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Vertical Restraints Among Hospitals, Physicians and Health Insurers that Raise Rivals' Costs

A Case Study of Reazin v. Blue Cross and Blue Shield of Kansas, Inc. and Ocean State Physicians Health Plan, Inc. v. Blue Cross and Blue Shield of Rhode Island

Jonathan B. Baker*

Two recent district court opinions consider whether affiliations among hospitals, doctors and health insurers — through contract or ownership — violate the antitrust laws. This Article applies a raising rivals' costs framework to the facts of those cases in order to assess whether the practices at issue were unreasonable.

When consumers buy health care, they purchase a complex product combining insurance, the services of medical professionals and the right to use specialized capital equipment typically found in hospitals. In this way, health care is created jointly by health insurers, physicians and hospitals. While the individual services sold by doctors, insurers and hospitals can be more finely parsed, this Article treats each as homogeneous¹ in order to focus on the antitrust consequences of contractual restraints among their providers.

In the traditional organization of the health care industry, consumers chose their provider of each component service independently. Patients selected separately their primary care physician, their health insurer if any, and, in conjunction with their doctor, the hospital at which care would be provided when hospitalization was necessary.²

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¹ For example, the term "hospital services" includes the services of non-physician professionals (such as nurses, dietitians, technicians and physical therapists) and non-professional staff (such as orderlies) provided in hospital settings, in addition to the use of specialized medical equipment. Moreover, some physician specialties not involving direct care, such as pathology or radiology, might be considered part of hospital rather than doctor services.

² To the extent that patients delegate health care decisions to their doctor, the choice of a hospital may be made by the physician rather than the patient.

Moreover, the providers of each component service were generally not tied contractually to the providers of other components. Insurers awarded reimbursement regardless of the doctor or hospital providing care. Doctors accepted patients regardless of the patient's insurer and often provided care at multiple hospitals. Hospitals served the patients of all insurers and many doctors.

The traditional organization of the health care industry is rapidly changing.³ Doctors, insurers and hospitals increasingly affiliate, whether by contract or merger, for the most part in order to lower the cost of providing health care.⁴ Under such arrangements, providers and insurers may agree not to provide health care or reimbursement in combination with unaffiliated parties, or they may charge patients a higher fee if a non-affiliated doctor or hospital is chosen. Health maintenance organizations (HMOs), for example, typically provide health insurance on the condition that patients obtain care exclusively through affiliated physicians and at affiliated hospitals, with exceptions for emergency care.⁵ Preferred provider organizations (PPOs)⁶ encourage patients to select affiliated doctors or hospitals, although they also offer partial coverage of care obtained from unaffiliated providers. Health care is increasingly sold prospectively, through a contract by which a patient commits simultaneously to an insurer, a set of physicians and a set of hospitals for the life of the agreement, typically one year. In contrast, traditional fee for service insurance contracts reimburse patients for their actual health care expenditures.

This change in industry structure is occurring against the background of a health insurance industry dominated in many sections of the country by two nonprofit providers frequently merged today.⁷ Blue Cross (for hospital services) and Blue Shield (for physician charges) collectively termed "BC/BS".⁸ In many states these health insurance

³ See *infra* notes 18-20 and accompanying text.

⁴ Doctors and hospitals, however, generally accept affiliations with multiple insurers.

⁵ HMOs and PPOs may be set up in a variety of organizational forms that differ in the extent to which affiliated doctors and hospitals share risks and profits. See generally Havighurst, *Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships*, 1984 DUKE L.J. 1070, 1073 n.3 (1984)(HMO organization); Gasparovich, *Preferred Provider Organizations and Provider Contracting: New Analyses Under the Sherman Act*, 37 HASTINGS L.J. 377, 379-80 (1985)(PPO organization).

⁶ "A Preferred Provider Organization sells the health care services of independent providers to third party payors at a discounted rate in exchange for expedited payment and preferential access to insured consumers. Insured consumers are free to use providers who are not part of the PPO, but usually face increased cost-sharing if they do so. PPOs may be organized by independent entrepreneurs or by hospitals." B. FURROW, S. JOHNSON, T. JOST & R. SCHWARTZ, *HEALTH LAW: CASES, MATERIALS AND PROBLEMS* 476 (1987).

⁷ The state Blue Cross and Blue Shield plans named as defendants in the two cases discussed below had merged by the time of the litigation.

⁸ Blue Cross and Blue Shield insurance plans often are controlled by a group of doctors or hospitals. Although the market for health insurance has grown larger and more competi-

plans provide the majority of private insurance coverage. Courts enforcing the antitrust laws carefully scrutinize their competitive initiatives because of BC/BS' high market shares.⁹

In recent years, the reorganization of the health care industry has spawned a number of antitrust suits challenging the creation of vertical restraints¹⁰ among hospitals, doctors and insurers.¹¹ This Article considers in detail two recent decisions involving the creation of affiliations among formerly independent health care providers: *Reazin v. Blue Cross and Blue Shield of Kansas, Inc.*¹² and *Ocean State Physicians Health Plan, Inc.*

tive in recent decades, the Blues have preserved large market shares in many localities, perhaps as a result of a reputational advantage associated with early entry. In many states these insurers are organized as non-profit firms in order to secure tax advantages. See generally Pauly, *Competition in Health Insurance Markets*, — L. & CONTEMP. PROBS. — (1989)(in press).

⁹ The Ocean State court argues incorrectly that antitrust law evaluates vertical business practices without regard to the market share of the firms involved. See *Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of R.I.*, 692 F. Supp. 52, 71 (D. R.I. 1988). In fact, most vertical restraints are tested under the rule of reason, which requires an analysis of market power. None are tested under a standard of per se legality. See generally ABA ANTITRUST SECTION, *ANTITRUST LAW DEVELOPMENTS* 55-108 (2d ed. 1984). Thus, antitrust law requires closer scrutiny of vertical practices implemented by a dominant firm, like BC/BS, than those created by firms with small market share. See Miller, *Vertical Restraints and Powerful Health Insurers: Exclusionary Conduct Masquerading as Managed Care?* — L. & CONTEMP. PROBS. — (1989)(in press)(evaluating legal consequences of BC/BS monopsony).

¹⁰ In antitrust usage, vertical arrangements are agreements between firms and their customers, distributors or suppliers. Thus, vertically related firms sell complementary products. This contrasts with horizontal arrangements between rivals that sell substitute products. These traditional antitrust distinctions are being undermined by the raising rivals' costs analysis applied in this Article, which focuses on the horizontal effects of vertical practices. Krattenmaker & Salop, *Anticompetitive Exclusion: Raising Rivals' Costs To Achieve Power over Price*, 96 YALE L.J. 209, 215 (1986).

Contracts among hospitals, doctors, and health insurers are classified in this article as vertical because patients treat the services of each as (demand) complements in providing health care. Similarly, a contract between an automobile manufacturer and a steel manufacturer is a vertical arrangement because car buyers view the contributions of the steel producer and the firm which transforms that steel into an automobile as complements in providing transportation services. The role of supply, demand, and transactions complements in antitrust law is discussed in detail in Baker, *Antitrust Analysis of Hospital Mergers and the Transformation of the Hospital Industry*, — L. & CONTEMP. PROBS. — (1989)(in press).

¹¹ See, e.g., *Ball Mem. Hosp., Inc. v. Mutual Hosp. Ins., Inc.*, 784 F.2d 1325 (7th Cir. 1986)(BC/BS introduction of PPO upheld); *Barry v. Blue Cross Calif.*, 805 F.2d 866 (9th Cir. 1986)(Blue Cross introduction of PPO upheld); *Brillhart v. Mutual Med. Ins. Inc.*, 768 F.2d 196 (7th Cir. 1985)(BC/BS introduction of PPO upheld); *Kartell v. Blue Shield Mass., Inc.*, 749 F.2d 922 (1st Cir. 1984)(upholding insurer's contractual requirement that participating physicians accept insurer reimbursement as payment in full), cert. denied, 471 U.S. 1029 (1985).

The reorganization of the health care industry also has led to two other types of antitrust cases not discussed in this article: lawsuits challenging the denial to doctors of hospital staff privileges, and litigation challenging the propriety of horizontal agreements among physicians forming a PPO. See, e.g., Enders, *Federal Antitrust Issues Involved in the Denial of Medical Staff Privileges*, 17 LOYOLA U. CHI. L.J. 331 (1986); Greaney & Sindelar, *Physician-Sponsored Joint Ventures: An Antitrust Analysis of Preferred Provider Organizations*, 18 RUTGERS L.J. 513, 551-59 (1987); Gasparovich, *supra* note 5, at 377.

