

THE JUDICIAL LEGITIMIZATION OF HORIZONTAL PRICE-FIXING AMONG PARTIALLY INTEGRATED HEALTH CARE PROVIDERS: AN ANTITRUST/HEALTH CARE CASE STUDY

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I. INTRODUCTION

How best to ensure affordable, quality health care has been the source of much public and academic debate. Some have proposed a version of command-economy (government ownership) allocation of health care, much like public school systems or the Veterans Administration, or public utility systems, in which fees and practices are intrusively regulated by a government agency.¹ For the most part, however, a free market approach with

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1. See generally John J. Flynn, *Antitrust Policy and Health Care Reform*, 39 ANTITRUST BULL. 59, 59 (1994) ("Among the economic and political challenges facing the United States today, none is more significant—yet difficult to resolve—than the complex puzzle of how to reform the delivery of health care services."). Notwithstanding a continuing preference for free market rather than government ownership or public utility models of health care delivery, existing law contains elements of all three. One interpretation of the November 1994 election is that a majority of the voting public has rejected institutional—public or private—depersonalized control of decisions like the selection of health care providers, which traditionally involves personal choice. See Pamela A. Paul-Shaheen, 23 J. HEALTH POL. POL'Y & L. 319, 355 (1998) (suggesting the 1994 election be viewed as a referendum on government-run health care). However, a *New York Times* study and article demonstrate a dramatic shift in health care coverage resulting from a laissez-faire political response. See Erik Eckholm, *While Congress Remains Silent, Health Care Transforms Itself*, N.Y. TIMES, Dec. 18, 1994, at 1, 34. The shift is from independent provider-patient markets to capitulated, for-profit HMOs owned by private corporations seeking to increase market concentration and control. *Id.* at 1. In this new "corporatization of health care," individuals have reduced control over selection of their providers and the nature of their care, while "[t]he H.M.O.'s are taking extraordinary profits." *Id.* at 34 (quoting John C. McDonald, Chief Exec. of Mullikin Medical Ctrs.).

significant deference to private self-regulation remains in place, resulting in the integration of providers by contract and increased concentration in health care markets.

For more than one hundred years, federal antitrust law, the primary societal means to police the free market, has posited that ongoing market competition and deconcentration among providers of goods and services produce lower prices and better service for the consuming public. Thus, agreements among competitors which eliminate price competition are regarded as facially unlawful under section one of the Sherman Act.² This rule against horizontal price-fixing has been applied when competitors agreed to fix only part of a price,³ when the prices were not literally fixed or agreed upon but merely stabilized or raised,⁴ when the defendants were professionals with arguably legitimate professional explanations,⁵ when competitors adhered to maximum rather than minimum fee schedules,⁶ and when competitors formed or joined an association or organization which directly engineered the price-fix.⁷ Although in recent years courts generally have returned to a laissez-faire approach and

2. 15 U.S.C. §§ 1 to 7 (1994). See generally Joseph W. deFuria, Jr., *Reasoning Per Se and Horizontal Price Fixing: An Emerging Trend in Antitrust Litigation?*, 14 PEPPERDINE L. REV. 39, 43 (1986) (noting that in the past "horizontal price fixing practices were sentenced to per se condemnation in a fairly traditional and predictable manner"). For a familiar recognition of the central role of antitrust in maintaining a free market economy, see Justice Black's opinion in *Northern Pacific Railway Co. v. United States*, 356 U.S. 1, 4 (1958) (describing the Sherman Act as "a comprehensive charter of economic liberty . . . providing an environment conducive to the preservation of our democratic political and social institutions").

3. See *Catalano, Inc. v. Target Sales, Inc.*, 446 U.S. 643, 649-50 (1980) (agreement to discontinue selling on credit, a component of price, held per se illegal).

4. *Palmer v. BRG of Ga., Inc.*, 498 U.S. 46, 49-50 (1990) (per curiam) (agreement to create a licensee-licensor relationship and share revenues held per se illegal).

5. *FTC v. Superior Court Trial Lawyers Ass'n*, 493 U.S. 411, 435 (1990) (re-manding the case, which involved an agreement to increase fee schedules by criminal defense attorneys, for the district court to apply a per se rule); *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 782 (1975) (adherence to fee schedules by attorneys constituted price-fixing in violation of the Sherman Act).

6. *Arizona v. Maricopa County Med. Soc'y*, 457 U.S. 332, 354 (1982) (agreement among doctors to place cap on fees held per se illegal).

7. *Superior Court Trial Lawyers Ass'n*, 493 U.S. at 415; *National Soc'y of Prof'l Eng'rs v. United States*, 435 U.S. 679, 694-96 (1978) (agreement to adhere to association's by-law banning competitive bidding held illegal under both per se and rule of reason analysis).

there has been a downturn in private antitrust enforcement, a consensus has remained surrounding the central tenet of antitrust: horizontal price-fixing is unlawful, without regard to the degree of market power possessed by the price-fixers or to any anticompetitive motive for the price-fixing.⁸

Should this long-standing antitrust rule apply in the field of health care delivery?⁹ Are non-integrated doctors independent competitors in the traditional sense of the rule against price-fixing?¹⁰ In the face of inflationary health care costs, should courts and antitrust enforcers be less stringent in striking down "efficiency-promoting" provider agreements which seek to reduce price competition by placing a cap on fees?¹¹

8. See, e.g., *Superior Court Trial Lawyers Ass'n*, 493 U.S. at 436 ("Conspirators need not achieve the dimensions of a monopoly, or even a degree of market power . . . to warrant condemnation under the antitrust laws."); *Maricopa County Med. Soc'y*, 457 U.S. at 347 ("We have not wavered in our enforcement of the per se rule against price fixing."); *United States v. National Assoc. of Real Estate Bds.*, 339 U.S. 485, 489 (1950) (price-fixing "is itself illegal under the Sherman Act, no matter what end it was designed to serve").

9. For one view, see Flynn, *supra* note 1, at 131 (arguing that "[h]ealth care is an industry that has too long been immune from rigorous review on fundamental legal and economic grounds, a fact for which we are now paying a heavy price in both extensive litigation and a major legislative effort to restructure the entire industry"). See also James F. Ponsoldt, *Refusals to Deal in "Locked-In" Health Care Markets Under Section Two of the Sherman Act After Eastman Kodak Co. v. Image Technical Services*, 1995 UTAH L. REV. 503 (examining another traditional rule concerning refusals to deal in the health care context).

10. Despite opinions to the contrary, the Supreme Court's answer to this question, is "yes." See *Maricopa County Med. Soc'y*, 457 U.S. at 348-49; cf. Carl J. Schramm & Steven C. Renn, *Hospital Mergers, Market Concentration and the Herfindahl-Hirschman Index*, 33 EMORY L.J. 869, 883 (1984) (arguing for special antitrust treatment of mergers in the medical context because of "characteristics peculiar to the hospital marketplace").

11. For a resounding "no" to this question in the merger context, see Dennis A. Yao, *The Analysis of Hospital Mergers and Joint Ventures: What May Change?*, 1995 UTAH L. REV. 381, 382 (seeking to "dispel the argument that competition does not lead to lower prices in hospital markets"); see also Duncan Cameron, *Hospital Mergers and Joint Ventures: The Not So Special Case*, 1995 UTAH L. REV. 403, 404 ("More and better research on the relationships between competition, prices, health care provision, improved health, and consumer satisfaction will likely further support the conclusion that health care markets respond normally to competition."). A private price-control regime might economically work no differently than a municipal services model. The framework for respective states to create "municipal services" models for health care exists in a number of municipalities which provide free, walk-in neighborhood clinics. See S.A. Reid, *Barebones Clinic Treats Poor for Free*, ATLANTA CONST., Oct. 17, 1994, at B6; cf. Hilary Stout & David Rogers, *'Single Payer' Concept for Health-Care Plan Is Alive and Well Despite Downgrading by Clinton*, WALL

These questions and concerns provide the context for the Eleventh Circuit's decision in *Levine v. Central Florida Medical Affiliates, Inc.*¹² In *Levine*, an internist brought antitrust claims against a preferred provider organization (PPO), a physician's advocacy group, and a hospital after his hospital staff privileges were revoked and he was denied membership in the PPO.¹³ The court ultimately held that the defendants' negotiations with the payors concerning the fees they paid providers did not constitute an illegal agreement to fix prices.¹⁴ *Levine* has subsequently been reaffirmed by *All-Care Nursing Service v. High Tech Staffing*, another Eleventh Circuit health care antitrust decision.¹⁵ This Article examines *Levine* as a representative health care/antitrust case and concludes that the court has abandoned antitrust stare decisis in the health care context, thereby creating unnecessary uncertainty with respect to the legitimacy of the use of fee schedules by non-integrated providers.¹⁶ Part I re-

St. J., Dec. 31, 1993, at 32 (discussing single-payor health care reform proposals and their impact on Clinton's managed competition proposal). See generally Catherine T. Dunlay & Peter A. Pavarini, *Managed Competition Theory as a Basis for Health Care Reform*, 27 AKRON L. REV. 141 (1993) (discussing managed care principles and features for health care reform).

Any "municipal service" model obviously begs the general policy debate regarding privatization. Compare Ferdinand Protzman, *Privatization in the East Is Wearing to Germans*, N.Y. TIMES, Aug. 12, 1994, at D1 (reporting that the cost of privatization of services in East Germany has been staggering to the economy and individuals), with John Tierney, *The Big City, Crossing Lake Messinger*, N.Y. TIMES MAG., Apr. 24, 1992, at 22, 24 (citing advocacy by Manhattan Institute and others for increased privatization of New York City services, including schools, because of inefficiency of local governmental bureaucracy). A proposed "municipal services" model also begs the political and ethical question of whether access to adequate health care, like secondary education, should be regarded as a protected component of individual liberty, essential to the exercise of all other rights.

12. 72 F.3d 1538 (11th Cir. 1996).

13. *Levine*, 72 F.3d at 1541-42.

14. *Id.* at 1548.

15. 135 F.3d 740, 748 (11th Cir. 1998) (holding that an agreement among otherwise competing nursing services to adhere to a fee schedule and implement a boycott of non-participants is not unlawful). The court held that "[a]lthough the PPP may stabilize prices to some degree, it is not the kind of 'stabilization' that can be viewed as price-fixing." *All-Care Nursing*, 135 F.3d at 748.

16. The defendants in *Levine* retained their economic independence and chose to provide health care service in a fee-for-service, rather than "capitated," fashion. *Levine*, 72 F.3d at 1548. "Capitation" contracts provide for an annual fee to cover an unlimited amount of service and thus require greater risk by the providers. Frances H. Miller, *Foreword: The Promise and Problems of Capitation*, 22 AM. J.L. & MED.

views Supreme Court horizontal price-fixing cases in order to understand the development and present state of the law in this area. Part II examines the specific facts and holding of *Levine*. Part III analyzes the Eleventh Circuit's attempt to distinguish *Levine* from *Arizona v. Maricopa County Medical Society*. Finally, Part IV critiques the reasons offered by the court in support of its holding that no illegal price-fixing occurred and suggests that contractual health care integration similar to that in *Levine* would therefore survive legal challenge. At a time when physicians are concerned about the increased power of managed care organizations caused by their unpoliced integration, and at a time when physicians are asking Congress to directly immunize their own independent price-fixing activities,¹⁷ perhaps courts should reconsider the message sent by decisions like *Levine*. These decisions disingenuously have reduced the role of the competitive process in maintaining long-term allocative efficiencies and at the same time have reduced the role of stare decisis by ordering private decision-making.

II. PRICE-FIXING UNDER THE SHERMAN ACT: SUPREME COURT CASES

A. *General Background: Trans-Missouri to Palmer*

Price-fixing agreements among competitors employing specific and informal fee schedules have been condemned from the nineteenth-century beginning of antitrust jurisprudence. In one of the earliest relevant cases, *United States v. Trans-Missouri Freight Ass'n*,¹⁸ the Court struck down an agreement among three railway companies to maintain fee schedules to create

167, 167 (1996).

17. See *FTC Chairman Pitofsky Opposes Bill Allowing Doctors to Bargain Collectively*, 67 U.S.L.W. 2072 (Aug. 11, 1998). "Enactment of H.R. 4277, the Quality Health-Care Coalition Act of 1998, Pitofsky predicted, 'would immunize anticompetitive activities that could diminish the effective functioning of health care markets. This, in turn, could harm consumers and raise health care costs.'" *Id.* The Eleventh Circuit decisions in *Levine* and *All-Care Nursing* protect the same anticompetitive conduct, without legislative support.

