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Antitrust and California's New Preferred Provider Organization Legislation: A New Alternative in Health Care Cost Containment

Carol A. Woo

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The July, 1983 amendment to California Insurance Code section 10133 allowed private health insurers to contract with a closed panel of hospitals and doctors for negotiated rates. This opened the way for the proliferation of Preferred Provider Organizations (PPO's), the newest alternative to traditional medical practice. Although PPO's will inject the much needed element of competition into the medical profession, thereby halting escalating health costs, antitrust concerns must be considered. The author examines various PPO structures and activities which invite antitrust litigation while suggesting methods by which a PPO may minimize antitrust liability.

I. INTRODUCTION

In an effort to contain the spiraling cost of health care services,[1] the California Legislature, in June, 1982, passed an amendment to California Insurance Code section 10133.[2] This amendment,

1. In 1960, the nation spent less than $26 billion on health care. By the end of 1983, health care reached $363 billion (14 times the cost in 1962). In California's largest urban centers, health care costs have risen nearly 200% since 1972, while the state's consumer price index over this same period rose only 140%. Paris, *Shock! Terror! Invisible Hand Strikes California Doctors,* FORBES, Nov. 7, 1983, at 38.

The culprits responsible for these unacceptably high costs are the providers of health care and the patient-consumer. Medical doctors in office-based practice derive approximately two-thirds of their income from third-party payors. Owens, *How Much of Your Money Comes From Third Parties?,* MED. ECON., Apr. 4, 1983, at 254.

Physicians and hospitals in providing services are generally not cost conscious inasmuch as they are not financially responsible for the services. Working on a fee-for-service basis, the doctor makes decisions as to diagnosis, treatment, return visits, tests, drugs, the need for and place of hospitalization, procedures to be used, and the need for referral. Doctors have no incentive to implement equally effective but less costly alternatives. Melia, Aucoin, Duhl & Kurokasa, *Competition in the Health-Care Marketplace: A Beginning in California,* 308 NEW ENG. J. MED. 788, 789-90 (1983) [hereinafter cited as Melia]; Weller, *Antitrust and Health Care: Provider Controlled Health Plans and the Maricopa Decision,* 8 AM. J.L. & MED. 223, 225 (1982) [hereinafter cited as Weller].

Similarly, consumers of health care are generally indifferent to medical care costs. Since insurance companies pay most bills for the vast majority of patients, the patient has no incentive to seek out equally effective but less costly alternatives. *Id.*

2. *See* Act of June 30, 1982, ch. 329, § 8, 1982 Cal. Legis. Serv. 2326, 2331-32 (West).

which became effective on July 1, 1983,[3] opened the way for private health insurers to contract with a closed exclusive panel of hospitals and doctors for negotiated rates.[4] Consequently, California is the vanguard of a revolution in health care delivery which has not seen such a fundamental change since private health care began in the 1930's.[5]

This recently enacted legislation has triggered a phenomenal growth of Preferred Provider Organizations (hereinafter PPO's) in California.[6] Preferred Provider Organizations are being touted as the most effective way yet invented to put a lid on health care costs, including health insurance premiums which have been rising 25% to 40% per year.[7] To be sure, all eyes are on California. Other states and the federal government will monitor PPO's carefully. If selective contracting works, the rest of the country will join the PPO bandwagon.

Although California's cost-containment mentality in the area of health care is extremely favorable to the proliferation and success of PPO's,[8] there is a major obstacle. The biggest issue looming on the PPO horizon is antitrust litigation.

The purpose of this comment is to provide basic familiarity with

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3. Passage of this amendment added to California Insurance Code section 10133 the following:

> (b) [A]n insurer may negotiate and enter into contracts for alternative rates of payment with institutional providers, and offer the benefit of such alternative rates to insureds who select such providers.
>
> (c) Alternatively, insurers may, by agreement with group policy holders, limit payments under a policy to services secured by insureds from institutional providers, and after July 1, 1983, from professional providers, charging alternative rates pursuant to contract with such insurer.

CAL. INS. CODE § 10133 (West Supp. 1983).

4. *Id.*

5. Along with the passage of the amendment to the California Insurance Code, which involves the private sector, two other pieces of legislation dealing with state and federal reimbursement to providers constitute the revolution referred to above. These other two pieces of legislation involve the public sector.

In March, 1983, Congress passed the Social Security Act of 1983, which included the most significant Medicare reform to be enacted since Medicare's inception. In June, 1982, the Governor of California also signed A.B. 799 which altered Medi-Cal reimbursement to providers. *California Contracting System,* CAL. BROKER, Sept. 1983, at 12-13; Melia, *supra* note 1, at 789.

6. As of July 2, 1983, California had 57 PPO's and 165 organizations that claimed to be a PPO or a variation on the theme. 4 NAT'L UNDERWRITER, July 2, 1983, at 1.

The explosive growth of PPO's appears to be occurring in large metropolitan cities having a surplus of physicians and rapidly growing HMO's, which are presumably taking patients away from other providers. Hunt, *Preferred Provider Organizations: The Latest in the Commercialization of Medicine,* PRIV. PRAC., Nov. 1982, at 15, 20.

7. *See* Paris, *supra* note 1, at 39.

8. *See supra* note 1 and accompanying text; *see also* Waldholz, *Discount Medicine: To Attract Patients, Doctors and Hospitals Cut Prices to Groups,* Wall St. J., Nov. 22, 1983, at 1, col. 1.

PPO's, to examine the important antitrust issues involved, to suggest how PPO's can minimize antitrust risks, and to conclude with a statement on the impact and future of PPO's: Is this the best method to achieve cost-containment in the delivery of health care services?

II. BACKGROUND

A. What is a Preferred Provider Organization?

Preferred Provider Organizations have existed for many years.[9] However, it was not until recently that they have experienced rapid growth[10] and have been labeled as the trend of the future.[11]

The PPO concept is different from a Health Maintenance Organization (HMO)[12] or an Independent Practice Association (IPA).[13] The fundamental distinction is that HMO's and IPA's involve provider risk,[14] whereas in a PPO, the risk is not borne by the provider but by the payor.[15]

Inasmuch as there are many variations of the PPO concept,[16]

9. Lewis, *Preferred Provider Organizations—A Developing Concept in Health Delivery,* SOCIOECONOMIC REP., Nov.-Dec. 1982, at 3-4. Prototype PPO's have existed for many years in the form of union health plans' "dual choice" programs. In their early days, these plans originated from the payor's desire to contain costs by steering members to specified discount providers. In contrast, today's PPO's have developed from provider concern over rising competition. Providers are seeking methods to protect their own piece of the patient pie which each year is sliced thinner as the number of competing providers increases. *Id.* at 4.

10. *See supra* note 6.

11. *See A new cure for health-cost fever,* BUS. WK., Sept. 20, 1982, at 117; Berger, *Selective Contracting: California's Hot Potato?,* HOSP. F., Nov.-Dec. 1982, at 7; Hunt, *supra* note 6, at 15.

12. An HMO takes the form of the traditional "closed panel" health organization. It provides health care at a central facility and employs providers at fixed salaries. Provider membership is limited, hence the "closed panel" designation. The patient-enrollee does not pay a deductible, and generally there is no out-of-pocket payment for treatment. *See* Weller, *supra* note 1, at 227-28. *See also* 42 U.S.C. § 300e(a)-(c)(1982) for a detailed discussion of HMO's under the Federal Health Maintenance Act.

