

IN THE MATTER OF
MICHIGAN STATE MEDICAL SOCIETY

FINAL ORDER, OPINION, ETC., IN REGARD TO ALLEGED VIOLATION OF
SEC. 5 OF THE FEDERAL TRADE COMMISSION ACT

Docket 9129. Complaint, July 27, 1979—Final Order, Feb. 17, 1983

This Final Order, among other things, requires an East Lansing, Mich. medical society to cease from entering into agreements with its members to affect the amount, manner of calculating or terms of reimbursement for physical services; and to refrain from influencing its members to refuse to enter into any participation agreement not acceptable to the Society or its members; or to complete the claim forms used by any third-party payer. The Society is barred from entering, either on its own behalf or on behalf of its members, into any agreement with a third-party payer that concerns the amount, manner of calculation, or terms of reimbursement; and from influencing, by any means, a member's decision to accept or reject a participation agreement. The order also bars the Society from engaging in any action having the effect of coercing, compelling or inducing a third-party payer to accept the position taken by the Society regarding the terms or conditions of a participation agreement. Additionally, the Society is required to publish provisions of the order in a prescribed manner and to provide current and future members with a copy of the order.

Appearances

For the Commission: *Steven T. Kessel, M. Elizabeth Gee, Jill M. Frumin and Valorie P. Watkins.*

For the respondent: *A. Stewart Kerr, William A. Sankbeil and John L. Shoemaker, Kerr, Russell and Weber, Detroit, Mich.*

COMPLAINT

Pursuant to the provisions of the Federal Trade Commission Act, as amended (15 U.S.C. 41 *et seq.*), and by virtue of the authority vested in it by said Act, the Federal Trade Commission, having reason to believe that the named respondent has violated the provisions of Section 5 of the Federal Trade Commission Act and that a proceeding by it in respect thereof would be in the public interest, hereby issues this Complaint, stating its charges as follows:

PARAGRAPH 1. Respondent Michigan State Medical Society is a corporation formed pursuant to the laws of the State of Michigan, with its principal business offices at 120 W. Saginaw St., East Lansing, Michigan. Respondent is a professional association for Michigan

physicians. Approximately 8,700 physicians are members of respondent, constituting a substantial majority of Michigan physicians.

PAR. 2. Respondent charters component medical societies which are organized at the county level in the State of Michigan. Membership in respondent is a prerequisite to membership in a component society.

PAR. 3. Some members of respondent are engaged in the business of providing medical health care services to patients for a fee. Except to the extent that competition has been restrained as herein alleged, some members of respondent have been and are now in competition among themselves and with other physicians. [2]

PAR. 4. Respondent is organized for the purposes, among others, of guarding and fostering its members' material interests and insuring that its members receive fair remuneration for services rendered. Respondent engages in activities which further its members' pecuniary interests. By virtue of such purposes and activities, respondent is a corporation organized for the profit of its members within the meaning of Section 4 of the Federal Trade Commission Act, as amended, 15 U.S.C. 44.

PAR. 5. Third party payers for health care services that do business in Michigan, including Blue Cross and Blue Shield of Michigan ("BCBSM") and Michigan Medicaid, and some subscribers of BCBSM, are engaged in interstate commerce. The acts and practices described hereinbelow are in interstate commerce or affect the interstate activities of respondent's members, third party payers or some BCBSM subscribers, and are in or affect commerce within the meaning of Section 5(a)(1) of the Federal Trade Commission Act, 15 U.S.C. 45(a)(1).

PAR. 6. Respondent has restrained competition among physicians in the State of Michigan by acting as a combination of at least some of its members, or by combining or conspiring with at least some of its component societies or with at least some of its members, to:

A. Fix, stabilize, or otherwise tamper with the fees which physicians in Michigan receive for their services.

B. Engage in concerted action to restrict, regulate, impede or interfere with the health care cost containment or reimbursement policies of BCBSM or Michigan Medicaid.

C. Engage in concerted negotiations with BCBSM with respect to the health care cost containment or reimbursement policies of BCBSM.

PAR. 7. Respondent has engaged in acts and practices in furtherance of the combination and conspiracy, including among other things: [3]

A. Soliciting and collecting "proxies" from respondent's members which enabled respondent to collectively terminate such members' written agreements with BCBSM and Michigan Medicaid to provide medical services to persons who receive benefits from BCBSM or Michigan Medicaid, if BCBSM and Michigan Medicaid did not adopt reimbursement policies acceptable to respondent;

B. Engaging in concerted action against BCBSM which included, among other things, organizing a concerted refusal by members of respondent to deal with BCBSM.

C. Engaging in negotiations with BCBSM with respect to the health care cost containment or reimbursement policies of BCBSM.

D. Entering into an agreement with BCBSM with respect to the health care cost containment or reimbursement policies of BCBSM.

PAR. 8. The purpose, tendency and effect of the combination and conspiracy and of the acts and practices described in Paragraphs Six and Seven has been to:

A. Restrain competition among physicians in the State of Michigan.

B. Fix, stabilize, or otherwise tamper with the fees which physicians in Michigan receive for their services.

C. Deprive third party payers of the benefits of competition among physicians in Michigan.

D. Deprive subscribers and consumers of the benefits of third party payers' independently determined reimbursement policies or health care cost containment efforts.

PAR. 9. The combination and conspiracy and the acts and practices described in Paragraphs Six and Seven constitute unfair methods of competition and unfair acts and practices in violation of Section 5 of the Federal Trade Commission Act.

INITIAL DECISION BY

THOMAS F. HOWDER, ADMINISTRATIVE LAW JUDGE

JUNE 19, 1981

PRELIMINARY STATEMENT

The Federal Trade Commission issued its complaint in this case on July 27, 1979, charging the respondent Michigan State Medical Society ("MSMS") with engaging in unfair methods of competition and unfair acts and practices in violation of Section 5 of the Federal Trade Commission Act, 15 U.S.C. 45.

Specifically, paragraph six of the complaint charged that respondent restrained competition among physicians in the State of Michigan by acting as a combination of at least some of its members, or by combining or conspiring with at least some of its component societies or with at least some of its members, to:

Fix, stabilize, or otherwise tamper with the fees which physicians in Michigan receive for their services; [2]

Engage in concerted action to restrict, regulate, impede or interfere with the health care cost containment or reimbursement policies of Blue Cross and Blue Shield of Michigan ("BCBSM") or Michigan Medicaid; and

Engage in concerted negotiations with BCBSM with respect to the health care cost containment or reimbursement policies of BCBSM.

In furtherance of the alleged combination and conspiracy, paragraph seven charged respondent MSMS with engaging in various acts and practices, including:

Soliciting and collecting "proxies" from respondent's members which enabled respondent to collectively terminate such members' written agreements with BCBSM and Michigan Medicaid to provide medical services to persons who receive benefits from BCBSM or Michigan Medicaid, if BCBSM and Michigan Medicaid did not adopt reimbursement policies acceptable to respondent;

Engaging in concerted action against BCBSM which included, among other things, organizing a concerted refusal by members of respondent to deal with BCBSM;

Engaging in negotiations with BCBSM with respect to the health care cost containment or reimbursement policies of BCBSM; and

Entering into an agreement with BCBSM with respect to the health care cost containment or reimbursement policies of BCBSM.

According to paragraph eight, the purpose, tendency and effect of the alleged combination and conspiracy and of the acts and practices described in paragraphs six and seven was to:

Restrain competition among physicians in the State of Michigan;

Fix, stabilize, or otherwise tamper with the fees which physicians in Michigan receive for their services;

Deprive third party payers of the benefits of competition among physicians in Michigan; and

Deprive subscribers and consumers of the benefits of third party payers' independently determined [3] reimbursement policies or health care cost containment efforts.

Respondent answered on September 19, 1979, denying the above

allegations, and also challenging other allegations concerning "commerce" and whether it is a corporation organized for profit. Respondent further asserted various affirmative and special defenses.

Prehearing conferences were held on September 4, 1979; March 27, 1980; and September 3, 1980.

Documentary discovery was conducted beginning in October 1979. Following completion of discovery, adjudicative hearings were held in Washington, D.C., and Detroit, Michigan in June, September, October and March, 1980. The trial produced a transcript record of 2041 pages and approximately 418 exhibits. The record was closed on January 12, 1981.

Proposed findings and reply findings were filed by the parties in February 1981.

Any motions not heretofore or herein specifically ruled upon, either directly or by the necessary effect of the conclusions in this decision, are hereby denied.

This proceeding is before me upon the complaint, answer, testimony and other evidence, and the proposed findings of fact and conclusions of law filed by counsel supporting the complaint and by counsel for respondent. The proposed findings of fact, conclusions and arguments of the parties have been considered, and those findings not adopted either in the form proposed or in substance are rejected as not supported by the evidence or as involving immaterial issues not necessary for this decision.

Certain abbreviations, including the following, are used in this decision:

CX - Commission's Exhibit

RX - Respondent's Exhibit

The transcript of testimony is referred to with the last name of the witness and the page number or numbers upon which the testimony appeared.

Having heard and observed the witnesses, and after having reviewed the entire record in this proceeding, I make the following findings: [4]

FINDINGS OF FACT

I. RESPONDENT MICHIGAN STATE MEDICAL SOCIETY

1. Respondent Michigan State Medical Society, a Michigan corporation, is a professional association for Michigan physicians with its principal offices in East Lansing (Complaint, Par. 1; Answer, Par. 1).

As of January 1978, the membership of MSMS totaled approximately 8700 physicians (CX 6; CX 15-Z-2). Over 80 percent of medical doctors practicing in Michigan are members of MSMS (CX 50-A).

2. The House of Delegates is the MSMS legislative body (CX 4-F, N). Its powers and duties include adopting rules and regulations to administer the affairs of MSMS and transacting all of the business of MSMS not otherwise specifically delegated (CX 4-N). The House of Delegates has authority to appoint committees, to receive their reports, and to act on them (CX 4-N; Hayes 324-25). The House of Delegates is composed of representatives elected by MSMS' local component societies, as well as by specialty sections of MSMS representing medical specialty groups (CX 4-M; CPF 15; *see also* Hayes 325). About 90 percent of the delegates attending the 1978 MSMS House of Delegates annual session were elected by the local component societies (CX 11-Z-41-44).

3. The House of Delegates meets annually (CX 4-N; Hayes 325). There have also been special meetings called to deal with matters requiring immediate consideration (Hayes 326-27; *see also* CX 4-N). At regular and special meetings the House of Delegates receives and acts upon proposed policy resolutions (CX 4-N-O; Hayes 325).

4. The Council is MSMS' executive body (CX 4-F, P). It is elected by the House of Delegates and has authority between House of Delegates meetings to act on behalf of MSMS and for the House of Delegates (CX 4-F; Hayes 327). The Council's functions include carrying out directives and resolutions enacted by the House of Delegates, acting on matters that arise between House of Delegates meetings which must be resolved prior to the next scheduled House of Delegates meeting, and monitoring the functions of various MSMS committees, including committees appointed by the Council or by the House of Delegates (Hayes 328).

5. MSMS charters component societies which are organized at the county level in Michigan. Membership in MSMS is a prerequisite to membership in a component society (Complaint, Par. 2; Answer, Par. 2). Component societies are distinct organizational entities and, subject to MSMS review, adopt their own constitutions and bylaws (CX 4-F-G; [5] *see, e.g.*, CX 309). Component societies conduct separate membership meetings (*see, e.g.*, CX 325). As of 1978, MSMS had 55 component societies (CX 6-Z-118).

II. SECTION 4 JURISDICTION

A. Activities of the Michigan State Medical Society

6. The Michigan State Medical Society was established in 1910 pursuant to Act No. 171 of the Public Acts of Michigan for 1903, entitled "Act for the Incorporation of Associations not for Pecuniary Profit" (CX 5-B-C).

7. The stated purposes of the Michigan State Medical Society are as follows: "to federate and to bring into one compact organization the entire medical profession of the State of Michigan and to unite with similar societies in other states to form the American Medical Association; with a view to the extension of medical knowledge and to the advancement of medical science; to the elevation of the standard of medical education, and to the enactment and enforcement of just medical laws; to the promotion of friendly intercourse among physicians, and to the guarding and fostering of their ["material", found in the 1910 Articles, was deleted by 1941] interests; and to the enlightenment and direction of public opinion in regard to the great problems of medicine, so that the profession shall become more capable and more honorable within itself, and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life" (1941 Articles of Incorporation Extending Corporate Term, CX 5-J).

8. An additional purpose of MSMS is "To bring into one viable, effective organization the ethical physicians licensed to practice in Michigan in order that their contribution to human welfare will be enhanced" (June 1978 MSMS Constitution and Bylaws, CX 4-E).

9. In order to accomplish the above, the MSMS constitution provides that the organization will work to accomplish the following subpurposes: (A) to constitute, support and advise the American Medical Association in cooperation with similar societies of other states, in meeting its appropriate responsibilities; (B) to charter and organize constituent component medical societies; (C) to conceive, develop and administer health education programs designed to improve public understanding, awareness and acceptance of good medical standards, practices and concepts, as they relate to personal health, [6] scientific progress and society's advancement; (D) to stimulate advancement of the science and art of medicine and continually to seek to advance the medical, scientific, social, environmental, economic and medical political knowledge of its members in order that the doctor may better serve his patients and the public health generally; (E) to aid Michigan physicians individually and collectively in maintaining high levels of ethical conduct and standards of practice to protect and serve the

total public; (F) to provide medical leadership in meeting the health needs of the people by working with other medical and non-medical groups and individuals; (G) to preserve, protect and enhance physician-patient relationships, as basic to the delivery of quality health care; (H) to promote quality medical and health care by development and support of activities appropriate to this goal; (I) to advocate fair remuneration for services rendered; (J) to insure the adequacy of medical manpower by attracting capable people into the medical and health professions and to work toward the most effective distribution of their services; (K) to encourage medical students and physicians-in-training to participate in organized medicine in order to enable MSMS to be representative of all physicians; (L) to support the efforts of those who would preserve, protect and enhance the reputation and services of the medical profession; (M) to institute and provide specific services to meet the needs of the members; and (N) to foster and support continuing medical education (June 3, 1978 MSMS Constitution and Bylaws, CX 4-E).

10. The Scientific Assembly is one of the three major divisions of MSMS, and it is defined as "**** the convocation of its members for a presentation and discussion of subjects pertaining to the art and science of medicine and to the conservation of the health of the public" (June, 1978 MSMS Constitution and Bylaws, CX 4-E and F).

11. MSMS has the following standing scientific committees, which are called upon from time to time to study and develop programs dealing with specific diseases and problems such as: Committee on Aging; Committee on Blood Banks; Committee on Cancer; Committee on Cardiac Disease Control; Committee on Child Welfare; Committee on Diabetes Control; Committee on Highway Injury; Committee on Iodized Salt; Committee on Maternal and Perinatal Health; Committee on Mental Health; Committee on Occupational Medicine; Committee on Respiratory Diseases; Committee on Rural Medical Service; Committee on Venereal Disease Control (June, 1978 MSMS Constitution and Bylaws CX 4-S).

In pursuit of its goals, MSMS has been actively engaged in the following programs: [7]

1. *Continuing Medical Education*

12. The MSMS Commission on Continuing [Medical] Education ("CCME") was given the responsibility of developing standards for minimal continuing education requirements for doctors practicing in Michigan (CX 7-U). In May, 1974 it recommended (and the House of Delegates subsequently adopted) a program which would require 150 hours of continuing education over a three-year period (CX 7U and W).

13. Subsequently, the AMA provisionally authorized the CCME to review and accredit continuing education programs in Michigan (CX 7-U-V).

2. Public Health Activities and Education

14. MSMS participated in the National Immunization Month (October, 1973) by issuing news releases, broadcasting radio and television messages, holding news conferences, and printing posters to be hung in doctors' offices, in an effort to increase the level of immunization among Michigan citizens (CX 7-I).

15. MSMS was also involved in a pilot program (funded by a grant from the AMA) to improve medical care and health services in correctional institutions in four Michigan counties (CX-9V; CX 10-Y; CX 11-Z-5). In addition, it researched issues concerning the development of nuclear power in Michigan (CX 9-Z-15); broadcast radio programs regarding health issues (CPF 54); and distributed signs warning of the secondary effects of smoking (CX 9-X).

16. In 1974 and 1975, the MSMS Public and Environmental Health Committee took the following actions: Recommended that use of the Dri-dot Blood Test for gonorrhea be discontinued; worked on a new immunization reporting system between physicians, local health departments, and schools; studied the toxicology of the environment; and debated the role of public health medical practice. During this same time period, the Council approved the following recommendations of this Committee: that MSMS appoint a physician to serve as the Society's official representative to the Michigan Diabetes Association; that MSMS support efforts to eliminate the tuberculin skin test from the Michigan School Code; and that MSMS recognize the Michigan Heart Association guidelines for hypertension screening (CX 8-Z-13).

17. In addition, MSMS aided the State Department of Public Health in locating residents suffering from Reye's Syndrome, as part of a special disease control project (CX 9-Y); established a family planning training [8] program for physicians in rural areas (CX 9-V); lobbied against the legalization of laetrile (CX 11-Z-S); passed a resolution urging the President and Congress to consider implementing a recommendation of the National Academy of Science's Committee regarding the Veteran's Administration health care system (CX 11-Z-30).

3. The Profession

18. Pursuant to House of Delegates Resolution 73A-13, MSMS in 1974 voiced concern for the shortage of primary care physicians in Michigan. MSMS wrote letters to deans of medical schools, directors of training, and six hospitals with family practice residency programs,

and wrote letters to the Boards of Trustees of all Michigan hospitals, voicing this concern. MSMS also issued news releases, and speeches were given by MSMS officials, to encourage more physicians to train as primary care specialists (CX 7-H).

19. MSMS engaged in activities to aid physicians with alcohol and drug abuse problems (CX 9-Y, 9-Z-10, CX 145-C, CX 10-Z-18, CX 182-Z-3, CX 11-Z-12); conducted a seminar on the subject of better physician/patient relationships (CX 11-Z-13); and served on an advisory committee to the Michigan Health Data Corporation, to assist in the task of collecting data to evaluate the performance of Michigan hospitals.

4. *Maternal and Perinatal Health*

20. In 1974, the Committee on Maternal and Perinatal Health of MSMS was approached by the Michigan Department of Public Health and asked to consider the initiation of a family planning training program in rural areas. The Committee mailed questionnaires to physicians in various areas of the state to obtain information on current developments in family planning, and to create a format for dispensing family planning information (CX 9-Z-8-9).

21. The Committee also sponsored a conference on maternal and perinatal health, published and distributed desk reference cards for use by physicians and hospitals, sponsored a program for expectant parents and continued various studies and projects (CX 8-Z-10).

22. Committee discussions covered such topics as standards for perinatal nutritional care, fetal monitoring, maternal deaths from oxytocin, ectopic pregnancy deaths, etc. (CX 9-Z-13-14; CX 10-Z-21; RPF 59). In addition, the Committee studied maternal mortality in the state, perinatal morbidity and mortality and supported a Maternal Mortality Registry and a Placental Tissue Registry (CX 11-Z-[9]5). MSMS also arranged to have newborns covered by hospital insurance, and worked on a plan to screen newborns for diseases (CX 8-Z-10).

5. *Alcohol and Drug Abuse*

23. The MSMS Committee on Alcohol and Drug Dependency was instrumental in 1975 and 1976 in the implementation of the Public Intoxification Act and the development of regulations governing the operation of detoxification centers. The Committee also recommended that legislation be enacted making it illegal for physicians to dispense Schedule II Drugs from their offices in quantities larger than for one day's usage (CX 9-Z-10).

24. MSMS assisted in a month-long campaign on alcoholism, held in February of 1976 (CX 174-B).

6. *Eye Care*

25. The Committee on Eye Care in 1974-1975 considered at its meeting the following subjects: the Lion's Club Preschool Vision Screening Program, low vision clinics, ophthalmology referrals for rehabilitation, vision aspects of the Medicaid Program, eye care for trainable mentally retarded children, problems of coverage insufficiency, safety glasses for one-eyed amblyops, vision problems in low income areas, mobility of preschool and young children with severe vision impairment, and legislation to make school vision screening mandatory. During this time, the Committee on Eye Care also continued to serve in an advisory capacity to the Vision Section of the Michigan Department of Public Health's Bureau of Maternal and Child Health, and the Division of Services to the Blind of the Michigan Department of Social Services (CX 8-Z-10).

26. In 1975 and 1976, the Committee reviewed two proposed drafts for the Vision Section of the Medicaid Manual, studied the development of techniques for vision testing the mentally retarded and/or handicapped child, and developed guidelines for the treatment of tropias (CX 9-Z-12; CX 10-Z-20).

7. *Miscellaneous Programs and Activities*

27. The Committee on Aging drafted principles on improving care for the elderly, and also monitored federal and state legislation and programs pertaining to the elderly (CX 8-Z-9).

28. In October, 1975, the MSMS Committee on Highway Injury studied several bills pending before the Michigan Legislature concerning emergency medical service and other safety related issues (CX 9-Z-11). [10]

29. In 1975, the MSMS Ad Hoc Task Force on Public Health Statutes Revision Project ("PHSRP") was created by the MSMS Committee on State Legislation and Regulations to monitor the Public Health Statutes Provision Project. The Ad Hoc Task Force subsequently formulated MSMS responses to recommendations, and played a significant role in modifying the PHSRP Proposals as they were drafted into legislative form (CX 9-Z-5).

30. Pursuant to Resolution 75A-36, MSMS resolved to work closely with the Michigan Department of Health to upgrade and enforce existing guidelines for proper quality control of independent laboratories (CX 8-Z-25).

31. During May, 1975-1976, the Committee on Children and Youth accomplished the following: Agreed to work in cooperation with the Michigan Chapter of the American Academy of Pediatrics and the Michigan Perinatal Association toward the development of more in-

tensive care centers for infants in Michigan; recommended the development of a program in Michigan for the screening of newborns for disease (particularly congenital); endorsed the Right to Read Program; lent its support to efforts in the state to promote and provide educational programs on bicycle safety; and suggested that the Committee offer its counsel, when needed, to the Michigan Community Coordinated Child Care Council. The MSMS Council, during this same time period, approved recommendations of this Committee that MSMS support amendments to the Michigan Education Code to provide for the periodic re-evaluation of children enrolled in special education programs; and that MSMS support amendments to the Michigan Education Code to provide that children with scientifically documented learning disabilities, as well as physically handicapped and/or mentally retarded children, be eligible for special education programs under the Michigan Education Code (CX 9-Z-11).

32. Between May, 1975 and May, 1976 the Commission on Continuing Medical Education received provisional authorization to perform accreditation surveys within the State of Michigan by the AMA Council on Medical Education (CX 9-R).

33. During this period, MSMS was instrumental in getting the state legislature to pass a bill that defined death (CX 9-Y).

34. At this time an MSMS committee was appointed to respond to Mental Health Department Rules and Regulations regarding use of psychotropic drugs, and one set of such rules was amended pursuant to the review of this committee (CX 10-G). [11]

35. MSMS periodically informed its members of the possible legal ramifications of generic drug substitution (CX 10-G).

36. In the summer of 1977, the MSMS Committee on State Legislation and Regulations lobbied for MSMS regarding proposed Eye Bank legislation; laetrile legislation; a one-day, one-trial jury system; legislation on head and neck radiation-thyroid cancer; health and human sexuality education legislation; the New Public Health Code; legislation concerning patients' rights and responsibilities; legislation regarding dentists signing death certificates; and legislation dealing with a hospital construction moratorium (CX 182-H-I).

37. From May, 1977 to May, 1978, the MSMS Committee on CME Accreditation conducted 16 surveys, with seven hospitals receiving accreditations for the first time (CX 11-Z-4).

38. The MSMS Task Force on Medical Care Costs developed practical guides to assist hospital medical staffs in developing cost containment strategies and programs, helped the MSMS Committee on CME programming in developing a course on medical care costs for the 1978 MSMS Scientific Meeting, and maintained liaison with the

Michigan Medical School Council of Deans in developing programs on medical care costs for medical students (CX 189-H).

39. Pursuant to Resolution 78A-33, MSMS resolved to urge government hospitals to participate with private hospitals in making serious efforts toward cost containment; and further, that they share their cost performance data, and work toward greater public accountability (CX 11-Z-31).

40. Pursuant to Resolution 78A-57, the House of Delegates was directed to request component medical societies to investigate laboratory ownership arrangements and to take immediate action to assure that their physician members not be associated with any laboratory ownership schemes which may exploit patients (CX 11-Z-36).

B. Activities of MSMS Involving Pecuniary Benefit to Its Members

41. As noted in finding 7, *supra*, respondent MSMS is organized in part to further its members' pecuniary and business interests. To this end it engages in substantial activities or offers substantial services for [12] the economic benefit of its membership. One of its stated purposes is advocating fair remuneration for physicians' services. MSMS' activities and services include lobbying and legislative activities on bills having economic significance to members, intervening in or initiating lawsuits which affect members' pecuniary interests, close association with and control of organizations that further members' financial interests through the providing of services, public relations activities, practice management seminars, low-cost insurance programs, a variety of retirement plans, vacation package plans, continuing medical education courses which are available to MSMS members at a cost far below the charge to nonmembers, and a monthly magazine and newsletter dedicated in large part to reporting socio-economic trends and furnishing economic advice.

1. Corporate Purposes and Tax Status

42. MSMS was founded and exists as a federation for all physicians licensed to practice in Michigan (CX 5-B; CX 4-E). One of the purposes for which MSMS was incorporated in 1910 was "the guarding and fostering of [physicians'] material interests" (CX 5-B). The MSMS Constitution, as amended in 1978, proclaims that one of the objects of the corporation is "to advocate fair remuneration for services rendered" (CX 4-E; CX 7-N). MSMS maintains in-house staff and facilities, including a Bureau of Economics, which engage in many of the activities or furnish many of the services described *infra* (see, e.g., CX 123-C).

43. MSMS is exempt from federal income taxation pursuant to

Section 501(c)(6) of the Internal Revenue Code, 26 U.S.C. 501(c)(6) (1976) (CX 141-C), which exempts "business leagues, chambers of commerce, real estate boards and boards of trade" with members that share common business interests (Treas. Reg. Section 1.501(c)(6)-1 (1958)), rather than under Section 501(c)(3) of the Code, which exempts organizations formed and operated solely for religious, charitable and scientific purposes, 26 U.S.C. 501(c)(3) (1976). MSMS members can deduct their MSMS dues as ordinary and necessary business expenditures directly connected with or pertaining to their trade or business (Treas. Reg. Section 1.162-1(a) (1958)).

2. *Lobbying and Efforts to Influence Government Action*

44. Respondent MSMS furthers its members' pecuniary interests by engaging in lobbying and legislative activity. MSMS actively and intensively lobbied for proposed legislation which increased Medicaid payments to physicians; which lowered the cost of professional liability insurance; which prevented [13] chiropractors from obtaining state licensure status¹ and which reduced physicians' state income tax liability.

45. At House of Delegates meetings from 1974 through 1978, Council Chairmen reported that one of MSMS' priorities for each year was pursuing legislative objectives to accomplish MSMS' goals (CX 7-Z-5; CX 8-S; CX 9-Z-2; CX 10-Z-7; CX 11-Z-1; CX 182-S). The importance to MSMS of its lobbying activities is apparent from the intricate network of committees, programs and registered professional lobbyists it has employed to carry out this function.

46. MSMS employs both an independent registered lobbyist (CX 173-J-K; CX 236) and a registered lobbyist/employee (CX 237; CX 6-B). MSMS expects its lobbyists to establish and maintain individual liaison with members of the Michigan Legislature, to attend sessions; to report back pertinent details; and to discuss MSMS' strategic options (CX 172-J-K; CX 46-C, F, I-J).

47. MSMS also has a Committee on Federal Legislation to monitor the activities of the U.S. Congress, and to advise MSMS members how legislation under consideration would affect the practice of medicine in Michigan (CX 9-Z-12; CX 8-Z-10; CX 11-Z-13-14). Lobbying for or against federal legislation is managed through the American Medical Association's Washington office (CX 9-Z-12), with input from MSMS (CX 187-C; CX 133-B; CX 11-Z-5; CX 10-Z-20; CX 9-Z-12, U; CX 8-Z-7).

¹ This latter measure would have effectively enlarged the areas of medical treatment in which they could compete with physicians. MSMS approved the final legislative version which removed proposed language giving chiropractors the right to perform physical examinations; the right to perform incisive surgical procedures or invasive procedures requiring instrumentation; and the right to dispense or prescribe drugs (CX 10-Z-23; CX 57-B; CX 46-C; see CX 8-Z-5, Z-15).

48. MSMS lobbied energetically in 1975 and later to obtain higher reimbursement for physicians' services under the Medicaid program (CX 8-Z-15; CX 10-Z-23; CX 11-Z-6, Z-20, Y). In 1977, MSMS claimed that as a result of this lobbying, it had succeeded in increasing Medicaid reimbursement for 80 percent of all physicians' Medicaid services (CX 11-Y; *see also* CX 11-Z-20, Z-6). "This accounts for over 80% of the total Medicaid payout" (CX 88-B).

49. MSMS launched a major legislative drive in 1974 to lower the cost to its members of professional liability insurance (CX 7-N; CX 8-U, 8-Z-6, Z-7, Z-15, Z-17, Z-18, Z-20, Z-[14] 22, Z-23; CX 9-Z-16). Beginning in 1974, the cost of professional liability insurance to Michigan MDs increased sharply, and many MSMS members were in danger of losing their insurance coverage entirely (CX 7-I, Z-5, Z-6; CX 8-U, 8-Z-6, Z-7, Z-17; CX 32-B, J; CX 177-F).

50. MSMS' then President stated that "[t]he MSMS Council, our Committee on Professional Responsibility, and our staff all rate [this] malpractice situation as our *No. 1 MSMS priority*" (CX 32-B) (emphasis in original). During the first half of 1975, "[t]he Legislature enacted 15 professional liability bills which MSMS either conceived or supported" (CX 233-A).² MSMS encouraged legislation to protect members' livelihoods by making it more difficult for patients to sue physicians for malpractice (CX 233-A). For example, MSMS proposed legislation to require that prior to filing a medical malpractice lawsuit, a complainant file an "Affidavit of Merit" signed by an expert witness attesting to the merit of the claim (CX 8-V, Z-23; CX 9-Z-1; CX 10-Z-2; CX 233-A; CX 8-Z-18). MSMS also sought and obtained a statutory definition of medical malpractice, which made it more difficult for plaintiffs to prevail, by differentiating malpractice from maloccurrence or poor result (CX 9-Z, Z-7, Z-20; CX 10-F, Z-2, Z-23; CX 11-Z-5, Z-20; CX 96-B; CX 97-C-E; CX 177-N-O). MSMS lobbied for professional liability legislation, which was subsequently enacted, and which included a statutory definition limiting the class of those qualified to testify as an expert witness in medical malpractice lawsuits to a "Doctor of Medicine [or] Osteopathy who is actively engaged in the practice of medicine or surgery, in the particular specialty or field involved." The legislation specified that the "Doctor must spend most of his time in clinical practice in that specialty, and in the same *locale* as the defendant physician" (emphasis in original) (CX 9-Z-21; *see also* CX 9-Z; CX 177-N; CX 10-F). A fixed statute of limitations for medical malpractice was also established (CX 8-V, Z-18, Z-23; CX 9-Z, Z-7; CX 10-Z-2; CX 233-B); as well as a requirement for binding arbitration (CX 8-V, Z-18, Z-23; CX 9-Z; CX 10-Z-41; CX 233-B); a

² MSMS legal counsel drafts legislation for MSMS which legal counsel considers "[o]ne of the most important things [they] do" for MSMS (CX 77-C; *see also* CX 8-V).

prohibition against contingency fees for attorneys (CX 7-Z-20; CX 8-V, Z-23; CX 233-B); and a requirement that medical malpractice claimants disclose all sources of collateral income (CX 8-V, Z-18).

51. MSMS was active in the successful effort to amend the Michigan Single Business Tax statute, thus enabling physicians to decrease their state income tax liability (CX 96-A; CX 97-C, F; CX 9-Z-31, Z-32; CX 10-Z-23, Z-41). MSMS also [15] claimed that it had a significant impact on the defeat of "Proposition D," for a graduated state income tax. "Efforts to defeat Proposition D were led by the Committee against Higher Taxes, which MSMS members, more than any other group, help to finance" (CX 57-G).

52. MSMS also lobbied to protect its members' economic interests by pursuing and obtaining legislation which immunized physicians from lawsuits arising from performance as a "Good Samaritan" during an emergency situation occurring in a hospital (CX 233-C; CX 8-V), or from serving on a peer review committee (CX 233-C; CX 8-C, Z-23; CX 9-Z-1; CX 77-C).

3. *MSMS Involvement with Michigan Doctors Political Action Committee*

53. MSMS also furthers its members' pecuniary interests by pursuing its legislative objectives through the Michigan Doctors Political Action Committee ("MDPAC"). Organized by MSMS, and still closely affiliated with it, MDPAC complements MSMS' legislative efforts by contributing money to political campaigns in order to elect "friendly legislators".

54. MSMS itself cannot legally contribute money to support political candidates of its choice (CX 9-U), but MDPAC can and does contribute to political campaigns (CX 217-B; CX 9-U; CX 10-U). MSMS believes that "[o]nly by supporting *and* electing friendly legislators can [it] get friendly legislation" (emphasis in original) (CX 9-U; *see also* CX 110-U; CX 46-H; CX 217-B).

55. MDPAC holds its annual meeting at MSMS headquarters (CX 21-D). MDPAC's chairman, an MSMS member, reports to the MSMS House of Delegates annually (CX 6; CX 9-U; CX 10-U-V; CX 11-M). MDPAC holds its annual membership luncheon while the House of Delegates is in session (CX 242). Those who attend the membership luncheon are virtually all MSMS Delegates (CX 242). MSMS and MDPAC also co-sponsor an annual congressional reception in Washington, D.C., which enables MSMS members to meet their congressmen and to discuss legislative matters of importance to MSMS members (CX 52-D; *see* CX 9-X; CX 133-B).

56. MSMS raises money for MDPAC's candidate funding activities y soliciting contributions to MDPAC (CX 95-B; CX 96-B; CX 129-A;

CX 155-B). When MSMS members receive their annual dues billing, the statement includes a MDPAC contribution request (CX 96-B; CX 129-A; 155-B). MSMS also includes requests for contributions for MDPAC in its monthly magazine (CX 72-M-N) and biweekly newsletter (CX 95-B; CX 129-C-D). The Chairman of MDPAC solicits contributions from MSMS members during his annual presentation at the MSMS House of Delegates meetings (CX 9-U; CX 10-U-V). [16]

4. *Litigation*

57. MSMS initiated a lawsuit to prevent BCBSM from reducing its outpatient psychiatric benefits (CX 136-B). BCBSM's proposed actions would have reduced payments to MSMS physicians for these services. In 1978, MSMS also intervened in a lawsuit between BCBSM and Michigan's Insurance Commissioner because the outcome of the lawsuit could have affected rates of reimbursement to physicians. A decision favoring MSMS' position was rendered. MSMS legal counsel claimed that the decision in the case was "a victory for physicians" and that it would have "a favorable impact on our other litigation against BCBSM, particularly the psychiatric suit" (CX 136).

