HOSPITALS, PHYSICIANS, AND HEALTH INSURERS: GUARDING AGAINST IMPLIED AGREEMENTS IN THE HEALTH CARE CONTEXT

ANTHONY J. DENNIS*

I. INTRODUCTION

The explosive growth of the health care industry,[1] coupled with the skyrocketing costs[2] of health care, has resulted in increased scrutiny of the industry by the public, press, politicians, and federal and state regulators. Various public interest groups, journalists, legislators, and presidential candidates have assailed the manner in which health care is financed and delivered in America. The escalating costs of health care have placed health care issues firmly on the national political agenda.[3]

The health care industry has responded to these attacks through a va-

* Counsel at Aetna Life and Casualty Company; a member of the National Health Lawyers Association and the Health Care and Insurance Industry Committees of the Antitrust Section, American Bar Association. Admitted to practice in Connecticut and the District of Columbia, Mr. Dennis received a J.D. from Northwestern University School of Law and a B.A., *cum laude*, from Tufts University.

The author would like to thank all those who reviewed and commented on this Article. The views expressed in this Article are solely the author's own and do not reflect the views of the Aetna Life and Casualty Company.

1. *See* N. Motenko, *Health Care Developments*, 60 ANTITRUST L.J. 639, 648 (1991) ("[H]ealth care is now the number one industry in the United States.").

2. *See* Robert Pear, *States Are Moving To Re-Regulation Of Health Costs*, N.Y. TIMES, May 11, 1992, at A1. "From 1981 to 1991, medical prices rose more than twice as fast as the Consumer Price Index for all items. Total national spending on health care soared to $738 billion last year, from $290 billion in 1981." *Id.* Geraldine Alpert & Thomas R. McCarthy, *Beyond* Goldfarb*: Applying Traditional Antitrust Analysis to Changing Health Markets*, 29 ANTITRUST BULL. 165, 166 (Summer 1984).

> Rising costs of health care have been a concern of the public and policy makers for at least a decade as health expenditures have soared, accounting for a growing proportion of the gross national product (GNP). In 1950 national health expenditures represented 4.4 percent of GNP. Today they represent over 10 percent and are rising to an estimated 12 percent of GNP by 1990. Even in constant dollar terms, per capita personal health expenditures rose at a rate of 4.8 percent per year between 1950 and 1980.

Id.

3. The health care issue vaulted Harris Wofford from Pennsylvania, the dark horse Democratic contender for the late Senator John Heinz's Senate seat, to the United States Senate in 1991 over former United States Attorney General and former Pennsylvania Governor Richard Thornburgh. *See Health, the Lose-Lose Issue*, ECONOMIST, Nov. 16, 1991, 27, 27. The issue of health care

riety of means. In addition to the public relations campaign normally expected in such a situation, the industry has also engaged in a variety of novel financing arrangements in an attempt to reduce the costs of health care. These new financing arrangements have prompted hospitals, physicians, and health insurers to enter into new contractual relationships with one another and thus have derivatively increased the risk that they may violate or be accused of violating the federal antitrust laws.

Moreover, in the 1980s federal authorities vigorously began to apply federal antitrust laws to the health care industry. The authorities hoped that such an enforcement initiative would discourage anti-competitive behavior and consequently curb escalating medical costs. As a result of these developments, antitrust counseling in the health care industry has grown increasingly important over the last several years.

All members of the health care industry, medical providers and health insurers alike, need to be sensitive to the antitrust laws and learn to avoid high-risk behavior. This Article discusses and explores the importance of the federal antitrust laws to the health care industry in the provider network context and then suggests guidelines for avoiding antitrust liability.

A. Health Care Financing and Delivery: Old Staples and New Techniques

Indemnity insurance has been the traditional staple of the health care industry.[4] Under an indemnity plan, the health care insurer—known as a third-party payor in insurance parlance—promises to pay eighty percent of the cost of medical services covered by the insurance contract while the insured party—the patient—pays the remaining twenty percent.[5] Unfortunately, indemnity insurance does not assist in curtailing medical costs for several reasons. First, the physician who prescribes medical treatment has no incentive to utilize the least expensive tests and procedures since the doctor is assured of receiving full payment by a combination of the patient and the health insurer. Second, the patient has little or no incentive to demand less expensive medical treatment since the indemnity insurer pays the lion's share of the cost. Finally, the

cost and delivery also figured prominently in the 1992 Presidential election. *See* Susan Dentzer, *Clinton's Big Test*, U.S. NEWS & WORLD REP., Nov. 23, 1992, 26, 26-30.

4. *See* Edward P. Potanka, Alternative Health Care Delivery Systems: A Legal Overview 1, 4, 6 (May 22, 1989) (paper presented to the Association of Life Insurance Counsel, on file with author).

5. *Id.*

indemnity insurer is frequently able to recover its costs and a certain level of profit by charging higher health insurance premiums. Thus, none of the three parties in the typical health care transaction has a motive to lower costs when indemnity insurance covers the claim.

The concept of managed care[6] was introduced in earnest in the early 1980s largely to inject price competition into the health care marketplace and to curtail increasing medical costs.[7] Managed care plans offer prepaid health insurance in which customers pay an up-front fee or premium in return for nearly unlimited access to a network of medical providers at little or no additional cost.[8] Such plans include health maintenance organizations ("HMOs"),[9] preferred provider organizations ("PPOs")[10] and several variations[11] on these two basic managed care en-

6. A federal district court in Kansas characterized managed care as an "emerging alternative delivery system" that "radically alter[s] traditional notions about delivery and financing health care." Reazin v. Blue Cross & Blue Shield, Inc., 663 F. Supp. 1360, 1371 (D. Kan. 1987) (*Reazin II*). The court mentioned Health Maintenance Organizations ("HMOs") and Preferred Provider Organizations ("PPOs") as examples of such alternative delivery systems. *Id.*

7. *See* Robert J. Enders, *Alternative Delivery Systems*, *in* ANTITRUST HEALTH CARE ENFORCEMENT AND ANALYSIS 195, 195-96 (M. Elizabeth Gee ed., 1992); Potanka, *supra* note 4, at 5, 9-17; Peter D. Fox, *Forward: Overview of Managed Care Trends*, *in* THE INSIDER'S GUIDE TO MANAGED CARE 1-5 (Susan K. Chambers ed., 1990); Hal Belodoff, *HMOs—New Challenges—New Products*, *in* THE INSIDER'S GUIDE TO MANAGED CARE, *supra*, at 241, 241-42.

8. *See* Gary S. Davis, *Introduction: Managed Health Care Primer*, *in* THE INSIDER'S GUIDE TO MANAGED CARE, *supra* note 7, at 13-29; Fox, *supra* note 7, at 1; Potanka, *supra* note 4, at 6-17.

9. HMO enrollees, also known as subscribers, are directed to use only those health care providers who are members of that particular HMO's provider network. Enrollees who use network providers for the treatment of conditions covered by the HMO contract pay no deductible, and the HMO directly pays for the cost of treatment. On the other hand, enrollees who obtain treatment outside the provider network must pay 100% of the medical expenses and receive no reimbursement from the HMO plan. Thus, patients are strongly steered toward using the provider network, thereby guaranteeing a patient flow that enables HMOs to conclude volume-discount deals with providers. HMOs then pass the cost savings to the consumer in the form of a reduced price for health insurance—the cost of membership in the HMO. *See* Harold S. Luft, *How Do Health-Maintenance Organizations Achieve Their Savings?*, 298 NEW ENG. J. MED. 1336, 1336 (1978); Linda E. Demkovich, *"PPO" - Three Letters That May Form One Answer to Runaway Health Costs*, 15 NAT'L J. 1176 (1983) (explaining the differences and similarities between HMOs, PPOs, and fee-for-service arrangements); Reazin v. Blue Cross & Blue Shield, Inc., 899 F.2d 951, 956-57 n.5 (10th Cir. 1990) (*Reazin III*).

> HMOs and preferred provider organizations ("PPOs") are so-called "alternative delivery systems" which have emerged as cost-effective alternatives to traditional indemnity insurance. HMOs and PPOs are prospective reimbursement arrangements, in which a member or subscriber pays a monthly amount to medical care providers [or managed care companies] who then oversee all the health care needs of the member. In an HMO or PPO, the member typically pays less for health care coverage than under a traditional indemnity insurance plan, but is limited in his or her choice of medical care providers.

Id.

10. Similar to those who belong to an HMO, enrollees in a PPO are encouraged to use provid-

tities. Managed care has been somewhat more successful in influencing physician behavior regarding the selection of less expensive medical treatment.[12]

Under a managed care approach, physicians and other medical providers such as hospitals, allied health professionals, and outpatient surgery centers commonly enter into capitation contracts with managed care companies to provide medical services to plan members.[13] A capitation contract typically contains, *inter alia*, a payment provision in which the health care provider receives an annual or periodic payment for each enrollee in the plan, regardless of the amount of care actually rendered. Health care providers in a managed care provider network normally do not receive any additional payments from the managed care plan for treating member patients.

Managed care plans control medical treatment costs by inducing providers to prescribe low-cost, yet medically appropriate, care. Since medical providers receive only discounted, or capitated, fees for services rendered, they attempt to reduce their operating costs so that the capitation payment they receive yields some net profit. Consequently, a capitation contract may be viewed as a volume discount contract in which the provider assumes some financial risk.

Managed care plans bargain with health care providers for the lowest possible price for medical services. These plans are able to obtain favorable prices by promising a sizable volume of patients who are enrollees or subscribers of the plan. However, providers bear the risk that the plan will not provide enough enrollees to make it economically worth-

---

ers in the PPO provider network. If the PPO enrollees do use PPO providers, they pay little or no deductible; the PPO directly covers the costs. Unlike an HMO, however, a PPO will partially cover the cost of medical care rendered by providers who do not belong to the PPO's provider network. Thus, members of a PPO's provider network are said to be "preferred." As a result, patient steerage is also not as strong in a PPO. *See* Luft, *supra* note 9, at 1337; Demkovich, *supra* note 9, at 1176; *see generally* Robert E. Youle & Paul C. Daw, *Preferred Provider Organizations: An Antitrust Perspective*, 29 ANTITRUST BULL. 301, 303-04 (Summer 1984).

11. In the last few years, the area of managed care has become a veritable alphabet soup of names and abbreviations. Managed care organizations have also begun to sell their services on a stand alone, or unbundled, basis. For example, managed care plans have rented their provider networks to others, including self-insured groups. They have sold their services as third-party administrators ("TPAs"). TPAs process the insurance related paperwork, including claim forms, without assuming the underlying insurance risk.

12. *See supra* note 9.

