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Monopsony as an Agency and Regulatory Problem in Health Care

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MONOPSONY AS AN AGENCY AND REGULATORY PROBLEM IN HEALTH CARE

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Antitrust courts have shortchanged the economic analysis of buyer-side market power in health care. This failure derives to a surprising degree from a single judicial decision, then-Judge Stephen Breyer's 1984 opinion for the First Circuit Court of Appeals in *Kartell v. Blue Shield of Massachusetts*.[1] Breyer's opinion, while sound when read in context, has been understood by subsequent courts to excuse health insurers' imposition of price and nonprice terms on contracting providers on the grounds that insurers merely are acting as aggressive purchasing agents, thus implying that their actions are welfare-enhancing for consumers. This view of health insurers as proxies for end-users collapses a three-level model of industrial production—comprised of provider-suppliers, insurer-producers, and patient-consumers—into a single buyer-seller dyad. It thereby sidesteps an inquiry into the competitive conditions of resale that is central to the traditional antitrust analysis of producer

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[1] When most people think of *Kartell*, they recall Justice Breyer's opinion when he sat on the First Circuit. That decision, however, came at the end of a seven-year legal battle. The district court originally dismissed the complaint in light of the state action doctrine. Kartell v. Blue Shield, 1979-1 Trade Cas. (CCH) ¶ 62,480 (D. Mass. 1978) (*Kartell I*). That decision was reversed by the First Circuit with instructions to abstain from exercising federal jurisdiction until a parallel state court suit was resolved. Kartell v. Blue Shield, 592 F.2d 1191 (1st Cir. 1979) (*Kartell II*). The federal district court ultimately certified the state statutory questions to the Supreme Judicial Court of Massachusetts for its determination. Kartell v. Blue Shield, 425 N.E. 2d 313 (Mass. 1981) (*Kartell III*). Based on the state court's ruling, Blue Shield received summary judgment under the state action doctrine on all alleged anticompetitive conduct with the one exception of its prohibition against balance billing. Kartell v. Blue Shield, 542 F. Supp. 782 (D. Mass. 1982) (*Kartell IV*). The First Circuit declined to review the district court's refusal to permit plaintiffs to amend their complaint after it permitted the Massachusetts Medical Society to intervene in the law suit. Kartell v. Blue Shield, 687 F.2d 543 (1st Cir. 1982) (*Kartell V*). After trial, the district court held that Blue Shield's ban on balance billing violated Section 1 of the Sherman Act. Kartell v. Blue Shield, 582 F. Supp. 734 (D. Mass. 1984) (*Kartell VI*). The

monopsony. Simultaneously, it avoids questions that are specific to health care regarding insurers as buying agents for consumers, such as the relationship between risk-aggregation and individual treatment preferences and the arguably competing "clinical agent" role played by physicians.

The *Kartell* court's failure to delve into agency issues is attributable to the regulatory climate in which the challenged conduct occurred, which constrained Blue Shield's ability to exploit supplier discounts for its own advantage and walled off its rate-related conduct from important public policy considerations of health care quality and access. Because regulatory conditions and industry practices have changed dramatically since the *Kartell* decision was rendered, it is incumbent on antitrust courts to pay closer attention to agency issues when evaluating buyer-side conduct in health care. More generally, the *Kartell* experience teaches that regulation has significant implications for antitrust analysis even, perhaps especially, when it falls short of constituting "state action."

In *Kartell*, the First Circuit held that Blue Shield of Massachusetts' ban on balance billing by participating physicians did not violate the antitrust laws notwithstanding the defendant's position as the state's largest health insurer.[2] Judge Breyer assumed that Blue Shield's contractual restrictions on physicians would reduce health care costs for Blue Shield subscribers. In other words, rather than exploiting its market power, the nonprofit Blue Shield would act as the individual consumer's faithful agent. These assumptions, in addition to a tendency in the opinion to focus on the cost (price) of medical care to the near exclusion of considerations of quality and access, were defensible in the highly regulated environment in which the challenged conduct took place. Health insurance at that time was a fee-for-service, unmanaged enterprise, which made insurers look much like purchasing agents when bargaining over fees with physicians and not like health care providers in their own right. Other state regulatory processes were in place to keep premium rates stable and to protect quality of and access to health care. Consequently, antitrust courts did not view quality and access as competitive concerns, and judges

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First Circuit reversed this finding in Breyer's celebrated opinion. Kartell v. Blue Shield, 749 F.2d 922 (1st Cir. 1984) (*Kartell VII*).

[2] "Balance billing" in Medicare and private fee-for-service health insurance means "the practice of billing patients in excess of the amount approved by the health plan. In Medicare, a balance bill cannot exceed 15 percent of the allowed charge for nonparticipating physicians." PHYSICIAN PAYMENT REVIEW COMMISSION, 1997 ANNUAL REPORT TO CONGRESS 482 (1997). Physicians who sign participation agreements with Medicare, thereby "accepting assignment," get paid directly by the government rather than collecting Medicare amounts from patients and may not balance bill. *Id.* at 481–82.

gave little thought to developing an integrated competition policy with respect to these issues.

Breyer's assumptions can no longer be taken for granted. Health care antitrust law requires a more sophisticated and comprehensive approach to buyer-side conduct and the multiple agency relationships between initial purchasers and end-users. The regulatory explanation for *Kartell*'s analysis also demonstrates an important general proposition: lack of "state action" sufficient to immunize conduct from antitrust scrutiny should not remove regulatory considerations from the competitive equation. To the contrary, as the Supreme Court's recent decision in *Verizon Communications, Inc. v. Law Offices of Curtis V. Trinko, LLP* acknowledges, courts should display greater sensitivity to the de facto as well as de jure impact of state regulation on antitrust analysis.[3]

The article is organized as follows. Part I returns to the source, explaining the controversy in *Kartell*, examining Breyer's opinion, and summarizing its impact on other courts. Part II looks at *Kartell* through the lens of classic monopsony theory involving suppliers, producers, and consumers, and focuses on the opinion's oversimplification of the relationship between health insurers and insured individuals. It further considers whether lower input prices result in lower consumer prices in the end-product market, and, therefore, whether monopsony power can be welfare-enhancing. Part III evaluates *Kartell*'s disregard of other important principal-agent problems in health care that arguably influence the welfare analysis of insurer conduct. It explores the degree to which group insurers stand in the shoes of individual consumers and the implications of non-insurer agency relationships, such as between physicians and patients. Part IV seeks to explain *Kartell*'s blind spots in regulatory terms and evaluates the implications of major changes in the structure and regulation of health insurance since 1980. The article contends that the reach and substantive content of antitrust law depend upon the regulatory environment in which alleged monopsony power is exercised, and asserts an important role for antitrust courts in the future.

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[3] 124 S. Ct. 872, 881 (2004) ("Antitrust analysis must always be attuned to the particular structure and circumstances of the industry at issue. Part of that attention to economic context is an awareness of the significance of regulation."); *see also* Town of Concord v. Boston Edison Co., 915 F.2d 17 (1st Cir. 1990) (holding that the existence of full price regulation in the electricity industry made a "price squeeze" by a forward-integrated monopolist less likely to have an exclusionary effect on competitors) (Breyer, C.J.).

I. REVISITING *KARTELL* AND ITS PROGENY

A. HISTORY OF THE DISPUTE

Blue Shield of Massachusetts was created by state statute in 1941, under sponsorship of the Massachusetts Medical Society.[4] From 1941 to 1967, Blue Shield compensated physicians according to a fixed fee schedule and permitted physicians to charge additional fees to certain classes of higher-income patients (i.e., balance billing).[5] In 1968 Blue Shield implemented a charge-based system of reimbursement, in which Blue Shield paid physicians their "usual and customary" fees and largely prohibited the practice of balance billing.[6] As with Medicare's fee-for-service system, what followed was a period of rapidly escalating costs for physician services (and escalating premiums for Blue Shield subscribers).[7] By 1975 Blue Shield was in a bind. While costs attributable to physician fees were rising dramatically, the state Insurance Commissioner placed substantial political pressure on Blue Shield, which also faced competition from private carriers, not to increase subscriber premiums.[8] As reserves plummeted from $26 million in January 1975 to less than $1 million in March 1976,[9] Blue Shield's only viable option was to limit physician fees. Through various ploys, the 1968 system of "usual and customary" charges devolved once again into a fee schedule imposed by Blue Shield (and implicitly approved by the Insurance Commission).[10]

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[4] Sylvia Law and Barry Ensminger provide a detailed study of the history and background of the dispute. *See* Sylvia A. Law & Barry Ensminger, *Negotiating Physicians' Fees: Individual Patient or Society? (A Case Study in Federalism)*, 61 N.Y.U. L. REV. 1, 24 (1986). For an engaging discussion of the economic issues underlying *Kartell*, see H.E. Frech, *Monopoly in Health Care Insurance: The Economics of* Kartell v. Blue Shield of Massachusetts, *in* HEALTH CARE IN AMERICA: THE POLITICAL ECONOMY OF HOSPITALS AND HEALTH INSURANCE (H.E. Frech, ed.) (1988).

[5] *Kartell III*, 425 N.E. 2d at 317.

[6] *Id.* at 317–18.

[7] Law & Ensminger, *supra* note 4, at 26.

[8] *Id.*

[9] *Kartell III*, 425 N.E. 2d at 318. In response to the 1975 financial difficulties, the Medical Society and Blue Shield agreed to freeze physician rates for the following year. Law & Ensminger, *supra* note 4, at 26. There was more pragmatism than altruism to the Medical Society's decision. A provision of the original 1942 Participating Physician's Agreement required physicians to consent to reduced pro rata compensation of their claims in the event that Blue Shield had insufficient funds to pay claims in full. *Kartell III*, 425 N.E. 2d at 322. In essence, physicians and Blue Shield shared risk under the agreement. The sharing of risk was part of a political compromise permitting Blue Shield to incorporate without establishing the same type of financial reserves that would have been required of a commercial insurer. *Id.* at 321.

[10] *Kartell VI*, 582 F. Supp. at 740–41. "Blue Shield imposed these limitations, at least in part, because it believed that the Commissioner of Insurance would disapprove its rates if Blue Shield did not aggressively limit physicians' fees." Law & Ensminger, *supra* note 4, at 27 (citing trial transcript of testimony of Blue Shield executive).

From the perspective of limiting costs, these actions were successful. By 1982, Blue Shield payments were 30 percent less than physicians' standard charges.[11]

Facing Blue Shield's efforts to limit fees, the Medical Society fought back, fronting physician-plaintiffs in separate state and federal lawsuits. The state suit, *Nelson v. Blue Shield,*[12] challenged Blue Shield's prohibition against balance billing and other practices as illegally coercive under state contract and insurance law. The state suit was ultimately dismissed because the plaintiffs failed to exhaust their administrative remedies.[13] The federal suit, *Kartell v. Blue Shield,* alleged violations of Sections 1 and 2 of the Sherman Act.[14] Specifically, the suit challenged the following practices: (1) Blue Shield's prohibition against balance billing, (2) Blue Shield's refusal to compensate non-participating physicians except for emergency services, and (3) Blue Cross's refusal, by agreement with Blue Shield, to make payments to physicians for medical services except under limited circumstances.[15] Blue Shield's principal defense was that the challenged practices were mandated by state law and therefore exempt from antitrust liability under the state action doctrine.

The *Kartell* dispute generated three published federal district court opinions, three federal appellate court opinions, and one Massachusetts Supreme Judicial Court opinion. The district court originally dismissed the complaint, finding all of Blue Shield's conduct immunized under the state action doctrine.[16] The First Circuit reversed, holding that in

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[11] *Kartell VI,* 582 F. Supp. at 741.

[12] 387 N.E. 2d 589 (Mass. 1979).

[13] *Id.* at 592–93.

[14] That the litigation was paid for by the Medical Society, and that the lawyers had before them the entire roster of physician members from which to select named plaintiffs, suggest that antitrust lawyers do, after all, have a sense of humor. Unfortunately, Dr. Kartell's own fate was tragic. In 2000, he was convicted of voluntary manslaughter in the hospital room shooting of his estranged wife's lover and sentenced to 5–8 years in prison. *See* Jordana Hart, *Doctor Is Guilty in Death of His Rival,* BOSTON GLOBE, June 24, 2000, at B1. His medical license was revoked later that year.

[15] *Kartell VI,* 582 F. Supp. at 736. Blue Cross organizations are the oldest health insurers in the United States and trace their origins to state hospital associations' needs during the Depression to assure revenue to their members. As non-profit "service benefit plans," they provided hospital services directly to insured individuals—not merely a financial indemnity for covered expenses incurred—and paid participating hospitals a negotiated fee. Blue Shield organizations were established shortly thereafter by state medical societies to cover physician services on a similar, but not identical, basis. *See* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 295–310 (1982). In recent decades, many Blue Cross and Blue Shield organizations have merged, become for-profit corporations, and otherwise blurred the distinctions between them and commercial health insurers. *See* Robert Cunningham & Douglas B. Sherlock, *Bounceback: Blues Thrive as Markets Cool Toward HMOs,* HEALTH AFF., Jan–Feb. 2002, at 24–38.

