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LEGAL ISSUES IN CREATING PPOs:*

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I. INTRODUCTION

The development of alternate health care delivery and reimbursement mechanisms, particularly those known as "Preferred Provider Organizations" (PPOs)¹, raise a multitude of legal issues. Each PPO will exist in different market conditions and under different state laws. Therefore, while this Article seeks to identify and discuss the legal issues, it cannot provide definitive answers. This Article can, however, serve as a guideline or checklist for PPO analysis and provide recommendations and alternatives for dealing with the legal roadblocks that occur in the formation and operation of PPOs. This discussion will be general in nature and cannot substitute for legal advice regarding any particular factual situations encountered.

II. ANTITRUST CONSIDERATIONS

The emergence of alternative mechanisms such as PPOs represents one innovative response to the competitive and financial pressures currently experienced by health care providers. As a result of the new economic pressures and the new approaches designed to counter those pressures, the health care industry has witnessed increased activity in the area of antitrust litigation. These challenges arise when existing business enterprises form new cooperative business ventures.

Alternative delivery systems, including PPOs, are composed of independent providers who are traditionally competitors or potential competitors. These competitors or potential competitors are now combining in cooperative business ventures. The formation of cooperative business ventures among competitors will result in careful scrutiny by other business entities and by federal and state governments who might view the combination as an unreasonable restraint of trade in violation of antitrust laws. Antitrust challenges are costly to defend. Under civil law, the risks of being found in violation of the antitrust laws are heightened by the possibility of treble damages and, under criminal law, by possible fines and imprisonment. This area requires careful analysis by those considering the establishment of a PPO.

¹ Preferred Provider Organizations (PPOs) are organized systems of health care providers, operating through contracts with payors (such as employers, insurers, or union trust funds), to provide comprehensive health care services to subscribers, generally on a fee-for-service basis. Incentives are provided to patients and payors to utilize PPO member physicians and hospitals. In turn, the providers anticipate the ability to maintain or increase their market share of patients. *See generally* D. COWEN, *PREFERRED PROVIDER ORGANIZATIONS* 3-11 (1984). *See also* Larson, *Do PPOs Practice Quality Medicine?*, 25 *PHYSICIAN'S MGMT.* 297 (1985).

Although PPOs are frequently confused with Health Maintenance Organizations (HMOs), there are significant differences. In general, an HMO is a system of health care delivery and financing which provides health services to voluntarily controlled members who pay a fixed annual or periodic fee. AMERICAN MEDICAL ASSOCIATION, *REPORT OF THE COUNCIL ON MEDICAL SERVICE* (1980). For a definition of a federally qualified HMO see 42 U.S.C. § 300e (1976).

A. *Antitrust Statutes*

The Sherman Antitrust Act² provides the principal basis for antitrust scrutiny of PPOs. Section 1 of the Sherman Act prohibits contracts, agreements, combinations, or conspiracies in restraint of trade. The courts have found such restraints to include price fixing,³ group boycotts,⁴ tying arrangements,⁵ division of markets,⁶ and customer allocation.⁷ Section 2 of the Sherman Act proscribes monopolization as well as attempts and conspiracies to monopolize. Violation of the Sherman Act is a felony and carries a fine of up to \$100,000 or imprisonment for up to three years for an individual, and a fine of up to \$1 million for a corporation. Civil remedies under the Act include treble damages to a private claimant, punitive damages, recovery of plaintiff's costs and reasonable attorneys' fees, and injunctive relief.⁸

Section 5 of the Federal Trade Commission Act⁹ prohibits unfair methods of competition, which have been held to encompass not only all Sherman Act and Clayton Antitrust Act¹⁰ violations but also any restraint of trade contrary to the policy and spirit of those laws.¹¹

The Clayton Act is less likely to pose problems for PPO formation, as most of its provisions relate to sales of commodities rather than to the provision of services as generally contemplated by PPOs. Nevertheless, any PPO must be analyzed in light of section 7 of the Clayton Act,¹² which governs mergers, acquisitions, and joint ventures in restraint of trade.

State antitrust statutes are frequently analogous to federal antitrust laws with respect to the practices they prohibit and the penalties imposed. Some state anti-

² 15 U.S.C. § 1 (1982) (original version at Ch. 647, § 1, 26 Stat. 209 (1890)).

³ *Arizona v. Maricopa County Medical Soc'y*, 457 U.S. 332 (1982); *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150 (1940). See also R. BORK, *THE ANTITRUST PARADOX* 267 (1978) (a finding that the price fixing agreement is ancillary to an integration of productive capacity may save a particular practice from per se proscription).

⁴ *Klors, Inc. v. Broadway-Hale Stores, Inc.*, 359 U.S. 207 (1959).

⁵ *Jefferson Parish Hosp. Dist. v. Hyde*, _____ U.S. _____, 104 S. Ct. 1551 (1984); *International Salt Co. v. United States*, 332 U.S. 392 (1947).

⁶ *United States v. Topco Assocs.*, 405 U.S. 596 (1972). See also *United States v. Cadillac Overall Supply Co.*, 1978-1 Trade Cas. (CCH) ¶ 61,892 (5th Cir. 1978); L. A. SULLIVAN, *HANDBOOK OF THE LAW OF ANTITRUST* 225 (1977).

⁷ *White Motor Co. v. United States*, 372 U.S. 253 (1963). See R. POSNER, *ANTITRUST LAW: AN ECONOMIC PERSPECTIVE* 162 (1976).

⁸ 15 U.S.C. § 15(a) (1982).

⁹ 15 U.S.C. § 45 (1982) (original version at Ch. 311, § 5, 38 Stat. 719 (1914)).

¹⁰ 15 U.S.C. § 13 (original version at Ch. 323, § 2, 38 Stat. 730 (1914)).

¹¹ See *FTC v. Brown Shoe Co.*, 384 U.S. 316 (1966) (rejecting notion that FTC only had power to prohibit outright violations of Clayton or Sherman Acts, where defendant had effectively foreclosed its competitors from shoe market).

¹² 15 U.S.C. § 18 (1976).

trust statutes, however, have different requirements and govern different conduct than do the federal laws.¹³

B. Federal Antitrust Jurisdiction

Prior to the consideration of an antitrust complaint under federal law, a court must determine if a defendant's activity falls within the federal jurisdictional requirements. An antitrust complaint must contain allegations that the plaintiff's business is in, or affects, interstate commerce and that either the defendant's general business activity or the specific challenged activity substantially affects interstate commerce. Traditionally, health care providers and members of the "learned professions" successfully argued that their business or practices were local in character and that any effect on interstate commerce was incidental and remote.¹⁴ Recent Supreme Court decisions, however, many involving health care providers, indicate that a defense based on the absence of impact on interstate commerce may not exempt conduct from federal antitrust statutes.¹⁵

C. Methods of Case Analysis

The Supreme Court has held that, while most restraints of trade must be analyzed in terms of the nature, purpose, and effect of the restraint, some types of restraints are so inimical to competition and so unjustified that they are conclusively presumed to be illegal. These restraints are called *per se* violations. They require no inquiry into their effect on competition or their business justification. *Per se* violations include price fixing, group boycotts, division of markets, and tying arrangements.¹⁶

In situations where restraints of trade other than *per se* violations are involved, the legal analysis follows the rule of reason approach. The rule of reason tests an alleged restraint of trade to determine whether it promotes, suppresses, or

¹³ In Texas, for example, an illegal trust is defined as a combination of capital, skill, or acts by two or more persons to "fix, maintain, increase or reduce the . . . cost of insurance . . ." TEX. BUS. & COMM. CODE ANN. Art. 15.02(b)(2) (Vernon 1968). Unless this provision were construed to refer only to the price of insurance premiums, a PPO could be held to violate the terms of this statute. Texas courts have not construed this provision so narrowly, applying the prohibition to any combination that affects insurance costs. See *Commercial Standard, Inc. v. Board of Ins.*, 34 S.W.2d 343 (1931). The Texas law serves as an example of why creators of PPOs must consult and comply with the antitrust laws of each state in which the PPO or its member organizations do business or, in the case of physicians, each state in which they are licensed to practice medicine.

¹⁴ E.g., *United States v. Oregon State Medical Soc'y*, 343 U.S. 326, 338-39 (1952).

¹⁵ See *Hospital Bldg. Co. v. Trustees of Rex Hosp.*, 425 U.S. 738 (1976); *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975); *Cardio-Medical Assoc. v. Crozer-Chester Medical Center*, 552 F. Supp. 1170 (E.D. Pa. 1982), *rev'd in part*, 721 F.2d 68 (3d Cir. 1983).

¹⁶ See *Northern Pac. Ry. v. United States*, 356 U.S. 1 (1958).

destroys competition. The court considers the facts peculiar to the challenged activity, the nature of the restraint and its probable effect on competition, and other relevant information necessary to determine whether the conduct is, in fact, anticompetitive.¹⁷ The courts have not established a special standard for the analysis of the activities of health care providers.

D. Potential Substantive Antitrust Violations

1. Price Fixing

Inherent in the formation of most PPOs is the creation of contractual arrangements among physicians, hospitals, payors, and employers. These agreements raise the concern that they could be viewed under antitrust theory as evidence of concerted activity among competing or potentially competing entities. These activities may be viewed as restricting price, quality, or service in an anticompetitive manner. The antitrust issue most frequently raised when analyzing a PPO is the claim that the participating providers are engaged in illegal price fixing. As noted earlier, price fixing is per se unlawful. Price fixing may be found in agreements to charge uniform prices, set minimum or maximum prices, employ uniform discount or credit policies, or share pricing information.

The Supreme Court, however, in *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*¹⁸ and other cases, has indicated that the per se rule does not necessarily apply to each instance of literal price fixing among competitors. The Court has distinguished between agreements whose predominant purpose is the suppression of price competition and those in which the price restraint is incidental to some otherwise valid business purpose. Therefore, the method by which a restraint is characterized is crucial. Those agreements found to be "naked" price fixing arrangements are unlawful per se, where agreements in which price restraint is "ancillary" to a valid purpose are judged under the rule of reason. Rule of reason analysis permits courts to determine whether an arrangement tends to promote competition despite the existence of a price restraint. Thus, PPO agreements which satisfy the *Broadcast Music* predominant - purpose test will possibly be analyzed under the more-easily-met rule of reason standard.

The Supreme Court also considered in two recent cases the possibility that a traditional per se analysis might not be applied to members of the learned professions. In *Goldfarb v. Virginia State Bar*, the Court, in dicta, advanced the possibility that the professions may be "treated differently" than other occupations;¹⁹ in *National Society of Professional Engineers v. United States*,²⁰ the Court noted that professional services "differ significantly from other business

¹⁷ *Chicago Bd. of Trade v. United States*, 246 U.S. 231, 238 (1918).

¹⁸ 441 U.S. 1 (1979).

¹⁹ 421 U.S. at 788 n.17.

²⁰ 435 U.S. 679 (1978).

services."²¹ Nevertheless, the holdings in these cases indicate that at least price fixing activities by the learned professions would be scrutinized under the per se rule.

The extent of these decisions was subject to debate after the Supreme Court decided *Arizona v. Maricopa County Medical Society*.²² *Maricopa* involved agreements among physician members of medical care foundations to accept no more than predetermined maximum prices as full payment for services rendered to policyholders of foundation-approved insurance plans. The Court held that such agreements were per se price fixing violations.

In *Maricopa*, organizations composed of and controlled by seventy percent of the physicians in the geographic area canvassed their members to determine what would constitute an acceptable fee schedule. This market dominance, while not relied upon by the Court, is noteworthy. It enabled these competitors "to sell their services to certain customers at fixed prices and arguably to affect the prevailing market price of medical care."²³ The restraint was not "ancillary" to a valid arrangement but rather "fit squarely in a horizontal price fixing mold."²⁴

The Court rejected the defendants' arguments that the public service and professional aspects of health care delivery entitled them to a special exemption from the per se standard. The Court was not persuaded that a different standard should be applied because "cost containment" was an objective of the agreements.²⁵ It found the fixing of maximum prices to be as objectionable as the fixing of minimum prices. "In this case, the rule is violated by a price restraint that tends to provide the same economic rewards to all practitioners, regardless of their skill, their experience, their training, or their willingness to employ innovative and difficult procedures in individual cases."²⁶

A careful review of the *Maricopa* decision and its underlying facts, however, suggests that not all agreements that have price fixing components will inevitably be subject to the per se standard. In *Maricopa* the Court could not find a way in which the scheme would enhance competition or foster efficient service. The fee arrangements in *Maricopa* were not ancillary to any other lawful foundation activities. The foundation did not sell insurance or otherwise market health care services, nor were the fee schedules essential to other foundation activities, such as utilization review or claims administration. They merely established a price schedule to be followed by existing insurers in paying providers, with no resultant procompetitive effect. Further, the arrangement in *Maricopa* was not established to permit competing practitioners to offer a product different from the product which could be offered absent the combination agreement; neither did it provide for capital pooling and risk sharing by the competitors, as in a partnership or joint venture. Instead, the Court found that

²¹ *Id.* at 696.

²² 457 U.S. 332 (1982).

²³ *Id.* at 356.

²⁴ *Id.* at 357.