13. *See* Gerald L. Coe & Jeffrey M. Sconyers, *Contracting (Risk-Provider Oriented)*, *in* THE INSIDER'S GUIDE TO MANAGED CARE, *supra* note 7, at 78, 82-83; Davis, *supra* note 8, at 27; Potanka, *supra* note 4, at 9.

while since it is impossible to guarantee a certain level of enrollment. Furthermore, no guarantee exists that the population of enrollees will be relatively healthy, a key factor which affects the ability to keep operating costs at a minimum.

Managed care plans also curb increasing health care costs by engaging in various forms of utilization review. Utilization review consists of an in-house review of the treatment the plan physicians or other plan medical providers prescribe.[14] Pursuant to utilization review, managed care plans will intervene when a lower cost, medically appropriate alternative is available.

Managed care has forced participants in the health care marketplace into new contractual relationships with one another. Insurance companies now bargain and contract directly with hospitals and physicians for high-quality, low-cost medical care instead of passively reimbursing them for the care rendered. As a result, medical providers have become more savvy and sophisticated. For example, some physicians have organized independent practice or physician associations ("IPAs") in order to combine and leverage their bargaining power with the insurance companies. In addition, some hospitals have used their affiliations with other hospitals or formed physician-hospital organizations ("PHOs") in order to bargain more effectively with health insurers.[15]

B. Crashing the Party: Antitrust, the Federal Government, and Eager Plaintiffs

These new structures and contractual relationships inevitably brought increased regulatory scrutiny and litigation. Federal and state regulators, as well as private plaintiffs, often use antitrust law as their weapon of choice in the health care context. In the early 1980s, the Federal Trade Commission ("FTC") and the Antitrust Division of the United

14. A combination of doctors and registered nurses who are employees of the managed care plan typically conduct utilization review. The nurses ordinarily handle routine medical review situations. The medical doctors, who often carry the title of "medical director" within the managed care plans, review the treatment of complex or life-threatening medical conditions. Managed care plans also involve doctors in the provider network in utilization review. A patient's primary care physician ("PCP") acts as a gatekeeper who monitors the level of care and decides whether to refer the patient to another provider for more specialized care. *See* Potanka, *supra* note 4, at 10-11. Managed care plans also use pre-admission certification and continued stay review to control costs. Under these two programs, patients must obtain the health plan's prior approval before undergoing certain medical procedures or extending their hospital stays. *See* Potanka, *supra* note 4, at 14-16.

15. *See* Davis, *supra* note 8, at 16; Noah D. Rosenberg, *Independent Practice Associations with Checklist*, *in* THE INSIDER'S GUIDE TO MANAGED CARE, *supra* note 7, at 263, 266-67.

States Department of Justice ("DOJ")—the two federal agencies charged with enforcing the federal antitrust laws—began an explicit and highly visible campaign to attack perceived antitrust violations within the health care industry. The agencies initiated antitrust suits against doctors,[16] challenged hospital mergers,[17] and issued numerous press releases.[18] Furthermore, the leadership of the FTC and the Antitrust Division of the DOJ delivered several public speeches to underscore the applicability of the federal antitrust laws to the health care industry and to emphasize the federal government's objective to commence criminal enforcement actions whenever appropriate.[19] These events demonstrated that an era of antitrust enforcement had clearly arrived for the health care industry.

These developments shocked many in the health care industry. Doctors believed that because they practiced a "profession" not a "trade," they were immune from the Sherman Antitrust Act which regulates "trade or commerce."[20] In the mid-1970s, the courts eliminated the so-called "learned professions" exemption from the federal antitrust laws, thus bringing doctors, lawyers, and other professionals within the scope of the antitrust statutes.[21] For their part, insurance companies had al-

16. *See, e.g.*, FTC v. Indiana Fed'n of Dentists, 476 U.S. 447 (1986) (group boycott of health insurers by dentists); Arizona v. Maricopa Medical Soc'y, 457 U.S. 332 (1982) (maximum price fixing by doctors); United States v. Alston, 1991-1 Trade Cas. (CCH) ¶ 69,366 (D. Ariz. 1990) (price fixing by three Tucson dentists). There are several such cases on the record. *See also* Motenko, *supra* note 1, at 639 ("[W]e have had continued aggressive enforcement in the health care area.").

17. *See, e.g.*, United States v. Carilion Health Sys., 892 F.2d 1042 (4th Cir. 1989); United States v. Rockford Memorial Corp., 898 F.2d 1278 (7th Cir.), *cert. denied*, 111 S. Ct. 295 (1990).

18. *See, e.g.*, U.S. Dep't of Justice Press Release No. 88-188 (May 25, 1988) (regarding proposed hospital mergers in Roanoke, Virginia and Rockford, Illinois which the government contested).

19. There are numerous public speeches on the record. For example, the current Chair of the FTC, Janet Steiger, and the Acting Assistant Attorney General in charge of the Antitrust Division, Rick James, regularly speak at antitrust and health care seminars and bar association meetings across the country. Every year Ms. Steiger, or her designee, speaks to the National Health Lawyers Association at their annual February meeting regarding antitrust in the health care field. Mr. James' two immediate predecessors—James Rill and Charles Rule—gave a speech each year while in office at the annual meeting of the Antitrust Section of the American Bar Association. These officials often address antitrust enforcement in the health care field in their public pronouncements.

20. *See* Sherman Antitrust Act, 15 U.S.C. § 1 (1988 & Supp. 1990) ("Every contract, combination . . . or conspiracy, in restraint of trade or commerce . . . is declared to be illegal.").

21. *See* National Soc'y of Prof. Eng'rs v. United States, 435 U.S. 679 (1978) (engineers); Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975) (lawyers and other professionals). "The nature of an occupation, standing alone, does not provide sanctuary from the Sherman Act." *Id.* at 787. *See generally* 6 JULIAN O. VON KALINOWSKI, ANTITRUST LAWS AND TRADE REGULATION §§ 49.02[1][a], 52.01[1] (1992).

ways been somewhat comforted by the McCarran-Ferguson Act[22] which exempts certain insurance-related conduct from the federal antitrust laws. Some insurance companies were surprised that they now had to worry about their activities in the health care field. Yet, by the 1980s, the McCarran-Ferguson exemption to the federal antitrust laws provided them only limited protection. For example, the statutory language of the McCarran-Ferguson Act stated that the exemption applied only to the "business of insurance."[23] Judicial decisions clearly indicated that the "business of insurance" was not synonymous with the "insurance business."[24] Therefore, an insurance company's activities are not automatically exempt from the federal antitrust laws merely because they are undertaken by an insurance company. Rather, only those arrangements that involve spreading or transfering of risk or that implicate the relationship between the policyholder and the insurer qualify for protection from the antitrust laws under the McCarran-Ferguson Act.[25]

Furthermore, under indemnity plans, most interactions of insurers involve their insureds. As a result of this relationship, the McCarran-Ferguson Act would probably protect much of this activity from the federal antitrust laws. In contrast, in the managed care setting, the insurer is deeply involved in relationships with doctors, hospitals, outpatient surgery centers, allied health professionals, and other health care providers.

---

22. *See* McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015 (1988); WILLIAM C. HOLMES, 1990 ANTITRUST LAW HANDBOOK § 7.01[2]; 6 VON KALINOWSKI, *supra* note 21, §§ 47.01-47.02. Congress passed the McCarran-Ferguson Act in 1945 to protect both the insurance industry and, indirectly, individual policyholders from the alleged destabilizing effects of the antitrust laws. It was under a sustained attack in Congress at the time of writing this Article. Representative Jack Brooks (D-Tex.) introduced a bill to substantially amend the McCarran-Ferguson Act ("Brooks bill") in the 102d Congress. H.R. 9, 102d Cong., 2d Sess. (1991). An earlier bill, identical to H.R. 9, was introduced in the 101st Congress. H.R. 1663, 101st Cong., 2d Sess. (1989). The Brooks bill proposed to significantly scale back the protections afforded by the McCarran-Ferguson Act. The insurance industry and its supporting trade associations, including the American Insurance Association ("AIA"), the Health Insurance Association of America ("HIAA") and the American Council of Life Insurers ("ACLI") disagree over the exact meaning of the language found in the Brooks bill. Some consider it an outright repeal of the protections found in the McCarran-Ferguson Act, while others believe that it leaves the insurance industry with a somewhat cryptic and insignificant level of protection.

23. *See* McCarran-Ferguson Act, 15 U.S.C. § 1013 (1988). The Act's other principal requirements are that state law regulate the activity in question and that the activity must not constitute "boycott, coercion or intimidation." *Id.* § 1013(b).

24. *See* HOLMES, *supra* note 22, § 7.01[2]; 6 VON KALINOWSKI, *supra* note 21, §§ 47.01-47.02; *see also* Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119 (1982); Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205 (1979).

25. *See* HOLMES, *supra* note 22, § 7.01[2]; 6 VON KALINOWSKI, *supra* note 21, §§ 47.01-47.02.

Antitrust disputes arising from these relationships would probably not qualify for McCarran-Ferguson protection since provider contracts are service contracts not insurance contracts. Rather, the actual insurance contract exists between the insurer/managed care plan and the customer/enrollee. Consequently, it became apparent to many health insurers that they were fully subject to the federal antitrust laws. Finally, the federal government's heightened interest in applying the federal antitrust laws to the health care industry set the stage for future investigations and litigation.

C. *Scope of Article: Antitrust Issues and Recommendations for Reducing Risks*

This Article discusses the antitrust issues commonly presented when managed care companies interact with health care providers in constructing or reconfiguring their provider networks. The Article then advances several recommendations specifically designed to reduce the antitrust risks in this area. In Section II, the Article briefly describes the political and business dynamic that exists between managed care companies and doctors, hospitals, and other providers that are part of, or seek to become part of, a provider network. Section III describes and analyzes the antitrust statutes and the case law implicated by provider network decisions. This section explains the relevance and applicability of the so-called terminated dealer cases to the health care industry and analyzes and describes behavior that may tend to prove the existence of an implied agreement in restraint of trade.

Section IV examines an important and widely-discussed health care case[26] involving hospital provider networks in order to illustrate the principles presented earlier in this Article and to underscore the steps necessary to avoid antitrust violations and to reduce the risk of litigation. The Article concludes with several recommendations designed to assist both managed care companies and health care providers avoid antitrust liabil-

26. *See infra* notes 99-140 and accompanying text discussing the *Reazin* litigation. Members of the health care industry widely followed and discussed the *Reazin* litigation. However, research indicates that apart from news reports on the litigation at the federal district and appellate court levels, academics wrote little scholarly commentary on the meaning and significance of the litigation. To date, only one law review article has discussed *Reazin*. *See* Arnold Celnicker, *A Competitive Analysis of Most Favored Nations Clauses in Contracts Between Health Care Providers and Insurers*, 69 N.C. L. REV. 863, 876-79 (1991). Celnicker discusses *Reazin* as part of a larger analysis of most favored nations contract clauses.

ity for allegedly conspiring to exclude other providers from managed care provider networks.

