



UNC
SCHOOL OF LAW

NORTH CAROLINA LAW REVIEW

Volume 66 | Number 2

Article 2

1-1-1988

Provider-Based Preferred Provider Organizations: A Viable Alternative under Present Federal Antitrust Policies

H. Ward Classen

Follow this and additional works at: <http://scholarship.law.unc.edu/nclr>



Part of the [Law Commons](#)

Recommended Citation

H. W. Classen, *Provider-Based Preferred Provider Organizations: A Viable Alternative under Present Federal Antitrust Policies*, 66 N.C. L. REV. 253 (1988).

Available at: <http://scholarship.law.unc.edu/nclr/vol66/iss2/2>

This Article is brought to you for free and open access by Carolina Law Scholarship Repository. It has been accepted for inclusion in North Carolina Law Review by an authorized administrator of Carolina Law Scholarship Repository. For more information, please contact law_repository@unc.edu.

PROVIDER-BASED PREFERRED PROVIDER ORGANIZATIONS: A VIABLE ALTERNATIVE UNDER PRESENT FEDERAL ANTITRUST POLICIES?

H. WARD CLASSEN†

New means and modes of providing health care are currently under development in this country. One new form, the Preferred Provider Organization (PPO), promises to ensure the continuing availability of cost efficient, high quality health care to the health care consumer. This form allows subscribers the advantages of standardization and efficiency found in other plans but permits a larger degree of flexibility in choosing providers. A significant pitfall to the viability of PPOs is their potential to violate federal antitrust laws. In this Article Mr. Classen examines the antitrust ramifications of PPOs. The discussion includes identification of the aspects of PPOs which cause the greatest antitrust concerns, examination of the pertinent antitrust law, and illumination of possible antitrust exceptions available to PPOs. The Article concludes that PPOs remain a viable health care vehicle despite their potential antitrust problems.

In response to rising expenditures for health care¹ and the increasing number of practicing physicians,² new means of providing health care services constantly are being developed in this country. Many of these "alternative delivery systems"³ offer unlimited, cost-efficient, high-quality health care for one pre-

† Associate General Counsel, International Mobile Machines Corp., Philadelphia, Pa.; B.A. Trinity College 1982; J.D. The Catholic University of America 1985. The author wishes to express his sincere gratitude to Patrick E. Quinlan, Esq., Allyn L. Simon, Joanne L. Anderson, Charles Dillman and the law firm of Weinberg and Green for their help in producing this Article.

1. The following table summarizes the rise in national health expenditures in the United States since 1970:

<u>Year</u>	<u>Total (bil. dol.)</u>	<u>Per Capita (dol.)</u>	<u>% of Gross National Product</u>
1970	75.0	349	7.4
1975	132.7	590	8.3
1980	248.1	1,054	9.1
1983	357.2	1,473	10.5
1984	390.2	1,595	10.3
1985	425.0	1,721	10.7

BUREAU OF THE CENSUS, U.S. DEP'T OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES 1987, at 84 (107th ed. 1987).

2. The number of medical degrees granted each year continues to increase. In 1960, 7,032 medical degrees were conferred; 8,314 in 1970; 12,447 in 1975; 14,902 in 1980; and 15,814 in 1982. *Id.* at 148.

3. "Alternative delivery system" is a generic term referring to the myriad of entities providing health care in the United States that are alternatives to traditional insurance plans such as Blue Cross/Blue Shield. Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Independent Practice Associations (IPAs) are the most well-known. See Classen, *A Supermarket of Health Programs*, BALTIMORE BUS. J., July 7-13, 1986, at 14.

paid price. Nonetheless, many individuals are reluctant to join them because of the restrictions imposed upon subscribers.⁴ Preferred Provider Organizations (PPOs) have grown quickly in recent years in response to public concern,⁵ by providing high-quality health care without the drawbacks of other alternative delivery systems.⁶

The rapid increase in the popularity of PPOs has caught many regulatory agencies by surprise; consequently, regulation of PPOs is not uniform. The major challenge to the continued development of PPOs is the close scrutiny they will receive under the existing federal antitrust laws,⁷ despite recognition that they will play a significant role in the delivery of cost-efficient health care in the future.⁸

Aspects of PPOs that are of great concern to the United States Department of Justice include communications among physicians about prices, fees, and other economic terms; the exclusion of certain physicians from the PPO panel; exclusive contracts with physicians; limitations on the types of services offered by particular physicians regarding the geographic areas or patients they can serve; and peer review of prices.

This Article investigates whether provider-based PPOs are a viable alternative for the continued delivery of health care under the present federal antitrust laws. It first reviews the major forms of PPOs and the relevant sections of the federal antitrust laws that affect them. The Article then explores previous decisions in this area and discusses the current antitrust concerns presented by PPOs. Finally, the Article posits that despite present federal antitrust policies, provider-based PPOs remain a viable alternative for providing high-quality, cost-efficient health care in the United States.

4. Health Maintenance Organizations (HMOs), for example, restrict subscribers to using a set panel of physicians, often excluding the subscribers' personal physicians. Furthermore, subscribers often may not receive health care outside their geographic area. *Id.* Providers such as hospitals and physicians often are reluctant to join HMOs because they bear a portion of the risk of over-utilization, *id.*, as well as having to meet substantial regulatory requirements. See 42 U.S.C. §§ 300e to 300e-17 (1982).

5. There are approximately 250 PPOs in the United States today, compared to a mere handful a few years ago. Two-thirds of these have been in operation for only about one year. Stromberg, *PPOs and Regulation*, HEALTHSPAN, Oct. 1986, at 2. One health care executive has projected that 50% of the medically insured population of the United States will be enrolled in a PPO by the year 2000. WASH. ACTIONS ON HEALTH, Jan. 5, 1987, at 8.

6. PPOs do not restrict subscribers to a limited number of providers. Furthermore, physicians are not required to bear a portion of the risk. They are paid on a fee-for-service basis and thus do not have the incentive to overly restrict health care services. See Tichon, *PPOs: Definition and Background*, in ATTORNEYS AND PHYSICIANS EXAMINE PREFERRED PROVIDER ORGANIZATIONS 4 (J. Waxman ed. 1984).

7. See *infra* notes 28-52 and accompanying text. Legislation previously has been proposed in Congress to weaken state statutes restricting the development of PPOs. See H.R. 733, 99th Cong., 1st Sess. (1985); H.R. 2956, 97th Cong., 1st Sess. (1983).

8. See J. McGrath, Assistant Att'y Gen., Antitrust Div., Dep't of Justice, Remarks at the 33d American Bar Association Antitrust Spring Meeting (Mar. 22, 1985) [hereinafter McGrath Remarks]; *PPS Dissolves After Justice Threatens to File § 1 Action*, Antitrust & Trade Reg. Rep. (BNA) 721 (Oct. 18, 1984); FTC Advisory Opinion to Health Care Management Associates, 3 Trade Reg. Rep. (CCH) 22,036, at 22,641 (June 8, 1983).

I. PREFERRED PROVIDER ORGANIZATIONS

A PPO is a health care financing and delivery program that provides financial incentives to consumers to utilize certain "preferred" providers.⁹ A PPO typically offers health care services through independent providers, such as physicians or hospitals, to third party payors, such as insurance companies and employers, at discounted rates in return for the expedited payment of claims. The PPO carefully selects the providers that deliver the services to ensure that a wide range of quality services is available.¹⁰ In essence, the PPO contracts with health care providers to provide services at a discounted rate and with purchasers of health care services to satisfy their health care needs.

PPOs contract with a panel of "preferred" providers comprised of physicians, hospitals, or both. The ideal makeup of a "panel" includes a cross-section of providers who will offer quality health care and a full range of services. Although beneficiaries or subscribers of the PPO are given complete freedom to choose their treating physician,¹¹ they are strongly encouraged to choose a "preferred" provider from the existing panel. This encouragement takes the form of economic incentives such as no copayments, lower deductibles, and higher coverage.¹²

The PPO in turn negotiates a fee schedule with the individual physicians who constitute the "preferred" provider panel. Member physicians usually discount their fees or provide a maximum fee schedule. Physician fees can be established on the basis of a relative value guide,¹³ conversion factors,¹⁴ or even capitation.¹⁵ Health care providers benefit through increased or guaranteed patient volume and the quick and efficient payment of claims.¹⁶ The providers forming the PPO do not take an insurance-type risk, market services, or collect premiums. Instead, they negotiate their fees or rates with the payor, leaving the payor to bear any financial risk.

The financial well-being of a PPO is contingent on many factors. To be successful a PPO must have a wide geographic distribution of physicians, be oriented to primary care, offer legitimate consumer savings, maximize physician

9. Alternatively, a PPO has been defined as "an entity that offers health care services through providers who are otherwise independent to third party payors such as insurance companies and employers, normally at discounted rates in return for expedited payment of claims." PRACTICING LAW INSTITUTE, HEALTH CARE: LEGAL RESPONSES TO NEW ECONOMIC FORCES 272 (1985).

10. Providers for the "preferred" panel are carefully selected on the basis of objective criteria. The PPO screens high-quality physicians, and generally selects a preferred panel on the basis of the number of malpractice actions, board certification, submission to utilization review, *see infra* notes 17-18 and accompanying text, as well as cost consciousness, geographic location, and specialty coverage.

11. Tichon, *supra* note 6, at 5.

12. Tichon, *supra* note 6, at 5.

13. Tichon, *supra* note 6, at 4-6; *see also* Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332, 340-41 (1982) (defining relative value schedules).

14. Tichon, *supra* note 6, at 4-6; *see also* Maricopa, 457 U.S. at 340-41 (defining conversion factors).

15. Tichon, *supra* note 6, at 4-6. Capitation is a "uniform per capita payment." WEBSTER'S NEW COLLEGIATE DICTIONARY 163 (1981).

16. Tichon, *supra* note 6, at 5-6.

involvement, and ensure a solid relationship between the providers and purchasers of the services offered. As in any business, financial success is directly related to efficiency and productivity. To that end, PPOs attempt to increase efficiency through a system of managerial oversight known as "utilization review."

Utilization review involves comprehensive review of all treatment decisions, prior authorization of treatment before it is offered, referral authorization, and second opinions.¹⁷ Furthermore, utilization review includes investigation of other options such as same-day surgery and referrals to home health care. The underlying theory of utilization review is that education, behavior modification, and sanctions will eliminate the delivery of unnecessary health care.¹⁸

Although all PPOs have the same general characteristics, they exist in a number of different forms. Among the most prevalent are entrepreneur or broker-based PPOs, payor-based PPOs, and provider-based PPOs. In addition, new forms recently have been developed.¹⁹

Entrepreneur or broker-based PPOs are perhaps the most common existing form of PPOs. Under an entrepreneur structure, a claims administrator or insurance broker negotiates an agreement between the providers and the purchasers. Upon receiving a commitment from a substantial number of providers, the broker will market this "panel" to her clients and other purchasers of health care services. She profits from the fee structure and administrative fees. The broker is not associated with the providers or purchasers. This structure, unless backed by an insurance company, is extremely risky for the providers, because there is very little protection against payor insolvency or misconduct by those administering the plan.²⁰

A second type of PPO is the payor-based PPO, which is usually organized and controlled by an insurance company, employer, or union trust fund.²¹ Typically, these PPOs contract with hospitals and physicians to provide health care services to the PPO's beneficiaries. The provider acts only as an employee of the PPO serving on a contractual basis. The provider maintains his traditional "fee-for-service" status but at a negotiated rate. The payor attempts to reduce its health care expenditures by negotiating substantial discounts from the physicians' usual fees in return for increased patient volume and the quick payment of all claims. The physician, while charging a lower price, can increase his overall income through the sheer volume of patients generated by the payor's many

17. Utilization review, which attempts to reduce costs by eliminating the delivery of unnecessary health care, has been the basis of at least one suit. *See Wickline v. State*, 228 Cal. Rptr. 661 (1986) (patient who was prematurely discharged because of a utilization review's decision to cease health care payments subsequently had leg amputated as a result of his premature discharge), *rev. dismissed*, 741 P.2d 613, 239 Cal. Rptr. 805 (1987).

