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# SmileCare v. Delta Dental: Aberration or Signpost for the Future of Antitrust Enforcement in the Supplemental Insurance Industry

Elizabeth J. Fowler

# COMMENT

## *SmileCare v. Delta Dental*: Aberration or Signpost for the Future of Antitrust Enforcement in the Supplemental Insurance Industry?

*Elizabeth J. Fowler**

A recent article in a prominent dental journal chronicles the case of a fifty-four year old woman in desperate need of dental care.[1] Despite having basic insurance coverage for dental care through her husband's part-time job, the woman could not afford the steep copayment required by the dental insurer in order to obtain services.[2] As a direct result of forgoing necessary dental care for a serious oral health condition, the woman was eventually hospitalized.

The patient's dentist was willing to perform the treatment and waive the cost-sharing amount, accepting the third-party coverage as payment in full. He made repeated attempts to persuade the dental insurer to allow him to provide the services under such an arrangement, but the insurer refused. The dental insurer suggested instead that the dentist simply provide the care at no cost.[3]

Although cost sharing in the form of deductibles and copayments is common among health and dental insurers to limit unnecessary utilization of services, it can impose substantial barriers to access to care for patients with limited financial

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1. *See* Gary T. Chiodo & Susan W. Tolle, *Cost-Containment by Third Party Payers: The Impact on Providing Care for Underinsured Patients*, 41 GEN. DENTISTRY 113, 113 (1993).

2. *See id.* at 113-114. According to the article, the coverage required at least a 50% copayment. *See id.* at 113. The total fee for the services that this patient received was $2,510, and the required copayment was $1,355. *See id.* at 114. Faced with such a steep copayment, the husband confessed that it "might as well be one million dollars; we just don't have that kind of money." *Id.*

3. *See id.*

means. In fact, out-of-pocket costs often represent *the* determining factor in deciding among dental or medical treatment options, irrespective of efficacy or quality.[4] Medical care providers frequently waive copayment requirements for patients who could not otherwise afford treatment. Most dental insurers and a handful of states, however, expressly forbid this practice among dentists.[5]

In response to the problem of underinsured dental patients and the ban that many dental insurers place on waiver of copayments, the SmileCare Dental Group of Irvine, California, developed an innovative insurance product known as "supplemental dental care plans."[6] These plans, offered to employers, labor unions, and individuals, were modeled after supplemental insurance products purchased by Medicare beneficiaries and were designed to offset the out-of-pocket costs not covered by a subscriber's primary dental insurance.[7] The supplemental insurance coverage relieves patients of copayments for services, since the supplemental insurer pays this portion of the bill directly to providers.[8]

Immediately following the introduction of this new dental insurance product, Delta Dental Plan of California, the state's predominant dental insurer, retaliated by instituting a new policy prohibiting its participating providers from accepting supplemental payments from SmileCare.[9] Delta Dental deemed any provider who violated this policy in breach of contract. As a penalty for breach, providers faced reduced fees, threats of termination, or actual termination.[10] With a sixty percent market share for dental insurance and a participation rate of ninety-five percent by California dentists, Delta Dental's policy greatly affected SmileCare's business. SmileCare responded by filing a claim against Delta Dental.

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4. *See* Chiodo & Tolle, *supra* note 1, at 115.

5. *See infra* notes 29-31 and accompanying text (discussing opposition by the American Dental Association and dental insurers to waiver of copayments for dental services).

6. *See* SmileCare Dental Group v. Delta Dental Plan of Cal., 858 F. Supp. 1035, 1036 (C.D. Cal. 1994), *aff'd*, 88 F.3d 780 (9th Cir. 1996), *cert. denied*, 117 S. Ct. 583 (1996)

7. *See id.*

8. *See id.*

9. *See* SmileCare Dental Group v. Delta Dental Plan of Cal., 88 F.3d 780, 781-82 (9th Cir. 1996), *cert. denied*, 117 S. Ct. 583 (1996).

10. *See id.*

In *SmileCare Dental Group v. Delta Dental Plan of California*,[11] SmileCare alleged that Delta Dental violated section 2 of the Sherman Act.[12] According to SmileCare, Delta Dental engaged in intentional predatory or anticompetitive conduct and characterized Delta Dental's practice as a "group boycott." The Court of Appeals for the Ninth Circuit disagreed and affirmed the lower court's dismissal of SmileCare's complaint for failure to state a claim.[13]

The *SmileCare* case is unique because it is the first to examine whether a primary insurer's policy of prohibiting providers from accepting supplemental payments in lieu of patient copayments violates antitrust laws. The judicial affirmation of Delta Dental's policy has significant implications for the dental insurance industry and, potentially, for other markets like the Medigap market for Medicare supplemental insurance.

This Comment maintains that the circuit court in *SmileCare* wrongly upheld the dismissal of SmileCare's complaint against Delta Dental. Part I examines the market for dental care services and recent antitrust enforcement activity in the health care industry. Part II discusses the circuit court's reasoning and holding in the *SmileCare* case. Part III argues that the court misconstrued the application of SmileCare's group-boycott claim and erred in considering Delta Dental's "business justification" for its policy prior to determining whether Delta Dental engaged in anticompetitive and predatory conduct. This Comment concludes that *SmileCare* represents an unwarranted departure from accepted principles in antitrust jurisprudence but does not signify a major shift in evaluating antitrust cases in the supplemental insurance industry or the health care market as a whole.

## I. USE OF DENTAL SERVICES AND ANTITRUST ENFORCEMENT IN THE HEALTH CARE INDUSTRY

### A. THE DEMAND FOR AND USE OF DENTAL SERVICES

The growth of dental insurance over the past twenty-five years[14] has caused a concurrent increase in the use of dental

11. The district court's opinion appears at 858 F. Supp. 1035 (C.D. Cal. 1994). The circuit court's opinion appears at 88 F.3d 780 (9th Cir. 1996).

12. *See* 88 F.3d at 782.

13. *See id.* at 782.

14. In 1970, insurance payments accounted for only four percent of all

services.[15] Private dental plans currently cover an estimated forty percent of the U.S. population.[16] Studies show that those with dental insurance, regardless of the level of coverage, use dental services more often and seek preventive care more frequently as compared to those who lack insurance.[17] In fact, those without dental insurance usually seek care only on an emergency basis.[18]

Although insurance may improve access to dental care, it does not necessarily create the same "moral hazard," or overconsumption, that prevails in other sectors of the health care

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dental care payments. By 1980, the market for dental insurance increased to 31% of total payments, and as of 1994, insurance accounted for approximately 45% of all payments for dental care. *See* M.H. Anderson, *Dental Insurance Companies: Partners or Adversaries?*, 19 COOPERATIVE DENTISTRY 41, 41 (1994).

15. *See, e.g.*, H. Barry Waldman, *Dental Insurance: Its Variations and Relationship to the Use of Dental Services*, J. AM. C. DENTISTS, Summer 1989, at 4, 6 (discussing the increase in aggregate and per-capita expenditures for dental services between 1980 and 1987 and observing that, compared to those without insurance, individuals with dental insurance have more visits per person, a greater likelihood of a single dental visit and multiple dental visits in the past year, and a greater likelihood of a check-up with the last dental visit). *But see* Tryfon Beazoglou et al., *Dental Care Utilization Over Time*, 37 SOC. SCI. MED. 1461, 1461 (1993) (contending that per-capita real dental expenditures experienced no net growth between 1978 and 1989 based on a number of possible factors, including a reduction in dental disease due to increased exposure to fluoridation, substitution of refined sugar by artificial sweeteners, and improved oral health habits).

16. *See* Jay W. Friedman et al., *Rethinking Dental Insurance*, J. PUB. HEALTH DENTISTRY, Summer 1995, at 131, 131 (noting that over 100 million people in the U.S., approximately 40.5% of the total population aged two years and older, carry some form of private dental insurance); Diana Reese, *Smile Insurance: Who Offers It, How to Get It, What's Covered*, 9 AM. HEALTH 40, 40 (1990) (citing a survey conducted by the Health Insurance Association of America finding that 80% of large corporations, with 10,000 or more employees, offer dental insurance, but that only 40% of companies overall offer such insurance).

17. *See* Anderson, *supra* note 14, at 41. For example, 70% of those with dental insurance will visit their dentist at least once a year, compared to 50% of those without insurance. *See id.*; *see also* CENTERS FOR DISEASE CONTROL AND PREVENTION, U.S. DEP'T OF HEALTH AND HUMAN SERVICES, PUB. NO. 93-1511, VITAL AND HEALTH STATISTICS—DENTAL SERVICES AND ORAL HEALTH: UNITED STATES, 1989, at 9 (1992) (reporting results from the 1989 National Health Interview Survey that people with dental insurance had an average of 2.8 dental visits per person per year compared to 1.7 visits for those without dental insurance); H. Barry Waldman, *Dental Insurance Coverage and the Use of Dental Services by Children*, J. DENTISTRY FOR CHILDREN, Mar.-Apr. 1989 at 125, 127 (reporting that children with private dental insurance were more likely to have had a dental visit in the past year than children without insurance).

18. *See* Anderson, *supra* note 14, at 41.

industry.[19] Because the price elasticity of demand[20] for dental care is relatively small,[21] additional insurance coverage will not necessarily lead to an increase in the use of services.[22] This observation is particularly accurate for dental services other than basic preventive services such as oral exams and prophylactic

19. Economists use the term "moral hazard" to explain why individuals with insurance consume more services than they would if they paid the cost of those services out-of-pocket. *See* PHILIP JACOBS, THE ECONOMICS OF HEALTH AND MEDICAL CARE 107-08 (3d ed. 1991). Insurers commonly use copayments and deductibles to reduce the moral-hazard effect. *See* M. Susan Ridgely & Howard H. Goldman, *Putting the "Failure" of National Health Care Reform in Perspective: Mental Health Benefits and the "Benefit" of Incrementalism*, 40 ST. LOUIS U. L.J. 407, 416 n.39 (1996). Importantly, the moral-hazard phenomenon occurs more frequently when the absolute value of the elasticity of demand exceeds one. *See* JACOBS, *supra* at 108.

20. Economists employ the concept of "price elasticity of demand" to measure consumer response in quantity demanded to a change in price. *See* JACOBS, *supra* note 19, at 77-78. An elasticity measure with an absolute value of less than 1.0 is relatively inelastic, or unresponsive to changes in price. Thus, when the elasticity of demand is less than 1.0, a decrease in price would lead to a decrease in total expenditures, because the relative increase in the quantity purchased would not outweigh the price decrease. *See id.* Conversely, when the elasticity measure exceeds 1.0 demand responsiveness is elastic, and a decrease or increase in price would lead to a corresponding increase or decrease in total expenditures because the change in consumer demand would outweigh the change in price. *See id.* at 79.

To illustrate this concept, consider the price of basic goods like bread and milk, presumably goods with inelastic prices. Out of necessity, all people requiring these foods will probably pay whatever price is charged. Few will refuse to buy the products because of price. If the prices falls, total expenditures will also fall because people pay less for the goods and the lower price will lure few new consumers into the market to increase the quantity demanded. Conversely, the demand for most luxury goods is relatively price elastic. If, for example, the price of airline tickets dropped, more people will take advantage of the opportunity to purchase the fares cheaply and total expenditures will rise. As the price increases, however, fewer people will buy fewer tickets and total expenditures will drop.

