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## Private Antitrust as a Public Good<sup>1</sup>

### *Blue Cross and Blue Shield United of Wisconsin and Compcare Health Services Insurance Corp., v. The Marshfield Clinic and Security Health Plan of Wisconsin, Inc.*

by Warren Greenberg

In February 1994, Blue Cross and Blue Shield United of Wisconsin ("Blue Cross") and its wholly-owned health maintenance organization ("HMO"), Compcare Health Services ("Compcare"), brought suit against the Marshfield Clinic ("Marshfield"), a group of 400 physicians, and its wholly owned HMO, Security Health Plan, for their alleged violations of Sections 1 and 2 of the Sherman Act<sup>2</sup> as well as State of Wisconsin antitrust statutes.<sup>3</sup>

Blue Cross asserted in its Complaint that Marshfield Clinic physicians would not negotiate in good faith with Compcare and, in particular, would only allow a modest discount on charges for Marshfield physicians who would contract with Compcare HMO.<sup>4</sup> Moreover, Marshfield Clinic physicians would not accept any utilization controls on physician services. In addition, Blue Cross asserted that it was paying higher fees for physician services because the north-west Wisconsin area was monopolized by Marshfield.

Blue Cross sought relief which would allow its HMO to enter the market on reasonable payment terms. It asked for the removal of barriers-to-entry in phy-

sician primary care and specialty markets. In addition, Blue Cross sought the divestiture of a number of satellite primary care clinics which Marshfield Clinic had previously purchased from independent physicians. Finally, Marshfield Clinic was to be prohibited from allocating markets with a number of nearby HMOs and clinics.

Although Compcare and Blue Cross would gain from the lower fees negotiated with Marshfield physicians, and would potentially benefit from a more competitive physician services market, there are significant costs in litigating this case. Moreover, other managed care plans and insuring organizations in the geographic area might reap the benefits of a potential Blue Cross victory and a more competitive market without bearing the costs of litigation. In short, they might be able to free ride on the po-

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tential success of Blue Cross.

This paper will first describe Marshfield in more detail. Second, it will describe the benefits that Blue Cross would receive from winning this case and will estimate the costs to Blue Cross in this litigation. The paper also will estimate the potential benefits to third parties if Blue Cross were to win this case. Finally it will estimate the public good aspects of this case, and identify the market characteristics under which firms will bring antitrust cases when others will be able to benefit from the result.

### *Blue Cross and Blue Shield v. Marshfield Clinic*

The Marshfield Clinic is the fifth largest clinic in the United States. It consists of 400 physicians, 300 of whom practice at the Marshfield Clinic in Marshfield, Wisconsin.<sup>5</sup> In addition to the Marshfield Clinic headquarters, the Clinic owns and operates 23 satellite clinics throughout northwest Wisconsin. There are between three and fifteen physicians at each of these clinics with many of the physicians practicing primary care medicine. Most of the physicians at the Marshfield Clinic headquarters are specialty care physicians. Marshfield physicians are paid on a salary basis.<sup>6</sup>

Since 1986 the Marshfield Clinic has been sole owner of Security Health Plan ("SHP"), an individual practice association ("IPA") HMO based in Marshfield, with 300 non-Marshfield employed physician affiliates and approximately 70,000<sup>7</sup> enrollees throughout northwest and central Wisconsin. The physician affiliates are paid on a capitated basis, and are required by contract to refer all of their SHP patients to Marshfield for specialized care.<sup>8</sup> The physician

affiliates also see non-SHP patients and many of these patients are referred to the Marshfield Clinic for specialty services as well.

The Marshfield Clinic also controls the 524-bed St. Joseph's Hospital, the largest hospital in the Northwest Wisconsin market. It is a nonprofit hospital owned and operated by the Sisters of the Sorrowful Mother. Only physicians employed by the Marshfield Clinic have full staff privileges.<sup>9</sup> St. Joseph's also has the most sophisticated equipment; specializing in cardiac surgery, neonatal care, and oncology in the area. The three other hospitals in central and northern Wisconsin with more than 200 staffed beds are Wausau Hospital, Sacred Heart Hospital-Eau Claire, and Luther Hospital.

The physician product market may be broken out into primary, pediatric, and specialty care components. Cross-elasticity of demand for primary care services and pediatric services appears to be low. Although some children would occasionally visit a primary care physician, most would probably see pediatricians. Adults would rarely visit a pediatrician.

Specialty care physicians were defined in terms of services delivered in 400 plus diagnostic-related-groups ("DRGs") at in-patient hospital settings. It was believed, for example, that there was little cross-elasticity of demand between, for example, eye surgery and different types of heart surgery. It was also believed that there was little cross-elasticity of supply for different types of surgeons and physicians.