¹² 663 F. Supp. 1360 (D. Kan. 1987). An earlier opinion in this litigation, *Reazin v. Blue*

v. Blue Cross & Blue Shield of Rhode Island.¹³ Both cases resulted from the reorganization of health care provision among insurers, hospitals and doctors. In each, BC/BS, the dominant insurer, was accused of anti-trust violations resulting from its aggressive response to a new HMO. Each rival HMO involved a vertical affiliation between a competing insurer and some doctors (and in *Reazin*, a further affiliation with one of four area hospitals). BC/BS responded to new competition in both cases by creating or modifying its own vertical arrangements with hospitals or physicians. These BC/BS actions were challenged under the antitrust laws. In both cases, juries found against BC/BS, although the large insurer was awarded a judgment notwithstanding the verdict in *Ocean State*.

Because the modern reorganization of the health care industry is primarily motivated by insurer and provider desires to cut costs, new vertical arrangements in the industry will most likely be procompetitive. As a consequence, such restraints generally will be permitted under the antitrust laws.¹⁴ Vertical restraints can nevertheless be anticompetitive, as when they confer market power by "raising rivals' costs."¹⁵

This Article argues that an economic logic of "raising rivals' costs" may underlie the jury verdicts in *Reazin* and *Ocean State*. The discussion below describes how vertical restraints among hospitals, doctors and health insurers may create market power by raising costs for existing and potential competitors, without also creating offsetting efficiencies. If these new arrangements raise the costs of disfavored hospital-insurer-doctor combinations, they may give favored affiliated networks of

Cross & Blue Shield of Kans., Inc., 635 F. Supp. 1287 (D. Kan. 1986), will hereinafter be referred to as *Reazin I*.

¹³ 692 F. Supp. 52 (D. R.I. 1988).

¹⁴ Before the mid-1970s, courts reviewing antitrust cases were hostile to vertical restraints and mergers. Since that time, the antitrust regulation of vertical practices has changed dramatically. See *Continental T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36 (1977), *overruling* *U.S. v. Arnold, Schwinn & Co.*, 388 U.S. 365 (1967). Moreover, after *GTE Sylvania*, courts and governmental enforcers generally have upheld non-price vertical restraints against antitrust challenge. See generally J. KWOKA, JR. & L. WHITE, *THE ANTITRUST REVOLUTION* 264-72 (1989). Today the mainstream view accepts a relaxed scrutiny of vertical restraints, presuming that such arrangements were created to lower production distribution costs or otherwise improve the efficiency of resource allocation. See *infra* note 37; but cf. Fox & Sullivan, *Antitrust — Retrospective and Prospective: Where Are We Coming From? Where Are We Going?*, 62 N.Y.U. L. REV. 936, 956 (1987) (The Supreme Court "has never incorporated the claim of the radical right that antitrust law should reprehend only that which is allocatively inefficient, or their insistence that private business transactions are efficient.").

¹⁵ Krattenmaker, Lande & Salop, *Monopoly Power and Market Power in Antitrust Law*, 76 GEO. L.J. 241 (1987); Salop & Scheffman, *Cost-Raising Strategies*, 36 J. INDUS. ECON. 19 (1987); Krattenmaker & Salop, *supra* note 10, at 243. Vertical restraints also can confer market power through mechanisms not involving raising rivals' costs, for example by facilitating horizontal coordination among dealers or by facilitating manufacturer collusion through raising entry barriers.

insurers and providers the power to raise the price of health care over competitive levels (or keep prices from declining).¹⁶ The resulting harm to competition would be comparable to the harm generated by horizontal price-fixing among the affiliate groupings.¹⁷

Section I of this Article shows how the *Reazin* and *Ocean State* litigation emerged from the reorganization of the health care industry. Section II argues that the vertical practices at issue in these cases were probably not intended to reduce production costs or to achieve any other economic efficiency. Section III constructs raising rivals' costs explanations to show how the challenged vertical arrangements could permit firms to obtain market power. As will be seen, it is difficult to be confident that all the factual predicates are met for these raising rivals' costs interpretation because the courts did not frame their opinions in such terms. With this evidentiary difficulty in mind, the concluding section evaluates the varying judgments entered by the two courts following jury verdicts of liability.

I. THE REORGANIZATION OF THE HEALTH CARE INDUSTRY

Figures 1 and 2 illustrate the modern trend in the institutional organization of health care provision. In the past, depicted in Figure 1,¹⁸ patients would choose among a smorgasbord of options for obtaining health care.¹⁹ Patients would select a doctor from the many physicians

¹⁶ The power to raise prices encompasses the power to keep prices from declining when the competitive price falls, as may occur when seller's marginal costs decline. Krattenmaker, Lande & Salop, *supra* note 15, at 258.

¹⁷ Horizontal price fixing and a raising rivals' costs practice both create market power by reducing aggregate industry output below what a competitive industry would produce and raising industry prices above competitive levels. If, however, a practice that raises rivals' costs produces a reduction in an industry's output equal to that created by collusion among the excluding firm and its rivals, the social loss from raising rivals' costs most likely would be larger than from interfirm cooperation. Both anticompetitive schemes require that firms expend resources on ensuring that the market price rises: it is costly for an excluding firm to bar its rivals from low-cost inputs or to create some other instrument of non-price predation, and it is costly for a cartel to coordinate and police its agreement. But if an excluding firm successfully raises rivals' costs, a production inefficiency is created insofar as more resources are employed in production by the disfavored rivals than would be employed under a collusive agreement. See Krattenmaker, Lande & Salop, *supra* note 15, at 247-48 (comparing the market power exercised by restraining one's own output with the market power exercised by restraining rivals' output).

¹⁸ In this diagram, MD₁ and MD₂ each could be thought of as single doctors or as a group medical practice. Differences among medical specialties are ignored; it is assumed that MD₁ and MD₂ provide the same services. Similarly, the hospitals, HSP₁ and HSP₂, could each represent a set of affiliated hospitals (under common ownership or management). Moreover, figure 1 — suitably generalized with additional hospitals, doctors, and insurers — is presumed to include all providers within the geographic market in which health care competition occurs.

¹⁹ This stylized model is intended to emphasize the changes in industry structure reflected in *Reazin* and *Ocean State*. It is not intended to encompass all variations in the organization of health care provision characteristic of the past or present. Other commentators have

in an area (represented as MD₁ and MD₂). Each physician could be affiliated with multiple hospitals (HSP₁ and HSP₂), permitting patients some choice among hospitals. Moreover, patients obtaining medical care from any combination of doctor and hospital could obtain reimbursement by contracting with any provider of health insurance (INS₁ or INS₂). In most locations, however, BC/BS traditionally served most of the private health insurance market.²⁰

Health care provision is moving away from the model of Figure 1 and toward the model represented in Figure 2. The insurer, often taking the form of an HMO or PPO, may now contract with a subset of area doctors and hospitals to provide medical services for subscribers. Patients obtaining reimbursement from a particular insurer are increasingly limited to selecting from among the doctors and hospitals affiliated with that insurance plan. Providers, however, often acquire affiliations with several insurers. Health care provision is becoming organized such that integrated or affiliated combinations of hospitals, doctors and insurers compete with other integrated or affiliated combinations for patients. While this transformation is not yet complete, it is well underway in many areas of the country.

The transformation of the health care industry is largely a response to cost cutting pressures. In the traditional model of Figure 1, insurers reimbursed patient health care expenditures in full, retrospectively. Under such a reimbursement rule, patients and their doctors had no incentive to economize on care or cost. Health care providers were extremely cautious — and expensive — in their approach to medicine. For example, costly tests were routinely employed to rule out remote diagnoses and hospitals delayed patient discharge.