[16] *Kartell I,* 1979-1 Trade Cas. (CCH) ¶ 62,480 (D. Mass. 1978).

light of the related state court action, *Nelson v. Blue Shield*, the federal court should abstain until Massachusetts was afforded the opportunity to interpret Blue Shield's enabling statute for itself.[17] The complaint in *Nelson v. Blue Shield*, however, was dismissed without addressing the substantive statutory questions.[18] In response, the federal district court certified the state law issues to the Massachusetts Supreme Judicial Court. The state high court ruled that Blue Shield's prohibition against balance billing was not mandated by state law, but that both its refusal to compensate non-participating physicians for non-emergency services and the general prohibition against Blue Shield and Blue Cross competing to insure physician services were required by statute.[19]

Based on these rulings, the federal district court held that Blue Shield's state-mandated conduct was immunized under the state action doctrine.[20] Because the prohibition against balance billing was not state-mandated, the court ruled that the antitrust suit challenging that practice could proceed. However, the court also held that the legality of the prohibition would be judged under the rule of reason, not the per se standard usually applied to price fixing.[21] After a lengthy bench trial, the district court determined that Blue Shield's prohibition of balance billing was an unreasonable restraint of trade and therefore a violation of Section 1 of the Sherman Act.[22] It is this decision that was reviewed in Breyer's First Circuit opinion. Although the Medical Society attempted through additional litigation to resurrect the broader claims,[23] the antitrust claim considered by the court ultimately focused on the isolated issue of balance billing.

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[17] *Kartell II*, 592 F.2d 1191 (1st Cir. 1979).

[18] Nelson v. Blue Shield, 387 N.E. 2d 589 (1979).

[19] *Kartell III*, 425 N.E. 2d 313 (Mass. 1981).

[20] *Kartell IV*, 542 F. Supp. 782, 788–92 (D. Mass. 1982).

[21] *Id.* at 796.

[22] *Kartell VI*, 582 F. Supp. 734, 745–55 (D. Mass. 1984). The court held, however, that the same practice *did not* violate Section 2. *Id.* at 755.

[23] The Medical Society felt that it had lost control of the litigation midstream. It sought to change legal teams and amend the complaint to broaden its scope. Dr. Kartell and the original team of lawyers resisted. As a result, the Medical Society sought to intervene in the lawsuit as a party. The Medical Society also filed a second lawsuit with a new set of fronted physician plaintiffs pleading the substance of its desired amended complaint. The district court granted the Society's motion to intervene, but denied its motion to amend the complaint. The district court also dismissed the second lawsuit. The Medical Society sought interlocutory review from the First Circuit. The appellate court ruled that it lacked jurisdiction in the absence of a final order or judgment. *Kartell V*, 687 F. 2d. 543 (1st Cir. 1982).

B. JUDGE BREYER'S OPINION

In eleven sharply written pages, Breyer disposed of a complicated antitrust dispute that had lasted over seven years.[24] Breyer found a way of resolving the dispute largely without reference to or reliance upon the evidence actually submitted to the district court.[25] Instead, he focused on the centrality of the insurer-insured agency relationship, thereby framing the dispute in a manner where he could conclude that Blue Shield's conduct did not create antitrust liability, even assuming that Blue Shield possessed and exercised significant market power. Breyer's description of the market acknowledges that Blue Shield combines physician services and insurance into a product that it sells to consumers in exchange for a premium.[26] Given the prohibition against balance billing, he notes, "Blue Shield pays [the contract] amount directly to the doctor; the patient pays nothing out of pocket and therefore receives no reimbursement."[27] By assuming that Blue Shield acts merely as a faithful purchasing agent, Breyer is able to collapse the three-stage physician-insurer-consumer relationship into a single transaction between insurers as "buyers" and physicians as "sellers" of medical services.

"Sellers"
MEDICAL PROVIDERS
(Physicians)
⇓
"Buyers"
HEALTH INSURANCE
(Blue Shield)

Breyer writes:

> We disagree with the district court's finding of "restraint." To find an unlawful restraint, one would have to look at Blue Shield as if it were a "third force," intervening in the marketplace in a manner that prevents willing buyers and sellers from independently coming together to strike price/quality bargains. Antitrust law typically frowns upon behavior that impedes the striking of such independent bargains. The persuasive

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[24] *Kartell VII*, 749 F.2d 922.

[25] The district court noted that the parties submitted so many exhibits, many of which ran "hundreds of pages" and contained "thousands of numbers" that the court had "the near-impossible task of deciding the credibility of two competing, undigestible piles of paper." *Kartell VI*, 582 F. Supp. at 737.

[26] *Kartell VII*, 749 F.2d at 923 ("Blue Shield provides health insurance for physician services. . . . The consumers of Blue Shield's insurance . . . can see any 'participating doctor,' *i.e.*, a doctor who has entered into a standard Participating Physician's Agreement with Blue Shield.").

[27] *Id.*

> power of the district court's analysis disappears, however, once one looks at Blue Shield, not as an inhibitory "third force," but as itself the purchaser of the doctors' services.[28]

The agency theme pervades the opinion. Breyer notes:

> Several circuits have held in antitrust cases that insurer activity closely analogous to that present here amounts to purchasing, albeit for the account of others. And, they have held that an insurer may lawfully engage in such buying of goods and services needed to make the insured whole.[29]

From this basis, he reasons that "from a commercial perspective, Blue Shield in essence 'buys' medical services for the account of others,"[30] although he is sensitive to that fact that he is arguing by analogy.

> The relevant antitrust facts are that Blue Shield pays the bill and seeks to set the amount of the charge. Those facts led other courts in similar circumstances to treat insurers as if they were "buyers." The same facts convince us that Blue Shield's activities here are *like* those of a buyer.[31]

This analogy drives the subsequent antitrust analysis. "[T]here is no law forbidding a legitimate insurance company from itself buying the goods or services needed to make its customer whole."[32] "Here, Blue Shield and the doctors 'sit on opposite sides of the bargaining table.' And Blue Shield seems simply to be acting 'as every rational enterprise does, *i.e.*, [to] get the best deal possible.'"[33] "These [ ] considerations convince us to apply mainstream antitrust doctrine, which allows a buyer or seller freedom to bargain for price, rather than to seek analogies with more unusual cases that do not."[34]

If Blue Shield is just a "buyer" facing willing physician-sellers, then, according to the court, it should enjoy the deference antitrust law ordinarily extends to buyers. The opinion continues: "Antitrust law rarely stops the buyer of a service from trying to determine the price or characteristics of the product that will be sold."[35] Phrased differently, if the insurer-insured agency relationship legitimately turns the insurer into the consumer, then the insurer's conduct is not illegal. Breyer writes:

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[28] *Id.* at 924.

[29] *Id.* at 925.

[30] *Id.*

[31] *Id.* at 926.

[32] *Id.* at 928.

[33] *Id.* at 929–30 (citations omitted).

[34] *Id.* at 930.

[35] *Id.* at 925.

"Thus, the more closely Blue Shield's activities resemble, in essence, those of a purchaser, the less likely that they are unlawful."[36]

Next, Breyer cites with approval numerous cases where courts have held that insurers purchasing on behalf of their insureds do not violate antitrust law.[37] Plaintiffs sought to distinguish these cases on the grounds that those insurers, unlike Blue Shield of Massachusetts, did not have market power.[38] Indeed, excluding public sources of insurance such as Medicare and Medicaid, Blue Shield (combined with Blue Cross for hospital services) covered 74 percent of the private health insurance market.[39] Around 99 percent of all physicians had signed Participating Agreements with Blue Shield.[40] Payments under these agreements accounted for 13 to 14 percent of physician practice revenue.[41]

Rather than defining a market (product and geographic) and assessing barriers to entry, Breyer simply assumed that Blue Shield possesses "significant market power" and that "Blue Shield uses that power to obtain 'lower than competitive' prices."[42] Nonetheless, Breyer rejected the claim that Blue Shield's market power provided a basis for distinguishing the defendant's insurance line of cases. He also rejected the claim that Blue Shield's market power was as an independent basis for liability under Section 2. To establish a Section 2 violation, just as in the case of monopoly, a plaintiff must show not only monopsony power but monopsony conduct. Monopsony conduct is action that is either predatory or

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[36] *Id.*

[37] *Id.*

[38] Although the case is explicitly about buyer-side distortion of competition, the word "monopsony" appears nowhere in Breyer's opinion. Plaintiffs did argue that the prohibition against balance billing violated Section 1 and Section 2 of the Sherman Act. The Section 2 claim alleged a monopoly *both* in the market for selling insurance *and* in the market for purchasing physician services. The latter is a monopsony problem. *Kartell VI*, 582 F. Supp. at 736. However, the district court held that Blue Shield's ban on balance billing was a unreasonable restraint of trade in violation of Section 1, but not a violation of Section 2.

[39] Another 23% represented commercial indemnity insurance. Consistent with the year and geographic location, only 4% of the market belonged to health maintenance organizations (HMOs). *Kartell VII*, 749 F. 2d at 924.

[40] *Id.* at 926.

[41] *Id.* at 924.

[42] *Id.* at 927. Establishing the existence of insurer market power in health care markets is usually not this easy. Most courts have concluded that defendant health insurers lack market power. In terms of product market, they reason that all health insurance options are close substitutes. *See, e.g.*, Blue Cross & Blue Shield v. Marshfield Clinic, 65 F.3d 1406 (7th Cir. 1995) (rejecting argument for a separate HMO market). In terms of geographic market, they reason that health care financing is regional if not national in scope. *See, e.g.*, Ball Mem'l Hosp., Inc. v. Mutual Hosp., Inc., 784 F.2d 1325, 1330–33 (7th Cir. 1986). Furthermore, courts typically assume that barriers to entry in health care financing are relatively low. *Id.* at 1335.

exclusionary. To Breyer, while physician fees without balance billing might be below the competitive level, they were not predatory in the sense of falling below the incremental cost of providing the services.[43] Breyer did not expressly consider whether the prohibition against balance billing was exclusionary; i.e., would the practice deter the entry of competing insurance companies into the market?[44] The most conventionally defensible answer to the question of exclusionary conduct would be "no."[45] In most settings, Blue Shield's conduct (paying lower than competitive rates of physician compensation) would make it easier for a new insurance carrier to enroll a provider panel of disgruntled Blue Shield physicians and enter the market.[46]

Breyer then focused on the effects of Blue Shield's market power on "price." Here, Breyer's discussion becomes confused. First, he fails to distinguish input prices (physician fees) from output prices (subscriber premiums). Second, it is not always clear when Breyer's references to price are meant to be interpreted as part of a general doctrinal discussion or when they are meant to be understood in light of the actual trial

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[43] *Kartell VII*, 749 F. 2d at 928. Theoretically defining and empirically establishing the appropriate "cost" benchmark for purposes of predation is difficult. *See generally* Phillip Areeda & Donald F. Turner, *Predatory Pricing and Related Practices Under Section 2 of the Sherman Act*, 88 HARV. L. REV. 697 (1975). The problem is even more complicated in the monopsony setting. The textbook monopsonist does not pay an input price below the supplier's marginal costs. Facing an upward-sloping supply curve, it suppresses the quantity of the input it demands in order to pay a lower price. However, it still pays the supplier's marginal cost at the reduced level demanded (it just pays marginal cost at a different part of the supplier's cost curve).

[44] Expressly dealing with the question of exclusionary conduct would have been helpful. *Kartell*'s silence on this issue has made it easier for subsequent courts to misread the opinion as permitting any non-predatory insurance contracting practices, even in the presence of substantial market power. This is too broad an interpretation and one that is contrary to established doctrine (predation is not the only test for monopsony conduct). Other contracting practices, such as exclusive dealing arrangements or most-favored-nation clauses, may well have exclusionary effect and could therefore be the basis of Section 2 liability even in the absence of predation. *See* discussion *infra* notes 62–63 and accompanying text.

[45] If anything, one might expect that a "predatory" monopsonist acting to exclude a current competitor or deter new entry would pay *more*, not less to suppliers, and subsequently attempt to recoup its losses by reducing price after its exclusive buying position had been restored. More credible predatory tactics would likely involve efforts to raise rivals' costs. Frech, however, advocates a different position. He claims that Blue Shield's low prices and its ban on balance billing, combined with the Blues' large market share and commitment to complete first-dollar insurance coverage, worked to exclude the entry of competing private insurers. *See* Frech, *supra* note 4, at 306 n.15. The persuasiveness of this scenario relies, in part, on the difficulties physicians would have in shifting to non-Blue Shield insurers, given the size of Blue Shield's market share. *Id.* at 304–05. This kind of "lumpiness" in medical markets could well lead to surprising, non-textbook results.