21. *See, e.g.*, Douglas Conrad et al., *Dental Care Demand: Insurance Effects and Plan Design*, 22 HEALTH SERVICES RES. 341, 356 (1987) (reporting that the price elasticity of demand for dental care among an insured adult population is relatively low, falling between 0.01 to 0.266); A.G. Holtmann & E. Odgers Olsen, Jr., *The Demand for Dental Care: A Study of Consumption and Household Production*, 11 J. HUM. RESOURCES 546, 559 (1976) (confirming that elasticities with respect to price and waiting time for dental care were small).

22. *See* David Grembowski & Douglas A. Conrad, *Coinsurance Effects on Dental Prices*, 23 SOC. SCI. MED. 1131, 1137 (1986) (reporting that while dental insurance reduces patients' sensitivity to price for dental care, coinsurance rates have a minimal effect on the average annual payments for most dental services).

care.[23] For example, nonprice factors may influence the demand for restorative, periodontic, endodontic, and surgical dental services such as root canals, dentures, and amalgams.[24] Moreover, like the demand for medical care, providers play an influential role in determining demand for dental services,[25] which further reduces the importance of price in determining a patient's choice of care.

Copayments provide one solution for preventing overconsumption of services. For some individuals, however, cost-sharing obligations may still pose a financial barrier to obtaining necessary dental care despite insurance coverage.[26] Many dental plans have maximum annual limits that are too low to cover comprehensive treatment or deductibles and demand copayments which keep access to care out of the financial reach of patients.[27] Although full-coverage dental insurance does not require out-of-pocket payments, such plan options are often considerably more expensive than a dental plan with less than 100% coverage.[28]

In response to financial concerns of patients, providers sometimes elect to waive copayments for their patients and accept the insurance reimbursement as payment in full. Providers may also waive copayments in order to attract business. Most insurers, as well as the American Dental Association and Delta Dental Plans Association,[29] oppose the practice of waiving co-

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23. *See id.*

24. *See id.* (reporting that variation in coinsurance rates has a minimal effect on utilization, especially for services other than oral exams and prophylaxes, and that other non-price factors may have an equal or greater effect on demand for services). Even for prophylactic treatments, a 100% reduction in coinsurance rates increases the cost of such care by only eight cents. *See id.* at 1135.

25. *See id.* at 1138 (noting that once a patient decides to visit a dentist, the provider, rather than the patient, determines the demand for care).

26. *See* Chiodo & Tolle, *supra* note 1, at 114 (describing the barriers to receiving necessary dental care that cost-sharing can impose even for people with dental insurance).

27. *See* Friedman et al., *supra* note 16, at 131 (citing reasons for the limited impact of dental insurance on the oral health of the U.S. population).

28. *See SmileCare*, 88 F.3d at 782 (noting that the cost of Delta Dental's full coverage option is substantially higher than the cost of its primary plans that include copayments).

29. Delta Dental Plans Association is a national organization that operates nonprofit dental service plan corporations in virtually every state. *See* Gary M. Smith, Comment, *Provider Control of Health Insurers: Are Doctors Still Calling the Shots?* 34 ST. LOUIS U. L.J. 1079, 1080 n.10 (1990). The Association traditionally enjoys close ties to the dental profession. *See Delta Dental Plans Association:*

payments because it increases the moral hazard of insurance.[30] Moreover, several states currently ban waiver of copayments, and courts have upheld such restrictions on dentists as a valid business practice in the insurance industry.[31] As a result, a

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*Delta Dental Plans Special Relationship with the Profession*, 87 J. AM. DENTAL ASS'N 1102, 1102 (1973) ("The awareness of the special relationship existing between the [dental] profession and its own *sponsored and endorsed* Delta Plans has been manifested in many ways . . . .") (emphasis added). In fact, the American Dental Association played a key role in providing financial support to Delta Dental in its early days by purchasing stock in the plans' national underwriting company. *See id.* Similarly, Delta Dental provides support for the dental profession. *See id.* ("The Delta Dental Plans system has . . . done an extraordinary job of projecting the influence and the viewpoint of the [dental] profession . . . .").

*Hoffman v. Delta Dental Plan of Minnesota*, 517 F. Supp. 564, 570 (D. Minn. 1981), explored the mutually beneficial relationship between Delta Dental Plans and state dental associations. In *Hoffman*, which involved a "group boycott" antitrust action against the dental service plan corporation, the court observed that the state dental association created and controlled Delta Dental by dominating its board of directors. *See id.* at 571. This intimate relationship was sufficient to establish a conspiracy between Delta Dental and the Minnesota Dental Association. *See id.*

30. Section 1-K of the American Dental Association (ADA) Principles of Ethics and Code of Professional Conduct states in part: "A dentist who accepts a third party payment under a copayment plan as payment in full, without disclosing to the third party payer that the patient's payment portion will not be collected, . . . is engaged in overbilling." *See* Gary T. Chiodo & Susan W. Tolle, *Dental Care Financing*, GEN. DENTISTRY, Sept.-Oct. 1993, at 368, 368 (alterations in original); *see also* Huntley Paton, *Dentists Love to Hate Former Banker Olson*, S.F. BUS. TIMES, May 25, 1987, at 14 (reporting that the California Dental Association and Delta Dental Plan have implemented policies to deny membership to dentists who waive patient costs). According to Delta Dental, waiving copayments and accepting the insurance reimbursement as payment in full increases the moral hazard by further insulating patients from out-of-pocket costs. *See SmileCare*, 858 F. Supp. at 1038.

31. In 1991, at least 15 states prohibited dentists from waiving patient copayments without disclosure to the insurance carrier or other third-party payer. *See* Brenda Harrison & Joseph Nicosia, *Waiving Copayment: A Look at State Laws*, 122 J. AM. DENTAL ASS'N 95, 95 (1991). Some states, such as Illinois and Massachusetts, regard waiver of copayments as "irregularities" in billing. *See id.* Other states, such as Texas, regard the practice of waiving copayments as "unprofessional and dishonorable conduct" for a dentist. *See* Mark J. Hanna, *Waiver of Co-payments or Deductibles . . . Is It Legal?*, TEX. DENTAL J., Oct. 1994, at 49, 49. Apparently, organized dentistry and dental insurers spearhead the opposition to waiver of copayments. *See* Chiodo & Tolle, *supra* note 1, at 116.

Most states do not prohibit this practice, however. The Attorney General of California, for example, issued an opinion on this matter: "[W]here a dental insurance plan provides that the insurance company will pay a fixed percentage of a dentist's 'usual fee,' a dentist who claims a 'usual fee' that does not account for the fact that he has waived a patient's copayment does not violate California laws against misrepresentation and fraud." CAL. BUS. & PROF. CODE § 1680 (West 1996) (citations omitted). *But see* Reynolds v. California

vigorous debate has ensued within the dental profession over whether or not waiver of copayments is ethical.[32]

Patients for whom full coverage is prohibitively expensive or unavailable may purchase supplemental insurance to provide coverage for deductibles and copayment amounts. The market for supplemental health insurance is particularly prominent among Medicare beneficiaries who purchase such coverage to offset out-of-pocket costs not covered under Medicare.[33] In fact, over twenty-two million elderly, or seventy-five percent of all Medicare beneficiaries, carry Medicare Supplemental Insurance, also known as Medigap, coverage.[34]

Several factors distinguish the dental industry from the rest of the medical industry. For example, dental insurance is much less common among the U.S. population than health insurance.[35] Practices that are accepted in the health industry, such as waiver of copayments, are not prevalent in the dental industry.[36] In fact, according to one estimate, approximately

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Dental Services, 200 Cal. App. 3d 590, 602 (Cal. App. 1988) (ruling that the nonwaiver of copayment provision under CDS, a specialized health care service plan, did not constitute an agreement to fix prices).

32. *See* Chiodo & Tolle, *supra* note 30, at 368-371 (presenting a discussion regarding waiver of copayments). Some believe that states should allow dentists to waive copayments under certain circumstances but not for the purpose of "undercutting" other dentists practicing in the same market. *See id.* at 370. Others contend that the ADA should reevaluate its position on waiver of copayments and allow providers to use their own professional judgment regarding such waivers. *See id.* at 371; *see also* Chiodo & Tolle, *supra* note 1, at 114-16 (discussing access to health and dental care in light of the utilitarian principle of distributive justice and advocating greater discretion in the dental profession to allow providers to waive copayments).

33. *See* Thomas Rice et al., *The Effectiveness of Consumer Choice in the Medicare Supplemental Health Insurance Market*, 26 HEALTH SERVICES RES. 223, 224 (1991).

34. *See Medigap: GAO Reports that Major Insurers Often Exclude Medigap Applicants*, 4 Health Care Pol'y Rep. (BNA) 37 (Sept. 16, 1996).

35. The number of people in the United States who have some form of private dental insurance is estimated to be only 100 million. *See* Friedman et al., *supra* note 16, at 131. On the other hand, approximately 29 million Americans lack adequate health insurance, resulting in "the risk of [exposure to] large out-of-pocket expenditures for an unusually expensive, catastrophic illness." Pamela Farley Short, *New Estimates of the Underinsured Younger than 65 Years*, 274 J. AM. MED. ASS'N 1302, 1305 (1995).

36. *See* Chiodo & Tolle, *supra* note 30, at 370 (bemoaning the fact that physicians have the option of "checking a box on the office visit form marked 'bill insurance only'" to treat a poor working patient with a strep throat, whereas a dentist cannot exercise similar professional judgment and waive the patient's fee for a toothache).

Several reasons have been offered to explain why waiver of copayment is accepted by medical but not dental insurers. For example, the ADA House of

twenty-three percent of patients with traditional fee-for-service insurance have benefited from a waiver of copayment by their medical provider,[37] even though dental providers are forbidden from engaging in the same practice. Additionally, supplemental insurance is not as widely available or as common in the dental industry as it is in other sectors of the health insurance industry, especially the Medicare beneficiary market.

## B. ANTITRUST ENFORCEMENT IN THE HEALTH CARE INDUSTRY

The Sherman Act,[38] the Clayton Act,[39] the Robinson-Patman Act,[40] and the Federal Trade Commission Act[41] represent the foundation of federal antitrust laws. The statutory framework of these antitrust provisions has remained rela-

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Delegates recently adopted a policy resolution that most dental care represents "discretionary" services. *See id.* Undoubtedly, patients with a dental-health problem serious enough to warrant a hospital stay might disagree with this assessment.

37. *See* Mark S. Lachs et al., *The Forgiveness of Coinsurance: Charity or Cheating?*, 322 NEW ENGLAND J. MED. 1599, 1599 (1990).

38. 15 U.S.C. § 1 (1994). Section 1 of the Sherman Act prohibits contracts, combinations, and conspiracies that unreasonably restrain trade. Specifically, section 1 provides: "Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States . . . is hereby 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." *Id.*

Section 2 of the Sherman Act provides: "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." 15 U.S.C. § 2 (1994).