In the past fifteen years, the health insurance industry has moved away from unscrutinized, retrospective reimbursement in several ways. Government insurers (Medicare and Medicaid) and fee-for-service private insurers (such as many BC/BS plans) increasingly reimburse providers with a fixed payment based on patient diagnosis. Health care providers now have a greater incentive to economize on treatment; they profit when the care they provide costs less than the reimbursement they receive.²¹ Similarly, PPOs and HMOs — the institutional arrange-

described the transformation of the health care industry similarly. See, e.g., Havighurst, *supra* note 5, at 1071-75 (new forms of industry organization); *Reazin v. Blue Cross & Blue Shield of Kan., Inc.*, 663 F. Supp. 1360, 1371 (D. Kan. 1987) ("Perhaps more so than any federal antitrust litigation to date, this case results from the unprecedented economic pressures and turmoil within the health care services and financing industries from the beginning of this decade.").

²⁰ Patients who do not seek private insurance can self-insure, rely on governmental programs (Medicare and Medicaid), or can receive benefits from employers who self-insure.

²¹ Further, with the expansion of deductibles and co-payment provisions in health insur-

FIGURE 1: Traditional Organization of Health Care Provision

FIGURE 2: Emerging Organization of Health Care Provision

ments most commonly generating the reorganization depicted in Figure 2 — often accomplish the substitution of prospective reimbursement for retrospective reimbursement.²² Doctors and hospitals contract to provide care for all patients of the HMO during a year in exchange for a fixed fee per patient (capitation). The health care providers then earn profits by cutting costs.

This ongoing reorganization of the health care industry led to the litigation in *Reazin* and *Ocean State*, challenging vertical restraints between insurers and doctors or hospitals. Both cases were prompted by a BC/BS plan's competitive response to the establishment of a competing HMO. Rival HMOs threaten BC/BS to the extent they are successful in cutting the costs of health care for their subscribers; under such circumstances the HMO could charge less for insurance than BC/BS.

Reazin involved a suit brought by Wesley,²³ the largest of four hospitals in Wichita,²⁴ and by Health Care Plus, a small but successful Wichita HMO,²⁵ against the state's BC/BS insurer.²⁶ BC/BS provided 60% of the health insurance in an area comprising most of Kansas:

ance contracts, patients have increased incentive to economize and to instruct their providers to control costs.

²² In addition, these arrangements help lower the costs of care by allowing better insurer monitoring of provider care decisions. See *infra* note 45.

²³ Dr. Walter Reazin was the Chairman of the Wesley Board of Trustees. Wesley was a large, successful tertiary care teaching hospital associated with the University of Kansas School of Medicine. *Reazin*, 663 F. Supp. at 1371, 1373.

²⁴ In 1984, Wesley accounted for 43% of city inpatient admissions and 35% of the city's 2,264 hospital beds. The two rival hospitals that were alleged to have conspired with BC/BS served 30% and 22% of total admissions, and controlled 34% and 25% of the city's hospital beds. A fourth hospital obtained 5% of total admissions and accounted for 6% of city hospital beds. *Reazin I*, 635 F. Supp. 1287, 1297 (D. Kan. 1986).

²⁵ The district court found that Health Care Plus (HCP) is an "individual practice association," or "gatekeeper," model HMO in which members must select a primary care physician from those under contract with HCP. A member's monthly premiums pay for all needed medical care so long as it is obtained from the chosen primary care physician, or a specialist or hospital authorized by that physician as needed. [citations omitted]. Each physician contracting with HCP is paid a capitation fee, a specified amount for each member choosing that physician as his or her primary care provider. HCP does not separately contract with specialists; rather, each primary care physician determines in his own discretion whether to refer to an HCP patient elsewhere for needed medical attention, upon which HCP pays the specialist's fees. HCP sets aside a portion of the capitation fund . . . and a hospital fund, to cover specialist and hospital costs for services rendered HCP patients. Funds not used at the end of a year are returned to the contracting physicians, each of whom receives a pro rata share of the refund based on the number of HCP patients treated.

Although not contracting with specialists, HCP does contract with hospitals. HCP has capitation agreements with Wesley and [another Wichita hospital]. Under these contracts the hospitals are paid a certain monthly figure per member. These amounts are paid whether or not the members receive care at the hospitals, but if the members do seek services there the hospitals must provide care and are paid no more than the monthly capitation. HCP has fee-for-service contracts with [two other

Health Care Plus served 8-12% of insurance business in the county surrounding Wichita.²⁷ Plaintiffs complained because BC/BS terminated a contract under which it would pay Wesley for hospital care provided to BC/BS subscribers.²⁸ BC/BS apparently intended to reimburse its subscribers directly for the cost of care obtained at Wesley, although at

Wichita hospitals], under which those hospitals are not paid capitation but are simply reimbursed for any services which may be provided HCP members.

Reazin, 663 F. Supp. at 1374-75 (citations omitted).

²⁶ BC/BS was the largest nonfederal source of revenues to hospitals in its service area. It accounted for 16% of a large Wichita hospital's (not Wesley) revenues, while no other competitor accounted for as much as 5%. *Id.* at 1416-17.

²⁷ *Id.* at 1398-99 (market definition), 1416 (BC/BS' share), 1465 (finding no. 21) (Health Care Plus' share). Measured by premiums dollars, BC/BS had 62% of the private health care financing business in Kansas, while its next largest competitors, Bankers Life and Aetna, had 4% and 3% of the market respectively. *Id.* at 1464 (finding no. 16).

²⁸ In early 1984, responding to pressure from patients, legislators, and state regulators to reduce the rapid rate of increase in patient premiums and hospital utilization, BC/BS replaced cost-plus reimbursement of hospitals with a program that established a reimbursement maximum based upon a patient's entering diagnosis. The contracts between BC/BS and hospitals to implement this program also included a "most favored nations" clause, under which participating hospitals agreed that BC/BS reimbursements never would exceed the reimbursements the hospital accepted from competing insurers for the same patient diagnosis. *Id.* at 1375.

Also in 1984, BC/BS responded to cost-cutting pressures and the presence of a competing HMO by setting up an HMO of its own. The BC/BS HMO was far less successful than Health Care Plus. Health Care Plus' early presence in Wichita provided it with an advantage over the BC/BS HMO plan in attracting patients. Furthermore, Health Care Plus' higher capitation rates provided an advantage in attracting physicians. *Id.* at 1376; *cf. infra* note 72 (subscriber switching costs). In consequence, the BC/BS HMO abandoned the Wichita market, although it continued to operate elsewhere in Kansas. *Id.* at 1377.

In 1985, BC/BS attempted to introduce a preferred provider organization into Wichita and to reintroduce an HMO. The BC/BS PPO had difficulty developing a reimbursement system satisfactory simultaneously to physicians and hospitals. While Wesley participated actively in negotiating terms for the BC/BS PPO, a BC/BS executive allegedly attributed Wesley's desire to participate to HCA's intention to force a rival Wichita hospital out of business. *Id.* at 1378-79. BC/BS and two Wichita hospitals other than Wesley developed a new HMO plan. Those negotiations also involved the possibility that the rival hospitals would give BC/BS discounts on the level of diagnosis-based reimbursements they would accept, contingent on BC/BS termination of Wesley. *Id.* at 1380-82. BC/BS' contract with Wesley permitted termination on 120 days notice. *Id.* at 1389.

On August 1, 1985, the *Wall Street Journal* reported that HCA intended to introduce group health insurance and a PPO plan in approximately twenty cities over the next eighteen months, as part of a corporate effort to become a fully-integrated health care company. *Id.* at 1380. Later that month, the BC/BS executive committee voted to terminate its diagnosis-based reimbursement contract with Wesley, effective January 1, 1986. BC/BS would continue to reimburse its subscribers for care at Wesley, but at levels no higher than reimbursements given rival hospitals for the same services. BC/BS would no longer directly pay Wesley any subscriber reimbursement. *Id.* at 1383-85.

By early November, BC/BS had negotiated discount reimbursement contracts with the two rival hospitals. In November, Wesley and its affiliate Health Care Plus filed suit against BC/BS and the two competing Wichita hospitals charging that the termination of Wesley was illegal. *Id.* at 1387-88. BC/BS counterclaimed, alleging in part that HCA's acquisitions of Wesley and Health Care Plus were undertaken in order to eliminate competition from BC/BS and competing Wichita hospitals. *Id.* at 1390.

a rate not to exceed those charged by rival hospitals contracting with BC/BS.²⁹

BC/BS terminated Wesley's contract shortly after Health Care Plus had been acquired by Hospital Corporation of America (HCA), the large national hospital chain that had previously acquired Wesley.³⁰ The HCA acquisitions and BC/BS' termination of the contract with Wesley created two affiliated groupings of health care providers. The first grouping consisted of the HCA insurer (Health Care Plus), the HCA hospital (Wesley), and affiliated physicians.³¹ The second grouping, an inchoate affiliation,³² was comprised of BC/BS and the city's remaining doctors and hospitals.

