No. 80-419

IN THE

# Supreme Court of the United States

OCTOBER TERM, 1980

STATE OF ARIZONA,
*Petitioner,*

vs.

MARICOPA COUNTY MEDICAL SOCIETY,
MARICOPA FOUNDATION FOR MEDICAL CARE, and
PIMA FOUNDATION FOR MEDICAL CARE,
*Respondents.*

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

## BRIEF FOR PETITIONER

KENNETH R. REED
Special Assistant Attorney General
114 West Adams, Suite 760
Phoenix, Arizona 85003
(602) 254-1973
*Counsel of Record*

ROBERT K. CORBIN
Attorney General of Arizona
ALISON B. SWAN
Chief Counsel
Antitrust Division
CHARLES L. EGER
Assistant Attorney General
Antitrust Division
114 West Adams, 6th Floor
Phoenix, Arizona 85003
(602) 255-4751
*Counsel for Petitioner*

## QUESTION PRESENTED

Is an agreement among competing physicians establishing fee schedules for their individual services a *per se* violation of section 1 of the Sherman Act?

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## BRIEF FOR PETITIONER

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### OPINIONS BELOW

The June 5, 1979, memorandum and order of the District Court denying plaintiff's motion for partial summary judgment on the issue of liability under the *per se* standard (Pet. App. D), its August 6, 1979, order denying plaintiff's motions for reconsideration of the June 5 order and for partial summary judgment under the Rule of Reason (Pet. App. E), and its August 8, 1979, order certifying the June 5 decision for interlocutory appeal (Pet. App. F) have not been officially reported. The opinion of Judge Sneed, the concurring opinion of Judge Kennedy and the dissenting opinion of Judge Larson filed March 20, 1980 (Pet.

App. A), as amended on April 28, 1980, (Pet. App. B), and the Court of Appeals' order of June 18, 1980, denying the petition for rehearing (Pet. App. H), are reported at 643 F.2d 553.

## JURISDICTION

The opinion of the United States Court of Appeals for the Ninth Circuit was filed on March 20, 1980, and modified on April 28, 1980. The State of Arizona timely filed a petition for rehearing and rehearing en banc which was denied on June 18, 1980. The petition for a writ of certiorari was filed September 16, 1980, and was granted March 9, 1981. 450 U.S. _____. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

## STATUTORY PROVISION INVOLVED

Section 1 of the Sherman Act, 15 U.S.C. § 1, provides in pertinent part:

> Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States or with foreign nations, is hereby declared to he illegal.

## STATEMENT

### The Foundations Have Established and Maintained Uniform Fee Schedules for Doctors' Services

The Maricopa and Pima Foundations for Medical Care are associations of doctors in Arizona's two most populous counties[1] which were created to promote "fee-for-service

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[1] Pet. App. D at 38-39; J.A. 123 ¶ 1; 144 ¶ 1; 188 ¶ 428. The Maricopa Foundation's parent corporation the Maricopa County Medical Society is also a named defendant. The Maricopa Society formed the Maricopa Foundation in 1969 and the two organizations share the same personnel and offices and the Society appoints the members of the Foundation's governing board. J.A. 189-90 ¶¶ 3, 5; 210 ¶ 90; 272 ¶¶ 2-3, 5; 273 ¶¶ 314-15; *see also* C.R. 7(b), Exhibit MF-119

[1] The Pima Foundation's parent the Pima County Medical Society was named as a defendant but it agreed to a consent judgment and is no longer a party. 643 F.2d, at 554 n.2.

medicine."[2] With approximately 1750 active members, the Maricopa Foundation has consistently maintained its membership levels at over 70 percent of the physicians in Maricopa County. (J.A. 407). The Pima Foundation has approximately 400 members (J.A. 74 ¶ 4) and in November 1975 its membership included "[m]ore than 80 percent of the privately practicing physicians in the Pima County area." (C.R. 7(a), Exhibit PF-125).

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[2] J.A. 171 ¶ 317; 210 ¶ 91. "Fee-for-service medicine" refers to the sale of doctors' services for a fee based upon the services rendered in contrast to work performed for a salary or for capitation payments. *See generally* Goldberg and Greenberg, *The Effect of Physician-Controlled Health Insurance: U.S. v. Oregon State Medical Society*, 2 J. Health Pol., Pol'y & L. 48, 51 (1977); Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 Duke L.J. 303, 306; Kallstrom, *Health Care Cost Control by Third Party Payors: Fee Schedules and the Sherman Act*, 1978 Duke L. J. 645, 647.

The foundations' by-laws grant their members the power "to vote on the adoption of ... uniform fee schedules."[3] To arrive at their fee schedules, the foundations first consult with the different medical specialty associations to determine the prices charged by their members (J.A. 163 ¶ 44; 200 ¶ 44; *see, e.g.*, Reply Apps. A and B) and then use this information to formulate the fee schedules sent to foundation members for formal approval. (J.A. 164 ¶ 54; 202 ¶ 54). These fee schedules have two components, the "relative value" and the "conversion factor." The "relative value" is a numerical weight assigned for each type of service or procedure performed by a physician. Thus, a routine, follow-up office visit might have a relative value of 1.0, while a home visit might have a relative value of 7.0. The "conversion factor" is the dollar amount used to determine fees for a particular medical specialty. Thus, in 1978 the conversion factor for surgery was $10.50, while that for anesthesiology was $13.25. (J.A. 268 ¶ 304). The actual price

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[3] J.A. 155 ¶ 37 (collecting citations); *see also id.* 134 ¶ 37; 162 ¶ 34; 198 ¶ 4; *Arizona v. Maricopa Medical Soc'y*, 643 F.2d, at 555.

Conveniently choosing to ignore the explicit language in their own by-laws and in extensive correspondence, respondents attmept to argue that "[t]his action does *not* involve an agreement by doctors on prices to charge their patients ...." Br. in Opp. at 1. The distinction respondents seem to be making is that they have agreed upon the "level of reimbursement," *e.g., id.* at 3, or the amount they will be paid by their patients and third-party payors rather than upon the prices they charge those patients and third-parties. This is a distinction without a difference.

If anything, the distinction respondents seek to draw is suggestive of greater price uniformity. In *United States v. National Association of Real Estate Boards*, 339 U.S. 485 (1950), the prescribed rates from the fee schedule were used in the great majority of transactions, although in exceptional circumstances a lower charge was made. These occasional deviations did not lessen the illegality of the agreed-upon fee schedule. *See also International Salt Co. v. United States*, 332 U.S. 392, 398 (1947) (that violation had not occurred in all transactions did not preclude summary judgment on liability). Where, as here, the agreement is on the level of reimbursement rather than the quoted price, any incentive to deviate from the agreed-upon price is eliminated even in "exceptional circumstances."

for a particular procedure is determined by multiplying the relative value for that procedure by the applicable conversion factor. (*See, e.g.*, J.A. 35-36).