18. 166 U.S. 290 (1897).

"reasonable" rates on all freight traffic.¹⁹ The actual holding centered around the "plain meaning" of section one of the Sherman Act and found all restraints of trade illegal, even if reasonable.²⁰ However, in dicta, the Court said that the defendants' proffered justifications for the adherence to rate schedules were not valid even under a reasonableness test.²¹ Specifically, the Court rejected the defenses of the inefficiency of ruinous competition,²² the reasonableness of the fixed prices,²³ and freedom of contract.²⁴ These defenses remain important, however, because they are often offered today by health care provider defendants.²⁵

By 1927, at the time of *United States v. Trenton Potteries Co.*,²⁶ the Court had replaced the literal meaning approach toward reading section one of the Sherman Act with a rule of reason approach.²⁷ Nevertheless, horizontal price-fixing remained facially unlawful. *Trenton Potteries* was a criminal case in which the Court held that an agreement fixing uniform prices among sanitary pottery dealers was presumed to be illegal, even

19. *Trans-Missouri Freight Ass'n*, 166 U.S. at 312-14.

20. *Id.* at 328.

21. *Id.* at 329-31.

22. *Id.* at 330-31. The Court also noted that the special character and public importance of the railway system did not grant the railroads greater liberty to form contracts in restraint of trade. *Id.* at 332.

23. *Trans-Missouri Freight Ass'n*, 166 U.S. at 332. For the Court, allowing reasonable price-fixing would have been to allow the railroads to define reasonableness. Further, even if a price were unreasonable, practical factors would have prevented shippers from challenging the charge: "[A]ny individual shipper would in most cases be apt to abandon the effort to show the unreasonable character of a charge, sooner than hazard the great expense in time and money necessary to prove the fact, and at the same time incur the ill-will of the road itself in all his future dealings with it." *Id.*

24. *Id.* at 333.

25. See, e.g., *Levine v. Central Fla. Med. Affiliates*, 72 F.3d 1538, 1546-48 (11th Cir. 1996). The *Levine* defendants implicitly raised all three defenses in support of the use of fee schedules to support their PPO. See *Levine*, 72 F.3d at 1546-48. Because both the district court and the court of appeals summarily dismissed the plaintiff's claims, however, the defendants were never in the procedural posture of having to raise any of these defenses directly with evidentiary support. See *id.* at 1541.

26. 273 U.S. 392 (1927).

27. See *Standard Oil Co. v. United States*, 221 U.S. 1, 60 (1911); *United States v. Addyston Pipe & Steel Co.*, 175 U.S. 211, 237-38 (1899).

under the rule of reason.²⁸ Whether the fixed prices were reasonable or not was likewise "immaterial."²⁹ In a criminal procedural setting in which the failure to allow a defendant to argue reasonableness might have been reversible error, the Court's ruling represented a strong condemnation of literal price-fixing agreements, regardless of form, and served as the origin of the per se doctrine.³⁰

In *United States v. Socony-Vacuum Oil Co.*,³¹ the Court made clear that per se illegal price-fixing was not limited to the literal fixing of a uniform price or to formal reliance on fee schedules by competitors.³² Also, a combination need not possess market power to trigger antitrust liability. According to the Court:

Any combination which tampers with *price structures* is engaged in an unlawful activity. Even though the members of the price-fixing group were in no position to control the market, to the extent that they raised, lowered, or stabilized prices they would be directly interfering with the free play of market forces.³³

The defendant oil companies in *Socony-Vacuum* did not reach an agreement on the price at which to sell their oil and did not formally circulate price schedules.³⁴ Rather, the defendants entered into contracts with each other to buy excess oil in order to prevent prices from being decreased by the oversupply

28. *Trenton Potteries*, 273 U.S. at 398.

29. *Id.* at 401.

30. The Court in *Trenton Potteries* did not actually use the term "per se." However, the Court's holding that price-fixing agreements constituted unreasonable restraints on their face meant that no structural analysis of the market was required, the definition of per se antitrust illegality. *See id.* at 396-98.

31. 310 U.S. 150 (1940).

32. *Socony-Vacuum*, 310 U.S. at 220-25.

33. *Id.* at 221 (emphasis added). Despite such language, in the health care context a PPO likely will not be challenged by the government absent a showing of market power. *See Douglas J. Hammer, Refusals to Deal in "Locked-In" Health Care Markets: General Counsel's Response*, 1995 UTAH L. REV. 549, 557. Hammer describes the government's concern in the following manner:

It appears that the federal enforcement agencies' primary concern about provider membership and health care delivery systems has been "over-inclusion" of providers. . . . Where PPOs have contracted with a high proportion of practicing physicians in a service area, . . . the agencies have not hesitated to indicate their intention to challenge such exclusive arrangements.

Id. at 557.

34. *See Socony-Vacuum*, 310 U.S. at 159.

in a depressed market.³⁵ Such conduct had the effect of establishing a floor for oil prices, a species of illegal price-fixing.³⁶ The Court explained that:

[P]rices are fixed . . . if the range within which purchases or sales will be made is agreed upon, if the prices paid or charged are to be at a certain level or on ascending or descending scales, if they are to be uniform, or if by various formulae they are related to the market prices.³⁷

The inclusion of the "various formulae" prohibition has important consequences for analyzing the fee determination mechanism at issue in *Levine*.³⁸

The issue of price-fixing through creation of fee schedules by members of a profession arose in *Goldfarb v. Virginia State Bar*.³⁹ There the Court struck down a minimum fee schedule created by a county bar for lawyers engaged in title searches and held that the learned nature of the legal profession was not a defense.⁴⁰ Such Sherman Act immunity for public-service professions would have allowed learned professionals "to adopt anticompetitive practices with impunity."⁴¹ The Court reiterated the per se illegality of price-fixing by learned professionals, even in the face of a public safety and health defense, in *National Society of Professional Engineers v. United States*.⁴² There-

35. *Id.*

36. *Id.* at 223. For an article supporting the use of such price agreements, see John E. Lopatka, *The Case for Legal Enforcement of Price Fixing Agreements*, 38 EMORY L.J. 1, 40 (1989) (arguing that "withholding legal enforcement of price fixing agreements will decrease or even eliminate the social benefit that might be derived from efficient cartels"). Arguments in favor of "efficient" private cartels, of course, parallel economic arguments made to support centralized planning by government. Historically, they have been an anathema to free markets with competition-based policing.

37. *Socony-Vacuum*, 310 U.S. at 222.

38. As will later be shown, the *Levine* court ignored the law as articulated in *Socony-Vacuum*. See *infra* text accompanying notes 194-98.

39. 421 U.S. 773 (1975).

40. *Goldfarb*, 421 U.S. at 787.

41. *Id.*; cf. Proger, *Antitrust and Health Care: Where Have We Come From and Where Are We Now*, 5 HEALTH L. VIGIL 2 (1982) (suggesting public interest and professional concerns can be considered under rule of reason).

42. 435 U.S. 679 (1978). The Court explained: "The Society . . . invokes the Rule of Reason, arguing that its restraint on price competition ultimately inures to the public benefit by preventing the production of inferior work and by insuring ethical behavior. . . . [T]his Court has never accepted such an argument." *Profession-*

fore, a ban on competitive bidding by an association of engineers was held illegal.⁴³ As in *Socony-Vacuum*, the Court stated in broad terms, "an agreement that 'interferes with the setting of price by free market forces' is illegal on its face."⁴⁴

This strong language does not tell the entire story of *Professional Engineers*, however. Even though the Court held that the defendant's conduct was per se illegal, it nevertheless responded to the defendant's arguments under a rule-of-reason analysis,⁴⁵ paving the way for the development of the "quick look" doctrine a year later in *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*⁴⁶ Together, *Professional Engineers* and *Broadcast Music* could have signaled reconsideration of the per se rule of illegality, thus allowing defendants greater opportunity to justify their actions on procompetitive or other policy grounds. This opportunity is qualified, though, for the rule of reason "does not support a defense based on the assumption that competition itself is unreasonable."⁴⁷

Broadcast Music analyzed the legality of blanket licenses for the sale of music rights.⁴⁸ A blanket license allows for the purchase of such rights on a combined artist basis, instead of each composer licensing his copyrighted works individually.⁴⁹ Blanket licenses are usually sold by integrated joint-selling agencies composed of broadcasting industry members. In this case, CBS alleged that such an arrangement constituted price-fixing because "the composers and publishing houses have joined togeth-

al Engineers, 435 U.S. at 693-94. The lead author of this Article participated in the *Professional Engineers* case as an attorney for the Justice Department.

43. *Id.*

44. *Id.* at 692 (quoting *United States v. Container Corp.*, 393 U.S. 333, 337 (1969)).

45. *Id.* at 692-96.

46. 441 U.S. 1, 19-20 (1979). In determining the legality of an actor's conduct, a court should take a quick look to determine "whether the practice facially appears to be one that would always or almost always tend to restrict competition and decrease output, and in what portion of the market, or instead one designed to 'increase economic efficiency and render markets more, rather than less, competitive.'" *Broadcast Music*, 441 U.S. at 19-20 (quoting *United States v. United States Gypsum Co.*, 438 U.S. 422, 441 n.16 (1978)).

47. *Professional Engineers*, 435 U.S. at 696. The Court pointed out that "the Sherman Act reflects a legislative judgment that ultimately competition will produce not only lower prices, but also better goods and services." *Id.* at 695.

48. *Broadcast Music*, 441 U.S. at 5.

49. *Id.*

er into an organization that sets its price for the blanket license it sells.⁵⁰

In *Broadcast Music*, the Court, for the first time, did not condemn a horizontal price agreement under a per se analysis.⁵¹ The Court created the "quick look" doctrine methodology to determine when a per se or rule-of-reason analysis was to be employed.⁵² After a closer look at the questioned conduct and the proffered reasons behind it, the Court decided that the case should be remanded and judged by a rule of reason standard, thus allowing greater consideration of the competitive effects of the conduct.⁵³ Four justifications behind the blanket license were found compelling: (1) the prevention of piracy;⁵⁴ (2) the pro-competitive benefits in promoting a new product, the blanket license;⁵⁵ (3) the promotion of copyright law;⁵⁶ and 4) increased efficiencies created via decreased transactions costs.⁵⁷ More-

50. *Id.* at 8. Here, the joint-sellers against whom CBS brought suit were Broadcast Music and ASCAP.

51. *Id.* at 10; see deFuria, *supra* note 2, at 49 ("Unfortunately, the Supreme Court's consideration of factors for applying the per se rule to an alleged horizontal price fixing practice in *Broadcast Music* contradicted earlier Court pronouncements regarding the general application of the per se rule to price fixing cases.").

52. *Broadcast Music*, 441 U.S. at 19-20; see *supra* note 46 and accompanying text.

53. *Broadcast Music*, 441 U.S. at 24-25.

54. *Id.* at 20 ("Individual sales transactions in this industry are quite expensive, as would be individual monitoring and enforcement, especially in light of the resources of single composers.").

55. *Id.* at 22.

56. *Id.* at 19. The Court noted:

Although the copyright laws confer no rights on copyright owners to fix prices among themselves or otherwise to violate the antitrust laws, we would not expect that any market arrangements reasonably necessary to effectuate the rights that are granted would be deemed a *per se* violation of the Sherman Act.

Id.

