Annals of Health Law

Volume 5
Issue 1 *1996*

Article 3

1996

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INTRODUCTION

Ah, *Posner.*

There was an episode of the television show *M*A*S*H*, you may recall, in which company clerk Radar O'Reilly was intent on impressing a certain nurse. The mischievous meatball surgeons thus began to coach him on ways to demonstrate superior intellect and cultural refinement. In the area of classical music, they told him what to say about several composers, but, if the name of J. S. Bach arose for any reason, he was told to only lean back, eyes half-closed, and sigh, "Ah, Bach."

Thus do I begin most discussions of the *Marshfield Clinic* case, with a similar *hommage* to Chief Judge Richard A. Posner of the Seventh Circuit Court of Appeals, the author of the opinion in the case of *Blue Cross & Blue Shield United of Wisconsin, Inc. v. Marshfield Clinic.*[1] Prior to Judge Posner's opinion, the antitrust dispute between Marshfield Clinic and Blue Cross had generated substantial interest and commentary in the health care community and the antitrust bar principally (as two commentators put it) because of "the prominence of the featured players and the dollar value of the jury verdicts."[2] The original verdict against the Clinic—$48 million after trebling—was reduced by the trial judge to $17 million. Much of the drama ended when the Seventh Circuit promptly reversed nearly every jury finding and vacated the entire judgment.

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1. 65 F.3d 1406 (7th Cir. 1995), *cert. denied*, 116 S. Ct. 1288 (1996).

2. Bradley G. Clary & Michael A. LaFond, *Antitrust and Integrated Delivery Systems: Blue Cross . . . v. The Marshfield Clinic . . .*, HEALTH L. DIG., Feb. 1995, at 3, 9.

I. THE COURT'S OPINION

Free At Last

From the perspective of those who defended the Clinic from the blunderbuss charges leveled by Blue Cross, the appellate decision was deeply gratifying, albeit vastly overdue. Blue Cross essentially alleged that Marshfield, a 400-member physician-owned clinic with twenty-one branches, had monopolized the delivery of physician services in the largely rural portions of northern and central Wisconsin that it serves.[3] Marshfield allegedly accomplished this goal in many ways, including by acquiring physician practices and opening new clinics in admittedly underserved rural locations. Marshfield had also established its own HMO, the co-defendant Security Health Plan. Security's network included the 400 physicians employed by Marshfield and some 900 other independent "affiliates."[4] The agreements with the affiliates were nonexclusive; in addition to their HMO patients, the affiliates cared for fee-for-service patients covered by indemnity insurers such as Blue Cross and participated in other PPO and HMO networks. Marshfield's conduct allegedly injured Blue Cross as an indemnity insurer because the Clinic charged Blue Cross's insureds "monopoly" prices, some or all of which Blue Cross was required to pay. Marshfield had also allegedly injured Blue Cross's largest HMO subsidiary, co-plaintiff Compcare, by excluding it from the market for HMO services. This was accomplished by Marshfield's refusal to enter into a contract (on terms that Blue Cross deemed "reasonable") to make its employed physicians part of Compcare's HMO network.[5]

The Seventh Circuit opinion in *Marshfield* confirms that successful plaintiffs must, at some point, prove their allegations. There was simply no evidence, Judge Posner pointed out, that Marshfield was a monopolist in any market, that Marshfield had engaged in predatory conduct, that Marshfield somehow "controlled" the independent doctors in its service area, or that Marshfield's allegedly "supracompetitive" prices—which were comfortably in line with those of other large clinics but higher than the prices of the "average" doctor in Wisconsin—reflected anything but the quality of its world-class physicians and facili-

3. 65 F.3d at 1409.
4. *Id.*
5. *Id.* at 1408.

ties.[6] The court also confirmed that there was nothing suspect, much less anticompetitive, about the Clinic's decision to enter the health insurance business by establishing its own HMO, discrediting the plaintiffs' argument that the HMO's very structure entailed price fixing. Nor could the Clinic's reputation for rendering services of exceptionally high quality convert it into an "essential facility" required to deal with Blue Cross's HMO.[7]

There was much more, though the opinion moves so quickly that some of the issues are hard to spot by those not involved in making the record. While most attention has focused on the court's holding that no evidence supported the finding that HMOs constitute a "market" separate from other health insurance plans, the court also rejected the jury's findings that Marshfield was guilty of monopolization in some or all of several dozen other markets for primary care and various specialty care services.

The "evidence" to support these latter conclusions was supplied by Blue Cross's economist and relied, we repeatedly argued, on three untenable assumptions.

(1) The geographic markets for primary care could consist of thirty- to fifty-mile circles drawn around each of the Marshfield Clinic satellite offices. Because some of these offices were quite close to each other, this approach produced what Judge Posner called "a dizzying series of concentric circles," some of which overlapped entirely but which the economist insisted were separate geographic markets for the same primary care product.[8] Thus, the same consumer in northern Wisconsin could simultaneously live in as many as six different geographic markets for the same product.[9] There is no legal definition of a geographic market that can produce this result.

(2) Specialty care product markets could be defined as each separate "diagnostic related group" (DRG), as defined by Medicare. DRGs, of course, group various services to predict the length of hospital stays, not to define markets. Mind you, the economist's definition did not combine *groups* of DRGs (such as all those related to cardiac surgery or to oncology), which could be a starting point for defining a physician services

6. *Id.* at 1412 ("Generally you must pay more for higher quality.").

7. The essential facilities principle obligates natural monopolists to provide access to would-be competitors. *Id. See also* Clary & LaFond, *supra* note 2, at 7.

8. *Id.* at 1411.

9. *See Marshfield*, 883 F. Supp. 1247, 1271 (W.D. Wis. 1995) (Exhibit 984 appended to district court opinion).

market. Instead, the expert insisted that each of the 494 individual DRGs was a *separate* specialty care product market, not substitutable for another in any sense. Having some fun with this argument, Judge Posner noted that the concept of supply substitutability alone rendered absurd the conclusion that "circumcision of a male 17 years old or older" was a separate product market from "circumcision of a male under 17."[10]

(3) In calculating Marshfield's "monopoly" share of these oddly defined markets, *all* of the services rendered by the independent physicians affiliated with Marshfield's HMO—*even to non-HMO patients*—would be included as a sale of services by Marshfield. Under this theory, when one of the independent doctors in Marshfield Clinic's HMO network treated a non-HMO patient insured by Blue Cross's indemnity plan (a transaction from which Marshfield Clinic received not a dime), that sale was added to Marshfield's market share because Marshfield allegedly "controlled" those doctors. Judge Posner made short work of this argument as well, noting the undisputed evidence that affiliates could (and did) work for other health plans, and that they derived only a tiny portion of their income from the Marshfield HMO.[11]

Not Even Close

While the litigation between Marshfield and Blue Cross, taken as a whole, continues to generate discussion on questions of health care policy, antitrust law, and even litigation strategy, Judge Posner's opinion is best understood as simply restoring sanity; simply demanding that the most fundamental rules of antitrust law, such as market definition, be followed by the plaintiffs; and simply requiring *proof* of each essential element. For if these are the tests applied to the trial record in *Marshfield*, it is not a close case. If this sounds immodest, consider the posture of both sides on appeal. Conventional wisdom has it that successful appellants of adverse jury verdicts must distill one or two purely legal issues for the appellate court; arguments based solely on the insufficiency of the evidence to support a civil jury verdict are for losers. Before the Seventh Circuit, however, we appealed on multiple essential elements of each claim. Our arguments were based not on improper evidentiary rulings or jury instructions but solely on the sufficiency of the evidence. In

10. 65 F.3d at 1411.
11. *Id.*

other words, we accepted the highest burden an appellant can have and plainly satisfied a respected Seventh Circuit panel.

If that does not persuade you, look at the *amici curiae* brief filed by the Department of Justice Antitrust Division (DOJ) and the Federal Trade Commission (FTC) on Blue Cross's motion for reconsideration before the Seventh Circuit. The government is, of course, an active antitrust plaintiff; in recent years, it has opposed many HMO mergers and hounded the purveyors of "most favored nation" clauses (MFNs), including Blue Cross itself.[12] The government thus had every incentive to argue that the jury's findings should have been upheld, but it did not do so. After taking a look at the record (at our prompting), the government expressly declined to support Blue Cross's argument for affirmance:

> The United States and the Federal Trade Commission take no position on the sufficiency of the record to support the jury's verdict. We are concerned, however, that the Court's explanations of its conclusions on two issues may mislead readers *unfamiliar with the record and arguments in this case* as to the law applicable to market definition and [MFNs] . . . .[13]

In the end, all the government could request was "clarification" that no HMO market was proven to exist *in this case*, something the original Seventh Circuit opinion had stated in at least three places.[14] As the DOJ's experience shows, if one looks for evidence of meaningful antitrust facts in this record, one comes up empty.

