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Antitrust and the Future of Cost Containment Efforts in the Health Profession

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By Eric L. Richards*

Antitrust And The Future Of Cost Containment Efforts in the Health Profession

I. INTRODUCTION

In a recent opinion, *Arizona v. Maricopa County Medical Society*,[1] the United States Supreme Court decided that section 1 of the Sherman Act[2] was "violated by an agreement among competing physicians setting, by majority vote, the maximum fees that they may claim in full payment for health services provided to policy holders of specified insurance plans."[3] The original complaint, filed by the State of Arizona in October 1978, was directed against two county medical societies[4] and two foundations for medical care (FMC) organized by the societies.[5] The State prayed for injunctive relief[6] based on the theory that the defendants were engaged in an illegal price fixing conspiracy. The district court denied a state motion for summary judgment,[7] but did certify for

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1. 102 S. Ct. 2466 (1982).
2. Section 1 of the Sherman Act, in pertinent part provides: "Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal." Act of July 2, 1890 (Sherman Act) § 1, 15 U.S.C. § 1 (1976).
3. 102 S. Ct. at 2469.
4. After the defendants filed their answers one of the medical societies was dismissed by consent. *Id.*
5. For an explanation of FMC's and their interrelationships with medical societies, see *infra* notes 62-68 and accompanying text.
6. 102 S. Ct. at 2469 n.1.
7. Three reasons were cited by the district court for denying the motion for summary judgment. First, it believed that " 'a recent antitrust trend appears to be emerging where the Rule of Reason is the preferred method of determining whether a particular practice is in violation of the antitrust law.' " 102 S. Ct. at 2469 n.2 (quoting app. to petition for cert. at 43). Second, it did not read the prior Supreme Court opinions invalidating maximum price-fixing, Albrecht v. Herald Co., 390 U.S. 145 (1968); Kiefer-Stewart Co. v. Seagram & Sons, 340 U.S. 211 (1951), as necessarily establishing a per se rule. Finally, the court noted that " 'a profession is involved here.' " 102 S. Ct. at 2469 n.2 (quoting app. to petition for cert. at 45). Accordingly, the district court denied

interlocutory appeal the question: " 'whether the FMC membership agreements, which contain the promises to abide by maximum fee schedules, are illegal per se under section 1 of the Sherman Act.' "[8] By a divided vote,[9] the court of appeals[10] affirmed the district court's order denying summary judgment. In a 4 to 3 opinion the Supreme Court reversed the lower court, finding the maximum fee arrangement to be horizontal price-fixing and, therefore, per se illegal.[11]

As an aid to understanding the *Maricopa County* decision, this Article will explore the economic environment of the health care industry. It will examine the rampant cost escalation that plagues the industry and explain how much of this inflationary surge is

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the motion for summary judgment since there was insufficient evidence as to the purpose and effect of the allegedly unlawful practices and the power of the defendants to support such a motion under rule of reason analysis. *Id.* (quoting app. to petition for cert. at 47).

8. 102 S. Ct. at 2469 (quoting Arizona v. Maricopa County Medical Soc'y, 643 F.2d 553, 554 (9th Cir. 1980)).

An interlocutory order may be entered pursuant to 28 U.S.C. § 1292(b) (1976), which provides:

> When a district judge, in making in a civil action an order not otherwise appealable under this section, shall be of the opinion that such order involves a controlling question of law as to which there is substantial ground for difference of opinion and that an immediate appeal from the order may materially advance the ultimate termination of the litigation, he shall so state in writing in such order. The Court of Appeals may thereupon, in its discretion, permit an appeal to be taken from such order, if application is made to it within ten days after the entry of the order: *Provided, however*, That application for an appeal hereunder shall not stay proceedings in the district court unless the district judge or the Court of Appeals or a judge thereof shall so order.

On August 8, 1979, the district court entered an order providing:

> "This Court's determination that the Rule of Reason approach should be used in analyzing the challenged conduct in the instant case to determine whether a violation of Section 1 of the Sherman Act has occurred involves a question of law as to which there is substantial ground for difference of opinion and an immediate appeal from the Order denying plaintiff's motion for partial summary judgment on the issue of liability may materially advance the ultimate determination of the litigation. Therefore, the foregoing Order and determination of the Court is certified for interlocutory appeal pursuant to 28 U.S.C. § 1292(b)."

102 S. Ct. at 2469 n.3 (quoting app. to petition for cert. at 50-51).

9. *See infra* notes 149-75 and accompanying text. The Supreme Court noted this division stating that "each of the three judges on the panel had a different view of the case." 102 S. Ct. at 2469.

10. 643 F.2d 553 (9th Cir. 1980).

11. 102 S. Ct. at 2480. Justice Stevens wrote for the majority and was joined by Justices Brennan, White, and Marshall. Justice Powell filed a dissenting opinion which was joined by Chief Justice Burger and Justice Rehnquist. Justices Blackmun and O'Connor took no part in the consideration or decision of the case.

precipitated by a third party financing method which offers little incentive to control costs. It will then trace the development of the health maintenance organization (HMO), a device which has been heralded as holding great promise for containing medical costs without sacrificing quality health care. This background will intimate that the FMC's under attack in *Maricopa County* were not designed to contain costs but were actually anticompetitive schemes designed to undermine the development of the more promising HMO's.[12]

The Article will then pursue a three-pronged survey of the antitrust developments that lay the groundwork for the Court's inquiry in *Maricopa County*. Initially, this will entail an examination of the line of cases which extended the reach of the antitrust laws to the professions in general[13] and the health care profession in particular.[14] Secondly, this part of the Article will focus on the judicial construction of the McCarran-Ferguson Act's[15] antitrust exemption for the "business of insurance."[16] Finally, an overview will be presented of the judicial fashioning of an appropriate standard of review—a rule of reason or a per se rule—for cost containment efforts which employ maximum fee schedules.

With this background, the Court's skepticism over the cost containment justification forwarded by the FMC's in *Maricopa County* will be better understood. Analysis of the court of appeals and Supreme Court decisions in *Maricopa County*, coupled with the earlier economic discussion, should provide a useful guide for determining both the effectiveness and legality of future cost containment efforts in the health care industry.

II. THE HEALTH CARE DELIVERY SYSTEM—BACKGROUND

A. Cost Escalation in the Health Care Industry

From April 1981 to April 1982 employment in the service industries surpassed the job total in the production sector for the first time in the history of the American economy. Most of this surge occurred in the consumer areas, with health services leading the way with an increase of 235,000 jobs over the year. This raised the total number of health service jobs to 5,717,000.[17] Health care, pres-

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12. *See infra* notes 54-68 and accompanying text.
13. Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975). *See infra* notes 71-86 and accompanying text.
14. Hospital Bldg. Co. v. Rex Hosp. Trustees, 425 U.S. 738 (1976). *See infra* notes 87-90 and accompanying text.
15. 15 U.S.C. §§ 1011-15 (1976).
16. 15 U.S.C. § 1012(a)-(b) (1976). *See infra* note 99.
17. Stetson, *Service Industry Employment Surpasses Manufacturing*, Blooming-

ently both a major industry and a growth industry,[18] accounted for only 3.6 percent of the gross national product (GNP) in 1929 when total health expenditures were approximately $3.6 billion.[19] In 1965 this had climbed to $43 billion or 6.2 percent of the GNP, and by 1978 had reached $192 billion, or about 9.1 percent of the GNP.[20] "Recent projections by the Health Care Financing Administration, assuming no major institutional changes in the health sector, are for 1990 health care expenditures of $758 billion representing 11.5 percent of the projected 1990 GNP."[21]

B. Market Failure—The Reasons for Soaring Medical Costs

Basically, the "rising medical care prices are the consequence of demand increasing more rapidly than it can be accommodated by supply . . . . This is not the whole story . . . but it is a significant part of the story."[22] Part of this rising demand can be explained by the growth of the over sixty-five segment of the population and our rising living standard which frees more and more of our income for health care.[23] However, more important than either of these factors in explaining cost escalation in the health industry is the shift in the way medical costs are financed today.[24]

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ton Herald-Telephone, July 14, 1982, at 15, col. 1. For the decade ending in 1981, health service jobs rose by 2.1 million, or 63 percent. *Id.*

18. Feldman & Zeckhauser, *Some Sober Thoughts on Health Care Regulation*, in REGULATING BUSINESS 93 (1978). In 1974, the health care industry assumed the position as the third largest industry in the nation. *See* INSTITUTE OF MEDICINE, CONTROLS ON HEALTH CARE: PAPERS OF THE CONFERENCE ON REGULATION IN THE HEALTH INDUSTRY 6 (1974).
19. M. FLETCHER, ECONOMICS AND SOCIAL PROBLEMS 290 (1979) [hereinafter cited as FLETCHER].
20. Drury & Enthoven, *Competition and Health Care Costs*, in THE ECONOMY IN THE 1980S: A PROBLEM FOR GROWTH AND STABILITY 393-94 (M. Boskin ed. 1980).
21. *Id.* at 394.
22. FLETCHER, *supra* note 19, at 290.
23. *Id.* "As our incomes go up, we spend more on medical services, both in absolute terms and as a proportion of total income." *Id.*
24. > [Today] bills are likely to be paid by some third party: a private health insurance company or a government bureau or agency. Such *third party payments* reached the level of half of all personal health care expenditures for the first time in 1970. By fiscal 1975 these third parties took the responsibility for paying over two-thirds of total expenditures.

 Id. at 291. Individuals were responsible for only 8 percent of total payments in the case of hospital care costs. *Id.*

 Health insurance took root during the Great Depression in the 1930's. "Between 1940 and 1972, fiscal intermediaries increased their population coverage from 12 million to 182 million persons . . . ." Kallstrom, *Health Care*

> There is a broad consensus among health care policy experts that the health care market does not behave competitively. . . . The principal culprit is thought to be a deep-pocket, cost-based financing system that promotes inefficiency in both the supply and consumption of health services by removing the usual discipline of price competition.[25]

In addition, conditions for a competitive market do not exist because "[h]ealth is not a neatly divisible commodity produced by large numbers of competitors all adjusting prices and input mixes to maximize profits. Doctors and hospitals have predominantly captive clienteles, and may exercise substantial market power."[26] Further, there are serious information problems in identifying benefits because "[m]uch of what determines health remains a mystery."[27]

While health care consumers may be concerned with rising costs, they may not be willing to accept the fact that cost reduction could very well entail a corresponding reduction in the resources expended by the health care industry.[28] In short, normal market forces do not operate since no party is overly concerned with cost control.[29]

Cost Control by Third Party Payors: Fee Schedules and the Sherman Act, 1978 DUKE L.J. 645, 674 n.121.

25. Millstein & Buc, *Supreme Court Ruling Adds Fuel to Debate Over Health Planning*, The Nat'l L.J., July 13, 1981, at 26, col. 4. "In addition, due to the technical nature of most health services, doctors rather than consumers make most consumption decisions, and doctors' economic incentives are generally to utilize a greater, not a lesser, volume of health services." *Id.* Defensive medicine, stemming from rampant malpractice suits, may also explain doctors' motives toward increasing the services they prescribe. *See* Drury & Enthoven, *supra* note 20, at 417.
26. Feldman & Zeckhauser, *supra* note 18, at 95. "Few appendicitis victims can be trusted to shop around for the most economical hospital or surgeon." *Id.*
27. *Id.*
28. Note, *Controlling Health Care Costs Through Commercial Insurance Companies*, 1978 DUKE L.J. 728. "Consumers want their health services to be provided at more reasonable rates, but at the same time they expect to fully benefit from all advances in health technology and to be given comprehensive treatment." *Id.* at 728-29.
29. "For hospitals, the normal insurance mechanisms are cost reimbursement or the third party payment of charges." Drury & Enthoven, *supra* note 20, at 398. Physicians normally employ a fee-for-service system which requires insurers to directly pay physicians for each service rendered. "To increase income, a physician has only to provide more numerous or more costly services. There is therefore a fairly strong incentive to do so, and certainly no economic incentive to be conservative." *Id.* at 397.