13. An IPA, a hybrid HMO, provides services at the offices of its providers and reimburses the providers on a fee-for-service basis, up to an amount agreed upon by the provider members of the IPA. Not all IPA's are "health plans" but are traditionally "open panel"—open to all interested providers in the area. Weller, *supra* note 1, at 227-28.

14. *See* Lewis, *supra* note 9, at 3.

15. *Id.*

16. While there are many PPO variations, there are generally three types of PPO's. The provider-based PPO is organized by a hospital or physician. "For example, a local hospital could develop a network of other local hospitals and then

there is no standard definition of a PPO. However, although the term is generic and used to describe a wide variety of arrangements, there are certain features which are characteristic of all PPO's:

(1) "A PPO is essentially an agreement between a third-party payor and a provider for the provision and reimbursement of services."[17]

(2) A typical PPO consists of a designated panel of health care professionals or institutions which comprise the "preferred provider" panel.[18]

(3) The PPO has contracted with the third-party payor to provide health care services on a traditional fee-for-service basis at a discounted price in exchange for payment within a designated time.[19]

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market this network of hospital services to employers or insurance companies (both payors for health care services)." Enders, *The Preferred Provider Organization—Pro-Competitive Alternative or Antitrust Problem?,* HOSP. F., Nov.-Dec. 1982, at 42.

The second type of PPO is purchaser-based as it is organized by an employer, insurance company or other third-party payor for health care services. *Id.*

> Under this type of PPO, the benefits coordinator of the payor would usually take the lead in obtaining the participation of a sufficient number and type of hospitals and professionals to satisfy the anticipated patient load that the payor provides (e.g., employees of the self-insured employer, subscribers to an insurance plan, etc.).

Id.

The third type of PPO is entrepreneur-based. An individual or business entity, who is not a provider of health care services, puts together a number of providers to render services at a reduced cost. *Id.*

> The entrepreneur, in turn, markets this cost-saving health care delivery system to large buyers of health care services (e.g., self-insured employers or insurance companies). Alternatively, the entrepreneur could proceed by exploring the interest of large buyer(s) of health care services to participate in a discount delivery system if the entrepreneur can obtain sufficient quantity and type of providers to service (at a discount price) the projected patient load. To an extent, this entrepreneur is like a broker—matching buyers with sellers of health care services on terms favorable to both. In a sense, this entrepreneur is finding or making a market for his PPO.

Id.

17. *See supra* note 9.

18. "Some PPO's include only primary care physicians, while others have a comprehensive geographic and specialty network of doctors, hospitals, pharmacies, and diagnostic facilities." O'Connor, *Preferred Provider Organizations: A Market Approach to Health Care Competition,* HOSP. F., Nov.-Dec. 1982, at 16.

19. "Most PPO's reimburse physicians at 10 to 20 percent below 'usual and customary' charges." *Id. Accord* Katz, *Preferred provider organizations: New relation of the HMO,* POST GRAD. MED., June, 1983, at 143; Zannoth, *PPO 'Newest Kid on the Block' in Health Care Delivery Systems,* 81 MICH. MED. 627 (1982). "Providers can justify reduced rates because the PPO promises rapid claims payment and reduced administrative costs." O'Connor, *supra* note 18, at 16-17. The payor has an incentive to ensure fast payment since the payor's cost will be held down as long as the provider is encouraged to participate by the promise of rapid claims payment. Lewis, *supra* note 9, at 3.

(4) The PPO is guaranteed a defined pool of patients,[20] who are not locked into a specific panel of health care providers,[21] but have an economic incentive to utilize a PPO provider member.[22]
(5) A PPO commonly includes "a program of utilization review (UR)[23] and a management information system which provides cost and use data for employers and trust funds."[24]

B. Antitrust and the Professions

Since the unanimous landmark decision in *Goldfarb v. Virginia State Bar,*[25] the United States Supreme Court has held that the activities of professionals (including lawyers,[26] engineers,[27] hospital administrators,[28] and physicians[29]) are subject to scrutiny under the federal antitrust laws.[30] Additionally, the Court has ex-

20. This patient pool usually consists of employees (and their dependents) whose employers participate in a PPO type of health plan. Lewis, *supra* note 9, at 2. The fact that a provider is guaranteed "a patient pool safe from raiding by, or wandering off to, non-member providers" gives the provider an incentive to provide a discount. *Id. See also supra* note 19.

21. "Patients are not restricted to one clinic or physician; they have free choice among providers whenever care is needed." O'Connor, *supra* note 18, at 16. A patient may either select a provider from a list of PPO providers or may select a non-member provider. Zannoth, *supra* note 19, at 627.

22. Built-in incentives, such as eliminated co-payments and/or increased benefits give patients nearly 100% coverage when they choose providers who participate in the plan. Typically, only 80% of health care costs are covered when a non-member provider is selected. O'Connor, *supra* note 18, at 16.

23. These systems range from a cursory claims check, little more than a paper chase, to fairly sophisticated data collection and concurrent review systems. Some have physician peer-review committees that review ambulatory and ancillary services as well as inpatient utilization. Because PPO providers are not at risk for the cost of care as they are in HMOs, analysis of utilization patterns is an important cost-control mechanism. UR is the plans' assurance that care is given in an appropriate, but cost-effective manner, and that providers do not merely increase the number of services to make up for a discount.

Id. at 17. *See also* Perler, *Utilization Review for the PPO,* HOSP. F., Nov.-Dec. 1982, at 23 (detailing the ingredients of a practical plan for concurrent review).

24. Lewis, *supra* note 9, at 2.

25. 421 U.S. 773 (1975) (fixing legal fees).

26. *Id.*

27. National Soc'y of Professional Eng'rs v. United States, 435 U.S. 679 (1978) (agreements to avoid competitive bidding).

28. Hospital Bldg. Co. v. Trustees of Rex Hosp., 425 U.S. 738 (1976) (interfering with expansion project).

29. Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332 (1982) (setting of maximum fee agreements by physicians).

30. 421 U.S. at 787. ("The nature of an occupation, standing alone, does not provide a sanctuary from the Sherman Act.") *See also* Note, *The Antitrust Liabil-*

pressly determined that third-party agreements between insurance companies and pharmacists to furnish prescription drugs to insured policy holders at controlled costs, are not exempt from the antitrust regulations as being part of "the business of insurance."[31] Even though the judiciary has had little antitrust experience in the health care industry,[32] health care providers may be subject to the same rules of antitrust liability which apply to other industries.[33]

C. Antitrust Fundamentals

The heart of antitrust analysis is section 1 of the Sherman Act, which provides in relevant part: "Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade . . . is . . . illegal."[34] While "[t]his section, if read literally, would prohibit most if not all commercial contracts, since all agreements could be said, in some manner, to restrain trade . . . [t]his was not the intent of Congress. Congress and the courts have concurred in limiting section 1 only to unreasonable restraints of trade."[35] To determine whether a certain business practice constitutes a restraint of trade[36] under the Sherman Act, two basic

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ity of Professional Associations After Goldfarb: Reformulating the Learned Professions Exemption in the Lower Courts, 1977 DUKE L.J. 1047; Kauper, *Antitrust and the Professions: An Overview,* 52 ANTITRUST L.J. 163 (1983) (general discussions of antitrust and professions as a whole).

31. Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205, 220 (1979) (setting forth three criteria for determining whether the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-15 (1976) provides an exemption from antitrust laws).