58. In March 1978, the MSMS Council authorized a direct payment of \$11,000 to help pay the expense of another physicians' professional organization which was involved in a dispute with BCBSM over differential reimbursement to participating and non-participating physicians. MSMS' Council believed that this expenditure would assist MSMS' legal counsel in carrying on its own lawsuit to prevent BCBSM from instituting a policy of differential payments to physicians (CX 187-F; CX 114-E; CX 11-U).

59. MSMS filed an *amicus curiae* brief before the U.S. Supreme Court in *Group Life and Health Ins. Co. v. Royal Drug Co., Inc.*, 440 U.S. 205 (1979), because the case involved "the extent to which Blue Cross-Blue Shield organizations may fix prices and discriminate against non-participating professionals free of antitrust liability" (CX 136-B; see CX 187-E; CX 191-F; CX 11-U).

60. MSMS legal counsel also filed an *amicus curiae* brief on behalf of a physician accused of malpractice who was countersuing the plaintiff's attorney for malicious prosecution (CX 136-B; CX 189-D; CX 190-D; CX 191-F).

5. *Professional Liability Insurance*

61. MSMS has advanced the economic interests of its members through the creation, funding and control of Michigan Physicians Mutual Liability Insurance Company ("MPMLC"). MPMLC sells professional liability insurance to physicians, including MSMS members, at low rates (Finding 64, *infra*).

62. In 1975, amidst MSMS' concern regarding the malpractice crisis (Finding 49, *supra*), MSMS created MPMLC (CX 8-U, Z-3; CX 9-T-U; CX 10-V-W; CX 38-A). MSMS invested over \$200,000 to help finance MPMLC (CX 12-S; *see* CX 9-J; CX 171-D; CX 177-J; CX 178-I; CX 10-V). "Approximately \$20,000 of that money has remained as an investment of the society in MPMLC—the amount of money that we do not intend to retrieve and will not retrieve" (CX 12-S; *see also* CX 171-D). [17]

63. MSMS controls MPMLC. The Michigan Bureau of Insurance required that MPMLC's original incorporators be MSMS members (CX 8-Y; CX 235-A; CX 6). During 1976 and 1978, the overwhelming majority of the MPMLC board of directors were MSMS members (CX 231; CX 6; *see* CX 10-V). MPMLC's officers have consistently been MSMS members (CX 6; CX 231; CX 9-R-U; CX 10-V-W; CX 11-O-P), including MPMLC's President from 1976-1978, Vernon V. Bass, MD, who also served as President of MSMS during 1978 (CX 6; CX 9-T; CX 10-V; CX 11-O; CX 231). MPMLC's President reports annually to the MSMS House of Delegates (CX 9-T-U; CX 10-V-W; CX 11-O-P). An MSMS employee maintains "official liaison" with MPMLC (CX 177-F). MSMS features current MPMLC news articles in its biweekly *Medigram* (CX 88; CX 155-B; CX 38-A).

64. MPMLC provides Michigan physicians with malpractice insurance (CX 10-V; CX 11-O; CX 38-A; CX 88-A; CX 177-F) at low rates (CX 10-V; CX 11-O). As MPMLC President Bass told the 1978 House of Delegates, "You have every right to be proud of your Michigan Physicians Mutual Liability Company. Its superb board of directors are now considered insurance executives with a physician's heart and empathy. It is a management company that is extremely responsive and an effective organization" (CX 11-O).

6. Publications

65. Both *Michigan Medicine*, the "Official Journal of the Michigan State Medical Society" (CX 58-A; CX 64-A) and *Michigan/Medicine Medigram*, MSMS' biweekly newsletter (CX 27-I), publish articles with a special emphasis on legislation, economic issues and medical news in Michigan (CX 11-Z-8; CX 9-V, Y, Z-5).

66. At its August 2, 1975, meeting, the MSMS Council responded to membership demand for socio-economic and news articles, in lieu of scientific news, by resolving that *Michigan Medicine* should no longer carry any scientific articles and that the position of Scientific Editor should be eliminated (CX 9-Z-17, Z-18; CX 171-B-C; CX 58-B). MSMS members reacted very favorably to the Council's actions. In response to an MSMS survey of 400 members, "83.7% of those responding said they prefer the news-magazine rather than the former

scientific publication” and “[t]he respondents said they rate CME, government programs, legislation, and legal advice as the four most important topics” (CX 10-Z-22).

67. *Michigan Medicine* publishes a variety of monthly columns which contain legal, economic and business advice for members (see, e.g., CX 64-C, 66-C). For example, in one issue of *Michigan Medicine*, MSMS legal counsel advised members about the professional and economic dangers of practicing without malpractice insurance (CX 64-C). An article in another issue advised members on the costs and advantages of incorporating their medical practices (CX 66-C). [18]

7. Public Relations and Membership Services

a. Public Relations

68. The public image of physicians is a vital concern of MSMS because most physicians rely on the public as their source of income, and because physician-patient relationships are dependent on the trust and respect accorded both to an individual physician and to the profession as a whole (see CX 10-Z-22; CX 9-Z-17). The MSMS Constitution proclaims that one of MSMS' purposes is “to support the efforts of those who would preserve, protect and enhance the reputation of *** the medical profession” (CX 4-E; see also CX 5-B; CX 7-N). To fulfill this purpose, MSMS set up a Committee on Public Relations (CX 7-N; CX 10-Z-22), and hired a public relations consultant (CX 10-Z-22).

69. MSMS used public relations to solicit support for the MSMS activities challenged in this case. In 1977, MSMS encouraged members to distribute to patients an MSMS-produced brochure explaining MSMS' reaction to BCBSM's new reimbursement policies (CX 184-F-G; CX 95-A). MSMS hoped to win public support for its position and thereby pressure BCBSM to be more responsive to MSMS' demands. The House of Delegates also developed a “detailed set of recommendations” for MSMS leaders handling media and public inquiries about MSMS' actions regarding BCBSM (CX 11-Z-19).

70. MSMS' public relations activities reinforced its legislative lobbying efforts regarding malpractice. During its intensive public relations campaign in 1975, MSMS spent approximately \$31,000 on advertising in order to “solicit public support for [MSMS'] legislative package” (CX 8-V-W). MSMS believed that if every MSMS member launched a “concerted effort to generate support and help from the public” for MSMS' legislative package, they could lower the cost of professional liability insurance (CX 34-A-C; CX 8-V-W; CX 8-Z-6, Z-7).

b. *Member Services*

(i) *Practice Management and Physician Service Group*

71. Respondent MSMS advances its members' economic interests by offering them a wide variety of money-saving practice management programs to increase the efficiency, productivity and profitability of their practices. The Physician Service Group ("PSG"), a wholly-owned, for-profit MSMS subsidiary, currently provides this service for MSMS members.

72. MSMS has advised physicians on financial management and the business side of practice through [19] publications, seminars and workshops (CX 66-C; CX 9-Z-5; CX 11-Z-7; CX 21-C; CX 11-Z-19, Z-20; CX 10-Y). MSMS members pay less to attend these workshops and seminars than non-members (CX 52-A).

73. MSMS has advised physicians on the financial aspects of opening a practice, office set-up, personnel management, streamlining paperwork, billing and collecting fees, patient flow, methods of obtaining referrals and the advantages or disadvantages of incorporating a medical practice or entering a partnership (CX 52-A; CX 126-A; CX 204-A, F, H-K).

74. In July 1978, the MSMS Council became concerned that MSMS was endangering its tax-exempt status by providing services to members which were turning a profit for MSMS (CX 141-C-D). MSMS also perceived an "increasingly critical Internal Revenue Service attitude toward the 501(c)(6) tax exempt status of organizations such as MSMS engaging in activities 'unrelated' to the incorporated purpose of the organization" (CX 141-C; CX 190-H). Council members, officers, staff and legal counsel discussed various MSMS options for providing "membership services outside of the clearly established tax-exempt scientific and socio-economic needs and services of [MSMS]" (CX 141-C; *see also* CX 190-H). PSG, a wholly-owned for-profit subsidiary was therefore established (CX 12-S-T; CX 190-H; CX 141-C-D).

75. MSMS controls PSG. MSMS' legal counsel drafted PSG's Articles of Incorporation and the Council approved them (CX 190-H). PSG was capitalized with funds contributed by MSMS (CX 12-R-T). MSMS owns all outstanding shares of PSG stock, approximately a \$50,000 investment (CX 12-S-T; CX 141-C). PSG's offices are located in the MSMS headquarters building (CX 141-C). MSMS members and employees serve as PSG's officers and Board of Directors (CX 6; CX 141).

76. PSG offers a wide variety of services, including many previously provided by MSMS, to MSMS members which inure to their financial benefit. For example, PSG offers members a credit card office payment plan at a group discount rate which assists physicians in saving money by cutting billing costs and reducing the number of uncollecti-

ble accounts (CX 161-B). PSG also offers MSMS members a bill collection service to help physicians collect delinquent accounts (CX 141-D). This service costs MSMS members less money than would using an independent bill collection service (CX 218-A). Other PSG services available to MSMS members include private financial and estate planning, loans to physicians, practice management consultations and practice management seminars (CX 141-D; CX 152-H).

(ii) *Insurance Programs for Members*

77. MSMS offers its members insurance programs such as disability (CX 223; CX 61-C; CX 8-Z-11), group term and [20] permanent life (CX 226; CX 58-C; CX 8-Z-11; CX 9-Y), workers' compensation (CX 74-C), office overhead protection (CX 225), and hospital, surgical and major medical insurance plans (CX 102-C; CX 229-A-D; CX 127-B; CX 178-D; CX 8-Z-11; CX 11-Z-16). MSMS considers these insurance programs to be a valuable benefit of membership (CX 58-C; CX 74-C; CX 61-C; CX 102-C) because they provide "broad insurance protection at low net cost" for enrolled members (CX 74-C). Three of the MSMS-sponsored insurance programs pay MSMS members annual dividends (CX 225-A; CX 58-C). During 1975, the MSMS-sponsored group term and permanent life insurance program paid enrolled members more than \$80,000 in dividends (CX 9-Y).

(iii) *Retirement Plans*

78. MSMS established a pension trust fund in 1978 after a membership survey demonstrated members' interest in such a fund (CX 186-E; CX 190-G; CX 11-V). The MSMS pooled pension trust fund is especially valuable for members who have no pension plan because these physicians can enroll in any one of the variety of MSMS plans without spending any money on the legal or accounting costs ordinarily associated with adopting such a plan (CX 189-F). The MSMS pension trust fund also enables members with an existing "Keogh or P.C. retirement plan" to switch easily to an MSMS plan (CX 189-F).

(iv) *Auto Leasing and Discount Rental Programs*

79. MSMS has arranged for "significant discounts" to MSMS members in renting or leasing a car or truck (CX 97-G; CX 227-A, C; CX 143-C; CX 227-A-B, D-G).

(v) *Continuing Medical Education*

80. MSMS offers continuing medical education courses for physicians (CX 9-V, Z-11, Z-12; CX 10-Z-12, Z-13; CX 43-A; CX 52-D), at a lower cost to MSMS members than to non-members (CX 182-J; CX 88-B; CX 89-A; CX 90-A; CX 189-G; CX 216-A).

(vi) *Vacation Plans*

81. MSMS members who join an MSMS-sponsored travel tour enjoy the "charter cost savings" of a group vacation package (CX 148-C; CX 86-A).

8. *Relationship with American Medical Association*

82. American Medical Association ("AMA") engages in substantial activities for the pecuniary benefit of its [21] members.³ Membership in a constituent society of AMA is a prerequisite to membership in AMA.⁴ MSMS is a constituent society of AMA (CX 5-B, J; CX 4-E). Membership in MSMS makes physicians eligible for membership in AMA.

III. INTERSTATE COMMERCE

83. MSMS members receive substantial amounts of money which move across state lines as reimbursement for physicians' services covered under the Medicaid program and the Federal Employees Health Benefits Program ("FEHBP") (Finding 84, *infra*).

84. In fiscal 1977, Michigan Medicaid paid \$110,585,629 for physicians' services covered by Medicaid. In fiscal 1978, Michigan Medicaid expenditures for reimbursement to physicians totaled \$119,268,000 (Dempsey 1774). For each of those years the Michigan Department of Social Services drew half of the amount of total physicians' services expenditures from federal funds in Washington, D.C. (Dempsey 1777; CX 728-B, ¶ 4). During the years 1977 and 1978, BCBSM paid \$30 million annually in reimbursement for health benefits, including physicians' services, under FEHBP contracts covering 36,000 federal employees in Michigan (Hustead 879-80, 871-72). All of these funds flowed across state lines from Illinois (location of the bank of the National Association of Blue Cross and Blue Shield Plan, *see* Finding 97, *infra*), into Michigan.

85. As noted earlier, Finding 1, *supra*, as of March 1975, over 80 percent of the physicians in Michigan were members of respondent MSMS (CX 50-A). As licensed physicians, MSMS members regularly purchase and prescribe drugs and other medical products (*see, e.g.*, CX 95-C-D).

86. Michigan physicians purchase significant amounts of drugs and other medical products directly from manufacturers in other states. The amount of money involved in these transactions is substantial. For example, Bausch & Lomb, Inc., a New York company which sells

³ *American Medical Ass'n*, 94 F.T.C. 701, 987 (1979), *aff'd*, 638 F.2d 443 (2d Cir. 1980).

⁴ *Id.* at 710.

its products directly to physicians, had sales in Michigan in 1979 of \$4.2 million (CX 728-E, ¶¶ 15-16). Hoechst-Roussel Pharmaceuticals, Inc., a New Jersey company which sells directly to physicians, had 1979 sales in Michigan of approximately \$4.6 million (CX 728-F, ¶¶ 21-22). [22]

87. Because MSMS members prescribe drugs and the use of other medical products, their prescription patterns necessarily affect sales of drugs and other medical products to Michigan purchasers, such as pharmacies, who are not physicians.

88. Manufacturers of drugs and other medical products located outside of Michigan sell significant amounts of their products to Michigan purchasers other than physicians. The amounts of money involved in these interstate transactions are substantial. For example, Astra Pharmaceutical Products, Inc., manufactures its products in Massachusetts and sells its prescription drugs to wholesale supply houses in Michigan; its sales into Michigan in 1979 totaled \$980,755 (CX 728-D, ¶¶ 10, 12-13). A. H. Robins Co., Inc., a Virginia manufacturer selling directly to wholesalers, hospitals and retailers, has annual sales in Michigan in excess of \$5 million (CX 728-E, ¶¶ 17-19). Burroughs Wellcome Co., a North Carolina manufacturer which sells its products to clinical laboratories in Michigan, had sales in Michigan in 1979 of approximately \$9 million (CX 728-F, ¶¶ 23-25). The Purdue Frederick Co., a New Jersey manufacturer selling pharmaceutical products to hospitals, and medical supply wholesalers and retailers, had sales in Michigan in 1979 in excess of \$1 million (CX 728-G, ¶¶ 26-28). Becton Dickinson and Co., a New Jersey manufacturer which sells to health care facilities and distributors in Michigan, had sales in Michigan in 1979 of \$6,214,066 (CX 728-G-H, ¶¶ 29-30, 32).

89. Under the Medicaid program the federal government pays 50 percent of the cost of Medicaid payments for physicians' services in Michigan (CX 728-B, ¶ 3; CX 728-A, ¶ 1). In fiscal 1977, Michigan Medicaid paid \$110,585,629 for physicians' services covered by Medicaid. In fiscal 1978, Michigan Medicaid expenditures for reimbursement to physicians totaled \$119,268,000 (Dempsey 1774). For each of those years the Michigan Department of Social Services drew half of the amount of total physicians' services expenditures from federal funds in Washington, D.C. (Dempsey 1777; CX 728B, ¶ 5).

90. FEHBP is a general health insurance plan under which the federal government, through the Office of Personnel Management ("OPM"), contracts with a number of insurers to provide health benefits for federal employees and their dependents (Hustead 854-55).

91. FEHBP enables federal employees and their dependents, wherever located in the United States, to take advantage of the service

benefits offered by Blue Cross and Blue Shield plans (Hustead 854, 859). OPM arranges for the provision of these benefits through a contract with the National Association of Blue Cross and Blue Shield Plans ("NABCBSPP"), an umbrella organization consisting of all the local Blue Cross and Blue Shield plans in the nation (Hustead 867-68). (OPM's contract with NABCBSPP for FEHBP Blue Cross-Blue Shield benefits is hereinafter referred to as the "OPM contract.") [23]

92. The OPM contract provides standardized benefits. This means that FEHBP offers identical Blue Cross and Blue Shield health insurance coverage to all federal employees nationwide (Hustead 863). Under NABCBSPP's service benefit plan, an employee may choose either high option or low option, and within each of those categories, he or she may choose either self-coverage or family coverage (Hustead 863). All employees electing the same option make the same premium payments and receive the same benefits, regardless of where they are located (Hustead 863).

93. Under the OPM contract, each local Blue Cross and Blue Shield plan pays for benefits, including those for physicians' services, rendered to federal employees in its plan area (Hustead 870-71, 868).

94. When BCBSM pays Michigan physicians for services covered under the OPM contract, NABCBSPP reimburses BCBSM for the expenditures with funds sent to Michigan from NABCBSPP's bank in Chicago, Illinois (Hustead 868, 872-73). The amount of NABCBSPP's reimbursement payments is substantial. During the years 1977 and 1978, NABCBSPP paid BCBSM \$30 million annually in reimbursement for health benefits, including physicians' services, under contracts covering 36,000 federal employees in Michigan (Hustead 879-80, 871-72).

95. Because the FEHBP premium rate is based on benefits expenditures and the rate is uniform for all subscribers wherever located, changes in BCBSM benefit payments to Michigan physicians affect the premiums paid to NABCBSPP's bank in Chicago, both by the federal government and by federal employees under FEHBP.

96. Under the terms of OPM's contract with NABCBSPP, a uniform standardized premium is paid for federal employees throughout the country with Blue Cross and Blue Shield coverage under FEHBP (Hustead 863). In their annual calculation of this nationwide premium rate, NABCBSPP and OPM consider the total of expenditures by all participating Blue Cross and Blue Shield plans (including BCBSM) over the past year for all enrolled federal employees and estimate total expenditures for the upcoming year. From this data, NABCBSPP and OPM establish an average uniform per capita premium rate (Hustead 875-76; Reveley 663). Each covered employee pays about 40

percent of this premium, and the federal government pays the remainder (Hustead 865).

97. OPM collects the federal employees' share of the premium for Blue Cross-Blue Shield coverage through payroll deductions at local payroll offices located throughout the world (Hustead 867, 872). OPM transfers these premium payments to Washington, D.C. (Hustead 872), then sends the employees' [24] contribution, combined with the federal share of the premium, to the Continental Bank in Chicago, Illinois (Hustead 865, 873).

98. A change in benefit payouts by an individual state or regional Blue Cross and Blue Shield plan, including BCBSM, affects the calculation of total nationwide expenditures by participating plans, and thereby affects the uniform nationwide premium rate. A change in the uniform nationwide premium rate is reflected in the amount of premium payments paid by OPM and by all federal employees with Blue Cross and Blue Shield coverage (Hustead 876-79, 865; Reveley 664-65).

99. Changes in BCBSM reimbursement payments to Michigan physicians affect the per capita premium costs for employees in states other than Michigan who receive Blue Cross and Blue Shield benefits under the more than 125 national accounts contracts with equalized rates in which BCBSM participates (Reveley 643, 649). With equalized rates, the premium paid by each employee is based on total benefit expenditures and a single rate is charged regardless of the state in which the employee lives (Reveley 648-649). Examples of such national accounts are Ford Motor Co., K-Mart and the Budd Company (Reveley 661).

100. A national account is an interstate agreement among Blue Cross and Blue Shield plans to provide service benefits to a single group of subscribers whose members reside in more than one state or other geographic area (Reveley 649, 643).

101. Of 250 national accounts in which BCBSM is involved, more than 125 of them use the "equalization" mechanism for determining per capita premium rates (Reveley 648-49).

102. In those national accounts using the equalization mechanism, changes in benefits payments by any of the Blue Cross and Blue Shield plans participating in the account affect the calculation of the nationwide equalized premium rate.⁵ The amount of money paid for benefits under these national accounts is substantial. Of the approximately \$186 million paid in total [25] Blue Shield benefits for em-

⁵ If one state has a greater proportion of covered employees than other states, changes in benefits payments for that state will have proportionately greater impact on the equalized rate (Reveley 649). In the Ford national account, for example, approximately 63 percent of the Ford employees with Blue Cross-Blue Shield coverage are located in Michigan and are enrolled through BCBSM (Reveley 657). As of December 1977, the Ford national account covered 330,710 persons in Michigan, including employees and their dependents (CX 661-F; Reveley 654).

ployees and their dependents covered under the Ford national account in 1978, BCBSM paid approximately \$77 million on behalf of Ford employees and their dependents in Michigan (Reveley 660-61).

103. Changes in reimbursement payments by BCBSM to Michigan physicians increase or otherwise affect the cost to automobile manufacturers of BCBSM health benefits policies purchased on behalf of Michigan employees. This, in turn, affects the amount remaining to pay wages and benefits other than health care for all automobile company employees, including those who reside in states other than Michigan (Glasser 504, 566).

104. The United Automobile Workers union ("UAW") negotiates national contracts with Ford, Chrysler, and General Motors covering these companies' employees in 34 states, including Michigan. The benefits paid out to UAW members under these contracts, including benefits for health care, are part of a collective bargaining agreement (Glasser 561-62, 598, 609, 611).

105. BCBSM has contracts with Ford, Chrysler and GM for the providing of most of the bargained health benefits, including the cost of physicians' services, to UAW members in the State of Michigan (Glasser 537-38, 560).

106. Occurrences that increase or otherwise affect payments for physicians' services by BCBSM on behalf of UAW members affect the amount of money available for other benefits and wages of all UAW members employed nationwide by Ford, Chrysler, and GM.⁶

107. Contacts between MSMS officials and representatives and parties in other states provided MSMS with knowledge and experience to assist respondent in engaging in the acts and practices challenged in the complaint. For example, MSMS developed the concept of its Division of Negotiations based upon contacts with and guidance from the AMA Department of Negotiations (*see, e.g.*, CX 10-P; CX 75-D; [26] CX 177-S-T).⁷ MSMS members also traveled interstate to attend meetings and seminars related to negotiating activities (CX 10-Z-4; CX 10-Z-3; CX 9-X; CX 411-A-J), and made attempts to influence policies of medical societies in other states in order to strengthen MSMS' position against third-party payers in Michigan (*see, e.g.*, CX 97-A).

108. Proxy and deparicipation solicitation as well as actual deparicipation were arranged in part through the mail, and MSMS continually informed members of its efforts in this direction in MSMS publications which are also sent through the mail (*see, e.g.*, CX 392;

⁶ It may also be that increased costs of UAW members' health care coverage may result in an overall increase in automobile manufacturers' labor costs. If so, to the extent that labor costs are reflected in the price of automobiles, increased health care costs may mean that the price of automobiles sold in interstate commerce is increased.

⁷ The AMA has its headquarters in Chicago, Illinois (CX 95-D).

425; 398-A-K; 372-A-B; 2-A-B; 330; 337; 352; 324-A; 325-A; 488-90; 490-94; 296-301; 108-C-F; 152-B, G; 69-C; 130-B; 131-A-C).

IV. THIRD-PARTY REIMBURSEMENT FOR
PHYSICIANS' SERVICES IN MICHIGAN

A. *Blue Cross and Blue Shield of Michigan*

109. BCBSM is a third-party payer for health care services. It provides hospital and medical care benefits to individual and group subscribers (Hayes 329-33; CX 249; *see, e.g.*, CX 229-K-N). Annually, BCBSM pays out several hundred million dollars in benefits payments to compensate for services performed by physicians (*see, e.g.*, CX 462-Z-33).

110. Blue Cross of Michigan and Blue Shield of Michigan were originally separately incorporated. However, they merged in 1975 to form BCBSM (Hayes 361-62). From 1940 to 1970 the MSMS House of Delegates elected Blue Shield of Michigan's Board of Directors. In 1970, the House of Delegates enacted a resolution severing its relationship with Blue Shield of Michigan, giving up the right to select directors (Hayes 315-317).

111. BCBSM's subscribers include Michigan members of the UAW and their families (Glasser 488). As of 1979, BCBSM's UAW subscribers numbered between 1.6 and 1.8 million people (Glasser 487).

112. In the latter part of the 1960's, BCBSM formed a committee to develop a new benefit program, because the fixed fee mechanism of paying physicians employed until then had not been substantially readjusted between 1958 and 1967 (Hayes 737-38).

113. Until 1968, the only subscribers receiving full service benefits (*i.e.*, medical services with no individual [27] out-of-pocket expenses) were those with an income falling short of a fixed amount (\$7,500 at that time). When a "formally participating"⁸ physician treated a patient whose income exceeded the limit, he/she could charge the patient in excess of the fixed fee (Hayes 738; Glasser 589, 591).

114. The UAW objected to the imposition of such an income limit, because its members whose income exceeded this amount were obligated to pay additional charges (Glasser 592). It wanted full service benefits (Hayes 738, 742).

115. After 1970, MSMS maintained a liaison with BCBSM to provide professional input on policies (Hayes 318). Dr. Hayes of BCBSM communicated with professional providers of services, including MSMS (Hayes 309, 313, 314).

116. BCBSM employs the term "service benefits" to identify the

⁸ See definition, finding 119 *infra*.

nature of the product that it provides to its subscribers (Hayes 329). "Service benefits" denotes a plan under which BCBSM pays providers of health care directly for medical services rendered to subscribers, and pays for covered services in full so that the subscribers incur no out-of-pocket expenses (Hayes 329-30; Glasser 489). The providing of service benefits by BCBSM therefore entails direct payments to physicians, including MSMS members. BCBSM does not provide any contracts other than for service benefits (Hayes 329-30).

117. Service benefits coverage is distinguished from indemnity insurance. An indemnity insurance contract provides for payment to subscribers of a fixed amount for a specific medical occurrence. In contrast, the service benefit contract provides for payment for service in full, without regard to a fixed amount (Hayes 330-31; Glasser 498-99). BCBSM does not offer indemnity insurance to its subscribers (Hayes 331).

118. BCBSM and its corporate predecessors have offered service benefit policies since 1940 (Hayes 341-42), and BCBSM considers service benefits to be a "founding and lasting principle" of its health care policies (CX 249-R). The services benefits concept also provides a competitive difference for BCBSM as opposed to other commercial insurance carriers. Some BCBSM subscribers, such as UAW, strongly prefer service benefits to other forms of coverage, because they believe that this assures that individual subscribers will not be overcharged by providers of health care (Glasser 491-92).

119. Service benefits coverage is closely tied to the concept of "physician participation" (Hayes 360). A "formally [28] participating physician" signs an agreement with BCBSM in which he or she promises to provide services to BCBSM subscribers, to accept BCBSM payment for such services as payment in full, and not to bill subscribers additionally for these services (Hayes 352). The greater the number of physicians who agree to formally participate, the more readily BCBSM can assure its subscribers that they will receive service benefits (Hayes 360). Both BCBSM and its subscribers believe it to be of critical importance that an adequate number of physicians agree to formally participate (Hayes 360; Glasser 496, 502-03, 570).

120. When a BCBSM subscriber is treated by a physician who has not signed a participation agreement with BCBSM, the physician's office staff will, in the vast majority of cases, fill out a BCBSM form for that subscriber and transmit it directly to BCBSM. The nonparticipating physician may elect to indicate on the claim form that he or she would like to be paid directly by BCBSM for that case, or he or she may check a box indicating that BCBSM is to reimburse the subscriber directly (Hayes 357-58). The nonparticipating physician may participate with BCBSM for that particular case, and accept

BCBSM's reimbursement as payment in full for that case (Hayes 358, 369). This is called "per-case participation," and the claim is processed identically to those of formally participating physicians.⁹

121. Formal participation enables BCBSM to develop records concerning the trends of costs and the filing of claims and to implement cost-containment policies based on these records (CX 249-R; Glasser 492-98).

122. By statute, BCBSM is required to have a majority of Michigan physicians enrolled as participating physicians in order to offer service benefits to subscribers (Hayes 360). As a practical matter, BCBSM cannot assure delivery of service benefits if formal participation by physicians falls significantly below the sixty-percent level (Hayes 360; Glasser 502).

123. When a BCBSM subscriber is treated by a participating physician, that physician's office staff prepares a claim form which it transmits to BCBSM. BCBSM processes the form and makes direct payment to the physician, and that payment constitutes full payment for services rendered (Hayes 352, 354-56, 371): [29]

124. If a physician elects not to participate, either formally or on a per-case basis, BCBSM reimbursement is made directly to the subscriber (Hayes 357-59, 368). In this circumstance, the subscriber may be obligated to make an out-of-pocket payment to his or her physician above the amount of BCBSM's reimbursement, because the nonparticipating physician is not obligated to accept BCBSM reimbursement as payment in full (Hayes 358-59).

125. When a nonparticipating physician treats a subscriber and decides not to participate on a per-case basis for that claim, the subscriber must sign a consent clause on the claim form indicating the subscriber's awareness that the physician's charge may exceed the BCBSM reimbursement, and that the excess charge is to be paid by the subscriber. In the event the subscriber has not executed this consent clause, when BCBSM mails its reimbursement to the subscriber, a statement is included to the effect that BCBSM has paid an appropriate fee based on its formula, and that if the subscriber receives a charge in excess of this amount, it will be paid by BCBSM (Hayes 359).

126. The nonparticipating physician is at liberty to determine the patient's ability to pay a fee higher than the amount of a BCBSM reimbursement for a given case, and based on this judgment, can decide whether or not to participate on a per-case basis (Hayes 358-59). Therefore, for the nonparticipating physician, BCBSM reimbursement constitutes the minimum, but not the maximum, amount

⁹ Per-case participation is provided for in a 1963 Consent Decree between BCBSM and the Michigan Insurance Commissioner (Hayes 768).

expected as payment to be paid for services rendered to a BCBSM subscriber; because the nonparticipating physician has the option of accepting BCBSM reimbursement as payment in full, or demanding a higher reimbursement from the subscriber.

127. Neither BCBSM nor the UAW believes that per-case participation by physicians is an acceptable substitute for formal participation, because optional per-case participation does not assure subscriber receipt of service benefits. Frequently, BCBSM subscribers are unaware of a physician's participation status, or they neglect to ask about this (Hayes 360-61; Glasser 508-10). Thus, subscribers who visit nonparticipating physicians risk an unanticipated out-of-pocket expense (Glasser 508-10).

128. Therefore, BCBSM seeks to encourage as many physicians as possible to formally participate (CX 249-R). BCBSM places no limit on the number of physicians who may formally participate (Hayes 353).

129. BCBSM determines reimbursement for every claim submitted by comparing the physician's charge entered on the claim form against two standards—the treating physician's "profile", and the prevailing "screen"—and pays the lower [30] amount indicated (Hayes 362, 367). "Profiles" measure individual physician's past charges for a particular medical service or procedure. "Screens" determine maximum BCBSM reimbursement to physicians in a given geographic area for that service or procedure.

130. A physician's "profile" is the charge that the physician most frequently makes for a specified service. BCBSM determines a physician's profile from the claim forms submitted by him over the previous 12-month period (Hayes 363). BCBSM keeps profiles on all physicians who submit claims, whether or not they participate (Hayes 367).

131. A "screen" is the amount which BCBSM determines to be the reasonable maximum reimbursement for a specified service rendered by any physician in a given geographic area, and is based on physicians' actual charging patterns in that area. Currently, BCBSM calculates "screens" on a statewide basis. Previously, BCBSM had divided the state into several geographic regions for purposes of determining screens. Under the past system, maximum reimbursement in some parts of the state, such as metropolitan Detroit, was higher than in other parts of the state (Hayes 364-66).

132. In some instances, BCBSM calculates screens in terms of percentages of charges paid in full. For example, a screen at the "80th percentile" means that maximum BCBSM reimbursement is an amount predetermined to pay in full 80 percent of claims for a given procedure (Hayes 364).

133. Some of the service benefits packages which BCBSM provides to subscribers are developed by the subscribers themselves. For example, since 1963, the UAW has independently developed health care coverage which it seeks to have employers supply UAW members (Glasser 483). These are developed with the in-house expertise of the UAW Social Security Department, and through consultation between the UAW and health care providers. (Glasser 476, 482-83). The benefits are then collectively bargained-for between the UAW and employers (Glasser 478-81). The plan, reflecting the outcome of negotiation, is then purchased from BCBSM (or another health insurer) (Glasser 483).

B. Michigan Medicaid

134. Under the Medicaid program, established pursuant to 42 U.S.C. 1396 *et seq.* (1976 & Supp. III 1979), health care providers, including physicians, throughout the United States are reimbursed from a combination of federal, state, and sometimes local funds for medical services rendered to millions of eligible low-income persons (CX 728-A).

135. Michigan's Medicaid program is administered by the Michigan Department of Social Services, which makes direct payments to physicians, including MSMS members, and other [31] providers of health care, for covered services rendered to eligible persons (Mich. Comp. Laws Ann. Sections 400.1, 400.105-.112 (West 1976 & Supp. 1980-81), *as amended by* Act of Dec. 12, 1980, Pub. Act. No. 321, Mich. Adv. Sess. Laws Rep. (CCH 657; *see generally* CX 421, CX 7-S)).

136. Both the Federal Government and the State of Michigan define the relationship between individual physicians and the Medicaid program (Mich. Comp. Laws Ann. Sections 400.105-.112 (West 1976 & Supp. 1980-81), *as amended by* Act of Dec. 12, 1980, Pub. Act No. 321, Mich. Adv. Sess. Laws Rep. (CCH) 657; 42 U.S.C. 1396 *et seq.* (1976 & Supp. III 1979); 42 C.F.R. 430-456 (1979) (and amendments)). A physician who agrees to treat a Medicaid recipient agrees to accept Medicaid's payment for covered services rendered (42 C.F.R. 447.15 (1979), *as amended by* 45 FR 24,889 (1980)). The amount of Medicaid reimbursement is determined by reimbursement policies which are similar to those used by BCBSM (*see* 42 C.F.R. 447.341 (1979), *as amended by* 45 FR 24,889 (1980); Findings 129-130 *supra*).

V. ACTIVITIES OF MSMS LEADING TO THE COMMISSION'S COMPLAINT

A. Relationship Between MSMS and BCBSM

137. As noted, finding 110, *supra*, before 1970 the House of Delegates of MSMS selected the Board of Directors of BCBSM (Hayes 315-317). In addition, until 1970, representatives of BCBSM attended all House of Delegates meetings to keep MSMS abreast of BCBSM activities (Hayes 315-317).

