IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 01-17451

INTERNATIONAL HEALTH CARE MANAGEMENT, et al.,

Plaintiff-Appellants

v.

THE HAWAII COALITION FOR HEALTH, et al.,

Defendants-Appellees

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF HAWAII

BRIEF FOR THE AMERICAN MEDICAL ASSOCIATION AS AMICUS CURIAE IN SUPPORT OF APPELLEES

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DISCLOSURE OF CORPORATE AFFILIATIONS AND FINANCIAL INTEREST

Pursuant to Fed. R. App. P. 26.1, amicus curiae American Medical Association ("AMA") makes the following disclosure: AMA is a not-for-profit professional membership association that does not have stock.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Other Authorities

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INTEREST OF AMICUS CURIAE

The American Medical Association submits this brief amicus curiae in support of defendant-appellees Hawaii Coalition for Health, Hawaii Medical Association, Queens Physician Group, and several individual physicians. Founded in 1847, the AMA is the largest medical society in the United States. It is dedicated to promoting the science and art of medicine and the betterment of

public health. Its approximately 275,000 physician members practice in all fields of medical specialization and in every state.

Physicians today are confronted with a bewildering array of contractual proposals from insurance companies, health maintenance organizations, and other third-party payers. Payer contracts set forth the terms of the physician-payer relationship across a broad spectrum of issues – from patient eligibility for coverage, to procedures for submitting claims, to obtaining review of a payer's medical necessity determinations. Cf. Pegram v. Herdrich, 530 U.S. 211 (2000). The manner in which these issues are addressed have significant implications both for the physician and for patients -- whose access to care may turn upon complicated contractual provisions setting forth a physician's relationship to a health plan.

In light of the complexity and importance of physician-payer contracts, physicians often seek guidance from their state, local, and national medical societies on the meaning and practical implications of particular contract terms. Medical societies are well suited to provide such guidance. They have familiarity with medical practice, the needs of patients, and the legal and regulatory environment in which health care is delivered and financed.

Absent any threat of boycott or coercion, medical societies have a legitimate role to play in assisting their members to review and understand the complex variety of contract terms used by payers in their physician contracts. Far from forbidding medical societies from playing this role, antitrust law has long recognized the procompetitive value of joint efforts by health care professionals to provide information to payers. See United States v. Alston, 974 F.2d 1206, 1214 (9th Cir. 1992); Barry v. Blue Cross of California, 805 F.2d 866, 868 (9th Cir. 1986); U.S. Dep't of Justice and Federal Trade Commission, Statements of Antitrust Enforcement Policy in Health Care, Stmts. 4-5 (1996).

In this case, however, a payer has invoked the federal antitrust laws to sue a state medical association, along with its members, for expressing its views to the payer on provisions in the payer's proposed physician contracts. The payer has also objected to the medical society's communications with its members concerning the payer's response to the information provided by the medical society. The AMA believes that a finding of liability based on these activities would be inconsistent both with antitrust principles and with sound health policy. The AMA therefore respectfully submits this brief *amicus curiae.*

BACKGROUND

1. Physician Provider Agreements

In Hawaii as in every state, payers generally require physicians to sign physician provider agreements (PPAs) in order to receive payment for medical services to their members. PPAs are complex contracts that include provisions governing all aspects of the physician's relationship with the payer. They cover, for example, documentation required for payment of claims and the physician's rights to appeal decisions of the plan. PPAs also include provisions which directly affect the ability of the physician to provide care to patients. Thus, they may limit a physician's ability to prescribe pharmaceuticals that are not listed on a plan's formulary, to admit a patient into a hospital, or to provide certain expensive procedures deemed by the physician to be in the best interests of the patient.

