horizontal or vertical, will be illegal when there is market power, regardless of whether the PPO is a joint venture or whether the exclusion is the least restrictive means to achieve the desired ends. The requirement that there be no market power when refusing to deal is incorporated into the test for a legitimate restraint in cases of joint ventures. When joint venture analysis is used, market share, if indicative of market power, may render a horizontal restraint illegal. The requirement is also implicit in the \(St. \text{ Bernard}\) defense which demands use of the least restrictive measure toward achievement of a legitimate business goal. It is presumed that "legitimate" subsumes the meaning "procompetitive." A monopoly which excludes competitors is not procompetitive.

The FTC and DOJ advisory letters emphasize that, in PPOs, inclusion is more dangerous than exclusion.\(^{119}\) A PPO which excludes all but a small share of providers in the relevant market is less subject to antitrust challenge than more inclusive plans which potentially create a monopoly. This is particularly true when a very inclusive plan is coupled with long-term, exclusive provider contracts. In such cases, an anticompetitive intent is unnecessary to find a boycott, although exclusion coupled with market power may serve as evidence of such intent. Under the Colgate doctrine,\(^{120}\) absent an intent to

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\(^{117}\) \(Id.\) at 988.
\(^{118}\) \(Id.\)
\(^{119}\) J.P. McGrath, \(supra\) note 64; Letter to Gilbert M. Frimet, Esq., \(supra\) note 78.
monopolize, a unilateral refusal to deal does not violate antitrust law. In *Barry v. Blue Cross of California*, the court concluded that a Blue Cross plan which provided superior reimbursement for services of participating providers to reimbursement for services of nonparticipants did not constitute an unlawful boycott. "The [plaintiffs] argued that the plan involved had the consequence of boycotting . . . nonparticipating physicians by interfering with their access to patients insured by the Plan." The court agreed. However, it also stated that "every contract between a buyer and seller has precisely . . . [this] effect." The plaintiffs further claimed that the PPO's "referral clause" which encouraged patients to visit participating physicians because of favorable reimbursement, was a concerted refusal to deal between Blue Cross and participating providers because it discouraged patients from visiting nonparticipants. The court held that such a clause merely injected information into the market permitting the play of ordinary market forces. It also found that Blue Cross possessed no monopoly power and that no less restrictive means existed by which it could engage in its procompetitive activity. The court noted that the plaintiffs' proposed alternative to have Blue Cross reimburse participants and nonparticipants at the same rate was not an option. Such an alternative would eliminate any incentive for providers to join the plan and offer discounts. Finally, since Blue Cross' refusal to deal was unilateral, even if it had monopoly power its actions would be legitimate if it harbored no anticompetitive motive.

VI. *Colgate to Reazin, the Right Not to Deal(?)*

In 1919, the Supreme Court stated:

[in the absence of any purpose to create or maintain a monopoly, the [Sherman] Act does not restrict the long recognized right of trader or manufacturer engaged in an entirely private business, freely to exercise his own independent discretion as to parties with whom he will deal.]

In 1960, the Supreme Court constructed a retainer around *Colgate* when it

121. *Id.* at 307.
122. 805 F.2d 866 (9th Cir. 1986).
123. *Id.* at 871.
124. *Id.*
125. *Id.* at 872.
126. *Id.* at 872-73.
127. *Id.* at 873.
128. *Id.*
decided *United States v. Parke, Davis & Co.* 131 Parke-Davis claimed it did no more than maintain resale prices solely through unilateral refusals to do business with noncomplying customers and that its actions fell within the *Colgate* doctrine. The Court rejected this argument. It found that Parke-Davis induced wholesalers to stop selling to offending retailers; that it secured adherence to its prices from a number of retailers, assuring each that its competitors would maintain prices if the retailer would do likewise; 132 that it solicited retailers’ assistance in reporting discounts by other druggists; and that Parke-Davis permitted offending retailers to purchase its products again after they had indicated a willingness to stop discounting. 133 The Court concluded that Parke-Davis had thus embarked upon a program to secure compliance with its suggested resale prices that “plainly exceeded the limitations of the *Colgate* doctrine,” and stated:

> [w]hen the manufacturer’s actions, as here, go beyond mere announcement of his policy and the simple refusal to deal, and he employs other means which effect adherence to his resale prices, . . . he has put together a combination in violation of the Sherman Act. 134

So, “mere announcement of the policy and simple refusal to deal” are the safe parameters.