18. *Id.* at 663.

19. One variant is an Exclusive Provider Organization, which limits subscribers to utilizing only the "preferred" provider panel. Another is a Management Premium PPO, which provides for risk sharing by purchasers and providers. Providers are still compensated on a fee-for-service basis, but a portion of the fees are set aside and returned to purchasers if providers are unable to control prices.

20. R. Lavine, Remarks at the Seventh Annual Institute on Medicare and Medicaid Payment Issues 1 (Apr. 17, 1986) [hereinafter Lavine Remarks].

21. *Id.*

beneficiaries.²²

Provider-based PPOs, the focus of this Article, are typically organized by a hospital, a network of hospitals, or a group of physicians in order to sell their services to large purchasers of health care services or directly to beneficiaries.²³ Usually, a provider-based PPO is owned and operated by the hospital at which the majority of the participating physicians practice. A number of recent PPOs, however, have been organized by physician groups.²⁴ Typically, these physicians join together to make themselves more competitive in the existing market. Another provider-based alternative is a joint venture between a hospital and a group of physicians.²⁵

Provider-based PPOs, especially those that are sponsored by physicians, are subject to great scrutiny under existing federal antitrust laws.²⁶ Often the temptation for physicians to communicate about prices, fees, and other economic terms is simply too great. To withstand antitrust challenges, a provider-based PPO must gain its financial benefits by increasing the members' competitiveness in the existing market and not by eliminating or discouraging competition from other physicians.²⁷

II. RELEVANT FEDERAL ANTITRUST STATUTES

Because of their potential for fostering anti-competitive behavior, PPOs are closely scrutinized under a number of federal antitrust laws. Federal legislation is particularly important because PPOs until recently have been regulated only lightly, if at all, by state agencies.²⁸

A. *The Sherman and Clayton Antitrust Acts*

Section 1 of the Sherman Antitrust Act²⁹ prohibits "[e]very contract, combination . . . or conspiracy, in restraint of trade or commerce . . ." ³⁰ The

22. *Id.*

23. *Id.* One example of a large purchaser is the United States Department of Defense. "The Pentagon's massive plan to reform its health care system for 6.2 million dependents and retirees would result in three giant, at-risk preferred provider organizations (PPOs) . . ." *Defense Department Plan Opens Vast PPO Opportunity*, WASH. ACTIONS ON HEALTH, July 7, 1986, at 4.

24. Lavine Remarks, *supra* note 20, at 2.

25. See generally Letter from M. Elizabeth Gee, Assistant Director, Bureau of Competition, Federal Trade Commission, to Michael A. Duncheon (Mar. 17, 1986) [hereinafter Letter from Gee to Duncheon] (opinion letter from FTC for "an incorporated joint venture of a limited number of hospitals and physicians in two counties of California").

26. See Calvani, *Competition in Health Care—FTC Views*, 5 Trade Reg. Rep. (CCH) 50,479, at 56,275-85 (Feb. 20, 1986).

27. *Id.* at 56,284-85.

28. Stromberg, *supra* note 5, at 2. Recently, the following states have adopted legislation allowing insurance company sponsored PPOs: California, Florida, Indiana, Kansas, Louisiana, Maryland, Michigan, Minnesota, Nebraska, North Carolina, Virginia, Wisconsin, and Wyoming. *Id.*

29. 15 U.S.C. §§ 1-7 (1982).

30. *Id.* § 1. The section provides in full:

Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal. Every person who shall make any contract or engage in any combination or conspiracy hereby declared to be illegal shall be deemed guilty of a felony, and, on conviction . . .

United States Supreme Court has interpreted this section as prohibiting only "unreasonable" restraints of trade.³¹ Any potential violation of section 1 must be unreasonable in comparison to the economic realities of the marketplace.³² Yet, the Supreme Court has deemed certain agreements and business practices to be per se unreasonable and hence illegal because they have an inherently adverse effect on competition.³³ These per se violations include the division of markets, certain group boycotts, tying arrangements, and price-fixing.³⁴ Thus, the Supreme Court has established a rule of reason/per se dichotomy in analyzing trade restraints under the Sherman Antitrust Act.

To violate section 1 of the Sherman Antitrust Act there must be a conspiracy among two or more individuals.³⁵ One person's actions, no matter how anticompetitive, are ineffective to form a conspiracy. Furthermore, there must be an agreement between the conspiring parties.³⁶ An express agreement is not required, because an unlawful agreement may be inferred from the words or conduct of the parties in the course of their dealings.³⁷ Conscious parallel business conduct is not sufficient to constitute a violation of section 1 of the Sherman Antitrust Act when the facts indicate that intelligent businessmen would act in the same manner.³⁸ Collusion, however, is per se illegal.³⁹

tion thereof, shall be punished by fine not exceeding one million dollars if a corporation, or if any other person, one hundred thousand dollars, or by imprisonment not exceeding three years, or by both said punishments, in the discretion of the court.

Id.

31. *E.g.*, *Standard Oil Co. v. United States*, 221 U.S. 1, 54, 59-60 (1911).

32. *United States v. Topco Assocs., Inc.*, 405 U.S. 596, 607 (1972) ("An analysis of the reasonableness of particular restraints includes consideration of the facts peculiar to the business in which the restraint is applied, the nature of the restraint and the reasons for its adoption.") (citing *Chicago Bd. of Trade v. United States*, 246 U.S. 231, 238 (1918)).

33. *See Topco Assocs.*, 405 U.S. at 607 (Court has "developed the doctrine that certain business relationships are per se violations of the Act without regard to a consideration of their reasonableness").

34. *See id.* at 601, 611 (agreements among competitors to sell their products only within marketing territory allocated to each); *Klor's, Inc. v. Broadway Hale Stores, Inc.*, 359 U.S. 207, 212 (1959) (group boycott: refusal by some traders to deal with certain other traders); *Northern Pac. Ry. v. United States*, 356 U.S. 1, 5 (1958) (tying arrangements: "an agreement by a party to sell one product but only on the condition that the buyer also purchases a different (or tied) product"); *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 212-13 (1940) (price fixing: agreement between "members of a combination, controlling a substantial part of an industry, upon the prices members are to charge for their commodity").

35. For the text of this section, see *supra* note 30 and accompanying text.

36. *See generally* S. OPPENHEIM & G. WESTON, *FEDERAL ANTITRUST LAWS: CASES AND COMMENTS* 94-131 (1968) (describing agreements and indirect arrangements among competitors involving price).

37. *Id.* at 100.

38. *Theatre Enters. v. Paramount Film Distrib. Corp.*, 346 U.S. 537, 541-42 (1954); *United States v. American Soc'y of Anesthesiologists*, 473 F. Supp. 147, 158-59 (S.D.N.Y. 1979). Parallel conduct in conjunction with an intent or attempt to achieve collusion, or acts against the parties' own self-interest, may support a finding of concerted actions. *See Theatre Enters.*, 346 U.S. at 541.

39. *See United States v. Topco Assocs., Inc.*, 405 U.S. 596 (1972) (cooperative association that establishes territorial licenses is a horizontal restraint and, therefore, a per se violation of § 1 of the Sherman Act); *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150 (1940) (group agreement to raise and maintain spot market prices of gasoline constitutes conspiracy to fix prices, a per se violation of the Sherman Act, even though not all competition was eliminated from market and other factors may have contributed to rise in price).

Section 1 directly impacts PPOs and their delivery of health care.⁴⁰ The primary antitrust concern is price-fixing among competitors or potential competitors, which is a per se violation of section 1.⁴¹ Any individual health care provider may freely negotiate his price structure with a broker or other purchaser of health care services. Once he chooses to participate in a PPO, however, any communication or concerted activity as to price schedules or fees easily could be viewed as a per se violation.⁴²

Section 2 of the Sherman Antitrust Act⁴³ also applies to PPOs and punishes "[e]very person who shall monopolize, or attempt to monopolize, or combine or conspire with any person or persons, to monopolize any part of the trade or commerce among the several states"⁴⁴ This prohibition against monopolization applies directly to PPOs. Provider-based PPOs are particularly subject to scrutiny under section 2 of the Sherman Antitrust Act if they have sufficient market power and contract with a large percentage of physicians in the relevant geographic market.⁴⁵ In evaluating any potential violation, a court will closely review market shares and the number of participating physicians, as well as the intent of the contracting parties.

Section 2 of the Clayton Act,⁴⁶ as amended by the Robinson-Patman Act,⁴⁷ provides that it is

unlawful for any person engaged in commerce, in the course of such commerce, either directly or indirectly, to discriminate in price between different purchasers of commodities of like grade and quality, where either or any of the purchasers involved in such discrimination are in commerce, where such commodities are sold for use, consumption, or resale . . . and where the effect of such discrimination may be

40. See *Jefferson Parish Hosp. v. Hyde*, 466 U.S. 2, 4-5 (1984); *Arizona v. Maricopa County Medical Soc'y*, 457 U.S. 332, 335-36 (1982); *Hospital Bldg. Co. v. Trustees of Rex Hosp.*, 425 U.S. 738, 739 (1976); see also *infra* notes 62-91 and accompanying text (discussing analogous United States Supreme Court cases on price-fixing).

41. Examples of per se violations of § 1 include *McLain v. Real Estate Bd.*, 444 U.S. 232 (1980); *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975); *Mandeville Island Farms, Inc. v. American Crystal Sugar Co.*, 334 U.S. 219 (1948); *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150 (1940).

42. See *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 782-83 (1975) (price schedule set out by local bar association is price fixing and a classic § 1 violation). The first clause of § 1 prohibits any "contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade . . ." 15 U.S.C. § 1 (1982).

43. 15 U.S.C. § 2 (1982).

44. *Id.* Section 2 provides in full:

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, or with foreign nations, shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding one million dollars if a corporation, or, if any other person, one hundred thousand dollars, or by imprisonment not exceeding three years, or by both said punishments, in the discretion of the court.

Id.

45. See FED. TRADE COMM'N, ENFORCEMENT POLICY WITH RESPECT TO PHYSICIAN AGREEMENTS TO CONTROL MEDICAL PREPAYMENT PLANS 15-16 (1981) [hereinafter *FTC REPORT*].

46. 15 U.S.C. § 13 (1982).

47. Robinson-Patman Anti-Discrimination Act, ch. 592, § 1, 49 Stat. 1526, 1526 (1936).

substantially to lessen competition or tend to create a monopoly . . . or to injure, destroy, or prevent competition⁴⁸

This section, on its face, applies only to "commerce," and seemingly exempts the discounting of physicians' services.⁴⁹ Nevertheless, a number of health care related claims have been based on this Act, and it is a potential means of challenging the legality of a PPO.⁵⁰

Section 3 of the Clayton Act⁵¹ prohibits exclusive dealing arrangements that reduce competition by requiring a purchaser to deal exclusively with the seller. This provision also is apparently irrelevant to PPOs, because the Clayton Act does not govern the delivery of services. However, such conduct when undertaken by PPOs may violate the Sherman Act.⁵²

B. Other Relevant Statutes

The Federal Trade Commission Act⁵³ also must be considered when evaluating the legality of certain actions taken by PPOs. The Act prohibits all "[u]nfair methods of competition . . . and unfair or deceptive acts or practices in or affecting commerce . . ." ⁵⁴ This broadly worded legislation allows the Federal Trade Commission (FTC)⁵⁵ great leeway in determining whether a PPO promotes "unfair methods of competition." The meaning of "unfair" is relative and has a variety of interpretations.⁵⁶ One solution to this uncertainty is to

48. 15 U.S.C. § 13 (1982).