²⁵ *Id.* at 351 (cost containment was an objective of the agreements).

²⁶ *Id.* at 348.

the combination has merely permitted [the physicians] to sell their services to certain customers at fixed prices and arguably to affect the prevailing market price of medical care . . . The agreement . . . is [one] among hundreds of competing doctors concerning the price at which each will offer his own services to a substantial number of consumers.²⁷

The *Maricopa* decision suggests a business organization spectrum. At one end of the spectrum is the professional corporation (i.e., of physicians), at the other end is the entity in *Maricopa*. Professional corporations, by statutory definition, pool capital and share risks. The *Maricopa* entity, however, did not pool capital, or share the risks of the venture. Its price fixing was a naked restraint, not ancillary to any other lawful activities. Significantly, the Court stated that

each of the foundations is composed of individual practitioners who compete with one another for patients. Their combination . . . does not permit them to sell any different product. The foundations are not analogous to . . . other joint arrangements in which persons who would otherwise be competitors pool their capital and share the risks.²⁸

For a cooperative business venture to avoid per se antitrust analysis and fall within the purview of the rule of reason, it must resemble a traditional business entity as much as possible. The cooperative business venture should be established to offer a different, better product than that offered by the participants individually, and the participants should pool capital and share the risks of the venture.

It is not yet clear what ultimate effect *Maricopa* will have on PPOs and other alternate health care provider arrangements in analyzing antitrust issues in general and traditional per se violations in particular. The Court forcefully rejected arguments for carving out an exception to per se treatment merely because of the unique nature of the health care industry.²⁹ These points suggest an expansive reading of *Maricopa* in assessing its application to the health care industry and to PPOs specifically.

On the other hand, the case was decided by a narrow 4-3 margin, with three vigorous dissents. Most significantly, the business organization in *Maricopa* differs markedly from that of a properly crafted PPO. Using the guidance provided in *Maricopa*, PPOs, if organized as cooperative business ventures between hospitals or hospital groups and members of their medical staffs, may minimize antitrust exposure if they structure the venture substantially as follows:

- the participants pool their capital and share the risk of loss in the venture;

²⁷ *Id.* at 355-57.

²⁸ *Id.* at 357.

²⁹ The *Maricopa* defendants failed to convince the Court of the validity of their position by arguing that the industry is relatively removed from the competitive model, is the object of statutory and voluntary cost containment efforts, is an industry with which the judiciary has had little antitrust experience, and which is composed of professions historically immune from such a high degree of antitrust scrutiny. *Id.* at 348-50.

- each participant has the opportunity to profit from the venture;
- the PPO does not include a high proportion of area physicians;
- the ultimate authority to set the fee schedule is in the hands of the cooperative business venture and not the physicians;
- the cooperative business venture is not subject to unilateral control by the physician competitors;
- the PPO physician fee component of the total discount package is negotiated by the PPO separately with each buyer.

If a PPO is so structured, it appears to avoid the pitfalls of *Maricopa*. Further, if the PPO is a new and perhaps *better* entrant in the health care delivery market and exhibits these characteristics, the price arrangements that accompany the formation and operation of the PPO will probably be viewed as ancillary in nature and subject to examination under the rule of reason.

2. Group Boycotts; Refusals to Deal

A second potential basis for antitrust liability is the theory of the group boycott or concerted refusal to deal. A refusal to deal arises where an entity is deprived of suppliers, customers, or other essential trade relationships by concerted action among other entities designed to keep the target from competing in the marketplace. Such activity is generally viewed as a per se violation of the antitrust laws.³⁰

Group boycotts must be distinguished from unilateral refusals to deal. A unilateral refusal to deal is a decision by only one person or entity. Such a refusal has been held to be lawful provided it is not in furtherance of any other anticompetitive purpose and is supported by legitimate business reasons.³¹ Nevertheless, even unilateral refusals to deal may be unlawful. In *United States v. Parke, Davis & Co.*,³² Parke, Davis claimed it did no more than maintain resale prices solely through unilateral refusals to deal with noncomplying customers. The Court, however, reviewing a panoply of actions designed to coerce resale price maintenance, concluded that Parke, Davis had embarked on a program to "effect adherence to his resale prices, . . . [forming] a combination [among itself and complying customers] in violation of the Sherman Act."³³

Many group refusals to deal are upheld upon a finding that the refusal is intended to advance the group's economic interests and not to adversely affect competition. In such cases, where an exclusionary intent is not apparent and the restrictive result is ancillary to the valid business purpose, the courts tend to employ a rule of reason approach.³⁴ The most likely source of a group boycott claim is a provider excluded or terminated from membership in the PPO.

³⁰ *United States v. General Motors Corp.*, 384 U.S. 127 (1966).

³¹ *United States v. Colgate & Co.*, 250 U.S. 300 (1919), *Hawaiian Oke & Liquors, Ltd. v. Joe E. Seagram & Sons*, 416 F.2d 71 (9th Cir.), *cert. denied*, 396 U.S. 1062 (1970).

³² 362 U.S. 29 (1960).

³³ *Id.* at 44.

³⁴ *See, e.g., Jefferson Parish Hosp. Dist. v. Hyde*, _____ U.S. _____, 104 S. Ct. 1551 (1984); *Arizona v. Maricopa County Medical Soc'y*, 457 U.S. 332 (1982).

However, the PPO may exclude or terminate a provider so long as the PPO contracts define objective standards and reasons for termination or nonappointment and the motive for such exclusion is not anticompetitive.³⁵ The guidelines for such provisions should be based on objective criteria other than economic concerns and should be the least restrictive alternative available to accomplish the PPO's legitimate goals. Articulated and consistently applied criteria such as quality of care or the physical limitations of the PPO and its institutional members should survive judicial scrutiny. For example, credentials requirements may be applied in selecting PPO participants if the intent and effect of the requirements are to ensure the efficient rendering of quality patient care and the availability of necessary medical services.³⁶ Restrictions pertaining to the number of physicians permitted to participate in the PPO may be established if the physical structure of the PPO is self-limiting, or if the hospital(s) involved in the PPO can only service a limited volume of patients.³⁷

PPO market share in each health care delivery market will determine whether a refusal to deal is so anticompetitive that it must be analyzed under the per se rule. The greater the PPO's market share, the more sensitive the PPO must be in establishing objective criteria for excluding or terminating physicians. If a PPO possesses a substantial majority of the market (e.g., if sixty percent of the patients in the service area are subscribers, or if seventy-five percent of the admitting hospitals are members) and it is clear that there is tangible economic benefit to participation in the PPO, exclusion or termination of providers from the PPO will be scrutinized more closely. In such a situation, the exclusion must be carefully supported by objective criteria set forth in the PPO contractual arrangement to insure that the overall effect of such provisions are not anticompetitive.

Practical measures that should be considered in avoiding antitrust liability for concerted refusals to deal include: 1) objective standards for the appointment of providers to the PPO; 2) comprehensive due process protections for providers challenging exclusions or terminations from the PPO. Such process should include the right to notification of a denial, an explanation of the reasons for denial, the right to a hearing, and a decision on the record of the hearing examiner or committee; and 3) a vote by a nonbiased hearing examiner or, preferably, a vote by a committee composed of individuals other than potential competitors of the provider under scrutiny.³⁸ Conversely, the criteria should

³⁵ Hoffman v. Delta Dental Plan, 517 F. Supp. 564 (D. Minn. 1981).

³⁶ See Robinson v. Magovern, 521 F. Supp. 842, 844-46 (W.D. Pa. 1981), *aff'd*, 688 F.2d 824 (3d Cir.), *cert. denied*, 459 U.S. 971 (1982).

³⁷ See Deeson v. Professional Golfers' Ass'n of Amer., 358 F.2d 165 (9th Cir.), *cert. denied*, 388 U.S. 846 (1966) (professional association entitled to adopt reasonable measures to restrict size, although required to treat participants in same category equally).

³⁸ Silver v. New York Stock Exchange, 373 U.S. 341 (1963). Antitrust implications arise from failing to inform applicants of evaluation criteria, even if objective. An applicant who has access to inside information about the application process, or who is

not function to exclude, for example, entire classes of licensed primary care providers such as osteopaths,³⁹ nor should it condition PPO membership on membership in a particular professional association.⁴⁰ Proper written contracts, procedures, memoranda, and communications are essential in establishing the absence of an anticompetitive motive.

Recent cases have indicated that even where competitors of the excluded provider-selected provider members, the rule of reason dictates that no cognizable boycott claim arises when competitors are merely denied equal access to a PPO.⁴¹

The relative market share of the entity that excludes the practicing professional is also significant.⁴² One traditional antitrust theory holds that an otherwise defensible activity may be found to be an unlawful concerted refusal to deal where a market is so small that denying access to a facility is tantamount to closing the market to the applicant.⁴³ This so-called essential facilities doctrine provides, in essence, that where facilities cannot practically be duplicated by would-be competitors, those in possession must allow the facilities to be shared on fair terms. It is an illegal restraint of trade to foreclose the use of a scarce facility. An essential facility is not necessarily defined as indispensable. It is sufficient if duplication of the facility would be economically infeasible and if the denial of access will inflict a severe handicap on a potential market entrant.⁴⁴

Thus, practices that have the effect of excluding providers from PPO participation will not always result in group boycott violations. Where the PPO

already familiar with it, will have an advantage over one not privy to such information. Any action failing to accord procedural safeguards may result in the imposition of liability. In such a case, the court will not inquire into the reasons behind the organization's decision. Instead, the court will rely on the well-settled "recognition that the according of fair procedures is of fundamental significance, that serious and irreversible economic injury may result from their denial," *id.* at 365, and that any later review of the substantive basis of the decision cannot adequately establish what the outcome would have been absent the unfair process. *Id.* See also, *Robinson*, 521 F. Supp. at 896-97 and 916-17; *Pontius v. Children's Hosp.*, 552 F. Supp. 1352 (W.D. Pa. 1982).

³⁹ See *Weiss v. York Hosp., Inc.*, 548 F. Supp. 1048 (M.D. Pa. 1982).

⁴⁰ See *Boddiker v. Arizona State Dental Ass'n*, 680 F.2d 66 (9th Cir.), *cert. denied*, 459 U.S. 837 (1982).

⁴¹ *Feminist Women's Health Center v. Mohammad*, 586 F.2d 530 (5th Cir. 1978). The Fifth Circuit acknowledged that standards of ethical and professional responsibility should be governed by the rule of reason absent a showing of minimal indicia of anticompetitive purpose. *Id.* at 546. Crucial to the defense of the professional standards for selection would be the genuineness of the justification, the reasonableness of these standards themselves and the manner of their enforcement. However, actions of coercion or intimidation that extend beyond the professional standards should not be governed by the rule of reason but rather by the per se rule. *Id.* at 547.

⁴² *Id.*

⁴³ See *Otter Tail Power Co. v. United States*, 410 U.S. 366 (1973); L.A. SULLIVAN, *HANDBOOK OF THE LAW OF ANTITRUST* 131 (1977).

⁴⁴ See *Hecht v. Pro-Football, Inc.*, 570 F.2d 982 (D.C. Cir. 1977), *cert. denied*, 436 U.S. 956 (1978). *But see Pontius v. Children's Hosp.*, 552 F. Supp. 1352 (W.D. Pa. 1982) (doctrine expressly rejected in context of denial of hospital staff privileges).

does not possess excessive market power, liability may be avoided. Further, if the purpose of the rejection of certain providers is not to exclude those providers from essential trade relationships, a group boycott may not exist. The expansion of business opportunities, promotion of efficiency, and enhancement of professional competency of the PPO through its member professionals are all permissible motives for practices whose effects are exclusionary.

3. Exclusive Dealing

Agreements between providers and PPOs may give rise to an additional antitrust violation commonly referred to as exclusive dealing. Exclusive dealing arrangements ordinarily arise in situations in which a supplier of a product (e.g., the provider or PPO) prohibits a purchaser (e.g., the PPO or payor, respectively) from handling competing products. Conversely, it may also occur where the purchaser (PPO) prohibits the supplier (provider) from performing services for other purchasers. Generally, exclusive dealing contracts have been viewed by the courts as governed by the rule of reason standard unless the exclusive dealing is in furtherance of some other restraint of trade. Factors such as the duration of the contract and the extent of the foreclosure of the competitive market have been deemed significant in assessing the legality of the arrangement.⁴⁵

In the PPO context, the issue of exclusive dealing arrangements may be raised where a PPO contractually prohibits a provider from dealing with other health care delivery systems. These arrangements are generally considered to be without a significant purpose other than diminishing competition and, as such, tend to be viewed as per se violations of antitrust law. Of more concern is the more common practice of a PPO or PPO-related organization entering into an exclusive agreement with one or a limited number of providers or provider groups to the exclusion of other providers. This situation has been discussed in terms of the objective criteria that should be applied to such decisions. However, the factual context also raises the possibility that such agreements are exclusive arrangements in violation of section 1 of the Sherman Act. Numerous courts have found that such exclusive arrangements, at least in the hospital context, are permissible under the rule of reason analysis. The courts have held that the anticompetitive effect of excluding providers who have not contracted with the hospital is outweighed by the benefits of efficiency, availability, and responsiveness; such decisions recognize that considerations

⁴⁵ See *Tampa Elec. Co. v. Nashville Coal Co.*, 365 U.S. 320, 327-28 (1961) (determination must involve type of goods and degree of market foreclosure in relation to market size); *Standard Oil Co. v. United States*, 337 U.S. 293 (1949) (finding that competition has been foreclosed and a substantial share of commerce affected satisfies requirement that contract substantially reduced competition).

related to economics and the quality of care may be more effectively addressed through the exclusive arrangement.⁴⁶

Once again, the creators of a PPO must be mindful of the danger underlying such exclusive arrangements. Once the market share foreclosed by the exclusive arrangements reaches a critical level in the view of a court, the arrangement will be more closely scrutinized for potential anticompetitive effects.⁴⁷ Similarly, where a PPO establishes an exclusive contract or such an agreement is made by all or a substantial majority of admitting hospitals, or by one group practice of specialists, an excluded provider of that specialty may be successful in alleging unlawful exclusive dealing since the market share circumscribed by the arrangement could be substantial.