In *Reazin v. Blue Cross and Blue Shield of Kansas* 135 and *Reazin II,* 136 the mammoth opinion of the court denying the plan’s motion for a judgment N.O.V. and granting summary judgment against the plan’s counterclaim issued on May 22, 1987, the court ruled against the plan and upheld the following jury award:

- $5,400,000.00 in damages
- 2,176,983.75 in plaintiffs’ legal fees
- 246,844.99 in costs
- $7,823,828.74 total

This enormous sum resulted from the plan refusing to deal with HCA’s Wesley Hospital. What happened to *Colgate?*

There are, of course, two ways to look at *Reazin.* It could be said that the plan was merely entering into a PPO with St. Joseph’s Hospital and St. Francis Hospital and that it was under no obligation to include Wesley Hospital. It could also be said, as the court did, that the plan entered into an

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132. *Id.* at 33-34.
133. *Id.* at 35-36.
134. *Id.* at 44.
137. *Id.* at 1493.
agreement with St. Joseph's and St. Francis under the terms of which those hospitals agreed to give the plan a discount on existing rates in return for the plan terminating its contract with Wesley, thus increasing the patient population of St. Joseph's and St. Francis.

When a plan discusses with a provider or providers the termination of a contract with a competitor of that provider or those providers, the seeds of litigation are sown. Perhaps that is the principle lesson of Reazin.

As noted earlier, chiropractors remain active plaintiffs. In fact, one of their lawsuits reached a federal appellate court over 10 years ago and the litigation is still continuing.38

In Leone v. Pierce County Medical Bureau,139 a "not for publication" opinion of the United States Court of Appeals for the Ninth Circuit, the defendant health insurer offered chiropractic coverage only as an optional rider for an additional premium.140 Also, chiropractic benefits were limited to treatment that would have been covered "if it had been performed by a participating physician."141

The plaintiffs alleged that the corporate defendant was, in effect, a structural conspiracy, i.e., M.D.s and osteopaths protecting themselves from competition from chiropractors. This was, the chiropractors claimed, a per se violation of section one of the Sherman Act.142 The Ninth Circuit disagreed:

The Supreme Court recently indicated that "a plaintiff seeking application of the per se rule" to an alleged boycott must show that it "falls into a category likely to have predominantly anticompetitive effects." That case involved a challenge to an expulsion from a joint venture. The court held that application of the per se rule was improper because the plaintiff had not shown that the defendant joint venture "possesses market power or unique access to a business element necessary for effective competition." In the present case, the chiropractors also fail to show that the bureaus possess market power or control a necessary competitive element. Application of the per se rule is, therefore, unwarranted.143

The Ninth Circuit held that the plaintiff chiropractors had not shown the

139. No. CA 84-4374, slip. op. (9th Cir. July 16, 1985).
140. Id. at 3.
141. Id. at 2.
142. Id. at 3.
143. Id. (citation omitted).
necessary competitive injury. Because this is an unpublished opinion, it is worth quoting from at length.

