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# FEDERAL ANTITRUST LAW AND THE *ROYAL DRUG* PHARMACY AGREEMENT: IMPLICATIONS FOR FORMULATING NATIONAL HEALTH POLICY

MARY HOLLOWAY RICHARD\*

In 1945, Congress passed the McCarran-Ferguson Act<sup>1</sup> to exempt the "business of insurance"<sup>2</sup> from the federal antitrust laws. In 1979, in *Group Life & Health Insurance Co. v. Royal Drug Co.*,<sup>3</sup> the Supreme Court construed that exemption not to include "cost containment agreements"<sup>4</sup> between a health insurer and licensed pharmacists. Even though the case has been remanded and the Court has not yet ruled on the validity of the agreement under the antitrust laws,<sup>5</sup> the decision by the Supreme Court will be an important factor in the national health policy debate. The context in which the agreement arose

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<sup>1</sup> 15 U.S.C. §§ 1011-15 (1976).

<sup>2</sup> *Id.* The McCarran-Ferguson Act reads in pertinent part: "§ 1011. Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.

"§ 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, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided*, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

"§ 1013(b). Nothing contained in this Act shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate or act of boycott, coercion, or intimidation."

<sup>3</sup> 440 U.S. 205 (1979).

<sup>4</sup> Respondents argued in their brief to the Supreme Court that characterization of the agreement as a cost containment agreement is an inaccurate description of an actual price-fixing agreement and also questioned the right of the insurer to function as an agent to contain costs. Brief for Respondent at 57-64, *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979).

<sup>5</sup> Regarding the complaint, an appeal on the merits is planned by the plaintiffs. *Cf. Proctor v. State Farm Mut. Ins. Co.*, 561 F.2d 262 (D.C. Cir. 1977), where the court on remand from the Supreme Court in light of the *Royal Drug* decision held that vertical agreements between insurers and automobile repair shops which determined where insureds could go for repairs at prevailing labor rates passed muster under the antitrust laws because there was neither anticompetitive effect nor purpose.

and the antitrust challenges leveled against the agreement are considered in this article. It is suggested that application of the antitrust laws, coupled with legislative intervention, could bolster competition in the ailing health industry and thereby drive down the cost of health care.

*The Royal Drug Agreement: History, Antitrust Challenges,  
Judicial Treatment*

In 1969, Blue Shield of Texas, a nonprofit insurer, sought authorization for issuing new policy forms. The proposed agreement, for which authorization was required by state law, was filed in March, disapproved in May,<sup>6</sup> and exempted from the approval requirements in September. Subsequent statewide mailings to licensed pharmacists resulted in a number of agreements between Blue Shield and pharmacies throughout Texas. The insurance policy at issue in *Royal Drug*, almost a duplicate of the 1969 agreement, was approved in October, 1974, by the Insurance Commissioner of Texas for use in Bexar County, Texas. Blue Shield offered to enter into the Pharmacy Agreement with all licensed pharmacists in that county that same year.<sup>7</sup>

*Terms of the Insurer-Pharmacist Agreement*

The agreement in question was first offered by Blue Shield to certain groups in Texas as a prescription drug insurance policy supplemental to its group medical-surgical policies.<sup>8</sup> Insurers first entered the field of health insurance in order to increase business and profits through the sales of comprehensive policies to large employers,<sup>9</sup> and

<sup>6</sup> Although not pertinent to the analysis presented in this article, counsel for the nonparticipating pharmacies have argued that approval of the Pharmacy Agreement was not denied by the state; rather, approval of a large form embodying the Pharmacy Agreement was denied and later approved. Reply Brief for Appellants at 7, *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979). This goes to the argument concerning state regulation of insurance which Blue Shield used unsuccessfully to fight losing the antitrust exemption.

<sup>7</sup> Brief for United States as Amicus Curiae at 4, 440 U.S. 205.

<sup>8</sup> See Brief for Respondents at 5, *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979).

<sup>9</sup> In many cases, health insurance is thrown in as a "sweetener" for a highly profitable package, including life insurance, disability, and even casualty insurance. B. EHRENREICH & J. EHRENREICH, *THE AMERICAN HEALTH EMPIRE: POWER, PROFITS & POLITICS* 109-10 (1970). On group policies, the industry claims to lose money, and they claim that the investment income which companies attribute to their health insurance business is barely adequate to cover the underwriting loss; the bigger companies, however, report substantial consistent profits. *Id.* at 107.

Blue Shield has found an increasing demand in the prescription drug area.<sup>10</sup>

Under the Pharmacy Agreement, the participating pharmacy agrees to accept from the insured no more than the two dollar deductible in full payment for each dispensed drug; the participating pharmacist is then entitled to file a claim for additional reimbursement directly from Blue Shield.<sup>11</sup>

The following example was supplied by the Justice Department and cited by the Supreme Court in its decision,<sup>12</sup> and it illustrates the operation of the insurance policy and the Pharmacy Agreement:

Suppose the usual and customary retail price for a quantity of Drug X charged both by "participating" Pharmacy A and "non-participating" Pharmacy B is \$10.00, and the wholesale price (or acquisition cost) to both is \$8.00. If an insured buys Drug X from Pharmacy A, the insured pays \$2.00. Pharmacy A receives \$2.00 from the insured and \$8.00 from Blue Shield, or \$10.00 total. If an insured buys Drug X from Pharmacy B, the insured pays Pharmacy B \$10.00, and receives \$6.00 (75 percent of the difference between the retail price and \$2.00) from Blue Shield. While Pharmacy B receives the same as Pharmacy A, the insured must pay \$4.00 for the drug and also must take steps to obtain reimbursement.

If the pharmacy's acquisition cost for the drug is \$5.00 rather than \$8.00, the situations of Pharmacy B and the insured are unchanged. But now Pharmacy A will receive only \$5.00 from Blue Shield, for a total of \$7.00.<sup>13</sup>

Blue Shield sent a standard form letter to all licensed pharmacists in the state offering them the opportunity to enter into a pharmacy agreement with Blue Shield.<sup>14</sup> There were apparently no negotiations with or among pharmacists following the offer.<sup>15</sup> Blue Shield characterized the plan as a service benefit insurance plan utilizing health care provider agreements.<sup>16</sup> Blue Shield perceived that it was meeting a

<sup>10</sup> Brief for Appellants at 4, *Royal Drug Co. v. Group Life & Health Ins. Co.*, 556 F.2d 1375 (5th Cir. 1977). Blue Shield in its brief to the Fifth Circuit illustrated this demand with the following example: "Between early 1972 and October, 1975, alone, there was a 3,100% increase in the number of pharmaceutical claims processed by Blue Shield under the policy. In October, 1975, Blue Shield was handling these claims at the rate of approximately 31,000 claims per month as compared with only 1,000 claims per month in early 1972. . . ."

<sup>11</sup> Brief for Respondents at 5, *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979).

<sup>12</sup> 440 U.S. 205 n.3.

<sup>13</sup> Brief for United States as Amicus Curiae at n.1, 440 U.S. 205.

<sup>14</sup> Brief for Petitioners at 8, 440 U.S. 205.

<sup>15</sup> *Id.*

<sup>16</sup> See Brief for United States as Amicus Curiae at 11, 440 U.S. 205.

policyholder need to offset ever more costly medical care by offering coverage in the form of goods and services rather than in the form of cash reimbursement, and by assuming the responsibility of paying for policy benefits.<sup>17</sup> Blue Shield characterized the Pharmacy Agreement as an insurance policy covering the risk that a policyholder will need to obtain prescription drugs;<sup>18</sup> the process would aid policyholders in finding low-overhead pharmacies with which to deal.<sup>19</sup>

The participating pharmacies named as defendants by *Royal Drug* are large, high-volume chains that sell many nonpharmaceutical items.<sup>20</sup> Although participation in the Pharmacy Agreement may be attractive in terms of potential increased volume of pharmaceutical sales, it is more likely that pharmacies are induced to participate by the prospect of increased sales in nonpharmaceuticals, such as household or personal items, to persons entering their stores for the purpose of having a prescription filled.<sup>21</sup> The nonparticipating pharmacists are, on the other hand, largely independent retailers selling only pharmaceuticals, and many of them provide special services such as home deliveries, patient consultation, and twenty-four hour service.<sup>22</sup>

The subscriber who patronizes a nonparticipating pharmacy must ultimately pay 25 percent of a reasonable charge for the drug as determined by Blue Shield plus the two dollar professional dispensing fee or deductible. In other words, the subscriber in that situation must take the initiative to go to the insurer for reimbursement and even then is only reimbursed for a portion of the charge. Royal Drug pharmacy perceives this system as placing an onerous burden on the subscriber

<sup>17</sup> *Id.*

<sup>18</sup> *Id.*

<sup>19</sup> *Id.* The Justice Department stated that Blue Shield offered to deal directly with any pharmacy willing to accept a low price for its services and that any pharmacy that can distribute drugs for two dollars or less per prescription could accept Blue Shield's offer. Brief for Appellant at 6, 556 F.2d 1375. The nonparticipants argued that the 2 percent mark-up ceiling effected by this Pharmacy Agreement would not even cover their costs.

<sup>20</sup> The participating pharmacies are three retail pharmacy chains—Walgreen's, Sommers, and Rieger. Brief for Respondent at 4, 440 U.S. 205 (1979). Respondent's brief provides some insight into the character of those chain stores at 8, n.5: "In a recent newspaper advertisement, Petitioner Sommers advertised the following items for sale in its discount 'drug stores': Spalding Tennis Set, Golden Ram Golf Balls, Delux Car Caddy with CB Mike Holder, beach towels, plastic coated playing cards . . . Lone Star beer . . . Fritos Corn Chips . . . coloring books, Right Guard Deodorant, Schick Super II Razor, L'Oreal Preference Shampoo and Revlon Nail Polish. San Antonio Express, June 6, 1978, at 9-A."

<sup>21</sup> Nonparticipating pharmacies have argued that their services have not been taken into account in the reimbursement formula used by Blue Shield. While such a reimbursement formula works well for the large, multi-product chain stores, the independent pharmacy offering only drugs and special services, such as 24-hour service, are not so amenable to such a system.

<sup>22</sup> *Id.*

that results in coercing subscribers to boycott nonparticipating pharmacists.<sup>23</sup>

### *Judicial Treatment of the Royal Drug Complaint*

As a result of the Blue Shield plan, eighteen independent pharmacy owners in Bexar County, Texas, brought an action in federal district court against Blue Shield of Texas and three participating retail drugstore chains for violation of section 1 of the Sherman Act. The plaintiffs alleged both combination and conspiracy to fix prices by the participating pharmacies and the insurer, as well as an illegal boycott.<sup>24</sup>

The district court's decision<sup>25</sup> that the McCarran-Ferguson exemption applied to the agreement in question was reversed on appeal to the Fifth Circuit.<sup>26</sup> The court of appeals found that the exemption did not apply because three prerequisites to its application had not been met. First, Blue Shield had no obligation to fix retail prices of pharmaceuticals. Second, the activity was not regulated by the state simply because the state had a general regulatory scheme regarding insurance. Third, the activity was not the "business of insurance" solely because it affected rates.<sup>27</sup> In so holding, the Fifth Circuit contradicted not only several district court cases, but also a long-standing construction of the McCarran-Ferguson exemption.<sup>28</sup>

Justice Stewart, writing the majority opinion, upheld the appellate court decision and rejected the blanket exemption for insurers.<sup>29</sup> The Court found a narrow construction of section 2(b) of the McCarran-Ferguson Act<sup>30</sup> to be particularly appropriate where the agreement involves persons wholly outside the insurance industry, and the Court reaffirmed the three requirements for application of the exemption.<sup>31</sup> Four justices dissented, interpreting the legislative history not to have intended such narrow limits to the exemption and criticizing the ma-

<sup>23</sup> See note 19 *supra*.

<sup>24</sup> *Royal Drug Co. v. Group Life & Health Ins. Co.*, 415 F. Supp. 343, 345 (W.D. Tex. 1976).

<sup>25</sup> This decision followed the majority rule. See notes 57-58 *infra* and accompanying text.

<sup>26</sup> *Royal Drug Co. v. Group Life & Health Ins. Co.*, 556 F.2d 1375 (5th Cir. 1977).

<sup>27</sup> *Id.* at 1381.