[46] It is true that the new entrant would have higher costs than the monopsonist. This, in turn, would constrain the degree of price competition that entry would engender.

court record. Most of Breyer's focus on price is of a doctrinal, not an empirical, nature. Thus, the axioms recited are plentiful. Antitrust rules cannot and should not turn on the reasonableness of the price in question, he cautions, observing that "normally the choice of what to seek to buy and what to offer to pay is the buyer's."[47] "Courts only rarely try to supervise the price bargain directly,"[48] Breyer notes, expressing particular concern about judicial intervention because "the prices at issue here are low prices, not high prices."[49]

A final important theme in Breyer's opinion is that of antitrust channeling—defining a division of labor between state regulation and federal common law oversight of private markets by antitrust courts.[50] Breyer consciously refrains from extending antitrust law into the health care domain.

> The rising costs of medical care, the possibility that patients cannot readily evaluate (as competitive buyers) competing offers of medical service, the desirability of lowering insurance costs and premiums, the availability of state regulation to prevent abuse—all convince us that we ought not create new potentially far-reaching law on the subject. And, the parties have not seriously argued to the contrary.[51]

Breyer's basic objection is to using antitrust law as a smokescreen for judicial regulation, as opposed to using it in order to ensure meaningful competition.[52] At the same time, the opinion reflects skepticism on Breyer's part—not universally shared among antitrust judges—regarding competition as an effective force in health care.[53] With that subtext, seven years of antitrust litigation came to an end.

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[47] *Kartell VII*, 749 F.2d at 927–29.

[48] *Id.* at 928.

[49] *Id.* at 930.

[50] *See infra* Part IV.

[51] *Kartell VII*, 749 F.2d at 928.

[52] During Breyer's academic career, of course, he had become expert in regulation and understood its limitations. *See, e.g.*, STEPHEN G. BREYER, BREAKING THE VICIOUS CIRCLE: TOWARD EFFECTIVE RISK REGULATION (1993); STEPHEN G. BREYER, REGULATION AND ITS REFORM (1982). Other antitrust courts have been less cautious in breaching the antitrust-regulatory divide. *See, e.g.*, FTC v. Butterworth Health Corp., 946 F. Supp. 1285, 1296 (W.D. Mich. 1996) (allowing the two largest hospitals in Grand Rapids to merge on condition that they comply with a highly regulatory judicial order to refrain from exploiting their newly acquired market power). For a general evaluation of Breyer's antitrust analysis on the bench see Edward Fallone, *The Clinton Court Is Open for Business: The Business Law Jurisprudence of Justice Stephen Breyer*, 59 MO. L. REV. 857, 867–72 (1994).

[53] *See* Peter J. Hammer & William M. Sage, *Antitrust, Health Care Quality, and the Courts*, 102 COLUM. L. REV. 545, 611–14 (2002) [hereinafter *Health Care Quality and the Courts*] (finding that the majority of antitrust courts assert the textbook virtues of competition in health care cases).

C. JUDICIAL TREATMENT OF BUYER-SIDE MARKET POWER AFTER *KARTELL*

Justice Breyer's decision in *Kartell* has been influential. Although Breyer's analysis was a contextualized assessment of antitrust issues in the complicated political and regulatory environment of Massachusetts, most courts have read *Kartell* as stating black letter principles capable of rote application. It is usually the starting point, and often the ending point, of antitrust analysis of health insurance practices. As a consequence, courts have failed to develop a sophisticated framework for evaluating buyer-side market power in health care.

The mantra that insurers stand in the shoes of those they insure and bargain on their behalf is now widely recited. In *Ball Memorial Hospital,* for example, Judge Easterbrook cites *Kartell* for the statement that "the Blues are financial intermediaries, purchasing agents for the consumers of medical services."[54] Nor does he limit the scope of insurer agency to matters of price. "The Blues, as financial intermediaries, may drive any bargains open to consumers of services."[55] Similarly, subsequent First Circuit decisions lost sight of the fact that Breyer was using the "purchasing agent" metaphor to shed light on a complicated set of economic relationships, not to synthesize specific empirical evidence into a conclusive statement of fact. The opinion in *Ocean State Physicians Health Plan v. Blue Cross* declares: "We held [in *Kartell*] that, for antitrust purposes, a health insurer like Blue Shield *must be viewed* 'as itself the purchaser of the doctors' services.'"[56] Even some cases dealing with modern managed care, rather than old-fashioned Blues plans and fee-for-service medicine, have rotely echoed *Kartell.*[57]

Subsequent cases have read *Kartell* as extending insurers almost unquestioned deference to negotiate lower input prices. In *Ocean State,* the court reasoned that "a health insurer's unilateral decisions about the prices it will pay providers do not violate the Sherman Act—unless the prices are 'predatory' or below incremental cost—even if the insurer

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[54] 784 F.2d at 1325.

[55] *Id.*

[56] 883 F.2d 1101, 1111 (1st Cir. 1989) (emphasis added). *See also* Westchester Radiological v. Empire Blue Cross, 707 F. Supp. 708, 712 n.6 (S.D.N.Y. 1989) ("For antitrust purposes, Blue Cross is treated as a buyer where it pays the bill and seeks to set the amount to be charged."), *aff'd,* 884 F.2d 707 (2d Cir. 1989).

[57] Ambroze v. Aetna Health Plans, 1996 U.S. Dist. LEXIS 7274 at *27 (S.D.N.Y. 1996), *vacated, remanded,* 1997 U.S. App. LEXIS 1048 (2d Cir. N.Y. 1997), *on remand, sub nom.* Finkelstein v. Aetna Health Plans, 1997 U.S. Dist. LEXIS 10759 (1997), *aff'd,* 1998 U.S. App. LEXIS 12493 (1998).

is assumed to have monopoly power in the relevant market."[58] An even stronger statement of *Kartell*'s holding can be found in *Finkelstein v. Aetna Health Plans*: "The crux of the *Kartell* line of cases is that in the complex context of health insurance contracts, no antitrust liability lies where an insurer 'pays the bill and seeks to set the amount [and the terms] for the charge.'"[59] The defendants in *United States v. Delta Dental of Rhode Island* went so far as to assert a rule of per se legality, in light of *Kartell*, for all buyer behavior short of predation.[60] The district court, however, correctly rejected this suggestion.[61]

The focus on price and predation has led to a related failing. Courts have paid insufficient attention to exclusionary conduct in assessing buyer-side market power. In *Ocean State*, the First Circuit considered whether Blue Cross's Prudent Buyer policy (containing a most-favored-nation clause) was "exclusionary" in violation of Section 2. The court answered in the negative: "[A] policy of insisting on a supplier's lowest price—assuming that the price is not 'predatory' or below the supplier's incremental cost—tends to further competition on the merits and, as a matter of law, is not exclusionary."[62] The court reasoned that this outcome was "compelled" by *Kartell*, ignoring that Blue Cross's Prudent Buyer policy could be exclusionary in ways quite different from the prohibition against balance billing at issue in the earlier case.[63]

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[58] *Ocean State*, 883 F.2d at 1110–11. A problem with this definition is that no rational supplier would sell below its marginal cost, even to a monopsonist, unless it (rather than the monopsonist) were being predatory. *See supra*, note 43.

[59] 1997 U.S. Dist. LEXIS 10759, at *14 (alteration in original).

[60] "Delta contends that these decisions [*Kartell* and *Ocean State*] stand for the straightforward proposition that MFN clauses, absent pricing that is predatory or below incremental cost, are competitive as a matter of law." United States v. Delta Dental of R.I., 943 F. Supp. 172, 186 (D.R.I. 1996) (declining to hold that a most-favored-customer clause in a dominant insurer's fee contracts with participating dentists was presumptively procompetitive). In other contexts, MFN clauses can facilitate horizontal coordination among sellers, particularly in concentrated industries. *See* ROBERT PITOFSKY, HARVEY J. GOLDSCHMID & DIANE P. WOOD, TRADE REGULATION: CASES AND MATERIALS 529–31 (5th ed. 2003)

[61] The magistrate judge, although bound by First Circuit precedent, rejected Delta's claim. "Despite *Kartell* and *Ocean State's* broad language, these decisions, properly construed, fail to establish a *per se* validation of MFN clauses in all cases where pricing is not predatory or below incremental cost." *Id.* at 189. The district court, over Delta's objection, adopted the Magistrate's Report and Recommendation. *But cf. Marshfield Clinic*, 65 F.3d at 1415 ("'Most favored nations' clauses are standard devices by which buyers try to bargain for low prices . . . and that is the sort of conduct the antitrust laws seek to encourage.") (Posner, J.).

[62] 883 F.2d at 1110.

[63] A prohibition against balance billing might facilitate entry into the market for insurance by making a newcomer's price more attractive to providers, whereas an MFN can be used to deter entry by competitors because a supplier's decision to discount marginal units for a new entrant would require it to discount inframarginal units as well. Even if one were to conclude that an MFN is procompetitive and not exclusionary, as can be the

Kartell and its progeny provide an inadequate basis for evaluating medical monopsony power, particularly in a world of managed care. What is called for, however, is not a rejection of *Kartell* but an appreciation of its rationale and limitations in light of traditional economic principles regarding buyer-side market power.

II. *KARTELL* AS AN ECONOMIC PROBLEM: STANDARD MONOPSONY THEORY

The core insight of Breyer's opinion in *Kartell* is that Blue Shield was not a "third force" intervening between physician-sellers of medical services and patient-buyers, but was itself a purchaser. The outcome of the case thus turns on the court's analysis of the agency relationship between insurer and patient. To Breyer, the insurer's role as purchasing agent is straightforward: Blue Shield negotiates a favorable price for physician services that patients require. Breyer analogizes this function to other situations in which an agent with superior information or bargaining power—in his examples, a parent, landlord, or corporate employer—makes payment on behalf of a principal party with whom it has a pre-existing relationship.[64]

Because the case involves insurance benefits rather than more typical goods or services, Breyer never sees Blue Shield as buying inputs from suppliers in order to create and sell a final product to consumers. Two decades of hindsight with respect to the evolution of the health insurance industry reveal this to be a staggering omission. Managed care is all about integrating the financing and delivery of health care services into a single product. Moreover, market structure and competition have direct implications for the fidelity of Breyer's principal-agent relationship between insurer and insured. The exercise of monopsony power can be a form of agency failure, particularly if it contributes to higher prices or reduced output in the final product market. The monopsonist maximizes its own surplus, not the surplus or utility of its customers.

Simplifying the insurer-insured agency relationship leads Breyer to short-circuit the standard economic analysis of monopsony. In the court's discussion of price, for example, Breyer does not specify whether the

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case, it would require analysis quite different from that implicated in *Kartell*. *See generally* Jonathan B. Baker, *Vertical Restraints Among Hospitals, Physicians and Health Insurers that Raise Rivals' Costs: A Case Study of* Reazin v. Blue Cross and Blue Shield of Kansas, Inc. *and* Ocean State Physicians Health Plan, Inc. v. Blue Cross and Blue Shield of Rhode Island, 14 AM. J.L. & MED. 147 (1988).

[64] *Kartell VII*, 749 F.2d at 925. The fact of the pre-existing relationship allows Breyer to distinguish these examples, and Blue Shield's conduct, from situations where otherwise independent buyers enter into "sham" group purchasing arrangements in order to exercise market power. *Id.*

prices under review are in the input market or the final product market. Some passages suggest a belief that Blue Shield's conduct produces lower prices in the end-market, such as when Breyer notes that "courts at least should be cautious—reluctant to condemn too speedily—an arrangement that, on its face, appears to bring low price benefits to the consumer."[65] Unfortunately, Breyer cites no record evidence to defend this assertion as an empirical proposition. In most instances of monopsony power, moreover, Breyer's contention is false as a theoretical matter.[66] There is a fundamental need for antitrust courts to go back to basics and assess buyer-side market power in light of standard economic understandings of monopsony power and established exceptions to such an analysis.

A. ECONOMIC ANALYSIS OF MONOPSONY POWER

A monopsonist is simply a monopoly buyer rather than a monopoly seller. Just as the monopolist facing a downward-sloping demand curve can raise prices and profits by restricting output in the final product market, the monopsonist facing an upward-sloping supply curve can depress the price of the input by restricting the quantity of its purchases. Graphically, monopsony problems appear identical to monopoly problems—only upside down and backwards.[67] This apparent familiarity can be dangerous. As Mark Pauly cautions, it not easy to think straight while standing on one's head, and "intuition can easily (and persuasively) be led in the wrong direction."[68]

Because the monopsonist buys fewer inputs, it produces less output in the final product market than would sellers under competitive conditions. Accordingly, monopsony markets are allocatively inefficient and are associated with a deadweight loss comparable to that of monopoly.[69]

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[65] *Id.* at 931. One assumes that the court was not merely equating the direct effect of a ban on balance billing—reduced out-of-pocket costs to patients—with reduced total costs to consumers of health insurance (i.e., premiums plus out-of-pocket costs). Even though patients receive medical services directly from physicians, those services are nonetheless "inputs" from the perspective of health insurance.

