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COMMENTARY: PROFESSIONAL PEER REVIEW AND THE ANTITRUST LAWS

William G. Kopit*

Professor Havighurst’s fundamental premise—that peer-review activities must be judged by their competitive effect—is a critical point which is often overlooked by health care practitioners and health care attorneys alike. There can no longer be any question that courts will evaluate peer review not by the worthiness of the participant’s goals or the public purpose which the goals embody, but on the impact of those activities in the marketplace. To the extent that the impact is deemed pro-competitive, peer review will withstand antitrust scrutiny. However, to the extent that the impact is determined to be anti-competitive, peer review will be judged violative of the antitrust laws. Professor Havighurst also emphasizes that in making this fundamental determination courts will primarily look at the consumer’s interest rather than that of the competitor.1

Before entering into a discussion of the antitrust principles themselves, it is perhaps useful to discuss two exemptions which may apply to peer review activity: the business of insurance exemption and the implied repeal exemption.

Little time need be devoted to discussion of the business of insurance exemption, as the Supreme Court has clearly held that the exemption does not apply.2 Union Labor Life Ins. Co. v. Pireno3 involved an antitrust challenge by a chiropractor to the chiropractic association’s determination that the plaintiff was involved in inappropriate utilization of chiropractic services. As those determina-

1. While it has been virtually an antitrust cliche that the antitrust laws protect competition and not competitors, the case law often obscures or disregards this significant distinction. However, it is encouraging to note that the courts have given increased emphasis to this principle. See, e.g., Matsuschita Elec. Indus. Co. v. Zenith Radio Corp., 106 S. Ct. 1348 (1986); Continental T.V., Inc. v. GTE Sylvania Inc., 433 U.S. 36 (1977).

2. Because much peer-review activity is undertaken pursuant to contract with one or more insurance companies, it was at least arguable that contracts and activities undertaken in accordance with those insurance contracts were exempt under the business of insurance provisions of the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015.

tions were made under contract with the insurance company providing for utilization review services, the insurance company and the chiropractic association argued that they were exempt from the antitrust laws under the business of insurance exemption. The Supreme Court, relying on *Group Life & Health Insurance Co. v. Royal Drug Co.*, determined that the contract for utilization review was not part of the business of insurance.

The implied repeal doctrine is the other possible exemption. Professor Havighurst correctly recognizes that federally financed and regulated peer review organizations (PROs) are protected with regard to their performance of review over public programs. However, Professor Havighurst states that immunity does not extend to private review performed by PROs. In fact, the legislative history is somewhat ambiguous. Specifically, it states:

The amendment facilitates the performance of private review by requiring a peer review organization to make available its facilities and resources to private payors paying for health care in its area on a contract basis.

While this language can be read as merely permitting the use of the facilities of the PRO rather than involving its standard setting and review functions, it is at least possible that the language should be interpreted to mean that PROs will perform private review upon request. The latter interpretation perhaps will carry with it the implied repeal authority which extends to federal review. In any event, even assuming there is immunity for PROs, such immunity would not extend to other kinds of review organizations.

Thus, it is necessary to discuss the applicability of antitrust principles to such PROs. In undertaking that analysis, it is important

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4. *Id.* at 126.
6. *Pireno*, 458 U.S. at 126, 134. The Court affirmed the Second Circuit's determination on this point, and affirmed a remand to the district court for trial on the merits. *Id.* at 125, 134. However, the plaintiff was elected president of the chiropractic association and the case was settled without ever coming to trial.
8. Professor Havighurst draws no distinction between Medicare and Medicaid. Yet, PROs perform Medicaid review only at the election of the state.
10. Congressman Wyden proposed a bill called the Health Care Quality Improvement Act of 1986 that would extend peer review protection against the antitrust laws to a variety of peer review organizations, rather than merely PROs. *H.R. 5540, 99th Cong., 2d Sess.*, 132 CONG. REC. H7068 (Sept. 17, 1986). This bill may be reintroduced at the next session.
11. *But see supra* note 10.
to distinguish peer review from fee review. Peer review is the process whereby standards for medical practice relating to appropriate utilization and quality of care are established and individual practitioners are judged for compliance with those standards. In contrast, fee review is the process whereby fees for particular services are retrospectively reviewed for their reasonableness. Professor Havighurst indicates that fee review should be unobjectionable so long as it continues to be retrospective in its application. However, the distinction between the two situations here is somewhat semantic. Plainly, the first time the organization determines that a fee is unreasonably high that determination is retrospective. To the extent that determination is made publicly available, establishment of the maximum would appear to be prospective with regard to subsequent fees for the same type of service.

In contrast, the establishment of standards regarding appropriate utilization or quality of care appears to be less subject to antitrust risks. Admittedly, the establishment of such standards, by definition, "standardize" the product, but such standardization is necessary to permit meaningful price comparisons. One procedure may be half as expensive as another, but it cannot be viewed as a meaningful substitute to the extent that it is inefficacious or dangerous.