The ostensible purpose of the foundation fee schedules is to establish "the maximum level of reimbursement" that a foundation member may receive for services performed under a foundation-endorsed pre-paid health plan.[4] The foundations establish certain minimum standards which must be met if a health plan is to receive their formal en-

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[4] Pre-paid health plans fall into two general categories. One is based upon indemnification under which a third-party such as an insurer or an employer pays the health care provider all or part of the price for medical services actually performed. The economic risk of this type of health plan is borne by the third-party and no economic integration among the different providers is required. The other category is defined by capitation payments in which subscribers to the plan pay the providers a fixed periodic fee in return for which the providers agree to furnish any future medical services that might be required. In this category, the economic risk is borne by the providers and some degree of economic integration among the providers is required. The foundation-endorsed health plans all fall into the first category while independent practice associations and health maintenance organizations authorized under the Health Maintenance Organization Act of 1973, 42 U.S.C. § 300e *et seq.*, are in the second category. *See* Kissam, *Health Maintenance Organizations and the Role of Antitrust Law*, 1978 Duke L.J. 487, 490. It is generally acknowledged that the second category of pre-paid health plans provides significantly greater incentives for cost-containment than the first. *See, e.g.*, Kissam, *supra*, at 490.

While precise market share data are not available, a 1974 analysis by the Maricopa Foundation placed it with approximately four times as many subscribers as health maintenance organizations and approximately three times the number of subscribers as all other indemnification health plans combined. (C.R. 7(b), Exhibit MF-90 at 2). These ratios would indicate that the Maricopa Foundation had approximately 63 percent of the pre-paid health care market compared to 16 percent for health maintenance organizations and 21 percent for other indemnification plans.

dorsement.[5] If a third-party[6] payor agrees to abide by the fee schedule and other minimum standards established by the foundations, the foundations will formally endorse its health plan. In turn, the foundations' members agree to accept as full payment for any medical services provided pursuant to foundations plans their "usual and customary fees . . . but not to exceed the maximum level of reimbursement established by the foundation." Br. in Opp. at 4.

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[5] *See, e.g.*, C.R. 7(b), Exhibit MF-64 (Maricopa Foundation for Medical Care, Minimum Standards for Foundation-Endorsed Group Insurance Programs, January 1, 1976).

The minimum standards promulgated by the foundations have other anticompetitive and inflationary provisions in addition to the obvious one involved with the agreed-upon fee schedules. The foundations' minimum standards require relatively low deductible amounts to be paid by patients (*e.g., id.*, at 4 ¶ 10, 12 ¶ 38) which encourages overutilization of medical services with a concomitant increase in insurance premiums and physicians' incomes. *Cf.* Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 Duke L.J. 645, 647. Similarly, the foundations' minimum standards provide that payments may only be made to certain categories of health care providers (*see, e.g.*, C.R. 7(b), Exhibit MF-64, at 3 ¶ 7) which of course constitutes a boycott of the other categories of licensed health care providers who are not eligible to receive payment. *E.g., Virginia Academy of Clinical Psychologists v. Blue Shield*, 624 F.2d 476 (4th Cir. 1980). To the same effect, the foundations' minimum standards require that hospitals only be paid for 80 percent of their charges (C.R. 7(b), Exhibit MF-64, at 10 ¶ 2), while the physician members of the foundations receive 100 percent of their charges.

[6] Respondents and even the United States in its amicus brief refer repeatedly to payments by health insurers and, while this is a convenient shorthand, it is somewhat lacking in precision. Under foundation-endorsed health plans, payments might be made either by health insurance companies or by major employers such as Motorola, Inc. or the State of Arizona which are sufficiently large that they do not need an intermediate insurance company to underwrite the actuarial risk. To the same effect, the foundation-endorsed health plans have deductible limits which must be met by the patient before any third-party reimbursements is made and payments against the deductible limits are made directly by the patients and not by any third-party.

Although the foundations' fee schedules supposedly set only maximum prices and purportedly are limited to foundation-endorsed health plans, they actually have had an inflationary impact which belies their characterization as "maximum" fee schedules and which reaches much further than formally-endorsed plans. A 1974 analysis by the Maricopa Foundation, for example, boasted that its fee schedule had increased between 30 to 33 percent in just five years. (C.R. 7(b), Exhibit MF-90). Moreover, the foundations' fee schedules have been set at levels higher than both the average and median fees of Arizona doctors as determined by the foundations' own price surveys.[7] And, once the fee schedules are established through the elaborate process of price surveys and formal voting, foundation members revise their prices so that some 85 to 95 percent charge prices at or above those established by the fee schedules. *Arizona v. Maricopa County Medical Society*, 643 F.2d 553, 555 (1980). Indeed, defendants readily admitted that member

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[7] *Compare, e.g.*, J.A. 247-48 ¶¶ 225-27, 230 ("1975 fee survey indicated that the average conversion factor . . charged by physicians within the State of Arizona for medicine was $10.20; for surgery was $9.28 and for anesthesia was $12.30"), *with* J.A. 249 ¶ 233 (foundation fee schedule approved following 1975 fee survey included conversion factors of $11.00 for medicine, $9.50 for surgery, and $12.00 for anesthiology). *See also* pages 11 to 12, *infra*.

Although respondents claim that they "never set a maximum reimbursement level in excess of . . . the . . . prevailing average or median fees charged by physicians in the community," Br. in Opp. at 4, this argument is demonstrably incorrect and is refuted by facts respondents themselves admitted to be true pursuant to Rule 36, Federal Rules of Civil Procedure. Under Rule 36(b), "Any matter admitted under this rule is conclusively established unless the court on motion permits withdrawal or amendment of the admission" and since respondents have made no such motion they cannot now escape the consequences of their admission.

doctors required concerted price increases as a condition of continued membership in the foundations.[8]

## Agreed-Upon Increases in "Conversion Factors" Result in Across-the-Board Increases in Doctors' Prices

The conversion factors apply to all medical procedures and an increase in the conversion factors therefore results in an across-the-board increase in doctors' prices. The steps leading to the December 1, 1977, revision of the Maricopa Foundation fee schedule illustrate how this process operated.