Consider, for example, the record on the HMO product market issue, and you will find the most basic evidence missing. The claim that Blue Cross's HMO, Compcare, was "excluded" from the HMO market by Marshfield's refusal to join its network accounted for about ninety percent of the damages awarded. This claim depends entirely on the existence of a separate HMO market, as both the trial and appellate courts noted. If one were trying to prove such a market, what evidence would be adduced? One would probably start with some data showing that consumers do *not* readily substitute HMOs for other plans when

12. *See generally* Anthony J. Dennis, *Potential Anticompetitive Effects of Most Favored Nation Contract Clauses in Managed Care and Health Insurance Contracts*, 4 ANNALS HEALTH L. 71 (1995).

13. Brief for the United States and the Federal Trade Commission as Amici Curiae in Support of Petition for Rehearing at 3, *Marshfield*, 65 F.3d 1406 (7th Cir. 1995) (Nos. 95-1965, 95-2140) (emphasis added).

14. 65 F.3d at 1409-10.

shopping for health care services. One would probably also have an expert economist opine that, in light of such data and other evidence, HMOs and other plans are not good substitutes and thus do not compete in the same market. The plaintiffs here did neither. The only data in the record on consumer substitution was offered by Marshfield and cuts the other way. Moreover, plaintiffs' economist not only failed to support the crucial concept of an HMO market, but he testified that Compcare had been excluded from "the health care financing market," which he agreed included HMOs and all other forms of insurance.[15]

This is not a promising start if one wishes to make this the test case for establishing the first separate HMO market accepted by any court. As shown below, none of plaintiffs' evidence at trial on the issue of an HMO market spoke to the critical issue of "interchangeability." Plaintiffs were reduced to arguing on appeal that HMOs and other health plans were simultaneously good substitutes in the health care financing market and *not* good substitutes in an HMO "submarket"—a position unanimously rejected by the courts and commentators as a fundamental misreading of the United States Supreme Court's decision in *Brown Shoe*.[16]

I dwell on the specific state of the record because one cannot assess the significance of Judge Posner's opinion without appreciating how dramatically deficient the record in this case actually is. Nor can one understand—without complete stupefaction—how such fundamental holes in this record could exist without appreciating the nature and origin of this dispute. This complaint was filed as a means to force the Clinic to give Blue Cross a managed care contract on the terms Blue Cross wanted rather than the terms the Clinic was offering.[17] Indeed, Blue Cross's Chief Executive Officer confided to the head of St. Joseph's Hospital that he intended by this litigation to "own the Marshfield Clinic."[18] Assuming that this particular nun was not prepared to lie, the CEO's statement may explain why Blue Cross did not confine itself to a claim that Marshfield was "essential" for any HMO and therefore must do business with Blue Cross.

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15. *See infra* part II.

16. Brown Shoe Co. v. United States, 370 U.S. 294 (1962). *See infra* part II.

17. For a description of these negotiations, *see* Kevin D. McDonald, Blue Cross v. Marshfield: *If Antitrust Law Is a Tuxedo, This Case Is a Brown Shoe*, 9 ANTITRUST HEALTH CARE CHRON., No. 3, at 2, 10 (1995) [hereinafter McDonald].

18. Record at 261, *Marshfield*, 883 F. Supp. 1247 (W.D. Wis. 1995) (No. 94-C-137-S).

Instead, it claimed that nearly every business decision of the Clinic for the last two decades was illegal: every decision to open each of the twenty-one satellite clinics in underserved portions of rural Wisconsin; every decision to enter into each of the hundreds of agreements by which independent doctors affiliated with Marshfield's HMO; and every decision to enter into each of the dozens of other agreements with hospitals, clinics, doctors, and other health insurers. According to Blue Cross, this concatenation of conduct and agreements in more than thirty "monopolized" markets violated the law under *nine* separate antitrust theories, to wit, monopolization, attempted monopolization, conspiracy to monopolize, conspiracy in restraint of trade, price fixing, conspiracy to allocate customers, conspiracy to allocate territories, conspiracy to allocate products, and unlawful tying (yes, *tying*).[19]

As the saying goes, when you have said everything, you have said nothing. A plaintiff taking such an unfocused approach runs the risk that what may prove to be the controlling issue (or issues) will be overlooked. Thus, even if one persuades a jury to vent its ill will toward physicians as a group, one may later find oneself, as Blue Cross did here, arguing that Marshfield "controlled" all the doctors in northern Wisconsin but unable to tell the appellate court how many non-Marshfield doctors there are in any given area—something Judge Posner found remarkable.[20] One may also find oneself arguing to the Supreme Court that this is a cert-worthy case because of the express MFNs in Marshfield's contracts with its HMO affiliates when (gulp) such provisions do not exist.[21]

Adopting the Proper Posner

The body of this article will analyze the opinion produced by Judge Posner, with emphasis on the issues Blue Cross has deemed worth of certiorari: (1) the existence of a separate HMO market, and (2) the legality of the supposed MFNs. A

19. The plaintiffs recoiled viciously whenever asked to connect any such claim to a specific market, to a specific reduction in competition, or to a specific injury to Blue Cross. That, they retorted during the briefing on post-trial motions, was the jury's job, not theirs. Plaintiffs' Opposition and Brief in Response to Defendants' Renewed Motion for Judgment as a Matter of Law and Motion for a New Trial at 113 (No. 94-C-137-S). Judging by their certiorari petition, they next believed it was Judge Posner's job. Cert. Petition at 11, *Marshfield,* 116 S. Ct. 1288 (1996) (No. 95-1118).

20. 65 F.3d at 1409.

21. *See infra* part III.

close reading of the opinion, however, shows that the result of those two issues turns not on any novel conclusion of law but on the sufficiency of the evidence. As a sufficiency case, moreover, it is an easy one.

That having been said, however, Judge Posner is someone who cannot order tea without generating debate among antitrust lawyers. His customary wit and irreverence are fully on display in the *Marshfield* decision. Indeed, Judge Posner's candor and (as he terms it) "impure" writing style[22] have caused many—including Blue Cross here—to equate these personality traits with judicial activism.[23] But that will not wash. On the central issues in *Marshfield*, Judge Posner continually reminds us that the result must turn on the record evidence[24] and binding precedent.[25]

A close reading of the opinion also reveals that the only significant issues mishandled by the court were decided in Blue Cross's favor. In a conclusion that truly is unprecedented, Judge Posner rejected our argument that Blue Cross had no standing as an indemnity insurer to sue Marshfield for the allegedly "supracompetitive" prices charged to Blue Cross's insureds. We pointed out that the Clinic's contractual relationship was directly with the insured and did not include Blue Cross, and that the United States Supreme Court limits standing in overcharge cases to the direct purchaser. Judge Posner hurdled that argument by simply assuming the existence of a contract between Blue Cross and Marshfield—an assumption that is expressly contrary to the record and to the only case law presented to the court. That conclusion also has the potential for enormous practical consequences, none of which was discussed by our most famous judicial pragmatist.[26] Finally, Judge Posner failed to notice the full consequences of his quite proper conclusion that Blue Cross's attempt to equate "above average" prices with "supracompetitive" prices was nonsense. But Blue Cross's failure to compare Marshfield's prices with those of comparable

22. Richard A. Posner, *Judges' Writing Styles (And Do They Matter?)*, 62 U. CHI. L. REV. 1421, 1430 (1995).

23. Cert. Petition at 21, *Marshfield* (No. 95-1118).

24. 65 F.3d at 1409 ("[I]f there is a reasonable basis for this finding [of a separate HMO market] in the evidence, we are bound to accept it regardless of what we might think as an original matter.").

25. *Id.* at 1413 ("We are not authorized to abrogate doctrines that have been endorsed and not yet rejected by the Supreme Court . . . .").

