ORIGINAL

In the

Supreme Court of the United States

ARIZONA,	)	
	)	
Petitioner,	)	
	)	
v.	)	NO. 80-~~1~~ 419
	)	
MARICOPA COUNTY MEDICAL SOCIETY, ET AL.	)	

Washington, D. C.

November 4, 1981

Pages 1 thru 70

ALDERSON REPORTING

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IN THE SUPREME COURT OF THE UNITED STATES

- -x

ARIZONA, :

Petitioner, :

v. : No. 80-419

MARICOPA COUNTY MEDICAL SOCIETY, :

ET AL. :

- -x

Washington, D. C.

Wednesday, November 4, 1981

The above-entitled matter came on for oral argument before the Supreme Court of the United States at 11:20 a.m.

APPEARANCES:

KENNETH R. REED, ESQ., Phoenix, Arizona;
on behalf of the Petitioner.

STEPHEN M. SHAPIRO, ESQ., Office of the Solicitor General, Department of Justice, Washington, D. C.; amicus curiae.

PHILIP P. BERELSON, ESQ., Palo Alto, California;
on behalf of the Respondents.

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PROCEEDINGS

CHIEF JUSTICE BURGER: We will hear arguments next in Arizona against Maricopa County Medical Society.

Mr. Reed, I think you may proceed whenever you are ready.

ORAL ARGUMENT OF KENNETH R. REED, ESQ.,

ON BEHALF OF THE PETITIONER

MR. REED: Mr. Chief Justice, may it please the Court, this case is here on certiorari to review what the lower courts have characterized as a controlling question of law on which there is substantial ground for difference of opinion.

The United States District Court denied our motion for partial summary judgment on the question of a violation, on the ground that the legality of Respondent's agreed upon fee schedules was to be judged under the rule of reason rather than per se rule.

QUESTION: He did deny it with leave to file a similar motion later after more discovery had taken place, didn't it?

MR. REED: To be sure, and we subsequently filed, Justice Rehnquist, a motion for partial summary judgment on the question of violation, based on the rule of reason. That motion was filed in support of our papers for a preliminary injunction, and both of those questions were

before the Ninth Circuit, both the 1292b petition for interlocutory appeal and the appeal of the denial of summary judgment motion.

QUESTION: Summary judgment in your favor.

MR. REED: No, Your Honor. Summary judgment had been denied by the District Court under both the rule of reason theory and per se theory, and our request for continuation of the preliminary injunction was also denied under the theory that it did not violate either the per se standard and there was not enough evidence to show that it violated the rule of reason.

QUESTION: But didn't Judge Coppel give you leave to renew your motion for summary judgment on either standard after more discovery had taken place, just that there wasn't enough facts in the record to say what the effect of the plan was?

MR. REED: He did in fact give us leave to refile. We did in fact refile it. He did in fact deny it. I think the question this Court has to decide is how much additional discovery need be taken and on what additional issues must discovery be taken if at all before reaching a decision.

I think, as we talk in the briefs, there is talk in the papers about disputed facts, about the desire for further discovery, but I think the facts, Justice Rehnquist,

necessary for this Court's decision are clear and simple, undisputed, and have been established by Respondent's own Rule 36 admissions and the affidavits Respondents themselves have prepared and submitted and filed with the lower courts, and those facts are really only three.

One, Respondents are trade associations of competing physicians. Two, as part of their activities, Respondents formulate and prepare lists of prices covering the range of services that they perform. Three, as part of their function, the Respondents prepare minimum standards which they utilize in endorsing pre-paid health plans, whether insurance health plans or by third party payors such as the state of Arizona, which reimburses health care plans as an employer.

For an insurer or an employer to receive Respondents' endorsement, the third party payor must agree to accept these minimum standards, one of which is the agreement to pay Respondent's members up to the amount set forth in the agreed upon fee schedules. In return, in return, Respondents' members agree not to bill any more than what is set forth in those fee schedules.

Those facts, Justice Rehnquist, are established beyond cavil.

QUESTION: I thought that the physician was free to bill the patient whatever he wanted.

MR. REED: That's right, Your Honor. The physician can -- a member of the society, a member of one of the Respondents can bill less than the fee schedule.

QUESTION: What about more?

MR. REED: Not at all. He could prepare a piece of paper that said more. He has been guaranteed of receiving what is set in the fee schedule.

QUESTION: And if the patient wishes to pay him more, and he sends a bill to the patient for more, and the patient pays him more, he doesn't have to return it, does he?

MR. REED: Not at all, Your Honor.

QUESTION: Can he enforce his higher bill in court against a patient?

MR. REED: He is under a contractual obligation as a member of the society, of the Respondent society --

QUESTION: Not to. Is that it?

MR. REED: -- not to seek to collect --

QUESTION: Well, can the patient defend on that basis?

MR. REED: I would think so, Your Honor. I would think the claim would be between the insurance carrier --

QUESTION: Well, do we know from any Arizona court decision whether the patient can defend on the basis of this agreement?

MR. REED: There is not an Arizona court decision

I can cite you to, Your Honor. I would suggest, Justice Rehnquist, that questions such as that are irrelevant. Going back into the decisions of this Court, starting out with Justice Peckham's opinion in the Trans-Missouri Freight Association case, continuing through the recent decision in cases such as California Retail Liquor Dealers versus Midcal Aluminum, any agreement, any agreement among competitors raising, lowering, stabilizing prices is itself a per se violation of the antitrust laws.

QUESTION: Yes, but Justice Rehnquist's question really goes to whether or not there is any such agreement like that at all. If these doctors are completely free, despite what some piece of paper says, to charge the patient more, and they do, what kind of an agreement to set prices is there?

MR. REED: Your Honor, any agreement among competitors to set prices is a violation of the law.

QUESTION: Well, I am saying, is there an agreement if the first line says, we agree, and the next line says, we don't agree?

MR. REED: Mr. Justice White, any agreement among competitors to set prices is a per se violation. Any person obviously has a legal right not to abide by that agreement. An agreement to fix prices is legally unenforceable. The oil companies in Socony-Vacuum Oil Company could not legally

have been compelled to abide by the price fixing agreement.

QUESTION: Following up on Justice White's question, supposing that the agreement, if there be such, of the foundation says that you will not charge more than -- you will not be reimbursed or charge more than $900 for this service, and the physician gets his $900 reimbursement but bills the patient $1,600, and the patient says, no, I don't want to pay $1,600 and doesn't pay the $1,600. Can the physician nonetheless sue him and collect it?

MR. REED: I would think not, Your Honor.

QUESTION: What makes you think not?

MR. REED: Because the agreement among the physicians, one of the criteria on which they signed their membership application when they joined the foundation is agree not to seek recovery, not to receive more than the amount of money set forth by the fee schedule. Anybody can file a piece of paper and go down to court and seek recovery on a claim, seek recovery on a claim, whether it has merit or not. There is a contractual obligation and an agreement among the competing physicians that they will accept the amount set forth in the fee schedules.

QUESTION: Where is that in the record in this case?

MR. REED: Your Honor, I would direct your attention to Page 9 of Respondent's reply brief on the

merits.

QUESTION: What color?

MR. REED: Red. Quoting, "Foundation member health care providers agreed to accept as payment in full for patients covered by Foundation endorsed insurance the maximum level of reimbursement from the insurer for services rendered."

I also direct your attention to the affidavit of Thomas Finley, the executive director of one of the foundations. It appears at Page 78 of the joint appendix, at Paragraph 16 of his affidavit, and I think his statement there nicely sums up what is involved here. This is an affidavit prepared by the Respondents and signed by one of Respondent's executives. Quote:

"The Foundation does exercise direct control over the establishment of maximum payment rates for medical services." Direct control. That is his language. "However, these rates are a ceiling, not a floor, for Foundation members. Each doctor who is a member of the Foundation expressly agrees that covered expenses will be reimbursed at no more than the maximum rate established by the Foundation." Period, close quote.

There is no question, Your Honor, that there is that express agreement.

QUESTION: Will be reimbursed by whom?

MR. REED: By the insurance company or other third party payor.

QUESTION: But not necessarily by the patient.

MR. REED: That is correct, Your Honor, except to the extent of the deductible coverage, or the first $100 that may be paid in any one calendar year.