    Distinguished British playwright, George Bernard Shaw, commenting on the dilemma facing doctors under the fee-for-service arrangements, remarked: "That any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make one despair of political humanity." G. SHAW, THE DOCTORS DILEMMA, act V (1942).

> The customary practice in the medical industry is for doctors and hospitals to submit bills and for insurance companies to pay them. Health care costs are rising precipitously because under this customary practice there are no incentives for restraint. Doctors, knowing that they will be paid what they charge, have no incentive to control the amount and the price of services. Insured patients are ineffective in limiting the care they receive; aside from usually insignificant deductibles and coinsurance obligations under their policies, all care is essentially "free" from their perspective.[30]

Because at the time of purchase others share in the overall cost of health care services, health care is a subsidized commodity.[31] In some instances the subsidy takes the form of government support for the construction of health care facilities, purchase of equipment, or the training of manpower. At other times, as with Medicare and Medicaid,[32] the government directly pays for medical care. For most people the major subsidy is fellow insureds participating in some collective health plan.[33] A major motivation for the soaring use of insurance by consumers is the tax deduction for health insurance premiums[34] and the exclusion from employees' taxable income of whatever amount an employer contributes toward health care premiums.[35] This latter fact makes premium costs virtually invisible to the employee.[36] Thus, when doctors increase their prices for services, insurance companies pass the increase on to employers in the form of higher premiums. "Employers, in turn, allow health benefits to become a larger percentage of total employee compensation."[37]

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30. Kallstrom, *supra* note 24, at 647. "[W]ith an estimated 80-90 percent of Americans having at least some public or private health insurance, and well over half rather comprehensively covered, the medical care system has almost a blank check for its services." McClure, *The Medical Care System Under National Health Insurance: Four Models*, 1 J. HEALTH POL., POL'Y & L. 22, 34 (1976). "In the long run, of course, insureds do pay for this care through higher premiums, but it is irrational for any given patient to refrain from drawing on the collective fund at the moment the utilization decision is made, especially when nothing prevents others from exploiting the insurance fund." Kallstrom, *supra* note 24, at 647-48. *See* FLETCHER, *supra* note 19, at 292.
31. *See* Feldman & Zeckhauser, *supra* note 18, at 96. "This web of subsidies . . . is a primary source of misallocation problems within the health care system . . . ." *Id.*
32. Enacted in 1965, Medicare covered 27 million elderly and disabled persons in 1978. Medicaid, a joint federal/state program which pays for the health care of welfare recipients and other low income people, covered nearly 23 million beneficiaries in 1978. Drury & Enthoven, *supra* note 20, at 396.
33. In 1979 the Congressional Budget Office estimated that in 1976, 92-95 percent of the population had some form of health insurance. *Id.* at 397.
34. I.R.C. § 213 (West 1982).
35. I.R.C. § 106 (West 1982).
36. Drury & Enthoven, *supra* note 20, at 396.
37. *Id.* at 408. "The tax treatment of health insurance premiums encourages employers and employees to use untaxed dollars to purchase group insurance having low deductibles. This accessible and inviting market for first dollar

Therefore, it has been acknowledged that "the rapid growth of health care costs in this country has resulted from the increasing separation between receipt of medical services and out-of-pocket payment for them."[38] In short, there is not economic competition in the health care industry.

> It is true that services are provided predominantly in the private sector and that there are multiple independent producers. But the existence of public and private insurance *removes consideration of cost from virtually all of the relevant transactions in this industry*. With no consciousness of cost, there can be no *economic* competition.[39]

C. Cost Containment Strategies

Two fundamental approaches can be pursued to introduce cost containment into the health care industry: "by government fiat. . . or by adjusting private market incentives."[40] Political solutions to the current cost escalation dilemma face serious obstacles. First, the health care system has been described as reflecting "an uneasy balance between the tradition of intense economic individualism inherited from the past and the current need for a broad social approach to health care problems."[41] However, up to this point, "the demand for individual freedom for both consumers and providers of health care services weigh[ed] far more heavily in the balance than [did] any concern for an adequate overall social policy."[42] Second, it has been suggested that "governmental efforts to grapple with costs directly through regulation have reflected a concern for a symptom of the health care system's underlying problems rather than a desire to find and address root causes."[43] Accord-

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coverage has provided no real incentive to innovate with seemingly less attractive coverages." Note, *supra* note 28, at 729.

38. Schwartz, *Introduction* to NEW DIRECTIONS IN PUBLIC HEALTH CARE: A PRESCRIPTION FOR THE 1980S 5 (C. Lindsay ed. 1980).
39. Drury & Enthoven, *supra* note 20, at 407 (emphasis in original).
40. Kallstrom, *supra* note 24, at 648.
41. FLETCHER, *supra* note 19, at 296.
42. *Id.*

> [Thus,] it is not surprising that we have a medical care system which is highly technical, disease-oriented rather than health oriented, largely fragmented and uncoordinated, and which uses methods of organization which often seem to be based on private gain rather than on the most effective or efficient attainment of the public good.

Greifinger & Sidel, *American Medicine*, 18 ENV'T 16 (1976).

This result is certainly consistent with political and economic realities. "There is no natural constituency for . . . [reforms] and they face difficult political obstacles. The burden of rising health care costs is spread through every industry and across both the public and private sectors. Organizations that represent physicians and hospitals would prefer to maintain the status quo." Drury & Enthoven, *supra* note 20, at 415.

43. Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 DUKE L.J. 303, 304.

ingly, some commentators have recommended a market approach, singling out the third party payors as the likely initiators of needed reform since "[g]iven the chance to run their natural courses, market incentives should draw insurance companies into the business of offering cost containment as a service to health care consumers."[44]

Traditionally, there have been two basic types of third party payors that might assume the lead in cost containment efforts: Blue Cross and Blue Shield plans and the private commercial carriers.[45] The Blue service plans originated as creatures of the health care providers[46] and it has been cautioned that "[a]lthough provider control has become attenuated, it still exists in some plans."[47] Typically, the Blues "reimburse hospitals for their costs and physicians for their reasonable professional charges, as determined under a 'usual, customary and reasonable fee' formula (UCRF)."[48] This method of reimbursement seems to encourage doctors to raise their "usual" charges to the maximum reimbursable level, then to collectively raise their "customary" fees when the UCRF schedule is recomputed.[49] "Thus, Blue Shield plans, even though in a position to control costs because of their contractual relationship with providers, may have in fact contributed to cost escalation."[50]

Fee schedules implemented by the private commercial carriers should be contrasted "with the less defensible 'usual, customary and reasonable fee' approach traditionally employed by Blue Shield service plans."[51] The private carriers have not been per-

44. Kallstrom, *supra* note 24, at 649. This is because "[u]nder the present system, only the third party payor has any immediate incentive to control costs." *Id.* at 648.
45. *Id.* at 649. Blue Cross and Blue Shield plans are non-profit, tax-exempt organizations which contract directly with health care providers in order to obtain services required by their subscribers. The private carriers do not deal directly with providers; instead, they contract with their subscribers to indemnify them for their medical expenses. About 40% of the insurance population is now covered by the Blues. *Id.* at 649-50.
46. Blue Cross is an offspring of the hospital associations while Blue Shield was created by the state medical societies. *Id.* at 650.
47. *Id.*
48. *Id.* "Thus, the Blue Shield plans usually agree to pay participating physicians their 'usual' fee up to a stated percentile of the range of fees that are 'customary' for a particular procedure in the area, with 'reasonable' increases if there are complications." *Id.*
49. *Id.* "Although obstensably [sic] serving as a maximum price ceiling, the UCRF could thus easily become a minimum price floor and could allow doctors, with only casual collusion, to racket costs upward each time the UCRF schedule is revised." *Id.*
50. *Id.* at 650-51.
51. *Id.* at 646.

ceived as having been tainted by a close link with the providers as have the Blues.[52] Accordingly, fee schedules imposed as cost control agreements between single private insurers and single health care providers may "be effective in combating the price escalation that now plagues the third party payment system."[53]

Other advocates of a market solution to the cost escalation problem have warned that "[a]s long as the [health care] market is structured around individual services, it will be difficult to introduce economic restraints."[54] They believe that the development of HMO's offers greater promise of reform since "[a] better notion of product around which to create an economically competitive market is that of comprehensive care."[55] HMO's, "a small but viable sector of the medical economy . . . are potentially significant vehicles for controlling health care costs."[56] HMO's both insure and provide health care to a population of voluntarily enrolled members. Structurally, they possess certain characteristics which are conducive to cost containment:

> First, the HMOs' distinctive integration of insurance and provider functions results in an organization operating with a budget that is largely fixed in advance. This creates much stronger incentives to deliver services economically than any that exist in the fee-for-service sector, and in fact certain well-established HMOs have shown a marked ability to reduce substantially the total costs of medical care to consumers. HMOs also may encourage more comprehensive and integrated provision of services in order to take advantage of economies of scale and of integration.[57]

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52. *See supra* notes 45 & 46.
53. Kallstrom, *supra* note 24, at 646. Several explanations have been presented as to why the fiscal intermediary may wish to impose price ceilings on providers. "First and foremost, controlling medical cost inflation could reverse the pattern of financial loss that has plagued many health insurance plans for a number of years." *Id.* at 648 n.9. Second, by efficiently reducing costs, the third party payor "could expect to capture a larger segment of the health insurance market by reducing the price of his coverage to consumers below that of his competition." *Id.* Third, by aggressively containing costs, the insurance industry could place the pressure of health care inflation on "those best able to prevent cost increases—the hospitals and the doctors." *Id.* "Finally, a cost control program would make medical insurance plans more consistent with the standard and sensible insurance practice of seeking to restrict payouts." *Id.*
54. Drury & Enthoven, *supra* note 20, at 408.
55. *Id.* at 409.
56. Kissam, *Health Maintenance Organizations and the Role of Antitrust Law*, 1978 DUKE L.J. 487, 488. In 1965 there were an estimated 20 HMO's serving 1.5 million people. By 1978 those numbers had increased to 170 organizations with an enrollment in excess of 6 million people. *Id.* at 488 n.2.
57. Kissam, *supra* note 56, at 490. *See* McNeil & Schlenker, *HMOs, Competition and Government*, 53 MILBANK MEMORIAL FUND Q. 195, 200-01 (1975).

"HMOs are financed by capitation payments for individuals or families, and their physicians are salaried. Providers thus are discouraged from offering medical care of doubtful or marginal value, and are encouraged to supply

By making both patients and providers more cost conscious,[58] the HMO's are in sharp contrast to the traditional financing programs which have been utilized in the medical profession. The traditional financing programs "have systematically fostered the demand-stimulating effects of third-party payment and foreclosed experimentation with ways of offsetting those effects."[59] Accordingly, these characteristics have made the HMO's a threat to the fee-for-service providers and insurers. Thus, organized medicine initially reacted to the development of these institutions by condemning them as a form of unethical medical practice.[60] Lately, however, the attack on HMO's has been more subtle; providers have adopted the HMO form in a preemptive or defensive manner to "deter entry by or to discipline more aggressive, independently-sponsored HMOs."[61]

Defensive HMO's are frequently in the form of the foundations for medical care (FMC) that are established by county medical societies in the areas where HMO's are likely to develop.[62] Generally open to participation by all physician members of the initiating medical society, the FMC's reimburse participating physicians on a fee-for-service basis. "This organizational form differs dramatically from the closed-panel HMO, which typically employs physicians on a salaried or profit-sharing basis and provides its services in physically integrated group practice facilities."[63]

The FMC's participants are usually required to accept certain controls over their practice—particularly, maximum fee schedules

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more cost-effective care." Feldman & Zeckhauser, *supra* note 18, at 103. They "set their price prospectively. This completely changes the incentives found in the traditional system . . . . The financing and service functions are merged in a single organization. The cost consequences of the decisions made by an organization's providers are fully reflected in their prospective fee." Drury & Enthoven, *supra* note 20, at 409.

