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ANTITRUST, JOINT VENTURES AND THE END OF THE AMA'S CONTRACT PRACTICE ETHICS: NEW WAYS OF THINKING ABOUT THE HEALTH CARE INDUSTRY

CHARLES D. WELLER*

On June 18, 1982 the Supreme Court of the United States in *Arizona v. Maricopa County Medical Society*¹ ruled that neither "the fact that doctors rather than nonprofessionals" were involved, nor the judiciary's "little antitrust experience in the health care industry," nor the view that "the health care industry was so far removed from the competitive model" justified special treatment for the health care field. The *Maricopa* decision poignantly symbolizes the end of an era for the nation's \$400 billion health care industry. As a recent American Medical Association (AMA) National Leadership Conference accurately pointed out, there are "changing economic realities—It [is] not business as usual."² The era when antitrust was unknown to health care, and when health insurance was built upon the AMA's contract practice and "free choice" ethics apparently is over.³

Antitrust and the private market principles that the antitrust laws embody constitute an entirely new way of thinking about the health care industry. One of the most illuminating branches of this new way of thinking about the health care industry, with its fragmented structure consisting of many independent firms, is the antitrust law of joint ventures.

This article begins by examining how perverse incentives caused by non-price competition among doctors and hospitals fuel high inflation in health care; how price competition can be injected into provider markets for private sector solutions to work; and how the present structure of American health insurance was built upon the AMA's illegal contract practice and "free choice" ethics. The article then reviews fundamental principles of antitrust and joint venture law and applies them to ten examples taken from the health care field.

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1. 102 S. Ct. 2466 (1982).

2. *Economic Realities Altering Profession, Medical Leaders Told*, Am. Med. News, March 4, 1983.

3. See *infra* text accompanying notes 78-91.

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I. COMPETITION AND THE HEALTH CARE INDUSTRY⁴

A. *The Principal Cause of High Health Care Costs: The Perverse Incentives of Non-Price Competition Among Doctors and Hospitals*

Perverse incentives are the principal cause of high health care costs. Under the predominant forms of public and private health insurance, there is virtually no price competition between doctors and other providers of health care services. Consequently, there are little or no incentives for doctors and hospitals to perform efficiently: "Probably the principal factor contributing to inflation has been the predominant system of third party reimbursement based on what institutions spend and what physicians charge."⁵ In the system of "usual and customary" reimbursement to physicians and "cost" reimbursement to hospitals that currently dominates health care financing, the question of the efficient use of resources does not arise. This system actually rewards cost-increasing behavior with more revenue and punishes cost-reducing behavior with less revenue. Such an incentive system perversely and persistently inflates prices and wastes resources.

Physicians order services that directly or indirectly account for approximately seventy percent of total health care costs.⁶ Even though physician orders generate these costs, the physicians have no financial responsibility for them. Physicians have no incentive to seek out equally effective but less costly alternatives. As a result, "most physicians do not have the vaguest notion of what things they order cost."⁷

The same disincentives for efficiency and incentives for waste operate on hospitals. The hospital that screens out unnecessary admissions and discharges patients as soon as medically appropriate loses revenue.

Consumers similarly are largely indifferent to costs. Since insurance pays most bills for the vast majority of patients, the consumer has no

4 The policy analysis presented here, applying market principles to the health care field, is taken from the writings of others, particularly the writings of Walter McClure. See generally McClure, *The Medical Care System Under National Health Insurance: Four Models*, 1 J. HEALTH POL., POLY & LAW 22 (1976); Enthoven, *Health Care Costs: Why Regulation Fails, Why Competition Works, How to Get There From Here*, 11 NAT'L J. 885 (1979); Ellwood, *Models for Organizing Health Services and Implications of Legislative Proposals* (pt. 2), 50 MILBANK MEMORIAL FUND Q. 73 (1972); A. ENTHOVEN, *HEALTH PLAN* 70-113 (1980); C. HAVIGHURST, *DIREGULATING THE HEALTH CARE INDUSTRY* (1982); Havighurst, *Health Maintenance Organizations and the Market for Health Services*, 35 LAW & CONTEMP. PROB. 716 (1970); W. McClure, *Comprehensive Market and Regulatory Strategies for Medical Care* (1980) (published InterStudy paper).

5 HEW, *FORWARD PLAN FOR HEALTH: FISCAL YEARS 1980-1982*, at 34 (1976). See also S. REP. NO. 1285, 93D. CONG., 2D SESS., reprinted in 1974 U.S. CODE CONG. & AD. NEWS, see *supra* note 4.

6 Egdahl, *Fee For Service Health Maintenance Organizations*, 241 J.A.M.A. 588 (1979).

7 Am. Med. News, June 22, 1979, at 9, col. 2 (quoting Dr. Darrell Cannon).

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incentive to seek out equally effective but less costly doctors and hospitals.

Perverse incentives result in rewards to inefficient providers at the expense of the efficient. Since extravagant care is rewarded with more reimbursement, a "spare no expense" mentality develops and drives health care costs unnecessarily high.⁸ Unless this system of perverse incentives is changed, the health care industry will continue to experience unacceptably high inflation.

There are basically two ways to address the problem of perverse incentives: government regulation and market reform. Government regulation attempts to use public economic controls as a substitute for missing market incentives for efficiency.⁹ Health planning agencies and hospital rate-setting commissions exemplify the regulatory approach.

Market reform is a new approach to reducing health care costs. Recently there has been a tremendous increase in the interest in and number of proposals for using "competition" as a therapy for the health care field's high rates of inflation.¹⁰ The essential requirement for market reform, however, is the introduction of price competition among health care providers.

B. *The Competitive Alternatives: Provider Price Competition Over Fees and Premiums*

As the Supreme Court stated long ago, price is the "central nervous system of the economy."¹¹ Price competition *among providers* is central to a market solution to the health care cost problem. "There is one awesome condition that hospitals and physicians must meet if the market is to work: . . . doctors and hospitals have to compete with each other for consumers on the basis of price."¹²

Presently, considerable *non-price* competition exists in provider markets. What is missing is provider competition over price:

8. See, e.g., V. FUCHS, WHO SHALL LIVE? 92-95 (1974); Enthoven, *Cutting Costs Without Cutting the Quality of Care*, 298 NEW ENG. J. MED. 1229, 1234-35 (1978) (curtailing "flat of the curve" medicine); McNeerney, *Why Does Medical Care Cost So Much?*, 282 NEW ENG. J. MED. 1458 (1970).

9. See generally P. AREEDA & D. TURNER, 1 ANTITRUST LAW 221-27 (1978) (competition in regulated industries).

10. See *Competition in Health Care: Would It Bring Costs Down?*, CONG. Q. WEEKLY REP., Aug. 4, 1979, at 1587 and STAFF OF HOUSE COMM. ON WAYS AND MEANS, SUBCOMM. ON HEALTH, 97TH CONG., 1ST SESS., DESCRIPTION OF PROPOSALS TO STIMULATE COMPETITION IN THE FINANCING AND DELIVERY OF HEALTH CARE (Comm. Print 1981) for a discussion of the legislative proposals, and Weller, *The Primacy of Standard Antitrust Analysis in Health Care*, 14 U. TOL. L. REV. 609 (1983) for a discussion of antitrust enforcement.

11. United States v. Socony Vacuum Oil Co., 310 U.S. 150, 224 n.59 (1940).

12. See H. H. Wood, *The Importance of the Market*, 2 J. HEALTH POL., POL'Y & LAW 447, 448 (1978).

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[T]he truth is that hospitals have always competed with each other in multihospital settings. The competition has been for physicians, reputation, patients, and other prizes as opposed to reduced costs, but it has been occurring for a long time. What the new market forces are provoking is a different set of competitive goals for hospitals: efficiency, appropriate utilization, cost effectiveness, and innovative patterns of care.¹³

Health care providers can compete over price in two basic ways: competition with respect to fees, and competition with respect to premiums. Provider price competition *over fees* may exist when consumers have to pay some of the bill when they receive health care services. The consumer who has to pay a portion of the bill will be sensitive to price in non-emergency situations.¹⁴

Provider competition *over premiums* may exist when consumers choose between competing groups of providers who offer their services for a premium. However, present competition over premiums is between insurers, not doctors and hospitals. Specifically, provider price competition over premiums requires, first, health care plans, that is, distinct groups of providers who offer their services for a premium, and second, consumer choice of health care plans and other forms of health insurance on a price incentive basis.¹⁵ That is, consumers must be able to choose between providers, between the different health care plans with their limited group of providers, and other forms of insurance based on the relative efficiency of the providers involved. For example, an employer could use a cafeteria-style offering of fringe benefits, or the employee could pay a portion of the premium should he or she select an insurer that costs more than the employer's fixed contribution.

C. Health Care Plans

Health care plans are *limited* groups of health care providers who provide health care to consumers for a premium. Health care plans may be sponsored by physicians, insurers, labor unions, employers, or others. Health care plans can take several forms. For example, staff model Health Maintenance Organizations (HMOs) provide services at

13. Friedman, *Does Market Competition Belong in Health Care?*, 54 HOSPITALS 47, 49 (1980). See also Williams, *How to Meet the New Demands in Ambulatory Care*, TRUSTEE, Dec. 1980, at 47.