49. See *Ball Memorial Hosp. v. Mutual Hosp. Ins. Co.*, 784 F.2d 1325, 1340 (7th Cir. 1986).

50. See generally *Jefferson County Pharmaceutical Ass'n v. Abbott Laboratories*, 460 U.S. 150 (1983) (sale of pharmaceutical products to state and local government hospitals for resale in competition with private pharmacies violates Robinson-Patman Act); *Abbott Laboratories v. Portland Retail Druggists Ass'n*, 425 U.S. 1, 3-4 (1976) (nonprofit hospitals that purchase drugs at favored prices from pharmaceutical companies are exempt from Robinson-Patman Act if drugs are for their own use); *De Modena v. Kaiser Found. Health Plan, Inc.*, 743 F.2d 1388, 1394 (9th Cir. 1985) (HMOs that purchase drugs for their members are purchasing for their own use and thus are exempt from Robinson-Patman Act; any such drugs sold to those who are not members violates Act), *cert. denied*, 469 U.S. 1229 (1985); *Tim W. Koerner & Assocs., Inc. v. Aspen Labs, Inc.*, 492 F. Supp. 294, 302-03 (S.D. Tex. 1980) (in absence of forbidden tying arrangements, manufacturer of orthopedic and electrosurgical supplies is not precluded by Clayton Act or Sherman Act from refusing to deal with someone), *aff'd*, 683 F.2d 416 (5th Cir. 1982).

51. 15 U.S.C. § 14 (1982).

52. See *Northern Pac. Ry. v. United States*, 356 U.S. 1, 10-11 (1958); *Pay Less Drug Stores N.W., Inc. v. City Prods. Corp.*, 1975-2 Trade Cas. (CCH) 60,385 (D. Or. June 18, 1975).

53. 15 U.S.C. §§ 41-77 (1982).

54. *Id.* § 45(a)(1).

55. The FTC is an independent regulatory body of the federal government responsible for investigating antitrust concerns and consumer protection actions. The FTC does not enforce the Sherman Act, but does have authority to act against "unfair methods of competition" under the powers granted to it by the Federal Trade Commission Act. *Id.* § 45(a)(2); see *FTC v. Cement Inst.*, 333 U.S. 683, 691 (1948). The FTC shares its antitrust duties with the United States Department of Justice. The Department of Justice traditionally is concerned with price-fixing and other criminal activities, while the FTC usually limits its investigations to noncriminal matters. The FTC also has the authority to enforce a large number of consumer protection statutes. See 15 U.S.C. §§ 52-70k (1982).

56. *Raladam Co. v. FTC*, 316 U.S. 149, 151 (1942) (FTC findings made with "meticulous particularity" and supported by substantial evidence should not be set aside); *FTC v. R.F. Keppel & Brother, Inc.*, 291 U.S. 304, 314 (1934) (although courts should determine what practices or methods of competition are unfair, FTC determinations are of weight); *Allen B. Wrisley Co. v. FTC*, 113 F.2d 437, 441 (7th Cir. 1940) (unfair trade methods are not per se "unfair methods of competition");

obtain a "no action" opinion letter from the FTC before implementing any proposed structure.⁵⁷

III. ANTITRUST CONCERNS

PPOs present numerous antitrust concerns because they have the potential to restrict competition among health care providers. Potential antitrust violations arise through the communication of prices, fees, and other economic terms,⁵⁸ the selection of the "preferred" provider panel,⁵⁹ exclusive agreements prohibiting providers from contracting with other alternative delivery systems,⁶⁰ and the selection of providers.⁶¹

A. Price-Fixing

The greatest potential for antitrust violation in the operation of a PPO is price-fixing among the member providers. As a rule, any joint effort by market competitors creates opportunities for greater economic power. By agreeing to set prices at an artificial level, physicians who control a substantial portion of a health care market may unfairly utilize their market power.

In *Arizona v. Maricopa County Medical Society*⁶² the United States Supreme Court considered the legality of physician members of an alternative delivery system setting their own maximum price schedule.⁶³ The physicians in

In re Amtorg Trading Corp., 75 F.2d 826, 830 (C.C.P.A.) ("unfair methods of competition," though not defined by the statute relating to the powers of the FTC, include practices involving deception, bad faith, fraud, or oppression, or acts found to be against public policy because of their dangerous tendency to unduly hinder competition or create monopolies; Act was not intended to fetter free and fair competition as commonly understood and practiced by honorable opponents in trade, *cert. denied*, 296 U.S. 576 (1935); *FTC v. Paramount Famous-Lasky Corp.*, 57 F.2d 152, 154 (2d Cir. 1932) (practices against public policy because of "dangerous tendency unduly to hinder competition or create a monopoly" constitute "unfair methods of competition"); *People ex rel. Fahner v. Testa*, 112 Ill. App. 2d 834, 838, 445 N.E.2d 1249, 1252 (1983) ("unfair practice" and "unfair methods of competition" under terms of the Consumer Fraud and Deceptive Business Practices Act are "inherently not susceptible to precise definition . . . [They] must be defined on a case-by-case basis because of the futility of trying to anticipate all unfair methods and practices a fertile mind might devise."); *Seaboard Sur. Co. v. Ralph Williams' N.W. Chrysler Plymouth, Inc.*, 81 Wash. 2d 740, 743, 504 P.2d 1139, 1141 (1973) ("unfair method of competition" employed in Federal Trade Commission Act has broader meaning than common law "unfair competition").

57. The FTC may act against a violator in several ways. It may bring suit in an administrative action or seek an injunction in federal court. 15 U.S.C. § 57b (1982). When an entity believes that its actions may violate the antitrust laws, it may ask the FTC for its opinion. The FTC will issue an "opinion" letter giving its unbinding opinion as to the legality of a certain activity. *Id.* § 57b-4(d).

An opinion letter is provided by the FTC upon request. The FTC evaluates the factual circumstances and issues an opinion stating whether it will bring "action" or take "no action" against the inquiring entity. The word "opinion," however, is crucial: even if the FTC states it will not take action against the proposed activity, the letter is not legally binding. Nonetheless, receiving an opinion letter is extremely important because it may result in substantial monetary savings for an entity that later would have been found to violate the antitrust laws.

58. See *infra* notes 62-91 and accompanying text.

59. See *infra* notes 114-17 and accompanying text.

60. See *infra* notes 92-96 and accompanying text.

61. Opinion of the Attorney General of Ohio (to Laurel Call), 1984-1 Trade Cas. (CCH) 65,796, at 67,310 (Nov. 17, 1983).

62. 457 U.S. 332 (1982).

63. Although the alternative delivery system was not identified as a PPO, it had all of the

Maricopa formed a nonprofit corporation to promote fee-for-service health care and to provide an alternative to existing health insurance plans.⁶⁴ The corporation established a schedule of maximum fees that member physicians could charge for their services. Each physician was paid on the basis of this fee schedule, which was computed using "relative values" and "conversion factors."⁶⁵ The member physicians were limited by the maximum fee schedule and could not seek additional payments from their insured patients.⁶⁶

Under the plan, a patient was permitted to visit any physician, including those who were not members of the corporation.⁶⁷ If she visited a physician who was employed by the corporation, the patient was guaranteed complete medical service at no cost.⁶⁸ If a plan member visited a nonmember physician, she would be reimbursed only up to the limit set by the maximum fee schedule and would pay any additional charge.⁶⁹

The Supreme Court held the maximum fee schedule agreement illegal per se under section 1 of the Sherman Antitrust Act.⁷⁰ The Court concluded that the agreement "permitted [the physicians] to sell their services to certain customers at fixed prices and arguably to affect the prevailing market price of medical care."⁷¹ The *Maricopa* Court rejected the corporation's analogy to a partnership or joint venture in which competitors pool their capital and share the risk of loss as a single entity in a larger market.⁷² Because the *Maricopa* group was composed of independently competing physicians who agreed on fees to charge their individual patients, the Court concluded that the agreement constituted horizontal price-fixing.⁷³

The physicians contended that a per se analysis was inappropriate when the agreement had procompetitive justifications.⁷⁴ They defended the agreement under a rule of reason standard, noting that the corporation offered high-quality health care, free choice of physicians, complete health coverage, and low premiums.⁷⁵ The Court responded that "claims of enhanced competition are so unlikely to prove significant in any particular case that we adhere to the rule [of per se invalidation of all price-fixing agreements]."⁷⁶ Under the reasoning in *Mari-*

characteristics of a PPO. Compare *supra* notes 9-27 and accompanying text (defining and describing different types of PPOs) with *Maricopa*, 457 U.S. at 339-42 (setting out characteristics of the *Maricopa* alternative delivery system).

64. *Maricopa*, 457 U.S. at 339.

65. *Id.* at 340. Each specialty was assigned a conversion factor and each medical service within a specialty was assigned a relative value. The product of these two figures determined the fee schedule. The corporation solicited advice from members of the medical community as to the proper values of the relative values and conversion factors. *Id.*

66. *Id.* at 341.

67. *Id.*

68. *Id.*

69. *Id.*

70. *Id.* at 357.

71. *Id.* at 356.

72. *Id.* at 356-57.

73. *Id.* at 357.

74. *Id.* at 351.

75. *Id.* at 351-52.

76. *Id.* at 351.

copa, a court must enforce the established interpretation of the Sherman Anti-trust Act; any changes to that interpretation are matters for legislative consideration.⁷⁷

The physicians relied on *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*⁷⁸ In that case the Supreme Court upheld a "blanket license" agreement under which the American Society of Composers, Authors and Publishers (ASCAP) marketed the right to use copyrighted compositions of all its members for a set fee.⁷⁹ The *Maricopa* Court distinguished *Broadcast Music*, however, on the ground that ASCAP's "blanket license" was a different product from anything an individual member could sell.⁸⁰ The doctors in *Maricopa* sold the same medical services individually or as a group. The agreement was simply a vehicle for fixing uniform prices for those services.⁸¹

The corporation in *Maricopa* shared many of the characteristics of a PPO. In addition to establishing a maximum fee schedule, the corporation undertook utilization review to determine the appropriateness of the health care delivered, and made payments to the member physicians through a form of insurance coverage.⁸² Furthermore, patients who visited physicians not belonging to the corporation were reimbursed up to the level of the maximum fee schedule for member physicians.⁸³

Although *Maricopa* is the only Supreme Court decision involving price-fixing by an entity similar to a PPO, administrative and lower court decisions have addressed the topic.⁸⁴ In March 1986 the FTC issued an opinion letter to the legal counsel of a PPO indicating that it will not blindly accept provider-based PPOs generally formed along the guidelines set forth by the Supreme Court in *Maricopa*.⁸⁵

In drafting its opinion letter the FTC examined a joint venture among sixteen nonprofit hospitals and sixteen related physician groups in two California

77. *Id.* at 354-55. The Court concluded that "Congress may consider the exception that we are not free to read into the statute." *Id.* at 355.

78. 441 U.S. 1 (1979).

79. *Id.* at 8 n.13, 18, 24.

80. *Maricopa*, 457 U.S. at 355-56. ASCAP members were still permitted to sell their own compositions; but under the blanket license ASCAP could sell compositions of any member. *Broadcast Music*, 441 U.S. at 23.

81. *Maricopa*, 457 U.S. at 356. The physicians, in defending the procompetitive justifications of their organization, argued that maximum fee schedules "make it possible to provide consumers of health care with a uniquely desirable form of insurance coverage that could not otherwise exist." *Id.* at 351. The argument implies that the organization offered a product that individual physicians could not. The Court later acknowledged that individual doctors cannot package services. Still, the Court insisted that the instant agreements "fit squarely into the horizontal price-fixing mold." *Id.* at 357.

82. *Id.* at 339-40.

83. *Id.* at 341.

84. See *Ball Memorial Hosp. v. Mutual Hosp. Ins. Co.*, 784 F.2d 1325 (7th Cir. 1986); Letter from Charles F. Rule, Acting Assistant Att'y Gen., Antitrust Div., Dep't of Justice, to F.M. Bush III, Esq. (Apr. 7, 1987) [hereinafter Letter from Rule to Bush] (opinion letter for a PPO); Letter from Charles F. Rule, Acting Assistant Att'y Gen., Antitrust Div., Dep't of Justice, to Robert Taylor (October 3, 1986) [hereinafter Letter from Rule to Taylor] (same).

