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PROVIDER-SPONSORED ALTERNATIVE HEALTH CARE DELIVERY SYSTEMS: REDUCING ANTITRUST LIABILITY AFTER *MARICOPA*

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I. INTRODUCTION

The phenomenal rate of inflation experienced by the health care industry in the past several years has been a substantial cause of concern for everyone affected—physicians, hospitals, insurers, employers and consumers. Public reaction to the tremendous increase in health care costs has created pressure on health care providers to compete on the basis of price and to deliver services more efficiently. The recent growth of alternative health care delivery systems (ADSs) has been a direct response to a number of problems created by increasing health care costs including increased competition in health care delivery, resistance by payors and consumers to spiraling costs, physician surpluses, an oversupply of hospital beds, and consumer demand for more convenient access to services.

ADSs can be described generally as any arrangement for health care delivery or financing that operates on a basis other than the traditional fee-for-service system. They are designed to control health care costs by increasing price competition between providers and encouraging providers to reduce utilization of services. The formation of an ADS promotes competition among providers to

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participate in the ADS as well as competition among the ADSs themselves for purchasers of their services.

ADSs have been structured in several different ways, such as health maintenance organizations (HMOs), individual practice associations (IPAs), preferred provider organizations (PPOs), exclusive provider organizations and foundations for medical care. The various types of ADSs share one common characteristic in that each consists of a limited group of providers which has contracted to provide comprehensive health care services to groups such as insurance company policyholders or a business's employees. Alternative health care plans not only take different forms but also can be sponsored by different groups such as health care providers (physicians and hospitals), purchasers (insurance carriers and self-insured employers) or brokers (third party administrators and entrepreneurs).

For example, the now familiar "closed panel" HMO, is a single entity which provides comprehensive health care services on a prepaid basis at a central facility. The services are delivered by providers who are employed and salaried by the HMO. It is referred to as a "closed panel" because its physician membership is limited. The patient-subscriber pays a fixed price in advance of treatment and is guaranteed complete coverage for all medical needs provided that he uses the HMO's providers. As a result, the HMO undertakes a financial risk: if the premiums or fees prospectively collected by the HMO fail to cover the cost of the services rendered, the HMO must absorb the loss. This gives the provider an incentive to operate efficiently and reduce utilization of services.

Another type of HMO—the IPA, provides services at the offices of its member-physicians. Physicians are usually reimbursed on a fee-for-service basis up to a limit negotiated between the IPA and the individual physicians. Accordingly, it is often referred to as a "fee-for-service HMO." IPA-type HMOs generally involve two separate entities: the HMO and the IPA. The HMO operates and administers the prepaid benefits segment of the plan while the IPA provides physician services to the HMO through a service agreement. The IPA also separately contracts with individual physicians to deliver services to HMO enrollees. As part of the contract the IPA agrees in advance with its physicians on fees and utilization control procedures. These agreements often are subject to risk sharing arrangements whereby the IPA retains a certain percentage of each physician's fee to pay for costs arising from utilization

of medical services above a projected rate. If the utilization of medical services by the HMO enrollees falls at or below the projected rate, the HMO typically distributes incentive payments to the IPA. If not, the IPA indemnifies the HMO for excess utilization.

A PPO, by contrast, is a health care delivery model under which designated physicians, hospitals or other providers contract their services to a defined group of patients on a predetermined fee-for-service basis. These patients usually are the beneficiaries of health care plans provided by employers, insurance carriers or union trust funds. Although PPOs can vary considerably in their organization, most have the following characteristics:

1. A designated panel of preferred providers that may include physicians, hospitals or both;
2. The marketing of the services of the panel to employers, insurers, unions or individuals;
3. A negotiated payment modality for providers which can be on a fee-for-service or relative value scale basis, including discounts ranging from five to twenty percent, but may also include per diem rates, diagnostic related grouping (DRG) payments and true capitation;
4. Providers charge reduced rates in exchange for anticipated increased patient volume and prompt, guaranteed claims payment;
5. Economic incentives for patients to use panel providers, such as the elimination or reduction of co-payments and/or deductibles;
6. Controls on utilization of services including retrospective review on a spot basis, comprehensive concurrent review and prior authorization.

In theory, everyone involved in an ADS can benefit. For providers, an ADS offers the opportunity for a steady and increased patient load, more rapid claims processing and reduced administrative costs. Sponsoring an ADS may also offer individual providers the opportunity to maintain the independence of their practice. For purchasers, utilization and peer review procedures common to many ADSs could be the most effective tools for reducing health care costs. The use of a data collection system allows the purchaser and the ADS to evaluate the performance of the plan and make appropriate adjustments. A purchaser also may realize cost savings from the negotiation of a fee schedule in advance of treatment. Fi-

nally, a patient may save money through the elimination or reduction of co-payments and/or deductibles if plan providers are used.

Despite the potential procompetitive benefits, the formation and operation of many types of ADSs present several significant antitrust problems, particularly if providers sponsor or control the ADS. The less the actual integration of practice, the greater the problem is likely to be.¹ For example, many of the currently popular PPOs consist of loose amalgamations of otherwise independent physicians, hospitals and other providers. This article examines questions raised by provider-sponsored ADSs and sets forth recommendations for reducing the antitrust risks.

II. APPLICATION OF THE ANTITRUST LAWS TO ADSs

The antitrust laws primarily applicable to alternative health care plans are the Sherman Antitrust Act² and its state law counterparts.³ Section 1 of the Sherman Act makes unlawful contracts, combinations, agreements and understandings which unreasonably restrain trade in interstate commerce. State antitrust laws generally parallel the federal statute and reach similar conduct on an intrastate level. There is no longer any doubt that the antitrust laws apply to the professions generally, and to health care delivery systems specifically.⁴

A critical factor in analyzing any ADS under the antitrust laws is its structure. As indicated earlier, an ADS can be sponsored and organized by brokers, purchasers or providers. The selection of a particular organizational format has significant antitrust implications. A broker-sponsored ADS, for example, is generally characterized by the lack of any direct or indirect control or interest in the plan by health care providers and third-party payors. The ADS essentially acts as an intermediary between providers selling their services and purchasers buying such services for their insureds or employees. A broker-sponsored ADS should pass antitrust muster as long as it does not serve merely as a facilitator for price fixing, boycott or other anticompetitive behavior, and there are no agreements between either competing providers or payors concerning

1. For discussion of integration of practice, see *infra* notes 42-48 and accompanying text.

2. 15 U.S.C. §§ 1-7 (1982).

3. See, e.g., Virginia Antitrust Act, VA. CODE ANN. §§ 59.1-9.1 to -9.18 (Repl. Vol. 1982).

4. *Arizona v. Maricopa County Medical Soc'y*, 457 U.S. 332 (1982); *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975).

any aspect of their involvement in the plan.⁵

Similarly, a purchaser-sponsored ADS is usually organized by an entity, such as a self-insured employer, insurance company or union trust fund, that pays for health care services or represents employees needing these services. A purchaser-based ADS should be viewed as a vertical arrangement between buyers and sellers. It should be lawful under the antitrust laws provided that it does not enter into horizontal agreements with other health care purchasers or participate in anticompetitive agreements among competing providers.