58. "Patients can select an . . . [HMO] at a time when they are not in immediate need of services, when they can evaluate the philosophy and propensities of competing organizations against their costs. In other words, *in such a market patients can exercise economic judgment*." Drury & Enthoven, *supra* note 20, at 409 (emphasis added).

59. Havighurst, *supra* note 43, at 306.

60. Kissam, *supra* note 56, at 492. HMO's were also said to provide unreasonable competition for physicians. *See, e.g.*, American Medical Ass'n v. United States, 130 F.2d 233, 238-40 n.23 (D.C. Cir. 1942), *aff'd*, 317 U.S. 519 (1943). This claim may not be entirely without merit. "HMOs' particular financial incentives arguably could produce certain kinds of over-economizing that are damaging to patients." Kissam, *supra* note 56, at 492.

61. Kissam, *supra* note 56, at 491.

62. *Id.* at 492 n.19. Two other common forms of defensive HMO's also exist. Blue Cross and Blue Shield plans may create programs designed to protect their sizeable market shares. Also, a dominant hospital in a small city might initiate such a plan to service a selected population. *Id.*

63. *Id.*

and peer review.[64] Where the FMC's "are arms of large, multi-market 'monopolies' such as Blue Cross or state medical societies, there may be particular incentives for them to engage in predatory pricing or promotion against an individual HMO trying to enter a single market."[65] Further, if the maximum prices become the minimum price, price competition will likely cease to exist.[66]

Accordingly, the FMC's are subject to attack on several fronts. First, "[a]lthough FMCs are a step in the right direction where they are effective, they may be seen . . . as mild half-measures compared to the independent initiatives they preempt—both independently operated HMOs and insurance plans having their own cost-containment machinery."[67] Second, the use of maximum fee schedules and other forms of price control or communication among health care providers subjects those involved to potential antitrust liability.[68]

III. ANTITRUST AND COST CONTAINMENT EFFORTS

While "there are powerful reasons why certain kinds of fee schedules are desirable in the insurance context,"[69] such arrangements may be found to violate the Sherman Act's proscription against unreasonable restraints of trade.[70] The Supreme Court has made clear its commitment to enforcing the antitrust laws.[71] For example, in *City of Lafayette v. Louisiana Power & Light*

64. This is the very type of organization and controls that were the subject of the judicial inquiry in *Maricopa County*. *See infra* notes 137-48 and accompanying text.
65. Kissam, *supra* note 56, at 491. "Defensive HMOs are likely to set their premiums at entry limiting levels and to recruit aggressively only among those groups that are most likely to be attracted to competitive HMOs." *Id.*
66. *See* Arizona v. Maricopa County Medical Soc'y, 102 S. Ct. at 2474-75 (quoting Albrecht v. Herald Co., 390 U.S. 145, 152-53 (1968)). Maximum price schedules may be acceptable if they are administered individually by private insurance carriers.

> [A]ntitrust policy objects not merely to fixed minimum, but also to maximum prices when they are established by concerned professionals, and even when the period of fix is relatively short. However, where those with economic interests adverse to the profession's are in a position to control the schedule, antitrust objections are obviated.

Kallstrom, *supra* note 24, at 678.
67. Havighurst, *supra* note 43, at 315-16.
68. *See supra* notes 65-66 and accompanying text.
69. Kallstrom, *supra* note 24, at 664. "They contribute to the predictability of risks and thereby permit lower premiums." *Id.* at 664-65.
70. *See supra* note 2.
71. "Congress 'exercis[ed] all the power it possessed' under the Commerce Clause when it approved the Sherman Act." California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97, 111 (1980) (quoting Atlantic Cleaners & Dyers v. United States, 286 U.S. 427, 435 (1932)).

Co.,[72] the Court stated "that Congress, exercising the full extent of its constitutional power, sought to establish a regime of competition as the fundamental principle governing commerce in this country."[73] In sweeping language, the Court has also stressed:

> Antitrust laws in general, and the Sherman Act in particular, are the Magna Carta of free enterprise. They are as important to the preservation of economic freedom and our free-enterprise system as the Bill of Rights is to the protection of our fundamental personal freedoms. And the freedom guaranteed each and every business, no matter how small, is the freedom to compete—to assert with vigor, imagination, devotion, and ingenuity whatever economic muscle it can muster.[74]

Due to their inherent anticompetitive tendencies concerted efforts to promote cost containment in the health care industry must be carefully implemented, lest they run afoul of the antitrust laws. Proponents of cost containment measures have historically identified three strategies for avoiding antitrust liability. First, they have attempted to convince the courts that there is an implied antitrust exemption for the professions.[75] Second, they have claimed to be within the antitrust exemption for the "business of insurance."[76] Finally, they have called for the application of a rule of reason standard for maximum price schedules designed to promote cost control in the health profession.[77]

A. Implied Antitrust Exemptions For Professional Activity

The antitrust laws, "created for and . . . developed in an environment of commercial competition . . . have not, as of yet, been applied extensively to the field of medicine."[78] Early decisions by

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72. 435 U.S. 389 (1978). Rejecting a claim that the insurance business was not within the purview of the Sherman Act, the Court in United States v. South-Eastern Underwriters, 322 U.S. 533 (1944), stated: "Language more comprehensive is difficult to conceive. On its face it shows a carefully studied attempt to bring within the Act every person engaged in business whose activities might restrain or monopolize commercial intercourse among the states." *Id.* at 553.
73. 435 U.S. at 398. *See* Mandeville Island Farms, Inc. v. American Crystal Sugar Co., 334 U.S. 219, 229-35 (1948).
74. United States v. Topco Assoc., Inc., 405 U.S. 596, 610 (1972).
75. *See infra* notes 78-98 and accompanying text.
76. *See infra* notes 99-111 and accompanying text.
77. *See infra* notes 115-33 and accompanying text.
78. Horan & Nord, *Application of Antitrust Law to the Health Care Delivery System*, 9 CUMBERLAND L. REV. 685 (1979).

    > The antitrust laws exist in order to promote the abstract standard of societal benefit through unrestrained competition and cannot, in the foreseeable future, be expected to evolve to a state of compatibility with many of the existing practices in the health care delivery system. The present efforts to apply the antitrust laws to health care providers are part of a calculated plan to bring about fundamental changes in the operation of the health care delivery system.

the United States Supreme Court indicated that medicine, as well as the other professions, might enjoy an implied exemption from the Sherman Act.[79] However, in 1975, with the resolution of *Goldfarb v. Virginia State Bar*,[80] the Court extended the reach of the antitrust laws to the anticompetitive activities of the professions.

In *Goldfarb*, the Court was called upon to decide "whether a minimum fee schedule for lawyers published by the Fairfax County Bar Association and enforced by the Virginia State Bar violate[d] § 1 of the Sherman Act . . . ."[81] Resting on its perception of a history of judicial recognition of an implied exclusion from antitrust for the "learned professions," the court of appeals had decided against liability, holding that the practice of law is not "trade or commerce."[82] The Supreme Court reversed the court of appeals stating that "[t]he nature of an occupation, standing alone, does not provide sanctuary from the Sherman Act . . . ."[83] It emphasized that "the public-service aspect of professional practice [is not] controlling in determining whether § 1 includes professions."[84] The Court stressed that, "[i]n the modern world . . . the activities of lawyers play an important part in commercial intercourse, and . . . [the] anticompetitive activities by lawyers may exert a restraint on commerce."[85] In opening the door of antitrust enforcement to professional activities, the Court did offer one limitation:

> The fact that a restraint operates upon a profession as distinguished from a business is, of course, relevant in determining whether that particular restraint violates the Sherman Act. It would be unrealistic to view the practice of professions as interchangeable with other business activities, and automatically to apply to the professions antitrust concepts which originated in other areas. The public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently.[86]

Soon after the *Goldfarb* Court held that professional activities were "trade or commerce" within the meaning of the Sherman Act,

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Id.

79. United States v. National Ass'n of Real Estate Bds., 339 U.S. 485, 490 (1950); Atlantic Cleaners & Dyers v. United States, 286 U.S. 427, 436 (1932); FTC v. Raladam Co., 283 U.S. 643, 653 (1931); Federal Club v. National League, 259 U.S. 200, 209 (1922). *But see, e.g.*, American Medical Ass'n v. United States, 317 U.S. 519, 528 (1943).
80. 421 U.S. 773 (1975).
81. *Id.* at 775.
82. Goldfarb v. Virginia State Bar, 497 F.2d 1, 13 (4th Cir. 1974).
83. 421 U.S. at 787 (citing Associated Press v. United States, 326 U.S. 1, 7 (1945)).
84. 421 U.S. at 787 (citing United States v. National Ass'n of Real Estate Bds., 339 U.S. 485, 489 (1950)).
85. 421 U.S. at 788.
86. *Id.* at 788-89 n.17.

the Court further eroded the jurisdictional barrier which sheltered the health care professions from antitrust constraints. Originally, activities were within the reach of the Act if they occurred in or in the flow of interstate commerce.[87] This jurisdictional prerequisite was widened to include health activities that materially affect interstate commerce in *Hospital Building Co. v. Trustees of Rex Hospital*.[88] *Rex Hospital* involved a proprietary hospital's suit against a competing not-for-profit hospital. Allegedly the not-for-profit hospital conspired to prevent the proprietary hospital from obtaining governmental approval to relocate and expand its facility. In rejecting the argument that the provision of hospital and medical services is "strictly a local intra-state business,"[89] the Court held that, taken together, the hospital's interstate purchases of medical supplies, its revenues from out-of-state insurance companies, its management fees paid to its out-of-state parent, and the out-of-state financing it procured for its new facility established a substantial impact on interstate commerce.[90]

Goldfarb and *Rex Hospital* greatly increased the susceptibility of the health care profession to antitrust liability. After these two decisions, a profession seeking to escape antitrust liability must show that its anticompetitive activities " 'serve the purpose for which the profession exists, *viz.* to serve the public. That is, it must contribute directly to improving service to the public. Those which only suppress competition between practitioners will fail to survive the [antitrust] challenge.' "[91]

In *National Society of Professional Engineers v. United States*,[92] the Court made its first post-*Goldfarb* inquiry into the anticompetitive activities of a professional organization. While supporting *Goldfarb*'s denial of an implied antitrust exemption for the professions, *Professional Engineers* did concede that anticompetitive professional practices might be examined under the rule of reason analysis. However, it cautioned that only procompetitive justifications would support such acts.[93]

87. *See* Gulf Oil Corp. v. Copp Paving Co., 419 U.S. 186, 201-02 (1974); Mandeville Island Farms Inc. v. American Crystal Sugar Co., 334 U.S. 219, 229-33 (1948).
88. 425 U.S. 738 (1976).
89. *Id.* at 742.
90. *Id.* at 744. *Rex Hospital* illustrates the Sherman Act's expanding reach under the "affectation doctrine" of the Commerce Clause. "If it is interstate commerce that feels the pinch, it does not matter how local the operation which applies the squeeze." United States v. Women's Sportswear Mfg. Ass'n, 336 U.S. 460, 464 (1949).
91. Horan & Nord, *supra* note 78, at 699 (quoting Boddicker v. Arizona State Dental Ass'n, 549 F.2d 626, 632 (9th Cir. 1977)).
92. 435 U.S. 679 (1978).
93. *Id.* at 692. *See infra* note 96 and accompanying text.