4. Monopolization

Section 2 of the Sherman Act sets forth three separate offenses regarding monopolies: monopolization, attempted monopolization, and conspiracy to monopolize. Unlike section 1, which requires an agreement between separate entities to establish a violation, section 2 creates liability for acts undertaken by one entity alone. Claims against a PPO and its member provider institutions alleging all three section 2 offenses may be made by physicians and other practitioners who are denied access to hospital facilities by virtue of termination or denial of staff privileges. The excluded practitioner might attempt to show that the PPO and its members have monopolized, attempted to monopolize, or conspired to monopolize that practitioner's specialty area by refusing to provide access to hospital or PPO member facilities.

PPO agreements which prevent providers from joining other PPOs, or require providers to use PPO facilities for medical services that can be performed outside the PPO member institutions, could raise questions of the PPO's monopolization or attempted monopolization of the market for those services. The antitrust result in these circumstances would depend on the PPO's ability to demonstrate that the exclusionary act is justified by some independent pro-competitive interest and is not the result of monopolization or an attempt to monopolize the market for those services.⁴⁸

⁴⁶ See, e.g., *Jefferson Parish Hosp. Dist. v. Hyde*, _____ U.S. _____, 104 S. Ct. 1551 (1984) (O'Connor, J., concurring); *Dos Santos v. Columbus Cuneo-Cabrini Medical Center*, 684 F.2d 1346 (7th Cir. 1982); *Harron v. United Hosp. Center Inc.*, 522 F.2d 1133 (4th Cir. 1975), cert. denied, 424 U.S. 916 (1976).

⁴⁷ See *Tampa Elec. Co. v. Nashville Coal Co.*, 365 U.S. 320 (1961) (coal requirements contract for \$128 million over 20 years not unlawful); cf. *Standard Oil Co. v. United States*, 337 U.S. 293 (1949) (exclusive arrangement foreclosing 65% of oil market unlawful).

⁴⁸ The current test for monopolization is that the entity under scrutiny "(1) possess monopoly power in the relevant market and (2) willfully acquire or maintain that power as distinguished from its growth or development as a consequence of a superior product, business acumen or historic accident." *United States v. Grinnell Corp.*, 384 U.S. 563, 570-71 (1976). An attempt to monopolize requires a specific intent to do so, and the fact that the defendant has come dangerously near to achieving the unlawful

Increasing market share by making participation in an arrangement more attractive than nonparticipation does not imply a specific intent to monopolize.⁴⁹ Whatever percentage share of the market a PPO gains by such agreements is not in itself sufficient to establish the requisite specific intent for an attempt to monopolize.

E. Possible Antitrust Defenses

1. Learned Professions Exemption

Participation in a "learned profession" was a ground for antitrust immunity until the Supreme Court's decisions in *Goldfarb v. Virginia State Bar*,⁵⁰ and *National Society of Professional Engineers v. United States*,⁵¹ which held professionals to the same standards as other commercial entities for antitrust purposes. It is abundantly clear that the health care industry and its various components are no longer immune from antitrust scrutiny. Supreme Court decisions have made it plain that courts are no longer reluctant to intrude into the activities of the learned professions and their associations and organizations.

2. State Action Exemption

The Supreme Court in *Parker v. Brown*⁵² held that a state's raisin marketing program that restricted competition was not covered by the antitrust laws. The Court stated that the Sherman Act prohibited individual acts, not state acts.⁵³ After *Parker*, courts generally applied a blanket antitrust exemption to activities dictated by or closely regulated by the states. Recent decisions, however, have limited *Parker's* application. In *Goldfarb*, the Court held that a bar association's minimum fee schedules were illegal, rejecting the state action defense. The Court determined that although the Supreme Court of Virginia regulated the practice of law, it had not acted specifically to fix fees.⁵⁴ In *Cantor v. Detroit Edison Co.*,⁵⁵ the Court held that Detroit Edison illegally had tied sales of electricity and light bulbs. The Court rejected the argument that since the provision of free light bulbs was approved by the state, the practice was thereby exempt as state action. Most recently, in *Community Communications Co. v.*

monopolization. *Lorain Journal v. United States*, 342 U.S. 143, 153 (1951). A substantial amount of one element often substitutes for a lesser quantity of the other element under both monopolization, *see, e.g.*, *United States v. Aluminum Co.*, 148 F.2d 416, 429-33 (2d Cir. 1945), and an attempt to monopolize, *Lessig v. Tidewater Oil Co.*, 327 F.2d 459 (9th Cir.), *cert. denied*, 377 U.S. 993 (1964).

⁴⁹ *Hoffman v. Delta Dental Plan*, 517 F. Supp. 564 (D. Minn. 1981) (PPO's agreed discount rate can be marketing device to increase market share, not strategy to destroy competitors).

⁵⁰ 421 U.S. 773 (1975).

⁵¹ 435 U.S. 679 (1978).

⁵² 317 U.S. 307 (1943).

⁵³ *Id.* at 351-52.

⁵⁴ 421 U.S. at 788-89.

⁵⁵ 428 U.S. 579 (1976).

City of Boulder,⁵⁶ the Supreme Court held that the state action doctrine does not extend to municipal subdivisions. In that case the Court stated that the state action doctrine exempts only conduct engaged in as an act of government, or acts undertaken pursuant to state policy where the state policy is "clearly articulated and affirmatively expressed."⁵⁷

Despite the limits, the state action exemption to antitrust law has continuing validity, especially with regard to the delivery of health care services. Providing, reducing, or expanding health care services is pervasively regulated by state and federal law and agency rule. For example, state Certificate of Need (CON) laws and state acts under the National Health Planning and Resources Development Act of 1974⁵⁸ enable states to enact their legitimate interests in the delivery of health care services. Recent cases have held or suggested that the state action defense may be available in a variety of circumstances. For example, in *Phoenix Baptist Hospital & Medical Center v. Samaritan Health Services*,⁵⁹ participation by a competitor hospital in CON hearings, pursuant to a clearly expressed state policy and an actively supervised regulatory scheme, constituted state action rendering its activities immune from antitrust scrutiny. In *Gambrel v. Kentucky Board of Dentistry*,⁶⁰ the dental association refused to give denture prescriptions and laboratory work orders directly to patients where such action was prohibited by state law under its valid exercise of police power. This conduct was found to be exempt from antitrust scrutiny based on the state action exemption. This line of cases provides support for the proposition that a PPO will be exempt from antitrust review under the state action exemption if it was created pursuant to a clearly articulated state mandate, evidenced by a pervasive regulatory scheme, or where the activities of the PPO are regulated pursuant to state law, policy, or rules such as CON regulations.

Health planning laws and regulations, however, do not create a blanket antitrust immunity for the planning and CON processes. The Supreme Court, in *National Gerimedical Hospital v. Blue Cross of Kansas City*,⁶¹ reviewed the actions of defendant Blue Cross, which refused membership to the complaining hospital because the hospital had not obtained a certificate of need for its construction. Blue Cross based its defense on antitrust immunity provided under the health planning laws. The Supreme Court held that the planning act granted no such immunity and that Blue Cross would have to defend the antitrust charges on the merits. The Court, reiterating the rule expressed in *Silver v. New York Stock Exchange*,⁶² stated that where, for example, a state health planning agency has expressly urged a form of cost-saving cooperation among providers, antitrust immunity may be "necessary to make the [National Health Planning Act]

⁵⁶ 455 U.S. 40 (1982).

⁵⁷ *Id.* at 52 (emphasis added). See also *City of LaFayette v. Louisiana Power & Light Co.*, 435 U.S. 389, 410-13 (1978).

⁵⁸ 42 U.S.C. § 300(K) (1982).

⁵⁹ 668 F.2d 847 (9th Cir. 1982), *cert. denied*, 103 S. Ct. 3096 (1983).

⁶⁰ 689 F.2d 612 (6th Cir. 1982), *cert. denied*, 459 U.S. 1208 (1983).

⁶¹ 452 U.S. 378 (1981).

⁶² 373 U.S. 341 (1963).

work."⁶³ It restated the congressional intent that state health planning agencies and providers who voluntarily work together to carry out the state's health planning statutory mandate should not be subject to antitrust laws. The Court distinguished *National Gerimedical*, however, because the conduct at issue was found not to be cooperation among providers, but rather merely an insurer's refusal to deal with a provider that had failed to heed the advice of a state health planning agency.⁶⁴

Relying on *National Gerimedical*, the Court of Appeals for the Sixth Circuit, in *Huron Valley Hospital Inc. v. City of Pontiac*,⁶⁵ refused to dismiss an antitrust suit charging that a competitor hospital had captured the CON process and caused denial of plaintiff's application for approval of new construction.⁶⁶ The plaintiff alleged that the competitor hospital in the target community blocked approval of the needed CON and manipulated the administrative process to obtain a license for itself and rebuild its existing hospital. The *Huron Valley* decision reversed a lower court determination⁶⁷ that the national health planning laws provided state action antitrust immunity. The Sixth Circuit established that the mere existence of a CON process does not provide an exemption from the antitrust laws to entities that use or are required to participate in the process. Rather, it is the mandated activities *arising out of* such regulatory schemes that provide state action immunity from antitrust scrutiny with respect to the practices of those entities that would otherwise be deemed violations of antitrust law.

*North Carolina v. P.I.A. Ashville, Inc.*⁶⁸ is instructive in connection with the application of both the implied repeal⁶⁹ and state action doctrines to health planning laws. At the initial trial stage, a defense based upon the state action doctrine was successful, as the court held that a hospital merger is immune from antitrust liability where the state has granted a CON for such merger following due process hearings pursuant to its regulatory powers. A three-judge appellate court panel originally affirmed the lower court decision.

However, after a rehearing en banc, the trial court decision was reversed and remanded for a new trial. The Fourth Circuit found that while the CON requirements constituted a clearly articulated and affirmatively expressed state policy, there was no active state supervision due to an absence of any monitoring of the use of the hospital acquisition after its consummation.⁷⁰

The status of the state action exemption with regard to health care providers remains unclear in the wake of seemingly inconsistent decisions in *Samaritan*

⁶³ *Id.* at 357.

⁶⁴ 452 U.S. at 393.

⁶⁵ 666 F.2d 1029 (6th Cir. 1981).

⁶⁶ *Id.* at 1031.

⁶⁷ *Huron Valley Hosp. v. City of Pontiac*, 466 F. Supp. 1301 (1979).

⁶⁸ 1982-2 Trade Cas. ¶ 64,764 (W.D. N.C. 1981), *aff'd*, 722 F.2d 59 (4th Cir. 1983), *rev'd and remanded after hearing en banc*, 740 F.2d 274 (4th Cir. 1984), *pet. for cert. filed*, No. 84-480, 53 U.S.L.W. 3271 (U.S. Sept. 24, 1984).

⁶⁹ See *infra* text accompanying notes 72-93.

⁷⁰ 740 F.2d at 277-79.

Health Services, Gambrel, Huron Valley and P.I.A. Ashville. While courts have not entirely repudiated a state action immunity for health care provider activities, those activities must be essentially compelled by a state regulatory or statutory scheme and the intent underlying that scheme. In an effort to resolve this uncertainty, a petition for certiorari has been filed with the Supreme Court in *P.I.A. Ashville*.⁷¹

3. The Doctrine of Implied Repeal

Closely related to the state action theory is the doctrine of implied repeal. This doctrine provides that where two legislative actions are inconsistent, the subsequent act implicitly repeals the prior act to the extent of the inconsistency.⁷² Antitrust immunity may be implied if a subsequent legislative act is deemed to conflict with certain aspects of antitrust law. It is critical to note, however, that "[i]mplied antitrust immunity is not favored, and can be justified only by a convincing showing of clear repugnancy between the antitrust laws and the regulatory system."⁷³ "Only where there is a 'plain repugnancy between the antitrust and regulatory provisions' will repeal be implied."⁷⁴ "Repeal is to be regarded as implied only if necessary to make the . . . [subsequent law] work and even then only to the minimum extent necessary."⁷⁵ Health care litigants seeking refuge behind this doctrine have met with little success. The Supreme Court recently held, in the unanimous *National Gerimedical* decision, that the National Health Care Planning and Resources Development Act of 1974 is "not so incompatible with antitrust concerns as to create a 'pervasive' repeal of the antitrust laws as applied to every action undertaken in response to the health planning process."⁷⁶

This reasoning was followed in *Huron Valley Hospital Inc. v. City of Pontiac*,⁷⁷ where the Sixth Circuit ruled that the authority granted to state planning agencies under the Federal Health Planning Act to review new hospital construction does not impliedly repeal antitrust law oversight of the hospital marketplace. The court in *Huron Valley* also rejected an implied repeal defense. Overcoming the defendant's assertion that antitrust law was inapplicable to CON process activities, the court found that the predatory practices of certain hospitals preventing the issuance of plaintiff's CON were subject to antitrust oversight.