32. 457 U.S. at 349. *See generally* Weller, *The Primacy of Standard Antitrust Analysis in Health Care,* 14 U. TOL. L. REV. 609, 613-15 (1983) (history of antitrust enforcement in the health care industry from 1939 to present).

33. *See* 457 U.S. at 349.

34. 15 U.S.C. § 1 (1976). In Northern Pac. Ry. Co. v. United States, 356 U.S. 1 (1958), the Supreme Court set forth the purpose of the Sherman Act stating:

> The Sherman Act was designed to be a comprehensive charter of economic liberty aimed at preserving free and unfettered competition as rule of trade. It rests on the premise that the unrestrained interaction of competitive forces will yield the best allocation of our economic resources, the lowest prices, the highest quality and the greatest material progress, while at the same time providing an environment conducive to the preservation of our democratic political and social institutions. . . . [T]he policy unequivocally laid down by the Act is competition.

Id. at 4. *See also* Blake, Bork, Bowman & Jones, *The Goals of Antitrust: A Dialogue on Policy,* 65 COLUM. L. REV. 363 (1965).

35. Heitler, *Health Care and Antitrust,* 14 U. TOL. L. REV. 577, 581 (1983) (footnote omitted).

36. Where antitrust is concerned, there is no precise definition for the term "restraint of trade." "[It] is a legal term of art, deriving its meaning from the current decisions and constructions making up the particular body of law in which it appears. . . . [N]othing less than the whole body of case-law constitutes the definition of 'restraint of trade.'" A.D. NEALE & D.G. GOYDER, THE ANTITRUST LAWS OF THE UNITED STATES OF AMERICA 22 (3d ed. 1980) [hereinafter cited as NEALE].

doctrines are utilized: the per se rule and the rule of reason.[37]

1. Per Se Doctrine

The per se doctrine, which is an evidentiary rule, tests whether price-fixing has occurred.[38] Inasmuch as price is the "central nervous system of the economy,"[39] the defendants' activities constitute a per se violation of the Sherman Act "if their purpose is to fix prices or if their conduct, should it achieve its goal, will be to affect market price."[40] The per se doctrine applies to practices which experience has shown "are so 'plainly anticompetitive,' . . . and so often 'lack . . . any redeeming virtue,' . . . that they are conclusively presumed illegal without further examination [as to whether they might or might not be reasonable in a particular case]."[41] "Such arrangements, often called 'naked restraints' on price, cannot be justified."[42] This harsh rule against price-fixing agreements is based upon the principle that these pernicious agreements "cripple the freedom of traders and thereby restrain their ability to sell in accordance with their own judgment."[43]

2. Rule of Reason Doctrine

The second standard, which can also be utilized to determine whether price-fixing has occurred, is known as the rule of reason doctrine.[44] It is a rule of construction.[45] The rule of reason test requires an inquiry into the purpose of the restraint, its probable

37. *See generally* Bork, *The Rule of Reason and the Per Se Concept: Price Fixing and Market Division*, 74 YALE L.J. 775 (1965); L. SULLIVAN, HANDBOOK OF THE LAW OF ANTITRUST §§ 63-72, at 165-97 (1977) [hereinafter cited as SULLIVAN]; NEALE, *supra* note 36, at 23-32.

38. NEALE, *supra* note 36, at 30.

39. United States v. Socony-Vacuum Oil Co., 310 U.S. 150, 226 n.59 (1940).

40. SULLIVAN, *supra* note 37, § 70, at 192.

41. Broadcast Music, Inc. v. Columbia Broadcasting Sys., 441 U.S. 1, 7-8 (1979).

42. SULLIVAN, *supra* note 37, § 74, at 198. *See, e.g.*, Northern Pac. Ry. v. United States, 356 U.S. 1 (1958) (tying arrangements); Fashion Originators' Guild of Am. v. Federal Trade Comm'n, 312 U.S. 457 (1941) (group boycotts); United States v. Socony-Vacuum Oil Co., 310 U.S. 150 (1940) (price fixing); Addyston Pipe & Steel Co. v. United States, 175 U.S. 211 (1899) (division of markets).

43. Kiefer-Stewart Co. v. Joseph E. Seagram & Sons, Inc., 340 U.S. 211, 213 (1951), *overruled on other grounds*, Copperweld Corp. v. Independence Tube Corp., 104 S. Ct. 2731 (1984). For a discussion of *Copperweld*, see *infra* notes 90-100 and accompanying text.

44. For a discussion of the rule of reason, see generally SULLIVAN, *supra* note 37, §§ 63-66, at 165-82; NEALE, *supra* note 36, at 23-30.

45. *See supra* note 38 and accompanying text.

or actual effect, and any benefits unique to the arrangement which may outweigh any negative impact on competition.[46] The rule of reason is directed towards "winnowing out the restraints which are merely ancillary or incidental to competition,[47] or which do not affect competition to a significant degree. . . ."[48] In short, the analysis turns on whether the procompetitive benefits outweigh the anticompetitive harms.[49]

III. Application of Antitrust Principles to Preferred Provider Organizations

Although much of the literature on the subject of PPO's[50] has hailed the concept as an innovative and cost-reducing alternative to existing delivery systems[51] which will introduce competition into the medical marketplace,[52] it is far from clear that a PPO is the pro-competitive vehicle that its proponents claim it to be.[53] How the PPO is structured and functions has a strong impact on the creation of antitrust litigation risks. Among the most frequently litigated activities in the medical profession are price-fixing by practitioners and boycotts.

A. Price-Fixing

Under California Insurance Code section 10133, groups of providers or individual providers may enter into contracts with private third-party payors.[54] Since individual providers are often at a bargaining disadvantage, many such providers are now forming

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46. *See* Note, *Antitrust Law—Maximum Prices and the Per Se Rule—Should Law Be Divorced From Economic Realities?—Arizona v. Maricopa Medical Society, 457 U.S. 332 (1982),* 56 Temp. L.Q. 162 (1983); *see also* Chicago Bd. of Trade v. United States, 246 U.S. 231, 238 (1918).

47. For example:

> The owner of a small . . . retail business may wish to sell it and move to another district. The goodwill he has built up is a valuable asset of the business which a would-be buyer expects to have to pay for and hopes to profit by. If the seller . . . were immediately to set up in another shop next door, the buyer would [be] swindled. It is common in such [a case] for the contract of sale to include a restrictive covenant by which the seller binds himself not to compete against the buyer [for a certain period of time].

Neale, *supra* note 36, at 26.

Restraints of this type are legitimate under the rule of reason inasmuch as the restriction involved is subordinate to the main and legitimate purpose of protecting the buyer. *Id.*

48. Neale, *supra* note 36, at 29-30.

49. Sullivan, *supra* note 37, § 72, at 195-96.

50. *See supra* note 11; O'Connor, *supra* note 18, Paris, *supra* note 1.

51. Enders, *supra* note 16, at 42.

52. *Id.*

53. *Id.*

54. *See supra* note 3.

PPO's or becoming members of PPO's. The PPO acts as a broker and negotiates contracts with third-party payors.[55] While such activity is clearly authorized by section 10133, the method of determining what fees a PPO will charge for certain procedures may make a PPO the target of litigation over alleged price-fixing[56] violations.