II. PROVIDER NETWORKS: THE DYNAMIC BETWEEN THE PLAYERS

Managed care plans are, in effect, large "purchasers" of health care services offered by doctors, hospitals, and other health care professionals. The American public rarely buys medical or health care services directly from providers. Rather, managed care companies buy such services, add an insurance component which spreads the risk and the potential costs of serious illnesses, and then offer this combined product[27] to the public. Given their central role in the health care market, managed care plans are often the target of intense pressure and lobbying from various providers and provider groups who jockey to do business with the health plan. By necessity, some providers will be selected for inclusion in the network and some will not. Depending upon the particular facts and the competitive impact upon the provider in question, declination or termination decisions may lead to litigation.

In addition to initially selecting providers for inclusion in their networks, managed care companies also periodically review and reconfigure their networks in order to maintain adequate geographic and service coverage[28] for their membership. For an example of the need for adequate geographic coverage, suppose an HMO successfully attains a new contract to provide health insurance to the employees of a large employer. The HMO would review the location of the employer's plant(s) and the employees' residences and compare that data to the geographic location of the doctors and hospitals in its network. If an inadequate geographic overlap exists, that HMO must contract with additional providers located near the employees in order to ensure coverage for all enrollees in the health plan. Depending upon the patient flow at other network locations, the HMO may deem it fiscally prudent to terminate or refuse to renew its contracts with some of the doctors currently in the network. The terminated providers might conceivably file antitrust suits alleging that their exclusion was the product of a boycott conspiracy between the plan and some other party, usually another provider or group of providers.

27. Industry insiders call the combined product "health care financing." Health care financing differs from health care services which are offered by medical providers.

28. Service coverage means having the right mix of medical specialties represented in the network in order to effectively address the medical needs of its members.

As this Article discusses below, if a managed care company makes decisions concerning the composition of its provider network unilaterally and pursuant to objective guidelines, then it can overcome most, if not all,[29] antitrust challenges. Antitrust problems may arise, however, if a managed care plan makes, or appears to make, a termination, declination or non-renewal decision regarding a provider in response to an understanding with a third party[30] such as a competing provider.

III. IMPLIED AGREEMENTS IN RESTRAINT OF TRADE

A. *Generally*

Section 1 of the Sherman Act prohibits contracts, combinations or conspiracies in restraint of trade.[31] Illegal restraints of trade can take numerous forms including price fixing, geographic or customer market allocations, and boycotting.[32] The language of section 1 clearly indicates,

29. A provider excluded or terminated from a given network by a managed care plan acting unilaterally nonetheless may be able to sue successfully under the federal antitrust laws. In geographically remote areas sometimes only a single managed care plan exists. In this instance, the plan's exclusion of a provider from its network may mean that the provider will suffer substantial economic harm because patients in that geographic market will be steered toward other providers who are members of the network. Antitrust analysis suggests that a provider-controlled plan might be considered an "essential facility" for the providers in that location; if so, the plan would be precluded from excluding them. *See Health Care Committee Task Force on Preferred Provider Organizations, Who Gets In and Who Is Left Out: Group Boycotts and Essential Facilities*, *in* MANAGED CARE AND ANTITRUST: THE PPO EXPERIENCE 39, 40-42, 53-56 (M. Elizabeth Gee & Phillip A. Proger eds., 1990); *see, e.g.*, Aspen Skiing Co. v. Aspen Highlands Skiing Corp., 472 U.S. 585 (1985); *see also* HOLMES, supra note 22, § 2.06 (discussing the "essential facilities doctrine"). Other managed care companies seeking to enter the market might also sue the health plan, regardless of whether it is provider-controlled or not, if the provider contracts contain an exclusivity provision that prohibits the network providers from signing contracts with any other private, third-party payor. In that situation, a new market entrant might sue the health plan for monopolization under § 2 of the Sherman Act. *See* Sherman Antitrust Act, 15 U.S.C. § 2 (1988 & Supp. 1990) (prohibiting monopolization); *see generally* 3 VON KALINOWSKI, *supra* note 21, §§ 7.00-9.00 (discussing monopolization).

30. Copperweld Corp. v. Independence Tube Corp., 467 U.S. 752 (1984). *Copperweld* and its progeny would generally protect provider network decisions made in the name of the plan by a managed care plan's provider relations or provider contracting officer from a Sherman Act § 1 conspiracy claim. In *Copperweld,* the United States Supreme Court held that a parent corporation cannot conspire with its wholly-owned subsidiary under § 1 of the Sherman Act. *Id.* at 777. In dictum, the Supreme Court stated that "officers or employees of the same firm do not provide the plurality of actors imperative for a § 1 conspiracy." *Id.* at 769. Therefore, a plaintiff or prosecutor could not successfully assert that a conspiracy existed between a managed care company and its employee in charge of provider contracting. For a discussion of the requirement of at least two actors under § 1 of the Sherman Act, see *infra* note 33 and accompanying text.

31. *See* Sherman Antitrust Act, 15 U.S.C. § 1 (1988 & Supp. 1990). *See also supra* note 20.

32. *See* HOLMES, *supra* note 22, § 1; 2 VON KALINOWSKI, *supra* note 21, § 6. Such antitrust

inter alia, that at least two parties must enter into an agreement that restrains trade in order for an antitrust violation to occur[33]—a party cannot conspire or agree with itself to restrain trade.

Generally two types of agreements exist under the antitrust laws: express and implied agreements.[34] Finding proof of express agreements poses few problems. A contract between two sellers fixing the prices that they each will charge is an example of an express contract to restrain trade. Because they are so obvious, express contracts are rare. Most corporations and experienced business managers are too sophisticated to memorialize an illegal or legally questionable arrangement in writing. Consequently, most agreements involved in antitrust suits take the form of implied agreements. These agreements are tacit agreements and must be proved by circumstantial evidence.[35] Parties in antitrust litigation often expend most of their time and effort attempting to prove or rebut the alleged existence of an implied agreement. In determining the existence of an implied agreement, a court generally considers the following factors:[36]

---

violations are *per se* illegal. 2 *id.* § 6.02[1]. Thus, if a court finds that such an agreement existed, then the court must find an antitrust violation. The defendant's arguments concerning lack of intent, lack of anti-competitive impact and the presence of pro-competitive benefits are irrelevant. *See, e.g.*, Northern Pac. Ry. Co. v. United States, 356 U.S. 1, 5 (1958). "[T]here are certain agreements or practices which because of their pernicious effect on competition and lack of any redeeming virtue are conclusively presumed to be unreasonable and therefore illegal without elaborate inquiry as to the precise harm they have caused or the business excuse for their use." *Id.* Courts analyze other antitrust violations under the "rule of reason" which permits the defense to present these and other arguments. *See* HOLMES, *supra* note 22, § 1.04; 2 VON KALINOWSKI, *supra* note 21, § 6.02[2]. Although they have been traditionally analyzed under the per se standard, it is no longer entirely settled what legal standard should apply to group boycotts. In Northwest Wholesale Stationers, Inc. v. Pacific Stationery and Printing Co., 472 U.S. 284 (1985), the United States Supreme Court held, in part, that if a defendant possessed "market power or exclusive access to an element essential to effective competition," then the per se standard applied. Of course, an inquiry into market power is one of the hallmarks of the rule of reason test. Thus, in a de facto sense, the court advocated a truncated rule of reason test for the group boycott in question.

33. *See* HOLMES, *supra* note 22, § 1.03[1]; 2 VON KALINOWSKI, *supra* note 21, § 6.01[2] (proving such an agreement requires a showing of "two or more legally independent actors . . . who engage in concerted action"); *see also* Nelson Radio & Supply Co. v. Motorola, Inc., 200 F.2d 911, 914 (5th Cir. 1952), *cert. denied*, 345 U.S. 925 (1953) ("It is basic in the law of conspiracy that you must have two persons or entities to have a conspiracy. A corporation cannot conspire with itself any more than a private individual can.").

34. *See* HOLMES, *supra* note 22, § 1.03[1]; 2 VON KALINOWSKI, *supra* note 21, § 3.02[2] ("The concerted action may be demonstrated by an express agreement or it may be inferred by the courts."); § 6.01[3] ("concerted action may be established by direct or circumstantial evidence").

35. 2 VON KALINOWSKI, *supra* note 21, §§ 3.02[2], 6.01[3].

36. *Id.*; *see infra* notes 38-53, 81-98 and accompanying text. At one time, the federal judiciary

(1) The course of dealing between the parties, including oral and written communications, the dynamics of the relationship, historic methods of doing business, etc.;

(2) whether an opportunity to conspire existed (e.g., attendance at a common meeting);

(3) parallel or other conduct in the marketplace suggesting a conspiracy, including conduct that would be considered economically irrational but for the existence of a conspiracy;

(4) whether an economic motive to engage in an alleged conspiracy was present; and

(5) whether other, plausible explanations exist for the parties' apparent anti-competitive conduct.

No single factor is dispositive of the concerted action analysis. For example, proving that two competitors attended the same trade association meeting that gave them an opportunity to conspire will not by itself prove the existence of a tacit conspiracy in violation of the antitrust laws. Similarly, parallel behavior by two or more competitors in the marketplace, without more, does not conclusively prove the existence of a conspiracy since such behavior may be the product of business decisions reached independently by the parties.[37] Several factors tending to prove the existence of a tacit conspiracy are required before a court will conclude that an implied conspiracy or agreement exists.

B. The Matsushita *and* Monsanto *Decisions*

In 1986 in *Matsushita Electric Industrial Co. v. Zenith Radio Corp.*,[38] the United States Supreme Court issued its most recent articulation of the standard for determining whether an implied agreement exists.[39] The opinion illustrates, in particular, the fourth factor listed above—whether there was an economic motive to engage in an alleged conspiracy. In

did not ordinarily engage in such an extensive analysis. See *infra* notes 65-80 and accompanying text.

37. *See, e.g.*, Theatre Enter. v. Paramount Film Distrib. Corp., 346 U.S. 537 (1954); *see generally* HOLMES, *supra* note 22, § 1.03[3]; 2 VON KALINOWSKI, *supra* note 21, § 6-18 to 6-23.

38. 475 U.S. 574 (1986).

39. This Article does not introduce or discuss the Supreme Court's 1988 decision in Business Elec. Corp. v. Sharp Elec. Corp., 485 U.S. 717 (1988). In *Sharp*, the Court held that an agreement between a calculator supplier and dealer to terminate another dealer did not constitute *per se* price fixing absent an agreement on specific prices or price levels. *Sharp* was a decision regarding vertical price fixing which did not break new ground in the area of implied agreements; therefore, this Article does not discuss it.