A jury found that BC/BS acted improperly in terminating Wesley. BC/BS was held liable for monopolization under Sherman Act Section 2, for a conspiracy in restraint of trade in conjunction with other city hospitals in violation of Sherman Act Section 1, and for tortious interference with Wesley's business relations under state law. Plaintiffs were awarded nearly \$8 million in damages and costs.³³

The plaintiff in *Ocean State*, a three year old HMO, charged the

²⁹ *Id.* at 1386 (quoting Blue Cross & Blue Shield of Kan., Inc., press release (Aug. 29, 1985)). The court does not explain how contract termination would have injured either Wesley or consumers when, had it been effected, BC/BS subscribers would have continued to receive some reimbursement for care obtained at Wesley. The court appears to presume that Wesley would have lost customers to rival hospitals, perhaps because patients would find it relatively more expensive to use Wesley once they were required to handle the administrative costs of reimbursement rather than having their insurer deal directly with the hospital, see *Reazin I*, 635 F. Supp. 1287, 1295-96 (D. Kan. 1986), or perhaps because patients would not have been fully reimbursed for expenses incurred at high cost tertiary care teaching hospitals if BC/BS rates were determined by charges at competitive hospitals. See *Reazin*, 663 F. Supp. at 1425-27 (upholding award of damages to Wesley). Moreover, contract termination may have increased the proportion of patients failing to pay Wesley.

³⁰ Hospital Corporation of America (HCA) acquired Wesley as part of a national strategy of acquiring tertiary care "centers of excellence" throughout the country in order to meet patient preferences for quality health care. *Reazin*, 663 F. Supp. at 1377. HCA acquired Health Care Plus as a way of developing the internal management experience necessary to create and market HMOs elsewhere in the country. *Id.* at 1378. Both affiliates had substantial management autonomy, and their interaction with HCA largely was financial. *Id.* at 1378. After the events which led to litigation, HCA decided to withdraw from the health care financing business, and reduced its affiliation with Health Care Plus to that of a passive investor. *Id.* at 1475 (finding no. 88).

³¹ Although other area hospitals had contracted with Health Care Plus, they also had negotiated with BC/BS concerning BC/BS' termination of Wesley. *Id.* at 1374-75, 1382, 1474 (finding no. 77).

³² See *supra* note 28.

³³ The jury found that the contract termination injured Wesley by causing it to lose some business from BC/BS subscribers, and determined that Wesley suffered more than \$1.5 million in damages. *Reazin*, 663 F. Supp. at 1425-27. These damages were trebled and punitive damages of \$750,000 were awarded on the state law tortious interference claim. *Id.* at 1427-30. Defendants also were required to pay more than \$2.4 million in costs and attorneys fees. *Id.* at 1449-59. The large damage award to Wesley was upheld even though the date of contract termination had yet to occur when the complaint was filed, and even though the parties

Rhode Island BC/BS plan with monopolization of the state health care insurance market. BC/BS controlled a large portion of the Rhode Island market, with a share alternately measured at 57% and 80%, while plaintiff Ocean State, the HMO, controlled roughly 10%.³⁴ The district court entered a judgment in favor of BC/BS, notwithstanding a jury verdict in favor of Ocean State.

The *Ocean State* court held that BC/BS did not exercise its market power unlawfully when it insisted upon a most favored nations clause in its contracts with physicians,³⁵ despite the harm created by that provision for the competing HMO, which had contracted to share its financial risk with affiliated doctors.³⁶ The court found that BC/BS was entitled to become the low cost producer of insurance by bargaining for low physician fees. The "inevitable" harm to Ocean State resulting from this use of BC/BS bargaining power was a natural consequence of competition, not the result of an antitrust violation.³⁷

agreed to maintain the status quo (by staying termination of BC/BS' contract with Wesley) pending the outcome of the litigation.

³⁴ *Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of R.I.*, 692 F. Supp. 52, 57-58 (D. R.I. 1988).

³⁵ The most favored nations clause was termed the "prudent buyer policy." It required physicians accepting a low reimbursement from a provider, such as Ocean State, to charge no higher rate to BC/BS if they decided to accept BC/BS' reimbursement. *Id.* at 60.

Ocean State also complained about two other BC/BS programs: the new HealthMate product, and "adverse selection rating factors." BC/BS marketed HealthMate as an alternative to the Ocean State HMO. HealthMate was offered only when BC/BS was competing with Ocean State for business, as when an employer allowed employees to select among health care alternatives (A state law mandated that employers offer an HMO to their employees as a health insurance option if an HMO provided services in the area where an employee resided. *Id.* at 57). HealthMate offered greater coverage than the standard BC/BS product, but limited subscribers to participating physicians. All BC/BS participating physicians were required to accept the HealthMate payment as payment in full. HealthMate was marketed with a financial incentive to employers. *Id.* at 58.

BC/BS introduced "adverse selection rating factors" whenever it feared it would lose healthier subscribers to an HMO. BC/BS charged employers the lowest rate on its standard policy when employers offered only standard BC/BS coverage. It charged a higher rate when employers offered standard BC/BS, HealthMate, and a competing HMO such as Ocean State. It charged the highest rate to employers offering standard BC/BS and competing HMO, but not offering HealthMate. *Id.* at 59.

³⁶ From its inception in 1983, Ocean State withheld 20% of its physician fees until the end of the year, paying them to doctors only if the HMOs revenues exceeded costs. From BC/BS' perspective, Ocean State was obtaining medical services at a discount of up to 20% when compared to the fees BC/BS was required to pay. Only in 1984 did the HMO return the withheld funds to affiliated doctors. The competitive responses of BC/BS that prompted the *Ocean State* litigation occurred in 1986. *Id.* at 60.

³⁷ *Id.* at 71. The court further held that it was entitled to conclude that the jury found no antitrust violation, despite the jury's express finding of a violation of Sherman Act Section 2, because the jury awarded no damages on the antitrust claim and, in consequence, must have found no harm to the plaintiff. *Id.* at 66. In reaching the conclusion that plaintiff suffered no loss, the court ignored the \$2.5 million compensatory damages (and \$500,000 punitive damages) found by the jury on Ocean State's tort claim against BC/BS for intentional interference with contractual relationships, apparently on the bootstrap theory that this loss did not arise

These two case studies show that conduct associated with the transformation of the health care industry can easily raise antitrust questions. Patients no longer contract independently with hospitals, doctors and insurers; and insurers impose new requirements on physicians and hospitals who accept their subscribers. If a careful economic analysis is not undertaken, the restraints associated with this reorganization could readily be characterized as unlawful under the antitrust statutes. A number of legal categories could be invoked, including tying arrangements, exclusive dealing, requirements contracts, group boycotts, customer restraints or monopolization. The litigated cases focus on challenges to the competitive responses of BC/BS to industry change,³⁸ undoubtedly because the insurer's large market share often makes a monopolization claim plausible. In principle, however, all insurer contracts with hospitals and doctors, including those of HMOs and PPOs, also bear antitrust risk.³⁹

The remainder of this Article investigates circumstances under which reorganizations in the health care industry and their associated vertical restraints should be considered to violate the antitrust laws. The next two sections identify some efficiency benefits of this reorganization and its ancillary vertical restraints, and some ways in which predatory firms can employ such restraints anticompetitively to create market power by raising rivals' costs.

II. VERTICAL RESTRAINTS THAT LOWER HEALTH CARE COSTS

In the past decade, antitrust law has come to recognize that vertical integration and vertical restraints often create both private gains and production efficiencies by reducing seller marginal cost.⁴⁰ If the health care industry is no exception to this general rule, vertical practices associated with its ongoing reorganization from the model of Figure 1 to

from an antitrust violation. The court also granted defendant's motion for a new trial on plaintiff's state tort law claim, holding that the jury's verdict against BC/BS contradicted the clear weight of the evidence that BC/BS' actions were justified responses to competitive conditions. *Id.* at 73.

³⁸ *But cf.* Ball Mem. Hosp., Inc. v. Mutual Hosp. Ins., Inc., 784 F.2d 1325 (7th Cir. 1986)(hospitals challenged BC/BS' introduction of a PPO).