QUESTION: Well, isn't there a term of the agreement that the doctor will charge nothing to the customer except the reimbursible expense?

MR. REED: Excuse me, Justice Stevens. I am not sure I understood.

QUESTION: Does not the overall agreement provide that the doctor who joins the plan when he is performing services for an insured person under the plan will collect all of his fees from the insurance company except for the deductible amount?

MR. REED: That's correct. That's correct.

QUESTION: So there won't be an additional charge to the customer if the agreement is adhered to.

MR. REED: That is absolutely correct. That this may be characterized as a maximum fee schedule is of no moment. Again, the cases have consistently held in this Court that any agreement among competitors raising, lowering, stabilizing, tampering with prices is a per se violation.

Justice Peckham's opinion in Trans-Missouri made that point, one of the first price fixing cases before this Court. The most recent case to present this issue, Midcal Aluminum, again, maximum price fixing is unlawful.

QUESTION: What is the Foundation's share of the market in the state?

MR. REED: Foundation member physicians have approximately 70 percent of the physicians in the area as members. The precise market share I cannot tell you. Your Honor, the precise market share is not a matter that is relevant either to a per se analysis or rule of reason analysis.

Justice Rehnquist, if you go back to Judge Addison Pipe, and take it through to former Solicitor General Robert Borak's most recent, I think very thoughtful analysis of antitrust paradox, makes a very telling point.

QUESTION: Well, neither of them were members of this Court at that time.

MR. REED: To be sure, Your Honor. Fortunately, however, I think the rationale was accepted by this Court when it affirmed the Nationwide Trailer Rental case and again in the Broadcast Music case by Justice White, and again in the GTE Sylvania case, and the point is this, that where there is economic integration, where there is a pooling of productive assets, a sharing of risk and

benefits, an incidental elimination of price competition is permissible.

Thus, Judge Taft in Addison, Justice White, you made this point yourself in BMI when you made mention of partnerships --

QUESTION: That was a Court opinion. The Court did it.

MR. REED: To be sure. When you made the reference to partnerships, mergers, or joint ventures as being examples where economic assets have been pooled, there is a sharing of risk and benefits. There, there is an economic integration. Even where there are only two individuals, and this is Robert Borak's example, two individuals that legitimately form a partnership and pool their assets, if they independently, without pooling their assets, agree to eliminate competition, that is a per se violation without regard to their market share.

QUESTION: If the Foundation had only 10 percent of the market in Maricopa County, would that be the case?

MR. REED: Absolutely. Absent an economic integration of the productive assets, whether it is 10 percent or whether it is only two physicians, agreeing on prices, that is a per se violation, absent an economic integration of pooling of assets, absent the sharing of risk benefits.

QUESTION: Mr. Reed, that may be a fair inference from what the Court has said, but the Court has never quite said that, has it? It has never said that two people can't horizontally fix prices. There is no such case out of this Court that holds that on all fours.

MR. REED: That two persons cannot horizontally --

QUESTION: Two corner grocers get together and say, we won't charge less than a dollar for hamburger. There is no such case, is there?

MR. REED: Not two persons. But I think, Justice Stevens, if you refer back to Justice Douglas's opinion in Socony-Vacuum, he did indicate, and I think very definitely in his Footnote 59, that it matters not. The Section 1 violation is complete, even though the conspirators do not have the power to carry out their agreement. Power to accomplish the end is not relevant. It is not material to the violation.

So, to be sure, we have not had before this Court the precise situation of those two individuals, but we have had the issue decided.

QUESTION: I think all the price fixing cases in this Court have been cases in which the defendants had market dominance. It may be that isn't required, and I agree with you that Justice Douglas's language certainly doesn't seem to require that.

MR. REED: I think that is not necessarily the case, Your Honor. In the opinion in the Nationwide Trailer case, which was affirmed procurium by this Court, the District Court was expressly unable to determine the market share of the defendants and unable to determine that the fee schedule had in fact been used. It found that the members of the trade association had among themselves prepared, agreed upon, and published a fee schedule. It had not -- it did not make any finding in its findings of fact that expressly said that it didn't have the evidence to make any finding, that it was used or that it was followed, and absent any showing of market share, no ability to show that they had the power to put it into effect.

Nonetheless, the District Court there held that the mere preparation, publication, and circulation among its members of a fee schedule was a per se violation, and this Court affirmed that decision.

I think the Respondents here have gone much further, gone much further than anything in any of the earlier cases to come before this Court. The people in Socony-Vacuum, the realtors in National Association of Real Estate Boards, the lawyers in Goldfarb, the trailer rental operators in the Nationwide Trailer case agreed among themselves on the prices, on a price list. They had no guarantee, however, that they would be able to receive the

prices that they agreed upon in their price list.

QUESTION: But Goldfarb was a minimum fee. A minimum fee.

MR. REED: To be sure, and so was National Association --

QUESTION: And a person could not get the service in this part of Virginia affected by Goldfarb from any lawyer except by paying that minimum fee. Isn't that quite different from a maximum fee?

MR. REED: I believe so, Your Honor, and I believe this case presents a more egregious. The minimum, and while it didn't occur in Goldfarb, it did occur in the National Association of Real Estate Boards, where there was a stated minimum, a number of transactions went down from there, and in point of fact, transactions were made as noted by Justice Douglas in that opinion, transactions were made below the agreed upon price.

QUESTION: Is your charge here primarily then one of conspiracy, and nothing more?

MR. REED: Your Honor, that is sufficient to entitle me to summary judgment on the question of the violation. I think there is much more that we can go into in the medical profession, but on the question of whether Respondents' formulation and preparation of fee schedules is a violation of the law, those facts those facts alone are

sufficient to establish a violation.

QUESTION: Regardless of the market share or anything else?

MR. REED: Regardless of the market share. The only exception being the question, is there an economic integration, is there a pooling of productive assets? There is not here. And the simple agreement among non-integrated competitors, which is what we have, on a price schedule is under the cases and in my view a per se violation of the antitrust laws.

What has been done here is more than simply a minimum violation, minimum fee schedule, rather. The members of this society had guaranteed themselves payment up to the so-called maximum that they have agreed upon, and the effect of this, the effect of this, Justice Rehnquist, I think is evidenced pretty clearly by something that occurred during the course of this litigation, wherein the District Court -- an injunction had remained in effect for a few months, and Respondents' members wanted to increase their prices.

They went into the District Court and asked that the preliminary injunction be lifted so that they could increase their prices an aggregate of $1.8 million a month, and they asked that as a condition of a continuation of this preliminary injunction, if the injunction were to continue

enjoining them from increasing their fee schedule, the state of Arizona would be required to post a bond of $1.8 million a month for every month that they were enjoined from promulgating a new fee schedule.

Even if Respondents had not gotten the guarantee that they would receive what they had agreed upon, even if Respondents had done no more than agree upon a maximum level of prices, establish maximum prices, that agreement would still be -- should still be per se unlawful.

I go back again to one of the first price fixing cases to come before this Court, Justice Peckham's opinion in Trans-Missouri, and he identified there the evil, one of the evils of a maximum price fixing agreement among competitors, and if I may take the liberty of quoting to the Court from Page 323 of 166 US, "In business or trading combinations, they may even temporarily or perhaps permanently reduce the price of an article traded in or manufactured". Reduce the price. "Trade or commerce under those circumstances may nevertheless be badly and unfortunately restrained by driving out of business the small leaders and worthy men whose lives have been spent therein."

He went on on the next page to say, "In this light, it is not material that the price of an article may be lowered."

Mr. Peckham was talking hypothetical economics there, but well based economics.

QUESTION: But do we know that the same effects would result in the physician patient service relationship as between the railroad shipper analysis?

MR. REED: I think the economic effect of that, Number One, to show that Justice Peckham was not off base is seen in the second American Tobacco case. The second American Tobacco case, you will recall, is where the major tobacco companies reduced their price on the cigarettes they sold to provide a competitive alternative to the so-called ten-cent brands. By reducing their price, they kept the ten-cent brands off the market.

The stated purpose for this -- for the original inception of these foundations, and I am quoting from the joint brief in opposition, the red one, at Page 8, "is a competitive alternative to the utilization of closed panel prepaid health insurance plans", stated differently, a group of competitors, the Respondents here, reducing their prices to compete with HMOs, just like -- just like the major tobacco companies reduced their prices to keep the ten-cent cigarettes off the market in the second American Tobacco case.