57. *Broadcast Music*, 441 U.S. at 22 ("[A] bulk license of some type is a necessary consequence of the integration necessary to achieve these efficiencies, and a necessary consequence of an aggregate license is that its price must be established."). For support of the use of an efficiencies defense in the area of health care, see Thomas L. Greaney, *Regulating for Efficiency in Health Care Through the Antitrust Laws*, 1995 UTAH L. REV. 465 (arguing that "decision makers can and should explicitly evaluate the procompetitive potential of even the most suspect agreements among rivals"). Greaney admits, nevertheless, that the Supreme Court has never adopted such a view. *Id.* at 466. Greaney's position would undermine the per se rule and the beneficial policies behind it. See *infra* note 100. The confusing identity between "efficiency" and "competition" has entered the antitrust debate. Obviously, the

over, the creation of a blanket license had no facially anticompetitive effects on the market, in part because individual composers remained free to license their compositions at any price. In declining to use the per se rule, the Court employed language arguably at odds with the prohibition against tampering with "price structures" in *Socony-Vacuum*: "Not all arrangements among actual or potential competitors that have an impact on price are *per se* violations of the Sherman Act or even unreasonable restraints."⁵⁸ Overall, the "quick look" doctrine modified the traditional per se rule by allowing a defendant to argue that its conduct was pro-competitive in cases in which such conduct might otherwise have been deemed unlawful on its face.⁵⁹

The dynamics of the "quick look" doctrine were further demonstrated in *NCAA v. University of Oklahoma*⁶⁰ and *FTC v. Indiana Federation of Dentists*.⁶¹ Both cases are prime examples of the Court's giving a quick look to defendants' conduct, deciding not to use the per se rule, then condemning the conduct anyway under the rule of reason, specifically holding that proof of defendants' market power was not necessary because the conduct, on its face, was anticompetitive and created facially anticompetitive effects on the market.⁶² In *NCAA*, the Court

two concepts are not identical. Activities that improve short-term efficiencies also improve competition only when the respective market remains sufficiently competitive that efficiency savings are passed on to consumers.

58. *Broadcast Music*, 441 U.S. at 23 (listing, for example, "[m]ergers . . . [j]oint ventures and other cooperative arrangements . . . where the agreement on price is necessary to market the product at all").

59. The *Levine* defendants likely could not benefit from such a defense. The main justification for the arrangement at issue related to the greater ease with which it allowed doctors to reach patients. See *infra* note 144 and accompanying text. This represents a pro-efficiency, not a pro-competitive, rationale. For example, the buying scheme in *Socony-Vacuum* certainly could be labeled efficient, despite its terrible effect on competition.

Broadcast Music was followed just one year later by *Catalano, Inc. v. Target Sales, Inc.*, 446 U.S. 643 (1980), in which the Court summarily struck down an agreement to discontinue selling beer on credit under the per se illegality rationale after only a very brief look. The lead author of this Article participated as a Justice Department attorney on behalf of the amicus curiae in *Catalano*.

60. 468 U.S. 85 (1984).

61. 476 U.S. 447 (1986).

62. *Indiana Federation of Dentists*, 476 U.S. at 459-61; *NCAA*, 468 U.S. at 109-13.

acknowledged that the NCAA's price-setting plan for college football telecasts, utilizing a form of price schedule, appeared to be one that would always restrict price competition.⁶³ Nevertheless, the Court refused to apply the per se rule. The critical factor behind this decision was the nature of the industry, specifically that "horizontal restraints on competition [were] essential if the product [were] to be available at all."⁶⁴ Even though the Court moved away from the application of the per se rule, as noted above, a friendly ruling for antitrust defendants in the face of price schedules, the plaintiff still did not have to show that a defendant held market power:

As a matter of law, the absence of proof of market power does not justify a naked restriction on price or output. To the contrary, when there is an agreement not to compete in terms of price or output, "no elaborate industry analysis is required to demonstrate the anticompetitive character of such an agreement."⁶⁵

The Court demonstrated its commitment to this principle in *Indiana Federation of Dentists* by stressing that no market analysis is required when proof of actual detrimental effects, such as decreased output or services, already exists.⁶⁶ The Court also found that disruptions of the price-setting mechanism, in this case the withholding of patient information desired by insurers, could be condemned as illegal even without proof of higher prices.⁶⁷

63. *NCAA*, 468 U.S. at 100. The exact content of the NCAA's plan is not relevant for present purposes. Basically, an NCAA representative and a television network would set the price a participating school in a telecast would receive for the school's rights. See *id.* at 92-95, 106 n.30. The lead author of this Article served in NCAA as counsel to the plaintiffs.

64. *Id.* at 101.

65. *Id.* at 109 (citation omitted).

66. *Indiana Federation of Dentists*, 476 U.S. at 460-61 (noting that market power "is but a 'surrogate for detrimental effects'" (quoting PHILIP AREEDA, ANTITRUST LAW § 1511, at 429 (1986))).

67. *Id.* at 461-62. Specifically, the Court stated:

A concerted and effective effort to withhold (or to make more costly) information desired by consumers for the purpose of determining whether a particular purchase is cost justified is likely enough to disrupt the proper functioning of the price-setting mechanism of the market that it may be condemned even absent proof that it resulted in higher prices or, as here, the purchase of higher priced services, than would occur in its absence.

Id. (citation omitted).

Although both *NCAA* and *Indiana Federation of Dentists* were decided in favor of the plaintiffs, invalidating a price schedule and an informal limitation on services without regard for defendants' market power and specifically rejecting defense arguments that such market power was a necessary component of the rule of reason inquiry, the continuing viability of the *per se* rule seemed uncertain throughout the 1980s.⁶⁸ The two 1990 cases, *FTC v. Superior Court Trial Lawyers Ass'n*⁶⁹ and *Palmer v. BRG of Georgia, Inc.*,⁷⁰ demonstrate that the *per se* rule is still the primary rule governing horizontal price-fixing cases. In both instances, the Court struck down price agreements, including a proposed fee schedule increase and a price-sharing formula, without giving the defendants' proffered justifications much of a "quick look."⁷¹ *Superior Court Trial Lawyers Ass'n* involved an agreement among defense lawyers for indigents to engage in a group boycott until their fees were raised by the District of Columbia.⁷² Quoting from *Socony-Vacuum*, the Court stated that no such arrangements can ever be justified:

The effectiveness of price-fixing agreements is dependent on many factors, such as competitive tactics, position in the industry, the formula underlying pricing policies. Whatever economic justification particular price-fixing agreements may be thought to have, the law does not permit an inquiry into their reasonableness. They are all banned because of their actual or potential threat to the central nervous system of the economy.⁷³

Further, the Court once more made clear that *per se* condemna-

68. For an article written at the time explaining this situation, see James Paul Murphy, Comment, *The Demise of the Per Se Rule in Horizontal Price-Fixing Cases: A Historical Perspective*, 23 GONZAGA L. REV. 635, 654 (1988) ("The present vestiges of the *per se* rule against horizontal price-fixing leave the practitioner and the business person alike with little guide as to what type of conduct cannot escape Section 1 liability.").

69. 493 U.S. 411 (1990).

70. 498 U.S. 46 (1990).

71. *Palmer*, 498 U.S. at 48-50; *Superior Court Trial Lawyers Ass'n*, 493 U.S. at 423-25.

72. *Superior Court Trial Lawyers Ass'n*, 493 U.S. at 414.

73. *Id.* at 435 (citation omitted). Price-fixing agreements are bad because "[t]he conceivable social benefits are few in principle, small in magnitude, speculative in occurrence, and always premised on the existence of price-fixing power which is likely to be exercised adversely to the public." *Id.* (quoting 7 PHILIP AREEDA, ANTI-TRUST LAW § 1509, at 412-13 (1986)).

tion is not contingent on a defendant's possession of a significant market share.⁷⁴ That a group would enter into a price-fixing agreement, in itself, suggests an ability for such a group to affect market prices.⁷⁵ Without the assurance that their agreement, seeking an increase in fee schedules, would succeed and guarantee stable prices, the actions of conspiring price-fixers would contravene economic rationality.⁷⁶

The *per se* rule received an even stronger reaffirmation in *Palmer*, a case in which the Court summarily reversed an Eleventh Circuit decision upholding a revenue-sharing formula between national and state bar review companies.⁷⁷ The formula in question did not formally set prices. Under the agreement, the state company gave the national company \$100 for every student enrolled in the state company as well as forty percent of all revenues over \$350.⁷⁸ In return, the national company agreed not to compete in the state.⁷⁹ Stressing the *per se* illegality of such a combination, the Court made clear that *Socony-Vacuum* was still good law by citing the following from the 1940 opinion: "Under the Sherman Act a combination formed for the purpose and with the effect of raising, depressing, fixing, pegging or stabilizing the price of a commodity . . . is illegal *per se*."⁸⁰ How this strong language squares with *Broadcast Music's* principle of allowing pro-competitive justifications for price arrangements among competitors is not exactly clear.⁸¹

74. *Id.* at 430-31.

75. *Id.* at 435 n.18. According to the Court, "[v]ery few firms that lack power to affect market prices will be sufficiently foolish to enter into conspiracies to fix prices. Thus, the fact of agreement defines the market." *Id.* (quoting ROBERT BORK, *THE ANTITRUST PARADOX* 269 (1978)).

76. What stands out about *Superior Court Trial Lawyers Ass'n* is that the case was ever brought at all. In the lax antitrust enforcement era of the 1980s, the challenging of the conduct of a group of defense lawyers for indigent clients provides legal cynics with powerful material and illuminates the political motives behind many enforcement decisions.

77. *Palmer v. BRG of Georgia*, 498 U.S. 46, 48-49 (1990).

78. *Palmer*, 498 U.S. at 47.

79. *Id.*

80. *Id.* at 48 (citation omitted). The lead author of this Article served in *Palmer* as counsel to the plaintiffs.

81. For an explanation of this seeming contradiction, see Murphy, *supra* note 68, at 650 ("In a clear-cut horizontal price-fixing case where price floors are determined by agreement, a defendant will cite *BMI* and be allowed to assert defenses—pro-competitive justifications for their conduct. Thus, procedurally, the *per se* rule

B. Doctors and Price-Fixing: Arizona v. Maricopa County Medical Society

In 1982, after *Goldfarb*, *National Society of Professional Engineers*, *Broadcast Music*, and *Catalano*, but before *NCAA* and *Indiana Federation of Dentists*, the Supreme Court confronted the issue of price-fixing among doctors in *Arizona v. Maricopa County Medical Society*.⁸² In *Maricopa*, the Court found a maximum price agreement among doctors using fee schedules to be per se illegal, holding that "[t]he anticompetitive potential inherent in all price-fixing agreements justifies their facial invalidation even if procompetitive justifications are offered for some."⁸³ These words signify that, even after *Broadcast Music*, the reasonableness of an agreement to adhere to fee schedules should not be an issue when literal price-fixing is involved.⁸⁴ What makes the use of the *Socony-Vacuum* rule in this case so significant is the fact that the set fees, as in *Levine*, were maximum, not minimum, prices; although as the Court acknowledged, "maximum" fee schedules frequently become uniform fee schedules, particularly when there is no incentive for price competition.⁸⁵

The Maricopa Foundation for Medical Care was a nonprofit organization of private physicians of which seventy percent of the doctors in Maricopa County were members.⁸⁶ Designed to promote fee-for-service medicine, the foundation engaged in three main activities: (1) the establishment of a schedule of maximum fees that participating doctors received for services rendered to patients insured under foundation-approved plans; (2) review of the necessity of the medical treatment afforded to these insured patients; and (3) payment from insurance compa-

applies only after a mini-rule of reason analysis.").

82. 457 U.S. 332 (1982).

83. *Maricopa County Med. Soc'y*, 457 U.S. at 351 (emphasis added).

84. *Id.* at 351 n.23 ("Whatever economic justification particular price-fixing agreements may be thought to have, the law does not permit an inquiry into their reasonableness. They are all banned because of their actual or potential threat to the central nervous system of the economy." (quoting *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 226 n.59 (1940)).

85. See *id.* at 347; discussion *infra* Part IV.

86. *Maricopa County Med. Soc'y*, 457 U.S. at 339.

ny accounts to foundation doctors for services performed.⁸⁷ The Pima Foundation for Medical Care, a codefendant in the litigation, performed similar functions.⁸⁸ For the Court's purposes, the activities of the two groups were treated the same in light of the question presented, namely: "[W]hether the Sherman Act prohibits the competing doctors from adopting, revising, and agreeing to use a maximum-fee schedule in implementation of the insurance plans."⁸⁹

The plaintiff did not challenge the peer review or claim administration functions of the foundations. However, the foundations did not contend that these two activities required the use of the maximum fee schedules at issue.⁹⁰ The mechanism by which the maximum fees were derived is important for analyzing the method later questioned in *Levine*.⁹¹ Both foundations arrived at the fixed fees by multiplying a "relative value" and a "conversion factor." A relative value stipulated the numerical weight for the various medical services. A conversion factor assigned the dollar amount used to determine fees for particular medical specialties such as "medicine" and "laboratory." Changes in either factor of the two-factor mechanism were proposed by the board of trustees of each foundation and approved by a vote of the entire memberships.⁹²

The application of the fee schedules was limited to patients insured under foundation-approved plans. For these patients, the doctors agreed to charge no higher than the fixed fee. Charg-

87. *Id.* at 339-40. In light of these functions the foundation was considered an "insurance administrator" by the Director of the Arizona Department of Insurance. *Id.* at 340. Participating doctors had no direct financial interest in the foundation's operation. *Id.*

88. *Id.* A dispute existed regarding the percentage of doctors in the Pima County group: some evidence suggested eighty percent, while an affidavit by the executive director claimed thirty percent. *Maricopa County Med. Soc'y*, 457 U.S. at 340 n.8. However, it seems that because the Court found the fee-setting scheme to be per se illegal, *id.* at 357, the true market share of the group was irrelevant for purposes of this litigation.