<sup>28</sup> *Proctor v. State Farm Mut. Auto. Ins. Co.*, 561 F.2d 262 (D.C. Cir. 1977), *vacated*, 440 U.S. 942 (1979), *Frankford Hosp. v. Blue Cross*, 554 F.2d 1253 (3d Cir.), *cert. denied*, 434 U.S. 860 (1977); *Anderson v. Medical Serv. of the District of Columbia*, 551 F.2d 304 (4th Cir. 1977); *Manasen v. California Dental Serv.*, 424 F. Supp. 657 (N.D. Cal. 1976).

<sup>29</sup> 440 U.S. 205 (1979).

<sup>30</sup> See note 2 *supra*; see also notes 41-53 *infra* and accompanying text.

<sup>31</sup> 440 U.S. 205, 210, 231 (1979).

majority for limiting the "business of insurance" to horizontal transactions or transactions that spread the risk of loss between the insurer and the insured.<sup>32</sup>

*Application of the Antitrust Laws to the Health Sector:  
Treatment of Insurers*

*History of the Exemption for Insurer*

The purpose of the federal antitrust laws is clear<sup>33</sup> even though judicial interpretation has appeared less than entirely consistent at times.<sup>34</sup> Preceding the passage of the Sherman Act was an increasing awareness of the burgeoning power of big business in America and abuses of that power. Congressional response to protect the public and to preserve the market structure was passage of the Sherman Act in 1890. Application of the Sherman and Clayton<sup>35</sup> acts between 1890 and 1944 produced a body of court-made law to restore the prized competition to various sectors of the economy.<sup>36</sup>

Dictum in *Paul v. Virginia*,<sup>37</sup> only six years after the passage of

<sup>32</sup> *Id.* at 233. The dissent would have held the agreement within the "business of insurance" exemption because the agreement affected costs directly and was a direct arrangement to provide services, precisely the risk assumed in the policy, and because of the state interest in the financial viability of such plans and in the control of formulas by which providers are reimbursed by insurers. According to the dissent, relevant precedent has not interpreted section 2(b) to require limiting application of the exemption to insurer-insured agreements; the minority points out that rate agreements among insurers, clearly exempted, do not spread the risk. *Id.* at 248-49.

<sup>33</sup> 15 U.S.C. §§ 1-7 (1976). Justice Black said of the legislative intent in enacting the Sherman Act: "The Sherman Act was designed to be a comprehensive charter of economic liberty aimed at preserving free and unfettered competition as the rule of trade. It rests on the premise that the unrestrained interaction of competitive forces will yield the best allocation of our economic resources, the lowest prices, the highest quality and the greatest material progress, while at the same time providing an environment conducive to the preservation of our democratic political and social institutions." *N. Pac. Ry. v. United States*, 356 U.S. 1, 4 (1958). *But see* Note, *Antitrust and Nonprofit Entities*, 94 HARV. L. REV. 802, 806 n.32 (1981), demonstrating that courts and scholars do not agree on the purpose of the legislation—whether it is to maximize efficiency, to protect competition for its own sake, or to achieve other ends.

<sup>34</sup> For oft-used examples of apparent inconsistencies in Supreme Court antitrust opinions, compare *Appalachian Coals, Inc. v. United States*, 288 U.S. 344 (1933) with *United States v. Trenton Potteries Co.*, 273 U.S. 392 (1976). For a report of four relatively recent and apparently inconsistent Supreme Court cases, see Blumstein & Calvani, *State Action as a Shield and a Sword in a Medical Services Antitrust Context: Parker v. Brown in Constitutional Perspective*, 1978 DUKE L.J. 389, 399 n.52 [hereinafter cited as Blumstein & Calvani].

<sup>35</sup> 15 U.S.C. §§ 12-27 (1976).

<sup>36</sup> See *Standard Oil Co. v. United States*, 221 U.S. 1 (1911) (discussion of application of rule of reason doctrine).

<sup>37</sup> 75 U.S. (8 Wall.) 168, 183 (1868). See discussion in *United States v. South-eastern Underwriters Ass'n*, 322 U.S. 533, 543 (1944), of reaffirmation by the courts of the *Paul* dictum that issuance of an insurance policy was not a transaction in commerce.

the Sherman Act, set a trend that lasted nearly a century. The Court in *Paul* declared that the insurance business was neither trade nor commerce within the purpose of the commerce clause.<sup>38</sup> As a result, the insurance industry was regulated freely by the states, particularly with regard to rate setting and taxation. It was generally thought that federal regulation did not apply in the area of insurance and that exemption from the federal antitrust laws was by virtue of the failure of the insurance industry to qualify as either trade or commerce.<sup>39</sup> The equilibrium was shattered with the exposure of reprehensible conduct within the insurance industry and the Supreme Court response in 1944.<sup>40</sup> In *United States v. South-eastern Underwriters Ass'n*,<sup>41</sup> initiated by the Justice Department after interpreting a prior decision as holding that a health maintenance organization was engaged in trade for purposes of the Sherman Act, the defendant insurance company's only defense to charges of price fixing and monopoly was that the business of insurance was neither trade nor commerce.<sup>42</sup> The Supreme Court rejected this either/or treatment of antitrust regulation, holding that activities intimately related to state welfare could be subject to state regulation while other activities could be regulated by the federal government.<sup>43</sup> Relying on the sweeping "every person" language of the commerce clause,<sup>44</sup> the Court found that neither the clause nor the cases construing it granted a blanket exemption from the bounds of interstate commerce.<sup>45</sup> The majority recognized the value of competition, stating that competition would be harmful neither to the insurer nor to the insured, and pointed out that no state had authorized com-

<sup>38</sup> 75 U.S. (8 Wall.) at 183.

<sup>39</sup> *Id.*

<sup>40</sup> *United States v. South-eastern Underwriters Ass'n*, 322 U.S. 533 (1944).

<sup>41</sup> *American Medical Ass'n v. United States*, 130 F.2d 233 (D.C. Cir. 1942), *aff'd*, 317 U.S. 519 (1943). The attorney general in the *South-eastern Underwriters* case believed that the plan was insurance, and he brought the indictment thinking that the Court had already held that insurance was commerce; this fact is recognized by the Supreme Court in the *Royal Drug* opinion. 440 U.S. 205, 225 (1979).

<sup>42</sup> *United States v. South-eastern Underwriters Ass'n*, 322 U.S. 534, 535 (1944). Association members represented 90 percent of the total business of six states where noncompetitive premium rates on fire and allied lines of insurance were fixed by the association. The association employed boycotts, coercion, and intimidation to force nonmembers to buy insurance only from association members and only on association terms. The lower court had sustained the defendant insurance company's demurrer solely because the "entire" business of insurance could never be commerce, even though a substantial part of the business was interstate within the meaning of the antitrust laws. *Id.* at 536.

<sup>43</sup> *Id.* at 548. For a discussion of the legislative history, see Weller, *The McCarran-Ferguson Act's Antitrust Exemption for Insurance: Language, History and Policy*, 1978 DUKE L.J. 587 [hereinafter cited as Weller].

<sup>44</sup> U.S. CONST. art. 1, § 8, cl. 3.

<sup>45</sup> 322 U.S. 534, 561 (1944).



binations of insurance companies to engage in coercive or restrictive activities and that insurance companies had no vested right to engage in such practices.<sup>46</sup>

Perceiving this decision as a threat to both the insurance industry and to state regulation of that industry, Congress passed the McCarran-Ferguson Act in 1945 to exempt insurance activities from federal antitrust regulation if three conditions were met.<sup>47</sup> An analysis of the legislative history, according to one commentator, indicates that the Act essentially codifies the *Parker* doctrine<sup>48</sup> with regard to the insurance business<sup>49</sup> and that a two-step test is appropriate for correct application of section 2(b) of the Act:

First one must determine whether the federal antitrust laws "invalidate, impair, or supersede" state insurance regulation of the anticompetitive activities in question, as that standard has been interpreted by the Supreme Court in *National Securities*. If not, no exemption should be granted. Second, if federal law does "invalidate, impair, or supersede" state insurance regulation, then the federal antitrust laws are inapplicable only to the extent that anticompetitive conduct is regulated by state insurance laws.<sup>50</sup>

### *Subsequent Development and Application of the McCarran-Ferguson Act Exemption*

The legislative history of the McCarran-Ferguson Act has been interpreted by courts to exclude from the "business of insurance" the following: annuity contracts,<sup>51</sup> mergers between insurance companies,<sup>52</sup>

<sup>46</sup> *Id.* at 562.

<sup>47</sup> See text at notes 26-27.

<sup>48</sup> *Parker v. Brown*, 317 U.S. 341 (1943) (interpretation of Sherman Act to apply to individual and not state action). See also Verkuil, *State Action, Due Process and Antitrust: Reflections on Parker v. Brown*, 75 COLUM. L. REV. 328 (1975); Comment, *The State Action Exemption in Antitrust: From Parker v. Brown to Cantor v. Detroit Edison Co.*, 1978 DUKE L.J. 871; Blumstein & Calvani, *supra* note 34.

<sup>49</sup> Weller, *supra* note 43, at 593. Weller provides an extensive review of the legislative history of the McCarran-Ferguson Act and concludes that the act "implements fundamentally federalist, congressional purposes. Congress was primarily concerned with preserving state taxation and regulation of insurance from constitutional annihilation and did not intend to emasculate the federal antitrust laws. Contrary to the thrust of some lower court decisions, Congress never intended state regulation to be exclusive if federal and state authority could be accommodated concurrently. Preserving state regulation under principles of federalism requires preemption under the McCarran Act only when the concurrent authority of both sovereigns is irreconcilable." *Id.* at 640.

<sup>50</sup> *Id.* at 640-41.

<sup>51</sup> *SEC v. Variable Annuity Life Ins. Co.*, 359 U.S. 65 (1959).

<sup>52</sup> *SEC v. National Securities, Inc.*, 393 U.S. 453 (1969).

Blue Cross and Blue Shield plans and other prepaid plans,<sup>53</sup> and insurance advertising.<sup>54</sup> A series of cases interpreted the legislative history of the Act to focus on such characteristics of insurance as the underwriting risks in which companies engage in exchange for premium payments, the relationship between the insurer and the insured, and the regulation by the state of rates as evidence of state interest in financial viability.<sup>55</sup> The courts have had to resort to focusing on the nature of insurance when the appropriateness of applying this exemption is at issue.<sup>56</sup>

A review of judicial treatment of cases involving section 2(b) of the McCarran-Ferguson Act indicates that the courts have failed to apply the exemption narrowly in contradiction of accepted tenets of statutory construction.<sup>57</sup> Generous judicial construction of the term "insurance" includes a host of activities generally related to the interests of the insurer and the insured.<sup>58</sup> The division within the circuits compelling the Supreme Court to grant the writ of certiorari in the *Royal Drug* case rested on just this issue.

The Third Circuit, in a 1973 case, held that approval by the state insurance department constituted regulation by the state sufficient to exempt an arrangement whereby a nonprofit insurer reimbursed a hospital for services provided its subscribers at a discount.<sup>59</sup> In the District

<sup>53</sup> *Jordan v. Group Health Ass'n*, 107 F.2d 239 (D.C. Cir. 1939); *Michigan Hosp. Serv. v. Sharpe*, 339 Mich. 357, 63 N.W.2d 638 (1954); *Hospital Serv. Corp. v. Pennsylvania Ins. Co.*, 101 R.I. 708, 227 A.2d 105 (1967). See also dissent in *Royal Drug*, 440 U.S. 205 240-42 n.9 (1979).

<sup>54</sup> *FTC v. National Cas. Co.*, 357 U.S. 560 (1958).

<sup>55</sup> For a representative case, see note 11 *supra* and accompanying text.

<sup>56</sup> See notes 58-61 *infra* and accompanying text.

<sup>57</sup> See generally, 2A SUTHERLAND, STATUTORY CONSTRUCTION (4th ed. Sands 1973).

<sup>58</sup> See note 28 *supra* and accompanying text (*Proctor* decision represents majority viewpoint) (*Manasen* decision far-reaching in application of antitrust laws to nonprofit corporation engaged in operation of prepaid dental care program). See also notes 59-63 *infra* and accompanying text.