³⁹ *Cf.* Barry v. Blue Cross Calif., 805 F.2d 866 (9th Cir. 1986)(physicians challenged Blue Cross' introduction of a preferred provider plan in a state where the Blue Cross market share was 16%). The smaller the market share of the firms imposing the vertical restraint, the less likely the practice would create market power, even if it were predatory.

⁴⁰ See, e.g., Preston, *Territorial Restraints: GTE Sylvania*, in J. KWOKA, JR. & L. WHITE, *supra* note 13, at 273-89; see generally Fisher, Johnson, & Lande, *Do the DOJ Vertical Restraints Guidelines Provide Guidance?* 32 ANTITRUST BULL. 609, 615-16 (1987); R. BORK, *THE ANTITRUST PARADOX* 288-309, 330-81 (1978)(influential commentary advocating relaxed scrutiny of vertical practices); R. POSNER, *ANTITRUST LAW* 171-211 (1976)(influential commentary advocating relaxed scrutiny of vertical practices).

the model of Figure 2 will lower the costs of providing health care. When non-price vertical restraints have as their dominant motive and effect the lowering of production costs, they do not violate the antitrust laws.⁴¹

The industry's reorganization lowers the costs of health care provision primarily by replacing retrospective reimbursement of doctors and hospitals with prospective reimbursement, as through capitation fees or diagnosis-related reimbursements,⁴² by introducing deductibles and co-payments into patient contracts with insurers, and by increasing insurer monitoring of provider care decisions.⁴³ These mechanisms reduce costs by solving two incentive problems associated with the traditional model of health care provision: the incentive for care providers to over-provide medical care and the incentive for patients to seek excess care.⁴⁴ The restrictions on doctors and hospitals associated with the health care industry's reorganization typically support the introduction of these cost reduction mechanisms.⁴⁵ An HMO or PPO can best control costs if its subscribers do not obtain a significant fraction of their medical care from doctors or hospitals who are not subject to the reimbursement limitations and utilization review that affiliated providers contract to accept.⁴⁶ Accordingly, these new forms of business or-

⁴¹ Non-price vertical restraints are unlawful only if they are unreasonable, with the exception of some forms of tying which are illegal per se. Both the tying exception and the per se prohibition against resale price maintenance are narrowly construed. *Business Elec. Corp. v. Sharp Elec. Corp.*, 108 S. Ct. 1515, 1520-22 (1988) (announcing presumption in favor of a rule-of-reason standard); see *Jefferson Parish Hosp. Dist. No 2 v. Hyde*, 466 U.S. 2, 32 (1984) (O'Connor, J., concurring) (Chief Justice Burger and Associate Justices Powell and Rehnquist joined in the concurring opinion by Associate Justice O'Connor which advocated abolishing application of per se doctrine to tying arrangements).

⁴² One commentator terms Medicare's shift during the mid-1980s from retrospective cost reimbursement to prospectively determined rates as "the most important change in federal health policy since the adoption of the Medicare and Medicaid programs." Havighurst, *supra* note 5, at 1077 n.14.

⁴³ See generally Joskow, *Alternative Regulatory Mechanisms for Controlling Hospital Costs*, in *A NEW APPROACH TO THE ECONOMICS OF HEALTH CARE* (M. Olson, ed., 1981); *NATIONAL HEALTH INSURANCE: WHAT NOW, WHAT LATER, WHAT NEVER?* (M. Pauly, ed. 1980). Moreover, under a cost-based reimbursement scheme, physicians have a diminished incentive to control their charges to insurers if the "cost" of care is determined by reference to their own customary rates rather than regional averages.

⁴⁴ Typical utilization controls include requiring second opinions before costly procedures are undertaken, restricting hospital lengths of stay, and reviewing care decisions before reimbursing providers.

⁴⁵ However, prospective reimbursement, subscriber copayments, and insurer utilization review have also been introduced by traditional fee-for-service health insurers.

⁴⁶ If patients obtain care from unaffiliated providers, the HMO or PPO can limit its expenditures by refusing to reimburse subscribers completely for the charges made by those unaffiliated doctors and hospitals. Unaffiliated providers, however, are not subject to the utilization controls imposed by insurers to reduce physician and hospital incentives to provide more care than necessary. Moreover, it is conceivable that an association of doctors, hospitals, and insurers can conserve more resources than the traditional organization of health care

ganization may prohibit patients from seeking care elsewhere (HMOs), or may impose extra charges on patients who do so (PPOs).

Although vertical restraints have been imposed with the dominant motive and effect of creating production efficiencies in the provision of health care, the vertical restrictions challenged in *Reazin* were most likely not of this social cost-saving type. BC/BS defended its termination of Wesley as a permissible competitive response to HCA's acquisition of both Wesley and Health Care Plus, not as a way to control the fees it must pay providers for care given to subscribers.⁴⁷ BC/BS did not claim that its action reduced the costs of providing medical care, or that the termination improved social resource allocation by requiring that patients choosing Wesley pay for the higher costs associated with what was presumably the higher quality care offered at a tertiary care teaching hospital.⁴⁸ Further, BC/BS did not suggest that it sought to induce Wesley to control costs by imposing a higher co-payment on patient charges at that hospital;⁴⁹ had this been the insurer's goal it would have continued to administer the reimbursement of those hospital charges, inasmuch as the contractual relationship would permit

provision through achieving scale economies or through better forecasting of patient demand. In addition, such an association may be better able than unintegrated providers to cut costs by tailoring its operation to avoid shortages or excess capacity.

⁴⁷ In a memorandum to all Kansas hospitals defending its termination of Wesley, BC/BS' President wrote:

With the size and resources of HCA . . . we could only come to the conclusion that our role with the Wesley Medical Center has drastically changed. We no longer fit into their long range plans. Thus, [we arrived at] our decision to cease contracting with HCA and . . . Wesley

We cannot stand idly by and watch insurance-hospital corporations, such as HCA, monopolize the delivery and financing of care by seeking to enroll Blue Cross and Blue Shield subscribers in their insurance program [I]f hospitals decide to compete with Blue Cross and Blue Shield in the manner that HCA is competing, Blue Cross and Blue Shield must make a business decision about its future relationship with those entities. Hospitals that . . . do not seek to enroll subscribers in other programs . . . will experience no change in the contractual relationship that has historically served Kansans well.

Reazin v. Blue Cross & Blue Shield of Kan., Inc., 663 F. Supp. 1360, 1387-88 (D. Kan. 1987). In court, BC/BS offered a similar defense. *Id.* at 1392.

⁴⁸ The author is grateful to Joseph Simons for this observation.

⁴⁹ If insurer reimbursement is partial, the transactions costs involved in paying for hospital services may be increased if hospitals bill patients, and patients then seek reimbursement on their own from insurers; rather than if hospitals bill both patients and insurers, and insurers pay hospitals directly. *Cf. Reazin I*, 635 F. Supp. 1287, 1295 (D. Kan. 1986) (a non-contracting hospital must submit its claims on paper rather than using the less costly tape-to-tape billing program). To the extent patients bear the transactions costs increase, such increase operates as a higher co-payment to raise the patients' incentive to economize on utilization. In the instant case, Wesley announced that other than existing deductibles and co-payments, BC/BS subscribers would not be required to pay any excess charges. *Reazin*, 663 F. Supp. at 1380. Under such circumstances, there could be no transaction costs reduction from altering the existing system in which BC/BS handles the administrative tasks of reimbursement on behalf of its subscribers.

BC/BS to continue its utilization review.⁵⁰ In addition BC/BS did not argue that it terminated its contract with Wesley in order to induce care providers to accept prospective reimbursement or greater utilization review, and so generate incentives for hospitals to control costs. In the absence of such arguments, the court readily found that the termination was not intended to achieve an efficiency, "but to sanction a perceived competitor and deter competition in the health care financing market."⁵¹

In contrast, the district court in *Ocean State* believed that the most favored nations clause challenged in that litigation was designed exclusively to produce cost savings for BC/BS. The court concluded that the contract provision lowered the physician fees charged to BC/BS' subscribers by ensuring that BC/BS' physician reimbursements were as low as the payments made by any other insurer,⁵² particularly the Ocean State HMO.⁵³ But if BC/BS set out to bargain down the charges of its affiliated doctors,⁵⁴ it is curious that it limited its attention to those doctors who were affiliated with both plans.⁵⁵ As reported by the district court, moreover, the trial record appears to contain no evidence that the BC/BS new contract provision was introduced in conjunction with other reforms such as prospective reimbursement designed to reduce doctor incentives to over-provide care and overcharge patients.⁵⁶

Rather, the *Ocean State* record suggests that BC/BS intended this contract provision to raise a physician's costs of affiliating with multiple insurers. A BC/BS management employee observed that "not one guy in the state isn't going to know the implication of signing with Ocean

⁵⁰ See *Reazin I*, 635 F. Supp. at 1295-96 (BC/BS cost containment programs are implemented through insurer contracts with hospitals).

