

its professions.”²⁹ This is noteworthy because while the Court was mindful of protecting the federal government’s exclusive authority to regulate interstate commerce, the justices also made it quite clear the states did not surrender their professional regulatory powers. In the context of the case against Mountain, this is a point worth emphasizing, since the DOJ’s actions here trample on North Carolina’s ability to supervise and regulate physicians and medical organizations, while not advancing a genuine interest related to interstate commerce.

Seven years after *Goldfarb*, the Supreme Court made its first—and to date only—major decision related to antitrust prosecution of physician organizations. In *Arizona v. Maricopa County Medical Society*,³⁰ a divided Court³¹ held that a maximum-fee schedule adopted by a physician group was *per se* unlawful under Section 1 of the Sherman Act. The majority explicitly rejected any call to put the Medical Society’s actions in proper context, citing the circular nature of the *per se* rule:

The respondents’ principal argument is that the *per se* rule is inapplicable because their agreements are alleged to have procompetitive justifications. The argument indicates a misunderstanding of the *per se* concept. The anticompetitive potential inherent in all price-fixing agreements justifies their factual invalidation even if procompetitive justifications are offered for some. Those claims of enhanced competition are so unlikely to prove significant in any particular case that we adhere to the rule of law that is justified in its general application. Even when the respondents are given every benefit of the doubt, the limited record in this case is not inconsistent with the presumption that the respondents’ agreements will not significantly enhance competition.³²

In dissent, Justice Powell preferred to actually look at the facts, and concluded:

The medical care plan condemned by the Court today is a comparatively new method of providing insured medical services at predetermined maximum costs. It involves no coercion. Medical insurance companies, physicians, and patients alike are free to participate or not as they choose. On its face, the plan seems to be in the public interest.³³

The situation in *Maricopa* is not dissimilar from this case. Like *Maricopa*, no coercion was involved, and the fee schedule arrangement—to

the extent one actually exists here—is wholly voluntary. And if the government were to go to trial in this matter, they would almost certainly use a *per se* standard in analyzing Mountain’s actions. In doing so, the government would be able to obtain a judgment against Mountain without having to prevent any substantial evidence as to the actual context of Mountain’s operations or their effect on the marketplace; the government would only need to demonstrate that prices were fixed in some manner to prevail. Yet, as Justice Powell warned us in *Maricopa*, this approach often works against the supposed intent of the antitrust laws:

It is settled law that once an arrangement has been labeled as “price fixing” it is to be condemned *per se*. But it is equally well settled that this characterization is not to be applied [457 U.S. 332, 362] as a talisman to every arrangement that involves a literal fixing of prices. Many lawful contracts, mergers, and partnerships fix prices. But our cases require a more discerning approach. The inquiry in an antitrust case is not simply one of “determining whether two or more potential competitors have literally ‘fixed’ a ‘price.’ * * * [Rather], it is necessary to characterize the challenged conduct as falling within or without that category of behavior to which we apply the label ‘*per se* price fixing.’ That will often, but not always, be a simple matter.” *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*, 441 U.S. 1, 9 (1979).

Before characterizing an arrangement as a *per se* price-fixing agreement meriting condemnation, a court should determine whether it is a “‘naked restraint[t] of trade with no purpose except stifling of competition.’” *United States v. Topco Associates, Inc.*, 405 U.S. 596, 608 (1972), quoting *White Motor Co. v. United States*, 372 U.S. 253, 263 (1963). See also *Continental T.V., Inc. v. GTE Sylvania Inc.*, 433 U.S. 36, 49–50 (1977). Such a determination is necessary because “departure from the rule-of-reason standard must be based upon demonstrable economic effect rather than * * * upon formalistic line drawing.” *Id.*, at 58–59. As part of this inquiry, a court must determine whether the procompetitive economies that the arrangement purportedly makes possible are substantial and realizable in the absence of such an agreement.³⁴

In *Maricopa*, the Medical Society’s purpose was not to stifle competition, but to contain rising medical costs. Here, there is no evidence which suggests Mountain’s intentions were to stifle or impair competition. Instead, Mountain’s principal function was to provide patients and insurers with access to a broad network of health care providers. Superficially, at least, this would seem to be “pro-competitive.”

But once again, there is substantial evidence to suggest the government’s actions in cases like *Maricopa* and Mountain are about something other than antitrust.

C. The DOJ-FTC “Statements”

In the years following *Goldfarb* and *Maricopa*, the DOJ and FTC developed substantial experience going after physician organizations. The DOJ has filed five civil claims against physician groups since 1991, all of which have resulted in consent orders. None of these cases involved a remedy as drastic as the one imposed here on Mountain—outright dissolution—although in 1983, a preferred provider organization did dissolve on the eve of DOJ action. There is no record of any DOJ or FTC complaint against a physician group proceeding to trial, judgment, and appeal. Thus, there is no controlling precedent from the Supreme Court or any court of appeals on the constitutionality of the specific policies used by the government in reviewing and prosecuting physician activities.

The major policy at issue is the FTC–DOJ Statements of Antitrust Enforcement Policy in Health Care (“Statements”). The Statements were adopted by joint action of the FTC and DOJ Antitrust Division in September 1993, and revised by the agencies in 1994 and 1996. Congress never enacted the Statements into law, and thus these policies remain nothing more than the opinion of the FTC and the DOJ’s Antitrust Division.

In physician network cases, the critical policy is Statement 8, which effectively labels all networks owned by nominally competing physicians as *per se* illegal. Statement 8 says these networks are only legal under the Sherman Act if the physicians “share substantial financial risk.” As lawyers at the firm representing Mountain before this Court noted in 1996: “It is this requirement that has generated the most controversy. This is so not because the concept of sharing risk is unusual in the context of a legitimate joint venture. Instead, the controversy stems from the fact that the enforcement statements ‘approve’ only two forms of risk sharing: capitation and withholds.”³⁵ Capitation means physicians are paid a fixed amount per month for each consumer enrolled in a given health plan; withholds means the payer keeps a certain percentage of a physician’s reimbursement unless certain cost

²⁹ 421 U.S. at 793.

³⁰ 457 U.S. 332 (1982).

³¹ The case was decided by a 4–3 vote, because Justices Blackmun and O’Connor were recused.

³² 457 U.S. at 351.

³³ *Id.* at 357.

³⁴ *Id.* at 361.

³⁵ Bruce R. Stewart and E. John Steren, “Will New Guidelines Clarify Role of Antitrust Law in Health Care?” Legal Backgrounder, Vol. 11, No. 23 (June 21, 1996).