2d Civil No. B210943

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA
SECOND APPELLATE DISTRICT
DIVISION FIVE

JAN E. HENSTORF, M.D., JAMES KAYVANFAR, M.D., CALIFORNIA ORTHOPAEDIC INSTITUTE MEDICAL ASSOCIATES, INC., CHARLES T. RESNICK, M.D., INC., and JAMES S. MANION, M.D., INC.,

Plaintiffs/Appellants,

v.

STATE COMPENSATION INSURANCE FUND,

Defendant/Respondent.

Appeal from the Superior Court of Los Angeles County
Honorable Anthony J. Mohr
Case No. BC 367524

AMICUS CURIAE BRIEF OF THE AMERICAN MEDICAL ASSOCIATION AND THE CALIFORNIA MEDICAL ASSOCIATION IN SUPPORT OF PLAINTIFFS AND APPELLANTS

Francisco J. Silva, Cal.BN 214773
CALIFORNIA MEDICAL ASSOCIATION
1201 J Street, Suite 200
Sacramento, CA 95814
Telephone: (916) 551-2888
Facsimile: (916) 551-2027

Jon N. Ekdahl, Ill.BN 0726893
Leonard Nelson, Ill.BN 2032384
Catherine Hanson, Cal.BN 120896
Wes Cleveland, Ill.BN 628498
Henry S. Allen, Jr. Ill.BN 33227
AMERICAN MEDICAL ASSOCIATION
515 North State Street
Chicago, Illinois 60610
Telephone: (312) 464-4600
Facsimile: (312) 464-5846

Counsel for Amici Curiae,
American Medical Association and California Medical Association

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Federal Cases

California Cases

California Statutes

Other Authorities

STATEMENT OF INTEREST

The American Medical Association ("AMA"), an Illinois not-for-profit corporation with approximately 240,000 members, is the largest organization of physicians, residents, and medical students in the United States. Its objects are "to promote the science and art of medicine and the betterment of public health." It members practice in all areas of medical specialization and in every state, including California.[1]

The California Medical Association ("CMA") is a non-profit, incorporated professional association of more than 35,000 physicians practicing in the State of California. CMA's membership includes California physicians engaged in the private practice of medicine in all specialties. CMA's primary purposes are "… to promote the science and art of medicine, the care and well-being of patients, the protection of public health and the betterment of the medical profession." CMA and its members share the objective of promoting high quality, cost-effective health care for the people of California.

[1] Amici appear herein in their own persons and as representatives of the Litigation Center of the American Medical Association and the State Medical Societies. The Litigation Center is a coalition of the AMA and the state medical societies of every state and the District of Columbia. Its purpose is to represent the general interests of the medical profession in the courts, according to AMA policy.

I. INTRODUCTION

Appellants in this case have alleged that a joint agreement between State Compensation Insurance Fund (SCIF) and Blue Cross of California (BCC) created a collusive monopsony that is negatively affecting the provision of medical services to injured workers in the State of California. More specifically, through its anticompetitive exercise of buyer-side market power, the SCIF/BCC arrangement has artificially depressed physician workers' compensation payments to levels that are substantially below competitive levels.

The inadequate compensation stemming from SCIF's and BCC's collusive monopsony will have a detrimental effect on health care access, and the quality of medical services provided to California's injured workers. Appellants have alleged that access will be adversely affected because physicians increasingly are unable to afford to provide services to injured workers via the BCC network through which all of SCIF's workers compensation patients are now funneled. Under-compensation also impedes the ability to recruit those physicians to California who are able and willing to care for California's injured workers.

II. PROCEDURAL HISTORY AND ARGUMENT SUMMARY

Appellants filed their original complaint against WellPoint Health Networks, Inc., BCC, and SCIF on March 3, 2007. (See Appellants' Opening Brief, filed on February 3, 2009). WellPoint Health Networks,

Inc., and BCC are no longer defendants in this case, for reasons described in Appellants' Opening Brief, pages 3-4. On February 25, 2008, Appellants filed their current First Amended Complaint (FAC). It contains the important allegations that that SCIF violated the Cartwright Act by concerted action with BCC whereby SCIF withdrew from the market for the purchase of physician services to workers compensation patients and forced physicians wishing to continue furnishing services to SCIF's workers compensation patients to join BCC's medical network, effectively making BCC the sole purchaser of those service. As a result of this collusion, a monopsony has been created in the market for physician services to workers compensation patients. Moreover, the colluding parties have extracted physician fees below competitive levels, and among the lowest in the country. This, the complaint alleges, makes it "impractical for a sufficient number of physicians to treat injured workers and makes it difficult, if not impossible, to recruit a sufficient number of new physicians to California. (See the FAC, pages 3-4, and paragraph 16 and 17).

