Note

Preferred Provider Organizations and Provider Contracting: New Analyses Under the Sherman Act

Concerned with escalating health care costs,\(^1\) government, business, and consumer groups have begun to demand reform. Consequently, there have been unprecedented modifications in health care insurance and reimbursement methods,\(^2\) as well as regional experiments in health care financing, regulation, and alternative delivery systems. Although dissimilar in many respects, the resulting "cost-containment" programs commonly eschew traditional fee-for-service pricing structures\(^3\) in favor of some method of large-scale discounting. These programs emphasize increased use of competitive market principles.\(^4\)

One form of reimbursement system, the Preferred Provider Organization ("PPO"), has experienced particularly rapid growth in response to cost-containment demands. A PPO is a direct, prepaid health care purchasing arrangement between a particular employer or insurer and a health care provider.\(^5\) A typical PPO is characterized by a contract between a third-party payor and a provider to provide health care services...

---

1. From 1965 to 1981, health expenditures grew from 6% to 9.8% of the gross national product, and per capita expenditures exploded from $211 to $1225 per year, a 480% increase over 16 years. Gibson & Waldo, National Health Expenditures, 1981, 4 HEALTH CARE FINANCING REV. 1, 19-20 (1982). Although there are some basic and unchangeable factors that have fueled this increase, such as aging of the population, new medical technology, and the generally increasing cost of resources, at least one commentator suggests that the principal reason for the excessive rise is the increasing over-elaboration of medical practice styles. See McClure, The Competition Strategy for Medical Care, 468 ANNALS 30, 35 (1983).


3. A fee-for-service system is the typical form of pricing and selling in most personal service industries today. In the medical field, an independent practitioner determines what service (treatment) is necessary, provides that service, and sets an independently determined price. Fee-for-service practice provides the physician with the greatest degree of autonomy and with ultimate control over output and prices and is linked to higher costs for medicine. See id. at 26. Fee-for-service payment contrasts both with the capitative approach, by which a physician receives a flat sum per patient per year, see id. at 247, and the prepaid approach, which is the subject of this Note.


5. Negative Prognosis, BARRON'S, Aug. 19, 1985, at 28. For a more detailed explanation of PPOs in the marketplace, see infra text accompanying notes 22-29.
to the policyholders at a predetermined discounted price. The key feature of the PPO is provider reimbursement through prospective payments, payments determined and fixed by contract in advance of actual treatment. PPOs have been labelled as the trend of the future in health care delivery systems.

One implication of the PPO is that the traditional relationship among patients, physicians, and insurance companies as third-party payors has been altered—often radically, and possibly illegally. Furthermore, if, as some health planners contend, we are witnessing the birth of a newly organized $450 billion health care industry, its arrival is accompanied by substantial litigation and intense antitrust scrutiny.

Individual practitioners have opposed contractually fixed fees and have responded to the increase in PPOs by initiating a spate of litigation in opposition. The individual providers have alleged that the fixed fees restrain trade and competition for health care services in violation of the Sherman Act ("Act"). While courts have established fairly clearly when a fixed-fee arrangement constitutes a restraint of trade in violation of section 1 of the Act, courts have not conclusively determined whether a PPO fixed-fee arrangement may constitute a monopoly in violation of section 2 of the Act.

This Note examines whether the fixed-fee component of the PPO violates the Act, and under what circumstances such a violation would be likely to occur. The Note begins by describing the relationship between health care providers and third-party payors in a PPO arrangement. More specifically, it focuses on fee arrangements between physicians and Blue Shield, a powerful third-party payor leading the

---

6. In the context of this Note, "provider" refers to any individual practitioner rendering service, such as a physician, dentist, or podiatrist.
9. See generally The Upheaval in Health Care, BUS. WK., July 25, 1983, at 44.
11. See Comment, supra note 7, at 141-42.
13. Id. § 1.
14. Id. § 2.
15. Blue Cross and Blue Shield are private health insurers offering hospital and medical service plans. The Blue Cross and Blue Shield Association coordinates the Blue Cross and Blue Shield plans of the nation, although each plan operates independently and is regulated by its state insurance association. HEALTH INSURANCE ASSOCIATION OF AMERICA, supra note 10, at 6-25. The nonprofit member plans service statewide and other geographical areas, offering both individual and group coverage. Blue Cross plans provide hospital care benefits on
PPO movement.

The Note then reviews sections 1 and 2 of the Act, federal antitrust law crucial to the evaluation of these fee arrangements. As part of this discussion, the Note highlights the existing dichotomy in antitrust ideology between the traditional distributive goals and the newer efficiency-oriented goals.

The Note next discusses several early, foundational cases and examines the current litigation under sections 1 and 2 over fixed-fee arrangements. The Note determines that, under section 1 analysis, an accurate characterization of the insurer's role, as a third party to the provider-patient relationship, establishes the necessary components to evaluate the fee arrangements under a resale price maintenance model. With respect to section 2 claims against PPOs, the Note argues that the courts in these cases failed to consider a key element in antitrust analysis: the insurer's market share. When an insurer has monopoly power in the market for health care insurance, the fixed-fee arrangement imposed by the insurer violates section 2 of the Act if, through vertical integration, the insurer uses its monopoly power in such a manner so as to cause anticompetitive effects in the secondary market of physicians’ services. The Note demonstrates that, when an insurer is a monopolist in the market for health insurance, the fixed-fee component of the PPO does in fact violate section 2 of the Act, regardless of whether a court follows a distributive or efficiency-oriented antitrust policy.

**PPOs in the Marketplace**

Generally, there are three types of PPOs. First, the provider-based PPO is organized by a hospital or physician who develops and markets a network of services to payors of health care services. The second type of PPO, the purchaser-based PPO, is organized by a third-party payor for health care services who recruits the participation of a sufficient number of hospitals and physician offices.

In 1982 there were 68 Blue Cross plans and 69 Blue Shield plans in the United States, some of which were joint plans, making a total of 103 Blue Cross and Blue Shield plans. *Id.* at 14-17. These plans covered approximately 40% of the national market for private medical insurance. *Id.* at 14-17. This included hospital protection, surgical expense protection, physicians’ expense protection, and major medical expense protection. *Id.* Blue Cross, Blue Shield, and other plans paid approximately 65% of the total $65 billion in private medical expense benefit payments during that same time. *Id.* at 22. See generally Kallstrom, *Health Care Cost Control by Third-Party Payors: Fee Schedules and the Sherman Act*, 1978 DUKE L.J. 645, 649-50 (1978).

16. See infra notes 177-79 & accompanying text.

number and types of hospitals and professionals to satisfy the anticipated patient load that the payor will provide. The third type of PPO is entrepreneur-based: an individual or business entity who is not a provider of health care services organizes health care providers to render services at a reduced cost. The PPO is then marketed to large buyers of health care services, such as self-insured employers or insurance companies. Some PPOs include only primary care physicians, while others have a comprehensive geographic and specialty network of doctors, hospitals, pharmacies, and diagnostic facilities. Most PPOs reimburse physicians at ten to twenty percent below "usual and customary" charges.

In 1983, Blue Shield established its first PPO. In this purchaser-based program and those that have followed, Blue Shield determines in advance a reasonable price for each service to be performed by a physician. Blue Shield then contracts with each individual preferred provider physician to accept those fixed fees as payment in full for his services. Under Blue Shield's preferred provider plans, a preferred provider is prohibited from engaging in any balance billing to the patients, and any co-payment received from the patient, as required for certain services, is deducted from the contract-specified fee.

A nonparticipating physician, one who chooses not to enter a contractual relationship with Blue Shield, is not barred from treating Blue Shield's insureds. There are, however, disincentives for the insured to obtain care from a nonparticipating physician. First, services from a nonparticipating physician could cost the patient significantly more. For example, Blue Shield may pay up to one hundred percent of the

18. Id.
19. Id.
21. Id.; accord Katz, Preferred Provider Organizations: New Relation of the HMO, Postgraduate Med., June 1983, at 143; Zannoth, PPO: 'Newest Kid on the Block' in Health Care Delivery Systems, 81 Mich. Med. 627 (1982). Historically, the insurance industry reimbursed physicians on a cost basis for their "usual, customary, or reasonable" fees, which were felt to reflect the prevailing community price. Ratino v. Medical Serv., 718 F.2d 1260, 1264 (4th Cir. 1983). A "usual" fee is one a physician himself would charge for a given service. "Customary" is that range of usual fees charged by physicians of similar training and experience for the same service. Id.; see P. Starr, supra note 2, at 385.
22. See American Association of Preferred Provider Organizations, Directory of Preferred Provider Organizations (1985). In January 1985, Blue Cross and Blue Shield together had 11 plans of this sort in the United States operating in nine states. See id. at 1 passim.
24. See infra notes 144-47 & accompanying text.
insured's bill for services from a participating provider, while Blue Shield usually pays only fifty to eighty percent of the insured's bill for services from a nonparticipating provider.27 Furthermore, when a patient is treated by a nonparticipating provider, the patient must pay the physician directly and then seek reimbursement from Blue Shield for the allowable percentage.28 Conversely, if a patient receives treatment from a participating provider, the physician is reimbursed directly by Blue Shield for most transactions,29 thereby removing the patient from the payment process.