1. Price-Fixing Agreements Between Preferred Provider Organizations

Price-fixing agreements are firmly ensconced in antitrust prohibitions.[57] In many instances, the line between legal and illegal fee arrangements may be extremely fine. For example, agreements between independent PPO's to fix a common price for various health care services violate section 1 of the Sherman Act.[58] Such practices clearly constitute "naked restraints" and would therefore be illegal per se.[59] However, it would not be illegal for individual PPO's to be aware of the fact that other PPO's are receiving substantially similar fee reimbursement schedules.[60]

2. Price-Fixing by Physicians

Sinister antitrust implications arise when physicians agree as a group on an acceptable fee arrangement. In *Arizona v. Maricopa County Medical Society,*[61] which has been widely touted as a

55. *See* Hunt, *supra* note 6, at 18-19.

56. The classic definition of the term "price-fixing" refers to any contract, combination, or conspiracy "formed for the purpose and with the effect of raising, depressing, fixing, pegging, or stabilizing the price of a commodity in interstate or foreign commerce. . . ." United States v. Socony-Vacuum Oil Co., 310 U.S. 150, 223 (1940).

"[N]ot all contracts that have an effect upon price are properly considered price-fixing agreements. Obviously, where a buyer and seller agree upon a price, there is no violation . . . ." Kallstrom, *Health Care Cost Control by Third Party Payors: Fee Schedules and the Sherman Act,* 1978 DUKE L.J. 645, 656.

57. *See generally* SULLIVAN, *supra* note 37, pt. d, §§ 73-78, at 197-212; NEALE, *supra* note 36, at 36-57; R. BORK, THE ANTITRUST PARADOX: A POLICY AT WAR WITH ITSELF 263-79 (1978).

58. *See* NEALE, *supra* note 36, at 36.

59. *See generally* United States v. Trenton Potteries Co., 273 U.S. 392 (1927) (leading case on price-fixing).

60. *See, e.g.,* Kallstrom, *supra* note 56, at 679.

61. 457 U.S. 332 (1982).

weathervane of antitrust analysis in the health care industry,[62] the Supreme Court reviewed the propriety of maximum fee setting by physicians who were members of two medical foundations. In compiling its fee schedule, the Board of Trustees of each foundation would solicit advice from various medical societies about the setting of fees.[63] The Board would formulate a new fee schedule which limited the amount that a doctor could recover for services performed on patients insured under plans approved by the foundations.[64] It would then submit the schedule to the entire physician membership for majority approval.[65] While revisions occurred periodically,[66] the parties agreed that 85% to 95% of the doctors in Maricopa County charged at or above the maximum fee levels allowed by the foundation.[67]

The Court held that the maximum fee[68] agreements constituted horizontal[69] price-fixing agreements by the physicians under the per se rule,[70] thereby violating section 1 of the Sherman Act.[71] In spite of this ruling, the impact of the *Maricopa* decision "does not make every . . . contract [which fixes price] *per se* illegal."[72]

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62. *See* Fried, *The Impact of Recent Antitrust Case Law on Health Care Professionals,* 10 LAW, MED. & HEALTH CARE, 254, 255 (1982).

63. 457 U.S. at 340-41.

64. *Id.* at 341. If an insured visited a non-member doctor, coverage would be limited to the maximum allowance in the Foundation's schedule. *Id.* Similarly, member doctors were free to treat non-participating patients at fees higher than those permitted in the schedule. *Id.*

65. *Id.*

66. *Id.*

67. *Id.* at n.10.

68. *Cf.* Note, *supra* note 46, at 181-83 (wherein the author posits that agreements establishing maximum prices have the inherent potential to benefit consumers by forcing economic efficiency).

69. A "horizontal agreement" is "an agreement among entrepreneurs in direct competition with each other." E. KINTER, AN ANTITRUST PRIMER 42 (2d ed. 1973) [hereinafter cited as KINTER]. Compare vertical price-fixing agreements which are agreements between two entrepreneurs who would normally not be in "direct competition with each other, nor would they generally be operating at the same levels in the economy." *Id.* at 43.

70. *But see Broadcast Music,* 441 U.S. at 8-10, wherein the Court held the per se rule should not be applied until the Court gains enough experience with a specific practice to know that it is unduly anticompetitive. *Accord* White Motor Co. v. United States, 372 U.S. 253, 263 (1963).

71. 457 U.S. at 357.

> In this case the rule is violated by a price restraint that tends to provide the same economic rewards to all practitioners regardless of their skill, their experience, their training, or their willingness to employ innovative and difficult procedures in individual cases. Such a restraint also may discourage entry into the market and may deter experimentation and new developments by individual entrepreneurs. It may be a masquerade for an agreement to fix uniform prices, or it may in the future take on that character.

Id. at 348.

72. Fried, *supra* note 62.

"Professionals 'fix prices' all the time. One need only look to medical group practices or even law firms for examples of 'price-fixing' by professionals which do not violate the law."[73] Considering Justice Stevens' observation in the Court's opinion—"[e]ven if a fee schedule is . . . desirable, it is not necessary that the doctors do the price-fixing"[74]—the *Maricopa* decision appears to be limited to those instances of overt price-fixing by physicians.[75]

While separate provider entities may not legally agree to set fees, they may combine to form joint ventures[76] or parent-wholly-owned subsidiaries.[77] In *Maricopa,* Justice Stevens indicated that if the providers had combined and formed a joint venture, the defendants would have escaped antitrust violations under the per se rule.[78] "Joint ventures . . . enhance competition by creating new efficiencies or new productive capacity not achievable by the separate entities"[79] and thus are subject to antitrust analysis under the rule of reason.[80] "The threshold requirements for escaping per se treatment are that the offending activity be only literal, not effective price fixing, and that the price-fixing or any other re-

73. *Id.*

74. 457 U.S. at 352 (footnote omitted).

75. *See supra* note 72. (The author states *Maricopa* will be narrowly restricted to its facts and will not have a significant impact on practice in the health care industry). *Compare* Cohen & Tiano, *The Aftermath of Maricopa,* 10 LAW, MED., & HEALTH CARE 248 (1982) (wherein the authors conclude that *Maricopa* will have a broad application in the health care industry).

76. "Joint venture" is defined as "[a]n association of persons jointly undertaking some commercial enterprise. It requires a community of interest in the performance of the subject matter, a right to direct and govern the policy in connection therewith, and duty . . . to share both in profit and losses." BLACK'S LAW DICTIONARY 753 (5th ed. 1979).

It should be noted that the joint venture concept is, by its own nature, unclear. In the words of one commentator, it is "a vague and protean concept" potentially applicable to "all situations in which two or more persons or independent firms join forces to achieve some common goal." Pitofsky, *Joint Ventures Under the Antitrust Laws: Some Reflections on the Significance of Penn-Olin,* 82 HARV. L. REV. 1007 (1969).

77. The typical parent-subsidiary structure is formed when one entity has working control through stock ownership of another entity, the subsidiary corporation.

The power to control appears to be the most important criterion used to determine single entity status as other criteria break down and become irrelevant in complex antitrust litigation. Areeda, *Intraenterprise Conspiracy in Decline,* 97 HARV. L. REV. 451, 464-70 (1983).

78. 457 U.S. at 356-57.