26. *See infra* part IV.

providers of similar quality not only precludes a finding of "supracompetitive" prices, it removes any basis for a finding of antitrust injury.[27]

Of Winners and Losers

As a result of these omitted brush strokes, a sliver of Blue Cross's claim remains. The jury's finding that Marshfield's HMO had entered into a market division agreement with another HMO could survive, Judge Posner said, due to internal Marshfield documents indicating that the two HMOs had agreed "not to open offices in each other's territories."[28] Noting the lack of proof as to what portion of the $600,000 in "overcharge" damages awarded to Blue Cross could be attributable to this particular market division agreement, the court remanded the case for a new trial on damages as to that single claim. Based upon this holding, Blue Cross actually declared Judge Posner's opinion a victory, or so their trial counsel announced to the Milwaukee papers: "This means that we have won."[29]

Well, let's think about that. Blue Cross's damages award, once as much as $48 million, was vacated. Compcare, to whom ninety percent of the damages had been awarded, was removed from the case entirely. The award of attorney fees and costs was vacated. The "sweeping injunction,"[30] which at one time compelled the Clinic to deal with Blue Cross on "nondiscriminatory" terms and to stop charging "supracompetitive" prices, was vacated. Even the costs of the appeal were awarded to Marshfield.

As for the remand, Blue Cross has gone from nine theories, thirty markets, dozens of predatory acts, and literally hundreds of challenged agreements to one theory, one market, and one agreement. To establish damages, Blue Cross must prove that a market division agreement between two *HMOs* in a never-identified geographic area caused the price of services rendered to Blue Cross *indemnity* patients to rise above competitive levels. Blue Cross must do so, moreover, having already taken the position that each of the other agreements and predatory acts challenged—all since found to be legal—had caused the same price

27. *See infra* part V.
28. 65 F.3d at 1416.
29. Geeta Sharma-Jensen, *Ruled a Natural Monopoly: Appeals Court Softens Verdict in Marshfield Clinic Case*, MILWAUKEE J. SENTINEL, Sept. 19, 1995, at D1.
30. 65 F.3d at 1408.

rise. Connecting its damages to a specific claim is precisely what Marshfield maintained Blue Cross could never do and what Blue Cross argued it was not required to do. If damages are shown, moreover, any resulting injunction must be limited to forbidding future market division agreements.[31] Critically, Marshfield cannot be enjoined to "deal" with Blue Cross.[32] Thus, Blue Cross's hope of forcing its contract terms on Marshfield through litigation rather than hard bargaining—always the driving force of this dispute—has been dashed.

As with any debate over winners and losers, the key lies in defining the terms. I do not know what victory means to Blue Cross, but if Judge Posner's opinion feels like a win, losing must involve a human sacrifice.

II. THE HMO MARKET AND THE *MARSHFIELD* RECORD: "MY KINGDOM FOR AN ECONOMIST!"

At the conclusion of post-trial motions, the damages award to Blue Cross and its HMO, Compcare, was almost exactly $17 million after trebling. More than $15.2 million, however, represented lost profits to Compcare for being "excluded" from the HMO market by virtue of Marshfield's refusal to accept its contract terms.[33] If the market is overall health care financing, however, Compcare has not been excluded from anything because all other sellers in that market (most notably, Blue Cross's indemnity plan) compete vigorously without such a contract. Thus, as even the district judge agreed,[34] Compcare's award is necessarily gone unless there is a separate HMO market.[35]

Blue Cross contends that the court's rejection of its HMO market was not based on the sufficiency of the evidence but on

31. 65 F.3d at 1416.
32. *Id.*
33. Cert. Petition at 7, *Marshfield*, 116 S. Ct. 1288 (1996) (No. 95-1118).
34. *Marshfield*, 883 F. Supp. 1247, 1253 (W.D. Wis. 1995).
35. No plaintiff to date has succeeded in claiming that HMOs comprise a product market distinct from other forms of health insurance. *See* U.S. Healthcare, Inc. v. Healthsource, Inc., 986 F.2d 589, 598-99 (1st Cir. 1993) (affirming fact finder's rejection of HMO market); Ball Memorial Hosp., Inc. v. Mutual Hosp. Ins., Inc., 784 F.2d 1325, 1331 (7th Cir. 1986) (affirming rejection of alleged "HMO services" market); National Benefit Adm'rs, Inc. v. Blue Cross & Blue Shield of Ala., Inc., 1989-2 Trade Cas. (CCH) ¶ 68,831, at 62,372 (M.D. Ala. 1989), *aff'd*, 907 F.2d 1143 (11th Cir. 1990); Hassan v. Independent Practice Assocs., P.C., 698 F. Supp. 679, 695 n.47 (E.D. Mich. 1988) (granting summary judgment). *See also* Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of R.I., 692 F. Supp. 52, 68 (D.R.I. 1988) (market is a "means to finance health care"), *aff'd*, 883 F.2d 1101 (1st Cir. 1989), *cert. denied*, 494 U.S. 1027 (1990).

exotic economic theories imposed by Judge Posner as a matter of law.[36] If he was unclear on this point, it was not for lack of trying: "Compcare persuaded the jury that HMOs constitute a separate market . . . and if there is a reasonable basis for this finding in the evidence, we are bound to accept it regardless of what we might think as an original matter."[37] Nor did Judge Posner break new ground in stating the standard for product market definition: "In defining a market, one must consider substitution both by buyers and by sellers."[38] For this Judge Posner cites Professor Areeda, hardly a "Chicago school radical" of the type Blue Cross attempted to demonize in its petition for certiorari.[39] Substitution by buyers goes by several polysyllabic names, such as demand substitutability, interchangeability, and (price) cross-elasticity of demand; the essential inquiry is whether a consumer is so likely to switch to product B if the price of product A rises that a monopoly of product A would be fruitless. Far from novel, the cases establish that no product market finding can be sustained without proof that the market includes all products deemed "reasonably interchangeable by consumers."[40] Even *Brown Shoe*, the 1962 United States Supreme Court case on which plaintiffs principally relied, makes the same point: "[T]he boundaries of the relevant market *must* be drawn with sufficient breadth to include . . . competing products . . . ."[41]

Plaintiffs have argued that *Brown Shoe* lists several "factors" relevant to product market analysis, such as different product features, and that these factors can produce a "submarket" for product A standing alone, even if consumers regard product B as a good substitute. I am aware of only one district court that has accepted this view, and that decision was promptly reversed by the Sixth Circuit in *White & White, Inc. v. American Hospital Supply Corp.*[42] It is now accepted among circuit courts that the "practical indicia" of submarkets discussed in *Brown Shoe* are simply "evidentiary proxies for direct proof of substitut-

36. *See, e.g.,* Cert. Petition at 10-11, *Marshfield* (No. 95-1118).

37. 65 F.3d at 1409.

38. *Id.* at 1410 (citing IIA PHILLIP E. AREEDA ET AL., ANTITRUST LAW: AN ANALYSIS OF ANTITRUST PRINCIPLES AND THEIR APPLICATION ¶ 530a (1995)).

39. Cert. Petition at 21-22 n.19, *Marshfield* (No. 95-1118).

40. United States v. E.I. du Pont de Nemours & Co., 351 U.S. 377, 394-95 (1956).

41. Brown Shoe Co. v. United States, 370 U.S. 294, 326 (1962) (emphasis added).

42. 723 F.2d 495, 502 (6th Cir. 1983).

ability."[43] I know of no contrary view, and none was presented to the Seventh Circuit by Blue Cross.

Given this state of the law, the trial record on substitution by buyers is particularly dismal for Blue Cross. No consumer of HMO services—no enrolled employee, no sponsoring employer—testified at trial. No data on consumer views or reaction to price changes was presented by plaintiffs.[44] The only such data in the record came from *Marshfield's* expert, who described his interviews of large employers considering HMOs, all of whom acknowledged the interchangeability of competing plans.[45]

The expert economist for plaintiffs, moreover, directly contradicted the existence of a separate HMO market. First, he acknowledged that he had been retained to consider *all* of the markets affected by the alleged conduct of Marshfield and its HMO; he had not been limited or told to ignore any markets; and he was aware of the complaint's allegation that the defendants had monopolized the "HMO services" market.[46] Nonetheless, he had *not* concluded that there was a separate HMO market. Well, then, from what market had Compcare been excluded? Why, from the "health care financing" market, he responded, which includes HMOs and other health insurance plans.[47] This was devastating since, as the cases above hold, once two products are deemed interchangeable in "a broad market, there are no 'economically significant' submarkets."[48]

As if this record were not bad enough for plaintiffs, there were also dozens of admissions in the Blue Cross documents (as you might imagine) that HMOs and other health plans directly compete. While it is difficult to choose, my favorite is in the 1993 Form 10-K filed with the Securities and Exchange Commission. Under the heading "Competition," it stated: "The

43. Rothery Storage & Van Co. v. Atlas Van Lines, Inc., 792 F.2d 210, 218 (D.C. Cir. 1986), *cert. denied*, 479 U.S. 1033 (1987). *Accord, e.g.*, H.J., Inc. v. ITT Corp., 867 F.2d 1531, 1540 (8th Cir. 1989).