On the other hand, a provider-sponsored ADS, in which physicians and/or hospitals join together to market their services to third-party purchasers, creates several antitrust concerns. This is because a provider-sponsored ADS is made up of competing providers and the ADS will, by necessity, make decisions regarding fees, provider membership and utilization review that directly affect these competitors. The two principal antitrust issues raised by a provider-sponsored ADS involve⁶ the potential for price fixing

5. See Letter from William F. Baxter, Assistant Attorney General, Antitrust Division, U.S. Dep't Justice, to Dr. Irwin S. Smith (Sept. 21, 1983) [hereinafter cited as Antitrust Letter—Smith] (Although the Department of Justice is not authorized to give advisory opinions to private parties, the Antitrust Division will in certain circumstances review an organization's proposed business conduct and state its enforcement intentions under the federal antitrust laws. 28 C.F.R. § 50.6 (1984)); Federal Trade Commission Advisory Opinion to Health Care Management Associates (June 7, 1983) [hereinafter cited as FTC Advisory Opinion—HCMA]; cf. *Virginia Academy of Clinical Psychologists v. Blue Shield of Va.*, 624 F.2d 476 (4th Cir. 1980) (holding joint policy by two plans to refuse to pay for services rendered by clinical psychologists unless billed through physicians to be a restraint of trade), *cert. denied*, 450 U.S. 916 (1981).

6. The formation and operation of an ADS may present other antitrust questions which should be less prevalent than price fixing and group boycott issues. For example, if the ADS prevents member-providers from participating in other alternative health care plans, the ADS may be charged with entering into an exclusive dealing contract in violation of § 1 of the Sherman Act, 15 U.S.C. § 1 (1982), or § 3 of the Clayton Act, 15 U.S.C. § 14 (1982). An exclusive dealing arrangement is unlawful if it results in a substantial foreclosure of competition in the relevant market. Cf. *Tampa Electric Co. v. Nashville Coal Co.*, 365 U.S. 320 (1961) (exclusive dealing contract did not violate § 3 of the Clayton Act when performance would not have foreclosed competition); *Standard Oil Co. v. United States*, 337 U.S. 293 (1949) (exclusive dealing contract tending to foreclose competition held in violation of § 3 of the Clayton Act). In analyzing the legality of an exclusive dealing arrangement, a court will define the effective area of competition, examine the market shares of the ADS and the other parties involved, and ascertain the alternatives available for other providers and health care plans. The definition of the relevant market will be a difficult issue in these cases because a reasonable argument can be made that the relevant market consists of all competing physicians and practice groups, rather than just competing ADSs. As a general matter, exclusivity provisions should not raise serious antitrust concerns where the market share of the ADS is small. An ADS may be charged with possessing monopoly power or

among participating providers in establishing their fees and claims by providers not allowed to participate in the ADS that the participating providers have engaged in a group boycott or concerted refusal to deal with them.⁷

A. *Potential Price Fixing Liability*

The antitrust issue most frequently raised when analyzing a provider-sponsored ADS is the claim that the participating providers are engaged in illegal price fixing.⁸ The setting of price by competitors, whether by agreement to charge a uniform price, or by employing uniform discounts or similar formulas, is per se unlawful

attempting to monopolize the market in violation of § 2 of the Sherman Act, 15 U.S.C. § 2. The definition of the relevant market also is critical for these antitrust offenses, and it is unlikely in most jurisdictions that a violation will be found absent a substantial market share.

7. Price fixing and group boycott problems usually do not arise in a provider-based HMO where the participating providers are salaried employees of the HMO or are part of an integrated medical group which contracts to provide services to the HMO for a fixed amount. In these situations, the HMO is viewed as a single business entity rather than a collection of competing providers. Therefore, these types of provider-based ADSs are not included within the scope of this article.

8. Some traditional defenses may be available to exempt the activities of an ADS from antitrust liability. For example, the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015 (1982), exempts from application of the federal antitrust laws the "business of insurance" to the extent such business is regulated by state law, provided that its activities do not constitute a boycott, coercion or intimidation. It may be possible to structure an ADS in such a way that participating providers sufficiently spread the risks of operating to constitute the "business of insurance." However, several courts have recently determined that cost control devices, participating provider agreements, and agreements among competing physicians cannot qualify for exemption under the McCarran-Ferguson Act. *See* *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982); *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979); *Virginia Academy of Clinical Psychologists v. Blue Shield of Va.*, 624 F.2d 476 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981). *But see* *Klamath Lake Pharmaceutical Ass'n v. Klamath Medical Serv. Bureau*, 701 F.2d 1276 (9th Cir.), *cert. denied*, ___ U.S. ___, 104 S. Ct. 88 (1983).

It also may be possible to immunize an ADS's activities on the basis of the *Parker v. Brown*, 317 U.S. 341 (1943), state action exemption. A practice may be immune from antitrust liability under the state action doctrine if it embodies a clearly articulated and affirmatively expressed state policy to displace competition and is actively supervised by the state itself. *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105 (1980) (quoting *City of Lafayette v. Louisiana Power & Light Co.*, 435 U.S. 389, 410 (1978)). The state action doctrine, however, probably will not immunize an ADS unless its provision for competing providers to determine fees and membership is clearly articulated and affirmatively expressed as state policy by the state statutes which provide for the establishment and licensing of health care plans. These arguments have not met with a great deal of success. *See* *Ratino v. Medical Serv. of D.C.*, 1983-2 Trade Cas. (CCH) ¶ 65,641 (4th Cir. 1983); *Virginia Academy of Clinical Psychologists*, 624 F.2d 476.

under section 1 of the Sherman Act.⁹

By a vote of four to three, the Supreme Court in *Arizona v. Maricopa County Medical Society*¹⁰ held that it was a per se violation of section 1 for physician members of a foundation for medical care to agree to accept no more than set maximum prices in full payment for medical services rendered to policyholders of specified insurance plans. The foundation for medical care was a non-profit corporation comprised of about seventy percent of the licensed physicians in the area.¹¹ These physicians provided services on a fee-for-service basis for insurance plans approved by the foundation. The foundation was formed by county medical societies for the purpose of promoting fee-for-service medicine, and to offer a competitive alternative to existing health insurance plans, HMOs and other forms of health care delivery systems. The key functions of the foundation were to (1) establish a schedule of maximum fees that participating physicians would agree to accept as payment in full for services performed for patients insured by plans approved by the foundation, (2) review the medical necessity and appropriateness of treatment provided to such patients, and (3) reimburse physicians for services from insurance company accounts. The maximum fees to be paid by insurers were set by a vote of the participating physicians.¹²

The State of Arizona charged the medical societies and foundation with engaging in an illegal price fixing conspiracy.¹³ In its defense, the medical societies made four principal arguments, asserting that the foundation offered customers a desirable form of health delivery, that the challenged agreement actually lowered fees, that the foundation was a joint venture rather than a horizontal combination, and that the rule of reason, rather than the per se

9. *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 222-23 (1940). There are two standards for determining the legality of conduct challenged under the antitrust laws. The basic standard of review is the "rule of reason" under which the reasonableness of the challenged conduct is measured by determining whether, in the circumstances taken as a whole, the procompetitive benefits of the conduct outweigh any anticompetitive effects. Certain restraints, however, such as price fixing, group boycotts and horizontal market divisions, are conclusively presumed unreasonable and, regardless of any business justification, are per se illegal. The Supreme Court has criticized the indiscriminate use of the per se rule. See *Broadcast Music, Inc. v. Columbia Broadcasting Sys. Inc.*, 441 U.S. 1, 8-10 (1979); *Continental T.V., Inc. v. GTE Sylvania Inc.*, 433 U.S. 36, 47-59 (1977).

10. 457 U.S. 332 (1982).

11. *Id.* at 339.

12. *Id.* at 339-42.