Relevant Antitrust Concepts

The Sherman Act and its Bifurcated Focus

The Sherman Act is the core of antitrust analysis.30 Section 1 of the Act provides in pertinent part that “every contract, combination ... or conspiracy, in restraint of trade ... is ... illegal.”31 Section 2 provides that “[e]very person who shall monopolize ... any part of the trade or commerce among the several States ... shall be deemed guilty ... .”32 The policy underlying the Act is the promotion of competition.33 Two doctrines are used to determine whether a certain business practice constitutes a section 1 or section 2 violation: the per se rule and the rule of reason.34 Most section 2 claims are evaluated under the rule of reason.35

Under the per se rule, no “elaborate study of the industry” is needed to establish a violation of the Act; certain practices, the nature and necessary effect of which “are so plainly anticompetitive that no elaborate study of the industry is needed to establish their illegality,” are “illegal per se.”36 The per se rule applies when the court has “experience with a particular kind of restraint [or monopoly]” and is therefore able “to ... conclusive[ly] presum[e] that the restraint [or monopoly] is unreasonable.”37

28. Blue Cross of California, supra note 26, at i; see Ratino v. Medical Serv., 718 F.2d 1260, 1264 (4th Cir. 1983).
31. Id. § 1.
32. Id. § 2.
34. See generally Bork, The Rule of Reason and the Per Se Concept: Price Fixing and Market Division, 74 YALE L.J. 775 (1965).
37. Id. at 692; see Arizona v. Maricopa Medical Soc’y, 457 U.S. 332, 344 (1982). Historically, the per se rule has applied to only a limited number of practices: price fixing; horizontal, territorial, or customer division; concerted refusal to deal; RPM; and some tying arrangements. H. Hovenkamp, supra note 35, at 126.
The rule of reason standard differs from the per se rule with respect to the level of examination required. The rule of reason standard sets forth the factors a court may consider when a business practice is not plainly anticompetitive and that court lacks sufficient information to determine whether that practice constitutes a restraint or a monopoly. Under this standard, a court evaluates the competitive effects of a business practice by analyzing the facts peculiar to the industry in which the practice occurred, the history of the restraint, and any benefits unique to the arrangement that might outweigh any negative impact on competition. Thus, when the court lacks sufficient experience with a business practice or restraint, the rule of reason analysis guides the court in determining a practice's or restraint's competitive significance.  

The scope of a court's evaluation of an activity's effect on competition under the rule of reason analysis depends upon that court's antitrust ideology. Modern antitrust jurisprudents generally are divided into two groups: the "Chicago School" jurisprudents, who espouse allocative efficiency as the foremost and overriding goal; and those who look to the history of the antitrust laws and demand consideration of nonefficiency values or distributive goals.  

The Chicago School's position has dominated antitrust analysis in the past decade. Allocative efficiency focuses on maximizing consumer welfare and is measured by the economic indicators of output and price. An efficient business practice increases output or decreases price, thereby promoting consumer welfare. Because consumer welfare is increased, the practice is viewed as procompetitive and thus legal. On the other hand, if a practice decreases output or increases price, the goal of maximizing consumer welfare is defeated and the practice is viewed as anticompetitive.  

Traditional antitrust ideology espouses distributive goals such as

38. See H. Hovenkamp, supra note 35, at 126.  
42. See H. Hovenkamp, supra note 35, at 49.
power dispersion, economic opportunity, and free market competition.\textsuperscript{43} The recurrent theme is the protection of the interests of entrepreneurs and small businesses.\textsuperscript{44} The goals that further these interests are termed distributive because their implementation redistributes wealth within society.\textsuperscript{45} Measuring the achievement of these goals, however, does not lend itself to economic definition; rather, measurement is through the subjective interpretations of "restraint of trade"\textsuperscript{46} and "monopoly."\textsuperscript{47}

### How the Fee Arrangements May Violate the Sherman Act

The fixed-fee component of a PPO may violate the antitrust laws in three ways. First, the method of determining a PPO's reimbursement rates may constitute a horizontal restraint of trade in violation of section 1 of the Sherman Act. A horizontal restraint of trade results when two or more competitors enter an agreement that has an anticompetitive effect.\textsuperscript{48} If the reimbursement rates are determined by an agreement between two or more competing providers or insurers, this agreement would be a classic horizontal restraint of trade. This horizontal restraint of trade would constitute a violation of section 1 of the Act if the insurer's fee-setting board were controlled by service providers, or if either overt or tacit collusion could be shown between the insurer and service providers in determining the fees.\textsuperscript{49}

Second, the fixed-fee agreements themselves may constitute resale price maintenance ("RPM"), a type of vertical restraint of trade that violates section 1 of the Act.\textsuperscript{50} RPM is defined as manufacturer or supplier regulation of the price at which a product is resold by an independent retailer.\textsuperscript{51} It traditionally occurs when a manufacturer sets either the minimum or maximum price at which a distributor or retailer may resell its product and is illegal per se.\textsuperscript{52} With respect to PPOs, the insurer and

\textsuperscript{43} Id. at 40-44.
\textsuperscript{44} See Fox, supra note 40, at 1167 ("Antitrust law historically has valued freedom and autonomy of firms without market power."). The maxim that the antitrust laws protect "competition not competitors" should be amended by adding "unless individual competitors must be protected in the interests of preserving competition." Schwartz, supra note 40, at 1078.
\textsuperscript{45} While all antitrust policies are concerned with the distribution of wealth, implicit within "distributive policies" is the recognition that there is an alternative policy that is more efficient. Distributive policies distribute wealth in a way we find subjectively more attractive. Hovenkamp, supra note 40, at 2-3.
\textsuperscript{47} Id. § 2.
\textsuperscript{48} See United States v. Addyston Pipe & Steel Co., 175 U.S. 211 (1899).
\textsuperscript{49} See Arizona v. Maricopa Medical Soc'y, 457 U.S. 332, 335-36 (1982) (An agreement among competing physicians setting maximum fees that may be claimed in full payment for policyholders is illegal price fixing.); Kallstrom, supra note 15, at 679; infra notes 79-106 & accompanying text.
\textsuperscript{50} See H. HOVENKAMP, supra note 35, at 247.
\textsuperscript{51} Id.
\textsuperscript{52} Dr. Miles Medical Co. v. John D. Park & Sons Co., 220 U.S. 371 (1910); see Albrecht
the service providers also may stand in a vertical relationship to one another. If the patient-insured occupies a third vertical slot, and the insurer-provider contracts are interpreted to set the price that providers could charge their patients, the PPO would be a per se violation of section 1 of the Act.53

Third, a PPO could violate section 2 of the Act. A section 2 violation occurs if a monopolist in one market abuses its monopoly power by vertically integrating into a secondary market, creating anticompetitive effects in that secondary market.54 With respect to PPOs, two relevant product markets55 are involved: the market for health insurance itself in which the insurer sells its coverage, and the market for provider services in which physicians sell their services to fee-for-service patients. This latter market is a secondary market. The insurer affects this secondary market because every fee-for-service patient is a potential insured. A consumer can receive the same service from a physician whether he pays a fee to the physician or a premium to the insurer. Each patient who decides to pay the premium rather than the fee diminishes the pool of consumers in the market for physicians’ services and increases the pool of clients for which the insurer must acquire physician services. Therefore, an insurer who has dominant market power in the sale of health insurance also will have dominant market power in the purchase of physicians’ services because it must acquire services from the physicians’ market to meet the needs of its insureds. Thus, a PPO could violate section 2 if the insurer has dominant market power56 in a particular geographic market57 and abuses this power.58


53. See infra notes 75-90 & accompanying text.

54. See H. HOVENKAMP, supra note 35, at 146.

55. "A relevant [product] market is the smallest market for which the elasticity of demand and supply are sufficiently low so that a firm with 100% of that market could profitably reduce its output and increase its price substantially." H. HOVENKAMP, supra note 35, at 59. In other words, if a price increase or volume decrease would cause consumers promptly to substitute a different product, the market would not be wide enough in defined product terms. See L. SULLIVAN, supra note 40, at 41. The courts consistently have held that the relevant product market includes all products that are either identical to or available substitutes for the defendant's product. 16 J. VON KALINOWSKI, ANTITRUST LAWS AND TRADE REGULATION § 6.02[4] (1985 & Supp. June). "Determination of a relevant product market and a relevant geographic market both address the same question: is there a grouping of sales in which the defendant has market power?" H. HOVENKAMP, supra note 35, at 70 n.1.

56. To determine market power, the court determines a relevant product market, determines a relevant geographic market, and computes the defendant's percentage of output in the relevant market thus defined. H. HOVENKAMP, supra note 35, at 59.

57. The relevant geographic market is the area in which a firm can increase its price without large numbers of its customers turning to alternative supply sources and without other producers flooding the market with substitute products. Id. at 70-73; see United States v. Grinnell Corp., 384 U.S. 563, 575-76 (1966).
Anticompetitive effects in a secondary market in violation of section 2 also may be caused by monopsony power, dominant purchasing power within a relevant product market. Monopsony power, like monopoly power, generally is presumed by the courts to be inherently dangerous to competition and the public welfare. Thus, an insurer who exerts monopsony power in the market for physicians' services likely will cause anticompetitive effects within that market.

Prospective Payment Systems: Section 1 Challenges

The Foundation Cases

*Horizontal: A Review of Maricopa* and its Continuing Role

The only United States Supreme Court case dealing directly with physicians' maximum fee schedules as a means of health care cost containment is *Arizona v. Maricopa Medical Society*. Maricopa involved a fee-for-service plan administered by a nonprofit medical foundation. The foundation was composed of approximately seventy percent of the licensed physicians engaged in private practice in Maricopa County, Arizona. It was organized for the purposes of promoting fee-for-service medicine and providing a competitive alternative to existing health insurance plans in the community.