A decision whether to sign a PPA requires both an understanding of arcane contractual language and a judgment about whether that language is, on balance, beneficial for the physician and his or her patients. Reaching an informed decision on whether to sign a PPA often involves a degree of legal, economic, and management expertise that most physicians do not possess. Moreover, even if they have such expertise, most physicians lack the time needed to analyze these provisions carefully. As one work on payer-physician contracts describes it:

> [PPAs] present difficult issues, particularly to the busy physician or practice manager who is confronted with a steady stream of managed care contracts. . . . In the ideal world, such agreements would be reviewed by competent legal counsel and negotiated thoroughly on the physician's behalf. On the other hand, in the real world, time pressures, the cost of legal services, and a perceived inability of any individual physician or group to negotiate an arrangement with a managed care payor leads many physicians to look at the fee schedule or payment mechanism, and if that seems acceptable, to sign the contract without reviewing, much less negotiating, its non-financial terms. Many managed care contracts appear to have been drafted to encourage this response, consisting as they often do of seeming reams of complicated legal provisions . . .

James Wieland and Robert A. Berenson, M.D., "Analyzing and Negotiating Managed Care Agreements," chapter in Physicians Survival Guide: Legal Pitfalls and Solutions (National Health Lawyers Association and American Medical Association, 1991), at 195.

2. Role of Medical Associations in Negotiation of PPAs

In most geographic areas, there are numerous health plans. Each of these plans has its own set of PPAs. The terms of these PPAs often vary significantly from payer to payer. For assistance in navigating this complex array of contractual provisions, physicians frequently turn to their medical associations. With access to legal and consulting expertise, medical associations are in a better position than individual physicians or physician groups to understand the meaning of various contractual terms and to appreciate their practical significance.

Review of proposed PPAs by medical associations permits a knowledgeable entity to analyze these complicated documents and to provide information to help physicians make informed decisions. Moreover, it avoids the costs and inefficiencies that would be incurred if each physician or physician group were to hire separate lawyers and consultants. In this way, medical association review of PPAs provides efficiencies that allow physicians to reduce their practice costs.

Medical association involvement in negotiation of PPAs can also provide useful information for payers. For example, the medical association may have the knowledge and expertise to provide payers with information on the costs that physicians incur in providing various types of services. This information can help a payer decide how much to pay for a given service. Also, a medical association can point out practical problems caused by specific contractual provisions. This information can assist the payer in deciding whether to modify the provision, retain it, or abandon it. Once again, this exchange of information promotes efficiency.

3. The Hawaii Medical Association

This case provides an example of the legitimate role of a medical association in the negotiation of a PPA. Specifically, the Hawaii Medical Association (HMA) evaluated the particular terms of PPAs that managed care

health plans, including the Hawaii Health Network (HHN), asked physicians to sign. After its review of HHN's proposed PPA, HMA issued a statement expressing concern over some aspects of the contract presented by HHN, including the fact that HHN's PPA did not take into account provider costs in developing a fee schedule, did not give physicians the right to appeal payments they regarded as unfair, and did not give physicians an opportunity to comment on proposed fee changes before they became effective. See Appellants' Excerpts of Record ("ER") 369 (Decision and Order pp. 2-3).

HMA offered to engage in discussions with HHN over the particular provisions that the association viewed as inappropriate. At HHN's insistence, HMA presented proposed written revisions of the provisions to which it objected. HHN was, of course, in no way obligated to adopt any changes requested by HMA. Indeed, HHN refused to discuss relevant issues with the association or to adopt any of the suggested revisions to the PPA.

HMA issued a statement to its members which explained the particular provisions of HHN's proposed PPA that the association regarded as inappropriate. The association also informed its members of its unsuccessful attempt to discuss these provisions with HHN. Although the association presented

its views regarding particular provisions, each individual physician or physician group was free to agree or disagree with the views of the association.

Ultimately, the individual physicians – not the association – made the decision as to whether or not to sign the PPA offered by HHN. Some physicians decided not to sign the PPA, but many other physicians did. No action was taken or threatened by the association against HHN or against HMA members who signed the PPA. Moreover, no attempt was made to facilitate agreement on fees to be charged by physicians to HHN.