138. In 1970, MSMS severed its formal relationship with BCBSM (Hayes 317) although an informal liaison was retained through Dr. Louis Hayes of BCBSM. Dr. Hayes communicated with MSMS through its staff about administrative matters, or when the issue was policy matters, through the MSMS' President or Council Chairman. MSMS contacted BCBSM when there were matters of concern to discuss (Hayes 314, 318). From 1968 to 1980, Dr. Hayes was also an alternate delegate from Wayne County to the MSMS House of Delegates (Hayes 324).

B. MSMS Areas of Concern

139. In 1974, respondent MSMS formed a negotiating committee, which was to operate as a liaison between respondent and BCBSM (Crandall 1678). The chairman of this committee was Dr. Donald Crandall (Crandall 1679).

140. At this time several issues were of primary importance to MSMS and its members. One such issue was the determination of MSMS to have a uniform claim form and coding system, which MSMS members believed would be more efficient and [32] would serve to facilitate cost containment (Crandall 1680; Hayes 746). Because physicians treat patients insured by a number of insurance carriers, a uniform claim form would eliminate the need to deal with many different types of forms.

141. BCBSM agreed, in principle, that the use of uniform claim forms and coding systems was justified as a method of insuring the accuracy of information provided by the individual filling out the forms (Hayes 747). However, BCBSM believed that the changes proposed by MSMS would be too expensive because of the required adjustment to BCBSM's data processing system (Hayes 388), estimated to be more than \$1 million. In addition, BCBSM felt that the system proposed by MSMS was too complex and detailed (Hayes 389). A report written by BCBSM in October 1979 detailed its objections (CX 446 E-I).

142. Another subject of controversy between BCBSM and MSMS

was that of a statewide screen for Michigan physicians. Prior to 1978 physicians were reimbursed based on a regional screen (*See Finding 131, supra*).

143. During meetings of the MSMS Negotiating Committee in 1974 and 1975 this issue was raised. The Committee suggested to BCBSM that a statewide screen would more accurately reflect the cost of doing (medical) business in the State of Michigan and that this was especially true because of the specialists practicing statewide (Hayes 752; Crandall 691; CX 458D).

144. BCBSM rejected physician demands for a statewide screen for reasons of cost and equity. BCBSM reasoned that if a statewide screen was created by raising all regional screens to the level of the highest screen (covering the Detroit metropolitan area) the result would mean an increase of approximately \$7 million in the payments made by BCBSM to physicians. Such an increase BCBSM believed would be unacceptable to its subscribers and to the Michigan Insurance Bureau (CX 107H-I).

145. Another option available to BCBSM was to create a single screen by averaging all the existing regional screens. This would have had the advantage of not increasing reimbursement, but would also have reduced payments to physicians in the Detroit area, 69% of the total BCBSM payout. However, BCBSM believed that this would have been unacceptable to Detroit doctors (CX 462-Z-33, Z-34, CX 445C).

146. The third area of contention between BCBSM and MSMS concerned the updating of physician's profiles (Crandall 1694). In discussions between BCBSM and MSMS, respondent asked BCBSM to send out profiles annually for physicians to review (Hayes 754, 755). As of 1974, only 33 percent of Michigan physicians requested updates on their profiles on an annual basis (Hayes 755; CX 107). [33]

147. BCBSM was unwilling to automatically update physicians' profiles, because to do so would have increased reimbursements, e.g., 1974 by \$13 million (CX 107-I).

C. MSMS Negotiations with BCBSM

148. In April 1975, the MSMS Negotiating Committee issued a report to the MSMS House of Delegates, which was excerpted in *Michigan Medicine* (CX 462A-Z-33, Z-36). This report summarized the prior year's activities and negotiations with BCBSM regarding uniform claim forms and coding, statewide screens and automatic profile updates from BCBSM (CX 47A-F; CX 8L-0) and stated:

The recalcitrant attitude of Blue Shield on the subjects of regionalization of fees and physician profiles, coupled with what appears to be a total lack of willingness to

cooperate with MSMS in the development of a uniform claim form or even consider the use of CPT procedural code, can only bring the Committee to one logical conclusion: Blue Shield apparently has no intention of ever compromising on, or cooperating with, MSMS on any of the issues we have discussed with them during the past year (CX 47-F; CX 8-0).

149. The Negotiating Committee therefore specifically recommend that the MSMS House of Delegates urge MSMS members to join in a concerted campaign against BCBSM to compel BCBSM to modify its position:

(A) All MSMS members who have a formal participation agreement with Blue Cross-Blue Shield to notify same, by letter, that they no longer will participate, these letters to be mailed to MSMS, in care of the Negotiating Committee with Third-Party Carriers, which will have the option of exercising the nonparticipation "proxies" upon 10-day advance notice to the physician; (B) All members to not submit any Doctor's Service Report "Payment to Doctor" claim forms for services rendered to Blue Cross-Blue Shield; (C) All MSMS members to continue submitting Doctor's Service Report "Payment to Subscriber" claim forms, duly signed by the subscriber (or patient) and the physician; and (D) All MSMS members to not take any "per case payment," as this could be construed as "participation" by Blue Cross-Blue Shield (CX 47-F; CX 8-0) (emphasis in original).

150. During its May, 1975 annual meeting, the House of Delegates authorized the Negotiating Committee to collect nonparticipation proxies from all physicians. These would be held by MSMS and would be "executed only with prior notice and at the discretion of the council, upon recommendation of the [34] Negotiating Committee if a negotiating impasse develops with Michigan Blue Cross/Blue Shield" (CX 8-0).

151. The House of Delegates' decision to authorize the Negotiating Committee to collect "non-participation proxies", was reported to the MSMS membership in a May 1975 *Medigram* (CX 38-A), and was subsequently communicated to the membership in greater detail in the August 1975 issue of *Michigan Medicine*, (CX 8). In May 1975, Dr. Crandall sent letters on behalf of MSMS to several MSMS component societies requesting the opportunity to personally explain the significance of the House of Delegates decision to collect proxies, and also to explain "why it is imperative MSMS has the cooperation and support of the doctors" (CX 330; CX 337; CX 352). Additionally, a member of the Negotiating Committee spoke at a component society meeting advising the membership of the decision to collect proxies and requesting support (CX 310-D; CX 445-A). However, MSMS did not collect proxies in 1975, apparently because negotiations with BCBSM proceeded more smoothly on some of the issues in question.

152. Subsequent to the 1975 House of Delegates meeting, negotiations resumed between the Negotiating Committee and representa-

tives of BCBSM (Hayes 402). These meetings were attended on behalf of BCBSM by the BCBSM Board of Directors' Professional Relations Committee, along with BCBSM management. Previously, only management representatives had attended on behalf of BCBSM (Hayes 402). Dr. Crandall reported this as a concession by BCBSM in recognition of the "overwhelming" support the MSMS House of Delegates expressed for the Negotiating Committee by authorizing collection of proxies, and that this demonstrated the "clout" MSMS could exert against third-party payers:

The Professional Relations Committee of the Blue Shield Board then intervened in the face of this overwhelming support by MSMS delegates for the Negotiating Committee's stands. The BC/BSM Board recognized the significance of the disagreement and guaranteed that progress would be made if the Negotiating Committee reinstated deliberations. The Negotiating Committee had thus established its credibility and its clout through the support of all the MSMS delegates (CX 411-D).

153. At an October 8, 1974, meeting of the MSMS Negotiating Committee, BCBSM stated that it would accept a uniform claim form developed by the AMA (CX 445-B; CX 446E-I). The Negotiating Committee was agreeable, as they were merely interested in the development of some type of uniform claim form (Crandall, 1687-88). Eventually, the AMA form was rejected by BCBSM. However, BCBSM agreed to continue working on the development of a uniform claim form (CX 446-I). [35]

154. A uniform claim form was drafted by BCBSM and Medicaid representatives (Hayes 748). But by January 1975, it seemed to MSMS that BCBSM was no longer committed to the project (Crandall 1684). An impasse between the parties developed (Crandall 1686).

155. In May 1975, there was a joint meeting of the members of the MSMS Negotiating Committee and BCBSM's Professional Relations Committee. At this time it was decided that work would continue on the uniform claim form and coding system, and that BCBSM would continue to work with Michigan Medicaid to draft a sample form (Hayes, 750; Crandall, 1686-1687).

156. Between the 1975 and 1976 House of Delegates meetings, MSMS and BCBSM (and other third-party payers) came into an agreement on a single coding system and uniform claim form (CX 9-M-N; CX 411-D). However, MSMS' demands concerning a statewide screen and profile updates remained unresolved (Hayes 403; CX 411-D).

157. The issue of a statewide screen was the subject of numerous discussions within the Negotiating Committee. (Crandall 1690; Hayes 383-84; 401-02).

158. For some time there were four regions for the purpose of setting screens. Region No. 1 had always been the greater metropoli-

tan Detroit area, consisting of Wayne, Oakland and Macomb Counties. Region 2 included all counties in Michigan in which there was a city with a population in excess of 50,000. Region No. 3 consisted of all of the other counties in the lower peninsula; and Region No. 4 contained all of the counties in the upper peninsula. After several years, BCBSM consolidated these into three regions, because the physicians' screen in the upper peninsula gradually came more into line with those in the lower. Accordingly, Regions three and four were combined (Hayes 365).

159. During this period, BCBSM reimbursement to physicians often varied from region to region (Hayes 365-66). MSMS objected to this, contending that the cost of practicing medicine was uniform statewide (CX 458-D) and that regionalization of fees "antagonized and created further dichotomy between physicians in the State of Michigan" (CX 458-E). In addition, MSMS contended that regionalization of screens was a cause of maldistribution of physicians in the State of Michigan (CX 458-E).

160. It was MSMS' position, that while it favored BCBSM implementing a statewide screen, it was not urging that BCBSM increase its overall dollar payout to physicians in the process (Hayes 752; CX 462-Z-33; Crandall 1692). [36]

161. During one of the discussions between them, the MSMS Negotiating Committee suggested to BCBSM that it utilize its own cost containment guidelines, and lower the percentage increase in the various regions of the state until a statewide screen was achieved. This could be done, it was suggested, on a gradual basis over a reasonable time period of BCBSM's choosing (Hayes 752-53).

162. The Negotiating Committee also took the position with BCBSM that regionalization of screens was unfair to subscribers in outlying areas, because these patients had to pay the same premiums, but were receiving less in the way of benefits (Crandall 1692-93).

163. On October 8, 1974, BCBSM promised MSMS a report responding to certain suggestions regarding the updating of physician profiles. However, no such report was ever received by MSMS (CX 47-E; CX 445 A-D).

164. In January 1975, BCBSM told to the MSMS Negotiating Committee that it would work out some mechanism which would accomplish a statewide screen. But in February 1975, BCBSM stated to the Negotiating Committee that it would not do so, because a statewide screen was against BCBSM policy (Crandall 1693).

165. In February 1975, BCBSM told the MSMS Negotiating Committee that it would reconsider its rejection of a statewide screen, if MSMS would guarantee that there be no decrease in formal participa-

tion in Region No. 1 if such a screen was implemented (Crandall 1693-94).

166. The Negotiating Committee responded to BCBSM that it could not guarantee any level of participation in Region No. 1, because participation was entirely a matter of individual decision on the part of each physician (Crandall 1694).

167. In 1976, the AMA created a Department of Negotiations, which offered a series of instructional seminars on negotiations (CX 10Z-3). Members of the MSMS Negotiating Committee attended these seminars (CX 411-D-E; CX 10-Z-3). They determined that a state level Division of Negotiations, corresponding to and communicating with the AMA organization could function as an effective mechanism (CX 411-D-E; CX 1, 0-Z-3).

168. In May 1976, when the MSMS House of Delegates held its annual meeting, the delegates agreed to create an MSMS Division of Negotiations. The functions of the new Division were to include, but not be limited to:

1. Identification of specific problems amenable to negotiations;
2. Assembly of pertinent data and research of problems; [37]
3. Establishing of guidelines;
4. Negotiation of solutions;
5. Devising of specific action plans;
6. Coordination of all negotiation activities of MSMS;
7. Giving assistance to physicians, medical groups and communities as requested for negotiating problems;
8. Educating the membership regarding the use and techniques of negotiation;
9. At the earliest time possible, obtain authorization from all members of MSMS for the department of negotiations of MSMS to be the exclusive bargaining agent for all;
10. Collect immediately "non-participation proxies" from all physicians to be held in escrow at MSMS, to be executed in the event of failure of negotiations; and
11. The department of negotiations formulate a "negotiated participation agreement" with third-party payors which shall eliminate reasons for nonparticipation. (CX 13-Q; CX 9-Z-31).

169. Dr. Crandall explained to the House of Delegates that the Division of Negotiations would negotiate (with third-party payers) the manner of determining fees, but not specific fees (CX 13-Z-13).

170. During debate over the resolution to form the Division of Negotiations, concern was expressed by some delegates about the propriety of requesting nonparticipation proxies from MSMS members. An amendment was offered to strike this provision from the

resolution (CX 13-Z, Z-1, Z-2). Speaking against the amendment, one delegate pointed out that the proxies would give MSMS a weapon to use against BCBSM:

It has been my observation during the past year that one of the very effective tools that people have in negotiating in behalf of physicians in this state is the participation agreements the physicians maintain with Blue Cross and Blue Shield. [38]

It is my feeling that the negotiation department ought to know one of two things: Either it ought to know that it is not able to get the participation proxies, in which case it could structure its negotiations accordingly; and more hopefully and, I believe, more likely, it would have in hand a proxy from a larger majority of physicians in Michigan, which it could use as it came to the autos.

When I go hunting, I like to have a full gun, and so should the department of negotiations (CX 13-Z-6, Z-7).

171. The proposed amendment was defeated and collection of proxies was authorized (CX 13-Z-9).

172. The proxies collected by MSMS would not be exercised without the approval of the Council of Delegates, and upon ten-days' notice to each physician who signed one (CX 178-H).

173. The August, 1976 issue of *Michigan Medicine* stressed the need for unified membership support for the Division of Negotiations, and stressed the necessity of members submitting nonparticipation proxies (CX 75).

174. The Division of Negotiations reported to the Council of Delegates at the latter's meeting in July 1976, and proposed that the Division recommend to the Council the circumstance in which the proxies should be used (CX 177B-C, R-U). A follow-up report was submitted to the Council on August 23, 1976 (CX 472), advising the Council that a mailing to MSMS members soliciting nonparticipation proxies would be sent on August 25, 1976 (CX 472 B-F).

175. A resolution was proposed and adopted, resolving that the results of the proxy solicitation be given only to the Chairman of the Division on Negotiations, the President of MSMS and the Chairman of the Council (Crandall, 1703; CX 472-B; CX 178-H).

176. Shortly after its establishment, the Division of Negotiations discovered that BCBSM was developing a new method of reimbursement for services performed by hospital-based radiologists and pathologists (CX 10-Z-3; CX 463). MSMS objected to this, contending that this amounted to interference with the contractual relationship between these specialists and their hospital employers (Crandall 1700; Hayes 775-76).

177. The Michigan Radiological Society had expressed its concern about the manner in which they would be reimbursed by BCBSM

(Hayes 777), and had then contacted MSMS, requesting advice and assistance (CX 464). [39]

178. In June 1976, Dr. Crandall proposed that a meeting be held between the Negotiating Committee and representatives of the affected specialists (CX 468). He suggested to the presidents of the pathology and radiology societies that MSMS could assist them and that there should be a solicitation of pathologists and radiologists' depar-ticipation proxies to be held in escrow at MSMS (CX 177-S).

179. This meeting was held at MSMS headquarters on July 21, 1976. It was decided that nonparticipation proxies would be collected from all MSMS members ". . . to be executed only with the approval of the Council and within ten days notice to each physician signing a non-par[ticipation] proxy, in the event of failure of negotiations with Blue Cross/Blue Shield" (CX 650-C).

180. Simultaneously, the Michigan Radiological Society established its own Ad Hoc Committee to deal with and respond to BCBSM's proposed reimbursement system for hospital based physicians (RX 3-A), and published its own position paper (RX 3-A-F).

181. On August 18, 1976, BCBSM requested that the Michigan Society of Pathologists submit cost containment ideas regarding laboratory and x-ray testing services (RX 40A). In addition, BCBSM that month issued its "Initial Report on Hospital-based Physician Compensation: Pathology and Radiology." The report recommended that discussions be held with representatives of these groups, including MSMS, to keep them informed and to provide for an input mechanism (CX 69-D).

182. On September 29, 1976, the Board of Directors of BCBSM approved a cost containment plan relating to reimbursement for hospital-based physicians (RX 38-A).

183. In summary, as of August 25, 1976, the Division of Negotiations had received Council approval to solicit nonparticipation proxies from MSMS members and obtained approval to keep the results secret. Additional impetus for proxy solicitation resulted from the agreement between MSMS and the specialty societies to collect and use proxies (Finding 179).

184. Nonparticipation proxies were solicited from MSMS members by letter dated August 25, 1976 signed by then Council Chairman Dr. Ernest P. Griffin (CX 2). This letter reviews the prior negotiations between MSMS and BCBSM and refers to the 1975 decision of the MSMS House of Delegates to solicit nonparticipation proxies:

The House approved that report to give its Negotiating Committee with Third Party Carriers the power to negotiate effectively with Blue Cross/Blue Shield. A certain

percentage of the physicians in Michigan must be participating or Blue Cross/Blue Shield may lose special advantages it holds under its enabling legislation. [40]

In 1975, the major issues MSMS and BC/BS were negotiating were the uniform claims form and uniform coding system. As you know, after the approval of the report, both the claims form and the coding became a reality.

(CX 2-A).

185. The members were advised that "Blue Cross/Blue Shield continues, however, to propose and execute unilateral programs that are not in the best interest of MSMS members." These programs include "so-called cost containment programs that in effect reduce reimbursements to physicians or place the responsibility for the reduction of costs solely on the practicing physician" (CX 2-A).

186. The letter explained that collection of proxies was now necessary to combat those unilateral cost-containment programs:

[We now ask for your proxy, so that the MSMS Committee can function as an equal with BC/BS. Our MSMS position must be backed with the power to non-participate, if it becomes necessary to use the proxies. Our tactical strength can be applied more quickly if the proxies are already in the hands of the Negotiating Committee, rather than waiting for receipt of them from the physicians throughout the State (CX 2-A).

187. Two "powers of attorney" were sent with the letter, one captioned "Power of Attorney to Michigan State Medical Society Re: Blue Cross/Blue Shield," the other captioned "Power of Attorney to Michigan State Medical Society Re: Michigan Medicaid" (CX 2-C). The powers of attorney are substantially identical, each providing that:

I [name typed] , hereby designate Michigan State Medical Society, a Michigan corporation, as my agent and attorney-in-fact for the purpose of canceling my participation agreement with Blue Cross-Blue Shield [or, with respect to Medicaid, my participation in the Michigan Medicaid program].

This power of attorney shall remain in full force and effect until June 30, 1978, unless revoked by me in writing prior thereto (CX 2-C).

These powers of attorney gave the Negotiating Committee the right to deparicipate Michigan physicians from BCBSM and Medicaid if an impasse was reached in negotiations, and the Division of Negotiations and the MSMS Council determined that deparicipation was warranted (CX 10-Z-3; CX 411-E-G). [41]

188. MSMS officials made efforts in the weeks which followed the sending of this soliciation, to assure component society and membership support. In October 1976, Dr. Griffin addressed the Board of Directors of the Oakland County Medical Society (an MSMS component society) concerning both the proxy soliciation effort, and the

efforts of specialists' organizations and MSMS to oppose BCBSM's hospital-based physician reimbursement proposals. Dr. Griffin stressed the importance of the Negotiating Committee, and in particular, the need for component society support for that committee's efforts (CX 311-B).

189. In October 1976, the MSMS Negotiating Committee reported to the Council that "we have received an overwhelming response from physicians who have indicated they are very willing to lend support to the MSMS proxy solicitation campaign" (CX 473-A). The Negotiating Committee reported that MSMS had received support from the Genesee County Medical Society, the Michigan Societies of Radiology and Pathology, and other specialty societies and professional corporations (CX 472-A; CX 10-P-Q). It stated further that the dispute between hospital-based specialists and BCBSM over reimbursement methods had been concluded favorably to the specialists. "The Committee on Negotiations feels it was instrumental in combining the forces of the Michigan radiologists and pathologists in confronting the initial Blue Cross/Blue Shield proposals" (CX 473-A). Council Chairman Griffin issued a report which reiterated the Negotiating Committee's assertions, noting further that, as a consequence of MSMS actions, present methods for reimbursing hospital-based physicians remained in effect (CX 653-A-B).

190. Ultimately, a majority of Michigan physicians executed proxies and submitted them to the Negotiating Committee (CX 10-Z-3; CX 411-F). The Committee identified them as "the most significant factor in establishing the authority of the Division of Negotiations" (CX 10-Z-3).

191. Dr. Hayes of BCBSM, an MSMS member, received a copy of the proxy solicitation (Hayes 409). Dr. Hayes transmitted copies of the solicitation to BCBSM's president, John McCabe, as well as to other BCBSM executives who had in the past dealt with MSMS under Dr. Hayes' direction (Hayes 412). Although BCBSM was not apprised of the results of the proxy solicitation, it was seriously concerned about its implications and expressed that concern in a letter prepared by Dr. Hayes for Mr. McCabe's signature. This letter was sent to MSMS, its Council, and its component societies on September 15, 1976 (Hayes 412-14; CX 393). In part, the letter stated:

If the ultimate intent of garnering proxies is attained—wholesale de-participation by physicians—there will be ominous implications for all concerned. [42]

Obviously, the ability of BCBSM to deliver service benefits would be diminished. In the process, MSMS could lose its strongest ally in the struggle to retain our current method of financing and delivering health care—keeping it in the private sector.

Our subscribers—your patients—would be impacted. They may be subjected to greater

out-of-pocket expense. In the process, their attitudes about physicians are sure to deteriorate (CX 393-B-C).

It closes with an offer to conciliate:

We are most anxious to continue relating to the medical profession—whether in an atmosphere of “liaison,” or one of “negotiation”—is not important. We are necessary to each other and must meet, discuss and reach agreements. BCBSM stands ready to meet and discuss—and has asked for an early exploratory meeting. We hope for an early response (CX 393-C).

192. Discussions between BCBSM and MSMS continued in November 1976, but no resolution of outstanding reimbursement issues was reached (CX 10-Z-4; CX 411-H).

193. In the fall of 1976, the MSMS Division of Negotiations was involved in discussions with BCBSM on cost containment and it set up a “brainstorming session” in November 1976 to identify potential problem areas, and to develop dialogue to solve such problems and to avoid confrontation. The “brainstorming session” was attended by leaders of the MSMS and Division of Negotiations, by and representatives of BCBSM (Crandall 1707; CX 373-B).

194. In 1977, BCBSM made several major changes in its reimbursement policies. The first change was to increase reimbursement to physicians who formally participated with the goal of encouraging all Michigan physicians to do so (Hayes 416). This was done with no prior notice to MSMS (Crandall 1708; RX 8).

195. BCBSM decided to implement a statewide screen for participating physicians, and to automatically update the physicians’ profiles for all physicians who agreed to participate for a one-year period beginning in October 1977. These profiles would be updated to the charge levels shown on claim forms filed by the participating physicians from July 1976 to June 1977. This would allow participating physicians a cumulative carry-over of annual customary fee increases in the event they elected not to file an annual request with BCBSM for a fee increase. The cumulative carry-over was intended to give these physicians who did not apply for an annual profile increase an increase based on the total rate of increased charges from the date of their last profile increase, rather [43] than for only a twelve-month period, as had previously been BCBSM’s policy (Hayes 419-20; CX 356-O).

196. In BCBSM’s view, the new reimbursement policy was directed at encouraging cost containment, and improving payout levels and equity in payment to physicians (RX 8; CX 636-C; CX 638-B; RX-10; RX-60). Principally, BCBSM implemented this policy to encourage formal participation (Hayes 419; 702). BCBSM promoted formal par-

ticipation because this would assure the subscriber a service benefit (Hayes 787). Formal participation had fallen below the level BCBSM felt was necessary to assure full service benefits to its subscribers (Hayes 360, 709).

197. In many respects, these new reimbursement policies gave physicians reimbursement increases which had been previously demanded by MSMS. However, BCBSM offered the statewide screens and profile updates only on those physicians who agreed to formally participate. They were not offered to nonparticipating physicians, including those who participated only on a per-case basis (Hayes 421). BCBSM's new reimbursement policies increased reimbursement payments to participating physicians, but not to nonparticipating physicians (Hayes 422-23).

198. However, these new policies were not designed to interfere with other BCBSM reimbursement policies, which in the ordinary course of events increased reimbursement to all physicians, whether participating or nonparticipating. BCBSM would have continued to adjust the profiles of those nonparticipating physicians who requested adjustments, and would have continued to increase area screens for nonparticipating physicians based on actual charging patterns (Hayes 423).

199. "Service benefit performance" is defined by BCBSM as the percent of claims in which no out-of-pocket payments need be made by subscribers. Effective service benefits refer to the percentage of all claims for which physicians accepted BCBSM payments as payment in full (Hayes 729-32). Effective service benefits are those where 90 percent of the services to the subscribers are paid without additional payment by the subscriber (Hayes 723), even though less than 90 percent of doctors in the state of Michigan formally participate.

200. It was BCBSM's position, as of the spring of 1977, that its effective service benefit level was too low. This was the result of a gradual decline over a period of almost one year (Hayes 731). As of April 1977, BCBSM's effective service benefit performance was 97.6 percent. At that same time, 94.5 percent of the claims were submitted with instructions to pay the physician, which meant the physician was either a per-case physician or a formally participating physician (Hayes 733, RX 48 A-X). As of April 1977, BCBSM paid only 80.3 percent of all dollars charged by physicians. [44] Therefore, although BCBSM had a 97.6% effective service benefit, it paid only 80.3% of physicians' charges (Hayes 791).

201. When a subscriber is treated by a nonparticipating physician who elects to not participate on a per-case basis, the charge may be equal to that which BCBSM would have reimbursed under its applicable formula (Hayes 729).

202. As noted, finding 122, *supra*, Dr. Hayes testified that service benefits are not assured unless there is at least a 60 percent formal participation rate by Michigan physicians (Hayes 360). However, in 1977, only 58 percent formally participated (Hayes 710).

203. At the same time BCBSM announced its new physician reimbursement policies. It also announced a new cost containment policy called Target Limitation on Expenditures ("TLE"). Under TLE, a ceiling was placed on the aggregate amount that BCBSM would reimburse physicians statewide for each type of service. If payments to physicians exceeded the ceiling, BCBSM would subsequently lower reimbursement to physicians for that service. If payments were less than the targeted amount, BCBSM would increase payments to physicians for that service (RX 10-C-D; Hayes 424-26; CX 356-P).

204. BCBSM was concerned, at this point, with the increase in the utilization by subscribers of physicians' services, rather than by an increase in charges by physicians (Hayes 424, 704, 711-712).

205. TLE was approved by the BCBSM Board of Directors before all details were worked out (Hayes 712).

206. Also at this time, two other benefit programs were announced: the Vision Care Plan and the Hearing Care Plan (Hayes 428-29). In October 1976 the UAW and Ford Motor Company negotiated employee vision and hearing care benefits (Glasser 510-17) which were to become effective in October 1977 (Glasser 511). Chrysler Corporation and General Motors also agreed to these benefits. Ford and Chrysler purchased vision care benefits from BCBSM, while General Motors purchased vision care benefits from a commercial insurer. All three companies purchased hearing benefits from BCBSM (CX 92-D; CX 182Q; Glasser 518-19).

207. The details of the vision and hearing care packages were part of the collective bargaining agreement between the automobile companies and the UAW, with no input from BCBSM (Hayes 429; Glaser 477-83, 511-19, 559, 564, 569-70).

208. Unlike normal service benefit plans, the Vision Care Plan paid its nonparticipating physicians only 75 percent of the amount paid to participating physicians (Glasser 514-15, 596; Hayes 763). Per-case participation was not allowed [45] (Glasser 511-17). The UAW member paid the first twenty percent of the fee. Treatment by either optometrists or ophthalmologists would be reimbursed (Hayes 765).

209. The Hearing Care Plan provided for usual, customary and reasonable reimbursement to participating physicians, audiologists and hearing instrument providers, and *no* reimbursement to nonparticipating providers (Glasser 518, 597; Hayes 763). Again, no individual case participation was permitted (Glasser 519).

210. Ford proposed, and the UAW agreed, that nonparticipating

providers not be reimbursed for hearing care, because such services are not emergency services, and therefore delays which might result from a shortage of participating providers would not present a problem (Glasser 519). The UAW and Ford agreed that reimbursement differentials between participating and nonparticipating physicians was a good idea, because such differentials increased participation, and resulted in better cost and quality controls (Glasser 517, 519).

211. MSMS opposed BCBSM's new reimbursement policies and the vision and hearing care benefits. Its position was that these programs interfered with the physician-patient relationship and discriminated against patients of nonparticipating providers (Hayes 764). The MSMS Committee on Negotiations offered to meet with BCBSM to develop a reimbursement system more acceptable to MSMS than TLE (CX 637; Hayes 428; CX 89-A).

212. In late June 1977, BCBSM representatives met with representatives of MSMS to explain the then-proposed new reimbursement and cost-containment policies, indicating that BCBSM's Board of Directors would consider the proposals in July (Hayes 426). In August 1977, after the reimbursement changes had been approved by BCBSM's Board of Directors, BCBSM sent a letter to MSMS which described these new policies (CX 356-O-P). On July 9, 1977, the MSMS Committee on Third Party Carriers forwarded a special report to the MSMS Council, detailing its reactions to the new policies (CX 355). The report expressed gratification that, "after three years of continuing negotiations," BCBSM had offered proposals which suggested that the goals of the MSMS House of Delegates were feasible (CX 355-A). It can be inferred that the "goals" referred to were the MSMS goals of state-wide screens and automatic profile updates. However, the report rejected BCBSM's new reimbursement policies because they applied only to participating physicians (CX 355-A-B). It also rejected BCBSM's cost-containment proposal (CX 355-C). The MSMS Council considered this report at its July 23, 1977, meeting, adopting a resolution that the BCBSM reimbursement policies be rejected "because they discriminate against nonparticipating physicians," but urging continued discussions with BCBSM (CX 182-F). [46]

213. Also at the July Council meeting, the Council was advised of the automobile manufacturers' vision care plan. Based on this report, the Council resolved that the appropriate MSMS committee immediately reiterate to BCBSM "the MSMS position that no distinction in fees be made between participating and nonparticipating physicians." It resolved further that "the committee immediately apprise the Council of the results of its discussion and, based on the committee report, that the Council consider calling a special meeting of the House of Delegates on this matter." Finally, it instructed the Council

Chairman to send a letter or telegram to BCBSM, informing it of the Council's actions (CX 182-Q-R).

214. Dr. Crandall wrote to Dr. Hayes on August 15, requesting a ten day moratorium before the implementation of reimbursement differentials (CX 637), and Dr. Hayes responded that, with respect to the vision care package, the automobile companies involved and the UAW would have to consent (CX 638). With regard to BCBSM's new physician reimbursement policies, BCBSM rejected the moratorium request, although BCBSM was willing to discuss options that might be more acceptable to MSMS (CX 638; RX 10; Crandall 1717).

215. Dr. Hayes wrote to MSMS again on August 29 to inform MSMS that Chrysler and Ford, and the UAW had rejected the proposed moratorium regarding the vision care program (CX 639).

216. The MSMS Council, at its next regularly scheduled meeting on September 7, 1977, decided to call a special meeting of the MSMS House of Delegates for October 26, 1977, to discuss these developments (CX 183). The Council also instructed MSMS attorneys to study potential legal actions against BCBSM and the parties to the automobile contracts. A resolution was passed informing BCBSM that MSMS would not participate in any discussions with BCBSM until the reimbursement issues were resolved. MSMS wrote its members to suggest that they individually withhold any decision or judgment on the new policies until there was a full discussion of them by MSMS, possibly at the special meeting (CX 362).

217. MSMS also sent a memorandum to the presidents of the component societies and specialty societies requesting that they ask their members to withhold decision or judgments concerning the new reimbursement policies until all the facts were disseminated (CX 364). This memorandum enclosed a "background paper" which stressed that "should a significant number of the presently participating physicians elect not to continue their participation, this could have an effect on the Blue Cross/Blue Shield's reimbursement policies" (CX 365-C).

218. The special meeting of the House of Delegates was held on October 26, 1977 (Hayes 434; CX 15; CX 94). Dr. Bass, MSMS' President stated that, "**** my one request to you is that [47] you act in a unified way to adopt new policies. You must be unified in the decisions that are reached today" (CX 15-L).

219. A resolution was passed stating that it was the MSMS position to encourage individual physicians to departicipate from BCBSM (Crandall 1723). Authorization was passed for the MSMS Council to recommend that physicians not use the BCBSM claim form (Crandall 1727-28).

220. The House of Delegates instructed the Negotiating Committee

to begin discussions with key BCBSM subscriber groups to provide direct "medical input" into service benefit programs, instructed the MSMS Council to urge Michigan employees to seek MSMS advice in selecting health insurance carriers; and resolved to authorize the Council to seek alternate health insurance for MSMS members to replace BCBSM group plans. The delegates resolved, in addition, that the Council undertake such legal actions as deemed appropriate, and membership dues were increased by \$35 to this end (CX 15-Z-28; Z-64, Z-66; CX 94-A-B; Hayes 435).

221. *Medigram* headlines in the November 1, 1977 issue stated that MSMS recommended departicipation (CX 94-A-D; Crandall 1725). MSMS leadership also wrote every MSMS delegate, alternate, and county and specialty society president recommending departicipation (CX 556-B; CX 371-A). Members were instructed to send letters to Dr. Hayes, and were sent postcards on which they could indicate their decision to departicipate to be sent to MSMS.

222. Several MSMS component societies joined with MSMS to urge that physicians departicipate from BCBSM, and some engaged in specific actions to encourage or facilitate departicipation. The Ingham County Medical Society, an MSMS component (CX 257), advised its members that "your Delegates, along with the others in the Michigan State Medical Society House of Delegates, told Blue Cross/Blue Shield of Michigan what it could do with the new Reimbursement Policies and the Hearing and Vision Programs." It advised: "The big job ahead is going to be to convince all of the physicians, who are individuals with individual ideas, that this is the way to go" (CX 260-B). The Ingham County Society sent a mailing to its members urging that they departicipate (CX 258-B). On December 28, 1977, this component's executive director, acting in his official capacity (CX 262), sent a memorandum to Ingham County's MSMS delegates advising them that:

To keep up the flow of non-participating letters to Blue Cross Blue Shield of Michigan objecting to the new Reimbursement Policies, the Executive Committee has suggested that the Delegates now make followup telephone calls to selected physicians or practicing groups who have not informed the Society that their letters have been sent (CX 261-A). [48]

The memorandum provides a list of "procedural guidelines" to assure that "everyone is operating on the same track" (CX 261-A-B). These guidelines advise delegates to inform Ingham County's executive director of any physicians who have already sent in departicipation letters, as well as the names of those who do not plan to departicipate (CX 261-B). Eleven "call lists" were distributed to Ingham County's MSMS delegates, each bearing the names and telephone numbers of

physicians to be contacted by a designated delegate (CX 261-C-M). In November and December 1977, Ingham County Medical Society received confirming copies of correspondence from Ingham County physicians and physician groups to BCBSM, advising BCBSM that the physicians and groups were formally departing from BCBSM, or that they would no longer participate on a per-case basis (CX 263-78; 280-88; 292-94; 296-301; 303-04; 306-08).