Purchasers of plan coverage are given a choice of whether to purchase chiropractic benefits. All state contracts must include chiropractic benefits and a number of private purchasers have also opted for such coverage. Unless it is presumed that these purchasers are acting irrationally, there must be some economic justification for the price differential between basic coverage and coverage with chiropractic benefits. Otherwise, no purchasers would opt for coverage with chiropractic benefits. The plaintiffs, in fact, admit that an increase in the number of health professionals under a given plan will increase the cost of providing service. Without any economic data on what costs the inclusion of chiropractors would involve, it is impossible to say that the defendants' policy is a restraint of trade and not a recognition of economic realities. Moreover, because plan purchasers are given a choice of coverage, an analysis of the relevant markets is necessary to determine whether the plan arrangement reduces "the importance of consumer preference." The plaintiffs recognize that a demonstration of the defendants' market power is essential to their case yet they fail to present any evidence on this issue. The defendants' plans cover only a small percentage — 20 percent to 30 percent — of the health care markets in Washington and that percentage has been declining. They also face competition from closed-panel or HMO plans. Finally, a substantial portion of the defendants' plans do provide for chiropractic benefits. Without significant market power, any attempt by the defendants to foist unreasonable fees upon plan purchasers desiring chiropractic benefits would simply drive those purchasers to deal with other health care providers. The evidence indicates, however, that several purchasers have chosen the chiropractic benefits with the additional premium. The plaintiffs have failed to establish any competitive injury. The evidence they presented on their projected business losses is irrelevant; competitive injury to the market is the significant consideration. The choice of benefits offered to plan purchasers distinguishes Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia, on which the plaintiffs rely for support. In that case, there existed an absolute prohibition on the inclusion of benefits for psychologist treatment. Reimbursement was available for psychologist treatment if it was billed through a plan physician, but plan purchasers — who are the significant economic actors in the market for health services — were offered no choice regarding the direct inclusion of

144. Id. at 5-6 (citations omitted).
psychologist benefits for their subscribers. In *Blue Shield of Virginia*, no choice of benefits was offered and consumer preferences and the natural market forces were, accordingly, stymied. In the present case, plan purchasers are offered a choice and several have exercised the option for chiropractic benefits. In the absence of a market analysis, a trier of fact could not conclude that this situation does not represent a competitive market.\(^{145}\)

*Johnson v. Blue Cross/Blue Shield of New Mexico*,\(^{146}\) is pending before the United States District Court for the District of New Mexico. It was scheduled to go to trial on August 31, 1987 but was continued indefinitely sua sponte by the court. The plaintiffs are chiropractors. The defendants are now the Blue Cross and Blue Shield plan and the New Mexico Medical Society, the individual plan trustee defendants having been dismissed by the plaintiffs.\(^{147}\)

The plaintiffs allege an agreement to boycott chiropractors (1) between the plan and the medical society and (2) between the plan and the M.D.s on its board, as in *Virginia Academy*. For good measure they also allege a hazy sort of conspiracy between BCBSA, which is not a defendant, and the plan.\(^{148}\) BCBSA, or its predecessors BSA and NABSP, required that plans have either the endorsement of the area medical society or participating provider agreements with over fifty percent of the area M.D.s in order to use the Blue Shield name and mark.\(^{149}\) This requirement was intended to, and did, coerce the plan to agree with the medical society not to offer chiropractic coverage in return for receiving the medical society’s endorsement.\(^{150}\) The court entered two important pre-trial orders. The first denied class action status to the plaintiffs. The second denied the plan’s motion for summary judgment.\(^{151}\) In denying the plan’s motion for summary judgment, the court found no direct evidence of any agreement. Indeed, the most pertinent evidence on that issue was a memorandum of a medical society committee chairman written after the plan offered chiropractic coverage on an optional basis, as in *Leone*.\(^{152}\) The memorandum expressed anger over the plan’s action but admitted the medical society had no control over the plan, and

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145. *Id.* at 4-6 (citations omitted).
146. No. CV 83-1637 HB (N.M. May 14, 1987).
147. The plan’s D & O carrier, Harbor Ins. Co., refused to commit itself either to pay attorneys’ fees or a judgment if there were one, and indicated that because the complaint alleged that the trustees were acting on behalf of their own economic interests there might well be no obligations of any kind on the carrier.
149. *Id.* at 4.
150. *Id.*
151. *Id.* at 1.
152. *Id.* at 8-9.
therefore could do nothing about it. Nevertheless, the court found that a jury could infer a conspiracy from facts adduced through discovery and from the deposition testimony of one of the plaintiffs' expert witnesses.