13. *Id.* at 336.

rule, should apply to the maximum price fixing agreement.¹⁴

The Supreme Court held that the arrangement constituted an agreement among competitors to fix maximum prices and therefore was per se illegal. The Court made it clear that the long standing application of the rule against price fixing by competitors was so well established that there was no leeway to apply a different rule to the health care industry or health professionals.¹⁵ The type of practice involved, i.e., price fixing, rather than the industry in which it appeared, determined whether a per se rule or a rule of reason analysis was proper.¹⁶ The Court concluded that price fixing agreements must be avoided at all cost, without analysis of any purported procompetitive justifications or other cost containment objectives.¹⁷

In response to the foundation's arguments, the Court explained that the insurance companies individually, rather than the physicians, could have established the fees, that the lower prices did not justify elimination of competition, and that the practices of the physician members were not sufficiently integrated to constitute a joint venture to which the rule of reason might apply.¹⁸

An important element of the Court's reasoning was the fact that there was a less restrictive alternative available to implement the foundation's health insurance plan and its desire to cap the amount of physician reimbursement. The health insurers, which had no incentive to fix above-competitive fees, could have unilaterally set the maximum reimbursement. Thus, it was not necessary for the doctors to do the price fixing.¹⁹

The *Maricopa* decision is significant because of its direct and mechanical approach to price fixing, and the Court's unwillingness to grant special consideration to the health care industry or health care professionals. The Court ruled in no uncertain terms that (1) agreements among competitors to fix maximum prices do not escape per se condemnation, (2) the fact that physicians rather than non-professionals were parties to the price fixing agreement did not preclude application of the per se rule, (3) the judiciary's lack

14. *Id.* at 342, 351.

15. *Id.* at 348-50.

16. *Id.*

17. *Id.* at 349.

18. *Id.* at 351-54.

19. *Id.* at 352-53.

of antitrust experience in the health care industry was no reason for not applying the per se rule, and (4) the per se rule was applicable even if the agreement had procompetitive justifications.

Maricopa essentially proclaims that per se rules can apply when joint activity of competing providers is involved, regardless of the economic efficiency or cost containment justifications. While not precluding provider sponsorship of ADSs, *Maricopa* at least cautions that a provider-sponsored ADS must be carefully planned and structured if antitrust problems are to be avoided.

B. *Methods for Avoiding Price Fixing Problems*

1. Use of an Independent Management Entity

One of the key variables used in determining whether an ADS will have a price fixing problem is how its fees are established. A provider controlled, sponsored and operated ADS presents the highest potential of antitrust liability and is extremely suspect after *Maricopa* because of the danger that its activities will be considered concerted action. A health care plan that is controlled by a group of competing physicians is treated as the agent of the physician group; its plans, practices and policies are scrutinized under the antitrust laws as concerted activity.²⁰

Provider control of a health plan may be found in a variety of circumstances. For example, in *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*,²¹ the Fourth Circuit found the Blue Shield plan to be under physician control because of the presence of a number of factors. The state Medical Society had in the past sponsored Blue Shield and nominated a majority of its physician board members, the physicians constituted a majority of the board and participating physicians were members of the plan.²² This analysis followed that of *United States v. Sealy, Inc.*,²³ where the Supreme Court found that the conduct of Sealy, Inc. was actually concerted action by the independent competitors controlling the company. Sealy was jointly owned by a group of independent mattress manufacturers to do national marketing and to license

20. *Virginia Academy of Clinical Psychologists v. Blue Shield of Va.*, 624 F.2d 476 (4th Cir. 1980), cert. denied, 450 U.S. 916 (1981).

21. *Id.*

22. See *id.*, 624 F. 2d at 480.

23. 388 U.S. 350 (1967).

the Sealy trademark.²⁴ The licensee-manufacturers owned ninety-eight percent of Sealy stock, were represented on eleven of the fourteen seats of the board of directors and held positions on the firm's Executive Committee.²⁵ Even after the board structure was changed so that six of the seven Sealy board members were outside directors with no affiliation with any of the independent business-licensees of Sealy, a federal court held that a jury might still find control vested in the licensees:

Although six of the seven directors have no past affiliation with Sealy, it is not clear that the licensees exercised no influence or control over the board. One of the board members is the president of Sealy; a relevant fact will be the degree of influence he holds over the outside directors. Moreover, it is the Sealy licensees, who own more than 90 percent of Sealy's shares, that elect the "independent" directors. It would not be unreasonable for a jury to find that Sealy's new board of directors is not as independent as Sealy suggests.²⁶

Other possible methods of "control" include participating contracts with voting rights, the original selection of a board of directors and management with a self-perpetuating board, and veto rights over new applicants for membership.²⁷

Although a provider-controlled ADS is likely to be viewed as a combination of its participating providers, it may be able to establish its fee structure through *independent* management. This can be accomplished in a number of ways such as by (1) appointing a third party administrator to manage and operate the ADS, including the negotiating and setting of its fee, (2) retaining a person or group for the specific purpose of setting the fees, (3) establishing a committee of non-providers to determine the fee structure, or (4) having a sponsoring insurance company or employer set the reimbursement schedule. Whichever entity is selected to manage the ADS, it should be separate and distinct from the participating providers, and the providers should not control the fee setting mechanism. Specifically, the providers should not have access to fee information of their competitors and should not participate in

24. *Id.* at 351.

25. *Id.* at 352.

26. *Ohio-Sealy Mattress Mfg. Co. v. Duncan*, 1980-2 Trade Cas. (CCH) ¶ 63,307, at 75,603 (N.D. Ill. 1980); *see also* *United States v. Topco Assocs., Inc.*, 405 U.S. 596, 609 (1972).

27. *Topco Assocs., Inc.*, 405 U.S. at 602; *Associated Press v. United States*, 326 U.S. 1, 9-11 (1945).

the review of fees or discounts offered by contracting providers. In addition, the board of directors of the ADS should be composed of non-providers. Participating providers could serve on an advisory council, but the board of directors should have the final authority over policy decisions such as the fee structure and utilization control procedures.

This does not mean, however, that provider input is completely prohibited. Input by providers to independent management often will be necessary, procompetitive and entirely lawful.²⁸ In fact, the Federal Trade Commission (FTC) has ruled that a group of competing providers may comment on a third party payor's reimbursement policy so long as it does not authorize a common agent to negotiate with the payor on their mutual behalf.²⁹ Nevertheless, in practice such input can be dangerous because it supplies the factual underpinnings from which a court or jury might infer a combination or conspiracy leading to a section 1 violation.³⁰ Therefore, it is important to be able to objectively verify that all final policy decisions, especially those relating to fees, are made independently by the ADS's managing entity.

Price fixing problems should be minimized if the entity managing the ADS meets with individual providers and negotiates with each a discount from that provider's usual and customary fees, or unilaterally establishes fees or discounts from usual fees. In the absence of provider participation or influence, courts will not treat individual bilateral contracts between a buyer, the ADS, and a seller, the physician, as per se illegal price fixing because such agreements do not involve sales to third parties but are merely arrangements for the purchase of goods and services. Such arrangements should be evaluated under the "rule of reason" and generally will be upheld because of their procompetitive effects.³¹

28. Cf. *Monsanto Co. v. Spray-Rite Serv. Corp.*, 104 S. Ct. 1464, 1470-71 (1984) (communications between manufacturers and distributors regarding competitors' prices deemed necessary in an efficient distribution system; such communications alone are not concerted action); *Roesch, Inc. v. Star Cooler Corp.*, 1982-1 Trade Cas. (CCH) ¶ 64,575 (8th Cir. 1982); *Edward J. Sweeney & Sons, Inc. v. Texaco, Inc.*, 637 F.2d 105 (3d Cir. 1980), *cert. denied*, 451 U.S. 911 (1981).