Professional Engineers involved a civil antitrust case brought by the United States

> to nullify an association's canon of ethics prohibiting competitive bidding by its members. The question . . . [was] whether the canon may be justified under the Sherman Act . . . because it was adopted by . . . a learned profession for the purpose of minimizing the risk that competition would produce inferior engineering work endangering the public safety.[94]

While recognizing *Goldfarb*'s intimation that certain professional restraints might survive antitrust scrutiny, even though they would violate the laws in another context,[95] the Court still rejected the Society's justification for its anticompetitive ban on bidding. The Court explained:

> There are . . . two complementary categories of antitrust analysis. In the first category are agreements whose nature and necessary effect are so plainly anticompetitive that no elaborate study of the industry is needed to establish their illegality—they are "illegal *per se*." In the second category are agreements whose competitive effect can only be evaluated by analyzing the facts peculiar to the business, the history of the restraint, and the reasons why it was imposed. In either event, the purpose of the analysis is to form a judgment about the competitive significance of the restraint; it is not to decide whether a policy favoring competition is in the public interest, or in the interest of the members of an industry . . . . [T]hat policy decision has been made by the Congress.[96]

Describing price as the "central nervous system of the economy,"[97] *Professional Engineers* held that "an agreement that 'interfere[s] with the setting of price by free market forces is illegal on its face.' "[98]

B. An Antitrust Exemption for the "Business of Insurance"

After the Court's refusal to imply an antitrust exemption for the professions, health care insurers and providers hoped to find shelter from the rigors of antitrust under the McCarran-Ferguson Act's exemption for the "business of insurance."[99] Because of the con-

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94. 435 U.S. at 681.
95. *Id.* at 686. *See supra* text accompanying note 86.
96. 435 U.S. at 692. "Contrary to its name, the Rule [of Reason] does not open the field of antitrust inquiry to any argument in favor of a challenged restraint that may fall within the realm of reason. Instead, it focuses directly on the challenged restraint's impact on competitive conditions." *Id.* at 688.
97. 435 U.S. at 692. *See* United States v. Socony-Vacuum Oil Co., 310 U.S. 150, 226 n.59 (1940).
98. 435 U.S. at 692 (quoting United States v. Container Corp., 393 U.S. 33, 337 (1969)). "While this is not price fixing as such, no elaborate industry analysis is required to demonstrate the anticompetitive character of such an agreement." 435 U.S. at 692.
99. Act of Mar. 9, 1945 (McCarren-Ferguson Act), 15 U.S.C. §§ 1011-15 (1976). The Act provides in part:

> [§ 1012] (a) The business of insurance, and every person engaged

gressional commitment to a free enterprise system,[100] the Supreme Court has consistently held that exemptions from antitrust must be construed narrowly.[101] Accordingly, it has narrowed the "business of insurance" exemption, identifying three criteria relevant in determining if a particular practice qualifies for the McCarran-Ferguson Act's antitrust shelter: "*first*, whether the practice has the effect of transferring or spreading a policy holder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry."[102]

Using this constricted view, the Court concluded there was no exemption in *Group Life & Health Insurance Co. v. Royal Drug Co.*[103] That case involved a Blue Shield policy which attempted to control the cost of prescription drugs. If an insured selected a participating pharmacy—one which had entered into a "Pharmacy Agreement"—he was required to pay only $2 for every prescription drug. The remainder of the cost would be paid directly to the participating pharmacy by Blue Shield.[104] In *Royal Drug* the Court carefully noted that the only issue before it was

> whether the Court of Appeals was correct in concluding that the Pharmacy Agreements are not the "business of insurance" within the meaning of . . . the McCarran-Ferguson Act. If that conclusion is correct, then the Agreements are not exempt from examination under the antitrust laws. Whether the Agreements are *illegal* under the antitrust laws is an entirely

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> therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
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> [§ 1012] (b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, . . . unless such Act specifically relates to the business of insurance . . . .
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> . . . .
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> [§ 1013] (b) Nothing contained in this chapter shall render the . . . Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation.

15 U.S.C. §§ 1012(a)-(b), 1013(b) (1976).

100. United States v. Topco Assocs., Inc., 405 U.S. 596, 610 (1972); Standard Oil Co. v. FTC, 340 U.S. 231, 248-49 (1951).

101. Abbott Laboratories v. Portland Retail Druggists Ass'n, 425 U.S. 1 (1976); Connell Constr. Co. v. Plumbers & Steamfitters, 421 U.S. 616 (1975); Federal Maritime Comm'n v. Seatrain Lines, Inc., 411 U.S. 726 (1973); United States v. McKesson & Robbins, Inc., 351 U.S. 305 (1956).

102. Union Labor Life Ins. Co. v. Pireno, 102 S. Ct. 3002, 3009 (1982) (citing Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205 (1979)).

103. 440 U.S. 205 (1979).

104. *Id.* at 209. Since Blue Shield would only reimburse the participating pharmacy for its cost of acquiring the drug, "only pharmacies that . . . [could] afford to distribute prescription drugs for less than . . . [the] $2 markup . . . [could] profitably participate in the plan." *Id.*

separate question . . . .[105]

Finding the program at issue in *Royal Drug* to evidence none of the criteria essential to a finding of the McCarran-Ferguson Act's applicability,[106] the Supreme Court denied it an antitrust exemption, explaining that "[t]he exemption is for the 'business of insurance,' not the 'business of insurers.' "[107]

Last year, in *Union Labor Life Insurance Co. v. Pireno*,[108] the Court again examined the "business of insurance" exemption and denied its application to an alleged conspiracy to eliminate price competition among chiropractors. The program in *Pireno* involved the use of a "peer review committee" composed of practitioners that advised insurance companies as to whether particular treatments and fees were "necessary" and "reasonable." In denying the exemption, the Court stressed that the criteria relevant to the exemption[109] were not satisfied[110] and expressed particular concern that the program threatened to restrain competition in non-insurance markets.[111]

Like *Royal Drug*,[112] *Pireno* emphasized that "[t]he only issue before us is whether petitioners' peer review practices are exempt from antitrust scrutiny as part of the 'business of insurance.' . . . Thus in deciding this case we have no occasion to address the merits of respondent's Sherman Act claims."[113]

Royal Drug and *Pireno* demonstrate the Supreme Court's constriction of the "business of insurance" exemption. Coupled with *Goldfarb*'s denial of a general antitrust exemption for professions—a view reinforced by *Professional Engineers*—and *Rex Hospital*'s recognition of an expanding reach for the Sherman Act, cost containment reformers were forced to shift their efforts to-

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105. *Id.* at 210.
106. *See supra* text accompanying note 102.
107. 440 U.S. at 211. In narrowly construing the insurance exemption the Court stated: "If agreements between an insurer and retail pharmacists are the 'business of insurance' because they reduce the insurer's costs, then so are all other agreements insurers may make to keep their costs under control—whether with automobile body repair shops or landlords." *Id.* at 232.
108. 102 S. Ct. 3002 (1982).
109. *See supra* text accompanying note 102.
110. 102 S. Ct. 3002, 3009-10.
111. *Id.* at 3010. "[T]he practices retrain competition in a provider market—the market for chiropractic services—rather than in an insurance market." *Id.* at 3011.
112. *See supra* text accompanying note 105.
113. 102 S. Ct. at 3007. Criticizing the *Pireno* decision, Justice Rehnquist complained that "[a]lthough the Court protests that its decision says nothing about petitioners' antitrust liability, there can be little doubt that today's decision will vastly curtail the peer review process. Few professionals or companies will be willing to expose themselves to possible antitrust liability through such activity." *Id.* at 3014 (Rehnquist, J., dissenting).

ward convincing the judiciary that health care restraints are properly scrutinized under a rule of reason analysis.[114]

C. Maximum Fee Schedules: Rule of Reason v. Per Se Analysis

Since most health care cost containment programs involve agreements to control fees—generally maximum fee schedules—the Court has had to determine if the usual per se rule against price fixing applies to such programs. It has been asserted that "[p]rice fixing . . . should not escape per se condemnation simply because . . . [it] enjoy[s] the respectability of having been mandated by the ethical rules of a given profession."[115]

This conflict between per se or rule of reason analysis has been thrust to the forefront in the judicial controversy surrounding cost containment efforts in the health field. Judge Hand offered strong support for an open approach in antitrust analysis when he wrote:

> [A]s everyone now agrees . . . restriction alone is not enough to stamp a combination as illegal; it must be "unreasonable" in the sense that the common law understood that word; and that never has been, and indeed in the nature of things never can be, defined in general terms. Courts must proceed step by step, applying retroactively the standard proper for each situation as it comes up, just as they do in the case of negligence, reasonable notice, and the like.[116]

Furthermore, the Court has cautioned against too hasty an application of per se rules, stressing that their "advantages are not sufficient in themselves to justify the creation of *per se* rules. If it were otherwise, all of antitrust law would be reduced to *per se* rules, thus introducing an unintended and undesired rigidity in the law."[117] Despite these convincing arguments for rule of reason analysis, the judiciary has simultaneously recognized the importance of per se rules since "[o]nce established, . . . [they] tend to provide guidance to the business community and to minimize the burden on litigants and the judicial system of the more complex rule-of-reason trials."[118] Indeed maximum fee schedule cases have historically been accorded per se treatment. For example, in

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114. This movement was fueled by *Professional Engineer*'s interpretation of the *Goldfarb* decision. *See supra* text accompanying notes 86 & 93-95.

115. Note, *The Professions and Noncommercial Purposes: Applicability of Per Se Rules Under the Sherman Act*, 11 U. MICH. J.L. REF. 387, 413 (1978). "In . . . [this case], courts should not hesitate to pierce the veil of professional self-regulation during their inquiries into noncommercial purpose." *Id.*

116. United States v. Associated Press, 52 F. Supp. 362, 368 (S.D.N.Y. 1943), *aff'd*, 326 U.S. 1 (1945).

117. 433 U.S. at 50 n.16.

118. Continental T.V., Inc. v. GTE Sylvania, Inc., 433 U.S. 36, 50 n.16 (1977). "Per se rules are perceived as promoting values not only of judicial economy but also of certainty and prophylaxis." Note, *supra* note 115, at 391.

Kiefer-Stewart Co. v. Joseph E. Seagram & Sons, Inc.,[119] the Supreme Court reaffirmed the notion that " '[u]nder the Sherman Act a combination formed for the purpose and with the effect of raising, depressing, fixing, pegging, or stabilizing the price of a commodity in interstate or foreign commerce is illegal *per se*.' "[120] The case arose after several liquor producers agreed to sell liquor only to wholesalers who would resell at prices fixed by the producers. The Court assessed per se liability because "agreements among competitors to fix maximum resale prices . . . no less than those to fix minimum prices, crippled the freedom of traders and thereby restrain their ability to sell in accordance with their own judgment."[121]

Seventeen years later, the Supreme Court, in *Albrecht v. Herald Co.*,[122] reaffirmed *Kiefer-Stewart*'s logic. In *Albrecht* the Court found the Sherman Act to proscribe, under its per se standard, a newspaper's program of issuing exclusive territories and terminating carriers whose prices exceeded its suggested maximum. Citing *Kiefer-Stewart*, Justice White's majority opinion emphasized that the Court had previously rejected the view that setting maximum prices constituted no restraint on trade.[123] Noting the long accepted rule that resale price fixing is a per se violation of the law,[124] *Albrecht* held "that the combination formed . . . to force petitioner to maintain a specified price for the resale of newspapers . . . constituted, without more, an illegal restraint of trade . . . ."[125] In the majority's view,

> [m]aximum and minimum price fixing may have different consequences in many situations. But schemes to fix maximum prices, by substituting the perhaps erroneous judgment of a seller for the forces of the competitive market, may severely intrude upon the ability of buyers to compete and survive in the market. Competition, even in a single product, is not cast in a single mold. Maximum prices may be fixed too low for the dealer to furnish services essential to the value which goods have for the consumer or to furnish services and conveniences which consumers desire and for which they are willing to pay. Maximum price fixing may channel distribution through a few large or specifically advantaged dealers who otherwise would be subject to significant nonprice competition.[126]

