

No. 81-225

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IN THE  
**Supreme Court of the United States**  
OCTOBER TERM, 1981

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BLUE SHIELD OF VIRGINIA,  
BLUE SHIELD OF SOUTHWESTERN VIRGINIA  
and  
NEUROPSYCHIATRIC SOCIETY OF VIRGINIA, INC.,  
v. *Petitioners,*  
CAROL MCCREADY,  
*Respondent.*

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On Writ of Certiorari to the United States Court of Appeals  
for the Fourth Circuit

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**MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE*  
AND BRIEF *AMICUS CURIAE* OF  
AMERICAN PSYCHOLOGICAL ASSOCIATION  
IN SUPPORT OF RESPONDENT**

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## INTEREST OF AMICUS CURIAE

The American Psychological Association (APA), a nonprofit scientific and professional organization founded in 1892, is the major association of psychologists in the United States. The APA has more than 52,000 members—1,227 in Virginia—and includes the vast majority of psychologists holding doctoral degrees from accredited universities in the United States. The purpose of the APA, as set forth in its bylaws, is to “advance psychology as a science and profession, and as a means of promoting human welfare by the encouragement of psychology in all branches in the broadest and most liberal manner.” A substantial and growing number of APA’s member psychologists are health-care providers licensed to provide mental health services to individual clients.

Since 1948, one of APA’s major functions has been to accredit doctoral programs in professional psychology. Another of APA’s central functions is to establish ethical standards and guidelines for the delivery of psychological services. The *Ethical Principles* of psychologists have been incorporated in the laws of most states, thus governing the professional conduct of psychologists licensed in those states.

APA has undertaken several recent projects described in this brief which have assisted the public and other interested institutions in identifying qualified practitioners. And in order to provide consumers and third-party payers with a formal but readily accessible avenue of redress should a question arise regarding services or fees, APA has actively participated in the establishment of peer review programs on a nation-wide basis.

APA has long been active in the effort to improve and upgrade mental health care delivery in the United States, and it is the vitality of a competitive and cost-effective service delivery system which lies at the heart of this case. For the reasons set forth in this brief, *amicus* believes that the judgment of the appellate court, if

affirmed, will ensure fair price competition in an open market for mental health services and will improve the delivery to consumers of such badly needed services at a reasonable price.

## INTRODUCTION AND SUMMARY OF ARGUMENT

Respondent is a subscriber to a pre-paid health plan who required services for mental and emotional disorders.<sup>1</sup> Mental and emotional disorders afflict more Americans than any other category of disabling condition. According to the 1978 Report of the President's Commission on Mental Health, at least 15 percent of the population—approximately 33 million people—require some form of professional mental health treatment at any given time. But as the Commission found, the mental health field is plagued by a shortage of personnel trained to deliver these much needed services.<sup>2</sup>

Psychologists are fully trained and qualified to provide psychotherapeutic mental health services, which studies have shown to be effective in curing or ameliorating mental and emotional disorders. Indeed, no other mental health profession—psychiatry included—requires of all its practitioners as high a degree of education and training specifically in mental and emotional processes as does the profession of psychology. Generally, a doctoral level program in clinical psychology requires four to five years of rigorous and extensive didactic and field placement experience. Additional assurance that mental health services by psychologists will be of high quality is provided by licensure and certification statutes regulating the practice of psychology in all 50 states and the District of Columbia, by the APA's ethical principles and professional

<sup>1</sup> Respondent brought this case as a class action. But no ruling on that issue has occurred because the District Court granted petitioners' motion to dismiss for lack of standing.

<sup>2</sup> 1 PRESIDENT'S COMMISSION ON MENTAL HEALTH, REPORT TO THE PRESIDENT 2-10 (1978). [PRESIDENT'S COMMISSION REPORT]

standards, and by a nation-wide system of professional standards review committees.