29. See *Michigan State Medical Soc'y*, 44 ANTITRUST & TRADE REG. REP. (BNA) 426, 443 (Feb. 24, 1983).

30. See *Monsanto Co.*, 104 S. Ct. at 1471; *Battle v. Lubrizol Corp.*, 1982-1 Trade Cas. (CCH) ¶ 64,576 (8th Cir. 1982).

31. See, e.g., *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 214 (1979); *Sausalito Pharmacy, Inc. v. Blue Shield of Cal.*, 1982-2 Trade Cas. (CCH) ¶ 64,766 (9th Cir.), *cert. denied*, 459 U.S. 1016 (1982); *Medical Arts Pharmacy of Stamford, Inc. v. Blue*

The U.S. Department of Justice and the FTC recently advised two groups who were forming PPOs that they would have no price fixing problems since provider reimbursement would be determined by the PPO's independent organizer-administrator, rather than by the providers themselves.³² The first group, Health Care Management Associates (HCMA), intended to create a PPO, with HCMA acting as its marketing and administrative arm. The PPO would contract with doctors and other licensed health care providers, and with third-party payors, such as insurance companies and self-insured employers, concerning the terms for the provision of health care services to patients. HCMA would not be affiliated with any providers, but would contract with participating providers on their method of payment. Patients whose insurers had contracted with the PPO would receive treatment from participating providers at charges less than their usual fees. The contracting providers would not vote on or collectively influence the fee levels. The PPO would not be involved in an individual physician's fee setting and the fee discounts would be individually negotiated with the physicians. Furthermore, HCMA would not disseminate current fee information among the participating physicians but only to the third-party payors.

Although the Justice Department recognized that the PPO is an organization composed of competing providers and thus could present antitrust concerns, it concluded that HCMA's proposed PPO was not likely to cause competitive problems. The Department reasoned that, given the use of individually negotiated discounts from customary fees and safeguards against the exchange of fee information among providers, the operation of the PPO was not likely to either facilitate collusive behavior among providers or eliminate effective competition in the area. Furthermore, the Justice Department observed that the emergence of PPOs can benefit the public by increasing competition among providers, stimulating cost containment efforts and contributing to lower health care costs.³³

Cross and Blue Shield of Conn., Inc., 675 F.2d 502, 505-06 (2d Cir. 1982); Proctor v. State Farm Mut. Auto Ins. Co., 675 F.2d 308, 337 (D.C. Cir.), *cert. denied*, 459 U.S. 839 (1982); General Glass Co. v. Globe Glass & Trim Co., 1980-2 Trade Cas. (CCH) ¶ 63,531 (N.D. Ill. 1980).

32. See Antitrust Letter—Smith, *supra* note 5; Letter from William F. Baxter, Assistant Attorney General, Antitrust Division, U.S. Dep't Justice, to Donald W. Fish, Esq. (Sept. 21, 1983) [hereinafter cited as Antitrust Letter—Fish].

33. Antitrust Letter—Smith, *supra* note 5, at 4. In a March 22, 1985 speech, J. Paul McGrath, Assistant Attorney General, Antitrust Division, U.S. Department of Justice, stated that provider-sponsored PPOs generally provide significant procompetitive benefits and rec-

Like the Justice Department, the FTC found that HCMA's PPO was procompetitive and would not violate the antitrust laws.³⁴ According to the Commission, the PPO would be a vertical arrangement between individual sellers (participating providers) and purchasers (third-party payors, acting on behalf of their insureds or beneficiaries) for the sale and purchase of health care services. HCMA would facilitate these transactions by performing certain functions much like an agent or broker. In addition, the PPO did not involve any agreements among competing providers concerning any aspect of their involvement in the program. As a result, the FTC ruled that the operation of the program would not constitute either a horizontal or vertical price fixing arrangement, or an unlawful joint sales agency arrangement.³⁵

Hospital Corporation of America (HCA) also obtained business review letter approval from the Department of Justice for a PPO in two Florida counties.³⁶ HCA proposed to create a subsidiary, MSA, which would develop and market a PPO in the area. MSA would enter into contracts with doctors and other medical services providers, hospitals and third-party payors (such as insurance companies and self-insured employers), under which patients would receive treatment from contracting providers and hospitals at reduced rates. MSA would individually negotiate the amount of the discount offered by each affiliated doctor and hospital. As a result, the size of the discount and the resulting fee could vary among different providers and hospitals. Participating providers would be free to lower their discounted fees or to change their usual and customary fees at any time, but would agree not to raise their discounted fees for one year from the execution of a contract with MSA. MSA would have a local advisory board of trustees composed of contracting providers, representatives of contracting hospitals and third-party payors. However, the provider members of the board would not have access to confidential fee information concerning their competitors, and the board would not review the fees or discounts offered by contracting providers. Final authority for pricing, membership and other policy decisions would reside with MSA's executive director and board of directors. Given these

ommended that regulatory barriers to the formation of competitive PPOs be removed. Speech by J. Paul McGrath, to the Antitrust Section of the American Bar Association Meeting (Mar. 22, 1985) [hereinafter cited as McGrath Speech].

34. See FTC Advisory Opinion—HCMA, *supra* note 5, at 145.

35. *Id.*

36. See Antitrust Letter—Fish, *supra* note 32.

facts, the Justice Department recognized that, while the proposed PPO would be an organization composed of competing providers, it would still have procompetitive effects and was not likely to cause competitive problems.³⁷

As noted previously, *Maricopa* teaches that a provider-controlled ADS which sets the compensation of its competing providers is likely to constitute horizontal price-fixing.³⁸ However, as the above examples illustrate, the determination of the standard price for a group of competing providers by independent, bilateral contracts with a third-party management entity, which is not controlled by the providers, has been upheld. Thus, a provider-sponsored ADS may be able to avoid horizontal price-fixing by employing a truly independent manager or administrator to establish the fee structure and enter into individual agreements with the participating providers.³⁹

2. Integration of Practices and Establishment of Joint Venture

The Supreme Court in *Maricopa* suggested that one method by which a health care plan may avoid price fixing liability is to partially integrate the activities of the participating providers and create a joint venture. If the providers can sufficiently integrate their practices and form a legitimate joint venture, their agreement regarding fees may then be tested under the rule of reason analysis.

In *Maricopa*, the Court drew a distinction between the foundation for medical care and "partnerships or other joint arrangements in which persons who would otherwise be competitors pool their capital and share the risks of loss as well as the opportunities for profit."⁴⁰ The Court explained that "[i]n such joint ventures, the partnership is regarded as a single firm competing with other sellers in the market."⁴¹ Thus, *Maricopa* suggests that the rule of reason could be applied to the fee setting process where providers

37. *Id.*

38. See *supra* notes 10-19 and accompanying text.

39. The manager or administrator must be truly independent of the provider-based ADS. If the manager is in reality directed or controlled by the participating providers, a court most likely will "pierce the veil" to find that the manager is merely a joint sales agent for the providers. The providers could then be held individually liable for price fixing violations. It is therefore important to recognize that the determination of the independence of the ADS's manager will be based upon a factual test.

40. 457 U.S. at 356.

41. *Id.*

form a partially integrated ADS and/or share the financial risks associated with the ADS. Unfortunately, the Court provided little guidance for determining when the provider members of an ADS have sufficiently integrated their practice to avoid the per se rule. As a result, reliance upon the unrefined language in *Maricopa* regarding the organization of an ADS as a joint venture entails a degree of risk that the fee setting mechanism of the ADS will be challenged under the antitrust laws. Nevertheless, these risks may be worth taking if direct provider control is important to the ADS organizers.