39. 15 U.S.C. § 14 (1994). Section 3 of the Clayton Act, which encompasses standards similar to section 1 of the Sherman Act, prohibits exclusive dealing arrangements and tying arrangements that may substantially lessen competition or tend to create a monopoly. *See id.* Section 7 of the Clayton Act prohibits mergers and acquisitions that may substantially lessen competition or tend to create a monopoly. *See* 15 U.S.C. § 18 (1994).

40. 15 U.S.C. § 13 (1994). The Robinson-Patman Act, which amended section 2 of the Clayton Act, deals with price discrimination in the sale of goods or commodities. *See id.*

41. 15 U.S.C. § 45 (1994). Section 5 of the Federal Trade Commission Act (FTCA) prohibits unfair methods of competition in commerce. *See id.* While the Clayton Act permits private damage suits by individuals who were injured as a result of antitrust activities, private parties are not permitted to bring suit under the FTCA. *See* JAMES H. SNEED & DAVID MARX, ANTITRUST: CHALLENGE OF THE HEALTH CARE FIELD 6 (1990). In addition to these federal laws, most states also have antitrust laws that correspond to the federal statutes. *See id.* at 7 (describing state antitrust laws as "little" Sherman, Clayton, and FTCA provisions and noting that while most state laws parallel the federal statutes, some state laws may incorporate different substantive standards).

tively static since 1950.[42] In contrast, the health care industry has undergone substantial change with regard to financing and delivery of care.[43] Antitrust enforcement in health care has evolved to adapt to these myriad changes.

Since the 1970s, when the Supreme Court first demonstrated a willingness to apply federal antitrust laws to health care financing and delivery arrangements,[44] the health care in-

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42. *See* Celler-Kefauver Amendments of section 7 of the Clayton Act, ch. 1184, 64 Stat. 1125 (1950) (codified as amended at 18 U.S.C. § 18 (1994)).

43. *See, e.g.*, L.R. Gruber et al., *From Movement to Industry: The Growth of HMOs*, 7 HEALTH AFFAIRS 197 (1988) (documenting recent changes in the health care industry vis-a-vis the growth of HMOs and managed care generally).

44. Three landmark cases set the stage for increased antitrust activity in the health care industry. The first case, decided by the Supreme Court in 1975, repudiated the traditional argument that "learned professions" (i.e., physicians, lawyers, and other prestigious, self-regulated professions) did not fall within the definition of "trade or commerce" and hence were exempt from antitrust liability under the Sherman Act. *See* Goldfarb v. Virginia St. Bar, 421 U.S. 773, 781-92 (1975) (invalidating an attorney fee schedule set by the state bar).

The second noteworthy case, *Hospital Building Co. v. Trustees of Rex Hospital*, 425 U.S. 738 (1976), entailed a claim by a newly built hospital against several hospitals in the same market and the local Blue Cross plan. The new hospital alleged a refusal to deal and market allocation in violation of sections 1 and 2 of the Sherman Act. The defendants claimed that their practices involved only local activity and did not involve "any part of the trade or commerce among the several States" as the Sherman Act requires. *Id.* at 743. In rejecting this argument, the Supreme Court construed "interstate commerce" broadly and implied that the federal antitrust laws would apply to institutional providers and professional associations, as well as individual providers. *See id. See generally* KENNETH R. WING, THE LAW AND THE PUBLIC'S HEALTH 214-15 (4th ed. 1994) (discussing the Supreme Court decision in *Rex Hospital* and its implications for antitrust enforcement in the health industry).

The third important decision from this era involved the McCarran-Ferguson Act, which provides an exemption from antitrust laws for the "business of insurance," but only to the extent that the state regulates such business and the claim does not involve a boycott, coercion, or intimidation. 15 U.S.C. §§ 1012(b), 1013(b) (1994). The Supreme Court, in *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), took a narrow view of the McCarran-Ferguson exception, specifying that the Act is limited to activities involving the spreading or underwriting of risks, and involving agreements between the insurer and the policy holder. *See id.* at 217-24.

In *Royal Drug*, plaintiffs challenged an arrangement between an insurer and selected pharmacies to fix the retail prices of drugs and pharmaceuticals sold to policyholders. *See id.* at 207. In responding to the plaintiff's claim that the practice amounted to a group boycott against nonparticipating pharmacies, the Court noted that the McCarran-Ferguson Act exempted only the "business of insurance" from antitrust laws and not the "business of *insurers*." *Id.* at 211 (emphasis added). "Arrangements for the purchase of goods and

dustry has experienced a flurry of antitrust enforcement activity.[45] In particular, both the Federal Trade Commission (FTC) and the Department of Justice (DOJ) have vigorously investigated and enforced antitrust provisions as the health care market has consolidated through vertical integration, joint ventures, and mergers and acquisitions.[46] The stated objective of the FTC has been to prevent market concentration and unreasonable restraints on competition in order to preserve consumer choice.[47]

Regardless of the precise nature of the antitrust claim, courts have traditionally held that an antitrust complaint should not be dismissed for failure to state a claim unless appears behond doubt that plaintiff can prove no set of facts in support of his claim which would entitle him to relief."[48] Anti-

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services" do not involve any underwriting or spreading of risk, the Court emphasized. *Id.* at 214. Moreover, Congress intended the McCarran-Ferguson antitrust exemption to involve "[t]he relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement." *Id.* at 215-16. From this language, the Court stated that the clear focus of the law "was on the relationship between the insurance company and the policyholder." *Id.* at 216.

45. *See* Robert M. Langer, *Recent Developments—A Practitioner's Guide to State Antitrust Health Care Issues*, ANTITRUST, Fall 1995, at 32, 32 (describing the recent state and federal antitrust initiatives in the health care industry as "unprecedented"). *See generally* U.S. DOJ & FTC, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN THE HEALTH CARE AREA (Sept. 15, 1993) (clarifying the agencies' enforcement intentions with regard to physician joint ventures, surveys of hospital price and cost information, and hospital mergers); U.S. DOJ & FTC, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN THE HEALTH CARE AREA (Sept. 27, 1994) (creating an "antitrust safety zone" for mergers between general acute-care hospitals and physician network joint ventures under certain circumstances); U.S. DOJ & FTC, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN THE HEALTH CARE AREA (Aug. 28, 1996) (expanding the use of "rule of reason" treatment to pricing agreements among providers organizing joint ventures and multiprovider networks).

46. *See* Stephen J. Squeri, *Government Investigation and Enforcement: Antitrust Division and the Federal Trade Commission*, *in* 37TH ANN. ANTITRUST L. INST. 539, 624-28 (1996) (describing recent guidelines issued jointly by the DOJ and FTC regarding antitrust enforcement policy of mergers, joint ventures, and multi-provider networks in the health sector).

47. Mark J. Horoschak, *Antitrust Enforcement Policy for Health Care Markets*, *in* HEALTH CARE REFORM L. INST. 35, 37 (1994), states the general objectives and central purpose of the FTC's antitrust enforcement program for the health care market. These guidelines address enforcement in the areas of hospital mergers, joint ventures, joint purchasing agreements, and physician networks. *See id.*

48. *Rex Hospital*, 425 U.S. at 746; *see also* Poller v. Columbia Broadcasting Sys., Inc., 368 U.S. 464, 473 (1962) ("[S]ummary procedures should be used sparingly in complex antitrust litigation where motive and intent play leading roles.").

trust litigation is not, however, exempt from the provisions of Rules 12(b)(6) and 56 of the Federal Rules of Civil Procedure. Indeed, a recent Supreme Court case even casts doubt on the notion that courts disfavor summary judgment in antitrust claims. In *Matsushita Electric Industrial Co. v. Zenith Radio Corp.*,[49] the Court held that summary dismissal is justified when the factual context of a plaintiff's claim is implausible or makes no economic sense.[50] Scholars have questioned whether *Matsushita* really established a new standard for summary dismissal in antitrust cases,[51] however, and courts continue to demonstrate an unwillingness to dismiss cases based on the rationale of earlier, more traditional cases.[52]

Another consideration in the debate over summary dismissal of antitrust claims is the treble-damages provision of the Clayton Act.[53] While the goals of the treble-damages rem-

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49. 475 U.S. 574 (1986).

50. *See id.* at 587. In *Matsushita*, American television manufacturers alleged that Japanese manufacturers engaged in a predatory pricing scheme. The Court rejected plaintiff's claims, stating that "if the factual context renders respondent's claim implausible—if the claim is one that simply makes no economic sense—respondents must come forward with more persuasive evidence to support their claim than would otherwise be necessary." *Id.*; *see also* Crown Drug Co., Inc. v. Revlon, Inc., 703 F.2d 240, 245-46 (7th Cir. 1983) (holding that summary resolution of antitrust claims is "especially welcome where . . . the key allegation of the complaint is demonstrably unsupportable"); Heart Disease Res. Found. v. General Motors Corp., 463 F.2d 98, 100 (2d Cir. 1972) (affirming the district court's dismissal of an antitrust action where plaintiffs submitted only a "bare bones statement of conspiracy or of injury under the antitrust laws without any supporting facts").

51. *See* Stephen Calkins, *Supreme Court Antitrust 1991-92: The Revenge of the Amici*, 61 ANTITRUST L.J. 269, 298 (1993). Calkins focuses on language in *Eastman Kodak Co. v. Image Technology Services, Inc.*, 504 U.S. 451 (1992), where the Supreme Court stated that *Matsushita* "did not introduce a special burden on plaintiffs facing summary judgment in antitrust cases" but rather "demands only that the nonmoving party's inferences be reasonable in order to reach the jury, a requirement that was not invented, but merely articulated, in that decision." *Id.* at 468 (internal quotation omitted); *see also* Stephen Calkins, *Summary Judgment, Motions to Dismiss, and Other Examples of Equilibrating Tendencies in the Antitrust System*, 74 GEO. L.J. 1065, 1123 (1986) (opining that *Matsushita* was "the quintessential overblown antitrust case" and that the unique and bizarre facts of *Matsushita* almost always made the case distinguishable).

52. *See, e.g.*, American Ad Mgmt., Inc. v. GTE Corp., 92 F.3d 781, 788 (9th Cir. 1996) (stating that "because antitrust cases consist of primarily factual issues, summary judgment should be used 'sparingly'").

53. Section 4 of the Clayton Act, 15 U.S.C. § 15 (1994), provides for treble damages and attorney fees for private plaintiffs who suffer actual injury as a result of conduct by a defendant that violates federal antitrust laws.

edy in private actions are admirable,[54] many commentators argue that treble damages create inefficiency, encourage meritless suits, and cause overdeterrence.[55] Appropriate use of summary dismissal can effectively curb nuisance suits and the misuse of private antitrust actions for strategic purposes.

Several types of antitrust challenges relate particularly to the health care context: monopolization, attempted monopolization, and horizontal restraints of trade in the form of coercive group boycotts.