14. Proposals for major-risk insurance use, coinsurance, and deductibles to increase consumer price sensitivity. See, e.g., Feldstein, *A New Approach to National Health Insurance*, 23 PUBLIC INTEREST 93 (1971); McClure, *supra* note 4, at 44-47. See also C. PIELPS, HEALTH CARE COSTS: THE CONSEQUENCES OF INCREASED COST SHARING (1982).

15. P. Ellwood & W. McClure, Health Delivery Reform 2 (Nov. 17, 1976) (unpublished InterStudy paper). See *supra* note 4. See also *infra* part III.B.

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a central facility and employ providers.¹⁶ Staff model HMOs are usually health care plans, because it would be financially impossible to employ large groups of providers. Another type of HMO—the Independent Practice Association (IPA)—provides services at the offices of its member-physicians and reimburses the physicians in various ways.¹⁷ IPAs traditionally have been open to all interested area physicians and, therefore, are *not* health care plans because they do not involve a limited group of providers.¹⁸ Only IPAs that have limited groups of providers qualify as “health care plans.” Similarly, HMOs of all kinds may, or may not, be “health care plans.”

Health care plans create price competition among providers. Obviously, an efficient group of providers affiliated with a health care plan could offer services for a lower premium than an inefficient group. If the number of physicians or other providers is not limited, however, price competition and its private incentives for provider efficiency are lost.

In summary, market reforms in health care must be designed to eliminate existing perverse incentives, and to do this must introduce price competition among health care providers over fees or premiums.

D. Guild Opposition to Price Competition Among Providers: The AMA's Contract Practice Ethics

In a guild model of the economy, price competition is a restraint of trade. The health professions have a deeply rooted commitment to a guild model of the economy. As an American Medical Association publication stated the AMA has “clung to many features of the guild form of organization and the ethics based on these relations.”¹⁹

For more than fifty years, the AMA and its affiliated societies took the position that price competition by physicians was “unethical.”

16 U.S. DEPT. HEALTH & HUMAN SERVICES, INVESTOR'S GUIDE TO HEALTH MAINTENANCE ORGANIZATIONS 14 (1982).

17 *Id.* at 15.

18 IPAs traditionally are organized by local medical societies who follow the now illegal contract practice ethics and guild “free choice” ethics. See *infra* text accompanying notes 20-46.

19. AMERICAN MEDICAL ASSOCIATION, ECONOMICS AND THE ETHICS OF MEDICINE 8 (1936). See also AMERICAN MEDICAL ASSOCIATION, AN INTRODUCTION TO MEDICAL ECONOMICS 18-19 (1933).

While the relations of employer and employee, of landlord, merchant and capitalist were completely transformed by the coming of the machine and the factory, the relations of patient and physician remained almost unaltered from the dawn of history, through all the changes from domestic to household and factory industry. . . . [I]t is a rule with few exceptions that whenever an attempt has been made to transplant the ethics, theories or forms of organization of business into the fields of art, science, law, education or medicine the result has been harmful to professional standards and progress.

Id.

Little has changed in fifty years.

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Under the AMA's long established contract practice and "free choice" ethics, physicians were prohibited from providing medical services in contracts that paid less than "usual fees," involved "underbidding," or were not open to all interested physicians (AMA "free choice").

By rejecting price competition among physicians, the medical professional for over fifty years has operated at odds with the nature of the free market system. Guild economics rejects private market principles. Contractual arrangements with health care plans and insurers that create price competition among physicians are opposed as "unethical" and "unfair competition." Instead, contractual arrangements that eliminate physician price competition are viewed as "fair competition" and "ethical."

II. THE END OF THE AMA'S CONTRACT PRACTICE ETHICS

A. American Medical Association v. Federal Trade Commission

In *American Medical Association v. Federal Trade Commission*²⁰ the United States Supreme Court affirmed two opinions where standard antitrust analysis was used in ruling that the AMA's ethical restrictions on physician advertising, solicitation, and contract practice were illegal.²¹ The two opinions, one written by an administrative law judge and one by the Commission, together run over three hundred pages and contain the most extensive examples of standard antitrust and rule of reason analysis yet applied to the health care field. They are an invaluable resource that to date has largely been untapped by the courts and commentators alike.

Regarding the AMA's advertising and solicitation ethics, the trial judge's exhaustive opinion cited numerous examples of ethical restrictions on the dissemination of information concerning the price, type, and availability of medical services.²² The advertising and solicitation ethics were restrictively applied to innovative clinics and preventive medicine programs;²³ HMOs and other prepaid group practice plans;²⁴ announcements, from letters and brochures;²⁵ newspaper advertising;²⁶ radio and television advertising;²⁷ publicity in the news media;²⁸ Yel-

20. 94 F.T.C. 701 (1979), *modified and enforced*, 638 F.2d 443 (2d Cir. 1980), *aff'd mem.*, by an equally divided court, 102 S. Ct. 1744 (1982). The Commission's opinion is also reported at 1980-1 TRADE CAS. (CCH) ¶ 63,164 (1979).

21. The trial judge's antitrust analysis may be found at 94 F.T.C. at 801-911, 936-66 (1979) and the Commission's at 94 F.T.C. at 996-1017 (1979).

22. 94 F.T.C. at 808-96, 936-56. The Commission's analysis is at 94 F.T.C. at 1002-11.

23. *Id.* at 820.

24. *Id.* at 828.

25. *Id.* at 836.

26. *Id.* at 841.

27. *Id.* at 846.

28. *Id.* at 848.

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low Page listings;²⁹ direct contact with institutions and physicians;³⁰ various other incidents involving direct contacts with potential users of medical services;³¹ open houses;³² and other methods of soliciting patients.³³ The Commission concluded, "The evidence confirms that the restrictions have been applied as an absolute ban governing situations in which the dangers contemplated by respondent are imperceptible if they exist at all,"³⁴ and held the AMA's advertising and solicitation ethics unlawful restraints of trade.

The most important part of the case, however, involved the AMA's contract practice and "free choice" ethics. Unfortunately, this portion of the case has generally been ignored. As their name suggests, the contract practice ethics govern every contractual arrangement a physician can enter to provide medical services. The AMA defined contract practice in the following broad terms: "It is unprofessional for a physician to dispose of his services under conditions that make it impossible to render adequate service to his patient or which interfere with reasonable competition among the physicians of a community."³⁵

In practice, the AMA's interpretation of this broad language made it unethical for a physician to enter any contract that generated competition among doctors over price and efficiency. Specifically, the following contractual arrangements were considered "unethical" and "unfair":

- (1) When the compensation received is inadequate based on the usual fees paid for the same kind of service and class of people in the same community.
- (2) When the compensation is so low as to make it impossible for competent service to be rendered.
- (3) When there is underbidding by physicians in order to secure the contract.
- (4) When a reasonable degree of free choice of physicians is denied those cared for in a community where other competent physicians are readily available.
- (5) When there is solicitation of patients directly or indirectly.³⁶

Thus, under the AMA's contract practice ethics, it was unethical for a physician to provide medical services under a contract when, e.g., "the compensation received is inadequate based on the usual fees . . .

29 *Id.* at 862.

30 *Id.* at 884.

31 *Id.* at 886.

32 *Id.* at 887.

33 *Id.* at 888.

34 *Id.* at 1009.

35 *Id.* at 1011 n.59.

36 *Id.* at 1012. For a comprehensive collection of the AMA's positions through 1959 on contract practice, including Item (4) guild "free choice," see JAMA, Jan. 17, 1959, at 1 (special edition devoted to the AMA's Report on Medical Care Plans).

paid in the same community," or when "there is underbidding by physicians in order to secure the contract," or when "free choice of physician is denied" ³⁷

The Federal Trade Commission applied standard antitrust principles to the AMA's ethical interest in the adequacy of physician compensation and found they were similar to traditional forms of price-fixing:

It is evident from a facial examination of [the] AMA's ethical provisions and from evidence concerning adoption of these restraints that they are designed to limit price competition among doctors. Respondent does not suggest any alternative motive cognizable under the antitrust laws We believe that this restriction is so akin to the more traditional forms of price-fixing that it should be treated in the same fashion. ³⁸

Of all the contract practice ethics' provisions, however, the AMA's "free choice" provision is the most important and least understood. "Free choice" of doctor and hospital sounds so good and wholesome that few people ever stopped to examine what it really means and how it was applied. The Commission found, after analysis, that the purpose of the AMA's "free choice" ethic was "primarily . . . anticompetitive" and its primary purpose was "suppressing the activities of competitors, not solicitude for the rights of patients." ³⁹ The Commission's "free choice" ruling is a landmark in health care law and policy.

Ironically "freedom of choice" is an essential element of both the AMA and private market models of medical care. Yet the differences between market "free choice" and AMA "free choice" are profound.

The AMA's "free choice" ethic means that each doctor must be allowed to participate in each health care plan or other insurance arrangement. The AMA's Judicial Council declared "free choice of physician . . . expressly requires that any qualified licensed physician residing in the area in which the plan operates be allowed to participate." ⁴⁰ The practical effect of the AMA's "free choice" ethic is to prohibit physician price competition and health care plans. Market "free choice," on the other hand, means consumers have a right to choose between competing groups of providers (health care plans) and traditional insurers on the basis of price, quality, service, and benefits.