The Marshfield Clinic market share exceeded 60 percent of patient events (the number of times that patients saw physicians during the year) for each of three years from 1991-1994 in nine of thirteen satellite clinics of Marshfield in primary physician care and in eight of thirteen

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clinics in pediatric care. The other ten clinics had insufficient data or consisted mostly of specialty physicians.

The specialty markets consisted of the number of procedures performed at St. Joseph's Hospital where only Marshfield Clinic physicians practiced. In fourteen markets including cardiac valve surgery, bypass surgery, and chemotherapy, St. Joseph's Hospital performed more than 60 percent of the procedures in the relevant geographic market for the years 1991-1994.

The relevant geographic market for primary care physicians and pediatricians was defined in terms of geographic markets surrounding each of the twenty-three satellite clinics. A thirty-mile radius was set, and was increased by ten-mile increments until Elzinga-Hogarty calculations of 75 percent combined LIFO (Little-In-From-Outside) and LOFI (Little-Out-From-Inside) were met.<sup>10</sup>

For specialty care markets, a map was drawn which would encompass all of Northwest Wisconsin based on the referring patterns of Marshfield Clinic's 23 satellite clinics. Elzinga-Hogarty statistics were calculated for each of the more than 400 DRGs in the geographic area with nearly all passing the 75 percent Elzinga-Hogarty cut-off point.

Along with the high market shares of the Marshfield Clinic are the high barriers-to-entry for physician services erected by Marshfield. Only Marshfield physicians were provided staff

privileges at the four hospitals dominated by Marshfield including St. Joseph's Hospital.<sup>11</sup> This, of course, inhibits growth of primary care or specialty care physicians. Marshfield physicians also would refuse to provide cross coverage to non-Marshfield physicians who needed to be absent from their practice for a few days. Marshfield also enforced a non-compete clause with its formerly employed physicians which kept such physicians from practicing medicine within thirty miles of the Marshfield Clinic for

three years after termination.

Another barrier to the specialty care physician services market is the Wisconsin capital expenditure review program ("CER") which requires approval through the Cost

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Containment Commission of most expenditures exceeding \$1,000,000 for hospital-based institutions and exceeding \$500,000 for clinic based institutions.<sup>12</sup> Because of pressure by existing hospitals, it is often difficult to justify to regulatory agencies the entry of a new hospital or the purchase of new equipment. Without new tertiary care facilities, specialists will be deterred from entering the market.

Finally, the referral network to Marshfield Clinic physicians may increase the proficiency of specialty services as more procedures are performed at Saint Joseph's Hospital. This increased number of procedures can be a circular phenomenon which may lead to even more referrals to specialty care, thus creating a

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barrier-to-entry. At the same time, specialists will refer patients back to the primary care physicians of Marshfield.

Patients who visit a Marshfield Clinic physician generally are aware that for specialty services the patient would be referred to a Marshfield Clinic specialist and would most likely be treated at St. Joseph's Hospital. Referrals increase the demand for Marshfield Clinic primary care physicians which, in turn, increases the referral to and demand for Marshfield Clinic specialists.

The dominance of St. Joseph's Hospital engendered by the link between Marshfield Clinic's primary and specialty care appears to be reflected in its financial data. St. Joseph's rate of return computed as net income as a percent of total assets was 13.5 percent in 1991,<sup>13</sup> compared to 7.7 percent at Sacred-Heart Hospital-Eau Claire, 6.3 percent at Wausau, and 6.8 percent at Luther.<sup>14</sup> St. Joseph's rate of return on equity for 1991 was 18.2 per cent compared to 9.6 per cent at Sacred Heart, 15.0 per cent at Wausau, and 11.5 per cent at Luther.<sup>15</sup> These high rates of return may reflect the market dominance of Marshfield Clinic and St. Joseph's Hospital in specialty services in the Northwest Wisconsin market.

The Marshfield Clinic and its primary and specialty physicians, the St. Joseph's Hospital, and the Security HMO, formed a vertically integrated network. Each of the components of the network led to the monopolization of primary care and specialty physician services. The St. Joseph's Hospital benefitted by the stream of Marshfield referrals. It also benefitted by the patients from Security HMO. Yet the biggest beneficiaries were the Marshfield physicians. Because of their control of St. Joseph's and three

additional hospitals, it was very difficult for new physicians to enter the market. Control of Security also made it difficult for non-Marshfield physicians to gain referrals. Those physicians who were affiliated with Security were required to refer to Marshfield and often referred non-Marshfield patients as well. The loss of Security patients could be a devastating blow for non-compliance.