223. Kalamazoo Academy of Medicine is the MSMS component society for Kalamazoo County, Michigan (CX 327). Kalamazoo Academy's MSMS delegates reported the results of the MSMS House of Delegates special session to the Academy's Board of Directors at its November 1, 1977, meeting. A motion was adopted that a letter be sent to the Academy's membership by a special mailing, reporting the actions taken by the MSMS House of Delegates (CX 329-B). On November 4, 1977, a letter on Kalamazoo Academy stationery, signed by the Academy's MSMS delegates, was sent to the component society's membership (CX 328). In part it stated:

[W]e now as a unified body recommend that you become a *non-participant* in BCBSM if you presently are a participating doctor. We advise you to drop your own personal medical insurance with BCBSM, and encourage your patients to do so, also (CX 328-A) (emphasis in original).

224. In September 1977, the Mason County Medical Society, another MSMS component society (CX 336), passed a resolution supporting MSMS' opposition to BCBSM's differential reimbursement policies (CX 378). In December 1977, Muskegon County Medical Society, also an MSMS component society (CX 343), published a message from its president in its monthly membership newsletter, urging "each and every physician" of the Muskegon County Society to immediately send a departure letter to BCBSM in support of MSMS House of Delegates' actions (CX 344-A).

225. Members of the St. Clair County Medical Society, an MSMS component society (CX 322), decided at that society's December 13, 1977, general membership meeting to draft and circulate a letter for individual physicians to execute and send to BCBSM as soon as possible announcing that they were resigning from participation, either formally, or per-case (CX 724-C). At a subsequent St. Clair Society executive committee meeting, those present were advised that 59 of 87 St. Clair County Medical Society members had signed departure letters and [49] submitted them to the county society. It was also reported that other members may have departed, but without sending copies of their letters to the county society (CX 325-A). In February 1978, the St. Clair Society forwarded 50 separate departure letters (some signed by more than one physician) to MSMS (CX

481-A-Z-25). Forty-three of these consisted of an identical form letter announcing to MSMS that the signing physician had cancelled his participation with BCBSM (CX 481-G-L, N-S, U-Z-25).

226. The Oakland County Medical Society, an MSMS component society (CX 309), held an emergency membership meeting in September 1977 to protest BCBSM's new reimbursement policies and the vision and hearing care programs (CX 318). On October 26, 1977, the Oakland County Society's Board of Directors agreed that a resolution by the society's MSMS delegates recommending that physicians departicipate from BCBSM be published in the society's next monthly magazine (CX 312-C). A "survey" was mailed to individual Oakland County Society members in November 1977, and was also published in the December 1977 edition of the Oakland County Society's magazine. Entitled "OCMS Says Departicipate Now," it advised members that the survey was designed to "determine how the membership is responding to the OCMS Board of Directors recommendation, as well as that of the Michigan State Medical Society, that physicians totally cease participation with Michigan Blue Cross and Blue Shield of Michigan" (CX 317; CX 483). In January 1978, the Oakland County Society sent a letter, signed by its president, to MSMS, urging that MSMS not soften its stand on departicipation, and advising MSMS that "the Oakland County Medical Society and the medical staffs of the major hospitals in the county have gone on record as urging complete departicipation" (CX 314-D). The Oakland County Society's Board of Directors subsequently passed resolutions in February 1978, supporting MSMS, and in March, continuing to urge departicipation (CX 315-B; CX 316-C).

227. Between November 1977 and June 1978, BCBSM received 410 letters from participating MDs cancelling their participation with BCBSM (Kaleal 1131; *see also, e.g.*, CX 263; 271; 273-75; 280; 283-84; 287-88; 293-94; 296-97; 299-300; 303-04; 307-08; 481-B; 503-A-B; 506-07; 515; 521; 531-32; 538; 540; 574-74; 576; 584; 598; 601-B; 608-09; 612-13; 615; 627-28); and another 980 letters from nonparticipating MDs, reaffirming their nonparticipating status (Kaleal 1131; *see also, e.g.*, CX 265; 268; 270; 276; 286; 292; 301; 306; 481-C-F; 502; 509; 511-14; 517; 519-20; 533; 539; 541-42; 544; 557-59; 564; 578; 580; 589; 591; 593; 595; 602; 604-05), with many advising further that MDs would not participate on a per-case basis (Kaleal 1131; *see also, e.g.*, CX 265; 276; 288; 300-01; 306; 512; 514; 517; 519-21; 533; 542; 557; 576; 580; 589; 591; 595; 602; 615). Many of these letters announced that participation, formal or per-case would terminate effective January 1, 1978, the termination date urged by MSMS (*see, e.g.*, CX 263-65; 270-74; 276-77; 280-85; 287-88; 297-300; 303; 307-08; 484-85; 488-91; 494; 496-[50]98; 500-02; 509; 515; 517; 519-21; 531-33; 536; 538; 540;

542-43; 557; 559; 567; 573-74; 576; 580; 583-85; 591-92; 595-96; 598; 601-B; 602-03; 608-09; 612-15; 620-22; 628-29). Some letters are identical photocopies of form departure letters (*see, e.g.*, CX 484-85; 488-91; 494; 496-98; 500-01), and many mention MSMS specifically or show copies being sent to either MSMS or a component society (*see, e.g.*, CX 268-69; 273-74; 276; 280; 284; 286-87; 292; 299; 306; 308; 481-C-F; 502; 507; 509; 511-12; 560-B; 578; 579-B; 585). In addition, most of the letters were addressed directly to Dr. Hayes of BCBSM, which MSMS had advised (*see, e.g.*, CX 270-71; 274-76; 280; 284; 286-87; 484-85; 488-91; 503-A; 509; 511-14; 531-32; 533; 538; Hayes 436).

228. According to Mr. Glasser of the UAW, the union received complaints from its members about their inability to receive vision care services from participating ophthalmologists (Glasser 531) because, in the first year after the vision care program was implemented, only 38 percent of ophthalmologists participated. It was his belief that, if optometrists were not included as alternative providers, the vision care program would have been crippled (Glasser 532).

229. After the special meeting of the House of Delegates in October 1977, the Division of Negotiations met with BCBSM representatives to discuss MSMS problems with the new physician reimbursement policies (Crandall 1725-26). A meeting was held on December 28, 1977, at which the parties expressed a desire for better communications between the two groups (CX 642-A).

230. Between August 17, 1977 and June 2, 1978, BCBSM had a net gain of 962 formally participating physicians (Kaleal 1142, 1162). Between November 1, 1977 and June 1, 1978, BCBSM received letters from Michigan physicians who supported the new policies (Kaleal 1126).

231. From November 1, 1977 to June 2, 1978, BCBSM received 2550 letters from physicians relating to the new policies; 1103 from physicians who signed new participation agreements, 410 from physicians who wanted to departicipate, 57 from physicians reaffirming their participation and 980 from physicians reaffirming their nonparticipation (Kaleal 1130).

232. As of April 1, 1978, the percentage of formally participating physicians was 62 percent (Hayes 721).

233. BCBSM was able to attract more physicians than departedicipated as the result of the increased compensation it offered to participating physicians, and determined that it was unnecessary to undertake specific additional measures to counter the departure campaign (Hayes 440).

234. Due to BCBSM's continued refusal to extend the [51] statewide screen to nonparticipating physicians, on December 14, 1977, the

MSMS Council initiated actions designed to result in a request to members to cease filling out claim forms.

235. The MSMS Committee on Forms and Codes filed a report on December 27, 1977 which noted that it would be the patients who would potentially suffer the most harm if this action was taken (CX 452-A). The Committee suggested that, instead, MSMS might advise physicians to fill out only the minimum data required for processing:

Advantages are a minimum of reprogramming and disruption of office procedure, the structural maintenance of the uniform claim form, and the potential to confound the BCBSM system enough to demonstrate the physicians' concerns while still meeting the legal and ethical requirements for payment to patients (CX 452-B).

236. BCBSM believed that the refusal to fill out BCBSM's claim forms was more serious than the problems posed by departicipation (Hayes 440-41), because this would increase administrative costs and would lengthen the time necessary for payment of claims (Hayes 443). BCBSM believed that MSMS would eventually take this action (Hayes 443). A meeting was scheduled to avoid this problem (Hayes 444-45).

237. This meeting occurred on December 28, 1977. Attending were Mr. McCabe and Dr. Hayes of BCBSM, and Dr. Crandall and other MSMS representatives (CX 642).

238. It was MSMS' position that BCBSM must cease distinguishing between participating and nonparticipating physicians in its reimbursement policies (CX 381; CX 383; Hayes 447-48). BCBSM management was, at that point, unwilling to do so (CX 382).

239. MSMS agreed to delay action to give BCBSM time to respond (CX 381-A), and suggested to its membership that it defer departicipation until March 15, 1978 (CX 127-A). Despite these meetings between the parties, the differential reimbursement issue was not resolved.

240. On February 27, 1978, a letter from Drs. Bass and Crandall was hand-delivered to the BCBSM President, Mr. McCabe (CX 253). The letter stated that:

[T]he MSMS Committee on Negotiations reaffirms the House of Delegates position that the Blues should apply all aspects of the physician's reimbursement program equally to participating and nonparticipating physicians.

We must remind you, however, that the extension of our present recommendations that MSMS members continue to [52] participate on a per-case basis and continue to complete the BCBSM claim form will expire March 15 unless BCBSM restores full parity to the nonparticipating physicians (CX 253-D).

241. BCBSM requested that MSMS delay action until after March 15 (CX 254-B-C) in a letter which noted that although the BCBSM

Board of Directors had not eliminated differential reimbursement at its March 2, 1978 meeting, it had discussed the February 27 letter. BCBSM also advised MSMS that a recommendation would be considered by the appropriate BCBSM committees to apply the statewide screen to nonparticipating physicians. This would be considered at the April 1978 meeting of the BCBSM Board of Directors (CX 254-B).

242. In May of 1978, BCBSM implemented a statewide screen for all physicians, and MSMS agreed to cease collective action regarding departicipation and a potential refusal to fill out BCBSM claim forms. Pursuant to a written agreement dated May 3, 1978, which MSMS' House of Delegates approved at its session, the parties agreed that:

BCBSM Management on May 11, 1978 will recommend to the BCBSM Board, immediate authorization to implement a statewide screen for all physicians to be effective July 1, 1978 (CX 11-Z-1),

and that

Effective May 7, 1978, MSMS will urge cooperation on the Michigan Medical Claims Forms completion and discontinue its efforts to urge physician departicipation (CX 11-Z-1).

243. Four goals to be reached through collective action by both parties, were enunciated in the agreement: (1) An effective program to control health care costs should be implemented as soon as possible; (2) there will be an effective service benefit program; (3) reimbursement policy should be supportive of service benefit and cost containment principles; and (4) all physicians should be treated equally within a reimbursement system that is consistent with the above principles (CX 11-Z-1).

244. Dr. Crandall believed that the agreement was important because it gave MSMS an "identifiable target" within BCBSM with which to negotiate, and participating and nonparticipating doctors would be reimbursed equally when the four goals were reached (CX 11-Z).

245. He indicated his belief that the agreement was in large part the result of "**** the failure of Blue Cross/Blue Shield to reach their goal of 85 to 90 percent participation" (CX 11-Y-Z). [53]

246. In the summer of 1978, BCBSM implemented a statewide screen for nonparticipating physicians which increased BCBSM payments to those physicians by millions of dollars (Hayes 456-57).

247. Subsequent to the May agreement, deliberations were held between MSMS and BCBSM representatives to develop an "acceptable new approach to the Blues' system of reimbursement for medical care" (CX 398-A-C). A proposal dated January 15, 1979, was devel-

oped by these representatives (CX 398-F-I). The MSMS Council recommended to the membership that it be disapproved, but polled the MSMS membership to determine whether physicians accepted the proposal (CX 398-A; J-K). At the 1979 annual session of the MSMS House of Delegates, the delegates voted to reject the proposal.

248. It was the position of the MSMS House of Delegates that (1) the cost containment program was insufficiently precise, and (2) there were potential ramifications because of the then-pending FTC investigation that resulted in this litigation (Crandall 1738-39).

VI. MSMS ACTIONS REGARDING MICHIGAN MEDICAID

A. Reduction in Payments

249. In December of 1975, the Governor of Michigan issued an order calling for an eleven percent reduction in Medicaid payments because of a lack of funds (CX 173-N; CX 404-B). Although MSMS had, until that time, encouraged Michigan physicians to participate in the Medicaid program (CX 404-B), the Medicaid Liaison Committee recommended:

That MSMS inform the Governor, all members of the Legislature, the Department of Social Services and the public media that, because of the 11 percent reduction in Medicaid payments, MSMS can no longer encourage its membership to participate in the Medicaid program and that it leaves up to each individual physician's discretion whether he wishes to provide medical care to Medicaid patients (CX 416-B; CX 173-N).

The MSMS Council approved this recommendation (CX 173-N).

250. On December 18, 1975, Dr. Siegel of the MSMS Medicaid Liaison Committee announced this recommendation to the news media and gave a statement which was forwarded to component society presidents and executives and to publication editors (CX 404). The statement was published in *Medigram* (CX 43-A-C).

251. At a 1977 House of Delegates meeting, Dr. Siegel commented that through his statement:

***MSMS announced that it could no longer encourage [54] physicians to participate in the Medicaid program, and left the decision to each individual physician's discretion. The results were predictable, as the number of participating physicians dropped dramatically forcing patients into emergency rooms and Medicaid mills and increasing dramatically the cost of the program (CX 413-A-B).

252. When the MSMS Medicaid Liaison Committee determined that the state intended to maintain the eleven percent reduction (CX 427-C-D), it demanded that the eleven percent be restored and that

reimbursements be raised to the 1976 Medicare screen level (CX 427-E).

253. MSMS warned state officials that physicians might refuse to treat Medicaid patients. Dr. Siegel stated that:

I warned the state that if they continue to force physicians to subsidize the Medicaid program through such measures as continuation of the 11 per cent cut, they may find themselves able to save the entire \$811 million appropriation (CX 427-E).

254. MSMS had collected Medicaid departicipation proxies during the summer and fall of 1976. (Findings 187, 190 *supra*; CX 411-F; CX 413-B). Although Dr. Siegel testified that he never threatened that they would be used (Siegel 1829) he did admit to telling the MSMS House of Delegates that he "waved" them in front of the Governor (Siegel 1845-46; CX 413-B).

255. In April 1977, one month prior to Dr. Siegel's 1977 House of Delegates remarks, Dr. Crandall, whose Division of Negotiations coordinated with the Medicaid Liaison Committee, and who served as a member of the Medicaid Liaison Committee in 1976 (CX 424-B), stated that the Medicaid Liaison Committee had threatened state legislators that MSMS would exercise the Medicaid proxies if the reimbursement issue could not be immediately resolved (CX 411-F).

256. In November 1976, the Michigan Attorney General threatened antitrust litigation against MSMS because it had collected and threatened to use the proxies (CX 411-F; CX 413-B-C; CX 170-A-B; CX 392; Siegel 1861).

257. In the August 12, 1977, *Medigram*, Dr. Siegel informed the membership that reimbursements would soon be increased to a parity level with Medicare and, if so, he believed "**** that Michigan physicians have an obligation to reopen their doors to Medicaid patients" (CX 413-C; CX 10-Z-6). He related a "remarkable fall" in physician participation to the MSMS announcement that it would no longer encourage physicians to participate in the Medicaid program (CX 88A). [55]

B. Per-Case Participation

258. The Michigan Department of Social Services advised MSMS that physicians treating Medicaid recipients should bill Michigan Medicaid directly for all covered services. However, MSMS was also told that physicians were free to terminate their relationships with Medicaid recipients at any time (CX 421-A; CX 424-A).

On March 10, 1976, the MSMS Council resolved that:

[I]t is the policy of MSMS that physicians may participate in Medicaid on a per-service basis and bill the Medicaid program or at their discretion be free to enter into a private pay agreement with the Medicaid-eligible patient; that implementation of this policy become a high priority of the Medicaid Liaison Committee in its Liaison with the State; and that the Medicaid Liaison Committee provide a progress report on this item to the House of Delegates May 1-2 (CX 175-D).

259. MSMS informed the Department of Social Services of this resolution (CX 419A-B) but the Department of Social Services refused to accede. Therefore, a resolution was offered at the 1976 House of Delegates annual meeting which stated that:

RESOLVED: That Michigan State Medical Society advise members to provide only emergency services for Medicaid patients until meaningful negotiations with Michigan Department of Social Services have achieved recognition of per-case participation as was originally agreed (CX 422-C).

The Department of Social Services replied that:

[We] know that a resolution has been prepared which would encourage MSMS members to take Medicaid clients only on an emergency basis unless physicians are allowed to participate in the program on a per service basis. If this resolution is passed and were adhered to by the majority of MSMS physicians, it probably would have a severe health and financial impact by reducing services rendered and the flow of Medicaid dollars to the medical community. On the other hand, it might increase costs by channeling many more Medicaid patients to the emergency wards of hospitals (CX 421-A).

260. The Department of Social Services also told the Medicaid Liaison Committee that:

Our position * * * is based on the premise that our clients are in fact, by definition, poverty stricken. The purpose of the Medicaid program is to provide these [56] people who have very limited means with the best available medical care with only a minimum of financial contribution on their part. Therefore, it would not be in the best interests of our clients' health or financial condition to allow medical providers the option of negotiating payment for services which are otherwise paid for by our program. To do so would invite all kinds of abuse by those few providers who are apt to victimize the Medicaid population (CX 421-A).

261. On April 30, 1976 the Medicaid Liaison Committee advised the MSMS Council that the Committee unanimously agreed to remain firm on the issue of per-case participation regarding Medicaid recipients. The Council adopted a resolution that a special meeting of the House of Delegates might be requested by the Council if the state took action against any individual physician who tried to participate on a per-case basis (CX 424-B; CX 176-O). At the 1976 House of Delegates annual meeting, the delegates authorized the Medicaid Liaison Com-

mittee to request a special meeting if any such action was taken (CX 426-B).

262. On May 6, 1976, MSMS members were informed by Dr. Robert M. Leitch, in his capacity as MSMS President, that:

[T]he Medicaid Liaison Committee obtained House approval to *noncomply* with the State's insistence that all Medicaid services must be charged to the State. *The Medicaid Liaison Committee now advises individual physicians in the State that it is MSMS policy that physicians may bill Medicaid on a per service basis* (CX 425) [emphasis in original].

263. In the year following, the State of Michigan took no action against any individual physician for noncompliance with the Michigan Department of Social Services policy (CX 413-B).

VII. MSMS' KNOWLEDGE THAT ITS ACTION MIGHT BE
IN VIOLATION OF THE ANTITRUST LAWS

264. MSMS' attorney warned MSMS not to engage in collective bargaining of reimbursement terms with third party payers, either through its Negotiating Committee, or through the fiction of engaging in such negotiations through a separate medical guild or union. In a 1978 memorandum to the Council, he said:

The only purpose of such negotiations could be to raise, lower, stabilize or otherwise tamper with fees. This would put MSMS, its sponsored guild and perhaps individual physicians in a vulnerable position with respect to the antitrust laws. Indeed, we have repeatedly stated that the MSMS negotiations committee [57] in its ongoing relationships with Blue Cross/Blue Shield must walk a fine line; it can present its viewpoints as to services rendered by physicians the belief or opinion of organized medicine that certain fee systems and/or certain specific fees are inappropriately high or low, but it cannot, it must not, come to an agreement with a third-party payer as to fees to be charged. We emphasize this because the extant negotiating committee is already working in the area that we assume a guild or labor union would (CX 190-J).

265. The MSMS Council considered and stated its opposition to BCBSM's new reimbursement policies and the vision and hearing care reimbursement differentials at the July 1977 Council meeting (CX 182-E-G-R). At that same meeting, MSMS legal counsel warned that MSMS committees must "avoid the implied threat of organized boycotts or other sanctions by organized medicine." He stated that when advocating economic positions on behalf of MSMS, these committees should not stray "into threatening postures which could invite public disapprobation and swift legal retribution" (CX 182-O).

266. At the October 26, 1977 special meeting of the House of Delegates, a delegate requested MSMS counsel to advise the delegates

whether the recommendation that physicians departicipate from BCBSM constituted a boycott (CX 15-Z-46). Counsel replied: "There is no question but that this type of action will probably elicit some sort of legal action against you" (CX 15-Z-46). Notwithstanding, the delegates then voted to recommend that physicians departicipate from BCBSM (Findings 219, 221 *supra*).

267. The Michigan Attorney General's response to MSMS' threat to exercise Medicaid nonparticipation proxies in 1976 was to declare that it was going to initiate an antitrust action against MSMS (Finding 256; CX 179-A-B; CX 411-F; CX 413-B-C). In November 1976, the MSMS Council held a special meeting to discuss the impending lawsuit, which was attended by among others, Drs. Griffin, Crandall and Siegel (CX 179-A). MSMS' attorney advised the council that MSMS' chances of winning such a suit were only about one in ten, but the Council elected to take no action to settle the affair (CX 179-B).

268. MSMS officials subsequently asserted that MSMS' willingness to risk litigation over the proxies proved the strength and unity of MSMS and Michigan physicians. Dr. Crandall stated:

Allegedly MSMS was in violation of restraint of trade because of the possession and threatened utilization of the nonparticipation proxies in the Medicaid program. MSMS was asked to sign a consent judgment that would fully strip MSMS of any ability to negotiate or speak [58] collectively for Michigan physicians. Despite legal counsel advice, the MSMS council elected not to sign any consent judgment but to let the lawsuit take its ultimate course.

*** MSMS refused to back down from its previous position. If the lawsuit had been pursued, the Attorney General would have orchestrated the demise of the entire Michigan Medicaid program as the majority of Michigan physicians would have withdrawn from the program individually. But all parties agreed the lawsuit would not be pursued if MSMS agreed not to initiate the proxies at that time. This action clearly demonstrates the significant clout MSMS and the state's physicians have if they will work in unison (CX 411-F-G).

LEGAL DISCUSSION

I. Section 4 Jurisdiction

The Federal Trade Commission's jurisdiction over corporations, under Section 5(a)(2) of its enabling statute, is limited by Section 4 to the following:

any company, trust *** or association, incorporated or unincorporated, which is organized to carry on business for its own profit or that of its members, and has shares of capital or capital stock or certificates of interest, and any company, trust *** or association, incorporated or unincorporated without shares of capital stock or capital stock or

certificates of interest *** which is organized to carry on business for its own profit or that of its members.

(15 U.S.C. 44).

Respondent cites *Community Blood Bank v. F.T.C.*, 405 F.2d 1011 (8th Cir. 1969), to support its position that the Commission lacks jurisdiction over the activities of respondent which form the basis for the complaint in this case, since MSMS is not engaged in activities which result in profits which are distributed to its members.

For purposes of this decision, however, this point has been settled by the Commission in *American Medical Ass'n.*, 94 F.T.C. 701, 982-93 (1979), *aff'd*, 638 F.2d 443, 447-48 (2d Cir. 1980). In that case, the Commission upheld the ALJ's [59] ruling that jurisdiction could be asserted over nonprofit organizations "whose activities engender a pecuniary benefit to its members if that activity is a substantial part of the total activities of the organization rather than merely incidental to some non-commercial activity," 94 F.T.C. at 983.

In this connection, MSMS has promoted its members' financial interests by lobbying for proposed legislation to increase Medicaid payments to physicians (Finding 48); and to lower the cost of physicians' malpractice insurance (Finding 49). It claimed responsibility for legislation preventing chiropractors from legally enlarging the scope of their operations (Finding 44). It successfully pursued an amendment to the Michigan Single Business Tax statute, thus reducing state income tax liability for physicians (Finding 51).

MSMS also litigated a suit on behalf of its members to prevent BCBSM from lowering its reimbursements for outpatient psychiatric services (Finding 57), it intervened in a lawsuit between BCBSM and the Insurance Commissioners of Michigan where the result could have affected physician reimbursements (Finding 57), and it participated in various other lawsuits where the economic interests of its members would be affected by the outcome (Findings 57 through 60).

MSMS created the Michigan Physicians Mutual Liability Insurance Company to make professional liability insurance available to physicians at reduced rates (Findings 61 through 64). It publishes *Michigan Medicine* and *Medigram*, both of which contain articles and information about economic issues of interest to its members (Findings 65-67). It also conducts a public relations effort on behalf of physicians (Findings 68-70).

MSMS offers seminars and workshops (at reduced cost to members) on financial management and techniques to increase the efficiency and productivity of medical practices (Findings 71 to 73).

The Physicians Service Group, a wholly-owned for-profit MSMS subsidiary, features a credit card office payment plan at a group

discount rate, a bill collection service, loans, and financial and estate planning, etc. (Findings 74 to 76).

Through the aegis of MSMS, members may obtain insurance programs (Finding 77), retirement plans (Finding 78), auto leasing and discount car rental programs (Finding 79), continuing medical education at a lower cost to members than nonmembers, and vacation plans, etc. (Findings 80 and 81). [60]

In addition, because membership in MSMS enables physicians to join AMA, MSMS members are thus eligible to receive the valuable benefits available through the national organization. See 94 F.T.C. at 988-89.

It should be recognized that in *National Commission on Egg Nutrition* ("NCEN"), the Commission held that while the FTC "**** properly exercises jurisdiction over such nonprofit corporations as trade associations which carry on business for the sake of their members, it may not exercise jurisdiction over nonprofit corporations which are organized and actually engaged in business for purely charitable purposes." 88 F.T.C. 89, 175, *aff'd* 570 F.2d 157 (7th Cir. 1977), *cert. denied*, 439 U.S. 821 (1978). It is abundantly clear from the above summary that many of MSMS activities cannot be described as "purely charitable."

In *NCEN*, among the factors considered relevant in determining jurisdiction were: the original stated purpose of the organization; sources of funding; publications; activities; relations with profit oriented parties; and tax status. 88 F.T.C. at 177. Significantly, when MSMS was established in 1910, one of its stated purposes was to foster the material interests of Michigan physicians (Finding 7). The 1978 Constitution and Bylaws has, as one of its stated goals, the advocacy of "fair remuneration for services rendered" (Finding 9).

As discussed above, MSMS commercial activity is not merely "incidental" to its other activities. The formation of Physician's Service Group clearly illustrates this. It is also significant that MSMS is exempt from federal income taxation under Section 501(c)(6) of the Internal Revenue Code (Finding 43) which exempts "business leagues, chambers of commerce, real estate boards and boards of trade," rather than under Section 501 (c)(3) of the Code, which exempts organizations formed and operated solely for religious, charitable and scientific purposes (Finding 43). See *AMA*, 94 F.T.C. at 989. *Ohio Christian College*, 80 F.T.C. 815 (1972).

For the above reasons, I must reject respondent's contention that it is exempt from the Commission's jurisdiction.

II. Interstate Commerce

Respondent argues that its activities do not satisfy the "commerce" requirements of the Federal Trade Commission [61] Act. However, there is sufficient evidence in this case to reject this contention, with respect to both actions "in commerce" and "affecting commerce." The record shows the following:

(a) *Medicaid* — In fiscal years 1977 and 1978, Michigan Medicaid disbursed approximately \$110 million and \$120 million, respectively, to physicians in the state. Half of that amount was composed of federal funds originating in Washington, D.C. (Findings 84 and 89).

(b) *Federal Employees Health Benefits Program ("FEHBP")* — The federal government provides health insurance benefits to its employees through contracts with various insurers, including BCBSM (Findings 84 and 91). When BCBSM pays Michigan physicians for services rendered to federal employees, the money is forwarded into the state from the National Association of Blue Cross and Blue Shield Plans, in Chicago, Illinois (Findings 91 and 94). In 1977 and 1978, NAPCBSP paid BCBSM \$30 million for services provided to the 36,000 federally covered individuals in Michigan (Finding 94). Changes in BCBSM's reimbursement rates would naturally affect these amounts.

So too, because the FEHBP premiums are computed upon expenditures, and a uniform premium rate is charged to subscribers nationwide, changes in BCBSM payments of benefits would affect premiums paid across state lines (Finding 95).

(c) *National Accounts* — BCBSM is involved in some 250 national accounts (Finding 101). Over half of these use the "equalization" method to set per capita premium rates (Finding 101). This means that the premium paid by each employee is based on total benefit expenditures, and a single rate is charged regardless of the state in which the employee lives (Finding 102). Therefore, changes in BCBSM reimbursement rates to physicians would affect commerce from this standpoint.

In addition to the above, the record shows that officers and representatives of MSMS have traveled across state lines in their efforts to gather support from other medical societies, and have used the United States mail to this end (Findings 107 and 108).

The mail was also used by MSMS for proxy and deparicipation solicitations (Finding 108), to correspond with MSMS' members to keep them informed of developments in MSMS' struggle with BCBSM. [62]

Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975), involved the legality of a minimum fee schedule for title searches performed by

attorneys. This schedule was imposed by the local bar organization. The facts showed that a significant portion of funds for purchasing homes in Virginia came from outside the state, and significant numbers of home loans were guaranteed by federal agencies in Washington, *e.g.*, the Veterans Administration and the Department of Housing and Urban Development. Therefore, the Supreme Court found a sufficient nexus to interstate commerce to support jurisdiction. 421 U.S. at 783. The Court further held that when the requisite effect on interstate commerce is shown, no specific magnitude need be proved. 421 U.S. at 785.

In *McLain v. Real Estate Board of New Orleans*, 444 U.S. 232 (1980), the Supreme Court interpreted its holding in *Goldfarb*. *McLain* involved allegations concerning "a continuing combination and conspiracy among respondents to fix, control, raise, and stabilize prices for the purchase and sale of residential real estate***." The Court held:

On the record thus far, it cannot be said that there is an insufficient basis for petitioners to proceed to trial to establish Sherman Act jurisdiction. It is clear that an appreciable amount of commerce is involved in the financing of residential property in the Greater New Orleans area and in the insuring of titles to such property. The presidents of two of the many lending institutions in the area stated in their deposition testimony that those institutions committed hundreds of millions of dollars to residential financing during the period covered by the complaint. The testimony further demonstrates that this appreciable commercial activity has occurred in interstate commerce. Funds were raised from out-of-state investors and from interbank loans obtained from interstate financial institutions. Multistate lending institutions took mortgages insured under federal programs which entailed interstate transfers of premiums and settlements. Mortgage obligations physically and constructively were traded as financial instruments in the interstate secondary mortgage market. Before making a mortgage loan in the Greater New Orleans area, lending institutions usually, if not always, required title insurance, which was furnished by [63] interstate corporations. Reading the pleadings, as supplemented, most favorably to petitioners, for present purposes we take these facts as established.

444 U.S. at 245.

In *McLain*, the district court had found that, under *Goldfarb*, a substantial volume of interstate commerce must be involved, and that the challenged activity must be inseparable from its interstate aspects for jurisdiction to exist. The Supreme Court disagreed, and held that the authority of Congress under the commerce clause extends beyond activities in interstate commerce to reach activities which ". . . while wholly local in nature, nonetheless substantially affect interstate commerce." [emphasis in original] 444 U.S. at 241.¹⁰

¹⁰ It is interesting to note that in the district court, an affidavit had been filed by a loan guarantee officer of the Veterans' Administration disclosing that VA-insured loans for residential purchases in the Greater New Orleans area for the years 1973-1975 amounted to \$46.3 million, \$45.9 million, and \$53.5 million, respectively. 444 U.S. at 237.

It is unnecessary to show that the unlawful conduct itself had an effect on interstate commerce, nor is jurisdiction restricted to activities with an integral relationship to activity in interstate commerce when only an effect on interstate commerce is alleged. *McLain, supra*, 444 at 241, 243.

For the above reasons, the "commerce" requirements of the statute have been satisfied.

III. MSMS Has Engaged In An Unlawful Conspiracy

There is no doubt that the activities of professional societies and their members have been deemed to be subject to scrutiny under the antitrust laws. The initial step in determining whether such activities constitute a violation of these laws is the selection of the appropriate standard of review, *i.e.* the *per se* rule or the rule of reason.

Complaint counsel argue that the *per se* rule is applicable, because the instant case involves horizontal agreement by respondent, some of its component societies and [64] some of the members of each, to fix prices and to boycott third-party payers, and that such agreements have traditionally been held to be *per se* violations of the antitrust laws.

Historically, price-fixing agreements and boycotts have been considered quintessential examples of anticompetitive behavior. This is because the violence they perpetrate against competition has been viewed as so severe.

In construing and applying the Sherman Act's ban against contracts, conspiracies, and combinations in restraint of trade the [Supreme] Court has held that certain practices are so "plainly anticompetitive" *National Society of Professional Engineers v. United States*, 435 U.S. 679 (1978); *Continental T.V. Inc. v. GTE Sylvania Inc.*, 433 U.S. 36 (1977), and so often "lack any redeeming virtue", *Northern Pacific R. Co. v. United States*, 356 U.S. 1 (1958), that they are conclusively presumed illegal without further examination under the rule of reason generally applied in Sherman Act cases.

Broadcast Music, Inc. v. Columbia Broadcasting System, Inc., 441 U.S. 1 (1979).

"A horizontal agreement to fix prices is the archetypal example of such a practice. It has been long settled that an agreement to fix prices is unreasonable *per se*. It is no excuse that the prices fixed are themselves reasonable". *Catalano, Inc. v. Target Sales, Inc.*, 100 S.Ct. 1925, 1927 (1980). See *United States v. Trenton Potteries Co.*, 273 U.S. 392, 397 (1928); *United States v. Trans-Missouri Freight Association*, 166 U.S. 290, 340-341 (1897).

Such agreements, the nature and necessary effect of which are so plainly anticompetitive that no elaborate study of the industry in

which they occur is needed to determine their illegality, are violations *per se*. However, a recent line of cases, while recognizing that the actions of professionals and professional associations are subject to antitrust scrutiny, has held that activities which might constitute *per se* illegalities in the context of the sale of commodities, might require more extensive investigation, *i.e.*, application of the rule of reason, where professional services are involved. *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975). The practice of professions is not automatically interchangeable with business, *National Society of Professional Engineers v. United States*, 435 U.S. 679, 687 (1978), and, therefore, the competitive effect of agreements in these [65] professions may be evaluated by examining the facts peculiar to the professions. The newness of review of professional activities, and the special considerations involved in the delivery of health services have made several courts reluctant to adopt a *per se* rule of illegality. *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 1980-2 Trade Cases (CCH) ¶ 63,395 at p. 76,012-13 (4th Cir. 1980) [624 F.2d 476]. *Arizona v. Maricopa Medical Society*, 1980-1 Trade Cases (CCH) ¶ 63,239 at p. 78, 154 (9th Cir. 1980) [643 F.2d 553].