Recognition of psychology as an independent profession on a co-equal footing with psychiatry is expressed in such major federal statutes as the Federal Employees Health Benefits Act and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). These and many other federal statutes require direct recognition of clinical psychologists as independent health-care providers, i.e., as health professionals qualified to deliver services without mandatory referral or supervision by a physician. Moreover, 30 states and the District of Columbia, representing more than 80 percent of the American population, have enacted laws establishing the direct recognition of psychological services for reimbursement purposes ("freedom of choice" laws). (Point I)

Physicians have strenuously opposed recognition of psychologists as independent health-care providers and view the economic competition posed by psychologists as threatening. Their opposition is evidenced both in official publications by organized psychiatry and in the statements of individual psychiatrists. Blue Shield of Virginia, like other Blue Shield plans, has historically had a policy of "control by the medical profession," which has been criticized both by Congress and by the Federal Trade Commission's Bureau of Competition. As the Fourth Circuit observed, petitioners were motivated by a wish to stamp out free competition for psychotherapy services and to preserve as much as possible their domination and control of the market. (Point II)

In the circumstances of this case, respondent and other consumers have standing to assert antitrust violations which diminish their property by increasing the net cost of psychotherapeutic mental health services. The treble-damages provision of the Clayton Act was intended by Congress primarily as a remedy for individuals, "especially consumers." *Brunswick Corp. v. Pueblo Bowl-O-*

*Mat, Inc.*, 429 U.S. 477, 486 n.10 (1977). Moreover, as this Court unanimously ruled in *Reiter v. Sonotone Corp.*, 442 U.S. 330, 339 (1979), a consumer whose money has been diminished by reason of an antitrust violation has been injured in his property within the meaning of Section 4 of the Clayton Act, even if that consumer has suffered no business or commercial injury. The private treble-damages remedy was enacted to achieve two major objectives—compensation for private harm and enforcement of the national economic policy in favor of competition. Both of these Congressional objectives would be furthered by allowing consumers standing in a case such as this. And because the injuries to psychologists and to consumers of psychological services are quite distinct, compensation for the private harm done consumers can be furthered *only* by allowing consumer standing. Recognition of respondent's standing in this case will also advance the important societal objective of ensuring the delivery of psychological services at a reasonable and affordable cost. (Point III-A)

None of the specific reasons for denying standing raised by petitioners in this case hold up under scrutiny. First, because the economic injury to psychologists and consumers is quite distinct, granting standing to both will not result in the multiple or duplicative recoveries prohibited by *Hawaii v. Standard Oil Co.*, 405 U.S. 251 (1972). Second, recognition of respondent's standing is not inconsistent with the decision of this Court in *Illinois Brick Co. v. Illinois*, 431 U.S. 720 (1977) because in that case this court expressly did "not address the standing issue . . . ." *Id.* at 728 n.7. Third, petitioners' assertion that respondent's alleged injury results from the independent decision of her employer to purchase a group contract that did not cover psychologists' services is legally irrelevant and factually erroneous. Finally, *amicus* is puzzled by petitioners' contention that the "target area" rule "was rejected by the majority" below. Far from rejecting the rule, the majority squarely

held that both psychologists *and* consumers "were in the target area." *McCready v. Blue Shield of Va.*, 649 F.2d 228, 231 (4th Cir. 1981). (Point III-B)

# I. PSYCHOLOGISTS ARE FULLY TRAINED AND QUALIFIED TO PROVIDE PSYCHOTHERAPEUTIC MENTAL HEALTH SERVICES

## A. The Nature of Services Required by Mentally and Emotionally Disturbed Persons

Ms. McCready, the respondent in this case, seeks to represent a class of persons who are subscribers to Blue Shield's prepaid health plan and who are in need of services for mental and emotional disorders including but not limited to depression, anxiety, drug use problems, alcohol-related disorders, phobias, obsessive-compulsive behavior, hysterical symptoms, schizophrenia, and psychosomatic conditions.<sup>3</sup>