[66] *See* discussion *infra* note 70 and accompanying text.

[67] For a graphic illustration of the classic monopsony problem, see Roger D. Blair & Jill Boylston Herndon, *Physician Cooperative Ventures: An Economic Analysis*, *infra* this issue, 71 ANTITRUST L.J. 989, 999 (Figure 2) (2004).

[68] Mark V. Pauly, *Monopsony Power in Health Insurance: Thinking Straight While Standing on Your Head*, 6 J. HEALTH ECON. 73, 73–74 (1987) [hereinafter *Thinking Straight*] ("Although monopsony is, at least at the level of abstract theory, closely related to the well-known positive and normative theory of monopoly, lack of familiarity with its practical application in health insurance markets can make analysis difficult, counterintuitive, or potentially erroneous.").

[69] *See* Roger D. Blair & Jeffrey L. Harrison, *Public Policy: Cooperative Buying, Monopsony Power, and Antitrust Policy*, 86 NW. U. L. REV. 331, 335–36 (1992) (illustrating the deadweight loss associated with monopsony power).

Significantly, consumers of the final product made by a monopsonist typically do not benefit from the monopsonist's exercise of market power. The fact that the monopsonist pays less for supplies in the input market need not mean that the monopsonist will charge lower prices in the final product market. Indeed, the opposite is generally the case.[70]

In health care, monopsony buyers are typically large insurance companies (or government payers like Medicare). The input market consists of suppliers of medical services—hospitals, physicians, pharmaceuticals, etc.—necessary to treat insured patients. Pauly uses a "final product" metaphor to model the problem:

> When an insurance policy provides full coverage, and when the insurer may affect the unit price or quantity of service, it is obviously natural to think of the market as delivering a single product—insured medical care—in return for a lump sum (insurance) premium. The insured may have some choice as to which of many possible providers to use, but the final result is *as if* the insurer bought the medical services (as inputs) at prices which the insurer may be able to affect, and in quantities over which it may have some control, and then in effect resold this package to the insured patient in return for the insurance premium. It is *as if* doctors, hospitals, or other providers are "upstream" producers of inputs which are combined with insurance to produce a final product.[71]

This vertical set of relationships, in which health care providers are suppliers of a product that is repackaged and sold by insurance companies, can be captured in the following diagram.

Upstream
MEDICAL PROVIDERS
⇓
HEALTH INSURANCE
⇓
CONSUMERS
Downstream

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[70] *See* Roger D. Blair & Jeffrey L. Harrison, *Antitrust Policy and Monopsony*, 76 CORNELL L. REV. 297, 306 (1991) ("Ironically, the reduced input prices the monopsonist enjoys do not lead to reduced output prices. In fact, when the monopsonist has market power in the output market, the reduced input prices cause *higher* output prices."). *See also* HERBERT HOVENKAMP, FEDERAL ANTITRUST POLICY: THE LAW OF COMPETITION AND ITS PRACTICE, § 1.2b, at 13–16 (2d ed. 1999). When inputs are used in fixed proportions, a monopsonist that sells in a competitive market will charge the same competitive price, but will produce less than a non-monopsonist firm. *Id.* at 15. A monopsonist that resells in a cartelized or monopoly market will charge a higher than competitive price. *Id.*

[71] Mark V. Pauly, *Market Power, Monopsony, and Health Insurance Markets*, 7 J. HEALTH ECON. 111, 113 (1988) [hereinafter *Market Power and Monopsony*] (emphasis added).

The insurance monopsonist in the upstream input market will almost always be a monopolist in the downstream insurance market, implying that the monopsony problem cannot be viewed in isolation.[72] In addition, medical providers may possess and exercise market power in the upstream market. This is more likely to be true for hospitals than physicians because there are fewer hospitals in each geographic market, but it may apply as well to certain physician specialties. As a result, models of monopsony power must sometimes be combined with models of bilateral monopoly bargaining.

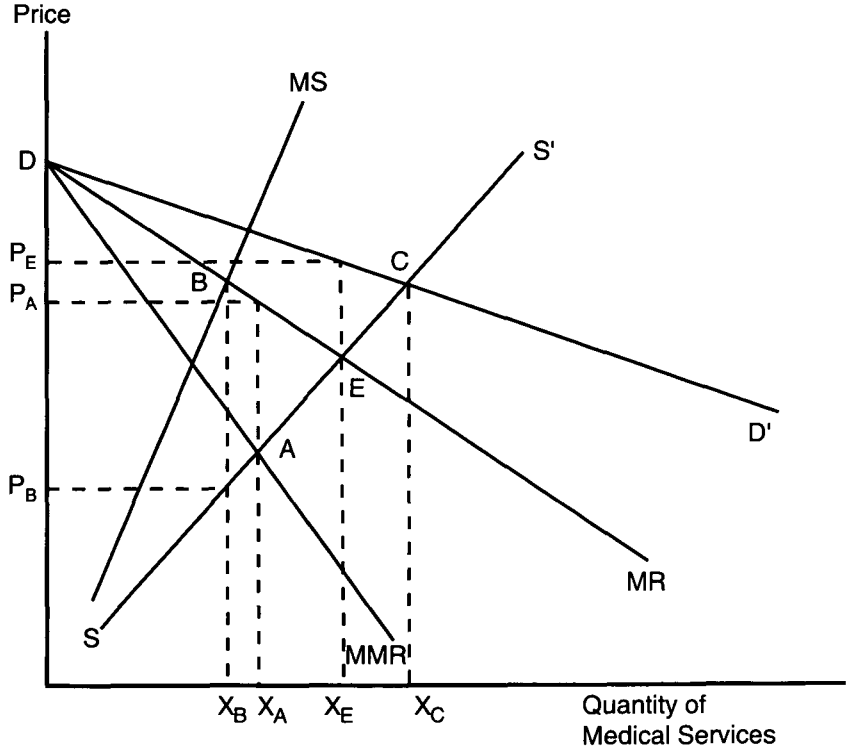

Figure 1[73]

Pauly analyzes these problems and sketches a number of possible equilibria. There is a possible competitive equilibrium where neither insurance companies nor medical providers have market power (point C). There is a possible equilibrium where a passive monopsony

[72] *Id.* at 113.

[73] *Id.* at 116 (Figure 1).

insurance company (or a competitive insurance market) faces active upstream monopoly medical providers (point A). There is a possible equilibrium where an active monopsony insurer faces passive upstream monopoly providers (or a competitive upstream provider market) (point B).[74] Finally, there is a possible equilibrium where an integrated provider-insurer exercises its market power, but only in the final product market (point E). Conceptually, point E can be thought of either as the traditional Blue Cross-Blue Shield situation of a dominant insurer being held captive to provider interests, or as a large managed care company that directly employs medical providers for its own benefit.

Welfare economics can shed light on the relative desirability of these equilibria. Not surprisingly, the competitive equilibrium is preferable (in the absence of other market failures). Market power anywhere in the stream of production typically produces inefficiency. However, point E, the single integrated monopolist, is preferable to points A or B. One vertical monopoly is typically better than two separate monopolies because it avoids distortions associated with multiple markups.[75] Significantly, it is not possible to make general statements about the degree of inefficiency associated with point A compared to point B. Which is worse in practice depends upon the relative elasticities of supply and demand.

Equally important for antitrust purposes, it is not possible to infer positive welfare effects from the simple observation that payments to medical providers have been reduced. Moving from point A to points B, C, or E are all associated with reduced payments for inputs, but not all moves improve total welfare. As Pauly remarks, "Ultimately, the resolution of the question of whether efficiency is improved by aggressive

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[74] While acknowledging that downstream health care monopsonists are likely to face upstream monopolists, in assuming passive monopolists versus active monopsonists and vice versa (points A and B), Pauly does not deal with the problem of bilateral monopoly. In their article in this issue, Blair and Herndon contend that monopoly medical providers facing a monopsonist buyer will negotiate their way to the same outcome as the integrated provider (point E in Pauly's figure). *See* Blair & Herndon, *supra* note 67. As such, if the bilateral monopoly negotiations are not undermined by strategic behavior, it provides an interesting example of where countervailing power could lead to a welfare improvement. Two market failures are sometimes better than one. Unfortunately, antitrust law is not always well equipped to deal with this possibility. *See generally* Peter J. Hammer, *Antitrust Beyond Competition: Market Failures, Total Welfare, and the Challenge of Intramarket Second-Best Tradeoffs*, 98 MICH. L. REV. 849 (2000).

[75] As suggested by Blair & Herndon, *supra* note 67, formal integration or merger is not the only way to internalize the externalities associated with double markups. One can imagine various contractual mechanisms short of merger that could accomplish similar ends. Bargaining in the shadow of bilateral monopoly, however, is notoriously unpredictable. *See generally* Richard Friedman, *Antitrust Analysis and Bilateral Monopoly*, 1986 WISC. L. REV. 873 (1986).

insurers who exercise market power against providers must be empirical."[76] In other words, this is not an area where policy makers or antitrust courts can safely trust their intuitions.[77]

B. *KARTELL*'S WELFARE ANALYSIS AND BREYER'S TREATMENT OF PRICE

How does standard monopsony analysis apply to *Kartell*? In the classic monopsony model, the buyer faces an upward-sloping supply curve and obtains lower input prices by suppressing the level of its purchases. There is no gain in productive efficiency. A monopsonist health insurer therefore purchases fewer physician services at a lower cost, and lowers output in the final product market (i.e., health insurance benefits). Moreover, because health insurance monopsonists typically are also monopolists, lower input prices do not lead to lower consumer output prices. As a general proposition, therefore, monopsony power decreases rather than increases economic welfare.

Breyer's opinion has been fairly criticized for inferring positive welfare effects simply from the fact that Blue Shield reduced its input prices for physician services.[78] The record supports the conclusion that Blue Shield was able to obtain lower physician fees and therefore lower prices in the input market.[79] There is no record evidence, however, that lower fees paid to physicians resulted in lower premiums for Blue Shield subscribers, and Breyer certainly referenced no evidence about the adequacy of output.[80]

In this respect, Breyer was simply mistaken to believe that possible market power on the part of Blue Shield had no antitrust significance. Moreover, vigilant application of the antitrust laws to facilitate competition among insurers is necessary to safeguard the integrity of the insurer-insured agency relationship. The competitiveness of the insurance industry was among the factors the Supreme Court identified in *FTC v.*

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[76] Pauly, *Market Power and Monopsony*, *supra* note 71, at 117.

[77] Pauly, *Thinking Straight*, *supra* note 68, at 73–74.

[78] *See* HOVENKAMP, *supra* note 70, at 14–15. *See also* Herbert Hovenkamp, *Antitrust Policy After Chicago*, 84 MICH. L. REV. 213, 257 (1985). To infer positive welfare effects from lower input prices alone, one would have to tell credible stories about the significance of state rate regulation, or possibly Blue Shield's nonprofit status on the insurer's behavior. *See infra* Part IV.

[79] *Kartell VI*, 582 F. Supp. at 741 (reporting that Blue Shield's fixed schedule of physician fees was 30% below the physicians' standard charges).

[80] Lower prices in the final product market are strong indications of procompetitive efficiencies. Higher levels of output can serve similar functions, although measuring "output" in an insurance market is not an easy task.

Indiana Federation of Dentists for why a demand from an insurance company for patient x-rays in order to verify the need for dental treatment could be treated as a demand from consumers themselves.[81]

Whatever concern Breyer had for maintaining competitiveness in the market for health insurance—the market of greatest interest to individual consumers—was subsumed into a strong resistance to imposing antitrust liability for "low [input] prices." Taking its cue from Breyer, the court in *Ocean State* cited a Blue Cross estimate that the Prudent Buyer policy (containing the challenged most-favored-nation clause) saved it approximately $2 million in input prices.[82] There was no evidence, however, that the reduced input prices were passed along to consumers or that they led to an expansion of output in Blue Cross's final product market.[83] Rather, the court suggested that improved consumer welfare was not a predicate for absolving the defendant of antitrust liability: "In the present case, Ocean State alleges that Blue Cross never actually passed along its savings to subscribers. But nothing turns on whether Blue Cross in fact lowered its rates. The fact remains that achieving lower costs is a legitimate business justification under the antitrust laws."[84] Whether a reduction in input prices can properly be viewed as an increase in efficiency and therefore as a legitimate business justification, however, depends upon its origins. If the lower input prices result from the exercise of monopsony power, then they lead to allocative inefficiency in the end-market and not to increases in productive efficiency.[85] This possibility was not even considered by the court in *Ocean State.* It is difficult to get the right answers if you do not ask the right questions.

