

either for physicians nationally or for those located within the western North Carolina marketplace. Without evidence or standards, the complaint's assertion that the physicians increased prices unreasonably is simply arbitrary and capricious.

E. Request for Relief

Since the complaint's requested relief was essentially obtained through the proposed Final Judgment, we will reserve commentary on this subject until Part IV. However, since the analysis above demonstrates the government's complaint is defective in nearly every aspect, the Court could simply dismiss the complaint for failure to state a claim entitling the government to obtain relief.²⁵

Part II: Historical Background

A. Origins of Government Intervention in Healthcare

The case against Mountain ultimately has little to do with enforcing the Sherman Act and everything to do with protecting the federal government's intrusive role in the healthcare market. Indeed, if the DOJ actually believed in the type of free market they claim to be protecting here, they would be seeking to protect Mountain's right to exist rather than destroy it. But as things stand, the government maintains a direct interest in destroying Mountain, and in general preventing physicians from collectively bargaining with managed care companies. This interest is not genuinely motivated by antitrust concerns, but by simple budget politics.

In 1965, Congress brought an end to the free market that successfully served Americans for most of the republic's history. That year, Congress created Medicaid and Medicare, two programs designed to finance healthcare for the indigent and elderly, respectively.²⁶ The original concept was for the government to simply pay the bills for medical expenses while not interfering with physicians and the services they provided. This concept soon proved unworkable.

The core problem with Medicaid and Medicare was the divorcing of demand for services from the ability to pay. Once health care became free for certain individuals, these folks were able to spend indiscriminately. Recognizing this problem (but refusing to admit defeat), Congress responded by imposing arbitrary cost controls on Medicare and Medicaid. Originally, the two programs paid "reasonable costs" of services chosen and provided by

physicians. But following passage of several amendments in 1983, Medicare and Medicaid switched to a payment system based on DRGs, or "diagnosis-related group." This change was intended to lower government spending on health care.

The DRG approach is precisely the kind of non-market price fixing the government now accuses Mountain of. A DRG divides all medical problems into a set number of categories, and then assigns a fixed, arbitrary fee for each "diagnosis," a figure that supposedly represents the average cost for treating the problem. A health care provider gets only the fixed DRG amount, regardless of actual work performed. This means that for the provider to make a profit, he must incur costs below the DRG rate.

The DRG approach is used not just under Medicare and Medicaid, but in privately owned insurance programs as well. Because the government's 1965 interventions led to an exponential rise in health care costs, Congress decided to encourage a DRG approach in private insurance by passing the HMO Act of 1973. HMOs, or health maintenance organizations, exist as comprehensive prepaid insurance plans, where providers accept a DRG-like fixed rate for medical services irrespective of actual costs. Prior to 1969, the only HMO of significant stature was Kaiser Permanente, which relied on labor unions compelling their members to join.²⁷ Today, of course, HMOs are the dominant provider of private health insurance coverage in the United States.

The rise of HMOs derives not from their popularity in the market, but from the 1973 law. Congress essentially rigged the market in favor of HMOs, giving them generous subsidies, and expanding tax incentives for employers that enrolled their employees in HMOs. The government's encouragement made HMOs a dominant force in the health care marketplace independent of the need to fairly compete for customers.

Indeed, it is difficult to imagine HMOs succeeding in a genuinely competitive free market. The DRG-based approach HMOs use is entirely incompatible with America's capitalist ideals. Customers generally don't voluntarily pay for what they know to be inferior service. Yet HMOs only profit by forcing costs below the level at which optimum customer service can be provided. The economic principle is egalitarian rather than capitalist: it's more important for an HMO to serve

everyone than to serve everyone well. In the absence of government encouragement, few customers would voluntarily subscribe to this theory when it comes to something as essential to their life as health care.

Despite all of the government's interference, health care costs continue to rise. Rather than admit fault, the government prefers to scapegoat others for the shortcomings of Medicare, Medicaid, and managed care. Physicians are by far the easiest target. In DRG-based models, physicians are effectively stripped of their power to deal one-on-one with their patients, thus subjecting all medical judgments to the whims of government bureaucrats and HMO administrators, few of whom have any actual knowledge or experience in health care. At the same time, physicians have found their incomes restricted by non-market forces, namely the arbitrary DRG levels that bear little if any relation to actual supply and demand. Despite this, the government promotes the theory, at issue in this case, that it's the physicians that are acting illegally by trying to increase their income and their control over how they provide medical care. According to the DOJ's thinking, it is more important for the HMOs and government insurance programs to be protected from their own errors than to permit physicians even a minimal ability to defend their professions and personal livelihoods.

B. Origins of Physician Antitrust Prosecutions

For more than 80 years, the Sherman Act was not applied to the activities of physicians, attorneys, and other so-called "learned" professions. In passing the Sherman Act, Congress's target was alleged industrial trusts, such as Standard Oil and the railroads. But in 1975, the U.S. Supreme Court extended the Sherman Act's reach to independent professionals in *Goldfarb v. Virginia State Bar*.²⁸ There, the Court was asked to examine whether a minimum fee schedule for legal services constituted illegal price fixing, notwithstanding the fact a state bar itself prescribed the schedule.

A unanimous Court ruled against the bar, holding that the Sherman Act contained no exception for specific professions, even those regulated by state governments. At the same time, however, the Court noted: "In holding that certain anticompetitive conduct by lawyers is within the reach of the Sherman Act we intend no diminution of the authority of the State to regulate

²⁵ See Fed. R. Civ. Proc. 54(c).

²⁶ See 42 U.S.C. 1395, *et seq.*

²⁷ Scott Holleran, "What You—and Your Employer—Probably Don't Know About Your Health Plan," (Jan. 1999) (available online at <http://www.afcm.org/historyofhmos.html>).

²⁸ 421 U.S. 773 (1975).