Consider, for example, a medical community that is divided into three distinct groups, each affiliated with an insurance arrangement called a health care plan. Assume for simplicity that there is only one conventional insurer, where the benefits permit a consumer to go to any

37. 94 F.T.C. at 1012.

38. *Id.* at 1014.

39. *Id.* at 1015. See also A. SOMERS & H. SOMERS, DOCTORS, PATIENTS AND HEALTH INSURANCE 409-13 (1961); A. ENTHOVEN, HEALTH PLAN 77 (1980).

40. 94 F.T.C. at 903.

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physician in the community and be indemnified up to the "usual, customary and reasonable" fee. Under market "free choice" consumers can choose between the health care plans or the conventional insurer on the basis of their differing premiums, quality, and other factors. Thus, consumers can freely choose their doctor either at the time they select a health care plan or, if they choose traditional insurance, at the time they go to the doctor. Also, under market "free choice," each health care plan's limited group of doctors has incentives to perform efficiently, because its health care plan's premiums then can be lower and the plan's benefits broader.

By contrast, under the AMA's "free choice" ethic each health care plan is unethical because it excludes, in the example, two-thirds of the physicians in the community. Health care plans that create incentives for their physicians to perform efficiently are what the medical profession terms "closed panels." As the AMA's Maryland affiliate affirmed in 1967, "the closed-panel practice of medicine . . . is an abridgement of 'freedom of choice.'"⁴¹ Thus, contrary to the ordinary meaning of the words "free choice," under AMA "free choice" consumers are *denied* the right to choose competitive groupings of doctors and insurance health care plans. Under the AMA's "free choice" ethic, no matter which insurer a consumer chooses, every interested doctor is included. Provider competition over price and efficiency is thus necessarily lost, as the patient has no incentive to switch from inefficient providers to efficient ones. As a 1939 AMA publication stated, that was precisely their intention:

In place of that is essentially "cut-throat price competition" that has so frequently demoralized business, the medical profession has substituted the requirement that there be reasonable competition among qualified physicians. Therefore, the organization of a medical care plan which gives a few physicians a monopoly on the provision of medical service for members by denying those members the right to choose their own physicians from among all qualified physicians in the community has been opposed by the stipulation in the "Principles of Medical Ethics" that there be no interference with reasonable competition in a community.⁴²

Indeed, the Commission ruled that the AMA's "free choice" ethics "had the effect of impairing competition from alternative providers" and discouraged the "use of innovative arrangements that can deliver services at lower cost."⁴³ In general, the Commission concluded that the AMA's contract practice ethics, although couched "in terms of

41. *Id.*

42. AMERICAN MEDICAL ASSOCIATION, ORGANIZED PAYMENTS FOR MEDICAL SERVICES 142 (1939).

43. 94 F.T.C. at 1015.

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preventing impairment of medical judgment and deterioration of medical care" in fact "bear little relation to those objectives."⁴⁴ In summarizing the entire case the trial judge concluded, "These ethics restrictions do not deal with the medical or therapeutic aspects of a physician's practice; at issue are predominantly restrictions on economic activities."⁴⁵ The trial judge ruled that the AMA's ethics deprived "consumers of the free flow of information about the availability of health care services" and "stifle[d]" the rise of almost every type of health care delivery that could potentially pose a threat to the income of fee-for-service physicians in private practice."⁴⁶ The voluminous record in the case could lead to no other conclusion.

The single most important impact of the AMA's contract practice and "free choice" ethics was how they fundamentally shaped the basic structure of American health insurance today.

B. *The Impact of the AMA's Contract Practice Ethics: The Present Structure of American Health Insurance*

In the 1920's and 1930's, there was rapid growth in a form of health insurance entirely different from the forms that prevail today. "[T]he voluntary insurance of 1932 was not the type of voluntary insurance familiar to us today."⁴⁷ Blue Cross and Blue Shield plans did not exist. As a practical matter, commercial insurers did not write health insurance.⁴⁸

The form of insurance that predominated and was growing rapidly in the 1920's and 1930's was what are now called health care plans. Hospitals and doctors were breaking into groups competing through insurance over premiums, efficiency, quality, and benefits:

The real difference between all of those programs and the Blue Cross and Blue Shield was that all of the early programs provided care in a single institution under the care of a single group of physicians connected with that institution. All of those early plans were what we would now call HMOs [health care plans]. There was a cooperative arrangement between a group of physicians, an institution and a financing mechanism.⁴⁹

The health care plans that were forming in a competitive market were generating price competition over premiums and efficiency among

44. 94 F.T.C. at 1012.

45. *Id.* at 917.

46. *Id.*

47. O. ANDERSON, *THE UNEASY EQUILIBRIUM* 100 (1968).

48. R. EILERS, *REGULATION OF BLUE CROSS AND BLUE SHIELD PLANS* 13 (1963).

49. 46 HOSPITALS 68, 71-72 (1972) (interview with John R. Mannix, recipient of the 1974 Justin Ford Kimball Award). See also P. WILLIAMS, *THE PURCHASE OF MEDICAL CARE THROUGH FIXED PERIODIC PAYMENT* (1932), Leland, *Contract Practice*, 98 J.A.M.A. 808 (1932) (Director of the AMA's Bureau of Medical Economics).

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groups of doctors and hospitals. For this very reason, the AMA House of Delegates in 1933 endorsed a report that proscribed these plans as "contract practice schemes:"

One of the pernicious effects of contract practice schemes is that each of them stimulates the launching of other similar schemes until there are many in the field competing with each other. The first may have safeguards against many of the abuses of contract practices, but as new ones are formed the barriers are gradually broken down in order to secure business.⁵⁰

The AMA and its affiliated societies vigorously applied their contract practice, "free choice," and other ethics to suppress the health care plan form of health insurance. For instance, in 1936 the AMA's Judicial Council enforced the ethics against several physicians affiliated with a proposed health care plan for International Harvester employees in Wisconsin.⁵¹ Similar action led to the AMA's criminal conviction under the antitrust laws in 1943.⁵²

Over the next few years, the tide began to change. As an AMA Bureau of Medical Economics study reported:

The result of the position taken by medical societies and by hospital administrators in sympathy with medical ethics was to bring gradually into disrepute those plans which did not follow the more essential principles that have been outlined. New plans promoted by commercial agencies or profit-seeking promoters no longer appealed to hospital administrators. The day of the commercial and competitive schemes began to wane and in their stead rose the city-wide, noncommercial associations of hospitals designed to offer hospital facilities on a prepayment basis.⁵³

The contract practice and "free choice" ethics, in addition to being used to suppress health care plans, were incorporated into the profession's own health insurance plans beginning in 1933:

[I]n 1933, the next stage of the movement toward some form of health insurance was on its way. The chief providers of services, hospitals and physicians, had been heard from. They had declared themselves in favor of some form of voluntary health insurance if sponsored, initiated, and controlled by the respective representatives of the hospital

50. 94 F.T.C. at 1013.

51. *Id.* at 899. Another example of Judicial Council enforcement of the contract practice, advertising, and solicitation ethics is found on the same page. The private enforcement of private law is, of course, classic cartel conduct. *See, e.g.,* Fashion Originators' Guild of Am. v. FTC, 312 U.S. 457 (1941).

52. 94 F.T.C. at 899-900; *American Med. Ass'n v. United States*, 317 U.S. 519 (1943).

53. AMA BUREAU OF MEDICAL ECONOMICS, GROUP HOSPITALIZATION 41 (1937). *See* 94 F.T.C. at 899-907. *See also* Note, *American Medical Association: Power, Purpose & Politics*, 63 YALE L.J. 937, 976-96 (1954); A. SOMERS & H. SOMERS, *supra* note 39, at 263-340; *American Med. Ass'n v. United States*, 317 U.S. 519 (1943); M. DAVIS, *AMERICA ORGANIZES MEDICINE* (1941); C. RAYCE, *PROFESSIONAL POWER AND AMERICAN MEDICINE* (1968); 94 F.T.C. at 808-914, 1002-18.

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and medical associations.⁵⁴

The AMA's contract practice and "free choice" ethics were also incorporated into Medicare and Medicaid, the nation's principal public health insurance programs.⁵⁵ The perverse incentives of non-price competition were then pervasively in place.

C. *The Final Order in American Medical Association v. FTC*

A Final Order was entered by the Federal Trade Commission against the AMA on May 19, 1982. The Order prohibits the AMA from restraining trade under the guise of ethical restrictions on advertising, solicitation, and contract practice.⁵⁶ At the same time the Order expressly permits the AMA to adopt and enforce ethical guidelines regarding "false or deceptive" advertising and solicitation of persons "vulnerable to undue influence."⁵⁷ The Order also expressly permits the AMA to conduct "professional peer review of fee practices of physicians."⁵⁸

The conduct of the AMA and its affiliates found by the FTC clearly established the need for an effective order. The essential guild features

54 O ANDERSON, *supra* note 47, at 104. See also 94 F.T.C. at 753.

55 See, e.g., Harris, *Annals of Legislation: Medicare* (pts. 1-4), NEW YORKER, July 2, 9, 16, 23, 1966; A. SOMERS & H. SOMERS, *MEDICARE AND THE HOSPITALS* (1967).