Under the foundation's plan, a subscriber was guaranteed complete coverage for the full amount of his medical bills if he was treated by a participating physician. Participating physicians agreed to accept scheduled amounts as payments in full for their services to subscribers. The physicians were free to charge less than the scheduled amount and were unrestricted completely as to nonpolicy holders. The medical foundation itself established and periodically revised the maximum fee schedule through a vote of the entire foundation membership. A subscriber was free to employ nonparticipating physicians, but was covered only for charges that did not exceed the maximum fee schedule.

The issue before the *Maricopa* Court was whether the doctors' concerted participation in the fee-setting mechanism should be declared ille-

---

63. *Id.*
64. *Id.* at 339.
65. *Id.* at 341.
gal per se or evaluated under the rule of reason. The Court held that such agreements were subject to a per se standard even though they fixed maximum rather than minimum prices. Thus, in contrast to the rule of reason analysis, the Court precluded any inquiry into the actual effects of the fee-setting mechanism on consumers.

The Court also rejected the physicians' argument that the procompetitive effects of such an arrangement outweighed its anticompetitive effects, reasoning that the "anti-competitive potential inherent in all price-fixing agreements justifie[d] their facial invalidation even if procompetitive justifications [were] offered." The Court stated that a price restraint of this sort "tends to provide the same economic rewards to all practitioners regardless of their skill, their experience, their training, or their willingness to employ innovative and difficult procedures in individual cases. Such a restraint [could] also . . . discourage entry into the market and . . . deter experimentation and new developments by individual entrepreneurs."

The Court also noted that foundations, as physician cartels, had monopoly potential in the market for medical services. It recognized that with this power, the foundations could interfere with the market for health care insurance, the secondary market in this situation, by dictating terms to all insurers within the relevant geographic market. The ability of a physician foundation to dictate prices to competing health insurers by virtue of its monopoly in the medical services’ market would reduce drastically price competition within the health care insurance

---

66. Id. at 348-50.
67. Id. at 351.
68. Id. at 348. Maricopa dealt exclusively with a horizontal fee-fixing arrangement. Arguably, however, the potential anticompetitive effects of any arrangement fixing maximum fees would be equally onerous. In this light, the Court expressly reserved the question of whether an insurer-initiated system of fee fixing would stand up to antitrust attack. Id. at 352-53 n.26; see also Easterbrook, supra note 61, at 898 (fee schedules promulgated by insurers less likely to clear the market). Because the Blue Shield system in theory does not contain any agreement between competitors and thus no element of horizontal price control, the legality of a system in which the insurer imposes the maximum fees is recognized in dicta. Maricopa, 457 U.S. at 352 n.25. But see Blue Shield v. McCready, 457 U.S. 465, 469 n.4 (1982) ("Blue Shield Plans are combinations of physicians, operating under the direction and control of their physician members." (quoting Virginia Academy of Clinical Psychologists v. Blue Shield, 624 F.2d 476 (4th Cir. 1980)); Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205, 232 n.40 (1979) (Supreme Court noting that "[r]ecent studies have concluded that physicians and other health-care providers typically dominate the boards . . . of Blue Shield plans); Kallstrom, supra note 15, at 682-83; Rankin & Wilson, Sausalito Pharmacy and the Antitrust Consequences of Insurer-Imposed Maximum Limitations on Fees, 26 ST. Louis U.L.J. 601, 608 (1982) (FTC suggested flatly prohibiting physicians from serving on insurers' boards). It also should be noted that the Court's neutral approach toward the legality of an insurer-imposed plan was in the context of rebutting respondents' contention that only physicians could successfully implement maximum fee schedules. Maricopa, 457 U.S. at 353 n.26.
69. Maricopa, 457 U.S. at 354 n.29.
70. Id. at 354.
market. Although the Court did not speculate on this scenario's impact on consumers, it recognized such secondary market behavior as a potentially undesirable consequence of the physician-imposed maximum fees.\(^7\)

The Court's suggestion that interference in a secondary market by a monopolist is objectionable should not be limited to interference caused by a physician cartel. For instance, if the monopolist was an insurer with the ability to dictate monopolistic prices to competing physicians, the result would again be interference in a secondary market—this time in the market for physicians' services. Although the players have reversed roles in this example, the similarities are striking: in both cases, the two relevant product markets are health insurance and medical services; the two groups of competitors involved are insurers and physicians; and the instrument facilitating the market interference is maximum reimbursement rates. Had the Court been confronted with this situation, it probably would have concluded that the same undesirable potential for interference in a secondary market existed.

*Maricopa* has continued to be relevant in current antitrust actions brought against PPOs for two reasons. First, *Maricopa* is the only Supreme Court case involving a similar subject matter—a fixed-fee reimbursement system for physicians. Second, because of its substantive similarity, physicians attacking PPOs as anticompetitive have relied on *Maricopa*'s per se condemnation of the fixed fees and, consequently, have not alleged any anticompetitive effects resulting from such arrangements. As a result, the courts have not examined the alleged impact of the agreements on competition.\(^7\)

This omission in pleading, however, is understandable in light of the fact that the contractually set fees in *Maricopa*, conclusively presumed to be anticompetitive, are structurally identical to the contractually set fees in PPOs today.\(^7\) Because the fee mechanisms themselves are operatively identical, any anticompetitive effects flowing from them arguably should be identical as well. If no allegation of the specific anticompetitive effects was necessary in *Maricopa*, neither should it be necessary for PPOs.

This line of reasoning, however, fails to account for an important difference between the fixed-fee arrangement in *Maricopa* and today's PPOs: the nature of the fee-setting mechanism. In *Maricopa*, the physician's fees were fixed by physicians. This was horizontal price fixing and thus per se illegal.\(^7\) In contrast, physicians' fees in PPOs are set by in-

\(^7\) Id.

\(^7\) See H. HOVENKAMP, supra note 35, at 124-34.

\(^7\) Both arrangements fix the maximum fee that a physician can receive for performing a particular procedure; both guarantee a subscriber a set rate; although both allow subscribers to select nonparticipating providers, both have built-in disincentives for subscribers to do so; and both allow for periodic reevaluation of the level of the set fees by the group imposing the set fees. The only significant difference lies in who imposes the fees.

\(^7\) *Maricopa*, 457 U.S. at 347-48.
surers, not physicians, a practice that the Maricopa Court did not declare per se illegal. Therefore, an antitrust attack against today's PPOs should be pursued under the rule of reason doctrine rather than the per se rule.

In addition to Maricopa, one group of cases has had a significant impact on the current controversy over fixed fees. The pharmacy cases have defined and established the relationship between the insurer and providers and, therefore, merit brief consideration.

Vertical: The Pharmacy Cases

The seminal pharmacy case is Group Life & Health Insurance Co. v. Royal Drug Co., which involved an allegation of a per se violation of section 1 of the Act for resale price maintenance. As stated earlier, RPM is defined as manufacturer or supplier regulation of the price at which a product is resold by independent retailers. Because it describes a relationship between a supplier and a buyer, rather than between direct competitors, RPM is a vertical restraint.

In Royal Drug, Blue Shield's policies entitled each policyholder to obtain any prescription from a participating pharmacy for a fixed price of two dollars. Blue Shield then reimbursed each participating pharmacy its cost, resulting in a two-dollar fixed profit per sale. A policyholder who selected a nonparticipating pharmacy would be required to pay the full price and then obtain reimbursement from Blue Shield. Blue Shield would reimburse the subscriber seventy-five percent of the difference between the price paid and two dollars. Thus, subscribers patronizing nonparticipating pharmacies would pay an additional twenty-five percent and bear the burden of paying up front and then seeking reimbursement.

A group of independent pharmacists brought suit against Blue Shield, claiming that Blue Shield's capped prescription rates constituted RPM in violation of section 1 of the Act. Blue Shield argued that these pharmacy agreements were part of the "business of insurance" and, therefore, exempt from antitrust scrutiny. The district court ruled in favor of Blue Shield and held that the challenged pharmacy agreements

76. See supra notes 50-53 & accompanying text.
77. Albrecht v. Herald Co, 390 U.S. 145 (1968) (maximum RPM also illegal per se); Kiefer-Stewart Co. v. Joseph E. Seagram & Sons, 340 U.S. 211 (1951); Dr. Miles Medical Co. v. John D. Park & Sons Co., 220 U.S. 373 (1911); H. Hovenkamp, supra note 35, at 247; see supra text accompanying notes 50-53. The classic RPM model would exist in the context of the pharmacy cases, if Blue Shield were held to be occupying the role of the supplier who regulates the price the independent pharmacies may charge to consumers.
78. The pharmacy's cost was the price the pharmacy actually paid to acquire the drug from the distributor, and did not include overhead or other retail transaction costs. Royal Drug, 440 U.S. at 209.
79. Id.
fell within the "business of insurance" exception to the antitrust laws. The Fifth Circuit affirmed the district court's decision, and the pharmacists sought certiorari before the United States Supreme Court.

The Supreme Court held that the challenged pharmacy agreements were not part of the "business of insurance" and, therefore, were subject to antitrust scrutiny. Thus, the Court remanded the case to the district court for a trial on the merits of the price-fixing allegations. In dicta, the Court characterized the pharmacy agreements as "merely arrangements for the purchase of goods and services by Blue Shield." This language indicates that the requisite resale component for RPM is lacking in fixed-fee schedules and has been relied on by lower courts in analyzing Blue Shield's relationship with pharmacies as well as with providers in the fee schedule cases.