QUESTION: But wouldn't we know more if we had deposition testimony --

MR. REED: Most certainly.

QUESTION: -- or witness testimony?

MR. REED: Most certainly. Most certainly. I would think, Justice Rehnquist, that we could spend the next ten years and after ten years, or five years, perhaps, we could have the definitive treatise on medical economics. But Chief Justice Warren made a very important point in the Brown Shoe case, and that is that we should not protract already complex antitrust cases by looking into peripheral economic facts.

QUESTION: Well, but --

MR. REED: And the per se rule in Northern Pacific Railroad is recognized as being based in part upon the necessity and the wisdom of avoiding unnecessary expenditures of judicial resources. The whole notion of Rule 56 summary judgment proceedings is to decide cases prior to trial, if possible, when all of the material facts have been established beyond dispute.

QUESTION: But how do you know when all the material facts have been established?

MR. REED: Because under Rules 56E and 56F, a party posing a summary judgment motion has the obligation of identifying material issues of disputed fact that require a trial, or under 56F, if there hasn't been enough of an opportunity to conduct discovery, identifying the specific

issues of fact on which further discovery is required that will require trial.

First of all, we have never during the course of this litigation had a 56E statement or a 56F statement. Be that as it may, there have been a number of factual contentions that have been raised that it has been suggested require further discovery or that it has been suggested are in dispute. Justice Rehnquist, yes, we could conduct five years or ten years of court time and lawyers' time to explore those. None of those matters are material. None of those matters require a trial. The fact that a group of independent competitors agree on a fee schedule -- under Nationwide Trailer Rental, that is enough to constitute the violation.

QUESTION: Whether it be physicians, a health group, or trailer rental, or a shipper consumer, none of that varies at all?

MR. REED: I think starting with Socony-Vacuum, Justice Douglas said there that as far as the price fixing law goes, the Sherman Act establishes one rule of law for all industries, and again in Goldfarb, and again in Professional Engineers, this Court said, this Court held that the particular nature of an industry does not create an exemption from the antitrust laws.

QUESTION: Don't you have to establish that there

is a direct connection between these fees that you say, these maximum fees that were agreed upon and insurance premiums?

MR. REED: Not at all. Not on the question of violation.

QUESTION: Why? The patient doesn't pay the doctor.

MR. REED: To be sure.

QUESTION: And so it is a three-cornered arrangement. The doctor performs the services for the patient, he charges the insurance company.

MR. REED: Absolutely. The insurance company or other third party reimbursers, like the state of Arizona.

QUESTION: So this isn't like other cases of maximum agreements, where the customer is paying the price agreed upon. Here the patient doesn't pay the doctor anything.

MR. REED: The third party reimbursement mechanism, Your Honor, Justice White --

QUESTION: How do you know there is any connection between, or how do you know what the connection is between these agreed upon fees and premiums? That is what the patient pays, is a premium.

MR. REED: On the question of violation, Your Honor, on the question of whether the agreement here

violates the antitrust laws, that is not an issue. It is a partial summary judgment. We are dealing in this case before this Court simply with the matter of whether this agreement is a violation of the antitrust laws, not who has standing to sue, not the amount of damages, not jurisdictional issues, not the McCaren Ferguson issue. Those are all matters which were not apppealed from which are still in the District Court.

This is the narrow controlling question of law, certified by the District Court, reviewed by the Ninth Circuit, whether the agreement involved here is a violation of the antitrust laws.

QUESTION: Do you think it facilitates the writing of medical insurance for the insurance companies to have some notion in advance of what they are going to have to pay?

MR. REED: Absolutely, Your Honor, and the question becomes whether the notion in advance, the maximum fee schedule, if you will, should be set by the insurance company unilaterally or by a horizontal association of competitors.

Respondents take issue with the state of Arizona that in our workmen's compensation --

QUESTION: Suppose the insurance company comes to the medical society and says, we propose -- we want to write these plans, but we have got to know what premiums to

charge, so we are going to say we will pay you these figures, and they propose this list, and they say, but of course we like to know if you are -- we can't sell any insurance to anybody unless you all agree to these figures. Because no patient will ever -- They need some guarantees.

And you say the Sherman Act forbids the medical association from responding with a yes, we agree.

MR. REED: The medical association has a group. The Sherman Act, I say, prohibits any agreement among competitors among that. It does not prohibit the individual decisions by individual physicians to accept a unilateral maximum schedule promulgated by --

QUESTION: So you say the individual physicians could all write a letter and say, we agree.

MR. REED: That's correct. Individuals, Your Honor.

QUESTION: Mr. Reed, how many insurance companies are parties to these agreements?

MR. REED: I believe the number is four with regard to the Pima Foundation for Medical Care, and seven with regard to the Maricopa Foundation for Medical Care.

QUESTION: Do they make competitive bids to become parties, or how are they selected?

MR. REED: In order for an insurance company to be endorsed by the foundation, to be accepted by the

foundation, the insurance company must agree to accept the foundation's minimum standards.

QUESTION: Is there any competition among the insurance companies?

MR. REED: There is no divergence. There is one set of minimum standards by the foundations which the different insurance companies must accept.

QUESTION: Do they change from year to year, or may they change?

MR. REED: May the fee schedules change from year to year?

QUESTION: Yes.

MR. REED: Yes, they do, Your Honor.

QUESTION: May I ask you, have any non-members, non-member doctors objected to this arrangement?

MR. REED: During --

QUESTION: At least none of them are parties here.

MR. REED: I believe there is --

QUESTION: You would think they might have an objection, because they don't agree to limit. Unless you are a member, you haven't agreed to limit your billing to the patient.

MR. REED: To be sure.

QUESTION: But they are not parties here, and they haven't --

MR. REED: They are not parties. There was during the course of the lower court proceedings, when the desire to raise prices $1.8 million a month came up, affidavits were submitted by the executive directors of both foundations saying that unless we can increase our prices by this amount, an estimate of one-quarter to one-half the members of the Maricopa Foundation and one-quarter to one-third of the members of the Pima Foundation were threatening to resign unless they could get this $1.8 million a month price increase.

If the Court has no further questions, I will reserve the balance of my time for rebuttal. Thank you.

CHIEF JUSTICE BURGER: Mr. Shapiro, at some point will you focus on how this program injures consumers?

ORAL ARGUMENT OF STEPHEN M. SHAPIRO, ESQ.,
AMICUS CURIAE

MR. SHAPIRO: I will, Your Honor.

Our position concisely is that a maximum fee agreement has many of the objectionable features of an ordinary price cartel, that although the arrangement is denominated a maximum fee arrangement, that the individual doctors have very little incentive to charge less than the prescribed maximum. In this case, it is stipulated that almost all of them do charge the maximum, and it is also stipulated that every year they hike the maximum further and

further, which raises the costs of the insurance companies that do business with the foundations, and ultimately redounds to the detriment of the consumers that pay for the premiums on the insurance policies.

Our position is that it is harmful to consumers, and I will elaborate that point in the course of my argument.

QUESTION: Are the insurance companies objecting?

MR. SHAPIRO: There is no indication of their position in this record.

QUESTION: Or of the non-member doctors?

MR. SHAPIRO: No indication of that in this record.

Our submission is that the maximum fee schedules that were adopted by the foundations are in fact per se violations of Section 1 of the Sherman Act, and we further contend that the per se rule can be applied at this stage of the litigation, in view of the specific admissions which the foundations made in the District Court.

I would like first to describe the legal standard which governs in a case of this kind, and then explain why Arizona was entitled to summary judgment under that standard.

Ever since this Court's ruling in Socony-Vacuum, it has been black letter law that competitors may not combine to restrain independent decision-making on price. As the Court stated in Socony, and I quote, "Any combination which tampers with price structures is engaged in an

unlawful activity." And in the unanimous decision of this Court in Kiefer-Stewart, the Court reaffirmed that an agreement among competitors fixing maximum prices is subject to the per se prohibition just like a uniform price agreement or a minimum price agreement.

In Professional Engineers, the Court summarized its past opinions concisely by stating that any agreement that interferes with the setting of price by free market forces is unlawful on its face.