56 Part I is directed at advertising and solicitation, and prohibits the AMA from restricting:

A . . . the advertising or publishing by any person of the prices, terms or conditions of sale of physicians' services, or of information about physicians' services, facilities or equipment which are offered for sale or made available by physicians or by any organization with which physicians are affiliated;

B. . . the solicitation, through advertising or by any other means, including but not limited to bidding practices, of patients, patronage, or contracts to supply physicians' services, by any physician or by any organization with which physicians are affiliated;

Nothing contained in this Part shall prohibit respondent from formulating, adopting, or disseminating to its constituent and component medical organizations and to its members, and enforcing reasonable ethical guidelines governing the AMA's conduct of its members with respect to representations, including unsubstantiated representations, that respondent reasonably believes would be false or deceptive within the meaning of Section 5 of the Federal Trade Commission Act, or with respect to uninvited, in-person solicitation of actual or potential patients, who, because of their particular circumstances, are vulnerable to undue influence.

Part II is directed at contract practice, and prohibits the AMA from restricting:

A . . . the consideration offered or provided to any physician in any contract with any entity that offers physicians' services to the public, in return for the sale, purchase or distribution of his or her professional services, except for professional peer review of fee practices of physicians.

B. . . the growth, development or operations of any entity that offers physicians' services to the public, by means of any statement or other representation concerning the ethical propriety of medical service arrangements that limit the patient's choice of a physician;

C. . . the growth, development or operations of any entity that offers physicians' services to the public, by means of any statement or other representation concerning the ethical propriety of participation by non-physicians in the ownership or management of said organization; . . .

57. *Id.*, pt. I.

58. *Id.*, pt. II.

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of the contract practice, "free choice" advertising and solicitation ethics had never been repealed or abandoned.

First, the AMA and its affiliates continued to enforce these ethics after their criminal conviction in 1943,⁵⁹ as repeated examples of post-1943 enforcement attest.⁶⁰

Second, the AMA and its affiliates did not abandon the anticompetitive application of their "free choice" ethics after they made historic and laudatory language changes in their "free choice" ethics in June, 1959.⁶¹ Less than six months after the AMA House of Delegates adopted the recommendation of the Larson Report permitting closed panel plans, the House of Delegates changed its mind. In 1959, the AMA House of Delegates disapproved the concept of closed panel practice.⁶² The anticompetitive conduct by the AMA and its affiliates continued after 1959 as if the June 1959 changes had never been made. For example, from 1969 until after the FTC suit was filed, the Harvard Community Health Plan had continuing restrictions placed on its advertising.⁶³ From 1970 through December 1976, the Arizona Health Plan was harassed because it was "no different than a Kaiser-type closed-panel system and was 'unacceptable' to organized medicine."⁶⁴ In December 1976, the New Haven County Medical Society disparaged HMOs as "socialized medicine." The AMA's ethics were also used to undercut the operation of the Florida Health Care Plan throughout the

59. *American Med. Ass'n v. United States*, 317 U.S. 519 (1943).

60. 94 F.T.C. at 808-911, 1002-18.

61. Professors Somers and Somers described the historic change in the AMA's "free choice" language in their invaluable book, A. SOMERS & H. SOMERS, *DOCTORS, PATIENTS, AND HEALTH INSURANCE* 355 (1961):

[T]he official AMA policy with respect to closed panel practice underwent a far-reaching change. Its longstanding opposition to this type of health insurance, primarily in the name of "free choice," was abandoned in favor of the flexible policy set forth in the Larson Report recommendations adopted by the House of Delegates in June, 1959. . . . that the individual should have free choice of either his physician or his medical plan.

The specific language, based on the Larson Report, is contained in an AMA interpretation of its "free choice" ethics adopted in June, 1959, in a simple clause adding the language "preferred system of medical care:"

FREE CHOICE OF PHYSICIAN

The American Medical Association believes that free choice of physician is the right of every individual and one which he should be free to exercise as he chooses:

Each individual should be accorded the privilege to select and change his physician at will or to select his preferred system of medical care and the American Medical Association vigorously supports the right of the individual to choose between these alternatives:

Lest there be any misunderstanding, we state unequivocally that the American Medical Association firmly subscribes to freedom of choice of physician and free competition among physicians as being prerequisites of optimal medical care. The benefits of any system which provides medical care must be judged on the degree to which it allows or abridges such freedom of choice and such competition.

Id. at 341.

62. 94 F.T.C. at 903.

63. *Id.* at 833.

64. *Id.* at 831.

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1970's.⁶⁵ As late as June 1977, doctors affiliated with this plan continued to be harassed, just as doctors affiliated with health care plans have been harassed for over fifty years.⁶⁶ Interestingly, the 1981 version of the AMA's "free choice" ethics are materially unchanged from the version the AMA adopted in June 1959.

Third, AMA officials took positions in 1981-1982 that are virtually unchanged from fifty years ago. Although the positions were taken with respect to legislation, they are relevant in showing the intent with which the AMA's vague 1981 Opinions might be applied to private markets without an effective order in place.⁶⁷ For example, a recent report from the AMA's Board of Trustees, which was adopted by the House of Delegates, criticized the "pro-competition" bills before Congress along lines unchanged from the early 1930's. The report says:

Sponsors of insurance plans particularly under the more comprehensive competitive models, would be expected to exercise their purchasing power to control selection of providers and facilities through special arrangements with them. The availability of care to plan subscribers would be governed by such arrangements, with controls established to limit costs and thus create a competitive advantage.

The report continues:

These ends would be fostered through provider contracts, closed panel arrangements, negotiated fee schedules, and a greater reliance on large group practices, where costs theoretically could be lowered through strict internal controls.⁶⁸

Also, a September 19, 1981 *American Medical News* article, *Top AMA Leader Assails Gephardt's "Competition" Plan*, indicates the AMA favors some features of the competitive proposals but conspicuously excludes the most important element—health care plans:

Specifically, the AMA favors changes in the market place that would:

- Provide consumers with multiple-choice insurance options.

65. *Id.* at 829-30, 906.

66. *Id.* at 907.

67. *United Mine Workers v. Pennington*, 381 U.S. 657, 670-71 n.3 (1965). The AMA revisions also use vague language, rather than the approach recommended by the Supreme Court in *National Soc'y of Prof. Eng'rs v. United States*, 435 U.S. 679, 699 (1978) (quoting *United States v. National Soc'y. of Prof. Eng'rs*, 555 F.2d 978, 983 (D.C. Cir. 1977)), of developing "ethical guidelines more closely confined to . . . legitimate objective[s]." *Id.* at 699. The AMA's contract practice ethics were untouched by an April, 1976 AMA statement on advertising and solicitation. Brief for Appellant at 6-7, 435 U.S. 679 (1978). The 1977 and 1981 editions of the AMA's Judicial Council Opinions did not delete the contract practice ethics. They reverted to broad statements similar to the original Principles of Medical Ethics.

68. *Competition Legislation is Criticized*, *Am. Med. News*, June 19-26, 1981, at 1, col. 4. An AMA delegate recently described the Enthoven competitive health plan proposals to be "socialized medicine" because, in essence, they were inconsistent with these illegal ethics against physician price competition. Rogers, *Pro-competition Bills and Socialized Medicine*, *Am. Med. News*, May 8, 1981, at 8, col. 3.

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- Require equal employer contribution to any plan regardless of the coverage.
- Supply a non-taxable rebate to employees when the plan they choose costs less than the employer contribution.
- Limit the amount of tax-deductible premium payments that the employer can claim.
- Prohibit tax deductions for unqualified plans.⁶⁹

Without health care plans and their competitive collections of doctors, the AMA's changes only perpetuate the present competition among insurers that follow guild "free choice" ethics and fail to introduce competition among physicians with respect to efficiency. Finally, the February 24, 1981 *Wall Street Journal* quotes the AMA's Executive Vice President, Dr. James Sammons, as being "violently opposed" to any cutback in "free choice" for Medicaid patients.⁷⁰ There is no sound reason to believe the AMA and its affiliates would react any differently to changes in their guild "free choice" ethics for any other type of patients absent an effective order.

Finally, it should be noted that the FTC's Order does not encroach on the power or authority of the states. If anything the Order enhances the authority of the states, since it is directed at private guilds that were found to have usurped governmental powers.⁷¹

Accordingly, a fair and effective injunctive order against the AMA was justified. At the same time, the amended Order gives the AMA and its affiliates the ability to address false and deceptive practices, as well as abusive fee practices of physicians. Although the AMA argued in the Supreme Court that the Order prohibits medical societies from preventing the "terrible tragedy that can result from deceptive advertising" and from addressing "fee gouging and secret fee splitting arrangements,"⁷² it is apparent from reading the Order that it does not. Accordingly, the Federal Trade Commission's Order against the AMA, and continuing FTC antitrust jurisdiction over the medical profession, are vital to private market solutions to the nation's health care problems.

III. FUNDAMENTAL ANTITRUST CONCEPTS

A. *Fundamental Antitrust Principles*⁷³

The antitrust laws, the Supreme Court has observed, are a "charter

69. *Competition Legislation is Criticized*, Am. Med. News, June 19-26, 1981, at 1, col. 4.