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119. 340 U.S. 211 (1951).
120. *Id.* at 213 (quoting United States v. Socony-Vacuum Oil Co., 310 U.S. 150, 223 (1940)).
121. 340 U.S. at 213.
122. 390 U.S. 145 (1968).
123. *Id.* at 152.
124. 390 U.S. at 151. *See* United States v. McKesson & Robbins, Inc., 351 U.S. 305 (1956); Kiefer-Stewart Co. v. Joseph E. Seagram & Sons, 340 U.S. 211 (1951); United States v. Socony-Vacuum Oil Co., 310 U.S. 150 (1940); United States v. Trenton Potteries Co., 273 U.S. 392 (1927).
125. 390 U.S. at 153.
126. *Id.* at 152-53. In a stinging dissent, Justice Harlan complained that "to con-

This judicial proscription against all price fixing continued until 1979, when the Court appeared to relax its position that all price fixing arrangements—minimum or maximum—were per se illegal. The case, *Broadcast Music, Inc. v. Columbia Broadcasting System*,[127] involved an antitrust challenge to the blanket license scheme utilized by American Society of Composers, Authors and Publishers (ASCAP) and Broadcast Music, Inc. (BMI). The licensing procedure was designed to overcome the fact that "as a practical matter it was impossible for the many individual copyright owners [of music] to negotiate with and license the users and to detect unauthorized uses."[128] Members of ASCAP grant the society the nonexclusive rights to license performances of their works, and ASCAP issues licenses and distributes royalties to the copyright owners. BMI, owned by members of the broadcast industry, operates in a similar manner. By selling blanket licenses, these organizations give the licensees the right to perform any and all of the music for a stated period of time. The fees for a blanket license are usually either a percentage of total revenues or a flat

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clude that no acceptable justification for fixing maximum prices can be found simply because there is no acceptable justification for fixing minimum prices is to substitute blindness for analysis." *Id.* at 157 (Harlan, J., dissenting). He explained that "[r]esale price maintenance . . . lessens horizontal intrabrand competition. The effects, higher prices, less efficient use of resources, and an easier life for resellers, are the same whether the price maintenance policy takes the form of a horizontal conspiracy among resellers or of vertical dictation by a manufacturer plus reseller acquiescence." *Id.* Thus, he concluded that it was possible to infer a combination of resellers since "it is the resellers and not the manufacturer who reap the direct benefits of the policy." *Id.* Vertically imposed price ceilings were, in Harlan's view, an entirely different matter. "Other things being equal, a manufacturer would like to restrict those distributing his product to the lowest feasible profit margin, for in this way he achieves the lowest overall price to the public and the largest volume." *Id.* at 157-58. In dictating a price ceiling, "he [(the manufacturer)] is acting directly in his own interest, and there is no room for the inference that he is merely a mechanism for accomplishing anticompetitive purposes of his customers [(resellers)]." *Id.* at 158. Justice Harlan went on to explain:

> The *per se* treatment of price maintenance is justified because analysis alone, without the burden of a trial in each individual case, demonstrates that price floors are invariably harmful on balance. Price ceilings are a different matter: they do not lessen horizontal competition; they drive prices toward the level that would be set by intense competition, and they cannot go below this level unless the manufacturer who dictates them and the customer who accepts them have both miscalculated. Since price ceilings reflect the manufacturer's view that there is insuffficient competition to drive prices down to a competitive level, they have the arguable justification that they prevent retailers or wholesalers from reaping monopoly or supercompetitive profits.

Id. at 159.

127. 441 U.S. 1 (1979).

128. *Id.* at 5.

amount. Prior to this lawsuit Columbia Broadcasting System (CBS) held blanket licenses from both groups.[129] CBS contended that the licensing system constituted price fixing and a tying arrangement, both per se unlawful under the Sherman Act.[130] In denying relief to CBS, the Court explained: "We have never examined a practice like this one before . . . . And though there has been rather intensive antitrust scrutiny of ASCAP and its blanket licenses, that experience hardly counsels that we should outlaw the blanket license as a *per se* restraint of trade."[131]

Broadcast Music rang sweet to the ears of commentators who have cautioned against too hasty an application of per se liability to professions with which the Court is not familiar: "[U]ntil the 'business and economic stuff' of a given profession's activities have been reduced to predictable patterns, ad hoc determinations . . . are preferable to the unchecked extension of per se rules into this new area of the courts' antitrust jurisdiction."[132] The Court in *Broadcast Music* had adopted this approach, forsaking the per se approach until it was better acquainted with the practices of the music industry.[133]

This was the background from which *Maricopa County* arose. With cost escalation in the health care industry running rampant, it was suggested that costs could be brought under control only through programs which made providers and users more cost conscious. Numerous commentators argued that among the free market alternatives, only enforcement of fee schedules by private insurers[134] and the development of closed-panel HMO's[135] had any real hope of containing costs. Therefore, the development of open-panel FMC's, like those at issue in *Maricopa County*, was received with some skepticism. They were perceived as conspiracies designed to undermine the effectiveness of the more promising alternatives. Accordingly, "[i]t . . . [was] argued that vigorous enforcement of the antitrust laws against . . . [these] concerted actions taken by physicians with respect to health care financing could significantly improve the climate for private cost-containment initiatives."[136] Accepting the Court's reluctance to exempt anticompetitive activities from the Sherman Act, the FMC's were forced to rest their defense on the hope that *Broadcast Music* her-

129. *Id.*
130. *Id.* at 4-6.
131. *Id.* at 10.
132. Note, *supra* note 115, at 416 (quoting White Motor Co. v. United States, 372 U.S. 253, 263 (1963)).
133. *See supra* text accompanying note 131.
134. *See supra* notes 51-53 and accompanying text.
135. *See supra* notes 54-59 and accompanying text.
136. Havighurst, *supra* note 43, at 305.

alded the rule of reason approach to maximum fee schedules in the health profession.

IV. *ARIZONA v. MARICOPA COUNTY MEDICAL SOCIETY*: PER SE ANALYSIS FOR MAXIMUM FEE SCHEDULES IMPLEMENTED BY DEFENSIVE HMO's

A. Factual Background

The FMC's involved in *Maricopa County* were not-for-profit corporations licensed as "insurance administrators"[137] by the State of Arizona.[138] Organized "for the purpose of promoting fee-for-service medicine and to provide the community with a competitive alternative to existing health insurance plans,"[139] the FMC's performed three basic functions:

> [They] establish[ed] the schedule for maximum fees that participating doctors agree[d] to accept as payment in full for services performed for patients insured under plans approved by the foundation[s]. [They] . . . review[ed] the medical necessity and appropriateness of treatment provided by . . . [their] members to . . . insured persons. [They were] . . . authorized to draw checks on insurance company accounts to pay doctors for services performed for covered patients.[140]

The FMC's claimed that their price fixing "subserv[ed] a general purpose of setting minimum standards and performing peer review and administrative tasks for health insurance plans."[141] In

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137. Arizona v. Maricopa County Medical Soc'y, 643 F.2d 553, 554 (9th Cir. 1980). Originally the defendants moved to dismiss on the ground that they were engaged in the "business of insurance" and were therefore exempted from the proscriptions of the Sherman Act by the McCarran-Ferguson Act. For a discussion of the "business of insurance" exemption, see *supra* notes 99-114 and accompanying text. This motion was denied since "the agreements between physicians participating in the foundation-approved plans . . . spread no risk peculiar to the business of insurance." 643 F.2d at 559 n.7 (quoting Arizona v. Maricopa County Medical Soc'y, No. CIV-78-800 PHX WPC (D. Ariz. June 11, 1979)). The defendants did not appeal this portion of the order. 102 S. Ct. 2466, 2469 n.2 (1982).
138. 643 F.2d at 554. The Maricopa Foundation for Medical Care is composed of licensed doctors of medicine, osteopathy, and podiatry engaged in private practice. It numbered approximately 1,750 doctors—about 70 percent of the practitioners in Maricopa County. 102 S. Ct. at 2470. The Pima Foundation for Medical Care included 400 member doctors—representing somewhere between 30 to 80 percent of the Pima County doctors. *Id.* at 2471 n.8. The two FMC's in the case have been described as "exemplify[ing] a type of organization that is beginning to play a significant part in the health services market." 643 F.2d at 554. *See supra* notes 62-68 and accompanying text.
139. 102 S. Ct. at 2470.
140. *Id.* at 2470-71. It was emphasized that "participating doctors . . . have no financial interest in the operation of the foundation." *Id.* at 2471.
141. 643 F.2d at 555. "No challenge is made to their peer review or claim administration functions. Nor do the foundations allege that these two activities

compiling the fee schedules the foundations made use of "relative values" and "conversion factors."[142] When periodically revising the fee schedules, "[t]he foundation board of trustees would solicit advice from various medical societies about the need for change in either relative values or conversion factors in their respective specialties. The board would then formulate the new fee schedule and submit it to the vote of the entire membership."[143]

Insurers[144] obtained foundation approval only after they agreed to pay all of the doctors' charges up to the scheduled maximum. In turn, the doctors agreed to accept the amounts as payment in full for their services. However, "[t]he doctors . . . [remained] free to charge higher fees to uninsured patients and they also . . . [could] charge any patient less than the scheduled maxima."[145]

Some dispute existed over the precise impact of the fee sched-

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make it necessary for them to engage in the practice of establishing maximum fee schedules." 102 S. Ct. at 2471. *See also supra* text accompanying note 140. The state contended that the fee schedules were not inseparable from the professional standards review of the foundations, noting that "the foundations offer peer review and administrative services for at least one health program—the foster child program—in which prices paid the doctors are not set by themselves but by the third party payor." 643 F.2d at 555.

142. 102 S. Ct. at 2471.

> The conversion factor is the dollar amount used to determine fees for a particular medical specialty. Thus, for example, the conversion factors for "medicine" and "laboratory" were $8.00 and $5.50, respectively, in 1972, and $10.00 and $6.50 in 1974. The relative value schedule provides a numerical weight for each different medical service—thus, an office consultation has a lesser value than a home visit. The relative value was multiplied by the conversion factor to determine the maximum fee.

Id. Relative value scales have been challenged in the past by both the Federal Trade Commission and the Justice Department as price fixing devices. *See* United States v. Illinois Podiatry Soc'y, Inc., 1977-2 Trade Cas. (CCH) ¶ 61,767 (N.D. Ill. 1977) (consent decree); United States v. Alameda County Veterinary Medical Ass'n, 1977-2 Trade Cas. (CCH) ¶ 61,738 (N.D. Cal. 1977) (consent decree); American College of Radiology, 89 F.T.C. 144 (1977) (consent decree); American Academy of Orthopedic Surgeons, 88 F.T.C. 968 (1976) (consent decree); American College of Obstetricians & Gynecologists, 88 F.T.C. 955 (1976) (consent decree).

143. 102 S. Ct. at 2471.

144. Seven insurance companies underwrote health plans approved by the Maricopa foundation and three companies participated with the Pima foundation. *Id.* at 2471 n.11.

145. *Id.* at 2471. Thus,

> [a] patient who is insured by a foundation-endorsed plan is guaranteed complete coverage for the full amount of his medical bills only if he is treated by a foundation member. He is free to go to a nonmember physician and is still covered for charges that do not exceed the maximum fee schedule, but he must pay any excess that the nonmember physician may charge.