89. *Id.* at 342.

90. *Id.* at 340. This issue could take on significant importance with respect to the legality of fee schedules adhered to by provider groups.

91. See *infra* text accompanying notes 140-59.

92. *Maricopa County Med. Soc'y*, 457 U.S. at 340-41; see also *Levine v. Central Fla. Med. Affiliates, Inc.*, 72 F.3d 1538, 1546 (11th Cir. 1996) (describing a similar system used by the defendants in that case).

es lower than the fixed fee were also allowed. For uninsured patients, a doctor could charge any fee he or she chose. A customer insured under foundation-endorsed plans who wished to be treated by nonmember physicians could go elsewhere, but that person had to pay the excess of any charge over the foundation's maximum fee.⁹³ A factual dispute existed between the defendants and the state of Arizona on the impact the fee schedules had on medical fees and insurance premiums.⁹⁴ The most important aspect of this debate is that the Court found no need to resolve it in order to strike down the fee schedules.⁹⁵ Further, the Court acknowledged "that 85-95% of physicians in Maricopa County bill at or above the maximum reimbursement levels set by the Maricopa Foundation."⁹⁶ Thus, given the ultimate holding of the case, the fact that the set prices were the lowest in the area, and hence more consumer-friendly, could not save the price arrangements. This outcome represents a strong stand by the Court against any health care defense that a fee-setting scheme serves the public interest by producing lower costs, even if this appears to be the case.⁹⁷

Before discussing the particulars of the Maricopa arrangement, the Court articulated the reasons behind the use of a *per se* rule in antitrust cases. The Court outlined four rationales for *per se* condemnation of certain economic restraints: (1) economic prediction;⁹⁸ (2) judicial convenience; (3) business certainty; and (4) the importance of the role of the legislative branch—the power of Congress to prevent federal courts from utilizing a *per se*

93. *Maricopa County Med. Soc'y*, 457 U.S. at 341.

94. *Id.*

95. *See id.* at 342.

96. *Id.* at 341 n.10.

97. *See, e.g., Dolph Schmidt, Antitrust—Application of Per Se Rule Against Price Fixing to Doctors' Maximum Fee Schedules—Arizona v. Maricopa County Medical Society*, 31 U. KANSAS L. REV. 479, 489 (1983) ("Maximum price fixing is arguably a practice that theory and past judicial experience have not necessarily shown to be harmful."). The problem, of course, is that competitive harm from maximum fee schedules is not suitable for static proof. Such harm evolves over time as "competitors" integrate maximum fees into their market decisions and price competition disappears.

98. *Maricopa County Med. Soc'y*, 457 U.S. at 348 (stating that "[t]he *per se* rule 'is grounded on faith in price competition as a market force'" (quoting James A. Rahl, *Price Competition and the Price Fixing Rule—Preface and Perspective*, 57 NW. U. L. REV. 137, 142 (1962))).

analysis in particular—or all—cases.⁹⁹ Relevant to each of these considerations is the overall importance to society of respect for and confidence in a recognizable “rule” of law, incorporated in *stare decisis*. While recognizing that the *per se* approach may lead to the invalidation of efficiency-promoting agreements, the Court reasoned that the consistency of the *per se* method served utilitarian ends: “[I]n the present legal framework the costs of implementing a rule of reason would exceed the benefits derived from considering each restrictive agreement on its merits and prohibiting only those which appear unreasonable.”¹⁰⁰ The Court’s language creates a definite presumption that the *per se* rule should be used in cases dealing with a prohibited category of restraint such as horizontal price-fixing.¹⁰¹

When the Court addressed the specific issues in the case, it rejected the defendants’ attempt to justify the maximum fee schedule on pro-competitive grounds.¹⁰² The argument offered

99. *Maricopa County Med. Soc’y*, 457 U.S. at 354. The Court explained: Given its generality, our enforcement of the Sherman Act has required the Court to provide much of its substantive content. By articulating the rules of law with some clarity and by adhering to rules that are justified in their general application, however, we enhance the legislative prerogative to amend the law.

Id. For a recent reaffirmation of the importance of the legislative prerogative, see *FTC v. Ticom Title Ins. Co.*, 504 U.S. 621, 632-35 (1992), which discusses the power granted to states to regulate trade in ways inconsistent with the Sherman Act. See also Flynn, *supra* note 1, at 66 (noting that *Ticom* recognizes “a long-standing political value of antitrust policy important to health care reform proposals: the presumption that antitrust policy applies to all economic activity in society unless otherwise exempted by the Congress”).

100. *Maricopa County Med. Soc’y*, 457 U.S. at 344 n.14 (citation omitted). Regarding the efficiency of the *per se* rule, the Court noted, “As in every rule of general application, the match between the presumed and the actual is imperfect. For the sake of business certainty and litigation efficiency, we have tolerated the invalidation of some agreements that a full blown inquiry might have proved to be reasonable.” *Id.* at 344; *cf.* *Chicago Board of Trade v. United States*, 246 U.S. 231, 240 (1918) (looking at the effects of a price rule and finding “the rule had no appreciable effect on general market prices”).

101. That the Court may have little antitrust experience in a particular industry does not warrant non-application of the *per se* rule. The defendants in *Maricopa County* unsuccessfully tried to argue this very important point in regard to the health care field. 457 U.S. at 349-50.

102. One commentator feared that the Court’s ruling spelled doom for all PPOs. See Gary B. Wilcox, Commentary, *Preferred Provider Organizations: Can the Doctors Do the Price Fixing?*, 37 OKLA. L. REV. 733, 756 (1984) (“The Court’s refusal to seriously consider procompetitive justifications before characterizing the [Foundations’]

by the foundations resembled the "creation of a new product" line of reasoning from *Broadcast Music*.¹⁰³ The defendants contended that the fee schedules were a necessary feature of a unique insurance coverage plan which afforded consumers "a choice of doctors, complete insurance coverage, and lower premiums."¹⁰⁴ The Court rejected this proffered justification on three main grounds. First, the choice of doctors and complete insurance coverage was not "unique" to the challenged plans.¹⁰⁵ Second, for the Maricopa Foundation to argue that it provided complete coverage when thirty percent of the county's doctors were not in the plan was factually incorrect.¹⁰⁶ When a patient wanted to use a non-foundation doctor, he opened himself to having to pay a portion of that doctor's fee. Finally, even if a maximum fee is needed to ensure complete insurance coverage and lower premiums, the doctors do not need to be the ones who do the price-fixing.¹⁰⁷

This last point is very important because it serves as a possible distinguishing feature from the fee schedule mechanism in *Levine*. The Court employed an alternatives analysis in attacking the role of the doctors in establishing the maximum fee schedules. The Court pointed to the Arizona Comprehensive Medical/Dental Program for Foster Children, which the Maricopa Foundation administered under a maximum fee schedule prescribed by a state agency.¹⁰⁸ Also, the long experience of insurance companies in fixing maximum rates influenced the Court that the setting of the fees by the doctors was unnecessary.¹⁰⁹ Nevertheless, while nullifying the arrangements before

activity as per se illegal presents the most ominous barrier to the continued development of physician-sponsored PPOs.").

103. See *Broadcast Music, Inc. v. Columbia Broadcasting Sys.*, 441 U.S. 1, *passim* (1979).

104. *Maricopa County Med. Soc'y*, 457 U.S. at 351.

105. *Id.*

106. *Id.* at 352.

107. *Id.*

108. *Id.* at 353.

109. *Maricopa County Med. Soc'y*, 457 U.S. at 353 ("Insurers are capable not only of fixing maximum reimbursable prices but also of obtaining binding agreements with providers guaranteeing the insured full reimbursement of a participating provider's fee."). The danger of doctors engaging in maximum price-fixing is as follows: "[M]aximum prices can yield excess profits while also being manipulated to prevent undesirable entry of competitors or regulators into the market." Schmidt,

it, the Court made it clear that this case did not "present the question whether an insurer may, consistent with the Sherman Act, fix the fee schedule and enter into bilateral contracts with individual doctors."¹¹⁰

The last part of the opinion distinguished the case from *Broadcast Music*. Unlike the product market in *Broadcast Music*, where little competition existed among composers selling their music rights, the doctors in *Maricopa* directly competed with one another for patients.¹¹¹ Also, the *Maricopa* arrangement did not lead to the creation of a new product, but rather "merely permitted [the doctors] to sell their services to certain customers at fixed prices and arguably to affect the prevailing market price of medical care."¹¹² Finally, the Court rejected the argument that the foundations constituted a type of integrated joint venture or partnership arrangement.¹¹³ Because the individual physicians in this case did not share a risk of loss, the doctors could not claim this protection.¹¹⁴ In clear language, the Court stated, "The agreement under attack is an agreement among hundreds of competing doctors concerning the price at which each will offer his own services to a substantial number of consumers."¹¹⁵ Read literally, this language clearly should have voided the maximum fee schedule at issue in *Levine*.¹¹⁶

supra note 97, at 489.

110. *Maricopa County Med. Soc'y*, 457 U.S. at 353 n.26.

111. *Id.* at 356.

112. *Id.*

113. *Id.*

114. *Id.* at 356-57.

115. *Maricopa County Med. Soc'y*, 457 U.S. at 357 (emphasis added). The Court distinguished HMO-type medical providers: "If a clinic offered complete medical coverage for a flat fee, the cooperating doctors would have the type of partnership arrangement in which a price-fixing agreement among the doctors would be perfectly proper." *Id.*

116. This point assumes that the word "substantial" used by the *Maricopa* Court relates to a qualitative, rather than a quantitative, measure. See *Standard Oil Co. of Cal. v. United States*, 337 U.S. 293, 321-22 (1949). In any event, the Court in *Maricopa* did not explicitly rely on any definition of market share. The Court's last two sentences do not bode well for horizontal price agreements: "[T]he fee agreements disclosed by the record in this case are among independent competing entrepreneurs. They fit squarely into the horizontal price-fixing mold." *Maricopa County Med. Soc'y*, 457 U.S. at 357. If fee agreements among competitors squarely qualify as horizontal price-fixing, the *per se* rule is triggered, and the price arrangement should be struck down, regardless of the portion of the market affected. While admitting the truth of this assertion, some observers think the Court's stance too rigid.

III. *LEVINE V. CENTRAL FLORIDA MEDICAL AFFILIATES*

A. *General Background and Procedural History*¹¹⁷

Dr. Scott Levine, an internist, moved to Orlando, Florida, in 1989 to practice medicine as a sole practitioner. Dr. Levine sought, and eventually received, full active staff privileges with the Orlando Regional Healthcare System, Inc. ("ORHS"). ORHS is a nonprofit group that owns and manages five hospitals in the Orlando area, including Sand Lake Hospital. Dr. Levine proved a capable physician. In his first full year as a sole practitioner, he earned \$533,176, more than twice the average earnings of private internists in Florida for 1990.¹¹⁸

Levine also sought membership into Central Florida Medical Affiliates, Inc. ("CFMA") and Healthchoice, Inc.¹¹⁹ CFMA is an association of competing doctors which acts as a physician advocacy group. One of the objectives of CFMA is to ensure physician participation in a "Master Payor Rate Schedule." This schedule, which constitutes one factor in a two-factor fee determination formula, is created by Healthchoice, an affiliated physician-provider organization.¹²⁰ Provider members of the PPO remain in-

See Schmidt, *supra* note 97, at 491.