A wholly defensible antitrust proposition is that no liability should flow from insurer practices that demonstrably lead to lower consumer prices in the end-market. Although Breyer's opinion sweeps more broadly, some courts have viewed *Kartell* as requiring savings to end-users. The district court in *Westchester Radiological* maintained that cost savings directly benefited Blue Cross subscribers: "Blue Cross produces *lower prices for consumers* by using its bargaining power to produce radiol-

[81] 476 U.S. 447, 463 (1986) ("[Insurers] are themselves in competition for the patronage of the patients . . . .").

[82] 883 F.2d at 1110.

[83] The court does assert, without citing supporting evidence in the record, that Blue Cross's MFN provided it with "more business at lower prices." *Id.* at 1111.

[84] *Id.* at 1111 n.11. Similarly, in discussing whether the practice was exclusionary, the court simply classified the price reductions as a legitimate business justification. "[T]he efficiency justification—lower costs—is evident." *Id.* at 1112.

[85] A monopsonist pays lower input prices. This lowers its average costs, but not its marginal costs. Thus a profit maximizing monopsonist does not reduce its prices, but instead, simply earns a higher profit.

ogy services as part of a bundle of hospital services."[86] Unlike *Kartell*, the court in *Westchester Radiological* credited evidence of this benefit: "[T]o the extent that consumer welfare is the goal of antitrust, a court should be hesitant to extend antitrust law to strike down a system that currently saves consumers about $25 million a year in radiology fees."[87] If the court was correct as a factual matter, then Blue Cross's contracting practice would be defensible.[88] Not surprisingly, the regulated nature of the industry that Breyer touches on in *Kartell* played a significant role in *Westchester Radiological* as well.[89]

The court in *Delta Dental of Rhode Island* similarly opted for a narrow reading of *Kartell* by limiting it to insurer conduct that produces lower consumer prices. The court wrote: "*Kartell* is distinguishable from this case because the ban on balance billing at issue in *Kartell* resulted in low prices for Blue Shield's enrollees, while the Government alleges that Delta's Prudent Buyer policy at issue here ultimately results in higher prices for Rhode Island dental services consumers."[90] *Delta Dental of Rhode*

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[86] *Westchester Radiological*, 707 F. Supp. at 710 (emphasis added). The court goes on: "Blue Cross is simply acting as a rational buyer attempting to get *the best possible terms for its subscribers*." *See id.* at 713 (emphasis added).

[87] *Id.* at 714. Ironically, the opinion then cites Judge Bork for the proposition that the "real danger for the law is less that predation will be missed than that normal competitive behavior will be wrongly classified as predatory and suppressed." *Id.* (citing ROBERT BORK, THE ANTITRUST PARADOX 7–9 (1978)). The court's consumer welfare analysis here, however, is highly contingent on public regulation, not free markets, for its validity.

[88] 707 F. Supp. at 710 n.2. The radiologists contended that they could bill $25 million more per year if they could bill patients directly. It is not obvious whether (or to what extent) these reduced costs were associated with an exercise of Blue Cross's market power (monopsony power mediated through depressing the quantities of the input demanded) or whether they were due to more sophisticated purchasing by the insurance company. The opinion makes no direct reference to monopsony power, although the court speaks of "bargaining power" and "market power" as reasons for the cost reduction. *See id.* at 710, 713. The court also acknowledges that an active purchaser could reduce costs in procompetitive ways. "The agreements permit a sophisticated buyer, Blue Cross, to monitor and predict charges, and permit it to offer cost containment as a service to its less sophisticated, individual subscribers." *See id.* at 710.

[89] The challenged practice in *Westchester Radiological* was the defendant's insistence on "bundling" radiologists' professional charges for inpatient radiology services into its payments to hospitals rather than paying the physicians separately. The court observed: "[T]he Blue Cross purchasing system attacked here is supervised by state regulators. Although that supervision may or may not rise to the level needed to invoke the state action exception to the antitrust laws, there is no dispute that New York State sets the reimbursement rate that Blue Cross may pay to hospitals for patient care." *Id.* at 714.

[90] 943 F. Supp. at 177. This revisionist reading of *Kartell* carries through the opinion. *See id.* at 177 n.5. ("These low prices, however, benefitted Blue Shield enrollees through lower premium rates."); *see Id.* at 180 ("But in *Kartell*, the court found that market power was irrelevant because Blue Shield was doing nothing more than using market power to obtain a low price for its enrollees."). This interpretation becomes more defensible if one focuses simply on the balance billing prohibition and its likely effect on out-of-pocket consumer payments, rather than the implications of Blue Shield's alleged exercise of

Island also asserts as one, though not the only, basis for distinguishing *Ocean State* that "*Ocean State*, like *Kartell*, involved lower consumer prices."[91]

Another sensible—and limited—reading of *Kartell* centers on judicial skepticism and self-restraint. Fear of chilling procompetitive behavior not infrequently induces antitrust courts to create doctrinal firewalls.[92] While a monopsonist obtains lower input prices by suppressing the level of its purchases and not by improving productive efficiency, there are many procompetitive ways that a health insurer can reduce costs. These include the standard managed care toolkit: utilization review, financial incentives, and selective contracting. Indeed, in *Kartell*, Blue Shield argued that it brought better information to bear on policy decisions than that possessed by individual consumers.[93] Therefore, antitrust courts must be able to distinguish pro- from anticompetitive sources of lower costs.

This analysis is difficult because health care "costs" and the very notion of the "supply curve" for medical services are such ill-defined concepts. The district court in *Kartell*, for example, found that the supply of doctors in Massachusetts had in fact risen steadily over the time in question.[94] This would tend to suggest that monopsony power was not being exercised because lower-than-competitive monopsony rates should deter physician entry into the market. Unfortunately, there are so many other factors that could influence the number of physicians in a market that few inferences can defensibly be made from this fact alone.

If *Kartell* reaches the correct result, it is because other factors restrained Blue Shield from exploiting its monopoly power vis-à-vis consumers. Blue Shield was a nonprofit entity created by state statute. Some antitrust courts have reasoned that nonprofit hospitals will not exercise market power in the same manner as for-profit entities,[95] although nonprofits enjoy no general antitrust immunity.[96] Blue Shield's nonprofit status

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monopsony power in the input market. "In *Kartell*, Blue Shield's ban on balance billing clearly saved subscribers from incurring additional provider costs." *Id.* at 191 n.4.

[91] *Id.* at 178.

[92] *See, e.g.*, Matsushita Elec. and Indus. Co. v. Zenith Radio Corp., 475 U.S. 574 (1986); Monsanto Co. v. Spray-Rite Serv. Corp., 465 U.S. 752 (1984).

[93] "Blue Shield also claims that whatever power it possess arises from its ability as an 'expert' to prevent doctors from charging unknowledgeable consumers *more* than a free (and informed) market price." *Kartell VII*, 749 F. 2d at 927.

[94] *Id.*

[95] *Butterworth Health Corp.*, 946 F. Supp. at 1295.

[96] *See* NCAA v. Board of Regents, 468 U.S. 85, 100 n.22 (1984); *see also* United States v. Rockford Mem'l Corp., 171 F. Supp. 1251, 1287 (N.D. Ill. 1989 ("Accordingly, the court finds that the defendants 'consumer-aligned' boards and not-for-profit status will not

afforded subscribers little intrinsic protection. More likely, active state regulation may have ensured that lower input prices from buyer-side market power were passed along to consumers.[97] Blue Shield's efforts to restrict physician fees commenced in 1975 in response to pressure from the state Insurance Commissioner.[98] With continued state oversight, it is conceivable that Blue Shield's subscribers were beneficiaries of the insurer's market power. Still, it remains an empirical question whether and in what circumstances particular regulations yield measurable consumer benefits, and Breyer fails to cite evidence of this sort. Therefore, *Kartell* is best regarded as a potential regulatory exception to the general rule that monopsony impairs welfare, and not as a template for evaluating buyer-side market power as a matter of baseline analysis.

Significantly, there are other, less intuitive scenarios in which lodging monopsony (and monopoly) power in a health insurer—depicted correctly using Pauly's "final product" approach rather than Breyer's oversimplification of the insurer-insured agency relationship—may lead to improved social welfare (or at least no short-term welfare loss). For one, the classic monopsony model implicitly assumes that the physician's decision to supply services reflects a discrete, marginal choice. Herndon persuasively argues that physician supply is better modeled as an "all-or-none" proposition, not a marginal decision.[99] If the physician's supply decision is "all-or-none," meaning that physicians do not respond to reduced fees by selectively limiting the quantity or quality of service they provide to patients whose insurers offer lower compensation, then a monopsonist like Blue Shield could reduce physician fees to the level dictated by the average cost curve without suppressing the quantity of inputs demanded.[100] Importantly, the "all-or-none" model depends upon the existence of contractual, legal, and professional norms to prevent physicians from discriminating among patients according to source of payment.

A second possibility, identified by Blair and Herndon, is that countervailing buyer-side market power could act as a second-best solution to

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necessarily prevent the defendants from engaging in anti-competitive activity."), *aff'd*, 898 F.2d 1278, 1285–86 (7th Cir. 1990).

[97] *See infra* notes 139–144 and accompanying text.

[98] *See supra* notes 8–11 and accompanying text.

[99] Jill Boylston Herndon, *Health Insurer Monopsony Power: The All-or-None Model*, 21 J. HEALTH ECON. 197 (2002). This is another example of how various types of lumpiness in health care markets can lead to non-textbook results.

[100] While not producing short-term welfare losses, there remain concerns about dynamic efficiency in the "all-or-none" scenario. *Id.* at 200 n.4.

upstream provider market power.[101] In the absence of strategic behavior, negotiations between parties with countervailing market power could move the market from the isolated upstream provider monopoly equilibrium (point A in Pauly's figure),[102] or the isolated monopsonist equilibrium (point B), to the output and quantity decisions of the integrated monopolist (point E).[103] Point E represents a welfare improvement relative to A or B, although point E is still unambiguously less desirable than the competitive outcome (point C). This scenario would call for a case-by-case assessment of the economic effects of buyer-side market power using a total welfare standard.[104]

A third situation, discussed by Martin Gaynor and colleagues, involves moral hazard in health insurance.[105] It is well established that insured individuals have less incentive to avoid covered losses, a problem that manifests itself in health insurance as overuse of expensive, marginally beneficial medical services rather than failure to protect oneself from illness or injury. Moreover, insured individuals often rely on the treatment recommendations of physicians and other health professionals who are paid on a fee-for-service basis. Moral hazard in health insurance therefore afflicts providers as well as patients.[106] Moral hazard is socially wasteful. A monopsonist that curtails input supply by paying below-market fees to physicians might counteract both types of moral hazard, increasing social welfare even if those discounted fees are not passed on to subscribers in the form of lower premiums. However, an insurer would have to offer clear evidence of these effects in order for them to be taken seriously, which would not be easy.[107] To date, antitrust receptivity to second-best type arguments has been tepid at best.

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[101] Blair & Herndon, *supra* note 67.

[102] *See* graph, *supra* note 73.

[103] For a comprehensive discussion of this possibility, see ROGER D. BLAIR & JEFFREY L. HARRISON, MONOPSONY: ANTITRUST LAW AND ECONOMICS 112–21 (1993).

[104] Hammer, *supra* note 74, at 906–14.

[105] *See* Martin Gaynor et al., *Are Invisible Hands Good Hands? Moral Hazard, Competition, and the Second Best in Health Care Markets*, 108 J. POL. ECON. 992 (2000).

[106] *See* Sherry Glied, *Managed Care*, *in* HANDBOOK OF HEALTH ECONOMICS 1A, at 707, 723–25 (Joseph P. Newhouse & A.J. Culyer eds., 2000). Consequently, there is no reason to assume that the inflated physician fees in *Kartell* under Blue Shield's "usual and customary" charge system represented the physicians' actual "costs."

[107] Gaynor et al., *supra* note 105 (concluding that welfare-enhancing effects on moral hazard might occur in noncompetitive but not in competitive insurance markets). In addition, the specific practice at issue in *Kartell*, balance billing, increases patients' out-of-pocket co-insurance costs at the point of service and therefore acts as a counterweight to moral hazard.

III. *KARTELL* AS AN AGENCY PROBLEM: HEALTH CARE COMPLEXITIES

Justice Breyer was wrong to ignore the "final product" model of monopsony, but he was right to place the agency issue at the heart of the *Kartell* dispute. Faithful agency relations, enforced through appropriate legal mechanisms, can produce results quite different from those predicted by conventional economic theory. Analysis of the multiple and conflicting agency relations in health care, however, is difficult. Lawrence Casalino provides an exposition of contemporary agency relations in medical markets that stands in sharp contrast to Breyer's simple buyer-seller dyad.[108] Casalino details not only the relationships traditionally at the heart of health care (physicians, patients, and insurers), but also the new wrinkles introduced by managed care, integrated provider practice groups, and employer sponsorship.