Id. at 2471-72.

ules on medical fees and insurance premiums. The state argued that the schedules raised members' fees above the average and median fees charged by Arizona doctors. It contended that "the periodic upward revisions of the maximum fee schedules . . . [had] the effect of stabilizing and enhancing the level of actual charges by physicians, and that the increasing level of their fees in turn increase[d] insurance premiums."[146] Contesting the appropriateness of the statewide figures used for comparison,[147] the foundations

> argue[d] that the schedules impose a meaningful limit on physicians' charges, and that the advance agreement by the doctors to accept the maxima enables the insurance carriers to limit and to calculate more efficiently the risks they underwrite and therefore serves as an effective cost containment mechanism that has saved patients and insurers millions of dollars.[148]

B. The Court of Appeals

The court of appeals stated that "the challenged practice . . . [was] not a per se violation."[149] However, the fact that a restraint may appear reasonable is not controlling: "The key . . . is the agreement's impact on competition. If competition is promoted the agreement passes muster; if it suppresses or destroys competition it does not."[150] The court was concerned that the record revealed nothing about the redeeming virtues or competitive harms of the challenged arrangement.[151] Additionally, the court was "uncertain about the competitive order that should exist within the health care industry pursuant to the Sherman Act as interpreted by the courts."[152] Finally, since the "present supply and demand

146. *Id.* at 2472.
147. 643 F.2d at 555. The foundations did "concede that eighty-five to ninety-five percent of physicians in Maricopa County bill at or above the maximum reimbursement levels set by the county FMC." *Id. See* 102 S. Ct. at 2471 n.10.
148. 102 S. Ct. at 2472. "[T]he Attorneys General of 40 different States, as well as the Solicitor General of the United States and certain organizations representing consumers of medical services, have filed *amicus curiae* briefs supporting the State of Arizona's position on the merits . . . ." *Id.*
149. 643 F.2d at 560.
150. *Id.* at 556. Restraints proscribed by the Sherman Act may be " 'based either (1) on the nature and character of the contracts, or (2) on surrounding circumstances giving rise to the inference or presumption that they were intended to restrain trade and enhance prices.' " *Id.* (quoting National Soc'y of Professional Eng'rs v. United States, 435 U.S. 679, 690 (1978)). *See supra* text accompanying notes 92-93.
151. 643 F.2d at 556. "In truth, we know very little about the impact of this and many other arrangements within the health care industry. This alone should make us reluctant to invoke a per se rule with respect to the challenged arrangement." *Id.*
152. *Id.* The opinion noted that professions had only recently been brought

functions of medical services in no way approximate those which would exist in a purely private competitive order . . . , [the court] lack[ed] baselines by which could be measured the distance between the present supply and demand functions and those which would exist under ideal competitive conditions."[153] For these reasons, per se liability was not imposed.

The court said the issue was "whether fees paid to doctors under . . . [the] system [as it exists] would be less than those payable under the FMC maximum fee agreement."[154] Therefore, it did not believe that it could properly invoke per se liability unless it could assume that "the FMCs are but devices to enable member doctors to capture a greater share of potential monopoly profit, which their monopoly power makes available, than otherwise would be possible."[155] The court of appeals was not prepared to make that assumption. Recognizing "that economic motives frequently lie behind even the best of good works,"[156] and that the fee schedules could well be contrary to antitrust principles,[157] the court asserted that "[t]o affix the per se label to appellees' conduct . . . [would] substitute an unsupported belief for proper proof."[158]

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within the reach of the Sherman Act. *Id. See* Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975). For a discussion of *Goldfarb*, see *supra* text accompanying notes 81-86.

153. 643 F.2d at 556. Judge Sneed writing for the Court of Appeals recognized that it was particularly difficult to determine the competitive order that should exist within the health care industry. Essential to such an understanding is the realization that access to the profession is time consuming and expensive for both the applicants and society. Also, "numerous government subventions of the costs of medical care have created both a demand and supply function for medical services that is artificially high." *Id. See supra* notes 31-37 and accompanying text.

154. 643 F.2d at 556. Thus, the issue was whether the fee schedules enhanced prices: "In simplified economic terms, the issue is whether the maximum fee arrangement better permits the attainment of the monopolist's goal, *viz.*, the matching of marginal cost to marginal revenue, or in fact obstructs that end." *Id.*

155. *Id.* at 557.

156. *Id.*

157. *Id.* On two separate occasions the Supreme Court has found maximum resale price arrangements to constitute per se violations of the Sherman Act. *See* Albrecht v. Herald Co., 390 U.S. 145 (1968); Kiefer-Stewart Co. v. Joseph E. Seagram & Sons, 340 U.S. 211 (1951). For a discussion of these cases, see *supra* notes 116-23 and accompanying text. Judge Sneed argued, however, that "[t]his circuit has not extended those rulings to horizontal agreements that establish maximum prices." 643 F.2d at 557 n.4. "It can hardly be said . . . that a per se rule forbidding horizontal maximum price agreements is well settled." *Id.* He did imply that if the exchange of price information involved in the arrangement was found to raise or maintain prices, it might well violate the Sherman Act. *Id.* at 557. *See* Maple Flooring Ass'n v. United States, 268 U.S. 563 (1925).

158. 643 F.2d at 557. Responding to the charge that the schedules violated the

Responding to the state's assertion that joint action "tamper[ing] with price structures" automatically offends antitrust,[159] the court of appeals cited *Broadcast Music* as having held that minimum price fixing in the market for copyrighted music was not per se unlawful.[160]

Being unable to evaluate the competitive aspects of any feature of the total structure of the health care profession, the majority was opposed to a per se standard. "Here the novelty of the market or markets and the inadequacy of the record make an inquiry into the affected areas of competition essential."[161] In reaching this conclusion the court drew comfort from the Supreme Court's recognition of a fundamental distinction between the professions and traditional commercial entities:

> [M]arketing restraints that regulate professional competition may pass muster under the Rule of Reason even though similar restraints on ordinary business competition would not. We believe this recognizes that a restraint may serve the public, the transcendent end of all professions, even though its presence in a purely commercial setting would violate the antitrust law.[162]

Judge Kennedy, in a concurring opinion, agreed that the court lacked "experience in judging the maximum reimbursement schedules" to brand them per se violations of the Sherman Act.[163] Noting that the antitrust laws may have a different application in a

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Sherman Act because they were designed to forestall government price controls that might force prices down to a lower level, Judge Sneed stressed:

> To eschew profit maximization in order to forestall price control is neither irrational nor, under the facts of this record, in violation of the Act. We observe in passing that only a government lost in an impenetrable legal maze, after having contributed substantially to the creation of monopoly conditions, would threaten price control if full monopoly profits are reaped and enforcement of the antitrust laws if private means are used to prevent the harvest.

Id.

159. *Id. See* United States v. Socony-Vacuum Oil Co., 310 U.S. 150, 221 (1940).
160. 643 F.2d at 557. *See* Broadcast Music, Inc. v. Columbia Broadcasting System, 441 U.S. 1, 9 & n.14 (1979). *See supra* text accompanying notes 127-33.
161. 643 F.2d at 558 n.5. The court of appeals was uncertain as to the competition between and among FMC's, insurance carriers, hospitals, and HMO's. It noted that "[w]hen a questioned business practice affects more than one sphere of competition, the Rule of Reason of course recognizes that the enhancement of competition in one sphere may offset the weakening of competition in another." *Id. See* First Beverages, Inc. v. Royal Crown Cola Co., 612 F.2d 1164, 1170 n.8 (9th Cir. 1980).
162. 643 F.2d at 560. *See* National Soc'y of Professional Eng'rs v. United States, 435 U.S. at 696 & n.22; Goldfarb v. Virginia State Bar, 421 U.S. at 788-89 n.17; Boddicker v. Arizona State Dental Ass'n, 549 F.2d 626 (9th Cir. 1977).
163. 643 F.2d at 560 (Kennedy, J., concurring). " 'It is only after considerable experience with certain business relationships that courts classify them as per se violations . . . .' " *Id.* (quoting United States v. Topco Assocs., Inc., 405 U.S. 596, 607-08 (1972)).

professional setting,[164] Judge Kennedy reiterated that "[p]er se rules should be derived from considerations of economic impact in particular cases illustrating the category of prohibited acts, and therefore a trial is appropriate to explore further the impact on competition of the challenged reimbursement schedules."[165]

In a strong dissent, Judge Larson would have measured the standard of liability by a three step inquiry. First, he would ask if this was the type of " 'naked price restraint' "[166] which had previously been adjudged per se illegal. "If so, then only some peculiarity of the health care industry can justify application of a lesser standard."[167] He believed that formulation and dispersal of the relative value guides and conversion factor lists[168] clearly constituted illegal price fixing,[169] and he could "find nothing in the nature of either the medical profession or the health care industry that would warrant their exemption from per se rules for price-fixing."[170]

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164. *See supra* text accompanying note 86 & 92-95.

165. 643 F.2d at 560 (Kennedy, J., concurring).

> This is not to suggest, however, that I have found these reimbursement schedules to be per se proper, that an examination of these practices under the rule of reason at trial will not reveal the proscribed adverse effect on competition, or that this court is foreclosed at some later date, when it has more evidence, from concluding that such schedules do constitute per se violations.

Id.

166. *Id.* at 563 (Larson, J., dissenting).

167. *Id. See, e.g.*, Silver v. New York Stock Exchange, 373 U.S. 341, 347 (1963).

168. *See supra* note 142.

169. *See* Albrecht v. Herald Co., 390 U.S. 145, 151-53 (1968); Kiefer-Stewart Co. v. Joseph E. Seagram & Sons, 340 U.S. 211, 213 (1951); Kartell v. Blue Shield of Mass., Inc., 592 F.2d 1191, 1193 n.2 (1st Cir. 1979); Quinn v. Mobil Oil Co., 375 F.2d 273, 274, 276-78 (1st Cir.), *cert. dismissed*, 389 U.S. 801 (1967); Crane Distributing Co v. Glenmore Distilleries, 267 F.2d 343, 345 (6th Cir. 1959); Vandervelde v. Put & Call Brokers & Dealers Assoc., 344 F. Supp. 118, 134 (S.D.N.Y. 1972).

170. 643 F.2d at 564 (Larson, J., dissenting). The dissent read the Supreme Court's decision in *National Society of Professional Engineers* as holding that "when the nature and character of an agreement among professionals is plainly anticompetitive, no extended analysis is necessary to find it forbidden under the Sherman Act." 643 F.2d at 564 (Larson, J., dissenting). Furthermore, "[c]ommentators have suggested that the commercial aspects of the professions, including medicine, should be subject to customary per se rules." *Id. See* Horan & Nord, *supra* note 78, at 700; Weller, *Medicaid Boycotts & Other Maladies from Medical Monopolists*, 11 CLEARINGHOUSE REV. 99, 104 (1977); Note, *supra* note 115, at 399 & n.36, 414-15.

Judge Larson interpreted the fee schedule arrangement as having "a wholly commercial nature . . . [that] has no relation to any public service aspect of the medical profession . . . ." 643 F.2d at 565 (Larson, J., dissenting). He recognized that Congress was aware of the special problems of the health care industry. *See* STAFF OF PERM. SUBCOMM. ON INVESTIGATIONS OF SENATE GOVERN. AFFAIRS COMM., 96TH CONG., 1ST SESS., CALIFORNIA RELATIVE

Second, if the conduct was not the type traditionally found to be per se illegal, Larson would inquire if "it possess[es] such harmful features that it should now be declared per se illegal."[171] Judge Larson was persuaded that "[t]he entire system is designed to avoid providing anyone with an incentive to control costs."[172] This led him to conclude that "[e]ven if this were the first judicial examination of this form of restraint, its anticompetitive vices are egregious and its procompetitive features nonexistent, so that this Court could declare it to be within the per se rules."[173]

Finally, Judge Larson noted that, "if the rule of reason must be applied, . . . the practice [was] so plainly anticompetitive that only a truncated rule of reason analysis need be carried out."[174] He clearly did not subscribe to the majority's cautious approach, believing that "even if the rule of reason is the correct standard by which to judge . . . [the foundations'] activities, a detailed economic analysis of the industry is not necessary. This agreement to

VALUE STUDIES: AN OVERVIEW (Staff Study 1979); STAFF OF SUBCOMM. ON OVERSIGHT & INVESTIGATIONS OF HOUSE COMM. ON INTERSTATE & FOREIGN COMMERCE, 95TH CONG., 2D SESS., CONFLICTS OF INTEREST ON BLUE SHIELD BOARDS OF DIRECTORS (Comm. Print 1978); *Skyrocketing Health Care Costs: The Role of Blue Shield: Hearings Before the Subcomm. on Oversight & Investigation of the House Comm. on Interstate & Foreign Commerce*, 95th Cong., 2d Sess. (1978); *Competition in the Health Service Market (pts. 1-3): Hearings Before the Subcomm. on Antitrust & Monopoly of Senate Comm. on the Judiciary*, 93d Cong., 2d Sess. (1974). He emphasized that "[t]he policy decision that competition is in the public interest has been made by Congress . . . [and] [o]nly Congress can declare that health care is to be exempted from this mandate." 643 F.2d at 566 (Larson, J., dissenting).