79. Weller, *supra* note 1, at 234-35.

80. *Id.* at 235.

straint be a necessary part of the joint venture."[81]

In order to qualify as a joint venture, there are several preliminary requirements which must be met: (1) a combined entity must be formed in order to permit either (a) entry into the market of a new product, service, or technology not otherwise available from individual members,[82] or (b) entry of joint venturers who would otherwise be unlikely to enter the market in the absence of the risk-spreading aspects of the joint venture;[83] (2) the members, who would otherwise be competitors, must pool their capital and share the risks of loss as well as the opportunities for profit;[84] and (3) the combined entity (either collectively or individually) must not have substantial market power so as to exclude competitors from the market or affect market prices.[85]

In assessing antitrust implications under the less repressive rule of reason analysis, the Court in *United States v. Penn-Olin*[86] set forth comprehensive guidelines which trial courts might take into account in assessing the anti-competitive effects of a joint venture.[87] In summary, "[t]he joint venture Rule of Reason approach is predicated on the existence of some degree of integration."[88] If the joint venturers allege that the venture is integrated, when in fact the joint venture is being used as a camouflage for

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81. *Id.* (footnote omitted). In other words, the restraint is ancillary to the purpose of the joint venture. *See also Broadcast Music,* 441 U.S. at 1 (price-fixing was considered "a necessary consequence" of the joint venture).

82. *See* Brodley, *Joint Ventures and Antitrust Policy,* 95 HARV. L. REV. 1523, 1525-26 (1982).

83. *Id.* at 1526.

84. 457 U.S. at 356.

85. *See* R. POSNER, ANTITRUST LAW: AN ECONOMIC PERSPECTIVE 117-18 (1976) [hereinafter cited as POSNER].

86. 378 U.S. 158 (1964).

87. [T]he number and power of the competitors in the relevant market; the background of their growth; the power of the joint venturers; the relationship of their lines of commerce; the competition existing between them and the power of each in dealing with the competitors of the other; the setting in which the joint venture was created; the reasons and necessities for its existence; the joint venture's line of commerce and the relationship thereof to that of its parents; the adaptability of its line of commerce to non-competitive practices; the potential power of the joint venture in the relevant market; an appraisal of what the competition in the relevant market would have been if one of the joint venturers had entered it alone instead of through [the joint venture]; the effect, in the event of this occurrence, of the other joint venturer's potential competition; and such other factors as might indicate potential risk to competition in the relevant market. In weighing these factors the court should remember that the mandate of the Congress is in terms of the probability of a lessening of substantial competition, not in terms of tangible present restraint.

Id. at 176-77.

88. Kopit & Klothen, *Antitrust Implications of the Activities of Health Maintenance Organizations,* 25 ST. LOUIS U.L.J. 247, 269 (1981) [hereinafter cited as Kopit].

concerted activity, the joint venture rule of reason approach "pierces the veil" and holds the venture illegal.[89]

In addition to the joint venture approach suggested in *Maricopa,* the more recent case of *Copperweld Corp. v. Independence Tube Corp.*[90] signaled to the health care industry that PPO's may also form legitimate parent-wholly-owned subsidiary relationships[91] to escape section 1 Sherman Act violations.

In *Copperweld,* Independence Tube Corporation filed a section 1 Sherman Act suit against Regal Tube Company, its wholly-owned subsidiary, and Yoder Company, another tubing company. Yoder Company was subsequently exonerated from any antitrust liability, leaving the parent corporation and its wholly owned subsidiary as the sole parties to the section 1 Sherman Act conspiracy.[92] On appeal from the court of appeals,[93] the issue before the Court was whether a parent corporation and its wholly-owned subsidiary are legally capable of conspiring with each other under section 1 of the Sherman Act.[94]

The Court noted that section 1 of the Sherman Act "reaches unreasonable restraints of trade effected by a 'contract, combination . . . or conspiracy' between *separate* entities,"[95] and that a parent and its wholly-owned corporate subunit invariably exist as one and "*always* have a 'unity of purpose or a common design.' "[96]

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89. *Id.*

90. 104 S. Ct. 2731 (1984).

91. *See supra* note 77. The parent-wholly-owned subsidiary relationship is not to be confused with the company practice of conducting its business through branches, divisions, or departments. The latter business arrangement does not ordinarily give rise to antitrust challenges. Willis & Pitofsky, *Antitrust Consequences of Using Corporate Subsidiaries,* 43 N.Y.U. L. REV. 20 (1968).

92. 104 S. Ct. at 2733.

93. Independence Tube Corp. v. Copperweld Corp., 691 F.2d 310 (7th Cir. 1982), *cert. granted,* 103 S. Ct. 3109 (1983).

94. 104 S. Ct. at 2740. The Court's analysis was limited to wholly-owned subsidiaries and did not address "under what circumstances, if any, a parent may be liable for conspiring with an affiliated corporation it does not completely own." *Id.*

95. *Id.* (emphasis in original).

96. *Id.* at 2733 (emphasis in original).

> A parent and its wholly owned subsidiary have a complete unity of interest. Their objectives are common, not disparate; their general corporate actions are guided or determined not by two separate corporate consciousnesses, but one. They are not unlike a multiple team of horses drawing a vehicle under the control of a single driver. With or without a formal "agreement," the subsidiary acts for the benefit of the parent, its sole shareholder. If a parent and a wholly owned subsidiary do "agree" to a course of action, there is no sudden joining of economic resources that

Repudiating the intra-enterprise conspiracy doctrine,[97] the Court held that "Copperweld [a parent] and its wholly owned subsidiary [Regal] are incapable of conspiring with each other for the purposes of § 1 of the Sherman Act."[98]

Although the Court found the unilateral activities of a parent and its wholly-owned subsidiary to be incongruent with the separate entity requirement of section 1 of the Sherman Act, *Copperweld* plainly indicates mere formulation of a parent-wholly-owned subsidiary structure does not give rise to carte blanche exemption from section 1 conspiracies. While the intra-enterprise conspiracy doctrine can no longer be used as a basis for a section 1 conspiracy, a conspiracy will exist under the rule of reason analysis[99] if either the parent or its wholly-owned subsidiary attempts to restrain the competitive ability of outsiders or controls the subsidiary by stock acquisition specifically calculated to effectuate restrictive practices.[100]

3. Exchanges of Price Information

In instances where pernicious price-fixing is absent, concerted action to fix prices may exist where a particular industry engages in "activities" which are in themselves legitimate but may also be used to disguise or facilitate collusion.[101] For example, a PPO may exchange fee or cost information among competing provider

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had previously served different interests, and there is no justification for § 1 scrutiny.

Id. at 2742.

97. The intra-enterprise conspiracy doctrine "provides that § 1 [Sherman Act] liability is not foreclosed merely because a parent and its subsidiary are subject to common ownership." *Id.* at 2736.

> Few defendants are actually found liable solely on the basis of intraenterprise conspiracy doctrine, but the availability of that doctrine induces unsuccessful suits that would not otherwise occur, complicates and lengthens independently meritorious suits, confuses judges and juries, and sometimes leads to condemnation—without justification in antitrust policy—of unilateral behavior.

Areeda, *supra* note 77, at 451.

For cases in which the Court utilized the doctrine of intra-enterprise conspiracy to find a section 1 Sherman Act conspiracy, see generally Perma Life Mufflers, Inc. v. International Parts Corp., 392 U.S. 134 (1968); Timken Roller Bearing Co. v. United States, 341 U.S. 593 (1951); Kiefer-Stewart Co. v. Joseph E. Seagram & Sons, Inc., 340 U.S. 211 (1951); United States v. Yellow Cab Co., 332 U.S. 218 (1947). To the extent that the holding in each case was supported by the intra-enterprise conspiracy doctrine, *Copperweld* has disapproved and overruled those portions. However, in each case there was at least one alternative basis for finding an antitrust violation by the defendant. Thus, the intra-enterprise conspiracy doctrine was not necessary for a finding of substantive liability.