The actions of respondent MSMS, therefore, will be examined under the rule of reason.

Under the rule of reason, attention is focused on the impact of the challenged restraint on competitive conditions. "Contrary to its name, the Rule does not open the field of antitrust inquiry to any argument in favor of a challenged restraint that may fall within the realm of reason." *National Society of Professional Engineers, supra*, 435 U.S. at 688.

Certain practices by members of a profession might survive scrutiny under the rule of reason even though they would be viewed as a violation of the Sherman Act in another context. *Goldfarb, supra*, 421 U.S. at 788-89. However, the *Goldfarb* case does not fashion a broad exception under the rule of reason for the professions. *National Society of Professional Engineers, supra*, 435 U.S. at 696.

The Commission's complaint charges that respondent, some of its constituent societies, and some of its members, have unlawfully conspired to fix prices paid by, and to boycott, third-party payers BCBSM and Michigan Medicaid.

To support a charge of unlawful price fixing, it is necessary to demonstrate that the activities cited had the potential effect of raising, lowering, or stabilizing prices, *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 221 (1940), even though the members of the price-fixing group are in no position to control the market.

"The generic concept of boycott refers to a method of pressuring a party with whom one has a dispute by withholding or enlisting others

to withhold patronage or services from the target." *St. Paul Fire & Marine Insurance Co. v. Barry*, 438 U.S. 531, 541 (1978). The ordinary meaning is a concerted refusal to deal. [66]

Individuals may do many things independently and, thus, legally, which they may not combine with others to accomplish. *De Jong Packing Co. v. United States Department of Agriculture*, 618 F.2d 1329, 1335 (1980). *Joseph E. Seagram & Sons, Inc., v. Hawaiian Oke & Liquors, Ltd.*, 416 F.2d 71, 76 (9th Cir. 1969), *cert., denied*, 396 U.S. 1062 (1970). "What is charged as unfair is the attempt to coerce a change in marketing practices by concerted action; to obtain by concert of action market power not possessed by the purchasers individually and, by exercise of that market power, to obtain a favorable change in marketing practices that could not have resulted from the free play of competitive forces." *De Jong Packing, supra*, 618 F.2d at 1335.

The target of the boycott need not be a competitor of the boycotters to run afoul of the antitrust laws. *Indiana Federation of Dentists, supra*, Initial Decision, Docket 9118 at p. 88 [101 F.T.C. 54]. Concerted refusals to deal are held unlawful in cases where the target is a customer of some or all of the conspirators, and the target is denied access to desired goods or services because of a refusal to accede to particular terms set by some or all of the "sellers." *St. Paul Fire & Marine Insurance Co., supra*, 438 U.S. at 543.

It is obvious that MSMS, and many of its constituent societies and members, have engaged in a conspiracy to boycott against Michigan Medicaid and BCBSM. By threatening to cease treating Medicaid patients (Findings 249-262), to cease filling out BCBSM claim forms, (Findings 219 and 234) and to cease participation in BCBSM (Findings 219-228) respondent endeavored to extract concessions from these third-party payers which would not otherwise be forthcoming. Its aim was to obtain higher reimbursements for treatment of Medicaid patients; to eliminate differential treatment by BCBSM of participating and non-participating physicians; and to eliminate regional differentials in reimbursements. By and large, respondent was successful in obtaining its aims by the use of such tactics.

Respondent cites many reasons and rationalizations for its actions regarding third-party payers, but the only defense to a finding of restraint of competition under the rule of reason is that the challenged activities had some procompetitive effect. Respondent has failed to introduce evidence of this. Laudatory social purposes are irrelevant in this connection. *Indiana Federation of Dentists*, Initial Decision, Docket 9118 at p. 88 [101 F.T.C. 54]. Under the prevailing law, the only factors which can be weighed against the anticompetitive effects of respondent's actions are possible procompetitive [67]

effects, not public policy considerations. *National Society of Professional Engineers*, 435 U.S. at 692-93. If respondent is convinced that the nature of its profession, the nature of BCBSM as a monopolist, or any other public policy factor compels and justifies its being shielded from the antitrust laws, its recourse is to appeal to Congress. *National Society of Professional Engineers, supra*, 435 U.S. at 689.

Respondent argues that its challenged actions were legitimate, because any "alleged price tampering was ancillary to an otherwise valid commercial purpose." (Respondent's Trial Brief at 29). Respondent relies on *Columbia Broadcasting System, Inc. v. American Society of Composers, Authors and Publishers*, 562 F.2d 130 (2d Cir. 1977), which held that an ancillary restraint will be tolerated under the rule of reason if reasonably necessary to the legitimate primary purpose of the arrangement; is of no broader scope than reasonably necessary; does not unreasonably effect competition in the market place; and is not imposed by a party or parties with monopoly power.

It is obvious that respondent's activities are not permissible as an ancillary restraint. Respondent asserts that it acted in reaction to the "unreasonable and anticompetitive" behavior of BCBSM. However, the primary purpose of respondent's activities was what respondent eventually accomplished: an increase in reimbursement from Michigan Medicaid and the elimination of regional and participating/non-participating physician reimbursement distinctions. The fact that 80% of all Michigan physicians were members of MSMS (Finding 1), gave Respondent sufficient "clout" to extract these concessions.

Despite the fact, as it turned out, that there was no overall decrease in physician participation (Finding 230), nevertheless anticompetitive effects and consumer injury did result from MSMS's actions. Michigan Medicaid increased its reimbursement to physicians. Differential reimbursement to doctors in different regional areas was eliminated, at a cost of "millions of dollars" to BCBSM (Finding 246). As a matter of logic, this will lead to higher BCBSM premiums. [68]

Health and safety factors can be considered under the ancillary restraint doctrine even where the restraints on the market do not enhance competition, *Tripoli Co. v. Wella Corp.*, 425 F.2d 932, cert. denied, 400 U.S. 831 (1970), but public policy type arguments do not suffice. *National Society of Professional Engineers, supra*, 435 U.S. at 692-693, 696 n.22. Arguments that Respondent's conduct was defensive, *Kiefer-Stewart Co. v. Joseph E. Seagram & Sons, Inc.*, 340 U.S. 211 (1951), or designed to fight unfair or illegal conduct by other parties, *Fashion Originators' Guild of America v. Federal Trade Commission*, 312 U.S. 457 (1941) are irrelevant.

Complaint counsel have established that MSMS conspired with its members and component societies to restrain competition. "It is now

well established that an organization of professionals whose members accept and follow anticompetitive organizational policy declarations may be found to have conspired with its members to that end." *Indiana Federation of Dentists, supra*, Docket 9118 at p. 36 [101 F.T.C. 54].

Parallel action may be evidence of a conspiracy. The close similarity of letters sent by parties supposedly acting independently (Finding 227), as found in this case, lends credence to the view that they were aware of each other's actions and were acting in concert.

While mere conscious parallel action is not sufficient to demonstrate conspiracy, neither is express agreement required; it is enough that knowing that concerted action was contemplated or invited [the defendants] gave their adherence to the scheme and participated in it.

De Jong Packing Co., supra, 616 F.2d at 1354. *American Tobacco Co. v. United States*, 328 U.S. 781 (1946). The agreement may be shown by concerted action, the parties working together with a single design for the accomplishment of a common purpose. The common design is the essence of the conspiracy or combination whether the parties act separately or together, or by common or different means, so long as they seek the same result. *American Tobacco, supra* at 809. And it is not necessary to find that the concerted activity was successful. *Socoy-Vacuum Oil Co., supra*, 310 U.S. at 224-25, n. 59. [69]

To find unlawful conspiracy, it is necessary that there be two or more individuals or entities attempting to accomplish a lawful or unlawful objective through unlawful means. *Pettibone v. United States*, 148 U.S. 197, 203 (1893). Where concerted action is encouraged by a central coordinating party and those who participate know that their activity is necessary for success of the plan, a conspiracy can be found to exist. It is not necessary to show that participation was coerced or that co-conspirators would be subject to punishment for withdrawing from the conspiracy. *Interstate Circuit, Inc. v. United States*, 306 U.S. 208, 226-27 (1939). The parties may be engaged in uniform or different activities to further the plan, and the identities of the conspirators may change during the conspiracy. *Craig v. United States*, 81 F.2d 816, 822 (9th Cir.), *cert. denied*, 298 U.S. 690 (1936).

"It is elementary that an unlawful conspiracy may be and often is formed without simultaneous action or agreement on the part of the conspirators" *Interstate Circuit, supra*, 306 U.S. at 226-27. Once a conspiracy is established only "slight evidence" is needed to connect any particular participant. *United States v. Cadillac Overall Supply Co.* 568 F.2d 1078, 1087 (5th Cir.), *cert. denied*, 437 U.S. 903 (1978).

Organizations such as MSMS, with its many physician members, inherently consist of two or more persons, and are, therefore, combi-

nations. *American Column & Lumber Co. v. United States*, 257 U.S. 377, 399 (1921). Thus, when a trade association agrees or combines with some of its constituents or component societies to accomplish some anticompetitive, unlawful objective, e.g. a boycott or attempt to tamper with prices or terms of reimbursement, a conspiracy necessarily results. *United States v. National Society of Professional Engineers*, 389 F.Supp. 1193, 1201, 1216 (D.D.C., 1974), *vacated*, 422 U.S. 1031 (1975), *aff'd. on remand*, 404 F.Supp. 457 (D.D.C. 1975), *aff'd.*, 435 U.S. 679 (1978). *Indiana Federation of Dentists*, Initial Decision, Docket 9118, at 36-37 [101 F.T.C. 54].

I so find in this case.

IV. Respondent's Affirmative Defenses Are Without Merit

A. Respondent's Activities are not protected under the *Noerr* Rule

Respondent MSMS argues that the actions it took in its dispute with Michigan Medicaid (Findings 249 through 263) may not be found to violate the antitrust laws, because these activities constituted protected activity under the doctrine established in *Eastern Railroad Presidents Conference v. Noerr Motor Freight*, 365 U.S. 127 (1961) (hereinafter "Noerr"). [70]

That case involved a struggle between railroad and trucking interests, in which the railroads were accused of unlawfully conducting a "publicity campaign against the truckers designed to foster the adoption and retention of laws and law enforcement practices" inimical to the trucking industry. 365 U.S. at 129. The Supreme Court ruled that:

[T]he Sherman Act does not prohibit two or more persons from associating together in an attempt to persuade the legislature or the executive to take particular action with respect to a law that would produce a restraint or monopoly.

365 U.S. at 136.

The Court based its decision on two grounds:

(1) In a representative democracy such as this, these branches of government act on behalf of the people and, to a very large extent, the whole concept of representation depends upon the ability of the people to make their wishes known to their representatives. To hold that the government retains the power to act in this representative capacity and yet hold, at the same time, that the people cannot freely inform the government of their wishes would impute to the Sherman Act a purpose to regulate, not business activity, but political activity, a purpose which would have no basis whatever in the legislative history of that Act.

(2) The right of petition is one of the freedoms protected by the Bill of Rights, and we cannot, of course, lightly impute to Congress an intent to invade these freedoms.

365 U.S. at 137-38.

Accordingly, the intent of the defendants to injure the trucking industry was held to not preclude their right to inform government officials of their opinions regarding the passage or enforcement of laws. 365 U.S. at 139. However, the Court expressly excluded from its holding those situations where ostensible activity to influence government action was merely a "sham" to cover action designed to injure the business relationships of a competitor. 365 U.S. at 144. [71]

In addition, the Court pointed out that an association of two or more persons in an attempt to influence legislation, the end result of which might be a restraint on trade or a monopoly, is essentially dissimilar from "**** the combinations normally held violative of the Sherman Act, combinations ordinarily characterized by an express or implied agreement or understanding that the participants will jointly give up their trade freedom, or help one another to take away the trade freedom of others through the use of such devices as price-fixing agreements, boycotts, market-division agreements and other similar arrangements." [citation omitted] 365 U.S. at 136.

The Supreme Court subsequently considered the *Noerr* rule in *United Mine Workers v. Pennington*, 381 U.S. 657 (1965); and in *California Motor Transport Co. v. Trucking Unlimited*, 404 U.S. 508 (1972).

In *Pennington*, a small mining company claimed there was a conspiracy involving the United Mine Workers ("UMW"), several large mining companies and the U. S. Secretary of Labor to drive small mining companies out of business. It was contended, *inter alia*, that the UMW and the large operators had jointly lobbied the Secretary of Labor to secure business policies unfavorable to small mine owners. Concerning this effort, the Court stated:

Joint efforts to influence public officials do not violate the antitrust laws even though intended to eliminate competition. Such conduct is not illegal, either standing alone or as part of a broader scheme itself violative of the Sherman Act.

381 U.S. at 670

In *California Motor Transport Co.*, it was alleged that highway carriers engaged in a joint campaign of administrative and judicial harassment to prevent rivals from obtaining operating rights. The Supreme Court, assuming the *Sacramento Coca-Cola Bottling Co. v. Chauffers Local 150*, 440 F.2d 1096 (9th Cir. 1971). For a review of authorities on this point, see *In re Airport Car Rental Litigation*, 474 F.Supp. 1072, 1079-83 (N.D. Cal. 1979).

In the case-at-bar, respondent MSMS was dealing with Michigan Medicaid in the latter's capacity as a purchaser of medical services for eligible individuals. The "political expression" activity cases relied on

by respondent are therefore [72] inappropriate.¹¹ Moreover, the *Noer* rule should not be construed to sanction attempts to deal with government officials "by means of threats, intimidation and other coercive measures" *Sacramento Coca-Cola, supra*, 440 F.2d at 1099.

B. Respondents Activities Are Not Exempt From Antitrust Scrutiny Under The McCarran-Ferguson Act

Under the McCarran-Ferguson Act, 15 U.S.C. 1011 *et seq*, the nation's antitrust laws are applicable to the business of insurance only to the extent that such business is not regulated by state law. Respondent contends that its activities are protected by that statute.

In support of its position, respondent cites *Bartholomew v. Virginia Chiropractors Ass'n*, 1980-1 Trade Case ¶ 63,075 (4th Cir. 1979) [612 F.2d 812]. In that case, certain health care insurers, the American Chiropractors Association (ACA) and the Virginia Chiropractors Association (VCA) established a peer review system to determine reimbursement of insurance claims. Under this system, when a patient's bill was sent to his insurer for reimbursement, the insurer forwarded the bill to the VCA for consideration of the peer review committee as to usual and customary charge for the particular service rendered. Disputes between the patient and the insurer were resolved by ACA. (1980-1 Trade Case at p. 77,332). The circuit court found that the defendants' actions "touched upon 'the business of insurance'," (1980-1 Trade Cases at p. 77,335), distinguishing the case from *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 105 (1979), and stating: [73]

This conclusion does not trespass upon the teachings of [*Royal Drug*]. In that case there were two segregated and disparate operations: one, the offering of insurance, and the other, the procurement of drugs, admittedly an act only thinly tangential to insurance*** In the present instance, there is an integration of component acts resulting in a single, composite business—insurance.

1980-1 Trade Cases at p. 77,335.

Respondent MSMS argues that *Bartholomew* presents a factual situation very similar to that in the instant case, in view of the formation and activities of MSMS' Physician's Liaison Committee. This committee met with BCBSM to enunciate four goals to be reached through collective action by both parties (Finding 243).

As noted by complaint counsel (in its Brief Supporting the proposed

¹¹ See *Missouri v. NOW, Inc.*, 620 F.2d 1301 (8th Cir. 1980); *Subscription Television, Inc. v. Southern California Theater Owners Ass'n*, 576 F.2d 230 (9th Cir. 1978); *Crown Central Petroleum Corp. v. Waldman*, 486 F. Supp. 769 (M.D. Pa. 1980) rev'd on other grounds, 1980-81 Trade Cases CCH ¶ 63635 (3rd Cir. 1980) [634 F.2d 127]; *Metro Cable Co. v. CATV of Rockford, Inc.*, 516 F.2d 220 (1975).

Findings of Fact and Conclusions of Law, p. 60), this defense was not pleaded in respondents' Answer and Affirmative Defenses, and was not otherwise argued by respondent except for a reference in its trial brief.

However, it is clear that MSMS is not in the "business of insurance," despite the discussions which occurred between BCBSM and, on the part of MSMS, the Physician's Liaison Committee (Finding 243). An insurance contract is defined in *Royal Drug* as one which involves spreading and underwriting of the policy holder's risk. 440 U.S. at 211. In that case the Court noted that the McCarran-Ferguson Act was concerned with the relationship between the insurer and the insured. 440 U.S. at 215-216.

But even if these activities of MSMS be considered as "insurance" under McCarran-Ferguson Act, that Act expressly provides that nothing in it is to render the federal antitrust laws inapplicable to any "agreement to boycott, coerce or intimidate, or act of boycott, coercion, or intimidation." 15 U.S.C. 1013(b). *Indiana Federation of Dentists*, Docket No. 9118, at p. 22-23 [101 FTC 54]. *St. Paul Fire & Marine Insurance Co. v. Barry*, 438 U.S. 531 (1978).

McCarran-Ferguson, therefore, in no way shields respondent from liability in this case. [74]

CONCLUSIONS OF LAW

1. The Federal Trade Commission has jurisdiction over respondent and over the subject matter of this proceeding.
2. The respondent is a "corporation" within the meaning of Section 4 of the Federal Trade Commission Act and is subject to the jurisdiction of the Federal Trade Commission.
3. The challenged acts practices and methods of competition of respondents are in, and affect, commerce within the meaning of the Federal Trade Commission Act.
4. Respondent has conspired with some of its members, and with individual component societies, and has acted as a combination of its members to restrain competition among physicians in the State of Michigan by:
 - a. Fixing, stabilizing, or otherwise tampering with the fees which physicians in Michigan receive for their services.
 - b. Engaging in concerted action to restrict, regulate, impede, or interfere with the health care cost containment and reimbursement policies of third-party payers for physicians' services, including Blue Cross and Blue Shield of Michigan and the Michigan Medicaid program.

c. Engaging in concerted negotiations with Blue Cross and Blue Shield of Michigan, with respect to the health care cost containment or reimbursement policies of Blue Cross and Blue Shield of Michigan

5. The above combination or conspiracy, and the acts and practices committed in furtherance thereof, have eliminated, restricted, restrained, foreclosed and frustrate competition [75] among physicians and have caused substantial injury to the public.

6. The combination or conspiracy, and the acts and practices committed in furtherance thereof, constitute unfair methods of competition, and unfair acts or practices in or affecting commerce and are in violation of Section 5 of the Federal Trade Commission Act, 15 U.S.C. 45.

7. The Order entered in this proceeding is necessary to remedy the violations of law committed by the respondent and to protect the public now and in the future. [76]

ORDER

I.

Definitions

It is ordered, That for purposes of this order the following definitions shall apply:

A. *MSMS* means Michigan State Medical Society, its House of Delegates, Council, committees, officers, representatives, agents, employees, successors and assigns.

B. *Third-party payer* means any person, corporation, government agency or other entity which agrees to pay for or reimburse all or part of any expense for physicians' services incurred by another person or group of persons. *Third-party payer* includes, but is not limited to, Blue Cross and Blue Shield of Michigan, and Medicaid.

C. *Medicaid* means the program of health care for indigent persons created by Title XIX of the Social Security Act, entitled "Grants to States for Medical Assistance Programs," 42 U.S.C. 1396 [77] *et seq.* (1976 & Supp. III 1979), including regulations, policies and procedures of Michigan that implement the program in Michigan.

D. *Reimbursement* means money paid by a third-party payer for physicians' services.

E. *Physician* means a doctor of medicine or of osteopathy.

F. *Participation agreement* means any agreement between a third-party payer and a physician in which the third-party payer agrees to pay the physician for the provision of physicians' services and in

which the physician agrees to accept payment from the third-party payer for the provision of physicians' services.

II.

It is further ordered, That MSMS shall cease and desist from:

A. Entering into or attempting to enter into any agreement or understanding, either express or implied with any MSMS members to affect or [78] attempt to affect the amount, manner of calculating, or terms of reimbursement, including, but not limited to, any agreement or understanding that:

1. any MSMS members will cancel or refuse to enter into participation agreements;
2. any MSMS members will refuse to complete claim forms used by any third-party payer;
3. MSMS can act on behalf of any members through proxy, power of attorney, or otherwise, to cancel or refuse to enter into any participation agreement; or
4. any MSMS members will sign or enter participation agreements only on terms acceptable to MSMS or to any other MSMS member.

B. Advocating, suggesting, urging, advising, inducing or recommending that any MSMS members engage in any action to affect or attempt to affect the amount, manner of calculating, or terms of reimbursement, including, but not limited to, advocating, [79] suggesting, urging, advising, inducing or recommending that any MSMS members:

1. cancel, or refuse to enter into, a participation agreement with any third-party payer;
2. refuse to complete claim forms used by any third-party payer;
3. agree to permit MSMS to act on behalf of any MSMS members through proxy, power of attorney, or otherwise, to cancel, or refuse to enter into, any participation agreement; or
4. sign or enter participation agreements only on terms acceptable to MSMS or to any other MSMS member.

C. Entering into or attempting to enter into any agreement or understanding, either express or implied, with any third-party payer concerning the amount, manner of calculating, or terms of reimbursement, or the terms or conditions of any participation agreement. [80]

D. Acting or purporting to act as an agent for or representative of any MSMS members concerning their position with respect to the amount, manner of calculating, or terms of reimbursement, or con-

cerning their decision to accept or reject the terms or conditions of any participation agreement.

E. Making any express or implied threat of acts by any MSMS members, or engaging in any other acts, with the purpose or effect of coercing, compelling or inducing any third-party payer to accept a position taken by MSMS or any MSMS members concerning the amount, manner of calculating, or terms of reimbursement, or the terms or conditions of any participation agreement.

III.

It is further ordered, That this Order shall not be construed to prevent MSMS from:

A. Participating in professional peer review of fees charged by individual physicians in individual cases. [81]

B. Engaging in *bona fide* exercise of rights permitted under the First Amendment to the United States Constitution to petition any federal or state government executive agency or legislative body concerning legislation, rules or procedures, or to participate in any federal or state administrative or judicial proceeding.

C. Responding to a request for information or opinion by any third-party payer.

IV.

It is further ordered, That MSMS:

A. Mail a copy of this Decision and Order to each of its component societies, each of its specialty sections, and each of its members within thirty days following service of this Order.

B. Publish this Order on the first pages of an issue of *Michigan Medicine* published no later than 60 days after the date the Order is served, and on the first pages of the first *Medigram* published after the Order is served. The Order shall be [82] published in the same type size normally used for articles which are published in *Michigan Medicine* and in the *Medigram*.

C. For a period of ten years, provide each new MSMS member with a copy of this Decision and Order at the time the member is accepted into membership.

D. Require, as a condition of affiliation with MSMS, that any component society or specialty section agree by action taken by its governing body to be bound by the provisions of Parts I-III of this Order.

V.

It is further ordered, That MSMS shall file a written report with the Commission within ninety days of the date of service of this Order, and annually on the anniversary date of the original report for each of the five years thereafter, and at such other times as the Commission may by written notice to MSMS require, setting forth in detail the manner and form in which it has been complied with this Order. [83]

VI.

It is further ordered, That MSMS shall notify the Commission at least thirty days prior to any proposed change to itself, such as dissolution, assignment, or sale resulting in the emergence of a successor corporation or association, or any other change which may affect compliance with this Order.

OPINION OF THE COMMISSION

BY CLANTON, *Commissioner*:

I. Introduction

This case involves allegations that direct competitors, acting through a professional association, conspired to restrain trade by organizing boycotts and tampering with the fees received from third party insurers of their services. Of particular antitrust significance is the fact that the competitors are medical doctors practicing in Michigan, the association is the Michigan State Medical Society, and the insurers are Blue Cross and Blue Shield of Michigan ("BCBSM") and Michigan Medicaid.

More specifically, the complaint in this matter charges, and the administrative law judge found, that the medical society unlawfully conspired with its members to influence third-party reimbursement policies in the following ways: by seeking to negotiate collective agreements with insurers; by agreeing to use coercive measures like proxy solicitation and group boycotts; and by actually making coercive threats to third party payers. The ALJ concluded that these practices unreasonably restrained competition, in violation of Section 5 of the Federal Trade Commission Act, 15 U.S.C. 45, and [2] ordered the society to refrain from engaging in coercive or threatening behavior directed toward health insurance reimbursement policies.

As explained more fully below, we affirm the ALJ's conclusions on liability and enter an order designed to prohibit future conspiratorial,

coercive activity by MSMS with respect to reimbursement policies and related issues. Our order, however, would not prohibit MSMS from providing information and views to private insurance companies, nor would it preclude respondent from participating in various state agency proceedings dealing with Medicaid issues, including reimbursement.

II. Respondent

MSMS, incorporated under the laws of Michigan, with its principal offices in East Lansing, is a professional association to which 80% of the physicians in Michigan belong. It is composed of 55 component medical societies, organized at the county level, and various specialty organizations. MSMS is itself a constituent society of the American Medical Association. MSMS' legislative unit, the House of Delegates, is composed of representatives from each of these component and specialty societies. For our purposes, it is sufficient to note that the powers and duties of the House of Delegates include the adoption of all rules governing MSMS' activities as well as the transaction of all business not specially delegated to committees. Elected from the House of Delegates is MSMS' executive body, the Council, which is authorized to act for the House in several ways relevant to this case. The Council executes the directives and resolutions of the House of Delegates between annual sessions of the larger body and monitors the work of House committees. (IDF 1-5)¹ [3]

III. Third-Party Payers

Because the third-party reimbursement system of purchasing health-care services lies at the heart of this matter, it is important to offer a description of its most salient features. Third-party payers are insurers of their subscribers' needs for health-care services. In exchange for payment of premiums, subscribers (in the case of private insurance) receive guarantees from the insurer to pay in full or partially for specifically covered medical services obtained by the subscriber during the term of the coverage. BCBSM is such a private third-party payer for health care services, providing hospital and medical care benefits to individual and group subscribers. Michigan

¹ Abbreviations used throughout this opinion are as follows:

ID-Initial Decision page number
IDF-Initial Decision finding number
CX-Complaint Counsel's exhibit number
RX-Respondent's exhibit number
RAB-Respondent's Appeal Brief page number
CAB-Complaint Counsel's Answering Brief page number
RRB-Respondent's Reply Brief page number
Tr.-Trial transcript page number
O.A. Tr.-Oral Argument transcript page number

Medicaid is a state-operated public assistance program that purchases health care services rendered to persons eligible for its form of insurance coverage.

Under BCBSM's "service-benefit" coverage, a "participating physician" is one who agrees to provide the services listed in a contract to subscribers, accepting the BCBSM payment in full and not charging the patient beyond that amount. A "non-participating" physician may participate for one time only ("per-case"), accepting BCBSM's scheduled reimbursement fee as payment in full. Alternatively, he may decline to participate in BCBSM insurance to any extent, in which case BCBSM reimburses its subscriber a fixed fee upon the physician's certification that he performed a service. The subscriber pays the physician's bill, which may exceed the benefit level paid by the insurer. Thus, a nonparticipating physician has no contractual obligation to BCBSM to accept the insurer's fee as payment in full for services rendered to a subscriber, and it is his option whether to accept BCBSM reimbursement as payment in full or to demand a higher payment from the subscriber. (IDF 126)

The number of physicians who contract to participate in a service benefit plan is a crucial element of the workability and attractiveness of the plan to potential and present subscribers. For one thing, by law BCBSM must have a minimum 50% of all Michigan doctors participating in order to offer service benefits at all. In BCBSM's view, though, the minimum threshold of physician participation required to assure satisfactory availability of services is 60%. (Hayes Tr. 360) According to the ALJ, "per case" participation does not adequately minimize costs and assure a subscriber of the availability of service benefits, so that only full participation will satisfy BCBSM's purposes. The ALJ also found that records and information generated by full participation facilitate BCBSM's cost-containment measures, which enhances its competitive position. (IDF 121) [4]

It is necessary to explain how BCBSM calculates the reimbursement paid to participating physicians in order to elucidate respondent's defense that it was attempting to influence only the manner of setting fees, rather than the actual levels of fees. BCBSM sets its reimbursement fees (which are described as "usual, customary and reasonable") for individual medical procedures and services by comparing three statistics: a physician's actual charge, the physician's "profile," and the "screen" for that service. The "profile" measures the individual physician's past charges for medical procedures and the "screen" compares the charges of other physicians in the relevant area. BCBSM determines a physician's profile from the claim forms submitted by him over the previous 12 months, whether or not he was fully participating. (IDF 130) Screens are employed to set a maximum

reasonable fee for a given procedure in a given area, based on physicians' actual charging patterns, and they are designed so that a certain percentage of the charges for a particular service (say, 80%) should be paid in full. (This assumes, of course, that physicians' actual charges for a particular service vary, which they do, with some above and some below what BCBSM determines to be its usual, customary and reasonable, or "UCR," fee for the service.)

Some of the acts challenged here arose in MSMS' attempt to compel BCBSM to calculate screens on a statewide basis instead of regionally.² As this introduction suggests, the question at hand is whether respondent's efforts to secure, among other things, the statewide screen, are correctly characterized as collective price-fixing and fee-tampering. To describe the character of the underlying events in coherent detail, it is first necessary to lay out MSMS' relationship with BCBSM and then turn to the chronology relating to Michigan Medicaid.

IV. Respondent's Relationship With Blue Cross and Blue Shield of Michigan

For thirty years prior to 1970, the board of directors of BCBSM was elected by the House of Delegates of MSMS. (IDF 109-110) While that control relationship was formally severed in 1970, liaison between the Council of MSMS and the management of BCBSM has continued uninterrupted, although differences in interests have arisen. In March 1974, the Council considered certain problems that physicians were having with insurance companies and governmental purchasers of medical services, problems that the Council determined to approach in a more aggressive way than it had theretofore. [5] Thus, in that year, the Council formed its "Negotiating Committee With Third Party Carriers," with Dr. Donald Crandall serving as chairman at all times relevant to this case.

A. *The Uniform Code and Claim Forms*

The first problems considered by the Negotiating Committee involved the quantity of paperwork required of participating physicians by insurance claim forms and the various procedural coding systems used by health insurers. At that time, MSMS strenuously preferred that all third-party payers adopt as a uniform code the American Medical Association's "Current Procedural Terminology" (CPT). Michigan Medicaid was apparently willing to use CPT if it became the single coding system for all Michigan health insurers. (CX 8L) But

² Prior to certain events described momentarily, BCBSM calculated four separate screens in Michigan based upon charging patterns corresponding to patterns of urban concentration.

BCBSM balked at this initiative, contending that conversion to the single code would be too costly (\$1.1 million).

Believing that BCBSM was responding unreasonably, the Negotiating Committee requested that the House of Delegates unilaterally force the issue by officially adopting CPT as the only code to be used by physicians for all insurance forms. The Negotiating Committee also indicated that if these coding (and other) objectives could not be met by negotiation by the end of the year, it might recommend to the Council 1) statewide nonparticipation by members of MSMS or 2) unspecified legal action.³

In a closely related and contemporaneous sequence of events, the Negotiating Committee urged that a uniform claim form be used by all third-party payers. (*Id.*) In 1974, the Negotiating Committee preferred a form designed by the Michigan Department of Social Services and based on an AMA proposed claim form, but containing features tailored to Michigan insurance carriers and apparently containing sufficient information to permit insurers to process claims expeditiously. At one point, MSMS perceived that all third-party carriers were in accord with its proposal, with BCBSM and Michigan Medicaid both initially expressing their approval of the form. MSMS' optimistic expectations of industry-wide adoption of the form were not fulfilled, however. The greatest stumbling block was BCBSM's subsequent report that its claim-processing equipment could not accept the form. To condense this episode somewhat, MSMS' Negotiating Committee regarded this BCBSM reversal as unreasonable. It reported to the House that every effort to obtain BCBSM's input into development of a uniform claim form had been spurned and [6] that BCBSM had no intention of cooperating in that project, presumably because BCBSM hoped to force the continued use of its own form. (CX 8N)

MSMS purportedly favored no particular claim form—rather, its goal was merely to achieve uniformity. On its part, BCBSM agreed in principle to reduce physicians' administrative burdens by cooperating in the use of a uniform form, but believed that the form proposed by MSMS would entail excessively costly conversion of its data processing system. (IDF 141; Hayes Tr. 386)

Reaching this additional impasse, the Negotiating Committee proposed to the Council the same action as it did with respect to the single coding system described above. Nevertheless, in 1975, MSMS and BCBSM reached agreement on a uniform claim form (IDF 153). Thus, these particular events remain relevant to this proceeding only

³ The Committee also recommended, it should be noted, that the House instruct its Committee on State Legislation and Regulation to (1) petition the office of the Insurance Commissioner and/or (2) seek legislation, to mandate the use of CPT in Michigan.

to illustrate the year and the context in which MSMS first suggested an organized withdrawal from participation in BCBSM. Even though these claim form disputes were settled, the screens and profiles provided further points of friction between MSMS and BCBSM and gave rise to the conduct at issue in this case.