1. Monopolization

To state a valid monopolization claim under section 2 of the Sherman Act, a private plaintiff must allege: (1) possession of monopoly power in the relevant market, (2) willful acquisition or maintenance of that power, and (3) causal antitrust injury.[56]

Under the first element, a court will examine whether the defendant has monopoly power. The Supreme Court defines monopoly power as "the power to control prices or exclude competition" within a relevant market.[57] To identify monopoly power, a plaintiff must first provide proof of a relevant market. This analysis involves two aspects: a relevant *product* market, which includes products that are "reasonably interchangeable" with the product allegedly monopolized, and a relevant *geographic* market, the geographic area in which the sellers compete for consumers.[58] Under some circumstances, predominant market

54. The private treble-damages provision presumably fosters four goals: (1) deterrence of violators; (2) compensation of victims; (3) forfeiture of ill-gotten gains; and (4) punishment for wrongdoing. *See* Edward D. Cavanagh, *Detrebling Antitrust Damages: An Idea Whose Time Has Come?*, 61 TUL. L. REV. 777, 783 (1987).

55. *See id.* at 791 (discussing grounds for criticism of the treble-damages provision, including: inefficiency, unfairness, overdeterrence, encouragement of baseless suits, and impairment of ability of American traders effectively to compete with foreign rivals).

56. Nugget Hydroelectric v. Pacific Gas and Electric Co., 981 F.2d 429, 436 (9th Cir. 1992).

57. Eastman Kodak Co. v. Image Tech. Services, Inc., 504 U.S. 451, 481 (1992) (citations omitted).

58. Daniel M. Wall, *Monopolization Under Section 2 of the Sherman Act, in* 37TH ANNUAL ANTITRUST LAW INSTITUTE 385, 387-88 (1996). In determining the relevant product market, a plaintiff must identify demand substitutes, defined as products that consumers would substitute if the defendant substantially raised the price of the product, and supply substitutes, which relate to barrier to entry. *See id.* On the other hand, defining the relevant geographic market requires an evaluation of historic patterns of distribution, determinations of the size of the market area, and an analysis of transportation

share may be used to infer monopoly power.[59] The difficulty with this approach, however, lies in determining what level of market share constitutes a predominant share.[60]

To establish the second element of a monopolization claim, "willful acquisition or maintenance of monopoly power," the plaintiff must allege "predatory," "anticompetitive," or "exclusionary" conduct.[61] Examples of predatory conduct include price squeezing and predatory pricing.[62] Numerous court cases involving a monopolization claim revolve around whether a particular market structure is the result of prohibited monopolistic behavior or the consequence of a superior product, business acumen, or historic accident.[63]

With regard to the final element, in order to demonstrate an antitrust injury, a plaintiff must show that its injury was

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costs. *See id.* at 388-89.

As a question of fact, courts generally reserve for a jury the right to define the relevant market. *See American Ad Mgmt. v. GTE Corp.*, 92 F.3d 781, 790 (9th Cir. 1996). Further, in applying Rule 12(b)(6) to an antitrust claim, courts should be very "circumspect" in applying substantive legal rules to market conditions. *See* Storer Cable Comm., Inc. v. Montgomery, 826 F. Supp. 1338, 1348 (N.D. Ala. 1993). As the Supreme Court advised in *Eastman Kodak*: "Legal presumptions that rest on formalistic distinctions rather than actual market realities are generally disfavored in antitrust laws. Courts should thus approach antitrust claims on a case-by-case basis, taking care to examine closely the economic reality of the market at issue." 504 U.S. at 467.

59. *See Eastman Kodak*, 504 U.S. at 481 (ruling that defendent's command of 80-95% of the market with no readily available substitutes allowed plaintiff to avoid summary judgment). Plaintiffs may employ the following steps to calculate market share: (1) identify all firms in the relevant market, (2) choose an output measure, and (3) calculate shares by firm. *See* Wall, *supra* note 58, at 391. In addition, the Herfindahl-Hirshman Index (HHI), which measures market concentration, also can be used to determine market share. *See id.* The HHI can be calculated by squaring the shares of market participants; values may reach 10,000, which constitutes an absolute monopoly. *See id.*

60. *See* Hunt-Wesson Foods, Inc. v. Ragu Foods, Inc., 627 F.2d 919, 925 (9th Cir. 1980), *cert. denied*, 450 U.S. 921 (1981) (finding that a food manufacturer with 65% market share in a prepared spaghetti sauce market sufficiently supported a Sherman Act monopolization claim); Wall, *supra* note 58, at 390 (citing cases in which courts implied monopoly power from market shares varying from 50-90%). *But see* General Comm. Engineering, Inc. v. Motorola Comm. & Electronics, Inc., 421 F. Supp. 274, 291-92 (N.D. Cal. 1976) (finding that a market share of 64-71% did not demonstrate monopoly power due to the competitive nature of the industry in question).

61. Aspen Skiing Co. v. Aspen Highlands Skiing Corp., 472 U.S. 585, 602 (1985); *see also* Wall, *supra* note 58, at 392 (stating that plaintiff must allege intent as well as unreasonably exclusionary conduct).

62. *See generally* Wall, *supra* note 58, at 392-93 (discussing examples of prohibited monopolistic conduct and the relevant case law for each example).

63. *See id.* at 392.

caused by the predatory conduct, not by competition.[64] More specifically, a plaintiff must prove that the injury is "of the type the antitrust laws were intended to prevent and that flows from that which makes defendants' acts unlawful."[65]

2. Attempted Monopolization

The attempt-to-monopolize offense is designed to discourage unilateral activity that poses a threat to competition such that, if left unchecked, would result in the acquisition of monopoly power.[66] A claim by a private plaintiff for attempted monopolization, which also falls under section 2 of the Sherman Act,[67] entails four elements: (1) specific intent to control prices or destroy competition, (2) predatory or anticompetitive conduct to accomplish the monopolization, (3) dangerous probability of success, and (4) causal antitrust injury.[68]

Specific intent and anticompetitive conduct are essential elements of an attempt claim.[69] Proof of intent to prevail over competitors by improper means can be demonstrated through direct or indirect evidence but a "dangerous probability of success" also must be demonstrated.[70] The Supreme Court firmly established that this element requires an inquiry into relevant product and geographic markets and an analysis of a defendant's economic power in that market.[71] In *Spectrum Sports, Inc. v. McQuillan*, the Supreme Court rejected an approach used by the Ninth Circuit Court of Appeals that held parties in

64. *See* Pacific Express, Inc. v. United Airlines, Inc., 959 F.2d 814, 818 (9th Cir. 1992), *cert. denied*, 506 U.S. 1034 (1992).

65. Atlantic Richfield Co. v. USA Petroleum Co., 495 U.S. 328, 334 (1990) (citations omitted).

66. *See Hunt-Wesson Foods*, 627 F.2d at 925.

67. 15 U.S.C. § 2 (1994).

68. *See Pacific Express*, 959 F.2d at 817.

69. *See Hunt-Wesson Foods*, 627 F.2d at 926 (stating that while plaintiff must allege both specific intent and anticompetitive conduct, such conduct may imply intent).

70. *Id.; see* E. THOMAS SULLIVAN & JEFFREY L. HARRISON, UNDERSTANDING ANTITRUST AND ITS ECONOMIC IMPLICATIONS 241 (2d Ed. 1994) (discussing the elements of a claim for attempted monopolization and the proof necessary to establish the element of intent).

71. Spectrum Sports, Inc. v. McQuillan, 506 U.S. 447, 458 (1993). The Supreme Court in *Spectrum Sports* held that establishing that the defendant engaged in "unfair" or "predatory" tactics is sufficient to prove the necessary intent, but it is not sufficient to establish "dangerous probability of monopolization" in an attempt case. *Id.* at 459.

violation of the "attempt" provisions of the Sherman Act without such an assessment of market power.[72]

3. Refusal to Deal

In general, competitors need not deal with one another.[73] This freedom to associate, however, is not absolute. In some circumstances, a competitor may be liable for abuse of its market power for refusing to deal without an adequate business justification.[74] Indeed, an affirmative duty to deal exists under narrow circumstances and is imposed only when the defendant possesses monopoly power over the product.[75] Whether the product is competitively essential is also important, but a defendant can prevail nonetheless if it had a valid, efficiency-enhancing reason for refusing to deal.[76]

4. Group Boycotts

Section 1 of the Sherman Act prohibits conduct in which an agreement is made among competitors not to deal with third parties.[77] Such behavior is often referred to as a group boycott or a horizontal refusal to deal.[78] Early examples of

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72. *See id.*

73. The longstanding Supreme Court doctrine holds that "[i]n the absence of any purpose to create or maintain a monopoly, the [Sherman] act does not restrict the long recognized right of trader or manufacturer engaged in an entirely private business, freely to exercise his own independent discretion as to parties with whom he will deal." United States v. Colgate & Co., 250 U.S. 300, 307 (1919).

74. *See* Aspen Skiing Co. v. Aspen Highlands Skiing Corp., 472 U.S. 585, 605-11 (1985) (upholding defendant's liablity for monopolistic exclusionary behavior where defendant entered into a joint marketing arrangement with plaintiff that was essential to plaintiff's viability, where defendant did not provide a business justification for its refusal to deal, and where termination of the agreement devastated both the plaintiff and consumers).

75. *See* P. AREEDA & H. HOVENKAMP, ANTITRUST LAW 664-66 (1996 Supp.) (discussing circumstances in which a monopolist might be required to cooperate with its competitor).

76. *See* Patrick J. Ahern, *Refusals to Deal After Aspen*, 63 ANTITRUST L. J. 153, 170-82 (1994) (discussing *Aspen Skiing* and the use of the "business justification" for refusal to deal); Wall, *supra* note 58, at 393-95 (describing the approach that courts take in evaluating a claim based on unilateral refusal to deal and outlining relevant case law).

77. *See* 15 U.S.C. § 1 (1994). The basic statutory elements of a section 1 violation include: (1) a contract, combination or conspiracy among separate entities, (2) that unreasonably restrains trade, and (3) is in or affects interstate or foreign commerce. *See* Victor E. Grimm, *Relationships Among Competitors*, *in* 26TH ANNUAL ANTITRUST LAW INSTITUTE 117, 120 (1985).

78. *See* Horoschak, *supra* note 47, at 40 (discussing boycotts and threats

group boycotts in a health care context involved attempts by physicians to shut out alternative providers or exclude new types of health plans or financing schemes such as prepaid capitation.[79]

Although group boycotts are traditionally regarded as a per se antitrust offense when there is market power or control of an essential facility,[80] depending on how an alleged boycott is structured, courts may apply the "rule of reason" analysis instead. A practice that would always or almost always tend to restrict competition and decrease output will be treated as a per se violation of the antitrust laws.[81] Such practices are presumed

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of boycotts as an example of an invalid horizontal restraint on trade). Generally, in examining an alleged horizontal restraint on trade or competition, courts will ask three questions.

First, is the practice "inherently suspect" such that it appears likely to restrict competition and reduce output? If the activity is not inherently suspect, the court will consider the competitive effects of the practice, including an analysis of market power. *See id.* at 37-38.