Matsushita, American television manufacturers brought suit under the Sherman Act, claiming that a group of twenty-one Japanese electronics manufacturers had conspired for over twenty years to drive the American corporations out of business through predatory pricing techniques.[40] Super-competitive prices in Japan allegedly subsidized the predatorily low price of Japanese electronics products in the United States.[41] The Court concluded that the alleged conspiracy did not exist and consequently found that the Japanese manufacturers did not violate the antitrust laws.[42]

The Japanese manufacturers' economic interests and motives were central to the Court's analysis.[43] In order to price predatorily, the Japanese would have had to forgo substantial profits from their sales in the United States for over twenty years.[44] Furthermore, "[f]or the investment to be rational, the conspirators must have a reasonable expectation of recovering, in the form of later monopoly profits, more than the losses suffered."[45] At best, such a predatory conspiracy would have a minimal chance of success.[46] In addition, considering that in those twenty years the Japanese had not yet succeeded in driving the American companies from the U.S. electronics market,[47] any intent to conspire would have been economically irrational.[48] Because the alleged predatory pricing would have been economically unreasonable, the Court concluded that the Japanese lacked motive to engage in such a conspiracy; consequently,

---

40. *See Matsushita*, 475 U.S. at 577-78.

41. *Id.*

42. *Id.* at 597.

43. *Id.* at 588-93.

44. *Id.* at 591-93.

45. *Id.* at 588-89.

46. *Id.* at 590. The Court stated:

> Such a conspiracy is incalculably more difficult to execute than an analogous plan undertaken by a single predator. The conspirators must allocate the losses to be sustained during the conspiracy's operation, and must also allocate any gains to be realized from its success. Precisely because success is speculative and depends on a willingness to endure losses for an indefinite period, each conspirator has strong incentive to cheat . . . . The necessary allocation is therefore difficult to accomplish.

Id.

47. *Id.* at 591 ("Two decades after their conspiracy is alleged to have commenced, petitioners appear to be far from achieving this goal.").

48. *Id.* at 587. The Court concluded that the petitioner had no economic incentive to join the conspiracy. *Id.* Indeed, the Court went further to conclude that the petitioner "had every incentive *not* to engage in the conduct with which they are charged." *Id.* at 588.

the Court found that no conspiracy existed.[49]

The *Matsushita* Court articulated the standard that plaintiffs must satisfy in order to survive summary judgment when attempting to prove an implied agreement in violation of the antitrust laws. The Court stated: "[I]f the factual context renders respondents' claim implausible—if the claim is one that simply makes no economic sense—respondents must come forward with more persuasive evidence to support their claim than would otherwise be necessary."[50] The Court relied upon the standard concerning implied agreements that it previously adopted in an earlier antitrust case, *Monsanto v. Spray-Rite Service Corp.*[51]

> [I]n *Monsanto* . . . we held that conduct as consistent with permissible competition as with illegal conspiracy does not, standing alone, support an inference of antitrust conspiracy. . . . To survive a motion for summary judgment or for a directed verdict, a plaintiff seeking damages for a violation of [section] 1 [of the Sherman Act] must present evidence 'that tends to exclude the possibility' that the alleged conspirators acted independently. . . . Respondents in this case, in other words, must show that the inference of conspiracy is reasonable in light of the competing inferences of independent action or collusive action that could not have harmed respondents.[52]

As *Matsushita* and *Monsanto* illustrate, the test for determining whether conduct is unilateral or undertaken pursuant to a tacit conspiracy or implied agreement with another party is highly fact specific. The verbal standards used by the Supreme Court in *Monsanto* and *Matsushita* can go only so far in assisting antitrust lawyers in specific counseling situations or in aiding courts in determining whether an implied agreement exists. Attorneys and courts are left to rely on the list of factors discussed above and the general principle that, as always, the plaintiff bears the burden of proof, especially in antitrust cases where an erroneous charge and conviction may result in deterring "perfectly legitimate conduct."[53]

---

49. *Id.* at 592 ("The alleged conspiracy's failure to achieve its ends in the two decades of its asserted operation is strong evidence that the conspiracy does not in fact exist.").

50. *Id.* at 587.

51. 465 U.S. 752, 764 (1984). The *Monsanto* Court held that the mere receipt of complaints from dealers concerning the conduct of another dealer was not, in itself, sufficient to establish a conspiracy. *Id.* Here, however, the Supreme Court also found evidence "tending to exclude the possibility" of merely unilateral action. *Id.*

52. *See Matsushita*, 475 U.S. at 574, 588 (citing *Monsanto*, 465 U.S. at 764).

53. *See Monsanto*, 465 U.S. at 763.

C. *The Relevance of the Terminated Dealer Cases*

1. *The Similarities Between Manufacturers and Dealers and Managed Care Companies and Providers*

Antitrust cases specifically addressing the relationship between managed care plans and their provider networks are almost nonexistent.[54] Although antitrust risks in this area appear to be significant, they have yet to manifest themselves in either extensive case law[55] or written commentary.[56] A lawyer, academician, or judge with interest in this area must analogize between provider networks and the facts found in certain non-health care cases. But which antitrust opinions are relevant?

This Article maintains that the dealer termination cases[57] and the relationship between manufacturers and dealers presented and discussed in those cases most closely approximate the relationship between managed care plans and providers. It is reasonable to view managed care companies as manufacturers[58] and the individual providers as the dealers who stand on the front lines dealing face to face with the customers. Manu-

54. *Reazin* is the only case directly on point. *See infra* notes 99-140 and accompanying text.

55. *See infra* notes 99-140 and accompanying text.

56. Research uncovered no law review articles that squarely discussed and addressed the antitrust issues presented by provider networks and the selection process undertaken by managed care companies in creating those networks. The whole concept of managed care and the application of the antitrust laws to managed care is still fairly novel. Academic commentators have not yet grappled with many of the antitrust issues presented by the new relationships found today in the health care field. This Article was written, in part, in the hope that others will subsequently contribute to the literature.

57. *See generally* HOLMES, *supra* note 22, §§ 1.03[2], 1.09[2].

58. Section II of this Article analogizes managed care plans to "purchasers" of health care services offered by providers. Here, this Article states that one should view managed care plans as standing in the shoes of a manufacturer. There is no inconsistency in these two assertions although at first blush, it may seem otherwise. Both points of view assume that managed care plans and providers stand in a vertical relationship with one another. In addition, the first statement is certainly true in an economic sense. Managed care plans do indeed "purchase" medical services from providers since they bargain for volume discounts with respect to a variety of medical treatments and procedures. Furthermore, there are a few judicial opinions that generally view insurance companies as "purchasers." *See, e.g.*, Quality Auto Body, Inc. v. Allstate Ins. Co., 600 F.2d (7th Cir. 1981); Sausalito Pharmacy, Inc. v. Blue Shield of California, 1981-1 Trade Cas. (CCH) ¶ 63,885 (N.D. Cal. 1981), *aff'd* 677 F.2d 47 (9th Cir. 1982). However, for purposes of analyzing provider network decisions in particular under the antitrust laws, managed care plans are most logically viewed as manufacturers. These plans generally dictate the parameters of the relationship with providers and determine on what basis the health insurance product will be offered to the public. The "product"—known in the industry as "health care financing" which is a combination of the medical services rendered by a provider and the insurance or risk spreading component contributed by the plan—is offered to the public at the provider's place of business. The doctor's office or hospital operating room is analogous to a dealer showroom for purposes of antitrust analysis. Using the automotive

facturers maintain dealership agreements to facilitate the sale of their goods or services. Manufacturers commonly compile an approved list of dealers authorized to do business on their behalf. Similarly, managed care companies maintain a network of providers through which they do business. Consequently, manufacturers and managed care plans often have the same problems in their relationships with dealers or, in the health care context, with providers. Dealers/providers without contracts often lobby to gain admission to the network. Sometimes dealers/providers will badmouth other dealers/providers or will lobby the manufacturer/managed care company to cease doing business with another dealer/provider. Because the dealer/provider level of competition is important in facilitating the sale of the products or services, the manufacturer/managed care plan maintains regular contact with the dealer/provider regarding, *inter alia*, the state of sales, the reception of the product or service by the public, and the success of promotional schemes.

2. *The Terminated Dealer Cases*

According to the "*Colgate* doctrine," announced by the Supreme Court in 1919 in *United States v. Colgate*,[59] a participant in the economic marketplace has the right under section 1 of the Sherman Act to "exercise his own independent discretion as to parties with whom he will deal."[60] Accordingly, a seller or manufacturer has the right to make unilateral decisions regarding the retailers or dealers with whom it will transact business free from antitrust liability. The challenge lies in determining whether the manufacturer unilaterally reached the contracting

industry as an example, a managed care company stands in the shoes of General Motors and the providers are akin to the local GM dealers.

Those involved in the health care industry often refer to "third party payors"—managed care companies—that act as "purchasers" of medical services from providers. However, upon engaging in an extended antitrust analysis of provider network decisions, the only antitrust paradigm that has conceptual integrity involves viewing the managed care companies as manufacturers and the providers as dealers. Some antitrust health care opinions ignore the significance of this relationship and thereby needlessly complicate the jobs of both judges and practitioners who must apply antitrust law to this non-traditional industry. This Article finds external support for this paradigm from the Tenth Circuit's brief passing reference to it. *See Reazin III*, 899 F.2d at 965. In *Reazin III*, the court casually noted that "[t]his case does not involve only . . . the termination of a vertical relationship akin to a dealer termination." The case involved a third-party payor's termination of a hospital. Clearly, the Tenth Circuit viewed the parties' relationship in the same manner as this Article suggests.

59. 250 U.S. 300 (1919).

60. *Id.* at 307.

decisions or whether such decisions were the product of a conspiracy with a third party or parties. Nonunilateral contracting decisions which are the product of a conspiracy may be subject to attack under section 1 of the Sherman Act.[61]

Antitrust suits alleging that such business decisions are the result of an illegal conspiracy may be styled in several ways. An antitrust suit may allege a conspiracy to boycott the victimized dealer,[62] a conspiracy to fix prices by terminating those dealers that do not adhere to a resale price maintenance scheme,[63] or a conspiracy to divide the market either along customer or geographic lines by terminating or excluding those dealers who do not obey restrictive guidelines regarding the sale of the manufacturer's product.[64] Regardless of the type of section 1 claim alleged, the critical component is the existence of some form of agreement among the conspirators. Express or implied agreements are the factual predicate of all Sherman Act section 1 suits, since the Act requires proof of concerted, not unilateral, action. Despite the different kinds of violations that might be alleged, the quintessential suit in the terminated dealer context is a suit alleging an illegal boycott.

a. Early Cases: A Rigid Approach Toward the Concerted Action Requirement

In the early manufacturer-dealer cases, courts applied a rigid framework when they interpreted implied agreements.[65] The courts used a fairly low threshold for finding such tacit conspiracies. They often found them based upon communications between the alleged co-conspirators. These communications may in fact have been conducted for perfectly legitimate business reasons. The Supreme Court's decisions in *Klor's, Inc. v. Broadway-Hale Stores*[66] and *United States v. General Motors*[67]

61. *See supra* notes 30-33 and accompanying text.