Maricopa has strongly affirmed antitrust law's abhorrence of price fixing, its relevance to the learned professions, and its reliance on presumptions of illegality. . . . Antitrust law could be more precisely focused and could better adapt to our evolving economy if a more flexible spectrum of section 1 illegality were explicitly adopted.

Id.; cf. Murphy, *supra* note 68, at 654 ("Without clear rules, even in areas of extreme anticompetitive behavior, the Sherman Act loses its potency and purpose.").

117. For the discussion of the facts and procedural history of the case, see *Levine v. Central Florida Medical Affiliates, Inc.*, 72 F.3d 1538, 1542-44 (11th Cir. 1996). The lead author of this Article served in *Levine* as counsel to the plaintiffs.

118. *Levine*, 72 F.3d at 1542. The court used a disbelieving tone in describing Dr. Levine's success, suggesting that it simply could not take seriously an antitrust challenge from one so well off.

119. *Id.* at 1542.

120. *Id.* at 1546-47. PPOs have been characterized as follows:

Preferred provider organizations . . . combine features of both HMO and fee-for-service insurance coverage. If the PPO insured receives care from a "preferred" provider, who has contracted with the PPO to render services sub-

dependent, and Healthchoice markets medical services to prospective payors on a fee-for-service, non-capitated basis.¹²¹ CFMA members are required to be Healthchoice provider panel members as well, although Healthchoice may contract with non-CFMA doctors.¹²² Still, CFMA serves as the main source of Healthchoice's physician providers.¹²³

Levine's numerous attempts to join Healthchoice and CFMA all failed. Healthchoice repeatedly denied Levine's request for membership on the grounds that no more internists were "needed" based upon privately determined "need" requirements in the geographic area. When Levine sought CFMA membership, his telephone call was answered by a Healthchoice employee, who once more told Levine that no more internists were needed.¹²⁴

ject to managed care constraints, the insurance premium covers the full costs of care. If instead the insured chooses to obtain care from a non-contracting provider, PPO coverage functions as indemnity insurance. This means that insured patients have to pay their non-PPO provider bills directly. They will usually be reimbursed for only part of that expense, however, because non-preferred provider charges ordinarily exceed those allowed by the PPO.

Francis H. Miller, *Vertical Restraints and Powerful Health Insurers: Exclusionary Conduct Masquerading as Managed Care*, 51 LAW & CONTEMP. PROBS. 195, 200-01 (1988).

121. *Levine*, 72 F.3d at 1546-47. For an explanation of the historical effects of such a system, see Flynn, *supra* note 1, at 73. Flynn explains that "the medical profession's continued insistence upon the fee-for-service method for paying for health care . . . resulted in 'the creation of a monopoly in medical practice through the exclusion of alternative practitioners' and the prevention of customer cost and quality controls." *Id.* (quoting PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 21 (1982)). In many respects, Dr. Levine qualifies as such an "alternative practitioner," albeit a very successful one.

122. *Levine v. Central Fla. Med. Affiliates*, 864 F. Supp. 1175, 1177 (M.D. Fla. 1994). Tellingly, the Eleventh Circuit did not mention that CFMA doctors were required to join Healthchoice. The court's omission of this fact is understandable, in light of the plaintiff's contention that CFMA restricted its membership to erect a boycott of non-members doctors. See *Petition for Writ of Certiorari* at 5 (on file with author; see also Mark A. Gtlick, *Unilateral Refusals to Deal in the Health Care Industry After Eastman Kodak Co. v. Image Technical Services*, 1995 UTAH L. REV. 537; Ponsoldt, *supra* note 9, at 583. To the extent CFMA consists of a group of competitors with anticompetitive designs, the greater the likelihood is that Healthchoice exists to allow the doctors to reach agreement indirectly on fees because they could not do so directly.

123. *Levine*, 864 F. Supp. at 1177; *Levine*, 72 F.3d at 1547. The Eleventh Circuit does not provide a quantitative percentage revealing how many Healthchoice providers did not belong to CFMA. The court's silence on this point may suggest that most, if not all, Healthchoice doctors are CFMA members. If true, the assertion that CFMA and Healthchoice are independent is laughable.

124. *Levine*, 72 F.3d at 1543. For real world background on the issues raised

CFMA and Healthchoice offices and employees were the same.¹²⁵

Healthchoice members agree to limit the size of its physician panel available to patients based on the respective need for various specialists.¹²⁶ Thus, if a specialty is already adequately represented, no more applications are accepted from doctors in that specialty. Such a "need" limitation parallels public utility regulation, which limits entry in order to limit competition. This approach is the antithesis of free market economics. Physician providers are not directly involved in determining the number of Healthchoice doctors needed, which is instead handled by a regular staff of the PPO.¹²⁷ The Healthchoice need-based system is not absolute, however. When a physician joins the group practice of an existing Healthchoice provider, that new physician automatically becomes eligible to join Healthchoice. This exception purportedly allows Healthchoice to deal more efficiently with issues from cross-coverage by physicians involved in a group practice.¹²⁸

In January of 1991, after repeatedly attempting to join Healthchoice and retaining an attorney to help him in that effort, Dr. Levine's staff privileges at Sand Lake Hospital were summarily suspended, a decision initiated by a competing internist who also served on the CFMA Board. Levine's privileges at the other ORHS hospitals were not immediately affected. Sand Lake Hospital placed Levine on one-year probation, limiting the procedures he was authorized to perform, and the doctor regained his privileges in May of 1991. The state of Florida, which automatically was notified regarding the suspension, subsequently declined to take any action against Dr. Levine. For the year 1991, Levine earned \$724,722, thirty-one percent more than he earned in 1990.¹²⁹

In March of 1993, Levine brought suit in United States

when physicians are excluded from PPOs, see Ron Winslow & Edward Felsenthal, *Physicians Fight Back as Insurers Cut Them from Health Networks*, WALL ST. J., Dec. 30, 1993, at 1, col. 1.

125. See *Levine*, 72 F.3d at 1543.

126. *Id.* at 1547.

127. *Id.*

128. *Id.* at 1546-47. For a more thorough discussion of how Healthchoice and CFMA operate, see *id.*

129. *Levine*, 72 F.3d at 1544.

District Court of Florida against CFMA, Healthchoice, Sand Lake Hospital, and ORHS, alleging violations of sections one and two of the Sherman Act.¹³⁰ Levine's complaint contained three counts. He first claimed a section one violation against CFMA and Healthchoice for maintaining and adhering to price schedules and for "maintaining a closed panel of physicians [which denied him] physician provider membership."¹³¹ More specifically, the count asserted that CFMA, through its policies and practices, conspired with its members, with Healthchoice, and with others to reduce price competition.¹³² Count Two alleged a section two violation, namely that all of the defendants monopolized the market for medical patients "whose employers have contracted with Healthchoice."¹³³ Count Three claimed that the suspension of Levine's staff privileges by Sand Lake Hospital and ORHS constituted a concerted refusal to deal in order to prevent price and service competition in violation of section one.¹³⁴ In light of these allegations, Levine sought damages in excess of \$100,000 and injunctive relief.¹³⁵

In June of 1994, the four defendants each filed a Rule 56 motion for summary judgment. The district court granted each motion, finding that the plaintiff "failed to establish an antitrust

130. *Id.* The exclusion of one doctor from a provider network has been held to meet the jurisdictional interstate commerce requirement of the Sherman Act. *Summit Health, Ltd. v. Pinhas*, 500 U.S. 322, 330-31 (1991). However, *Pinhas* was decided before *United States v. Lopez*, 514 U.S. 549 (1995), a decision many regard as signaling a retreat from a fifty-year expansive view of when the jurisdictional nexus of the Commerce Clause has been satisfied.

131. *Levine*, 72 F.3d at 1544.

132. *Levine*, 864 F. Supp. at 1182-83.

133. *Levine*, 72 F.3d at 1544.

134. *Id.* Although a split exists in the circuits on whether a section one claim is appropriate in this circumstance, the Eleventh Circuit supports such actions. See *Boczar v. Manatee Hospitals & Health Care Systems, Inc.*, 993 F.2d 1514, 1519 (11th Cir. 1993) (holding that independent contractors on a hospital's medical staff may conspire with each other under the Sherman Act and that hospital staff members may conspire with hospitals as well); *Bolt v. Halifax Hospital Medical Center*, 891 F.2d 810, 819 (11th Cir. 1990) (same).

135. Dr. Levine also brought various pendant state law claims which were dismissed by the court without prejudice. *Levine*, 72 F.3d at 1544. A separate complaint filed in state court ultimately was settled. State law is increasingly becoming a source of refuge for physicians excluded from provider networks. See Flynn, *supra* note 1, at 86 n.67 ("Physicians excluded from HMOs and PPOs have begun to file lawsuits challenging their exclusion on a number of grounds other than antitrust, including interference with the physician-patient relationship.").

injury, and, therefore, he lacks standing" to bring all three claims.¹³⁶ This ruling meant that the district court did not reach the merits of Levine's claims. On appeal, the Eleventh Circuit specifically declined to address the standing issue, finding instead that Levine failed to establish a genuine issue of material fact that the conduct of the defendants was per se illegal or created an anticompetitive effect in relevant markets in violation of the antitrust laws.¹³⁷ Levine's petition for writ of certiorari to the United States Supreme Court was denied.¹³⁸

*B. A Closer Look at the Relationship Between CFMA and Healthchoice.*¹³⁹

Healthchoice markets physicians, most of whom are CFMA members, to a diverse array of health care payors, including employers, insurance companies, third-party administrators, and governmental agencies. Healthchoice is one of the largest PPOs in the Orlando area. In the words of the Eleventh Circuit: "Healthchoice maintains a limited panel of providers who have agreed to accept no more than a maximum allowable fee for services rendered or products furnished to Healthchoice enrollees. These maximum fees may or may not be lower than the provider's ordinary charges."¹⁴⁰ Providers agree to have their maximum fees set because membership in Healthchoice is, itself, limited and "may increase their number of patients."¹⁴¹

1. How Fees Are Calculated.—Prospective Healthchoice employers are given a schedule of the PPO's fees. Healthchoice's

136. *Levine v. Central Fla. Med. Affiliates, Inc.*, 864 F. Supp. 1175, 1182 (M.D. Fla. 1994).

137. *Levine*, 72 F.3d at 1545.

138. *Levine v. Central Fla. Med. Affiliates, Inc.*, 117 S. Ct. 75 (1996).

139. The facts in this section are summarized from the court's opinion. See *Levine*, 72 F.3d at 1546-47 for the complete discussion.

140. *Id.* at 1546.

141. *Id.*; see Flynn, *supra* note 1, at 89-90 ("As health insurers have become more price conscious and better at negotiating discounts and capitation fees, providers increasingly claim that they lack the bargaining power individually to negotiate fair fees and therefore need to band together to negotiate collectively with large insurers."). One spin on this argument is that the doctors' fear of price competition in the open market leads them to join together to ensure the receipt of high fees.

schedule of fees is determined by multiplying the unit value of a medical service's "Current Procedural Terminology" ("CPT") code and a monetary conversion factor assigned by Healthchoice to each major medical specialty. The CPT code unit value approximates the resource cost for each procedure, and this estimate is derived from information provided by Medicare. The monetary conversion factor in each specific fee is created by Healthchoice. The collection of conversion factors comprises the "Master Payor Rate Schedule." CFMA members, directly and through CFMA, itself, and other Healthchoice providers agree to abide by this schedule. The Healthchoice board of directors, half of whom are CFMA physicians, approves the Master Payor Rate Schedule; however, the CFMA members of the board are not allowed to participate directly in this decision. Healthchoice's contracts with CFMA members and other providers include the Master Payor Rate Schedule, but not the CPT code unit values.¹⁴²

When a payor agrees to Healthchoice's schedule of fees, the set fees represent the maximum a provider will receive from a payor for each product or service. A payor will pay the provider the lower of two figures, the actual charge given by the provider or the maximum allowable fee under the Healthchoice schedule. If a provider finds the fee reimbursement of a contract with a specific payor unacceptable, that provider may "opt out" of the contract.¹⁴³

2. *The Healthchoice Regime.*—The Healthchoice plan creates economic disincentives for enrollees to use other providers,¹⁴⁴ in addition, of course, to including only Healthchoice providers on lists of participating providers distributed to enrollees. A payor possesses the power to deter use of other physicians by requiring "the enrollee to pay a higher deductible" and by requiring the enrollee to cover any provider charges over the maximum allowable reimbursement established by the payor.¹⁴⁵ Fi-

142. *Levine*, 72 F.3d at 1544-46.