As of January 1, 1976, the Maricopa Foundation had an approved conversion factor of $9.50 for surgery with different conversion factors for the other medical specialties. (J.A. 249 ¶¶ 233-34). At its March 21, 1977, meeting the Maricopa Foundation's Board of Trustees "directed that speciality societies be consulted in April and May of 1977 so that by June of 1977 the Board will have material available to determine new conversion factors." (J.A. 260 ¶ 279; *see also* C.R. 7(b), Exhibit MF-51). On April 14, 1977, the foundation sent a series of letters to the various surgical and other specialty societies asking that their members be

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[8] In both the district court and the court of appeals, respondents claimed that doctors were threatening to leave the foundations if they could not increase their agreed-upon fees, an open admission that fees for individual services were controlled by the collective membership and could not be adjusted individually by doctor or insurer. See the dissenting opinion of Judge Larson, 643 F.2d, at 567; Appellees' Brief in the Court of Appeals at 24.

polled about desired changes in conversion factors.[9] While a few of the specialty societies declined to participate in this pricing poll because they viewed it to be unlawful price-fixing (*see, e.g.*, C.R. 7(b), Exhibits MF-20 to -22), most responded with the requested information regarding desired price levels. (*E.g.*, J.A. 264-66 ¶¶ 291-96; *see, e.g.*, Reply App. C).

The surgical specialties were unanimous in rejecting the foundations' current conversion factor of $9.50 and all of these societies recommended that the conversion factor be increased. Dr. Richard Zonis, president of the Arizona Society of Otolarynology, for example, had forwarded copies of the April 14 inquiry to members of the society, compiled the responses he had received, and forwarded them to the foundation. (C.R. 7(b), Exhibits MF-13 to -19). Although five of the six responses received by Dr. Zonis indicated they would be satisfied with an increase in the surgical conversion factor to only $10.00 (*id.*, Exhibits MF-14 to -16, -18 to -19) and the other indicated that a five to ten percent increase would be sufficient (*id.*, Exhibit MF-17), Dr. Zonis' note forwarding the results of his poll said, "All of our members feel that an increase is in order, the range being from 10.0 - 11.0 or an increase of 10%, which amounts to about the same thing. I personally favor a 10% increase to

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[9] J.A. 261 ¶¶ 281-82; *see, e.g.*, Reply App. A

These requests for pricing information and desired increases were sent to the Arizona Chapter of the American College of Chest Physicians, Arizona Opthalmological Society, Arizona Society of Allergists, Arizona Society of Anesthesiologists, Arizona Society of Internal Medicine, Arizona Society of Otolaryngology, Arizona Thoracic Society, Maricopa County Pediatric Society, Maricopa County Plastic Surgeons Society, Phoenix Dermatological Society, Phoenix Obstetrical and Gynecological Society, Phoenix Orthopedic Association, Phoenix Radiology Society, Phoenix Society of Gastroenterology, Phoenix Surgical Society and Phoenix Urological Society. C.R. 7(b), Exhibits MF-29 to -46.

The requests sent to each of these specialty societies was identical and the responses from each were in the same vein. In the interest of brevity, however, only the responses from the surgical specialities are discussed in the text.

10.5." (*Id.*, Exhibit MF-13). To the same effect was a survey by the Phoenix Obstetrical and Gynecological Society. Dr. Frank Loffer, secretary-treasurer of that society, wrote: "Your letter of April 14, 1977, ... was discussed by the Executive Committee of the Phoenix Obstetrical and Gynecological Society. It was their feeling that the conversion factor for surgery should be increased to $10.50." (C.R. 7(b), Exhibit MF-8). Similarly, the response of the Maricopa County Plastic Surgeons Society said, "[W]e discussed [your letter] at our recent meeting of the Maricopa Plastic Surgeons. It was the feeling of the membership that the surgical rate should be [$10.00] ...." (C.R. 7(b), Exhibit MF-7)

The results of the foundation's price survey were considered at the June 21, 1977, meeting of its Board of Trustees (J.A. 267-68 ¶ 301; C.R. 7(b), Exhibit MF-4), and various methods were discussed for increasing the foundation's fee schedule. (J.A. 268 ¶ 302). Although most of the surgeons and surgical specialty societies which had responded to the original April 14 letter had indicated that they would be satisfied with an increase to only $10.00, the board recommended to the members of the foundation that the surgical conversion factor be increased to $10.50. (J.A. 275-76). This increase was approved by the foundation's membership (J.A. 277-78) and went into effect December 1, 1977. (J.A. 268 ¶ 304). As a result of this series of events, all surgical procedures were thereafter compensated on the basis of the foundation's new $10.50 conversion factor rather than the $9.50 conversion factor which had previously applied. Comparable increases went into effect simultaneously for the other medical specialties. (J.A. 268 ¶ 304).

### Agreed-Upon Increases in "Relative Values" Result in Increases in the Prices for Specific Medical Procedures

A "relative value" applies only to a particular medical procedure. If the only prices to be increased are those for a relatively limited number of procedures then such price

increases are accomplished through increases in the relative values of those few procedures instead of changing the conversion factor. An example involving two relatively common gynecological procedures will illustrate how changes in relative values are used to effect price changes for particular medical procedures.

At its September 20, 1976, meeting the foundation's Board of Trustees discussed the relative value used for diagnostic laparoscopies (J.A. 254 ¶ 255) and decided to request the opinion of the Phoenix Obstetrical and Gyneological Society on the usual doctor's fee for this procedure. (J.A. 255 ¶ 256). As a result of the foundation's request, "[t]he subject of fees for the diagnostic laparoscopic examination were discussed with the members of the Phoenix Obstetrical and Gynecological Society . . . . It was the unanimous opinion of the members present that the fee for diagnostic laparoscopy ought to be raised to par with that of laparoscopic tubal cauterization [or tubal ligation]." (C.R. 7(b), Exhibit MF-58). At the January 17, 1977, meeting of the foundation trustees a decision was reached to review all prices being charged for laparoscopies and to present a compilation to the board at its next meeting. (C.R. 7(b), Exhibit MF-54).

The review of the laparoscopy fees for diagnostic laparscopies and tubal ligation by laparoscopies was considered by the foundation's board at its February 21, 1977, meeting. (C.R. 7(b), Exhibit MF-51). Although the average fee for diagnostic laparoscopies was $266.05 and the median fee only $250.00, the foundation approved an increase in the conversion factor for this procedure so that the allowable price would be $275.00. (C.R. 7(b), Exhibits MF-48 and -51; J.A. 258-59 ¶¶ 269-73). To the same effect, the conversion factor for tubal ligation was changed to allow a price of $325.00 even though the median fee for this procedure was $300.00 and the average fee $315.53. (C.R. 7(b), Exhibits MF-48 and -51; J.A. 259 ¶¶ 274-76). Thus, for each of these procedures, the foundation established a fee level higher

than what it knew to be the average and median fees for the particular procedure involved. The amount physicians received for performing laparoscopies was thus increased from $190.00 to $275.00. (J.A. 254 ¶ 255; 258-59 ¶ 272). Comparable increases have been effected for other medical procedures. (*E.g.*, J.A. 256-57 ¶¶ 261-63).