Second, if the activity or practice is inherently suspect, is there a plausible efficiency justification for the practice? For example, what is the likelihood that the practice is capable of creating or increasing competition by reducing costs? An efficiency justification is plausible if it cannot be rejected without an extensive factual inquiry. *See id.* at 38

Finally, if an efficiency justification is plausible, is it valid? A justification is generally not valid if it appears, after further scrutiny, that the parties are really arguing that the market will operate better with less competition, that the asserted efficiencies are trivial, or that the restraint is not reasonably necessary to produce the stated efficiency. *See id.*

79. *See, e.g.*, Wilk v. American Med. Ass'n, 895 F.2d 352, 362 (7th Cir. 1990), *cert. denied*, 498 U.S. 982 (1990) (holding unlawful the AMA boycott of chiropractors under the "rule of reason"); American Med. Ass'n v. United States, 317 U.S. 519, 535-36 (1943) (upholding conviction against a medical association for conspiracy to restrain trade by coercing members and practicing physicians from accepting employment under a group health membership corporation that paid providers on a risk-sharing prepayment basis).

80. The Supreme Court has long held that certain concerted refusals to deal or group boycotts are so likely to restrain competition without redeeming efficiency that they should be condemned as per se violations of the Sherman Act. *See, e.g.*, Klor's, Inc. v. Broadway-Hale Stores, Inc., 359 U.S. 207, 212-13 (1959) (holding as per se unlawful an agreement between an appliance retailer and several suppliers that constituted a refusal to deal with a competing retailer).

In general, courts will apply the per se rule where a defendant acts in an inherently unreasonable manner. *See* Craig D. Bachman, *Per Se Offenses, in* ANTITRUST HEALTH CARE ENFORCEMENT AND ANALYSIS 4 (M. Elizabeth Gee ed., 1992). Examples of antitrust activity traditionally analyzed under the per se rule include price-fixing, concerted refusals to deal (group boycotts), division of markets, and some tying arrangements. *See id.* at 8.

81. *See, e.g.*, Northwest Wholesale Stationers, Inc. v. Pacific Stationery and Printing Co., 472 U.S. 284, 289-90 (1985).

illegal, and the court will not engage in an elaborate balancing test between the precise harm incurred and the pro-competitive effects of the practice.[82]

Under a rule of reason analysis, which applies to the majority of antitrust cases,[83] courts will consider: (1) the market or markets involved, and (2) a determination of whether the acts or practices unreasonably affect competition.[84] Courts have demonstrated a reluctance to condemn rules adopted by professional associations as unreasonable per se.[85] As the Supreme Court has explained, "we have been slow to condemn rules adopted by professional associations as unreasonable per se and, in general, to extend per se analysis to restraints imposed in the context of business relationships where the economic impact of certain practices is not immediately obvious."[86]

## II. *SMILECARE DENTAL GROUP V. DELTA DENTAL PLAN OF CALIFORNIA*

In *SmileCare Dental Group v. Delta Dental Plan of California*,[87] the United States Court of Appeals for the Ninth Circuit took the controversial step of affirming the lower court's

82. The per se approach allows courts to make categorical judgments regarding business practices that have been regarded as particularly pernicious, thereby avoiding the significant costs associated with litigating a rule of reason inquiry. *See* Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332, 343-344 (1982); *see also* Bachman, *supra* note 80, at 7 (noting that when the per se rule applies, a court may condemn the defendant's conduct without an extensive inquiry into the stated purpose of the activity or its actual impact on the market).

83. The trend in antitrust case law has been away from the cursory analysis applied under a per se approach and toward a rule of reason approach. *See* SULLIVAN & HARRISON, *supra* note 70, at 85. This is especially true if the court presiding over the case has not had previous experience with the practice challenged in the case at hand. *See id.*; *see also* Douglas C. Ross, *Rule of Reason Analysis: The "Quality" Defense in Health Care Cases*, *in* ANTITRUST HEALTH CARE ENFORCEMENT AND ANALYSIS 13 (M. Elizabeth Gee ed., 1992) (reporting that the vast majority of restraints alleged to be anti-competitive are evaluated under the "rule of reason" approach).

84. *See* WING, *supra* note 44, at 223-24 (outlining the basic analysis that courts take under a "rule of reason" approach).

85. *See* F.T.C. v. Indiana Fed'n of Dentists, 476 U.S. 447, 458-59 (1986) (examining a practice that resembled a group boycott on the part of dentists and their association under the rule of reason rather than applying a per se analysis).

86. *Id.*

87. 88 F.3d 780 (9th Cir. 1996), *cert. denied*, 117 S. Ct. 583 (1996).

dismissal of the plaintiff's antitrust complaint[88] for failure to state a claim.[89] The *SmileCare* court reached its decision by accepting the lower court's conclusion that Delta Dental's policy of prohibiting supplemental insurance payments did not have any anticompetitive effects and that the policy represented a legitimate business practice.[90] Further, the court affirmed the lower court's dismissal of SmileCare's group boycott claim on the grounds that Delta Dental was not engaged in a conspiracy.[91]

### A. ANTICOMPETITIVE EFFECTS OF DELTA DENTAL'S POLICY

In its complaint, SmileCare alleged that Delta Dental possessed market power in the dental insurance market by virtue of its sixty percent market share for dental insurance in the state and its nonexclusive contractual relationship with ninety-five percent of California dentists.[92] SmileCare also alleged that Delta Dental's policy prohibiting supplemental insurance payments was calculated to eliminate SmileCare's dental plans

88. SmileCare filed suit against Delta Dental on September 8, 1993, alleging that Delta Dental's policy prohibiting participating providers from accepting supplemental insurance payments in lieu of patient copayments violated section 2 of the Sherman Act. *See id.* at 782. Specifically, SmileCare brought a claim for monopolization, attempted monopolization, and refusal to deal. *See id.* at 783. Following dismissal of these claims with leave to amend, SmileCare amended its complaint and added a group boycott claim. *See id.* The lower court dismissed the amended complaint on July 25, 1994. *See id.*

In addition to federal claims under the Sherman Act, SmileCare also filed supplemental claims under state law alleging tortious interference, trade libel, breach of contract, and violations of the California Health and Safety Code and California Business and Professions Code. *See SmileCare*, 858 F. Supp. at 1037. The lower court dismissed SmileCare's state law claims without prejudice, however, and the appellate court did not consider those claims. *See SmileCare*, 88 F.3d at 782 n.1.

89. *See SmileCare*, 88 F.3d at 783. The court stated that "[d]ismissal for failure to state a claim is appropriate where 'the complaint states *no set of facts which, if true, would constitute an antitrust offense*, notwithstanding its conclusory language regarding the elimination of competition and improper purpose.'" *Id.* (emphasis added) (citation omitted). The lower court also noted the appropriateness of a 12(b)(6) motion, given the extraordinary costs associated with discovery in antitrust actions. *SmileCare*, 858 F. Supp. at 1037.

90. In its concluding remarks, the *SmileCare* court stated that "[b]ecause Delta Dental's co-payment plan is concededly legitimate, and because SmileCare has failed to allege that Delta Dental's enforcement of its no-waiver clause has any anticompetitive effects, we affirm the district court [in dismissing the complaint]." 88 F.3d. at 786.

91. *See id.*

92. *See id.* at 782.

from the market and maintain its dominant market position.[93] The court declined to address the issue of market power and disregarded SmileCare's allegations of antitrust injury.[94] Instead, the primary issue on appeal, according to the court, was whether Delta Dental's policy of prohibiting providers from accepting copayments from supplemental insurers had any anticompetitive effects.[95]

In reaching its conclusion that the policy did not, in fact, have any impermissible anticompetitive effects, the court made two findings. First, on the basis of the lower court's analysis and precedent, the court found the copayment policy valid.[96] Second, the court affirmed the lower court's finding that the parties were not true competitors because SmileCare's "Coverage Plus" supplemental plan did not compete with Delta Dental's primary plan.

1. The Validity and Merits of Copayment Plans

The *SmileCare* court seemed to accept the argument that insurance creates a "moral hazard" by desensitizing patients to the cost of care, thereby inducing them to seek more care than they would if the services were not covered.[97] Despite approval

93. *See id.* at 785. Since virtually all of California dentists contract with Delta Dental, the state's largest dental insurer, the logical result of providers' refusal to deal with SmileCare is the elimination of the plan from the market. SmileCare also claimed that as a result of Delta Dental's policy, consumers were deprived of full-coverage dental care. *See id.*

94. The *SmileCare* court cited two reasons for disregarding the issue of market share or market power. First, Delta Dental conceded that it possessed market power for dental insurance. *See id.* at 783 n.2. Second, the court noted that market share does not necessarily equate to monopoly power since other factors such as ease of entry must also be considered. *See id.*

95. While acknowledging the amount of time and effort that the parties devoted to evaluating the market benefits of insurance copayment plans, the court discounted the discussions and clarified that the "key issue . . . [was] whether Delta Dental's refusal to recognize as contractually valid a participating dentist's acceptance of co-payment from a supplemental insurer rather than from the patient herself [had] any impermissible anticompetitive effects." *Id.* at 783-84. Moreover, the court added that potential harm to SmileCare was not sufficient to establish an antitrust claim, since "the antitrust laws protect competition, not competitors." *Id.* at 784 n.3 (citations omitted).

96. Although the court noted that previous court cases had addressed the legality of copayment plans and waiver prohibition clauses and that the validity of copayment plans was not the primary issue in this case, the *SmileCare* court nevertheless revisited the lower court's discussion of "moral hazard" theory and non-assignment clauses. *SmileCare*, 88 F.3d at 783.

97. *See id* at 784. Specifically, the court stated that "insurance creates a 'moral hazard' because it desensitizes patients to cost and induces them to

of the actuarial soundness of SmileCare's supplemental dental plan by the California Department of Corporations,[98] the court noted the economic validity of mandatory copayments because they offset the adverse economic effect of insurance.[99] Mandatory cost-sharing is also legally valid, the court found, because various cases have upheld the use of copayments to hold down the cost of medical care.[100] Based on these principles, the court in dicta recognized that payments made directly to dental providers were equivalent to a waiver of copayments and could therefore be prohibited.[101]

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seek inordinate amounts of care." *Id.*

98. First Amended Complaint for Plaintiff at ¶ 13, SmileCare Dental Group v. Delta Dental Plan of Cal., 858 F. Supp. 1035 (C.D. Cal. 1994) (No. 93-5437 RG).

99. *See SmileCare*, 88 F.3d at 784. The court restated the lower court's reasoning that mandatory copayments combat the effect of the moral hazard of insurance by "forcing patients to reflect upon the cost of services and moderate their demands for treatment." *Id.* (citations omitted).

100. *See id.* at 783. The court stated that *Kennedy v. Connecticut General Life Insurance Co.*, 924 F.2d 698 (7th Cir. 1991), established the legality of copayment plans by holding that insurers have a legal entitlement to create copayment requirements. *See SmileCare*, 88 F.3d at 783. The Ninth Circuit adopted this holding in *Davidowitz v. Delta Dental Plan of California, Inc.*, 946 F.2d 1476 (9th Cir. 1991).