ARGUMENT

I. THE ANTITRUST LAWS DO NOT PROHIBIT A MEDICAL ASSOCIATION FROM PRESENTING ITS VIEWS TO A PAYER REGARDING A PROPOSED CONTRACT OR FROM INFORMING ITS MEMBERS OF THE PAYER'S RESPONSE.

A. The Collective Provision of Information to Payers by Physicians, Without A Boycott or Other Coercive Action, is Procompetitive

A medical society that expresses to payers its views on contract-related issues – without engaging in or threatening a boycott – does not restrain trade. To the contrary, by providing information to the payer and generating efficiencies for the physicians, the association's actions promote competition.

As this Court has observed, "[o]ne of the foundations of an ideal competitive market is the free flow of information to buyers and sellers." Barry,

805 F.2d at 872. See generally Richard Posner, Information and Antitrust, 67 Geo. L.J. 1187 (1979). In the health care context, the need for information is particularly great. The market for medical services is one "characterized by striking disparities between the information available to the professional and to the patient." California Dental Ass'n v. FTC, 526 U.S. 756, 771 (1999). Indeed, it is this fundamental asymmetry in the information available to the medical profession and the general public that underlies physicians' ethical obligations to advise patients of all appropriate treatment options and to advocate the best interests of their patients. See American Medical Association, Council on Ethical and Judicial Affairs, Code of Medical Ethics: Current Opinions with Annotations (1998), § 8.08 ("Informed Consent"), § 8.13 ("Managed Care") ("The duty of patient advocacy is a fundamental element of the physician-patient relationship . . .).

Likewise, payers often lack critical information about the physicians with whom they wish to contract and about the patients served by those physicians. For example, whether an insurer should pay for a particular medical service may depend on the circumstances in which such service is provided by local physicians. See generally Annot., What Services, Equipment or Supplies are "Medically Necessary" for Purposes of Coverage Under Medical Insurance, 75 A.L.R. 4th 763 (1990). That issue cannot be meaningfully addressed without the input of practicing physicians. Similarly, payers may not have information concerning the

costs incurred by medical practices in performing particular services, or the administrative requirements that are imposed by other payers in the market. This is particularly so where, as in this case, the payer is a new entrant to a local market with distinctive characteristics. ER 333 (Transcript of Hearing at 41:16-19).

By the same token, individual physicians often lack the information they need to assess the financial, legal, and ethical implications of proposed PPAs. Indeed, for individual physicians and small group practices, the cost of obtaining such information can be prohibitive. Medical societies can effectively pool the resources of their members to gather and meaningfully analyze contract-related data. By approaching a payer collectively, physicians can achieve economies in the development and dissemination of information that would otherwise be unattainable.

Thus, collective efforts by health care professionals to develop and convey information to purchasers is viewed more favorably under the antitrust laws than similar activities occurring in an ordinary commercial context. See California Dental Ass'n, 526 U.S. at 771 & n.10 (citing Goldfarb v. Virginia State Bar, 421 U.S. 773, 788-89 n.17 (1975)) (distinctive features of the professions "may require that a particular practice, which could properly be viewed as a

violation of the Sherman Act in another context, be treated differently").[1] As long as the physicians do not agree to enforce their views or recommendations through an actual or threatened boycott, the informational value of their joint action outweighs any theoretical threat to competition. See Virginia Academy of Clinical Psychologists v. Blue Shield, 624 F.2d 476, 483 (4th Cir. 1980) (it is "not illegal [for a medical society] . . . to make recommendations aimed at persuading Blue Shield to adopt its proposal and use its services, absent some form of coercion"), cert denied, 450 U.S. 916 (1981).