## Proceedings Below

The State of Arizona brought this action seeking declaratory and injunctive relief against the establishment and use of agreed-upon fee schedules by medical doctors in violation of section 1 of the Sherman Act, 15 U.S.C. § 1. The District Court's jurisdiction was invoked under 28 U.S.C. §§ 1331 and 1337 and section 16 of the Clayton Act, 15 U.S.C. § 26. Following completion of relevant discovery, the State of Arizona moved for partial summary judgment on liability on the ground that defendants' price-fixing activities were a *per se* violation section 1 of the Sherman Act, 15 U.S.C. § 1. The District Court denied this motion on June 5, 1979.[10] It reasoned that *Continental T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36 (1977), established a trend away from the *per se* rule and that the *per se* rule would no longer be applicable to price-fixing agreements. Alternatively, it interpreted *Goldfarb v. Virginia State Bar*, 421 U.S. 733 (1975), and *National Society of Professional Engineers v. United States*, 433 U.S. 679 (1978), to mean that the *per se* rule could never be applied against professionals, even in a horizontal price-fixing case such as this. Subsequent motions for reconsideration of this order and for partial summary judgment on liability based upon the Rule of Reason were also denied. (Pet. App. E). On August 8, 1979, the district court certified for interlocutory appeal pursuant to 28 U.S.C. § 1292(b) its "determination that the Rule of Reason approach should be used in analyzing the chal-

[10] Pet App. D. This order also denied defendants' motions to dismiss the complaint and granted plaintiff's motion for partial summary judgment on the issue of subject matter jurisdiction. Only that portion of the order which addressed the issue of liability was appealed.

lenged conduct ... to determine whether a violation of Section 1 of the Sherman Act has occurred." (Pet. App. F).

A divided panel of the Court of Appeals affirmed with Judges Sneed and Kennedy each writing individual opinions and Senior District Judge Larson filing a dissent. *Arizona v. Maricopa County Medical Society*, 643 F.2d 553 (9th Cir. 1980). Judge Sneed followed the district court in holding that the *per se* rule could not be applied to the anticompetitive activities of doctors. Relying on *Broadcast Music, Inc. v. Columbia Broadcasting Co.*, 441 U.S. 1 (1979), and distinguishing *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150 (1940), Judge Sneed reasoned that it was impossible to determine whether the doctors' fee schedules were *per se* unlawful without first determining whether the agreed-upon prices were unreasonably high, unreasonably low, or were higher than other fee schedules.[11] Even if the doctors' fee schedules were viewed simply as establishing maximum prices, Judge Sneed was unwilling to hold them *per se* unlawful. He declined to follow *Albrecht v. Herald Co.*, 390 U.S. 145 (1968), and *Kiefer-Stewart Co. v. Joseph E. Seagram & Sons*, 340 U.S. 211 (1951), saying, "This circuit has not extended those rulings to horizontal agreements that establish maximum prices." 643 F.2d, at 557n.4. Judge Kennedy concurred in a

[11] Judge Sneed reasoned, "We do not know how health insurers such as Blue Cross *(sic)* fix their fee schedules in the relevant geographic area or whether the fees they offer exceed the appellees' maximum fees .... This makes it impossible to evaluate the pro- and anticompetitive aspects of a given feature of the total structure, although these aspects must be weighted together in determining whether a per se rule, or even the Rule of Reason, should brand the questioned feature illegal." 673 F.2d, at 558.

Judge Sneed went on to speculate that the doctors' agreed-upon fee schedules might be unreasonably low so as to discourage entry of new competitors or unreasonably high so as to exact a monopoly profit and that until the reasonableness of the foundations' fee schedules was determined it would be impossible to determine whether they were *per se* unlawful. *Id.*, at 558-559.

separate opinion, stating that a trial was necessary before the *per se* rule could be applied. *Id.*, at 560.

Senior District Judge Larson dissented. He rejected the reasoning of the district court and Judge Sneed "that per se rules were being supplanted by greater use of the rule of reason." He concluded that this was the sort of "naked price restraint" which had previously been adjudged illegal *per se* and that there was no peculiarity of the health care industry that justified the application of a less strict legal standard to defendants' conduct. And, finally, Judge Larson rejected the defense recognized by Judge Sneed that the reasonableness of the price is a defense to a price-fixing charge.[12]

## SUMMARY OF ARGUMENT

The Court has repeatedly held that any agreement that "raised, lowered, or stabilized prices" is "beyond the pale" and *per se* unlawful under the Sherman Act. *United States v. Socony-Vacuum Oil Co.*, 310 U.S., at 221. While the non-commercial activities of the so-called learned professions might arguably be subjected to less stringent scrutiny than comparable anticompetitive schemes in other businesses, this Court has shown no hesitation in applying the *per se* rule to fee schedules agreed upon by professionals. *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975); *United States v. Utah Pharmaceutical Association*, 371 U.S. 24 (1962); *United States v. National Association of Real Estate Boards*, 339 U.S. 485 (1950). The *per se* rule should likewise be applied to the physicians' fee schedules involved here. Even though the health care industry suffers from more

[12] *Id.*, at 563-569. Judge Larson said, "I do not agree with the majority's belief that the relevant inquiry is whether fees are higher or lower as a result of the defendants' conduct. I am confident that the fee schedule does have the effect of raising prices, and that in its absence consumers would ultimately obtain less expensive medical care. The majority's emphasis on the level of fees, however, is a version of the 'reasonableness of prices' justification for price-fixing. This defense has been repeatedly rejected." *Id.*, at 568.

pervasive anticompetitive restraints than other industries and even though doctors' prices are increasing at a higher rate than prices in other sectors of the economy, these are affirmative reasons for applying the *per se* analysis to the doctors' price-fixing scheme and not, as the Ninth Circuit would have it, for applying a less rigorous test.

The Ninth Circuit's acceptance as a defense of the alleged reasonableness of the agreed-upon prices is an aberration in the antitrust law contrary to the decisions of this Court and every other Court of Appeals. *E.g., Catalano, Inc. v. Target Sales, Inc.*, 446 U.S. 643 (1980). To the same effect, the Ninth Circuit's refusal to apply the *per se* rule to horizontal agreements fixing maximum prices is contrary to the decisions of this Court and the other Courts of Appeals. *E.g., Kiefer-Steward Co. v. Joseph E. Seagram & Sons, Inc.*, 340 U.S. 211 (1951).