B. Regional Screens

In October 1974, the Negotiating Committee asked BCBSM to abolish differences among the screens for the four geographical regions of Michigan.⁴ Screens in the Detroit area were significantly higher than elsewhere, but MSMS contended that this differential was out of date, since the costs of practicing medicine had been equalized throughout the state as specialization had permeated Michigan. In respondent's view, these outdated differences in reimbursement levels created dissension among physicians and maldistribution of medical resources. (IDF 159; Crandall Tr. 1692)

The Detroit area (Area 1) accounted for 69% of BCBSM's total reimbursement payout of \$300 million/year, with the other areas accounting for 22%, 8% and 1%. BCBSM believed that if it abolished regional screens but did not increase its total payout level (*i.e.*, did not abandon its cost-containment targets) it would have to reduce payments to Area 1 physicians by \$14.5 million. BCBSM feared that such a reduction in reimbursement would make participation less attractive to a substantial number of providers in that region. To raise all other area screens to Area 1 levels, on the other hand, would cost an extra \$7 million/year. (IDF 144) BCBSM believed that such an increase would be unacceptable to its subscribers and to the Michigan Insurance Bureau. [7]

Dr. Crandall, on behalf of the Negotiating Committee, suggested that BCBSM design a method of eliminating the regions without raising its statewide payout. (Crandall Tr. 1692) In his view, BCBSM could do this over a period of only one or two years without affecting participation by MSMS members in any region. (*Id.*) Before it would attempt such a design, BCBSM requested from MSMS a prediction of the likely effect of any reduction in Area 1 payout levels on MSMS members there. Apparently this overture came to naught—MSMS claims that it never received a specific proposal from BCBSM on which to survey its Area 1 members. (CX 8N) BCBSM eventually told MSMS that it could not eliminate regional differences in screens at that time, but that it might reconsider if MSMS could guarantee that

⁴ Region 1 was the Detroit Metropolitan area; Region 2 included all counties in Michigan in which there was a city with a population in excess of 50,000; Region 3 included all other counties in the Lower Peninsula; and Region 4 contained all other counties in the Upper Peninsula. Regions 3 and 4 were combined as the screens in the Upper Peninsula came more in line with those of the Lower Peninsula.

a statewide screen would result in no loss in physician participation in Area 1. (CX 462Z 36)

C. Updating of Physician Profiles

Another bone of contention between BCBSM and MSMS was the manner in which the insurer kept its profiles, or physicians' billing histories. BCBSM customarily revised its profiles only upon the request of physicians, and only one third of the physicians filed such requests each year. In 1974, MSMS requested that BCBSM automatically update the profiles of participating doctors. (CX 8N) BCBSM responded that it could not annually update profiles and still stay within its cost-containment program, estimating that such an initiative would add \$13 million to its reimbursement payout each year. (IDF 147) The Negotiating Committee then asked BCBSM just to send physicians their profiles annually without their having to request them, so that they would be able to update them themselves. BCBSM first indicated that it would do so, according to MSMS documents, but then refused because that change would involve additional administrative costs and because the annual mailing would amount to an invitation to request updating, which BCBSM did not want to precipitate. This response angered the Negotiating Committee because it seemed to lay upon physicians the burden of insuring that their profiles were accurate, even though BCBSM possessed the data necessary to do so. Furthermore, because of the lag in revising profiles, BCBSM at times informed subscribers that their physicians were "overcharging them" when in fact the physicians' customary fees had long since risen. (CX 8-O; Crandall Tr. 1696)

D. Authorization To Seek Proxies

Becoming frustrated in its negotiations with BCBSM on these issues, MSMS authorized its first proxy solicitation. Reacting to what it perceived to be

the recalcitrant attitude of Blue Shield on the subjects of regionalization of fees and physician profiles, coupled with what [8] appears to be a total lack of willingness to cooperate with MSMS in the development of a uniform claim form or even consider the use of the CPT procedural code, (CX 8-O)

the Negotiating Committee recommended that the House of Delegates urge MSMS members to write letters to BCBSM withdrawing from participation but mail them to the Negotiating Committee to be held as "proxies." The House of Delegates authorized the committee to collect the proxies, but to use them only at the discretion of the Council, with prior notice to the members who submitted them, "if a

negotiating impasse develops with Michigan Blue Cross/Blue Shield.” (*Id.*)

Although it secured the authority to collect such “departicipation proxies” in May 1975, the committee did not go forward and collect them then because negotiations with BCBSM began to go more smoothly. (IDF 151) As noted earlier, the claim form issues were resolved in 1975. Furthermore, BCBSM began to engage its directors in the talks instead of management personnel, an escalation that MSMS’ Negotiating Committee attributed to the members’ show of support for the proxy initiative. (IDF 152)

E. *The Proxy Solicitation*

In 1976, in conjunction with the creation of an expanded negotiations “division,” the House of Delegates decided to obtain blanket authority to negotiate on behalf of all MSMS members.⁵ (IDF 168–70) In so doing, the House of Delegates resolved to collect departicipation proxies, for the purpose of negotiating with third party payers over the manner of determining reimbursement amounts, but not over specific fees. (IDF 175) While the MSMS House understood, on advice of counsel, that it would run antitrust risks if it negotiated specific fees, it felt safe in negotiating, on behalf of members, the means by which reimbursement fees were determined. (CX 13Z 13) [9]

The first time that MSMS actually used this authority and collected such proxies was in a dispute that soon arose over a BCBSM proposal to change the manner of reimbursing hospital-based pathologists and radiologists. Believing that the proposed reimbursement plan for hospital-based physicians interfered with contractual relations between physicians and their hospital employers, (RAB 54) the Negotiating Committee moved to solicit departicipation proxies not only from the affected specialty groups but from all MSMS members. (IDF 178–80)

Each member of MSMS was urged by letter to resist “so-called cost-containment programs that in effect reduce reimbursement to physicians or place the responsibility for the reduction of costs solely on the practicing physician.” (CX 2C; 472C) The letter, from the Council chairman, referred pointedly to the fact that a threshold percentage of physicians must formally participate in order for BCBSM to operate under its enabling legislation. It enclosed two blank “powers of attorney,” one for BCBSM and one for Medicaid, empowering the Negotiating Committee to cancel the signer’s participation in either

⁵ The new division’s intended purposes were to (1) identify specific problems amenable to negotiations, (2) assemble relevant data, (3) establish guidelines, (4) devise specific plans of action, (5) coordinate all negotiating activities of MSMS, (6) assist physicians who request negotiating aid, (7) educate members about negotiation, (8) obtain authorization from all members to be the exclusive bargaining agent for all, (9) collect proxies, and (10) formulate a negotiated participation agreement with third party payers which would eliminate reasons for nonparticipation. (IDF 168)

program if such action was deemed warranted by the Council. These powers of attorney were revocable at any time. While promising to give ten days notice before actually using the proxies, the letter indicated that the Negotiating Committee's tactical strength was enhanced merely by holding them. (CX 2C) MSMS leaders actively campaigned for the solicitation and, ultimately, a majority of MSMS members sent in executed proxies. (IDF 190)

As a result of this response, the dispute over radiologists' and pathologists' reimbursement was resolved in MSMS' favor with the *status quo* being preserved and BCBSM withdrawing its proposal.⁶ (CX 653A-B; 10N-Q) As explained below, these proxies also played a role in MSMS' dealings with Medicaid. [10]

F. The Second Departicipation Drive

In 1977, three new reimbursement programs that were initiated simultaneously by BCBSM precipitated further collective departicipation efforts by respondent. In the first such program, BCBSM initiated several major changes in its reimbursement policies, some of which were responsive to positions taken by MSMS, but they applied only to physicians who formally participated in BCBSM's service-benefit plan. In an explicit effort to encourage formal participation, BCBSM increased overall reimbursement, implemented a statewide screen and updated profiles, all for participating physicians only.⁷ (Hayes Tr. 700)

These 1977 reimbursement changes were prompted by BCBSM's concern over an increased rate of utilization of medical services in conjunction with a decline in "effective service benefits."⁸ In BCBSM's view, corrective action was needed to increase the degree of full participation, and all of BCBSM's changes were intended to increase those incentives.⁹ Switching to the statewide screen apparently resulted in an increase in total payout (Hayes Tr. 781), but it was BCBSM's view that increasing the level of participation would nonetheless facilitate cost-containment. (IDF 196)

In the second controversial program, BCBSM introduced a new cost-containment policy called Target Limitation on Expenditures ("TLE"), which set a statewide ceiling on total reimbursement for types of services, rather than setting specific fees for services. As

⁶ During this radiology/pathology dispute, BCBSM invited the Michigan Society of Pathologists to submit cost-containment ideas regarding laboratory and x-ray testing services. The two sides finally agreed on a cost-containment plan relating to hospital-based physicians. (IDF 181)

⁷ These new policies were not designed to interfere with or eliminate other BCBSM reimbursement mechanisms which would have continued to increase reimbursement for all nonparticipating physicians through the usual adjustments to profiles and increases in area screens. (IDF 198)

⁸ The term "effective services benefits" refers to the percentage of all claims for which physicians accept BCBSM payments in full, with no out-of-pocket payments by subscribers. In 1977, BCBSM believed that its effective service benefit level was too low.

⁹ In April 1977, only 58% of Michigan's doctors formally participated. (IDF 202)

claims came in, BCBSM would adjust payments upward or downward to hit the expenditure target for each type of service for a given period. (IDF 203) [11]

The third reimbursement program arose from the UAW's collective bargaining process where, with no input from BCBSM, the union negotiated with the auto makers a package of hearing and vision benefits which were purchased from BCBSM. Unlike other service-benefit plans, the vision care plan paid non-participating physicians only 75% of the amount paid to participating physicians, with no per-case participation allowed, and the hearing care package paid nothing to non-participating physicians. (IDF 208) This "discrimination" in favor of participation was purposeful, due to the UAW's belief that the increased level of participation likely to result from the differentials would yield better costs and quality outcomes. (IDF 210)

MSMS opposed the new BCBSM reimbursement policies and the UAW vision and hearing care packages precisely because they discriminated against nonparticipating physicians, creating incentives for patients to switch physicians and thereby interfering with physician-patient relationships. Respondent also opposed the TLE program on grounds that it ignored the quality of care and would lead to an outflow of physicians from Michigan. Accordingly, MSMS officially "rejected" these new BCBSM policies, and called a special meeting of the House of Delegates to consider additional responses. (CX 355; CX 182F; IDF 212)

At that meeting, the Negotiating Committee recommended that all MSMS members react to these new reimbursement policies by writing letters to BCBSM (rather than submitting powers of attorney), withdrawing from participation or reaffirming their nonparticipation. Dr. Crandall rallied all members to support this collective withdrawal campaign, and the president of MSMS urged members that they must be "unified in the decisions that are reached today."¹⁰ (IDF 218) [12]

As with the proxy solicitation, the MSMS leadership and members attending the special meeting were clearly aware that their proposed departicipation campaign bore antitrust implications. In a presentation on the proposal, MSMS' legal counsel advised that the House of Delegates was not, by the proposed action, authorizing the Negotiating Committee to fix prices, but only to argue persuasively with third-party payers. (CX 15Z 49) Counsel did advise, however, that the non-participation campaign would probably be regarded as a boycott and

¹⁰ Literature that MSMS prepared for members to distribute to patients on the 1977 BCBSM reimbursement policies stressed the adverse effect of the changes on patients themselves, notably by interfering with the physician-patient relationship or by rationing medical services (through TLE). (CX 371C) Even so, the evidence leaves little doubt that the members of MSMS—especially the Delegates attending the special meeting—were aware or were made aware that the new BCBSM reimbursement policies might have a financial impact on them. (CX 15E)

would elicit some sort of legal action.¹¹ (CX 15Z 47)

The House then adopted the resolution urging individual physicians to withdraw from participation in BCBSM. At the same time, the Negotiating Committee recommended that if BCBSM persisted in its discriminatory programs after the receipt of the anticipated number of withdrawal letters, the House of Delegates should instruct physicians not to fill out BCBSM claim forms.¹² (CX 15Z 1)

MSMS leaders wrote to every House delegate and alternate and to every component and specialty society president urging them to departicipate and to encourage all members to do likewise. Members were advised of the campaign through MSMS publications instructing them to send letters to Dr. Hayes of BCBSM. (CX 95) They were also sent postcards on which they could indicate their decision to departicipate. (IDF 221) Members of local medical societies were urged through publications to spread the word, distribute form letters for departicipation, and solicit executed letters. (CX 260B; IDF 222-26) One county society indicated its intention to note the names of those members who did not intend to send departicipation letters so that it could compile call lists for follow-up telephone campaigning. (IDF 222; CX 261B) Another county society wrote its members recommending that they departicipate and that they not only drop their personal insurance with BCBSM but encourage their patients to do so as well. (CX 328; IDF 223) MSMS also publicly urged all Michigan employers to drop BCBSM and seek their doctors' advice in selecting alternative health insurance carriers. (Crandall Tr. 1724) [13]

Although the call to arms was not as widely heeded as MSMS desired, between November 1977 and June 1978, 410 physicians cancelled their participation agreements and 980 non-participating doctors reaffirmed their non-participation. (IDF 227) Many of the letters to BCBSM were identical, resembling form letters (CX 481-501), and mentioning MSMS. (IDF 227) During the departicipation campaign, results of a survey published in *Michigan Medicine* indicated that, of those sampled who had ever participated in Blue Cross plans (at any time, not just during the relevant period), 21% had quit at the urging of MSMS.¹³

Despite this departicipation campaign, BCBSM's new reimbursement incentives for participating physicians proved much more at-

¹¹ MSMS' counsel also described several theories of action, including antitrust, on which MSMS itself might sue BCBSM. (CX 15Z 4-9) In fact, MSMS filed an *amicus curiae* brief in the Supreme Court in *Group Life and Health Ins. Co. v. Royal Drug Co., Inc.*, 440 U.S. 205 (1979), because the case involved "the extent to which Blue Cross-Blue Shield organizations may fix prices and discriminate against non-participating professionals free of antitrust liability." (IDF 59)

¹² MSMS denies that the Council or House of Delegates ever gave such authority or endorsed such a recommendation. (RAB 47) While the House of Delegates apparently never came to a decision or action on the question, such a recommendation was made by two MSMS committees to the House.

¹³ And 42% had quit because they were dissatisfied with the level of reimbursement. (CX 124C)

tractive, bringing in a net gain of 962 formal participants and raising the participation level to 62% in April 1978. (IDF 232) During the campaign, Dr. Hayes of BCBSM received daily reports on the participation losses, as well as the gains from the new reimbursement program. While BCBSM was not concerned about the departicipation drive to the extent that gains were running ahead of losses, it was nevertheless unhappy to be losing hundreds of previously participating physicians. There was also testimony that the participation level of Michigan ophthalmologists in the UAW vision-care plan was so low (38%) that the plan would have failed if optometrists had not been included as alternative providers. (IDF 228) On balance, however, BCBSM decided to take no action in response to the departicipation campaign. (Hayes Tr. 438)

This is not to say, though, that MSMS' collective action and threats had no effect on BCBSM's reimbursement policies. Even during the waging of this departicipation campaign, MSMS and BCBSM had continued to negotiate over a statewide screen for non-participating physicians. We noted earlier that during this dispute the MSMS Council also initiated action to have members stop filling out claim forms. In that vein, a committee of MSMS suggested that instead of ceasing to submit claims altogether, which would result in hardship to patients, members should fill in only barely minimal data, which should have the desired effect on BCBSM. This committee was correct, for BCBSM believed that a refusal to fill out claim forms would be far more disruptive than the implications of the departicipation effort, because the former tactic would surely increase both administrative costs and delays in payment of claims, thus affecting BCBSM's competitive position. (Hayes Tr. 452, 441) Consequently, in May 1978, BCBSM implemented a statewide screen for all physicians. (IDF 246) In exchange, MSMS agreed to cease all of its collective action regarding both departicipation and the proposed refusal to complete claim forms. (IDF 242) [14]

Having completed our chronology of MSMS' action with regard to BCBSM, we must now step back and describe the events that were taking place with respect to Medicaid during the same period. We will then judge both courses of conduct together.

V. Respondent's Relationship With Michigan Medicaid

A. Medicaid

Under the Medicaid program, established pursuant to 42 U.S.C. 1396 *et seq.* (1976), health care providers are reimbursed from combined federal, state and local funds, paid and administered by the

states, for services rendered to low-income Medicaid recipients. Physicians who agree to treat Medicaid recipients agree to accept the Medicaid reimbursement as full payment,¹⁴ and the amount of reimbursement is determined by mechanisms similar to those used by BCBSM. Michigan's Medicaid program is administered by the Michigan Department of Social Services ("DSS"), which makes direct payments to physicians and other providers for covered services rendered to eligible persons. (IDF 136)

B. The Medicaid Liaison Committee

The Medicaid Liaison Committee ("MLC") of MSMS is the formal successor to an earlier task force established by the Michigan government to deal with a broad array of issues growing out of the Medicaid program. Membership on the committee is divided between representatives of the state government and MSMS. The Michigan agencies participating in the committee include the various state departments concerned with health affairs as well as the units responsible for the budget. With this governmental component, the MLC is rather unique among the units of MSMS; nonetheless, it is constituted as an extension of respondent's House of Delegates. The MSMS representatives on the committee report directly to the House; they are authorized to act on MSMS' behalf regarding Medicaid matters and even to commit MSMS resources to the Medicaid program. (Siegel Tr. 1795-99)

C. Per-Case Participation

In 1976, MSMS came to believe that the Michigan DSS had breached a previous understanding about the terms on which physicians participated in the Medicaid program. In 1972, the representatives of MSMS had agreed with the state that its members would participate on a "per-case" basis. As later events disclosed, the DSS had interpreted that commitment as "per-person" participation, meaning that once a [15] physician had begun to treat a patient for one disorder, he would continue to do so for subsequent needs. The physicians, on the other hand, apparently understood their commitment as "per-service" only, with no continuing obligation to the patient. This misunderstanding caused friction when, in 1976, the DSS announced that physicians would not be permitted per-case participation and should not enter private-pay arrangements with Medicaid recipients.

In response to this DSS policy, the MLC recommended—and the MSMS Council adopted—a resolution declaring that physicians may

¹⁴This relationship between individual physicians and the Medicaid program is defined by both federal and state laws.

participate in Medicaid on a per-case basis or enter private fee arrangements with Medicaid-eligible patients. In doing so, the MLC obtained the approval of the House for members to "noncomply with the State's insistence that all Medicaid services must be charged to the State." (CX 425) A resolution was prepared advising members to provide only emergency services for Medicaid patients until the DSS permitted per-case participation on MSMS' terms. (CX 422C; CX 421A) The MLC defied the state to take legal action against any physician for failing to comply with the Medicaid policy. The state took no such action. (CX 10Z 6)

D. The Proposed Budget Reduction And The MSMS Resolution

The record shows that, despite their differences, the overall relationship between MSMS' Medicaid Liaison Committee and Medicaid was not wholly acrimonious. During 1975, for example, the MLC and the Michigan Departments of Social Services and Public Health conferred on various subjects, reaching agreement on such items as a code for neonatal and intensive care service, more adequate reimbursement for certain procedures and payment for consultant services in certain situations. (CX 8K) MSMS consulted continuously with representatives of the governor and legislature of Michigan on ways to contain rising Medicaid costs. (CX 426C) To paraphrase the director of the DSS, the state and the MLC have discussed cost-containment every year, since the state is always short of funds. (Dempsey Tr. 1755)

The year 1975 was no exception to the recurring shortage of public funds, and in December the governor's budget proposal called for significant reductions in many programs, including Medicaid. By MSMS' own rather detailed account, the governor issued an executive order affecting every facet of state government. Medicaid spending was to be cut by \$22 million, \$4 million of which was taken from the \$96 million [16] originally budgeted for physician reimbursement.¹⁵ According to the MLC, the effect of this reduction would be "an across-the-board discounting of all practitioners' billings by 11 percent, beginning January 1, 1976, and continuing through June 30, 1976." (CX 416)

The MLC had been aware of a possible reduction in Medicaid expenditures and had met with staff and members of state legislative appropriations committees, offering suggestions for cost reductions. But the MLC had cautioned the legislature against "across-the-board discounting," saying that such reductions in reimbursement would inhibit physicians from accepting new Medicaid patients. When the

¹⁵ Other line items were reportedly cut from Medicaid including \$6.7 million in hospital services and all of the appropriation for certain kinds of care for recipients over 21 years old. (CX 146)

reimbursement reduction was proposed despite this admonition, MSMS responded by formally adopting a policy resolution that it would *no longer encourage* its members to participate in the Medicaid program. (CX 416; IDF 249)

In adopting this official policy, the MSMS complained of

the increased harassment on the part of the state and the obvious inequity of expecting us to subsidize the program by accepting a fee reduction. (CX 10 Z 5)

Following the passage of the Medicaid resolution, according to MLC Chairman Siegel's report to the House,

the results were predictable. The number of participating physicians dropped dramatically, forcing patients into emergency rooms and Medicaid mills and dramatically increasing the cost of the program. (*Id.*)

The governor responded to MSMS' resolution and demand for restoration of the cut by calling a meeting of all providers of Medicaid-reimbursed services, including the hospital association, MSMS and the osteopathic association. Also attending were representatives of the state budget office, DSS and the legislature. They met to discuss the broader cost-containment plan of which the physician reimbursement reduction was a part. Dr. Siegel, as head of the MLC, was apparently well known in these circles by this time. By his own account of this meeting, he warned that if the 11% cut was not restored the state might be able to save the full appropriation for private physician participation in Medicaid. [17]

MSMS had collected the aforementioned powers of attorney for withdrawal from Medicaid by this time, but the record on the role they played in the meeting is ambiguous.¹⁶ In the printed version of Dr. Siegel's report to the House of Delegates, the following passage that had appeared in Dr. Siegel's prepared remarks (or a draft thereof) was deleted:

At one particular meeting I told the Governor that if the State continued its irresponsible methods, he could save the entire budgetary allocation for the Medicaid program as without physician participation there would be no program. *To emphasize my point, I waved our proxies at him.* (CX 413B-C) (emphasis added)

In prepared remarks to a negotiations seminar of the AMA in April 1977, Dr. Crandall also alluded to "*MSMS waving the proxies in the face of the legislature.*"¹⁷ (CX 411F)

¹⁶ The ALJ found that Dr. Siegel at least told the House of Delegates that he waved the proxies in front of the governor. (IDF 254)

¹⁷ Furthermore, in a reference to the suggestion of the Michigan attorney general that he might bring antitrust action against the medical society for threatening Medicaid, Dr. Crandall said,

(footnote cont'd)

Dr. Siegel's version of this experience, given in testimony, is that he did not tell the governor about the proxies. (Tr. 1860) Nonetheless, he explained that his statement to the House— [18] implying that he did tell the governor—was premised on his certainty that the Michigan state officials knew of the proxies.¹⁸ We find, therefore, a sufficient basis on which to conclude that Medicaid officials were well aware of the proxies at that time. There is also sufficient evidence that MSMS' purpose in this negotiation with the State of Michigan was to assure "adequate reimbursement."¹⁹ [19]

The record contains various assessments of the effects of this collective action. Dr. Siegel reported to the House of Delegates that the consequence of MSMS' threatened withdrawal was the state's raising all physician reimbursement to current Medicare screens. He boasted that Michigan was the only state to do so (*i.e.*, Michigan doctors were the only ones to "accomplish this feat.") (CX 11Y) He also reported that after the adoption of MSMS' Medicaid resolution, physician participation had fallen "markedly." (CX 88A) Other testimony, however, suggests that the MSMS resolution had no intimidating effect on Medicaid or other Michigan officials. The director of the DSS, for instance, testified that, while he recalled hearing about MSMS' proxy solicitation, he was never threatened with any proxies (Dempsey Tr. 1761), nor did he ever feel coerced or pressured by the MLC. (*Id.* 1776)

VI. Arguments Of The Parties

On appeal, respondent contends fundamentally that it has not fixed or tampered with physicians' fees and has not facilitated agreement among any of its members on their fees, since at no time have Michigan physicians charged uniform fees. All that respondent was attempting to do through any of the acts alleged in this complaint was

If the lawsuit had been pursued, the Attorney General would have orchestrated the demise of the entire Michigan Medicaid program as the majority of Michigan physicians would have withdrawn from the program individually. But all parties agreed the lawsuit would not be pursued if MSMS agreed not to initiate the proxies at that time. This action clearly demonstrates the significant clout MSMS and the state's physicians have if they will work in unison. (CX 411F-G) (emphasis added)

¹⁸ Dr. Siegel acknowledged that in his presentation to the House he was "dramatizing" what had happened. (Tr. 1862)

¹⁹ Dr. Siegel's report to the House of Delegates makes this purpose—to increase by collective action the amount of reimbursement paid by Medicaid—quite clear:

The year just past will be most remembered by the members of the [MLC] committee as dealing with one major issue - adequate reimbursement.

We were not content to have the 11 percent discount reinstated only to [be] replaced by a four percent discount as this did not address the major issue of the disparity between Medicaid payments and those of third party carriers. For instance, full Medicaid payment averages 23% less than is currently paid by Medicare because we are still being paid by Medicaid on the basis of 1973 Medicare screens. The Department of Social Services, when pressed on this issue, rightfully blamed the legislature for its insufficient budget - we therefore directed our ire at the leaders of the house and senate appropriations committees and we now have reason to believe that the Medicaid payments will be raised to the current Medicare levels with the next budget for the fiscal year beginning in October. If we accomplish our goal of Medicaid payments equal to Medicare, I believe Michigan physicians have an obligation to re-open their doors to Medicaid patients. (CX 10Z6) (emphasis added)

to insure that BCBSM and Medicaid honor their commitments to pay physicians "fair value" for their services. (RRB 10) MSMS also argues that its recommendations to members were merely policy positions and that it did not speak for or bind any of its members as a group. It argues further that its responses to BCBSM's 1977 reimbursement changes were well justified, and that in any event its responses had no impact upon BCBSM. With respect to the statewide screen, MSMS urges that it was primarily concerned about the distribution of physicians throughout the state. Respondent insists that it never requested that a statewide screen be set at the highest regional reimbursement level and that it never wanted to increase BCBSM's total statewide payout. (RAB 35) Furthermore, it had no idea whether a statewide screen would result in an increase in overall payout, so it denies any intent to raise fees. As for its Medicaid actions, these were a legitimate part of the budget process, according to MSMS. As this summary suggests, most of respondent's arguments go to the characterization of its acts. In order to articulate our legal assessment of the previously described course of conduct, it is instructive to give MSMS' interpretations a full airing. [20]

Complaint counsel argue that MSMS has engaged in concerted action with the purpose and effect of affecting—in fact, increasing—fees paid to its own members and has engaged in activity in the nature of a group boycott in order to achieve that purpose, all in violation of well-established principles of antitrust law dealing with price fixing. To MSMS' contention that it did not seek an increase in statewide payout, complaint counsel respond that those particular intentions should not be considered in a case charging collective action to influence fees or prices. (CAB 29 n. 2)

As to the collective nature of its efforts, MSMS insists that its departicipation letter drive was merely a policy of the society that members were free to follow or not, and not a collective or conspiratorial commitment to withhold or withdraw services from BCBSM. Respondent points out that even within its House of Delegates, which passed the resolution in question, only 16 of those 130 participating in BCBSM at the time submitted departicipation letters.²⁰ (RAB 47)

MSMS claims further that no damage to BCBSM's ability to offer service benefits resulted from its resolution. (*Id.*) More specifically, respondent attempts to show that its members' change from participating to nonparticipating status had no effect upon BCBSM, so that it cannot have frustrated any competitive or cost-saving innova-

²⁰ There were 384 Delegates, 112 of whom sent in letters withdrawing from participation or reaffirming their nonparticipation. Of the 130 Delegates who were formally participating physicians, only 16 were among the 112. (RAB 47)

tions by the insurer, as charged. MSMS' argument seems to be that formal participation is not essential to BCBSM's success, since a subscriber still receives a service benefit if treated by a nonparticipating physician, unless he or she consents to pay more. (RRB 7)

As mentioned earlier, respondent claims to have opposed BCBSM's 1977 reimbursement policies and the UAW's vision-care and hearing-care programs because they discriminated against a group of physician-providers and interfered with or influenced physician/patient relationships, in violation of BCBSM's enabling legislation. (RAB 40) MSMS was also incensed by BCBSM's representation that the 1977 reimbursement policies had been developed in consultation with MSMS. (RAB 44) [21]

As for the threat to have members stop filling out BCBSM claim forms, respondent protests that even though it obtained the authority to recommend such action, it never made the recommendation. (RAB 47; RRB 13) Admitting that it did obtain the authority, however, MSMS also points out that it never intended to harm patients, since it made no suggestion that its members stop filling in information that was minimally necessary to permit payment of claims. (RRB 13)

As for its Medicaid negotiations, MSMS explains that during preliminary stages of the legislative budget process, when input from MSMS and the MLC was routinely sought, Dr. Siegel discussed with state officials whether the legislature should reduce Medicaid payments or whether it should fund Medicaid according to the Medicare formula. Dr. Siegel gave his opinion, as MSMS' representative, that the Medicare formula would increase the quality of Medicaid care and actually reduce the costs of the program by neutralizing the "Medicaid mills." Dr. Siegel expressed opposition to the proposed 11% reimbursement reduction because he thought that the state should attack the Medicaid abusers directly instead of "punishing" all physicians. (RAB 11)

MSMS asserts that, in adopting its Medicaid participation resolution, it was only expressing a "policy." Complaint counsel contend, however, that the purpose and effect of the resolution was more than simply to enunciate policy, since the resolution was announced with fanfare and press coverage and referred to previous provider protests against Medicaid. Complaint counsel believe that the resolution was intended to encourage withdrawal as a means of coercing Medicaid and budget authorities with respect to physician fee levels.

MSMS attempts to neutralize its solicitation of Medicaid powers of attorney by pointing to the absence of proof that any state officials were coerced or intimidated by this alleged boycott threat. Although Medicaid reimbursement was raised to Medicare levels in 1977 following the MSMS resolution, restoration of the budget cuts did not occur

soon enough after MSMS' actions to create a persuasive or sufficient inference of causality, according to respondent. (RAB 28) Complaint counsel, however, would infer that state authorities were coerced or threatened from the fact that the attorney general responded by proposing antitrust action, as well as from the state's written response to the action. (CAB 34 n. 4; CX 421) [22]

Respondent stresses that none of its acts, however characterized, are either unreasonable or unlawful because they have had no effect on competition, for several reasons. First, BCBSM dictates the terms of participation, which doctors can either take or leave, and MSMS is powerless to affect them.²¹ (RRB 6) Second, MSMS contends repeatedly that its members' fees are not uniform and thus not fixed. Third, the doctors are not parties to BCBSM contracts with subscribers, so that they do not affect, through participation decisions, BCBSM's ability to offer service benefits. Rather, if a patient is treated by a nonparticipating physician, he still obtains his service benefit. Fourth, MSMS seems to reject as wholly impractical the idea that doctors would compete in innovative ways against BCBSM, taking the position that doctors should not become entrepreneurs in lieu of practicing their profession. Even further, claims MSMS, there is absolutely no record evidence of any reduction in the incentives of physicians to compete. (RRB 17)

Complaint counsel's theory on the effects, briefly recapped, is that MSMS' actions have all the earmarks of a combination or conspiracy to manipulate or affect prices, that the concerted refusal to deal was itself a separate combination as well as an instrumentality of the entire course of conduct, and that these concerted actions have produced anticompetitive effects. The most direct effect is that physicians have foregone their freedom and have ceased to compete among themselves over the terms on which they would deal with third-party payers, making it impossible for the third-party payers to compete against each other by testing their offerings in the market against other insurers. In a related vein, MSMS' boycott against BCBSM impeded that insurer's efforts to compete with other insurers by containing costs and providing full service benefits. Furthermore, MSMS' concerted efforts discouraged its members and other physicians from competing with each other in innovative ways, such as offering pre-paid care alternatives to BCBSM. (CAB 36-38) We turn to an analysis of these issues after resolving a preliminary question of jurisdiction. [23]

²¹ Dr. Siegel testified that he perceived the proxy action as a means of counterbalancing the leverage of those who "always seem to be negotiating for the services of individual physicians . . . [b]e it Blue Cross - Blue Shield of Michigan or the UAW or the state government." (Tr. 1831)

VII. Jurisdiction

The jurisdictional question presented in this appeal is whether the Michigan State Medical Society, by virtue of its status as a nonprofit organization, is exempt from the coverage of the FTC Act. That question was answered in the negative in a recent case involving state and local medical societies. *American Medical Association, et al.*, 94 F.T.C. 701 (1979), *aff'd sub nom. American Medical Association v. Federal Trade Commission*, 638 F.2d 443 (2d Cir. 1980), *aff'd mem. by an equally divided court*, 102 S.Ct. 1744 (1982). ("AMA")

Section 5(a)(2) of the FTC Act extends the Commission's jurisdiction to "persons, partnerships, or corporations;" Section 4 defines "corporation" to include:

any company, trust, so-called Massachusetts trust, or association, incorporated or unincorporated, which is organized to carry on business for its own profit or that of its members, and has shares of capital or capital stock or certificates of interest, and any company, trust, so-called Massachusetts trust, or association, incorporated or unincorporated, without shares of capital or capital stock or certificates of interest, except partnerships, which is organized to carry on business for its own profit or that of its members. (emphasis added)

In *AMA*, the Commission examined the activities of national, state and county medical societies and found at all levels that they were within its jurisdiction. 94 F.T.C. at 983. More specifically, the Commission found in that decision that it possesses jurisdiction over nonprofit organizations whose profit-related activities comprise a substantial part of their overall activities rather than being merely incidental to some noncommercial activity. In this case, the ALJ applied the same standard and found that MSMS is within the jurisdiction of the Commission. The subsequent affirmance of the *AMA* decision provides powerful support for us to reach the same conclusion in this case. [24]

Nevertheless, we have fully examined the specific facts of this case bearing upon the jurisdictional issue. Our ruling rests upon the ALJ's extensive findings with respect to respondent's activities conducted for the profit of its members. (IDF 41-82) We find them to provide convincing support for our holding that the Commission possesses the requisite statutory jurisdiction over MSMS.

To name but a few, MSMS' lobbying and litigation activity with respect to matters affecting physicians' pecuniary interests, its control of a malpractice insurance company, and its operation of a for-profit subsidiary are all pecuniary activities not merely incidental to noncommercial functions. Furthermore, in addition to its more altruistic and medically-oriented objectives, it is the purpose of MSMS to guard and foster its members' material interests. (ID 5) The MSMS

Constitution lists as one of its objectives the advocacy of fair remuneration for its members' services. (IDF 42) Thus, while MSMS is unquestionably a nonprofit organization, it is a nonprofit organization that devotes a substantial amount of its resources to activities that directly enhance the pecuniary interests of its members, who are independent competing entrepreneurs. Cf. *Arizona v. Maricopa County Medical Society, et al.*, 102 S.Ct. 2466, 2480 (1982).

As we observed in *AMA*, Congress clearly did not intend to bring all nonprofit corporations, regardless of their purposes and activities, within the Commission's jurisdiction. Neither, however, did Congress provide a "blanket exclusion" from FTC jurisdiction for all nonprofit corporations, since it recognized that certain corporations ostensibly organized not-for-profit, such as trade associations, may be vehicles through which a profit could be realized for themselves or their members. 94 F.T.C. at 984, citing *Community Blood Bank of the Kansas City Area, Inc. v. FTC*, 405 F.2d 1011, 1017 (8th Cir. 1969). It is also clear, certainly following *AMA*, that an organization may come within the coverage of Commission jurisdiction even though it only indirectly or partially promotes profit for its members. For those purposes, Section 4 of the FTC Act requires only that the activities of the corporation provide pecuniary benefits to its members, *Id.* at 985, and we find those requisites present in the case before us. [25]

VIII. Legal Discussion

This case presents several distinct issues concerning the legality of MSMS' actions vis-a-vis BCBSM and the Michigan Medicaid program. We first consider whether MSMS, with the support of at least some of its members, engaged in concerted activity in conducting the participation campaigns and organizing the other activities of the Division of Negotiations and the Medical Liaison Committee. Next, we determine whether the conduct of respondent was unreasonable, either under a *per se* theory or a rule-of-reason analysis. Finally, we consider whether MSMS' responses to proposed reductions in State Medicaid payments and other changes to that program were justifiable, both in terms of substantive antitrust standards and the *Noerr-Pennington* doctrine. *Eastern Railroad Presidents' Conference v. Noerr Motor Freight, Inc.*, 365 U.S. 127 (1961); *United Mine Workers v. Pennington*, 381 U.S. 657 (1965).

A. Conspiracy Allegations

The threshold issue here is whether MSMS' importunings with BCBSM and the Medicaid program amounted to conspiratorial conduct of the kind alleged in the complaint or simply represented non-binding expressions of views and policy, as argued by respondent.