On September 10, 2008, the trial court dismissed Appellants' lawsuit and entered judgment in favor of SCIF. (Appellants' Opening Brief, page 4). The trial court based its dismissal on Business & Professions Code §16770(g), which the court interpreted as an antitrust immunity statute that protected SCIF from Appellants' Cartwright Act allegations. On

September 18, 2008, Appellants' filed their notice of appeal. (Appellants' Opening Brief, page 5).

This brief argues that the trial court misinterpreted section 16670(g) and that, read correctly, section 16770(g) at most provides antitrust immunity with respect to per se allegations relating to the conduct connected with the formation of efficient-sized contracting units. Section 16770(g) does not provide any protection from per se antitrust allegations applicable to anticompetitive post-formation conduct. Nor does section 16770(g) immunize any conduct from antitrust allegations based on a rule of reason analysis. Accordingly Amici believe that the trial court's dismissal of Appellants' Cartwright Act claim should be reversed and that Appellants' claim be allowed to proceed.

III. ARGUMENT

A. Henstorf Has Sufficiently Pled A Legally Cognizable Antitrust Claim Under The California Cartwright Act.

Appellants have alleged that a collusive monopsony created by SCIF and BCC exercises substantial market power in the purchase of physician services to workers compensation patients. As a result of this improper exercise of monopsony power, Appellant's payments have been depressed below competitive levels. Appellants have alleged that this depression in physician payments constitutes an unreasonable restraint of trade that violates the Cartwright Act.

B. Section 16770's Legislative History Demonstrates That Section 16770 Was Only Intended To Protect The *Formation* Of PPOs From *Per Se* Antitrust Allegations.

Business & Professions Code §16770 was enacted as pro-competitive legislation designed to encourage the development of PPOs. (*Lori Rubenstein Physical Therapy, Inc. v. PTPN* (2007) 148 Cal.App.4th 1130, 1136.) Just as PPOs were being formed in California in response to legislation passed in 1982 that permitted their creation, the U.S. Supreme Court (Court) decided *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982). *Maricopa* ruled that a physician-sponsored PPO setting the maximum fees member physicians could charge insurers constituted a per se violation of federal antitrust laws. Proponents of AB 707/§16770 believed that the *Maricopa* decision was having a chilling effect on the PPO formation that the 1982 legislation was designed to foster. Proponents of AB 707/§16770 argued that this chilling effect occurred because opponents of particular PPOs were using *Maricopa* to bring, or threaten to bring, *per se* antitrust allegations against those who had formed, or were considering forming, PPOs. The State of California attempted to undo this chilling effect by enacting §16670 of the Business and Professions Code.

The legislative history of AB 707 demonstrates that the California Legislature intended to end this chilling effect by shielding conduct connected with the *formation* of PPOs from allegations of *per se* antitrust violations. For example, in its 1984 report on AB 707, the Assembly

Committee on Judiciary noted that AB 707 was "intended to overcome the reluctance of health care providers to form Preferred Provider Organizations ("PPOs") that results from legal advice which physicians have received that *mere formation* of a PPO might subject them to antitrust liability." (Exhibit 1, italics added).[2] Similarly, the August 19, 1985, report from the Senate Committee on the Judiciary report noted that AB 707 was intended to "require state courts to use the *rule of reason*, instead of the illegal *per se* standard, in any antitrust litigation challenging the *formation* of groups or combinations of health care providers and insurers." (Exhibit 2, italics added). That same report also stated that "According to the author's office, the bill [i.e., AB 707] is intended to require any health care combination challenged under the Cartwright Act to be gauged by the rule of reason test, and not deemed to be illegal per se," and that "for antitrust actions which challenge health care combinations…the business practice would be measured by the rule of reason test rather than being deemed, as under federal law, illegal per se."[3] (Exhibit 2.) The Committee also added:

> The author argues that the *Maricopa* court prematurely condemned health care combinations as illegal price fixing

[2] Report by Assembly Committee on Judiciary, Elihu M. Harris, Chairman, August 29, 1984.

[3] See also AB 707 Senate Committee on Judiciary Report as amended August 19, 1985.

> and per se violations of the Sherman Act, and that the more proper standard for assessing these arrangements (which he believes to offer significant benefits and to be procompetitive) is the rule of reason test. (Exhibit 2.)