## ARGUMENT

### I.

### AT LEAST IN THE CASE OF AGREED-UPON FEE SCHEDULES NEITHER THE HEALTH CARE INDUSTRY IN GENERAL NOR PHYSICIANS IN PARTICULAR SHOULD ENJOY ANY SPECIAL EXEMPTION FROM THE ANTITRUST LAWS

As early as 1950, this Court held that agreed-upon fee schedules for professional services were unlawful *per se*. *United States v. National Association of Real Estate Boards*, 339 U.S. 485 (1950). In *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975), this Court reemphasized that members of learned professions were not exempt from the Sherman Act and held that fee schedules for legal services were unlawful.[13] *National Society of Professional Engineers v. United States*, 435 U.S. 679 (1978), involved a less obvious restraint than the fee schedules present in *Real Estate Boards* and *Goldfarb* but this Court nonetheless held that a professional society's rule

[13] 421 U.S., at 781-83, 786-88. *See also United States v. Utah Pharmaceutical Ass'n*, 371 U.S. 24 (1962) *affirming per curiam* 201 F. Supp. 29 (D. Utah 1962) (pharmaceutical fee schedules *per se* unlawful).

against competitive bidding was "illegal on its face" recognizing that "no elaborate industry analysis is required to demonstrate the anticompetitive character of such an agreement." 435 U.S., at 692. Judge Sneed's opinion flies in the face of these holdings.

Judge Sneed's opinion focuses upon the characteristics of the health care industry rather than the nature of the challenged agreement. He reasoned that because "an industry is widely deviant from a reasonably competitive model," 643 F.2d, at 556, anticompetitive practices might be tolerated here that would be unacceptable in other contexts. He even felt that the prices agreed upon by this cartel might be defended on the ground that those prices were reasonable.

Judge Sneed's analysis is a dangerous departure from established Sherman Act analysis which ordinarily focuses upon the nature of the challenged agreement rather than the peculiarities of an industry. *E.g., National Society of Professional Engineers v. United States*, 435 U.S., at 688. By applying a different and more tolerant standard in "an industry widely deviant from a reasonably competitive model," Judge Sneed's rationale makes effective antitrust enforcement most difficult in precisely those cases where it is most needed. And, by making the legality of a price-fixing agreement turn upon the reasonableness of the agreed-upon prices when compared with other prices being charged in the marketplace, Judge Sneed creates an insoluble dilemma for the antitrust prosecutor trying to decide where first to begin in an industry characterized by pervasive anticompetitive practices.

What is involved here is nothing less than a compact among competitors on the prices they will receive for their individual services. "[T]o the extent that they raised, lowered, or stabilized prices they would be directly interfering with the free play of market forces. The [Sherman] Act places all such schemes beyond the pale and protects that vital part of our economy against any degree of interference. Congress has not left with [the courts] the deter-

mination of whether or not particular price-fixing schemes are wise or unwise, healthy or destructive." *United States v. Socony-Vacuum Oil Co.*, 310 U.S., at 221. Because the applicable inquiry focuses on the nature of the agreement and because the agreement here operates directly upon the prices charged, Judge Sneed's unprecedented approach should be rejected and respondents' conduct should be beld to be *per se* unlawful.

That this case involves a so-called learned profession is certainly no reason for applying a different analysis, particularly since a price-fixing conspiracy has been alleged and proven. In *Goldfarb* and again in *Professional Engineers* this Court did, to be sure, leave open the theoretical possibility that some marginally anticompetitive activity which might be unlawful in another industry might be defensible if it occurred in one of the learned professions. Whether this is anything more than a theoretical possibility is yet to be established because this Court has not yet found any actual conduct by a learned profession which falls within this narrow theoretical description. In any event, the agreement involved in the present case is far removed from any theoretical possibilities which might have been contemplated in *Goldfarb* and *Professional Engineers*. The agreement here deals with the prices to be paid for goods and services. Price is the most central element of commerce and there is nothing about the health care industry which distinguishes it in this regard from any other industry.

Nor is there anything about the health care industry in general or physicians in particular which would justify a different treatment than that applied to other learned professions. No one disagrees with Judge Sneed's concern that price levels in the health care industry are artificially high. *See* 643 F.2d, at 556. This Court took notice in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 232 n.40 (1979), that recently there has been "rapid escalation of health care costs to tbe detriment of consumers generally." Government studies of the health care industry and health

costs provide strong evidence of this fact[14] and such escalating costs certainly are no secret to those in need of medical services.[15] To the same effect, the Committee on Governmental Affairs in a study generally critical of the California Relative Value Studies, found that dramatic increase in health care costs to be of crisis proportions:

> One of the most crucial domestic problems facing the President and the Congress is the continuing increase in health care costs for our citizens. The statistics are startling. For example, in 1950, health care expenditures in our nation accounted for 4.5 percent of our Gross National Product. Total health care costs in Fiscal Year 1977 accounted for 8.8 percent of the Gross National Product or a total of $142.6 billion per year. The Department of Health, Education and Welfare has estimated that by 1980, we could be spending more than $230 billion per year for health care. This means that, in Fiscal Year 1977 $737 per year was spent for every man, woman and child for health care services and this figure could rise to $1,000 by 1980.
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> Almost 20 percent of all health care expenditures in Fiscal year 1977 — about $32 billion — was for professional services rendered by physicians. A considerable portion of this service was paid to physicians through

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[14] *See generally* Juba, *Price Setting in the Market for Physicians' Securities* [:] *A Review of the Literature*, Health Care Financing Grants & Contracts Report (Health, Educ. & Welfare Pub. No. (HCFA) 03012 9-79, 1979); Freeland, Calat and Schendler, *Projections of National Health Expenditures, 1980, 1985 and 1990*, 1 Health Care Financing Review, No. 3, 1-27 (1980); National Health Survey, Dept. of Health, Educ. & Welfare, *Family Out-of-Pocket Health Expenses, United States 1975*, (Public Health Service Pub. No. 51, 1979); Senate Committee on Governmental Affairs, *The California Relative Value Studies, An Overview*, 96th Cong. 1st Sess. (1979).

[15] *See* amici briefs in support of petition for a writ of certiorari by the Gray Panthers at vi, 6-7; American Association of Retired Persons and the National Retired Teachers Association at 2-3.