70. Schorr, *Reagan's Medicaid Plan Stirs Fear of Two-Class Health Care System*, WALL ST. J., Feb. 24, 1981, at 29, col. 4.

71. See, e.g., *St. Paul Fire & Marine Ins. Co. v. Barry*, 438 U.S. 531, 548-49, 553-54 (1978).

72. Brief for Appellant at 10-11, *St. Paul Fire & Marine Ins. Co. v. Barry*, 438 U.S. 531 (1978).

73. This article does not discuss antitrust exemptions because they have been so sharply

of economic liberty" that rest on the assumption that a free market economy will provide the highest quality, lowest prices, best allocation of resources, and greatest material progress:

The Sherman Act was designed to be a comprehensive charter of economic liberty aimed at preserving free and unfettered competition as a rule of trade. It rests on the premise that the unrestrained interaction of competitive forces will yield the best allocation of our economic resources, the lowest prices, the highest quality and the greatest material progress, while at the same time providing an environment conducive to the preservation of our democratic political and social institutions.⁷⁴

The rule of reason is the basic standard used in applying Section One of the Sherman Antitrust Act. Contracts, combinations, and conspiracies that *unreasonably* restrain trade are illegal. Contrary to its name, the rule of reason does not permit an inquiry into every argument that may fall within the realm of reason. Instead, "it focuses directly on the challenged restraint's impact on competitive conditions."⁷⁵ In effect, the rule of reason is a balancing test that weighs the competitive harms and benefits of any given arrangement. The test of legality is whether the procompetitive benefits outweigh the anticompetitive harms. The *per se* doctrine is a special case of the rule of reason. It applies when the anticompetitive effects of an arrangement far outweigh its procompetitive benefits, as in the case of price-fixing, market division, and group boycotts.⁷⁶

Despite the deceptive familiarity of the assumptions underlying the antitrust laws, they represent in practice a fundamentally different world view for health care professionals. Nowhere is the difference perhaps greater, or more important, than in the areas of joint action, and price competition among providers.

The health professions have traditionally assumed that the greatest benefits to society result when health care economic issues are addressed by all affected parties acting jointly through guilds. Thus, an economic issue affecting all hospitals was assumed to be best addressed

narrowed by the Supreme Court in recent years. The "learned profession" exemption was rejected unanimously in *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975). The special treatment the health care industry received on the "interstate commerce" issue ended in *Hospital Bldg. Co. v. Trustees of Rex Hosp.*, 425 U.S. 738 (1976). The state action exemption, *McCarran Ferguson Act* insurance exemption, and implied repeal doctrine have either been sharply narrowed over the last seven years or strictly applied to the health care field as elsewhere. See, e.g., Weller, *The "New" McCarran Ferguson Act Antitrust Exemption After Barry*, 49 INS. COUNS. J. 29 (1983); *National Gerimedical Hosp. v. Blue Cross*, 452 U.S. 378 (1981). See generally Sims, *What Is Left of The Traditional Defenses?*, National Health Lawyers Ass'n Fifth Annual Program on Antitrust in the Health Care Field (May, 1982).

74. *Northern Pac. Ry. Co. v. United States*, 356 U.S. 1, 4 (1958).

75. *National Soc'y of Prof. Eng'rs v. United States*, 435 U.S. 679, 688 (1978).

76. See generally L. SULLIVAN, ANTITRUST 186-97 (1977). See also *Muricopa*, 102 S. Ct. 2466, 2472-75 (1982) (for discussion by the Supreme Court).

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by all the hospitals joining together to find and implement a solution. Free market economics and the antitrust rest on opposite assumptions. The best results for society are assumed to result from the independent actions of all affected parties, buyers and sellers alike. That is what the Supreme Court meant by the phrase "the unrestrained interaction of competitive forces." That is why the basic antitrust law, Section One of the Sherman Act, generally prohibits joint action on private market economic issues as a "conspiracy in restraint to trade."

In addition, a free market requires and the antitrust laws protect incentives for sellers such as health care providers to render high quality service at the lowest cost. Price competition is the principal incentive for efficiency and, thus, is in the Supreme Court's terms "the central nervous system" of a private market.⁷⁷ As previously indicated, however, price competition is rejected in the guild model.

B. *Fundamental Principles of Antitrust Joint Venture Law*

Small groups of competitors, including hospitals and doctors, often can join together to achieve efficiencies and to become more competitive without violating the antitrust laws. In antitrust terminology these arrangements are referred to as "partial integrations" or "joint ventures." A joint venture in some respects is a "quasi-merger" where independent entities such as hospitals and doctors partially integrate their production, managerial, financial, or other operations. On a scale, joint ventures are between mergers, which are complete integrations, and cartels, which involve little or no integration.

There are two basic antitrust requirements for joint ventures to be lawful under the antitrust laws:

[F]irst, the elimination of price [or other] competition between the participating firms must result directly from the partial integration of their functions; second, this elimination of price [or other] competition must not appear to significantly reduce marketwide competition.⁷⁸

One of the decisive factors under the second requirement, the impact on market-wide competition, is the combined market share of the participating firms. Generally speaking, it is thus possible to restate the two basic requirements as follows: First, the restraint must be a neces-

77. *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 224-26 n.59 (1940).

78. L. SULLIVAN, *supra* note 76, at 206. See, e.g., *Broadcast Music, Inc. v. Columbia Broadcasting Sys., Inc.*, 441 U.S. 1 (1979); *University of Okla. v. NCAA*, 707 F.2d 1147 (10th Cir. 1983), *cert. granted*, 52 U.S.L.W. 3309 (U.S. Oct. 10, 1983) (No. 83-271); *U.S. v. Columbia Pictures Industries, Inc.*, 507 F. Supp. 412 (S.D.N.Y. 1980). See generally Brodley, *Joint Ventures and Antitrust Policy*, 95 HARV. L. REV. 1521 (1982); R. BORK, *THE ANTITRUST PARADOX* 279 (1978); Pitofsky, *Joint Ventures Under the Antitrust Laws: Some Reflections on the Significance of Penn-Olin*, 82 HARV. L. REV. 1007, 1016 (1969); *In re Brunswick Corp.*, 94 F.T.C. 1174 (1979), *aff'd*, 657 F.2d 971 (8th Cir. 1979), *cert. denied*, 102 S. Ct. 1768 (1982).

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sary part of a legitimate joint venture; second, the combined market share of the participants must be small.⁷⁹

Taken together, the basic antitrust requirements for joint ventures and partial integrations can be referred to as the "small groups can be beautiful" rule. The Supreme Court's *Arizona v. Maricopa County Medical Society* decision on June 18, 1982 provides a timely illustration of joint venture law and the first requirement of the "small groups can be beautiful" rule.⁸⁰ The second requirement of this rule is basically that the combined market share of the competitors involved be "small." The Supreme Court did not reach this issue in *Maricopa*, since the first requirement had not been met.⁸¹ The second requirement derives from the rule of reason's balancing approach, which allows groups of competitors to get together to achieve efficiencies or become more competitive so long as the procompetitive gains outweigh the competitive losses. One of the most important indicators of the loss of competition is the combined market share of the participants. That is, how much of the competition is subject to the restraint? Obviously, if all competitors are involved, all competition has been eliminated and a competitive market cannot operate. If only a small group of competitors are involved, however, the remaining competitors provide competition to the small group and a competitive market does exist. Ronald G. Carr, currently Deputy Assistant Attorney General in the Antitrust Division of the Department of Justice, summarized the applicable joint venture principles when he stated that the Division "will challenge the broad inclusion of more competitors than are necessary for efficient joint venture operation where the organization of rival joint ventures is a viable alternative."⁸²

When is a horizontal combination of doctors or hospitals "small,"

79. Prof. Sullivan elaborates on this requirement for partial integrations and joint ventures. The second condition . . . requires the court to look at structure at least in a truncated way. If the arrangement appears likely to dampen price competition market-wide by ending price competition between participants, it will be *per se* unlawful despite the integration. To tell whether it is likely to affect the market significantly, the court must evaluate power.

. . . How large must the market shares of participating firms be in order to warrant the conclusion that price competition is significantly affected? How is the market to be defined for answering the question? In general, the cases do not insist on any elaborate market definition . . . and seldom look to substitutes. The aggregate shares of the participating firms need not be exceedingly high — certainly they need not even begin to approach monopoly. If in the aggregate the shares are large enough so that an end to price competition between the participants will be noticed, then market-wide competition is affected.

L. SULLIVAN, *supra* note 76, at 209-10.

80. See *infra* text accompanying notes 92-104.

81. Significantly, the Supreme Court characterized the group of physicians involved—comprising between 30%-80% of local physicians—as "a group with substantial power in the market for medical services . . ." *Maricopa*, 102 S. Ct. at 2478 n.29. On the size of the physician groups, see *id.* at 2471 n.8.

82. Feb. 24, 1982 speech, "Some Observations on Information Exchange and Membership Practices." Health policy analysis is similar. See *infra* part I.C.