85. Letter from Gee to Duncheon, *supra* note 25, at 2. Mr. Duncheon, the legal counsel for the PPO, did not identify his client. *Id.* at 1.

counties.⁸⁶ The proposed staff of this PPO was comprised of equal numbers of the institutional providers and physicians. Each shareholder was to pay \$10,000 to purchase stock in the PPO, which would be used for operating funds.⁸⁷ Administrative fees were to be charged to the payors and, most likely, to participating providers to cover the expenses of utilization review, quality assurance, and beneficiary service programs. Deficits were to be paid out of capital reserves.

The PPO contracted with a little over ten percent of the physicians in the area and with hospitals for approximately sixteen percent of their beds.⁸⁸ The PPO's contracts were not exclusive, and other providers and payors were free to participate with other alternative delivery systems. Physicians were to be integrated fully into all aspects of the PPO, including marketing, contracting, quality assurance, and utilization review. The stated purpose of the PPO was to "compete successfully in the market for the sale and delivery of health care services to group health care purchasers."⁸⁹

The FTC, in its advisory opinion, did not decide whether such an organization was per se illegal. It did indicate that, under the guidelines of *Maricopa*, there was a substantial likelihood that such a provider-based PPO could be found per se illegal because of the proposed negotiation of price terms.⁹⁰ This conclusion raises some serious concerns about the continued viability of provider-based PPOs. The FTC reached its conclusion despite the fact the agreement in question did not require exclusivity among the PPO contractors, allowed the PPO providers to compete among themselves, and represented only a modest market share.⁹¹

B. *Exclusive Dealing Arrangements*

Exclusive dealing arrangements occur when a physician who is a member of a PPO agrees not to contract with other alternative delivery systems. Such an arrangement affects the ability of a competing alternative delivery system to enlist the best doctors. Exclusive contracts are evaluated under a rule of reason analysis. In determining the validity of the agreement, a court generally considers the degree of competition foreclosed by the agreement, its duration, and the market share of the contracting parties.⁹²

In one of the few actions taken in this area, the Department of Justice advised the Stanislaus Preferred Provider Organization, Inc. that it would take action against the organization on the ground that the PPO's exclusive agreements constituted an unlawful conspiracy to restrain competition in the delivery of health care.⁹³ The Stanislaus PPO enrolled fifty percent of the physicians in a

86. Letter from Gee to Duncheon, *supra* note 25, at 1.

87. Letter from Gee to Duncheon, *supra* note 25, at 2.

88. Letter from Gee to Duncheon, *supra* note 25, at 2.

89. Letter from Gee to Duncheon, *supra* note 25, at 2.

90. Letter from Gee to Duncheon, *supra* note 25, at 2, 3, 5-8.

91. Letter from Gee to Duncheon, *supra* note 25, at 2.

92. See *infra* notes 130-37 and accompanying text.

93. Department of Justice, Press Release at 1 (Oct. 12, 1984) [hereinafter Press Release]; 47 Antitrust & Trade Reg. Rep. (BNA) No. 1186, at 721 (Oct. 18, 1984).

major county in California and ninety percent of the physicians serving the largest city in that county.⁹⁴ According to the Department of Justice, the group was organized to inhibit and foreclose the development of competing PPOs as well as to reduce price competition among physicians delivering health care in the county. Furthermore, the PPO required its members to agree not to contract with any other PPOs.⁹⁵ Faced with a potential lawsuit under section 1 of the Sherman Antitrust Act, the Stanislaus PPO dissolved.⁹⁶

C. Boycotts

Another potential antitrust concern is the group boycott. A boycott can be a coercive tool that denies the boycotted party a free market in which to compete. In the PPO context, a boycott exists if an organization limits the number or type of preferred providers allowed to join its panel. Such limitations can arise in several ways. The most prominent are credential restrictions, exclusion of certain specialties, exclusion of nonphysicians, and utilization review determinations that terminate a provider's membership on the panel. Group boycotts are reviewed under both the rule of reason and per se analyses.⁹⁷

In *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*⁹⁸ an organization of clinical psychologists brought suit against Blue Shield of Virginia, alleging a violation of section 1 of the Sherman Antitrust Act. Blue Shield had refused to pay for services rendered by clinical psychologists that were not billed through a physician. The practical effect of the Blue Shield plan was to force psychologists to work through physicians.⁹⁹ The psychologists' organization charged that the plan reduced their ability to compete with physicians generally and psychiatrists specifically.¹⁰⁰

The district court applied a rule of reason analysis in holding that Blue

94. Press Release, *supra* note 93, at 2.

95. Press Release, *supra* note 93, at 2.

96. Press Release, *supra* note 93, at 1; McGrath Remarks, *supra* note 8, at 5.

97. The appropriate analysis depends on the purpose of the boycott. See *Northwest Wholesale Stationers, Inc. v. Pacific Stationery & Printing Co.*, 472 U.S. 284, 293-98 (1985) (absent a showing of market power or unique access to a business element necessary for effective competition, the rule of reason is appropriate in lieu of the per se approach in analyzing a boycott claim); *E.A. McQuade Tours, Inc. v. Consolidated Air Tour Manual Comm.*, 467 F.2d 178, 185-86 (5th Cir. 1972) (per se standard used only for arrangements presumptively unreasonable, such as a group boycott), *cert. denied*, 409 U.S. 1109 (1973). Recently, courts have applied the rule of reason analysis to boycott cases in the health care field, often finding an antitrust violation. See, e.g., *Wilk v. American Medical Ass'n*, 719 F.2d 207, 225-26 (7th Cir. 1983) (applied modified rule of reason test for physicians' alleged boycott of chiropractors), *cert. denied*, 467 U.S. 1210 (1984); *Virginia Academy of Clinical Psychologists v. Blue Shield of Va.*, 624 F.2d 476, 484-86 (4th Cir. 1980) (rule of reason analysis used to find insurance plan proviso requiring psychologists' fees be billed through physician violates Sherman Act), *cert. denied*, 450 U.S. 916 (1981); *Pontius v. Children's Hosp.*, 552 F. Supp. 1352, 1369-70 (W.D. Pa. 1982) (rule of reason analysis applied to find no antitrust violation of physicians' boycott of specific surgeon).

98. 469 F. Supp. 552 (E.D. Va. 1979), *aff'd in part, vacated in part*, 624 F.2d 476 (4th Cir. 1980).

99. *Virginia Academy of Clinical Psychologists v. Blue Shield of Va.*, 624 F.2d 476, 478 (4th Cir. 1980).

100. *Virginia Academy*, 469 F. Supp. at 560-61.

Shield had not violated the Sherman Antitrust Act.¹⁰¹ In examining the market affected, the court found that clinical psychologists were not equivalent to psychiatrists as providers of therapy. Although psychologists and psychiatrists both offered psychotherapy, psychiatrists were capable of providing a full range of medical treatment to patients.¹⁰² A psychologist could offer comparable treatment only in cooperation with a medical doctor.¹⁰³ Once the psychologist cooperated with a physician, he was treated equally with a psychiatrist under the Blue Shield plan.¹⁰⁴ Thus, the court concluded that Blue Shield did not unreasonably restrain the clinical psychologists' trade.¹⁰⁵

The United States Court of Appeals for the Fourth Circuit agreed with the lower court that a rule of reason rather than a *per se* analysis was appropriate. Merely calling an action a "boycott" does not render it *per se* illegal.¹⁰⁶ The court stated that "[b]ecause of the special considerations involved in the delivery of health services, we are not prepared to apply a *per se* rule of illegality to medical plans which refuse or condition payments to competing or potentially competing providers."¹⁰⁷

The court of appeals did not agree, however, that Blue Shield's plan passed the rule of reason test. The court stressed that it must evaluate "the impact of the challenged practice upon competitive conditions."¹⁰⁸ Contrary to the district court's finding, the appellate court found that clinical psychologists and psychiatrists did compete in that they both provided psychotherapy¹⁰⁹ under state license.¹¹⁰ The legislature encouraged,¹¹¹ and the medical field recognized, competition in psychotherapeutic treatment.¹¹² Blue Shield's plan had the effect of forcing two independent economic entities, the psychologist and psychiatrist, to act in concert, and necessarily diminished competition. The court of appeals concluded the plan was therefore an unreasonable restraint of trade forbidden by the Sherman Act.¹¹³

Selecting providers for the PPO panel also may pose antitrust problems.

101. *Id.*

102. *Id.* at 560.

103. *Id.* at 560-61. The court noted that such cooperation was generally a matter of "medical necessity." *Id.* at 560.

104. The only way in which psychologists and psychiatrists were treated differently was that the psychologists' bills were filtered through a supervising physician. This procedure might have wounded the professional pride of psychologists, but provided a reasonable supervisory process that did not violate antitrust laws. *Id.* at 561.

105. *Id.*

106. *Virginia Academy*, 624 F.2d at 484.

107. *Id.*

108. *Id.* at 485; see also *National Soc'y of Professional Eng'rs v. United States*, 435 U.S. 679 (1979) (test required by the rule of reason is whether the action promotes or suppresses competition).

109. *Virginia Academy*, 624 F.2d at 485. The court wrote that the competition between psychologists and psychiatrists "is susceptible to judicial notice." *Id.*

110. See VA. CODE ANN. §§ 54-273(10), -274, -309.1, -936 (1986).

111. See VA. CODE ANN. § 38.1-824 (1986).

112. The court pointed to the statement by Dr. Levi W. Hulley, Jr. that "[t]he Medical Society of Virginia should take a firm stand on this encroachment [by psychologists into the therapy field] and seek to stop it once and for all." *Virginia Academy*, 624 F.2d at 481 n.6.

113. *Id.* at 485.

The FTC approved a proposal submitted by Private Health Care Systems, Inc. (Private Health) that enrolled only ten to fifteen percent of the providers in an area.¹¹⁴ Private Health agreed not to enter into employment agreements with any groups of independently practicing, competing physicians. Under the plan, each physician was allowed to negotiate individually her fee schedule with Private Health. Insurers would subscribe with Private Health and the organization would not attempt to insure more than thirty percent of the population. In addition, no institutional provider, physician, employer, or insurer had any financial interest in the PPO.¹¹⁵

The FTC categorized Private Health as a joint purchasing agent for commercial health insurers and found no potential antitrust violations.¹¹⁶ It further concluded that the PPO was most likely to be procompetitive since it was unable to acquire, maintain, or improperly use market power. The FTC warned, however, that its opinion was valid only so long as the public interest was served.¹¹⁷

D. Refusals to Deal

Concerted refusals to deal, like boycotts, can be improperly used to manipulate the free market. Although there have been no cases in this area involving PPOs, there have been a great number of actions involving health care providers. Two of the most commonly litigated areas have been the refusal to grant staff privileges¹¹⁸ and tying arrangements granting the exclusive right to provide one service offered by the hospital.¹¹⁹

In *Robinson v. Magovern*¹²⁰ Allegheny General Hospital denied the request of Dr. John N. Robinson for staff privileges as a cardiothoracic surgeon.¹²¹ The hospital rejected his application based on a number of factors, which included a shortage of operating room space and time; the fact that he was on the hospital

114. FTC Advisory Opinion to Health Care Management Assocs., 3 Trade Reg. Rep. (CCH) 22,036 (June 8, 1983).

115. *Id.*

116. *Id.*

117. *Id.*

118. *See, e.g.,* Green v. City of St. Petersburg, 154 Fla. 339, 17 So. 2d 517 (1944); Jacobs v. Martin, 20 N.J. Super. 531, 90 A.2d 151 (1952); Halberstadt v. Kissane, 51 Misc. 2d 634, 273 N.Y.S.2d 601 (Sup. Ct. 1966), *aff'd*, 31 A.D.2d 568, 294 N.Y.S.2d 841 (1968); Khan v. Suburban Community Hosp., 45 Ohio St. 2d 39, 340 N.E.2d 398 (1976); Armstrong v. Board of Directors, 553 S.W.2d 77 (Tenn. Ct. App. 1976).