The federal antitrust agencies have recognized the correctness of this position. In their enforcement policy statements for the health care field, the agencies observe that collective provision of information by competing health care providers to a purchaser in an effort to influence the terms upon which the purchaser deals with the providers may well provide procompetitive benefits. U.S. Dep't of Justice and Federal Trade Commission, Statements of Antitrust Enforcement Policy in Health Care (1996) (the "Policy Statements"), Statement 4,

[1] The Court in California Dental Ass'n also relied on economics literature concerning information and the professions, including Carr & Mathewson, The Economics of Law Firms: A Study in the Legal Organization of the Firm, 33 J. Law & Econ. 307, 309 (1990); Akerlof, The Market for "Lemons": Quality Uncertainty and the Market Mechanism, 84 Q.J. Econ. 488 (1970); Leland, Quacks, Lemons, and Licensing: A Theory of Minimum Quality Standards, 87 J. Pol. Econ. 1328, 1330 (1979).

at 40. Indeed, the Statements recognize that the collective provision even of information concerning the amounts, levels, or methods of fees or reimbursement by competing health care providers to payers may be procompetitive. Statement Five explains that the collective provision of information about various aspects of reimbursement "can help purchasers efficiently develop reimbursement terms to be offered to providers and may be useful to a purchaser when provided in response to a request from the purchaser or at the initiative of providers." Id., Statement 5, at 44.[2]

This case illustrates the wisdom of these well-established principles. The HMA provided its views about particular provisions of the payer's PPA and attempted to engage in discussions with the payer over those terms. In doing so, the HMA pooled its members' resources to review the contracts and saved the payer the cost of individually polling the HMA's members. To be sure, the association hoped to influence the terms by which the payer dealt with its members

[2] See also In re Michigan State Medical Soc'y, 101 F.T.C. 191 (1983) (order prohibiting medical society from using coercion to obtain higher reimbursement levels, but explicitly permitting the society to "[p]rovid[e] information or views, on its own behalf or on behalf of its members, to third party payers concerning any issue, including reimbursement"); FTC Advisory Opinion to the American Society of Internal Medicine, 105 F.T.C. 505 519-20 (April 19, 1985) ("ASIM can seek to persuade third-party payors to change their reimbursement methods or amounts without running afoul of the antitrust laws so long as there is no coercive conduct engaged in or threatened").

However, HMA did not engage in any conduct to coerce the payer into accepting the association's views. Indeed, HHN largely rejected those views – without retaliation by the association or its members. Far from reflecting a boycott or other restraint of trade, these circumstances represent the efficient functioning of a market.

B. Case Precedent in This Circuit Supports the Lawfulness of HMA's Actions

In at least two decisions, this Court has recognized the procompetitive nature of collective physician input into conduct proposed by a payer. First, in Barry v. Blue Cross of California, 805 F.2d 866 (9th Cir. 1986), the plaintiffs alleged that the consultative role played by physicians in developing a fee schedule for a Blue Cross insurance plan and the terms of its participating provider agreement represented a horizontal agreement among physicians to fix prices. Barry, 805 F.2d at 868. This Court, however, concluded that any insurer that intends to offer a new reimbursement program "must 'canvass the doctors' to assure that the fee schedules of any new plan will be workable." Id. at 868 (quoting Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332, 353 n.28 (1982)).

The Court ruled that the evidence did not show that the comments and suggestions of the physicians had any effect on the insurer and that Blue Cross

retained final authority over all aspects of the plan. Because the evidence did not show "that the physicians actually control[led] the Plan," this Court held that the evidence did not present even a jury question regarding plaintiffs' claim of horizontal agreement to fix prices for physician's services. Id. at 868-69.