The court began its analysis with the observation that an inference of a conspiracy may be drawn when a defendant acts in contradiction to its economic interests. The court then pointed to a memorandum of a former plan marketing vice-president that indicated a potential for 65,000 to 70,000 new subscribers if chiropractic coverage was offered as evidence from which a jury could infer that the plan operated contrary to its own economic interest.

The court rejected the plan's argument that it had an economic motive for refusing to provide chiropractic coverage because it would have been forced to raise premium rates if such coverage were provided. The court stated that "this argument is belied by evidence in the record in which Blue Cross assured physician members of the New Mexico Medical Society that premium rates for contracts not receiving chiropractic coverage would not be increased." This conclusion, however, ignored evidence as to the lack of effect of adding chiropractic coverage on rates which would be only temporary — and indeed was temporary. It also ignored the fact that a unilateral desire (1) not to lose participating physicians and (2) to have the ability to offer service benefits with a large physician selection constituted an economic motivation consistent with the plan's actions.

The court went on to say, "[p]laintiffs have also demonstrated that defendants had a motive to enter into an agreement." The physician members of the medical society knew that the plan required their participation or the endorsement of the medical society if the plan was to retain its right to use the Blue Shield name and mark. In 1981, only sixty percent of the physicians in New Mexico were participating physicians. The plan would have suffered financially if it could not use the name and mark. The plan was concerned that if it provided chiropractic coverage, it would lose many participating physicians or that the physicians would take some action against Blue Cross.

The court rejected the plan's argument that none of this permitted an inference of an agreement. The facts were actually consistent with a unilateral

153. Id. at 7-10.
154. Id.
155. Id.
156. Id.
157. Id.
158. Id. at 8.
159. Id.
decision not to offer chiropractic coverage because, among other reasons including the necessity of raising rates, the plan did not want to lose its participating physicians and thus limit the number of physicians available to subscribers who had been promised service benefits rather than indemnity. 160

The court went on to state that an inference of agreement could also be drawn from the plan's "repeated attempts to reassure the physician members of the New Mexico Medical Society that the limited coverage of chiropractic benefits when demanded would preserve Blue Cross' right to exclude chiropractic benefits from all of its policies." 161 The court rejected the plan's argument that the logical inference to be drawn from the events following the plan's offering of chiropractic was that the plan was trying to mollify physicians so as not to lose their participation. 162 As noted above, a Medical Society memorandum prepared at the time chiropractic was offered acknowledged that the society had no right to control the plan's decision to offer chiropractic coverage. The court stated, nonetheless, that:

These communications are sufficient to allow a jury to infer an agreement between Blue Cross and the physician members of the New Mexico Medical Society to deny chiropractic coverage. A jury might find that Blue Cross was concerned that its decision to provide such coverage would be construed as a breach of its agreement, necessitating frequent communications between the organization and the physicians in order to reassure the physicians that Blue Cross was still opposed to coverage of chiropractic services in all of its contracts. 163

Again, this conclusion ignores the fact that not even the Medical Society or the physicians who were unhappy about the decision to offer chiropractic coverage, including one who resigned from the plan board, ever wrote or said that there had been any kind of an agreement or understanding with respect to chiropractic coverage. The plan's attempt to explain its decision to physicians was the logical action of a corporation that wanted to maintain good relations with physicians during a difficult time of transition. However, the court ignored that as a motive consistent with the plan's own economic interests.