119. *See, e.g.,* Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S. 2 (1984); Smith v. Northern Mich. Hosps., 703 F.2d 942 (6th Cir. 1983); Dos Santos v. Columbus-Cuneo-Cabrini Medical Center, 684 F.2d 1346 (7th Cir. 1982); City of Fairfax v. Fairfax Hosp. Ass'n, 562 F.2d 280 (4th Cir. 1977), *vacated*, 435 U.S. 992 (1978); Hannon v. United Hosp. Center, Inc., 522 F.2d 1133 (4th Cir. 1975), *cert. denied*, 424 U.S. 916 (1976); Zamiri v. William Beaumont Hosp., 430 F. Supp. 875 (E.D. Mich. 1977); Dattilo v. Tucson Gen. Hosp., 23 Ariz. App. 392, 533 P.2d 700 (1975); Centeno v. Roseville Community Hosp., 107 Cal. App. 3d 62, 167 Cal. Rptr. 183 (1979); Blank v. Palo Alto-Stanford Hosp. Center, 234 Cal. App. 2d 377, 44 Cal. Rptr. 572 (1965); Radiology Professional Corp. v. Trinidad Area Health Ass'n, 195 Colo. 253, 577 P.2d 748 (1978); Moles v. White, 336 So. 2d 427 (Fla. Dist. Ct. App. 1976); Rush v. City of St. Petersburg, 205 So. 2d 11 (Fla. Dist. Ct. App. 1967); Benell v. City of Virginia, 258 Minn. 559, 104 N.W.2d 633 (1960); Adler v. Montefiore Hosp. Ass'n of W. Pa., 453 Pa. 60, 311 A.2d 634 (1973).

120. 521 F. Supp. 842, (W.D. Pa. 1981) *aff'd mem.*, 688 F.2d 824, (3rd Cir.) *cert. denied*, 459 U.S. 971 (1982).

121. *Id.* at 848.

staff of seven other regional hospitals and would be unable to commit substantial time to the hospital; negative recommendations; and his failure to author significant scholarly publications.¹²² As a result of his denial of staff privileges, Dr. Robinson filed an antitrust action against the hospital and several of its thoracic surgeons.

The United States District Court for the Western District of Pennsylvania held that Dr. Robinson had failed to establish that the hospital and its staff had unreasonably restrained trade under section 1 of the Sherman Antitrust Act; nor, according to the court, had the hospital monopolized the delivery of health care services under section 2 by denying him staff privileges.¹²³ As to section 1, the *Robinson* court emphasized that the hospital's restrictive staff selection policy was reasonable, because its procompetitive effects—such as enhancing Allegheny General Hospital's reputation for excellence in patient care, teaching, and research—outweighed any anticompetitive effects.¹²⁴ The court agreed with the hospital that by restricting membership, Allegheny General improved its ability to compete with other hospitals and thus raised the prevailing level of care in the community, thereby benefitting the public.¹²⁵

With regard to section 2 of the Sherman Act, the *Robinson* court noted that a plaintiff alleging monopolization must prove possession of monopoly power by willful design.¹²⁶ The hospital in *Robinson* did not hold monopoly power in the thoracic surgery market: it had only a thirty percent market share and five active competitors.¹²⁷ Similarly, the thoracic surgery staff itself did not possess monopoly power.¹²⁸ The hospital's success in the area of cardiothoracic surgery resulted from medical ability rather than illegal conspiracy. The court therefore dismissed Dr. Robinson's section 2 claim.¹²⁹

In *Jefferson Parish Hospital District No. 2 v. Hyde*¹³⁰ the United States Supreme Court addressed the ability of a hospital to enter into a tying arrangement¹³¹ that granted a physician group the exclusive right to provide health care services at the hospital.¹³² The hospital in *Jefferson Parish* entered into an exclusive five-year contract with a group of physicians to provide anesthesiology services for the hospital's operating rooms. One physician brought suit alleging that as result of the contract he had been unfairly excluded from practicing anes-

122. *Id.* at 866.

123. *See id.* at 919-24. Under a separate claim, the court further held that the hospital staff did not interfere with a prospective contractual relationship between Dr. Robinson and the hospital when the hospital independently elected to deny him staff privileges. *Id.* at 926.

124. *Id.* at 919-23.

125. *Id.* at 919-20.

126. *Id.* at 886; *see* United States v. Grinnell Corp., 384 U.S. 563, 570-71 (1966).

127. *Robinson*, 521 F. Supp. at 887.

128. *Id.*

129. *See id.*

130. 466 U.S. 2 (1984). For an in-depth discussion of the effects of *Jefferson Parish*, see Classen, *Jefferson Parish and Its Progeny: More Efficient Health Care at What Price?*, 75 KY. L.J. 441 (1987).

131. A tying arrangement exists when a person agrees to sell one product, the "tying product," only on the condition that the vendee purchase another product, the "tied product." BLACK'S LAW DICTIONARY 1361-62 (5th ed. 1979).

132. *Jefferson Parish*, 466 U.S. at 4.

thesiology at the hospital.¹³³

The Supreme Court rejected a per se condemnation of all tying arrangements¹³⁴ and instead applied a reasonableness test in upholding the exclusive contract.¹³⁵ Although the hospital's patients were forced to choose an anesthesiologist associated with the contracting physician group, there was no evidence that the nature of the "tying product" (hospital surgery) or the "tied product" (anesthesia) had been adversely affected by the contract.¹³⁶ In concurrence, Justice O'Connor emphasized that exclusive contracts have procompetitive effects that should be safeguarded.¹³⁷

IV. THE EROSION OF ANTITRUST PROTECTIONS

At the same time that government regulation of the health care industry was rapidly increasing, traditional health care exemptions from the antitrust laws were being eroded.¹³⁸ The health care exemption has rested on a variety of legal grounds. The most common grounds for arguing a health care exemption are the "learned profession" exemption, the state action doctrine, the implied repeal argument, the *Noerr-Pennington* doctrine, and the McCarran-Ferguson Act.

133. *Id.* at 4-7.

134. *Id.* at 26-29. In holding this tying arrangement per se illegal, the United States Court of Appeals for the Fifth Circuit in *Jefferson Parish* had pointed to "market imperfections," such as health insurance (as a disincentive to compare costs) and the lack of sufficient information concerning competing hospitals. *Hyde v. Jefferson Parish Hosp.* Dist. No. 2, 686 F.2d 286, 290 (5th Cir. 1982) *rev'd*, 466 U.S. 2 (1984). The Supreme Court wrote that these factors "do not generate the kind of market power that justifies condemnation of tying." *Jefferson Parish*, 466 U.S. at 27.

135. *Jefferson Parish*, 466 U.S. at 29-32.

136. *Id.* at 31. The Court found that the average hospital patient would not distinguish between two certified anesthesiologists and, even if he could, was free to choose another hospital. *Id.* at 26-28.

137. *Id.* at 43-44 (O'Connor, J., concurring). Justice O'Connor noted the many positive aspects of the tying arrangement:

The tie-in improves patient care and permits more efficient hospital operation in a number of ways. From the viewpoint of hospital management, the tie-in ensures 24-hour anesthesiology coverage, aids in standardization of procedures and efficient use of equipment, facilitates flexible scheduling of operations, and permits the hospital more effectively to monitor the quality of anesthesiological services. Further, the tying arrangement is advantageous to patients because, as the District Court found, the closed anesthesiology department places upon the hospital, rather than the individual patient, responsibility to select the physician who is to provide anesthesiological services. The hospital also assumes the responsibility that the anesthesiologist will be available, will be acceptable to the surgeon, and will provide suitable care to the patient. In assuming these responsibilities—responsibilities that a seriously ill patient frequently may be unable to discharge—the hospital provides a valuable service to its patients. And there is no indication that patients were dissatisfied with the quality of anesthesiology that was provided at the hospital or that patients wished to enjoy the services of anesthesiologists other than those that the hospital employed.

Id.

138. Standing to bring an antitrust action has been expanded to include health care consumers, and not merely the health care providers who have been potentially injured by anticompetitive behavior. See *Blue Shield of Va. v. McCready*, 457 U.S. 465, 478-85 (1982) (Blue Shield subscribers had standing under Clayton Act to seek treble damages for Blue Shield's alleged Sherman Act violations).

A. "Learned Profession" Exemption

Originally, health care providers were viewed as being exempt from the antitrust laws because the practice of medicine was a "learned profession" and not "commerce."¹³⁹ In *Goldfarb v. Virginia State Bar*,¹⁴⁰ however, the Supreme Court held that professionals such as physicians and lawyers were not benefited by the "learned profession" antitrust exemption. The Court stated: "The nature of the occupation, standing alone, does not provide sanctuary from the Sherman Act, . . . nor is the public-service aspect of professional practice controlling in determining whether § 1 includes professions."¹⁴¹

In *Hospital Building Co. v. Trustees of Rex Hospital*¹⁴² the Supreme Court rejected the contention that provision of health care services was inherently local in nature and not subject to the Sherman Act.¹⁴³ The Court found that a hospital's activities may have a "substantial effect" on interstate commerce within the meaning of the Sherman Act.¹⁴⁴ By recognizing the commercial nature of health care, the *Rex Hospital* decision foreclosed the professional exemption argument.¹⁴⁵

B. State Action Doctrine

It has also been argued that, because the health care field is so heavily regulated, providers are immune from federal antitrust laws under the state action doctrine.¹⁴⁶ In *Cantor v. Detroit Edison Co.*¹⁴⁷ the Supreme Court concluded

139. *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 786-88 (1975). It was argued that Congress intended to exempt professions, and furthermore that "competition is inconsistent with the practice of a profession because enhancing profit is not the goal of professional activities; the goal is to provide services necessary to the community." *Id.* at 786.

140. 421 U.S. 773 (1975).

141. *Id.* at 787 (citing *United States v. National Ass'n of Real Estate Bds.*, 339 U.S. 485, 489 (1950); *Associated Press v. United States*, 326 U.S. 1, 7 (1945)).

142. 425 U.S. 738 (1976).

143. *Id.* at 741-46.

144. *Id.* at 745-46.

145. *Id.* at 746-47; see *City of Fairfax v. Fairfax Hosp. Ass'n*, 562 F.2d 280, 283 (4th Cir. 1977), *vacated*, 435 U.S. 992 (1978); *St. Bernard Gen. Hosp. v. Hospital Serv. Ass'n of New Orleans*, 510 F.2d 1121, 1125-26 (5th Cir. 1975); *Doctors, Inc. v. Blue Cross of Greater Philadelphia*, 490 F.2d 48, 50 (3d Cir. 1973) (district court dismissals reversed because defendants' activities in the health care field may substantially affect interstate commerce).

A direct connection with interstate commerce clearly will bring a health care provider under federal law. See *Boddicker v. Arizona State Dental Ass'n*, 549 F.2d 626, 629-30 (9th Cir.) (national scope of dental society's program affects interstate commerce), *cert. denied*, 434 U.S. 825 (1977); *Levin v. Joint Comm'n on Accreditation of Hosps.*, 354 F.2d 515, 518 (D.C. Cir. 1965) (JCAH accreditation examinations held clearly interstate activities); *Northern Cal. Pharmaceutical Ass'n v. United States*, 306 F.2d 379, 386 (9th Cir.) (pharmacists' association convicted of fixing the price of drugs received from out-of-state manufacturer), *cert. denied*, 371 U.S. 862 (1962); *United States Dental Inst. v. American Ass'n of Orthodontists*, 396 F. Supp. 565, 576-77 (N.D. Ill. 1975) (multi-state activities, along with purchases of orthodontic supplies from out-of-state suppliers, sufficiently affect interstate commerce).