Second, in United States v. Alston, 974 F.2d 1206 (9th Cir. 1992), Judge Kozinski wrote:

> [H]ealth care providers who must deal with consumers indirectly through plans such as the one in this case face an unusual situation that may legitimate certain collective actions. Medical plans serve, effectively, as the bargaining agents for large groups of consumers; they use the clout of their consumer base to drive down health care service fees. Uniform fee schedules—anathema in a normal competitive market—are standard operating procedure when medical plans are involved. In light of these departures from a normal competitive market, individual health care providers are entitled to take some joint action (short of price fixing or a group boycott) to level the bargaining imbalance created by the plans and provide meaningful input into the setting of the fee schedules.

Id. at 1214. Notably, this Court did not limit its decision to the setting of fee schedules. Rather, the Court suggested that physicians may need to negotiate such issues as reimbursement amounts, payment procedures, the mechanisms for adjusting disputes, and the method of referring patients collectively. Id.

Barry and Alston support the decision of the district court. Here, the HMA provided its views to HHN about particular features of the proposed PPA. However, HMA did not engage in any conduct to coerce HHN into accepting the association's views. It stopped far "short of price fixing or a group boycott." Id. HMA had no authority over the terms of the plan, and HHN was free to reject the views of the association – as it in fact did. As Barry and Alston teach, this conduct is procompetitive.

C. Analogous Precedent From Other Circuits Supports the Lawfulness Of HMA's Actions

The facts of this case are somewhat analogous to those presented in two related lines of cases. The first deals with the ability of medical associations to inform their members and others about their views on specific medical procedures. Thus, in Schachar v American Academy of Ophthalmology, 870 F.2d 397 (7th Cir. 1989), the American Academy of Ophthalmology stated its position opposing a medical procedure known as radial keratotomy. Plaintiffs alleged that this position caused hospitals to refuse permission to perform the procedure and cause insurers not to pay for the procedure.

The Seventh Circuit rejected plaintiffs' claim. It noted:

> All the Academy did is state its position that radial keratotomy was 'experimental' and issue a press release with a call for research. It did not require its members to

> desist from performing the operation or associating with those who do. It did not expel or discipline or even scowl at members who performed radial keratotomies. It did not induce hospitals to withhold permission to perform the procedure, or insurers to withhold payment; it has no authority over hospitals, insurers, state medical societies or licensing boards, and other persons who might be able to govern the performance of that surgery.

Id. at 398. The Seventh Circuit noted that even after the association's statement and press release, some hospitals continued to allow physicians to perform the procedure and many insurers continued to reimburse them for their services. Id. at 398-99. The court found that the association had not coordinated activities with hospitals and insurers, which were independent of the association. Rather, hospitals and insurers had engaged in "only uncoordinated individual action, the essence of competition." Id. at 399.

As in Schachar, there was no restraint here. The HMA simply presented its views on HHN's proposed PPA to HHN and to its members. It did not "require its members to desist from" associating with HHN. It did not "expel or discipline or even scowl at members" who signed up with HHN. It did not induce hospitals or insurers to refuse to deal with HHN. In short, it imposed no restraint whatsoever. Thus, the observation of the Seventh Circuit is as applicable here as it was in Schachar: "There can be no restraint of trade without a restraint." Id. at 397.

The second line of cases addresses the ability of associations to evaluate specific products and to inform its members and the public of its evaluation. See, e.g., Consolidated Metal Products, Inc. v American Petroleum Institute, 846 F.2d 284 (5th Cir. 1988) . There, the American Petroleum Institute evaluated products and signaled its recommendation of a product by a "seal of approval." Consumers and members of the association could look for the seal as an indication that after investigation, the product had received a favorable review from the trade association. The Fifth Circuit concluded, "Even if user reliance gives API significant influence over the market, that influence may enhance, not reduce, competition and consumer welfare." Id. The court explained that "product information is crucial to a competitive market." Id. at 296.

HMA is in a position analogous to API. As API evaluated products, HMA reviewed a PPA. As API expressed its view through a seal of approval, HMA expressed its position through communication with members. Just as no one was required by API to accept its evaluation of a particular product, no physician was in any way forced to accept the views expressed by the HMA. Rather, the comments of HMA, like the API's seal of approval, put decision-makers in a better position to make an informed decision. Thus, they enhanced the competitive process.