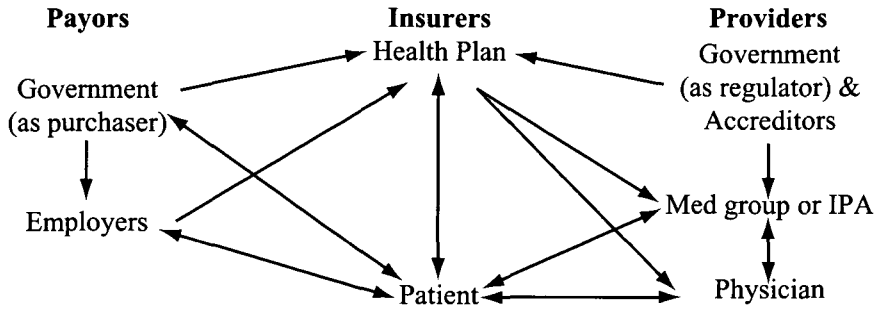

Figure 2. Contemporary Principal-Agent Relationships

Patients seldom pay directly for their own insurance coverage. Most private insurance is obtained through employers, from a limited menu of choices, while the government structures and finances insurance for the Medicare and Medicaid populations. Private insurance companies fund and, in the world of managed care, directly arrange the provision of medical services to subscriber-patients. At the same time, health care providers supply both medical services and information to individual subscriber-patients.[109] As the Casalino diagram indicates, the physician-patient agency relationship is increasingly mediated by medical groups

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[108] Lawrence Casalino, *Managing Uncertainty: Intermediate Organizations as Triple Agents*, 26 J. HEALTH POL., POL'Y & LAW 1055 (2001).

[109] Kenneth J. Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 AM. ECON. REV. 941 (1963).

and Individual Practice Associations (IPAs), fundamentally changing the unit of production for medical services. The diagram also acknowledges the role of the government in regulating aspects of both the provider-patient and the insurer-insured agency relationships.[110]

Kartell's treatment of health care agency fails to do justice to this multi-dimensional set of interactions among physicians, patients, employers, insurers, and the state. Breyer characterizes Blue Shield as nothing more than the arms-length buyer of physician services. The opinion offers three concededly "highly simplified examples" as analogies to Blue Shield's purchasing role and prohibition against balance billing: (1) a father buying a toy for his son, (2) a landlord hiring a painter to paint a tenant's room to the tenant's specifications, and (3) a large company hiring a doctor to treat its employees.[111] These examples illustrate the legitimate point that parties frequently engage in economic transactions on behalf of others. Nevertheless, one should pause to consider the applicability of Breyer's examples to insurance for physician services.

Three aspects of health insurance make Breyer's examples troubling. First, unlike a father or a landlord, a health insurer is acting as an agent for a collective body of subscribers. The insurer as agent must provide an effective mechanism for aggregating and expressing the preferences of its insureds. Second, there is typically a separate, pre-existing agency relationship between the physician and the patient. There is no comparable relationship between the son and the toy company or the tenant and the painter. This point also distinguishes some of Breyer's other insurance examples, such as when auto insurers pay for work in repair shops.[112] Third, in many important respects, the health insurer as agent is supposed to act on behalf of the insured's interest, not its self-interest. This is true of the father, who bears a fiduciary relationship to the minor child, but not of the landlord. In a world of managed care, moreover, the insurer must navigate an increasing number of conflicts of interest created when the financing function (traditional insurance) is integrated

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[110] Democratic governance is itself a form of principal-agent relations, the failure of which can complicate economic analysis of public regulation because of the influence of special-interest groups. *See generally* Roger G. Noll, *Economic Perspectives on the Politics of Regulation, in* 2 HANDBOOK OF INDUSTRIAL ORGANIZATION 1253 (Richard Schmalensee & Robert Willig eds., 1989); John Shepard Wiley, Jr., *A Capture Theory of Antitrust Federalism*, 99 HARV. L. REV. 713 (1986). The fact that health care markets function in the shadow of the law will be explored in greater detail in the next section. *See infra* Part IV.

[111] *Kartell VII*, 749 F.2d at 925.

[112] *Id.* at 925 ("Seventh Circuit has permitted auto insurance companies to furnish direct reimbursement to repair shops as payment for the repair services provided to policyholders.") (citing Quality Auto Body, Inc. v. Allstate Insurance Co., 660 F.2d 1195 (7th Cir. 1981)).

with the direct provision of medical services. Company doctors face similar pressures, but Breyer does not address them.[113]

From an antitrust perspective, a third party acting as a purchasing agent for a single customer is a substantially different problem than an insurance company collectively purchasing on behalf of a large group of subscribers. A closer analogy might be a league of parents seeking to buy toys on behalf of all their children or a union of landlords purchasing painting services for all of their buildings. Breyer is aware that a price-fixing agreement between otherwise independent buyers may masquerade as a purchasing organization[114] and that a purchasing organization may serve as a front for the collective action of sellers.[115] However, Breyer shows no concern for other collective aspects of group purchasing.

The claim here is not that collective purchasing necessarily creates antitrust problems. Group purchasing often enhances efficiency.[116] Moreover, if one applies the final product model, all manufacturers standardize their product offerings; even the menu of options associated with automobile purchasing reflects aggregate rather than individual preferences. However, health insurance has several attributes that make collective purchasing problematic from an economic, if not an antitrust, perspective.

The primary function of health insurance is to pool risk and thereby reduce it.[117] However, pure indemnity insurance is a thing of the past. "Selective contracting" has been the most successful aspect of modern managed care, at least financially, because it allows direct insurer-provider bargaining over fees. Network-model health maintenance organizations and insurers offering "preferred provider" products, which together represent the modal form of private insurance, aggressively negotiate discounts with physicians and hospitals in advance. Blue Shield and Blue Cross traditionally have set provider fees because of their history as "service benefit plans" that were obligated to provide covered services

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[113] *See generally* ELAINE DRAPER, THE COMPANY DOCTOR (2003).

[114] *Kartell VII*, 749 F.2d at 925 (citing Mandeville Island Farms, Inc. v. Am. Crystal Sugar Co., 334 U.S. 219, 235 (1948); United States v. Socony-Vacuum Oil Co., 310 U.S. 150 (1940)).

[115] *Kartell VII*, 749 F.2d at 749 (citing Va. Acad. of Clinical Psychologists v. Blue Shield of Va., 624 F. 2d 476 (4th Cir. 1980) (finding Blue Shield to be a combination not of its subscribers, but of its physicians)).

[116] *See generally* Clark C. Havighurst, *Antitrust Issues in the Joint Purchasing of Health Care*, 1995 UTAH L. REV. 409 (1995).

[117] On the other hand, medical savings accounts and other forms of "consumer-directed" coverage appear to be growing in popularity. *See* Jon Gabel, Anthony T. Lo Sasso & Thomas Rice, *Consumer-Driven Health Plans: Are They More than Talk Now?*, HEALTH AFF., Jan.–Feb. 2003, at 9.

directly to subscribers. However, even "Blues'" plans have become more selective in determining which providers participate in their panels. This limits consumer choice and reduces insurer fidelity to individual patient preferences in the name of serving collective subscriber interests (lower costs).[118] The close connection between health coverage and the workplace arguably magnifies these effects; employers' perceptions and preferences may distort insurer contracting practices and further distance competitive outcomes from true consumer preferences.[119] Moreover, the purchasing and risk-pooling functions may be in tension with each other if certain negotiating practices designed to prevent adverse selection (thereby benefiting the insurance pool) detract from individual quality of care or patient responsiveness.

None of these complicating factors made their way into the *Kartell* analysis. Indeed, Breyer excluded from his competitive inquiry even the obvious agency relationship that exists between physicians and patients. Physicians not only provide medical care, but also refer, prescribe, and recommend a range of products and professional and institutional services.[120] Some patients choose insurers in order to maintain covered access to physicians with whom they enjoy longstanding relations. Even when a subscriber seeks care for the first time from a physician, and has been directed to him or her by the insurer, the patient-physician bond is ethically, legally, and practically independent of both the contract of coverage between the subscriber and the insurer and the participating provider agreement between the physician and the insurer.

In *Kartell*, the court rejected the plaintiffs' argument that, because of prevailing prohibitions on the "corporate practice" of medicine and the obligations physicians owe directly to patients, Blue Shield as an insurance company should not be viewed as the "buyer" of physician services.[121] Breyer wrote:

> In our view, however, any such distinction is irrelevant for antitrust purposes. The relevant antitrust facts are that Blue Shield pays the bill and seeks to set the amount of the charge. Those facts led other courts

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[118] Even with nonselective networks, subscribers' preferences "ex ante" when purchasing coverage as potential patients and "ex post" when seeking and receiving care as actual patients may differ considerably.

[119] *See generally* MARK V. PAULY, HEALTH BENEFITS AT WORK (1997).

[120] It is well known that physicians control roughly two-thirds of overall personal health care spending in the United States through these mechanisms, even though physicians' fees account for only about 20% of the total. *See* U.S. DEP'T OF HEALTH AND HUMAN SERVICES, HEALTH, UNITED STATES 2003 at 310 (giving the percentage distribution of national health care expenditures by category of service) (2003) (DHHS Pub. No. 2003-1232).

[121] *Kartell VII*, 749 F. 2d at 926.

> in similar circumstances to treat insurers as if they were "buyers." The same facts convince us that Blue Shield's activities are *like* those of a buyer. Whether for ethical, medical, or related professional purposes Blue Shield is, or is not, considered a buyer is beside the point. We here consider only one specific argued application of the antitrust laws and we do not suggest how Blue Shield ought to be characterized in any other context.[122]

However, the court does not attempt to apportion purchasing authority, or other agency responsibility, between insurers and physicians.

To a degree, it is understandable that federal antitrust courts rarely dwell on the patient-provider relationship. Not only is it governed by a separate regulatory structure based largely on state law and professional self-regulation, but antitrust courts have so frequently been called upon to scrutinize physician conduct for anticompetitive effects (price-fixing agreements and group boycotts) that they may be unduly dismissive of physicians as faithful agents of patients in an economic sense.[123] Still, the last sentence of Breyer's quoted comment is intriguing. Recall that the sole practice being challenged in the suit was the ban on balance billing—the insurer setting the price of physician services and prohibiting additional charges to patients. While other language in the opinion suggests a broader right of the insurer as purchasing agent to strike deals on behalf of insureds affecting quality as well as price,[124] whenever Breyer feels pressured in his argument, he retreats to a narrower focus on price.[125] Indeed, it is likely that Breyer's implicit faith in the integrity of the physician-patient agency relationship and its ability to independently safeguard patient care made him more comfortable in freeing up insurers to act aggressively with regard to price. This move is defensible, however, only to the extent that quality is an exogenous concern, compartmentalized outside of and, therefore, unaffected by market activity.

As health insurance arrangements become more varied and intricate, conflicts of interest emerge between insurer and consumer interests, especially regarding the contract between insurer and physician that is

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[122] *Id.*

[123] *See* William M. Sage et al., *Why Competition Law Matters to Health Care Quality*, HEALTH AFF., Mar.–Apr. 2003, at 31, 38 (applying this reasoning to cases like *Kartell*).

[124] "To find an unlawful restraint, one would have to look at Blue Shield as if it were a 'third force,' intervening in the marketplace in a manner that prevents willing buyers and sellers from independently coming together *to strike price/quality bargains.*" *Kartell VII*, 749 F.2d at 924 (emphasis added).

[125] *See, e.g., id.* at 931 ("They do, however, counsel us against departing from present law or extending it to authorize increased judicial supervision of the *buyer/seller price bargain.*" (emphasis added)). Other aspects of the opinion expressly address, and reject, quality claims. However, the plaintiffs' quality-related arguments dealt with dynamic efficiency and innovation—the fear that a rigid price schedule would deter experimentation

at the heart of *Kartell.* Relatively speaking, Breyer had it easy. He could focus on the insurer-insured agency relationship without considering its effects on the physician-patient agency relationship. With the growth of managed care, and consequently the integration of health care financing with health care delivery, the "participating provider agreement" serves goals other than merely negotiating a low per-service price. Among other things, the provider may be called on to coordinate an array of medical services, may be offered financial incentives to conserve on treatment expense, may be subjected to insurer review of the necessity of recommended care, and may even be required to comply with specific clinical guidelines. Many of these provisions run counter to the specific preferences of the insured patient. At the extreme, the insurer may *become* the health care provider, as in closed-panel HMOs. In these situations, it is much harder to accept Breyer's description of the insurer as merely a purchasing agent.