146. See *Cantor v. Detroit Edison Co.*, 428 U.S. 579 (1976).

147. 428 U.S. 579 (1976). In *Cantor*, the Supreme Court severely limited the utilization of the state action defense. The Detroit Edison Company, the city's electric company, gave free light bulbs to its customers. The plaintiff, who sold light bulbs at retail, claimed the giveaway was an illegal tie-in. Detroit Edison sought protection under the state action doctrine, claiming exemption from the antitrust laws because it was regulated by the state utility commission. *Id.* at 582-83. The Court

that the mere regulation of an entity's activities is insufficient to confer immunity; the state must mandate its actions.¹⁴⁸ Nonetheless, the state action doctrine has since been used successfully as a defense by carefully regulated health care entities.¹⁴⁹

In *Gold Cross Ambulance & Transfer v. City of Kansas City*¹⁵⁰ the United States Court of Appeals for the Eighth Circuit upheld a municipal ordinance authorizing the City to use a single ambulance company to provide all of its ambulance service.¹⁵¹ That company's competitors brought suit, claiming that the exclusive contract violated the antitrust laws by foreclosing them from operating in the metropolitan area.¹⁵² However, the court of appeals found that a state statute permitting cities to "contract with one or more" operators to provide ambulance services¹⁵³ was a sufficient expression of state policy to provide antitrust immunity, and the restraint was necessary and reasonable for the provision of health care services.¹⁵⁴

C. Implied Repeal

A third defense to potential antitrust liability is the implied repeal of the federal antitrust laws to the extent of any inconsistency in legislation subse-

appeared to hold that *Parker v. Brown*, 317 U.S. 341, 352 (1943), the initial state action case, was limited to barring suits against state officials. See *Cantor*, 428 U.S. at 589-92. The Court further noted that Detroit Edison had originated the activity in question while the state remained neutral. *Id.* at 584-85.

148. *Cantor*, 428 U.S. at 589-92.

149. The state action doctrine provides that state action cannot grant an individual an exemption from violating the Sherman Act. "[A] state does not give immunity to those who violate the Sherman Act by authorizing them to violate it, or by declaring that their action is lawful . . ." *Parker v. Brown*, 317 U.S. 341, 351 (1943) (citing *Northern Sec. Co. v. United States*, 193 U.S. 197, 332, 344-47 (1904)); see Blumstein & Calvani, *State Action as a Shield and a Sword in a Medical Services Antitrust Context*: *Parker v. Brown in Constitutional Perspective*, 1978 DUKE L.J. 389.

In *Bates v. State Bar of Ariz.*, 433 U.S. 350 (1977), the Supreme Court set forth several factors to identify those state actions that immunize a practice from the antitrust laws. First, there must be a clearly defined state policy that compels the practice in question. Second, this policy must be actively supervised by the state. *Id.* at 361-62.

An important distinction exists between the regulatory activities of the state and local governments. The Supreme Court addressed these differences in *City of Lafayette v. Louisiana Power & Light Co.*, 435 U.S. 389 (1978). The Court refused to extend antitrust immunity to the activities of a municipally-owned power company. In discussing the distinction between state and local governments with regard to the *Parker* doctrine, Justice Brennan, for the plurality, stated: "We therefore conclude that the *Parker* doctrine exempts only anticompetitive conduct engaged in as an act of government by the State as sovereign, or, by its subdivisions, pursuant to state policy to displace competition with regulation or monopoly public service." *Id.* at 413. Chief Justice Burger, in his concurring opinion, emphasized that he would require an even stricter showing that the practice was compelled by the state. *Id.* at 424-26 (Burger, C.J., concurring). Consequently, the *Louisiana Power* decision removes the activities of most municipally-owned hospitals from the protection of the state action doctrine.

150. 705 F.2d 1005 (8th Cir. 1983), *cert. denied*, 471 U.S. 1003 (1985).

151. *Id.* at 1015. In *Gold Cross*, Kansas City established a municipal trust, which contracted with a single ambulance company to provide ambulance services. Because one corporation held the city's sole ambulance license, the other companies in the city were foreclosed from operating in the metropolitan area. *Id.* at 1008.

152. *Id.*

153. MO. REV. STAT. § 67.300(1) (1986).

154. *Gold Cross*, 705 F.2d at 1012-14.

quently passed. This defense is founded on the theory that a clearly contradictory regulatory system evidences an intent to supercede conflicting antitrust laws.¹⁵⁵ The application of this doctrine has been very limited, and it is not favored by the courts.¹⁵⁶

The implied repeal argument has been raised repeatedly in the context of the National Health Planning and Resources Development Act of 1974 (NHPRDA).¹⁵⁷ In *Huron Valley Hospital v. City of Pontiac*¹⁵⁸ the United States Court of Appeals for the Sixth Circuit rejected a claim that a state agency's authority to regulate hospital expansion under NHPRDA did not imply an exemption from the antitrust laws for hospitals.¹⁵⁹ In *National Gerimedical Hospital & Gerontology Center v. Blue Cross of Kansas City*¹⁶⁰ the Supreme Court stated that NHPRDA was "not so incompatible with antitrust concerns as to create a 'pervasive' repeal of the antitrust laws as applied to every action taken in response to the health-care planning process."¹⁶¹ The Court then held that there was "no specific conflict between the Act and the antitrust laws in this case."¹⁶² Such reasoning implies that conflict may arise in other circumstances, so that the implied repeal doctrine still may have continuing viability.

*North Carolina ex rel. Edmisten v. P.I.A. Asheville, Inc.*¹⁶³ provides further support for an implied exemption under NHPRDA. In *P.I.A. Asheville* the United States Court of Appeals for the Fourth Circuit initially rejected an antitrust claim against the Psychiatric Institute of America (PIA) for having two psychiatric hospitals in the same geographic area.¹⁶⁴ The court reasoned that because PIA had received a Certificate of Need for both transactions, it had implied immunity from the antitrust laws under NHPRDA.¹⁶⁵ On rehearing, the court of appeals reversed its previous decision, and found that the hospital was not entitled to state action immunity on the basis of its acquisition of a

155. See, e.g., *United States v. National Ass'n of Sec. Dealers*, 422 U.S. 694, 719-20 (1975) (antitrust laws must give way if regulatory scheme is to work).

156. See *National Gerimedical Hosp. & Gerontology Center v. Blue Cross of Kansas City*, 452 U.S. 378, 388-89 (1981) (when Congress does not intend antitrust laws to be repealed, intent must be clear).

157. 42 U.S.C. §§ 300k to 300n-6 (1982), *repealed by* Act of Nov. 14, 1986, Pub. L. No. 99-660, § 701(a), 100 Stat. 3743, 3799 (1986).

158. 666 F.2d 1029 (6th Cir. 1981).

159. *Id.* at 1033-34.

160. 452 U.S. 378 (1981).

161. *Id.* at 393.

162. *Id.* The case concerned "health system agencies" (HSAs) under NHPRDA. The petitioner, an acute care hospital, had sought to enter into a participating hospital agreement with Blue Cross of Kansas City. *Id.* at 380. Blue Cross refused because the hospital's construction had not been approved by the local HSA, a planning body designated by NHPRDA. *Id.* at 381. As a result of the HSA announcement that it would approve no additional acute-care facilities, the hospital did not seek approval for its construction. *Id.* at 381-82. Petitioner sued, alleging a wrongful refusal to deal and conspiracy under the Sherman Act. *Id.* at 382. Blue Cross defended on the implied repeal argument. *Id.*

163. 722 F.2d 59 (4th Cir. 1983), *rev'd on rehearing*, 740 F.2d 274 (4th Cir. 1984), *cert. denied*, 471 U.S. 1003 (1985). On motion for rehearing the court of appeals found that the NHPRDA did not impliedly repeal the application of the antitrust laws. *North Carolina ex rel. Edmisten v. P.I.A. Asheville, Inc.*, 740 F.2d 274 (4th Cir. 1984), *cert. denied*, 471 U.S. 1003 (1985).

164. *P.I.A. Asheville*, 722 F.2d at 61.

165. *Id.* at 60-63.

Certificate of Need and that NHPRDA did not implicitly repeal the application of the antitrust laws to the health care field.¹⁶⁶

D. Noerr-Pennington Doctrine

The *Noerr-Pennington* doctrine also has limited applicability to the health care field.¹⁶⁷ The doctrine, named for two Supreme Court decisions,¹⁶⁸ amounts to a first amendment antitrust exception.¹⁶⁹ "Joint efforts to influence public officials do not violate the antitrust laws even though intended to eliminate competition."¹⁷⁰ The Supreme Court held, however, that an entity can misuse its constitutional right to petition and lobby the government in order to achieve an anticompetitive effect.¹⁷¹ A situation may arise in which conduct "ostensibly directed toward influencing governmental action, is a mere sham to cover . . . an attempt to interfere directly with the business relationships of a competitor and the application of the Sherman Act would be justified."¹⁷² Consequently, participants in an adjudicatory or administrative proceeding are held to a standard of good faith regarding their actions.¹⁷³ At the same time, however, efforts to influence a public official to achieve an anticompetitive effect will not violate the Sherman Antitrust Act.¹⁷⁴

In *Feminist Women's Health Center v. Mohammad*¹⁷⁵ an abortion clinic sued a group of physicians for boycotting its facility.¹⁷⁶ The physicians argued that these actions, as well as their contact with the local health authorities, were protected by the *Noerr-Pennington* doctrine.¹⁷⁷ The court found the *Noerr-Pen-*

166. *P.I.A. Asheville*, 740 F.2d at 285.

167. The defense based on the *Noerr-Pennington* doctrine can be summarized by the following language: "Joint efforts to influence public officials do not violate the antitrust laws even though intended to eliminate competition. Such conduct is not illegal, either standing alone or as part of a broader scheme itself violative of the Sherman Act." *United Mine Workers v. Pennington*, 381 U.S. 657, 670 (1965).

168. See *United Mine Workers v. Pennington*, 381 U.S. 657 (1965); *Eastern R.R. Presidents Conference v. Noerr Motor Freight*, 365 U.S. 127 (1961).

169. In essence, the doctrine guarantees freedom of speech by preventing the Sherman Act from being utilized to restrict actions by competitors that constitute "speech."

170. *Pennington*, 381 U.S. at 670.

171. *Noerr*, 365 U.S. at 139. For an in-depth discussion of this area, see Barnett, *Joint Action by Competitors to Influence Public Officials: Antitrust Exemption or Trap?*, 24 BUS. LAW. 1097 (1969); Bern, *The Noerr-Pennington Immunity for Petitioning in Light of City of Lafayette's Restriction on the State Action Immunity*, 1980 ARIZ. ST. L.J. 279; Fischel, *Antitrust Liability for Attempts to Influence Government Action: The Basis and Limits of the Noerr-Pennington Doctrine*, 45 U. CHI. L. REV. 80 (1977); Oppenheim, *Antitrust Immunity for Joint Efforts to Influence Adjudication Before Administrative Agencies and Courts—From Noerr-Pennington to Trucking Unlimited*, 29 WASH. & LEE L. REV. 209 (1972); Robinson, *Reconciling Antitrust and the First Amendment*, 48 ANTITRUST L.J. 1335 (1979); Walden, *More About Noerr—Lobbying, Antitrust and The Right to Petition*, 14 UCLA L. REV. 1211 (1967); Note, *Limiting the Antitrust Immunity for Concerted Attempts to Influence Courts and Adjudicative Agencies: Analogies to Malicious Prosecution and Abuse of Process*, 86 HARV. L. REV. 715 (1973); Note, *Application of the Sherman Act to Attempts to Influence Government Action*, 81 HARV. L. REV. 847 (1968).

172. *Noerr*, 365 U.S. at 144.

173. *Id.* at 140.

174. *Id.* at 139-40.

175. 586 F.2d 530 (5th Cir. 1978), cert. denied, 444 U.S. 924 (1979).

176. *Id.* at 535.

177. *Id.* at 544.

nington issue triable and denied defendant's motion for summary judgment.¹⁷⁸ Similarly, in *United States Dental Institute v. American Association of Orthodontists*,¹⁷⁹ a motion to dismiss was denied when a national organization's attempts to influence a state agency not to certify postgraduate courses in orthodontics were allegedly part of a larger plan, undertaken in bad faith, to restrict the number of practicing orthodontists. This action would have protected the organization's monopoly.¹⁸⁰ In *Gold Cross Ambulance v. City of Kansas City*,¹⁸¹ however, the United States District Court for the Western District of Missouri recognized the *Noerr-Pennington* doctrine as protecting the right of a group of ambulance companies to lobby a municipality for the exclusive right to provide ambulance services in the municipality.¹⁸² These judicial interpretations of the *Noerr-Pennington* doctrine provide a viable but limited antitrust exemption.