The dissent in *SmileCare* disagreed with the majority's use of the holdings in *Davidowitz* and *Kennedy* because these cases based their interpretations on ERISA rather than the Sherman Act. *See SmileCare*, 88 F.3d at 787 (Pregerson, J., dissenting). While the *Davidowitz* court faced the issue of whether ERISA barred a non-assignment clause; the *SmileCare* court examined the anitcompetitiveness of Delta Dental's conduct, which forced SmileCare and other supplemental plans out of the dental insurance market. *See id.*

101. *See SmileCare*, 88 F.3d at 784. Although SmileCare argued that supplemental payments acted as a substitute for copayments rather than as a waiver, the lower court asserted that this distinction was "incorrect as a matter of law." *SmileCare*, 858 F. Supp. at 1039. "So long as a patient is not making the co-payments himself," the lower court added, "he is desensitized to cost, even though he must pay a premium for the supplemental insurance." *Id.*

In dicta, the *SmileCare* court noted that that supplemental insurance plans were not objectionable because they insulated patients from out-of-pocket costs but because they paid providers directly rather than indirectly through the patients. *See id.* at 784. In other words, Delta Dental would not oppose the supplemental payments if SmileCare made them directly to the patients who, in turn, mailed a check to their dentist. *See id.* Here the court made an analogy to a patient's rich aunt or best friend who paid the copayment on behalf of the patient. *See id.* If supplemental payments were made directly to the patient, such an arrangement would be comparable to the rich aunt's payment, because patients would be forced to "consider the pinch to their own wallets." *Id.*

The issue of copayments, the court stated, turned not on cost insulation,

2. SmileCare and Delta Dental as Competitors

The court provided a second reason for denying SmileCare's allegations that Delta Dental's policy was anticompetitive: the parties were not competitors.[102] In reaching this conclusion, the *SmileCare* court reiterated the lower court's finding, which rejected SmileCare's argument that its "Coverage Plus" supplemental plan, combined with Delta Dental's primary plan, was in competition with Delta Dental's full coverage plan.[103] According to the court, as a matter of law, the definition of *competitor* precluded Delta Dental from competing with itself.[104] Hence, as long as Delta Dental did not act to

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but on contractual terms. The primary plan policy required patients to submit copayments, and the provider contract with Delta Dental prohibited waiver of copayments. *See id.* The court noted that if an insurance policy requires copayments, then the physician must create a legal obligation for the patient to make such payments. *See id.* In fact, the lower court went one step further to say that patients enrolled in a primary plan that requires mandatory copayments are precluded from obtaining supplemental insurance. *See SmileCare*, 858 F. Supp. at 1038.

The lower court ultimately concluded, and the appellate court did not refute, that forcing providers to honor mandatory copayments is actually procompetitive, because it makes primary plans more feasible, thereby increasing consumer choice, reducing insurance costs, and enabling employers to furnish broader coverage. *See SmileCare*, 858 F. Supp. at 1038. According to the lower court, the Ninth and Seventh Circuits both recognize that the enforcement of contractual mandatory copayment provisions fosters competition by protecting against the moral hazard of insurance. *See id.* The appellate court referred to this language in its opinion. *See SmileCare*, 88 F.3d at 784. By eliminating the anticipated benefit of a reduced demand for services on the part of the primary plan, the court speculated that the SmileCare supplemental plan distorted the actuarial basis for Delta Dental's copayment plan by desensitizing patients to the costs of care. *See id.* In fact, in response to increased costs caused by patients seeking inordinate amounts of care, Delta Dental would likely raise its prices or abandon copayment plans altogether as unprofitable, with a resulting harm to consumers. *See id.* at 784 n.4. Based on this analysis, the court determined that the Delta Dental policy was not anticompetitive.

102. The SmileCare court adopted the lower court's finding that "SmileCare's supplemental insurance plan does not compete with Delta Dental's primary plan." *Id.* at 785 (citing *SmileCare*, 858 F. Supp. at 1039).

103. SmileCare argued that patients who wished to obtain 100% coverage for dental care had two options: (1) they could purchase the more expensive Delta Dental full coverage option, which did not include copayments, or (2) they could purchase both a Delta Dental primary plan, which included copayments, and a SmileCare supplemental plan. *See SmileCare*, 858 F. Supp. at 1039. These options would compete with each other, according to SmileCare, thereby reducing the cost of the full coverage option. *See id.* Further, SmileCare asserted that by disallowing supplemental payments, Delta Dental "stamps out supplemental plans," a decidedly anticompetitive result. *Id.*

104. *See SmileCare*, 858 F. Supp. at 1039 (asserting that SmileCare's alle-

crush its competition in the *primary plan* market, it did not act anticompetitively.[105]

## B. DELTA DENTAL'S LEGITIMATE BUSINESS INTEREST

In response to SmileCare's antitrust claim for "refusal to deal,"[106] the court concluded that even if the parties *were* competitors, the claim should be dismissed on the basis of Delta Dental's "valid business reason."[107] The court noted that al-

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gation that Delta Dental's policy against supplemental payment allows the insurer to insulate itself from competition is "incorrect as a matter of law," since, by the very definition of "competitor," Delta Dental cannot compete with itself). Competitive discipline comes from competing primary plans rather than supplemental plans, according to the lower court. *See id.*

In fact, according to the SmileCare court, SmileCare did not compete with Delta Dental, but rather, it attempted to encroach upon Delta Dental's method of disciplining its insureds. *See SmileCare*, 88 F.3d at 785. Adopting the lower court's conclusion, the court stated that rather than acting as competitors, "SmileCare has found a niche in the coverage 'gap' created by Delta Dental's co-payment plan, and now seeks to impose on Delta Dental its own way of doing business." *Id.* In concluding its argument, the court declared that SmileCare could not identify any antitrust law which required Delta Dental to "modify a legitimate way of doing business" in order to allow SmileCare to sell its insurance. *Id.*

The dissent took issue with the conclusion reached by the majority and the lower court that SmileCare and Delta Dental are not competitors. *See SmileCare*, 88 F.3d at 787. To reach such a conclusion, the court must conduct a factual inquiry into the relevant market. *See id.* (Pregerson, J., dissenting) (citing Thurman Industries, Inc. v. Pay 'N Pak Stores, Inc., 875 F.2d 1369, 1374 (9th Cir. 1989)). Based on the procedural posture of the case, the dissent argued that the lower court erred by finding that the two plans did not compete because it did not review any evidence. *See id.* Likewise, according to the dissent, the *SmileCare* majority erred by accepting the lower court's conclusion. *See id.*

105. *See SmileCare*, 858 F. Supp. at 1040.

106. In its complaint, SmileCare contended that Delta Dental improperly refused to deal with the SmileCare Coverage Plus supplemental plan. *See SmileCare*, 88 F.3d at 785. To support its claim under section 2 of the Sherman Act, SmileCare cited *Aspen Skiing Co. v. Aspen Highlands Skiing Corp.*, 472 U.S. 585, 602-05 (1985), for the proposition that a refusal to deal can constitute an antitrust violation without a legitimate business justification. *See SmileCare*, 88 F.3d at 785.

107. *SmileCare*, 88 F.3d at 786. The dissent rejected the approach taken by the majority in *SmileCare*. Specifically, the dissent noted that a business justification was an affirmative defense to anticompetitive conduct. *See id.* at 787. Whether a valid business reason justified a monopolist's conduct was a question of fact, as the majority stated. *See id.* According to the dissent, the majority erred in deciding the question of Delta Dental's legitimate business justification on a motion to dismiss. *See id.*

According to the dissent, the *SmileCare* court accepted Delta Dental's asserted defense as true while repudiating SmileCare's allegations. *See id.* at 788. On a motion to dismiss for failure to state a claim, the court should have

though the existence of a valid business reason for prohibiting supplemental plans was normally a question of fact, based on its preceding analysis regarding the validity of mandatory copayment plans, Delta Dental's legitimate business reason was "a foregone conclusion requiring no further analysis."[108] Moreover, the court noted that Delta Dental's primary plan predated SmileCare's supplemental plan.[109] More specifically, the *SmileCare* court accepted the lower court's finding that Delta Dental did not discontinue an existing arrangement or implement its policy prohibiting waiver of copayments in response to SmileCare's supplemental plan.[110]

### C. LACK OF CONSPIRACY TO ESTABLISH A GROUP BOYCOTT

Finally, in dismissing SmileCare's group boycott claim, the court reasoned that SmileCare failed to allege the essential element of a conspiracy between Delta Dental and another party.[111] While SmileCare cited *Klor's Inc. v. Broadway-Hale Stores, Inc.*[112] to support its claim that Delta Dental used its market power to induce dentists to "boycott" SmileCare's supplemental plans,[113] the court distinguished *Klor's* on the

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declined to consider the affirmative defense and determine only whether SmileCare's well pleaded facts, if true, could constitute an antitrust claim for which the plaintiff was entitled to relief. *See id.*

108. *See SmileCare*, 88 F.3d at 786.

109. *See id.* In *Aspen Skiing Co.*, a case on which SmileCare relied on for its argument that Delta Dental's policy represented a "refusal to deal," a ski resort backed out of a longstanding ticket-sharing arrangement that it had made with a smaller competitor. *See* 472 U.S. at 604-10 The Supreme Court upheld a claim made by the smaller competitor for "refusal to deal," because the resort's decision to discontinue the arrangement, which changed the character of the market, was not based on efficiency or a legitimate business reason. *See id.*

110. *See SmileCare*, 88 F.3d at 786.

111. *See id.* (stating that failure to allege a conspiracy between Delta Dental and any other party precludes SmileCare from bringing a group boycott claim). SmileCare alleged that Delta Dental used its dominant position in the market to coerce or induce dentists to boycott its supplemental plan. *Id.* at 785.

112. 359 U.S. 207 (1959).

113. In *Klor's*, the plaintiff and the defendant were competing retail stores for household items. *See id.* at 209. Klor's took steps to draw customers away from its competitor, and Broadway-Hale responded by persuading manufacturers and distributors not to sell to Klor's or to sell goods on unfavorable terms. *See id.* at 209. The Supreme Court held that Broadway-Hale's actions violated sections 1 and 2 of the Sherman Act, because the alleged conspiracy with manufacturers and wholesalers was designed to drive a competitor out of business. *See id.* at 209-10.

ground that Delta Dental's policy was actually procompetitive rather than anticompetitive and because the parties in this case were not competitors.[114]

## III. *SMILECARE*: QUASHING A LEGITIMATE ANTITRUST CLAIM

### A. ASSESSING ANTITRUST CLAIMS IN THE DENTAL INSURANCE INDUSTRY

The *SmileCare* decision takes antitrust enforcement in health care back twenty years to a time when courts gave the industry a substantial amount of deference.[115] In light of recent changes in the U.S. health care system with regard to financing and delivery arrangements,[116] courts are now generally more willing to examine the activities and conduct of insurers and providers.[117] The dental industry and the supplemental insurance industry are no exception.[118]

Recent Supreme Court cases cast doubt on the traditional view that federal antitrust claims are subject to a higher standard of review for summary dismissal motions than other claims.[119] The potential for high costs associated with discov-

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114. *See SmileCare*, 88 F.3d at 786. Again citing the lower court's reasoning, the SmileCare court distinguished the *Klor's* case because "SmileCare and Delta Dental are not competitors." *Id.*; *see supra* note 97 (discussing the lower court's determination that copayments actually encourage competition).