<sup>59</sup> *Travelers Ins. Co. v. Blue Cross of Western Pennsylvania*, 361 F. Supp. 774 (W.D. Pa. 1972), *aff'd*, 481 F.2d 80, 84 (3d Cir. 1973). The arrangement challenged in this case by a private insurer is typical of nonprofit insurers' arrangements with providers whereby lower reimbursement rates are negotiated. The lower rate is achieved by the hospital agreeing that costs applied to the favored subscribers will not include costs for capital construction or bad debts or costs of charity care. These arrangements are attractive to the hospitals because they represent guaranteed payments for services rendered the nonprofit insurers' subscribers. Note that in dictum the Third Circuit professed its belief that, if applied, the agreement could withstand antitrust scrutiny. *Id.* at 84. See also *Frankford Hosp. v. Blue Cross of Greater Philadelphia*, 417 F. Supp. 1004 (E.D. Pa.), *aff'd per curiam*, 554 F.2d 1253 (3d Cir. 1976), *cert. denied*, 434 U.S. 860 (1977). Cf. *Michigan Hosp. Serv. v. Sharpe*, 339 Mich. 357, 63 N.W.2d 638 (1954), indicating that courts have continued to hold that Blue Shield plans are not insurance even in states with enabling statutes which typically authorize plans to operate but do not specify whether they

of Columbia Circuit, it was held that an agreement between auto repairers and insurers to pay only prevailing rates for labor and parts was exempt by virtue of state regulation of the business of insurance and, more important, because the agreement was peculiar to the business of insurance.<sup>60</sup> Settlement and payment of claims were considered basic components of the contractual obligation owed by insurance companies to insureds, which directly affected the rate-making structure of the insurance company and the premium charged, and which was directly connected with the policy writing, interpretation, and enforcement.<sup>61</sup> In affirming the summary judgment, the Court of Appeals for the District of Columbia disagreed with the district court's narrow interpretation of the boycott exception to the antitrust exemption created by the McCarran-Ferguson Act.<sup>62</sup> It is interesting to note that the Supreme Court granted certiorari, vacated the judgment, and remanded this case, *Proctor v. State Farm Mutual Automobile Insurance Co.*, for further consideration in light of its decision in the *Royal Drug* case.<sup>63</sup> In *Royal Drug*, the Fifth Circuit, in more strictly scrutinizing the bounds of that exemption, viewed the underwriting function as the insurer's essential obligation and was unwilling to be persuaded that a reimbursement agreement was exempt merely because the premium was directly affected by such an agreement.<sup>64</sup>

### *Other Applications of the Antitrust Laws in Health Care*

Providers of health services of all types are cognizant of the federal antitrust laws today. Administrators and legal counsel for

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constitute insurance. Blue Cross and Blue Shield have historically taken the position that they are not insurance companies. Further, they enjoy a favorable bargaining position which virtually forces providers to pass costs not reimbursed by the "Blues" to uninsured patients and patients insured by commercial insurers. Although it is beyond the scope of this paper to delve into it properly, the subject of that favored position is now ripe for reassessment from a policy perspective. This is particularly appropriate if the Blues are reaping great profits as their critics suggest.

<sup>60</sup> *Proctor v. State Farm Mut. Auto. Ins. Co.*, 406 F. Supp. 27, 30 (D.D.C. 1975), *aff'd*, 561 F.2d 262 (D.C. Cir. 1977), *vacated*, 440 U.S. 942 (1979). *See also* Webster County Memorial Hosp. Inc. v. UMW Welfare & Retirement Fund of 1950, 1976-1 TRADE CASES ¶ 68,888 (D.D.C. 1976) (no antitrust violation where union fund negotiated maximum per diem for beneficiaries' medical care) (no decision on antitrust immunity).

<sup>61</sup> 406 F. Supp. at 27. *See also* *Manasen v. California Dental Serv.*, 424 F. Supp. 657, 669 (N.D. Cal. 1976).

<sup>62</sup> 561 F.2d 262, 271-73 (D.C. Cir. 1977).

<sup>63</sup> 440 U.S. 942 (1979).

<sup>64</sup> 556 F.2d 1375, 1386 (5th Cir. 1977). The Fifth Circuit expressed serious disagreement with the rationale underlying the *Manasen* decision which indicated that participants need not be strictly limited to insurance companies for the business of insurance protection to apply; the court distinguished *Travelers* as mere approval by the Third Circuit of actions of the state insurance commissioner who was urging cost containment measures by the hospitals. *Id.* at 1386, 1382.

hospitals, for example, currently evaluate all segments of hospital operations for anticompetitive activities in an effort to avoid costly litigation.<sup>65</sup> The exclusive contract, a management alternative employed in some hospital departments,<sup>66</sup> does exclude some practitioners from hospital privileges; this exclusion has been challenged as a violation of section 1 of the Sherman Act.<sup>67</sup> A number of courts have relied on a rule of reason analysis and have found that reasonable decisions pass muster.<sup>68</sup> Conscientious community planning of health services to meet the anticipated need most economically could also give rise to antitrust challenges, such as allegations of an illegal market division.<sup>69</sup>

Agreements concerning providers' prices and advertising are also subject to scrutiny under the antitrust laws. Agreements not to advertise or prohibitions against advertising by professional associations, accrediting entities, and certifying bodies are unlawful.<sup>70</sup> Even where the agreement or prohibition is a part of the entity's ethical code, the Federal Trade Commission has declared them unlawful. This is especially true where the agreements concern advertising prices. Also according to the Federal Trade Commission, the Relative Value Study Scale, a system of categorizing procedures in order to place a value upon them, is a price-fixing mechanism because of its tendency to

<sup>65</sup> One area of concern currently is the variety of shared purchasing arrangements employed by some health care facilities as a result of the pressure to contain costs. See, e.g., Tolan, *What are the Antitrust Implications of Shared Purchasing for Hospitals?*, HOSPITALS 76 (Oct. 16, 1979).

<sup>66</sup> The exclusive contract is defended as a pragmatic management tool for some hospital departments where the following are needed: better control and standardization of procedures, greater operational efficiency for the departments, better scheduling, better monitoring of patients within departments, greater economy, amassing expertise among operators or users of equipment and facilities. *Dattilo v. Tucson General Hosp.*, 23 Ariz. App. 392, 396-97, 533 P.2d 700, 704-705 (1975); *Adler v. Montefiore Hosp. Ass'n*, 453 Pa. 60, 67-68, 311 A.2d 634, 638 (1973), cert. denied, 414 U.S. 1131 (1974). Compelling arguments relying on these objectives can be made for departments such as pathology and radiology where continued availability of doctors and orderly use of sophisticated equipment are imperative. Kessenick, *Physicians' Access to the Hospital: An Overview*, 14 U.S.F. L. REV. 43, 66 nn.130-38 (1980) [hereinafter cited as Kessenick].

<sup>67</sup> *National Gerimedical Hosp. & Gerontology Center v. Blue Cross of Kansas City*, 101 S.Ct. 2415 (1981).

<sup>68</sup> *Sosa v. Board of Managers of Val Verde Memorial Hosp.*, 437 F.2d 173 (5th Cir. 1971); *Hyde v. Jefferson Parish Hosp. Dist.*, No. 78-750 (E.D. La. Jan. 23, 1981). See also Kessenick, *supra* note 66, at 70-71.

<sup>69</sup> See *National Gerimedical Hosp. & Gerontology Center v. Blue Cross of Kansas City*, 101 S.Ct. 2415 (1981). See generally *Hartford-Empire Co. v. United States*, 323 U.S. 386 (1945) (geographic division along product lines illegal); *Addyston Pipe & Steel Co. v. United States*, 175 U.S. 211 (1899) (geographic division illegal).

<sup>70</sup> *American Medical Ass'n*, 94 F.T.C. 701 (1979) (agreements not to advertise); *American Dental Ass'n*, 94 F.T.C. 403 (1979).

standardize the charges for various types of professional services and procedures.<sup>71</sup> Essentially, the Commission charges that adherence to the Relative Value Study Scale freezes the relationship among fees for different and distinct procedures; once published, the scale makes it simple for physicians to fix prices by merely agreeing upon a uniform conversion factor.<sup>72</sup>

The granting or denial of medical staff privileges may be subject to challenge under the antitrust laws, especially where the excluded practitioner is unable to practice, such as where there is only one hospital in town,<sup>73</sup> or where medical staff membership is conditioned upon use of that facility exclusively.<sup>74</sup> In a recent case,<sup>75</sup> chiropractors charged the American Medical Association, a number of certifying entities such as the American College of Surgeons, state and local medical societies, the American Hospital Association, the Joint Commission on Accreditation of Hospitals, and several individual defendants with conspiracy to monopolize health care services and to unreasonably restrain licensed chiropractors from competing in the delivery of health services. The American Medical Association asserted the exercise of its first amendment rights in its defense.<sup>76</sup> The plaintiffs were not successful in this federal district court case, but an appeal of that decision is certain. In *National Gerimedical Hospital & Gerontol-*

<sup>71</sup> In April, 1979, the California Medical Association signed a consent order which prohibited it from continuing the Relative Value Study activities in which it had engaged since 1956. The order describes the study as listing comparative numerical values for medical and surgical procedures and services; they are usually stated in nonmonetary amounts which are easily convertible into a dollar fee by applying a dollar conversion factor to the basic unit. California Medical Ass'n, 93 F.T.C. 519 (1979) (consent decree filed Apr. 17, 1979). See also American College of Radiology, 89 F.T.C. 144 (1977) (Federal Trade Commission consent order accepted Mar. 1, 1977); United States v. Illinois Podiatry Soc'y, Inc., [1970-1979 Transfer Binder] TRADE REG. REP. (CCH) ¶ 45,077.

<sup>72</sup> Address by Walter T. Winslow, Seminar on Antitrust in the Health Care Field, Washington, D.C., Jan. 8, 1979. Although there were many disclaimers that he did not officially speak for the Commission, the FTC staff member indicated that the Supreme Court had made it clear in *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975), that professional organizations would be subject to antitrust scrutiny. He also stated that the *Goldfarb* decision and *National Soc'y Professional Engrs. v. United States*, 435 U.S. 679 (1978), emphatically laid to rest the idea that professional associations are not accountable for antitrust transgressions—there will be no justification for restraint based on reference to other public benefits.

<sup>73</sup> Cf. *Hyde v. Jefferson Parish Hosp. Dist.*, No. 78-750 (E.D. La. Jan. 23, 1981), at 22, where the court found a minimal anticompetitive effect from an exclusive contract for anesthesiology services. The court stated, "[t]he East Jefferson group does not enjoy a monopoly nor does it control a substantial share of the provision of services in the relevant area." *Id.*

<sup>74</sup> A restraint of trade of some type obviously occurs where a practitioner dependent upon use of a hospital is denied staff privileges in the only hospital in the geographic area. This issue has not been directly answered by the courts, however.

<sup>75</sup> *Wilk v. American Medical Ass'n*, No. 76 C377 (N.D. Ill. 1981).

<sup>76</sup> *Id.*

*ogy Center v. Blue Cross of Kansas City*,<sup>77</sup> a new hospital brought an antitrust cause of action against the insurer for refusal to grant participating status to hospitals without construction approval from the local health planning agency. The Supreme Court, in a recent unanimous ruling in this case, held that implicit in the health planning law is not a repeal of the antitrust laws for health planning activities.<sup>78</sup>

*Peculiarities of Health Care: The Market and Formulation of  
Cost Containment Policy*

Neither a perusal of the legislative history of the McCarran-Ferguson Act nor an analysis of relevant case law serve as a guide in the appropriate application of the antitrust laws to health service agreements. Both legal issues and national policy considerations must be dealt with in the context of the health care crisis.

*The Crisis in Health Care*

Health care, once solely the province of the private sector, has enjoyed prominence as a political issue for decades. Professionals from diverse areas within the private and public sectors are searching for alternatives to an American health system plagued with high costs and failure to meet patient demand because of inaccessibility or inappropriateness of available services. Skyrocketing costs have resulted in, among other things, broader-based support for national health insurance.<sup>79</sup> Despite identification of many of the health system's ills, long-

<sup>77</sup> 101 S.Ct. 2415 (1981). The Supreme Court reversed the holdings of the Eighth Circuit Court of Appeals and the district court; the lower courts had held that there was such an implied repeal. 628 F.2d 1050 (8th Cir. 1980), *aff'g* 479 F. Supp. 1012 (W.D. Mo. 1979).