171. 643 F.2d at 563 (Larson, J., dissenting). *See, e.g.*, Broadcast Music, Inc., v. Columbia Broadcasting System, 441 U.S. 1, 19-20 n.33 (1979).

172. 643 F.2d at 567 (Larson, J., dissenting). Citing *Albrecht*, 390 U.S. 145, 152 (1968), Judge Larson listed three harms that resulted from the program's maximum fee setting provision:

> [E]limination of the freedom of individual sellers and buyers to determine prices, the possibility that the "maximum" price is in reality being used to establish a price floor or price uniformity, and the use of a maximum price structure to inhibit entry of competing forms of health care delivery which might capture a significant market share and deflect income from traditional fee-for-service physicians [are harms which result from maximum fee setting].

643 F.2d at 567 (Larson, J., dissenting).

173. 643 F.2d at 567 (Larson, J., dissenting). Civil liability under the Sherman Act may be based on the finding of either an unlawful purpose or an anticompetitive effect. McLain v. Real Estate Bd. of New Orleans, Inc., 444 U.S. 232 (1980); United States v. United States Gypsum Co., 438 U.S. 422, 436 n.13 (1978). "Defendants' purpose here was to fix prices and to suppress competition. These are per se unlawful purposes. It may not be necessary to assess the actual competitive effects of the controverted behavior where the unlawful purpose is clear." 643 F.2d at 567 n.12 (Larson, J., dissenting).

174. 643 F.2d at 563 (Larson, J., dissenting). *See, e.g.*, National Soc'y of Professional Eng'rs v. United States, 435 U.S. 679 (1978).

fix fees is so plainly anticompetitive that it is an unreasonable restraint of trade on its face."[175]

C. The Supreme Court

On appeal to the United States Supreme Court, the FMC's conceded that past decisions had established that price fixing agreements were unlawful on their face.[176] However, in *Maricopa County* the FMC's stressed "that the *per se* rule does not govern this case because the agreements at issue are horizontal and fix maximum prices, are among members of a profession, are in an industry with which the judiciary has little antitrust experience, and are alleged to have procompetitive justifications."[177]

In reversing the court of appeals, Justice Stevens, writing for a majority of four,[178] recognized that despite the Sherman Act's proscription of "*every* agreement 'in restraint of trade' . . . , Congress could not have intended a literal interpretation of the word 'every' . . . ."[179] Instead, in *Standard Oil Co. of New Jersey v. United States*,[180] the Supreme Court devised a rule of reason analysis. "As its name suggests, the rule of reason requires the fact finder to decide whether under all the circumstances of the case the restrictive practice imposes an unreasonable restraint on competition."[181] Many problems often plague the rule of reason analysis including the litigation being extensive and complex,[182] judges not

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175. 643 F.2d at 569 (Larson, J., dissenting). "In light of the total absence of real incentives for any of the plan's participants to limit fees, it is misleading to suggest that a redeeming virtue of the maximum fee schedule is cost control." *Id.* at 568.
176. *See supra* text accompanying notes 119-26.
177. 102 S. Ct. at 2472.
178. *See supra* note 11.
179. 102 S. Ct. at 2472 (quoting 15 U.S.C. § 1 (1976)) (emphasis original). For the text of section 1 of the Sherman Act, see *supra* note 2.
180. 221 U.S. 1 (1911).
181. 102 S. Ct. at 2472. Justice Brandeis explained the rule of reason test in Chicago Bd. of Trade v. United States, 246 U.S. 231 (1918):

> The true test of legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition. To determine that question the court must ordinarily consider the facts peculiar to the business to which the restraint is applied; its condition before and after the restraint was imposed; the nature of the restraint and its effect, actual or probable. The history of the restraint, the evil believed to exist, the reasons for adopting the particular remedy, the purpose or end sought to be attained, are all relevant factors. This is not because good intention will save an otherwise objectionable regulation or the reverse; but because knowledge of intent may help the court to interpret facts and to predict consequences.

Id. at 238.
182. Northern Pac. Ry. Co. v. United States, 356 U.S. 1, 5 (1958).

always competently understanding market structures and behavior,[183] and the result of the analysis not providing a clearcut conclusion as to the legality of a practice.[184] Thus, the Court recognized a need for per se liability when "experience with a particular kind of restraint enables the Court to predict with confidence that the rule of reason will condemn it."[185]

Accordingly, the majority believed that "inquiry under its rule of reason ended once a price fixing agreement was proved, for there was 'a conclusive presumption which brought [such agreements] within the statute.' "[186] Citing *Kiefer-Stewart*, Justice Stevens noted that this per se rule for price fixing also extended to maximum price fixing agreements since " 'such agreements, no less than those to fix minimum prices, cripple the freedom of traders and thereby restrain their ability to sell in accordance with their own judgment.' "[187] Reminding the Court that this view was reaffirmed in *Albrecht*,[188] Justice Stevens made clear that the Court had not in any way wavered in its enforcement of the per se rules against price fixing.[189]

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183. United States v. Topco Assocs., Inc., 405 U.S. 596, 609-10 (1972).
184. *Id.* at 609 n.10; Northern Pac. Ry. Co. v. United States, 356 U.S. at 5.
185. 102 S. Ct. at 2473.

> "*Per se* rules thus require the Court to make broad generalizations about the social utility of particular commercial practices. The probability that anticompetitive consequences will result from a practice and the severity of those consequences must be balanced against its procompetitive consequences. Cases that do not fit the generalization may arise, but a *per se* rule reflects the judgment that such cases are not sufficiently common or important to justify the time and expense necessary to identify them."

Id. at 2473 n.16 (quoting Continental T.V., Inc. v. GTE Sylvania, Inc., 433 U.S. 36, 50 n.16 (1977)).

186. 102 S. Ct. at 2473 (quoting Standard Oil Co. of N.J. v. United States, 221 U.S. 1, 65 (1911) (brackets original). "The power to fix prices, whether reasonably exercised or not, involves power to control the market and to fix arbitrary and unreasonable prices. The reasonable price fixed today may through economic and business changes become the unreasonable price of tomorrow." *Id.* at 2473 (quoting United States v. Trenton Potteries Co., 273 U.S. 392, 397 (1927)).

> "[F]or over forty years this Court has consistently and without deviation adhered to the principle that price-fixing agreements are unlawful *per se* under the Sherman Act and that no showing of so-called competitive abuses or evils which those agreements were designed to eliminate or alleviate may be interposed as a defense."

102 S. Ct. at 2474 (quoting United States v. Socony-Vacuum Oil Co., 310 U.S. 150, 218 (1940)).

187. 102 S. Ct. at 2474 (quoting Kiefer-Stewart Co. v. Joseph E. Seagram & Sons, 340 U.S. 211, 213). *See supra* text accompanying note 121. *But see* Justice Harlan's dissent in *Albrecht*, *supra* note 126.
188. 102 S. Ct. at 2474-75. *See supra* text accompanying note 122.
189. *See* Catalano, Inc. v. Target Sales, Inc., 446 U.S. 643 (1980) (holding that a horizontal agreement among competitors to fix credit terms contravened the

In *Maricopa County*, the majority condemned the foundations' program as

> 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. Such a restraint may discourage entry into the market and may deter experimentation and new developments by individual entrepreneurs.[190]

It was unimpressed that doctors—rather than nonprofessionals—were the parties to the restraint. *Goldfarb*'s language reserving a special inquiry for the "public service aspect[s], and other features of the professions"[191] was held inappropriate since "[t]he price fixing agreements in this case . . . are not premised on public service or ethical norms."[192]

Justice Stevens was equally unpersuaded by the argument that rule of reason analysis was appropriate in light of the judiciary's inexperience with the problems of the health care industry.[193] He believed such a proposition was inconsistent with *Socony-Vacuum*'s holding that " '[w]hatever may be its peculiar problems and characteristics, the Sherman Act, so far as price-fixing agreements are concerned, establishes one uniform rule applicable to all in-

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Sherman Act). "The *per se* rule 'is grounded on faith in price competition as a market force [and not] on a policy of low selling prices at the price of eliminating competition.' " 102 S. Ct. at 2475 (quoting Rahl, *Price Competition and the Price Fixing Rule—Preface and Perspective*, 57 Nw. U.L. REV. 137, 142 (1962) (brackets original)).

190. 102 S. Ct. at 2475. "It may be a masquerade for an agreement to fix uniform prices, or it may in the future take on that character." *Id.*

191. Goldfarb v. Virginia State Bar, 421 U.S. at 788 n.17. *See supra* text accompanying note 86.

192. 102 S. Ct. at 2475.

> The respondents' claim for relief from the *per se* rule is simply that the doctors' agreement not to charge certain insureds more than a fixed price facilitates the successful marketing of an attractive insurance plan. But the claim that the price restraint will make it easier for customers to pay does not distinguish the medical profession from any other provider of goods or services.

Id. at 2475-76.

193. *Id.* at 2476. The majority stressed that its position was not inconsistent with "the established position that a *new per se* rule is not justified until the judiciary obtains considerable rule of reason experience with the particular type of restraint challenged." *Id.* at 2476 n.19. *See* White Motor Co. v. United States, 372 U.S. 253 (1963). The four justices constituting the majority in *Maricopa County* believed that the Court already was sufficiently experienced with price fixing restraints. Further, the majority opinion was careful to indicate that it was not undermining its earlier decision permitting rule of reason analysis for vertical non-price restraints in Continental T.V., Inc., v. GTE Sylvania, Inc., 433 U.S. 36 (1977). 102 S. Ct. at 2476 n.19.

dustries alike.' "[194] He did not believe that the per se rule should be rejustified for every industry. Thus he explained that the underlying rationale for the per se approach—avoiding " 'the necessity for an incredibly complicated and prolonged economic investigation into the entire history of the industry involved . . . in an effort to determine at large whether a particular restraint has been unreasonable' "[195]—would be undermined by the foundations' approach. Accordingly, he labeled the foundations' "principal argument . . . that the *per se* rule is inapplicable because their agreements are alleged to have procompetitive justifications"[196] as a misunderstanding of the per se concept. He emphasized that "[t]he anticompetitive potential inherent in all price fixing agreements justifies their facial invalidation even if procompetitive justifications are offered for some."[197]

Describing its refusal to extend rule of reason analysis to the program as being grounded not only on "economic prediction, judicial convenience, and business certainty, but also on a recognition of the respective roles of the Judiciary, and the Congress in regulating the economy"[198] the majority acknowledged that the Court, due to the general nature of the antitrust laws, was required to "provide much of [the] . . . substantive content" in their enforcement.[199] At the same time, however, it believed that "[b]y articulating the rules of law with some clarity and by adhering to rules that are justified in their general application, . . . [it] enhance[d] the legislative prerogative to amend the law."[200] Thus, the Supreme Court agreed with Judge Larson's dissent,[201] holding that "[t]he respondents' arguments against application of the *per se* rule in this case . . . are better directed to the legislature. Con-

194. 102 S. Ct. at 2476 (quoting United States v. Socony-Vacuum Oil Co., 310 U.S. at 222).
195. 102 S. Ct. at 2476-77 (quoting Northern Pac. Ry. Co. v. United States, 356 U.S. 1, 5 (1958)).
196. 102 S. Ct. at 2477.
197. *Id.* However, the majority, questioning procompetitive aspects of the arrangement, stressed that "[e]ven if a fee schedule is . . . desirable, it is not necessary that the doctors do the price fixing." *Id.* This opinion, as the majority made clear, did not answer the question of "whether an *insurer* may, consistent with the Sherman Act, fix the fee schedule and enter into bilateral contracts with individual doctors." *Id.* at 2477-78 n.26 (emphasis added). That question was also not reached in Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205 (1979) (denying an antitrust exemption to insurer administered maximum fee schedules). *See supra* notes 103-07 and accompanying text.
198. 102 S. Ct. at 2478. *See* United States v. Topco Assocs., Inc., 405 U.S. 596, 611-12 (1972).
199. 102 S. Ct. at 2478.
200. *Id.*
201. *See supra* note 170.