Before the district court decided on remand the price-fixing claim in Royal Drug, the court in Medical Arts Pharmacy v. Blue Cross & Blue Shield relied upon the Supreme Court's language in Royal Drug to determine whether the same capped prescription rate agreements at issue in Royal Drug violated section 1 of the Act.

The court in Medical Arts found that Blue Shield's pharmacy agreements fundamentally differed from RPM agreements in that the pharmacy agreements did not involve the resale of any product. The only price established by the pharmacy agreement was the price that Blue Cross paid participating pharmacies for prescribed drugs. The consumer was but an incidental party to the transaction: a third-party beneficiary to a contract between Blue Cross and the pharmacy. "The price-fixing within the scope of the per se prohibition of section 1 . . . is an agreement to fix the price to be charged in transactions with third parties, [and] not between the contracting parties themselves." In Medical Arts, there was a third-party beneficiary, but no third party to the contract.

After Medical Arts was decided, Royal Drug's price-fixing claim was

81. Royal Drug, 440 U.S. at 207-08.
82. Id. at 208.
83. Id. at 210-17. The Supreme Court extensively analyzed this exemption and identified three criteria relevant in determining whether a particular practice is part thereof: first, whether the practice has the effect of risk spreading, id. at 211-15; second, whether the practice is an integral part of the policy relationship between the insurer and the insured, id. at 215-16; and third, whether the practice is limited to entities within the insurance industry, id. at 231. The Court found none of these factors present in the challenged pharmacy agreements.
85. Royal Drug, 440 U.S. at 214.
88. Id. (quoting Sitken Smelting & Ref. Co. v. FMC Corp., 575 F.2d 440, 446 (3d Cir.), cert. denied, 439 U.S. 866 (1978)).
tried and the pharmacy agreements between the physicians and the pharmacies were upheld against a section 1 challenge. The Fifth Circuit affirmed the district court's holding, echoing the Medical Arts court by stating that "absent any evidence of the presence and abuse of monopoly power, Blue Shield has the clear right to bargain for the lowest prices and best deal for itself and its customers/insureds."

Thus, the pharmacy cases established that the nature of the contractual relationship between an insurer and a pharmacy was a mere purchasing agreement. This characterization definitionally precluded a successful RPM claim because no resale price was imposed vertically.

**The Current Cases**

This section discusses the recent litigation surrounding fixed-fee schedules that has evolved in the shadows of *Maricopa* and the pharmacy cases. Together, *Maricopa* and the pharmacy cases provide a foundational analysis for the major challenges against PPOs. Due in part to poor pleading, and in part to oversimplification of the relationship of the parties in the pharmacy cases, the courts have, for the most part, analyzed fixed-fee schedules only under two familiar components of section 1 of the Act: horizontal price fixing and vertical resale price maintenance.

**Horizontal Restraints of Trade**

Allegations of price fixing through fixed-fee schedules have been most frequently examined under a horizontal model. This could be because, after *Maricopa*, horizontal claims against fixed-fee schedules are subject to the per se standard, which is easier to plead because allegations of anticompetitive effects are not required.

The circuit courts have made it clear that evidence of collusion is required to challenge fixed fees as a horizontal restraint. Collusion

90. Id. at 1438. In this most recent *Royal Drug* ruling, the court suggested that the agreements might have been evaluated differently had there been allegations of the presence or use of monopoly power. Id. at 1439. Although plaintiffs referred to Blue Shield as a "powerful buyer," id. at 1437, to the great number of pharmacy customers covered by the agreements, they failed to assert any statistics on market share, mention a monopsony buyer, or allege misuse of monopoly power in violation of § 2.
91. Arizona v. Maricopa Medical Soc'y, 457 U.S. 332 (1982); see supra notes 63-74 & accompanying text.
92. See supra notes 65-67 & accompanying text.
93. See supra notes 72-74, infra notes 100-14 & accompanying text.
94. See supra text accompanying notes 66-68.
95. Providers typically challenge fixed fees either because their particular medical speciality is under-represented on the insurer's board, and thus does not receive "protected pricing," see St. Bernard Gen. Hosp. v. Hospital Serv. Ass'n, 712 F.2d 978 (5th Cir. 1983), cert. denied,
can be established by either an express agreement between competitors, as in Maricopa, actual or constructive control of the insurer's decision making body by physician competitors, or any demonstrable participation by competitor physicians in determining the fee schedules. For example, if providers possessed veto power within the insurer's decision-making body, they could control that body. In this position, competing providers could argue amongst themselves on fees, membership, and other board policies.

Courts also have been receptive to allegations of novel horizontal control mechanisms to establish collusion. This is exemplified in Ratino v. Medical Service, a potentially important case on remand to the district court of Maryland. In Ratino, a plastic surgeon brought an action against Blue Shield alleging a horizontal price-fixing scheme through which competitor physicians controlled the Blue Shield board. Plaintiff alleged that the physicians controlled the fee schedule in two ways. First, rather than an express agreement to set fees, physicians retained control as a result of the Blue Shield board policies. These policies provided that Blue Shield would not change any of its plan mechanics "without approval of the participating physicians." Second, plaintiff claimed that physicians collectively exerted control over the maximum fee schedule by methodically submitting higher and higher bills to Blue Shield until their fees exceeded the maximum rate, a more indirect horizontal mechanism. By doing this, physicians were guaranteed to receive the maximum fee reimbursement. At the same time, the supracompetitive bills continually escalated the maximum allowable fee

104 S. Ct. 2342 (1984); see also Addino v. Genesee Valley Medical Care Inc., 593 F. Supp. 892 (W.D.N.Y. 1984), or because they have declined to contract with the insurer to become a preferred provider due to dissatisfaction with the reimbursement rates. See Pennsylvania Dental Ass'n v. Medical Serv. Ass'n, 745 F.2d 248 (3d Cir. 1984), cert. denied, 105 S. Ct. 2021 (1985); Glen Eden Hosp. v. Blue Cross & Blue Shield, 740 F.2d 423 (6th Cir. 1984).


97. Ratino v. Medical Serv., 718 F.2d 1260, 1271 (4th Cir. 1983) (If physicians control the fee, the practice is illegal per se); Virginia Academy of Clinical Psychologists v. Blue Shield, 624 F.2d 476, 481 (4th Cir. 1980) (Physician control of Blue Shield Board brings its actions within the purview of § 1 of the Sherman Act.).

98. Ratino v. Medical Serv., 718 F.2d 1260, 1270 (4th Cir. 1983) (program that camouflages an agreement among competing physicians illegal per se).

99. 718 F.2d 1260 (4th Cir. 1983).

100. Id. at 1271.

101. Id.

102. Id.
schedule.\textsuperscript{103}

The Fourth Circuit decided only that the issues raised were "complete[x], novel[l], and important[t]" triable issues of fact for a jury and remanded the case to the district court.\textsuperscript{104} The court noted, however, that, although there was no evidence of an overt agreement among competing physicians to establish maximum fee schedules as in \textit{Maricopa}, the program as described might camouflage such an agreement.\textsuperscript{105} If it did, it would be per se illegal price fixing under \textit{Maricopa}.\textsuperscript{106}

The district court in \textit{Addino v. Genesee Valley Medical Care Inc.}\textsuperscript{107} also was receptive to an allegation of a novel horizontal control mechanism. In \textit{Addino}, providers alleged that physicians controlled the Blue Shield board and had conspired with Blue Shield to lower the reimbursement rates for podiatric procedures.\textsuperscript{108} The plaintiffs provided evidence of physician control of the board as well as a built-in majority of physicians on two critical committees which controlled rates, membership, and board composition.\textsuperscript{109} The court, relying on \textit{Maricopa}\textsuperscript{110} and \textit{United States v. Trenton Potteries},\textsuperscript{111} granted summary judgment to the plaintiffs, holding that the mere power of the physicians to control fees was sufficient to establish collusion.\textsuperscript{112}

Because \textit{Maricopa} provides precedential support and dicta exists in subsequent cases recognizing various types of horizontal control mechanisms,\textsuperscript{113} a claim that fixed fees constitute a horizontal restraint in violation of section 1 is straightforward, and the outcome is fairly predictable.\textsuperscript{114} In contrast to this relatively clear area of antitrust law, confusion surrounds the treatment of vertical claims regarding fixed-fee schedules.

\begin{itemize}
  \item \textsuperscript{103} \textit{Id.}
  \item \textsuperscript{104} \textit{Id.} at 1268.
  \item \textsuperscript{105} \textit{Id.} at 1270.
  \item \textsuperscript{106} \textit{Id.; see United States v. Paramount Pictures, 334 U.S. 131 (1948).}
  \item \textsuperscript{107} \textit{593 F. Supp. 892 (W.D.N.Y. 1984).}
  \item \textsuperscript{108} \textit{Id.} at 894-95.
  \item \textsuperscript{109} \textit{Id.} at 896, 898.
  \item \textsuperscript{110} For a discussion of \textit{Maricopa}, see supra notes 63-74 & accompanying text.
  \item \textsuperscript{111} \textit{273 U.S. 392, 398 (1927) (agreements that create potential power to fix prices illegal per se).}
  \item \textsuperscript{112} \textit{Addino, 593 F. Supp. at 901.}
  \item \textsuperscript{113} \textit{See Pennsylvania Dental Ass'n v. Medical Serv. Ass'n, 745 F.2d 248, 257 (3d Cir. 1984), cert. denied, 105 S. Ct. 2021 (1985); Ratino, 718 F.2d at 1270.}
\end{itemize}
Resale Price Maintenance

Few areas of antitrust law have provoked more controversy than vertical restraints; claims of resale price maintenance are no exception. This confusion is responsible for much of the existing inconsistency among the circuits over the legality of fixed-fee schedules.