⁷¹ No. 84-480, 53 U.S.L.W. 3271 (U.S. Sept. 24, 1984).

⁷² See *Gordon v. New York Stock Exchange*, 422 U.S. 659 (1975); *United States v. National Ass'n of Security Dealers*, 422 U.S. 694 (1975).

⁷³ *National Ass'n of Security Dealers*, 422 U.S. at 719-20.

⁷⁴ *Gordon*, 422 U.S. at 682 (quoting *United States v. Philadelphia Nat'l Bank*, 374 U.S. 321, 350-51 (1963)).

⁷⁵ *Silver*, 373 U.S. at 357.

⁷⁶ 452 U.S. at 393 (emphasis added). The Court held that defendant Blue Cross' refusal to grant participating status to hospitals that had not obtained approval for construction from the local health planning agency was neither compelled nor approved by any governmental regulatory body, but was rather a voluntary decision on the part of such hospitals.

⁷⁷ 666 F.2d at 1029 (6th Cir. 1981).

Similarly, in *White & White Inc. v. American Hospital Supply Corp.*,⁷⁸ the court held that a Medicare regulation that permits hospitals to engage in the group purchasing of supplies as a form of prudent buying does not conflict with federal antitrust laws, and hence held that no repeal would be implied.⁷⁹

The Supreme Court, however, cautioned in *National Gerimedical* that "our holding does not foreclose future claims of antitrust immunity in other factual contexts . . . where, for example, a [state health planning agency] has expressly advocated a form of cost saving cooperation among providers, it may be that antitrust immunity is necessary to make the [federal health planning statutes] work."⁸⁰ Citing *National Gerimedical*, the Fourth Circuit, in *Hospital Building Co. v. Trustees of Rex Hospital*,⁸¹ held that when health care providers participate in local planning activities, they are immune from antitrust attack if their activities are in good faith and aimed at avoiding needless duplication of health care resources.⁸² This implied immunity does not require a finding that the health care defendants were compelled to engage in the challenged activity, said the court, but only that the health care statute "encouraged" such participation in the planning process.⁸³ The Fourth Circuit reversed a jury verdict in favor of plaintiff and ordered a new trial on jury instructions concerning implied immunity and *Noerr-Pennington* immunity.⁸⁴ The Supreme Court denied plaintiff's petition for certiorari.

On retrial, the appellate court found that both state and federal authorities had advocated health care planning, that federal legislation encouraged cooperation among governmental and private parties in planning, and that it could be impossible to engage in such efforts without involving potential competitors in the creation of a rational health planning scheme.⁸⁵ The court was able to distinguish *Rex Hospital* from *National Gerimedical*. In *National Gerimedical*, Blue Cross' refusal to grant participating status to hospitals failing to obtain planning agency approval for construction had not been mandated by any state plan or agency. In *Rex Hospital*, the defendants participated in the local health planning process, as contemplated by federal and state statutes. The defendants helped formulate a long-range plan for hospital development in the area and opposed plaintiff's application for a CON that conflicted with the plan. Without expanding the holdings of *Silver* and *National Gerimedical*, that the health planning statutes do not impose a blanket repeal of antitrust laws, the court in *Rex*

⁷⁸ 540 F. Supp. 951 (W.D. Mich. 1982).

⁷⁹ *Id.* See also *Ballard v. Blue Shield*, 529 F. Supp. 71 (S.D. W.Va. 1981) (no implied repeal where complaint alleged a group boycott to refuse health insurance coverage to chiropractic services).

⁸⁰ 452 U.S. at 393 n.18.

⁸¹ 691 F.2d 678 (4th Cir. 1982), *cert. denied*, 104 S. Ct. 231 (1983), *aff'd on retrial*, No. 4048 (E.D. N.C. 1984).

⁸² 691 F.2d at 685-86.

⁸³ *Id.* at 686.

⁸⁴ See *infra* text accompanying notes 94-99.

⁸⁵ 691 F.2d at 685.

Hospital found that health planning statutes do repeal antitrust laws to the extent that potential antitrust defendants participate in the health planning process in good faith.⁸⁶

The Fourth Circuit appeared to reinforce its holding in *Rex Hospital* when it handed down its decision in *North Carolina v. P.I.A. Ashville Inc.*⁸⁷ There, the court found that a merger was exempt where a CON authorizing it had been obtained. However, after a rehearing, the same court reversed the lower court holding and its own affirmance of that holding, finding no implied repeal or state action⁸⁸ to immunize the defendant from antitrust liability. The court noted that a change in hospital ownership did not require CON approval under federal health planning laws.⁸⁹ The court found, moreover, that no purpose of the federal health planning statute would be furthered by failing to apply antitrust standards to the transaction at issue (a private hospital acquisition) and that the legislative history of that statute shows concern for permitting competition to operate fully.⁹⁰ Finally, the court found no clear repugnancy between the health planning and antitrust laws, noting that the standards applicable to the acquisition under both laws could have been satisfied.⁹¹

To date, health care providers have succeeded in advancing only health planning laws as grounds for their implied immunity from antitrust scrutiny. Nevertheless, courts appear willing to permit concerted activities that otherwise would constitute antitrust violations, provided those activities are conducted in good faith within the scope of established health planning law and regulations that have the purpose of cost savings, the reduction of duplication, and the efficient provision of health care services. The increasing efforts by state and federal governments to control the spiraling costs of health care by means of revised reimbursement methods⁹² and stronger state health planning laws⁹³ suggest the continued viability of the implied immunity doctrine as expressed in *Rex Hospital*.

The recent advent of PPOs and other alternative delivery systems make their status under state and federal health planning laws somewhat uncertain. However, PPOs in general do not create new entities, add beds, services, or equipment to existing entities or otherwise undertake activities ordinarily within the purview of the health planning regulations. If a PPO is required to obtain a CON under state law and regulations, the CON, in conjunction with other evidence of the anticompetitive nature of a PPO, could provide some antitrust

⁸⁶ *Id.* at 685-87.

⁸⁷ 740 F.2d 274 (4th Cir. 1984), *pet. for cert. filed*, No. 84-4801 53 U.S.L.W. 3271 (U.S. Sept. 24, 1984).

⁸⁸ *See supra* text accompanying notes 52-67.

⁸⁹ 740 F.2d at 276.

⁹⁰ *Id.* at 283.

⁹¹ *Id.* at 284.

⁹² *E.g.*, the Medicare prospective payment system. *See infra* note 133.

⁹³ New York, Wisconsin and Massachusetts have all recently strengthened their CON statutes. *See* MASS. ANN. LAWS, ch. 133, § 25B (Michie/Law. Coop. 1975 & Supp. 1985) (amended 1982); N.Y. PUB. HEALTH § 2802 (McKinney 1977 & Supp. 1984-85) (amended 1982); WIS. STAT. ANN. § 50:35 (West Supp. 1985) (amended 1981).

protection from a challenge on the basis of concerted activities among competitors in its formation or practices. It may even be advisable for the PPO to seek the imprimatur of the state or local health planning agency before the PPO is constituted, particularly in areas where the creation of a PPO involves a large proportion of area providers and may have an adverse impact on those providers not involved in the PPO. This may be accomplished through the formal CON process or by insertion of the proposed PPO into the state or local health plan. These steps could protect the PPO from antitrust risk under the *National Gerimedical* and *Rex Hospital* decisions. It is important to note that a petition for certiorari has been filed with the Supreme Court in *P.I.A. Ashville* in an effort to obtain a dispositive solution to the tension between the health planning and antitrust laws.

4. *Noerr-Pennington* Doctrine

This doctrine provides that concerted efforts to persuade a government body or official to take a specific action are not antitrust violations. The doctrine is based on the right of the government to obtain the information it needs to act and on the constitutional right of individuals to petition the government.⁹⁴ Actions within the doctrine's scope are protected even if based on anticompetitive motives. The doctrine extends to efforts to persuade legislative bodies and courts, as well as administrative agencies; however, the doctrine does not protect "sham" efforts to affect governmental policy.⁹⁵ Collective efforts to exert undue or improper influence on decision makers are not protected from antitrust scrutiny, nor are filings of frivolous litigation or commencing administrative proceedings merely to harass competitors.⁹⁶ The *Noerr-Pennington* doctrine appears to have limited application to alternate delivery systems such as PPOs. However, in *Rex Hospital*, the doctrine was applied to the defendant hospitals' involvement in the CON process pursuant to state health planning law and regulations. Those concerted activities, arguably violations of antitrust law, were found by the court to be immune from antitrust risk under the *Noerr-Pennington* doctrine as well as the doctrine of implied immunity, discussed earlier.⁹⁷

⁹⁴ See *Eastern R.R. Presidents Conf. v. Noerr Motor Freight, Inc.*, 365 U.S. 127, 145 (1961) (where railroad association carried out misleading advertising campaign to promote legislation disadvantageous to truckers, held that first amendment protected such speech, even though anticompetitive in motive); *United Mine Workers v. Pennington*, 381 U.S. 657, 669-72 (1965) (attempt by mine operators and union to influence Secretary of Labor to set minimum wage at level exclusionary to small contractors held to be protected speech).

⁹⁵ *California Motor Transp. v. Trucking Unlimited*, 404 U.S. 510 (1972) (creating the "sham" exception to the *Noerr-Pennington* doctrine, applicable when administrative procedures are used for the purpose of eliminating competition).

⁹⁶ See, e.g., *Ernest W. Hahn, Inc. v. Coddling*, 615 F.2d 830 (1980) (repetitive sham litigation constituted an antitrust violation under sham exception to the *Noerr-Pennington* doctrine).

⁹⁷ 691 F.2d at 688. See *supra* text accompanying notes 72-92.

The reach of the *Noerr-Pennington* doctrine should not be overstated however. Advocacy is clearly protected; however, *actions* designed to achieve those same ends may not be shielded. In *Virginia Academy of Clinical Psychologists v. Blue Shield*,⁹⁸ two insurers were charged with antitrust violations for refusing to pay for services provided by clinical psychologists unless they were billed through physicians. A state law required direct payment, but defendants argued that they were protected under the *Noerr-Pennington* doctrine because they sought a judicial test of the statute. The Fourth Circuit ruled in favor of plaintiffs, stating that "[t]he collaboration in defiance of a statute may have been calculated to provoke a judicial resolution . . . but it amounted to no more than an agreement to persist in economically restricting commercial activity in the face of a state law designed to open up the health care market."⁹⁹ Thus, while the defendants' rights to urge the repeal of the challenged statute may have been protected under *Noerr-Pennington*, their continued violation of the statute was not protected. Under this analysis, if an entity seeking to create a PPO requests that a state or local health planning agency include the organization in its health plan, the *request* should be protected under *Noerr-Pennington*. The actual PPO formation and its activities, however, may not be protected from antitrust scrutiny; such exemption depends on the applicability of other antitrust defenses such as implied repeal or state action.

5. The McCarran-Ferguson Exemption

The McCarran-Ferguson Act¹⁰⁰ exempts the "business of insurance" from antitrust scrutiny to the extent that such business is regulated by state law, provided the challenged acts do not constitute "boycott, coercion, or intimidation."¹⁰¹ The McCarran-Ferguson Act, however, does not exempt from federal antitrust regulation all activities of insurance companies, as all acts of insurance companies are not considered to be the "business of insurance." The Supreme Court has held that not all aspects of a third-party provider contract are within the McCarran-Ferguson Act antitrust exemption. In *Group Life & Health Insurance Co. v. Royal Drug Co.*,¹⁰² the Supreme Court, in 1979, found that price fixing between Blue Shield and participating pharmacies did not involve an insurance relationship between insurer and insured. Blue Shield's prepaid prescription drug policy entitled insureds of Blue Shield to purchase drugs from any pharmacy, and Blue Shield had entered into agreements with some pharmacies to provide pharmaceutical products. If the insured purchased pharmaceuticals from a participating pharmacy, the insured paid only two dollars, the policy deductible. If the insured used a nonparticipating pharmacy, however, the insured was required to pay the full price and then was reimbursed to the extent of seventy-five percent of the price exceeding the two dollar deductible. Blue

⁹⁸ 624 F.2d 476 (4th Cir.), *cert. denied*, 450 U.S. 916 (1980).

⁹⁹ 624 F.2d at 482.

¹⁰⁰ 15 U.S.C. §§ 1011-15 (1976).

¹⁰¹ *Id.* at § 1013(b).

¹⁰² 440 U.S. 205 (1979).