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and when it is it "large?" Although the basic concept of a combined market share is simple, its application to specific situations is often complex and fact-intensive. What market or markets are involved,⁸³ and how does the joint venture relate to them? How much market power does the group have? These questions are rarely answered easily. As a practical matter, it is advisable to at least consider the combined market share of the joint venturers in the physician and hospital markets separately. What is the combined market share of the hospital joint venturers? What is the combined market share of the physician joint venturers?

Professor Brodley's recent article on joint venture law⁸⁴ comprehensively examines many of these issues. For example, he defines a horizontal joint venture as "a joint venture in the markets in which the parents compete."⁸⁵ Under Professor Brodley's standards, horizontal joint ventures raise threshold antitrust concerns when the provider market is concentrated and the collective market share of the parents is only fifteen percent.⁸⁶ At first blush the physician market is unconcentrated, since most physicians practice as solo practitioners and, thus, there are many firms with relatively small market shares. However, Brodley properly states that the term "oligopolistic market" describes a market that is "structurally noncompetitive."⁸⁷ As indicated earlier, provider markets in the United States are structurally noncompetitive, because there is virtually no provider price competition.⁸⁸ On one hand, horizontal joint ventures composed of fifteen percent or more of the local physicians should be presumptively unlawful. A "small group," on the other hand, would be a group with under fifteen percent of local physicians. Probably the most lenient antitrust analyst would draw the line around forty percent.⁸⁹

As a practical matter in the health care field it generally will make no difference whether the line is drawn at fifteen percent or forty percent. The "small group" concept goes to the heart of the different assumptions underlying the antitrust laws and traditional guild assumptions. Even a forty percent maximum means that the traditional guild approach of gathering together most or all providers to jointly take action on economic issues will be unlawful. Under the antitrust laws, the key

83. See also Edwards, Joffe, Kolasky, McGowan, Mendez-Penate, Ordovery, Proger, Solomon & Toepke, *Proposed Revisions of the Justice Department's Merger Guidelines*, 81 COLUM. L. REV. 1543 (1981) [hereinafter cited as Edwards]; U.S. DEPARTMENT OF JUSTICE, MERGER GUIDELINES (June 14, 1982).

84. Brodley, *supra* note 78.

85. *Id.* at 1552.

86. *Id.* at 1553.

87. *Id.* at 1543.

88. See *supra* text accompanying notes 4-10.

89. See, e.g., R. BORK, *supra* note 78, at 279.

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point for the guild model is that all affected parties generally cannot participate. The health care field's traditional assumption that it is best to include a high percentage of the provider community in joint action affecting economic issues simply violates the second requirement of the "small groups can be beautiful" rule.

The second requirement's concern with combined market share is consistent with an area of antitrust with which most people are more familiar—mergers. One of the decisive factors in determining the individual legality of mergers by competitors is the individual market shares of the merging firms as well as their combined market share. One recent analysis of antitrust merger law recommended that a horizontal merger should be presumed unlawful if the combined market share of the merging parties was ten percent or higher.⁹⁰

In the health care field, several hospital mergers have been challenged when the merging parties' combined market share was considered too large. For example, in *United States v. Hospital Affiliates International, Inc.*, the merger allegedly would have given the combined defendants 100% of the market for private psychiatric hospital beds in a defined region. A second hospital merger case, *In re American Medical International, Inc.*, challenged a merger that allegedly would have combined sixty-eight percent of the hospital beds in a county into one firm. The merging parties were not a "small group," and that fact coupled with other relevant issues led to the merger being challenged. On the other hand, hospital mergers by two hospitals with "smaller" combined market shares can be lawful.⁹¹

In summary, joint venture antitrust law and the "small groups can be beautiful" rule provide a basic yet powerful tool for antitrust analysis in the health care field. Competing health care providers can act jointly on private economic issues without violating the antitrust laws if two requirements are met: first, the joint restraint is a necessary part of a legitimate joint venture, and second, the combined market share of the participants is "small."

IV. ANTITRUST AND JOINT VENTURE LAW APPLIED TO THE HEALTH CARE INDUSTRY

A. Maricopa County

*Arizona v. Maricopa County Medical Society*⁹² involved non-profit

90. Edwards, *supra* note 85, at 1561. See also P. AREEDA & D. TURNER, ANTITRUST LAW § 915, at 4 (1980) (13-14% market share); L. SULLIVAN, *supra* note 76, at 293 (10%); Brodley, *supra* note 81, at 1553 (15%). Bork is the most lenient with a 40% maximum. R. BORK, *supra* note 78, at 222. Thus, generally speaking none would allow groups of competitors larger than 40%.

91. See *supra* note 90.

92. 102 S. Ct. 2466 (1982).

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medical care foundations established by two medical societies. The challenged restraint concerned the foundation's provision of a payment-in-full program for insurance companies through a maximum fee agreement. The Maricopa Foundation is composed of approximately 1,750 doctors, representing about seventy per cent of the private practitioners in Maricopa County. The Pima Foundation for Medical Care includes about 400 member doctors. The percentage of Pima County doctors belonging to the foundation was disputed but was between thirty percent and eighty percent.

Under the payment-in-full plan, member doctors agreed to a maximum schedule of fees. The maximum fee schedules were established by majority vote of the foundation member physicians. Member doctors have no other financial interest in the operation of the foundations. The fee schedules limited the amount member doctors could be paid for services performed for patients insured by insurers approved by the foundations. In return, the insurers agreed to pay the doctors' charges up to the scheduled amounts. Thus, patients insured by a foundation-endorsed insurer were guaranteed full payment for their medical bills when they were treated by a member physician.

The Supreme Court, in an incisive four to three decision, applied standard antitrust principles to the special facts of the health care field and held the foundations' maximum fee agreements⁹³ were *per se* illegal as horizontal price-fixing by physicians.

The defendants argued that their fee agreements made it possible to provide consumers of health care with a uniquely desirable form of insurance coverage that could not otherwise exist:

The features of the foundation-endorsed insurance plans that they stress are a choice of doctors, complete insurance coverage, and lower premium.⁹⁴

The Supreme Court found, however, that the defendants' contentions were not supported by fact. A choice of doctors and payment-in-full insurance coverage were "hardly unique to these plans."⁹⁵

First, the Court noted that in most parts of the country existing insur-

93. Horizontal "maximum" fee agreements initially may appear beneficial to consumers and the public. "Maximum" suggests that, unlike the usual price-fixing agreement, prices are being lowered rather than raised. However, a cartel price-fixing agreement is in effect a maximum fee agreement, since any cartel member that tries to charge a higher price will not make any sales. More specifically, the Supreme Court's careful attention to the special facts of the health care industry revealed that appearances are indeed deceiving. The *Maricopa* medical societies' foundations in effect were collectively bargaining prices on behalf of their physician members to prevent a more competitive alternative: insurer bargaining with physicians individually. The maximum fee agreement thus prevented physician fees from dropping to a competitively determined lower level. *Id.*

94. *Id.* at 2477.

95. *Id.*

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ers pay about the same percentage of doctor bills in full (seventy percent) and provide the same degree of choice as the *Maricopa* foundations.

Second, the Court found that even if participating agreements guaranteeing payment in full according to a maximum fee schedule were desirable, "it is not necessary that the doctors do the price-fixing."⁹⁶ As an example, the Court cited the Arizona Comprehensive Medical/Dental Program for Foster Children where the "maximum fee schedule is prescribed by a state agency rather than by the doctors."⁹⁷ The Court also cited *Group Life & Health Insurance Co. v. Royal Drug Co.*⁹⁸ for the proposition that "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."⁹⁹ Finally, in a footnote, the Court pointed to the Justice Department's position that it is lawful under the antitrust laws for an insurer to fix the fee schedule and enter into bilateral contracts with individual doctors.¹⁰⁰ Accordingly, the Court concluded "nothing in the record even arguably supports the conclusion that this type of insurance program could not function if the fee schedules were set in a different way."¹⁰¹

The Court also ruled that the foundations could not escape *per se* treatment as joint ventures. The Court held the medical foundations were not joint ventures because the participating physicians had not partially integrated their practices:

The foundations are not analogous to partnerships or other joint arrangements in which persons who would otherwise be competitors pool their capital and share the risks of loss as well as the opportunities for profit. In such joint ventures, the partnership is regarded as a single firm competing with other sellers in the market.¹⁰²

The Court also pointed out that it was not necessary for physicians to set the maximum fee schedule since, e.g., an insurer could do it: "Even if a fee schedule is therefore desirable it is not necessary that the doctors do the price fixing . . . [N]othing in the record even arguably supports the conclusion that this type of insurance program could not function if the fee schedules were set in a different way."¹⁰³ Not having met the first requirement for a joint venture, the medical foundations' fee agreement was ruled a naked restraint and *per se* illegal as horizon-

96. *Id.*

97. *Id.* at 2478.

98. 440 U.S. 205 (1979).

99. *Id.*

100. 102 S. Ct. at 2477 n.26.

101. *Id.* at 2477.