To sustain a claim of RPM under traditional analysis, the providers must demonstrate that an insurer, as an outside third party contracting with individual providers, established the prices those providers could charge their patients. That is, the providers must demonstrate that a resale existed, that the resale price was determined by the insurer, and that the resale price was not just announced unilaterally by the insurer.

Adhering to the reasoning of Royal Drug, courts traditionally have held that fixed-fee schedules do not constitute resale price maintenance. These courts viewed the insurer as being in the business of buying services for its clients and fixed-fee schedules as only contracts between the insurer and service providers. Thus, the fixed-fee schedules lacked the necessary resale component of RPM.

The court in Ratino however, appears to have cast doubt on this traditional analysis by broadening the scope of inquiry in determining whether fixed-fee schedules constitute RPM. In addition to a claim of horizontal restraint, the plaintiff in Ratino alleged that the maximum fee schedule established by Blue Shield, coupled with both direct and

116. See supra text accompanying notes 50-53.
117. A legally vital defense to a charge of resale price maintenance is available under the Colgate doctrine. United States v. Colgate & Co., 250 U.S. 300 (1919). The doctrine recognizes the long-standing right of a private trader unilaterally to announce in advance the circumstances under which he will refuse to deal. Because the Colgate exception covers only a unilateral announcement of terms by the trader, it would not be available to an insurer who contractually binds the providers to its terms. See Medical Arts Pharmacy v. Blue Cross & Blue Shield, 518 F. Supp. 1100, 1105 (D. Conn. 1981), aff'd, 675 F.2d 502 (2d Cir. 1982) (court rejects defendant's argument that pharmacy agreements are unilateral).
119. See supra notes 75-90 & accompanying text.
120. See, e.g., Webster County Memorial Hosp. v. United Mine Workers, 536 F.2d 419 (D.C. Cir. 1976) (hospital agrees to set maximum rate in exchange for direct payment); Feldman v. Health Care Serv. Corp., 562 F. Supp. 941 (N.D. Ill. 1982) (cap on balance billing by participating pharmacies); Blue Cross & Blue Shield v. Michigan Ass'n of Psychotherapy Clinics, 1980-2 Trade Cas. (CCH) ¶ 63,351 (E.D. Mich. 1980) (Clinics could not charge higher rates to Blue Cross members than to nonmembers); see also P. Areeda, Antitrust Analysis 530 (3d ed. 1981) ("It is difficult to see what could make [such an] agreement anticompetitive.").
121. Ratino v. Medical Serv., 718 F.2d 1260 (4th Cir. 1983).
122. See supra text accompanying notes 87-93.
indirect coercion, resulted in RPM. Plaintiff specifically alleged that the peer utilization review committees, which acted as policing mechanisms, and Blue Shield's unlawful use of its monopoly power directly coerced physicians into conformity with the set fees. Plaintiff also alleged that several characteristics of the Blue Shield plan amounted to indirect coercion. By paying the bills of participating physicians directly, but requiring each insured seeking services from a nonparticipating provider to pay the physician in full and then seek reimbursement from Blue Shield, the subscriber seeing a nonparticipating doctor bore a much greater burden. In addition, since Blue Shield's format covered "reasonable" fees, the nonreimbursable amount was impliedly unreasona-

Finally, Blue Shield encouraged clients employing nonparticipating physicians to obtain future services from participating physicians unless the nonparticipating physician lowered his fee.

As previously stated, the Ratino court decided only that the issues raised were triable issues of fact for the jury. Thus, the court did not directly discuss whether RPM was established. In remanding to the district court, however, it gave two important instructions.

First, the court stated that, because of the court's "limited experience with these types of arrangements," if no per se violation was found, the district court should proceed to analyze the facts under the rule of reason. Second, the court noted that Blue Shield's alleged monopolistic position was a factor to consider when analyzing the competitive effects of the fee arrangements.

The court's instruction to engage in a rule of reason analysis if necessary could apply to plaintiff's claim of RPM. A rule of reason analysis is used when the restraint or industry in which the restraint occurs is novel and permits consideration of anticompetitive effects of the alleged restraint. In Ratino, the parties involved in the fee agreements created a

---

123. The Ratino court fails to denote the horizontal or vertical nature of plaintiff's claims. It is clear, however, that reference to "provider agreements" refers to the contracts running between Blue Shield and the providers that impose the maximum fees. Ratino, 718 F.2d at 1262. Therefore, plaintiff's claim that the agreements standing alone constitute price fixing is a vertical claim of RPM.

124. Id. at 1271.

125. Id. at 1262 n.5.

126. Id. at 1264.

127. Id.

128. Id. at 1265.

129. See supra note 104 & accompanying text.

130. Ratino, 718 F.2d at 1272. Although the court fails to denote this specifically as RPM, it does cite two well-known RPM cases in support of its conclusion that "inexperience with these types of agreements" makes a rule of reason analysis appropriate. Id. (emphasis added) (citing Royal Drug, 440 U.S. 205; Medical Arts Pharmacy v. Blue Cross & Blue Shield, 518 F. Supp. 1100 (D. Conn. 1980)).

131. Ratino, 718 F.2d at 1272.
novel restraint because they did not neatly fit the supplier-retailer-consumer model, yet there was an obvious limitation on price. Thus, the Ratino court’s instruction could be construed as permitting a rule of reason analysis for RPM claims. The court’s acknowledgement of the potential impact on competition by an insurer with dominant market share also was insightful. By recognizing that factors external to the parties’ agreement may determine the legality of the agreement under the Act, the court greatly broadened the scope of inquiry for fee schedule cases.

Although somewhat factually dissimilar, the Third Circuit in Pennsylvania Dental Association v. Medical Service Association supported the Ratino court’s departure from traditional analysis. In Pennsylvania Dental, the court evaluated claims of a vertical restraint of trade resulting from insurer-provider agreements much like those in Ratino.

The Third Circuit reasoned that the insured was a purchaser of services and that Blue Shield was actually an indemnitor. Because the patient-insured “purchased,” the court concluded that a resale existed. Additionally, the court found that the necessary elements for a claim of RPM were alleged because the providers also specifically claimed that they had been coerced economically into accepting the reimbursement rates. Therefore, departing from past analysis, the court recognized that allegations of both the elements of RPM and economic coercion could give rise to a rule of reason analysis under an RPM claim. The court rejected the providers’ allegations of economic coercion, however, because Blue Shield lacked the necessary market power.

The health care industry is characterized pervasively by the absence of arms-length relationships or incomplete vertical integration, in which parties have partially shared and partially conflicting interests. For an excellent analysis of the patterns of control among consumers, providers, and insurers, see Evans, Incomplete Vertical Integration in the Health Care Industry: Pseudomarkets and Pseudopolies, 468 ANNALS 60 (1983).

134. Id. at 256.

135. Id. Although the court did not explain the context in which a subscriber could purchase, the subscriber could purchase in two situations. The most significant of these times occurs before an insured has reached his particular deductible under the insurance plan. In this situation, the physician still is bound contractually to charge the maximum fee, although it is the client who purchases the service directly from the physician and pays the fee directly to the physician. In effect, Blue Shield’s sole role in this instance would be that of a third party determining the price a provider could charge his patient. A second instance occurs if the insured receives a medical procedure that requires a co-payment. See, e.g., Prudent Buyer Plan Agreement, supra note 27, at 15 (Expenses incurred for mental disorders are paid 50% by Blue Cross and 50% by the insured.). Again, a maximum fee has been set contractually, but in this instance, both the insurer and the insured pay for the procedure. See Participating Physician Agreement, supra note 23, at 5 (deductibles and co-payments subtracted from the established fee).

136. See supra text accompanying note 135.

137. Pennsylvania Dental, 745 F.2d at 256.

138. Id.

139. Id. at 259. In the relevant geographic market of Pennsylvania, Blue Shield plans
The indemnitor label is significant because it recognizes the tripartite nature of the insurer-provider agreements. Whereas a purchase traditionally involves only two parties, the buyer and the seller, indemnification by definition involves the essential third party to RPM analysis. In this case, the insurer bargained on behalf of itself and ultimate consumers, and therefore, the resale was atypical. Thus, rather than the typical supplier-buyer RPM model, the fee agreements in Pennsylvania Dental involved a tripartite relationship.

The decision in Pennsylvania Dental is significant for two reasons. First, the court's characterization of Blue Shield as an indemnitor rather than a purchaser is more accurate. A pure indemnification occurs when a subscriber seeks health care from a physician of choice, negotiates the price of that treatment with the physician, and is reimbursed for all or part of that cost by the indemnitor. Although the Blue Shield plan does not precisely fit this "pure" model, characterizing Blue Shield as a purchaser because it is the ultimate payor is overly simplistic. Blue Shield does not participate in the decision of which health service is necessary, nor does it determine when or how that service will occur. In addition, Blue Shield as an entity cannot receive the services it is said to purchase. Furthermore, physicians traditionally have opposed as unethical any financial arrangement that involved "selling" their services to anyone but the patient. The legal and fiduciary relationship between doctor and patient further attenuates Blue Shield's characterization as a purchaser.