Shield argued that the price fixing was directly related to its relationship with each insured because it encouraged cost containment and resulted in reduced premiums. The Court, however, held that the contracts between the Blue Shield plan and the participating pharmacists were not the business of insurance and consequently were not exempt from antitrust scrutiny.¹⁰³ The Court, in a five-to-four decision, limited the "business of insurance" exemption to insurance contracts between insurers and insureds, risk spreading activities, and practices limited to entities within the insurance industry.¹⁰⁴

Having found no McCarran-Ferguson exemption applicable to *Royal Drug*, the Supreme Court remanded the case for trial on the merits. The appellate court affirmed the trial court decision that the prepayment plan constituted neither horizontal nor vertical price fixing.¹⁰⁵ It found no horizontal combination because the agreements between the group insurer and the participating pharmacies did not run between competitors in either the pharmaceutical or insurance industries. The court did not find vertical price fixing since there was no evidence that Blue Shield had monopoly power or, if it did, that such power had been abused.¹⁰⁶ Absent such evidence, the court held, Blue Shield had the right to bargain for the lowest price for itself and its insureds. The court further found no boycott to exist, since each pharmacy had the opportunity to participate in the plan, there was no evidence that Blue Shield conspired with other insurance companies, and Blue Shield did not limit the ability of nonparticipating pharmacies to deal with other insurers or the general public.¹⁰⁷

The typical PPO structure is in many ways analogous to the situation in *Royal Drug*. In *Royal Drug*, insureds were given a financial incentive to use "preferred" pharmacists. No such incentive existed for using a nonparticipating pharmacy, although insurance indemnification was nonetheless available for the use of those pharmacies as well. In a PPO model, subscribers are encouraged through economic incentives to use the participating providers. Although PPO subscribers may use other providers, they do not obtain the same economic benefits.

The McCarran-Ferguson Act exemption appears to be inapplicable to PPOs on two grounds. First, the specific scheme described in *Royal Drug*, which may be analogized to the typical PPO structure, is not the "business of insurance" under the Court's ruling in that case. Second, even if the Court had determined that the *Royal Drug* scheme was the "business of insurance," PPOs should not meet the general criteria rendering a plan "insurance" as described later.¹⁰⁸ Nevertheless, the decision on the merits in *Royal Drug* provides significant comfort to PPO organizers.

¹⁰³ *Id.* at 214.

¹⁰⁴ *Id.* at 211, 215-16, 220-21.

¹⁰⁵ *Royal Drug Co. v. Group Life & Health Ins. Co.*, 737 F.2d 1433 (5th Cir. 1984), *pet. for cert. filed*, No. 84-804, 53 U.S.L.W. 3419 (U.S. Nov. 19, 1984).

¹⁰⁶ 737 F.2d at 1436-37.

¹⁰⁷ *Id.* at 1438.

¹⁰⁸ See *infra* text accompanying notes 110-13.

6. Antitrust Compliance

The foregoing discussion demonstrates the numerous potential antitrust hazards for the ill-conceived and/or poorly structured PPO. Antitrust lawsuits may be filed by the federal or state governments or by individuals or entities aggrieved by the allegedly unlawful activity. In the few instances where governmental bodies have been asked to review PPO structures for possible antitrust violations, the agencies have found no significant antitrust problems. The PPO arrangements presented to them have been deemed generally procompetitive and lacking in those features, discussed above, which could serve as the basis for antitrust litigation.¹⁰⁹ Nevertheless, government agencies may revise their opinions as to the antitrust implications of PPOs as the PPO entities evolve. Agency opinions are merely advisory and should not be viewed as controlling legal precedent. Regardless of favorable opinions by government agencies, private litigants may file lawsuits against PPOs for alleged anticompetitive activities.

Therefore, it is advisable for creators of PPOs to have legal counsel undertake a thorough antitrust audit to illuminate possible antitrust problem areas. Counsel for the PPO should also assist the organization in preparing an antitrust compliance manual and in implementing an antitrust compliance program. The manual, together with an instructive program, should highlight areas of antitrust concern and provide the Board and the officers of the PPO with systems for avoiding or reducing antitrust liability.

III. REGULATORY OVERSIGHT

A. Insurance

1. Licensure Requirements

A major issue confronting PPO organizers involves the determination of whether the organization is subject to regulation and licensure as an insurance company under state law. If the PPO is deemed to be an insurance company, the organizers must weigh the cost and expense of compliance with insurance laws against the expected benefits of the PPO.

The licensing and regulation of insurance companies often call for the maintenance of certain levels of financial reserves by the regulated entity, strictly regulates the form and content of health care provider and subscriber agreements, prescribes forms of investments by the regulated entity, and imposes other forms of control intended to protect the subscribers, enrollees, or insureds of such an entity.¹¹⁰ The threshold question for this analysis is generally

¹⁰⁹ See Federal Trade Commission Advisory Opinion to Health Care Management Associates, 101 F.T.C. 1014 (1983); Department of Justice Business Review Letters to Health Care Management Associates and to Hospital Corporation of America (September 21, 1983); Opinion of Ohio Attorney General, 1984-1 Trade Cas. (CCH) ¶ 65, 796 (1983).

¹¹⁰ See, e.g., FLA. STAT. ANN. §§ 624-51 (West 1984).

whether the proposed PPO would constitute or give rise to a "contract of insurance" under state law. States describe a contract of insurance in different ways.¹¹¹ Although PPOs frequently perform functions traditionally allocated to insurance companies, such as claims administration, they generally do not undertake the indemnification of patients for health care benefits, or the underwriting or spreading of risks. Still, utilization controls imposed by a PPO, including a possible fee-retention system as a method of spreading risk, should be assessed under relevant state insurance laws to determine whether this constitutes risk spreading for insurance regulatory purposes.

PPOs frequently incorporate billing, claim processing, and other administrative services. A variety of jurisdictions require that insurance claims adjusters and persons performing various other functions relating to the sale, interpretation, and administration of insurance contracts be licensed.¹¹² At least ten jurisdictions require the registration of third party contract administrators.¹¹³ Therefore, PPO organizers must assess whether their staff requires licensure before doing business in each state.

2. Freedom of Choice; Antidiscrimination

If the PPO is classified as an insurance company for state law purposes, there are two categories of insurance laws and regulations that pose significant problems to PPOs: "freedom of choice" statutes, which prohibit insurers from limiting a beneficiary's selection to only certain providers, and antidiscrimination statutes, which prohibit insurers from reimbursing providers at different levels. For example, freedom of choice provisions in various states provide that "the policy may not require that the service be rendered by a particular hospital or person."¹¹⁴ The insurance law of some states prohibits interference by any other person with the exercise of free choice in the selection of a physician or optometrist.¹¹⁵ In Utah, regulations require that any physician who desires to participate in a PPO health insurance program under the program's terms must

¹¹¹ For example, Mississippi defines "insurance" as an agreement by which one party for a consideration, promises to pay money or its equivalent, or to do some act of value to the assured, upon the destruction, loss, or injury of something in which the assured or other party has an interest, as an indemnity therefore. MISS. CODE ANN. § 83-5-5 (1972). Under Georgia law it is defined as a "contract which is an integral part of a plan for distributing individual losses whereby one undertakes to indemnify another or to pay a specified amount or benefits upon determinable contingencies." GA. CODE ANN. § 33-1-2 (1982).

¹¹² See, e.g., FLA. STAT. ANN. § 626 (West 1984), GA. CODE ANN., §§ 33-23-2 (1982).

¹¹³ Arizona, California, Florida, Indiana, Kansas, Minnesota, Montana, Nevada, Tennessee and Utah. See, e.g., ARIZ. REV. STAT. § 20-485 (West 1982-83 Supp.).

¹¹⁴ This language is typical of many state statutes including those of Alaska, Arizona, Arkansas, Delaware, Georgia, Hawaii, Idaho, Indiana, Maryland, Oklahoma, Pennsylvania, South Dakota, Texas, Utah and Wyoming. See, e.g., KEN. REV. STAT. § 304.18-048 (Bobbs-Merrill 1981); OR. REV. STAT. § 743.531 (1979).

¹¹⁵ E.g., CONN. GEN. STAT. ANN. § 20-138b (1982).

be allowed to do so.¹¹⁶ If PPOs were deemed to fall within the state insurance laws, the freedom of choice provisions would certainly constrain their development. An attractive feature of PPO arrangements is that subscribers retain the freedom to use any provider, although incentives are given for the use of the preferred providers.

Antidiscrimination laws erect a different and potentially more difficult barrier to PPO creation. Such laws generally provide that a payor may not vary the reimbursement level for a covered expense based on the provider of the service or on any other discriminatory basis. A number of states have statutes that prohibit insurers from paying different rates to different health care providers, and others prohibit hospitals from charging different rates to different payors unless they can establish that the differences are cost justified.¹¹⁷ Such statutes necessarily restrict the organization and operation of most PPOs.

However, several states have adopted statutes or regulations that expressly permit the contractual arrangements contemplated by PPOs to provide discounts only for the services of preferred providers.¹¹⁸ Soon after Blue Cross/Blue Shield developed and introduced its preferred provider program, Minnesota adopted legislation to permit different benefits for covered services obtained from designated providers, thus avoiding the unlawful discrimination or rebating problems.¹¹⁹ In Virginia, the law effectively barred development of preferred provider arrangements. When it became clear that Blue Cross/Blue Shield of Virginia was interested in developing such an arrangement, the Virginia legislature quickly enacted the necessary legislation clarifying the authority of the Virginia Plans and Commercial Insurers to develop and offer such arrangements.¹²⁰

Careful analysis of the insurance laws and regulations of each state is necessary to determine whether freedom of choice or antidiscrimination provisions pertain. Where such provisions exist, it may be difficult or impossible to establish

¹¹⁶ UTAH INS. DEPT. REGS. Reg. 81-2 § 4 (1981).

¹¹⁷ See, e.g., Wyoming S.B. 101, Chap. 63, which requires that any hospital discounts, credits, rebates or other related reductions in price given by a tax-supported state or county hospital or other health care facility be applied uniformly to all persons. See also Colorado H.B. 1330 and Iowa H.B. 519 (both proposed legislation).

¹¹⁸ Such states include California, Florida, Indiana, Minnesota, Nebraska, Utah, Virginia and Wisconsin. See, e.g., CAL. INS. CODE § 11,512 (West Supp. 1985); FLA. STAT. ANN. § 627.6371-.6691 (West 1984); IND. CODE ANN. § 27-8-7-1 (West Supp. 1984-85); MINN. STAT. ANN. § 72A.20(15) (West Supp. 1985); VA. CODE §§ 38.1-347.2, 38.1-813.4 (Supp. 1984); WIS. STAT. ANN. § 628.36 (West Supp. 1984-85).

¹¹⁹ Minnesota H.B. 765 (codified at MINN. STAT. ANN. § 72A.20(15) (West Supp. 1985)).

¹²⁰ Virginia S.B. 110, Chap. 464 (1983 Session) (codified at VA. CODE §§ 38.1-347.2 and 38.1-813.4 (1984)). See also Florida S.B. 28-B FLA. STAT. ANN. § 627.6371-.6691 (West 1984); IND. CODE ANN. § 27-8-7-1 (West Supp. 1984-85); WIS. STAT. ANN. § 628.36 (West Supp. 1984-85). Legislation is also under consideration in Arizona, Colorado, Kansas, Louisiana, Michigan, Mississippi, Oklahoma, Pennsylvania, South Carolina, Vermont and Washington. See generally State Regulation of Preferred Provider Organizations: A Survey of State Statutes (American Hospital Association, March 1984).

PPOs along traditional structural formulas. However, recent experience has indicated that those states that wish to encourage such alternative delivery systems have enacted the laws necessary to permit PPO formation.¹²¹

3. HMO Regulations

Creators of PPOs must determine whether the organization would be sufficiently similar to a health maintenance organization (HMO) to place it within the class of entities regulated pursuant to state HMO law. The law of one jurisdiction defines a "health care plan" as

any plan whereby any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services, provided, however, a part of such plan consists of arranging for or the provision of health care services, as distinguished from indemnification against the cost of such service, on a prepaid basis through insurance or otherwise.¹²²

The relevant statute then defines an HMO as "any person who arranges for or provides a health care plan to enrollees on a prepaid basis."¹²³

Arguably, PPOs "arrange for" the provision of health care services. Nevertheless, PPOs generally do not provide or arrange for the provision of health care services on a prepaid basis, thus avoiding establishment of the PPO as the indemnitor for the care rendered to beneficiaries. A careful analysis of each state HMO statute is required to avoid inadvertently becoming subject to state regulation as an HMO.