143. *See id.* at 1546-48.

144. Healthchoice is all but required to allow *some* escape valve for plan enrollees to use the services of others, for "an exclusive arrangement between a PPO and an employer or insurer excluding competing providers from providing the service has earmarks of a concerted refusal to deal or boycott." *See Flynn, supra* note 1, at 74 n.38.

145. *See Levine*, 72 F.3d at 1547. The freedom of enrollees to use other doctors

nally, the plaintiffs further contended that "provider doctors are forbidden from participating for six months in any other plan for a prospective Healthchoice payor who has declined to do business with Healthchoice."¹⁴⁶

Moreover, Healthchoice policy creates a presumption that its providers should refer the PPO's patients to other Healthchoice physicians. A consistent failure to follow this policy may lead to a provider's removal from the panel of Healthchoice physicians. The alleged justification of this provision relates to the management of Healthchoice costs.¹⁴⁷

C. The Eleventh Circuit's Discussion of Price-Fixing¹⁴⁸

According to the Eleventh Circuit, "the uncontroverted evidence in the record . . . establishes that there was no agreement between Healthchoice, CFMA, and their member physicians to fix provider fees."¹⁴⁹ Nevertheless, the court did recognize that the conduct in question "is a kind of 'price fixing,' but it is a kind that the antitrust laws do not prohibit."¹⁵⁰

The court appears to have three reasons for reaching this

thus appears to be a technical, as opposed to a practical, right. Most individuals are not going to be in a position to pay the extra full costs of using alternative providers. Anatole France's observation that "the majestic equality of the laws, which forbid rich and poor alike to sleep under the bridges, to beg in the streets, and to steal their bread" parallels this system. ANATOLE FRANCE, *THE RED LILY* 80 (1894). In any event, Healthchoice's requirement of a higher deductible to use non-member providers may raise separate antitrust concerns. Flynn explains:

Insurers (particularly HMOs and PPOs) require insureds to use only specified providers or forfeit some or all insurance benefits, and may limit a provider's right to treat patients other than those belonging to the insured group. Similar practices in other industries raise antitrust issues analyzed under the labels of "exclusive dealing" and "tying arrangements."

Flynn, *supra* note 1, at 96.

146. See Petition for Writ of Certiorari at 5 (on file with author). The court did not respond to the evidence offered by Dr. Levine on this point.

147. *Levine*, 72 F.3d at 1547. Presumptive referrals should immediately raise antitrust concerns because they effectively lock out competing doctors from a particular consumer pool. See Michael Black & James Langenfeld, *Economic Theories of the Potential Anticompetitive Impact of Physician Owned Joint Ventures*, 39 ANTI-TRUST BULL. 385, 397 (1994) (noting a physician referral "opens up the possibility of anticompetitive effects" by limiting a consumer's search for alternative providers).

148. *Levine*, 72 F.3d at 1548-49.

149. *Id.* at 1548.

150. *Id.*

result: first, the fees as fixed were "maximum," not necessarily uniform; second, the fees were "partial," not both multiples of the fee (which as noted above was a medicare schedule); and third, the fees were not literally fixed by direct agreement among providers. First, the court minimized the degree of contact between Healthchoice, CFMA (the lead defendant), and its providers in the area of fee determination.¹⁵¹ Because a payor theoretically could negotiate the fees with Healthchoice without any provider involvement, the court reasoned that the doctors and, implicitly, CFMA, could not have been said to conspire to fix prices.¹⁵² Also, the court noted that providers are not consulted before Healthchoice employees compile the Master Payor Rate Schedule or CPT code unit values.¹⁵³

Second, the Eleventh Circuit attached great importance to the fact that the actual fees a doctor may charge are not set in concrete.¹⁵⁴ A panel member may always opt out of CFMA if not satisfied with a particular fee reimbursement. When a physician decides to stay in the plan, "[t]he only figure that is set is the maximum allowable fee that [the doctors] will be reimbursed by Healthchoice. Nothing prevents the physician from dropping his fees even further in order to compete should he choose to do so."¹⁵⁵

These two sentences are misleading and possibly supply the strongest basis for criticizing the *Levine* decision. The court may have sensed the tightrope it was walking here, for at this point, the curious "kind of 'price fixing'" line appears. To strengthen its position, the court characterized the Healthchoice arrangement as one "in which the payors decide the maximum amount they are willing to reimburse providers for medical services and providers decide whether they are willing to accept that limitation of the reimbursement they receive . . ."¹⁵⁶ The immediate problem with this description is that it totally leaves out the role of the Healthchoice fee schedule and the commitment by CFMA—an association of physicians—in the price-setting pro-

151. *Id.* at 1548.

152. *Id.*

153. *Levine*, 72 F.3d at 1548.

154. *Id.*

155. *Id.*

156. *Id.*

cess.

Third, and finally, the court relied on Department of Justice and Federal Trade Commission guidelines supporting the use of the "messenger model" in health care delivery systems.¹⁵⁷ For the DOJ and FTC, "[t]he critical antitrust issue [behind the policy] is whether the arrangement creates or facilitates agreements that restrict price or other significant terms of competition among the provider members of the network."¹⁵⁸ The Eleventh Circuit's discussion of the "messenger model" was limited.¹⁵⁹ The court simply stated that Healthchoice did not restrict price competition. No analysis was made of the role of CFMA, the lead defendant in the case. No analysis was offered to explain how Healthchoice fit into the "messenger model" or how the DOJ/FTC policy specifically related to the case at hand.

IV. *LEVINE* AND *MARICOPA*: CAN THEY BE DISTINGUISHED?

A. *The Eleventh Circuit's Attempt*

Despite *Maricopa's* seeming relevance to the topic at hand, the Eleventh Circuit relegated discussion of this Supreme Court case to a single footnote.¹⁶⁰ Furthermore, it made no attempt to distinguish *Levine* from *Maricopa*. Instead, the court simply lifted a passage from the *Maricopa* opinion and stated that the Healthchoice system was "implicitly sanctioned" by this quoted language.¹⁶¹ The operative portion of the *Maricopa* opinion for the court is as follows:

[A] binding assurance of complete insurance coverage . . . can be obtained only if the insurer and the doctor agree in advance on the maximum fee that the doctor will accept as full payment for a particular service. Even if a fee schedule is therefore desirable, it is not necessary that the doctors do the price fixing. . . . [I]nsurers

157. *Id.* at 1548-49.

158. *Levine*, 72 F.3d at 1549 (quoting FTC Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust, available in 1994 WL 642477, at *39).

159. *Id.*

160. *Id.* at 1549 n.13.

161. *Id.*

are capable not only of fixing maximum reimbursable prices but also of obtaining binding agreements with providers guaranteeing the insured full reimbursement of a participating provider's fee.¹⁶²

This language is immediately problematic in that Healthchoice is not an "insurer." CFMA, of course, is not even remotely a mere "messenger." As will be shown, this attempt by the court to distinguish *Levine* as well as the price schedule methodology used by Healthchoice and similar PPOs from the Supreme Court's decision in *Maricopa* lacks persuasive force.

B. Critique of the Eleventh Circuit's Use of *Maricopa*

Maricopa prohibits a foundation or association of doctors from agreeing to adhere to a maximum fee schedule.¹⁶³ *Levine* allows CFMA and CFMA doctors to agree to maximum fees instituted by Healthchoice, an affiliated PPO.¹⁶⁴ The key distinction relied on by the *Levine* court is that the doctors allegedly did not agree directly to fix prices among themselves, but rather merely agreed to accept no more than a fixed sum from Healthchoice, a quasi-"insurer."¹⁶⁵ Seemingly, in analyzing the correctness of *Levine*, the key questions become: What is Healthchoice? What is CFMA?

Even assuming the Eleventh Circuit's description of the facts was accurate,¹⁶⁶ a strong case existed at the summary judgment stage that Healthchoice is little more than CFMA in drag. First, CFMA members are *required* to join Healthchoice.¹⁶⁷ Coupled with the fact that Healthchoice doctors may be dropped from the PPO for failing to refer patients to

162. *Id.* (quoting *Arizona v. Maricopa County Med. Soc'y*, 457 U.S. 332, 352-53 (1982)).

163. *Maricopa County Med. Soc'y*, 457 U.S. at 348-51; see *supra* text accompanying notes 6, 10, 84, 87-88, 98, 101, 109, 115-16.

164. *Levine*, 72 F.3d at 1548-49; see *supra* text accompanying note 120.

165. See *Levine*, 72 F.3d at 1548-49.

166. The facts set out in the Petition for Writ of Certiorari at 3-10 (on file with author), which are supported by statements in the record from some of the defendants in the case, differs greatly from the version of the facts articulated by the court.

167. *Levine v. Central Fla. Med. Affiliates*, 864 F. Supp. 1175, 1177 (M.D. Fla. 1994); *supra* note 122.

other Healthchoice doctors,¹⁶⁸ the forced membership of CFMA doctors in Healthchoice raises an issue as to whether the agreement of CFMA providers to set maximum prices occurs in a context of a concerted refusal to deal on the issue of patient referral.¹⁶⁹ Such a situation casts further suspicion on the supposed independence of CFMA doctors. Second, at a minimum, CFMA doctors constitute the vast majority of Healthchoice physicians.¹⁷⁰ To the degree that the providers of CFMA and Healthchoice are the same individuals, and the employees, offices, and telephones of CFMA are those of Healthchoice, then only the most naive analysis would fail to wonder if Healthchoice were merely a front for CFMA. Third, and possibly most tellingly, Levine's call to CFMA was answered by a Healthchoice employee.¹⁷¹ The court never addressed why this would be the case. Despite these points, the court confidently concluded that Levine presented "no genuine issue of material fact" regarding an agreement between CFMA and Healthchoice or among members of CFMA, to fix prices,¹⁷² even in light of Healthchoice's acknowledged promulgation of fixed fees. The court seemed to suggest a meaningful difference between an arrangement in which competitors directly agreed with each other to create a particular fee schedule (which did not happen) and an arrangement in which competitors each agreed through an association to adhere to a fee schedule submitted by an agent (which did happen).¹⁷³

The Eleventh Circuit reached its conclusion despite the fact that Healthchoice clearly is not an insurer, the key point in the *Maricopa* language quoted by the court. Unlike an insurance company, Healthchoice does not provide capitated coverage and does not in any way assume the risk of covering the costs of

168. *Levine*, 72 F.3d at 1547.

169. *See supra* note 115 and accompanying text. The same force behind a concerted refusal to deal likewise flowers the seeds of an anticompetitive atmosphere from which price-fixing may arise. *See generally* *FTC v. Indiana Federation of Dentists*, 476 U.S. 447 (1986) (holding that a policy in which x-rays were withheld from insurers was an unreasonable restraint of trade and thus a violation of sections one and five of the Sherman Act).

170. *See supra* note 123.

171. *Levine*, 72 F.3d at 1543.

172. *Id.* at 1548.

173. *See id.* at 1549.

expensive medical care.¹⁷⁴ Furthermore, Healthchoice does not make the actuarial weighing of probabilities performed by insurers to achieve profitability. Healthchoice simply arranges a fee for each service performed by its member doctors. Much like an agent who works on commission, Healthchoice cannot suffer any financial losses beyond its sunk costs.

Because Healthchoice is not an insurer, the question becomes: What is it? The court acknowledged that Healthchoice is a physician-provider organization affiliated with CFMA.¹⁷⁵ At its basic level, a PPO is a combination of doctors (and hospitals). The very passage from *Maricopa* quoted by the court plainly stated: "[I]t is not necessary that the doctors do the price-fixing."¹⁷⁶ Arguably, if no doctors actually sat down to create the fee schedules, then the Eleventh Circuit's finding that the doctors themselves did not literally fix prices could be technically correct. This seems to be the implication of the court's reasoning. However, such an analysis is simply too facile. Healthchoice does not exist in a vacuum. It exists primarily, if not exclusively, to promote and market the business interests of its participating providers. No other rational explanation can exist to explain the PPO's existence. The court's readiness to isolate CFMA and its participating doctors from Healthchoice at the summary judgment stage is hard to explain, especially in light of *Maricopa*, absent a conclusion that the court was determined to reach the result it did.¹⁷⁷

Overall, the court's glaring failure to engage in an extended discussion of *Maricopa* given the underlying facts immediately casts suspicions upon the accuracy of the *Levine* court's conclusions. Further, *Maricopa* clearly prohibits an "agreement among . . . competing doctors concerning the price at which each will offer his own services."¹⁷⁸ Nevertheless, the Eleventh

174. See Flynn, *supra* note 1, at 91 n.77 ("PPOs do not assume responsibility for all the costs the insured may incur, as do HMOs.").