98. 104 S. Ct. at 2745.

99. Areeda, *supra* note 77, at 471.

100. 104 S. Ct. at 2738-39.

101. *See* NEALE, *supra* note 36, at 43-57; *see also* POSNER, *supra* note 85, at 135-67.

groups or promulgate recommended fee schedules. This exchange of information is a double-edged sword. On the one hand, reciprocal exchanges of price information appear to be wholly legitimate inasmuch as a businessman has a right to be well-informed about market conditions.[102] After all, the economic theory of competition does not require decisions to be made in the dark.[103] But, on the other hand, it is clear that these activities may be used to facilitate collusion between companies.[104] The circulation of information regarding fees creates the opportunity to apply pressure on a firm to set prices which are compatible with the rest of the industry without explicitly asking others to do so.[105] This exchange of price information through fee schedules may be construed to amount to a "tacit invitation" to follow a concerted pricing course if the invitation was uniformly acted upon.[106]

A decision that collusive price-fixing exists, rather than a legitimate exchange of information about business conditions, requires a showing that an apparent uniformity of prices results from collusion, not from conditions in the market.[107]

> In this context collusion means a real "meeting of the minds" in a common endeavour to suppress or limit price competition; moreover, it is implied that the plan or understanding can be relied on with reasonable confidence by the participants. The individual firm, in other words, must be under some fairly effective inhibition as regards "breaking the price line" when the temptation to do so appears strong. Conversely, when the members of a trade group are genuinely left free in their pricing decisions and do in practice exercise their own discretion, collusion cannot be inferred and no antitrust offense can be established.[108]

There is no doubt that reciprocal exchanges of price information, coupled with uniformity and inflexibility of prices, invite law enforcement officials to suspect concealed price-fixing.[109] Since "[t]he inferences are irresistible that the exchange of price information has . . . an anticompetitive effect in the industry,"[110] these

102. NEALE, *supra* note 36, at 44.
103. *Id.*
104. *Id.*
105. *See* POSNER, *supra* note 85, at 146.
106. *See* Kallstrom, *supra* note 56, at 679.
107. NEALE, *supra* note 36, at 50-51.
108. *Id.* at 51. *Accord* POSNER, *supra* note 85, at 145.
109. *See supra* note 102.
110. *See* United States v. Container Corp., 393 U.S. 333, 337 (1969) (Seller upon request by a competitor furnished information regarding recent prices charged or quoted to customers with the expectation of reciprocity. This exchange of information stabilized prices and was held illegal per se.). *See also* United States v.

tactics should be avoided at all costs.

4. Physician Control of Preferred Provider Organizations

The Federal Trade Commission has deemed physician control of prepayment plans another major area of antitrust concern.[111] Since many PPO's are established by physicians, who view it as an opportunity to retain their share of the patient market, the board of directors may consist of a number of practicing physicians. The Antitrust Division of the Department of Justice has found no antitrust objections when fee schedules are set by organizations not controlled by professionals.[112] In view of this statement, it appears that providers may serve on the board of directors as long as they do not comprise a majority of the board. In the event that providers do make up a majority of the board, antitrust sensitivities arise inasmuch as one of the functions of the board of directors is to determine fees. Fee setting by boards comprised of a majority of doctors could be construed as allowing doctors to decide what to pay themselves,[113] a violation of section 1 of the Sherman Act.[114]

However, while physicians are prohibited from controlling health care organizations, antitrust implications are vitiated where a majority of doctors on the board of directors are not actively practicing physicians.[115]

By the same token, risk of antitrust liability could also be created if the providers make up a majority of the payor's board of directors.[116] In such cases, it is easily inferred that the providers are controlling the insurer. "[T]he nature of the agreement between insurers and providers changes from an ordinary two-party contract . . . [to a horizontal agreement] because the insurer be-

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American Linseed Oil Co., 262 U.S. 371 (1923); American Column & Lumber Co. v. United States, 257 U.S. 377 (1921) (involving other sophisticated and well-supervised plans for the exchange of price data among competitors).

111. *See, e.g.,* Heitler, *supra* note 35, at 606-07.

112. Kopit, *supra* note 88, at 264. The Department of Justice, Antitrust Division, found no antitrust implications where a proposed prepaid legal plan organization would be governed by a board of directors consisting of a majority of non-lawyers. The program did not contemplate inviting any bar association to approve or endorse a particular fee schedule, and attorneys would act only in an advisor capacity on what the usual and customary fees are in a particular geographic area. *Id.* at n.70.

113. *See, e.g.,* Lynk, *Regulatory Control of the Membership of Corporate Boards of Directors: The Blue Shield Case,* 24 J.L. & ECON. 159, 173 (1981).

114. *See* Kopit, *supra* note 88, at 262-64.

115. FTC Advisory Opinion: Health Care Management Associates, June 7, 1983, at 1.

116. Note, *Limiting Provider Participation in Health Insurer Reimbursement Decisions: An Antitrust Cure for a Crisis in Medical Care Costs,* 72 GEO. L.J. 161, 175 (1983).

comes the agent of the providers who control it."[117] If this type of concerted action occurs, and prices of health care services are affected, serious price-fixing implications arise.[118]

B. Concerted Refusals to Deal

1. Limitations and Restraints on Providers or Third-Party Payors

Antitrust litigation is likely to arise where a PPO acts in a concerted[119] fashion to boycott[120] a particular program or entity.[121] When PPO's join together for the sole purpose of expressing dissatisfaction with the maximum reimbursement rate set by insurers and collectively threaten to cancel their contracts, concerted action clearly exists.[122] Additionally, concerted action arises when groups refuse to complete forms in an effort to influence reimbursement, or participate in insurance programs only on terms deemed acceptable by the groups.[123] In these types of situations,

117. *Id.* at 173.

118. *Id. See also* Sausalito Pharmacy, Inc. v. Blue Shield of Calif., 544 F. Supp. 230, 237 (N.D. Cal. 1981), *aff'd per curiam,* 677 F.2d 47 (9th Cir.), *cert. denied,* 459 U.S. 1016 (1982) (wherein the court stated that the "most troublesome" opportunity for restraint of trade exists when pharmacies control insurance companies); Virginia Academy of Clinical Psychologists v. Blue Shield of Va., 624 F.2d 476 (4th Cir. 1980), *cert. denied,* 450 U.S. 916 (1981) (court found a conspiracy among doctors in a Blue Shield plan which required in its by-laws that a majority of its board of directors be physicians); Hoffman v. Delta Dental Plan of Minn., 517 F. Supp. 564 (D. Minn. 1981) (fourteen members of a twenty-one member board of directors were required to be participating dentists in a pre-paid dental plan); Nurse Midwifery Assocs. v. Hibbet, 1982-83 Trade Cas. (CCH) ¶ 65,040 (M.D. Tenn. 1982) (United States District Court found a conspiracy where physicians controlled a medical malpractice insurance plan); *but see* Glen Eden Hosp., Inc. v. Blue Cross and Blue Shield of Mich., 555 F. Supp. 337 (E.D. Mich. 1983), *aff'd in part, rev'd in part,* 740 F.2d 423 (6th Cir. 1984) (provider minority control of an insurer may amount to a conspiracy if there is evidence that the minority provider actually controlled the insurer's reimbursement system).