Of course, the per se rule must be confined by the scope of its rationale. It applies to so-called naked restraints which cut off competitive or independent decision-making by independent rivals. It does not ordinarily apply to agreements on price which are necessary components of joint productive activity. This distinction is illustrated by a familiar example.

If a group of attorneys gets together and establishes a schedule of fees, this is a per se violation as the Court held in the Goldfarb case.

QUESTION: Minimum. Minimum fees.

MR. SHAPIRO: Minimum fees. And under Kiefer-Stewart, maximum fees are subject to the same per se prohibition. But if that same group of lawyers gets together and establishes a law firm, they may agree on the prices which they charge their clients. Members of firms

are not expected to compete against one another or to attempt to divert business from each other. Joint productive activity depends on cooperation rather than internal competition in an integrated business entity, such as a partnership.

Accordingly, the relevant inquiry in this case is twofold. First, have competitors in fact entered into an agreement limiting their pricing independence, and second, if they have, is that agreement an essential facet of joint productive activity, as in the case of a partnership or a merger of medical practices into a health maintenance organization?

In this case, these questions can all be answered with dispatch. In fact, all of the information that is needed to render a judgment on liability is contained in the foundation's very extensive admissions of fact which are on Pages 156 through 273 of the joint appendix in this Court.

Let me now summarize what the foundations have in fact admitted. The doctor members of the foundations vote by mail ballot on maximum fee schedules used to determine the fees which insurance companies pay them, and they agree to abide by those maximums. If an insurance company wishes to do business with the foundations, it must agree to pay the doctors up to the maximum which they have jointly prescribed.

The foundations have increased these maximums nearly on a yearly basis since they were formed in 1969 and 1971, and only 5 to 15 percent of the doctors in Maricopa Foundation bill less than the prescribed maximum.

Significantly, when the foundations tried to identify issues of fact for trial, they did not suggest that the medical practices of their members were integrated into a partnership or a joint venture arrangement. The undisputed fact is that the doctors here involved are hundreds of independent practitioners engaged in traditional fee for service medicine.

Accordingly, their price fixing falls into the category of a naked restraint, and is not an essential facet of joint integrated medical practice.

We note in this connection that the claims payment and review activities which the foundations carry on do not require that the doctors prescribe their prices, and the foundations have never made any contrary assertion.

In a period in which everyone is vitally concerned with inflation in the health care industry, it may seem somewhat unusual for the government to argue that doctors should not ban together and prescribe maximum prices for themselves. In fact, however, maximum price fixing is no cure for rising costs in the health care industry. Maximum price fixing has many of the objectionable features of an

ordinary price cartel.

For example, if the doctors --

CHIEF JUSTICE BURGER: We will resume there at 1:00 o'clock, Mr. Shapiro.

MR. SHAPIRO: Thank you, sir.

(Whereupon, at 12:00 p.m., the Court was recessed, to reconvene at 1:00 p.m. of the same day.)

AFTERNOON SESSION

CHIEF JUSTICE BURGER: Mr. Shapiro, you may continue.

ORAL ARGUMENT OF STEPHEN M. SHAPIRO, ESQ.

AMICUS CURIAE - RESUMED

MR. SHAPIRO: Thank you, Mr. Chief Justice.

Our submission is that maximum price fixing has many of the objectionable features of an ordinary price cartel, and that is the reason this Court condemned it in Kiefer-Stewart as illegal per se.

For example, if the doctors prescribe a maximum price of $1,000 for a particular operation, and most of them actually charge that maximum, as the record here shows, then the maximum has many of the features of a fixed uniform price, and since it is always in the power of the combination to raise the price, the so-called maximum is not a maximum at all, because it can be hiked at will by the doctors themselves, as this record clearly shows.

Moreover, this Court has never suggested that a professed goal of having reasonable prices is an excuse for price agreements among competitors.

QUESTION: Do you think Arizona's primary complaint here is the predatory nature of the agreement or the keeping out of other doctors?

MR. SHAPIRO: Arizona's point is that the

agreement could be used to keep out other doctors through depression of the price, and it could be used to inflate the cost of health insurance through elevating the costs. It is the aggregation of power through the combination to do those two things that is illegal.

QUESTION: But don't you need to know something about the market?

MR. SHAPIRO: You do not. That is precisely what you don't need to know in a case of naked price fixing, as this Court held in Socony and in Trenton Potteries, and many of its other decisions.

QUESTION: You used the phrase "could be used".

MR. SHAPIRO: It is the potential, as the Court pointed out in Trenton Potteries. It is the aggregation of power to -- which could be pressed to improper ends that Section 1 of the Sherman Act condemns as illegal per se. The aggregation of power in a price fixing combination.

This Court's -- Let me illustrate the point that I was making a moment ago. If the foundations were permitted to enforce their own conception of a reasonable maximum price, there would be an inevitable tendency to adjust that price upwards to promote their own economic welfare, and as this Court emphasized in the Socony case, those who fixed reasonable prices today would fix unreasonable prices tomorrow, and any insurance company that wished to do

business with the combination would be compelled to pay up to the fixed maximum price.

I would also point out in this connection that although the foundation's claim that a maximum price is essential to contain medical costs, they fail to suggest a single reason why that maximum price needs to be prescribed by a combination of competitors. If in fact a maximum price is a useful feature in medical insurance plans, the maximum can be prescribed by individual insurers who pay for the medical services and who actually have an incentive to reduce medical expenditures. That is the way the Blue Shield insurance policies operate throughout this country.

The present price fixing scheme prevents individual insurers from obtaining competitively negotiated agreements with individual doctors, and interferes with their efforts to contain medical costs. That is bad for the consumers, who pay for the insurance premiums.

In short, this price fixing scheme poses a serious threat to competitive conditions. It can be enjoined without causing injury to any joint productive activity. In these circumstances, we submit, the per se rule is properly applied, and it is properly applied on the record which is now before this Court. As this Court pointed out in the White Motors case some time ago, it is perfectly appropriate to use summary judgment procedures in a horizontal price

fixing case, and it referred to the Kiefer-Stewart decision, which is a maximum price fixing case, in making that observation.

For these reasons, we respectfully submit that the decision of the Court of Appeals should be reversed.

QUESTION: Mr. Shapiro, may I ask you one question, if you are through? You said there are two components of this agreement, one an agreement on what the schedule shall be, and secondly, each doctor agrees not to charge his customers more than the schedule, as I understand it, insured, where there is insurance, and you said Blue Shield is different in that Blue Shield specifies the schedule.

Would the Blue Shield program be illegal if Blue Shield specified the schedule and if every doctor that participated in the program agreed not to charge in excess of the schedule?

MR. SHAPIRO: The Justice Department's consistent position has been that if individual doctors sign up individually on the dotted line, which is the procedure, it is perfectly all right. But if the doctors combine together and use their concerted power to negotiate with the individual insurer to establish that price, that is illegal per se. That is what our business review letters have said for the past decade.

Thank you very much.

CHIEF JUSTICE BURGER: Mr. Berelson.

ORAL ARGUMENT OF PHILIP P. BERELSON, ESQ.,

ON BEHALF OF THE RESPONDENTS

MR. BERELSON: Mr. Chief Justice, and may it please the Court, this is a summary judgment case, and because of that I am going to spend a great deal of time talking about the facts and the lack of facts that are undisputed and are in the record.

First, I would point out that Respondents have submitted a statement of material facts in issue precluding summary judgment. It is found in the appendix, at Page 123, and I think it deals with many of the issues which I am going to discuss.

Most important, there is no fee schedule, no fee schedule as Petitioner and as the United States have used that term today. The evidence shows that there is no agreement concerning what doctors charge patients, and the District Court so ruled, and that is right in its opinion.

What the Petitioner is calling a fee schedule is really an agreement by members of a medical foundation which only affects medical foundation endorsed insurance, and it is an agreement to accept the maximum reimbursement levels as payment in full in the event that the doctor bills the patient more than that maximum reimbursement level and the

patient is medical foundation insured. Then the doctor will write off the difference.

If the doctor is not a member of the foundation, then the doctor is free to charge the difference to the patient.