There were no attempts made to calculate the potential benefits of vertical integration. One such benefit may be to provide information to the patient such that getting into the Marshfield system would provide a certain level of health care. There were also no attempts made to calculate the costs of vertical integration other than to suggest that vertical integration here can lead to monopoly power. In general, vertical integration can be benign except when linked to the establishment of monopoly power. In the health care industry, the probability of hospital staff privilege foreclosure and HMO referrals can make vertical integration suspect where there are high market shares of hospitals coupled with an HMO presence.

### **Potential benefits to Blue Cross and Blue Shield of Wisconsin of an antitrust victory**

The damages of the refusal to deal with Compcare were calculated at approximately \$5.1 million from 1990 to 1995.<sup>16</sup> In addition to the damages incurred by the exclusion of the Compcare HMO, Blue Cross was affected by the high prices of Marshfield physician services. For primary care, pediatric care, and specialty care services, the damages were calculated at approximately \$595,000.<sup>17</sup> When trebled under the

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Sherman Act the damages total to \$17.1 million.<sup>18</sup>

Were there also other benefits which might accrue to Blue Cross? Perhaps there might be value of deterring other physician groups in Wisconsin who might not negotiate with Blue Cross. In addition, although Blue Cross and Blue Shield plans throughout the United States form a weak association, benefits may be positive to many other plans in the Blue Cross and Blue Shield Association. Quantification of these last two possible benefits were not possible.

### **Potential costs to Blue Cross and Blue Shield**

The costs to Blue Cross are equal to attorney fees, other consultant fees, and the opportunity costs of Blue Cross officials and employees who helped with document preparation and assistance on this case. The attorney fees are approximately \$2.5 million according to the papers filed with the District Court; economic consulting fees approximately \$400,000; and the opportunity costs of Blue Cross individuals is at a minimum of \$64,000 (based on two executives at a two-week trial and six weeks of effort prior to trial) with no guarantee of winning. Total costs were, therefore, approximately \$3.0 million.

Moreover, there is the possibility of future legal and consulting costs and opportunity costs of Blue Cross officials during an appeals process.

### **The benefits and costs to Blue Cross and Blue Shield of bringing legal action**

With a benefit-to-cost ratio of 17 to 3 (\$17 million awarded by the judge at a \$3 million cost), Blue Cross needed less than a twenty

percent chance of winning in order to bring this suit. Blue Cross, of course, had to take into consideration risks such that the potential evidence would not be as convincing as Blue Cross believed, or defendant's had evidence about which Blue Cross was unaware.

### **Public benefits if Blue Cross wins**

If Blue Cross wins, entry will be easier for other HMOs which would like to enter the northwest Wisconsin market since Marshfield would have to negotiate with all potential entrants. It will also reduce prices of physician services to all health care plans since physician's services will no longer be monopolized.

How does one measure the public benefits? The public benefits would be equal to the market share of the private and public third party insuring organizations in the state minus the market share of Blue Cross. Thus, Blue Cross has a market share of seventeen percent in 1993 with eighty-three percent for the other insuring organizations, leaving out potential entry. Thus, the bulk of the gains will accrue to non-Blue Cross subscribers.

### **Why would firms bring antitrust actions when other parties benefit?**

There is a greater proportion of private antitrust suits brought today than at any time in the nation's history.<sup>19</sup> Prior to the 1980s, private firms brought six times as many suits as the government, whereas in the 1980s, there were ten times as many suits.<sup>20</sup> According to the Georgetown University study of antitrust litigation, private suits have been predominant during the forty-three years (from 1941-1984) of

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their study.<sup>21</sup> More than 1,000 private antitrust suits are filed each year. Of course, not all cases have public good effects and may involve simply internal private disputes between the parties.

First, it appears that firms will bring antitrust actions when the internal benefits exceed the internal costs; adjusted for risk of winning the suit. All things equal, benefits will be greater, the greater the market share of the firm. One might also hypothesize that higher market shares will allow firms to capture most or a good portion of the benefits. This will allow firms to reduce the public benefits of the antitrust action.

A second hypothesis is that firms would be more willing to bring an antitrust action when no other potential competitor has a market share which is significant. With a significant market share, the next largest firm would be able to capture most of the public benefits and challenge the leading firm on an equal basis.

Third, a firm is more anxious to bring an action when significant damages can be collected for past antitrust violations. As we have seen, Blue Cross was awarded a \$17 million judgment for just five years of antitrust damages.