Integration generally is defined as the coordination or joining together of functions such as production, management, promotion, distribution, financing and debt collection. A partially integrated plan results when the controlling providers still compete with each other for patients in independent medical practices and have either partially integrated their practices into the plan or made a substantial financial contribution to support the establishment or operation of the plan.⁴² A plan may be partially integrated by centralization of marketing, billing and debt collecting functions, or by sharing the potential financial risks resulting from unanticipated high costs or utilization.⁴³ The financial contribution may be in the form of a capital contribution by the group or may entail an indirect financial contribution to the plan's operation through a risk-sharing arrangement.⁴⁴ Risk-sharing might be achieved by retaining some portion of the fees payable to participating providers and distributing them to the providers only if a certain factor, such as reduction in individual patient utilization, were achieved. If this factor were not achieved, the retained fees could be distributed to the payors.⁴⁵

Where the providers of an ADS are able to centralize some of their functions so as to clearly achieve efficiencies and a sharing of the risks of operation, courts may be willing to treat the ADS as a joint venture to which the rule of reason applies. As one commentator has observed, however, "[o]nly those joint ventures where there is substantial but not complete integration of production, managerial, distribution, financial or other operations will be con-

42. See FTC Policy Statement on Physician Agreements to Control Medical Prepayment Plans, 46 Fed. Reg. 48,982, 48,989 (1981) [hereinafter cited as FTC Policy Statement].

43. *Id.* at 48,989 n.44.

44. *Id.* at n.41.

45. See *id.* at 48,989.

sidered. Without such integration, the 'joint venture' label simply masks a consensual cartel, and there is no reason to displace established antitrust rules governing cartel conduct."⁴⁶ Nevertheless, the rule of reason should be the appropriate standard for determining the validity of partially integrated health care plans if a new entity, with the potential to enhance competition, has been created.⁴⁷

A joint venture is normally considered lawful if: (1) any elimination of price competition between the participants results directly from the partial integration of their functions, i.e., the agreement fixing prices is a necessary part of the joint venture and is no broader than necessary for that purpose; (2) the market share of the participants as a group is small; and (3) the parties have not demonstrated a primary purpose or intent to restrict or eliminate competition.⁴⁸

In November, 1983, the Ohio Attorney General issued an advisory opinion concluding that PPOs should be analyzed under the rule of reason as joint ventures.⁴⁹ The Ohio Attorney General reasoned that a PPO's price setting function should not be subject to the per se rule because it is ancillary to the creation of a new competitive entity, the PPO.

Physicians or hospitals who combine to form a PPO do much more than fix prices; they pool their capital and undertake the risks associated with the establishment of a new method for marketing their services. The integration of marketing, claims administration, billing and other functions warrants the conclusion that the resultant price restraint is ancillary in nature.⁵⁰

Furthermore, the Ohio Attorney General noted that price restraints associated with a provider-sponsored PPO are generally no greater than necessary to achieve legitimate business purposes. As a competitor in the market for prepaid health care, a PPO must

46. Pitofsky, *Joint Ventures Under the Antitrust Laws: Some Reflections on the Significance of Penn-Olin*, 82 HARV. L. REV. 1007, 1016 (1969).

47. See FTC Policy Statement, *supra* note 42, at 48,989.

48. See R. BORK, *THE ANTITRUST PARADOX* 279 (1978); L. SULLIVAN, *HANDBOOK OF THE LAW OF ANTITRUST* 206 (1977); Weller, *The Antitrust Swamp: How Can Health Care Professionals Avoid It?*, HEALTH CARE FIN. MGMT. 26, 28 (1982). On March 22, 1985, the Department of Justice's Antitrust Division announced that it would normally analyze provider-sponsored PPOs under joint venture principles and would apply this three-part test to determine its legality. McGrath Speech, *supra* note 33.

49. OP. OHIO ATT'Y GEN., 1984-1 Trade Cas. (CCH) ¶ 65,796 (Nov. 17, 1983).

50. *Id.* at 67,308.

set the price at which it will deal with providers. In order to attract customers away from traditional insurers, the PPO usually must use discounts. Since this fee setting activity of a provider-based PPO is necessary for its successful operation, the Ohio Attorney General concluded that it should be judged under the rule of reason rather than summarily condemned under the per se rule.⁵¹

The Attorney General's opinion then analyzed typical provider-based PPOs under the rule of reason and declared that PPOs will usually promote, not restrain, competition by creating an incentive for providers to deliver efficient, quality patient care. When the PPO enters the marketplace, rational incentives for efficiency are restored in that consumers are encouraged, through the use of smaller copayments and deductibles, to use efficient providers. Efficient providers are rewarded by being assured a steady stream of patients. This, in turn, creates the incentive for other providers to form competing PPOs.⁵²

The Ohio Attorney General also observed, however, that PPOs will promote competition only so long as they do not possess undue market power. If too high a percentage of a community's providers are members, the PPO may become a monopoly, and the resulting suppression of competition will outweigh any procompetitive benefits.⁵³ On similar grounds, the FTC has warned that, while prepaid health care plans have the potential to enhance competition in the health care services market, antitrust concerns can arise under several circumstances, such as when a relatively large number of physicians join together to control a plan, or when a controlled plan has market power, or when a physician group of any size forms or operates a plan to effectuate an anticompetitive purpose. The FTC

51. *Id.*

52. *Id.* at 67,308-09.

53. *Id.* Unfortunately, there are no established rules on the maximum combined market share of participating providers that the antitrust laws will allow. One commentator has suggested that a joint venture should be presumptively unlawful if it is controlled by fifteen percent or more of the local hospitals or physicians, or both. See Brodley, *Joint Ventures and Antitrust Policy*, 95 HARV. L. REV. 1521, 1553 (1982). However, another antitrust analyst would draw the line at forty percent. See R. BORK, *supra* note 40, at 222, 279. In addition, the Department of Justice's Antitrust Division relied on a maximum of twenty percent of available providers as a factor in its favorable review of a PPO proposal. See Antitrust Letter—Smith, *supra* note 5. More recently, the Antitrust Division indicated that it would likely have no reason to challenge the size of a provider-sponsored PPO with less than twenty percent of the market and would apply a market-specific analysis to each case in which the size of the PPO exceeds twenty percent of the market. McGrath Speech, *supra* note 33.

noted that anticompetitive purposes, such as stabilizing physicians' fees or creating a plan that will dominate the market and exercise market power for the benefit of a group of physicians, may create the basis for challenging a partially integrated health care plan. The FTC also may challenge a plan if it unreasonably injures competing providers or plans.⁵⁴

More recently, the FTC approved the operations of a large HMO/IPA plan in Michigan whose enrollees comprise approximately twelve percent of the population of a three-county service area.⁵⁵ The HMO contracted with an IPA professional corporation, which included approximately sixty percent of the primary care physicians and sixty-five percent of the total number of physicians practicing in the area, for the purpose of providing medical services to the enrollees. The HMO charged enrollees a monthly premium and paid the IPA on a capitation basis. However, the physician-shareholders of the IPA were paid on a fee-for-service basis. The IPA used a fee schedule to determine the amount paid to physician-shareholders, who were paid the lesser of their actual charges or the fee schedule amount. In addition, a percentage of the fee due to the physicians was withheld by the IPA and placed in a special risk-sharing account. In the event that the HMO's capitation payments were not sufficient to pay for the medical services delivered by the IPA, the risk-sharing account was drawn upon for any deficit. Furthermore, the HMO and IPA had a risk-sharing arrangement in which they shared fifty percent of any deficit or surplus that resulted from the provision of health services other than medical services to the HMO's enrollees. Finally, the HMO and IPA annually negotiated the capitation payments made by the HMO and jointly budgeted and anticipated utilization and cost levels for health services other than the medical services provided by the IPA.⁵⁶

As a general matter, the FTC stated that health care plans in which physicians partially integrate their practices, either through a financial contribution or by a risk-sharing agreement, are scrutinized under the rule of reason. Such partially integrated plans are distinguishable from the types of arrangements held to be per se

54. See FTC Policy Statement, *supra* note 42, at 43,991-92.

55. Letter from Arthur N. Lerner, Asst. Director, FTC Bureau of Competition, to Gilbert M. Frimet, Esq. (Mar. 22, 1984) [hereinafter cited as FTC Letter—Frimet].