44. In their certiorari petition, plaintiffs claim that the district court upheld the verdict on the separate HMO market by making "specific reference to . . . consumer preferences . . . ." Cert. Petition at 11, *Marshfield*, 116 S. Ct. 1288 (1996) (No. 95-1118). No such reference can be found, either on the page plaintiffs cite or elsewhere in the opinion. *See Marshfield*, 883 F. Supp. 1247 (W.D. Wis. 1995).

45. Record at 2061-62, *Marshfield*, 883 F. Supp. 1247 (W.D. Wis. 1995) (No. 94-C-137-S).

46. *Id.* at 779-82.

47. *Id.* at 788-89.

48. II PHILLIP E. AREEDA & DONALD F. TURNER, ANTITRUST LAW: AN ANALYSIS OF ANTITRUST PRINCIPLES AND THEIR APPLICATIONS ¶ 535b at 419-21 (1978).

health care insurance industry is highly competitive. . . . Compcare and Valley[49] face substantial competition from other HMOs, PPOs, self-funded plans, the Parent [Blue Cross] and indemnity insurance carriers."[50] Another document identified Marshfield's HMO as one of the top three competitors of Blue Cross's *indemnity* plan.[51] We compiled no fewer than twelve such statements in a demonstrative exhibit.[52] No documents were discovered that even qualified much less contradicted this point.

This is not to say that plaintiffs ignored the issue entirely. After the economist testified, plaintiffs called their own HMO president, who was qualified as an "expert" on HMOs, and he opined that HMOs are a separate market from other plans. Our objection to his testifying as an expert was overruled even though he conceded that he had no background in economics, that this was the first time he had ever been asked to define a market, and that he had no expertise concerning other health plans (such as PPOs), even though he was about to testify that these plans were not in the same market as HMOs.[53] The cross-examination revealed that his opinion was based on the following: (a) HMO plans had different features than indemnity insurance and PPO plans, such as gatekeepers; and (b) even though many consumers did switch between HMOs and other plans (acknowledging that in the Marshfield area, consumers had switched from HMOs to indemnity plans, but he did not know to what extent), in his "experience" many consumers are quite loyal to HMOs. The latter point led to this telling exchange:

> Q: And there's [sic] some people who love Buicks. Is that right?
>
> A: There's [sic] some people who like Buicks, yeah. . . .
>
> Q: Is there a separate automobile market for Buicks? Does that make any sense?
>
> A: Yeah.[54]

Blue Cross made no mention of its HMO president's testimony in either its Seventh Circuit brief or its petition for certio-

49. Referring to another Blue Cross HMO, Valley Health Plan. *See infra* note 62 and accompanying text.

50. Exhibit 236 at 18, *Marshfield*, 883 F. Supp. 1247 (W.D. Wis. 1995) (No. 94-C-137-S).

51. Exhibit 884, *Marshfield* (No. 94-C-137-S).

52. *Id.*

53. *See* Brief in Support of Defendants' Motion in Limine to Exclude Expert Testimony of Jeffrey J. Nohl, *Marshfield* (No. 94-C-137-S).

54. Record at 1147, *Marshfield* (No. 94-C-137-S).

rari—a wise choice in my view. But this evidence fails to support the jury's finding not just because it is so feeble, or even because contrary evidence from Blue Cross's fact witnesses, economist, and sworn statements to the SEC overwhelmingly refutes it. The HMO president's testimony is insufficient because it critically fails to address the controlling issue of *interchangeability*. An antitrust chestnut is that the existence of different product features—the very essence of product differentiation—is meaningless if consumers view the products as substitutes for the same end use. (A case about glass and metal containers comes to mind.[55]) The well-prepared testimony of one of Blue Cross's employees demonstrates how plaintiffs simply do not get the point of interchangeability:

> Q: Do [Blue Cross indemnity] products compete with Security Health Plan?
>
> A: We compete for the same prospects. But no, I don't believe that we compete *with* the same product because I—they're different products.[56]

As for product loyalty by "some" consumers, Judge Posner himself previously pointed out that because sellers do not know which consumers are especially loyal or especially in need of a particular product feature, they must aim for the marginal consumer who reacts to changes in price and quality.[57] Anyone who thinks that Buicks *are* a separate automobile market need only look at the cases collected in *Tunis Bros. Co. v. Ford Motor Co.*[58] to find that the argument has been repeatedly rejected through the years—ever since the car in question was a Packard.

In its certiorari petition, Blue Cross abandoned all pretense that its evidence addresses the actual substitution of health plans by consumers. It relies entirely on the "practical indicia" of sub-

55. *See* United States v. Continental Can Co., 378 U.S. 441, 449 (1964).

56. Record at 631, *Marshfield* (No. 94-C-137-S) (emphasis added). In their appellate brief, plaintiffs asserted that they had presented "customer surveys," Appellees' Brief and Supplemental Appendix at 26, *Marshfield*, 65 F.3d 1406 (7th Cir. 1995) (Nos. 95-1965, 95-2140), but nothing they cited even addresses substitution between health plans. Blue Cross tacitly conceded the point by citing such surveys only for the proposition that HMOs are "distinct from other forms of health care financing." *Id.* As shown, however, distinct product features are not enough to establish a separate market if the "distinct" products are freely substituted. Blue Cross did not cite this "evidence" in its petition for certiorari.

57. United States v. Rockford Memorial Corp., 898 F.2d 1278, 1284 (7th Cir.) ("diet soft drinks sold to diabetics are not a relevant product market"), *cert. denied*, 498 U.S. 920 (1990).

58. 952 F.2d 715, 723-24 (3d Cir. 1991) (rejecting jury finding that Ford tractors are a separate product market), *cert. denied*, 505 U.S. 1221 (1992).

markets under *Brown Shoe* and points to only two indicia: (1) A Marshfield employee "admitted" in an internal document that its HMO "could charge monopoly prices as long as it was the only *HMO* operating in the region";[59] and (2) HMOs, unlike other plans, are subject to government regulations that require "certain employers to offer their employees a separate HMO option."[60]

The first point is flatly inaccurate and, in any event, circular. It is not surprising that no Marshfield document admitted to "monopoly" pricing; what *may* be surprising is that at least ten other HMOs operate in "the region" allegedly monopolized by Marshfield—including Valley Health Plan, Blue Cross's joint venture with the Mayo Clinic.[61] (Marshfield's supposed monopoly "power" was somehow unable to deter the entry of that joint venture.) Furthermore, the point is circular: this internal statement only raises the question of whether the Marshfield employee was correct in asserting that Marshfield could charge monopoly prices, a question that can only be answered by an examination of objective, market-based evidence that is entirely missing from this record.

The government regulation cited as the second of the "practical indicia" actually refutes plaintiffs' argument. Even plaintiffs describe the governmental regulations on which they rely as "preclud[ing] other types of health plans from substituting for HMOs."[62] If these other health plans were *not* already substitutes for HMOs, there would be no need to preclude them from substituting. Assume that Wisconsin passed a law requiring any employer providing company cars to offer sport utility vehicles as an "option." Would that indicate that sport utility vehicles are *not* considered good substitutes for other cars? Just the opposite, it seems to me. Regulations that insist that HMOs be included on the list of options only indicate that HMOs have a better lobby than other plans, not that they do not compete.

These desperate arguments underscore the woeful state of the record for plaintiffs, not only because the arguments do not work, but because they are the *best* that plaintiffs can offer. These "indicia" are the extent of the evidence that plaintiffs can

59. Cert. Petition at 15, *Marshfield*, 116 S. Ct. 1288 (1996) (No. 95-1118).

60. *Id.* at 16.

