IN THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

Nos. 95-1965, 95-2140

BLUE CROSS AND BLUE SHIELD UNITED OF WISCONSIN
and COMPCARE HEALTH SERVICES INSURANCE CORPORATION,

Plaintiffs-Appellees, Cross-Appellants,

v.

MARSHFIELD CLINIC and SECURITY HEALTH PLAN OF WISCONSIN, INC.,

Defendants-Appellants, Cross-Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WISCONSIN

BRIEF FOR THE UNITED STATES AND THE FEDERAL TRADE COMMISSION AS AMICI CURIAE IN SUPPORT OF PETITION FOR REHEARING

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INTEREST OF THE UNITED STATES AND THE FEDERAL TRADE COMMISSION

The United States and the Federal Trade Commission are principally responsible for enforcing the federal antitrust laws and have been active in the health care area. In the last 18 months, the Department of Justice and the Commission have filed over 20 antitrust health care cases, have jointly issued the "Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust," and have issued numerous business reviews and advisory opinions to health care providers. Currently, the Department and the Commission are conducting over 80 health care investigations. Thus, the United States and the

Commission have a strong interest in the clear articulation and proper application of antitrust principles in this area.

STATEMENT

Plaintiff Blue Cross/Blue Shield is a health insurer; its subsidiary, Compcare, is a Health Maintenance Organization (HMO). Defendant, Marshfield Clinic is a physician-owned clinic; it owns Security, an HMO.

Blue Cross filed suit against Marshfield, alleging violations of sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1, 2, and related state law violations. Blue Cross claimed that Marshfield had monopolized the HMO market and injured Blue Cross (as a potential competitor in that market through Compcare) by refusing to allow Marshfield doctors to deal with HMOs competing with Security, thus denying access to an "essential facility." In addition, Blue Cross claimed that Marshfield's monopolization of various health care markets and its related anticompetitive agreements with other health care providers resulted in supracompetitive prices for medical services, which injured Blue Cross as a purchaser of such services for its subscribers.

The jury found in favor of plaintiffs on all of a series of special verdicts and found damages of over $15 million. Defendants moved for judgment as a matter of law and for a new trial. The district court upheld the jury verdicts on liability, but granted a new trial (subject to a remittitur) on damages. It also entered an injunction, which this Court stayed pending appeal.

This Court reversed. It held that the record could not support a finding that HMOs constitute a relevant market, and thus that Security could not be liable for monopolizing HMO services. It also concluded that Marshfield does not have a monopoly share of physician services because it does not control the independent physicians who provide services under contractual arrangements with Marshfield and Security, and that monopoly power could not be inferred from Marshfield's prices.

With respect to the section 1 claim, the Court held that no collusion between Marshfield and its affiliated (non-employee) physicians had been proved because the only evidence of "collusion" was that Marshfield "would not pay them more than what these physicians charge their other patients," and this "is not price fixing." Slip op. at 15-16. The Court, however, found the evidence of market division "a little scanty, [but] sufficient to sustain the jury's verdict." Id. at 17. It remanded for revision of the injunction in accordance with its opinion and a new trial limited to damages for market division. Id. at 17-19.

DISCUSSION

The United States and the Federal Trade Commission take no position on the sufficiency of the record to support the jury's verdict. We are concerned, however, that the Court's explanations of its conclusions on two issues may mislead readers unfamiliar with the record and arguments in this case as to the law applicable to market definition and analysis of "most-

favored-nation" ("MFN") agreements -- issues that frequently arise in health-care antitrust cases.

1. Market Definition. As this Court has recognized, market definition is a factual question. Slip op. at 3; see also Brown Shoe Co. v. United States, 370 U.S. 294, 326 (1962); United States v. Rockford Memorial Corp., 898 F.2d 1278, 1283-85 (7th Cir.), cert. denied, 498 U.S. 920 (1990); Fishman v. Estate of Wirtz, 807 F.2d 520, 531 (7th Cir. 1986). Accordingly, this Court's holding that the record in this case contains no evidence to support the jury's finding that HMOs comprise a separate market from other forms of health care delivery should not preclude a finding on a different record of a relevant product market limited to HMOs. See U.S. Healthcare v. Healthsource, Inc., 986 F.2d 589, 598-99 (1st Cir. 1993) (recognizing that HMOs could be a separate market from other forms of health care financing, but concluding that plaintiff had not so proved).

We are concerned, however, that the Court's statement that "HMOs are not a market" (slip op. at 9) might be read inappropriately out of context, to establish a rule of general applicability. Such a misinterpretation would be extremely unfortunate, for market definition in a health care antitrust case requires careful attention to the facts. Terms such as "HMO" or "PPO" can refer to a range of health care plans that vary widely in price, quality, features, and the extent to which they compete with one another. Health care markets are evolving rapidly, as providers and purchasers search for more efficient

delivery systems. Thus, it is of critical importance that lower courts avoid any temptation to substitute reliance on generalizations or assumptions about the functioning of health care markets for careful analysis of the evidence presented in a particular case. In particular, we are concerned that the Court's observation that "the price that an HMO can charge is constrained not only by competition from other HMOs but also by competition from [other] forms of medical services contracting," (slip op. at 5) could be misinterpreted as a holding that any competition between two health care products necessarily forecloses the possibility that they are separate markets. As this Circuit has recognized, the products included in a relevant antitrust market "may not exhaust the alternatives open to [consumers]." Rockford, 898 F.2d at 1284. The question is the extent to which customers are likely to shift to various alternatives if prices for a particular product rise above a competitive level, id. at 1285. See also U.S. Healthcare, 986 F.2d at 599 (the issue in determining whether HMOs constitute a separate market is "whether a sole supplier of HMO services . . . could raise price far enough over cost, and for a long enough period, to enjoy monopoly profits").