The California Governor's veto of the 1984 version of AB 707, when considered in conjunction with 1985 correspondence between the Governor and AB 707's sponsor, also strongly supports the argument that Section 16770 was intended only to provide protection from *per se* antitrust condemnation for PPO formation-related conduct. At the time of his 1984 veto, the enrolled version of AB 707 contained the following language:

> It is the intent of the Legislature, therefore, that the formation of groups and combinations of providers and purchasing groups for the purpose of creating efficient-sized contracting units be recognized as the creation of a new product within the health care marketplace and, for that reason and to that extent, be *exempt* from state and federal antitrust laws.

(Italics added). This language signaled that conduct connected with PPO formation was to be afforded a blanket antitrust *exemption*. The Governor's veto message stated that although the AB 707 was intended to "overcome the objections" set forth in *Maricopa*, i.e., the *per se* application of the antitrust laws, veto occurred because AB 707 did not "meet the tests as set forth in *Maricopa*." (Exhibit 3.) In other words, the Governor vetoed AB 707 because the bill exempted PPO formation from potential antitrust liability under *both* the *per se* and rule of reason tests.

In response to the Governor's 1984 veto message, the 1985 California legislative session saw the introduction of a revised AB 707.

The 1984 and 1985 versions of AB 707 differed substantively in only one respect—the 1985 version of AB 707 abandoned any reference to an antitrust exemption. In place of exemption language, enacted AB 707/Section 16770(g) states:

> It is the intent of the Legislature, therefore, that the formation of groups and combinations of providers and purchasing groups for the purpose of creating efficient-sized contracting units be recognized as the creation of a new product within the health care marketplace, and be subject, therefore, only to those antitrust prohibitions applicable to the conduct of other presumptively legitimate enterprises.

The 1985 version of AB 707 removed any exemption reference to address the Governor's concern that Section 16770 not provide a blanket exemption or immunization of conduct connected with PPO formation-related conduct. That the California Legislature did not intend Section 16770 to provide a blanket exemption or immunity is shown in AB 707's sponsor's 1985 correspondence to the Governor subsequent to AB 707's legislative passage. AB 707's sponsor wrote, in part:

> When last year's version of Assembly Bill 707 came to you, it took a totally different approach from this year's legislation.
>
> After your veto message, I spent some time attempting to develop an approach which would avoid the complications of immunity from anti-trust law. I believe that the approach contained in this year's version of AB 707 will satisfy you.
>
> Basically, the bill does the following:
>
> 1. No exemption from antitrust activity is given in this bill.

> 2. However, in regard to the use of health care contracting the legislation directs the courts to apply the "rule of reason" test to such activities.
>
> This latest approach, far more moderate than the one I attempted last year, has, I believe, led to some of the muting of the opposition.

(Exhibit 4.) The legislative record shows that in 1985, the California Legislature did not intend § 16770 to provide a blanket exemption or immunity from potential antitrust liability connected with conduct undertaken to form PPOs. Instead, § 16770 was intended only to protect that conduct from the type of *per se* antitrust scrutiny to which the U.S. Supreme Court subjected the defendant PPO in *Maricopa*. The 1985 California Legislature never intended § 16770 to immunize that conduct from antitrust scrutiny under the rule of reason. Nor did the California Legislature intend to provide any immunity or exemption from *per se* or rule of reason antitrust scrutiny to post-formation conduct.

C. The Supreme Court Of California Has Clearly Stated That The Antitrust Liability Protections Provided By Section 16770 Apply Only To Formation-Connected Conduct.

As Appellant's Reply Brief points out, the Supreme Court of California has unequivocally stated that Section 16770's limited antitrust protection does not extend to post-formation conduct. In *Cianci v. Superior Court* (1985) 40 Cal.3d 903, decided within three months of AB

707's/Section 16770's enactment, the Supreme Court of California stated AB 707:

> would among other things add section 16770 to the Business and Professions Code. Under this provision, it is only the *formation* of health care services organizations that would be exempt from state and federal antitrust laws, *not* the *conduct* of such organizations.

(*Id*. at 923 n.7.) Thus, § 16770 reaches only to formation conduct, and based on the legislative history of AB 707/§ 16770 discussed in III.B above, it protects only against per se antitrust scrutiny. Appellant's Reply Brief correctly notes that Respondent has never acknowledged this definitive Supreme Court statement, let alone provided any rationale concerning why such an unequivocal statement should not be controlling in this case. The trial court should not have deviated from the *Cianci* ruling.

D. The Text Of Section 16770 Itself Does Not Provide A Blanket Antitrust Immunity Or Exemption From Either Conduct Connected With The Formation Of PPOs Or Post-Formation Conduct.