61. Record at 2126-28 & Exhibit 957, *Marshfield*, 883 F. Supp. 1247 (W.D. Wis. 1995) (No. 94-C-137-S).

62. Cert. Petition at 16, *Marshfield* (No. 95-1118).

cull from this record to support the verdict. If the day should come when a separate HMO market is proven, a possibility left open by Judge Posner, the record will contrast sharply with the plaintiffs' diffident effort in *Marshfield*. The economic expert will support, rather than contradict, the conclusion; the party will present and the jury analyze genuine data on actual consumer substitution; and the party will not simultaneously claim that HMOs are good substitutes in a "market" but bad substitutes in a "submarket." Nor is this too much to ask. When looking at the sufficiency of the evidence, the standard is merely reasonableness: "The mere existence of a scintilla of evidence in support of the plaintiff's position will be insufficient; there must be evidence on which the jury could *reasonably* find for the plaintiff."[63] Under this or any other standard, Judge Posner's conclusion that the "record shows" that the buyers of health insurance "regard HMOs as competitive not only with each other but also with the various types of fee-for-service provider, including [PPOs]."[64] cannot seriously be disputed. Which only brings us to the second requirement of product market definition, substitution by sellers, sometimes called cross-elasticity of supply. If the maker of product C can easily convert its facilities to produce product A, then a monopoly of product A is still fruitless. (As soon as the price of product A is set too high, the makers of product C will enter the market and drive the price back down.) The plaintiffs did not address this proof requirement at all. Their economist had chosen the health care financing market, and no other witness addressed supply substitution. Otherwise, the record reflected that Blue Cross had pervasive PPO networks in northern and central Wisconsin, using many of the same doctors affiliated with Marshfield's HMO.[65] (Blue Cross never tried to explain why independent doctors would join their PPO but not their HMO.) Moreover, when asked by a client to do so, Blue Cross established a "great" network for a point-of-service plan in the counties immediately surrounding Marshfield in only ninety days,[66] a network admittedly indistinguishable from an HMO network.[67]

These facts, in our view, made it impossible for the record to support a conclusion under plaintiffs' "essential facilities" claim

63. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 252 (1986) (emphasis added).
64. *Marshfield*, 65 F.3d at 1410.
65. *See, e.g.*, Exhibit 862, *Marshfield* (No. 94-C-137-S).
66. Record at 332-33, 344 & 709, *Marshfield* (No. 94-C-137-S).
67. *Id.* at 1123-25.

that Blue Cross could not set up a competing HMO in northern Wisconsin without the Clinic's doctors. As Judge Posner's opinion demonstrates, moreover, these facts also render futile, at least without evidence specifically addressing the question of supply substitution, the argument that other network-based health care plans can be excluded from the definition of an "HMO market."

III. Most Favored Nation Clauses: "It's Academic"

While the trial record presented to the United States Supreme Court on the question of the HMO market could not be much worse, I must make one concession: at least the record reflects the *existence* of one or more HMOs. The same cannot be said of the other presented question, which purports to be based on the existence of express "most favored nation" clauses in Marshfield's affiliated provider agreements. Blue Cross's petition for certiorari describes the issue this way:

> Security [Health Plan] agreements provide that affiliated physicians will be compensated for services provided to Security subscribers *at their usual fee rates*—so long as the affiliated physicians further agree to a "most favored nation" ("MFN") clause preventing them from receiving *less* from any other patient or health plan.[68]

Elsewhere, Blue Cross repeatedly attacks the "use of MFN clauses within those agreements"[69] and the "*explicitly* exclusive agreements with other local physicians to keep out potential competitors."[70] One can almost hear a voice ring out at Mission Control: "Houston, we have a problem. We have checked the record in the *Marshfield* case and there are *no* MFN clauses. Please advise."

The Supreme Court could not have been happy about this. I consider it a genuine first to ask the Supreme Court to consider a case involving MFN clauses when the record fails to reveal any MFN clause. In truth, Judge Posner did make reference to MFNs and noted that such clauses are "not price-fixing,"[71] but he also described an HMO's economic incentive in blunt terms: "if you get very sick . . . [it is] to let you die as quickly and

68. Cert. Petition at 4, *Marshfield*, 116 S. Ct. 1288 (1996) (No. 95-1118).
69. *Id.* at 19.
70. *Id.* at 9.
71. 65 F.3d at 1415.

cheaply as possible."[72] (Ah, Posner!) No one represented to the Supreme Court that *that* is true.

How did Blue Cross inject this "MFN" discussion, then? One must follow the progression of the plaintiffs' argument that the agreement between Marshfield's HMO and its independent affiliates, without more, constitutes per se price fixing. At trial, this argument was in its most pristine form: Marshfield's HMO, which is owned by doctors, agreed with *other* doctors on the prices the HMO would pay to those other doctors for services rendered to HMO patients. With this agreement, they "fixed" the price. Get it?[73] On appeal, plaintiffs were understandably uncomfortable with the sophistication of the argument that an HMO purchasing physician services "fixes" a price every time it agrees on how much it is willing to pay for those services—an argument that has been expressly rejected by the First Circuit.[74] Thus, in the section of their appellate brief entitled "Price Fixing," plaintiffs described the HMO affiliate agreements as follows:

> The "Affiliated Provider Subcontract" enables Marshfield to review and approve the physicians' fee schedules annually. This is not, as Marshfield states, a "buyer and seller setting a price." Affiliated physicians must submit to Marshfield a schedule of their "usual and customary charges" and their Marshfield payment is based on that schedule. Obviously, Marshfield does not wish to pay the affiliates more than the affiliates charge their non-enrollee patients, and the practical result of the contracts is to establish a floor for *all* of an affiliate's charges, *not* just charges to Marshfield. Thus, the physician's fee schedule subject to Marshfield's approval is the only one in effect for all of the physician's patients.[75]

In this passage, note that (1) Blue Cross does not suggest that the "Affiliated Provider Subcontract" contains an MFN clause (for good reason, as we shall see), and (2) Blue Cross does not say that Marshfield pays 100% of any affiliate's usual and customary charge, only that "their Marshfield payment is *based* on that schedule" (words carefully chosen, as we also shall see). The facts contained in the first three sentences, moreover, de-

72. *Id.* at 1410.

73. I have described the price-fixing argument as it was made at trial in more detail elsewhere. *See* McDonald, *supra* note 17, at 12-13.

74. *See* U.S. Healthcare, Inc. v. Healthsource, Inc., 986 F.2d 589, 594-95 (1st Cir. 1993).

75. Appellees' Brief and Supplemental Appendix at 15, *Marshfield*, 65 F.3d 1406 (7th Cir. 1995) (Nos. 95-1965, 95-2140) (citations to record omitted).

scribe only a "buyer and seller setting a price." Only the fourth sentence states that the "practical result" of the contract is to "establish a floor" for all prices because the Clinic "[o]bviously" does not wish to pay more than others. This grand conclusion characteristically fails to find support from anything in the record. While words such as setting a "floor" under prices are antitrust code for the effect of MFNs, going from assuming a "practical result" similar to that of MFN clauses based on no record evidence to telling the Supreme Court that such clauses are expressly found in the contract is quite a leap.

To the contrary, the specific subparagraph from the affiliate agreement cited in Blue Cross's appellate brief provides as follows:

> 3.01 *Professional Fee.* Subject to the limitations outlined below, Clinic agrees to reimburse the Affiliated Provider(s) at a rate of eighty-five percent (85%) of the lesser of Provider's usual and customary charges and Plan's maximum allowable charge for covered care that is rendered to eligible Participants in Plan except as outlined below in Plan's Prepaid Medicare Program.[76]

Nothing in this clause requires the affiliate to charge any particular fee to anyone else. More to the point of an MFN, nothing stops the affiliate from giving a *larger* discount from its fees to anyone else. It is not surprising, then, that every affiliate asked testified that the HMO agreement with Marshfield had no effect whatsoever on the prices charged to any other patient.[77] Plaintiffs made no attempt to show the affiliates' other prices or even their discounts to other health plans (including plaintiff's very own Valley Health Plan). On this point, all the record shows is the contradictory language of the contracts and the flat denials of the affiliates.