The related *Ambroze* and *Finkelstein* decisions illustrate how antitrust courts applying *Kartell* continue to shortchange agency questions, notwithstanding the growth of managed care. The physician plaintiffs were groups of anesthesiologists working at hospitals that had contracts with Aetna and were seeking changes to Aetna's standard physician contract.[126] Aetna refused, and threatened to terminate its contracts with the physicians' respective hospitals. Under pressure from the hospitals, the physicians signed the standard contract but then brought suit. The complaint alleged various antitrust violations, as well as state law claims for tortiously interfering with the contractual relations with their respective hospitals.

This case is interesting because it raises antitrust questions about physician-patient-insurer agency relationships in the wake of *Kartell.* The plaintiffs mainly objected to a clause in the contract permitting termination by the insurer without cause, which they maintained "was intended to stifle the independent, professional judgment of physicians, who ordinarily compete on the basis of quality of service, among other things . . . [and] permitted Aetna to reduce the quality of patient care."[127] Unlike a ban on balance billing which concerns price only, the plaintiffs alleged that this clause adversely affected the clinical quality of care, as well as interfered with fundamental aspects of the physician-patient relationship.

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and market entry. *Id.* at 929. These arguments did not address insurer-imposed constraints that would directly affect the quality of clinical dimensions of care.

[126] *Ambroze,* 1996 U.S. Dist. LEXIS 7274 at *1–*2.

[127] *Finkelstein,* 1997 U.S. Dist. LEXIS 10759 at *6. *See also Ambroze,* 1996 U.S. Dist. LEXIS 7274, at *1–*2. (noting plaintiffs' argument that the standard contracts "undermine . . .

Nonetheless, the *Ambroze* opinion relied heavily on Breyer's decision in *Kartell* in granting Aetna's motion to dismiss the antitrust claim. The court classified the insurer as the "buyer" of physician services for the patient,[128] and therefore concluded that the "only restraint is the one that flows inevitably and properly from the choice by [Aetna] to buy services and products of a particular type from doctors."[129] The broader scope of the insurer's agency obligations and the extent to which those obligations might conflict with the traditional physician-patient relationship did not alter the court's antitrust analysis.[130] As the court observed: "The fact that their Complaint is dressed up in terms of competition for better quality services rather than price competition does not differentiate this case from the logic of cases like *Kartell* and *Westchester Radiological*."[131] Nuances attributable to the managed care environment in which the case arose, such as the possible implications of the contract provision for clinical quality, were lost on the court.

IV. A REGULATORY EXPLANATION FOR *KARTELL*

Ultimately, the scope and content of antitrust law must depend on the legal as well as the economic environment in which the challenged conduct occurs.[132] The outcome in *Kartell* is dictated more by regulatory concerns than by economic theories of monopsony power. Breyer devotes a substantial portion of the opinion justifying his cautious application of federal antitrust law, in deference to state efforts to restrain rising health care costs. Unfortunately, courts applying *Kartell* have not been sufficiently sensitive to the ways in which the Massachusetts regulatory climate circa 1980 influenced the First Circuit's reasoning and conclusions, and therefore limit its usefulness as precedent. This is problematic because radical changes in the health care industry over the past twenty years have been accompanied by equally dramatic shifts in regulatory

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member anesthesiologists' independent professional judgment and restrict their ability to compete against each other on the basis of quality").

[128] "As in *Kartell*, the Court finds the 'relevant antitrust facts' to be that Aetna 'pays the bill and seeks to set the amount [and the terms] of the charge.'" *Ambroze*, 1996 U.S. Dist. LEXIS 7274, at *19 (alterations in original) (quoting *Kartell VII*, 749 F.2d at 926).

[129] *Id.* at *19 (alterations in original) (quoting *Westchester Radiological*, 707 F. Supp. at 711).

[130] *Id.* at *27 ("The basic point . . . is that a buyer generally has the right, uninhibited by antitrust laws, to set the terms of its bargain with the seller.").

[131] *Id.* at *29.

[132] In light of this, we have written elsewhere about the need to approach medical markets from the vantage point of developing a comprehensive competition policy. William M. Sage & Peter J. Hammer, *A Copernican View of Health Care Antitrust*, 65 L. & CONTEMP. PROBS. 241 (2002); Hammer & Sage, *Health Care Quality and the Courts*, *supra* note 53; William M. Sage & Peter J. Hammer, *Competing on Quality of Care: The Need to Develop a Competition Policy for Health Care Markets*, 32 U. MICH. J.L. REFORM 1069 (1999).

regimes, altering the demands on federal antitrust courts and testing their competence in new ways.

A. *KARTELL*-ERA REGULATION

Antitrust courts have substantial discretion in defining their role as common law overseers of the economy. In highly regulated industries such as health care, the division of labor between courts and legislatures is fluid.[133] State action as defined in the established case law removes only a small subset of regulated activity from the purview of antitrust; regulation "not amounting to action" is far more common, if less clear-cut.[134] As illustrated in Breyer's opinion, a number of factors influence how a judge will exercise this discretion.[135] What is the seriousness of the social and economic problem being addressed? What is the capacity of antitrust courts to engage in the substantive evaluation of the claim? How clear or obvious is the appropriate remedy? How likely is it that other state actors will address the problem? In *Kartell*, Breyer notes the inherent complexity of health care questions and recognizes that their resolution requires constitutive social choices in addition to standard economic analyses.[136] He also asserts a comparative advantage on the part of state regulators to address the "reasonableness" of pricing deci-

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[133] At one level, the "channeling" function of antitrust law is worked out through the state action doctrine, doctrines of implied and express repeal, abstention, primary jurisdiction, and the certification of questions to state courts. However, channeling concerns do not end at the boundaries of these formal doctrines. In nearly every antitrust case, the court must exercise discretion with respect to the scope of its own authority.

[134] *See, e.g.*, California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97 (1980) (holding that, to qualify for immunity, a challenged restraint must be clearly articulated and actively supervised by the state). *Cf.* Ogden Nash, *Where There's a Will, There's Velleity, in* I'M A STRANGER HERE MYSELF 172–73 (1938) (defining velleity as "low degree of volition not prompting to action").

[135] "These general considerations do not dictate our result in this case. They do, however, counsel us against departing from present law or extending it to authorize increased judicial supervision of the buyer/seller price bargain. Like the court in *Feldman v. Health Care Corp.*, we see 'no need to blaze new trails,' 562 F. Supp. at 946. Without such pioneering, we do not believe the antitrust laws forbid Blue Shield's 'balance billing' practice." *Kartell VII*, 749 F.2d at 931 (quoting Feldman v. Health Care Serv. Corp., 562 F. Supp. 941 (N.D. Ill. 1982)).

[136] "[T]he subject matter of the present agreement—medical costs—is an area of great complexity where more than solely economic values are at stake. How to provide affordable, high quality medical care is much debated. And, many different solutions—ranging from stricter regulation to greater reliance on competing service organizations—have been proposed. *See* Clark, *Why Does Health Care Regulation Fail?* 41 MD. L. REV. 1 (1981); A. Enthovin [sic], HEALTH PLAN (1980). This fact, too, warrants judicial hesitancy to interfere." *Kartell VII*, 749 F.2d at 931.

sions,[137] as well as a fear of turning antitrust courts into de facto public utility commissions.[138]

These considerations lead Breyer to abstain from converting a dispute over rate regulation into an antitrust problem. In this process, his discussion of Blue Shield as the consumer's purchasing agent serves as rationalization as much as explanation. Consequently, the logic of *Kartell's* holding and its applicability to other fact patterns are contingent upon the market/regulatory interface in which the antitrust question arises.[139] Other policy and economic pressures facing different regulatory structures could well lead to quite different divisions of labor.

Kartell began as a fight about reimbursement rates, but a fight that was mediated through state politics, not private markets. Blue Shield's fee reductions were a result of the Insurance Commissioner's denial of proposed premium increases. Moreover, the parties did not limit their battles to the courtroom, as both sides also sought state legislative intervention. In 1976, the Medical Society unsuccessfully lobbied for legislation forcing Blue Shield to compensate non-participating physicians.[140] In 1979, the legislature divested the Medical Society of its formal control of Blue Shield, a vestige of Blue Shield's origins as a provider-controlled insurer.[141] In 1984, while the appeal of the district court's antitrust decision was pending in front of the First Circuit, the Massachusetts legislature enacted a law giving Blue Shield express legislative authority to prohibit balance billing by participating physicians.[142] Blue Shield argued that the new legislation rendered the controversy moot, an argument that the court rejected.[143]

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[137] *Kartell VII*, 749 F.2d at 928 ("And, where monopoly power is regulated, the regulator, not the court, bears the burden of determining whether prices are reasonable.") (citing MASS. GEN. LAWS ch. 164, §§ 93–94 (designating state regulation of gas and electric rates)); *Id.* at 929 ("The claim that Blue Shield's price scheme is 'too rigid' because it ignores qualitative differences among physicians is properly addressed to Blue Shield or to a regulator, not to a court.").

[138] *Id.* at 927.

[139] Hammer & Sage, *Health Care Quality and the Courts*, *supra* note 53, at 637–38 (describing the meeting point between antitrust law and general regulation in terms of an interface, not a boundary).

[140] Law & Ensminger, *supra* note 4, at 27 n.146.

[141] *Id.* at 28 n.147.

[142] *Id.* at 21 n.106.

[143] *Kartell VII*, 749 F. 2d at 924 (reasoning that even if the court assumed that the new law immunized future conduct under that state action doctrine, it would not excuse the practice or balance billing retrospectively, or obviate the need to address the underlying question of antitrust liability).

Cost, quality, and access constitute the three domains of traditional health care regulation. Blue Shield was originally structured and regulated to facilitate access to insurance financing and, therefore, access to medical services. A nonprofit entity created by state statute, Blue Shield possessed substantial market share and faced limited competition from private carriers. Nearly all physicians participated on its panels, and its insurance products were sold to the public on a non-discriminatory, community-rated basis. Fee-for-service payment of physicians was the unchallenged norm, and insurance premiums were subject to regulatory approval. Blue Shield had no clinical authority, either legally or contractually. Medical quality was monitored by state licensing, by malpractice liability, and by professional self-regulation through hospital credentialing committees and similar bodies. These were discrete and separate realms, none of which was governed by private markets.[144]

Consequently, Breyer could portray Blue Shield in the *Kartell* opinion as merely a "purchasing agent" and could safely ignore potential complexities in the insurer-provider-patient agency relationship. In declaring that Blue Shield's ban on balanced billing was not an antitrust problem, Breyer drew obvious comfort from the active involvement of state regulators, particularly in terms of ensuring that savings to Blue Shield were passed on to consumers.

> [T]he price system here at issue is one supervised by state regulators. While that fact does not automatically carry with it antitrust immunity, it suggests that strict antitrust scrutiny is less likely to be necessary to prevent the unwarranted exercise of monopoly power. Of course, administrative regulation is a highly imperfect process. But, regulation by judicial decree is not necessarily preferable.[145]

Though unspoken, the pantheon of state regulatory and professional self-regulatory measures that could independently safeguard clinical quality must have also reassured the court. All in all, Breyer displays serious reservations about competition in health care (particularly with respect to quality)[146] and substantial sympathy for the state's regulatory endeavors.

A possible explanation for Breyer's deference to regulation is that neither the insurer nor provider sides of the market were particularly

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[144] While Blue Shield's charter promoted access to health insurance, and separate regulations maintained clinical quality, little in the traditional system was designed to control costs—precipitating the rate regulatory crisis that led to the *Kartell* litigation.

[145] *Kartell VII*, 749 F.2d at 931 (citations omitted). Breyer's skepticism about the efficacy of state regulation is justified. Many rate-setting regimes in health care keep prices high rather than low, either to promote quality and access for the uninsured (cross-subsidies) or because providers exercise political influence.

[146] *Id.* at 928.

competitive when *Kartell* arose. Recall Pauly's diagram of monopsony-monopoly power set forth above.[147] An integrated insurer-provider monopolist (Point E) causes less harm to consumers than if market power is held independently by physicians and/or insurers. This was essentially the position of Blue Shield when it was controlled by the Medical Society. Once those ties were loosened, the physician cartel that Blue Shield presumably had stabilized would have weakened. In that situation, a truly competitive approach could have ensured, through antitrust oversight, that Blue Shield did not retain its insurance monopoly. The result would have been more active price competition for both insurance and physician services, with the potential for greater innovation in production and a wider scope of price and nonprice characteristics.