175. *Levine*, 72 F.3d at 1542 (noting that CFMA "was organized to supply the Healthchoice PPO" with doctors).

176. *Arizona v. Maricopa County Med. Soc'y*, 457 U.S. 332, 352 (1982).

177. The Ninth Circuit is not as trusting. See *United States v. Alston*, 974 F.2d 1206, 1214 (9th Cir. 1992) ("In a market consisting of individual service providers and individual consumers, concerted action by the suppliers even on matters not directly related to price is viewed with the greatest suspicion.").

178. *Maricopa County Med. Soc'y*, 457 U.S. at 357.

Circuit's discussion did nothing to tackle this point. Even if the ultimate result of *Levine* were correct, the court deserves criticism for its slight treatment of relevant and binding Supreme Court authority.¹⁷⁹

V. *LEVINE* WAS WRONGLY DECIDED

A. *Levine Represents Bad Law*

As noted earlier, the *Levine* court articulated three reasons for finding in favor of the defendants: (1) the court minimized the role played by the Healthchoice providers and CFMA in the determination of their fees; (2) the court seemed satisfied that because actual fees were not set in concrete and that only "part" of the fee was fixed, no price-fixing had occurred; and (3) the court believed Healthchoice fell into the "messenger model" mode of health care delivery approved by the DOJ and FTC.¹⁸⁰ The court's reliance on these factors is misplaced.

1. *The Provider's Role in the Determination of Fees.*—The Eleventh Circuit's rationale concerning what role providers should play in setting their fees was addressed in the previous section of this Article discussing the spurious way the court tried to use *Maricopa* to justify its result.¹⁸¹ Basically, the court said Healthchoice, not the doctors or, by implication, CFMA, set the relevant fees. Thus, concerted action is lacking, and section one of the Sherman Act is not violated. For such reasoning to work, the interest of Healthchoice, vis-à-vis the interests of CFMA and its provider members, must be separate and independent. An insurance company poses no antitrust

179. A separate critique relates to the court's eagerness to resolve this case at the summary judgment stage. In *Eastman Kodak Co. v. Image Technical Services, Inc.*, 504 U.S. 451, 479-86 (1992), the Court stressed the need for a trial in antitrust cases instead of relying on theoretical assumptions to grant summary judgment. The whole tenor of the opinion sounded in favor of allowing antitrust plaintiffs to prove their cases before a fact finder. The *Levine* court did not mention *Eastman Kodak*, even though that decision was the primary source of law relied on to support the section two claim.

180. *Supra* text accompanying notes 151-59.

181. *Supra* text accompanying note 161.

problem in this regard because it is essentially a "customer" of the providers, in the business of making money with minimum risk. In fact, an insurance company has a direct incentive to limit the amount of fees a doctor receives. The less a doctor receives, the less an insurance carrier has to pay out. In this sense, although purchaser-supplier, an insurance company and a doctor are competitors for the same aggregate healthcare dollar.

Healthchoice, on the other hand, possesses no such independent profit incentive to limit the fees of its providers. CFMA's motives are those of its members. The PPO's only check in limiting its fees at all is a market incentive based on the need to attract payor customers. Of course, in the context of an alleged boycott, the potential for market pressure to do its job is severely hampered. The central antitrust policy against price-fixing relates to the distortion of market rates from concerted action. Competition is the lifeblood of a market system. From this perspective, the court's argument that the doctors or their organization were not the ones setting the fees, or directly involved in that process, is incredibly misplaced.¹⁸² The facts that providers did not set their own fees and that the fees nevertheless tended to be uniform and tending upward should immediately have signaled a red flag for the court. When a group of providers assign their fee-setting ability to a single party, which incorporates as an alter ego an organization of those providers, competition is not enhanced. If Doctors X and Y agree through CFMA and Healthchoice to charge the same fee for the same service, the effect on prices and the market is substantively the same as if Doctors X and Y simply by-passed Healthchoice and agreed with each other.¹⁸³

In short, the court's reliance on the alleged minimal role of Healthchoice doctors in the determination of their fees fails for several reasons. First, for all intents and purposes, Healthchoice

182. See *Hahn v. Oregon Physicians' Serv.*, 868 F.2d 1022, 1028-29 (9th Cir. 1988) (holding that there was a jury issue present on whether a horizontal boycott and a price-fixing agreement existed when provider members controlled the go-between insurer and operated it on a PPO basis).

183. The court's method of analysis is the diametrical opposite of that used by the Supreme Court in *Eastman Kodak*. In that case, the Court stated: "Legal presumptions that rest on formalistic distinctions rather than actual market realities are generally disfavored in antitrust law." 504 U.S. at 466-67.

cannot be so easily divorced from its panel members as the court would have it seem. Second, even if Healthchoice had separate interests from those of CFMA, the doctors' surrendering of their fee-setting abilities to the same source disturbs the functioning of the market price system, especially when Healthchoice, the new fee-setter, has no financial incentives to deliver low fees to the consumer. However one seeks to characterize the arrangement, the underlying fact remains the same: Otherwise independent doctors have collectively agreed to join the same price system.¹⁸⁴ Although *Maricopa* may allow for individual competing doctors independently to agree on rates with an insurance carrier, a customer surrogate, the *Levine* court misses the mark by focusing on this narrow *possible* exception instead of the clear import of the entire *Maricopa* decision.

2. *The Issue of Whether Actual Fees Were Set.*—The court's conclusion that "actual" fees were not set is both inaccurate and irrelevant. The inaccuracy stems from two observations which come pretty close to being downright silly. First, the court contended that the doctors did not conspire to fix fees because they only agreed to the Master Payor Rate Schedule.¹⁸⁵ Because this schedule is only one-half of the fee formula, the doctors could not have agreed to fix prices. The trouble with such an analysis is manifest. Even though Healthchoice doctors may not have agreed to accept a specific monetary fee, they nevertheless

184. See Flynn, *supra* note 1, at 90. Flynn points out that:

Often, health care providers that otherwise operate independently have discussed and agreed upon fees for certain services offered to powerful buyers. These fee schedules bear many of the earmarks of prohibited price fixing, much like the practices of organized labor bargaining collectively with employers. Ultimately, legislative exemptions from the antitrust laws were required for collective bargaining by officially recognized unions before the courts finally yielded in their hostility to collective bargaining as a prohibited form of horizontal price fixing.

Id. As *Levine* demonstrates, PPOs have not met the hostility faced by organized labor earlier in the century, even though PPOs often collectively bargain on behalf of providers. *Levine*, 72 F.3d at 1546-47. The federal judiciary's ease in validating PPOs usurps a decision which should be distinctly in the province of Congress. See *Arizona v. Maricopa County Med. Soc'y*, 457 U.S. 332, 354-55 (1982). The sad irony of this story is that many of the judges making these decisions are decidedly anti-labor and would likely have invalidated collective bargaining agreements in an earlier era.

185. *Levine*, 72 F.3d at 1548.

agreed to abide by the *same* fee, and that is what causes the anticompetitive effect on the market.¹⁸⁶ Also, the other half of the fee formula, a Medicare CPT code, is a fixed measurement. As a result, when a Healthchoice doctor agrees to the Master Payor Rate Schedule, he faces no uncertainty as to what his fee will ultimately be. Only the most formalistic of views would contend that no "actual" price-fixing occurred in such a situation—a contention specifically repudiated by the Court in *Catalano*.¹⁸⁷

Furthermore, Healthchoice's fee-setting method is almost identical to the method found illegal in *Maricopa*.¹⁸⁸ Like Healthchoice, the Maricopa Foundation used a relative value and a conversion factor to arrive at fees. Nothing in the *Maricopa* Court's analysis suggests its result would have been different if the foundation doctors had agreed to the relative values only. Nor should it. If competitors agree on X price, and the actual final price is merely the product of X and another fixed integral (say two), then actual price-fixing has still occurred. For illegal price-fixing purposes, $P = X \times 2$.¹⁸⁹ If it did not, then price-fixing pirates would never again have to fear section one liability; the loophole would be too great. For this reason, the Court in *United States v. Socony-Vacuum Oil Co.* included as per se illegal "various formulae . . . related to the market prices."¹⁹⁰

The *Levine* court's second inaccuracy regarding whether actual fees were fixed stems from what generously may be described as a naive point of view. The court concluded that no

186. See Flynn, *supra* note 1, at 92 n.78 (When a "price restraint . . . provides the same economic reward to all regardless of their individual abilities, the restraint may deter entry and experimentation with new methods of delivering the service and it may be a masquerade for fixing uniform prices."). Because of the Eleventh Circuit, providers who in the future find themselves in Dr. Levine's position are certainly less likely, *ceteris paribus*, to enter the Orlando medical market.

187. *Catalano, Inc. v. Target Sales, Inc.*, 446 U.S. 643, 649 (1980).

188. See *supra* text accompanying notes 104-16.

189. The Supreme Court's decision in *Catalano*, 446 U.S. at 647-48 bears this point out. In *Catalano*, the Court held an agreement to eliminate credit terms among alcohol distributors per se illegal because credit represented a component of price. *Id.* Similarly, the Master Payor Rate Schedule is a component of the price a doctor charges to Healthchoice customers and should be per se illegal if *Catalano* is still good law.

190. 310 U.S. 150, 222 (1940).

price-fixing occurred because “[t]he only figure that is set is the maximum allowable fee that [the doctors] will be reimbursed by Healthchoice. Nothing prevents the physician from dropping his fees even further in order to compete should he choose to do so.”¹⁹¹ The court here acknowledged that such an arrangement is “a kind of ‘price fixing,’” though “a kind that the antitrust laws do not prohibit.”¹⁹² The court’s reasoning is unexplained. For example, why would a CFMA provider lower his fees in order to compete? The Healthchoice system obviates any need for the doctor to compete. If Healthchoice has already arranged for a payor to reimburse a provider the maximum fee, then a doctor is certainly not going to lower his rates out of the goodness of his heart. The patient, who chooses the provider, has no cost incentive to shop for a lower fee. Also, the very reason Healthchoice allegedly exists is to take the negotiation process out of the hands of panel members. Yet now the court claims that competition is not harmed because the doctors can negotiate themselves.¹⁹³ Under the fee regime, however, when will the providers ever be face-to-face with the payors in order to negotiate? If panel doctors never even have an opportunity to negotiate, then common sense (as well as the evidence) dictates that the fees set by Healthchoice are almost certainly the “actual” fees.

The Eleventh Circuit’s conclusion that actual fees were not set is simply inaccurate. First, an agreement to receive the same fees or accept fees according to a price schedule is actual price-fixing. Second, the Supreme Court in *Maricopa* found literal price-fixing from use of a fee schedule almost identical to that used by Healthchoice. Finally, the idea that doctors possess any incentives to lower their fees is absurd and contradicted by the court’s own reasoning elsewhere. Still, the most amazing part of the *Levine* opinion is this: even if the court were accurate that

191. *Levine*, 72 F.3d at 1548.

192. *Id.*

193. The plaintiff contested the conclusion that providers had a chance to negotiate, arguing instead that such duties were the exclusive province of Healthchoice. See Petition for Writ of Certiorari at 4-5 (on file with author) (“By written agreement Healthchoice assured the CFMA providers that it would seek to negotiate agreements with prospective payors guaranteeing fees to the doctors no less favorable than the doctors and CFMA jointly agreed to in the master payor rate schedule.”).

actual fees were not fixed, such a conclusion is legally irrelevant.