62. *See, e.g.*, United States v. General Motors Corp., 384 U.S. 127, 145-47 (1966) (finding manufacturer-dealer conspiracy due to manufacturer's grudging acquiescence to a boycott scheme); Klor's, Inc. v. Broadway-Hale Stores, 359 U.S. 207, 211 (1959) (finding supplier-dealer conspiracy to boycott another dealer).

63. *See, e.g.*, *Monsanto*, 465 U.S. 752, 755-56 (vertical price fixing conspiracy between herbicide manufacturer and dealer); Battle v. Lubrizol Corp., 673 F.2d 984 (8th Cir. 1982) (vertical price fixing); Phillips v. Crown Cent. Petroleum Corp., 602 F.2d 616 (4th Cir. 1979) (horizontal price fixing); Blankenship v. Hearst Corp., 519 F.2d 418 (9th Cir. 1975) (vertical price fixing).

64. *See, e.g.*, Purity Prod., Inc. v. Tropicana Prod., Inc., 702 F. Supp. 564 (D. Md. 1988) (dealer refused to stay within assigned territory and was terminated).

65. *See* HOLMES *supra* note 22, § 1.03[2].

66. 359 U.S. 207 (1959).

illustrate this rigid approach.

In *Klor's*, the defendant, a retail drug store, was concerned over the price-cutting practices of a competitor, which had similar suppliers.[68] In an effort to stop this practice, the defendant retailer contacted the suppliers and attempted to induce them to stop supplying the price-cutter.[69] The suppliers apparently did not communicate with one another directly. Rather, the defendant retailer engaged in a series of separate communications with each supplier.[70] The Supreme Court nonetheless found a tacit conspiracy among the suppliers to boycott the price-cutting retailer.[71] The Court did not inquire into alternative motives for the suppliers' conduct or analyze evidence that would have tended to exclude the possibility of an implied agreement among the parties to boycott the price-cutting retailer.[72]

The Supreme Court's 1966 decision in *United States v. General Motors*[73] further illustrates the relatively low threshold that existed for finding illegal implied agreements among manufacturers and dealers. In *General Motors*, a group of General Motors ("GM") dealers in Los Angeles coordinated their efforts against other GM dealers who were selling automobiles to price-cutting independent retailers.[74] The defendant dealers contacted GM as a group and used their collective power to pressure GM to convince the other group of dealers to stop supplying the price-cutters.[75] GM reluctantly participated in the scheme[76] due to the pres-

67. 384 U.S. 127 (1966).

68. These included General Electric, RCA, Admiral, Zenith, and Emerson. *See Klor's*, 359 U.S. at 208.

69. *Id.* at 209.

70. *Id.*

71. *Id.* at 212. The Supreme Court concluded that "the allegations of [the] complaint disclose[d] . . . a boycott." *Id.* Consequently, the Court reversed the federal appellate court's decision to grant summary judgment for the defendant. *Id.* Remanding the case in the belief that a group boycott had occurred, the Court noted that the allegations involved "a wide combination consisting of manufacturers, distributors and a retailer." *Id.* at 213.

72. *Id.* at 210-13.

73. 384 U.S. 127 (1966). *See generally* Joe Sims & Phillip A. Proger, *Pricing Issues in Dealer and Franchise Relationships: Litigation Issues in Dealer Termination Cases*, 60 ANTITRUST L.J. 465, 468-70 (1991).

74. The complaining dealers organized a letter-writing campaign directed at GM, met with GM's regional personnel, and discussed possible collective action at their local trade-group meetings. After GM warned the offending dealers to stop selling automobiles (specifically Chevrolets) to the price-cutters, the complaining dealers jointly began to police and enforce the sales restraint. *GM*, 384 U.S. at 133-34.

75. *Id.*

76. The dealers first complained and demanded action from GM's regional manager, Robert

sure asserted by this relatively large and powerful group of GM dealers.[77] GM feared that to do otherwise would have constituted economic suicide for its products in Los Angeles County. Nonetheless, in a civil suit brought by the federal government, the Supreme Court held GM liable as a co-conspirator.[78]

The Supreme Court again clearly indicated that it was not interested in engaging in a detailed facts and circumstances type of analysis when analyzing implied agreements. If the alleged conspirators (manufacturers and dealers) had communicated and termination or some type of exclusionary behavior followed, then the Court concluded that an implied agreement in violation of the antitrust laws existed. This analytical approach toward the concerted action requirement of section 1 of the Sherman Act created dangerous consequences for manufacturers and dealers. These parties regularly interact with one another for a variety of reasons within the ordinary scope of business.[79] The fact that these interactions might form the basis of an antitrust suit represented a real and ongoing legal danger.

b. Recent Case Law: A Comprehensive Approach Toward the Concerted Action Requirement

Since the *General Motors* case, the federal judiciary has adopted a more comprehensive approach toward analyzing implied agreements.[80] Under this approach the courts acknowledge the fact that manufacturers and dealers regularly interact with one another for legitimate economic and business reasons. More recently, the federal judiciary has considered alternative explanations for the conduct of sellers or manufacturers accused of participating in illegal conspiracies to terminate or otherwise exclude the plaintiff. Consequently, manufacturers or sellers who have terminated, declined to sign, or refused to renew dealership agreements

O'Connor. The dealers confronted O'Connor with "evidence that some dealers were doing business with the discounters and asked for his assistance." O'Connor "promised he would speak to the offending dealers," but neglected to take action on the complaining dealers' behalf. *Id.* at 133. Taking matters into their own hands, some of the complaining dealers spoke directly to those dealers who were supplying the price cutters. *Id.*

77. Members of three dealer trade associations complained directly to GM's headquarters in Detroit, Michigan. *Id.* at 134. "Hundreds of the letters and wires descended upon Detroit," demonstrating the power of the complaining dealers. *Id.* at 134.

78. *Id.* at 141-42.

79. Such communications may concern inventory, prices, various non-price supports such as advertising campaigns, the public's reaction to a particular product, and the design of new products.

80. *See infra* notes 81-98 and accompanying text.

have been able to advance legitimate explanations for the decisions which the plaintiff alleged resulted from a tacit conspiracy. The opportunity to present such evidence provides defendants with a greater chance of prevailing in a section 1 Sherman Act lawsuit.

i. Monsanto Company v. Spray-Rite Service Corporation

In *Monsanto*,[81] the Supreme Court adopted a more flexible approach toward the issue of concerted action. The Court assumed that actual communication existed between the defendant manufacturer, Monsanto Company, and the distributors who allegedly participated in the conspiracy.[82] Previously, the Court probably would have considered this interaction sufficient evidence to prove the existence of an unlawful implied agreement between Monsanto and the surviving distributors.[83] In *Monsanto*, however, the Court engaged in a detailed analysis of the surrounding facts and circumstances in order to determine as accurately as possible whether Monsanto's decision to cease its commercial relationship with the plaintiff distributor was the product of a conspiracy or a unilateral business decision.[84]

The Court held, *inter alia*, the fact that the surviving distributors complained to the manufacturer about the pricing practices of the terminated distributor prior to termination was not, in itself, sufficient to prove the existence of a conspiracy in violation of the antitrust laws.[85] The Court reasoned that "[p]ermitting an agreement to be inferred merely from the existence of complaints, or even from the fact that termination came about 'in response to' complaints, could deter or penalize perfectly legitimate conduct."[86] "[S]omething more than evidence of complaints" is

81. 465 U.S. 752 (1984). *See supra* note 51; *see generally* Sims & Proger, *supra* note 73, at 465-66.

82. 465 U.S. at 765. The Court stated:

> [T]he fact that a manufacturer and its distributors are in constant communication about prices and marketing strategy does not alone show that the distributors are not making independent pricing decisions. A manufacturer and its distributors have legitimate reasons to exchange information about the prices and the reception of their products in the market.

Id. at 762.

83. *See supra* notes 65-80 and accompanying text.

84. *See Monsanto*, 465 U.S. at 765-68. The terminated distributor styled its complaint as a conspiracy to fix resale prices, alleging that Monsanto had terminated its relationship with the plaintiff because it failed to adhere to the conspirators' recommended price guidelines. *Id.*

85. *Id.* at 764.

86. *Id.* at 763.

necessary before finding a Sherman Act violation.[87] In determining what more is required, the Court articulated the requisite standard of proof for implied agreements:

> There must be evidence that tends to exclude the possibility that the manufacturer and nonterminated distributors were acting independently. . . . [T]he antitrust plaintiff should present direct or circumstantial evidence that reasonably tends to prove that the manufacturer and others "had a conscious commitment to a common scheme designed to achieve an unlawful objective."[88]

Even after applying the more flexible standard, the Court still found that the defendant violated the Sherman Act, in large part due to a newsletter that purported to summarize a meeting between the defendant manufacturer and the distributor who wrote the newsletter. The newsletter described Monsanto's efforts to work with distributors to collectively maintain resale prices above a certain level and alluded to Monsanto's intent to terminate its relationship with those distributors who did not maintain prices in the manner suggested.[89] The existence of the newsletter, and the portrait of collective action that it conveyed, undercut Monsanto's argument that it had reached its decision unilaterally pursuant to objective criteria.[90]

ii. Other Cases

Monsanto represented a watershed in the Supreme Court's approach toward the concerted action requirement and implied agreements in restraint of trade. The Court considered economic and business factors in

---

87. *Id.* The Court noted, however, that evidence of complaints contains some probative value. *Id.* at 764 n.8.

88. *Id.* at 764. (quoting Edward L. Sweeney & Sons, Inc. v. Texaco, Inc., 637 F.2d 105, 111 (3d Cir. 1980), *cert. denied,* 451 U.S. 911 (1981)).

89. *See Monsanto*, 465 U.S. at 765-66.

90. *Id.* at 765-68. Prior to terminating the plaintiff, Monsanto publicly articulated a set of criteria that it asserted it would use when determining the renewal of distributorship contracts. These criteria included:

> (i) whether the distributor's primary activity was soliciting sales to retail dealers; (ii) whether the distributor employed trained salesmen capable of educating its customers on the technical aspects of Monsanto's herbicides; and (iii) whether the distributor could be expected "to exploit fully" the market in its geographic area of primary responsibility.

Id. at 756.