119. *See* Eastern States Retail Lumber Dealers' Ass'n v. United States, 234 U.S. 600, 614 (1914), noting the difference between unilateral and concerted action: "An act harmless when done by one may become a public wrong when done by many acting in concert, for it then takes on the form of conspiracy." *See also* United States v. Colgate & Co., 250 U.S. 300 (1919). A unilateral refusal to deal without more and "[i]n the absence of any purpose to create or maintain a monopoly" is, generally speaking, lawful under the Sherman Act. *Id.* at 307.

120. *See generally* SULLIVAN, *supra* note 37, at 229-65 for a discussion of boycotts.

121. *See* KINTER, *supra* note 69, at 37.

122. *See* Heitler, *supra* note 35, at 593.

123. *See, e.g.,* Michigan State Medical Soc'y, No. 9129 (F.T.C. Feb. 17, 1983).

the provider groups are using the third-party payor as a vehicle by which to effectuate a price-fixing conspiracy. Such types of group boycotts have in some situations been found illegal per se.[124]

Another type of boycott arises when groups of providers seek to impose unreasonable restraints on a competing group of providers or on an individual provider.[125] For example, PPO's should not enter into any agreements which limit another provider's ability to participate in or be compensated by other programs.[126] In *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*,[127] the court found a boycott existed in defendant's refusal to pay fees for psychotherapy unless such treatment was supervised by and billed through a physician.[128] The requisite contract, conspiracy, or combination was founded on the fact that Blue Shield was in effect a combination of physicians, operating under the direction and control of its physician members.[129] These physicians were held to have acted jointly through Blue Shield to protect themselves from the competition of the clinical psychologists.[130]

Similarly, PPO's should refrain from limiting or prohibiting participating providers from contracting with or participating in the programs of other PPO's or other third-party payors.[131] Third-party payors should also remain free to contract with other PPO's.[132]

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124. *See* White Motor Co. v. United States, 372 U.S. 253, 263 (1963). *But see* ANTITRUST ADVISOR § 1.32, at 62 (2d ed. Supp. 1983) (although such concerted action would appear to be a "naked restraint" of trade under the per se analysis, "[t]here has been an almost universal refusal to apply the per se rule to 'boycotts' in [the medical profession]").

Rather, the courts have preferred to utilize the rule of reason doctrine when boycotts are involved. However, in spite of this:

> It does not by any means follow automatically that an arrangement will be legal just because it is not illegal per se. . . . [T]he question of the nature of the inquiry to be conducted under the rule of reason still remains. . . . [T]he important question is not the impact of the refusal to deal in the welfare of the excluded [group], but rather the impact of that refusal to deal on consumer welfare, i.e., on overall economic efficiency.

Id. at 69.

125. *See* Heitler, *supra* note 35, at 592.

126. *See Colgate & Co.*, 250 U.S. at 307 (proof of widespread individual refusals to deal is not itself adequate to establish the requisite conspiracy; although true group boycotts to coerce private behavior are illegal per se, unilateral refusals to deal are permitted).

127. 624 F.2d 476 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981).

128. *Id.* at 485.

129. *Id.*

130. *Id.*

131. *See* Kopit, *supra* note 88, at 284-86.

132. *Id.*

2. Exclusionary Practices

The exclusion of physicians and other providers from a PPO creates antitrust sensitivities.[133] The classic prescription for improving one's position of power in a market is to limit the number of participants.[134] A PPO may fear that too many practitioners in a specialty or given area will result in over-utilization, threaten the economic position of its members, and ultimately, endanger the competitiveness of the PPO.[135] Accordingly, it can be expected that PPO's will attempt to adopt measures limiting their provider membership.[136] This can be easily accomplished by closing certain categories of provider membership after a certain number is reached in a geographic area, or by ousting providers in those areas of saturation where the problem arises after the PPO is operational.[137]

In the above scenario, the excluded providers may have a potential cause of action under the Sherman Act[138] based on a concerted refusal to deal.[139] Although the Supreme Court has scrutinized boycotts under the per se rule,[140] the lower courts have preferred to examine the alleged concerted activity under the rule of reason.[141] The exclusionary practice will pass muster under the rule of reason doctrine if it can be proved that the practice has a procompetitive effect which outweighs the anticompetitive consequences.

> When the excluding physicians have a rational basis for limiting their number, such as statistics showing that increasing the number of physicians will increase utilization, none of the crucial components of the [rule of reason] test will be met. If competition in the relevant market existed, the anticompetitive intent criterion would be absent and the restraints would be ancillary to the [group's] organization as a competitor in that market.[142]

In addition to a rational basis for the exclusionary rule, the court may consider the impact of that refusal to deal on customer

133. *See generally* NEALE, *supra* note 36, at 58-75; *see also supra* note 120.
134. NEALE, *supra* note 36, at 58.
135. *See* Kopit, *supra* note 88, at 279.
136. *Id.*
137. *Id.* at 279-80.
138. *See supra* note 34 and accompanying text.
139. *See* Kopit, *supra* note 88, at 280.
140. *See supra* note 124 and accompanying text.
141. *Id.*
142. Kopit, *supra* note 88, at 280. *See also* Weller, *supra* note 1, at 243 (author posits that excluded providers will have an incentive to develop their own health plans and to compete).

welfare.[143] The excluding providers would have to objectively demonstrate that the exclusion was necessary to maintain the integrity of the PPO or the quality of medical services offered to the patient pool.[144] For instance, professional incompetence of the excluded provider(s) would have to be sufficiently demonstrated. However, exclusion from membership in a PPO cannot revolve around membership in the local medical society, admission to hospital staffs, or other external indicia unless those indicia can be directly attributed to the PPO's competitive posture or to the PPO's ability to meet its standard of care.[145] "Obviously there is considerable latitude for creative advocacy in this area. Some external indicia such as medical society membership, would appear to be unreasonable justifications for exclusions, while others, such as graduation from an accredited medical school, are less clear and subject to different interpretations by the courts."[146]

In a recent Federal Trade Commission advisory opinion, the FTC raised no objections to a plan wherein the PPO membership would not total more than 10% to 15% of all local area providers, with this participation rate relatively uniform across specialties.[147] The FTC's posture on this matter is consistent with its belief that PPO's, if structured properly, are likely to be procompetitive, both by generating competition between cooperating providers and other local providers, and by increasing competition among third-party payors.[148]

The boycott issue is not limited to membership in the contracting group,[149] and could arise in the context of medical referrals for specialty care.[150] Some PPO's are structured so that enrollees must consult with a primary care provider,[151] who may then refer the patient to a specialist within the provider network if he so desires.[152]

Arguably, a pattern of election by the primary care providers to treat a patient's leg, foot, back, or other infirmity rather than making referrals to specialty providers within the PPO network (i.e., podiatrists, chiropractors, optometrists, endodontists) would ap-

143. *See* Cardio-Medical Assoc. v. Crozer-Chester Medical Center, 536 F. Supp. 1065 (E.D. Pa. 1982), *aff'd,* 552 F. Supp. 1170 (E.D. Pa. 1982).

144. *See* Kopit, *supra* note 88, at 279-84.

145. *Id.* at 284.

146. *Id.*

147. *See supra* note 115, at 2.

148. *See* Clanton, *The FTC and the Professions,* 52 ANTITRUST L.J. 209, 224-25 (1983).

149. *See* NEALE, *supra* note 36, at 61-65; Kopit, *supra* note 88, at 282.