The court then turned to the issue of whether "the challenged conduct . . . constituted an unreasonable restraint of trade." 164 It rejected the plaintiffs'  

160. Id. at 8-9.  
161. Id.  
162. Id.  
163. Id. at 10.  
164. Id.
argument that the plan's conduct fell within "the narrow category of restrictive practices to which per se analysis applies"\(^{165}\) saying, "[while] the Supreme Court has included group boycotts in the category of practices labelled unlawful per se, it recently explicitly retreated from that position in *Federal Trade Commission v. Indiana Federation of Dentists ...*"\(^{166}\) The court added, "[a]lthough concerted action to raise prices may be per se illegal, concerted action on nonprice restrictions is judged under the rule of reason."\(^{167}\)

The court, having agreed that the case should be analyzed under a rule of reason, then rejected the plan's argument.\(^{168}\) The plan argued that because it did not possess market power, "an essential component of the inquiry under the rule of reason," there could be no violation.\(^{169}\) The court did acknowledge that "market power is traditionally defined as the ability to raise prices above those that would be charged in a competitive market."\(^{170}\)

The plan's market share was by the plaintiffs'estimation thirty percent and was probably lower. The usual giant commercial carriers were active in New Mexico, as was one well established, powerful HMO and several smaller HMOs. It seemed apparent that groups could, and would, switch from Blue Cross/Blue Shield coverage to a commercial insurer or one of the HMOs if the plan raised rates or cut back on benefits.

However, the court determined that the plan's market share might understate its market power. It pointed out that one of the plaintiffs' expert witnesses, an economist from the University of New Mexico, testified that the plan paid no premium taxes and no income tax, and, under UCR, got a discount from physicians.\(^{171}\) The expert testified in his deposition that with these cost benefits the plan should have been able to obtain a much larger market share than it did, and that the only logical conclusion as to why it

\(^{165}\) *Id.* at 12.
\(^{166}\) *Id.* (citation omitted).
\(^{167}\) *Id.* at 14 (citing *Monsanto Co. v. Spray-Rite Service Corp.*, 465 U.S. 752, 761 (1984)).
\(^{168}\) *Id.* at 13-14.
\(^{169}\) *Id.* at 15.
\(^{170}\) *Id.* (quoting *National Collegiate Athletic Ass'n. v. Board of Regents*, 468 U.S. 85, 109 n.38 (1984)).

\(^{171}\) None of these conclusions were accurate. The plan did pay a premium tax, although it was lower than that paid by commercial carriers because the plan took advantage of a New Mexico statute which authorized a lower tax to any corporation which invested a certain amount of its reserves in New Mexico corporations. Also, UCR does not really provide a discount. In ninety percent of the cases, the plan pays the usual fee of the physician not a discounted fee. There was nothing in the record to indicate that any other carrier paid more connection with the ten percent of fees submitted which might be above the maximum customary allowance. Like all non-profit corporations, the plan paid no income tax, but that was probably true of many commercial carriers and there was no evidence that any of them paid corporate income tax.
did not was that it was overpaying its executives and participating physicians, who must have had control over the plan. There was absolutely no evidence in the record that the plan paid participating physicians more than any other carrier or that it overpaid any of its executives. Indeed, there was no evidence as to what its executives were paid or what the executives of other insurance carriers were paid. The court set forth its conclusion in the following terms:

[Dr. Sass] notes that because of the non-profit status of Blue Cross, administrators and physicians controlling the Board of Directors have incentive to limit Blue Cross' market share by keeping the levels of reimbursements to physicians and administrative costs high, thereby artificially depressing Blue Cross' market share.

With respect to ease of entry, the court again relied on Dr. Sass who "concede[d] that the cost of entering the New Mexico health insurance market are [sic] relatively low, but also points out that none of the 116 insurance companies who have entered the market during the past ten years have been able to capture even a one percent market share." From this the court concluded:

These statistics suggest that Blue Cross' 25 to 30 percent share of the market may, in fact, reflect market power. When that market share is considered, as well as the market share of Blue Cross' nearest competitor [who had approximately 12½ percent market share], and the inability of entering companies to capture any significant portion of the market in health care insurance, it is apparent that a genuine issue of material fact exists as to whether Blue Cross possesses market power in the health care insurance field.