Unfortunately for Monsanto, the company failed to apply its criteria. The Court heard "reliable testimony" that Monsanto did not discuss these criteria with the plaintiff prior to its decision. *Id.* at 767-68. Furthermore, evidence showed that Monsanto representatives made several statements to the plaintiff indicating that Monsanto wanted to terminate it because of its unwillingness to raise its prices in accordance with the conspirators' wishes. *Id.* at 767-68.

attempting to understand the reasons for the parties' behavior in its determination of whether an illegal implied agreement between the parties existed. Several lower courts have subsequently followed the Court's more flexible approach.

For example, in *H.L. Hayden Co. v. Siemens Medical Systems*,[91] the United States Court of Appeals for the Second Circuit held that defendants, Siemens Medical Systems and other dealers, did not engage in an illegal conspiracy to boycott the plaintiff,[92] H.L. Hayden Co.[93] The Second Circuit found no violation of the antitrust laws despite evidence that the manufacturer, Siemens Medical Systems, terminated the plaintiff after receiving complaints from other dealers.[94] These dealers complained about the plaintiff because the plaintiff frequently resold the product in question to mail-order outlets which offered the good for a cheaper price. The Second Circuit concluded that the manufacturer's decision to terminate its relationship with the plaintiff was the result of its own unilateral business judgment and was essentially grounded upon the manufacturer's concern that sales through mail-order outlets would harm its commercial image.[95]

Business reasons advanced by defendants to justify their conduct in terminated dealer cases vary as much as the defendants' businesses them-

91. 1989-1 Trade Cas. (CCH) ¶ 68,622 (2d Cir. 1989).

92. The other plaintiff, Schein Dental, sold dental equipment through mail-order catalogs. *Id.* ¶ 61,279. In addition to owning and founding Schein Dental, Marvin Schein owned a 50% interest in Hayden. *Id.* Siemens purportedly decided to terminate Hayden's dealership agreement because of Hayden's practice of selling Siemens dental equipment to Schein Dental which then offered it to the public through mail-order catalogs. *Id.* ¶¶ 61,278-80, 61,282-85.

93. *See id.* ¶¶ 61,282-85. The Second Circuit relied upon the standards that the Supreme Court articulated in *Monsanto*, *see supra* notes 81-90 and accompanying text, and *Matsushita*, *see supra* notes 38-53 and accompanying text. The Second Circuit noted that Siemens interacted with the surviving dealers on several occasions and, therefore, had opportunity to conspire with them. On the other hand, the court carefully weighed the defendant's argument that it was concerned about its reputation for quality in the marketplace and that it had made a unilateral decision to terminate Hayden because of Hayden's sales of Siemens-manufactured products to a mail-order outlet. The defendant claimed that it considered itself the " 'Mercedes' of the dental x-ray market." *Id.* ¶ 61,279. The defendant contended that the mail-order sales undermined this image of quality. *Id.* ¶¶ 61,278-80, 61,282-85. Applying the Supreme Court's standards established in *Monsanto* and *Matsushita*, the Second Circuit found that evidence consistent with both a conspiracy and with unilateral action was not sufficient to prove the existence of an agreement to boycott Hayden. *Id.*

94. *Id.* Given the Supreme Court's decisions in both *Monsanto* and *Matsushita*, the appellate court knew that pre-termination discussions or complaints among the manufacturer and the surviving dealers about the soon-to-be-terminated dealer are not sufficient to prove the existence of a tacit conspiracy to boycott the terminated dealer.

95. *Id.* ¶¶ 61,282-85.

selves. Courts have dismissed antitrust suits against manufacturers and suppliers when they have found that the defendants terminated their relationship with the plaintiffs due to the plaintiffs' bad credit history,[96] poor performance,[97] or as part of a fundamental business restructuring.[98]

IV. PROVIDER NETWORK SELECTION DECISIONS: ANTITRUST RISKS AND RECOMMENDATIONS

Courts have utilized the comprehensive analysis explained and discussed above when analyzing alleged antitrust conspiracies within the health care industry. In *Reazin v. Blue Cross and Blue Shield (Reazin II)* [99] and in *Reazin v. Blue Cross and Blue Shield (Reazin III)*,[100] the United Stated District Court for the District of Kansas and the United States Court of Appeals for the Tenth Circuit, respectively, addressed the concerted action requirement of section 1 of the Sherman Act and the issue of implied agreements in the provider network context.[101]

A. The Reazin *Case*

The dispute addressed in *Reazin II* and *Reazin III* arose when Blue Cross and Blue Shield of Kansas ("Blue Cross") terminated its provider contract with Wesley Hospital ("Wesley").[102] Wesley, and the other plaintiffs involved in the suit,[103] alleged that Blue Cross did not take this

96. *See, e.g.*, Joe Requeira, Inc. v. American Distilling Co., 642 F.2d 826 (5th Cir. 1981); Schaben v. Samuel Moore & Co., 606 F.2d 831 (8th Cir. 1979).

97. *See, e.g.*, Dunnivant v. Bi-State Auto Parts, 851 F.2d 1575 (11th Cir. 1988); Chandler Supply Co. v. GAF Corp., 650 F.2d 983 (9th Cir. 1980).

98. *See, e.g.*, Odishelidze v. Aetna Life & Casualty Co., 853 F.2d 21 (1st Cir. 1988) (holding that an insurance company's decision to replace independent agents with in-house agents was a unilateral action and not an illegal boycott).

99. 663 F. Supp. 1360 (D. Kan. 1987).

100. 899 F.2d 951 (10th Cir. 1990).

101. Given their identity of facts and similar legal conclusion, this Article analyzes these two opinions collectively.

102. *Reazin III*, 899 F.2d at 954-55.

103. In addition to Wesley Hospital, the plaintiffs included Dr. Walter Reazin, Health Care Plus and New Century Life Insurance Company. Dr. Reazin's involvement in the litigation primarily resulted from Blue Cross' counterclaims against Wesley, Dr. Reazin and others after the filing of the original antitrust suit. Dr. Reazin was a member of a physician provider group (commonly called an independent physician association or "IPA") that had allegedly conspired to avoid doing business with Blue Cross' HMO which subsequently led to the HMO's demise. Blue Cross ultimately lost on all its counterclaims. *Id.* at 979-83; 663 F. Supp. at 1385. Health Care Plus was an HMO and New Century Life Insurance Company was a life insurer owned by Wesley's parent company, the Hospital Corporation of America. *Id.* at 1377-78.

action unilaterally but, rather, conspired with two other hospitals in the market area, Saint Joseph Hospital ("St. Joseph") and Saint Francis Hospital ("St. Francis") (collectively, the "Saints") to boycott Wesley.[104]

The Hospital Corporation of America ("HCA") purchased Wesley in November 1984, shortly prior to Wesley's termination by Blue Cross.[105] Through its subsidiaries, HCA was active in the medical services, health care financing, and hospital management businesses.[106] HCA was Blue Cross' competitor in the health care financing market through Health Care Plus ("HCP"), an HMO that it had purchased in 1985.[107] Blue Cross offered three products in the health care financing market: (1) indemnity insurance; (2) a PPO called Choice Care; and (3) an HMO known as HMO Kansas, Inc. ("HMOK").[108] Wesley alleged that Blue Cross had terminated it in order to discourage other Blue Cross providers from expanding into the health care financing market as Wesley had done through its voluntary acquisition by HCA.[109] Accordingly, the plaintiffs also added a Sherman Act section 2[110] claim, alleging that Blue Cross had "monopolized, attempted to monopolize, and/or conspired to monopolize the market for health care financing" by punishing those who dared to enter the market in competition with Blue Cross.[111] Finally, the plaintiffs also included a state law business tort claim:[112] tortious interference with prospective advantage.[113]

The jury in the federal district court returned a verdict in favor of the plaintiffs with respect to both the antitrust and business tort claims.[114] After numerous post-trial motions, the federal district court entered

104. *See Reazin III*, 899 F.2d at 954-55.

105. *See Reazin II*, 663 F. Supp. at 1377.

106. *Id.* at 1373.

107. *Id.* at 1378.

108. *Id.* at 1372.

109. *See Reazin III*, 899 F.2d at 954 ("Plaintiffs' theory was that Blue Cross, alarmed by a perceived competitive threat from . . . HCA through its acquisitions of . . . Wesley . . . HCP . . . and New Century . . . determined to 'hurt' Wesley and thereby send a message to other hospitals not to do business with entities Blue Cross believed were competitors.").

110. 15 U.S.C. § 2 (1988 & Supp. 1990).

111. *Reazin III*, 899 F.2d at 955.

112. Plaintiffs in antitrust lawsuits often allege common law business tort claims.

113. *Reazin III*, 899 F.2d at 955-56. Plaintiffs alleged that the defendant tortiously interfered with their present and prospective business relations. *Id.*

114. *Id.* at 955. The federal district court found that Blue Cross violated § 1 of the Sherman Act by engaging in a conspiracy to restrain trade and violated § 2 of the Sherman Act by monopolizing the market. *Id.* Finally, the district court held that Blue Cross tortiously interfered with plaintiffs' business relationships. *Id.*

judgment in favor of the plaintiffs and granted their motion for summary judgment on the defendant's counterclaim.[115] Blue Cross appealed this decision to the United States Court of Appeals for the Tenth Circuit.[116]

The Tenth Circuit reviewed the district court's denial of the defendant's motions for judgment notwithstanding the verdict, for a directed verdict, and alternatively, for a new trial.[117] The appellate court found that many meetings and interactions between the Saints and Blue Cross had occurred prior to the time when the Executive Committee of Blue Cross' Board of Directors decided in August 1985 to terminate Wesley effective upon the expiration of that calendar year.[118] Although the parties presented conflicting testimony, these prior interactions between Blue Cross and the Saints were undisputed.[119] Rather, the debate centered around the character and motivation for these interactions.[120] The court was forced to determine whether Blue Cross had decided unilaterally to drop Wesley from its hospital provider network; and if so, why Blue Cross had communicated beforehand with the Saints in the first place.

Blue Cross presented evidence that its discussions with the Saints focused only on the provision of hospital services to customers of Blue Cross' HMO, HMOK.[121] Blue Cross claimed that it was concerned about the competitive standing of HMOK, and that it had a genuine and legitimate interest in discussing contract issues with these two hospitals. Both courts noted that such meetings presented an "existing forum" to conspire.[122] However, proof of a mere opportunity to conspire, without more, is not sufficient to prove that an implied agreement among the parties existed in violation of the antitrust laws. Rather, as the Tenth

115. *Id.* at 956.

116. *Id.*

117. *Id.* at 959.

118. *Id.* at 963. During the spring and summer of 1985, Blue Cross and the Saints held a series of meetings. The district court found that the parties held a total of 27 meetings with one another. *Reazin II*, 663 F. Supp. at 1422.