<sup>78</sup> The opinion of the Court concerned only the insurer's response in this instance to the health planning process, and n.18 reads: "[W]e emphasize that our holding does not foreclose future claims of antitrust immunity to other factual contexts. . . . Where, for example, [a health systems agency (HSA)] has expressly advocated a form of cost-saving cooperation among providers, it may be that antitrust immunity is 'necessary to make the [National Health Planning and Resources Development Act of 1974, 42 U.S.C. §§ 300K *et seq.*] work.' . . . Such a case would differ substantially from the present one, where the conduct at issue is not cooperation among providers, but an insurer's refusal to deal with a provider that failed to heed the advice of an HSA."

As in the *Royal Drug* case, the antitrust laws have yet to be applied to these actions of the defendant. After both cases, it is clear that there will be a good deal of litigation in the future to determine whether the antitrust laws are applicable.

<sup>79</sup> See selected Hospital Cost Containment Proposals: Major Provisions, Comm. on Finance, United States Senate, Subcomm. on Health Staff Report, Oct. 11, 1977. See also the Carter administration's Hospital Cost Containment Act of 1979 submitted to the Senate by the Department of Health, Education, and Welfare past-Secretary Joseph Califano in Mar. 1979. The proposal is representative of the mechanisms conceived by policymakers. The proposal pertained only to hospital expenditures and would trigger a mandatory 9.7% cap only when those expenditures exceed the set level and then only for a short time. These mechanisms are attractive

range policies and solutions have yet to be developed and accepted. While the debate ranges from a totally public national health service to a free market system where costs are controlled by the market, much attention is paid to the concept of cost containment.<sup>80</sup>

*Competition Versus Regulation as a Solution:  
Is There a Health Care Market?*

According to the normative model of the market, an increase in demand causes an increase in price, which in turn induces profit-seeking firms<sup>81</sup> to increase supply. Increased supply then lowers prices, creating a new equilibrium.<sup>82</sup> Therefore, if the demand for medical ser-

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in light of the fact that 47.5% of the health care dollars in the United States goes to hospital and nursing home care, according to the National Science Foundation, National Institutes of Health. BUSINESS WEEK, Sept. 4, 1978, at 60. Although the first national health insurance plan was drafted in 1914 by the American Association for Labor Legislation and submitted to the state legislatures without success, comprehensive health insurance is still not politically feasible on a national level. Some commentators perceive that the middle class has a new-found or renewed interest in national health insurance, which may portend increased momentum in the future. Wall. St. J., Jan. 1, 1979, at 16, col. 1; Roberts & Bogue, *The American Health System: Where Have All the Dollars Gone?*, 13 HARV. J. ON LEGIS. 635 (1976). The current conservative tenor of the country suggests that a national health insurance plan at this time is very unlikely.

<sup>80</sup> Responses from the private sector include review of hospitals by the Joint Commission on Accreditation, the voluntary effort popularized during the Carter administration, and self-insurance by corporations, including preventive health and fitness centers. BUSINESS WEEK, Sept. 4, 1978, at 61-63.

See note 71 *supra*. One commentator has written that the federal government is no longer timid about intervention in the health arena, as indicated by the legislative record of the last decade or so, including promotion of the health maintenance organization concept. He notes that dissatisfaction with federal health policy is in direct proportion to federal responsiveness. Brown, *Formulation of Federal Health Care Policy*, 77 BULL. OF N.Y. ACAD. MED. 45-47.

Solutions suggested range from a totally national health system, such as Great Britain's, to a redistribution of wealth, to equal buying power of all consumers of health services and other goods. Turshen, "The British National Health Service: Its Achievements and Lessons for the United States" (unpublished work, 1977) [hereinafter cited as Turshen]. Compare Havighurst, *Controlling Health Care Costs: Strengthening the Private Sector's Hand*, 1 J. HEALTH POL., POL'Y & LAW 471 (1977) [hereinafter cited as Havighurst].

<sup>81</sup> In an economic analysis of health care applied to physicians and to health care institutions, it may be argued that hospitals that are nonprofit "firms" cannot be modeled as maximizing profits, a quality which inheres in the classic market model. Frech and Ginsburg note that "[t]his argument is one-half correct: most hospitals are nonprofit firms. However, most theories of nonprofit behavior give analytical results similar to profit maximization for the response of the industry to such changes as increased demand or higher costs." Frech & Ginsburg, *Public Insurance in Private Medical Markets—Some Problems of National Health Insurance* 79 (1978) (American Enterprise Institute) [hereinafter cited as Frech & Ginsburg]; Pauly, *The Behavior of Nonprofit Hospital Monopolies: Alternative Model of the Hospital*, in REGULATING HEALTH FACILITIES CONSTRUCTION (C. Havighurst ed. 1974). See generally Fuchs, *Health Care and the United States Economic System—An Essay in Abnormal Physiology*, in ECONOMIC ASPECT OF HEALTH CARE 95 (J. McKinley ed. 1973).

<sup>82</sup> It may be, however, that there are no individual markets that operate as classic markets or that have achieved perfect competition. Each market has individual characteristics,

vices increases, for example, because of an epidemic or because of increased access to services, such as occurred with the inception of Medicare, the supply should increase and prices should be driven down. This admittedly does not happen in the "market" for health services. The normative model functions according to decentralized decision making, and the two basic economic units perform the functions just described. Firms produce and supply goods and services, and households provide and consume goods and services. Firms then would include hospitals, physicians, and the like, and to some extent, the government through its direct operation of facilities.<sup>83</sup> Households include patients, employers, and the government.<sup>84</sup>

The issue remains as to whether the classic market theories apply in the health care system. Undoubtedly it does not operate as a classic market. The issue then becomes whether these theories can be applied in the health care system and, if so, how.

Identified aberrations within the health system abound. First among the identified eccentricities within the descriptive model of the health services market, the demand function of price is inelastic—utilization decisions are generally made without regard to cost.<sup>85</sup> Second, the physician's contribution to the decision-making process is generally greater than the patient/consumer's contribution. In other markets where the buyer has ample information to make his own informed decision or where a buyer might decide to forego a purchase if the price is inordinately high, the buyer exerts significant control on the

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and neither the antitrust laws nor economists have ever embraced perfect competition as a realistic goal. See generally SCHULTZ, *THE PUBLIC USE OF PRIVATE INTEREST* (1977); Sgontz, *The Economics of Financing Medical Care: A review of the Literature*, 9 *INQUIRY* No. 1 3, 16 (1972); and MARSHALL, *PRINCIPLES OF ECONOMICS* (1949). See also Comment, *Antitrust Liability for an Exchange of Price Information—What happened to Container Corporation?*, 63 *VA. L. REV.* 639, 642 (1977) (indicating few American industries conform to perfect model of competition).

<sup>83</sup> The federal government acts as a firm in operating the Veterans Administration hospital system, for example. See generally, Blumstein & Calvani, *supra* note 34, at 399.

<sup>84</sup> *Id.* at 399 n.52.

<sup>85</sup> Enthoven, *Competition of Alternative Health Care Delivery Systems*, in *PROCEEDINGS OF A CONFERENCE SPONSORED BY THE FEDERAL TRADE COMMISSION BUREAU OF ECONOMICS* at 322 (Mar., 1978). But see Frech & Ginsburg, *supra* note 81, at 71. Enthoven writes in terms of utility-maximizing consumers who pay for services out of their own incomes. In addition to patient-consumers being numbed into cost unconsciousness, he points out that "[i]n the predominant economy of independent physicians and community hospitals, neither the physicians nor the hospital has complete control over the costs and quality of this product. Each controls some aspects of it, and each responds to his/its own incentives. Not being profit-maximizing firms facing given market prices, neither has an economic incentive to minimize the cost of production. . . . It would be very expensive for the consumer to attempt to shop around for a less costly product, even if he had the motivation." Enthoven at 322-23. This last point is particularly true because of the methods of reimbursement existing in the marketplace—cost saving measures, such as a second opinion prior to surgery, are generally disfavored by insurers.



demand.<sup>86</sup> Another eccentricity is the existence of barriers to entry into the market as a provider of health services, which include certification, accreditation, and myriad requirements for subspecialty training.<sup>87</sup> Freedom of entry serves to ensure that prices are determined competitively and therefore is an integral component of the classic concept of the economic market. A survey of the literature suggests that agreement as to the deficiencies does not result in agreement as to the causes of or solutions of these problems. This can be illustrated by comparing the theories of Fuchs and Kramer<sup>88</sup> and Turshen<sup>89</sup> with those of Leffler,<sup>90</sup> Helms,<sup>91</sup> and Havighurst.<sup>92</sup> Fuchs and Kramer find that demand is irreparably damaged in the health system because of numerous and powerful imperfections, including restrictions created by licensure and professional control of medical education; limitations on practice implicit in the hospital medical staff appointment system; and absence of forms of rivalry, such as price cutting and advertising.<sup>93</sup> Turshen's

<sup>86</sup> Frech and Ginsburg suggest that a perfect agency relationship between physician and patient would result in "combining technical knowledge with the patient's attitudes toward health, pain, disability, and financial costs. . . . [T]he behavior would correspond to the case where the patient chooses using perfect technical knowledge." Frech & Ginsburg, *supra* note 81, at 73.

<sup>87</sup> Blumstein & Calvani, *supra* note 34, at 389. Well-recognized barriers include state licensing, hospital staff privileges, and medical society control at the state and local levels.

<sup>88</sup> Fuchs & Kramer, *Determinants of Expenditures for Physicians' Services in the United States, 1948-68*, NATIONAL COUNCIL FOR HEALTH SERVICES RESEARCH & DEVELOPMENT, NATIONAL BUREAU OF ECONOMIC RESEARCH #117 at 1 (1972) [hereinafter cited as Fuchs & Kramer]. See also TITMUSS, COMMITMENT TO WELFARE 138-52 (1968). The philosophy opposing private sector control has been articulated in this way: "Economic growth cannot solve the problem of poverty without the intervention of comprehensive and deliberately redistributive social policies. . . . [P]rivate markets in welfare cannot solve the problem of discrimination and stigma. . . . [P]rivate markets in welfare do not offer consumers more choices; and . . . social services in kind, particularly medical care, have characteristics which differentiate them from goods in the private market." *Id.* at 139. See generally Buchanan, *What Kind of Income Distribution Do We Want?*, 35 *ECONOMICA* 89 (1968).

<sup>89</sup> Turshen, *supra* note 80.

<sup>90</sup> Leffler, *National Health Insurance: A Social Placebo*, CURRENT TOPICS 24-25 (1977) [hereinafter cited as Leffler].

<sup>91</sup> Helms, *Contemporary Health Policy: Dealing with the Cost of Care* (1978) (printed by the American Enterprise Institute for Public Policy Research) (1978) [hereinafter cited as Helms].

<sup>92</sup> Havighurst, *supra* note 80.

<sup>93</sup> Fuchs & Kramer, *supra* note 89, at 1. They also contend that consumers have different experience in judging quality of physician services and that physicians play a major role in determining quality. Such an argument proves too much, however; the contenders leave themselves open to attack by the market proponents that patient education is a viable solution. Kessel criticizes the American Medical Association for presuming simultaneously to represent the public in determining the quality of providers needed and the quality of production standards and to represent the medical profession: "In other words, the AMA represents both the buyers and sellers of physicians' services in determining the output of physicians. Given this anomalous

premise is that health care is not a market good and, this being so, she finds that a true commitment to welfare and a desire to bolster competition are mutually exclusive;<sup>94</sup> she argues for a totally nationalized health system. The difference between this view and the free market alternative is a deeply philosophical one.

Leffler, on the other hand, concludes that the traditional economic forces of supply and demand do in fact determine price.<sup>95</sup> He characterizes the laws of supply and demand as the most severe regulators of efficiency in the market.<sup>96</sup> He indicates that, should they fail, incorporation into the public sector should follow, but he finds no evidence that this has happened in the area of health care.<sup>97</sup> Helms indicates that strong economic forces do work in medical markets; he would seek to explain perverse market behavior rather than abandon the market analysis.<sup>98</sup> The aberrant behavior is an efficient and predictable reaction to a variety of factors.<sup>99</sup> Havighurst theorizes that one of those factors is the subsidy provided by the tax laws that directly results in over-insurance or shallow, first dollar coverage,<sup>100</sup> which in turn results in overutilization of services.<sup>101</sup> The employer, provider, and patient all have little incentive to “shop around”<sup>102</sup> or to exercise restraint in consuming resources. Havighurst promotes cost containment achieved through the private sector as more likely to be effective and appropriate in a pluralistic society than would be government-

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position, it is difficult to believe that the AMA will ever permit the number of physicians to be produced that the public is willing to support with its patronage.” Kessel, *The A.M.A. and the Supply of Physicians*, 35 LAW & CONTEMP. PROBS. 267, 282 (1970).