This is accompanied by agreements by the members of the foundation to be bound by peer review, not to use the foundation to change the rates they bill their patients, not to discriminate in billing between foundation insured and non-insured patients, and it has absolutely no effect whatsoever without the additional component of an insurer voluntarily agreeing to participate in the program, and there is no evidence in the record that there is any ability to coerce insurers to participate. Indeed, the record is absolutely empty as to what the insurers really do in the market.

All we can say, and this is very limited, is that in 1979 Maricopa Foundation, one of the Respondents, insured about 1,000 people out of a population of 1.5 million in Maricopa County, about 7 percent, and in 1978, Pima Foundation covered about 6,000 people, or about 1 percent of the population of Pima County, and in that same year, only 31 percent of the physicians in Pima County were members of Pima Foundation. So, it is not an organization which exercises any sort of dominance over delivery of medical

care in the two areas where the Respondents are operating.

QUESTION: What is the connection shown by the record between the Pima Foundation and the Maricopa Foundation?

MR. BERELSON: There is none. There is no showing -- since it is summary judgment there would have to be undisputed facts.

QUESTION: Yes.

MR. BERELSON: There are no undisputed facts showing any connection other than that the Pima Foundation acted as an agent for the Maricopa Foundation for Maricopa Foundation endorsed plans when the patient happened to be in Pima County.

QUESTION: That is why you say on Page 123 of your statement in opposition to summary judgment that with respect to plaintiff's statement, one, that membership of Maricopa County Foundation includes medical doctors, you have no information sufficient to admit or deny plaintiff's statement with respect to Pima Foundation?

MR. BERELSON: They are entirely separate organizations. They are separate, and Maricopa Foundation does not participate in running of Pima, and Pima does not participate in running of Maricopa. And the record shows that their reimbursement schedules were different.

QUESTION: And yet the Petitioners here want a per

se rule applied to both.

MR. BERELSON: That is right. If you look at the complaint, there are allegations about an overall conspiracy throughout the state, but that has never been proved, and that is something that would certainly be disputed.

QUESTION: Well, did the Court of Appeals hold that the per se rule was not to be applied?

MR. BERELSON: At this stage --

QUESTION: Did it say on a remand that perhaps the evidence would show that a per se rule should be applied rather than rule of reason?

MR. BERELSON: I believe the Court of Appeals decision left that open. It is possible.

QUESTION: Do you leave it open? Would you say that you are not asking this Court to rule now that the rule of reason should apply?

MR. BERELSON: I am asking the Court to rule that on this state of the record, the rule of reason must be applied to determine whether or not there is a violation that will entitle the Petitioner to summary judgment, but when we have a trial, then we will have a full record, we will know the context, we will know the marketplace, we will have the experience for the Court to determine whether there is the type of conduct that could in the future be characterized as per se --

QUESTION: So you say when all of the evidence is in, it could be that you would lose but not under the rule of reason, but the Court wouldn't necessarily have to apply the rule of reason for you to lose.

MR. BERELSON: We contend that when all the evidence is in, we will win.

QUESTION: Of course you do.

(General laughter.)

MR. BERELSON: But if we assume that the Petitioner's facts were correct, then after you had the full evidentiary hearing and were able to determine whether the facts that we are putting forth are indeed the correct facts or not the correct facts, the Court may disagree with us, and it may say this is a per se violation. We don't think that will happen on the facts as they are developed.

QUESTION: But you are not asking this Court right now to say that we should reverse and remand for a trial under the rule of reason?

MR. BERELSON: I am saying --

QUESTION: I mean, with a final judgment based on the rule of reason.

MR. BERELSON: I am saying that in this particular case you have to reverse and remand for a trial and at the tiral when the evidence is in the judge will be able to determine whether or not the rule of reason should apply.

He won't know until he knows what the facts are.

QUESTION: The answer to my question is no, then.

MR. BERELSON: That's right. There is no evidence in this record supporting the Petitioner's claim that the maximum reimbursement rates of the medical foundation result in physicians' revising prices upward, because there is very little evidence in the record as to what pricing takes place in Maricopa or Pima Counties at all. What we do know from the record is that the Maricopa Foundation maximum reimbursement rates have lagged well behind the rate of increase of medical fees and the rate of increase of inflation both for medical and for general cost of living, both national and --

QUESTION: That is something you would rely on if you were trying the case on the merits, isn't it?

MR. BERELSON: That is right, but what I am trying to demonstrate to the Court is that what the Petitioner claims are undisputed facts are not facts at all.

QUESTION: Are you also suggesting that in any event this negates the idea of applying a per se rule?

MR. BERELSON: What we are saying is that unless the Petitioner can demonstrate an effect on price in the marketplace which it has chosen, that there can't be a per se violation. They have failed to do that.

QUESTION: May I ask whether the record shows that

maximum fees have been increased each year? I think someone suggested that.

MR. BERELSON: There have been increases. It has not been each year. But what --

QUESTION: How often since the agreements first went into effect?

MR. BERELSON: It happens -- I think there have been five prior to the time that the lawsuit was -- prior to the summary judgment motion, and --

QUESTION: Five increases?

MR. BERELSON: Five increases, and if you look at Appendix --

QUESTION: Over a period of how many years?

MR. BERELSON: Since -- I believe that is from 1971 in the case of the Maricopa Foundation, but I may be wrong on that year. The Appendix C to our brief shows the amount of the increases in the reimbursement levels of the Maricopa Foundation, and he compares it against published statistics on the rate of increase of medical fees in Maricopa County and nationwide, and shows that the rate is less for the maximum reimbursement levels, and that is consistent with the contention that we intend to prove at trial that the medical foundation is a mechanism for holding down costs, and it is the cost to the insurer of providing the medical care that the insurer has contracted to

indemnify.

I would like to explain how that works. You have to look at the three groups that are interested here. It was an observation from the Court which is quite true that there is a tripartite situation.

You have the patients. What does the patient want? A patient wants a commitment from his insurer to pay the medical bills. The patient does not want to have to pay a difference between what the insurance covers and what the doctor bills. He wants the insurance to cover the medical procedures which are necessary, not to be told that he can't have the procedure because he can't afford it and it is not covered.

He wants the best quality of care. He wants to choose the doctor who will give the care. And he wants the insurance cost to be as low as possible, consistent with delivering the other things that he wants.

QUESTION: Mr. Berelson, may I interrupt? I may have misunderstood something you said before. In order to accomplish the objectives you have just described, is it correct that the doctor members of the association agree that the patients will not have to pay anything more than the maximum fee schedule?

MR. BERELSON: They agree that that is true if the patient is covered by --

QUESTION: If he is covered, yes.

MR. BERELSON: -- by the foundation insurance, and if the doctor has become a foundation member.

QUESTION: Right.

MR. BERELSON: And the record shows that --

QUESTION: But limiting it to patients who have the insurance and doctors who are members of the foundation, is it clear on this record that there is an agreement establishing the maximum which the patients must pay?

MR. BERELSON: No, it is an agreement establishing that the patient pays nothing, the insurer pays --

QUESTION: Well, right, but the maximum the insurance company will pay --

MR. BERELSON: Exactly.

QUESTION: -- which in turn allows it to charge a lower insurance rate, presumably.

MR. BERELSON: Exactly. The maximum the insurer has to pay --

QUESTION: So it is clear on the record that there is an agreement to fix the maximum fees that the doctors will receive for the services performed for this particular segment of the market.

MR. BERELSON: No, because it's an agreement to make a proposal to insurance companies, which they are free to accept or reject. It doesn't fix anything.

QUESTION: Yes, but once the insurance -- it is a tripartite thing.

MR. BERELSON: That's right.

QUESTION: Once the insurance companies have accepted, and I think four of them have, there is then in effect an agreement among the doctors that in this particular segment of their work they will receive a maximum of so many dollars for such and such a service.

MR. BERELSON: Exactly, and it is an interesting fact that the doctor does not know, because he doesn't have circulated to him a listing in advance as to what those are going to be. He is supposed to charge all his patients the way he ordinarily charges them, and when the patient happens to be foundation insured, the foundation will pay the claim, and if the bill was more than what the maximum reimbursement level is, the doctor is informed of this, and then he has to write off the difference.

Now, let's look at what the insurer would like. The insurer would like to keep down the cost of the medical care that it is obligated to indemnify the patient for. That means minimizing the payments for the treatment that must be given, avoiding unnecessary treatment, and the insurer can also lower the cost by limiting the extent of the coverage of the insurance, by excluding coverage of certain procedures or certain types of illnesses.