B. Health Planning Laws and Regulations

The application of state health planning laws and regulations to a PPO depends on each state's definition of "health care provider." Ordinarily, PPOs constitute a contractual arrangement among separate independent entities including providers, payors, and subscribers. It is unlikely that the mere contract-

¹²¹ On January 24, 1985, Rep. Ron Wyden re-introduced H.R. 733, entitled "A Bill to Permit Group Health Care Payors to Provide for Alternative Rates with Providers of Health Care." 99th Cong. 1st Sess., 131 CONG. REC. H 167. The bill, presently before the Subcommittee on Health and Environment of the Energy and Commerce Committee, provides that group health plan payors, with the agreement of group policyholders and subject to the terms of any applicable collective bargaining agreement, may limit payments under their policies to services procured from health care providers charging alternative rates. Section 2(a)(1) of H.R. 733 permits group health plan payors to negotiate and contract for alternative rates of payment with, or determine alternative rates of payment for, providers of health care services and in turn offer the benefit of such alternative rates to their beneficiaries selecting such providers. Section 2(b) states that payments with respect to group health plan beneficiaries by the payor of alternative rates under 2(a)(1) and 2(a)(2) shall not constitute a violation of any state law or regulation. This bill therefore supersedes state freedom of choice and antidiscrimination laws and permits such practices in an effort to encourage the formation of PPOs.

¹²² TEX. INS. CODE ANN. art. 20A.02(h) (Vernon 1981).

¹²³ *Id.* art. 20A.02(j).

ing process will require that a CON be obtained for approval of the new entity. However, where additional services are provided, or where services, beds, or equipment may be reallocated among the various entities of the PPO, state CON law may require that such activity be reported or perhaps even delayed pending agency approval.

Most CON laws currently apply to capital expenditures made by, through, or on behalf of, a hospital, nursing home, or other health care provider.¹²⁴ Some states define provider to include free standing, nonacute care facilities such as chemical dependency units and outpatient rehabilitation facilities.¹²⁵ Where a PPO maintains any control over a capital expenditure that would ordinarily require the hospital incurring the expense to obtain a CON, the PPO itself may be required to obtain the CON. In addition, state statutes must be reviewed to insure that a hospital's capital contribution to the PPO in the form of start-up costs or additional payments to the corporation for capital purposes is not a capital expenditure that must be reported to or approved by state health planning agencies.

A proposed PPO may command such substantial market power or have such a significant impact on the area's health care delivery system that state and local health planning bodies may wish to or may be required to include the proposed PPO in their health plans. As noted above, this may also serve to immunize the PPO from antitrust scrutiny once it is operational.¹²⁶

C. State Professional Licensing Agencies; State Departments of Health

The majority of states have statutes that prohibit the corporate practice of medicine and proscribe arrangements that constitute fee splitting, illegal discounts, rebates, and referral fees in the provision of health care services. These pitfalls can be avoided provided the contracts executed by the various component members of the PPO do not inadvertently shift the responsibility for providing medical care from the physician and hospital providers to the PPO itself.

PPOs should not be subject to licensure or regulation under the various state departments of health statutory mandates, because PPOs do not directly provide medical services. Operationally, the PPO should seek to insure that other activities overseen by state health departments, such as record keeping and reporting requirements of the providers, remain the responsibility of those providers rather than being contractually assigned to the PPO.

D. ERISA

Employers and unions are key marketing targets for PPO development. Many medical benefit programs operated by unions and employers are those covered

¹²⁴ See, e.g., ALA. CODE § 22-21-260 to 22-21-277 (1975); CAL. HEALTH & SAFETY CODE § 437-439.5 (1979); IDAHO CODE §§ 39-4901 to 39-4914 (Supp. 1984).

¹²⁵ See, e.g., ALA. CODE § 22-21-260(5) (1975); IDAHO CODE § 39-4903(f) (Supp. 1984).

¹²⁶ See *supra* text accompanying notes 58-60.

by the Employee Retirement Income Security Act of 1974 (ERISA).¹²⁷ A PPO entering into an agreement with a benefit plan covered by ERISA risks being deemed, either expressly or impliedly, a fiduciary or administrator of the plan. A plan fiduciary is responsible for managing the assets of the plan in a prudent manner; the failure to act in accordance with fiduciary standards can result in liability for the breach of fiduciary duties.¹²⁸ A PPO found to be a fiduciary will also be liable for the breaches of other fiduciaries named in the plan documents.¹²⁹ ERISA, and the regulations spawned by the Act, include a comprehensive discussion of transactions prohibited to a fiduciary. Remedies for breach of fiduciary duty include restitution to the plan of any losses resulting from the breach, restoration to the plan of any profits realized by the fiduciary through his personal use of plan assets, as well as any other equitable or legal relief available, including the removal of the plan fiduciary.¹³⁰

The design of the PPO is not consistent with service as a plan fiduciary and the organization should avoid such characterization. To avoid potential liability as a fiduciary under ERISA, it is important to understand what functions could cause a court to view the PPO as a plan fiduciary. ERISA provides that a person is a fiduciary to the extent that he: exercises discretionary authority or control with respect to the management of the plan; exercises any authority or control with respect to the management or disposition of plan assets; renders investment advice for a fee or other compensation; or has discretionary authority or responsibility in administration.¹³¹

The agreement between the PPO and the employer or union covered by the ERISA plan should provide for several elements. First, fiduciary status should be expressly disclaimed; a clear indication that it remains the responsibility of the employer or union to expressly name the benefit plan's fiduciary is also important. Second, the name of the actual plan administrator should be set out. Third, it must be made explicit that the PPO does not have authority or responsibility for the disposition or management of plan assets. Last, the agreement should indemnify the PPO against any liability resulting from claims by plan beneficiaries or others.

Although the PPO may not be a plan fiduciary, it may nevertheless be subject to the bonding requirements contained in 29 U.S.C. § 1112 if it handles funds or other property of the plan within the meaning of the regulations pursuant to that section.

E. Medicare

Medicare law¹³² does not have a significant impact on the operation and organization of a PPO. Medicare imposes "Conditions of Participation" on

¹²⁷ 29 U.S.C. § 1001 (Supp. V 1982).

¹²⁸ See 29 U.S.C. §§ 1102-04 (West Supp. 1984).

¹²⁹ *Id.* at § 1105.

¹³⁰ *Id.* at § 1109.

¹³¹ *Id.* at § 1002(21)(A).

¹³² Health Insurance for the Aged Act § 100 (codified at 45 U.S.C. § 1395 (1982)).

numerous providers, including hospitals and nursing homes; these providers, if they seek reimbursement under the Medicare program, must meet all conditions of participation. Thus far, no conditions of participation have been enacted or proposed to govern PPOs. PPOs must be aware, however, that each provider entity that is a part of the PPO must continue to meet its own conditions of participation under the Medicare program. Failure to do so can lead to sanctions that may include decertification as a Medicare provider. That action may have a significant impact on the provider's ability to continue to do business, depending on the volume of its Medicare patient load, and may be cause to terminate a provider's participation in the PPO.

In many PPO situations, the costs and income attributable to the organization are allocated to the hospital participants. This should affect the hospital's cost reporting methodology and may change its level of reimbursement. Each hospital must determine which, if any, PPO costs will be allowable under Medicare. It is important to note that many of the cost-related questions concerning Medicare reimbursement to hospitals affiliated with PPOs will be clarified by the implementation now under way of the prospective payment system for Medicare reimbursement.¹³³

F. Securities Regulation

The structure of the PPO and any other affiliated entities, such as physicians' associations, determines whether those entities are subject to securities regulation. The critical factor is whether the contribution by the hospital and the physicians to the PPO or to any other corporate entity is considered the sale of a security by the PPO or that other entity. The physicians' association is particularly susceptible to this risk if it sells stock to a significant number of physicians.

The sale of any interest in the PPO or related entity, or any contribution made to a PPO or such entity, must be reviewed under federal and state securities law and regulations to determine whether that transaction is in fact a sale of securities.¹³⁴ If the transaction is a sale of securities, it gives rise to a plethora of filing, disclosure, and publication requirements under both state and federal schemes unless the transaction falls within an exemption. These provisions must be analyzed prior to the formation of any PPO.

G. Tax Considerations

Each tax exempt participant in the PPO must determine the effect of the PPO structure on its tax exempt status. There is no Internal Revenue Service revenue ruling specifically addressing this issue. However, in analogous fact situations, IRS revenue rulings have generally found the tax-exempt status of hospitals to

¹³³ See 42 C.F.R. §§ 405.470-477 and 489.20-23.

¹³⁴ For the federal definition of a security see 15 U.S.C. § 77b(1) (1982) and *SEC v. W. J. Howey Co.*, 328 U.S. 293 (1946). An example of a state securities law definition is found in *OHIO REV. CODE ANN. § 1707.01(B)* (Page 1978 & Supp. 1984).

be undisturbed. To maintain its section 501(c)(3) exemption under the Internal Revenue Code, a hospital must be operated to serve public interests, and no part of its net earnings may inure to the benefit of private individuals. This area has been labeled the "inurement issue" or the "prohibitions against private benefit and inurement."¹³⁵

The inurement issue frequently arises in situations where a hospital constructs and operates a medical office building. In revenue rulings issued in 1969, the IRS generally held that running a medical office building contributes significantly to a hospital's operation and is therefore substantially related to the performance of hospital tax-exempt functions. More recent private letter rulings continue to reflect this viewpoint, despite the advent of more complex medical office building arrangements.¹³⁶ In sustaining the hospital's tax-exempt status, the IRS has generally held that the arrangement furthers the hospital's tax-exempt purposes. An important factor in this analysis is the proximity of the office building to the hospital's emergency room and inpatient beds; proximity attracts physicians to serve in the emergency room and on the hospital staff, thereby improving the health care delivery system in the community.¹³⁷

Based on these analogous factual situations, it appears that the tax-exempt status of a hospital would not necessarily be jeopardized because of its membership in a PPO. Both the impetus and effect of PPO membership is the enhancement of the provision of cost-conscious medical care to the community without detrimentally affecting the quality of that care. The hospital that joins a PPO to improve the community health care delivery system is engaging in clearly justifiable conduct. Any advantages that may accrue to the hospital through the PPO arrangement can be shown to further the hospital's tax-exempt purposes with respect to medical care, rather than to constitute merely a private benefit or inurement.

Hospitals considering PPO membership should determine whether any portion of the revenue generated by PPO activities will constitute unrelated business income. The critical issue is whether the trade or business, that is, PPO-related business, is substantially related or contributes importantly to the hospital's tax-exempt purposes. As described above, there should be little difficulty in establishing that PPO business is no different than other hospital business and thus revenues so derived are not unrelated business income subject to taxation.

¹³⁵ See *Kenner v. Comm'r*, 318 F.2d 632 (7th Cir. 1963); *Eastern Ky. Welfare Rights Org. v. Simon*, 506 F.2d 1278 (D.C. Cir. 1974); *Harding Hosp., Inc. v. United States*, 505 F.2d 1068 (6th Cir. 1974).

¹³⁶ See, e.g., LTR 8234029, ¶ 3846 (82) (P-H, 1982) (operation of medical office building and urgent care facility are related to hospital's purpose in that greater use is made of hospital's diagnostic facilities, admissions are easier, and proximity of doctors to facilities increases their participation in hospital's education and research programs; therefore, hospital's tax exempt status not affected).

¹³⁷ *Id.*

IV. MALPRACTICE LIABILITY CONSIDERATIONS

Liability for medical malpractice arises where one whose duty it is to treat the patient with the requisite standard of care, fails to meet that standard of care, causing physical or emotional injuries.¹³⁸ Historically, malpractice actions brought against hospitals failed on the basis that the duty of providing proper medical care to patients was owed by physicians, and not hospitals. During the last several years, however, liability for medical malpractice has been extended to parties other than physicians, including hospitals.¹³⁹ This extension of liability has evolved under several theories. First, under the doctrine of respondeat superior, hospitals have been held responsible for the negligence of their employees, whether they be physicians, nurses, or other health practitioners.¹⁴⁰ This doctrine provides that an employer is responsible for the acts of its employees.¹⁴¹ The doctrine of respondeat superior should not create problems for PPOs named as parties with doctors and hospitals in medical malpractice litigation provided that the employer-employee relationship does not exist between the PPO and the affiliated hospitals, physicians' associations, and physicians.

Potentially more troublesome to a PPO is the doctrine of "corporate negligence" which has resulted in hospitals being held liable for the medical malpractice of their *nonemployed* physician staff members. Under the doctrine of corporate negligence, hospitals have been found to owe certain duties to patients, the breach of which constitutes negligence for which plaintiff patients have been permitted recovery in litigation against both physicians and hospitals. Courts have determined that a hospital generally owes a duty to its patients to insure the competency of the hospital's medical staff and to evaluate periodically the quality of medical treatment rendered on its premises or through use of its facilities.¹⁴² Hospitals also have the duty of exercising due care in medical staff appointments, reappointments, and termination.¹⁴³ Hospitals breach this duty when they fail to take reasonable steps to acquire and analyze the information necessary to make informed choices concerning medical staff appointments. According to the courts, the grant of staff privileges to a physician has the effect of holding that physician out as competent to practice medicine in his field of specialization.¹⁴⁴ At the very least, the failure of a

¹³⁸ See, e.g., *Cross v. Huttenlocher*, 188 Conn. 204, 440 A.2d 952 (1982); P. KEETON, PROSSER AND KEETON ON TORTS, 187 (5th ed. 1984).

¹³⁹ See *Cadilla v. Board of Medical Examiners*, 26 Cal. App. 3d 961, 103 Cal. Rptr. 455 (1972); *Sherman v. Board of Regents*, 266 N.Y.S.2d.