(RAB 46) As discussed previously, the evidence quite clearly reveals that MSMS members, acting through their House of Delegates, agreed in 1976 to establish a Division of Negotiations for the purpose of working out differences with third party payers. That Division was specifically empowered, *inter alia*, to coordinate all negotiating activities of MSMS, collect "non-participation" proxies and obtain a negotiated participation agreement with third party payers that would obviate the need for physician non-participation. (IDF 168) It also was specifically contemplated by MSMS that the Division of Negotiations would obtain authorization of all members to serve as their "exclusive bargaining agent." (CX 411E) The debate in the House of Delegates clearly indicated that, although the Division would not negotiate specific fees, it would have authority to negotiate the manner by which fees or reimbursement levels would be established.²² [26]

Thus, at the outset we find that the very creation of the Division of Negotiations reveals a collective purpose on the part of MSMS and its members to go beyond the point of giving advice to third party payers; in fact, it reveals a purpose to organize and empower a full-fledged representative to negotiate and resolve controversies surrounding physician profiles, screens and other similar matters.²³ There is, in fact, considerable additional evidence that the Negotiating Division not only had the authority to reach understandings with third party payers but also utilized that authority (acting as agent for its members) in soliciting, collecting and threatening to exercise physician deparicipation proxies, as well as in other negotiations with third party payers.

Similarly, despite the participation of its governmental representatives, the MLC was authorized by the House of Delegates to act on behalf of MSMS and its members, as Dr. Siegel's testimony confirmed. At all times, it seems clear that the MLC spoke and acted with the consensus and authority of the respondent and its members.²⁴ [27]

More specifically, respondent's acts and practices can properly be characterized as both agreements among horizontal competitors to set the terms of sale of their services and agreements to force third

²² Accounts of the House of Delegates meeting reveal some concern among the membership about the antitrust implications of conferring this authority upon the Division. MSMS' leaders responded that, while the Society would risk antitrust liability if it negotiated specific fees, it would be permissible to negotiate, on behalf of members, the manner in which reimbursement fees were set. (CX 13Z 13)

²³ Even the authority of the original Negotiating Committee, formed in 1974 by MSMS to pursue a more aggressive approach toward third party payers, was broad enough to encompass the power to negotiate agreements relating to the manner of setting fees; and the Negotiating Committee was presumably acting at all times described above within the scope of its delegated authority. At the formation of this predecessor committee, legal counsel advised the Society and its committee to avoid any formal recommendations that could be interpreted as price-fixing. (CX 166D)

²⁴ Although an organization may be held liable for antitrust violations committed by agents acting only under the apparent authority of the principal, *American Society of Mechanical Engineers, Inc. v. Hydrolevel Corp.*, 102 S.Ct. 1935, 1943-44 (1982), the facts here are much stronger inasmuch as the authority conferred upon the MLC and the Negotiating Division was quite explicit.

party payers to accept those terms.²⁵ First, as noted, MSMS initiated action to create the Negotiating Division and to give it the authority to bargain. A majority of the representative members of MSMS supported that action, the result of which is that the Division spoke for the entire membership. Second, the MSMS membership approved the grant of authority to the MLC, allowing it to speak on their behalf, notwithstanding the governmental component of that committee. In addition, the majority of MSMS' members lent their approval and authority to the collection of proxies or powers of attorneys, even though the entire membership did not actually submit them. Still further, a substantial number of MSMS members actually submitted letters of departicipation to BCBSM, many of which were identical form letters with copies sent to MSMS.²⁶ In the departicipation campaign, MSMS set out to insure that the degree of cooperation among its members reached the requisite level for effective action. And, in actually submitting their powers of attorney, a majority of the members of MSMS effected an even more explicit designation of MSMS as their bargaining agent.

Thus, it should be apparent that, wholly apart from the threatening behavior of the boycott, there was concerted behavior in the formation of the agreement among competing members of MSMS to have the Negotiating Division and the MLC bargain on their behalf (or as their agents) over the terms on which they would perform their services. In this regard, [28] the record shows substantially that the Negotiating Division and the MLC carried this role well beyond the point of general advocacy. Indeed, MSMS entered into a formal agreement with BCBSM at a later stage of the negotiations. (IDF 242-43)

There is ample precedent for finding that individual professionals, acting through their organizations, can conspire or combine to violate the antitrust laws. In several cases, combinations have been found to exist by virtue of the group adoption of ethical codes of conduct. *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975); *National Society of Professional Engineers v. United States*, 435 U.S. 679 (1978); *American Medical Association, et al.*, 94 F.T.C. 701 (1979), *aff'd sub nom. American Medical Association v. Federal Trade Commission*, 638 F.2d 443 (2d Cir. 1980), *aff'd mem. by an equally divided court*, 102 S.Ct. 1744 (1982).

Although the present case does not involve ethical codes or specific fees, there is no question about the collective nature of the actions

²⁵ While not all members of MSMS competed directly with one another, in view of the scope of the agreements, along with the putative and actual authority of MSMS to act on behalf of its members, it is not necessary to delineate precisely who competed with whom.

²⁶ Our findings here do not address the question whether each member of MSMS could be charged with having participated in the enumerated concerted courses of conduct, since that issue is not before us. It is sufficient to find that MSMS conspired with substantial numbers of willing or acquiescing members in the ways described, including ways that were putatively or actually binding on all.

under scrutiny; nor is there any doubt that these joint activities involved more than an attempt merely to influence third party payers through persuasion. In fact, the evidence shows that MSMS officials made repeated statements about the purpose of their activities and the success of these efforts. For example, the chairman of the Negotiating Division stated that

The [Negotiating] division also was to obtain authorization from all MSMS members to serve as their "exclusive bargaining agent" . . . and to formulate and negotiate participation agreements with third party payers (CX 411E) (Dr. Crandall)

And, with respect to the proxies,

The Negotiating Division was instrumental in combining the forces of the Michigan radiologists and pathologists in confronting this Blue Cross/Blue Shield recommendation and was subsequently successful in their efforts to maintain the present hospital-based reimbursement modalities. (CX 653B) (Report of the Division of Negotiations) [29]

In regard to Medicaid, the chairman of the MLC reported the following to the membership:

Of great benefit to your Medicaid Liaison Committee in these dealings has been the willingness of practicing physicians to "back our play." (CX 88A)

If anything, the evidence of collective activity is even stronger here than it was in *Goldfarb*, where the state bar's role in promoting fee schedules was mainly limited to promulgating guidelines that were enforced by the county bar associations. See *American Medical Association, et al.*, 94 F.T.C. at 998.

Turning to the boycott issue, the law is clear that the definition of that term is not limited to situations where the target of the concerted refusal to deal is another competitor or potential competitor. As the Supreme Court indicated in *St. Paul Fire and Marine Ins. Co. v. Barry*, 438 U.S. 531 (1978), a concerted refusal to deal may be characterized as an unlawful group boycott where the target is a customer or supplier of the combining parties. *Accord, Gibson v. Federal Trade Commission*, 682 F.2d 554 (5th Cir. 1982) (illegal group boycott found where targets were suppliers). In the instant case, the alleged boycott involves concerted threats by MSMS and its members to refrain from participating in BCBSM and Medicaid unless the latter modified their reimbursement policies. Although BCBSM and Medicaid—the targets of the boycott—are not in competitive relationships with MSMS, that fact alone does not preclude a finding of a boycott.

Respondent, however, argues that the proxies were not exercised and, in the case of the departicipation letter campaign, that there was

no adverse effect on BCBSM. As to the latter contention, MSMS points out that more physicians signed up to participate in BCBSM during the relevant period than withdrew from the program as a result of the campaign. The success or failure of a group boycott or price-fixing agreement, however, is irrelevant to the question of either its existence or its legality. Whether or not the action succeeds, "[i]t is the concerted activity for a common purpose that constitutes the violation." *American Medical Association*, 638 F.2d at 450. Furthermore, an agreement among competitors affecting price does not have to be successful in order to be condemned.

It is the "contract, combination . . . or conspiracy in restraint of trade or commerce" which §1 of the [Sherman] Act strikes down, whether the concerted activity be wholly nascent or abortive on the one hand, or [30] successful on the other. *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 224 n. 59 (1940).

Moreover, even if less than all members of an organization or association agree to participate, that fact does not negate the presence of a conspiracy or combination as to those who do participate.²⁷

As for the collection of proxies that were never exercised, the law does not require that a competitor actually refuse to deal before a boycott can be found or liability established. Rather, the threat to refuse to deal may suffice to constitute the offense. *Fashion Originators' Guild of America v. Federal Trade Commission*, 312 U.S. 457, 462 (1941); *Eastern States Retail Lumber Dealers' Association v. United States*, 234 U.S. 600 (1914). The evidence indicates that the threat implicit in the collection of departicipation proxies and the attendant publicity can be as effective as the actual execution of the threatened action. Indeed, it may be assumed that parties to a concerted refusal to deal hope that the announcement of the intended action will be sufficient to produce the desired response. That appears to be precisely what happened here, and there are contemporaneous testimonials by MSMS officials confirming the success of that strategy. For example, Dr. Crandall suggested that MSMS' "waving the proxies in the face of the legislature" persuaded the state attorney general that if he sued MSMS the state would have "orchestrated the demise of the entire Michigan Medicaid program." (CX 411F-G) Also, as noted above, the Negotiations Division credited the members' response to the proxy solicitation with the favorable outcome of the dispute between the radiologists and BCBSM. (CX 653A; CX 10Q) And, as further evidence, there is the fact that MSMS reached a formal

²⁷ In its recent decision in *Arizona v. Maricopa County Medical Society, et al.*, 102 S.Ct. 2466, 2469 (1982), for example, the Supreme Court based its finding of a conspiracy to fix prices on the majority vote of a medical society's members.

agreement with BCBSM which included the implementation of a statewide screen. (IDF 242)

In its defense, respondent claims that there were independent reasons—such as BCBSM's repentant correction of previous inequities—for BCBSM ultimately to adopt policies that coincided with the interests of MSMS and its members. (RAB 33) Whatever the significance of this argument for liability purposes, it does not affect the finding that respondent and its members combined and conspired to negotiate a satisfactory agreement with BCBSM and to back that action with measures designed to force BCBSM to modify its policies. [31] Since BCBSM is the target of the alleged conspiracy, not a participant, its reasons for taking the course that it did are of little probative weight as to whether MSMS and its members engaged in concerted activity.

To sum up this threshold discussion, we believe that the evidence unambiguously reveals that respondent, together with its members, sought to effect changes in the reimbursement policies of BCBSM and the state Medicaid program through collective negotiation of agreements with these third party payers, backed up by threats of physician departicipation if satisfactory agreements could not be worked out. We conclude, therefore, that these activities constitute an agreement among competitors to affect fees and that respondent's behavior in connection with the proxy campaigns amounted to a concerted refusal to deal or group boycott. Having found such a conspiracy, we now address its legality.

B. Legality Of The Concerted Action

Complaint counsel contend that MSMS' practices so closely resemble forms of conduct that have long been held *per se* illegal that the Commission should not hesitate to apply that standard. While the ALJ applied a rule of reason and still found MSMS' conduct unreasonable, the respondent argues that he applied that test in name only, ignoring certain exculpatory evidence. As noted earlier, respondent stresses that none of its acts are either unreasonable or unlawful because they have had no effect upon competition. (See p. 25, *supra*.)

The judicial principle of *per se* illegality was adopted by the courts to economize in the analysis of certain agreements or practices

which because of their pernicious effect on competition and lack of any redeeming virtue are conclusively presumed to be unreasonable . . . without elaborate inquiry as to the precise harm they have caused or the business excuse for their use. *Northern Pacific Railway Co. v. United States*, 356 U.S. 1, 5 (1958). [32]

Whenever the *per se* rule is thought to apply, it is necessary as an initial step to determine whether the practices in question bear so

close a resemblance to practices that have been previously deemed *per se* illegal that further market analysis can be dispensed with. For example, in *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*, 441 U.S. 1 (1979), the Supreme Court declined to apply the *per se* rule to a novel "blanket licensing" arrangement, even though it literally required agreement among composers on the prices to be charged for use of their compositions. The composers had delegated to their organization the power to fix the price of works covered by the blanket license, but the arrangement did not in any way restrain the individual owners from selling their compositions separately at any price. In effect, the blanket license amounted to a separate product offering, quite different from anything that any individual owner could offer for sale. For those reasons, the Court found that the arrangement in *Broadcast Music* did not sufficiently resemble the price-fixing arrangements traditionally and categorically forbidden under the Sherman Act.

In recent decisions relating to collective conduct among professionals, the Supreme Court has had several occasions to determine the applicability of the *per se* standard to various restrictive practices. In *Goldfarb*, the Court applied the *per se* rule to a professional association that took part in a conspiracy to adhere to minimum-fee schedules. 421 U.S. at 782. In *Professional Engineers*, after discussing the scope of the rule of reason, the Court chose to apply a *per se* standard to a national organization's ethical guidelines that prohibited members from negotiating fees until after a customer had selected an engineer. Most recently, in *Maricopa*, the Court specifically applied the *per se* standard to an agreement among competing physicians and their medical societies as to the maximum fees that they would claim as reimbursement for services rendered to insured groups. The *Maricopa* Court found the anticompetitive arrangement in that case to be "fundamentally different" from that in *Broadcast Music*. 102 S.Ct. at 2479.²⁸ [33]

As illustrated above, the *per se* standard may apply even if conspiratorial behavior does not establish specific prices or fees. Only *Goldfarb* and *Maricopa* involved efforts to set uniform fees, and even in the latter case, the agreements were limited on their face to maximum fees. Outside the professional context, the Supreme Court recently struck down as *per se* illegal agreements among competitors to restrict credit offerings, a practice that affected only one aspect of the price charged to customers. *Catalano, Inc. v. Target Sales, Inc.*, 446 U.S. 643 (1980). This ruling stems from the venerable principle of

²⁸ Similarly, in our AMA decision, we held *per se* unreasonable ethical guidelines prohibiting the receipt of inadequate compensation by physicians because those provisions were so closely akin to the more traditional forms of price fixing. 94 F.T.C. at 1014.

United States v. Socony-Vacuum Oil Co., 310 U.S. 150, 223 (1940), that the *per se* rule applies to agreements that affect prices even where an actual effect on prices is not shown.

Any combination which tampers with price structures is engaged in an unlawful activity [T]o the extent that they raised, lowered or stabilized prices they would be directly interfering with the free play of market forces. . . . Congress has not left with us the determination of whether or not particular price-fixing schemes are wise or unwise, healthy or destructive. *Socony-Vacuum*, 310 U.S. at 221, quoted in *Maricopa*, 102 S.Ct. at 2474.

In the instant case, it can hardly be denied that the practices in question bear a close resemblance to price-tampering combinations traditionally found to be unreasonable. For example, MSMS and its members collectively sought to negotiate changes in area screens, which are BCBSM's measures of maximum reasonable reimbursement for specific services in given geographic areas. Respondent also was involved in joint efforts to update physician profiles, a practice which could take account of legitimate cost increases but which could also lead to more rapid upward adjustment of price levels reflecting the enhanced market power of the combined market participants. And, MSMS' collective efforts to restore cuts in Medicaid payments to physicians have a fairly obvious relationship to fee levels under that program. Although MSMS contends that its purpose was only to affect the *manner* of setting fees, it is quite clear that at least a partial purpose and effect of respondent's actions was to increase both the reimbursement received by some physicians and the frequency with which the fee levels of many physicians were revised upward. As we discuss further, *infra* at 38, respondent's tampering with the means of setting prices is tantamount to tampering with reimbursement levels, even if specific fees or prices were not directly established. [34]

Thus, it would appear that respondent's conduct approaches the kind of behavior that previously has been classified as *per se* illegal. Nevertheless, since this conduct does not involve direct fee setting, we are not prepared to declare it *per se* illegal at this juncture and close the door on all asserted procompetitive justifications. We took a similar stance in our *AMA* decision with respect to several of the ethical restrictions at issue there, citing the Supreme Court's observation in *Professional Engineers* that the nature of competition in the professional services may differ from that found in other business activities. *American Medical Association, et al.*, 94 F.T.C. at 1003. Of course, in examining these proffered justifications under the rule of reason, our concern is with the competitive effects of the practices, not considerations unrelated to competition. *Professional Engineers*, 435 U.S. at 690. Moreover, as we noted in *AMA*, "the contours of the analysis

required under the rule of reason will vary somewhat depending upon the nature of the restraint." *American Medical Association, et al.*, 94 F.T.C. at 1004.²⁹

To briefly recap, respondent has offered the following justifications for its behavior: (1) the practices had no effect on fee levels and, in any event, BCBSM and Medicaid took independent action to correct the perceived problems; (2) MSMS simply sought to insure that physicians were treated fairly, especially in view of BCBSM's bargaining power; (3) the actions were, in part, an effort to counter BCBSM's violations of its charter and Michigan law in connection with its modified participation program; and (4) MSMS was striving to correct abuses of the Medicaid system and the poor perpetrated by "Medicaid mills."

With respect to respondent's first contention, MSMS claims that the conduct never led to uniform fees or prevented individual physicians from deciding whether to participate in BCBSM or Medicaid. We believe that these arguments miss the point with respect to the likely competitive effects of the restrictive practices. Where horizontal arrangements so closely relate to prices or fees as they do here, a less elaborate analysis of competitive effects is required. *National Society of Professional Engineers*, 435 U.S. at 692. The collective actions under scrutiny clearly interfere with the rights of physicians to compete independently on the terms of insurance coverage offered by BCBSM and Medicaid. Moreover, the joint arrangements directly hamper the ability [35] of third party payers to compete freely for the patronage of individual physicians and other physician business entities. As the record indicates, the cost of any service benefit package offered by third party insurers is directly affected by the level of physician participation in the program. Thus, even though physicians are not formal parties to BCBSM contracts with subscribers, as respondent points out, physician response to service benefit terms can have a significant impact on the cost and competitive viability of the plan.

Although it is unnecessary to show a specific effect on fee levels, the potential for competitive harm is illustrated by the debate that followed MSMS' demand that BCBSM adopt a statewide screen. Respondent claims that it never intended to increase the total payout to physicians because increases in one region could be offset by decreases in another. Yet, that proposed solution simply underscores the dilemma facing BCBSM: it could either increase reimbursement to all

²⁹ For example, there is little need for an elaborate market definition analysis in this case, since MSMS' members account for roughly 80% of the physicians in Michigan. Thus, no matter how the relevant product or geographic markets might be characterized, the potential impact of the agreements in question is substantial. Moreover, given the kind of horizontal arrangements at stake here, there may be less need for detailed market delineations in any event.

physicians or reduce reimbursement to some physicians, a prospect that obviously makes it difficult for BCBSM to resist upward pressures on fees and reimbursement levels.³⁰

MSMS also claims that BCBSM and Medicaid ultimately acknowledged the validity of its positions and took independent action to respond to those concerns. This justification is closely related to MSMS' contention that its actions were only designed to insure that member physicians were treated fairly, particularly in view of BCBSM's superior bargaining power. These arguments can be dealt with quite easily.

With respect to the reasons for actions ultimately taken by BCBSM and Medicaid, there is testimony by officials of both organizations suggesting that they were not coerced into making their decisions. Nevertheless, there is also clear contemporaneous evidence that MSMS' negotiations and boycott threats had an impact on the decisions of those entities, e.g. pp. 11, 16, *supra*. In this respect, it is particularly difficult to discount MSMS' own contemporaneous assessments of the success of its efforts, pp. 28-30, *supra*. [36]

On the question of whether the proposed policies of BCBSM and Medicaid were fair to physicians, respondent would apparently have us become enmeshed in weighing the comparative equities of the different parties to these transactions. In fact, considerable portions of the record are devoted to an assessment of the relative merits of MSMS' bargaining position. For us to consider whether the terms offered by the third party payers were fair or reasonable would lead us into the kind of regulatory posture that the courts have long rejected. *United States v. Trenton Potteries Co.*, 273 U.S. 392, 397-98 (1927); *Maricopa*, 102 S.Ct. at 2473-74. It would be analogous to the Commission serving as a quasi-public utility agency concerned with balancing interests unrelated to antitrust concerns. We believe that it is undesirable and inappropriate for us to step in and attempt to determine which party had the better case in these dealings.

Respondent further attempts to justify at least some of its actions by alleging that BCBSM's institution of a statewide screen and other inducements, limited to participating doctors, violated state law. This assertion, however, is neither supported by documented evidence nor does it constitute a sufficient excuse for a group boycott. In *Fashion Originators' Guild*, the defendant sought to justify a concerted refusal to deal with firms that used pirated designs by showing that the

³⁰ We do not imply that all forms of negotiation, even those that may have some indirect effect on fees, between MSMS and third party payers are likely to produce anticompetitive consequences. For example, as complaint counsel acknowledged (O.A. Tr. 33), discussions between MSMS and BCBSM on the question of a uniform claim form may raise no antitrust concerns. On the other hand, resort to concerted refusals to deal on that or other subjects raises more serious problems. We have no occasion here to address the legality of non price-related collective behavior.

conduct engaged in by those firms was tortious under state law. The Supreme Court had little difficulty in rejecting this argument, observing that

even if copying were an acknowledged tort under the law of every state, that situation would not justify petitioners in combining together to regulate and restrain interstate commerce in violation of federal law. 312 U.S. at 468.

In most instances there are, and were in this case, alternatives to the collective extra-legal course taken, such as petitioning government authorities or seeking redress in the courts. Indeed, some of those alternatives were considered by the Negotiating Committee in discussing how to respond to BCBSM's reluctance to negotiate a uniform claim form. (CX 8M) Respondent also suggests that its activities were motivated by concern for the welfare of its members' patients, especially in the case of Medicaid where, it is alleged, reductions in reimbursement levels might lead to lower physician participation rates and force low-income patients to seek less reputable providers (the so-called Medicaid mills). [37]

In *AMA*, we acknowledged that regulation of deceptive advertising claims by physician organizations could be procompetitive inasmuch as such regulation would protect honest providers and facilitate informed consumer choice. See also *Bates v. State Bar of Arizona*, 433 U.S. 350 (1977); *Friedman v. Rogers*, 440 U.S. 1 (1979). Nevertheless, we rejected a sweeping ban on advertising because the ban was overbroad, chilled legitimate provision of information and was not the only means of preventing deception. Similar arguments were advanced in that case to justify ethical guidelines prohibiting forms of compensation other than the traditional fee-for-service. For example, it had been argued that contract-based reimbursement "injects a type of commercialism into medical practice which is harmful to the public and the medical professions and results in inferior quality of medical service." *American Medical Association, et al.*, 94 F.T.C. at 1013. We concluded there that the relationship between such reimbursement mechanisms and health care quality was simply too tenuous, from a competitive perspective, to justify the broad restrictions imposed.

While we are not addressing ethical standards in this case, many of the quality and patient welfare arguments asserted here have a ring similar to those advanced in *AMA*. Even in the case of Medicaid reductions, where an argument might be made that arbitrary cuts could be counter-productive by impairing physicians' economic incentives to treat the poor, it is difficult to see how concerted agreements and refusals to deal can be sanctioned as a means of fighting proposed payment cutbacks. While granting MSMS' laudable concerns about

the effects of physician withdrawal from Medicaid, we observe that respondent clearly had public forums (protected under the *Noerr-Pennington* doctrine discussed *infra*) available to it to correct perceived mistakes made by the state legislature or the administrators of Medicaid; it could have expressed its views in ways that fell well short of organized boycott threats.

Finally, we find no suggestion among MSMS' justifications that the concerted behavior here enhanced competition in any market by injecting new elements or forms of competition, reducing entry barriers, or facilitating or broadening consumer choice. The price-related practices in question here are not ancillary to some broader procompetitive purpose, such as a joint venture, an integration of activities, or an offer of a new product or service as in *Broadcast Music*. [38] It was upon this basis that the Supreme Court found the price-fixing activities in *Maricopa* "fundamentally different" from the circumstances of *Broadcast Music*. The combination of competing physicians in the Maricopa foundation did not permit them to offer any different kind of product or service; it only fixed the maximum fees at which individual physicians would offer their services, permitting them potentially to affect the prevailing price of services and, thus, fitting "squarely into the horizontal price-fixing mold." 102 S.Ct. at 2480.

It might be argued that collective action would save administrative costs by better enabling physicians to bring to the attention of insurers the relevant cost factors justifying statewide screens, profile revisions and altered Medicaid reimbursement levels. But such an efficiency was deemed insufficient in *Maricopa* to justify the collective action necessary to achieve it. While admitting that it was less efficient for an insurer to deal with each physician individually, the Court would not condone an agreement or group boycott among physicians to determine acceptable reimbursement terms under an insurance plan. As in *Maricopa*, it is not clear here why insurers cannot obtain relevant cost data or other information from providers without the necessity for providers to engage in the kind of practices that occurred in this case. 102 S.Ct. at 2478, n. 28.

In fact, we believe there are less anticompetitive ways of providing such information to insurers. The order that we would impose upon respondent allows it to provide information and views to insurers on behalf of its members, so long as the Society does not attempt to extract agreements, through coercion or otherwise, from third party payers on reimbursement issues.³¹ In allowing respondent to engage in non-binding, non-coercive discussions with health insurers, we

³¹ Although considerable portions of this record were devoted to respondent's earlier argument that its collective actions were necessary to counterbalance the monopsony power of BCBSM, that position has apparently been abandoned on appeal, as complaint counsel observe. (CAB 44)

have attempted to strike a proper balance between the need for insurers to have efficient access to the views of large groups of providers and the need to prevent competitors from banding together in ways that involve the unreasonable exercise of collective market power. [39]

We also note that this case does not involve a situation in which industry-wide self-regulation is essential to the efficient functioning of the market, such as *Chicago Board of Trade v. United States*, 246 U.S. 231 (1918), wherein the classic articulation of the rule of reason was set forth. Nor is the instant case analogous to the establishment of industry-wide product standards which may enhance competition by facilitating consumer choice. Of course, even in such circumstances, broadly overreaching restrictions will be struck down. See *Radiant Burners, Inc. v. Peoples Gas Light & Coke Co.*, 364 U.S. 656 (1961); *Silver v. New York Stock Exchange*, 373 U.S. 341 (1963). While there are certainly examples of industry self-regulation and collective restraints that are necessary to make a service or goods delivery system work effectively, this case is not of that character.

To sum up, we find that MSMS' participation in collective actions designed to pressure third party payers to accept changes in reimbursement policies involves a clear threat to competition, with offsetting benefits to competition that are either very weak or non-existent.³² In our view, these practices unreasonably restrain trade and constitute violations of Section 5 of the FTC Act. As we discuss more fully below, in crafting a remedy for these violations, we intend to proscribe only collective activities that have a probable or foreseeable effect on prices or fees. Yet, even as to fee-related activities, we do not intend to preclude respondent from providing information to private insurers, nor do we limit the lawful rights of MSMS to petition governmental entities where fee-related issues are concerned.

C. Noerr-Pennington Issues

Before discussing the issue of relief, we must address respondent's *Noerr-Pennington* defense with respect to Medicaid. *Eastern Railroad Presidents' Conference v. Noerr Motor Freight, Inc.*, 365 U.S. 127 (1961); *United Mine Workers v. Pennington*, 381 U.S. 657 (1965). The ALJ rejected this defense on two grounds: first, because MSMS was dealing with Medicaid, [40] a governmental entity, in its capacity as a purchaser of services, respondent's reliance upon rulings protecting

³² We note that collective efforts by providers to enter into agreements with third parties may be coercive even absent a direct threat of a boycott, since the bargaining process itself carries the implication of adverse consequences if a satisfactory agreement cannot be obtained. In this case, however, the negotiation process undertaken by MSMS was closely intertwined with the use of departicipation threats and other sanctions against third party payers.

political expression was misplaced; and, second, MSMS' threats removed its activities from the realm of protected communications. MSMS contends that the ALJ improperly distinguished political expression from economic activity, since a communicant is always promoting some economic interest. (RAB 14) It points out that some of its activities were aimed at Medicaid and the legislature—both government entities. Respondent relies heavily upon *Crown Central Petroleum v. Waldman*, 486 F.Supp. 769 (M.D. Pa.), *rev'd on other grounds*, 634 F.2d 127 (3d Cir. 1980), involving gas station closings aimed at influencing DOE to raise dealer margins, acts that were deemed to be exempt under *Noerr*. It also relies upon *In Re Airport Car Rental Litigation*, 521 F. Supp. 568 (N.D. Cal. 1981), *aff'd* 1982-83 Trade Cases (CCH) ¶65,039 at 70,791 (9th Cir., November 16, 1982) [693 F.2d 84], in which activity was found to be exempt under *Noerr* even though the communicants were in a business relationship with the airport managers they sought to influence. (RAB 16)

Complaint counsel respond that MSMS' attempt to coerce Medicaid to raise reimbursement goes beyond the realm of influence protected by the *Noerr* immunity. They distinguish *Airport Car Rental* on grounds that the companies there only agreed to advocate a position that would injure their competitors, whereas here MSMS members are agreeing not to compete with each other and are dictating terms to Medicaid. (CAB 52) They also cite *Sacramento Coca-Cola Bottling Co. v. Chauffeurs, Teamsters & Helpers Local 150*, 440 F.2d 1096 (9th Cir.), *cert. denied*, 404 U.S. 826 (1971), a Ninth Circuit decision holding that threats clearly lose whatever *Noerr* immunity noncoercive forms of communication may have enjoyed. (CAB 52)

The essence of the *Noerr-Pennington* doctrine is that individuals or corporations may band together, without fear of antitrust liability, for purposes of influencing government processes. In *Noerr*, the focal point of the petitioning activity was the legislature, whereas in *Pennington*, the Supreme Court sanctioned collective attempts to get executive branch agencies to take particular action. More recently, in *California Motor Transport Co. v. Trucking Unlimited*, 404 U.S. 508 (1972), the Court extended the doctrine to include joint petitions seeking favorable decisions by judicial bodies. Although originally premised on an interpretation of the scope of the Sherman Act (*see Noerr*, 365 U.S. at 135), the Court in *California Motor Transport* made clear that the doctrine is also grounded in First Amendment principles. 404 U.S. at 510-511. The right to petition the government is protected even if the intent is to seek action that would [41] injure competitors. However, as the Supreme Court has explicitly stated, the *Noerr-Pennington* doctrine does not shield activities that are ostensibly designed to obtain favorable government responses but in reality are mere

shams to disguise anticompetitive behavior directed toward nongovernmental entities. *Noerr*, 365 U.S. at 144.

With this brief background, we turn to the issues presented here. The principal questions are (1) whether the activities of MSMS and its members exceed the bounds of legitimate political influence or lobbying activities, and (2) whether a different standard should apply to attempts to influence government officials involved in commercial activities.

As to the first question, it is argued that MSMS' efforts went beyond the simple joint expression of views to the State of Michigan, since the Society's members, through their representative, the MLC, sought to negotiate a satisfactory agreement with Medicaid regarding overall reimbursement levels and "per case" participation. As we have discussed previously, these negotiating efforts were backed up by the clear threat of withdrawal from the Medicaid program or, in the case of per-case participation, of refusal to handle anything other than emergency cases. In *Noerr*, the Court, in construing the scope of the Sherman Act, distinguished collective lobbying activities from the kind of joint practices typically condemned by the antitrust laws. The Court observed that efforts to persuade the legislature or executive to take particular action

bear very little if any resemblance to the combinations normally held violative of the Sherman Act, combinations ordinarily characterized by an express or implied agreement or understanding that the participants will jointly give up their trade freedom, or help one another take away the trade freedom of others through the use of such devices as price-fixing agreements, boycotts, market-division agreements, and other similar arrangements. 365 U.S. at 136.³³ [42]

The Court added that the Sherman Act did not apply to the activities under scrutiny, "at least insofar as those activities comprised *mere solicitation* of the governmental action with respect to the passage and enforcement of laws." *Id.* at 138 (emphasis added).

Thus, viewed from this perspective, the activities of MSMS and the MLC arguably fall beyond the borders of *Noerr-Pennington* in two respects. First, they amount to collective decisions to accept or reject the State Medicaid policies, not simply collaborative efforts to advocate a change in those policies. Second, the Society's actions involved threats of departicipation or restricted participation if disputes with Medicaid were not resolved. In effect, then, MSMS' activities went

³³ This distinction has been criticized for suggesting a rather artificial limitation on the reach of the Sherman Act as interpreted in other contexts. Fischel, *Antitrust Liability For Attempts To Influence Government Action: The Basis And Limits Of The Noerr-Pennington Doctrine*, 45 U. Chi. L. Rev. 80, 83 (1977). While there may be some validity to this observation—certainly collective attempts to "lobby" a supplier or customer, as distinct from the government, would be viewed with suspicion—efforts to influence legislators or other government decision-makers previously had not been characterized as an antitrust violation.

beyond the process of influencing legislative or administrative decisions and encompassed efforts that interfered directly with the competitive process, actions that are more closely analogous to the kind of anticompetitive agreements alluded to in *Noerr*.

The issue is complicated, however, by the emphasis in subsequent cases on the First Amendment basis for the *Noerr-Pennington* doctrine. More specifically, what modes of expression, other than oral or written advocacy, are protected by *Noerr-Pennington*? Respondent cites two cases, *Crown Central Petroleum* and *Missouri v. National Organization For Women*, 620 F.2d 1301 (8th Cir.), cert. denied, 449 U.S. 842 (1980), for the proposition that even boycott-type activities are immune from antitrust liability. In *Crown Central Petroleum*, the district judge concluded that a coordinated shutdown by gas station operators to protest Department of Energy ceiling price policies constituted a protected form of political speech under *Noerr-Pennington*. In reaching his decision, the judge applied a balancing test in which he weighed the competitive purpose and effect of the conduct against the First Amendment goals of protecting freedom of political expression and the right to petition the government. Although the judge acknowledged the conduct to be a boycott, he found it to be a permissible form of expression, since it was not primarily designed to injure competition (and, therefore, not within the sham exception to *Noerr-Pennington*) and might be the only effective method for the petitioners to bring their views to the government's attention. 486 F.Supp. at 768.

The issue facing the court in *Missouri v. NOW* concerned efforts by supporters of the Equal Rights Amendment to organize boycotts of convention facilities as a means of pressuring Missouri legislators to ratify the ERA Amendment. In concluding that this conduct did not violate the antitrust laws, [43] the court relied on two grounds for its decision: (1) the conduct in question did not represent the kind of anticompetitive, commercial behavior for which the Sherman Act was created, and (2) the boycott activity was protected by *Noerr-Pennington* because it furthered the expression of political views. Although the court invoked the *Noerr-Pennington* doctrine in support of its decision, a fair reading of the opinion indicates that the non-commercial, non-competitive relationship of the parties served as the primary reason for the court's conclusion that the antitrust laws were not applicable. In another boycott-type case, the Supreme Court has recently observed that, while a noncommercial boycott designed to force governmental and economic change is a form of constitutionally protected speech, the rights of business enterprises to associate together in ways that suppress competition may be curtailed. *NAACP v. Claiborne Hardware Co.*, 50 U.S.L.W. 5122, 5129-20 (July 2, 1982).