On these bases, the court denied the motion for summary judgment.

Counsel for the plan believe the opportunity may arise to request the court to reconsider its motion for summary judgment and plan to seek such reconsideration.

Before leaving chiropractors, we should consider the August 27, 1987 memorandum opinion and order of the United States District Court for the Northern District of Illinois in Wilk v. American Medical Association, This, of course, is the case brought by chiropractors against the American Medical Association ("AMA"), the Joint Commission on Accreditation of Hospitals ("JCAH") and a number of other professional societies such as the

172. Id. at 16.
173. Id. (footnote omitted).
174. Id.
175. Id. at 17.
American College of Physicians and the American College of Radiology. A jury found for defendants in the first trial, but the Seventh Circuit reversed in Wilk.\textsuperscript{177} Shortly before the second trial, the plaintiffs dropped their demand for damages and went forward solely with respect to the injunctive relief.\textsuperscript{178} This made the case equitable in nature and converted it from a jury trial to a bench trial.

The lengthy slip opinion of Judge Susan Getzendanner is a mixed bag. The plaintiffs obtained their injunction against the AMA, the American College of Radiologists and the American College of Surgeons, but not against JCAH, the American College of Physicians, the American Academy of Orthopaedic Surgeons and James H. Sammons, M.D., an AMA official. Judge Getzendanner began her opus magnum with an evidentiary ruling. Plaintiffs had relied upon a document entitled “Chiropractic in New Zealand: Report of the Commission of Inquiry” (“the New Zealand Report”) to show that chiropractic was a valid health care profession.\textsuperscript{179} The court refused to receive it for that purpose, agreeing with a report prepared by the United States Congress’ Office of Technology Assessment (“OTA”) which was critical of the report because it was not based upon “well designed, controlled clinical trials.”\textsuperscript{180} The court admitted the report into evidence for the limited extent “to show information available on chiropractic in the latter half of 1979.”\textsuperscript{181}

The AMA’s Ethical Principle 3 was the focal point of the opinion. Principle 3 reads:

\begin{quote}
A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily professionally associate with anyone who violates this principle.\textsuperscript{182}
\end{quote}

The court concluded “that the AMA and its members engaged in a group boycott or conspiracy against chiropractors from 1966 to 1980 when Principle 3 was finally eliminated.”\textsuperscript{183}

As is often the case there was a smoking gun. The AMA defended its actions on grounds of good health practices. The court, however, quoted a physician member of the Committee on Quackery as saying, “it would be well to get across that the Doctor of Chiropractic is stealing [the young

\begin{footnotes}
\item[177] 719 F.2d 207 (7th Cir. 1983).
\item[178] Wilk, No. 76 C 3777, slip op. at 3.
\item[179] Id.
\item[180] Id.
\item[181] Id. at 8.
\item[182] Id. at 3.
\item[183] Id. at 21.
\end{footnotes}
medical physicians'] money."^{184}

To the defendants' argument that the plaintiffs must specifically prove an impact on price and output, the court responded:

The cases do not support that proposition. As Professor Areeda recently noted in his article, "The Rule of Reason — a Catechism on Competition," 55 ANTITRUST LAW JOURNAL 571 (1986), the Supreme Court has held that the purpose of the inquiry into market definition and market power is to determine whether an arrangement has the potential for genuine adverse effects on competition. If there is actual proof of adverse effects, then the plaintiffs need not prove market definition and market power. The Supreme Court in Federal Trade Commission v. Indiana Federation of Dentists, stated that "the inquiry into market power is but a surrogate for detrimental effects."^{185}

The court found that the plaintiffs had established not only monetary injury but also injury to their reputations. The fact that a physician member of the Committee on Quackery had referred to chiropractors as "rabid dogs and killers" was not helpful.^{186} Basically, the court found that while chiropractic may at one time have been an unscientific discipline, it has changed but the AMA's position has not. With respect to the JCAH, the court found that the JCAH opposed chiropractic but it did so unilaterally and not in agreement with its own members or with the AMA.