⁵¹ *Reazin*, 663 F. Supp. at 1411.

⁵² *Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of R.I.*, 692 F. Supp. at 52, 60, 71 (D. R.I. 1988).

⁵³ At the time of the litigation, Ocean State had entered into contracts with almost half of all of the doctors in Rhode Island. *Id.* at 68.

⁵⁴ Lower physician charges could generate an efficiency gain if doctors had previously been charging monopoly rates. See M. WATERSON, *ECONOMIC THEORY OF THE INDUSTRY* 83-106 (1984) (describing benefits of eliminating successive monopolies through vertical affiliation or integration). Lower doctor fees, however, also could reflect an anticompetitive exercise of insurer monopsony power in the physician market.

⁵⁵ Further, Ocean State paid doctors less than those physicians billed BC/BS not because doctors lowered their rates to HMO subscribers, but rather because the doctors affiliated with Ocean State agreed to share the HMO's risks. The physicians affiliated with Ocean State allowed their reimbursement to vary with the financial health of the HMO. See *supra* note 36.

⁵⁶ While the most favored nations provision was introduced at the same time BC/BS introduced a product similar to an HMO, see *supra* note 35, BC/BS offered its new health insurance plan only if a competing HMO was also being marketed, for example, by an employer to its employees. Thus, neither BC/BS initiative appears directed primarily at reducing costs, although some efficiencies could have arisen as ancillary consequences of a scheme aimed primarily at creating market power.

State."⁵⁷ Doctors understood that if they ceased participating in Ocean State, the most favored nations clause could no longer be triggered, so they were no longer threatened with reduced reimbursement from BC/BS. Between the introduction of the BC/BS contract provision and the time of trial, 350 of the 1200 Ocean State physicians resigned from the HMO.⁵⁸

It appears unlikely that the contract provisions at issue in *Reazin* had the dominant motive and effect of lowering the costs of health care. In partial contrast, BC/BS' contract provisions in *Ocean State* may have generated some efficiency gain through lower physician fees. It is doubtful, however, that this was the insurer's intent in *Ocean State* and the court proffered no record evidence in support of this view.

Under the rule of reason, the social benefit generated by these practices must be balanced against the social harm. The anticompetitive effects are addressed in the next section of this article.

III. VERTICAL RESTRAINTS THAT RAISE RIVALS' COSTS

An affiliated group of hospitals, doctors and insurers may employ vertical restraints to create market power by raising the costs borne by affiliated groups of rival providers and insurers.⁵⁹ Although neither in *Reazin* nor in *Ocean State* was the argument framed in terms of raising rivals' costs, this approach offers a logical way of explaining the anticompetitive problems raised by the facts of the two cases.⁶⁰

The methodology of this section merits a preliminary comment. The analysis emphasizes identifying practices that generate market power,⁶¹ rather than identifying a legal pigeonhole under which the practices should be addressed under the antitrust laws. This approach identifies antitrust violations with harm to social welfare in the economists' sense of the term, a principle that is widely although not universally accepted today.⁶² Similarly, raising rivals' costs has been

⁵⁷ *Ocean State*, 692 F. Supp. at 61.

⁵⁸ However, some departures were not prompted by the most favored nations clause. *Id.* at 61, 73.

⁵⁹ Similarly, a practice that raises entry barriers could harm patients by permitting horizontal collusion among physicians, hospitals, or health insurers, or by permitting the exercise of market power by a dominant insurer. Practices that raise entry barriers can be thought of as raising rivals' costs, where the relevant rivals are potential entrants rather than existing competitors.

⁶⁰ *Cf. Ball Mem. Hosp., Inc. v. Mutual Hosp. Ins., Inc.*, 784 F.2d 1235, 1339-40 (7th Cir. 1986) (rejecting theory that BC/BS intended its PPO to raise rivals' costs).

⁶¹ Practices that create market power by raising rivals' costs can be thought of as creating an involuntary cartel. By raising costs to its rivals, the predator forces those rivals to reduce output much as the rivals would be required to do were they to cooperate with the predator to fix prices. Thus, a practice of raising rivals' costs and horizontal price fixing can lead to a similar injury to competition.

⁶² See generally ABA ANTITRUST SECTION, MONOGRAPH NO. 12, HORIZONTAL MERGERS: LAW

proposed as a unifying framework for addressing exclusionary vertical restraints under the antitrust laws based upon their economic effect, regardless of whether the violation is characterized as tying, exclusive dealing, a group boycott, monopolization, or under some other legal rubric.⁶³

The complaint in the *Reazin* case can be understood in terms of raising rivals' costs in two ways.⁶⁴ The lawsuit began when BC/BS announced it would terminate the contract for insurer reimbursement of patient charges at Wesley hospital. Had the termination gone into effect, according to the first theory it might have reduced patient willingness to choose Wesley, made it impossible for Wesley to achieve efficient production scale, and thereby increased Wesley's marginal costs of serving patients. Moreover, the termination might have raised Wesley's payment collection and processing costs, if BC/BS' collection operations achieved scale economies no single hospital could match. As a result, Wesley could have become a weaker competitor for the two hospitals affiliated with BC/BS. The vertically affiliated combination of Wesley, Health Care Plus, and associated doctors would have been forced to increase patient charges, permitting BC/BS and its hospital and physician affiliates to share monopoly profits.

Additionally, the contract termination may have raised rivals' costs by convincing other existing and potential rivals to BC/BS in the health insurance market that BC/BS would make increased competition expensive for them.⁶⁵ Once they realized the costs of cutting prices, as

AND POLICY 5-26 (1986); cf. Krattenmaker, Lande & Salop, *supra* note 15, at 245 n.25 (comparing narrow and broad views of consumer welfare). As used in this article, the term economic efficiency means the maximization of the aggregate (producer's plus consumers') surplus. The technical difference between this criterion and the Pareto efficiency criterion is unimportant in this context. See generally R. JUST, D. HUETH & A. SCHMITZ, *APPLIED WELFARE ECONOMICS AND PUBLIC POLICY* (1982).

⁶³ Krattenmaker & Salop, *supra* note 10, at 215-19. As a basis for antitrust intervention, the raising rivals' costs logic is controversial because it leads to prohibiting some vertical arrangements. Those who believe that harmful vertical practices are rare fear that courts will apply this rationale inappropriately and that as a consequence many procompetitive vertical arrangements will be inhibited. See, e.g., Brennan, *Understanding "Raising Rivals' Costs"*, 33 ANTITRUST BULL. 95, 110 (1988) (arguing that raising rivals' costs may lend academic authority to discredited foreclosure and predations doctrines).

⁶⁴ These two theories allocate the anticompetitive effect of BC/BS' actions to different markets. The first theory supposes that BC/BS acts to help its affiliated hospitals obtain or preserve market power in the hospital market. The second theory supposes that BC/BS obtains or preserves market power for itself in the insurance market.

⁶⁵ This theory is suggested by two bodies of economic literature. The first set of economic articles shows how firms can profit by creating a reputation as a price cutter because they can deter existing and future rivals from acting competitively. See Saloner, *Predation, Mergers, and Incomplete Information*, 18 RAND J. ECON. 165 (1987); Burns, *Predatory Pricing and the Acquisition Costs of Competitors*, 94 J. POL. ECON. 226 (1986); Milgrom & Roberts, *Predation, Reputation, and Entry Deterrence*, 27 J. ECON. THEORY 280 (1982); Kreps & Wilson, *Reputation and Imperfect Information*, 27 J. ECON. THEORY 253 (1982). The second body of economic literature

would be expected to occur were they to generate cost savings through affiliations with hospitals and doctors, existing rivals would keep prices high by refraining from vertical integration. Further, prospective entrants would be deterred from offering new health insurance plans such as HMOs in competition with BC/BS. Accordingly, BC/BS would remain free from intensified competition and would preserve its market power.