119. *Reazin III*, 899 F.2d at 963. "The evidence and testimony concerning the precise circumstances under which the Saints accepted the reduced maximum allowable payments" from Blue Cross "and learned of the proposed Wesley termination were conflicting." *Id.* *See also Reazin II*, 663 F. Supp. at 1423. However, these "discussions . . . eventually did take place." *Reazin III*, 899 F.2d at 962; *see Reazin II*, 663 F. Supp. at 1423. Despite the "conflicting testimony," the district court found that "a meeting of the minds" regarding "the essential elements of the unlawful scheme" occurred. *Reazin II*, 663 F. Supp. at 1423.

120. *Reazin II*, 663 F. Supp. at 1421-24; *see Reazin III*, 899 F.2d at 963-64.

121. *Reazin III*, 899 F.2d at 963-64; *Reazin II*, 663 F. Supp. at 1421-24.

122. *Reazin II*, 663 F. Supp. at 1422; *Reazin III*, 899 F.2d at 963.

Circuit acknowledged, evidence must exist " 'that tends to exclude the possibility' that the alleged conspirators acted independently."[123] The court noted that sufficient evidence must exist to support "a finding of 'a conscious commitment to a common scheme.' "[124]

The defendant's characterization of the prior communications as innocent discussions concerning Blue Cross' HMO threatened to undercut the plaintiffs' attempts to use these discussions as circumstantial evidence of a conspiracy to boycott Wesley. Other evidence, however, painted a significantly different picture of the interactions between Blue Cross and the Saints. Testimony indicated that Blue Cross and the Saints had discussed Wesley's termination in conjunction with a reduction in the maximum allowable payments ("MAPs") for various hospital-based medical services.[125] Blue Cross paid its hospitals based on these MAPs. The Saints entertained the idea of accepting a MAP reduction if Blue Cross terminated Wesley.[126] The parties reasoned that if Blue Cross terminated Wesley, the Saints would experience an increase in patient volume, rendering the MAP reduction economically worthwhile.[127]

Furthermore, documentary evidence strongly suggested that a tacit conspiracy existed between Blue Cross and the Saints to boycott Wesley. A memorandum from the Chief Financial Officer of St. Francis to the Chief Executive Officer of St. Joseph noted that St. Francis and St. Joseph " 'were working with Blue Cross on various options that would allow Blue Cross to cancel Wesley's Blue Cross contract.' "[128] The memorandum discussed the reduction in MAPs that the two hospitals would agree to if Wesley was terminated.[129] Finally, the Chief Financial

123. *Reazin III*, 899 F.2d at 963 (quoting *Matsushita*, 475 U.S. at 588 and *Monsanto*, 465 U.S. at 764). For a discussion of these two Supreme Court decisions and the judicial standards that they applied, see *supra* notes 38-53, 81-90 and accompanying text.

124. *Reazin III*, 899 F.2d at 964 (quoting *Monsanto*, 465 U.S. at 764; Edward J. Sweeney & Sons, Inc. v. Texaco, Inc., 637 F.2d 105, 111 (3d Cir. 1980), *cert. denied*, 451 U.S. 911 (1981)). *See supra* notes 81-90 and accompanying text.

125. *See Reazin II*, 663 F. Supp. at 1421-24; *Reazin III*, 899 F.2d at 963-64. The Senior Vice President of Blue Cross, among others, testified that the decision to terminate Wesley and the decision to seek reduced MAPs from the Saints were "related." *Id.* Written evidence was also suggestive of an actual boycott. *See infra* notes 128-35 and accompanying text.

126. The Tenth Circuit noted the existence of "abundant evidence that the only reason the Saints agreed to the reduced [MAPs] . . . was because they anticipated a shift of patients from Wesley to the Saints as a result of the termination of Wesley's contracting provider agreement." *Reazin III*, 899 F.2d at 964 n.18.

127. *Id.*

128. *Reazin III*, 899 F.2d at 964; *Reazin II*, 663 F. Supp. at 1422.

129. *See Reazin III*, 899 F.2d at 964; *Reazin II*, 663 F. Supp. at 1422.

Officer of St. Francis referred outright to the "Wesley Boycott" which involved a reduction in MAPs in return for the termination of Wesley.[130]

In addition, Wayne Johnston, the President of Blue Cross, wrote an internal memorandum entitled "Questions About Not Contracting With Wesley (HCA)"[131] that referred to the possible shift of patients based on the reduction in MAPs.[132] Johnston's memorandum also explicitly referred to possible antitrust concerns raised by their conduct and the need to develop a legitimate rationale for those actions:

> While it appears we can be selective in which hospitals we contract with and not be guilty of anti-trust violations, Wesley will undoubtedly seek public sympathy by contending they have been arbitrarily singled out by us. They will contend we should cancel contracts with hospitals that have any type of competitive program (St. Francis' PPO; Aetna PPO hospitals; Doorth C. Kombs Development of TPA with St. Francis and any hospital joining the VHA arrangement with Aetna[).] Will the public agree with Wesley's contention or *can we develop a sound rationale that the public will accept that Wesley/HCA is different and our action is in the public interest[?]*[133]

The memorandum demonstrated that the arrangement raised antitrust concerns for Blue Cross without fully allaying those concerns. In fact, this document confirmed the essence of the plaintiffs' theory that Blue Cross and the Saints had conspired to boycott Wesley in violation of the antitrust laws. Johnston expressed concern that Wesley would accuse Blue Cross of taking action against the hospital because it had an affiliation that placed it in competition with Blue Cross.[134] Instead of stating why this was not the case, the memorandum discussed the need to develop a legitimate rationale to give the situation a positive spin.[135] Mentioning the need to develop a legitimate rationale implies that one did not exist. Instead of benefitting Blue Cross, the memorandum ultimately hurt the company because it implied that Blue Cross was privately concerned about an antitrust violation and was attempting to manufacture a false explanation for its conduct. The written evidence and oral testi-

130. *Reazin III*, 899 F.2d at 964; *Reazin II*, 663 F. Supp. at 1422. While legal characterizations of business personnel are certainly not dispositive of the legal status of a given arrangement, the reference to a "Wesley Boycott" provided insight into the way in which the parties viewed their own conduct and constituted damaging evidence against Blue Cross.

131. *Reazin II*, 663 F. Supp. at 1422-23.

132. *See id.* at 1423.

133. *Id.* at 1423.

134. *Id.*

135. *Id.*

mony convinced both the federal district court and federal appellate court that an agreement between Blue Cross and the Saints existed.

Blue Cross tried to escape the strictures of the antitrust laws by arguing, *inter alia*, that the Blue Cross employees who engaged in the discussions with the Saints did not have the authority to commit Blue Cross to the conspiracy.[136] Therefore, Blue Cross asserted that it was not responsible for violating the antitrust laws.[137] The district court concluded, based upon agency law principles, that Blue Cross was liable for the conduct of its employee-agents and that, at most, the company could take action against these senior staff members for malfeasance.[138]

The Tenth Circuit in *Reazin III* affirmed the district court's opinion, holding that Blue Cross had illegally conspired with the Saints to terminate Wesley in violation of section 1 of the Sherman Act.[139] The case was remanded to the district court solely to recalculate the amount of expert witness fees to be awarded.[140]

B. Antitrust Guidelines: Guarding Against Unlawful Implied Agreements In the Provider Network Context

Reazin II and *Reazin III* demonstrate the antitrust dangers that are present when managed care plans and providers contract with one another. How should doctors, hospitals, other types of medical providers, and insurers guard against implied agreements in restraint of trade when engaging in provider contracting? This Article sets forth the following guidelines:

1. Unilateral Decisionmaking

Contracting decisions should be made unilaterally at all times. Managed care plans constructing provider networks should make independent decisions concerning the composition of these networks. The needs, geographic location, and preferences of customers certainly must be taken into account. However, the managed care plan must ultimately exercise sole discretion when determining with which providers to contract. Managed care companies can fully utilize their own in-house resources, including in-house medical directors who may be licensed

136. *Id.* at 1424.
137. *Id.*
138. *Id.*
139. *Reazin III*, 899 F.2d at 963-64.
140. *Id.* at 983.

doctors, when making these decisions. But managed care companies generally should not use outside "consultants," such as local area providers who are competitors of providers that may ultimately become involved in the network. Discussing the situation with area providers is strongly discouraged because soliciting the input and advice of these individuals, either formally as paid consultants or informally as helpful volunteers, may satisfy the concerted action requirement of section 1 of the Sherman Act. Similarly, providers must independently decide which managed care plans they will contract with and consequently, which provider networks they will join. They should therefore not make these determinations in conjunction with other providers in the market.[141]

Providers should "put their best foot forward" by demonstrating their medical capabilities to managed care companies. They should never venture an opinion, however, either orally or in writing, concerning the medical quality, credentials, or fitness of another medical provider. Nor should providers pressure a health insurer to terminate or avoid doing business with another provider. According to *Monsanto*, a court would most likely find complaints about a provider followed by termination insufficient to constitute an implied agreement among the complaining providers and the managed care plan to illegally boycott the terminated party. Nonetheless, when counselling providers, it is advisable to establish bright-line rules. Furthermore, antitrust lawyers should seek to reduce their clients' litigation risks as well as guard against an ultimate finding of liability. The fact that providers or managed care plans that are sued for a conspiracy to boycott another provider might ultimately prevail after several years of litigation should not be the sole motivation for legal advice. Clients should be directed to avoid behavior that presents a significant litigation risk as well as a significant liability risk. Finally, attorneys should inform their provider clients that in addition to the antitrust risks associated with making statements about the quality of other providers, a risk also exists that a terminated provider will sue based upon one or more common-law business torts, such as interference

141. Such decisions should not be made collectively unless all of the providers are members of the same incorporated practice group or IPA. Furthermore, the IPA must be integrated enough to qualify as a joint venture under the antitrust laws. *See* 1 VON KALINOWSKI, *supra* note 21, § 2.05 (discussing joint ventures); Jack R. Bierig, Antitrust Issues Facing Physicians, 30-31 (Jan. 29-31, 1992) (paper presented to the National Association of Health Lawyers, on file with author) (discussing the application of joint venture analysis to IPAs).

with an actual or prospective contractual relationship,[142] defamation, injury to business reputation, or false advertising.

2. Objective Guidelines

When making network selection decisions, managed care plans should use objective guidelines that are maintained in writing. In addition, managed care plans should maintain documents that demonstrate that network selection decisions were actually made pursuant to these written, objective criteria.[143]

Objective guidelines may include such factors as: (1) the geographic location of the provider in question; (2) the geographic location of customers (usually employers who purchase group health coverage for their employees) and individual enrollees; (3) the needs of the managed care plan for certain kinds of providers in the network; (4) academic credentials of the provider; (5) medical licenses held by the provider; (6) malpractice convictions of the provider; and (7) at which hospital(s) the provider has attained admitting privileges. These written guidelines will underscore and memorialize the unilateral nature of a managed care company's decisions concerning provider contracting and network selection.