102. *Id.*

103. *Id.*

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tal price-fixing.¹⁰⁴

B. *Medical Staff Boycotts*

Hospitals are protected by the antitrust laws from medical staff boycotts. Many hospital medical staffs are composed of physicians who are independent contractors. If the physicians agree to take joint action to force a hospital to adhere to their wishes, their joint action to force a hospital to adhere to their wishes rarely will meet the "small groups can be beautiful" rule's first requirement. It is not a legitimate joint venture under the antitrust law when competitors join together solely to achieve "strength in numbers" or "clout." Collective action to exclude a new competitor or to exclude a new form of competition in this manner usually constitutes a *per se* illegal group boycott. For example, the Maryland Attorney General took action against the staff of the Harford Memorial Hospital when it allegedly boycotted the hospital's efforts to negotiate a new contract with hospital radiologists.¹⁰⁵ Similarly, the Federal Trade Commission sued all five members of the medical staff of the Brownfield, Texas Regional Medical Center when they allegedly boycotted the hospital's efforts to contract with new physicians recruited to the area. The physicians entered a consent decree barring them from jointly refusing to provide emergency room coverage, perform administrative functions, and refer or accept patients from the newly-recruited doctors.¹⁰⁶

C. *Collective Bargaining by Purchasers*

Can purchasers such as companies and insurers who individually have little clout with hospitals group together and collectively bargain for lower hospital rates? Generally speaking, the "small groups can be beautiful" rule provides a ready answer: "no." In many circumstances collective bargaining by a large group of purchasers will almost surely violate the "small group" requirement. The antitrust concerns with collective bargaining by a large group of insurers are confirmed by the Health Insurance Association of America's (HIAA) interest in an anti-

104. The rationale of *Maricopa* has been criticized as being inconsistent with Chicago School of Economics analysis. See Easterbrook, *Maximum Price-Fixing*, 48 U. CHI. L. REV. 886 (1981); Gerhart, *The Supreme Court and Antitrust Analysis: The (Near) Triumph of the Chicago School*, 82 SUP. CT. REV. 319. The fundamental flaw in both critiques is their attempt to decide cases by theory and assumed facts as opposed to the facts in the record; that is, to substitute one view of economic analysis for the judicial process itself. Justice Stevens, on the other hand, was true to the judicial process, and provided a particularly penetrating analysis in *Maricopa* of the facts in the record.

105. *Maryland v. Medical Staff of Harford Memorial Hosp.*, 1981-2 TRADE CAS. (CCH) ¶ 64,430 (1981).

106. *In re Hope*, 98 F.T.C. 66 (1981).

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trust exemption for collective bargaining.¹⁰⁷ These concerns exist even though the commercial insurers represented by the HIAA nationally account for approximately only twenty percent of hospital revenues. As indicated earlier, a twenty percent combined market share, depending on other factors, may not constitute a "small group." Yet collective bargaining by a small group of purchasers can survive antitrust challenge under the "small groups can be beautiful" rule. This same principle is seen in the next example.

D. Joint Purchasing By Hospitals

Joint purchasing arrangements by hospitals provide a clear illustration of antitrust joint venture law and the "small groups can be beautiful" rule. Efficiencies result from this joint action and partial integration, since economies of scale in volume purchasing may be involved. Moreover, as long as the purchasing group accounts for only a "small" portion of the products purchased and does not engage in other anticompetitive practices, they are perfectly lawful. For example, the United States Department of Justice recently issued a favorable letter concerning the business review of a proposal that would make group purchasing available to all Ohio hospitals.¹⁰⁸ In the letter, the Department said it does not intend to launch an antitrust challenge against a program that would establish a statewide group purchasing consortium of Ohio-based, not-for-profit, local group purchasing programs. The Ohio Hospital Purchasing Consortium (OHPC), designed to help control hospital costs, would combine eight existing group purchasing programs in Ohio representing 160 of the 240 not-for-profit hospitals in the state. OHPC would make group purchasing on selected items available to all Ohio hospitals. Agreeing that the proposal could result in further cost containment by hospitals, the Department said it does not think the program would "restrain trade in any particular product market." Further, the Department found that the proposal adequately provides for competitive bidding by suppliers and that as a result the suppliers may be able to reduce costs of storage, inventory control, contract negotiations, and delivery.¹⁰⁹

107. HEALTH INSURANCE ASSOCIATION OF AMERICA, COMPETITION IN THE HEALTH CARE SYSTEM 12 (March 1981).

108. Justice Dept. Business Review letter to Ohio Hospital Association (June 9, 1982).

109. Curiously, one court recently stated that, "Group purchasing may bring about substantial savings to the individual hospitals within the group," and then ruled the group purchasing practices involved were unlawful. *White & White v. American Hosp. Supply Corp.*, 42 ANTITRUST & TRADE REG. REP. (BNA) 884, 914 (W.D. Mich. 1982). The ruling underscores the need for careful antitrust counselling before undertaking any activity with antitrust implications.

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E. *Collective Negotiation of Hospital Reimbursement Formulas*

Probably the classic conflict between antitrust and traditional guild thinking about health care economics involves the collective negotiation of hospital reimbursement formulas. Historically, hospitals in some localities became accustomed to negotiating reimbursement formulas collectively with major insurers such as Blue Cross. Collective negotiations by hospitals may seem only "fair," since an individual hospital naturally would feel overwhelmed dealing with a larger buyer by itself. Yet collective bargaining by 100% of local hospitals, even with a dominant insurer, is less "fair." No single insurer accounts for close to 100% of hospital revenues, and thus no single insurer could begin to effectively bargain with a collective hospital monopoly. In any event, the antitrust law of joint ventures does apply: collective bargaining of reimbursement formulas by large groups of hospitals are likely to be held *per se* illegal price-fixing.¹¹⁰

F. *Participating Contracts and Other Insurance Arrangements With Limited Groups of Providers*

A large number of antitrust cases have been brought by health care providers challenging insurance company participating contracts as "price-fixing" or "boycotts."¹¹¹ Typically the plaintiff-providers charge higher prices than allowed under the participating contract. The plaintiff-providers allege that an insurer's effort to get them to lower their prices is "price-fixing," and that the effect of the participating contract, shifting patients to participating providers, is a "boycott." Other insurance arrangements with much more limited groups of providers are likely to emerge as well.¹¹² Antitrust cases against these arrangements are likewise possible, again alleging "price-fixing" and "boycotts."

This example is included even though it does not involve a joint venture. The "small groups can be beautiful" rule is inapplicable because there is no group action by competitors. It is included because it illus-

110. *In re Michigan State Medical Soc'y*, 3 TRADE REG. REP. (CCH) ¶ 21,991 (1983). See also L. SULLIVAN, *supra* note 76, at 285-89; Justice Dept. Business Review letter to California Pharmaceutical Association (Nov. 1, 1976); Justice Dept. Business Review letter to Michigan Pharmacies' Collective Fee Negotiating Agent (Aug. 15, 1978).

111. See, e.g., *Sausalito Pharmacy, Inc. v. Blue Shield of Cal.*, 1982-2 TRADE CAS. (CCH) ¶ 64,766 (9th Cir. 1982); *Anderson v. Medical Serv. of the Dist. of Columbia*, 551 F.2d 304 (4th Cir. 1977); *Kartell v. Blue Shield of Mass., Inc.*, 592 F.2d 1191 (1st Cir. 1979); *Grigg v. Blue Cross & Blue Shield of Mich., Inc.*, No. 772990 (E.D. Mich. filed Dec. 22, 1977) (physicians); *Enright, Doctors v. Blue Shield: The First Big Battle*, 55 MED. ECON. 23 (1978). See also *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979); *Manasen v. Cal. Dental Serv.*, 1981-1 TRADE CAS. (CCH) ¶ 63,959 (N.D. Cal. 1980) (dentist); *Doctors, Inc. v. Blue Cross of Greater Phila.*, 557 F.2d 1001 (3d Cir. 1976) (hospitals).

112. See, e.g., FAH REV., July-Aug. 1982, at 1 (whole issue devoted to Preferred Provider Organizations).

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trates a fundamental misunderstanding of private markets and antitrust principles by some health care professionals. Typically these contracts are between a buyer and seller, such as an insurer and a provider. They are what the Supreme Court termed "merely arrangements for the purchase of goods or services."¹¹³ Under the antitrust laws, buyers are expected only to look and contract for the best services at the best price. As the first court to decide the issue stated: "What plaintiffs describe as price-fixing is, in fact, no more than a natural consumer-oriented competitive activity in getting the lowest competitive price."¹¹⁴ As to the "boycott" charge, the same court stated: "An unlawful boycott will not result from a buyer's refusal to pay a higher price for goods or services where it can buy them at a lower price."¹¹⁵ Accordingly, participating contracts and other insurance arrangements with limited groups of providers are basically procompetitive and generally lawful under the antitrust laws, so long as the insurer is independent of provider control. The situation where the insurer is controlled by providers follows.

G. *Provider Controlled Insurance Plans*

The preceding example may suggest to some health care professionals that the antitrust laws leave them defenseless. Hospitals and other providers are increasingly faced with alternative insurance plans. Preferred Provider Organizations (PPOs), health care plans with limited provider groups, and HMOs are developing in more and more communities around the country. Can hospitals group together to sponsor or affiliate with HMOs, health care plans, or PPOs without violating the antitrust laws?¹¹⁶

Antitrust joint venture law does apply here. More specifically, small groups of hospitals and other providers can combine in a variety of insurance arrangements to offer their services on the basis of quality, price, and service. On the other hand, large groups of providers *cannot* lawfully combine to form a single insurer under basic antitrust principles governing horizontal joint ventures.