Second, the indemnitor characterization recognizes the tripartite nature of the insurer-provider agreements and, therefore, provides a foundation upon which to base an RPM claim. Viewing Blue Shield as a third party affecting the price charged in a transaction involving two other parties, the court properly can analogize the Blue Shield plan to those typically found in RPM cases.

In a case decided after Pennsylvania Dental, Kartell v. Blue Shield, however, the First Circuit rejected Pennsylvania Dental's characterization of the insurer as an indemnitor. In Kartell, physicians alleged that the "ban on balance billing" provision in a Blue Shield plan insured only 35% of those with private insurance and represented only 9% of dental care purchased.

---

140. Indemnify: "[T]o make good a loss one person has suffered in consequence of the act . . . of another. . . ." W. JOWITT, JOWITT'S DICTIONARY OF ENGLISH LAW (2d ed. 1977).

141. P. STARR, supra note 2, at 291-94.


143. See generally cases cited in 16A J. VON KALINOWSKI, supra note 55, § 6B.01-03.

was illegal under sections 1 and 2 of the Act.\textsuperscript{145} The Blue Shield plan required contracting physicians to accept Blue Shield’s payments as the sole payment for their services.\textsuperscript{146} This “ban on balance billing” provision, therefore, prohibited participating physicians from billing their patients for the balance.\textsuperscript{147}

The district court used a rule of reason analysis\textsuperscript{148} to determine whether the Blue Shield plan violated the Act. The district court found abundant evidence\textsuperscript{149} of specific anticompetitive effects resulting from the Blue Shield plan.\textsuperscript{150} Reasoning that Blue Shield, through its monopoly power in the market for prepaid health care in Massachusetts, exerted sufficient economic pressure to force physicians into agreeing to Blue Shield’s plan,\textsuperscript{151} the district court enjoined the plan as an unreasonable vertical restraint of trade under section 1.\textsuperscript{152} Referring to Maricopa,\textsuperscript{153} the district court stated that “[t]he mere fact that the Blue Shield plan in this case does not constitute \textit{per se} horizontal price fixing does not make its adverse impact on competition any less objectionable than the plan struck down . . . in \textit{Maricopa}.”\textsuperscript{154}

On appeal, the First Circuit reversed.\textsuperscript{155} The court’s decision turned on its threshold characterization of the relationship between Blue Shield

\begin{footnotesize}
  \textsuperscript{145} Id. at 735-36.
  \textsuperscript{146} Id. at 738.
  \textsuperscript{147} Id. The plaintiffs in \textit{Kartell} took a novel approach to their claim by attacking not the fixed fees themselves, but rather the ban on physician balance billing. A ban on balance billing may more clearly represent a legally cognizable restraint of trade as well as measurable injury to plaintiffs. Plaintiffs here, however, acknowledged that health insurers are entitled to bargain for and limit what they pay to physicians for medical services rendered to subscribers and contested only the insurer’s right to limit the \textit{total} amount a physician could receive for medical services rendered. \textit{Id.} at 748 n.18.
  \textsuperscript{148} \textit{Kartell} has a procedural history spanning several years; a rule of reason standard was determined to be proper for this case by the district court in \textit{Kartell} v. Blue Shield, 542 F. Supp. 782 (D. Mass. 1982). \textit{Kartell}, 582 F. Supp. at 737.
  \textsuperscript{149} \textit{Kartell}, 582 F. Supp. at 748.
  \textsuperscript{150} The court found that Blue Shield’s system provided the same economic reward to all practitioners regardless of their skill, that it discouraged physicians from undertaking the training and incurring the expense of new equipment to learn and offer new and innovative (and qualitatively better) procedures, and that it made Massachusetts a less attractive place to practice medicine. \textit{Id.} at 751-53; \textit{see also} Arizona v. Maricopa Medical Soc’y, 457 U.S. 332, 348 (1982).
  \textsuperscript{151} \textit{Kartell}, 582 F. Supp. at 751, 748.
  \textsuperscript{152} \textit{Id.} at 755. The § 2 claims brought by plaintiffs were dismissed because the § 1 claims were dispositive.
  \textsuperscript{154} \textit{Kartell}, 582 F. Supp. at 750 (footnote omitted).
\end{footnotesize}
and the providers. Agreeing with *Royal Drug*, the court characterized the Blue Shield plan as "merely [an] arrangement[ ] for the purchase of goods and services by Blue Shield." As in *Royal Drug* and the other pharmacy cases, this characterization precluded plaintiff's RPM claim. The First Circuit also rejected the district court's emphasis on market power. Although the First Circuit conceded that Blue Shield had monopoly power, and that it may have used that power to set unreasonable and uncompetitive prices, the court maintained that a monopsonist is free to exploit its market power to bargain for all but predatory prices. The court stated that the desirability of lowering insurance costs, and the availability of state regulation, combined to "counsel . . . against extending [the law] to authorize increased judicial supervision of the buyer/seller price bargain." Thus, the First Circuit held that the Blue Shield plan did not constitute RPM or an unreasonable horizontal restraint of trade and vacated the injunction.

The First Circuit's opinion in *Kartell* is flawed in two respects. First, the court improperly characterized the relationship between Blue Shield and the providers as a buyer-seller arrangement. The Third Circuit's characterization in *Pennsylvania Dental* of Blue Shield as an indemnitor rather than "merely a purchaser" of services more accurately reflects the nature of the Blue Shield plan. That plan provides for purchasing by the insured and puts the doctor and patient in a traditional treatment relationship in all respects but one; the physician lacks any control over the price that patient will pay. The First Circuit, in fact, recognized the weakness in the purchaser characterization when it asserted that "[w]hether for ethical, medical, or related professional purposes Blue Shield . . . is not . . . considered a buyer is beside the point." This bifurcated reasoning is illogical. Blue Shield's role in the health care industry should not be characterized as a purchaser for legal purposes and as an indemnitor for other purposes. Simply because Blue

---

158. *See supra* notes 86-90 & accompanying text.
159. *Kartell*, 749 F.2d at 926.
160. *Id*. at 927. Predatory pricing generally refers to a business’ efforts to acquire or preserve monopoly power by underselling its rivals through prices set below short term marginal cost. H. HOVENKAMP, *supra* note 35, at 172-75.
162. *Id*. at 931.
163. *Id*. at 934.
164. *Pennsylvania Dental*, 745 F.2d at 256-57 (The court stated that it was more accurate to characterize Blue Shield as indemnitor than as a purchaser.).
165. *See supra* notes 5-8 & accompanying text.
166. *Kartell*, 749 F.2d at 926.
Shield's "activities here are like those of a buyer," the court should not make Blue Shield a legal purchaser for antitrust purposes. The legal characterization of Blue Shield's role should reflect its total relationship to the parties. This fundamental mischaracterization by the court taints its entire opinion.

Second, the First Circuit failed to consider whether the Blue Shield plan violated section 2 of the Act. While the court conceded that Blue Shield had monopoly power, it failed to consider the district court's reasoning that Blue Shield's monopolistic behavior in one market had an anticompetitive impact on a secondary market, thereby implicating a violation of section 2. Because the court conceded that Blue Shield had market power in its primary market, it should have evaluated the competitive effects of Blue Shield's power in a vertically linked secondary market.

In sum, no section 1 RPM claim against a fixed-fee schedule to date has been analyzed under the rule of reason. Rule of reason treatment of such claims was precluded by the original characterization of the parties to the arrangement by the Supreme Court in *Royal Drug*. Recently, however, the Fourth Circuit in *Ratino* and the Third Circuit in *Pennsylvania Dental* have recognized that the PPO fee arrangements are sufficiently novel to warrant a rule of reason analysis. This recognition suggests an awareness of the need to evaluate thoroughly the competitive effects of PPOs in the marketplace. A section 2 challenge to PPOs would afford the courts an opportunity for such thorough analysis.

**Prospective Payment Systems: Section 2 Challenges**

Physician challenges to the fixed-fee component of PPOs have focused largely on section 1 of the Sherman Act. In certain circuits, however, a viable cause of action may exist under section 2 of the Act for illegal use of monopoly power.

The test for illegal monopolization under section 2 has two components: presence of a large amount of market power in the relevant geographic and product markets, and monopoly conduct, which is defined as engaging in certain anticompetitive acts. To establish a section 2 violation by an insurer, a physician must prove that the insurer has monopoly

167. *Id.* (emphasis in original).
168. *Id.* at 927.
169. 582 F. Supp. at 734; see supra text accompanying notes 148-54.
171. *Ratino*, 718 F.2d 1260; see supra notes 121-32 & accompanying text.
172. *Pennsylvania Dental*, 745 F.2d 248; see supra notes 133-43 & accompanying text.
173. *See supra* notes 54-58 & accompanying text.
power in the market for health care insurance in the relevant geographic area\textsuperscript{175} and that the insurer used this monopoly power in an anticompetitive manner, such as by engaging in exclusionary practices\textsuperscript{176} or by vertical integration.