¹⁴⁰ See, e.g., *Grace v. Howlett*, 5 Ill. 2d 478, 283 N.E.2d 474 (1972); *Bing v. Thunig*, 2 N.Y.2d 656, 163 N.Y.S.2d 3, 143 N.E.2d 3 (1957); *Moeller v. Hauser*, 237 Minn. 368, 54 N.W.2d 639 (1952).

¹⁴¹ 57 C.J.S., *Master and Servant* § 561 (1948 & Supp. 1984).

¹⁴² See *Elam v. College Park Hosp.*, 132 Cal. App.3d. 332, 183 Cal. Rptr. 156 (1982); *Darling v. Charleston Community Memorial Hosp.*, 33 Ill. 2d 326, 211 N.E.2d 253 (1965).

¹⁴³ *Id.*

¹⁴⁴ *Id.*

physician to act in a competent manner gives rise to a triable issue of fact: whether the hospital followed the reasonable and proper procedures necessary to ensure the quality of the medical services rendered by that physician.

The creation of a PPO should not affect the application of these doctrines to the hospital or (perhaps) to physicians' association entities of the PPO. However, these theories of corporate negligence may be applied in a lawsuit brought by a patient *against the PPO* or the *physicians' association* alleging medical malpractice by a PPO member hospital or physician. This application of the corporate negligence theory would be more probable if a PPO or the physician association maintains a selection process for determining the acceptance of providers into the organization.

The exposure of a PPO or a physicians' association may be further increased if they administer a quality assurance program. A patient filing a malpractice action against a participating provider might join the PPO and the physicians' association in the lawsuit on the theory that the PPO or physicians' association negligently permitted the allegedly negligent provider to participate in the program. Conversely, if the PPO or physicians' association does *not* screen the credentials or monitor the quality of participating providers, plaintiffs might allege that such oversight is the duty of the PPO and physicians' association, and that the failure to undertake that duty constitutes negligent conduct. While the latter scenario appears less likely, based on current case law, the expansion of the doctrine of corporate negligence could result in litigation. Indeed, even the appearance in PPO promotional literature of such terms as "quality care" or "preferred providers" might be found by a court to allow plaintiffs to assume that the PPO expressly guarantees or warrants that it offers only quality, preferred care. Negligence of a participating provider may then be imputed to the PPO based on the doctrine of corporate negligence or even perhaps on the doctrine of breach of contract where the PPO has failed to live up to its announced standards.

V. PEER REVIEW

In *Union Labor Life Insurance Co. v. Pireno*,¹⁴⁵ the Supreme Court held that the use of a peer review committee to determine the reasonableness of chiropractic charges did not constitute the "business of insurance" within the meaning of the McCarran-Ferguson Act. The Court reiterated the three criteria relevant in determining whether a particular practice is part of the business of insurance and found that the peer review procedure met none of the three criteria.¹⁴⁶

It must be noted, however, that the Court in *Pireno* did not indicate its opinion of the legality of the underlying conduct. It merely found that the McCarran-Ferguson Act exemption from antitrust laws was not available to such conduct

¹⁴⁵ 458 U.S. 119 (1982).

¹⁴⁶ See *supra* text accompanying notes 110-13.

because the conduct did not constitute the business of insurance.¹⁴⁷ Therefore, while peer review functions of health care entities are not automatically immune from antitrust scrutiny, they nevertheless may be found to be legal under antitrust law. A staff report from the Federal Trade Commission concluded that the potential for abuse in peer review by the professions "seems relatively low."¹⁴⁸ The *Pireno* Court remanded the case for a full trial on the merits of the underlying claim, i.e., whether the peer review process in question actually violated antitrust laws.¹⁴⁹

While the final determination of the legality of peer review arrangements under the antitrust laws must await the result of *Pireno* on remand, it would seem that many such schemes should be permissible. First, notwithstanding *Pireno*, peer review mandated by federal or state law may well be exempt from antitrust scrutiny under the implied repeal or state action doctrines discussed above. In addition, many peer review plans should be permissible on their merits. In the Federal Trade Commission Advisory Opinion to the Iowa Dental Association,¹⁵⁰ the Commission asserted that voluntary utilization and fee review are permissible under the antitrust laws provided that the power of the physician-controlled organization is limited to making recommendations and that ultimate authority to pay rests elsewhere.¹⁵¹ The Commission also suggests that a consumer representative be placed on the peer review panel, that the voluntary and advisory nature of the process be stressed, and that no preferred status be conferred on participants or nonpreferred status conferred upon nonparticipants in the peer review process.¹⁵²

VI. STRUCTURE OF A COOPERATIVE VENTURE PPO

PPOs may be structured according to a variety of organizational models. These include payor-based PPOs (e.g., Aetna Choice, Blue Cross/Blue Shield), PPOs formed by entrepreneurs as brokers between payors and providers, hospital-based PPOs, physician-based PPOs, and cooperative ventures initiated by two or more of the participants described above (most commonly hospitals and physicians). Each of these models has different implications and advantages in terms of their functional characteristics, tax status, ability to earn and disburse a "profit," and potential legal liability (including antitrust and regulatory risks) as well as the financial exposure of the parties and entities involved. This section of the Article will describe the legal structure and operation of the cooperative venture PPO organizational model. A discussion of this PPO structure provides the opportunity to address in an operational context a significant

¹⁴⁷ *But see* *Royal Drug Co. v. Group Life & Health Ins. Co.*, 737 F.2d 1433 (5th Cir. 1984) (underlying conduct did not violate antitrust laws).

¹⁴⁸ *Iowa Dental Ass'n*, 3 TRADE REG. REP. (CCH) ¶ 21,918 (April 9, 1982) [1979-1983 Transfer Binder], FTC COMPLAINTS & ORDERS, ¶ 22, 270 [hereinafter *Iowa Dental Ass'n*].

¹⁴⁹ 458 U.S. at 134.

¹⁵⁰ *Iowa Dental Ass'n*, *supra* note 148.

¹⁵¹ *Id.* at ¶ 22,271.

¹⁵² *Id.*

number of legal issues described in the preceding sections of this article. The structure and function of the cooperative venture PPO may be used as guidelines for the formation of PPOs on other models.

The cooperative venture PPO consists of one or more hospitals, one or more physicians' associations (PAs), and a single PPO entity (see Exhibits 1 and 2). The PA and PPO may be for-profit or not-for-profit corporations; however, it may be advisable for these entities to be formed as for-profit organizations. A for-profit structure provides the traditional incentives associated with business ventures and permits the PPO and PA to take advantage of current or future opportunities to engage in profit-making health care related activities. The PA in particular may be a vehicle for numerous profit-generating singular or cooperative business ventures on behalf of or in conjunction with its members or its affiliated hospital.

Physicians seeking to create the cooperative venture PPO with their hospital will incorporate a PA comprising some or all of the medical staff physicians from that hospital. Ideally, this opportunity will be offered to the entire eligible medical staff to avoid some of the antitrust pitfalls described earlier. Once created, the PA, in conjunction with the PPO, may establish practice standards to eliminate inefficient and less competent members.

The proponents of the cooperative venture PPO assert that the competitive environment in the health care industry makes it imperative that hospitals and physicians cooperate as business partners, avoiding the traditional animosity between these groups. This PPO structure recognizes the nature and economic independence of these groups and seeks to provide safeguards within the corporate structure to assure, to the extent possible, that neither group is able to dictate the terms of participation in the PPO to the other group. The result of a "takeover" of the PPO by either the hospital or physician, it is theorized, could result in the nonparticipation of the other and thus the destruction of the PPO.

If these premises are accepted, the cooperative venture PPO should be organized as a cooperative corporate undertaking of physicians' associations and hospitals. The hospital and the PA should each own one half of the stock of the PPO corporation, and each entity should elect one half of the board of directors of the PPO. These provisions, and other similar measures described here, can safeguard the equality of ownership and of voting rights between the PA and hospital and maintain it as a cooperative venture.

The cooperative venture PPO is a restructuring of existing entities. In this PPO, the hospitals and physicians are shareholders in a new corporate structure and are also providers of health care in a system that rearranges functions and incentives to provide cost-efficient, high-quality care to purchasers. This dual role is best understood by separately describing the PPO corporate structure and the documents that create it, and the PPO operational functions and the agreements that mandate those functions.

A. *Corporate Structure*

To structure the cooperative venture PPO, certain provisions should be contained in the articles of incorporation and the bylaws. As noted, the cooperative venture PPO is to be owned and controlled equally by the hospital and PA. Therefore, the bylaws should provide for two classes of stock, one ("Class A") owned by the hospital or hospitals involved in the PPO, and one ("Class B") owned by the PAs of those hospitals (see Exhibit 1).

The PPO board of directors should consist of an even number of directors, one half elected by the holders of Class A stock, and one half elected by the owners of Class B stock. These proposed PPO bylaws would provide that at shareholder meetings, each class of stock would have one shareholder vote. In this way, shareholder decisions would reflect the unanimous agreement of both the hospital(s) and the PA(s). Similarly, the vote of fifty percent of the full board of directors plus one director, rather than a simple majority of a quorum, would be required to pass any resolution of the PPO directors. This requirement could prevent the board from taking official action by the vote of all of the directors elected by any one class of stock. For example, if the board of directors consists of ten directors, five of whom are Class A directors and five of whom are Class B directors, action should require the approval of six directors. At least one director from the "other faction" must vote with the other group in order to attain the majority-plus-one necessary for board action. Additional protection may be secured by requiring a majority-plus-two or -three vote for board action. In this and other provisions, the flexibility of this corporate structure permits it to be adapted readily as the PPO evolves.

This corporate structure may be used to form a network of hospitals and PAs. The same shareholder and board voting provisions, and the theory that underlies their application to a PPO with only one hospital and PA, applies to a network PPO as well. In a network structure, all the hospitals together own fifty percent of the shares of the PPO, and all the PAs own fifty percent of the PPO stock. The amount of stock in the PPO owned by each hospital and PA is determined by the members of the respective groups by a networking agreement or by the PPO. Regardless of the number of PPO shareholders, all the owners of each class of stock elect one half of the PPO board and have one vote in shareholder matters (see Exhibit 2).

All the hospitals and PAs affiliated with the proposed network PPO should execute a PPO shareholder agreement to further secure the equal ownership of each group in the organization. The shareholder agreement should restrict the transferability of shares of stock in the PPO. The PPO shareholder agreement provides that where the PPO consists of multiple hospitals or PAs (Exhibit 2), the hospital or PA wishing to terminate or being terminated may sell its interest in the PPO only to another member of its PPO shareholder group (i.e., a hospital may sell only to a hospital and a PA only to a PA). It may not sell to a third party, to a member of the other provider group, or to the PPO itself.

There are two basic purposes for these restrictions. First, they prevent one hospital or PA in the network from transferring its ownership interest in the PPO to an entity that may be incompatible with the quality, standards, reputation, or ethical requirements of the other shareholder hospitals or PAs in the PPO. Second, if the shareholders could freely transfer their interest, the equal balance maintained between hospitals and PAs in the ownership of the PPO would be destroyed.

Each physician desiring to purchase stock in the PA would execute a PA shareholder agreement. The PA shareholder agreement should restrict the transferability of shares of stock in the PA to prevent a physician from transferring his interest in the PA to a physician who may be unable to meet the standards of the PA or the PPO. The PA shareholder agreement provides that the physician shall cease to be a shareholder and a member of the PA upon the occurrence of any one of the following: failure to comply with the PPO's quality review and utilization management program (based upon objective standards); desire to transfer ownership of PA shares; loss of medical license; loss of hospital staff membership; or failure to pay dues. In the event of any of the above, the shareholder agreement provides that the PA shall redeem the share of PA stock owned by that physician.

B. PPO Functions

As described above, the legal structure of the PPO is significant in ensuring the continued viability of the cooperative venture in the face of potential conflicts and jealousies among the economically powerful and traditionally independent health care providers that constitute the PPO. Equally important is the proper allocation of the numerous PPO functions among the organization's various entities. Establishing an effective operational framework for the PPO entity is critical to providing cost-efficient, high-quality health care to the consumer (which is the product a PPO has to sell), as well as to reducing or eliminating the PPO's exposure to legal liability. The functions and obligations of the entities comprising the PPO are set forth and described in the provider agreements and service agreements executed by and among those entities. The provider agreements and service agreements are essential to the operation of the PPO. The PPO cannot offer to provide a managed health care plan unless the providers are in place within a structure that operates efficiently.

In general, a PPO is created to provide economic incentives to consumers to utilize the provider members of the PPO. These incentives, usually in the form of reduced deductibles and copayments for patients, reduced costs to payors, and increased efficiencies and claims management for providers, are established by aggressively containing the cost of care provided by the members of the PPO. This is accomplished through intensive and ongoing quality review and utilization management. The PPO implements these controls by enlisting and retaining cost-conscious health care providers, while avoiding or terminating inefficient providers. One of the central functions of the PPO, therefore, is to

implement the quality review and utilization program necessary to the viability of the PPO and to acquire and analyze quality, charge, utilization, and fee data from billing and patient records as part of that program. The PPO then uses the information to develop and administer the services provided by the physician and hospital members of the PPO, referred to as the "PPO-managed health care plan."