This, however, was not seriously contemplated when the *Kartell* litigation began in 1977. Health insurance was a highly regulated product. The state Insurance Commission put pressure on Blue Shield to contain premium growth, and Blue Shield responded by altering its physician reimbursement formula and related contractual provisions, such as the balance billing prohibition addressed in Breyer's opinion. That was all. In Massachusetts circa 1980, there were a few small HMOs, such as the Harvard Community Health Plan, which had been nurtured by the Federal HMO Act of 1973. Blue Cross and Blue Shield were the dominant insurers, whose principal role was to preserve patient access to coverage through community rating and similarly noncompetitive practices. Blue Shield was a nonprofit organization, with little incentive to innovate. It was legally separate from Blue Cross but required to coordinate with it, which meant there was no way to "assemble" a full-service health insurance product except through established channels.[148] None of the aggressive strategies that would become familiar as managed care—notably selective contracting, preauthorization requirements, and physician financial incentives to conserve treatment expense—were in use. Some were impermissible under state law, as was the "corporate practice" of medicine generally.[149]

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[147] *See supra* note 73 and accompanying text.

[148] This market division constituted "state action" as a formal matter. *See Kartell IV*, 542 F. Supp. at 788–92.

[149] *See* Jon A. Gabel, Thomas M. Rice, & Gregory de Lissovoy, *The Emergence and Future of PPOs*, 11 J. HEALTH POL., POL'Y & LAW 305 (1986) (describing relaxation in the 1980s of laws preventing selective contracting). One vehicle for challenging this strict regulatory climate was the Employee Retirement Income Security Act of 1974 (ERISA), which the *Kartell* plaintiffs argued preempted the state's attempt after the litigation arose to protect the balance billing prohibition from antitrust attack through direct legislation. Breyer was unmoved. *Kartell VII*, 749 F. 2d at 931–32.

In other words, the prevailing regulatory model of health insurance in most states at the time, including Massachusetts, precluded the functional integration of health care financing with health care delivery that is characteristic of modern managed care. This reduced opportunities for productive efficiencies, but also seemingly protected patients from experiencing changes in quality or access as a result of the lower rates Blue Shield paid its physicians. It also reassured the *Kartell* court that agency-related risks were minimal.[150] Even if the balance billing prohibition did not constitute "state action" as a doctrinal matter, Blue Shield was functionally a purchasing agent for patients as politically represented by the regulatory system, though not as consumers participating in an unfettered market.

B. MANAGED CARE REGULATION TODAY

In 1984, Breyer plausibly could squeeze physician-patient-insurer relations into a simple "buyer-seller" dyad and focus on price to the exclusion of access and quality. Changes in industry structure call these assumptions into question today. Managed care substantially blurs the line separating insurance from clinical services. Quality can no longer be viewed as an exogenous concern, unaffected by market activity. Although widespread health care regulation persists, competition plays a much larger role now than when *Kartell* was decided. Cost, quality, and access are interdependent in a competitive market. Goods and services that trade at higher prices typically have higher perceived quality.[151] Similarly, competitive visions of insurance have displaced the communitarian vision inherent in traditional Blue Cross-Blue Shield coverage. Largely through the active involvement of private employers as plan sponsors, access to affordable health insurance has come to be seen as the outcome of market processes, not government assurances.

How should antitrust law respond to monopsony power in health care when price and quality are not subject to separate and discrete regulatory oversight? While substantially less developed than Breyer's argument in *Kartell*, the *Ambroze* and *Finkelstein* decisions demonstrate a modern court struggling with a changed regulatory climate and the impact of managed

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[150] The one wildcard in mandating price reductions for Blue Shield (or any other insurer) is that physicians will cease participating in the program. This problem is severe among state Medicaid programs that pay very low per-service fees. *See* Sidney D. Watson, *Medicaid Physician Participation: Patients, Poverty, and Physician Self-Interest*, 21 AM. J.L. & MED. 191, 194–202 (1995).

[151] The *Kartell* plaintiffs argued that low fees discouraged them from providing higher quality care to patients who desired it and from investing in medical innovations. Breyer rejected this claim, regarding quality as largely unaffected by price competition. *Kartell VII*, 749 F.2d at 927.

care on antitrust analysis of buyer-side market power. In its first opinion, the district court fairly characterized the physicians' complaint as an attack on "the very concept of managed care" and declined to usurp the state's regulatory role through "a novel application of antitrust laws."[152] The Second Circuit reversed and remanded the case to afford plaintiffs the opportunity to amend their complaint.[153] Contemporaneously, New York enacted legislation addressing managed care contracting practices, including the conditions of physician termination.[154] In response, Aetna changed its standard physician contracts, limiting the grounds for physician termination.[155]

Significantly, the court in *Ambroze* and *Finkelstein* continues to view agency problems as solvable through state regulation. This is probably wrong. Today's regulatory system, relatively speaking, is designed to encourage innovation. It offers consumers efficiency gains but poses greater risks of agency failure. Direct premium regulation has receded as a policy tool, which adds importance to assuring the competitiveness of the insurance market, but a competitive insurance market is vulnerable to adverse price-related effects on quality and access. No new regulatory box will contain all of these effects. As a result, antitrust courts cannot be complacent about potential agency failures, as Breyer was in *Kartell* or as the district court was in *Ambroze* and *Finkelstein.*

This is true notwithstanding the backlash against managed care. The rhetoric of managed care regulation is always harsher than its substance. Threats to agency fidelity have been widely recognized and in some cases lessened, but never removed. For example, preauthorization requirements that lead to denial of physician-recommended care as not medically necessary are now subject to independent review in nearly all states.[156] Insurer use of physician financial incentives must be disclosed

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[152] *Ambroze,* 1996 U.S. Dist. LEXIS 7274, at *30. The court observed: "The existence of regulatory supervision over the managed care industry, as well as the recent flurry of legislative efforts to control HMOs, persuade this Court that judicial restraint in this highly charged area of law and policy is the best recourse." *Id.* at *30–*31 (citations omitted).

[153] Ambroze v. Aetna Health Plans, 1997 U.S. App. LEXIS 1048.

[154] *See* N.Y. PUB. HEALTH LAWS § 4406-d(2)(A) ("A health care plan shall not terminate a contract with a health care professional unless the health care plan provides to the health care professional a written explanation of the reasons for the proposed contract termination and an opportunity for a review or hearing.").

[155] The cover letter accompanying the changes stated that a physician contract would not be terminated solely because a provider advocated on behalf of a patient, filed a complaint against the company or appealed a decision of the company. *Finkelstein,* 1997 U.S. Dist. LEXIS 10759, at *7. As an alternative basis for its decision, the district court determined that the antitrust issues were moot in light of the new statute. *Id.* at *9–*10.

[156] *See* KAREN POLLITZ ET AL., ASSESSING STATE EXTERNAL REVIEW PROGRAMS AND THE EFFECTS OF PENDING FEDERAL PATIENTS' RIGHTS LEGISLATION (May 2002) (report to the

in many instances and may not exceed certain limits in a handful of states.[157] Physicians sometimes enjoy "due process" protection against arbitrary termination from insurer networks.[158] However, efforts to define a fiduciary obligation running from health insurers through physicians to subscriber-patients have not borne fruit.[159]

Market trends are more significant, and perhaps more reassuring, than these regulatory interventions. Tightly controlled managed care organizations with highly restrictive panels of participating physicians or burdensome preauthorization requirements did not prove attractive to consumers. Renewed, rapid growth in health care expenditures, despite aggressive price discounting and other care management, has triggered interest among private employers in shifting more of the cost and responsibility to employees.[160] Rather than the consolidation of health insurance into a handful of integrated, national, "brand-name" organizations, as was widely foreseen in the 1990s, the health insurance market is apparently remaining relatively diverse and unconcentrated.[161] These changes may not be ideal from a public policy perspective, but they reduce the likelihood of insurer monopsony and moderate its anticompetitive consequences. On the other hand, potential agency failures are burgeoning, and regulation cannot possibly keep up. It therefore is necessary for antitrust courts to make specific, theoretically informed, evidence-driven determinations regarding challenged conduct that take account of regulation but do not automatically defer to it.

Kaiser Family Foundation, *available at* www.kff.org/insurance/externalreviewpart2rev.pdf); RACHEL BEVINS MORGAN, 2003 STATE BY STATE GUIDE TO MANAGED CARE LAW 5-17–5-48 (2003) (compiling state independent review laws).

[157] For a discussion of mandatory disclosure as a potential solution to agency failure in health care, see William M. Sage, *Regulating Through Information: Disclosure Laws and American Health Care*, 99 COLUM. L. REV. 1701, 1743–71 (1999). *See also* Paul G. Mahoney, *Mandatory Disclosure as a Solution to Agency Problems*, 62 U. CHI. L. REV. 1047 (1995) (focusing on securities regulation).

[158] *See, e.g.*, Potvin v. Metropolitan Life Ins. Co., 997 P.2d 1153 (Cal. 2000) (holding that no-cause termination of a physician violated California's right of due process in private associations affecting public interests).

[159] *See* Pegram v. Herdrich, 530 U.S. 211 (2000) (holding that HMO physicians do not undertake fiduciary duties under ERISA when they make mixed eligibility-treatment decisions); William M. Sage, *UR Here: The Supreme Court's Guide for Managed Care*, HEALTH AFF., Sept.–Oct. 2000, at 219, 222–23 (criticizing *Pegram* as a "missed opportunity"). For a detailed discussion of a fiduciary model for oversight of agency issues in managed care, see Peter D. Jacobson, STRANGERS IN THE NIGHT: LAW AND MEDICINE IN THE MANAGED CARE ERA 222–49 (2002).

[160] *See* Gabel, Sasso & Rice, *supra* note 117, at 9.

[161] *See* Cunningham & Sherlock, *supra* note 15.

V. CONCLUSION

Monopsony remains a legitimate concern, even if it is not a threat in every market. In the absence of insurer market power, payer-provider contracting practices are unlikely to present serious antitrust issues. However, economic concentration among private health insurers is sometimes high, raising antitrust questions with implications for both the price and quality of medical treatment.[162] Antitrust law must, therefore, have tools capable of assessing its effects. Unfortunately, courts have not yet met the challenge.

Careful welfare analysis is not a hallmark of *Kartell*'s legacy. By simply deferring to state regulators, Judge Breyer's opinion dodges an important question—the welfare implications of a combined monopsonist-monopolist—that is clearly within the ambit of antitrust law. Breyer does suggest, however, that the degree of antitrust deference should depend upon the antitrust theory at issue and the remedy being sought. He intimates, for example, that antitrust courts might be more receptive to direct challenges to buyer-side market power than to secondary restraints such as the prohibition against balance billing.[163]

How can courts address the economic effects of increasingly complex agency relationships in health care? First, agency failure is a form of market failure and should be judged in that light by antitrust courts. Second, agency failure is likely to be exacerbated, not ameliorated, by the agent's market power. Competition therefore is an important safeguard for maintaining the integrity of agency relationships. Third, agency questions often implicate an array of non-antitrust regulatory protections. Courts should be sensitive to the legal and regulatory framework in which the challenged conduct arises in conducting their antitrust analysis. The *Kartell* decision is insufficiently attentive to many of these concerns.

Constructing a competition policy that strikes the correct balance among private markets, antitrust law, and public regulation along dimensions of cost, quality, and access is not easy. Markets are well suited to

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[162] *See* U.S. GENERAL ACCOUNTING OFFICE, PRIVATE HEALTH INSURANCE: NUMBER AND MARKET SHARE OF CARRIERS IN THE SMALL GROUP HEALTH INSURANCE MARKET (Mar. 25, 2002) (GAO-02-536R). Buyer-side market power is also endemic in public health insurance—Medicare and Medicaid—although there it is subject more to the vagaries of politics than economics.

[163] "Thus, where a monopoly is unlawful, antitrust courts typically seek to change the market's structure . . ." *Kartell VII*, 749 F.2d at 928. "[E]ven if the buyer has monopoly power, an antitrust court (*which might, in appropriate circumstances, restructure the market*) will not interfere with a buyer's (nonpredatory) determination of price." *Id.* at 929 (emphasis added).

minimize costs, because there are direct financial incentives to do so. Antitrust efforts to deal with quality are more complicated. Few direct financial incentives are in place to reward higher quality of care, and the informational infrastructure does not yet exist to enable quality competition to occur through consumer choice. The fact that it is difficult, however, should not excuse antitrust courts from the effort. Certainly, some conduct is better left to state or federal regulation. For example, antitrust law is not equipped to micro-manage every agency issue, such as the overall contracting practices of managed care or the fiduciary duties governing the physician-patient relationship. More generally, neither markets nor antitrust law is necessarily capable of promoting access to health insurance.[164] Without effective adjustment of paid premiums to reflect underlying health risk, for example, competition in insurance markets can make gaining access to heath care harder, not easier.[165] In other cases, however, antitrust judges need to be ready to roll up their sleeves and get to work.

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[164] *See, e.g., Butterworth Health Corp.*, 946 F. Supp. at 1285 (discrediting testimony by managed care companies because they represent only paying patients, not the community at large)

[165] *See* Joseph P. Newhouse et al., *Risk Adjustment and Medicare: Taking a Closer Look*, HEALTH AFF., Sept.–Oct. 1997, at 26.