To be sure, it is not really necessary for professionals to dominate the decisionmaking process relating to the safety or efficacy of a particular procedure or mode of treatment. However, it seems reasonable that professionals are the best qualified to make such determinations in the final analysis.

Whether the organization is involved in utilization review, quality review, or fee review, it appears to be relatively clear that antitrust liability should not attach so long as the organization is merely recommending rather than undertaking any final determination. As Professor Havighurst correctly perceives, the distinction is between attempting to persuade the purchaser, which is clearly permissible under the antitrust laws, and foreclosing competition by determining that a competitor has acted inappropriately.

12. Of course, Professor Havighurst would agree that to the extent the organization prospectively established maximum fees, such activity could be viewed as price fixing, a per se violation of § 1 of the Sherman Act. See Arizona v. Maricopa County Med. Found., 457 U.S. 332 (1982).


14. In this case the purchaser is not the individual patient but the insurance company or self-insured employer that has contracted with the PRO. There can be little question that
The federal antitrust enforcement agencies have recognized the legitimacy of this analysis in advisory opinions written to PROs. For example, in a letter to the Rhode Island Professional Standards Review Organization, Inc. (RIPSRO), the FTC advised the corporation that a peer-review program conducted by physicians to provide non-binding advice to insurers and other third-party payors of health care claims would not violate the antitrust laws. Focusing on potential benefits to consumers, the FTC considered the RIPSRO peer-review program pro-competitive insofar as it provides incentives to third-party payors to implement cost-containment programs and to providers to practice in a cost-conscious manner.

One of the benefits in limiting a PRO to making recommendations is that it may facilitate a reviewing court's ability to determine that an antitrust action can be dismissed on a summary judgment motion. Antitrust litigation is time-consuming and expensive, and, in that sense, even a prevailing defendant can be a loser in practical terms. Thus, the ability to obtain summary judgment is a significant benefit to a defendant, and PROs' limitation to recommendations rather than final decisions may permit the courts to more easily grant such motions. Absent some form of coercion or established pattern of passive acceptance of all recommendations, the organization would simply claim that there were no facts under which a violation could be established.

Assuming that the PRO has authority to make final decisions, it does not follow that such determinations will necessarily be anticompetitive. The most difficult case relates to fee review because such review carries with it many of the elements of price fixing. To the extent a court determines that a distinction between such activities and the Maricopa case are insignificant, then plainly the organization would be judged to violate the antitrust laws.

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third parties do indeed meet the test for purchasers under the antitrust laws. See Kartell v. Blue Shield, 749 F.2d 922, 925 (1st Cir. 1984).


16. See also Letter from Timothy Muris, Director, Bureau of Competition, FTC to Norman Klombers (Aug. 18, 1983) (FTC approves peer-review program proposed by the American Podiatry Association to provide advisory opinions regarding necessity of medical services and fees).

17. Arizona v. Maricopa County Med. Found., 457 U.S. 332 (1982) (holding that "maximum-fee agreements, as price-fixing agreements, are per se unlawful under § 1 of the Sherman Act").
Peer-review activities relating to either quality or utilization would not appear to be subject to the same risks. Admittedly, there would be some anti-competitive effect because the provider's action would be precluded. Nevertheless, any anti-competitive effect would appear to be more than offset by the pro-competitive purpose of providing the consumer with a safe and efficacious product. Thus, unless the plaintiff can establish particular evidence showing that there was an intent not to protect the consumer, but rather to exclude providers from providing appropriate products, it is unlikely that any violation would occur. Of course, that analysis would require a full discussion of motive in a hearing on the merits.

Unfortunately, any discussion of the antitrust risks of PROs serving the entire community may become largely academic in the near future. Competition has clearly come to health care delivery through the development of alternative health systems and managed health systems such as health maintenance organizations, preferred provider organizations, and other arrangements. All those arrangements typically share the characteristics of limiting providers and developing monetary incentives to restrict cost increases. The likelihood that all these organizations will select the same PRO to perform review is extremely small. Indeed, part of the way in which these entities compete with one another is to develop their own utilization review. What the organizations typically share, however, is the focus on cost rather than quality—at least for the short run. Thus, it is likely that any peer-review arrangement established by the organization will focus exclusively on reduction of costs, perhaps to the exclusion of quality. While that may be consistent with increased competition, it is not necessarily consistent with the consumer welfare. Nevertheless, it appears to be what the short-term future has in store for us.

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18. It could be argued that such conduct is not anti-competitive because the consequences are merely to lower the price to the consumer. However, the antitrust laws are concerned not merely with producing the lowest price, but producing an unfettered price. To the extent that such restrictions limit choice it could be argued that they are anti-competitive.

19. One of the unexplored areas is the extent to which variations from the "community standard" by such alternative arrangements will produce the potential for malpractice liability for the participating physicians as well as the organization itself.