The cooperative venture PPO provides physicians and hospitals with a powerful structure for negotiating separate agreements with each potential payor. In addition, the flexibility of the cooperative venture PPO permits the organization or its member hospitals and physicians to enter into agreements with payors based on a set plan separately negotiated with each health care provider; an alternate agreement is one in which the providers receive customary fees but with utilization controls superimposed upon their services. Regardless of the PPO structure or the method of contracting, it is advisable, from both an antitrust and operational standpoint, for the PPO to retain the option of submitting any payor agreement negotiated by the PPO to each hospital and physician in the organization for their acceptance or rejection. Ultimately, the PPO structure and method of contracting with payors must be determined by the specific organizational dynamics and requirements of the parties forming the PPO.

The PPO acts as the agent for the hospitals and physicians (represented in the PPO by the PA) that provide the services comprising the PPO managed health care plan. The PPO negotiates the plan with potential payors (e.g., insurance companies, self-insured employers, union trust funds), seeking the most favorable payment terms for its principals, the PAs and hospitals in the PPO. Only the PPO negotiates the price of the services offered in the plan. Neither the hospitals, the PAs, nor the physicians take part in the price negotiations or fee determinations. In fact, no provider has access to the fee and charge information concerning any other provider used by the PPO to negotiate price with the payor. The PPO would negotiate separately with each payor and would be prepared to negotiate separately the price of each service offered in the plan. These steps are strongly recommended as ways to significantly reduce the PPO's exposure to allegations of antitrust violations based on unlawful price fixing, discussed earlier.¹⁵³

When the negotiations result in a proposed contract, the PPO would submit that contract to the PA(s) and hospital(s). The PAs in turn submit the contract to each physician member. Allegations of price fixing are more likely if individual providers are required to accept whatever arrangement was negotiated by the PPO with the payor. Therefore, each physician and each hospital should have the option to accept or reject any contract negotiated by the PPO with any payor. The only contracting parties are the payor and provider; they do not include the PPO or PA. It is contemplated that a contract will not be implemented without some threshold number of provider acceptances. The option retained by each provider to accept or reject a payor contract is critical

¹⁵³ See *supra* text accompanying note 8-29.

in the attempt to prevent antitrust liability. It is also critical for the providers themselves to avoid establishing or appearing to establish a set fee for purposes of negotiation with a payor. For this reason it is suggested that the PPO, using fee and pricing information obtained from PPO member and nonmember physicians alike, negotiate with each payor reasonable fees for particular medical services. The incorporation of the PPO as a separate entity is all the more important from an antitrust standpoint where the PPO is negotiating fees and charges on behalf of the hospital and physician providers.

Under the operation of the cooperative venture PPO, each patient would be free to obtain services from "nonpreferred" providers who are not members of the PPO, albeit at a higher cost. This prevents further antitrust problems and avoids violation of "freedom of choice" laws that may exist under state insurance codes. The patients' ability to use any provider they wish, coupled with the fact that the providers are paid on the traditional fee-for-service basis rather than through a prepaid mechanism, preclude consideration of the PPO as an HMO for purposes of state HMO statutes. In addition, the PPO should not be subject to state insurance law if it does not indemnify or reimburse any party to the venture or spread the risk of loss over the PPO members. Therefore, payment should be made directly by the payor to the provider based upon the provider's claim filed with the payor.

Antitrust problems may also arise if a physician is rejected for or terminated from membership in the PA. It is therefore recommended that the PPO, composed of representatives of all the provider groups as well as nonproviders, have the ultimate decision with regard to the termination or rejection of a provider's application for PPO membership rather than place that decision in the hands of fellow providers. Rejection of one physician by other physicians for PA membership strongly suggests an intent to boycott or monopolize patient care or to refuse to deal with that rejected applicant based upon subjective criteria not reasonably related to the business goals of the PPO venture.

Physicians' association membership decisions made by a panel of objective, disinterested PPO representatives applying a set of uniform standards and criteria will be less vulnerable to antitrust sanction. Certain criteria are relatively free from controversy, such as licensing, staff membership, and other related standards. However, the PPO may also establish criteria related to cost efficiencies, quality of care, the need for certain specialties and not for others, the limitations of the physical facilities of PPO member providers, and other similar requirements. These criteria may survive antitrust scrutiny if they are related to a valid business goal and not established to exclude certain practitioners or groups of practitioners. As the PPO market share increases, the PPO must be especially sensitive to the need for such criteria to be objective, unbiased, and not overtly anticompetitive.

The cooperative venture PPO's presumed objectivity makes it appropriate for the organization to administer grievances between the various parties to the PPO venture: patients against providers, providers against payors, providers against patients. The PPO could create an administrative staff with an executive

director. The funds for operating the PPO should be derived from the capitalization of the PPO by its hospital and PA shareholders. However, a particularly efficient PPO, that is, one whose members provide cost effective care, may be able to negotiate agreements under which payors would provide a portion of the PPO's operating expenses.

The functions of the member hospitals under the model PPO are set forth in the service agreements between and among the hospitals and the PPO. The hospitals would agree to provide the covered services to eligible persons pursuant to the payor agreements negotiated by the PPOs and accepted by the hospital. The hospitals accept the amount negotiated in the payor agreement as full payment for the services provided to the eligible patient. The hospitals agree to treat PPO patients in the same manner as they treat all other patients and to accept or reject PPO patients only on the basis of the same criteria employed for other patients. Significantly, the hospitals would agree to accept and implement the PPO's quality review and utilization management program which is central to insuring the cost effectiveness of the PPO venture. In order for the PPO to negotiate the payors and implement the quality review and utilization management program, the hospital would agree to provide the PPO with all necessary records and information that are in its possession. The hospital's failure to adhere to any provision in its service agreement with the PPO could be grounds for termination of its membership in the organization pursuant to the terms of the proposed shareholder agreement.

The functions of the PA are set forth in the service agreement between the PA and the PPO. It is proposed that the PPO's obligation to monitor and control the provision of office-based physicians' services to be contracting patients be implemented by the PA. The PA would develop and enforce practice-related membership criteria for the PA, but it is recommended that the final decision to terminate the participation of any provider should reside with the PPO. As noted earlier, it is the independence and objectivity of the PPO that enables it to make decisions to terminate PA membership without engendering antitrust liability.

The PA would cooperate in the resolution of grievances filed pursuant to the grievance procedure of the PPO; it is suggested, however, that the PPO render the final decision on any grievance filed by any party. The PA would provide the PPO with a current list of all physician providers and the location where such providers perform services pursuant to payor contracts. Like the PPO member hospitals, the PAs would agree to provide the PPO with all records and information necessary to enable the PPO to negotiate with payors and to perform its administrative obligations. A PA's failure to perform any of these functions could constitute grounds for its termination as a PPO member.

The physician providers would execute a provider agreement with their PA. In addition to performing many of the functions that the hospitals must perform, each physician would notify the PA and the PPO of any eligible persons whose behavior jeopardizes the efficient rendering of services by the PPO. Each physician would, within the dictates of good medical practice and in the best

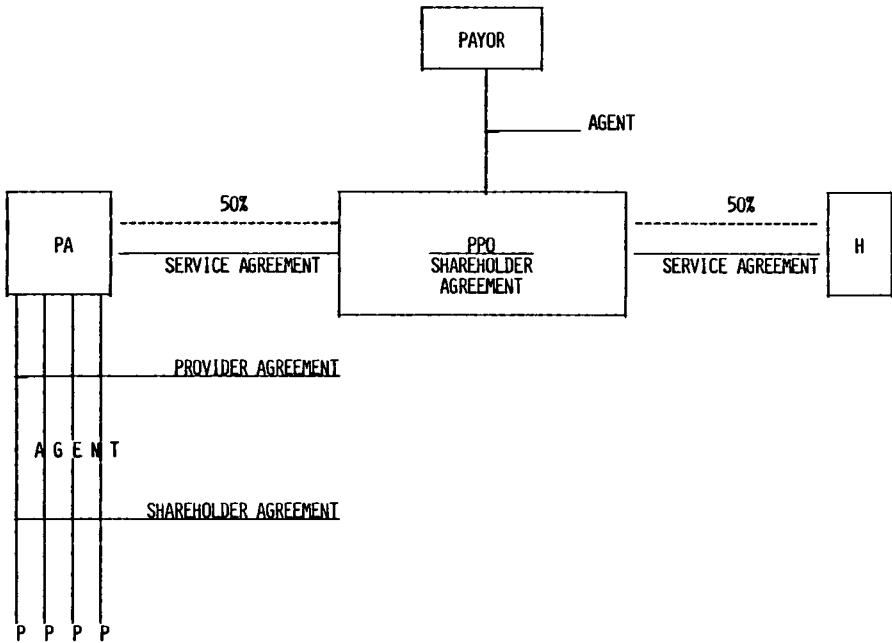
interest of his patients, attempt to refer PPO patients to other physician providers who are members. To avoid problems both with antitrust law and with standards governing the ethical practice of medicine, the proposed referral provision would be worded in an advisory rather than mandatory fashion. Each physician member of the PPO would be required to carry insurance at limits set by the PPO. As with hospitals and PAs, any violation of the recommended provider agreement between the physician and the PA, or any violation of the physician's obligations under the service agreement between the PA and the PPO should be grounds for terminating the physician's membership in the association.

In addition to the advantages describe above, the foregoing structure and operation of the model cooperative venture PPO may provide other legal benefits. For example, it is proposed that no provider be an employee of the PPO. The stockholder/independent contractor relationship of providers to the PA and PPO, evidenced by the existence of shareholder and service agreements and the absence of employment contracts or any other indicia of employment, would shield the PPO from professional negligence liability arising from the alleged malpractice of PPO member physicians or hospitals. This does not prevent liability from being imposed on a PPO for the professional negligence of its member providers. Indeed, as discussed above, courts are becoming more sympathetic to claims of "corporate negligence," where an institution fails to properly supervise or negligently grants privileges to a physician who then commits medical malpractice.¹⁵⁵ Nevertheless, the cooperative venture PPO structure provides the PPO with additional insulation against such claims.

As noted earlier, a PPO may take myriad forms. The PPO concept is sufficiently novel that no one particular corporate structure has emerged as clearly superior to any other structure. The PPO organization described in this section is relatively detailed and contains certain requirements intended to protect the venture from legal liability. However, regardless of what form it takes, a successful PPO must retain the flexibility necessary to respond to the changes that are constantly occurring in the health care industry, and the resulting opportunities for the members of that industry.

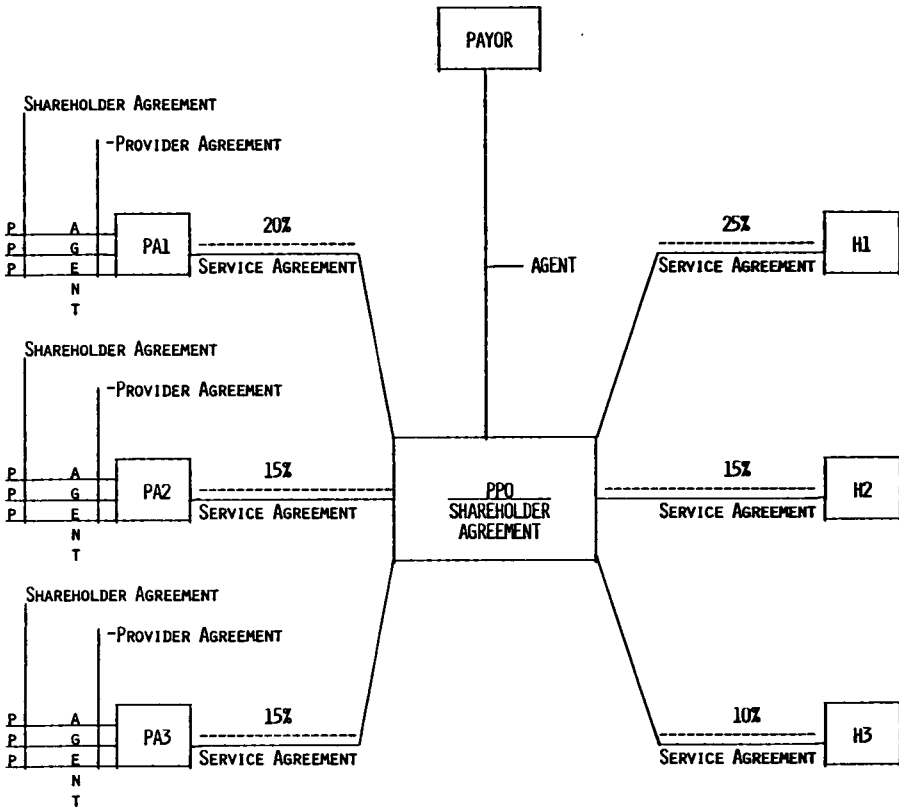
¹⁵⁴ See *supra* text accompanying notes 138-44.

EXHIBIT 1



(NOTE: ----Dotted line denotes stock ownership in PPO.)

EXHIBIT 2



(NOTE: ----Dotted line denotes stock ownership in PPO. The percentages are for illustrative purposes only.)