115. *See supra* note 44 and accompanying text (tracing the development of antitrust enforcement in the health care industry from a time in which the industry enjoyed a virtual exemption from federal antitrust laws to the present, in which courts demonstrate a willingness to find health care defendants liable for antitrust violations).

116. *See supra* note 43 and accompanying text (discussing recent monumental changes in the U.S. health care system).

117. *See supra* note 45 and accompanying text (noting that the FTC and the DOJ have vigorously enforced federal antitrust provisions in light of changes in the health care market).

118. *See supra* note 46 (discussing recent DOJ and FTC guidelines regarding antitrust enforcement in the health industry). Despite the court's high-handed approach and apparent disregard for the supplemental insurance industry, supplemental insurers need not be concerned that the holding in this case could have broader implications for their line of business. Based on recent holdings in other jurisdictions and the general policy statements promulgated by the FTC and DOJ expressing an increased rather than a decreased willingness to pursue antitrust enforcement in health care, the decision in *SmileCare* appears to be an aberration rather than a trend.

119. *See supra* notes 49-52 and accompanying text (discussing recent cases holding that courts should summarily dismiss antitrust cases only when fac-

ery and the incentive for meritless suits that accompanies the treble-damages remedy[120] may seem to justify enthusiastic application of the summary dismissal tools set forth in the Federal Rules of Civil Procedure. The standard for dismissing an antitrust claim is not *lower* than it is for other claims, however. The Supreme Court has held that such claims should be dismissed only if the factual context of a plaintiff's claim is implausible or makes no economic sense.[121] Thus, if the standard of review for antitrust cases is equivalent to that applied in other contexts, a plaintiff's allegations set forth in the complaint should be read broadly and liberally.[122]

In *SmileCare*, however, rather than accepting the plaintiff's allegations as true and applying the standard of review required in considering a Rule 12(b)(6) motion, the court rejected the claim and, instead, embraced Delta Dental's affirmative defense.[123] That Delta Dental's policy of prohibiting supplemental insurance would both eliminate consumer choice for full dental insurance coverage and "stamp out" all competition for such coverage should have alerted the court to potential anticompetitive conduct.

### B. SMILECARE'S CLAIM SHOULD HAVE SURVIVED DISMISSAL

The *SmileCare* court erroneously upheld the dismissal of SmileCare's antitrust action. Because SmileCare alleged predatory conduct with enough sufficiency, according to the generally accepted standard of review in antitrust cases, SmileCare's complaint should have survived a motion to dismiss for failure to state a claim. In addition, instead of acknowledging the importance of Delta Dental's market share for dental insurance and the fact that the insurer contracts with

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tual claims make no economic sense).

120. *See supra* note 55 and accompanying text (discussing criticism of the Clayton Act's treble-damages provision, including encouragement of baseless suits).

121. *See supra* note 50 (identifying cases in which courts found summary dismissal of antitrust claims justified for lack of support or lack of sound economic rationale).

122. *See supra* note 58 (citing Storer Cable Comm., Inc. v. Montgomery, 826 F. Supp. 1338 (N.D. Ala. 1993), for the proposition that the liberal system of notice pleading applies "in full force" to antitrust actions).

123. *See supra* note 107 (noting the dissent's accusation that the majority in *SmileCare* turned the standard of review "on its head" by repudiating SmileCare's allegations but accepting Delta Dental's defense as a "foregone conclusion").

nearly 100% of the providers in California,[124] the court mistakenly focused on Delta Dental's defense to the claim and the validity of copayment plans. Finally, in its high-handed approach toward supplemental insurance for dental care, the court ignored the widely accepted market for supplemental insurance in other sectors of the health care industry.[125]

### 1. The Court Erred in Basing its Decision on the Lower Court's "Finding" that Delta Dental's Policy Had No Anticompetitive Effect

The Ninth Circuit's decision to affirm the dismissal of SmileCare's antitrust claims centered on the court's "finding" that Delta Dental's policy had no anticompetitive effects.[126] In reaching this decision, the court reasoned that the parties to this action were not competitors,[127] and that because policies prohibiting waivers of copayments were economically and legally valid, prohibitions against supplemental insurance payments were correspondingly valid.[128]

In light of the procedural posture of the case,[129] the court's determination that Delta Dental's policy had no anticompetitive effect was incorrect for two reasons. First, in evaluating the prohibition of copayment waivers, the majority relied on cases interpreting the Employee Retirement Income Security Act (ERISA) rather than the Sherman Act.[130] The ERISA cases are irrelevant to the *SmileCare* case, because ERISA protects

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124. *See supra* note 92 and accompanying text (stating that Delta Dental holds a 60% market share for dental insurance and contracts with 95% of the dentists in California).

125. *See supra* notes 33-34 and accompanying text (discussing the importance and prevalence of Medicare supplemental insurance to offset out-of-pocket costs of health care for beneficiaries).

126. *See supra* notes 95-96 and accompanying text (discussing the court's focus on whether or not the policy against supplemental payments had any anticompetitive effects).

127. *See supra* notes 102-105 and accompanying text (discussing the court's finding that Delta Dental and SmileCare are not competitors).

128. *See supra* notes 97, 99-100 (outlining the court's discussion of the validity and merits of copayment plans).

129. *See supra* note 89 and accompanying text (noting that SmileCare's antitrust complaint was dismissed for failure to state a claim); *see also supra* notes 50-52 (outlining the standard for summary dismissal of antitrust claims).

130. *See supra* note 100 (noting that the cases cited by the *SmileCare* court addressed the issue of whether a non-assignment clause was barred by ERISA).

employee benefits, whereas antitrust laws protect competition and consumer choice. Although no previous cases had considered the validity of copayment plans in an action under the Sherman Act, the court placed undue reliance on cases decided within a different statutory framework.

Second, the court improperly equated waivers of copayment with supplementary insurance payments.[131] The court's conclusion ignored the existence and legitimacy of supplemental insurance in other sectors of the health care industry and the position of the California Attorney General that such waivers are acceptable under state law.[132] Ironically, Delta Dental admitted that it would not oppose the supplemental payments if they were made to patients who would then mail a check to their dentist.[133] Under this arrangement, according to Delta, patients must "consider the pinch to their own wallets."[134] This assertion makes no sense if Delta truly desires to sensitize patients to the cost of care, because patients pay the cost of care in form only and not in substance. In sum, the court's analysis that supplemental insurance plans were objectionable, not because they insulated patients from out-of-pocket costs but because they paid providers directly rather than indirectly, contradicts the assertion that supplementary insurance payments are equivalent to waivers of copayment.

The court also erred in finding that the parties do not compete against each other. Although SmileCare may not compete with Delta Dental in the market for partial coverage that includes cost sharing, SmileCare's supplemental plan combined with Delta Dental's primary plan certainly competes in the market for full coverage.[135] Importantly, determining the characteristics of the relevant product market, including

131. *See supra* note 101 (quoting the lower court's conclusion that SmileCare's argument that supplemental payments are a substitute for copayments rather than a waiver is "incorrect as a matter of law").

132. *See supra* text accompanying note 33 (discussing the role of supplemental insurance for elderly Medicare beneficiaries).

133. *See supra* note 101 (discussing the comparison between supplemental payments made directly to patients and a rich aunt paying a patient's copayment bill).

134. *SmileCare*, 88 F.3d at 784 n.4.

135. *See supra* note 103 (noting that patients who wish to obtain 100% coverage for dental care can either purchase Delta Dental or other full coverage or a Delta Dental primary plan combined with a SmileCare supplemental plan).

the issue of competition between parties, requires a factual inquiry, thus making summary dismissal inappropriate.[136]

2. SmileCare's Claims Asserted More than a "Bare Bones Statement"

*a. SmileCare Asserted a Valid Claim for Monopolization*

In order to survive a motion to dismiss for failure to state a claim, SmileCare must allege more than a "bare bones statement" of injury under the antitrust laws, and the factual context of the claim must be plausible.[137] Although the court failed to discern a legitimate claim for monopolization on the basis of the complaint, a closer look at SmileCare's allegations reveals a different picture. An objective review demonstrates that SmileCare alleged each of the elements necessary to establish a claim for monopolization under the Sherman Act with adequate sufficiency.[138]

SmileCare met the first element of a claim for monopolization, possession of monopoly power in the relevant market. For purposes of the motion to dismiss, Delta Dental conceded that it possessed market power in the relevant geographic and product markets.[139] SmileCare established the second element of a claim, willful acquisition or maintenance of market power, by demonstrating not only the unreasonableness of Delta Dental's policy but also by asserting that the policy would ultimately eliminate all supplemental insurance plans from the market and create a virtual monopoly for Delta Dental's full coverage option.[140] Delta Dental's prohibition against supple-

136. *See supra* note 58 (noting that, as a question of fact, a court ordinarily reserves for a jury the right to define the relevant market); *see also supra* note 104 (citing the dissent's assertion that the question of whether Delta Dental and SmileCare are competitors is a question of fact).

137. *See supra* notes 50-52 and accompanying text (summarizing the standard for summary dismissal of antitrust claims).

138. *See supra* text accompanying note 56 (outlining the elements of a claim for monopolization). Whether or not SmileCare's claim would prevail on its merits at trial is not at issue here. Rather, the issue is whether SmileCare's claims are sufficient to survive a motion to dismiss for failure to state a claim.

139. *SmileCare*, 88 F.3d at 783. Despite this concession, the *SmileCare* court declined to address the issue of market share or market power. *See supra* note 94.

140. *See supra* note 93 (restating SmileCare's allegation that Delta Dental's policy effectively eliminates supplemental plans from the dental insurance market and maintaining that this result is decidedly anticompetitive).

mental insurance is unreasonable in light of the determination by the California Department of Corporations that SmileCare's plan is actuarially sound[141] and the California Attorney General's acceptance of the practice of waiving dental copayment fees.[142] As SmileCare alleged in its complaint, elimination of supplemental insurance plans from the dental insurance market negatively affects consumer choice.[143]

In reviewing a motion to dismiss for failure to state a claim, such profound adverse effects in a market illustrate predatory and anticompetitive behavior.[144] Moreover, despite the court's rationale that the policy is both economically and legally valid,[145] such a prohibition is virtually unheard of in other sectors of the health care industry.[146]

With regard to the final element of a monopolization claim, Delta Dental's policy is undoubtedly injurious to SmileCare because of the effect the prohibition has on SmileCare's primary line of business. The policy prevents SmileCare from selling its product to a substantial proportion of the dental insurance market in California.[147] Consumers also suffer as a result of the Delta Dental policy in that those who wish to obtain total

141. *See supra* note 98 and accompanying text (noting the position of the California Department of Corporation).

142. *See supra* note 31 (noting the position of the California Attorney General).

143. *See supra* note 93 (stating SmileCare's allegations that consumers were deprived of full-coverage dental care by virtue of Delta Dental's policy).