When a business integrates vertically it obtains a certain amount of control over its products' distribution or sale at another level of the production-distribution chain. Vertical integration often enables firms to provide better products or services at lower prices.\textsuperscript{177} Courts, however, traditionally have perceived vertical integration as a substantial threat to competition.\textsuperscript{178} One of the primary anticompetitive threats is that the monopolist will not only cause anticompetitive effects at a new level, but also will acquire a second monopoly at that level.\textsuperscript{179}

Market Power

The facts of a recent First Circuit case illustrate the impact of an insurer's market power on providers. \textit{Kartell v. Blue Shield of Massachusetts}\textsuperscript{180} involved an allegation by a group of physicians that a "ban on balance billing" provision in a Blue Shield plan violated the Sherman Act. Although \textit{Kartell} was decided under a section 1 analysis, its facts also supported a section 2 allegation of abuse of monopoly power through vertical integration.\textsuperscript{181} Apparently without recognizing its significance, the district court laid the foundation for such a claim when it specified the relevant markets at issue in the insurer-provider

\textsuperscript{175} Monopoly power is loosely defined as "the power to control prices or exclude competition." United States v. E.I. du Pont de Nemours & Co., 351 U.S. 377, 391 (1956). Older cases required a very high degree of market control to establish monopoly power. See, e.g., United States v. American Tobacco Co., 221 U.S. 106, 156 (1911) (95% of cigarette sales in the United States); Standard Oil Co. v. United States, 221 U.S. 1, 33 (1911) (90% of national refining capacity). Later cases suggest that less market power may be sufficient. See, e.g., United States v. Griffith, 334 U.S. 100, 102 (1948) (film distribution monopoly in 51-62% of towns); Pacific Coast Agricultural Export Ass'n v. Sunkist Growers, Inc., 526 F.2d 1196, 1204 (9th Cir. 1975), cert. denied, 425 U.S. 959 (1976) (45-70% of market supports jury finding of monopoly). More recently, the Fifth Circuit announced that there is no rigid rule requiring even 50% market control, although 20% is clearly not enough. Yoder Bros. v. California-Florida Plant Corp., 537 F.2d 1347, 1367-68 & n.19 (5th Cir. 1976), cert. denied, 429 U.S. 1094 (1977).

\textsuperscript{176} See H. HOVENKAMP, supra note 35, at 142-43; E. SULLIVAN & H. HOVENKAMP, supra note 58, at 455. Exclusionary practices are those acts undertaken by someone with market share to either acquire or maintain monopoly power, for example, predatory pricing or integration into a different market. AMERICAN BAR ASSOCIATION ANTITRUST SECTION, AN- TITRUST LAW DEVELOPMENTS 109 (2d ed. 1984).

\textsuperscript{177} E. SULLIVAN & H. HOVENKAMP, supra note 58, at 481.

\textsuperscript{178} Id.

\textsuperscript{179} Id. at 482.

\textsuperscript{180} 749 F.2d 922 (1st Cir. 1984), cert. denied, 105 S. Ct. 204 (1985). For a full factual discussion of the case, see supra notes 144-47 & accompanying text.

\textsuperscript{181} See supra note 150 & accompanying text.
transactions.182

The district court in Kartell determined that the relevant product markets at issue were the health insurance and the physicians' services markets. The relevant geographic market was the Commonwealth of Massachusetts. Blue Shield clearly dominated the health care insurance market by providing coverage for seventy-four percent of the privately insured population in Massachusetts.183 This represented fifty-six percent of the Commonwealth's population, or 3.2 million total subscribers.184 Thus, the district court established Blue Shield's monopoly power.

Because the First Circuit conceded that Blue Shield had monopoly power, it should have inquired whether Blue Shield had used its monopoly power in an anticompetitive fashion. Evidence of vertical integration resulting in anticompetitive effects would satisfy the second prong of the section 2 test: monopoly conduct.

**Monopoly Conduct: Vertical Integration**

In the context of PPOs, the secondary market susceptible to vertical integration by an insurer is the market for provider services. Providers compete with one another in this market to sell their services to the total patient population, which includes those with and without private health care insurance. An insurer affects this market by soliciting its clients from the population interested in health insurance. Every subscriber who enrolls in a PPO is entitled to health care in the form of provider services and is guaranteed a relatively ascertainable ceiling on the cost of those services so long as he is treated by participating providers.

To make its participating providers easily identifiable, Blue Shield publishes and mails to each subscriber, along with literature encouraging patronage, a list of participating providers.185 Because subscribers receive full coverage when they seek treatment from participating providers and they must pay nonparticipating providers up front and then seek reimbursement from Blue Shield, it is reasonable to assume that Blue Shield's subscribers prefer to use participating providers. Consequently, the patient market for any provider who does not contract with an insurer, as well as the open market for physician's services, is diminished automatically.

The fixed-fee compensation scheme potentially distorts the market place even further. Faced with a diminishing fee-for-service patient population, resistant providers would be forced to capitulate and participate in PPOs just to maintain access to the marketplace. Although providers

---

183. *Id.* at 741.
184. *Id.* at 739, 741.
185. See, e.g., *BLUE CROSS OF CALIFORNIA*, *supra* note 26. It should be noted that Blue Cross claims no endorsement of any provider it lists. *Id.* at i.
may view the rates set by the insurer as unreasonable and uncompetitive, the insurer's monopoly in the health insurance market could coerce providers into accepting the contractual agreements without an opportunity for independent evaluation or the exercise of sound business judgment.

In summary, by exercising monopoly power in the market for health insurance, the insurer could interfere with competition in the market for physicians' services by methodically shrinking that second market. Whenever an insurer is shown to have a monopoly in its primary market, a likely consequence is the establishment of a monopsony in this second market. A monopsony would occur if the insurer became the dominant purchaser of physicians' services.

The Anticompetitive Effects

Demonstrating that a monopolist has integrated vertically into a secondary market does not end the inquiry. In order to succeed on a section 2 claim, plaintiffs also must show that the market power and vertical integration have resulted in unreasonable anticompetitive effects.186

Historically, acquisition of a second monopoly has been presumed to be anticompetitive for two reasons. First, courts have recognized that additional monopoly profits could be obtained through this secondary monopoly, thereby giving the monopolist a double monopoly. Second, the secondary monopoly acts as a barrier to entry in the primary market by forcing any potential entrant to enter competitively two market levels instead of one.187

As a result of the Chicago School's economic focus on allocative efficiency, this presumption has been the subject of increasing criticism. Chicago School commentators argue that, in most cases, vertical integration by a monopolist actually creates substantial efficiencies that result in increased consumer welfare, rather than the presumed anticompetitive effects.188 They point out that a monopolist at any single level of a distribution chain can recover all monopoly profits available in that chain. As a result, a double monopolist of two successive links will not make more monopoly profits than a single monopolist. Furthermore, they note that entry barriers are raised only if the integrated business is more efficient than its unintegrated competitors.189

The reasoning that supports these efficiencies, however, is inapplicable to the insurer because of its unique position in the marketplace. The typical vertical integration model occurs when a manufacturer acquires

---

188. Id.
189. Id. at 150-51.
190. Id. at 150, 199.
191. Id. at 150-51.
control over distribution of his product at another level of the production chain, that is, when he acquires control over another point at which the product is sold. For example, a shoe manufacturer could integrate vertically by acquiring retail shoe stores. Vertical integration by a monopolist insurer is atypical because of the insurer's position as both a buyer and seller of the same product. The insurer vertically integrates by acquiring market power at a purchasing point in the product chain. The insurer, therefore, is in a position to control both the prices it charges to its insureds (monopoly profits), as well as the prices it pays for the health services those insureds receive (monopsony profits). This model does not contain the flaw of the double monopoly model in which the monopolist would have to extract monopoly profits from itself to profit from both monopolies.192 Therefore, the argument that a monopolist at any one level in a production chain captures all the available monopoly profits ignores the monopsony profits available to the insurer.

The most recent cases dealing with secondary market manipulation by a monopolist reflect the Chicago School view that allocative efficiency is the overriding goal of antitrust law.193 For example, in *Paschall v. Kansas City Star*194 a divided Eighth Circuit court sitting en banc reversed a divided panel decision and held that a monopolist newspaper publisher who expanded its monopoly into a secondary market by switching from independent carriers to a self-distribution system did not violate section 2 of the Act.195 The court found that the integration resulted in procompetitive effects, such as a price reduction to some of the newspaper's subscribers and the potential for a wider range of services to individual readers.196 Thus, the court reasoned that consumers were not harmed because prices went down and output increased. The dissent, however, pointed out that only eight percent of the subscribers would receive a price reduction and that the other ninety-two percent would receive a price increase.197 The court did not address how a price decrease to only eight percent of the relevant market and the unsupported allegation of the potential of additional services could weigh so heavily in the competitive balance.

Because an anticompetitive effect as defined by the Chicago School is either increased price or decreased output in the secondary market that

---

192. Id. at 199.
193. See supra note 41 & accompanying text.
194. 727 F.2d 692 (8th Cir. 1984) (en banc), rev'd 695 F.2d 322 (8th Cir. 1982). *Paschall* is a recent case demonstrating a "rethinking" that resulted in a conclusion consistent with the Chicago School tenets. See generally Hovenkamp, *Vertical Integration by the Newspaper Monopolist*, 69 IOWA L. REV. 451 (1984) (criticism of panel decision from Chicago School point of view).
195. 727 F.2d at 704.
196. Id. at 701-04.
197. Id. at 705.
affects consumers, the holding in *Paschall* indicates that even the strained presence of these indicators is sufficient to declare vertical integration by a monopolist to be legal. Thus, the *Paschall* court's protection of a monopolist's vertical integration represents a triumph of allocative efficiency over distributive goals.