The case is on appeal to the Seventh Circuit. Less serious lawsuits, which are nonetheless time consuming and expensive, are brought by providers that want to contract with plans. As noted earlier, it is impossible to stop people from filing antitrust suits. One such action was Wheeler v. Blue Cross and Blue Shield,^{187} filed in the United States District Court for the District of Nevada. The plaintiffs were the Degenerative Disease Medical Center ("DDMC") and a number of its past and present patients. DDMC was a "hospital" that purported to cure cancer, arthritis and a number of other diseases through the intravenous application of dimethyl sulphoxide ("DMSO").^{188} At least eight insurers to which DDMC submitted claims denied coverage for the use of DMSO, laetrile and other therapy. The policies excluded payments because the treatments were either not medically necessary or not generally accepted treatments.^{189} One of the defendants sought advice from the Clark County Medical Society as to the nature and

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184. Id. at 22.
185. Id. at 25 (citation omitted).
186. Id. at 28.
188. Id. at 2.
189. Id.
validity of the treatment. The Wyoming plan sought general information from the Nevada plan as to the nature of DDMC.\textsuperscript{190} The treatments were legal because the Food and Drug Administration had authorized the use of DMSO for interstitial cystitis. It was the generally accepted medical opinion, however, that DMSO would not cure or arrest cancer or cure or help cure arthritis and the other illnesses treated at the facility.\textsuperscript{191}

The court granted the motions for summary judgment filed by all of the defendants. It pointed out that:

[s]omething more than the mere exchange of information and parallel behavior must be shown to support an inference of conspiracy. In addition, it must be shown that the parties acted against their own individual business interests or that there was motivation to enter into an agreement requiring parallel behavior.\textsuperscript{192}

The court went on to state that there was evidence of parallel acts by the defendants and exchanges of information between the Clark County Medical Society and Blue Cross and Blue Shield of Nevada and between Blue Cross and Blue Shield of Nevada and Wyoming Blue Cross and Blue Shield. The court pointed out, however, that:

Even consciously parallel behavior cannot, without more, support a reasonable inference that defendants acted in concert. Nor does evidence of exchanges of information, or mere opportunity to conspire allow a reasonable inference of conspiracy.\textsuperscript{193}

The court found that the Clark County Medical Society had shown that it was in conformity with good business practice that it had interpreted the experimental treatments given at the hospital, "admittedly the only center offering this treatment in the United States" as not generally accepted medical practice.\textsuperscript{194} The Nevada and Wyoming plans also acted in a rational, businesslike way from which no inference of conspiracy could be drawn.\textsuperscript{195}

The court, incidentally, erroneously found that Blue Cross of Nevada and Blue Cross of Wyoming "had opportunities to conspire through their communication and being under common directorship",\textsuperscript{196} but found that even if this were true no inference of conspiracy could be drawn.\textsuperscript{197}

The plaintiff hospital appealed the summary judgment entered against it but subsequently dismissed the appeal when the owner of the hospital and

\begin{itemize}
  \item \textsuperscript{190} Id.
  \item \textsuperscript{191} Id. at 3.
  \item \textsuperscript{192} Id. at 5 (citations omitted).
  \item \textsuperscript{193} Id. at 6 (citations omitted).
  \item \textsuperscript{194} Id. at 7.
  \item \textsuperscript{195} Id.
  \item \textsuperscript{196} Id. (emphasis added).
  \item \textsuperscript{197} Id.
\end{itemize}
some members of its staff were convicted of committing a number of crimes in connection with operation of the hospital.\textsuperscript{198}

VII. CONCLUSION

Officers and directors of the plans cannot be insulated from policy decisions of the type which boards of directors should make. Even if they were so insulated, it would not protect the plan itself from being named a defendant in an antitrust case as was shown in \textit{Reazin}. Because members of the board must make the important policy decisions for the plan, their protection from antitrust suits lies in making decisions which do not result in the plan violating the antitrust laws.