56. *Id.* at 3.

illegal in *Maricopa*.⁵⁷ The FTC advised the IPA that its use of a fee schedule for distribution of its capitation payment to its physicians did not appear to violate the antitrust laws, assuming that the physicians' joint participation in the HMO's program through the IPA was lawful. Here, the FTC found that the IPA physicians had a clear financial involvement in the HMO's operation because, in part, they had assumed a substantial risk by accepting a capitation payment from the HMO. In such a situation, the agreements on price by the IPA physicians relating to their participation in the HMO—both in setting maximum allowable fees for services provided to HMO patients and in collectively negotiating a capitation rate with the HMO—do not violate the antitrust laws unless they had, or were likely to have a significant anticompetitive effect.

The FTC did not find any significant anticompetitive effect arising from the IPA's adoption of a maximum fee schedule for its physicians and their treatment of HMO patients. The FTC noted that a fee schedule is a vehicle for determining how revenues will be distributed within the IPA, just as any business organization must determine how its revenues will be distributed.⁵⁸ As a result, the use of a fee schedule to determine the division of the capitation payment does not in itself present an antitrust problem. The FTC also indicated that the analysis of the legality of the IPA's fee schedule probably would not change if the number of physicians participating in the HMO grew.

The FTC explained that an antitrust problem could exist with regard to the joint negotiation and agreement by IPA physicians on the capitation rate they would accept from an HMO. This problem would arise if the IPA physicians did not have a financial or risk-sharing interest in the HMO. Such activity would violate the antitrust laws unless it is part of a true joint venture and its anticompetitive aspects are outweighed by its procompetitive benefits. In this instance, the FTC concluded that the establishment of a maximum fee schedule by the IPA was not unlawful so long as the physicians had made a substantial contribution to the operation of the plan or had undertaken a substantial financial risk. In sum, the FTC approved the fee setting activity of an IPA involving sixty-five percent of the physicians in a service area because the physicians had formed a legitimate joint venture through their use

57. *Id.*

58. *Id.*

of a risk-sharing arrangement.

In summary, a provider-sponsored ADS may be able to avoid price fixing liability by sufficiently integrating the practices of its participating physicians and entering into an arrangement which spreads the risk of financial loss among the physicians. If this can be accomplished, the ADS probably will be treated as a joint venture and thus evaluated under the rule of reason. Under the rule of reason analysis, the setting of fees by the ADS should be upheld as long as it is needed to market the plan to third-party payors, the market share of the participating providers is not substantial, and the purpose of the activity is not to decrease competition from other providers.

C. *Group Boycotts*

The other major area of potential antitrust liability for a provider-sponsored ADS lies in the concept of group boycotts or concerted refusals to deal. Providers excluded from an ADS may be distressed if it appears that the ADS confers significant financial benefits on participating providers. As a result, they may claim that participating providers have engaged in a concerted refusal to deal with them in violation of section 1 of the Sherman Act.

Although the exclusion of providers from a health care plan was not an issue in *Maricopa*, a broad reading of that case raises the specter that this form of conduct will be subject to per se treatment.⁵⁹ What is clear from *Maricopa* is that joint action by competing physicians will be extremely suspect. Since the Supreme Court has held in earlier cases that group boycotts in other industries are per se violations of the antitrust laws,⁶⁰ *Maricopa* suggests that the same rule will be extended to the health care industry.

Nevertheless, it is unclear exactly what type of concerted action will constitute a group boycott. While adopting a broad definition of boycotts, the Supreme Court also has noted that "boycotts are not a unitary phenomenon."⁶¹ In the health care field, as in other areas, some courts have tended to define group boycotts by

59. *Arizona v. Maricopa County Medical Soc'y*, 457 U.S. 332 (1982).

60. *See, e.g., Klor's Inc. v. Broadway-Hale Stores, Inc.*, 359 U.S. 207 (1959) (finding an agreement between manufacturers and large retail chain to sell to small independent appliance store at discriminatory prices to be a group boycott).

61. *St. Paul Fire & Marine Ins. Co. v. Barry*, 438 U.S. 531, 543 (1978) (quoting P. AREEDA, *ANTITRUST ANALYSIS* 381 (2d ed. 1974)).

whether their purpose or effect is to diminish competition. In such cases, the courts apply a rule of reason analysis to alleged group boycotts where there is no exclusionary effect or intent.⁶² This backdoor approach to introducing rule of reason analysis into the group boycott area may be particularly appropriate where quality of care issues arise. Such a situation may exist when a physician has been excluded from an ADS because he or she had rendered inappropriate or unnecessary services. However, for planning purposes it is difficult to rely on the possibility that a court will not mechanically apply the per se rule to a situation where some providers have been excluded by a group of competing providers, especially in view of the *Maricopa* decision.

Under the antitrust laws, it takes little to establish "concerted action" sufficient to prove a violation of section 1; neither a written nor even express oral agreement is required. Rather, an inference of concerted action can be raised by a set of circumstances, such as casual meetings or conversations followed by implementation of the challenged conduct.⁶³ As one court has noted, "[a] knowing wink can mean more than words."⁶⁴

As indicated in the discussion on price fixing,⁶⁵ a provider-sponsored or controlled ADS presents antitrust problems because of the danger that it will be treated as a combination of competing providers. The factors that are indicative of provider control have already been discussed⁶⁶ and will not be repeated here.

Even in the absence of actual control, antitrust courts have frequently found that a single business enterprise's refusal to deal was not "unilateral" in nature but the result of a combination or conspiracy. In *United States v. General Motors Corp.*,⁶⁷ for example, Los Angeles Chevrolet dealers complained to General Motors about sales by some Chevrolet dealers to discount houses.⁶⁸ These discount houses competed with Chevrolet dealers for new car sales in the Los Angeles area.⁶⁹ After receiving numerous dealer com-

62. See *Feminist Women's Health Center, Inc. v. Mohammad*, 586 F.2d 530 (5th Cir. 1978), cert. denied, 444 U.S. 924 (1979); *Levin v. Doctors Hosp. Inc.*, 233 F. Supp. 953 (D.D.C. 1964), rev'd on other grounds, 354 F.2d 515 (D.C. Cir. 1965).

63. *American Tobacco Co. v. United States*, 328 U.S. 781, 809 (1946).

64. *Esco Corp. v. United States*, 340 F.2d 1000, 1007 (9th Cir. 1965).

65. See *supra* notes 8-19 and accompanying text.

66. See *supra* notes 20-39 and accompanying text.

67. 384 U.S. 127 (1966).

68. *Id.* at 133-34.