As a Task Panel of the President's Commission on Mental Health recently noted, "the burden of mental illness in the United States is very large and probably constitutes our primary public health issue. For the past few years, the most commonly used estimate is that at any one time, 10 percent of the population needs some form of mental health care . . . . There is new evidence that this figure may be closer to 15 percent of the population."<sup>4</sup> According to the National Institute of Mental Health, Division of Biometry and Epidemiology, direct expenditures for treatment of psychological and emotional disorders are \$17 billion a year, which represents

<sup>3</sup> 2 PRESIDENT'S COMMISSION REPORT, *supra* note 2, at 4-8; GARFIELD & BERGIN, HANDBOOK OF PSYCHOTHERAPY AND BEHAVIOR CHANGE: AN EMPIRICAL ANALYSIS 3 (2d ed. 1978).

<sup>4</sup> 2 PRESIDENT'S COMMISSION REPORT, *supra* note 2, at 4.

about 11 percent of all health care expenditures nationally.<sup>5</sup>

Psychotherapy, which can be informally defined as "an interpersonal process designed to bring about modifications of feelings, cognitions, attitudes and behavior which have proven troublesome"<sup>6</sup> has been repeatedly established as efficacious in curing or ameliorating such conditions.<sup>7</sup> Psychological services have also proved valuable in treating the emotional aspects of many health conditions previously viewed as purely "physical" or "medical" in nature. For example, psychological principles have been successfully applied in the assessment and treatment of such conditions as tension (heart disease, ulcers), addiction (alcohol, drugs), and chronic pain.<sup>8</sup> Additionally, psychological techniques are being used for such purposes as physical rehabilitation of stroke victims, correction of curvature of the spine, controlling asthma attacks, and decreasing the risks associated with surgery.<sup>9</sup>

<sup>5</sup> *Id.*

<sup>6</sup> GARFIELD & BERGIN, *supra* note 3.

<sup>7</sup> *E.g.*, OFFICE OF TECHNOLOGY ASSESSMENT, UNITED STATES CONGRESS, BACKGROUND PAPER NO. 3: THE EFFICACY AND COST EFFECTIVENESS OF PSYCHOTHERAPY, 37-47 (1980); SMITH, GLASS & MILLER, THE BENEFITS OF PSYCHOTHERAPY (1980); Bergin & Lambert, *The Evaluation of Therapeutic Outcomes*, in GARFIELD & BERGIN, *supra* note 3, at 139; Smith & Glass, *Meta-Analysis of Psychotherapy Outcome Studies*, 32 AMERICAN PSYCHOLOGIST 752 (1977); See generally GARFIELD & BERGIN, *supra* note 3.

<sup>8</sup> *E.g.*, Olbrisch, *Psychotherapeutic Intervention in Physical Health: Effectiveness and Economic Efficiency*, 32 AMERICAN PSYCHOLOGIST 761 (1977); Kellner, *Psychotherapy in Psychosomatic Disorders*, 32 ARCH. GEN. PSYCHIATRY 1021 (1975); EMRICK, *A Review of Psychologically Oriented Treatment of Alcoholism*, 36 JOURNAL OF STUDIES ON ALCOHOL 88 (1975).

<sup>9</sup> See generally, STONE, COHEN & ADLER, *HEALTH PSYCHOLOGY* (1979).

The interdependence between mental and physical health has been recognized even in traditional medicine for some time.<sup>10</sup> Mental health is increasingly viewed as a necessary component of overall human health, and health care planners are acknowledging the role that psychology plays in decreasing the need for medical services by improving the physical and mental well-being of individuals afflicted with many diseases and disabilities.<sup>11</sup>

<sup>10</sup> See generally Kaufman, *Psychiatric Findings in Admission to a Medical Service in a General Hospital*, 26 JOURNAL OF THE MOUNT SINAI HOSPITAL 160 (1959); Kellner, *Psychiatric Ill Health Following Physical Illness*, 112 BRITISH JOURNAL OF PSYCHIATRY 71 (1966); Nigro, *A Psychiatrist's Experiences in General Practice in a Hospital Emergency Room*, 214 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 1657 (1970).