The Marshfield provider agreements also put the lie to plaintiffs' assertion in the certiorari petition that HMO affiliates were given "lucrative" contracts *"at their usual fee rates."*[78] As shown, the agreement expressly provides for a discount of eighty-five percent or even lower, depending on the HMO's maximum allowed price. The notion that Marshfield pays 100% of the affiliates' requested charges was a point uncritically accepted on

76. Exhibit 1444 at 3, *Marshfield*, 883 F. Supp. 1247 (W.D. Wis. 1995) (No. 94-C-137-S).

77. Defendants-Appellants' Supplemental Appendix at 460, 463, 470, *Marshfield* (Nos. 95-1965, 95-2140).

78. Cert. Petition at 4, *Marshfield*, 116 S. Ct. 1288 (1996) (No. 95-1118).

post-trial motions by the district judge.[79] If he had read more carefully the three transcript pages cited by the plaintiffs in support of this position, he would have seen that the witness was describing not the initial fee-setting provision, but the operation of a *withhold* provision in the provider agreement.[80] After Marshfield's HMO and the affiliate agree on the reimbursement schedule, the HMO initially pays ninety percent of the agreed-upon amount (the eighty-five percent amount) and withholds the remaining ten percent. At year end, based on a series of efficiency incentives, some or all of the ten percent is paid to the affiliate. This witness simply observed that, in several consecutive years, the affiliate had received the full ten percent withheld, or 100% of *what the HMO had previously agreed to pay.*[81] No person familiar with an HMO or with this record could argue in good faith that this evidence somehow refutes the existence of the express discount in the provider agreements.

Back to Judge Posner. Considering plaintiffs' claim of price fixing, he moved at breakneck speed to react to plaintiffs' reference to the "floors" under prices:

> [T]he only evidence of collusion is that the Clinic, when buying services from the affiliated physicians either directly or through Security [Health Plan], would not pay them more than what these physicians charge their other patients. This is said to put a floor underneath these physicians' prices, since if they cut prices to their other patients their reimbursement from the Clinic will decline automatically. This is an ingenious but perverse argument. "Most favored nations" clauses are standard devices by which buyers try to bargain for low prices, by getting the seller to agree to treat them as favorably as any of their other customers. The Clinic did this to minimize the cost of these physicians to it, and that is the sort of conduct that the antitrust laws seek to encourage. It is not price-fixing.[82]

Make no mistake. This was the first time in this litigation that the phrase "most favored nations" was used to describe these agreements. (Ironically, the *only* occasion on which the term was mentioned in the trial court was when Blue Cross requested a provision in the injunction to require Marshfield to give Blue

79. *Marshfield*, 883 F. Supp. 1247, 1259 (W.D. Wis. 1995).

80. Record at 868-70, *Marshfield* (No. 94-C-137-S) ("Are you familiar with an arrangement known as a withhold?").

81. *Id.*

82. 65 F.3d at 1415 (citations omitted).

Cross an HMO provider contract *that was to include an MFN clause*. The Judge declined.)

Judge Posner's MFN language understandably caused the gnashing of teeth by lawyers at the Department of Justice, but when they asked him to soften it, he did (by noting that there was no evidence in this record of any anticompetitive consequences of any MFN).[83] The key statement in his single paragraph, however, is the observation that MFNs do not constitute "price-fixing." No one, to my knowledge, has ever argued that they *do* constitute price fixing—not even the DOJ. But that is plaintiffs' only theory on MFNs here (remember, the "practical result" argument appeared under the heading "Price Fixing" in their brief). As we repeatedly pointed out below, Blue Cross never tried to link any affiliate agreement to any one of the markets they defined nor tried to show the impact of any affiliate agreement ("practical" or otherwise) on such a market. Thus, there is no shot at this being a "rule of reason" case, even if the record could be made to yield an MFN clause—and it cannot.

In this instance, Judge Posner's analysis has the effect of improving plaintiffs' argument factually but still rejecting it legally on grounds that are unassailable. His discussion of MFNs is best construed as an acknowledgment that the jury's finding of price fixing cannot stand, even granting Blue Cross the full benefit of its unsupported argument that the pricing provisions of the provider agreements "practically" act as MFN clauses—indeed, even if there were *express* MFNs.

IV. Indemnity Insurer Standing: Assume a Can Opener

On the question of standing, an HMO such as the plaintiff Compcare is different from an indemnity insurer such as the plaintiff Blue Cross. As a prepaid plan, an HMO contracts directly with providers like Marshfield for health care services and then sells them as a package to its enrollees. If, as the result of an antitrust violation, the price the HMO pays to a provider is supracompetitive, the HMO would have standing to sue for those overcharges. The patient/enrollee, however, would not have standing, because its contractual relationship is with the HMO only; the patient is not a "purchaser" with respect to the provider.

83. *Id.*

With an indemnity plan, just the reverse is true. The patient purchases services from any provider the patient chooses and is reimbursed by the insurer for some or all of the charges. In that case, it is the *patient* who has standing, not the insurer. That, in any event, is the teaching of recent Supreme Court decisions like *Associated General Contractors, Inc. v. California State Council of Carpenters*,[84] and a raft of Seventh Circuit cases that have limited antitrust standing, even more strictly than some other Circuits, to consumers and competitors.[85] Because an indemnity insurer does not purchase services from the provider, the indemnity insurer simply stands as a third party in a contractual relationship with the real purchaser—the patient—and is precisely the type of party that lacks standing.

> In torts, a leading treatise on damages set[s] forth the general principle that, [w]here the plaintiff sustains injury from the defendant's conduct to a third person, it is too remote, if the plaintiff sustains no other than a contract relation to such a third person, or is under contract obligation on his account, and the injury consists only in . . . increasing the plaintiff's expense or labor of fulfilling such contract . . . .[86]

A line of cases that Blue Cross cites as contrary actually relies on this very distinction. As HMOs developed, litigants often argued that they were not "really" purchasers of medical services, despite their express contracts with providers. Some even argued that doctors were ethically barred from "selling" to insurance companies, so the patients *had* to be considered the "purchasers" for all purposes. These were weak arguments. In one of the best-known cases, then Judge Breyer of the First Circuit Court of Appeals rejected them, observing that insurers were not limited to the option of reimbursement but, if they chose, could purchase the services directly themselves: "[T]here is no law forbidding a legitimate insurance company from *itself* buying the goods or services needed to make its customer whole."[87] When insurers choose to do so, they are purchasers

84. 459 U.S. 519 (1983).

85. *See, e.g.*, Greater Rockford Energy & Tech. Corp. v. Shell Oil Co., 998 F.2d 391 (7th Cir. 1993), *cert. denied*, 114 S. Ct. 1054 (1994); Southwest Suburban Bd. of Realtors, Inc. v. Beverly Area Planning Ass'n, 830 F.2d 1374, 1379 (7th Cir. 1987); *In re* Indus. Gas Antitrust Litig. (Bichan v. Chemetron Corp.), 681 F.2d 514 (7th Cir. 1982), *cert. denied*, 460 U.S. 1016 (1983).

86. *Associated Gen. Contractors*, 459 U.S. at 532 n.25 (alteration in original; citation omitted; emphasis deleted).

87. Kartell v. Blue Shield of Mass., Inc., 749 F.2d 922, 928 (1st Cir. 1984), *cert. denied*, 471 U.S. 1029 (1985) (emphasis added).

for purposes of the antitrust laws, no matter what the rules of medical ethics may provide.[88] However, there is nothing in this language or these holdings to suggest that where an insurer does *not* choose to act as a direct purchaser, it will still be considered a "purchaser" along with the patient. It is crucial, therefore, that the only court opinion in this line to turn on the question of standing expressly notes that the direct purchase of services by a prepaid Blue Shield plan had removed the *patient* as a purchaser, and, therefore, the insurance company was the *only* party with standing to challenge the anticompetitive conduct of the providers.[89]

Thus, we argued that while Compcare had standing to pursue its essential facilities claim, Blue Cross had no standing as an indemnity insurer to claim that Marshfield was guilty of monopolistically pricing services that Blue Cross does not buy. To support this argument on appeal, we had a record that was crisp and clean: Blue Cross witnesses conceded that, as an indemnity insurer, they had no contract with the provider.[90] The HMO president himself noted that the direct provision of services by an HMO means that it is "not just a financial mechanism as indemnity insurance is."[91] Marshfield's agreements with its patients expressly provide that the patient is responsible for the bill no matter what kind of insurance is carried, and Blue Cross's agreements with its insureds expressly *disclaim* any obligation to the provider.[92]

With that record, the only question is whether Blue Cross has standing because, as a convenience to its insured, it sends a check for its portion of the claim directly to the Clinic, and the Clinic accepts it on the patient's behalf. Can that be enough? When one's monthly car payment is deducted automatically from the checking account, has the bank thereby "purchased" an automobile? Think about it. The funds are not sitting at the bank like an old bunk bed in a storage bin to which the owner has the only key. They are invested, and the bank makes its

88. *Id.* at 926.