3. Avoid Disclosure of Upcoming Decisions

Managed care plans and providers subject themselves to the risk of attack under the antitrust laws whenever they discuss decisions that have yet to be made regarding certain providers. Disclosure of future-oriented information is dangerous because it permits parties to modify and coordinate their behavior in response to the information prior to the occurrence of the event. Changes in marketplace behavior subsequent to such information exchanges may raise suspicions and may constitute circumstantial evidence of an unlawful conspiracy among the party disclosing the information and the party receiving it.[144] Managed care plans should never disclose upcoming decisions regarding certain providers. A man-

142. This cause of action arose in the *Reazin* litigation. *See supra* note 113 and accompanying text.

143. In *Monsanto*, the defendant, Monsanto Company, had drafted a set of objective contracting criteria. 465 U.S. at 756. Unfortunately for Monsanto, it was unable to demonstrate in the face of countervailing evidence that it had actually applied its criteria when deciding whether to terminate the plaintiff's distributorship contract. *Id.* See *supra* note 90 and accompanying text.

144. For the factors that a court may consider when determining whether an implied agreement in restraint of trade exists, see *supra* notes 35-37 and accompanying text.

aged care company should never articulate outside the company its intention to terminate a provider or to refuse to renew a provider contract. In particular, the managed care company should never disclose such intentions to other providers in the market area.

This situation often presents a great temptation to managed care plans. After deciding to terminate a provider from the network, managed care plans usually desire to enter into negotiations with a replacement provider as soon as possible before the actual date of termination. These negotiations are risky from an antitrust perspective because such discussions may constitute circumstantial evidence of a conspiracy to boycott the terminated provider.[145] Attorneys must counsel managed care companies, as well as replacement providers or those suspecting that they may be replacement providers, to choose their words carefully and avoid these types of discussions whenever possible. To the extent that these discussions are unavoidable, such interactions should be carefully managed and expressed in the manner described below.

4. Communicate in Terms of Patient Volume and Steerage

Provider relations personnel employed by managed care plans sometimes desire to reveal to potential replacement providers their intention to terminate other providers from the network. Yet, no business reason exists to disclose this sensitive information. Potential replacement providers do not need to know the specific identities of those providers that the managed care plan intends to terminate. Potential replacement providers only need to be aware of the expected increase in patient volume resulting from the termination or declination decisions. For their part, managed care plans also have no compelling business reason for disclosing the specific identities of the providers whose termination is imminent. They only need to bargain for a favorable price for medical services based on the number of enrollees in the plan, the volume of patients that they are capable of steering to the provider, and the number of providers present in the network that are capable of handling the medical needs of the plan's enrollees. Thus, antitrust counselors should advise their clients to speak in terms of patient volume and the aggregate number of providers in the network, not specific termination decisions.

Patient volume and patient steerage constitute the core of the managed care plan/provider relationship. There is no need to disclose sensitive

145. *See supra* note 144.

information about specific upcoming termination decisions to providers. Providers only need to be cognizant of the "downstream" effects on patient volume and steerage caused by termination decisions.

One way to avoid discussing future terminations periodically throughout the managed care plan/provider relationship is to insert some form of elevator clause—a clause that ties compensation to some quantitative variable—into the provider contract at the outset of the relationship. This clause might contain a graduated payment provision dependent upon patient volume (number of enrollees in the plan) and/or the number of providers in the network. The chief financial officer of the managed care plan can certify the number of enrollees in the plan and/or the number of providers in the plan's network on a quarterly or semi-annual basis. Generally, the fewer the number of providers, the greater the patient steerage and the lower the capitation or other form of payment. An elevator clause in the provider contract will obviate the need to discuss the impact of impending provider terminations with the surviving providers and, as a consequence, will reduce antitrust risks.

5. *Sensitivity to Privileged and Non-Privileged Documents and Discussions*

The reader will recall that the President of Blue Cross in the *Reazin* litigation placed his company in jeopardy under the antitrust laws by drafting and then releasing an internal memo that raised the specter of an antitrust violation.[146] Although this officer knew to exercise vigilance toward the antitrust laws, the manner in which he expressed his vigilance backfired.

Antitrust advisors should instruct business personnel not to take it upon themselves to attempt to explain or address antitrust issues. All communications concerning potential antitrust violations or issues should be expressed by the company's lawyer or in correspondence addressed from the business person to the company's lawyer in order to preserve the attorney-client privilege[147] and protect such communica-

146. *See supra* notes 131-35 and accompanying text.

147. The attorney-client privilege protects certain attorney-client communications from discovery. 8 JOHN H. WIGMORE, EVIDENCE § 2292 (McNaughton Rev. 1961). The client holds the privilege and may waive it. 8 *id.* § 2321. The privilege may be claimed not only by natural persons but also by artificial persons such as corporations. Public communications or communications disclosed to third parties destroy the privilege. 8 *id.* § 2311. A federal district court has defined the attorney-client privilege as follows:

> The privilege applies only if (1) the asserted holder of the privilege is or sought to become

tions from discovery. Antitrust counselors should stress to their corporate clients that attempts by business personnel to explain or describe legal risks to company employees are generally not protected by the attorney-client privilege and are fully discoverable.[148]

If an internal investigation is warranted to determine whether an antitrust violation has occurred, corporate counsel should either personally interview employees or closely supervise an employee-directed investigation. Internal investigations must be under the attorney's strict direction and control in order to claim the protection from discovery afforded by the attorney work-product doctrine.[149] In addition, a managed care company's senior officers should be advised not to summarize their private discussions with corporate counsel in a memorandum addressed to their file or to another business person. Such a memorandum may convert a privileged discussion into a non-privileged one and/or may cause

---

a client; (2) the person to whom the communication was made (a) is a member of the bar of a court, or his subordinate and (b) in connection with this communication is acting as a lawyer; (3) the communication relates to a fact of which the attorney was informed (a) by his client (b) without the presence of strangers (c) for the purpose of securing primarily either (i) an opinion on law or (ii) legal services or (iii) assistance in some legal proceeding, and not (d) for the purpose of committing a crime or tort; and (4) the privilege has been (a) claimed and (b) not waived by the client.

United States v. United Shoe Mfg. Co., 89 F. Supp. 357, 358-59 (D. Mass. 1950). *See generally* 8 WIGMORE, *supra* § 2292.

148. *See supra* note 147 and accompanying text.

149. The attorney work-product doctrine provides another discovery exemption. The doctrine protects materials gathered or work product developed by attorneys in anticipation of potential or actual litigation. 8 WIGMORE, *supra* note 147, § 2292. The doctrine had its origins in the 1947 Supreme Court decision in Hickman v. Taylor, 329 U.S. 495 (1947). The doctrine eventually was embodied in Rule 26(b)(3) of the Federal Rules of Civil Procedure. *See* FED. R. CIV. P. 26(b)(3). Rule 26(b)(3) states:

> [A] party may obtain discovery of documents and tangible things otherwise discoverable under . . . this rule and prepared in anticipation of litigation or for trial by or for another party or by or for that other party's representative (including the other party's attorney, consultant, surety, indemnitor, insurer, or agent) only upon a showing that the party seeking discovery has substantial need of the materials in the preparation of the party's case and that the party is unable without undue hardship to obtain the substantial equivalent of the materials by other means.

Id.

Antitrust lawyers investigating possible antitrust violations should personally conduct the internal investigation of the client whenever possible. Legal oversight of the investigation will protect the work product generated and any documents or materials discovered during the course of the investigation from discovery because of the attorney work-product doctrine. Alternatively, lawyers who do not conduct the investigation should ensure that the nonlawyers conducting the investigation remain under the attorney's direction and control. As a prophylactic measure, the company and lawyer should prepare memoranda for their files documenting that the lawyer is managing and directing the internal investigation.

the loss of protection of the attorney work-product doctrine.[150] If a need exists generally to explain past corporate behavior to rank-and-file employees, then such company-wide releases should be drafted in close cooperation with the company's legal counsel.

Occasionally, a provider will send a letter to a managed care plan demanding, implicitly or explicitly, that the managed care plan terminate another provider from the network. Attorneys representing members of the medical community should advise providers not to write such letters since they are discoverable and may be construed by a court as an invitation to boycott the other provider. If a managed care company does receive such a communication, its attorney should advise company officials to politely thank the sender for the letter (e.g., "The thoughts and input of our network providers are always appreciated.") and to politely, yet firmly, state that "as always, decisions concerning the composition of the provider network are within the sole discretion of the managed care plan." As the terminated dealer cases illustrate, legitimate business reasons exist for providers and managed care companies to communicate with one another.[151] Yet, such communications must be carefully managed and controlled in order to prevent an inadvertent antitrust violation.

6. Antitrust Education and Guidelines

The relationships between managed care companies and providers raise a number of serious antitrust issues that antitrust education and written guidelines can productively address. Preventive lawyering can go a long way toward avoiding antitrust behavior and possible antitrust violations. Today health insurers as well as hospitals, doctors, and other providers of medical care are under strict fiscal constraints. Yet, given the antitrust risks—hefty monetary penalties and possibly prison sentences[152]—a little preventive education is money well spent.

V. CONCLUSION

The health care industry is the "number one industry in the United

150. *See supra* notes 147, 149 and accompanying text.

151. *See supra* notes 81-98 and accompanying text.

152. *See* Sherman Antitrust Act, 15 U.S.C. § 1 (1988 & Supp. 1990) (violation of § 1 is a felony punishable by up to three years imprisonment and a $350,000 fine for individuals and a $10 million fine for corporations).

States."[153] Perhaps because of its prominence, the industry has come under increased scrutiny and attack from a variety of quarters.[154] The weapon of choice for prosecutors and private plaintiffs has been the federal antitrust laws.[155] Attorneys must make health insurers, hospitals, physicians, and other kinds of medical providers aware that many of their activities are fully subject to the antitrust laws.[156]

This Article has analyzed and explained the antitrust risks associated with provider contracting and with the construction and modification of provider networks in the managed care setting. Noting the dearth[157] of written commentary on this critically important subject, this piece has sought to close this gap. This Article has advanced a paradigm for analyzing provider network selection decisions from an antitrust perspective.[158] This paradigm may help scholars, practitioners, and judges analyze these situations under the antitrust laws. The Article has provided six recommendations that will significantly reduce the antitrust risks associated with provider contracting and network selection decisions. Antitrust practitioners should consult these recommendations when advising their health care clients (whether they are members of the medical community or the health insurance industry) on how to avoid high risk behavior and inadvertent antitrust violations.

153. *See* Motenko, *supra* note 1.
154. *See supra* notes 1-3 and accompanying text.
155. *See supra* notes 16-19, 99-140 and accompanying text.
156. *See supra* notes 20-25 and accompanying text.
157. *See supra* note 56.
158. *See supra* notes 54-58 and accompanying text.