<sup>94</sup> Turshen, *supra* note 80, at 46. Turshen criticizes the English health system for acquiescing to doctors' demands that the private practice of medicine which now drains the public system be preserved within it; she contends that the preservation of private practice has altered the state-run system and has breached the principles of uniform and universal health services for all.

<sup>95</sup> Leffler, *supra* note 90, at 25.

<sup>96</sup> *Id.* at 24.

<sup>97</sup> *Id.*

<sup>98</sup> Helms, *supra* note 91, at 332. See also *id.* at 334-42 for a discussion of the theory that consumers can make substitutions in the medical market and the consumers will be liberated if both consumers and providers are made more cost conscious.

<sup>99</sup> *Id.* at 343.

<sup>100</sup> Essentially, consumers have insured themselves for great losses and have paid small premiums. Consumers pay the “first dollar” on medical bills, and the insurer covers the balance. The over-insurance problem has been exacerbated by the federal tax laws which encourage employers and individuals to buy more insurance. With payments not exacted in full for each good or service, the consumer tends not to choose products based on price. Employers are encouraged to provide group insurance and employees have an incentive to bargain for more medical insurance, which is not taxable as wages. *Id.* at 335.

<sup>101</sup> Havighurst, *supra* note 80.

<sup>102</sup> *Id.* See also note 79 *supra* and accompanying text.

sponsored controls.<sup>103</sup> Those favoring a private sector-based remedy urge patient education programs and legislation that would spur competition by sharing control over demand between providers and consumers, thereby destroying disincentives and offering consumers more alternatives.<sup>104</sup>

Pauly provides the common denominator for the government regulation and free market theories.<sup>105</sup> Pauly, in a highly pragmatic approach, finds that the answer to whether health care is inherently different depends on several factors: the type of care, consumer experience with that care, the type and scope of contact with physicians involved in providing that type of care.<sup>106</sup> His is a broader notion of information that takes into account information from informal sources.<sup>107</sup> The notion of information is important as it stimulates competition by preparing the consumer for an active, responsible role in the health market.<sup>108</sup> Weisbrod, in commenting on Pauly's analysis, suggests that quality and price information must be distinguished.<sup>109</sup> While price information will be easier to obtain and provide, it will be

<sup>103</sup> Havighurst, *Role of Competition in Cost Containment*, reprinted in *Competition in the Health Sector: Past, Present, and Future*, in PROCEEDINGS OF A CONFERENCE SPONSORED BY THE FEDERAL TRADE COMMISSION BUREAU OF ECONOMICS (Mar., 1978) at 359 [hereinafter referred to as PROCEEDINGS]. See generally Reynolds, *A New Scheme to Force You to Compete for Patients*, MEDICAL ECONOMICS 23 (Mar. 21, 1977) discussion of innovative service configurations). Reynolds discussed Elwood's theory that health maintenance organizations have lowered costs by forcing classic fee-for-service practices to compete for patients. Because they have been slow in gaining acceptance, however, Elwood suggests the Health Care Alliance (HCA) as an alternative; the HCA is a network of entirely new and competing entities. *Id.* Federal Trade Commission staff member Walter T. Winslow reported that the Commission remains on the alert for concerted efforts to frustrate the operation of health maintenance organizations (HMO): "I want to emphasize that we do not disfavor fee-for-service medicine in relation to HMO's or other alternative health care delivery systems. We do believe that in the long run, consumers will benefit from the availability of a wide variety of options. . . ." Remarks of Walter T. Winslow before the National Health Lawyers Association Seminar on Antitrust in the Health Care Field (Washington, D.C. Jan. 8, 1979). On the same subject and from the economist's perspective, Enthoven writes: "Thus, capitation-financed organized systems are not merely a device for financing the same bundle of services as that offered by the fee-for-service, cost-reimbursed third-party financed medicine; and they are not merely an incentive scheme for lowering cost or utilization. Rather, they are a framework within which providers can offer very different product mixes, emphasizing different values, depending upon the tastes of the consumers served." Enthoven, *Competition of Alternative Delivery Systems*, PROCEEDINGS, *supra* note 103, at 330-31.

<sup>104</sup> See notes 93 and 95 *supra*.

<sup>105</sup> Pauly, *Is Medical Care Different?*, PROCEEDINGS, *supra* note 103, at 19.

<sup>106</sup> *Id.* at 24.

<sup>107</sup> This notion of information includes that received from family and acquaintances with similar experiences. *Id.* at 27, 39-40.

<sup>108</sup> Weisbrod, *Comment* (to Pauly paper), PROCEEDINGS, *supra* note 103, at 49.

<sup>109</sup> *Id.*

misleading in situations where the information concerning quality or effect of care is not readily available or understood.<sup>110</sup>

A sizeable contingent is currently advocating government regulation of the health sector, although that possible solution is chosen for myriad and disparate reasons. Some view the market or the product, health care, as “inherently different,”<sup>111</sup> while others state that a survey of the marketplace’s actors forces the conclusion that regulation is the only feasible alternative.<sup>112</sup> Those with vested interests may welcome regulation in anticipation of attaining the prized status of the regulatee.<sup>113</sup> Commentators suggest that experience in other regulated industries illustrates the disappointments and dangers of regulatory systems built by lobbies with powerful, vested interests.<sup>114</sup> The view accepted for the purposes of this article is essentially that espoused by Professor Havighurst—before radical revision or replacement of the American health system, a practical national approach would be to at-

<sup>110</sup> *Id.*

<sup>111</sup> See notes 87-89 *supra*.

<sup>112</sup> The following statement by Senator Edward Kennedy is representative of this view: “The different elements of the health care system—employers, employees, doctors, insurance companies, hospitals—all understand what has to be done. But they all say they can’t do it. There seems to be only one way to get health care costs under control. The federal government has to become involved.” Interview with Senator Edward Kennedy, reprinted in Inglehart, *Health Focus*, NAT’L J. 598 (1976). Further, the analysis of Dr. Philip Caper focuses on the nature of the “industry” rather than on the performance record of or need for governmental regulation: “Health care is not and should not be considered a commodity, perceived to be the same kind as other goods and services. Health care is not governed by marketplace economics.” Caper, *Regulatory Reform: Highlights of a Conference on Governmental Regulation*, AMERICAN ENTERPRISE INSTITUTE (Moore ed. 1979).

<sup>113</sup> See, e.g., *Deregulation on the Road: Truckers Fight to Keep Protective Controls*, Washington Post, Oct. 29, 1979, at 1, col. 8; Drake & Kozak, *A Primer on Antitrust and Hospital Regulation*, 3 J. HEALTH POL., POL’Y & LAW 328 (1978); Drake and Kozak, of the office of Program and Policy Development of the American Hospital Association, state that traditional forces do not and apparently cannot be made to operate in the health care market. They, therefore, favor regulation as an instrument for expanding the range of consumer choices: “The growing interest in the influence of environment and individual behavior on the demand for health services can provide an opportunity for regulatory programs to enhance the consumer’s role in selecting modes of therapy through altered tax benefits and cost-sharing.” *Id.* at 341. While Professor Havighurst outlines a market-oriented strategy of this same general type, Drake and Kozak propose further regulatory intervention in the market to enhance its effectiveness. The distinction is subtle, but very important, particularly when the vested interests and powerful lobby of the hospital industry are considered.

<sup>114</sup> See generally Altman & Weiner, *Regulation as a Second Best*, in PROCEEDINGS, *supra* note 103, at 421; Pauly, *id.* at 19, 29-30; McClure, *The Medical Care System Under National Health Insurance: Four Models*, 1 J. OF HEALTH POL., POL’Y & LAW 22, 23 (1977) (shift health care from market good to merit good); Day, *Economic Regulation of Insurance in the United States*, DEPARTMENT OF TRANSPORTATION AUTOMOBILE INSURANCE AND COMPENSATION STUDY (1970); Stigler & Friedland, *What Can Regulators Regulate: The Case for Electricity*, 5 J. OF LAW & ECON. 1 (1962); Feldstein, *Consequences of Hospital Controls*, Wall St. J., Apr. 12, 1979, at 24, col.3.

tempt to motivate the participants operating within the private sector to act to contain the astronomical costs of health care.<sup>115</sup>

### *Discussion*

#### *Antitrust Analysis of the Pharmacy Agreement*

The insurer stated that the purpose of the Pharmacy Agreement is to provide a less expensive health service to its subscribers, which is certainly in itself an admirable goal, and it may be that the consumers would not receive any such price break without an insurer-backed plan. The actual effect of the agreement in Bexar County, Texas, however, may be to drive the smaller, independent pharmacies out of business. It may, at least for the life of the agreement, destroy any incentives the participating pharmacies might have to decrease their charges below the two dollars over acquisition cost negotiated by Blue Shield. Underlying these concerns is the view that providers should not grow rich in the provision of health services or in the effort to contain costs of health care.<sup>116</sup> Despite the fact that there is no clear statement of national health policy,<sup>117</sup> the courts and the Federal Trade Commission, in applying the antitrust laws to health care providers, put the cost containment burden on the insurer. Those branches have determined to apply the antitrust laws in order to strengthen the market and promote the beneficial effects of competition therein.<sup>118</sup> On remand, the *Royal Drug* case will offer some guidance to insurers as they negotiate and maintain cost containment agreements with providers on behalf of their subscribers. A discussion of the antitrust issues likely to be raised on remand follows.

#### *Per Se Analysis*

The advantage of labeling an agreement a per se violation, as with resale price maintenance,<sup>119</sup> or concerted refusal to deal,<sup>120</sup> or

<sup>115</sup> The diametrically opposing view is, of course, to argue for a total antitrust exemption for insurers—the ultimate regulation.

<sup>116</sup> See notes 87-89 *supra* and accompanying text.

<sup>117</sup> Health policy has been overshadowed by the general financial woe of the country in recent times. The proposed Reagan administration budget includes cutbacks in federal subsidies for health facilities, reimbursement programs, and medical education.

<sup>118</sup> This, in part, is precisely what Professor Havighurst has sought; see, e.g., Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 DUKE L.J. 303.

<sup>119</sup> *Albrecht v. Herald Co.*, 390 U.S. 145 (1968); *Dr. Miles Medical Co. v. John D. Park & Sons Co.*, 220 U.S. 373 (1911).

<sup>120</sup> *United States v. General Motors Corp.*, 384 U.S. 127 (1966); *Eastern States Retail Lumber Dealers' Ass'n v. United States*, 234 U.S. 600 (1914).

price fixing,<sup>121</sup> is that a violation may be deemed unreasonable with little or no analysis of the effect of the practice or any laudatory justifications for it.<sup>122</sup> The per se rule exists in support of the federal antitrust policy that decisions are to be made competitively rather than by a "benevolent" corporation with vested interests.<sup>123</sup>

A successful price-fixing challenge must establish an agreement, which can be inferred,<sup>124</sup> and the purpose or effect to fix prices.<sup>125</sup> The power to affect prices, however, is not required.<sup>126</sup> What occurred in Bexar County, Texas, appears to be of a different character. It appears that an insurer extended unilateral contract offers to each licensed pharmacy in the area and that the insurer made the offer attractive in order to secure sufficient acceptances. The result was that the insurer contracted with a number of pharmacies to provide health services—prescription drugs—to its subscribers. Subscriber choice would appear to be based on savings and convenience afforded in dealing with participating pharmacies. The insurer emphasizes that it followed the advice of the Federal Trade Commission and preserved the legality of the plan by arriving at the professional dispensing fee of two dollars independently. In other words, the insurer contends that it neither solicited nor received input from the retail pharmacies in setting this price.<sup>127</sup>

In accepting the insurer's offer, the participating pharmacies sought to increase their profits, either through increased volume of prescriptions filled or, more likely, through increased sales of non-

<sup>121</sup> Price fixing among competitors is a per se violation of section 1 of the Sherman Act. *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975); *United States v. Paramount Pictures, Inc.*, 334 U.S. 131 (1948); *Hartford-Empire Co. v. United States*, 323 U.S. 386 (1945); *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150 (1940).

<sup>122</sup> There is no such thing as a reasonable price fix, according to the Court in *United States v. Trenton Potteries, Co.*, 273 U.S. 392 (1927) (refusal to consider reasonableness of company's action).