The most onerous anticompetitive effect of fixed fees as defined by the Chicago School may be reduced output in the market for physicians' services. Reduced output could occur through two mechanisms. First, the fixed fees may decrease the availability of premium and innovative services resulting in technologically static, less individualized, and less effort-intensive medical treatment. Plans that set maximum fees have been held to eliminate any financial reward for excellence, as well as the incentive for individual improvement or innovation. Providers who want to compete by offering innovative or "premium" services may be discouraged from doing so because the pricing structure presumes that doctors' services are fungible. The fees provide the same economic rewards to all practitioners regardless of their skill, experience, or willingness to employ innovative and difficult procedures. In addition, the fixed-fees plans fail to compensate differentially for difficult and easy cases. Thus, superior treatment often may be undercompensated and

198. See *supra* note 150.
199. See *supra* note 150.
200. See *Arizona v. Maricopa Medical Soc'y*, 457 U.S. 332, 348 (1982). The disincentive to innovate is worthy of some further discussion. Innovation is the result of a conscious search for new and better solutions to pressing problems; such search activity is triggered by the stress of a competitive market. F. Sherer, *Industrial Market Structure and Economic Performance* 423 (2d ed. 1980). There are two distinguishable types of innovation: that which leads to a qualitatively better existence and that which raises productivity. *Id.* at 408. In the context of the Blue Shield plans, a cap on providers' fees decreases providers' revenue. Decreased revenue would affect quality innovation because there would be fewer resources (time) available to develop or learn qualitatively better procedures. Further, providers would have less incentive to spend the time or money to develop better techniques because any quality above the minimum standard would be unrecompensed.

Conversely, decreased revenue would likely have the opposite effect on productivity or efficiency creating innovation. Because the mainstay of the fixed-fee plans is volume, any procedure that increased efficiency and allowed a greater number of procedures to be performed could expect to be actively sought by participating providers. Although there are entry costs associated with efficiency-creating innovation as well, because such innovation would result in increased volume, the entry costs could be expected to be offset by the increased revenue that would result from the increased volume. Thus, the fixed-fee plans could be expected to channel providers' innovation toward efficiency and away from qualitatively better procedures. The long-term effects of such a trend on health care and consumer welfare are as yet untraced. For a discussion of the effects of firm size and concentration on innovation, see *id.* at 413-22; Markham, *Concentration: A Stimulus or Retardant to Innovation?*, in *Industrial Concentration: The New Learning* 247-48 (H. Goldschmid, H. Mann & J. Weston eds. 1974).

below-average treatment overcompensated. For example, a physician treating a case that is unusual, or in which complications develop, is not allowed to charge any more than a physician treating the simplest, most responsive form of the same illness. In some cases, repeated palliative treatments would result in greater reimbursement to the provider than would curative treatments.

The second way PPOs may reduce output is by hastening the exit of providers from the market. Any physician unwilling to forego innovation or to compromise the quality of his care may be restricted to an ever dwindling supply of patients. At some point, that physician may be forced to seek patients outside the relevant geographic market, resulting in increased transaction costs to the physician, thereby decreasing the availability of his service (output).

The Chicago School also would measure the anticompetitive effects of an insurer's integration in terms of increased cost. First, higher medical costs could result to patients not enrolled in a PPO, as participating physicians increase costs to those fee-for-service patients in order to subsidize the patients covered by PPOs. This increase probably would be short term, however, because as the cost for private care increased, so would the demand for the plans.

If lower prices are accompanied by restricted services, however, consumers' long-term interests, the focus of distributive antitrust ideologists, are likely to be harmed. Conventional price theory supports this conclusion. Under conventional price theory, if a monopsonist insurer suppressed prices below what physicians considered acceptable for quality treatment, more and more physicians would try to avoid contracting with the insurer and capture a larger share of the remaining fee-for-service market by lowering their rates. A consumer's long-term interests would be harmed because price competition would ensure that physicians were charging only marginally above cost, thereby causing all

202. Id. at 753; see Easterbrook, supra note 61, at 899.


204. Using one group of patients to subsidize another lower paying group also has occurred in the context of indigent patients. See Wall St. J., Mar. 8, 1985, at 33, col. 5; see also Rankin & Wilson, supra note 68, at 606 n.27 (providers allege that they are forced to charge more to uninsured patients); Rayack, The Physicians' Service Industry, in THE STRUCTURE OF AMERICAN INDUSTRY 396 (N. Adams 6th ed. 1982) (sliding fees used to raise prices above those established by health insurers).

205. As the demand for the Blue Shield plan increases, the market for physicians' services could dwindle even further until eventually the nonparticipating providers would be driven out of business. See Rankin & Wilson, supra note 68, at 606 n.27.


207. Marginal cost is the additional cost that a firm incurs in the production of one unit of output. See generally H. HOVENKAMP, supra note 35, at 10-14.
nonprice competition\textsuperscript{208} and any incentive to employ new or cost-intensive procedures to cease. Such procedures would be employed only if the cost of learning or using them (entry costs) could be recovered through an increased volume of care at the lower prices.

The fixed-fee plans also may harm consumers’ long-term interests by discouraging new competitor entry into the service market, especially in certain geographic markets. The binding and restrictive nature of fixed fees may tend to decrease the desirability of areas in which insurers have market power.\textsuperscript{209}

The fixed fees imposed through PPOs arguably restrict the fundamental freedom of physicians to bargain for and receive a market-determined price for services rendered. At least one court has felt that fixed-fee plans tend to “distort, eliminate, and impede price competition among physicians”\textsuperscript{210} by increasing prices and decreasing both output and consumer welfare.\textsuperscript{211}

\textit{Differing Antitrust Policy Goals}

Because the argument can be made that fixed-fee arrangements create anticompetitive effects in the market for physician services, the competitive effects of a PPO must be examined under the various antitrust ideologies adopted by the courts to determine when and if, in fact, these effects are anticompetitive. This section of the Note examines whether PPOs create anticompetitive effects in violation of section 2 under either the Chicago School ideology or distributive ideology.

The effects of a monopsonist insurer on the secondary market for physicians’ services may be viewed as unreasonably anticompetitive whether evaluated under either of the above models. Any court following the Chicago School almost certainly will consider the anticompetitive effects of PPOs unreasonable. Fixed fees do not benefit consumers when they reduce output, decrease innovation, and increase provider exodus from the market. Furthermore, medical prices for the participating providers’ remaining fee-for-service consumers are likely to increase in the short term. Although under classical price theory a long-term price de-

\textsuperscript{208} Nonprice competition refers to those services involved in marketing products. Generally, these include overhead expenses such as offices, salespeople, advertising, and service departments. \textit{See generally id.} at 252.


\textsuperscript{210} \textit{Id.} at 754.

\textsuperscript{211} The Department of Justice recently sought to challenge a provider-based PPO in Stanislaus County, California. Two indications that the PPO seemed to be anticompetitive in nature were the involvement of more than 50% of the providers in one market and 90% in another, and the requirement that providers not join another PPO without express approval. \textit{Psychiatric News}, June 7, 1985, at 3 (citing speech to 33rd American Bar Association spring meeting by J. Paul McGrath, Assistant Attorney General in the Antitrust Division).
crease could result, it probably also would be accompanied by a decrease in output.

A court that adopted the distributive ideology also would consider the anticompetitive effects of PPOs unreasonable. This ideology stresses distributive goals and focuses on protecting consumers' long-term interests and protecting the competitive process.\textsuperscript{212} The fixed-fee plans and their effects on a secondary market fail to meet the goals of this model. A health care system that treats physicians' services as fungible, discourages innovation and individualized treatment plans, and fosters competition based on quantity rather than quality of care, could hardly be said to serve consumers' long-term interests. The cost containment effects of PPOs provide a small benefit in contrast to the insidious change PPOs may cause in the quality of health care available in this country. Furthermore, the plan may hamper the competitive process by imposing the will of one firm with market power on thousands of independent providers. Therefore, it would destroy an environment conducive to vigorous rivalry that can lead to efficiency and progressiveness.

Thus, whether evaluated by a court looking to efficiency or distributive goals, PPOs create anticompetitive effects on the secondary market for physician's services. Consequently, certain PPO fee arrangements are contrary to section 2 of the Act.

\textbf{Conclusion}

The recent increase in litigation by service providers against insurer-organized PPOs signals a growing concern with the real and potential competitive effects of insurer-set maximum fees. This concern centers around an increasing loss of control over many aspects of health and patient care traditionally considered to be under the exclusive control of the private practitioner.

Based on \textit{Maricopa}\textsuperscript{213} and the pharmacy cases beginning with \textit{Royal Drug},\textsuperscript{214} the first lawsuits to challenge fixed-fee plans were poorly pleaded and narrowly analyzed. Relying on dicta in \textit{Royal Drug}, courts have characterized the relationship of insurer and provider as that of a standard buyer and seller without sufficient consideration of the insured-patient's role. The courts have overlooked that, in certain phases of the insured's coverage, namely the pre-deductible period, the provider and patient have a direct fee-for-service relationship. An accurate characterization of the insurer as an indemnitor rather than a buyer provides the

\textsuperscript{212} See Fox, \textit{supra} note 40, at 1167.


necessary resale component to establish resale price maintenance in violation of section 1 of the Sherman Act.

In certain situations, insurer-organized PPOs may violate section 2 of the Sherman Act. In particular geographic markets in which the insurer has a monopoly in the market for health insurance, the insured-organized PPO has a monopsony in the market for physician services. Vertical integration of this sort by insurers such as Blue Shield has resulted in demonstrable anticompetitive effects in the market for physician services whether evaluated under the Chicago School or traditional antitrust objectives.

Christine Gasparovich*

* Member, Third Year Class.