E. *McCarran-Ferguson Act*

The McCarran-Ferguson Act¹⁸³ is another ground for a health care exemption from the federal antitrust laws. The Act specifically exempts the "business of insurance" from the antitrust laws to the extent the business is regulated by state law.¹⁸⁴ The critical issue arising from the Act is what constitutes the "business of insurance."¹⁸⁵ In *Group Life & Health Insurance Co. v. Royal Drug Co.*¹⁸⁶ the Supreme Court set forth the necessary criteria for determining whether conduct may be considered the business of insurance under the Act.¹⁸⁷ The Court stated that one must consider whether the practice has the effect of

178. *Id.* at 542-43.

179. 396 F. Supp. 565 (N.D. Ill. 1975).

180. *Id.* at 581-84.

181. 538 F. Supp. 956 (W.D. Mo. 1982), *aff'd*, 705 F.2d 1005 (8th Cir. 1983), *cert. denied*, 471 U.S. 1003 (1985).

182. *Id.* at 969.

183. 15 U.S.C. §§ 1011-1015 (1982 & Supp. III 1985).

184. The McCarran-Ferguson Act was passed in 1944 to counteract the Supreme Court's decision in *United States v. South-Eastern Underwriters Ass'n*, 322 U.S. 533 (1944), which held the business of insurance to be interstate commerce and thus subject to regulation under the Sherman Act. *Id.* at 553, 560; see *SEC v. National Sec., Inc.*, 393 U.S. 453, 458 (1969). Antitrust actions involving insurance companies almost always focus on the McCarran-Ferguson Act. To obtain an exemption, an entity must meet the three requirements of the Act: (1) "business of insurance," 15 U.S.C. § 1012(a) (1982); (2) "to the extent that such business is not regulated by State Law," *id.* § 1012(b); and (3) preserving antitrust jurisdiction where there is a boycott, coercion, or intimidation, *id.* § 1013(b).

185. The "business of insurance" was defined by the Supreme Court in *SEC v. National Sec., Inc.*, 393 U.S. 453 (1969). The Supreme Court held that a state statute designed to protect the interests of those who own stock in insurance companies did not constitute sufficient state regulation of the business of insurance to provide protection from the federal securities antitrust laws under the McCarran-Ferguson Act. *Id.* at 457. In the context of discussing the relationship between different activities in which an insurance company may be engaged, Justice Marshall stated:

The [McCarran-Ferguson Act] did not purport to make the States supreme in regulating all the activities of insurance companies; its language refers not to the persons or companies who are subject to state regulation, but to laws "regulating the business of insurance." Insurance companies may do many things which are subject to paramount federal regulation; only when they are engaged in the "business of insurance" does the statute apply.

Id. at 459-60.

186. 440 U.S. 205 (1979).

187. *Id.* at 211-13.

transferring or spreading the policy holder's risk,¹⁸⁸ whether the practice is an integral part of the policy relationship between the insurer and the insured,¹⁸⁹ and whether the practice is limited to entities within the insurance industries.¹⁹⁰

Traditionally, it has been held that the system of third-party payors—such as Blue Cross/Blue Shield contracting to provide health care services for subscribers or for beneficiaries as opposed to indemnifying the costs of insureds—is a type of insurance.¹⁹¹ Various courts have also found the business of insurance to include tie-ins of insurance to loans,¹⁹² uniform agreements with hospitals specifying benefits,¹⁹³ tie-ins of certain terms of insurance coverage to title insurance policies,¹⁹⁴ and defining conditions for dealing with third-party providers of covered services.¹⁹⁵

Although liberally construed, the definition of "insurance" in health care coverage is not without its limits. In *Union Labor Life Insurance Co. v. Pireno*¹⁹⁶ the Supreme Court concluded that the functions of peer review committees in advising insurance companies as to the necessity of certain treatments did not constitute the business of insurance.¹⁹⁷ As under the *Noerr-Pennington* doctrine, the courts have closely scrutinized any effort by a health care provider to claim protection under the McCarran-Ferguson Act.¹⁹⁸

V. THE VIABILITY OF PROVIDER-BASED PPOs

Despite recent changes in health care law, provider-based PPOs remain a

188. *Id.*

189. *Id.* at 215-16.

190. *Id.* at 224; *see also* *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 128-29 (1982) (summarizing the Court's holding in *Royal Drug*).

191. *See* *Travelers Ins. Co. v. Blue Cross of W. Pa.*, 481 F.2d 80, 83 (3d Cir.), *cert. denied*, 414 U.S. 1093 (1973); *Anderson v. Medical Serv. of D.C.*, 1976-1 Trade Cas. (CCH) 60,884 (E.D. Va. Feb. 10, 1976) (mem.); *Manasen v. California Dental Servs.*, 424 F. Supp 657, 664-67 (N.D. Cal 1976), *rev'd per curiam on other grounds*, 638 F.2d 1152 (9th Cir. 1979). The extent to which the criteria set forth in *Royal Drug* may affect these holdings is not yet clear.

192. *See, e.g.*, *Dexter v. Equitable Life Assurance Soc'y*, 527 F.2d 233, 235 (2d Cir. 1975); *Adrisi v. Equitable Life Assurance Soc'y*, 503 F.2d 725, 727 (9th Cir. 1974), *cert. denied*, 420 U.S. 929 (1975); *cf.* Comment, *The McCarran Act's Antitrust Exemption for "the Business of Insurance": A Shrinking Umbrella*, 43 TENN. L. REV. 329, 351-56 (1976) (questioning the court's reasoning in *Adrisi*).

193. *Travelers Ins. Co. v. Blue Cross of W. Pa.*, 481 F.2d 80, 83 (3d Cir.), *cert. denied*, 414 U.S. 1093 (1973).

194. *McIlhenny v. American Title Ins. Co.*, 418 F. Supp. 364, 368-69 (E.D. Pa. 1976).

195. *Frankford Hosp. v. Blue Cross of Greater Philadelphia*, 417 F. Supp. 1104, 1109 (E.D. Pa. 1976), *aff'd per curiam*, 554 F.2d 1253 (3d Cir.), *cert. denied*, 434 U.S. 860 (1977).

196. 458 U.S. 119 (1982).

197. *Id.* at 134.

198. Traditionally, the courts have narrowly construed any express statutory exemption to the antitrust laws such as the McCarran-Ferguson Act. *See* *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 126 (1982); *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 231 (1979); *Federal Maritime Comm'n v. Seatrain Lines, Inc.*, 411 U.S. 726, 733 (1973); *United States v. McKesson & Robbins, Inc.*, 351 U.S. 305, 316 (1956). *See generally* *Hahn v. Oregon Physicians Servs.*, 689 F.2d 840 (9th Cir. 1982) (refusal of provider of prepaid health insurance to cover podiatric services was not "the business of insurance"), *cert. denied*, 462 U.S. 1133 (1983); *Nurse Midwifery Assocs. v. Hibbett*, 549 F. Supp. 1185 (M.D. Tenn. 1982) (denial of medical malpractice insurance by company induced by physician interested in eliminating competition was not "business of insurance").

viable alternative for delivering high-quality, cost-efficient health care. The FTC and the Department of Justice have recognized the benefits of PPOs and other alternative delivery systems, but at the same time have cautioned against incorporating provisions that may have undesired anticompetitive effects.¹⁹⁹ Consequently, provider-based PPOs must be carefully tailored to the informal and formal guidelines set forth by these regulatory agencies and by the Supreme Court in *Maricopa*.²⁰⁰

The Department of Justice has informally released the criteria it will consider in determining whether a PPO affects competition. Ultimately, the Department must determine if a PPO "facilitate[s] anticompetitive price-fixing agreements among providers or . . . inhibit[s] significantly the formation and entry of other joint ventures that would provide competing services to third-party payers."²⁰¹ Crucial to any such finding is whether a provider-based PPO creates actual or theoretical antitrust concerns.²⁰² Relevant organizational aspects that bear on this issue include the proportion of providers in the market who are PPO members, the availability of actual or potential competitive alternatives, activities of the PPO that could limit competition among members, the ability of panel members to participate in competing organizations, the parties' intent in forming or operating the PPO, and any procompetitive benefits derived from the organization.²⁰³

J. Paul McGrath, former Assistant Attorney General for the Antitrust Division of the Department of Justice, has elaborated on the Department's guidelines.²⁰⁴ He emphasized the necessity of an "efficiency-enhancing integration" sufficient to avoid *Maricopa*'s per se rule, and recommended agreements among physicians to accept discount fees with no balance billing of patients, utilization review by the PPO, joint marketing, PPO administration of claims, and an agreement by a panel of limited size to bid for contracts against other such groups.²⁰⁵ Though following these guidelines does not guarantee immunity from antitrust liability, it certainly provides a basis for reducing the risk of liability.²⁰⁶

Recently, the Department of Justice has stated it will not challenge the formation of a PPO that would act as an intermediary in negotiating contracts

199. As to the Department of Justice, see Letter from Charles F. Rule, Acting Assistant Att'y Gen., Antitrust Div., Dep't of Justice, to Frank Sanchez, at 2 (Oct. 3, 1986) [hereinafter Letter from Rule to Sanchez]; Letter from Rule to Taylor, *supra* note 84, at 1. As to the Federal Trade Commission, see FTC REPORT, *supra* note 45, at 1-2.

200. For a discussion of these guidelines, see *supra* notes 62-77 and accompanying text.

201. Letter from Rule to Sanchez, *supra* note 199, at 2; Letter from Rule to Taylor, *supra* note 84, at 3.

202. See Letter from Rule to Sanchez, *supra* note 199, at 2; Letter from Rule to Taylor, *supra* note 84, at 2.

203. See Letter from Rule to Sanchez, *supra* note 199, at 2-3; Letter from Rule to Taylor, *supra* note 84, at 3.

204. See McGrath Remarks, *supra* note 8.

205. McGrath Remarks, *supra* note 8, at 7-8.

206. Neither the Department of Justice nor the Federal Trade Commission are bound by these guidelines; generally, however, the guidelines are regarded as official nonbinding opinions. For the Department of Justice's Antitrust Division Business Review Procedure, see 28 C.F.R. § 50.6 (1986).

between providers and third-party payors.²⁰⁷ This particular PPO's parent organization owns several hospitals in the geographic area in which the PPO would operate.²⁰⁸ The PPO would negotiate contracts that would bind the hospital and those physicians participating in the PPO to charge PPO members no more than the negotiated maximum fee.²⁰⁹

Although this situation is factually similar to *Maricopa*, the Department of Justice recognized several distinct differences. First, the PPO would utilize a unique approach in determining its fee schedule.²¹⁰ The PPO manager would be selected by its board of directors, the majority of whom would be members of the parent corporation.²¹¹ The manager would receive input from physicians, the hospitals, and payors, but would retain ultimate control along with the board of directors.²¹² The pricing mechanism would be controlled by members of the parent corporation hospitals, who are motivated to keep physician fees as low as possible.²¹³ Second, the physician members of the advisory board would not have access to confidential information on the providers' customary fees or on the discounts offered to the PPO.²¹⁴ Third, the PPO would enroll only a small fraction of the area's providers.²¹⁵ Furthermore, there would be no requirement that the physicians contract exclusively with the PPO.²¹⁶ Fourth, the PPO would initially contract only with the three hospitals owned by the parent corporation.²¹⁷ Finally, the contracts between the PPO and the participating payors would be nonexclusive, allowing each to contract with other professional and institutional providers in the geographic area.²¹⁸

This decision indicates the willingness of the Department of Justice to recognize that a maximum fee schedule would not necessarily have an anticompetitive effect. It allows a PPO to be structured along the lines of *Maricopa* but to avoid the antitrust scrutiny. The Department scrutinized the number of participating physicians as well as the pricing mechanism. Although this decision provides welcome relief to health care providers trying to structure their entity, it does not guarantee protection from action by the FTC or from being found illegal by the judiciary.