<sup>123</sup> *Id.* at 397: "The aim and result of every price-fixing agreement, if effective, is the elimination of one form of competition." *But see Hyde v. Jefferson Parish Hosp. Dist.*, No. 78-750 (E.D. La. Jan. 23, 1981) at 17, where the court states that the per se rule should not be applied to cases involving professional activities.

<sup>124</sup> *Eastern States Retail Lumber Dealers' Ass'n v. United States*, 234 U.S. 600, 612 (1914) (circumstantial evidence). *See Interstate Circuit, Inc. v. United States*, 306 U.S. 208, 226 (1939): "[K]nowing action was contemplated and invited, the distributors gave their adherence to the scheme and participated in it."

<sup>125</sup> The effect on price can even be indirect. *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150 (1940).

<sup>126</sup> *Socony dictum* established that the power to affect or in fact having the effect of fixing prices was not a prerequisite to finding a section 1 violation of the Sherman Act. *Id.* at 224.

<sup>127</sup> Brief for Petitioner at 8, 26, *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979).

pharmaceuticals to consumers entering the retail drugstores for the purpose of having prescriptions filled there.<sup>128</sup> While it is reasonable to assume that the chain drugstores accepting the insurer's offer believed that nonparticipation would place them at a competitive disadvantage, this alone is not enough to constitute the agreement or concerted action contemplated by the per se price fix analysis under the Sherman Act. Certainly, acting in anticipation of the actions of competitors is a commercial reality, and no amount of sympathy for the independent pharmacy, unable to afford to participate in this plan, allows avoiding the requisite agreement or concert without additional facts, which have not yet appeared in the *Royal Drug* litigation.

Assuming facts are marshalled establishing an agreement between competitors, the analysis then focuses on the effect of the plan. The potential pernicious effects include stabilizing<sup>129</sup> prices or establishing a ceiling on prices of retail drugs.<sup>130</sup> If the participating pharmacists were to combine for the purpose of or with the effect of engaging in predatory pricing, a per se violation would be established.<sup>131</sup> This would be the case, for example, where the participating pharmacists were actually conspiring to drive the independent pharmacies out of business and to that end lowered their prices below marginal costs for a period of time.<sup>132</sup> Where the anticompetitive purpose is not so clear, the anticompetitive effect should be clearly demonstrated.<sup>133</sup> Depending upon the particular facts, this effect could take place within the population of subscribers or within the retail pharmaceutical market generally in that locale.<sup>134</sup>

Where buyer and seller agree on a price at which the buyer must resell a product or service, the buyer's freedom to resell at prices determined by his individual response to market competition is not main-

<sup>128</sup> See notes 20-22 *supra* and accompanying text.

<sup>129</sup> The *Socony* Court used a very broad sword to strike down price fixing, speaking in terms of "raising, depressing, fixing, pegging, or stabilizing" prices. *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 223 (1940). Blue Shield contended that it had no desire to stabilize prices in the retail market for prescription drugs at an artificially high level; rather, the Pharmacy Agreement represented an attempt to prevent prices from rising as quickly as they might have without it. Reply Brief for Petitioner at 26, *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979).

<sup>130</sup> Brief for Appellee at 27, 440 U.S. 205 (1979); *Kiefer-Stewart Co. v. Joseph E. Seagram & Sons, Inc.*, 340 U.S. 211 (1951).

<sup>131</sup> See generally *id.*

<sup>132</sup> See notes 169-187 *infra* for an analysis of a possible Robinson-Patman challenge.

<sup>133</sup> This is a pragmatic approach, but it is one attribute of the antitrust laws that the business community criticizes as destroying an element of predictability and thereby impeding the operation of the commercial sector.

<sup>134</sup> Compare note 170 *infra* and accompanying text for a discussion of the "effect on competition" component in the Robinson-Patman analysis.

tained.<sup>135</sup> This is known as vertical price fixing or resale price maintenance. In *Albrecht v. Herald Co.*,<sup>136</sup> the Court found that section 1 of the Sherman Act was violated where a publisher disciplined a distributor who had ceased to adhere to the maximum resale price set by the publisher.<sup>137</sup> The Court refused to interpret the earlier *Kiefer-Stewart* rule,<sup>138</sup> holding that maximum price agreements were per se unlawful, as applicable only to horizontal agreements.<sup>139</sup> The justifications for the per se status are several. First, potential buyers are likely to be discouraged from entering the market by the lowering of prices.<sup>140</sup> Second, the set price might not be as competitive as it could otherwise be. Third, the dealer would be deprived of a reasonable rate of return where the maximum price is set below cost.<sup>141</sup> Contrast a vertical price fix to the facts of the *Royal Drug* case where Blue Shield as a buyer has offered a contract to the participating pharmacy as a seller. The most that can be said is that the insurer has contracts with several pharmacies to provide services to the insurer's subscribers in accordance with those contract terms.

The Blue Shield Association in its Amicus Brief to the Supreme Court argues that the reimbursement formula found in the Pharmacy Agreement was designed "to allow the interplay of market forces in the retail drug industry to determine the cost of prescriptions."<sup>142</sup> The association essentially relies on three elements to illustrate the free play of market forces. First, the acquisition cost is said to be determined by market forces in the wholesale drug industry and unaffected by the pharmacy agreements.<sup>143</sup> Second, the deductible, or dispensing fee, was determined unilaterally based on relevant precedent holding that section 1 of the Sherman Act was violated by concerted action by pharmacists acting with the intent and effect of fixing retail drug prices.<sup>144</sup> Further, a Justice Department official has interpreted com-

<sup>135</sup> L. SULLIVAN, ANTITRUST 337 (1977) [hereinafter cited as SULLIVAN].

<sup>136</sup> 390 U.S. 145 (1968).

<sup>137</sup> *Id.* at 152 n.8.

<sup>138</sup> *Kiefer-Stewart Co. v. Joseph E. Seagram & Sons, Inc.*, 340 U.S. 211 (1951).

<sup>139</sup> *But see* Justice Harlan's opinion in *Albrecht v. Herald Co.*, 390 U.S. 145, 159 (1968).

<sup>140</sup> New entrants must often lower their prices at the beginning in order to dislodge previously established commercial relationships; therefore, the ability to lower prices would be an important factor in the decision to enter the industry's market.

<sup>141</sup> The nonparticipating pharmacies argue in effect that the Pharmacy Agreement as offered would deny nonparticipants a reasonable rate of return. Brief for Appellee at 7, 440 U.S. 205 (1979).

<sup>142</sup> Brief for Blue Shield Ass'n as Amicus Curiae at 28-29, *id.*

<sup>143</sup> *Id.* at 34-35.

<sup>144</sup> *North Calif. Pharmaceutical Ass'n*, 306 F.2d 379 (9th Cir.), *cert. denied*, 371 U.S. 862 (1962); *United States v. Utah Pharmaceutical Ass'n*, 201 F. Supp. 29 (D. Utah 1962).



pliance with those cases to require retail pharmacists to refrain from bargaining collectively with insurers over the amount of the dispensing fee or making a joint decision to reject or to accept the offer.<sup>145</sup> Third, the Justice Department has followed the development of prescription drug programs and has repeatedly stated that they do not violate the antitrust laws.<sup>146</sup>

Even if the reimbursement formula is arrived at competitively, a price-fixing charge based on allegations of a ceiling or stabilization of prices remains to be answered. Again, the Pharmacy Agreement appears to pass muster. The Blue Shield Association contends that the insurer is compelled to establish and continue plans at the behest of the employers and, therefore, must meet the employees' demands for financial savings and convenience.<sup>147</sup> Obviously, for such a plan to succeed, the insurer must consider the individual pharmacist's reaction to the fee incorporated in the plan as offered; a dispensing fee that the pharmacist is likely to accept must be offered.<sup>148</sup> If the pharmacists reject the plan, employers will almost certainly seek another carrier. Blue Shield argues that participating pharmacists are absolutely free to discount their dispensing fee below two dollars in order to gain a competitive advantage over participating and nonparticipating pharmacies in the area.<sup>149</sup> What troubles the nonparticipants is that no more than two dollars can be added to the acquisition cost under the agreement, thereby limiting the pharmacy's profit and making participation by independent pharmacies with higher overheads impossible.<sup>150</sup> This fee, determined unilaterally by Blue Shield and accepted by each pharmacy individually, does not violate the Sherman Act but, rather, constitutes a valid contract determined fairly by the parties bargaining at arm's length. If the bargaining positions are unequal, as where the insurer has monopsony power in the market, it seems that the plan would fail under antitrust scrutiny.<sup>151</sup> The result may be the same as that under the pre-*Royal Drug* interpretation of section 2(b) of the McCarran-Ferguson Act—the agreement is valid until the insurer attempts to

<sup>145</sup> Bernstein, "Antitrust Aspects of Prepaid Prescription Plans," 10-11, Address to Annual Convention of Retail Druggists, Las Vegas, Nev. (Oct. 15, 1969), as cited in Brief for Blue Shield Ass'n as Amicus Curiae at 30, 440 U.S. 205 (1979).

<sup>146</sup> *Id.* For a discussion of the reasonableness of the dispensing fee, see Brief for Blue Shield Ass'n as Amicus Curiae at 33, 440 U.S. 205 (1979).

<sup>147</sup> *Id.* at 30.

<sup>148</sup> See also *id.* at 34.

<sup>149</sup> *Id.* at 4.

<sup>150</sup> This brings to the forefront the unanswered policy question, which is what the end result of this market protection should be.

<sup>151</sup> See note 158 *infra* for the Justice Department's view on this issue in the context of the Robinson-Patman Act.

coerce, boycott, or intimidate. However, the impact of the section 1 analysis where the insurer has monopsony power or where the providers of health services are engaging in anticompetitive practices must not be underestimated.<sup>152</sup>

The nonparticipating pharmacies have also charged the insurer and participating pharmacies with a concerted refusal to deal, or a group boycott,<sup>153</sup> which the Supreme Court has declared a per se violation of the Sherman Act.<sup>154</sup> This prohibition is not a stranger to providers of health services; for example, refusal of medical staff privileges is often the subject of litigation.<sup>155</sup>

The argument made by the nonparticipating pharmacies is that the procedure for reimbursement of subscribers who choose to deal with them was purposely made so troublesome and unattractive that subscribers were effectively coerced to boycott the nonparticipants. Further, the nonparticipants attack the reimbursement formula applied when a subscriber deals with a nonparticipant as imposing a financial penalty that is calculated to result in the refusal to deal by the subscribers. They contend that it is unnecessary to use a different reimbursement procedure when a nonparticipating pharmacy is selected by the subscriber. Unlike the situation in which a subscriber deals with a participating pharmacy, the renegade subscriber must pay the pharmacy the entire retail price of the drug and, in addition, receives less in reimbursement from the insurer.

The coercion argument is not persuasive in light of the fact that the subscribers are free to do business with the nonparticipants. Regarding the challenge that the separate procedure is unjustified, the insurer's response, if supported by the facts,<sup>156</sup> is satisfactory:

<sup>152</sup> This makes it possible to uphold valid agreements and to invalidate agreements by insurers bearing so much market power that the potential for abuse is the paramount concern. This is not to say that "big is bad," but rather to reaffirm the need for a flexible, sensitive method of assessing such activities and arrangements between providers of health services and other products.

<sup>153</sup> Brief for Respondents at 109, 440 U.S. 205 (1979).

<sup>154</sup> *Radiant Burners, Inc. v. Peoples Gas Light & Coke Co.*, 364 U.S. 656 (1961).

<sup>155</sup> See, e.g., *Tyson's Corner Regional Shopping Center*, [1973-76 Transfer Binder] TRADE REG. REP. (CCH) ¶ 20,933 (FTC 1975) (denial of staff privileges per se violation where staff physicians have right to veto); *Boddicker v. Arizona State Dental Ass'n*, 549 F.2d 626 (9th Cir.), cert. denied, 98 S.Ct. 73 (1977) (restrictive or unnecessary membership requirements or expulsion from organizations where membership economically desirable); *Levin v. Joint Comm'n on Accreditation of Hospitals*, 354 F.2d 515 (D.C. Cir. 1966) (denial certification or accreditation); *U.S. Dental Inst. v. American Ass'n of Orthodontists*, 396 F. Supp. 565 (N.D. Ill. 1975) (ethical or other prohibitions limiting scope of medical practice).

<sup>156</sup> This should be fairly easy to prove, although additional discovery is almost certain to be needed, as the case comes back up through the courts on the merits of the antitrust challenges.