> various health insurance programs, such as Blue Cross-Blue Shield, Medicare and Medicaid.[16]

Data published in a study by the Department of Health, Education and Welfare shows a 350 percent increase in national health expenditures from 1965 to 1978, reaching $192 billion in 1978.[17] This same study projects virtually runaway increases to $440 billion in 1985 and $760 billion in 1990.[18] In addressing the causes for such dramatic increases the study states:

> Two factors are particularly noteworthy: 1) the role of third-party payments in increasing consumer demand for services; and 2) the associated fee-for-service and cost-based reimbursement systems which lack incentives to provide medical care in the least expensive manner.[19]

To recognize with Judge Sneed that health care costs are increasing at an alarming rate and that there may be other conspiracies operating in the marketplace which result in even higher prices is certainly no excuse or justification for the anticompetitive conduct involved here. As Justice Douglas so aptly put it in *United States v. Crescent Amusement Co.*, 323 U.S. 173, 188 (1944), "[T]he fact that there may be somewhere in the background a greater conspiracy from which flow consequences more serious than we have here is no warrant for a refusal to deal with the lesser one which is before us." If prices in the health care sector

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[16] Senate Committee on Governmental Affairs, *The California Relative Value Studies, An Overview*, 96th Cong., 1st Sess., at 5 (1979).

[17] Freeland, Calat and Schendler, *supra* note 14 at 1. The increase, computed at a compound annual, is 12.2 percent, as compared to a 9.0 percent growth rate for the Gross National Product. *Id.*

[18] *Id.*, at 1, 6.

[19] *Id.*, at 6. *See also In the Matter of American Medical Association*, CCH Trade Reg. Rep. ¶ 21,068 (F.T.C. 1979), *aff'd sub nom. American Medical Ass'n v. Federal Trade Comm'n*, 668 F.2d 443 (2d Cir. 1980), where the Commission determined that the AMA's ban on advertising reduced incentive to price competitively. CCH Trade Reg. Rep. ¶ 21,068, at 28-31.

are increasing at an alarming rate, it is a reason for enforcing the congressional policy in favor of competition rather than creating a judge-made rule authorizing deviation from the competitive norm.

Judge Sneed was correct to perceive that the supply and demand functions of the medical marketplace have been distorted by high barriers to entry and government subsidies of the costs of medical care. But those characteristics are no more prevalent in the health care industry than in the petroleum industry, the railroad industry, and a host of other industries which this Court, as Congress intended, has held to be subject to the Sherman Act. *E.g.*, *Northern Pacific R. Co. v. United States*, 356 U.S. 1 (1968); *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150 (1940). To allow these factors to justify an exemption from the *per se* rule in price-fixing cases would be tantamount to repeal of that rule.

But even if the pecularities of the medical marketplace were relevant, they would only underscore the inappropriateness of having organized medicine control the price-setting mechanism. Much of the distortion in the medical marketplace can be traced to the anticompetitive practices of traditional medical associations[20] which have aroused the concern of this Court,[21] as well as the Congress,[22] the

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[20] *See generally* Goldberg and Greenberg, *The Effect of Physician-Controlled Health Insurance*, 2 J. of Health Politics, Policy and Law, 48 (1977); Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 Duke L.J. 303.

[21] *Group Life & Health Ins., Co. v. Royal Drug Co.*, 440 U.S. 205, 232 n.40 (1979), and 440 U.S. at 253 (Brennan, J., dissenting.)

[22] *E.g.*, *Skyrocketing Health Care Costs: The Role of Blue Shield*, Hearing before the Subcommittee on Oversight and Investigations of the House Committee on Interstate and Foreign Commerce, 95th Cong., 2d Sess., 4-34 (1978).

regulatory agencies,[23] and numerous commentators[24] who have unanimously concluded that professional price restraints, including the very foundation fee schedules challenged here,[25] are and should be unlawful *per se*. In contrast to the absolute control over prices demonstrated by the foundations in the present case, the flowering of a competitive marketplace for health care in Minneapolis-St. Paul has demonstrated the benefits of price competition among doctors.[26] Recent experience has also shown that competing insurers can take meaningful steps to contain health care costs in an open market protected by the antitrust laws.[27]

Finally, the foundations here cannot point to any unique circumstances of their own to justify exemption from the normal *per se* rules. The foundations cannot argue that their fee agreements are ancillary because to be lawful an ancillary restraint must be subordinate and necessary to another legitimate transaction. *See* R. Bork, *The Antitrust*

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[23] *E.g., In the Matter of American Medican Ass'n*, No. 9064 (F.T.C. 1979) (initial decision); Kass & Paulter, Federal Trade Commission Staff Report on Physician-Control of Blue Shield Plans (November 1979); Council on Wage and Price Stability, *Physicians' Fees, A Study of Physicians' Fees* (1978) (C.R. 68, Exhibit 2).

[24] Havighurst and Kissam, *The Antitrust Implications of Relative Value Studies in Medicine*, J. Health Politics, Policy and Law 48, 75-77 (Winter 1979); Horan and Nord, *Applications of Antitrust Law to the Health Care Delivery Systems*, 9 Cumberland L. Rev. 685, 700 (1979); Canby and Gellhorn, *Physician Advertising: The First Amendment and the Sherman Act*, 1978 Duke L.J. 543, 578; Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 Duke L.J. 303; Weller, *Medicaid Boycotts and Other Maladies from Medical Monopolists*, 11 Clearinghouse Rev. 99, 104 (1977); Note, *The Professions and Noncommercial Purposes*, 11 U. Mich. J. of Law Reform 387 (1978).

[25] Kallstrom, *Health Care Cost Control by Third Party Payors: Fee Schedules and the Sherman Act*, 1978 Duke L.J. 645.

[26] See Faltermayer, *Where Doctors Scramble for Patients' Dollars*, FORTUNE MAGAZINE 114 (Nov. 6, 1978).

[27] *Cf., Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979). *See* Havighurst, *Controlling Health Care Costs*, 1 J. Health Politics, Policy & Law 471 (1977).

*Paradox* at 27 (1978). The foundations can and do perform all of their other functions without their members' entering into fee agreements, 642 F.2d, at 555, and the fee agreements thus cannot be considered ancillary to a legitimate transaction. The ordinary rules of *per se* illegality should therefore be applied here.