The Federal Trade Commission, through private opinion letters, also has provided insight into the criteria it will use in evaluating the anticompetitive effects of PPOs.²¹⁹ In a recent letter to the Commissioner of Insurance for Ne-

207. Letter from Rule to Bush, *supra* note 84, at 1-2.

208. Letter from Rule to Bush, *supra* note 84, at 1.

209. Letter from Rule to Bush, *supra* note 84, at 2.

210. Letter from Rule to Bush, *supra* note 84, at 4-5.

211. Letter from Rule to Bush, *supra* note 84, at 3.

212. Letter from Rule to Bush, *supra* note 84, at 3-4.

213. Letter from Rule to Bush, *supra* note 84, at 5.

214. Letter from Rule to Bush, *supra* note 84, at 3-4.

215. Letter from Rule to Bush, *supra* note 84, at 4.

216. Letter from Rule to Bush, *supra* note 84, at 4.

217. Letter from Rule to Bush, *supra* note 84, at 2.

218. Letter from Rule to Bush, *supra* note 84, at 3.

219. See Letter from Jeffrey I. Zuckerman, Bureau of Competition, Federal Trade Commission, to David A. Gates 2-3 (Nov. 5, 1986) [hereinafter Letter from Zuckerman to Gates].

vada, the FTC examined the use of exclusive contracting provisions in Health Maintenance Organization (HMO) contracts. The letter emphasized the procompetitive effects of exclusive contracts and briefly discussed their use by provider-based alternative delivery systems.²²⁰ The FTC recognized the danger inherent in physician-controlled organizations using exclusive contracts.²²¹ If a large percentage of physicians contracted exclusively with one alternative delivery system, price and service competition among physicians could be reduced. Exclusive contract agreements used for such purposes will be deemed illegal.²²² Although the FTC's letter is directed toward HMOs, it is directly applicable to PPOs. Both HMOs and PPOs operate under the basic premise that a limited panel of providers will provide services to their beneficiaries. Furthermore, the effect of an exclusive contracting agreement will be the same regardless of whether it involves an HMO or PPO.

The Department of Justice has similarly stated that anticompetitive effects could result from restrictions placed on participating physicians' competitive activities outside the PPO.²²³ The lack of such agreements thus would be a mitigating factor for any other anticompetitive effects of the PPO.²²⁴ Like the FTC, the Department of Justice did not prohibit the use of exclusive contracts by provider-based PPOs. Instead, it indicated that provider-based PPOs will be subject to close scrutiny.

The successful development of a provider-based PPO should be closely patterned upon the guidelines promulgated in *Maricopa*. It is vital that a provider-based PPO minimize the possibility that a court would conclude the PPO's fee arrangement is per se unlawful as illegal price-fixing. Under the per se analysis, it is generally no defense that a price-fixing arrangement or other anticompetitive agreement neither provides procompetitive benefits nor produces an adverse

220. The FTC's letter discussed extensively the procompetitive effects of exclusive contracts. It emphasized that exclusive agreements enable an alternative delivery system to provide the services consumers desire most, thereby allowing the alternative delivery system to be more competitive with other alternative delivery systems. This strategy also enables the alternative delivery system to have a closer relationship with its physicians. An alternative delivery system seeking exclusive contract arrangements with its physicians must demonstrate to them that it will meet their needs and be successful in attracting beneficiaries. A physician seeking to contract with the alternative delivery system must demonstrate that she is capable of attracting large numbers of patients and will be able to retain these patients by providing high-quality, cost-efficient services. Thus, the alternative delivery system and the physician become mutually dependent. *Id.* at 2-3.

Additionally, an alternative delivery system with a limited number of physicians exclusively on its panel may be able to develop an outstanding reputation that will enable it to attract even greater numbers of beneficiaries. If physicians are affiliated with a great number of alternative delivery systems, consumers will be unable to distinguish between the systems. When physicians associate with only one alternative delivery system, consumers will be better able to distinguish among the available systems. The result will be competition on the basis of price and increased quality. *Id.*

The FTC letter also discussed the negative aspects of exclusive contracting. These include the potential for restricting the range of physicians available to patients enrolled in a particular alternative delivery system, and for allowing one alternative delivery system to prevent another from entering the market or to drive the other out of the market by depriving it of access to those physicians it needs to operate efficiently. *Id.* at 4.

221. *Id.*

222. *Id.*

223. See *supra* notes 199-206 and accompanying text.

224. Letter from Rule to Taylor, *supra* note 84, at 4.

effect on prices. Consequently, a PPO should create an independent entity to establish fees. This entity should be comprised of nonphysicians and should be charged with collecting the information on which these prices will be based.

Price negotiation is not anticompetitive even though the provider-members of the PPO otherwise would be competing. Negotiating prices can be an integral part of a demonstratively procompetitive PPO. Nevertheless, due to the anticompetitive potential of such action it is wise to charge a nonphysician entity, rather than the providers themselves, with the responsibility of setting fees. By doing so, any real or perceived anticompetitive intent will be removed, along with any appearance of impropriety. To do otherwise is to invite increased antitrust scrutiny.

Another area of concern is restricting membership on the provider panel. Any limitation on panel membership should be achieved through objective standards, based upon legitimate administrative rather than economic reasons. Legitimate limitations can be founded upon the quality of care delivered or the physical limitations of the PPO. As the PPO's market share increases, it will be subject to stricter antitrust scrutiny—the greater the market share the PPO possesses, the greater the benefit of being a member of the PPO, and hence the greater the potential for reducing competition.

Similarly, restrictions on contracting with other alternative delivery systems must be made on an objective basis. As noted in the FTC's letter, such restrictions raise many concerns.²²⁵ Courts will evaluate the legitimacy of the agreement by determining whether it results in a substantial foreclosure of competition in the relevant market.²²⁶ The legality of any such agreement, as determined under *Jefferson Parish*, depends on the degree of concentration of the relevant product and geographic markets, the market shares of the PPO, and the duration of the agreement. As with restrictive membership on the PPO panel, exclusive contracting must be justified on noneconomic grounds.

It is imperative to a PPO that it be evaluated under a joint venture/rule of reason standard rather than the per se standard of *Maricopa*. Of particular importance are the following questions: What are the functions of the PPO in relation to third-party payors; how are the PPO pricing and service decisions made; are greater economic efficiencies achieved; is the management of the PPO separate and distinct from the individual physicians; is there a shared risk among the participating physicians; and do the members of the PPO panel compete against each other?

The fundamental determination in choosing the appropriate standard of review is whether the banding together of physicians in a PPO creates a "new product." In *Broadcast Music*, the Supreme Court applied the rule of reason in part because ASCAP marketed a product different from that of its individual

225. Letter from Zuckerman to Gates, *supra* note 219, at 3; *see supra* notes 219-22 and accompanying text.

226. *See Tampa Elec. Co. v. Nashville Coal Co.*, 365 U.S. 320, 325-35 (1961); *Standard Oil Co. v. United States*, 337 U.S. 293, 297-315 (1948).

members.²²⁷ Sharing the risk of loss and potential for profit of an entity competing in a market are crucial to a resolution of the "new product" issue. Joint marketing and other manifestations of integration will distinguish a PPO from the organization in *Maricopa*, in which the Court concluded that a new product had not been offered.²²⁸ Once a court has found that a new product exists or sufficient joint effort has been undertaken, it will still scrutinize whether the PPO's price-setting arrangement relates sufficiently to the legitimate purpose and operation of the entity.

The Department of Justice and the Federal Trade Commission have stated that it is appropriate to analyze provider-based PPOs under the principles applied to joint ventures.²²⁹ Joint ventures by competitors are legal when they enhance efficiency and promote competition, even though they are actually horizontal agreements among the venturers. To gain antitrust approval, horizontal agreements must be ancillary to a cooperative activity that promotes competition, the collective markets of the participating joint venturers must not be so large that the venture effectively forecloses competition, and the parties must have no anticompetitive intent.²³⁰

A provider-based PPO must demonstrate that the horizontal agreements of its operations, usually physician price-setting and utilization review standards, are reasonably related and ancillary to the new competitive venture.²³¹ Typically, this requires a showing that the PPO offers economic integration and efficiency advantages that outweigh any anticompetitive harms. Although providers usually do not share the risk, provider-based PPOs involve some level of integration to provide efficiencies.²³²

The Department of Justice has indicated that the size of a PPO is a relevant consideration.²³³ Membership must not be so inclusive that it prevents the formation of competing PPOs. The Department of Justice will not challenge a provider-based PPO with fewer than twenty percent of the physicians in the active market.²³⁴ As this percentage increases above twenty percent, the Department will apply a market-specific analysis to assess the organization's likely anticompetitive effects in that market.²³⁵ The Department of Justice will consider, however, the minimum size of the PPO panel needed to compete efficiently in the area, the nature of the PPO, the efficiencies achieved to the extent participating physicians are willing and able to participate in competing PPOs,

227. *Broadcast Music*, 441 U.S. at 21-25; see *supra* text accompanying notes 78-80.

228. The *Maricopa* Court stated that great consideration will be given to whether a new "product" was created, whether there was the pooling of capital or sharing the risk of loss among the competing participants, and whether price-fixing among the participants was necessary to achieve the goals of the organization. *Maricopa*, 457 U.S. at 352-56.

229. McGrath Remarks, *supra* note 8, at 7; FTC REPORT, *supra* note 45, at 12.

230. FTC REPORT, *supra* note 45, at 26-27.

231. FTC REPORT, *supra* note 45, at 7-8.

232. FTC REPORT, *supra* note 45, at 8.

233. See *supra* notes 215-17 and accompanying text.

234. McGrath Remarks, *supra* note 8, at 9.

235. McGrath Remarks, *supra* note 8, at 9.

and the potential competing alternative delivery systems in the market.²³⁶

Finally, the Department of Justice will examine any anticompetitive intent and any collateral agreements bearing no relationship to the PPO's success that may discourage competition.²³⁷ This inquiry usually involves reviewing price agreements, determining the ability of providers to associate with other plans, and discouraging member physicians and hospitals from granting greater price concessions to other PPOs. The PPO's agreement with its providers essentially must be no broader than necessary to protect its own interests.²³⁸

Provider-based PPOs will remain a viable alternative under federal antitrust policies as long as the organizations are carefully tailored to the aforementioned criteria. PPOs are not, in and of themselves, anticompetitive unless they are structured to reduce competition. Those entities that are designed to promote competition will certainly be welcomed by the federal agencies charged with enforcing the antitrust laws. At the same time, however, these agencies will closely examine all provider-based PPOs in light of their potential anticompetitive effect.

VI. CONCLUSION

In recent years, health care providers have come under increased scrutiny for potential antitrust violations and have lost on many of their traditional defenses. One of the most scrutinized areas is the increasing number of alternative delivery systems. Of these, PPOs—particularly provider-based PPOs—have garnered the most attention. Provider-based PPOs raise a number of concerns stemming from the potential ability of providers to reduce competition in the health care industry.

Despite these concerns, provider-based PPOs remain a viable alternative under the present antitrust laws, provided that they are carefully tailored to the guidelines set forth by the courts and federal agencies. Specifically, a provider-based PPO should avoid executing exclusive contracts, obtaining too great a market share, contracting with too many physicians in a geographic area, and communicating price information among the member providers. Provider-based PPOs, while closely regulated, will continue to be a legitimate option to provide health care, especially in light of the recognition by the Federal Trade Commission and the Department of Justice that PPOs will play an important part in the future delivery of high-quality, cost-efficient health care in the United States.

236. McGrath Remarks, *supra* note 8, at 9.

237. McGrath Remarks, *supra* note 8, at 9.

238. McGrath Remarks, *supra* note 8, at 10.