The insurer would like to accurately predict the costs of medical care because that enables the insurer to make better actuarial predictions, which means that it can lower its rates because it doesn't have to have a reserve to cover the unexpected, and it is worth pointing out that a big element in that unexpected is usually inflation, and the possibility of increases in the costs of medical services which you can't tell in advance. You are writing insurance that covers a period of time. You don't know what the cost of a particular procedure is going to be a year from now in the community.

The insurer needs a mechanism to negotiate cost containment. He needs one which is inexpensive and administratively feasible. He cannot go out and send his agents to negotiate individually with every one of the doctors in the community. In the record we see a number of 1,700 in Maricopa County, and keep in mind that you are talking about a number of insurers who do business in Maricopa County, although the number is not defined in the record.

But if we assume that it is even 50, if you have 50 insurers each trying to negotiate with 1,700 doctors, you can see the administrative nightmare that you get.

QUESTION: What about your colleague's suggestion that Blue Cross operates a little differently?

MR. BERELSON: Blue Cross does sometimes, but sometimes Blue Cross runs a foundation endorsed medical plan, so --

QUESTION: Well, what about the times, those sometimes --

MR. BERELSON: Yes.

QUESTION: -- that it manages to run its business without having an agreement among the doctors?

MR. BERELSON: Well, the point that I am trying to make is that --

QUESTION: They have individual doctors who sign up with them.

MR. BERELSON: Yes, but the same thing happens here. The individual doctors sign up with the medical foundation.

QUESTION: Well, something more than that happens here. This is an agreement among the doctors. In the Blue Cross case, Blue Cross seems to be able to present their schedules and get individual doctors either agreeing or not.

MR. BERELSON: The same thing happens here. The Maricopa Foundation --

QUESTION: No, something more than that happens here.

MR. BERELSON: Not at all. That is the point I am trying to make. The board of trustees of the medical

foundation --

QUESTION: I thought you just told Justice Stevens there was an agreement among the doctors.

MR. BERELSON: The agreement is not among the doctors. It is between the doctor and the medical foundation that the doctor will accept the medical foundation maximum payment --

QUESTION: Well, all right. You told Justice Stevens that once the insurance company agrees the doctors are bound to charge no more than a maximum fee, and that they have agreed among themselves to that.

MR. BERELSON: No, the doctor charges his usual fee, but is paid by the insurance some amount which may be less, and if it is less, he writes off the difference.

QUESTION: Well, he has agreed to collect from the customer no more than a maximum amount.

MR. BERELSON: He collects nothing from -- he has agreed to collect nothing from the customer, with the possible exception of a deductible. It becomes a transaction entirely between the doctor and the insurer and the patient is out of it.

QUESTION: Well, suppose as we read the record it doesn't look to us like this is the kind of an operation that Blue Cross runs.

MR. BERELSON: Well, that is right. It is not the

type of operation that Blue Cross runs, and that is why you have to have a factual understanding of what it does do in order to understand that it is a cost containment mechanism.

QUESTION: No, but you are suggesting it would be administratively impossible --

MR. BERELSON: Yes.

QUESTION: -- for the insurance company to operate with individual doctors without this kind of an arrangement.

MR. BERELSON: That is right. What I am suggesting is, the medical foundation does the same thing in this arrangement that Blue Cross does in its plans. Blue Cross sets a standard as to what the reimbursement will be on a Blue Cross plan. The doctor accepts it or rejects it.

QUESTION: Individually, but he doesn't get together with others and --

MR. BERELSON: Exactly. The same thing happens here, Your Honor. What happens here is, the medical foundation offers the doctor the opportunity to either individually accept or reject membership in the foundation, and there is evidence in the record of many doctors who feel that the maximum reimbursements are too low, and they reject it. Nobody is forced to join the foundation.

QUESTION: Who are the trustees or members of the foundation?

MR. BERELSON: The trustees are members of the

medical profession elected by the membership. Now, we have cited in our brief a study performed by Mr. William Link which was published in the Journal of Law and Economics, and the important point of that study is that the empirical evidence and the theory behind it demonstrates that when members of the medical profession perform this function of proposing a maximum reimbursement level, empirically, the result is that you get a lower level, and you get more doctors agreeing to accept it as payment in full.

That is the evidence that we would put in at trial to demonstrate that this is a pro-competitive cost containment device, and that there is no effect on the fee that the patient pays. There is an effect in that the cost of the insurance that he buys may be lower, and that is good.

QUESTION: Are there different insurance companies competing for the business of the foundation, or is it a self-insurer?

MR. BERELSON: No, any insurance company can offer a foundation endorsed plan. All they have to do is agree to the minimum standards of the foundation, and if they agree that the plan will meet those minimum standards, it becomes a foundation endorsed plan. You can have two insurers competing for the same business with the foundation with different --

QUESTION: Yes, but the prices have to be agreed

on, don't they?

MR. BERELSON: No.

QUESTION: Everybody charges the same --

MR. BERELSON: No.

QUESTION: I mean, don't they all have to follow the same fee schedule?

MR. BERELSON: No, there is no limit on what the insurer charges for the insurance.

QUESTION: No, I don't mean that. Don't all the insurance companies who sponsor foundation plans agree that they will reimburse doctors at the same rate?

MR. BERELSON: That is right. The rate which has been proposed by the medical foundation. But the important thing to remember is that the insurer does not have to accept that proposal. If the insurer can do better on its own, if the insurer can negotiate with doctors a lower reimbursement rate, there is nothing to stop it from doing that.

What I am suggesting to you is that as a empirical matter, which we can prove at trial, if given the opportunity, they are not going to get in the marketplace a better deal than they will get with the medical foundation.

QUESTION: Doesn't that all boil down to the question that -- the question that is presented is whether it is unlawful for a group that is not shown to be a

monopoly to agree among themselves on maximum prices, and would it be a defense for them to show that those prices are lower than the free market?

MR. BERELSON: No, that is not what it is at all, because they haven't agreed on a price. They have agreed on a proposal that anybody can accept or reject, and if it is rejected, it is not the price. The price is what they would ordinarily charge.

QUESTION: Yes, but the record shows that it has not been rejected, it has been accepted.

MR. BERELSON: No, it has been rejected, because only 7 percent of the people in Maricopa County are insured under this. The other 93 have rejected it.

QUESTION: Do those 7 percent of the people -- the rates of those people are enough to account for $1.8 million a year, the bond premium?

MR. BERELSON: No, no, that number just has nothing to do with what we are talking about here. The number that is important is that for the people who have been insured, the foundation can show for Maricopa County a saving of $8 million compared to what the medical fees would have been.

QUESTION: How many people are involved, if there is $8 million in savings every year?

MR. BERELSON: No, it is $8 million aggregate from

the start of the foundation. There is no number in the record for any particular year.

QUESTION: How many years are involved in the $8 million saving?

MR. BERELSON: I am not sure whether that is 1968 or 1971.

QUESTION: About ten years? So around $800,000 a year?

MR. BERELSON: Okay.

QUESTION: Savings, and that means that what are the aggregate amounts of money paid, then, if that is the savings between what it would be under this program as against some other program?

MR. BERELSON: There is nothing in --

QUESTION: It must be several million dollars.

MR. BERELSON: There are undoubtedly millions of dollars paid out through this mechanism. No doubt about it. Now, what we are saying is that this mechanism reduces that cost without --

QUESTION: Is that just 7 percent of the market then?

MR. BERELSON: -- without doing anything to demonstrably affect the price that a patient is being billed by his physician. If the patient doesn't use the foundation, there is no effect from the foundation.

QUESTION: Is it your contention -- let me just --

MR. BERELSON: Yes.

QUESTION: Is it your contention that even if the record convinces us that there is an agreement here to impose a maximum level on charges by doctors to insurance companies and patients, that that is not unlawful unless it is further shown that in a free market the rates would be higher? Is that your position?

MR. BERELSON: The rates would be different, not higher.

QUESTION: All right, that they would be different.

MR. BERELSON: Right, and we are talking about the rate that the doctor charges the patient, because that is the marketplace which the Petitioner is claiming a monopoly or price fixing in. The only effect on price is the cost to the insurer. That is the effect of the medical foundation. Petitioner complains that this is price fixing on what the patient is charged. There is no evidence of that. And there is no evidence that it fixes the price that the insurer must pay.