These cases suggest that protected political speech within the *Noerr-Pennington* context is not limited to simple oral or written statements. It is clear that First Amendment protection extends to certain forms of nonverbal conduct as well as verbal communication. See Note, *NOW or Never: Is There Antitrust Liability For Noncommercial Boycotts?*, 80 Colum. L. Rev. 1317 (1980). On the other hand, as the Supreme Court indicated in *California Motor Transport*, "First Amendment rights are not immunized from regulation when they are used as an integral part of conduct which violates a valid statute." 404 U.S. at 513-14.³⁴ In a similar vein, the Ninth Circuit Court of Appeals concluded that *Noerr-Pennington* immunity would not extend to influencing public officials by threats or other coercive measures. *Sacramento Coca-Cola*, 440 F.2d at 1099. The issue before us here is whether the activities of MSMS constitute the kind of illegal conduct that brings them outside the protective shield of *Noerr-Pennington*. [44]

MSMS' conduct not only involved efforts to persuade legislators and Medicaid officials, but its actions also directly interfered with competitive relationships, both among MSMS members and between MSMS and the Medicaid program. To be sure, any joint lobbying campaign may affect the competitive process apart from whatever outcome is sought in the government forum. For example, individual participants may compromise their views for the sake of presenting a united front, and the advocacy campaign itself, irrespective of its ultimate success, may have subtle long-term effects on the competitive interaction among industry members. These potentially adverse side effects, of course, are tolerable in light of the more important goals of preserving freedom of political expression and the right to petition the government.

Here, however, the evidence is unambiguous that MSMS went further and threatened physician withdrawal, in whole or in part, from Medicaid if reimbursement cuts were not restored and "per-case" participation was not allowed. While the threats may not have been quite as bold as they were in the case of BCBSM, the evidence is quite clear that MSMS, through the collection of proxies and the adoption of a resolution stating that members would no longer be "encouraged" to participate in Medicaid, intended to convey the message that it had clout, and would exercise that clout, to achieve its aims. In such circumstances, where more direct restraints are placed on the com-

³⁴ Although the Supreme Court in *Noerr* indicated that misrepresentations made in the course of a lobbying campaign to the legislature would not trigger potential antitrust liability, in *California Motor Transport* the Court pointed out that false statements made in the context of an adjudicatory or administrative proceeding would fall outside the mantle of *Noerr-Pennington* protection and might give rise to an antitrust violation. *California Motor Transport Co. v. Trucking Unlimited*, 404 U.S. 508, 513 (1972).

petitive process—*e.g.*, through negotiation or coercive means—*Noerr-Pennington* protection would appear to be far less compelling.

In reviewing respondent's conduct in light of the rationale behind *Noerr-Pennington*, we are persuaded that subjecting the practices to antitrust scrutiny will not chill exercise of First Amendment rights. As we have pointed out, the conduct at issue goes beyond the "mere solicitation" of governmental action and is similar in nature to the kinds of arrangements that the Court in *Noerr* viewed as being within the traditional purview of the antitrust laws. Moreover, we do not believe a prohibition on MSMS entering or attempting to enter into agreements with governmental third party payers on reimbursement issues will deter respondent from effectively exercising its First Amendment rights. As we indicate below in connection with the proposed remedial order, MSMS will be able to provide information and express its views to government agencies on all aspects of reimbursement policy as well as other issues. [45]

While we believe this analysis effectively resolves the *Noerr-Pennington* issue, we briefly discuss another basis advanced by complaint counsel for excepting the conduct in question here from the scope of the doctrine. Put simply, complaint counsel argue that *Noerr-Pennington* does not apply to situations where the government is acting in a commercial or proprietary capacity in its dealings with private parties. This approach is suggested in *Geo. R. Whitten, Jr., v. Paddock Pool Builders, Inc.*, 424 F.2d 25 (1st Cir.), *cert. denied*, 400 U.S. 850 (1970), where the court stated the following:

Noerr stressed the importance of free access to public officials vested with significant policymaking discretion. We doubt whether the Court, without expressing additional rationale, would have extended the *Noerr* umbrella to public officials engaged in purely commercial dealings when the case turned on other issues. *Id.* at 33.

Similar support is expressed by several commentators. I P. Areeda & D. Turner, *Antitrust Law* 52 (1978); Fischel, *supra*, at 115; Note, *Physician Influence: Applying Noerr-Pennington To The Medical Profession*, 1978 Duke L.J. 701, 708. *But see Airport Car Rental*, 521 F. Supp. 568, 581 (N.D. Cal. 1981), *aff'd* 1982-83 Trade Cases (CCH) ¶65,039 at 70,791 (9th Cir., November 16, 1982), a case which recently held that there is no commercial exception to the *Noerr-Pennington* immunity.

This commercial exception applies to the facts here, it is claimed, because MSMS and its member physicians are in the role of providers or sellers of medical services for which the government is paying the bill. Whatever the merits of this approach, we decline to address it, since there is an independent basis for our action.

IX. The Order

To summarize the remedial order proposed by the ALJ, as modified by the suggestion of complaint counsel (CAB 55 n.3), MSMS would be prohibited from

- * agreeing or attempting to agree with any of its members to affect the amount or manner of determining reimbursement, including agreements to cancel participation, refuse to complete forms, and the like;
- * advocating that its members engage in the prohibited actions described above; [46]
- * entering into or attempting to enter into any agreement with any third party payer concerning reimbursement;
- * acting as an agent for any of its members in their dealings with third party payers concerning reimbursement or the acceptance or rejection of any participation agreement;³⁵ and
- * threatening any coercive acts by any of its members with the purpose or effect of compelling any third party payer to accept positions taken by MSMS or any of its members concerning reimbursement.³⁶

The first portions of the ALJ's order are intended to prevent the recurrence of agreements among horizontal competitors and coercive actions in the nature of a group boycott, such as the proxy efforts and departicipation campaigns. In separate paragraphs of the proposed order (II. A. and II. B.), both the agreement to engage in coercive action and the advocacy or attempted organization of such collective behavior are prohibited. Furthermore, paragraph II. E. specifically prohibits coercive threats of action by MSMS members to compel any third party payer to accept terms of reimbursement or participation. These provisions are narrowly directed toward respondent's organization and encouragement of a concerted refusal to deal and toward its agreements with members affecting prices. In addition to these prohibitions, paragraph II. C. and D. of the proposed order limit MSMS' ability to reach joint agreements with third party payers over reimbursement terms. Like the prohibition against agreements among competitors to take collective, coercive action, these provisions are designed to prohibit direct competitors from using the vehicle of a

³⁵ The prohibition against MSMS acting as agent for its members was intended by complaint counsel to apply only to third party payers.

³⁶ The ALJ's order specifically would not apply to MSMS'

- a) peer review of individual physicians' fees,
- b) exercise of First Amendment rights before any state or federal government agency or body concerning legislation or rules or in any administrative or judicial proceeding, or
- c) responses to requests for information or opinion by any third party payer.

common agent to reach collective agreements with third party payers over reimbursement terms. [47]

There is little specific dispute about the appropriateness of the order's prohibitions against coercive activities or the encouragement of such conduct (even respondent's counsel suggests that a ban against boycotts would be appropriate if any relief is ordered, RAB 55). Respondent does express particular concern about the restrictions in paragraph II. C, which preclude MSMS from entering or attempting to enter into any agreement with third party payers on the subject of reimbursement, citing several circumstances in which such efforts are thought to be desirable. We will respond to that challenge momentarily, but it is first instructive to specify what the proposed order would not preclude.

The ALJ's order would not prevent MSMS from participating in peer review of individual physicians' fees. Nor would it preclude MSMS from providing information or opinions in response to a request from a third party payer, so long as respondent does not seek to reach an agreement with the third party payer. Furthermore, respondent's discussion with third party payers of an issue like the uniform claim form, which does not in any foreseeable way involve reimbursement, would not be prohibited. (O.A. Tr. 48, 33) Similarly, the order would not prohibit MSMS from bringing perceived violations of state law to the attention of third party payers. Finally, although Medicaid falls within the definition of a third party payer, MSMS would not be prohibited by the ALJ's order from participating in any proceeding of an agency of the State of Michigan regarding Medicaid. (O.A. Tr. 50) Nor would MSMS be barred from advocating its views to the legislature or other agencies, so long as it does not seek to extract an agreement or otherwise engage in coercive behavior. We believe that this interpretation is consistent with our reading of the scope of MSMS' First Amendment rights under the *Noerr-Pennington* doctrine.

Apart from its specific concerns with the order, alluded to previously, respondent generally argues that the ALJ's order is excessive in light of the nature of the violations. It argues further that the order trenches upon the prerogatives of the State of Michigan, which must rely upon MSMS' views with respect to cost-containment and physician distribution.

Respondent claims that the ALJ's proposed order would impermissibly infringe upon its First Amendment rights as well as those of its members. With respect to the members, MSMS asserts that the order restricts the freedom of individuals to express their opinions in public. (RAB 59) The order, however, would affect no individuals except those acting as official representatives or [48] agents of the Michigan State

Medical Society—*i.e.*, those persons who must be bound at a minimum to prevent the circumvention of an order against the organization. Of course, even officers of the Society would be free to express their own personal opinions. As for the respondent itself, the order limits its rights of free speech only to the minimal extent necessary to prevent the recurrence of the violations found here. Thus, we reject respondent's contention that the order would unnecessarily restrict activities that are not illegal. (RAB 56) As we point out below, in discussing our further modifications to the order, the relief is restrained and closely related to the conduct found to be unlawful.

Respondent contends further that the order would preclude it from committing its members to accept the specific fees or other reimbursement terms of insurance plans proposed by third party payers through the Michigan Health Care Economic Coalition, an organization of private providers, insurers and employers. (RAB 56-7) Although the order would not allow respondent to enter into binding agreements or threaten boycotts if acceptable terms cannot be agreed upon, our order specifically would permit MSMS to participate in the Coalition's discussions and provide information or advice to the Coalition concerning the interpretation or feasibility of particular proposals. In the context of the example cited by respondent—*i.e.*, a UAW-designed plan to assist the unemployed—the order would not prevent MSMS from informing the Coalition about any specific problems its members might have in providing services to, or collecting fees from, the unemployed.³⁷

As to its other claims that it would be unable to participate in interdisciplinary health-planning organizations, the operation of the order is not as MSMS asserts. Respondent claims that the order would place it in jeopardy for participating in the Governor's Task Force on Physician Reimbursement and the Statewide Health Coordinating Council, on which it has state-appointed representatives. (RAB 57-58) MSMS also charges that the order conflicts with two Michigan statutory schemes expressly calling for third party payers to negotiate with health care providers. One statute, the appropriations law for the Department of Social Services, Pub. Act No. 35, Section 68(1), 1981 Mich. Legis. Serv. 234 (West), provides, in pertinent part, that [49]

In conjunction with association representatives of allopathic and osteopathic physicians . . . , the department of social services shall develop, through negotiations, an alternative reimbursement system for physicians.

³⁷ There is no suggestion in the testimony of the only labor representative to testify in this proceeding, Mr. Melvin A. Glasser, Director of the UAW's Department of Social Security, that the issuance of an order similar to that proposed by the ALJ would impair the ability of his union's members, whether employed or unemployed, to obtain satisfactory health care coverage. (Glasser Tr. 423 *et seq.*) The order will in no way interfere with the ability of the UAW to obtain useful information from providers.

The other, the Nonprofit Health Care Corporation Reform Act, Pub. Act No. 350, Section 505(1), 1980 Mich. Legis. Serv. 1464 (West), provides, in pertinent part, that a

health care corporation may negotiate with one or more organizations that represent providers . . . in the development . . . of the provider class plan

In light of these statutory schemes, we offer the following comments. First, the ALJ's order contemplates that MSMS may provide responsive information and comments to third party payers, even as to reimbursement, so long as MSMS does not reach or attempt to reach an agreement with those parties concerning reimbursement terms. Additionally, under *Noerr-Pennington* principles, respondent may provide input into state Medicaid proceedings. Although the order would prohibit negotiations in contemplation of an agreement, there appears to be no role envisioned by the cited Michigan statutes or the operation of the aforementioned private task forces that is seriously hampered by the order. We would also make it quite clear that nowhere in these proceedings has the respondent raised a state-action defense to the charges or the contemplated relief; thus, there is no claim before us that the MSMS is compelled by state law to act in any way that contravenes the terms of this order.

Moreover, in light of the evidence and arguments presented in this case, we are reluctant to construe these state statutes in a fashion that conflicts with antitrust law or mandates that physicians engage in boycotts, coercion, threats or any other form of anticompetitive activity at issue here. Statutory mechanisms that contemplate exchanges of useful information between provider groups and insurers or state agencies should not be interpreted—without clear evidence, which is lacking here—to mandate conduct that necessarily constitutes a violation of antitrust laws. *Cf. Baxter Rice v. Norman Williams Co.*, 50 U.S.L.W. 5052, 5043-54 (July 1, 1982) (discussing the showing required to establish a conflict between a state statute and federal antitrust law). By permitting MSMS to provide input to third party payers, short of entering into agreements with them on behalf of its members, our order will not frustrate the [50] performance of any legitimate function of the Medical Society under the cited statutes. We also note that the State of Michigan did not appear as *amicus curiae* in these proceedings to argue or demonstrate otherwise.³⁸

³⁸ Respondent has attached as an appendix to its Reply Brief a letter addressed to it from Mr. Dempsey, the Director of Michigan's Department of Social Services, in which he expresses concern that the ALJ's order would forbid the continued cooperation of MSMS and his department on cost-containment and other issues. (RRB A-1) Likewise, a letter to MSMS from Mr. Gerald Miller, Director of Michigan's Department of Management and Budget, suggested that the ALJ's order would restrain MSMS from "engaging in negotiations pertaining to physician reimbursement." (RRB A-2) These letters were not a part of the record in this matter nor were they addressed to the Commission. Nonetheless, we acknowledge the concerns expressed therein and emphasize that

(footnote cont'd)

Although we believe the ALJ's order is generally reasonable, we nonetheless find it appropriate to modify the proposed order in several respects, one of which deals with the medical society's concern about its role as representative or spokesman for its members. Before explaining our modifications, however, it is important to expand upon our finding that the order generally is quite reasonable and related directly to respondent's illegal conduct.

The standard by which to judge remedial orders is whether the relief sought is a reasonable method of eliminating the consequences and preventing the recurrence of law violations. *National Society of Professional Engineers v. United States*, 435 U.S. 679, 698 (1978). In that case the Court recognized that a remedial order to correct or prevent a law violation might curtail the exercise of liberties otherwise enjoyed, just as a prohibition against price fixing "abridges the freedom of businessmen to talk to one another about prices." *Id.* at 697. But the "First Amendment does not 'make it impossible ever to enforce laws against agreements in restraint of trade . . .'" *Id.* quoting *Giboney v. Empire Storage & Ice Co.*, 336 U.S. 490, 502 (1949). Furthermore, in remedying an antitrust violation, "it is not necessary that all untraveled roads be left open and that only the worn one be closed." *International Salt Co v. United States*, 332 U.S. 392, 400 (1947). Thus, in *Professional Engineers*, the Court found that a prohibition against the adoption of an ethical code banning competitive bidding was reasonable. The Court also observed that where the ordered party fears that the [51] remedy imposed will block legitimate paths of expression, it bears the burden of showing the adverse consequences to the court in seeking a modification. 435 U.S. at 698-99.

It is well settled that the FTC is also empowered to issue remedial orders reasonably related to the violations found to exist. In *AMA*, the Second Circuit held that

it is well established law that it is within the discretion of the FTC to determine whether an order is "necessary to cope with the unfair practices found." 638 F.2d at 451, quoting *FTC v. Colgate-Palmolive Co.*, 380 U.S. 374, 392 (1965).

In reaching that decision, the Second Circuit relied upon *Professional Engineers* in holding that, in the remedial context, the AMA's range of expression on the ethics of physicians' contract practices may be restricted. 638 F.2d at 452. The *AMA* court ruled that the Commission's order banning restrictions on certain advertising and contractual arrangements was not overbroad, since it restrained only speech itself found to violate the FTC Act. The court held that

our modification of the ALJ's order ameliorates any potential loss of information and input from MSMS, as it prohibits only joint *agreements* among horizontal competitors and third party payers specifically affecting price or reimbursement.

[T]he Commission "must be allowed effectively to close all roads to the prohibited goal, so that its orders may not be by-passed with impunity, *FTC v. Ruberoid Co.*, 343 U.S. 470, 473 (1952), by the state and local medical societies." *Id.* at 453.

Similarly, the Ninth Circuit has recently held that

Any remedy formulated by the FTC that is reasonably necessary to the prevention of future violations does not impinge upon constitutionally protected commercial speech. *Litton Industries, Inc. v. Federal Trade Commission*, 676 F.2d 364, 373 (9th Cir. 1982).

These rulings are consistent with recent Supreme Court precedents on the scope of First Amendment protection. In *Central Hudson Gas & Electric Co. v. Public Service Commission*, 447 U.S. 557 (1980), the Court set out standards to be met by governmental orders that restrict protected expression. While requiring that the order directly advance a stated governmental interest and be no more extensive than necessary to serve that interest, the test also inquires into whether the speech is accurate and unrelated to illegal conduct—if it is related to or constitutes illegal conduct, the speech may lose its constitutional protection. See Sullivan, *First Amendment Defenses In Antitrust Litigation*, 46 Mo. L. Rev. 517, 573 (1981). Thus, we find the order before us to be reasonable, necessary and well within the bounds of judicially established remedial standards. [52]

Our clear purpose in crafting a remedy is to prevent agreements and boycotts or similar coercive threats of collective action to fix or affect prices. We believe that it is necessary and appropriate to prohibit MSMS and its members—direct competitors in the eyes of the law—from agreeing or joining together to affect specifically reimbursement amounts, terms or methods of calculation. We emphasize that we are not proposing to prohibit all collective activities simply because they may have some possible effect on fees. In fact, paragraphs II. A. & B. spell out specific forms of illegal conduct which, though not inclusive, clearly illustrate the kinds of concerted behavior proscribed by the order. The order is further warranted to prohibit MSMS from advocating or urging that its members engage in the activities otherwise prohibited by the order. Finally, there is an obvious need to prohibit MSMS from threatening any third party payer with collective actions by its members in order to affect the terms of reimbursement.³⁹ Even so, the ALJ's order, as modified below, does

³⁹ We also observe that the scope of our adjudicative order is consistent with consent orders entered by courts in Justice Department cases involving circumstances very similar to the Medicaid portion of this matter. Recently, for example, an association of nursing homes was enjoined from engaging in

- (a) any concerted refusal by nursing homes to participate in Medicaid;
- (b) any agreement, understanding, or course of conduct with the purpose or foreseeable effect that nursing homes will jointly accept or reject any terms of Medicaid participation, jointly reject Medicaid patients, or jointly threaten not to participate in Medicaid;
- (c) advocating or recommending that nursing homes individually do any of the three actions enumerated above;

(footnote cont'd)

not [53] impose an outright prohibition on MSMS expressing its views or the views of its members to third party payers. Stated as plainly as possible, it would not preclude communications that fall short of agreements or attempts to reach agreements on reimbursement.

We now turn to respondent's concern about the provisions of the order (II. C. & D.) that would restrict MSMS' latitude in acting as the representative or agent of its members with respect to their positions on reimbursement. We believe that a few modifications will preserve the essential feature of these provisions—*i.e.*, forbidding respondent from acting as an agent for purposes of negotiating agreements or engaging in coercive conduct—while allowing MSMS greater freedom to communicate with third party payers in a non-binding, non-threatening fashion.⁴⁰ As presently drafted, paragraph III. C. of the order permits respondent to provide information and opinions in response to requests from third parties. This exception recognizes that MSMS may have a useful role to play in offering suggestions and advice to third party payers on a wide variety of issues, including reimbursement. We believe that the potential value of this role is not limited to responsive communications but extends as well to similar communications initiated by respondent. Therefore, we have modified paragraph III. C. to make that clear.⁴¹

There is, of course, some inherent danger in allowing any collective dialogue with third party payers on questions directly related to reimbursement amounts or policies. Nevertheless, we believe that this risk is reasonable so long as the order clearly proscribes agreements with third party payers, whether extracted by negotiation or coercion, and any conduct in furtherance of such a result. As we pointed out previously, our order permits the efficient exchange of information and ideas between providers and insurers while guarding against the concerted imposition of price-related agreements by competing health care providers.

Inevitably, there will remain some definitional questions as to

(d) or causing or permitting at any meeting of the association any discussion or course of conduct having the purpose or foreseeable effect that nursing homes will jointly do any of those three things.

United States v. Montana Nursing Home Ass'n, Inc., 5 (CCH) Trade Reg. Rep. ¶50,816 (D. Mont. April 13, 1983). To the same effect is an almost identical consent order prohibiting another association of nursing homes from acting as an agent for its members in connection with any decision to accept or reject all or any terms of Medicaid participation. *United States v. South Carolina Health Care Ass'n*, 1980-2 (CCH) Trade Cases ¶63,316 (D.S.C. April 22, 1980). See also *United States v. Geneva County (Ala.) Bar Ass'n*, 1982-1 (CCH) Trade Cases ¶64,699 (M.D. Ala. April 15, 1982) (prohibiting a bar association for ten years from participating in activities or communications the purpose or effect of which is to fix fees or formulate or encourage the use of any list or guide on fees).

⁴⁰ For example, the mere fact that MSMS conveys its concerns to BCBSM or Michigan Medicaid about a particular reimbursement policy, and the third party insurer thereafter changes its policy, is unlikely, without more, to be construed as an agreement prohibited by the order. If, however, the overall course of dealing indicates that respondent is acting in a fashion that purportedly commits its members collectively to accept or reject a third party proposal, the chances are much greater that the order will apply.

⁴¹ It should also be pointed out that neither this case nor the order addresses the appointment of physician representatives, whether by MSMS or by any other group, to serve on the boards of third party payers or other medical organizations.

whether activity crosses the prohibited borders to constitute an illegal agreement or an attempt to reach one. As with any remedial order, in MSMS' compliance with these restrictions there may be a small attendant loss of otherwise permissible activity. But, as the Court in *Professional Engineers* observed, where this occurs it is a necessary consequence of remedying the law violation. 435 U.S. at 697. We believe, [54] though, that our modified order minimizes any dampening of legitimate representative behavior while banning that activity which we have found unlawful. To the extent that MSMS faces uncertainty over contemplated communications, we reiterate the suggestion of *Professional Engineers* that the respondent may obtain further guidance in post-order proceedings.

To this end, we have modified the ALJ's order so that II. C. now prohibits respondent from

C. Entering into or attempting to enter into any agreement or understanding, either on its own behalf or as representative of any of its members, with any third party payer concerning the amount, manner of calculating, or terms of reimbursement, or concerning the decision of any of its members jointly to accept or reject the terms or conditions of any participation agreement.

Paragraph II. D. of the ALJ's order is deleted. Conduct that would have been prohibited by that provision will be barred by the other provisions only if it involves collective agreements, attempted agreements or coercive conduct associated with reimbursement issues or members' decisions to accept or reject the terms of participation agreements. Neither paragraph II. C., as modified, nor the other provisions of the order would otherwise ban MSMS from providing third party payers with information, advice or opinions relating to reimbursement. Finally, paragraph III. C. of the ALJ's order, which would have directed that MSMS could only respond to requests by third party payers for such information (but could not initiate such communications), has been modified to reflect the expanded range of discourse allowable under our decision.⁴² With these modifications, we issue the attached order against the Michigan State Medical Society.

⁴² We have also made a few additional modifications to the order. In paragraph III. B. of the ALJ's order, the reference to "bona fide" exercise of First Amendment rights is deleted. In light of our discussion of the nature and scope of such rights, we regard the insertion of that term as superfluous and possibly confusing. With respect to Part IV of the order, we have modified paragraph A. to require that only a copy of the order be sent to members. To require that the entire decision be mailed to every member seems unduly burdensome and unnecessary. In paragraph B. we have eliminated the requirement that the order be published on the "first pages" of the Society's two regular publications; and in paragraph C. we have shortened the period from ten years to three years during which MSMS must provide new members with a copy of the order. Since we are not dealing with a long-established practice, there is less need for prolonged notification to new members. The other provisions in paragraph C. and Part V are necessary to assure continued effective compliance with the order.

CONCURRING STATEMENT OF COMMISSIONER PERTSCHUK

I agree fully with the Commission's opinion except that I join Commissioner Bailey in concluding that the conduct should have been judged *per se* unlawful. Because I believe a determination that a *per se* analysis should have been applied here is somewhat more difficult than in other cases, it may be useful to elaborate on how that determination should have been made.

In *Broadcast Music*,¹ the Supreme Court indicated that, once an arrangement has been identified as "price-fixing," it is *per se* unlawful; however, such a determination "will often, but not always, be a simple matter."² In that case, in fact, the Court found that a blanket licensing scheme in which composers agreed on a single price for use of all their compositions should not be condemned as unlawful *per se* even though it might be price-fixing in a "literal sense."³ The rationale for inquiring about competitive effects under a rule of reason analysis was, in part, that there were tenable arguments that the arrangement could help competition because it amounted to a separate product that was not available to the entertainment media by offerings of individual composers. [2]

In *Maricopa*⁴ the Court examined an arrangement in which foundations for medical care, composed of competing physicians, adopted maximum fee schedules after consulting with local medical societies and submitting proposed schedules to a vote of the entire membership of the foundations. The foundations had arranged with approved insurers that the insurers would agree to pay any charges up to the approved maximums and that the member physicians would accept these reimbursement levels as payment in full. Unlike the licensing arrangement in *Broadcast Music*, however, the Court found that this arrangement offered no tenable arguments of procompetitive benefits. It did not amount to a new risk-sharing entity in competition with other insurers, but essentially was "an agreement among hundreds of competing doctors concerning the price at which each will offer his own services to a substantial number of consumers."⁵

Here we examine conduct by competing physicians which amounted to a threatened refusal to deal with health insurers unless reimbursement rates were fixed at particular levels. The most that can be said for MSMS' agreement was that, technically, it did not directly establish the fees that competing physicians charged, but only the fees that the insurers paid. Yet, because of the great importance of

¹ *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*, 441 U.S. 1 (1979).

² *Id.* at 9.

³ *Id.* at 8.

⁴ *Arizona v. Maricopa Medical Society*, 50 LW 4687 (June 15, 1982) (80-419).

⁵ *Id.* at 4693.

third party payments, not only in Michigan, but all across the country, reimbursement levels have become the most central aspect of price in health care [3] transactions. The novelty of medical price-fixing is that all of us who pay health insurance premiums or taxes are victims, not merely those who receive services.

There is not even an argument here that MSMS' conduct was aimed at establishing a new competitive entity or that the efforts to force insurers to pay uniform levels of fees across the state led to efficiencies in fee determination, as was half-heartedly proposed in *Maricopa*.⁶ Thus, this case is actually much stronger than *Maricopa* in justifying *per se* condemnation of MSMS' attempt to force changes in reimbursement levels.

I do not quarrel with the Commission opinion's careful assessment of the nature of the commercial transactions here and a limited examination of proffered justifications. This analysis is a necessary predicate to concluding that the arrangement fits "into the horizontal price fixing mold."⁷ Once that determination is made, however, as I believe it should have been, a conclusion that the conduct is unlawful *per se* necessarily follows.

CONCURRING STATEMENT OF COMMISSIONER BAILEY

If I could agree that price-fixing by medical doctors should be subject to a rule of reason analysis (Slip Op. at 34), I would agree completely with the majority opinion. I believe the analysis conducted in the opinion convincingly demonstrates that MSMS' fee-related concerted behavior cannot be justified as procompetitive or as having no competitive effects.

However, the Supreme Court has clearly and consistently told us that once it is determined that a collaboration fosters price-fixing, no examination of alleged procompetitive justifications for that behavior is warranted. Further, "the nature of [the collaborators'] occupation, standing alone, does not provide sanctuary from the Sherman Act. . . ." *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 787 (1975). Very recently, in *Arizona v. Maricopa County Medical Society*, 102 S.Ct. 2466 (1982), the [2] Court applied this principle to a combination of competing physicians who were found to have engaged in maximum fee setting and unequivocally concluded that "the fact that doctors [were] parties to the price fixing agreement" could not change the analysis. 102 S.Ct. at 2475.

⁶ *Id.* at 4692.

⁷ *Id.* at 4693. This limited examination is for the purpose of determining the essential nature of the restraint, not overall competitive effects and "[t]he scrutiny occasionally required must not merely subsume the rule of reason [citing *Professional Engineers*], or else we should apply the rule of reason from the start." *Broadcast Music* at 19, fn. 33.

Here we are faced with collective actions that were intended to influence directly third party payments to physicians.¹ (Slip Op. 31) Because those payments represent the bulk of physicians' service fees, the doctors' united front had the potential to inhibit price and non-price competition both among doctors and among insurance companies. (Slip Op. 33, 35) I do not see room in the long line of precedent on price-fixing for an artificial distinction between conduct which involves direct fee setting and conduct which tampers with the method of setting fees. Therefore I would not qualify the description of the conduct before us by saying it "approaches the kind of behavior that previously has been classified as *per se* illegal". (Slip Op. 34) I think such conduct must, under present law, be viewed as classic price fixing. [3]

Any combination which tampers with price structures is engaged in an unlawful activity. . . . to the extent that [members of the price-fixing group] raised, lowered or stabilized prices they would be directly interfering with the free play of market forces. *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 218 (1940) quoted in *Maricopa*, 102 S.Ct. at 2474.

Therefore, I would have foregone inquiry into whether MSMS' fee-related collective activities had actual or potential offsetting benefits to competition.

FINAL ORDER

This matter having been heard by the Commission upon the appeal of respondent from the Initial Decision, and upon briefs and oral argument in support thereof and in opposition thereto, and the Commission having determined for the reasons stated in the accompanying Opinion to deny the appeal of respondent:

It is ordered, That the Initial Decision of the administrative law judge be adopted as the Findings of Fact and Conclusions of Law of the Commission, except to the extent inconsistent with the accompanying Opinion. Other Findings of Fact and Conclusions of Law of the Commission are contained in the accompanying Opinion.

It is further ordered, That the following Order to Cease and Desist be, and it hereby is, entered. [2]

¹ In my opinion, only in its claim that it fought reductions in Medicaid payments in order to preserve quality of care for low-income patients did respondent raise a colorable alternative explanation for its conduct. However, as the majority opinion clearly describes, the record will not support this assertion: MSMS' true purpose in threatening a boycott of the program was to increase physician reimbursements. (Slip Op. 16-19) Therefore the Medicaid incidents must be characterized as merely another battle in respondent's long campaign against third party influence on doctors' pricing practices.

I.

It is ordered, That for purposes of this order the following definitions shall apply:

A. *MSMS* means Michigan State Medical Society, its House of Delegates, Council, committees, officers, representatives, agents, employees, successors and assigns.

B. *Third-party payer* means any person, corporation, government agency or other entity which agrees to pay for or reimburse all or part of any expense for physicians' services incurred by another person or group of persons. *Third-party payer* includes, but is not limited to, Blue Cross and Blue Shield of Michigan, and Medicaid.

C. *Medicaid* means the program of health care for indigent persons created by Title XIX of the Social Security Act, entitled "Grants to States for Medical Assistance Programs," 42 U.S.C. 1396 *et seq.* (1976 & Supp. III 1979), including regulations, policies and procedures of Michigan that implement the program in Michigan.

D. *Reimbursement* means money paid by a third-party payer for physicians' services.

E. *Physician* means a doctor of medicine or of osteopathy.

F. *Participation agreement* means any agreement between a third-party payer and a physician in which the third-party payer agrees to pay the physician for the provision of physicians' services and in which the physician agrees to accept payment from the third-party payer for the provision of physicians' services. [3]

II.

It is further ordered, That MSMS shall cease and desist from:

A. Entering into or attempting to enter into any agreement or understanding, either express or implied, with any MSMS members to affect or attempt to affect the amount, manner of calculating, or terms of reimbursement, including but not limited to, any agreement or understanding that:

1. any MSMS members will cancel or refuse to enter into participation agreements;
2. any MSMS members will refuse to complete claim forms used by any third-party payer;
3. MSMS can act on behalf of any members through proxy, power of attorney, or otherwise, to cancel or refuse to enter into any participation agreement; or
4. any MSMS members will sign or enter into participation agree-

ments only on terms acceptable to MSMS or to any other MSMS member.

B. Advocating, suggesting, urging, advising, inducing or recommending that any MSMS members engage in any action to affect or attempt to affect the amount, manner of calculating, or terms of reimbursement, including, but not limited to, advocating, suggesting, urging, advising, inducing or recommending that any MSMS members:

1. cancel or refuse to enter into any participation agreement with any third-party payer;
2. refuse to complete claim forms used by any third-party payer;
3. agree to permit MSMS to act on behalf of any MSMS members through proxy, [4] power of attorney, or otherwise, to cancel or refuse to enter into any participation agreement; or
4. sign or enter participation agreements only on terms acceptable to MSMS or to any other MSMS member.

C. Entering into or attempting to enter into any agreement or understanding, either on its own behalf or as representative of any of its members, with any third-party payer concerning the amount, manner of calculating, or terms of reimbursement, or concerning the decision of any of its members jointly to accept or reject the terms or conditions of any participation agreement.

D. Making any express or implied threat of acts by any MSMS members, or engaging in any other acts, with the purpose or effect of coercing, compelling or inducing any third-party payer to accept a position taken by MSMS or any MSMS members concerning the amount, manner of calculating, or terms of reimbursement, or the terms or conditions of any participation agreement.

III.

It is further ordered, That this Order shall not be construed to prevent MSMS from:

A. Participating in professional peer review of fees charged by individual physicians in individual cases.

B. Exercising rights permitted under the First Amendment to the United States Constitution to petition any federal or state government executive agency or legislative body concerning legislation, rules or procedures, or to participate in any federal or state administrative or judicial proceeding.

C. Providing information or views, on its own behalf or on behalf of its members, to third party payers concerning any issue, including reimbursement. [5]

IV.

It is further ordered, That MSMS:

A. Mail a copy of this Decision and Order to each of its component societies, each of its specialty sections, and a copy of the Order to each of its members within thirty days following service of this Order.

B. Publish this Order in an issue of *Michigan Medicine* published no later than 60 days after the date the Order is served, and in the first *Medigram* published after the Order is served. The Order shall be published in the same type size normally used for articles which are published in *Michigan Medicine* and in the *Medigram*.

C. For a period of three years, provide each new MSMS member with a copy of this Order at the time the member is accepted into membership.

D. Require, as a condition of affiliation with MSMS, that any component society or specialty section agree by action taken by its governing body to be bound by the provisions of Parts I-III of this Order.

V.

It is further ordered, That MSMS shall file a written report with the Commission within ninety days of the date of service of this Order, and annually on the anniversary date of the original report for each of the five years thereafter, and at such other times as the Commission may by written notice to MSMS require, setting forth in detail the manner and form in which it has complied with this Order.

It is further ordered, That MSMS shall notify the Commission at least thirty days prior to any proposed change to itself, such as dissolution, assignment, or sale resulting in the emergence of a successor corporation or association, or any other change which may affect compliance with this Order.

Commissioner Douglas did not participate.