The administrative costs of processing claims for drugs purchased from non-participating pharmacies are higher than those purchased from participating pharmacies. In the former case, the insured typically sends in only a receipt for the prescription, which does not contain sufficient information to process the claim. Thereafter, Blue Shield must correspond with the insured to obtain additional information necessary to prepare a proper claim form. In addition, unlike claims information submitted by participating pharmacies, information received from insureds is not coded on special forms so as to allow direct input into Blue Shield's computers. The amount of work necessary to enter such information in data processing equipment is thus increased if an insured's prescription is filled by a non-participating pharmacy. . . .<sup>157</sup>

Assuming these facts are as represented, use of this reimbursement scheme is no more coercive than is the familiar commercial practice of discounting certain items in order to increase sales of those items. Directing purchasing patterns is not inherently unlawful under the antitrust laws; it may promote economies of scale and other efficiencies of operation.<sup>158</sup>

It must be remembered that all licensed pharmacies were afforded the opportunity to participate in the plan.<sup>159</sup> The purpose of the federal antitrust laws, once again, is to keep the marketplace functioning competitively. The laws were not designed to keep weaker entities afloat in the marketplace, nor were they designed to secure a certain level of profit for those entities.

### *Analysis Under the Rule of Reason*

If no per se violation is found, the rule of reason analysis would be applied to determine if there has been a violation of section 1 of the Sherman Act. The rule of reason applies in a section 1 analysis where there is no "vertical restraint which has achieved a garden variety status. That is, it is not a tie-in, an exclusive dealing arrangement. . . . Consequently, as the district court indicated, it must be carefully

<sup>157</sup> Brief for Appellant at 5-6 n.5, 440 U.S. 205 (1979).

<sup>158</sup> See *Arizona v. Maricopa Co. Medical Soc'y*, [1980-1] TRADE CAS. 78,152 (9th Cir. Mar. 20, 1980), modified [1980-1 Transfer Binder] TRADE REG. REP. (CCH) ¶ 63,573, cert. granted No. 80-419 (U.S. Sept. 16, 1980), where the district court held that certain novel arrangements should not be per se violations. In that case, medical organizations were charged with antitrust violations for establishing maximum physician fees under agreements with health insurance carriers. See generally SULLIVAN, *supra* note 135, at 2-7, for a discussion of allocative efficiency as an antitrust goal and the two principal approaches of the Harvard and Chicago schools.

<sup>159</sup> The argument is simply that no one has been excluded from dealing with anyone else. *United States v. General Motors Corp.*, 384 U.S. 127 (1966).

looked at on its own facts, in order to reveal whether any restraint of trade it causes is 'reasonable.' ”<sup>160</sup>

One instance in which condemnation is incurred under the rule of reason is where the provider of goods or services also controls the insurer; there the potential for abuse is so great that, on balance, an unreasonable restraint of trade can be found.<sup>161</sup> In this situation, the providers, for example, could agree to increase prices and carry out their agreement through their control of the insurers; the latter would have to possess substantial power in the insurance market, however.<sup>162</sup> These facts are not present in the *Royal Drug* case. If the insurers are not provider-controlled but do possess substantial or monopoly power in the market, and the independent pharmacy goes out of business ostensibly because of the great success of the participating pharmacies under the Pharmacy Agreement, the rule of reason analysis provides the framework for a constructive balancing of interests. While the Sherman Act does not promise protection for weaker firms, the balancing approach of the rule of reason would presumably fall on the side of the endangered independent pharmacies were offensive acts to be directed to subscribers, competitors, or the public in general<sup>163</sup> without the least concomitant benefit to the subscribers of the insured.

Another alternative under the rule of reason analysis is the approach that was adopted in the *Chicago Board of Trade* decision.<sup>164</sup> In that case the Court found that it was too simple a test merely to ask whether the agreement restrained competition. The government failed in its attempt to show discrimination against any part of the public, alteration of supply or change in prices, resulting hardship, and design of the plan specifically to alter supply.<sup>165</sup> The Court stated that the true test is whether the agreement “merely regulates” and thereby promotes competition, or destroys and suppresses competition.<sup>166</sup> The Court suggested that it is necessary to consider facts peculiar to the business, the conditions before and after imposition of the restriction,

<sup>160</sup> *Travelers Ins. Co. v. Blue Cross of Western Pennsylvania*, 481 F.2d 80, 84 (3d Cir.), cert. denied, 414 U.S. 1093 (1973).

<sup>161</sup> Prior to the Supreme Court's decision in the *Royal Drug* case, Havighurst wrote that he hoped that the issue of application of the antitrust laws would be resolved in a manner to guarantee insurers wide latitude in using provider agreements for cost containment purposes while also giving providers protection in true monopsony situations. Havighurst, *supra* note 80, at 330 n.126.

<sup>162</sup> Brief for United States as Amicus Curiae at 13-14, n.6, 440 U.S. 205 (1979).

<sup>163</sup> This, in the final analysis, is the objection to predatory pricing.

<sup>164</sup> *Chicago Board of Trade v. United States*, 246 U.S. 231 (1918).

<sup>165</sup> *Id.* at 238.

<sup>166</sup> *Id.*

and actual and probable effects of the restraint.<sup>167</sup> Fifteen years later the Supreme Court rendered its decision in *Appalachian Coals, Inc. v. United States*,<sup>168</sup> directing attention to the reasons for adopting the restraint, including economic conditions, intent, and effect. While these two decisions are perhaps anomalous, they have not been overruled and should not be ignored as an analytical alternative in a compelling factual setting.<sup>169</sup> For example, in certain situations an insurer might be justified in using policy terms to effect a group boycott by subscribers.<sup>170</sup> Similarly, according to one commentator, a noncompetitive market may be made more competitive by an agreement between private parties operating in that market.<sup>171</sup> The Act is not intended to make unlawful arrangements that affect price by improving competition.<sup>172</sup>

### *The Price Discrimination Analysis Under the Robinson-Patman Act*

The Robinson-Patman Act,<sup>173</sup> which amends section 2 of the Clayton Act,<sup>174</sup> prohibits any person engaged in commerce from discriminating

<sup>167</sup> *Id.*

<sup>168</sup> 288 U.S. 344 (1933).

<sup>169</sup> Of course, the most favorable situation is one in which the providers are motivated to establish or participate in a cost containment agreement to obtain a high quality product, a variety of services, and a lower price, and where these objectives are reached.

<sup>170</sup> This could include favoring a hospital with lower per day room rates, or a less complicated reimbursement system such as encountered in the *Royal Drug* facts, as well as other incentives for dealing with the most efficiently operated providers.

<sup>171</sup> One analysis proposed for applying the antitrust laws to nonprofit entities uses the following criteria: "1) Apply standard antitrust analysis to determine if illegal anticompetitive acts have been committed, without considering the social benefits that the firm confers on society. 2) If the entity has committed illegal acts, determine whether it pursues a social benefit that the competitive market is unable to achieve. 3) If there is such a market failure, determine whether the anticompetitive activity is necessary for its solution. 4) If so, balance the welfare loss from the anticompetitive activity against the value of the social interests that are served." Note, *Antitrust and Nonprofit Entities*, 94 HARV. L. REV. 802, 812 (1980). The author of this analysis contrasts his approach with the current approach and indicates that the "proposed test looks for more than the mere existence of a noncommercial motive before according a particular activity special treatment." *Id.*

<sup>172</sup> SULLIVAN, *supra* note 135, at 200. For an enlightening discussion of policy objectives and possible guidelines for applying the antitrust laws in this context, see Note, *Antitrust and Nonprofit Entities*, 94 HARV. L. REV. 802, 811-16 (1980). See also Note, *Tackling Intercollegiate Athletics: An Antitrust Analysis*, 87 YALE L.J. 655 (1978).

<sup>173</sup> 15 U.S.C. § 13(a) (1973).

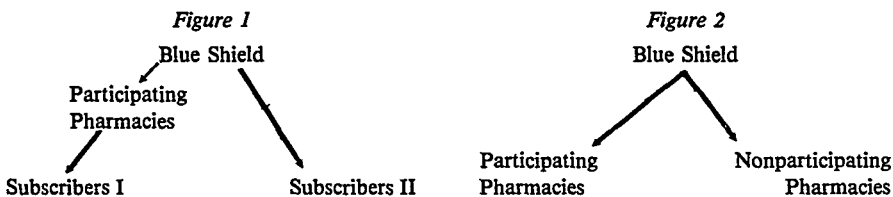
<sup>174</sup> See note 2 *supra*. The Clayton Act provides: "Sec. 2. (a) That it shall be unlawful for any person engaged in commerce, either directly or indirectly to discriminate in price between different purchasers of commodities of like grade and quality, where either or any of the purchases involved in such discrimination are in commerce, where such commodities are sold for use, consumption, or resale within the United States or any Territory thereof or the District of Columbia or any insular possession or other place under the jurisdiction of the United States,

minating between different purchasers of commodities of like grade and quality. There must be at least two purchases and an actual sale, as opposed to a consignment, lease, or agency. Further, a tangible article must be sold—a commodity, good, ware, product, or merchandise.<sup>175</sup> The seller must not discriminate with respect to the selling price, discounts, or credit terms offered. Injury to a competitor or a customer of the seller is also required.<sup>176</sup> Statutory defenses included in

and where the effect of such discrimination may be substantially to lessen competition or tend to create a monopoly in any line of commerce, or to injure, destroy, or prevent competition with any person who either grants or knowingly receives the benefit of such discrimination, or with customers of either of them. . . ." (emphasis added). 15 U.S.C. §§ 12-27 (1914).

<sup>175</sup> The question arising is whether Blue Shield sold services or commodities through its Pharmacy Agreement in Bexar County, Texas. The Blue Shield Association refers to the plan as one to "deliver promised drug *benefits*" (emphasis added), indicating the national organization's view of "drug benefits" as a service rather than a good. Brief for Blue Shield Ass'n as Amicus Curiae at 22, 440 U.S. 205 (1979). Although there is little doubt that the Pharmacy Agreement determines the price of the prescription drugs, the insurer contends that providing "a source of health care goods and services" rather than cash reimbursement is a traditional feature of Blue Shield and other insurance plans. Brief for Appellee at 13, 440 U.S. 205 (1979). See also note 170 *supra*.

<sup>176</sup> Assuming the sale of a good is established, the next critical jurisdictional elements to be established are at least two sales by the same seller at discriminatory prices. In this framework, Blue Shield must be viewed as the seller. The purchases could be either by the participating and nonparticipating pharmacists or by the two subscriber groups—those dealing with participating pharmacists and those dealing with nonparticipating pharmacists. The alternatives are depicted below:



In Figure 1, Subscribers I represents the group of subscribers dealing with participating pharmacies and receiving favorable treatment at the hands of the insurer; Subscribers II represents subscribers dealing with nonparticipating pharmacies. The analysis resulting from the approach depicted in Figure 1 is a second line analysis, which refers to competitive injury to buyers of the seller or supplier. See generally OPPENHEIM & WESTON, UNFAIR TRADE PRACTICES AND CONSUMER PROTECTION—CASES AND COMMENTS 831-88, ch. 10, § 3 (3d ed. 1974). This analysis, although somewhat asymmetrical, proceeds in the following manner: The seller is considered to relate to the participating pharmacies, on the one hand, and to the subscribers dealing with nonparticipating pharmacies, on the other hand, at the same level. This means that the reimbursement of cost to the participating pharmacy and the reimbursement of the Subscriber II group of 75% of the cost of the prescription less the \$2 deductible are considered to be the same kind of transaction. Therefore, the \$2 charge representing the only direct charge to subscribers dealing with participating pharmacies is not a focal point of the analysis. This does not appear to cause significant problems. Even if all of the jurisdictional elements are satisfied for this analysis, however, its application is clearly unwise from a policy standpoint. These insurer-negotiated agreements are well accepted. The ability of insurers to negotiate lower rates for subscribers and to encourage efficient utilization patterns, where lawful, should not be frustrated by a Robinson-

the Act,<sup>177</sup> validating transactions which would otherwise be discriminatory, include cost justification,<sup>178</sup> changing conditions affecting the marketability of goods,<sup>179</sup> and meeting competition.<sup>180</sup>

The insurer must qualify for treatment as a seller possessing market power. One commentator has characterized the potential offender as a firm that will be able to increase total revenue if it can sell at relatively higher prices to buyers with relatively inelastic demands.<sup>181</sup> The sales must evince a disparate ratio between the marginal cost and the price of the good.<sup>182</sup> Shoehorning a third-party payor into this framework, the insurer is the seller of prescription drugs and the agreement establishes the price the insurer "charges" subscribers.<sup>183</sup> Discrimination then occurs only if the seller deals with groups of buyers with differing elasticities separately. Persons choosing to deal with nonparticipating pharmacies may be patients with medical emergencies or nonambulatory patients who require twenty-four hour service, home delivery, or other special services.