gress may consider the exception that we are not free to read into the statute."[202]

Justice Stevens, finding *Broadcast Music* fundamentally different from the instant case,[203] did suggest that the former opinion might support favorable treatment for closed-panel HMO's. He described *Broadcast Music* as dealing with a product (the "blanket license") which "was entirely different from the product that any one composer was able to sell by himself."[204] Although a necessary consequence of the blanket license program was that a price had to be established, Justice Stevens explained that it constituted "price fixing only in a 'literal sense.'"[205] He distinguished this from *Maricopa County* where "[t]he members of the foundations sell medical services . . . [and] [t]heir combination in the form of the foundation does not permit them to sell any different product."[206] Offering some promise to HMO's, the *Maricopa County* majority suggested that "[i]f a clinic offered complete medical coverage for a flat fee, the cooperating doctors would have the type of partnership arrangement in which a price fixing agreement among the doctors would be perfectly proper."[207]

Justice Powell, in a strong dissent joined by the Chief Justice and Justice Rehnquist, did "not think [the] . . . decision on an incomplete record . . . [was] consistent with proper judicial resolution of an issue of this complexity, novelty, and importance to the public."[208] Initially, he criticized the result since "the foundation

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202. 102 S. Ct. at 2478-79. "'[Congress] can, of course, make *per se* rules inapplicable in some or all cases, and leave courts free to ramble through the wilds of economic theory in order to maintain a flexible approach.'" *Id.* at 2479 n.30 (quoting United States v. Topco Assocs., Inc., 405 U.S. 596, 609 n.10 (1972)).

203. Justice Stevens interpreted *Broadcast Music* as holding "that the delegation by the composers to ASCAP of the power to fix the price for . . . [a] blanket license was not a species of the price fixing agreements categorically forbidden by the Sherman Act." 102 S. Ct. at 2479. *See supra* notes 127-33 and accompanying text.

204. 102 S. Ct. at 2479. "'Thus, to the extent the blanket license is a different product, ASCAP is not really a joint sales agency offering the individual goods of many sellers, but is a separate seller offering its blanket license, of which the individual compositions are raw materials.'" *Id.* at 2479 n.31 (quoting Broadway Music, Inc. v. Columbia Broadcasting System, 41 U.S. 1, 22 (1979)).

205. 102 S. Ct. at 2479.

206. *Id.*

207. *Id.* at 2480. Such a venture would be beyond the reach of section 1 of the Sherman Act since a "partnership is regarded as a single firm competing with other sellers in the market." *Id.* Section 1 only proscribes joint activity in restraint of trade. "In the absence of any purpose to create or maintain a monopoly, the act does not restrict the long recognized right of trader or manufacturer engaged in an entirely private business, freely to exercise his own independent discretion. . . ." United States v. Colgate & Co., 250 U.S. 300, 307 (1919).

208. 102 S. Ct. at 2480 (Powell, J., dissenting).

arrangement foreclose[d] *no* competition."[209] The dissent complained that the majority overlooked the procompetitive impact of the plan on consumer interests. "To keep insurance premiums at a competitive level and to remain profitable, insurers—including those who have contracts with the foundations—step into the consumer's shoes with his incentive to contain medical costs."[210] Recognizing that as an appeal of a plaintiff's motion for summary judgment, "the inferences to be drawn from the record must be viewed in the light most favorable to the respondents,"[211] the dissenters concluded that the plan benefitted consumers by " 'enabl[ing] the insurance carriers to limit and to calculate more efficiently the risks they underwrite.' "[212]

The dissent conceded that once an arrangement has been labeled as price fixing it is per se unlawful; however, drawing on *Broadcast Music*, it reminded the majority that "it is equally well settled that this characterization is not to be applied as a talisman to every arrangement that involves a literal fixing of prices."[213] Thus, it cautioned the Court that an arrangement is not to be characterized as per se price fixing unless it is a " 'naked restrain[t] of trade with no purpose except stifling competition,' "[214] which re-

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209. *Id.* at 2481 (emphasis original).

> [P]hysicians who participate in the foundation plan are free both to associate with other medical insurance plans—at any fee level. . .— and directly to serve uninsured patients—at any fee level. . . . Similarly, insurers that participate in the foundation plan also remain at liberty to do business outside the plan with any physician—foundation member or not—at any fee level.

Id.

210. *Id.* at 2482. "Indeed, insurers may be the only parties who have the effective power to restrain medical costs, given the difficulty that patients experience in comparing price and quality for a professional service such as medical care." *Id. See supra* note 44 and accompanying text.
211. 102 S. Ct. at 2481 (Powell, J., dissenting). *See* United States v. Diebold, Inc., 369 U.S. 654, 655 (1962).
212. 102 S. Ct. at 2482 (Powell, J., dissenting) (quoting the majority's opinion at 2472). Justice Powell thus criticized the majority since, "even though the case is here on an incomplete summary judgment record, the Court conclusively draws . . . inferences [contrary to the record] to support its *per se* judgment." *Id.*
213. *Id.*

> The inquiry in an antitrust case is not simply one of "determining whether two or more potential competitors have literally 'fixed' a 'price' . . . . [Rather], it is necessary to characterize the challenged conduct as falling within or without that category of behavior to which we apply the label '*per se* price fixing.' That will often, but not always, be a simpler matter."

Id. (brackets original) (quoting Broadcast Music, Inc. v. Columbia Broadcasting System, 441 U.S. 1, 9 (1979)).

214. *Id.* (brackets original) (quoting United States v. Topco Assocs., Inc., 405 U.S. 596, 608 (1972), quoting White Motor Co. v. United States, 372 U.S. 253, 263

quires the Court to "determine whether the procompetitive economies that the arrangement purportedly makes possible are substantial and realizable in the absence of such an agreement."[215] Accordingly, the dissent would not have employed the per se standard without such an inquiry "especially . . . when the agreement under attack is novel, as in this case."[216]

Justice Powell was taken aback by the majority's suggestion that the foundations' arguments against application of the per se standard are more appropriately directed at the legislature.[217]

> This is curious advice. The Sherman Act does not mention *per se* rules. And it was not Congress that decided *Broadcast Music* and the other relevant cases. Since the enactment of the Sherman Act in 1890, it has been the duty of *courts* to interpret and apply its general mandate—and to do so for the benefit of consumers.[218]

Further, he was concerned that the majority failed to appreciate that "[m]edical services differ[ed] from the typical service or commercial product at issue in an antitrust case."[219] Thus, Justice Powell did not believe that the conventional "perfect market" antitrust analysis was readily applicable to the uniqueness of medical services. In any event, he certainly would not have condemned it on a per se basis,[220] stressing instead that "[i]n a complex econ-

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(1963)). *See* Continental T.V., Inc. v. GTE Sylvania, Inc., 433 U.S. 36, 49-50 (1977). "Such a determination is necessary because 'departure from the rule-of-reason standard must be based upon a demonstrable economic effect rather than . . . upon formalistic line drawing.' " 102 S. Ct. at 2482 (Powell, J., dissenting) (quoting *Continental T.V., Inc.*, 433 U.S. at 58-59).

215. 102 S. Ct. at 2482 (Powell, J., dissenting). Justice Powell cited *Professional Engineers*, *see supra* text accompanying notes 89-93, as reinforcing this view. *See* National Soc'y of Professional Eng'rs v. United States, 435 U.S. 679, 685, 693 (1978). *Cf.* Catalano, Inc. v. Target Sales, Inc., 446 U.S. 643, 646 n.8, 649-50 (1980). Further, he noted that in *Broadcast Music*, despite the existence of minimum price fixing in the "literal sense," 441 U.S. at 8, the Court rejected per se liability since the scheme "yielded substantial efficiencies that otherwise could not be realized." 102 S. Ct. at 2483 (Powell, J., dissenting). *But see supra* notes 203-06 and accompanying text.

216. 102 S. Ct. at 2483 (Powell, J., dissenting). Criticizing the majority's attempt to distinguish *Broadcast Music*, *see supra* notes 203-06 and accompanying text, Justice Powell observed that "[e]ach [of the two agreements] involved competitors and resulted in cooperative pricing. Each arrangement also was prompted by the need for better service to the consumers. And each arrangement apparently makes possible a new product by reaping otherwise unattainable efficiencies." *Id.* at 2484.

217. *See supra* text accompanying notes 200-02.

218. 102 S. Ct. at 2484 (Powell, J., dissenting).

219. *Id.* at 2485 n.13. "The services of physicians, rendered on a patient-by-patient basis, rarely can be compared by the recipient." *Id.*

220. *Id.*

> Affirmance of the district court's holding would not have immunized the medical service plan at issue. Nor would it have foreclosed an eventual conclusion on the remand that the arrangement should be

omy, complex economic arrangements are commonplace. It is unwise for the Court, in a case as novel and important as this one, to make a final judgment in the absence of a complete record and where mandatory inferences create critical issues of fact."[221]

V. CONCLUSION

The majority's resolution of *Maricopa County* seems correct both in terms of the prior related decisions and the economic realities of the health care industry. In keeping with *Goldfarb*'s rejection of an implied antitrust exemption for the professions, coupled with the constricted view of the exemption for the "business of insurance," the opinion evidences a judicial commitment toward application of antitrust principles to the medical profession. In particular, the *Maricopa County* decision illustrates the majority's skepticism over the cost containment justifications offered in defense of the FMC's and their maximum fee schedules. Such a conclusion certainly appears to be well founded in light of the economic analysis which implies that FMC's are not well suited for containing costs.[222]

Both the Supreme Court dissent and the majority of the court of appeals argued for rule of reason treatment for the FMC's, based primarily on the Court's lack of familiarity with the economic structure of the health care industry. However, the Supreme Court majority and Judge Larson, dissenting in the court of appeals, have taken the better reasoned approach. Noting the Court's history of forbidding price fixing, they were seriously concerned about horizontal agreements which had the effect of limiting pricing discretion. Perhaps the best course was Judge Larson's "truncated" rule of reason, which would condemn the FMC arrangement after only a cursory examination.[223]

Recognizing what it believed to be the causes and likely cures for the inflationary trend in health care, the court left itself room within the law of antitrust to accommodate promising cost containment efforts in the future. First, *Maricopa County* should effectively prevent FMC's from undermining the development of the cost conscious HMO's. This is due to the fact that FMC's will,

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> deemed *per se* invalid. And if the district court had found that petitioner had failed to establish a *per se* violation of the Sherman Act, the question would have remained whether the plan comports with rule of reason.

Id. See United States v. United States Gypsum Co., 438 U.S. 422, 441 n.16 (1978).

221. 102 S. Ct. at 2485 (Powell, J., dissenting).
222. *See supra* notes 61-68 and accompanying text.
223. *See supra* text accompanying notes 174-75.

hereafter, be subject to a per se analysis under the antitrust laws when they fix prices. Second, the majority in *Maricopa County* recognized that private arrangements in which individual insurers contract with individual doctors to contain costs might well be legal.[224] Finally, the Court, using the logic of *Broadcast Music*, emphasized that the closed-panel HMO's—perhaps the best cost containers—would not be within the reach of section 1 of the Sherman Act.[225] Viewed in this light, the Court has demonstrated its commitment to extending antitrust principles to the health care profession in order to promote effective cost containment.

224. 102 S. Ct. at 2477-78 & n.26. This question was not reached in *Royal Drug*. *See* Group Life & Health Ins. Co. v. Royal Drug Co., Inc., 440 U.S. 205, 210 n.5 (1979).

225. *See supra* notes 203-07 and accompanying text.