## II.

## AGREEMENTS AMONG COMPETITIORS ESTABLISHING PRICE SCHEDULES ARE *PER SE* UNLAWFUL WITHOUT REGARD TO THE REASONABLENESS OF THE PRICES AGREED UPON

The Ninth Circuit rejected application of the *per se* rule, with Judge Sneed stating, "The relevant inquiry becomes whether fees paid to doctors [absent agreed-upon fee schedules] would be less than those payable under the FMC maximum fee agreement." 643 F.2d, at 556. To make this "relevant inquiry," Judge Sneed suggested comparisons with other fee schedules used in the medical marketplace;[28] an analysis of respondents' own fee schedules to determine whether they were so high as "to capture a greater share of potential monopoly profit" *id.*, at 557, or "sufficiently low to discourage entry by potential competitiors", *id.*, at 558; and a comparison of "the present supply and demand functions and those which would exist under ideal competitive conditions." *Id.*, at 556. By adopting a

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[28] 643 F.2d, at 558. Justice Stewart's majority opinion in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S., 205, 232 n.40 (1979), noted,

> Recent studies have concluded that physicians and other health care providers typically dominate the Boards of Directors of Blue Shield plans. Thus there is little incentive on the part of Blue Shield to minimize costs, since it is in the interest of the providers to set fee schedules at the highest possible level. This domination of Blue Shield by providers is said to have resulted in rapid escalation by health care costs to the detriment of consumers generally.

With a cloud already hanging over the legality and reasonableness of Blue Shield's fee schedules, the Blue Shield fee schedules are hardly a reliable benchmark for judging the legality or reasonableness of respondents' fee schedules.

construction of the Sherman Act that the legality of a price-fixing scheme turns on whether prices might have been lower in the absence of the conspiracy, the Ninth Circuit broke with the law as set forth both by this Court and the other courts of appeals.[29]

In the recent reversal of another of Judge Sneed's "rule of reason" analyses in *Catalano, Inc. v. Target Sales, Inc.*, 446 U.S. 643 (1980), this Court emphasized that "[i]t has long been settled that an agreement to fix prices is unlawful *per se*. It is no excuse that the prices fixed are themselves reasonable." 446 U.S., at 647, *citing United States v. Trenton Potteries Co.*, 273 U.S. 392, 397-398 (1927); *United*

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[29] *See, e.g.*, First Circuit: *Kartell v. Blue Shield of Mass., Inc.*, 592 F.2d 1191, 1193 n.2 (1st Cir. 1979); *Ford Motor Co. v. Webster's Auto Sales, Inc.*, 361 F.2d 874 (1st Cir. 1966); Second Circuit: *Ring v. Spina*, 148 F.2d 647 (2d Cir. 1945); *Connecticut Importing Co. v. Continental Distilling Corp.*, 129 F.2d 651 (2d Cir.), *cert. denied*, 317 U.S. 664 (1942); Third Circuit: *Wholesale Auto Supply Co. v. Hickok Manufacturing Co.* 221 F. Supp. 935 (D.N.J. 1963); *United States v. Vehicular Parking, Ltd.*, 54 F. Supp. 828 (D. Del. 1944); Fourth Circuit: *Virginia Excelsior Mills, Inc. v. Federal Trade Commission*, 256 F.2d 538 (4th Cir. 1958); *Pennsylvania Water & Power & Co. v. Consolidated Gas, Electric, Light & Power Co.*, 184 F.2d 552 (4th Cir.), *cert denied*, 340 U.S. 906 (1950). Fifth Circuit: *Alabama v. Blue Bird Body Co.*, 573 F.2d 309 (5th Cir. 1978); *Greene v. General Foods Corp.*, 517 F.2d 635 (5th Cir. 1975), *cert. denied*, 424 U.S. 942 (1976); *Denison Mattress Factory v. the Spring-Air Co.*, 308 F.2d 806 (6th Cir.) *cert denied*, 393 U.S. 983 (1968); *Barber-Coleman Co. v. Nat'l Tool Co.*, 136 F.2d 339 (6th Cir. 1943); Seventh Circuit: *Sun Oil Co. v. Federal Trade Commission*, 350 F.2d 624 (7th Cir. 1965), *cert. denied*, 382 U.S. 982 (1966); *Henry G. Meigs, Inc. v. Empire Petroleum Co.*, 273 F.2d 424 (7th Cir. 1960); Eighth Circuit: *Sun Oil Co. v. Vickers Refining Co.*, 414 F.2d 383 (8th Cir. 1969); Tenth Circuit: *United States v. Utah Pharmaceutical Ass'n*, 201 F. Supp. 29 (D. Utah), *aff'd*, 371 U.S. 24 (1962); District of Columbia Circuit: *United States v. Nat'l Soc'y of Professional Engineers*, 555 F.2d 978 (D.C. Cir. 1977), *aff'd*, 435 U.S. 679 (1978).

*States v. Trans-Missouri Freight Ass'n*, 166 U.S. 290, 340-341 (1897). The rationale for this rule had been explained by Justice Douglas in *United States v. Socony-Vacuum Oil Co.*, 310 U.S., at 221:

> Ruinous competition, financial disaster, evils of price cutting and the like appear throughout our history as ostensible justifications for price-fixing. If the so-called competitive abuses were to be appraised here, the reasonableness of prices would necessarily become an issue in every price-fixing case. In that event the Sherman Act would soon be emasculated; its philosophy would be supplanted by one which is wholly alien to a system of free competition; it would not be the charter of freedom which its framers intended.
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> The reasonableness of prices has no constancy due to the dynamic quality of the business facts underlying price structures. Those who fixed reasonable prices today would perpetuate unreasonable prices tomorrow, since those prices would not be subject to continuous administrative supervision and readjustment in light of changed conditions. Those who controlled the prices would control or effectively dominate the market. And those who were in that strategic position would have it in their power to destroy or drastically impair the competitive system. But the thrust of the rule is deeper and reaches more than monopoly power. Any combination which tampers with pice structures is engaged in an unlawful activity.

For the second time in a year, the Ninth Circuit has ignored that rule and followed an approach which examines the reasonableness of the prices agreed upon rather than stopping its inquiry when it found an agreement among competitors regarding prices. Any agreement among competitors tampering with the price structure should be *per se* unlawful and the Ninth Circuit was in error by authorizing inquiry into the reasonableness of the agreed-upon prices.