89. Pennsylvania Dental Ass'n v. Medical Serv. Ass'n, 815 F.2d 270, 276 (3rd Cir.), *cert. denied*, 484 U.S. 851 (1987) ("This injury—i.e., the payment of overcharges . . .—is unquestionably an injury suffered by Blue Shield *alone*. No one else can possibly complain about it.").

90. Record at 108, 1129-30, *Marshfield*, 883 F. Supp. 1247 (W.D. Wis. 1995) (No. 94-C-137-S).

91. *Id.* at 1127.

92. Exhibit 385 at 57-58; exhibits 563 & 568, *Marshfield* (No. 94-C-137-S).

living from the difference between what it earns on those investments and what it pays it customers in interest. The bank transfers the monthly car payment only because it is contractually bound *to the customer owner* to do so. If the amount it transfers is more than it should be, the bank is injured because it loses the float on the amount it has "overpaid." So, if one happened to buy a Buick (sorry, I cannot resist) and the monthly payment therefor reflects a monopoly overcharge, does the bank have antitrust standing? (Put 10,000 of these cases together and there would be a nifty suit against General Motors by Bank of America.)

Not so under *Associated General Contractors*. Both the bank in the example and Blue Cross here are parties in a "contract relation" to the real customer, and the "injury consists only in . . . increasing [their] expense or labor of fulfilling such contract . . . ."[93] Blue Cross's standing argument works only if Blue Cross has become a party to the original contract by transferring money owed by the patient to the Clinic. For that, we looked at state contract cases; we found only one, but it was precisely apposite. In *Erika, Inc. v. Blue Cross & Blue Shield of Alabama*,[94] the question presented was whether payments by Blue Cross directly to a provider on its insured's behalf creates a contract between Blue Cross and the provider. The answer was no; the court found that Blue Cross was simply acting as the agent for the patient in making the payment.[95]

Judge Posner, to his credit, did not buy the argument that one who transfers money on the client's behalf—as brokers, escrow agents, or (gasp) lawyers commonly do—thereby becomes a purchaser entitled to sue for any flaw in the underlying transaction. Instead, he found another way to establish standing:

> The Supreme Court has been emphatic that only the direct purchaser from an allegedly overcharging defendant has standing to maintain an antitrust suit. . . . But here the money went directly from Blue Cross to the Clinic, and although the two entities were not linked by any overarching contract, *each payment and acceptance was a separate completed contract.* We do not think more is required to establish Blue Cross's right to sue to collect these overcharges.[96]

93. *Associated Gen. Contractors*, 459 U.S. at 532 n.25.
94. 496 F. Supp. 786 (N.D. Ala. 1980).
95. *Id.* at 787-88.
96. *Marshfield*, 65 F.3d at 1414 (emphasis added).

This passage, more than any other, reflects Judge Posner's famous devotion to economic thought. For just as the stranded economist in a rowboat with sealed tins of food thinks he can avoid starvation by "assuming" a can opener, Judge Posner avoids a legal hurdle by assuming a contract—created by the simple transfer of money. As shown, however, this assumption has support in neither the facts in the record nor the common law.[97]

The potential practical consequences of this reasoning are daunting. Now, anyone who pays a sum on a debtor's behalf has standing to sue the creditor for breaches of the agreement creating the debt. No assignment is necessary; for an insurance company, no state law of subrogation, with all of its nuances developed over more than a century, is required or relevant. Judge Posner voiced concern about the practical problems inherent in the patient suing for amounts already reimbursed by the insurer. But why is that concern so much more important in an antitrust case than in a personal injury case or any other where damages are routinely covered by insurance? There is no pretense, moreover, that the patient may *not* also bring suit for precisely the same wrong—yet it is to avoid such duplicative litigation that the law of antitrust standing has grown so rigorous in recent years.[98]

97. Those of you with encyclopedic knowledge of antitrust law may be wondering how any discussion of standing in a health insurance context could proceed this far without mentioning *Blue Shield of Va. v. McCready*, 457 U.S. 465 (1982), the case in which a patient was permitted to challenge an insurance company's alleged effort to keep certain providers (psychologists) out of the market. *McCready*, however, neither helps Blue Cross nor resolves the standing issue here. The most obvious reason is that McCready made no claim for overcharges, and even Justice Brennan conceded that standing in an overcharge case is strictly limited to the direct purchaser. *Id.* at 474. (Thus, Judge Posner did not rely on *McCready*.) Beyond that, the patient's claim in *McCready* was that a concerted refusal to deal *with her* had reduced competition in a psychotherapy market in which she was a consumer. *Id.* at 475. These facts have hindered attempts to read *McCready* broadly. Within a year of its issuance, *McCready* was described by the Supreme Court as affirming standing for "the direct victim of a boycott." *Associated Gen. Contractors*, 459 U.S. at 530 n.19. A Seventh Circuit panel including two of the judges, Posner and Bauer, who heard the *Marshfield* appeal squarely held post-*McCready* that antitrust standing is limited "to those who, as consumers or competitors, suffer immediate injuries . . . ." *In re* Indus. Gas Antitrust Litig., 681 F.2d 514, 520 (7th Cir. 1982). Moreover, a subsequent decision by the Ninth Circuit extending standing beyond consumers and competitors was accompanied by a searing dissent from then-Judge Anthony Kennedy, who explained the limited holding of *McCready* and its relation to *Associated Gen. Contractors*. Ostrofe v. H.S. Crocker Co., 740 F.2d 739, 749 (9th Cir. 1984).

98. *Associated Gen. Contractors*, 459 U.S. at 541-42.

What is the nature of this "contract" that has been invented? If Marshfield treats a Blue Cross patient who refuses to pay, can Marshfield sue Blue Cross for its eighty percent? As you might imagine, Blue Cross has never been subjected to (or heard of) such a suit. Nor has Blue Cross ever intervened as a party in a suit between Marshfield and a Blue Cross patient. If Marshfield renders inadequate care to a patient, which care Judge Posner now deems to have been partially "purchased" by Blue Cross and resold to the insured, can the patient sue Blue Cross for malpractice?

All of these issues deserve thorough treatment, which undoubtedly will be rendered in a future case. In the meantime, Blue Cross has dodged a bullet that should have made this case even easier than it is.

V. Antitrust Injury and Monopoly Overcharges: Not Your Average Prices

An aspect of this case that has generated significant comment is the plaintiffs' argument that the Clinic's prices were "supracompetitive."[99] Before the appellate opinion, I had identified this issue as one of the three most worrisome for any integrated practice that strives for technological sophistication and exceptional quality.[100] Some have interpreted Judge Posner's almost condescending rejection of plaintiffs' argument[101] as imposing a tougher standard than previously existed for proving monopoly overcharges.[102]

Understanding two points, I think, can assuage these worries. First—and again—the record is a dismal failure for persuading anyone that Marshfield's prices reflect anything other than its concededly exceptional quality and facilities. The antitrust case law provides established ways to adjust for quality and prove monopoly prices, but these methods were eschewed by the plaintiffs (because they produce the wrong result). Second, the plaintiffs thought their proof of "high prices" could carry a very high burden. Proof of "above average" prices *without more*, they argued, could establish monopoly power, predatory con-

99. *See, e.g.*, Melinda R. Hatton, *Marshfield Wins! The Appeals Court Vindicates Marshfield Clinic*, Group Prac. J., Nov.-Dec. 1995, at 12, 13.

100. *See* McDonald, *supra* note 17, at 13.

101. Recall his statement quoted above: "Generally you must pay more for higher quality." 65 F.3d at 1412.

102. James T. McKeown, *7th Circuit: HMO Isn't a Monopoly,* Nat'l L.J., Jan. 22, 1996, at B7, B11.

duct, antitrust injury, and damages. It is one thing to prove a monopoly and *then* show that the price level is what one expects: above competitive levels. It is quite another to say that a "high" price level alone proves both the fact of monopoly and the overcharge.

Taking the latter point first, Judge Posner addressed plaintiffs' proof of price levels when considering the question of monopoly power. The traditional indicator of monopoly power is a high market share; anywhere south of fifty percent generally prevents the inference of monopoly power based on share.[103] As discussed in the Introduction above, Judge Posner had already rejected the markets Blue Cross had defined. He went on to note that, even in plausibly defined markets for physician services, the plaintiffs had no chance of showing monopoly power through market share because there was no basis for including in Marshfield's share *all* sales by independent physicians who happened to be affiliated with Marshfield's HMO. Without the affiliates, Marshfield's share of even the badly defined markets was insufficient.