144. *See supra* note 61 and accompanying text (noting that predatory, anticompetitive, or exclusionary conduct can establish the second element of a monopoly claim). Delta Dental conceded, however, that it would not oppose supplemental payments if SmileCare made them directly to patients who then mailed the check to their dentist. *See supra* note 101 (noting Delta Dental's position on supplemental insurance payments which first pass through the insured).

145. *See supra* notes 97, 99-100 and accompanying text (discussing the court's reasoning that mandatory copayments are economically valid in that they offset the moral hazard of insurance and legally valid based on precedent).

146. *See supra* notes 33-37 (discussing the widespread use of supplemental insurance plans in the medical sector)

147. Only 40% of the U.S. population has dental insurance. *See supra* text accompanying note 16 (estimating the percent of the U.S. population with dental insurance). Of the limited California proportion of the population with insurance, Delta Dental controls the largest market share, and Delta Dental contracts with nearly all of the dentists in the state. *See supra* text accompanying note 92. These numbers suggest that by prohibiting supplemental insurance payments, Delta Dental has denied SmileCare access to a substantial proportion of its potential customer base.

coverage without purchasing the more expensive full coverage option are forbidden from purchasing SmileCare's "Coverage Plus" product or any other supplemental insurance product.[148]

### b. *SmileCare Also Alleged Attempted Monopolization with Enough Sufficiency*

To establish a claim for attempted monopolization, a plaintiff must allege specific intent to destroy competition and a dangerous probability of success.[149] The pleadings in the *SmileCare* case satisfy these elements.

Delta Dental's policy goes beyond a mere intention to exclude competition and expand its own business for full-coverage dental insurance. If Delta Dental wanted to maintain its market share for full coverage customers, it could have lowered its prices to be more competitive with the supplemental insurance plan when combined with its own partial coverage option. Instead of lowering prices, however, Delta Dental chose to cut out its competitor altogether.[150]

Attempting to acquire market power is not, in and of itself, illegal under the antitrust laws.[151] An intention to prevail over competitors using improper or unfair means is, however, prohibited under the Sherman Act, and this element can be estab-

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148. *See supra* note 103 (addressing SmileCare's claim that patients who wished to obtain 100% coverage for dental care could either purchase Delta Dental full coverage or a Delta Dental primary plan combined with a SmileCare or other supplemental plan, which is considerably cheaper). Strict enforcement of the Delta Dental policy leaves consumers with only one choice, the more expensive full coverage option. *See supra* note 101. Thus, in addition to extinguishing SmileCare's customer base, the Delta Dental policy also adversely effects consumer choice.

149. *See supra* text accompanying note 68 (outlining the elements necessary to establish a claim for attempted monopolization).

150. *See supra* note 103 (quoting SmileCare's allegation that Delta Dental's conduct is anticompetitive because it "stamps out supplemental insurance plans"). The lower court rejected this assertion by arguing that SmileCare and Delta Dental are not competitors. *See supra* Part II.A.2 (responding to SmileCare's claim that Delta Dental's conduct is anticompetitive by stating that the parties are not in competition with each other).

As the dissent points out, the lower court erred in rejecting SmileCare's allegations, since on a motion to dismiss for failure to state a claim, facts alleged by the nonmoving party are presumed to be true. *See* note 104 (discussing the lower court's error in rejecting claims made by SmileCare despite the procedural posture of the case).

151. Pacific Engineering & Production Co. v. Kerr-McGee Corp., 551 F.2d 790, 795 (10th Cir. 1976), *cert. denied*, 434 U.S. 879 (1977) (citing the nonactionability under federal law of a mere intention to expand one's business at the expense of a competitor's).

lished through direct or indirect evidence.[152] Whether or not SmileCare would have been able to produce this evidence is unclear. By allowing the complaint to be dismissed at an early stage in the litigation, the *SmileCare* court precluded discovery in this action. What is clear, however, is that Delta Dental had the capacity to eliminate competition in the market for full coverage based on its predominate market share.[153] This fact was also germane to establishing the "dangerous probability" element of an attempted monopolization claim, which requires an inquiry into relevant product and geographic markets and an analysis of a defendant's economic power in that market.[154]

### c. *SmileCare's Claim for Group Boycott Should Have Survived a Motion to Dismiss for Failure to State a Claim*

Applying the standard of review under Rule 12(b)(6),[155] SmileCare's claims asserting a "group boycott" also should have survived dismissal. Although the court declined to consider SmileCare's group boycott claim on the grounds that Delta Dental was not engaged in a conspiracy,[156] given the established ties between Delta Dental and dentists,[157] an argument could be made that a conspiracy did, in fact, exist. By reason of the traditionally close relationship shared between the plan and the dental profession, dentists might willingly accept and abide by contract terms imposed by Delta Dental.[158]

A counter-argument could be made, however, that dentists are not necessarily unified in their approach to payment and insurance issues. For example, the dental profession is currently engaged in an earnest debate over the ethics of waiving patient copayments.[159] Nevertheless, even if individual den-

152. *See supra* note 70 and accompanying text (discussing proof of intent in an attempted monopolization claim).

153. *See supra* note 93 and accompanying text (discussing the potential impact of Delta Dental's policy).

154. *See supra* notes 69-71 and accompanying text (discussing the inquiry required to establish the "dangerous probability" element of an attempted monopolization claim).

155. *See supra* notes 50-52 (outlining the standard of review for a Rule 12(b)(6) motion).

156. *See supra* note 111.

157. *See supra* note 29.

158. *See also supra* note 111 (discussing SmileCare's argument that Delta Dental used its dominant position in the market to induce, or possibly coerce, dentists to boycott SmileCare's supplemental plan).

159. *See supra* note 32 and accompanying text.

tists opposed Delta Dental's policy regarding supplemental insurance payments, the state dental association might have agreed to accept and uphold the provision. Since a conspiracy is not implausible under these circumstances, SmileCare's claim should have survived a motion to dismiss in order to give the plaintiff a chance to engage in discovery.

Even if the *SmileCare* court was reluctant to declare Delta Dental's policy invalid per se,[160] it should have applied a "rule of reason" approach.[161] This approach would have required the court to consider the market or markets involved and whether the acts or practices unreasonably affect competition.[162] Again, consideration of the dental insurance market, the unreasonableness of Delta Dental's policy, and its adverse effects on competition should have been more fully explored in discovery. Since the factual context of SmileCare's claim is credible, summary dismissal was inappropriate.[163]

### C. GIVEN THE PROCEDURAL POSTURE OF THE *SMILECARE* CASE, THE COURT SHOULD NOT HAVE CONSIDERED DELTA DENTAL'S BUSINESS JUSTIFICATION

The *SmileCare* court focused on the legitimacy of Delta Dental's prohibition against supplemental insurance payments.[164] It then used this reasoning to bolster Delta Dental's defense of a valid business justification to SmileCare's antitrust allegations and ultimately to dismiss the claims.[165] The business justification offered by Delta Dental was that the actuarial basis of its insurance plan requires patients to pay for cost-sharing amounts out of their own pockets in order to avoid the "moral hazard" associated with insurance.

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160. Courts seldom condemn rules adopted by professional associations as unreasonable per se or extend the per se analysis to restraints imposed in the context of business relationships where the economic impact of certain practices is unknown. *See supra* notes 85-86 and accompanying text (discussing the reluctance of courts to find per se unreasonable rules adopted by professional associations).

161. *See supra* notes 83-84 (discussing the applicability of the "rule of reason" approach to allegations of anticompetitive restraints).

162. *See supra* note 84 (discussing the factors considered in rule of reason cases).

163. *See supra* notes 50-52 and accompanying text (summarizing the standard for summary dismissal of antitrust claims).

164. *See supra* notes 97, 99-100 (addressing the validity and merits of copayment plans generally and Delta Dental's policy in the context of a copayment waiver).

165. *See supra* notes 90, 95 and accompanying text.

As the dissent aptly pointed out, however, to consider this defense, the court must *first* decide whether the conduct is anti-competitive.[166] Here, the *SmileCare* court accepted the truth of Delta Dental's asserted defense while rejecting the truth of the asserted claims.[167] The court did not adequately explain why it accepted the business justification as a "foregone conclusion." Whether a defendant asserts a valid business justification requires an extensive factual inquiry, thereby precluding summary dismissal under Rule 12(b)(6).[168]

Despite enthusiastic support by the court, Delta Dental's business justification is suspect. Consider, for example, results from empirical studies demonstrating that the price elasticity of demand for dental care is extremely low.[169] That the elasticity of demand is low suggests that patients will not, in fact, seek unnecessary or inordinate amounts of dental care simply because the services are covered by dental insurance.[170] This empirical evidence directly counters the court's finding that the Delta Dental policy is economically valid because it moderates the effect of the moral hazard of insurance by sensitizing patients to the cost of care.[171] More importantly, given the procedural posture of the *SmileCare* case, the question of whether or not a moral hazard is present and operational in the dental insurance industry should have been viewed as a question of fact, thereby precluding dismissal of SmileCare's claim.[172] Indeed, the court should have allowed SmileCare to present factual empirical evidence that supported its position.

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166. *See supra* note 107.

167. *See supra* note 104.

168. *See supra* notes 50-52 and accompanying text (summarizing the standard for summary dismissal of antitrust claims). Even the majority recognizes that the existence of a valid business reason is a question of fact. *See supra* text accompanying note 104 (quoting the court's pat declaration that Delta Dental's business defense is "a foregone conclusion requiring no further analysis").

169. *See supra* notes 20-21 and accompanying text.

170. *See supra* note 20.

171. *See supra* notes 19, 99.

172. *See supra* note 58. The Supreme Court has held that courts should examine the economic realities of markets on a case-by-case basis. *See* Eastman Kodak Co. v. Image Tech. Services, Inc., 504 U.S. 451, 467 (1992). The issue of moral hazard in the dental insurance industry certainly qualifies as a characteristic of the relevant product market. Thus, it was inappropriate for the *SmileCare* court to conclude that the moral hazard occurs in the dental insurance industry and then to use the theory to establish Delta Dental's business justification.

## CONCLUSION

The decision by the court in *SmileCare Dental Group v. Delta Dental Plan of California* is unique in that it involves an antitrust complaint in the supplemental dental insurance market. The case is also noteworthy because the United States Court of Appeals for the Ninth Circuit took the unexpected and controversial step of affirming the lower court's dismissal of SmileCare's antitrust complaint for failure to state a claim, despite ample evidence that Delta Dental's policy of prohibiting its providers from accepting supplemental insurance payments had potentially severe and adverse implications for consumers, providers, and supplemental insurance plans.

SmileCare's antitrust claims should have survived dismissal because the plaintiff alleged predatory conduct with enough sufficiency according to the generally accepted standard of review in antitrust cases. For reasons related to public health, the case should have been allowed to proceed. Cost sharing for dental services can represent a substantial barrier to access to care for patients with limited financial means, and supplemental dental insurance can bridge that gap in coverage.

Rather than a "signpost for the future" in antitrust enforcement, *SmileCare* represents an aberration that should not be repeated. Future courts should apply the current standard of review to antitrust complaints and resist the temptation to grant unwarranted deference to health care defendants.