## III.

## AGREEMENTS AMONG COMPETITORS ESTABLISHING PRICE SCHEDULES SHOULD BE *PER SE* UNLAWFUL EVEN IF THE PRICE SCHEDULES ARE NOMINALLY TERMED "MAXIMUM" SCHEDULES

This Court has made it clear that maximum price-fixing is unlawful *per se*. "For such agreements, no less than those to fix minimum prices, cripple the freedom of traders and thereby restrain their ahility to sell in accordance with their own judgment." *Kiefer-Stewart Co. v. Joseph E. Seagram & Sons, Inc.*, 340 U.S., at 213. *Accord, Albrecht v. Herald Co.*, 390 U.S., at 153; *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97 (1980). In no other circuit can competitors avoid the *per se* rule against price-fixing by denominating their agreed price level a "maximum." To the contrary, other circuits have expressly stated that horizontal maximum price-fixing is unlawful *per se*.[30]

Despite this persuasive authority, Judge Sneed held that, at least in the medical industry, maximum fee setting not only confers the benefit of a ceiling to prices, 643 F.2d, at 557, but that it also contributes to the "currently lively debate concerning 'limit-pricing' and predatory price-

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[30] First Circuit: *Kartell v. Blue Shield of Mass, Inc.*, 592 F.2d 1191, 1193 n.2 (1st Cir. 1979); *Quinn v. Mobile Oil Co.*, 375 F.2d 273, 274, 276-278 (1st Cir.), *cert. dismissed*, 389 U.S. 801 (1967); Second Circuit: *Janel Sales Corp. v. Lanvin Parfums, Inc.*, 396 F.2d 398 (2d Cir.) *cert. denied*, 393 U.S. 938 (1968); *Vandervelde v. Put & Call Brokers & Dealers Ass'n*, 344 F. Supp. 118, 134 (S.D.N.Y. 1972); Fourth Circuit: *Virginia Excelsior Mills, Inc. v. Federal Trade Commission*, 256 F.2d 538 (4th Cir. 1958); Sixth Circuit: *Crane Distributing Co. v. Glenmore Distilleries*, 267 F.2d 343, 345 (6th Cir. 1959).

cutting."[31] Judge Sneed therefore declined to follow this Court's decisions in *Kiefer-Stewart* and *Albrecht*.

This Court and the other Circuit Courts have long recognized what the practice of the foundations here bears out: "an identical or parallel system of maximum prices between [competitors] is likely to become a system of minimum prices."[32] When maximum prices are set by a horizontal rather than a vertical agreement the anticompetitive consequences are even greater, and the tendency for the maximum price to function as a minimum price stronger, because the interests of the cartel are unchecked by the countervailing interests of any third party.[33] The facts of the instant case serve to illustrate this point—that is, there is no competitive bargaining regarding the cost of services between either the physicians or the foundations and the

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[31] 643 F.2d, at 557 n.4. At bottom of this determination appears to be Judges Sneed's perception of the benevolence of the physicians, as evidenced by his attribution by them of the term "good works" to the pricing agreements:

> We are by no means unaware that economic motives frequently lie bebind even the best of good works. We are, however, simply not prepared to brand the appellees' conduct as "price fixing" and thus a per se violation of the Sherman Act on the basis of an unsupported *belief* that fee enhancement is the likely consequence of the appellees' maximum fee arrangement.

643 F.2d, at 557.

[32] *Quinn v. Mobile Oil Co.*, 375 F.2d 273, 277-78 (1st Cir. 1967) (Coffin J. concurring). *Accord, Albrecht v. Herald Co.*, 390 U.S. at 153 ("[I]f the actual price charged under a maximum price scheme is nearly always the fixed maximum price . . . that scheme tends to acquire all the attributes of an arrangement fixing minimum prices.")

[33] For this reason, informed commentators have urged that fee schedules promulgated by medical societies and their foundations for medical care "should be recognized as part of a profit-maximum strategy of a coalition of monopolists and held per se unlawful." Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 Duke L.J. 303, 377-378; Kallstrom, *Health Care Cost Control by Third Party Payors: Fee Schedules and the Sherman Act*, 1978 Duke L.J. 645, 678-680. *See also* Havighurst and Kissam, *The Antitrust Implications of Relative Value Studies in Medicine*, J. Health Politics, Policy and Law, 48, 68 (Winter 1979).

third-party payors.[34] The third-party payors have only the option of accepting the foundations' agreed-upon fee schedules or of not having their pre-paid health plans endorsed by the foundations. Such a result is the problem noted by this Court in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S., at 232 n.40:

> [E]xempting provider agreements from the antitrust laws would be likely in at least some cases to have serious anticompetitive consequences. Recent studies have concluded that physicians and other health-care providers typically dominate the boards of directors of Blue Shield plans. Thus, there is little incentive on the part of Blue Shield to minimize costs, since it is in the interests of the providers to set fee schedules at the highest possible level. This domination of Blue Shield by providers is said to have resulted in rapid escalation of health-care costs to the detriment of consumers generally.

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[34] *See generally* Havighurst and Hackbarth, *Private Cost Containment*, 300 New England J. of Medicine 1293 (1979); Havighurst, *Professional Restraints on Innovation in Health Care Financing*, 1978 Duke L.J. 303, for a discussion of the importance of such competitive bargaining.

To allow an exemption from the *per se* rule because the foundations denominate their fee schedules to set maximum prices[35] would be a virtual license to engage in all manner of anticompetitive practices. *See, e.g.*, note 5, *supra*. It would, for example, lend this Court's imprimatur to the agreed-upon increase for laparoscopies from $190.00 to $275.00 simply because this was nominally designated an increase in the allowable "maximum." Since the Sherman Act emphatically prohibits any sort of tampering by competitors with the competitive price structure, agreed-upon fee schedules should be *per se* unlawful no matter what they are called.

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[35] We assume, for the sake of argument, that respondents' fee schedules set maximum rather than minimum fees, but there is much to argue that what is involved here is a minimum or uniform fee schedule. This Court, in *Albrecht v. Herald Co.*, 390 U.S. 145, 153 (1968), recognized the principle that so-called ceilings on prices easily become floors:

> Moreover, if the actual price charged under a maximum price scheme is nearly always the fixed maximum price, which is increasing likely, as the maximum price approaches the actual cost of the dealer, the scheme tends to acquire all the attributes of an arrangement fixing minimum prices.

The record here is clear that the purpose of the letters, polls and meetings among the foundations and their members was to set one price for any given service. For example, a letter from Maricopa Foundation for Medical Care's president, Dr. Lawrence J. Shapiro admits, "The Maricopa Foundation for Medical Care is interested in maintaining as close-as-possible a relationship between the maximum allowance for Foundation plans and the usual and customary charges made by physicians in this area." CR 7(b), Exhibit MF-33. (Reply App. A) *See also* CR 7(b), Exhibits MF-3, MF-6 (Reply Apps. B and C) for further examples of the manner in which prices were set.

## CONCLUSION

The judgment of the Court of Appeals should be reversed and the case remanded with instructions to enter partial summary judgment on the issue of liability in favor of petitioner.

KENNETH R. REED
Special Assistant Attorney General

ROBERT K. CORBIN
Attorney General of Arizona

ALISON B. SWAN
Chief Counsel
Antitrust Division

CHARLES L. EGER
Assistant Attorney General
Antitrust Division

By _____
KENNETH R. REED
114 West Adams, Suite 760
Phoenix, Arizona 85003
(602) 254-1973
Counsel for Petitioner