That is where Judge Posner turned to prices. Plaintiffs had argued that they did not need to show monopoly power through market share because their evidence that the Clinic was able to charge monopoly prices by itself could support the finding: "Compcare also asked the jury to infer monopoly power directly from the Clinic's high prices . . . ."[104] You can see how quickly this argument assumes its answer; one cannot very well charge a "monopoly" price without monopoly power, so if we call the prices "supracompetitive" (and the jury agrees), bingo: the essential element of monopoly power is established.

Think of how this works in a case where the accused monopolist has a *low* market share. Low market share speaks directly to the central inquiry of market power: the ability of other sellers, either in or out of the market currently, to respond to the defendant's high prices by increasing their own output.[105] Evidence of high market share can never answer the monopoly question completely because it says nothing of the ability of new entrants to supply the product.[106] *Low* market share, on the

103. *Marshfield*, 65 F.3d at 1411.
104. *Id.*
105. Indiana Grocery, Inc. v. Super Valu Stores, Inc., 864 F.2d 1409, 1414 (7th Cir. 1989).
106. *E.g.*, Will v. Comprehensive Accounting Corp., 776 F.2d 665, 671-72 & n.3 (7th Cir. 1985), *cert. denied*, 475 U.S. 1129 (1986). *See also* Los Angeles Land Co. v.

other hand, indicates that even those currently in the market—regardless of potential new entrants—can expand output if the defendant charges a monopoly price.

If that is the state of the record, as it is here, it is extremely difficult to show monopoly power from prices alone. Judge Posner did not expand the opinion to cover all of these preliminary (and, to him, obvious) points, but the Seventh Circuit has discussed the issue in more detail elsewhere. In *Valley Liquors, Inc. v. Renfield Importers, Ltd.*,[107] the court stressed that market power "can rarely be measured directly" by consideration of price or output and suggested that the evidence necessary to support such an argument would "require[ ] sophisticated econometric analysis."[108] This is as it should be; it requires compelling evidence to explain why the many competitors of the defendant currently in the market will watch the defendant reap monopoly profits without responding.

Returning to the first point (what was the record?), Blue Cross offered several of its own employees (one of whom was an "expert" from Blue Cross's wholly owned consulting subsidiary) to testify that Marshfield's charges were higher than the average price for the same service charged by *all* Wisconsin providers. Such evidence, of course, ignores quality, reputation, and overhead, not to mention investment in education, research, and massively expensive equipment. But no Blue Cross witness made any effort to adjust these prices for quality, or to compare Marshfield with comparable providers. Marshfield's charges were simply lumped with those of solo practitioners, poverty clinics, and every other provider in Wisconsin. During the case presented by the defense, we introduced the price comparisons of providers found in the files of two *other* Wisconsin insurance companies—Blue Cross's direct competitors. These comparisons had been prepared prior to this litigation and showed that Marshfield's charges fell in the middle of the pack of mid- to large-sized clinics in Wisconsin and Minnesota.[109]

Brunswick Corp., 6 F.3d 1422, 1425-26 (9th Cir. 1993) (a 100% share does not prove market power unless the defendant could prevent new entry), *cert. denied*, 114 S. Ct. 1307 (1994).

107. 822 F.2d 656 (7th Cir.), *cert. denied*, 484 U.S. 977 (1987).

108. *Id.* at 668 (citations omitted).

109. Record at 1578-79, 1602-03, 1606, *Marshfield*, 883 F. Supp. 1247 (W.D. Wis. 1995) (No. 94-C-137-S). On one list of such clinics, Marshfield's charges ranked seventh out of ten; all of the clinics on the list exceeded the statewide "average," as you would expect.

On this record, it is hardly surprising, or momentous, that Judge Posner concluded that a naked comparison with statewide average prices says nothing useful to an antitrust court. This is not a case where a defendant was shown to have ninety percent of the market and to be charging prices thirty percent higher than one could find in a comparable, less concentrated market. Rather, the record showed only that a provider, with a low market share and quality alleged to be so exceptional that it was "essential," charged prices that were above the average prices of all other providers. If that is all one has, one is in trouble.

Nor is there anything newly burdensome in this for the plaintiffs. Antitrust treatises discuss several ways in which monopoly "overcharges" can be established. One can use a "before or after" method or a "yardstick" method, by which prices in the monopolized market are compared with prices in a (real or hypothetical) competitive market. Blue Cross was aware of these methods, for its expert at the damages trial made a halfhearted attempt at using a "yardstick" method to quantify the overcharges. (His analysis was remarkable for the fact that the "yardstick" he chose as a "competitive" market was an area located *inside* the market Marshfield had supposedly monopolized.) Why Blue Cross elected to hold this evidence until the damages trial is a mystery. In any event, when the jury made its *liability* findings that Marshfield charged "supracompetitive" prices and that Blue Cross had therefore suffered an antitrust injury, it had before it only evidence that Marshfield's prices were above the statewide "average."

Judge Posner, therefore, did not follow his analysis where it leads. Blue Cross's only alleged injury was the payment of overcharges (Compcare's injury was lost profits due to exclusion from the HMO market). When that is the claim, comparison with average prices is insufficient to establish even the *fact* of injury. Under the Clayton Act, antitrust injury is an essential element of every private antitrust claim and must be proven to establish liability, not just to quantify damages. A supracompetitive price is one shown to be higher than the price the same seller would charge in a comparable but competitive market. Evidence that prices are higher than "average" with no adjustment for cost or quality cannot support a finding of antitrust injury, especially when the average is taken from an area (here, the state of Wisconsin) not even claimed to be a market, much less a competitive one. After eliminating all of Compcare's

claims for lack of an HMO market, the court should have eliminated all of Blue Cross's claims for lack of an antitrust injury.

CONCLUSION

Imagine that you commissioned Marc Chagall to paint a mural, but he could only do so while being towed past the wall at ten miles per hour. The result would be something like the opinion Judge Posner produced in *Marshfield*: some portions with the expected brilliance, others that could have been improved by a more deliberate touch, and still others that were missed entirely. When one combines the boundless scope of plaintiffs' theories, the shocking gaps in the record, and the frenetic pace of the analysis (the Judge returned from one brief aside saying, "Forget all that . . . ."[110]), one is not surprised that the opinion is occasionally hard to follow. Judge Posner does not feel the need to unpack every argument, nor should he; when an expert draws two circles, one entirely inside the other, and then announces that they are separate geographic markets for the same product, little needs to be said.

In the end, an antitrust plaintiff must live with the choices made in litigating a claim. At trial, Blue Cross concentrated on two issues, chosen for their jury appeal: (1) the Clinic charges "high" prices, and (2) some Clinic doctors were mean to other doctors, making the Clinic look like a bully. This obviously played well to the jury. However, when the legal theory is that the defendant has committed every antitrust violation known to exist and some that are not (note the claim for "monopoly leveraging"), there is a grave risk that the record produced will support the essential elements of none. Analysis of the two issues Blue Cross selected for certiorari vividly underscores the point. The first issue—the HMO market—turns on a record lacking the most basic evidence of market definition (economic opinion and consumer substitution) and failing to address supply substitution entirely. The second issue—most favored nation clauses—is a fabrication.

Before it was reversed, the outcome of the *Marshfield* case was of vital importance to the growth of integrated health care, especially in rural areas. Now, the Seventh Circuit's opinion is important in the sense that any case rejecting specious and facile antitrust arguments is important. It should deter other well-

110. 65 F.3d at 1415.

heeled players in the health care industry from choosing baseless litigation as a shortcut to competitive success. For if others are tempted to follow Blue Cross's path, they may at some point seek the counsel of someone familiar with this case. I can see the room and hear the question: "But even if we put this past a jury, what happens on appeal?" Now I see the wise counselor leaning back, eyes half-closed. Now I hear a sigh: "Ah . . . ."

Postscript: After this article was submitted for publication, the Supreme Court of the United States issued an order on March 18, 1996, denying Blue Cross's petition for a writ of certiorari. Although the Court adhered to its usual practice of stating no reason whatsoever for its denial of certiorari, the author is persuaded that six or more of the Justices have subscribed to each and every argument he has presented here. As of this writing, Blue Cross has not yet described the denial of its petition for certiorari as a victory.