The original plaintiffs particularly fear diversion of customers to the participating chain pharmacies. A Robinson-Patman violation might be found, based on horizontal injury, if (1) the independent pharmacies and Blue Shield are considered to operate on the same plane, that is, horizontal competition is at issue; (2) the asserted administrative cost justification for the higher reimbursement rate is not supported by the facts; and (3) the nonparticipating, independent

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Patman Act challenge. Figure 2, according to the analysis in *Perkins v. Standard Oil Co.*, 395 U.S. 642 (1969), *reh. denied*, 396 U.S. 871 (1969), represents a third line injury to competition case. In *Perkins*, the Court reached such a conclusion by focusing on the character of the buyers rather than the fact of a sale to them. Professor Weston has criticized as artificial this analysis of what he considers to be a second line injury case; he bases his criticism on the premise that the disfavored retailer was just a buyer. Weston, Lecture at George Washington University National Law Center (Nov. 11, 1979).

<sup>177</sup> For a discussion of defenses in general, see OPPENHEIM & WESTON, *supra* note 176, at 889-971, §§ 4-7.

<sup>178</sup> H. TAGGART, *COST JUSTIFICATION* (1959).

<sup>179</sup> See generally The Report of the Attorney General's National Committee to Study the Antitrust Laws, at 178-79 (1955) (proviso explained); Steele, *Section 2(b) of the Robinson-Patman Act—Rules for Meeting Competition in the Past and Present*, 13 ANTITRUST BULL. 1223, 1250-51 (1968) (comprehensive discussion).

<sup>180</sup> The actions of the seller with knowledge who discriminates in good faith are limited—he may only meet, not beat, the price of the competitor or competitors. *Standard Oil Co. v. FTC*, 340 U.S. 231 (1951); *FTC v. A.E. Staley Mfg. Co.*, 324 U.S. 746, 759 (1945).

<sup>181</sup> SULLIVAN, *supra* note 135, at 681.

<sup>182</sup> With regard to the price of the good, the statute itself refers to the "cost of manufacturing"; this illustrates the difficulty in relying on Robinson-Patman to make fair the provision of what in actuality is a service.

<sup>183</sup> Although this is in effect what happens under such plans, this casting is artificial.

pharmacies are caused losses leading to a financial demise.<sup>184</sup> Although the Federal Trade Commission appears to consider price discrimination plus resulting diversion as constituting a prima facie case under Robinson-Patman,<sup>185</sup> courts have required something more, such as significant reduction in the number of sellers, significant increase in concentration, or merely persistent discrimination if the result is a drastically declining price structure.<sup>186</sup> Even if those elements were to be established in *Royal Drug* on remand, the *Anheuser-Busch*<sup>187</sup> decision stands for the proposition, in an analogous situation, that it is lawful for a firm to reduce its prices in one of several regional, oligopolistic markets as long as it does not act in a predatory or vindictive manner in so doing.<sup>188</sup> In that case, the court viewed the price cuts as part of a general heightened sales effort—a lawful attempt to gain a larger market share.<sup>189</sup>

With regard to vertical effects, the subscribers dealing with non-participating pharmacies presumably could be reached under the Robinson-Patman analysis, but only if the asserted justification for the reimbursement differential fails in light of facts developed for the case on remand.<sup>190</sup> It seems that the difficulty with regard to vertical effects is that it is conceptually troubling to regard the favored customer as a profit-making entity in this fact setting. Some circuits have indicated that a profit penalty upon the disfavored buyer is all

<sup>184</sup> With regard to second line injury, the prevailing view appears to require injury to competition, rather than injury to a competitor. This has not been clearly established, however, and may still represent an avenue for protecting lone competitors. It is not clear from the facts as presented in any of the three *Royal Drug* opinions that there has been any injury to competition in the market, although there is certainly that potential if the independent pharmacies are driven out of business. Predatory pricing would clearly warrant invalidation. For justification of the cost differential based on claim processing costs, see Brief for Blue Shield Ass'n as Amicus Curiae at 16-20, 440 U.S. 205 (1979); Brief for Petitioner at 5 n.5, *id.* But see note 175 *supra*.

<sup>185</sup> *Corn Products Ref. Co. v. FTC*, 144 F.2d 211 (7th Cir. 1944), *aff'd*, 324 U.S. 726 (1945); *General Nat. Gas Corp.* (FTC Dkt. 7782, June 30, 1960). But see SULLIVAN, *supra* note 135, at 684-875 n.5 (ch. 8B § 221), suggesting that the commission's decision seems inconsistent with the strict construction test. See, e.g., *Beatrice Foods Co.*, 76 F.T.C. 719, 800 (1969), *aff'd sub nom. Kroger Co. v. FTC*, 438 F.2d 1372 (6th Cir.), *cert. denied*, 404 U.S. 871 (1971); *Lloyd A. Fry Roofing Co.*, 68 F.T.C. 217, 260 (1965), *aff'd*, 371 F.2d 277 (7th Cir. 1966); *Champion Spark Plug Co.*, 50 F.T.C. 30 (1953).

<sup>186</sup> *Chapman v. Rudd Paints & Varnish Co.*, 409 F.2d 635 (9th Cir. 1969); *Borden Co. v. FTC*, 381 F.2d 175, 180 (5th Cir. 1967); *Tri-Valley Packing Ass'n v. FTC*, 329 F.2d 694, 702-705 (9th Cir. 1964).

<sup>187</sup> 363 U.S. 536 (1960).

<sup>188</sup> Of course, lines between vindictive and aggressive competition are inherently unclear and perhaps arbitrary.

<sup>189</sup> The declining market with which the Robinson-Patman Act is concerned is not the situation found in the retail market for prescription drugs.

<sup>190</sup> SULLIVAN, *supra* note 135, at 693 n.7 (ch. 8C § 224).



that need be shown and that this is inferred from the cost differential itself; evidence of low profit margins and price sensitive conditions may warrant an inference of injury upon a mere showing that buyers were charged different prices.<sup>191</sup>

A successful challenge under the Robinson-Patman Act adds little to what is offered under the Sherman Act, particularly under the Sherman Act's rule of reason analysis. Fitting the *Royal Drug* facts into the Robinson-Patman framework and casting the insurer as villain is tortuous; it does a disservice to the Act as well as to the litigating parties and subsequent litigants. Even though the Robinson-Patman Act ostensibly protects the smaller, independent competitor whereas the Sherman Act's orientation is to afford no special protection to smaller concerns but rather to preserve fair competition in the marketplace, possibly at the expense of the smaller concern, the rule of reason analysis, as discussed above, offers a pragmatic and promising approach—a way to balance preserving the need for competition with the need to protect consumers.<sup>192</sup>

### *Policy Implications*

This article presents the broad context within which the *Royal Drug* case arose. Until some action is taken by Congress, the antitrust laws will be applied to agreements such as the Pharmacy Agreement challenged in that case, despite the belief held by some that market principles cannot be applied to the provision of health services because the health system is inherently different. The foregoing analysis indicates that the agreement is likely to withstand the scrutiny of the antitrust laws and suggests which additional facts would lead to invalidation. While such an agreement should not give rise to a per se Sherman Act violation, the rule of reason should be applied in an effort to preserve competition while protecting the various groups concerned with prices and delivery of health services and health-related goods. The general deregulatory thrust of the current administration suggests that the members of the market will be left to police themselves and, therefore, that the antitrust laws and enforcement efforts of the

<sup>191</sup> *Standard Motor Products, Inc. v. FTC*, 265 F.2d 674 (2d Cir.), cert. denied, 361 U.S. 826 (1959); *E. Edelman & Co. v. FTC*, 239 F.2d 152 (7th Cir. 1956), cert. denied, 355 U.S. 941 (1958).

<sup>192</sup> See generally 3 OPPENHEIM & WESTON, *THE LAWYER'S ROBINSON-PATMAN ACT SOURCEBOOK* (1971) (House and Senate and Conference Committee Reports reprinted); ROWE, *PRICE DISCRIMINATION UNDER THE ROBINSON-PATMAN ACT*, app. (1970) (text of proposed bills preceding that finally enacted reprinted).

Federal Trade Commission will be relied upon to eliminate abuses within the market.

In the wake of the *Royal Drug* decision, insurers will continue to lobby for a total exemption but with renewed fervor. The antitrust exemption may be sought by those whose faith in the body of judicially developed antitrust law has faltered, as well as by those with vested interests, such as insurers and other providers.<sup>193</sup> While recognizing the potential vagueness in the antitrust laws that plagues business, the antitrust laws, particularly the rule of reason analysis, nonetheless provide a method for validating agreements truly meant to contain costs, though compromising competition to some degree, while invalidating those agreements which are anticompetitive on the balance.

Although the antitrust exemption contemplated by the commercial insurers would allow combining to bargain effectively for lower costs, it might nonetheless result in a significant restraint on competition. Further, it is not clear that all such bargaining must be done on a grand scale.<sup>194</sup> A more prudent approach would be to allow the insurers to operate under the antitrust laws for a period of time to allow for a reasoned analysis indicating whether an exemption is necessary. There is, of course, the possibility that insurers will not make such agreements without some promise of an exemption. It may be necessary to consider some legislative inducements in that event.<sup>195</sup>

Another possibility is judicial fashioning of a narrow exemption, comparable in scope to the *Parker* doctrine, that would allow for approaching a cost containment agreement in a slightly different manner, recognizing the distinct character of the third party intermediary as well as the distinct character of the product. The Justice Depart-

<sup>193</sup> A draft statute prepared by the commercial insurers' Health Insurers' Association of America and dated May 9, 1978, established a total exemption from the antitrust laws for insurers based on the assertion that "federal and state antitrust laws currently inhibit efforts by insurers, health benefit purchasers, and health care providers to undertake effective health cost containment activities." Draft Statute for an Antitrust Exemption for Health Cost Containment Activities, Health Insurers Association of America, Washington, D.C. at 1 (May 9, 1978). Kramer, *Senate Panel Votes Stiff Curb on FTC Powers*, Washington Post, Nov. 21, 1979, at A1, col. 1 (lobbyists succeeded in curtailing FTC activity in such areas as children's television advertising, used car lots, the insurance industry, and consumer standards), (effective antiregulatory sweep by powerful lobbyists).

<sup>194</sup> This, of course, would raise the question of negotiations across state lines, as in the case of insurers dealing with giant multistate corporations.

<sup>195</sup> See Pertschuk testimony, *Skyrocketing Health Care Costs: The Role of Blue Shield*, Hearings Before the Subcomm. on Oversight and Investigations of the House Comm. on Interstate and Foreign Commerce, 90th Cong., 2d Sess., 4-34 (1978), as cited in 440 U.S. 205, 232 n.40 (1979). See Leffler, *Doctors Fees and Health Costs*, Wall St. J., Feb. 2, 1979, at 16, col. 3; Havighurst, *supra* note 80, at 320-25.

ment, along those lines, had indicated that prepaid prescription drug plans are not invalid just because some competitors cannot accept the insurer's offer.<sup>196</sup> To apply the per se rule to prepaid health insurance plans would fly in the face of all current cost containment efforts in both the private and public sectors. It is sensible to resort first to alternative solutions which can be applied within the existing system, either as a prelude to radical changes or as a step toward eliminating the need for radical revision of the system. In addition to the suggestions made by Professor Havighurst, the antitrust laws should be relied upon as enforced by the courts via the flexible rule of reason, and by the Federal Trade Commission. The Commission's hands should not be tied when so much is at stake and where so much expertise has already been amassed. A prerequisite, however, is a determination of national health policy to guide agency and courts in applying the antitrust laws to the health sector.

<sup>196</sup> Brief for United States as Amicus Curiae at 10-11, 440 U.S. 205 (1979). "Transactions at a set price, through a . . . series of voluntary bilateral contracts, are not price fixing even though large numbers of sellers of services may be involved" (emphasis added). *Id.* at 11.