Fourth, firms may bring antitrust suits when there may be substantial time lags before the entry of new firms. For example, in

Marshfield, Blue Cross may have had marketing and brand name advantages over other health insuring organizations. Blue Cross may have been able to gain large benefits before new firms could decide when and if to enter as well the period of time in developing brand name loyalties.

Fifth, the average plaintiff gains 1.2 percent of the equity value of the firm in wealth gains when the announcement of the antitrust filing occurs.<sup>22</sup> Blue Cross and Blue Shield of Wisconsin as a for-profit firm, might have foreseen similar increases in wealth.

## Conclusion

There are a number of reasons why firms may bring private antitrust suits even though there are possibilities of public good effects which accrue to other firms. Public policy officials at the Department of Justice or the Federal Trade Commission may want to be cognizant of the factors which lead firms to bring private antitrust suits and reserve their resources for cases in which these or other factors are not present. There may also be the possibility of filing an *amicus brief*. In cases which involve significant legal precedent, however, public policy officials may want to act regardless of private action.

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## E N D N O T E S

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<sup>1</sup> Dr. Greenberg participated as an expert opinion economist, retained by Blue Cross and Compicare, in the litigation surrounding this article. A majority of the background and opinions are taken from Dr. Greenberg's expert report. Dr. Greenberg's expert report is on file in the offices of the Loyola Consumer Law Reporter.

<sup>2</sup> 15 U.S.C.A. §§ 1-2 (1995).

<sup>3</sup> WISC. STAT. ANN. § 133.03(2) (1995).

<sup>4</sup> See generally *Blue Cross v. Marshfield*, 881 F. Supp. 1309 (W.D. Wisc. 1994); *Blue Cross v. Marshfield*, 883 F. Supp. 1247 (W.D. Wisc. 1995); *Blue Cross v. Marshfield*, 65 F.3d

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1406 (7th Cir. 1995); *Blue Cross v. Marshfield*, No. 94 C 137 S, 1995 WL 1100115 (W.D. Wisc. Jan. 5, 1995).

<sup>5</sup> See generally Warren Greenberg's Expert Report [hereinafter *Greenberg*], at 4 (citing Marshfield Clinic Physician Recruiting Brochure, *The Marshfield Clinic: For The One In Four* at 19, n.d.).

<sup>6</sup> *Greenberg*, *supra* note 5.

<sup>7</sup> *Greenburg*, *supra* note 5, at 5. (citing WISC. OFFICE OF THE COMM'R OF INS., *PREPAID HEALTH PLANS IN WISC.* (1993)).

<sup>8</sup> *Greenberg*, *supra* note 5, at 5.

<sup>9</sup> *Greenburg*, *supra* note 5, at 4.

<sup>10</sup> *Greenburg*, *supra* note 5, at 7, 13 (citing Kenneth G. Elzinga and Thomas F. Hogarty, *The Problem of Geographic Market Delineation in Antimerger Suits* 45, 81 (The Antitrust Bulletin 18(1), Spring 1973).

<sup>11</sup> *Greenberg*, *supra* note 5, at 11.

<sup>12</sup> *Greenburg*, *supra* note 5, at 10.

<sup>13</sup> The only year for which data is available.

<sup>14</sup> *Greenberg*, *supra* note 5, at 19 (citing WISC. OFFICE OF HEALTH

CARE INFO., DEPT. OF HEALTH & SOC. SERV., DIV. OF HEALTH (1991-1993)).

<sup>15</sup> *Greenberg*, *supra* note 5, at 19 (citing WISC. OFFICE OF HEALTH CARE INFO., DEPT. OF HEALTH & SOC. SERV., DIV. OF HEALTH (1991-1993)).

<sup>16</sup> See *Blue Cross v. Marshfield*, 883 F. Supp. 1247, 1262 (W.D. Wisc. 1995).

<sup>17</sup> *Id.*

<sup>18</sup> *Blue Cross v. Marshfield*, No. 94 C 137 S, 1995 WL 110115 (W.D. Wisc. Jan. 5, 1995).

<sup>19</sup> John M. Bizjak and Jeffrey L. Coles, *The Effect of Private Antitrust Litigation on the Stock-Market Valuation of the Firm*, 85 AMER. ECON. REV. 436, 461 (1995).

<sup>20</sup> *Id.* at 436.

<sup>21</sup> *Greenberg*, *supra* note 5 (citing Steven C. Salop and Lawrence J. White, *Private Antitrust Litigation: An Introduction and Framework*, PRIVATE ANTITRUST LIT. 3 (LAWRENCE J. WHITE ED., 1988)).

<sup>22</sup> Bizjak and Coles, *supra* note 19, at 437.