Socony-Vacuum plainly states, "Any combination which tampers with price structures is engaged in an unlawful activity."¹⁹⁴ This aspect of *Socony-Vacuum* was expressly affirmed in the recent *Palmer* case, in which the Supreme Court took the extraordinary step of summarily reversing the Eleventh Circuit on this very issue in a per curiam opinion.¹⁹⁵ In *Palmer*, much like *Levine*, the Eleventh Circuit had affirmed a district court's finding that price-fixing did not occur because the two companies involved did not sit down and actually agree to prices.¹⁹⁶ The Supreme Court's response to that argument essentially asked, "So what?" and found that price-fixing may occur "even though there was no direct agreement on the actual prices to be maintained."¹⁹⁷ Such clear-cut language renders the *Levine* court's reliance on the contention that no "actual" fees were fixed arrogant, at best. Then again, the Eleventh Circuit reached its erroneous result in *Palmer* despite such opinions as *Socony-Vacuum*,¹⁹⁸ *National Society of Professional Engineers*,¹⁹⁹ *Indiana Federation of Dentists*,²⁰⁰ and *Catalano*,²⁰¹ cases which all stand for the proposition that actual price-fixing is not required to invalidate horizontal price agreements.

3. *The Court's Reliance on FTC Guidelines.*—The *Levine* court also pointed to FTC policy statements to support its result.²⁰² Using this source, the court concluded that

194. *Socony-Vacuum*, 310 U.S. at 221.

195. See *supra* text accompanying notes 77-81.

196. *Palmer v. BRG of Ga., Inc.*, 498 U.S. 46, 48 (1990) (per curiam).

197. *Palmer*, 498 U.S. at 48 (emphasis added).

198. 310 U.S. 150 (1940).

199. 435 U.S. 679 (1978).

200. 476 U.S. 447 (1986).

201. 446 U.S. 643 (1980).

202. *Levine*, 72 F.3d at 1548-49. The proposition that the health care industry would have its own set of guidelines has drawn criticism from some observers. See Cameron, *supra* note 11, at 405. The author explains that:

As anyone who provides antitrust counsel knows, nearly every client believes that their industry is special: although antitrust laws make sense for other industries, the client's industry is too competitive, complex, and so forth . . . [T]he enforcement agencies have apparently [accepted this argument in] establishing special guidelines for health care. I question whether the current research . . . warrants granting special status.

Id.

Healthchoice fell into the permissible "messenger model" of health care delivery.²⁰³ According to these statements, a "messenger" is "an agent or third party conveying to purchasers information obtained individually from providers in the network about prices the network participants are willing to accept, and conveying to providers any contract offers made by purchasers."²⁰⁴ Under the FTC's guidelines, "[s]uch arrangements, when properly designed and administered, rarely present substantial antitrust concerns."²⁰⁵ After quoting these passages, the court concluded that Healthchoice did not restrict price competition. No analysis was offered.²⁰⁶

Does Healthchoice really qualify as a third party messenger as defined by the FTC? The FTC language quoted by the court plainly states that the information conveyed to purchasers must be "obtained *individually* from providers in the network."²⁰⁷ Immediately, the Healthchoice regime presents a problem. The Healthchoice fee schedule is not a compilation of information gathered individually from providers. Rather, in the court's explanation of the facts, the finished fee schedule is presented to providers collectively.²⁰⁸ Furthermore, individual doctors are

203. *Levine*, 72 F.3d at 1549.

204. FTC Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust, available in 1994 WL 642477, at *38 [hereinafter FTC Statements].

205. *Id.*

206. *Levine*, 72 F.3d at 1548. Similarly, the Eleventh Circuit offered no analysis in *All-Care Nursing Service v. High Tech Staffing*, 135 F.3d 740, 748 (11th Cir. 1998) for its conclusion that the price stabilization by the defendant was not "the kind of" price stabilization that is unlawful.

207. *Levine*, 72 F.3d at 1549 (emphasis added). A serious question exists as to whether a messenger model analysis is even appropriate in the Healthchoice context. By the FTC's own terms, such an analysis is only appropriate when "[a] network . . . does not engage in joint pricing." FTC Statements, *supra* note 204, at *38. Arguably, a fee schedule represents the joint maximum prices the network of Healthchoice providers is willing to accept.

208. *Levine*, 72 F.3d at 1548. Antitrust's condemnation of collective economic activity parallels America's traditional mood toward collective action on the governmental level. See Walter Adams & James W. Brock, *Revitalizing a Structural Antitrust Policy*, 39 ANTITRUST BULL. 235, 236 (1994). The authors argue that:

Like the Constitution, antitrust policy asserts a blueprint for an organizational structure, which divides decision-making power, and disperses it among a multitude of hands—a governance structure that pits rival against rival in a system of checks and balances so as to harness the pursuit of profit and channel it into socially beneficial outlets.

not brought into the process of a specific transaction until after a payor has agreed to use Healthchoice. The FTC conception employed by the court instead suggests that the third party messenger should first agree with a provider on a fee then present that result to the payor.

Even assuming the court's conclusion that the doctors did not fix prices is correct, this difference as to when a provider agrees to a fee is critical. If Healthchoice and a payor agree on a fee prior to provider approval, the provider's role in the setting of his fee is effectively emasculated.²⁰⁹ Although the doctors may theoretically refuse to accept this agreed-upon fee, little incentive exists for them to refuse the offered payment. The fee presumably will be the one established by the fee schedule. Therefore, for a provider to refuse a fee as unsatisfactory, he is, in essence, refusing to treat any Healthchoice patients. Why would a doctor even be a CFMA member under such circumstances? The nonsensical nature of this situation demonstrates the weakness of the court's position. This point also shows why the court was wrong to rely on the provision that a doctor may "opt out" of a particular contract. Where is the incentive? Without one, the "opt out" option is illusory. Also, by the time a provider would make such a decision, Healthchoice's negotiations with a payor are complete. As a result, an institutional pressure exists against providers not to opt out of a contract for fear of upsetting payor clients.²¹⁰

Id.

209. When this occurs throughout the PPO, Healthchoice becomes a collective price-fixer, thereby creating the same anticompetitive effect as if the doctors had agreed among themselves to fix prices directly. See *supra* text accompanying notes 182-84.

210. The FTC supports this idea:

If the messenger coordinates individual providers' responses to a particular proposal, disseminates to members other providers' views or intentions as to the proposal, acts as an agent for collective negotiation and agreement by the providers, or otherwise serves to facilitate collusive behavior among network participants, network participants will run a serious antitrust risk.

FTC Statements, *supra* note 204, at *39. Needless to say, the *Levine* court does not quote *this* language from the FTC, even though it appears in the same paragraph as a quotation which the court does use. The "collective negotiation" phrase appears to be very damaging to the outcome the court wants to reach. Such selective lifting of what to cite only cements the result-oriented thrust of the *Levine* decision. One hopes that such judicial tactics are not widely employed.

More pernicious is that the FTC specifically rejects the saving grace of "opt out" provisions:

Use of an intermediary or "independent" third party to convey collective price offers to purchasers or to negotiate agreements with purchasers, or giving to individual providers an opportunity to 'opt out' of such agreements does not negate the existence of a price agreement or eliminate antitrust concern.²¹¹

This statement, coupled with the evidence questioning the independence of Healthchoice and CFMA, suggests the court's reliance on the FTC guidelines is misplaced.²¹² After all, what is the Healthchoice fee schedule if not a "collective price offer to purchasers"?²¹³

Overall, the reasons offered by the court in arguing that no illegal price-fixing occurred are unpersuasive. The FTC guidelines do not support the result.²¹⁴ Nor is actual price-fixing required as the court would have it seem, something the Eleventh Circuit should have learned after *Palmer*. Finally, anecdotal facts and common sense demonstrate that Healthchoice providers have a much greater role in the determination of their fees than the court admits.²¹⁵

211. *Id.* at *40 n.40.

212. A separate question is whether reliance on FTC guidelines is really appropriate at all. In *Levine*, two potential criticisms for using the guidelines exist. First, in our system, FTC pronouncements should carry less weight than Supreme Court precedent for a lower federal court. As a result, while consulting the FTC may be helpful, a court's focus should be on what the Supreme Court has said on a particular matter. Second, the motive behind the FTC guidelines may not apply when the plaintiff is a private party. FTC enforcement is a political decision. The fact that the FTC decides not to pursue an action against an economic actor does not mean that the antitrust laws have not been violated.

213. A defender of Healthchoice may emphasize that individual negotiations with payors establish fees instead of the fee schedule. While technically negotiations may occur between Healthchoice and a payor and may result in different fees, it seems unlikely that after going through all the trouble of establishing the fee schedule, Healthchoice will adopt a yard-sale mentality of "Everything's Negotiable." At the very least, the actual amount of fee negotiation was disputed and should have been submitted to a jury.

214. See Cameron, *supra* note 11, at 405 (questioning whether the "new Health Care Policy Statements are consistent with past enforcement practices").

215. Could the court have justified its result on any grounds? One possible escape was seen in *Retina Associates v. Southern Baptist Hospital of Florida*, 105 F.3d 1376, 1384-85 (11th Cir. 1997). In this case, the Eleventh Circuit summarily dismissed a price-fixing claim brought by a competitor against a group of physicians

VI. CONCLUSION

After an initial honeymoon period of stabilized fees by partially integrated health plans, health care costs have again increased significantly, in part because the normal rules of competition have not been applied. It is simply too late to question the long-term anticompetitive effect that horizontal price-fixing, through fee schedules or otherwise, has on a market economy, notwithstanding short-term "efficiency" or "profit-maximizing" claims. The laissez-faire view which would support the *Levine* decision would sound dire warnings if the government, instead of Healthchoice, imposed a similar maximum fee schedule. Yet the primary difference between a command economy and "efficient" monopoly is political, not economic. Although alternative concerns about freedom and autonomy may exist under such a regime, economic consistency and stare decisis suggest that the courts condemn partially integrated provider plans which involve uniform fees rather than, for example, fee discounts or annual capitation contracts (in which the providers bear directly a competitive risk). The focus of any inquiry into an arrangement such as Healthchoice should be: What is the long-term effect on price and service competition? Here, no reasonable observer can honestly contend that Healthchoice enhances the likelihood that providers will compete with one another on price or service terms. As long as we continue to adhere to a market approach to the distribution of health care services, and if price is the central nervous system of our economy, then anything which interferes with market price-setting should be presumed to be illegal. This is especially necessary in a key industry such

because the claim had "absolutely no relationship to the concerted refusal to deal alleged by Plaintiff and has caused Plaintiff no damages." *Retina Assocs.*, 105 F.3d at 1384. This reasoning resembles the standing argument advanced by the district court in *Levine*. Why would a doctor be harmed by price-fixing among his competitors? In theory, assuming the natural tendency of price-fixing to result in higher fees, the non-participating conspiracy member could underprice his competitors and increase his business. Dr. Levine's stunning success as an independent internist may support this point. In any event, such an argument is much more compelling than the fictions created by the court to resolve the issue. Dr. Levine's claim should still survive, however, because the Healthchoice fee schedule goes hand in hand with the concerted refusal to deal with the doctor. The Eleventh Circuit implicitly acknowledged that Dr. Levine had standing by disavowing such a basis for its decision.

as health care where the product is absolutely essential.²¹⁶

The purpose of the Healthchoice fee schedule is to present prospective payors with a uniform list of what fees member providers are willing to accept. There is no price competition. To justify Healthchoice's system, alternative justifications for its existence must be found. Supreme Court precedent, if followed, does not allow a court to neglect the illegality of horizontal price agreements. Such deals among competitors are *per se* illegal, and this has been the law of the land for the entire century. Congress has had ample opportunity to change this rule. That such action has not been taken compels the conclusion that our national legislature supports condemnation in this area. Further, health care has been the subject of much debate in Congress recently. As of yet, Congress has not exempted health care from antitrust scrutiny, and certainly not in the key competitive area of price.

The *Levine* decision represents a clear, but increasingly common, break from established law. The strict formalism in much of the court's analysis allows lawyers and clever economic actors to gut the substance and purpose of antitrust law. Ultimately, as far as societal interest is concerned, the authorization of private price-fixing and market centralization does not materially differ from a command economy's control of markets, except that private bureaucrats make the decisions affecting all of us outside the political process.

216. This reasoning directly counters the feelings of many antitrust scholars who argue that the health care industry should be treated with kid gloves. The inverse is seemingly true: As long as a private, free-market approach continues to be relied upon, with few command-economy alternatives to check the market, health care is the first thing which should be subject to the antitrust microscope. This point is strengthened by the fact that an inelastic demand exists for health care services. Regardless of how anticompetitive doctors act, consumers will still seek out their services.