Indeed, while broader markets might be relevant for some purposes, that does not preclude recognition of an HMO market in appropriate circumstances. For example, the evidence in a particular case might establish that some current HMO customers so strongly prefer HMOs that they would not switch to other

delivery systems even if price were raised to a noncompetitive level. If those customers were sufficiently numerous that the HMOs could profitably raise prices despite the loss of other customers (who did not so strongly prefer HMOs) to competing delivery systems, HMOs could collectively exercise market power. Thus, while it may generally be true that at least some customers will regard some PPOs as acceptable substitutes for some HMOs, only a fact-specific analysis on a particular record can establish whether the challenged practices threaten to harm consumers in a relevant market.[1]

The Court could avoid the risk of serious misinterpretation by modifying the opinion to emphasize that its conclusion that "Security is not a monopolist of HMO services because HMOs are not a market" (slip op. at 9) and its observations relating to the ability of HMOs to exercise market power were based on the record in this case and were not intended to foreclose the possibility of a different result on a different record. In particular, the Court should make clear that it did not reject

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[1]Similarly, in assessing the likelihood that providers of HMO services could exercise market power, it would not be appropriate for a court merely to assume that physicians will readily "shift from one type of service to another if a change in relative prices makes one type more lucrative than others" (slip op. 6). While some physicians who provide (or would be willing to provide) services through a PPO might join particular new HMOs if existing HMOs raised prices above a competitive level, other doctors might prefer not to assume the financial risks associated with HMO participation or might be unwilling to accept HMO-imposed constraints on their practice of medicine. Whether the possibility of physicians shifting among service delivery arrangements would significantly constrain the ability of HMOs to raise price is a factual question to be resolved on the record in individual cases.

the jury's finding of an HMO product market simply because HMOs face some competition, regardless of the likelihood that such competition will provide an effective constraint on the ability of HMOs to exercise market power.

2. Most-Favored Nation Clauses. As the Court observed, MFN clauses may serve legitimate purposes in particular circumstances, and we do not dispute the Court's conclusion that the record in this case does not establish per se illegal price-fixing. See slip op. at 16. We are concerned, however, that the Court's discussion may be misinterpreted as a holding that such clauses never violate the Sherman Act.

MFN clauses may raise serious concerns under the antitrust laws.[2] For example, among other situations, a court might be faced with evidence that a party with a significant degree of market power used an MFN clause to restrain competition or evidence that competing providers were using such clauses as a means of reducing competition. MFN clauses might cause providers to refuse to discount their fees to anyone, when the result of selective discounts would be a reduction in fees from a plan that provides a significant portion of their income. They might also impede competition among plans by making it very difficult for new plans to obtain viable panels of providers. Indeed, the

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[2]We do not read the First Circuit's decision in Ocean State Physicians Health Plan v. Blue Cross, 883 F.2d 1101 (1st Cir. 1989), cert. denied, 494 U.S. 1027 (1990), as establishing a rule of per se legality for that Circuit. It, too, addressed only the facts of a particular case.

United States has challenged MFN clauses in agreements between major health care plans and participating health care providers as unreasonable restraints of trade in three recent cases. The consent decrees negotiated in these cases prohibit the defendants from entering into or enforcing such agreements. United States v. Delta Dental Plan of Arizona, Inc., 1995-1 Trade Cas. (CCH) ¶71,048 (D. Ariz. 1995), see 59 Fed. Reg. 47349 (Sept. 15, 1994); United States v. Oregon Dental Service, 1995-2 Trade Cas. ¶71,062 (N.D. Cal. 1995), see 60 Fed. Reg. 21218 (May 1, 1995); United States v. Vision Service Plan, No. 1:49CV02693 (D.D.C. complaint and proposed consent decree filed Dec. 15, 1994), see 60 Fed. Reg. 5210 (Jan. 26, 1995).

This case does not require the Court to anticipate the circumstances under which an MFN might be held to violate the Sherman Act. We are concerned, however, that the Court's description of MFN clauses as "standard devices by which buyers try to bargain for low prices" and "the sort of conduct that the antitrust laws seek to encourage" (slip op. at 16) may be misunderstood as a conclusion that they necessarily pass muster under the Sherman Act or that an intent "to minimize the cost" (id.) of physicians' services is necessarily determinative.[3] We urge the Court, therefore, to make clear that its ruling related to the particular clause in the particular circumstances at issue

[3]Compare U.S. Healthcare, 986 F.2d at 596 (motive is important to the extent that it serves as "a guide to expected effects, but effects are still the central concern of the antitrust laws").

in this case and that other cases involving MFN clauses must be evaluated upon their own facts.

CONCLUSION

The United States and the Federal Trade Commission take no position on the ultimate question of the sufficiency of the evidence in this case. We urge the Court to grant rehearing, however, so that the panel may modify its opinion to leave no doubt (1) that whether HMOs constitute a separate market is a question of fact and that the Court's conclusions with respect to the sufficiency of the evidence in this case would not foreclose findings in other cases that HMOs constitute a relevant antitrust market, and (2) that its conclusion as to the MFN clauses in this case does not foreclose a different result on a different record.

Respectfully submitted.

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October 2, 1995

CERTIFICATE OF SERVICE

I hereby certify that on October 2, 1995, the foregoing BRIEF FOR THE UNITED STATES AND THE FEDERAL TRADE COMMISSION AS AMICI CURIAE IN SUPPORT OF PETITION FOR REHEARING was served by first-class mail, postage prepaid, on:

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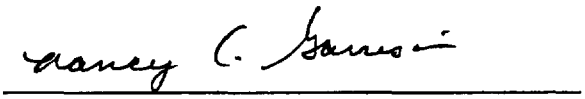

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