69. *Id.* at 132.

plaints, General Motors met with the complaining dealers and developed a program to stop the sales. This plan included placing threatening telephone calls to area dealers and informing principal offenders that sales to discount houses violated their franchise agreements.⁷⁰ The Supreme Court found that General Motors had not acted unilaterally (i.e., by simply terminating offending dealers), but rather had collaborated with complaining dealers to establish and enforce the restraint against sales to discount dealers.⁷¹ The Court specifically noted that the evidence showed that one of the purposes of this conspiracy was to protect the complaining dealers from price competition.⁷² After reviewing earlier boycott cases, the Court concluded: "The principle of these cases is that where businessmen concert their actions in order to deprive others of access to merchandise which the latter wish to sell to the public, we need not inquire into the economic motivation underlying their conduct."⁷³ The Court found that General Motors' participation in the boycott was illegal per se.⁷⁴

The extent to which courts will sometimes go to find concerted action is illustrated by *Nurse Midwifery Associates v. Hibbett*.⁷⁵ The plaintiffs, an obstetrician and an association of nurse-midwives, alleged that several hospitals and physicians conspired to prevent them from offering physician-supervised nurse-midwifery services in the Nashville area. The plaintiffs alleged, among other things, that a physician-sponsored medical malpractice insurer cancelled the plaintiffs' obstetrician malpractice policy. Plaintiffs argued that because one of the directors of the insurer was also a Nashville obstetrician who acted in his own economic interest in urging cancellation of the policy, the cancellation constituted a conspiracy under section 1 of the Sherman Act. The court agreed, finding that the director's personal stake in the decision was enough to constitute a conspiracy and denied defendant's motion

70. *Id.* at 136-37.

71. *Id.* at 145.

72. *Id.* at 147.

73. *Id.* at 146.

74. *Id.* at 145; see also *Six Twenty-Nine Prods., Inc. v. Rollins Telecasting, Inc.*, 365 F.2d 478 (5th Cir. 1966) (refusal of television station to accept filmed commercials submitted by advertising agency constituted furtherance of television station's monopoly, in violation of antitrust laws). But see *Carlson Mach. Tools, Inc. v. American Tool, Inc.*, 678 F.2d 1253 (5th Cir. 1982) (manufacturer's negotiations and agreement with a new distributor, prior to changing distributors, does not of itself violate antitrust laws).

75. 1982-83 Trade Cas. (CCH) ¶ 65,040 (M.D. Tenn. 1982).

to dismiss.⁷⁶

Based upon these authorities, it is clear that the exclusion of physicians from an ADS may lead to a group boycott charge if the ADS is provider controlled or the action is undertaken at the request of participating providers. To avoid per se treatment of the decision to exclude certain providers, an ADS should either appoint an independent manager or group to handle the selection process, or sufficiently integrate the practices of the participating providers to constitute a legitimate joint venture.

Under the first alternative, if the ADS is actually organized as a single, independent business which is run by a management entity, it may *unilaterally* decide not to deal with specific providers for virtually any reason. The antitrust laws generally permit a single business enterprise to choose the persons with whom it will deal:

In the absence of any purpose to create or maintain a monopoly, [the Sherman Act] does not restrict the long recognized right of trader or manufacturer engaged in an entirely private business, freely to exercise his own independent discretion as to parties with whom he will deal. And, of course, he may announce in advance the circumstances under which he will refuse to sell.⁷⁷

Although this doctrine has been sharply restricted over the years,⁷⁸ the principle that unilateral refusals to deal do not, without more,

76. See also *American Motor Inns, Inc. v. Holiday Inns, Inc.*, 521 F.2d 1230 (3d Cir. 1975); *Greenville Publishing Co. v. Daily Reflector, Inc.*, 496 F.2d 391 (4th Cir. 1974).

In *Albrecht v. Herald Co.*, 390 U.S. 145 (1968), a newspaper distributor charged the defendant newspaper with participation in a conspiracy in restraint of trade. Discussing the requirement of a combination or conspiracy under § 1 of the Sherman Act, the Supreme Court suggested that the requisite combination could have been found between the newspaper and the distributor's customers, even though the customers did not participate in the anticompetitive practices directed toward the distributor. *Id.* at 150 n.6. Under this expansive interpretation, it is possible that the relationship between an ADS and its providers, by itself, could be claimed to be a combination in restraint of trade. However, subsequent lower court cases have generally interpreted the *Albrecht* decision to mean that the members of a combination must at least have knowledge of the defendant's purpose to restrain trade, and must themselves intend to restrain trade. *Harold Friedman, Inc. v. Kroger Co.*, 581 F.2d 1068, 1074, 1078 (3d Cir. 1978); *Kreuzer v. American Academy of Periodontology*, 516 F. Supp. 1034, 1037-38 (D.D.C. 1981); see also *Interstate Circuit, Inc. v. United States*, 306 U.S. 208, 226-27 (1939) (court found unlawful conspiracy in pre-*Albrecht* case where there was no express agreement, but each party knew others were involved and that cooperation was essential to carrying out scheme); *Glen Eden Hosp. v. Blue Cross and Blue Shield of Mich.*, 740 F.2d 423 (6th Cir. 1984).

77. *United States v. Colgate & Co.*, 250 U.S. 300, 307 (1919).

78. See, e.g., *United States v. Parke Davis & Co.*, 362 U.S. 29 (1960).

constitute antitrust violations, is still very much alive.⁷⁹

Absent unusual circumstances, an independent management's unilateral limitations on the number of providers participating in an ADS should be viewed as procompetitive because such limitations furnish excluded providers with positive incentives to create competing health plans, thereby stimulating competition among providers for the plan's business. When such a plan sells a health care package that includes a designated group of contract providers, it is not boycotting nonparticipating providers. Although competition implies that some competitors will not get the business, and in that limited sense are excluded, this exclusion should result in increased competition at the provider level.⁸⁰ The antitrust laws are, after all, designed to protect competition, not the individual economic well-being of competitors.⁸¹

At some point, of course, an ADS could become sufficiently powerful that non-members would be competitively disadvantaged. In that case, claims of attempted monopolization of essential facilities might be made.⁸² Initially, however, as a health plan struggles to establish itself in the marketplace, a limitation on providers will likely be necessary to supply sufficient incentive for providers to join the plan and for other entirely procompetitive purposes.

Blue Cross of Washington & Alaska v. Kitsap Physicians Ser-

79. See, e.g., *Monsanto Co. v. Spray-Rite Serv. Corp.*, 104 S. Ct. 1464, 1470 (1984); *Russell Stover Candies, Inc. v. FTC*, 1983-2 Trade Cas. (CCH) ¶ 65,640, at 69,246 (8th Cir. 1983); *Hester v. Martindale-Hubbell, Inc.*, 659 F.2d 433, 436 (4th Cir. 1981), cert. denied, 455 U.S. 981 (1982); *Nifty Foods Corp. v. Great Atlantic & Pacific Tea Co.*, 614 F.2d 832, 841 (2d Cir. 1980); *Consolidated Farmers Mut. Ins. Co. v. Anchor Sav. Ass'n*, 480 F. Supp. 640, 649 (D. Kan. 1979).

80. If an ADS is to be successful in reducing health care costs, it can follow one of two basic approaches: (1) seek providers known to be cost effective in delivering health care and/or (2) rely on control mechanisms to eliminate unnecessary services. To restrict an ADS's ability to choose the providers with whom it deals may eliminate one of the most important cost saving features of such a health plan. In fact, the Department of Justice's Antitrust Division recently declared that PPOs should not be overly concerned about excluding physicians or hospitals as participants because the essential feature of a PPO is its selectivity and the primary competitive risks of a PPO are overinclusiveness rather than exclusion. Thus, the Antitrust Division stated that the exclusion of some interested providers will likely promote competition among panels and is a necessary part of the process. McGrath Speech, *supra* note 33.