150. Kopit, *supra* note 88, at 282.

151. *Id.*

152. *Id.*

pear to be a boycott.[153] However, in order to establish the requisite conspiratorial intent in such cases, more than a normal pattern of parallel behavior in referrals must be demonstrated.[154] There must be a showing of other circumstantial evidence pointing to conspiratorial intent. Since it is only in rare instances that documentation of an agreement is uncovered, "collective actions likely to produce uniform behavior amounting to a boycott" must be identified.[155] For example, the circulation of certain kinds of information likely to induce parallel action has been held to warrant a finding of a concerted refusal to deal.[156] Without more, an inference of conspiracy would not be permissible if the information circulated was otherwise difficult to obtain and had value to the recipients above and beyond its utility as a signal for concerted action.[157]

IV. Impact and Future of Preferred Provider Organizations

Preferred Provider Organizations are innovative health programs designed to cope with the old and complicated problems of escalating health care costs. However, as with every new concept, the advantages and disadvantages must be evaluated before any judgments are made. No doubt, the widespread proliferation of PPO's,[158] in one way or another, has sent a reverberating jolt up and down the spines of doctors, insurers, employers, and patient-consumers alike.

A. Impact on Doctors

Not surprisingly, doctors were the group most vocally opposed to the new law.[159] In fact, the opposition of organized medicine was the major reason the new law was not passed until the 1982 budget crisis in California.[160]

There are two reasons for this vehement opposition by doctors. Philosophically, most doctors do not think that the PPO concept

153. *Id.* at 282-83.
154. *Id.* at 283-84.
155. Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 Duke L.J. 303, 345.
156. *Id. See* Eastern States Retail Lumber Dealers' Ass'n v. United States, 234 U.S. 600, 612 (1914).
157. *See* Havighurst, *supra* note 155, at 345.
158. *See supra* note 10 and accompanying text.
159. Berger, *supra* note 11, at 10.
160. *Id.*

is in the best interest of consumers. Doctors contend that the same economic rewards will be available to all practitioners regardless of their skill, experience, or willingess to employ difficult and innovative procedures.[161] While selective contracting will make doctors more cost conscious,[162] the American Medical Association is extremely concerned about the potential for medical decisions made on the basis of cost or other professional judgment.[163] "There is always the danger that some avaricious (or just sloppy) PPO's will win contracts at prices so low that corners must be cut too finely."[164]

In reality, these fears may be far less devastating than expected. For instance, professional conduct may be motivated by other non-monetary factors such as ethical and public consideration,[165] or the threat or fear of malpractice suits.[166]

Moreover, the problem of the same compensation for less competent or industrious doctors already exists, as it is inherent in any insurance plan which involves a third-party payor[167]—be it Medicare, Medi-Cal, traditional private insurance, HMO's, IPA's, or PPO's.

Practically speaking, doctors have "little to gain and much to lose financially and professionally."[168] No matter how much time a doctor contributes toward improving his professional reputation in the community, his efforts may not be fully realized unless he is a member of the growing population of PPO's. Many people

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161. *See supra* note 71 and accompanying text.

162. *See supra* note 23 and accompanying text.

163. *See* Contracting Alert: Contracting and Professional Liability (California Med. Ass'n Dep't of Contract Evaluation/Negotiation Services), Dec. 9, 1983, at 1, which states:

> Many procedures and treatments cannot be performed on an inpatient basis, except with prior authorization. Physicians may be required to comply with peer review decisions, made either by a carrier or by a peer review organization under contract with the carrier. Obviously, these "peer review" or cost-containment decisions may affect discharge, availability of diagnostic procedures or various other conditions which influence the outcome of patient care. In short, most [PPO] contracts contain provisions which restrict a physician's ability to practice medicine and may place "cost" concerns over "quality" concerns.

164. Paris, *supra* note 1, at 39.

165. Comment, *The Role of Prepaid Group Practice in Relieving the Medical Care Crisis,* 84 HARV. L. REV. 887, 925-26 (1971).

166. *See* Contracting Alert, *supra* note 163, at 1.

> Despite the existence of contractual restrictions upon the physician's ability to treat a patient, there is no provision for a different or lower standard of care, in terms of obligation to the patient. Applicable standards of care and medical practice remain unaltered, regardless of the contractual restrictions imposed by an insuring arrangement. Therefore, physicians cannot allow contractual restrictions to change and/or amend their existing standard of quality care.

167. *See* Note, *supra* note 46, at 185-86.

168. *See* Berger, *supra* note 11, at 10.

will gravitate towards a PPO member physician since they are financially unable to privately bear the cost of medical care. The days of the solo practitioner are numbered. Doctors, now more than ever before, are being forced to join together in groups, realizing they face the same fate as the family farm and the corner grocery store.[169]

The amendment of California Insurance Code section 10133[170] is a strong and coercive device to force practitioners into cost containment. While no one begrudges physicians a decent living, discounts their long and costly training, or loses sight of the fact that malpractice insurance fees are exorbitant and office overhead expenses are high, there have been few economic restraints on doctors' fees in recent years. The rapid increase in medical care costs[171] has helped push health care costs out of control and into the legislature.

B. Impact on Insurers and Employers

In contrast to the physicians, insurance companies and employers welcome the new amendment as relief from sky-rocketing premiums. Health insurance premiums have climbed nearly 25% for the nation as a whole. In California, this figure rose to as much as 40%.[172] For those employers who offer a PPO plan to their employees, the savings will be anywhere from 10% to 25%.[173] Similarly, health insurance carriers will be in a position to offer lower rates to their customers.[174]

C. Impact on Patient-Consumer

The impact of California's new selective contracting statute on patient-consumers is such that the consumer's freedom of choice has been narrowed and in some cases stripped away.[175] With the exception of the wealthy, the population will face dwindling choices as to where it will go for health care and how it is

169. *Id.*
170. *See supra* note 3 and accompanying text.
171. *See supra* note 1 and accompanying text.
172. *See* Paris, *supra* note 1, at 39.
173. *Id.*
174. *See* Paton, *Revolution in Health-Care Financing: The Good and Bad of Preferred-Provider Organizations,* Los Angeles Times, May 25, 1983, pt. II, at 7, col. 3.
175. *See supra* note 22 and accompanying text.

treated.[176] Although, under the PPO concept, the patient has the choice of either seeing a PPO provider or seeing a non-member provider, the financial incentive is very coercive.[177]

Moreover, not to be forgotten is the question of whether or not the patient will receive proper medical attention under the new discount medicine law.[178] Will practitioners, in an effort to avoid red tape authorization procedures, settle for less effective medical care?[179]

V. Conclusion

The amendment of California Insurance Code section 10133, which allows private insurers to contract with a closed exclusive panel of hospitals and doctors for negotiated rates, is an interesting addition to the health care delivery system and will inject an element of competition into the health care industry for the first time. Through careful structuring of PPO's, it is possible to minimize both the breadth and severity of antitrust risks. With careful planning and implementation, the PPO can be a procompetitive alternative to traditional medical care. However, PPO's are not the sole answer to the problem of cost containment in the health care industry. Rather, a combination of measures by all sectors of the industry is required. Whether the PPO concept can contribute to this combination with few adverse effects remains to be seen. PPO's will be monitored with great fascination by the health care community. All eyes are watching California.

Carol A. Woo

176. *See supra* note 159.
177. *See supra* note 22 and accompanying text.
178. *See supra* notes 160, 163 and accompanying text.
179. *Id.*