QUESTION: But you say the very purpose of the whole arrangement is to keep insurance costs down, so the purpose of it is to minimize the insurance costs for the patients.

MR. BERELSON: That is right, and let me explain

why.

QUESTION: I assume you think it will work, if you are doing it.

MR. BERELSON: That's right, and it does work to the extent that some --

QUESTION: But you say it is good for the market because it provides cheaper medical care and cheaper insurance, but I don't think you are saying it is a totally useless gesture, or why bother with it?

MR. BERELSON: No, it is a very useful thing to do, and the reason --

QUESTION: Because it keeps costs down.

MR. BERELSON: And also because it enables the patient to get a product he couldn't get otherwise, because the only way you can get the type of insurance that will cover the entire cost of medical care and not have the patient pay the difference between a maximum and what the billing is is to have some type of operation such as this. Somebody has got to get doctors to agree to accept the maximum paid by the insurance as payment in full.

QUESTION: Mr. Berelson, let me put it to you directly. Do you contend that the arrangement that you have described has any impact on the costs, on anybody's charges for anything?

MR. BERELSON: Yes, it reduces the costs --

QUESTION: It keeps prices down, doesn't it?

MR. BERELSON: -- the costs of insurance --

QUESTION: It keeps the prices lower than they would be under a free market.

MR. BERELSON: There is a free market. It is an alternative in that free market that --

QUESTION: Well, it keeps them lower than if you didn't have this arrangement.

MR. BERELSON: That's right, because the arrangement gives you something different than the individual doctors could offer, and in that way it is like the Broadcast Music case, because what you have is something that --

QUESTION: It seems to me your position boils down to the contention, and maybe you are right -- I am just trying to think it through --

MR. BERELSON: Yes.

QUESTION: -- that an agreement to maintain prices is permissible if it will keep prices down.

MR. BERELSON: No, because there is no agreement that is maintaining prices. We are giving people an option. There is a proposal that is out there. If they accept it, the cost to the insurer is lower. If they don't accept it, maybe the insurer can do better on its own. The record is silent on that. We have to explore that. I am

suggesting that authorities, secondary authorities that we can look at and which, even though they are not in the record, support our contention, that we can prove this at trial.

It is the conflict between the doctor's goals, the insurer's goals, and the patient's goals that inflict a market force on medical foundations and prevent them from fixing a price at whatever they want.

QUESTION: Isn't it true that the patient can go to any doctor he wants to in the county?

MR. BERELSON: Absolutely.

QUESTION: And if he goes to a non-member, he is taking the risk that he will be charged whatever the doctor wants to charge him.

MR. BERELSON: That is right.

QUESTION: And how many, what percentage of the patients do you say are covered by --

MR. BERELSON: About 7 percent of the people in the county --

QUESTION: Have insurance?

MR. BERELSON: -- have this type of insurance in 1978, I believe.

QUESTION: How many of them go to doctors that are members? Or do you know?

MR. BERELSON: I don't think we can tell from the

record we have now.

QUESTION: I take it that the insurance -- that an awful lot of doctors -- a lot of patients are going to non-member doctors.

MR. BERELSON: Yes, yes. I would think so.

QUESTION: And the insurance company seems to get along all right.

MR. BERELSON: Sure, because the way the foundation --

QUESTION: Because they just announce -- the insurance company just has a -- it just says there is a maximum that I will reimburse for, that's all.

MR. BERELSON: That's right, and the patient gets the same amount paid to the doctor whether the doctor is a foundation member or not. There is no evidence of any effect that would coerce doctors to join the foundation, coerce patients to use foundation doctors, coerce insurers to use foundation insurance.

QUESTION: Without any foundation at all, why couldn't the insurance companies sell policies and say, here is our schedule, we will reimburse up to a certain amount for these procedures. If your doctor happens to charge you any more, that is too bad.

MR. BERELSON: That is exactly what happens, Your Honor.

QUESTION: yes.

MR. BERELSON: The difference in that situation is, the patient never knows in advance whether what the insurance pays will cover what the doctor bills. If he is a member of a foundation plan, and if the doctor is a foundation doctor, then he knows in advance that whatever it costs, the foundation insurance will pay the entire bill, and he doesn't have to worry about the difference.

QUESTION: Well, I don't see why this arrangement has anything to do with insurance rates. It has got to do with whether patients have some limit to their medical bills.

MR. BERELSON: That is the benefit from the point of view of the patient, and that is why doctors who are engaged in independent practices have an incentive to join a medical foundation, because this enables them to offer something to the patient which looks to the patient like an HMO. An HMO does the same thing in the sense that for a fixed amount of money paid for HMO, you get all the medical care that you need.

A doctor in private practice couldn't do that by himself.

QUESTION: Is there any -- I asked before, but I take it that it is correct that there is nothing in the record to indicate what the position of the non-member doctors in the community is with respect to this arrangement.

MR. BERELSON: The only evidence --

QUESTION: It must be that they haven't joined, they don't like it.

MR. BERELSON: Yes, there is evidence. One of the affidavits points out that a number of doctors have refused to join because they feel that the maximum reimbursements are so low that they are unfair and they just can't accept them. That is the only evidence that I am aware of in the record with respect to non-members.

We have urged that there is no showing that people are coerced to do this. People are free to do it or not, and therefore, the market forces come into play.

QUESTION: Well, none of them have claimed that what this really is is a conspiracy among the member doctors to run them out of business by setting rates, setting low rates and getting all the patients there are in town?

MR. BERELSON: Well, that is a concept that was introduced in the reply brief by the Petitioner, but it just doesn't make any sense from the economic --

QUESTION: There is nothing in the record about it, is there?

MR. BERELSON: That's right. Nothing in the record. You have to go back and get evidence in order to see whether that had anything to it or not.

What we are saying is that this foundation is

structured so that market forces do come into play.

QUESTION: Well, it is real strange that you say that it is perfectly obvious that this whole thing saves money, when one of the large patients, so-called, the state of Arizona, says, it doesn't save us any money at all; as a matter of fact, it costs us money. Apparently that is what they are saying.

MR. BERELSON: No, I don't believe that is what they are saying, and we show --

QUESTION: Well, why are they objecting, if you are saving them a lot of money?

MR. BERELSON: That is what I would like to know, Your Honor. It doesn't make any sense.

QUESTION: Isn't the reason, one of the reasons for their objection the feeling that if your organization were not in business, more HMOs would be in business?

MR. BERELSON: If that is their position, there is nothing in the record to support it, and it is not the basis for summary judgment. Yes, that may well be what they ultimately intend to show.

QUESTION: Well, they certainly are -- the state pays out a lot of money for insurance.

MR. BERELSON: Yes. We --

QUESTION: So they don't think that you are bringing them any Christmas present.

MR. BERELSON: Well, but the record does show that when the fostered chosen care plan for Arizona went from the Maricopa Foundation reimbursement schedule to a different one, the state paid more money for the same medical services. Why did they do that? I submit it makes no sense at all. They did it because they thought that what Maricopa Foundation was doing was not legal, and therefore they didn't want to participate in it.

But what we would like is an opportunity to show that it is legal, it saves costs of insurance, it lowers insurance costs. The market forces control what the maximum reimbursement rates can be. If the rates get too high, insurers will not write Maricopa Foundation or any medical foundation insurance. They will set their own reimbursement levels that are lower.

If the rates are too low, the doctors just won't renew their membership in the foundation. Unless you have broad coverage, a large number of doctors participating, you don't get the attraction of a lot of physicians who will accept payment as payment in full. So, that will cause the rates to go up. You hit an equilibrium which according to the Link study is going to be in the neighborhood of the average or median charge in the community.

QUESTION: Is there a state antitrust law?

MR. BERELSON: Yes, there is. As a matter of

fact, this action arose out of an investigation that was supposedly under the state antitrust law. They took depositions. They had a CRD type procedure.

QUESTION: But this suit wasn't based on the state antitrust law?

MR. BERELSON: There is a pendent state claim.

QUESTION: There is a pendent state claim.