The greater the provider influence on the plan board, the greater the danger of antitrust litigation because it leaves the way open for plaintiffs to allege that the trustees were acting in their own economic interests in setting prices, boycotting non-physicians, allocating territory or whatever. Because physicians and institutional provider representatives can bring much needed and valuable knowledge and expertise to a plan board, it does not make sense to exclude them from board membership. The real danger is not in their presence, but in their control or the perception of their control. Common sense balancing of provider input and provider influence both on the board and on key committees dealing with price, the participation of types of providers and other antitrust sensitive areas, along with knowledgeable antitrust advice can do much to reduce antitrust dangers.

\textsuperscript{198} \textit{Id.} at 9-10.
### APPENDIX

**PREFERRED PROVIDER ORGANIZATION CHECK LIST**

<table>
<thead>
<tr>
<th>PROS</th>
<th>CONS</th>
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<tbody>
<tr>
<td><strong>Monopoly:</strong></td>
<td><strong>Cons</strong></td>
</tr>
<tr>
<td>— Low market share.</td>
<td>— High market share.</td>
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<tr>
<td>(2,5,6,9,11,12,15)*</td>
<td>(4,7)</td>
</tr>
<tr>
<td>— Ease of market entry.</td>
<td>— Barriers to market entry.</td>
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<tr>
<td>(17,18)</td>
<td>(17,18)</td>
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<tr>
<td>— Nonexclusive contracts with providers.</td>
<td>— Exclusive contracts with providers.</td>
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<td>(7,9,11,15,18)</td>
<td>(4,8,15)</td>
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| **Price-Fixing:**                                                   | **Cons**                                                            |
| — Nonprovider controlled PPO sets prices.                          | — Provider controlled PPO sets prices where price-control is the dominant purpose underlying the price-fixing scheme. |
| (2,3,6,7,9,10,15)                                                  | (4,21)                                                             |
| — Provider controlled PPO fixes prices but the PPO constitutes a "joint" venture" which creates a new product or enhances efficiency, (i.e., price-setting is ancillary to an otherwise procompetitive business enterprise.) | — Nonprovider controlled PPO sets prices, but is unduly influenced by participating providers. |
| (5,8,11,12,13,14,19,20)                                            | (22,23,24,25)                                                      |

| **Boycott or Concerted Refusal to Deal:**                          | **Cons**                                                            |
| — Unilateral refusal to deal.                                      | — Concerted refusal, by providers to deal with other providers when such refusal does not further a legitimate business purpose. |
| (1,5,27)                                                          | (5)                                                                |

* Refer to *Table of Authorities for PPO Checklist*, for full cites of numerically referenced authorities.
PREFERRED PROVIDER ORGANIZATION
CHECK LIST

PROS

— Concerted refusal, among providers, to exclude other providers, when necessary to a legitimate business enterprise and when the PPO does not possess market power (i.e., PPO may have large market share provided it has a nonexclusive contract with providers).
(5,8,11,15,18)

CONS

— Concerted refusal, among providers, to deal with other providers, when the PPO possesses market power (i.e., a large market share combined with exclusive provider contracts).
(8)
TABLE OF AUTHORITIES
FOR PPO CHECKLIST

2. Letter from Emily H. Rock, Secretary, Federal Trade Commission, to Irwin S. Smith, M.D. (June 7, 1983).
6. Letter from William F. Baxter, Asst. Att’y Gen., Antitrust Div., Dep’t. of Justice, to Donald W. Fish, Senior Vice Pres. and General Counsel, Hospital Corp. of America (Sept. 21, 1983).
22. Barry v. Blue Cross of California, 805 F.2d 866 (9th Cir. 1986).