81. See, e.g., *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477 (1977).

82. See *Associated Press v. United States*, 326 U.S. 1 (1945); *Glen Eden Hosp., Inc. v. Blue Cross and Blue Shield of Michigan, Inc.*, 740 F.2d 423 (6th Cir. 1984). Cf. *Official Airline Guides, Inc. v. FTC*, 630 F.2d 920 (2d Cir. 1980) (sole publisher of airline schedules which failed to include connecting flights charged with monopolization), cert. denied, 450 U.S. 917 (1981).

*vice*⁸³ supports this conclusion. There, a Blue Cross plan established a closed panel HMO (HealthPlus) with a single physicians' clinic as the sole provider under the plan. Blue Cross agreed with the clinic that it would not contract with any other physicians in the area for its HMO until the clinic had taken all the business it wanted or was capable of handling. Blue Cross also required its subscribers to use the medical services of the designated clinic to the exclusion of all other physicians. Kitsap, an open panel HMO and the dominant health insurer in the area, alleged that Blue Cross had engaged in an illegal group boycott of other providers. The court disagreed:

Here, we have a situation where, on one hand, a health insurer offers health insurance to prospective subscribers and, on the other, the insurer contracts with physicians of its choosing to provide medical services to those who subscribe to the service. Neither relationship can be characterized as a "boycott." To be sure the unwillingness of HealthPlus to contract with every physician in the three-county area excludes some physicians from doing business with it. But this hardly constitutes a boycott under federal or state antitrust laws. HealthPlus is free to choose those physicians with whom it will contract.⁸⁴

The appointment of an independent management entity probably offers a significant degree of protection from claims that an ADS's membership decisions constitute a combination or conspiracy of its participating providers. Management should operate autonomously, be independent of providers and, along with the non-provider Board of Directors, be vested with final authority over all policy decisions such as membership and pricing. If implemented unilaterally, virtually any provider mix deemed desirable in the management's independent business judgment should be permissible. For example, participating provider status could be granted to a limited number of physicians or medical groups on a hospital's staff who account for a minimum number of admissions. If there are sound business reasons for management's decision, it should be supportable.⁸⁵ Selection of participating providers also might be

83. 1982-1 Trade Cas. (CCH) ¶ 64,589 (W.D. Wash. 1981).

84. *Id.* at 73,211; see also *Hahn v. Oregon Physicians' Serv.*, 508 F. Supp. 970, 975-76 (D. Or. 1981), *rev'd on other grounds*, 689 F.2d 840 (9th Cir. 1982), *cert. denied*, 103 S. Ct. 3115 (1983).

85. In the absence of business justifications which are reasonable from the ADS's business

made on the basis of reputations, specialties, or other criteria which might enhance the attractiveness of the plan to buyers.

Almost any criteria are possible. The key, however, is that provider membership decisions should be made unilaterally by independent ADS management on the basis of sound business justifications so that, if challenged, any suggestion that the management bowed to provider pressure can be rebutted.

Under the second alternative, the formation of a joint venture through partial integration would subject the ADS's membership decisions to evaluation under the rule of reason. The selection of a limited provider panel should pass muster under the rule of reason unless its purpose is to prevent or decrease competition from other providers, or the ADS contains a sufficiently large percentage of all physicians in the market area and precludes the formation of competing entities by prohibiting its members from affiliating with another ADS.

For example, the FTC recently approved a joint venture HMO/IPA plan involving sixty-five percent of the physicians practicing in the service area, but warned the plan that a requirement that all IPA members deal exclusively with the IPA might be unlawful because it would make it extremely difficult for a new or existing ADS to attract or retain a sufficient physician panel to compete effectively.⁸⁶ Absent these factors, the membership restrictions of the ADS should be lawful because the general purposes of the ADS are to expand the business opportunities of the member providers and to introduce a new competitive entity in the health care field. Furthermore, excluded providers remain free to pursue other available business opportunities, such as by competing for the business of subscribers of traditional insurers or by affiliating with other alternative health care plans. Thus, excluded providers are not deprived of essential trade relationships.

perspective, an inference of provider influence over this type of restriction might be overwhelming. However, the interests of the ADS and providers are not necessarily divergent. For example, the ADS management might independently conclude that for the efficient operation and marketability of the plan it is necessary to admit doctors who later become affiliated with other participating medical groups and who will have to provide coverage for that group's patients.

86. FTC Letter—Frimet, *supra* note 55; see also FTC Policy Statement, *supra* note 42, at 48,991. The Antitrust Division of the Department of Justice also recently commented that it will closely examine provider-sponsored PPOs which inhibit the freedom of providers to associate with other health plans. McGrath Speech, *supra* note 33.

III. CONCLUSION

The basic message of the Supreme Court's decision in *Maricopa* is that the per se rules of antitrust liability apply to joint activities of competing providers and that the health care industry will not receive special consideration. Many provider-sponsored or controlled ADSs are legally suspect after *Maricopa* because they may be viewed as a combination of otherwise competing, independent physicians.

In order to avoid price-fixing liability, an ADS has two principal options. First, it can establish its fee and reimbursement structure through an independent management entity which would market, manage and operate the ADS, or it can retain a consultant for the specific purpose of setting the fee schedule. The ADS's independent management entity should enter into bilateral contracts with individual participating physicians, and the physicians should not have access to or review of the fees offered by contracting providers. The ADS's board of directors should be vested with final authority over policy decisions such as the fee structure and membership and should be composed of non-providers. Participating providers could still serve on an Advisory Council and comment on the ADS's reimbursement policy, but the key point is that the management entity should be independent of the providers and the providers should not control the fee setting mechanism.

Second, *Maricopa* suggests that another method of avoiding price-fixing liability is to partially integrate the practices of the providers and create a joint venture. A partially integrated health care plan results when the participating providers centralize some of their functions, such as marketing, billing and debt collecting, and enter into a financial arrangement for sharing the risk of loss. If the ADS can sufficiently integrate the practices of its providers and arrange for risk-sharing, it should be treated as a joint venture and thus analyzed under the rule of reason, rather than the per se rule. Joint ventures are generally found to be lawful under the rule of reason because they create a new competitive entity and tend to enhance competition. The fee setting activity of the ADS, when viewed as a joint venture, should be upheld if it is needed to market the plan to third-party payors, the market share of the participating providers is not substantial, and the providers do not have the purpose of suppressing competition from other providers. However, the degree of integration of functions and risk sharing

needed to constitute a joint venture and take the health care plan out of the per se area remain unclear.

The other area of potential liability for an ADS is a claim by excluded providers that participating providers engaged in a group boycott or a concerted refusal to deal with them. Such a claim could arise if there is provider control of the ADS or the membership decision is made as a result of a request or influence from participating providers. One way for an ADS to reduce its antitrust liability is to appoint an independent manager or group to handle the provider selection process. The ADS's management should operate independently of the providers and use sound business considerations in making its membership decisions. The ADS's refusal to deal with certain providers can be lawful if it is done unilaterally by the ADS management entity and is based upon proper business judgments.

Alternatively, the formation of a joint venture through sufficient integration of functions and sharing of risks should allow the ADS's membership decisions to be evaluated under the rule of reason. The exclusion of providers from the ADS should be reasonable unless its purpose is to decrease competition from other providers or the ADS has substantial market power so that it effectively prevents the formation of competing plans. In the absence of these factors, the selection of a limited provider panel should be valid under the rule of reason because an ADS's entry in the market increases competition and excluded providers are able to join or form other alternative health care plans.