If the *Reazin* jury found an antitrust violation on the first theory, it must have resolved two factual questions against BC/BS. First, it must have concluded that Wesley's costs would rise significantly. The jury could have reached this view if it thought that a substantial number of patients would have switched away from Wesley following the contract termination — enough to cause the largest hospital in Wichita to lose scale economies in providing many services.⁶⁶ In support of this view, the jury may have believed that many BC/BS subscribers would remain loyal to the dominant insurer, rather than the hospital, if their costs of continuing to deal with both BC/BS and Wesley rose.

Despite BC/BS' large market share, this conclusion was not compelled. BC/BS announced it would continue to reimburse subscribers choosing Wesley even though it cancelled its contract with that hospital (although those subscribers would bear more administrative costs and might not always receive full reimbursement). Moreover, patients who selected Wesley, a tertiary care teaching hospital, because it offered high quality care, might remain loyal to Wesley even if the termination made them bear higher medical care expenses. Further, those Wesley patients reimbursed through Medicare and Medicaid would be unlikely to switch hospitals, assuming that their physicians remained affiliated with Wesley. If few patients would have left Wesley following BC/BS' contract termination, then Wesley's marginal costs would not have risen significantly and the practice would not have harmed competition through this raising rivals' costs mechanism.⁶⁷

Second, to find a violation on the first raising rivals' costs theory,

shows how firms can employ strategic instruments to gain or preserve market power by deterring entry. See generally Salop, *Strategic Entry Deterrence*, 69 AM. ECON. REV. 335 (1979). Although this is not, strictly speaking, a raising rivals' costs practice, the logic of this argument is sufficiently similar to one to justify treating it as an action raising rivals' costs.

⁶⁶ In the alternative, the jury could have concluded that Wesley would bear higher administrative costs if it billed patients itself rather than contracting with BC/BS for that service. No evidence in the opinions, however, bears on this possibility.

⁶⁷ Alternatively, by reducing Wesley's market share to the point where the hospital's contribution to profits would not cover its unavoidable fixed costs (including its administrative overhead and the salvage value of its plant and equipment), the contract termination might harm competition in the Wichita hospital market, even if Wesley's marginal costs do not increase. Under such circumstances, Wesley would exit from the market, allowing the rival hospitals affiliated with BC/BS to raise prices free of competition. As with the anticompetitive story described in the text, this theory depends upon both a substantial number of patients

the *Reazin* jury must have concluded that at least one of the components of health care services (hospitals, doctors or health insurers) in Wichita formed an antitrust market. Otherwise, BC/BS or its affiliates could not reasonably expect to raise prices (or prevent a price decline) by making the vertical grouping of providers and insurers affiliated with Wesley a less effective competitor.⁶⁸ Of three possibilities, a Wichita hospital market is the most plausible.⁶⁹ If the jury found a hospital market, then it could have concluded that BC/BS acted anticompetitively on behalf of its affiliated hospitals, the rivals to Wesley in a concentrated industry.⁷⁰

To find a violation on the second theory, that BC/BS created a reputation for aggressive competition, the *Reazin* jury must have resolved two other issues against BC/BS. First, it must have concluded that the contract terminating Wesley would raise costs for Health Care Plus by convincing the rival HMO that it would be expensive for that HMO to lower insurance premiums for patients or to otherwise compete vigorously. Similarly, it must have concluded that prospective entrants into the health insurance market should have reasonably feared competition from BC/BS, and so would have been deterred from entry. Based upon BC/BS' own statements, the jury might have found that by terminating Wesley, BC/BS in effect announced that rival insurers who affiliate with providers in order to compete more intensely with BC/BS could not expect to obtain affiliations with hospitals that service BC/BS' subscribers. This prospect would have deterred new competition by making it more difficult for new insurers to induce BC/BS subscribers to switch their coverage. The conclusion that competing

switching away from Wesley in response to its termination of its contract with BC/BS, and the existence of entry barriers in the hospital market.

It also is possible that the reorganization of the Wichita health care industry raised Health Care Plus' costs by precluding the HMO from contracting with the better quality providers of medical services. This argument is founded on the facts of the instant case, however, because Wesley is a desirable hospital and the HMO affiliated doctors are highly respected.

⁶⁸ If the antitrust market is in provider services rather than health insurance, then the tacitly colluding hospitals or doctors would compensate BC/BS in their reimbursement arrangement for managing what effectively is a provider cartel. See *infra* note 74.

⁶⁹ Baker, *supra* note 10 (metropolitan areas are plausible geographic markets for many hospital services). The case for a physician market most likely depends upon the willingness of new medical school graduates to locate at large distances from their medical school in response to high doctor salaries. The case for a health insurer market likely relies on the costs of patient switching among health care financing plans. Both of these alternatives are explored further below, in connection with an evaluation of a raising rivals' costs story on the *Ocean State* facts. See *infra* notes 73-78 and accompanying text.

⁷⁰ Under this theory, both Wesley and patients suffer injury directly resulting from the practices that harm competition, and the competing HMO is injured insofar as BC/BS' contract termination with Wesley causes the HMO to lose patients who have become unwilling to commit to obtaining care at Wesley. Hence, the court properly found that Wesley and the HMO have standing to challenge BC/BS' action. *Reazin I*, 635 F. Supp. 1287, 1315-17, 1319 (D. Kan. 1986).

insurers would be harmed was supported by evidence that two rival hospitals in Wichita agreed to accept a 20% lower reimbursement from BC/BS in exchange for BC/BS' decision to terminate Wesley.⁷¹

In addition, to find a violation on the second theory the jury must have been convinced that BC/BS could profit by raising costs to rival insurers. The jury may reasonably have supposed that BC/BS was benefited by avoiding the lower prices that would result from intensified competition, if it believed that BC/BS was charging its subscribers supracompetitive prices before it decided to terminate Wesley, or if it believed that Wesley, Health Care Plus, and their affiliated doctors would be able to achieve significant economies for an integration. The jury may have concluded that BC/BS was capable of exercising market power based upon BC/BS' large market share and a finding of entry barriers. While the height of entry barriers into health insurance is hotly debated in the abstract,⁷² the jury might reasonably have concluded that BC/BS deterred entry through demonstrating to prospective rivals its willingness to terminate Wesley.

As with the *Reazin* case, the complaint in *Ocean State* might be interpreted as alleging that BC/BS acted anticompetitively by raising costs to its existing HMO rival, Ocean State.⁷³ By introducing a most fa-

⁷¹ *Reazin v. Blue Cross & Blue Shield of Kan., Inc.*, 663 F. Supp. 1360, 1381-82 (D. Kan. 1987). The inference of harm to competitors would have been stronger had BC/BS not announced that it would continue partial reimbursement of its subscribers for care at Wesley, and had BC/BS convinced the rival Wichita hospitals to end their association with Health Care Plus.

⁷² Some argue that entry into the business of providing health insurance is extremely easy. One reason for this belief is that large employers can readily invite insurers from neighboring states to offer coverage to their employees, bypassing the local carriers. See *Ball Mem. Hosp., Inc. v. Mutual Hosp. Ins., Inc.*, 784 F.2d 1325 (7th Cir. 1986) (insurer access to capital is unlimited and patients are not the captive of existing insurers).

In contrast to this view, it may in fact be expensive for patients to change insurers, particularly when such switching would be associated with a change of medical providers (as most likely would be true if the new insurer were an HMO). See Neipp & Zeckhauser, *Persistence in the Choice of Health Plans*, 6 *ADVANCES HEALTH ECON. & HEALTH RES.* 47, 48-49 (1985). If switching costs are large, then new insurers would be forced to incur substantial promotional expenses (such as low introductory prices) as well as substantial delay (as potential switching patients wait for their existing insurance contracts to expire, or as unaffiliated new subscribers slowly move into the new insurer's market area). Assuming BC/BS is the dominant insurer, successful entry into health insurance markets then would depend upon the entrant obtaining affiliations with physicians and hospitals presently affiliated with BC/BS, some of whom may have exclusive affiliations. Even if it is easy for a new entrant to obtain physician affiliations, as is plausible, and hospital affiliations, as is possible (depending upon contractual relationships with existing insurers), the entrant may not be able to convince many patients to switch their coverage unless their preferred doctor and hospital combination is affiliated with the new insurer.