Consider, for example, a city with ten hospitals and assume that each hospital develops an alternative insurance plan with its medical staff. One hospital and its medical staff agrees to offer specified services for a

113. *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. at 214.

114. *Chick's Auto Body v. State Farm Mut. Auto. Ins.*, 1979-1 TRADE CAS. (CCH) ¶ 62,642, at ¶ 77,634-35 (N.J. Super Ct. Law Div. 1979).

115. *Id.*

116. For a more extensive analysis, see Weller, *Antitrust and Health Care: Provider Controlled Health Plans and the Maricopa Decision*, 8 AM. J.L. & MED. 223 (1982); McClure & Weller, *Competition and the Health Care Plan Therapy for Medical Markets: An Antitrust, Policy, and Historical Synthesis* (forthcoming).

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monthly premium through an arrangement with an existing insurer new to the area. Another hospital organizes an HMO, contracts for physician services with its medical staff, and opens several satellite outpatient centers to serve its HMO patients. Another hospital's medical staff sponsors an HMO and contracts with the hospital for hospital services. Yet another hospital and its medical staff enter a PPO agreement with a local employer. The PPO offers discounts and includes incentives for both the hospital and physicians to reduce hospital utilization. All of these examples, if properly put together, can comply with the "small groups can be beautiful" rule and antitrust joint venture law.

The lawful, small group arrangements represent new types of cooperation by providers and new forms of competition. The new cooperations may be multi-disciplinary, involving hospitals and their medical staffs. The new forms of competition provide competition by the small group of hospitals and providers over efficiency as well as quality and service with other providers and insurers. They are generally procompetitive and lawful.

From an antitrust perspective, the key is recognizing that each of these plans compete in more than the insurance market. Most importantly, they compete in provider markets as well. Every time a subscriber or employee chooses one of these plans, he or she has chosen its "small group" of providers over all others and has chosen that insurer over all others. If one plan and its group of providers offer higher quality services for a lower premium than the others, two things are likely to happen. One, more subscribers will switch to it, and two, the other plans and their providers will improve their quality and efficiency to become more competitive. All of this occurs without government mandates. All of this occurs as each provider group chooses to respond to Adam Smith's "invisible hand," which is what a free market is all about.

Can high percentages of the doctors or hospitals in a community join together to form their own alternative insurance plan? These arrangements violate the "small group" requirement for joint ventures and, thus, are unlawful under the antitrust laws. By including a high percentage of all providers, competition between providers over efficiency is substantially eliminated.¹¹⁷ Under the rule of reason's balancing test, too much competition is lost to outweigh any procompetitive benefits, and the arrangement is thus illegal.

117. Insurers controlled by small groups of providers compete in provider markets. At the other extreme, the cartel joint venture with 100% of local providers does not compete in provider markets, just as any successful cartel eliminates all competition among cartel members.

Applying these standards to the ten IPAs included in one study, all ten included from 42%-100% of local physicians and thus all would probably be unlawful. Egdahl, *The Potential of Organiza-*

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H. *Medicaid Boycotts*

The single most common government antitrust case in the health care field involves group boycotts of Medicaid or other government programs.¹¹⁸ Providers unhappy with low levels of government reimbursement join together to withhold their services until the government raises its reimbursement levels.

They join together to increase their "clout" with the government. Although the grievance may be perfectly valid, the means chosen generally is not. This type of provider joint action can represent precisely the kind of conduct the antitrust laws are designed to prevent: joint action by competitors to raise prices through a collective boycott. It usually violates both requirements of the "small groups can be beautiful" rule. First, there is no legitimate joint venture when the sole purpose of the venture is to raise prices. Second, a large group of providers is necessarily involved, because a small group usually does not have any clout.

On the other hand, it is perfectly lawful for *individual* providers to refuse to participate in Medicaid or any other insurance program because the prices are too low.

I. *Boycotts of Alternative Providers*

Imagine a city with excess hospital beds, and suddenly four new providers appear: an HMO, an emergicenter, an ambulatory surgery center, and a for-profit hospital. Can the established hospitals get together for cost-containment purposes and agree not to offer the HMO or the other new providers services or price discounts? Can they enter agreements with insurers such as Blue Cross not to pay for services rendered by the new providers?

Generally speaking, any of these actions by established hospitals have serious antitrust risks.¹¹⁹ None of these agreements are lawful

tions of Fee for Service Physicians for Achieving Significant Decreases in Hospitalization, 186 *ANNALS OF SURGERY* 388, 390 table 1 (Sept. 1977).

One important issue for research is how to determine a means of measuring structural competitiveness of provider markets. The traditional concentration measures of industrial organization economics are not applicable given the pervasive absence of provider price competition. Two important factors suggested by the preceding analysis are: first, the number of health care plans (with limited groups of providers) and second, the percentage of the insured population with incentive multiple choice. See, e.g., *Minn. Coalition Update* (Spring 1982) (only 20% of Minneapolis employers made equal contributions for all health insurance options and paid less than 100% of the total premium).

118. For example, seven of the twenty antitrust cases brought by state attorneys general as of mid-1980 involved provider boycotts of state programs. *Enforcement of State Antitrust Laws Gains Momentum*; *Ohio Sets Pace*, *FAH Rev.*, May-June 1981, at 23, 26.

119. See, e.g., *Ohio v. Mahoning County Medical Soc'y*, 1982-1 *TRAD. CAS. (CCH)* ¶ 64,557 (N.D. Ohio 1982) (hospitals' consent decree); *United States v. Halifax Hosp. Medical Center*, 1981-1 *TRAD. CAS. (CCH)* ¶ 64,151 (M.D. Fla. 1981) (consent decree).

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joint ventures under either test. The joint action is neither by a small group nor is it a legitimate joint venture intended to improve competition. To the contrary, the collective action is designed to exclude the new competitors from the market and will often be illegal *per se* as a group boycott. It may well be that new suppliers of services are not needed. However, under the antitrust laws, that is a decision to be made by the market or government but not by private groups of competitors. The criminal indictment and conviction of the American Medical Association for its actions against an HMO in Washington, D.C.¹²⁰ poignantly demonstrate the antitrust risks of this type of joint action.

J. Coalitions

Coalitions are one of the fastest growing new phenomena in the health care field. They range in composition from business-only groups to organizations with representatives from industry, labor, hospitals, physicians, dentists, pharmacists, commercial insurers, HMOs, and Blue Cross and Blue Shield. They are involved in a wide range of activities. The broad range of coalition membership and activities make it impossible to provide a complete antitrust analysis of coalitions here. The issue of health planning alone, e.g., is the proper subject of a separate article.¹²¹ It is possible, however, to discuss selected activities.

Can all local employers join together in a coalition and collectively bargain with doctors or hospitals for lower prices? As indicated in example C, hospitals are generally protected by the antitrust laws from collective bargaining by large groups of employers, while small groups of employers can conduct collective negotiations.

Can all local hospitals bargain collectively with all local employers, in something akin to labor negotiations? As examples C and E concerning collective negotiations by purchasers and collective negotiations by hospitals suggest, there are serious antitrust risks with two-sided collective negotiations as well. These risks are reflected in the fact that collective bargaining by labor unions is specifically exempted from the antitrust laws. Small groups of collective negotiations, however, can be lawful.

Can a coalition, however composed, lobby government at the federal, state, or local level for legislation affecting health care providers or regarding a CON (certificate of need) for a specific hospital? Generally speaking, as long as the coalition's activity is confined to lobbying, it is immune from antitrust liability under the *Noerr-Pennington* doc-

120. *American Medical Ass'n v. United States*, 317 U.S. 519 (1943).

121. See, e.g., Sims & Grimm, *Health Planning Activities Test Sherman Act*, HOSP. FIN. MGMT., July 1981, at 12.

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trine.¹²² However, as the *Rex Hospital* case pointedly demonstrates, care must be taken to stay within that exemption.

Can coalitions collect and share information on local health care costs and utilization and on methods of controlling health care costs? This type of activity can be structured and conducted in ways that are perfectly lawful and procompetitive. The safest information-sharing activity is when it is limited to facilitating individual action by individual businesses, individual providers, or other individual coalition members. Joint action by buyers or by providers can be perfectly lawful so long as they carefully comply with the "small groups can be beautiful" rule and the antitrust laws.¹²³

V. CONCLUSIONS

The present structure of American health care insurance, replete with its perverse incentives, was largely built over the last fifty years upon the American Medical Association's now illegal contract practice and "free choice" ethics. Justice Stevens' cogent analysis in *Maricopa* symbolizes a fundamental turning point in the history of American health care. The era of guild ethics is over. In the new era of antitrust in health care, large groups of providers can no longer join together to take economic action. Small groups of competitors, however, under standard antitrust law for joint ventures, can group together with new ways of providing quality services efficiently in a private system of health care delivery.

122. See, e.g., *id.*

123. See, e.g., U.S. Department of Justice Business Review letter to Maryland Health Care Coalition (Feb. 22, 1982); U.S. Department of Justice Business Review letter to Southwest Michigan Health Systems Agency, Inc. (March 3, 1982). See also G. LAMB & C. SHIELDS, *TRADE ASSOCIATION LAW AND PRACTICE* (rev. ed. 1971).