The text of § 16770 itself indicates that it does not provide a blanket antitrust immunity or exemption for conduct directly connected to PPO formation or post-formation conduct. One example of this textual evidence can be found in § 16770's statement that the formation of "groups and combinations of providers and purchasing groups for the purpose of creating efficient-sized contracting units be recognized as the creation of a *new product*. . ." (Italics added). As Respondent's Reply Brief notes, the

concept of a "new product" in antitrust analysis originated in *Broadcast Music v. Columbia Broadcasting System, Inc.*, 441 U.S. 1 (1979) and was also discussed in *Maricopa*. Categorizing an arrangement as a "new product" does not provide a blanket exception or immunity from potential antitrust liability. An arrangement's status as a "new product" only means that a court will subject the arrangement to a rule of reason analysis instead of the *per se* analysis that would otherwise apply.

This point was made clear in *Broadcast Music.* The "basic question" addressed was whether joint pricing by competitors associated with the issuance of blanket licenses to copyrighted musical compositions constituted price fixing subject to *per se* antitrust condemnation. (*Id* at 4.) In deciding that the blanket license was not subject to *per se* antitrust scrutiny, the Court stated that:

> we cannot agree that it [the blanket license] should automatically be declared illegal in all of its many manifestations. Rather, when attacked, it [the blanket license] should be subjected to a more discriminating examination under the rule of reason. It may not ultimately survive that attack, but that is not the issue before us today.

Accordingly, even if Respondent's conduct constituted a "new product," a "new product" designation means only that the arrangement is not automatically condemned as a per se antitrust violation. Instead, the arrangement is subject to a rule of reason evaluation, and Appellant should

be allowed to develop a factual record supporting its Cartwright Act claim against Respondent under a rule of reason analysis.

E. The SCIF/BCCs Collusive Monopsony Is Not An "Efficient-Sized Bargaining Unit" To Which Section 16770's Limited Liability Protection Applies.

Section 16770's limited antitrust liability protection is not universal—liability protection is afforded only to the formation of "efficient-sized" contracting units. The use of the modifying term "efficient-sized" has an important implication for this litigation. "Efficient-sized" implies that a combination will not be eligible to receive § 16770's limited antitrust liability protections unless the combination, on balance, it increases competition. This understanding of the term "efficient-sized" comports with the legislative intent underlying the enactment of § 16770, since § 16770 was designed to help implement the pro-competitive legislation that the State of California enacted in 1982 to permit independent physician practices to create PPOs. If § 16770 provides limited liability protection only for efficient contracting units, it follows, then, that § 16770 does not provide any antitrust liability protection for contracting units that, on balance, are not competitively efficient. The collusive monopsony created by SCIF and BCC is, on balance, not merely competitively inefficient, it is anticompetitive. Accordingly, the SCIF/BCC combination is not an efficient-sized contracting unit, and therefore, not entitled to § 16770(g)'s protection.

The collusive monopsony theory pled in Appellant's First Amended Complaint is a well-recognized, valid antitrust claim. Monopsony power is market power on the buy side of the market. (*Weyerhaeuser Co. v. Ross-Simmons Hardware Lumber Co.*, 549 U.S. 312, 320 (2007).) The health care delivery system for physician services to injured workers is particularly vulnerable to a combination of purchasers that exercises substantial market power. Appellants can neither store nor export their services. Appellants thus have limited options in terms of the persons and entities to which they can sell their services. Appellants' ability to terminate their relationship with the combination formed by SCIF and BCC in response to depressed payments would be largely contingent on Appellants' ability to contract with that combination's competitors. Appellants have pled, however, that the combination has few, if any, competitors. (See FAC pages 18-19). Even if competitors exist in some of the geographic areas in which Appellants provide their services, those competitors are likely to possess a substantially smaller market share than the collusive monopsony formed by SCIF and BCC. It is, therefore, highly unlikely that Appellants will be able to contract with these smaller competitors in lieu of the collusive monopsony because smaller competitors will not be able to furnish Appellants with sufficient patient volume to sustain Appellants' workers compensation practice. The collusive

monopsony, combined with the absence of competitors, means that Appellants are forced to accept the artificially depressed payments.