By contrast, the case relied on by HHN does not support its position. In Pennsylvania Dental Association v. Medical Service Association of Pennsylvania, 815 F.2d 270 (3rd Cir. 1987), the record contained direct evidence that the defendant dentists had agreed to boycott the Blue Shield program unless Blue Shield modified its cost containment program. Id. at 272-73. Here, by contrast, plaintiffs offer no evidence of any agreement by members of HMA to boycott HHN. Nor do they present any evidence that HMA sought to coerce its members, or anyone else, into refusing to deal with HHN. The absence of any concrete facts from which a jury could reasonably infer an agreement to boycott or coercive conduct by the medical association readily distinguishes this case from Pennsylvania Dental Association.

II. SUMMARY JUDGMENT SHOULD BE LIBERALLY GRANTED IN ANTITRUST ACTIONS CHALLENGING AN ASSOCIATION'S EXPRESSION OF ITS VIEWS, ABSENT SPECIFIC EVIDENCE THAT THE ASSOCIATION BACKED UP ITS EXPRESSED POSITION WITH A THREAT OF BOYCOTT OR OTHER COERCIVE ACTION.

Lacking any real evidence of agreement or coercion, plaintiffs are reduced to arguing that the threat of a boycott of HHN can be inferred because HMA notified its members of HHN's refusal to negotiate. This argument in effect asks this Court to draw inferences of unlawful conspiracy from action that, as shown above, promotes competition and is fully consistent with independent

action. For this reason alone, it should be rejected. See Matsushita Electric Industrial Co. v. Zenith Radio Corp., 475 U.S. 574, 588 (1986).

However, there is yet another reason to reject plaintiffs' request to have this Court permit a jury to infer unlawful conduct based on HMA's notification to members that HHN was refusing to discuss issues with it. Specifically, HMA's communications with its members are speech entitled to protection under the First Amendment. Although the First Amendment does not shield conduct that violates the antitrust laws, the antitrust laws should not be used as a vehicle to chill speech that is protected by the First Amendment. Even if speech by a well-respected organization is likely to affect the conduct of the organization's members, "[a]n organization's towering reputation does not reduce its freedom to speak out." Schachar, 870 F.2d at 389-400.

In order to vindicate First Amendment interests, an organization should be subject to antitrust liability only if it somehow goes beyond speech – for example, by conspiring to fix prices or by penalizing members who do not agree with the organization's position. Massachusetts School of Law at Andover v. American Bar Association, 937 F.Supp. 435, 443-44 (E.D. Pa. 1996). Denying summary judgment on the facts of this case will, as a practical matter, silence legitimate communications from medical associations to their members.

Associations such as the HMA have limited resources to defend themselves in plenary antitrust proceedings – particularly where an adverse jury verdict will result in treble damages and payment of plaintiffs' attorneys fees. Thus, the prospect of incurring the huge costs associated with an antitrust trial based on communications about contractual provisions is likely to cause associations to halt such communications.

At issue here is nothing more than the presentation by HMA of its views on a proposed contract and the truthful statement by HMA that HHN would not discuss that contract with it. If these communications are enough to get HHN past the summary judgment stage, the inescapable fact is that the presentation of such views by all medical associations will be substantially chilled. Solicitude for the First Amendment, as well as concern for the procompetitive dissemination of information, require that this result be avoided.

CONCLUSION

For the foregoing reasons, the decision of the district court should be affirmed.

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CERTIFICATE OF COMPLIANCE CONCERNING LENGTH LIMITATIONS

Pursuant to Fed. R. App. P. 32(a)(7)(C), the undersigned attorney and member of the bar of this Court certifies that this brief contains 4,351 words and therefore complies with the length limitations set forth in Fed. R. App. 32(a)(7)(B).

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