⁷³ The restriction could equally harm competition through the alternative mechanism of raising entry barriers. If patients find it expensive to switch insurers, then a most favored nations clause in BC/BS' contracts with physicians will raise entry barriers into the insurance market and protect BC/BS' dominant position to the extent that the contract provision makes

vored nations clause into its contracts with doctors, BC/BS may have ensured that Ocean State could no longer convince its affiliated physicians to share the financial risk of HMO operation. Indeed, the BC/BS contract provision amplified the financial risk of HMO affiliation to doctors. If Ocean State experienced an unsuccessful year, so that its payments to doctors were low, the physicians would also be forced to accept lower fees from BC/BS. Hence, unless Ocean State rendered its payment terms identical to those of BC/BS, most doctors would be unwilling to affiliate with both BC/BS and the HMO.

BC/BS may have achieved market power (or preserved existing high prices) by raising its competitor's costs of obtaining physician affiliations. Higher compensation costs may have generated BC/BS market power in *Ocean State* through two mechanisms. The first mechanism supposes that BC/BS was controlled by doctors who in effect employed the insurer to coordinate a physician cartel.⁷⁴ If doctors colluded tacitly, then rival insurers (such as HMOs) would be unable to obtain doctor affiliations (unless they encourage physicians to cheat on the cooperative price for doctor services).⁷⁵ The most favored nations clause may have deterred cheating on a physician cartel, thereby facili-

it less likely that a new HMO would be able to attract affiliations from doctors also affiliated with BC/BS.

If, however, the most favored nations clause at issue in the Rhode Island litigation were anticompetitive solely because it raised entry barriers to new insurance competition, the existing HMO rival would not be an appropriate plaintiff for vindicating competition. The existing rival would not have standing because it would lack antitrust injury. Health care consumers, or the state or federal government, would remain appropriate plaintiffs.

⁷⁴ Among those who believe that market power is present in health care markets, it is not settled whether BC/BS plans are mechanisms by which doctors and hospitals exercise market power in selling health care to patients, or mechanisms by which BC/BS exercises monopsony power in acquiring provider services. In either case the insurer management may appropriate the resulting rents. Alternatively, subscribers may obtain the benefits of an insurer monopsony through lower fees. See generally Pauly, *supra* note 8; Miller, *supra* note 9.

If physicians were to cooperate to raise prices, they would surely require the help of a cartel manager such as BC/BS because the large number of doctors in any area would make the costs of coordination otherwise prohibitive. Cf. Krattenmaker & Salop, *supra* note 10, at 238 (cartel ring master). Moreover, several factors render it plausible that the physicians in any metropolitan area form an antitrust market: the demand for many medical services is likely to be inelastic, entry from established physicians moving from other metropolitan areas is not plausible, and entry from new physicians choosing metropolitan areas in which to establish a practice is limited by the capacity of graduating medical school classes and by the degree to which new doctors are responsive to small changes in starting salaries in choosing where to settle.

Similarly, a hospital cartel also might be successful if formed in many regions of the country. In contrast with physicians, concentration may be sufficiently high in such markets as to make it possible for hospitals to coordinate their cooperative arrangement without need for a cartel manager such as BC/BS. See generally Baker, *supra* note 10.

⁷⁵ A doctor would be willing to accept a lower reimbursement rate from a HMO, thereby cheating on the tacit physician cartel, if he or she expects that the lower cost of physician services provided through the HMO would induce a large number of patients to switch from BC/BS and its affiliated doctors.

tating collusion among doctors, by making it uneconomic for physicians to lower their fees to those patients participating in the HMO.⁷⁶ Unfortunately, it is difficult to evaluate whether this plausible explanation for the anticompetitive effect of a most favored nations clause applied to the facts of *Ocean State* because no evidence was presented from which it would be possible to determine whether BC/BS in effect acted to manage a physician cartel in Rhode Island.⁷⁷

Second, BC/BS may have achieved market power if the contract provision caused so many doctors to terminate their affiliations with the rival HMO that Ocean State fell below a minimum efficient scale of production. Even assuming that the HMO's thirty percent decline in physician affiliations following BC/BS' introduction of a most favored nations clause was entirely attributable to that provision, it is not clear from the trial record whether the remaining 850 doctors were too few for such a production scale.⁷⁸

IV. CONCLUSION

By awarding judgment notwithstanding the verdict in the *Ocean State* litigation, the district court judge determined that there was no evidence from which the jury could properly find that plaintiff Ocean State had met its burden of proof.⁷⁹ If an antitrust violation depends

⁷⁶ Thus, a most favored nations clause facilitates collusion among horizontal rivals by allowing each rival to commit to bearing large costs of cheating on a cooperative arrangement. See generally Salop, *Practices that (Credibly) Facilitate Oligopoly Co-ordination*, in *NEW DEVELOPMENTS IN THE ANALYSIS OF MARKET STRUCTURE* 265-90 (J. Stiglitz & G. Mathewson eds., 1986).

An HMO might attempt to avoid the disincentive for doctors to affiliate with it created by the BC/BS' most favored nations clause by restructuring its physician compensation arrangement, described *supra* at note 36, to allow its doctors to reduce their fees without triggering the clause in bad years. For example, the HMO might characterize the withheld physician reimbursements as a capital contribution. BC/BS, however, presumably could respond by rewriting its contracts to preserve the disincentive for its affiliated doctors to participate in the HMO.

⁷⁷ For example, if the record contained evidence that BC/BS' physician reimbursement rates were higher in Rhode Island than in states where BC/BS does not have as large a market share (after controlling for regional variation in the costs of providing medical insurance and physician services), the jury might reasonably have inferred that Rhode Island doctors were exercising market power.

⁷⁸ In support of this theory, Ocean State alleged that physician shortages in certain vital medical specialties, such as cardiac surgery, resulted from BC/BS' introduction of the challenged contract provision. *Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of R.I.*, 692 F. Supp. 52, 61 (D. R.I. 1988). If Ocean State could remedy the crucial shortages at little additional expense, however, as by offering slightly higher reimbursement rates to cardiac surgeons, its costs would not have increased substantially.

This theory also requires that entry barriers preserve BC/BS from new competition in the health care market. Although this proposition is controversial in the abstract, see *supra* note 72, the most favored nations clause may have created an entry barrier for new insurers in the instant case by making it difficult for them to obtain physician affiliations.

⁷⁹ *Ocean State*, 692 F. Supp. at 64-65.

upon a demonstration that the challenged practice likely confers market power on an excluding firm by raising rivals' costs, it is uncertain whether this standard was met. The jury could reasonably have found that the challenged contract provision had no procompetitive purpose, but evidence on the presence or absence of beneficial effects was lacking.⁸⁰ Moreover, it is difficult to say whether a jury could reasonably have found that the most favored nations clause could permit BC/BS to achieve or preserve market power by increasing costs to the rival HMO. The main problem is the lack of evidence from which to determine whether BC/BS was effectively acting as a cartel manager for Rhode Island doctors, or whether the reductions in Ocean State's size increased its costs.⁸¹

When faced with a similar decision, the district court in *Reazin* appears to have properly denied motions for new trial and judgment notwithstanding the verdict.⁸² The evidence in the *Reazin* record seems sufficient to permit the inferences that BC/BS had an anticompetitive motive in terminating Wesley,⁸³ and that the termination had the anticompetitive effect of creating market power either for BC/BS⁸⁴ or, more likely, for its affiliated hospitals.⁸⁵

As the reorganization of the health care industry continues, vertical restraints among hospitals, doctors, and insurers such as those litigated in *Reazin* and *Ocean State* will be created with increasing frequency. Although such vertical restraints are often socially beneficial, this Article has shown that they can confer market power by raising rivals' costs and can, in consequence, violate the antitrust laws, regardless of the doctrinal category in which they are framed. Moreover, the raising rivals' costs framework offers a valuable conceptual tool for assessing the possible harm to competition.

⁸⁰ See *supra* notes 52-56 and accompanying text.

⁸¹ See *supra* notes 73-78 and accompanying text.

⁸² See *Reazin v. Blue Cross & Blue Shield of Kan., Inc.*, 663 F. Supp. 1360, 1410 (D. Kan. 1987)(standard of review).

⁸³ See *supra* notes 47-51 and accompanying text.

⁸⁴ See *supra* notes 66-70 and accompanying text.

⁸⁵ See *supra* notes 71-72 and accompanying text.