MR. BERELSON: In the federal action, which was not the basis for the summary judgment motion which you have before you today, but it is there. The state law is the Uniform State Antitrust Law, which is very similar to the Sherman Act. Indeed, it says that you look at the Sherman Act precedents.

In the opposition to the summary judgment motion, the medical foundations have argued that the maximum reimbursement levels are essential to the concept and operation of medical foundation endorsed insurance. We should be given an opportunity to produce the evidence and present it at a hearing to determine that.

The situation is very similar to the type of activity that the Court sanctioned in the Broadcast Music case. You have the creation of a new product, different from what any individual doctor could offer by himself. What happens is, you get full coverage insurance, which pays medical costs in full, and a peer review to avoid

unnecessary procedures. The medical foundation does put the doctor at risk, and the evidence of that is in the appendix at Page 309.

The doctor is not compensated for any additional complexity or difficulty in treatment. If he would charge more than the maximum reimbursement level because of complexity or difficulty, it is too bad, if he is dealing with a Maricopa Foundation patient and he is a Maricopa Foundation member. He has to write it off. If he performs a treatment which he in good faith believes is medically necessary, and peer review of the medical foundation disagrees with him, he is at risk for that. He has to write it off and accept their judgment.

If the costs of medical services that he must buy, if his costs of supplies and help go up because of inflation, he can't increase what he receives on the Maricopa Foundation patients. He is locked in for a year by his membership. And at the end of the year, he may decide not to renew, but at least for that one year he is at risk for the costs and the inflation factor.

The medical foundation reduces the transaction costs. It enormously simplifies the negotiations between insurers and physicians. It limits the complexity of establishing understandable maximum reimbursement levels which can be administratively handled in payments. It

lowers the cost and complexity of claim processing, and one of the functions that the medical foundations perform is the claims processing function for the insurers if the insurer desires them to do that.

All of these things make a medical foundation the same type of pro-competitive activity that the Court sanctioned in the Broadcast Music case. It doesn't affect the prices that the individual doctors charge individually. It only affects the prices that somebody can agree to accept by agreeing to Maricopa Foundation or Pima Foundation endorsed coverge.

QUESTION: Where in the record do we find this information that has been alluded to about the comparison between the increase in costs under this plan and national inflation figures and national medical fees?

MR. BERELSON: Appendix C in the back of the Respondents' brief. It is all --

QUESTION: Appendix?

MR. BERELSON: Yes, it is right at the back of the brief, the very last pages. You can see there --

QUESTION: What page is it, now?

MR. BERELSON: Just turn to the back, right inside the back cover.

QUESTION: Oh, yes.

MR. BERELSON: And you can see that the rate of

increase and the average annual change is less than any of the other numbers there which are there for purposes of comparison, the National Index for Medical Care, the Consumer Price Index for Physician Services, the Metropolitan Phoenix Medical Care Index.

Whether or not the same result could be accomplished in a less restrictive way is something that is in dispute, obviously, listening to Petitioner's argument and Respondents', and that in itself shows that this is not a case that is ripe for summary judgment at this time. We need to know more. We need to know enough about the industry in which this happened. We need to know about what the effects of this are.

QUESTION: I must confess, I am puzzled about why we need to know more. I can understand your argument that it is not necessarily unlawful. But can't we assume that you are going to prove that you have kept prices down, or kept the rates down, and that you have done a wonderful job for the people of the city, and there are still the same legal issues there?

MR. BERELSON: Well, the legal issue is whether you are going to characterize that as price fixing, and what I am suggesting to you is that the evidence that is in this record does not enable you to make that characterization.

QUESTION: I don't see how a showing that the

prices are lower than they would have been if they followed the general trend in the economy has any bearing on whether it is price fixing or not.

MR. BERELSON: Because we are talking about different prices for different things. We are talking about a comparison between what doctors bill patients and what insurers pay for the services that they have agreed to provide to their insureds.

QUESTION: I understand all that, but I just don't understand how any of the things you have described are relevant to the legal issue.

MR. BERELSON: They are relevant because they show that --

QUESTION: We have to decide, A, is this a price fixing agreement, and B, if it is, it is obviously maximum rather than minimum, although I know there is an argument to the contrary, but I think you are definitely right on that, and if it is a maximum price fixing agreement, is it unlawful.

MR. BERELSON: Well, you have to look at it in the same way that the Court analyzed the Broadcast Music agreement. Are you creating something that is different? In Broadcast Music --

QUESTION: You are arguing that you are creating something different.

MR. BERELSON: That's right.

QUESTION: You say it is good, because it keeps prices down.

MR. BERELSON: No, we are saying it is good because it offers a different product than the individual doctors offer.

QUESTION: Well, the doctors don't perform different operations under this plan than if there were a free market. You don't really contend that.

MR. BERELSON: Yes, but they --

QUESTION: You hope they don't, anyway.

MR. BERELSON: They agree that they will not have the patient at risk for the difference --

QUESTION: They won't charge any more than the schedule.

MR. BERELSON: -- between what his insurance is and what the bill is. It is a very important difference if you happen to be a patient and you don't have that type of insurance coverage, and it is the same sort of thing that you have in Broadcast Music, because you also have the alternative, and there is nothing in the record to contradict that everybody has the alternative of doing it individually, unilaterally, and that the pricing of that transaction is not affected in any way by the operation of this particular entity which is giving you a new type

service, a new type of product, and that is the important --

QUESTION: Your heavy reliance on Broadcast Music makes me wonder if you are in effect acknowledging that the fact that it is doctors in the medical profession doesn't really have much bearing on the issue.

MR. BERELSON: The fact that it is doctors in the medical profession suggests that we have to know more in order to see whether doctors in the medical profession should be treated like people who sell iron pipe or people who sell gasoline. I suggest that you don't treat them the same because the considerations are different.

QUESTION: Or people who sell music.

MR. BERELSON: Excuse me?

QUESTION: Or people who sell music.

MR. BERELSON: Or people who sell music. The considerations are different. The Court has recognized that the considerations can be different. We have to have a full record to see whether in fact they are different, and until you know that, you can't condemn this, or you shouldn't condemn this.

Furthermore, it would be unfair to have summary judgment granted before the Respondents have had an opportunity to put in the record the evidence that they claim shows pro-competitive aspects and the lack of affect on price of this particular conduct. We haven't had that

opportunity. I have alluded to the pre-complaint discovery that the Petitioners had. Because of the way this case came through procedurally, we just haven't had discovery on who is in the market, how they price, whether there is any effect all on their prices.

QUESTION: Well, the most, if I hear you, that you could really insist on is that we ought to have a mini-trial first to see whether the rule of reason applies, or whether it is per se.

MR. BERELSON: It would be something like what happened in the Society of Professional Engineers case, in which you developed a full record.

QUESTION: But you wouldn't necessarily have an entire antitrust trial on the assumption that the rule of reason was going to apply.

MR. BERELSON: It would depend upon whether the judge thought that would be the most expeditious way. He could have the full trial and then during the course of the trial make that determination.

QUESTION: But you wouldn't be entitled to it. Under the argument you are now making, you should have no more than a chance to put whatever evidence in that might be useful in deciding whether this is per se illegal price fixing.

MR. BERELSON: Yes, and unless the Petitioner was

able to put in undisputed facts to show that it was per se, then they cannot prevail on a per se theory and you do have to have that trial.

QUESTION: Do you think that a district judge has discretion in the timing of his decision as to whether to grant or deny a motion for partial summary judgment?

MR. BERELSON: I think a district judge does, but that the discretion has to take into account the experience and the theory and whether the precedents which deal with per se liability on price fixing are applicable and appropriate in this particular type of marketplace on the particular facts that are set forth.

In this case, the district court, if he has discretion, exercised it wisely, we believe, and we are just asking you to uphold that and to allow the proceedings to go back to their normal course, have discovery, and have a determination after appropriate discovery and after a full record.

Thank you.

CHIEF JUSTICE BURGER: Thank you, gentlemen. The case is submitted.

(Whereupon, at 1:45 p.m., the case in the above-entitled matter was submitted.)

CERTIFICATION

Alderson Reporting Company, Inc. hereby certifies that the attached pages represent an accurate transcription of electronic sound recording of the oral argument before the Supreme Court of the United States in the matter of:

ARIZONA vs. MARCIOPA COUNTY MEDICAL SOCIETY, ET AL.

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BY