Appellants' forced acceptance of depressed payment rates is likely to have a negative impact on the services that Appellants can provide to injured workers. University of Pennsylvania Health Economics Professor Mark Pauly has demonstrated that health insurers with monopsony power may profit from pushing provider prices "too low" so that consumers do not receive an adequate level of service.[4] For example, Appellants may be forced to reduce their office hours, cut back on staff and/or equipment, or invest less in continuing education—all of which would be detrimental to workers compensation patients. In the absence of meaningful competition, the collusive monopsony formed by SCIF and BCC may also be able to increase profits by reducing the level of service and denying medical procedures that Appellants would normally perform based on professional judgment. Evidence from mergers throughout the U.S. that have created entities possessing monopsony power also strongly suggests that monopsony power in the market for the purchase of physician services has not benefited competition or consumers.[5]

---

[4] Mark V. Pauly, Competition in Health Insurance Markets, 51 Law & Contemp. Probs. 237 (1998).

[5] See testimony from: Examining Competition in Group Health Care, Hearing before the Senate Judiciary Committee, 109th Cong. (Sept. 6, 2006), and Health Insurer Consolidation – The Impact on Small Business,

The anticompetitive concerns that Appellants have raised regarding the collusive monopsony formed by SCIF and BCC is neither speculative nor purely academic. Plaintiffs have successfully opposed the creation of entities that, if formed, would possess monopsony power in the market for the purchase of health care providers' services. For example, the U.S. Department of Justice (DOJ) has filed three lawsuits against proposed mergers of purchasers of health care provider services, alleging that, if unchecked, the resulting purchaser's buyer-side market power would reduce the quality of provider services due to artificially depressed payments, increase consumer prices, or both. See e.g., the DOJ complaints filed in *U.S. v. UnitedHealth Group, Inc. and Sierra Health Services, Inc.*, No. 08-0322, 2008 WL 4493605 (D.D.C. Sept. 24, 2008), U.S. v. *UnitedHealth Group, Inc., and PacifiCare Health Systems, Inc.,* No. 1:05CV02436, 2006 U.S. Dist. LEXIS 45938 (D.D.C. May 23, 2006), *U.S. v. Aetna Inc. and The Prudential Insurance Company of America*, No. 3-99 CV1398, 1999 U.S. Dist. LEXIS 19691 (N.D. Tex. Dec. 7, 1999). These three mergers were allowed to consummate only because the parties entered into settlements whereby the health insurers agreed to reduce their market share by selling off a portion of their pre-merger business.

Hearing before the House Small Business Committee, 110th Cong. (Oct. 25, 2007).

The most recent regulatory action limiting health insurer expansion based on monopsony concerns supports Appellants' argument that monopsonies like the one at issue in this case are not efficient-sized bargaining units. Independence Blue Cross and Highmark recently discontinued their attempt to merge in Pennsylvania due to the extensive merger conditions required by the Pennsylvania Department of Insurance (PDI). The PDI imposed these requirements because, in their absence, the resulting monopsony would be able to "lessen competition and disadvantage providers, resulting in fewer choices for consumers and weaker provider networks for consumers who depend on those networks for access to quality health care."[6] The PDI's nationally-recognized economic expert, LECG, also rejected the assertion that the consolidated entity's ability to exert market leverage to reduce provider reimbursement below competitive levels would translate into lower premiums—LECG called this assertion an "economic fallacy." Instead, LECG affirmed that the "clear weight of economic opinion is that consumers do best when there is a competitive market for purchasing provider services."[7]

[6] See the January 22, 2009, Statement of Joel Ario, Commissioner of the Pennsylvania Insurance Department, located at http://www.ins.state.pa.us/ins/cwp/view.asp?a=1347&Q=549692&PM=1.

[7] *Id.*

IV. CONCLUSION

Appellants properly pled a legally cognizable antitrust monopsony claim under the Cartwright Act, and § 16770 does not immunize SCIF from this allegation. Accordingly, this court should reverse the trial court's dismissal of Appellants' suit and permit Appellants' lawsuit to proceed.

DATED: May 8, 2009

Respectfully Submitted,
American Medical Association
California Medical Association
FRANCISCO J. SILVA

By:_____
Attorney for Amici Curiae
American Medical Association
California Medical Association

CERTIFICATE OF COMPLIANCE

(CALIFORNIA RULES OF COURT,

APPELLATE RULE 8.204(c)(1)

This brief is reproduced using a proportional spaced type face of 13 points. This office uses Microsoft Word, which reports that this brief is **3,481** words long and therefore conforms to the requirements set forth in the California Rules of Court, Appellate Rule 8.204(c)(1).

DATED: May 8, 2009

Respectfully Submitted,
American Medical Association
California Medical Association
FRANCISCO J. SILVA

By:_____
Attorney for Amici Curiae
American Medical Association
California Medical Association