<sup>11</sup> It has been repeatedly demonstrated that psychological intervention lowers the cost of medical services and eases the load on our overburdened medical facilities. Studies have consistently shown that emotionally distressed individuals are unnecessarily heavy users of general health services, and that significant declines in the use of those services occurred when such persons received psychological services. *E.g.*, Jones & Vischi, *Impact of Alcohol, Drug Abuse and Mental Health Treatment on Medical Care Utilization: A Review of the Research Literature*, 17 MEDICAL CARE 1 (Dec. 1979); Cummings & VandenBos, *The Twenty Year Kaiser-Permanente Experience with Psychotherapy and Medical Utilization: Implications for National Health Policy and National Health Insurance*, 1 HEALTH POLICY QUARTERLY 159 (1981); Rosen & Wiens, *Changes in Medical Problems and Use of Medical Services Following Psychological Intervention*, 34 AMERICAN PSYCHOLOGIST 240 (1979); Cummings & Follette, *Brief Psychotherapy and Medical Utilization in DORRIN, THE PROFESSIONAL PSYCHOLOGIST TODAY: NEW DEVELOPMENTS IN LAW, HEALTH, INSURANCE AND HEALTH PRACTICE* (1976); Goldberg *et al.*, *Effect of Short-term Outpatient Psychiatric Therapy Benefit on the Utilization of Medical Services in a Prepaid Group Practice Medical Program*, 8 MEDICAL CARE 419 (1970).

## B. Qualifications of Psychologists to Provide Mental Health Services

Since the last century, psychology and psychologists have figured prominently in research and teaching concerning mental, emotional and behavioral processes. Psychology is the scientific study of behavior and experience and the application of what is learned by that study to human problems. The practice of psychology has been defined as the rendering of services involving the application of principles, methods and procedures of understanding, predicting and influencing behavior, including diagnosis, prevention, treatment and amelioration of psychological problems and emotional disorders.<sup>12</sup> Psychologists, by virtue of their training and experience, are recognized as fully qualified to diagnose and provide psychotherapeutic treatment for mental disorders.

### 1. The Doctoral Degree

Generally, a doctoral level program in clinical psychology requires four to five years of rigorous and extensive didactic and field placement experience, with approximately three years devoted to coursework, one year to a full time supervised internship at a clinic, hospital or other training center, and one year of dissertation research. The basic training model of doctoral programs in clinical psychology is the scientist-professional model, i.e., the teaching of the basic science and methods of psychology combined with the theory and techniques of clinical intervention.<sup>13</sup> By way of contrast, physicians are not required to have any training specifically related to mental or emotional disorders in order to call themselves psychiatrists and practice psychiatry—all they need is

<sup>12</sup> See Cal. Bus. & Prof. Code Ann. § 2903 (Supp. 1981); Va. Code Ann. § 54-936(c)(d) (1978).

<sup>13</sup> See generally AMERICAN PSYCHOLOGICAL ASSOCIATION, CRITERIA FOR ACCREDITATION OF DOCTORAL TRAINING PROGRAMS AND INTERNSHIPS (January 1979).

an M.D. degree.<sup>14</sup> Moreover, the basic medical education includes only very limited coursework or clinical experience with mentally or emotionally disordered persons.

### 2. Licensure and Certification

At present, all 50 states and the District of Columbia have enacted laws regulating the practice of psychology.<sup>15</sup> These are either certification or licensure laws; certification laws limit the use of the title "psychologist" while licensing laws regulate the use of the title and also define the scope of those activities for which a license to practice is required. Most state psychology laws establish the doctoral degree in a field of study primarily psychological in nature plus two years of supervised experience as the minimum requirement for licensure or certification. State examining boards administering laws regulating the practice of psychology also require that applicants pass an examination, either written, oral or both. Most state boards employ a standardized written test developed by the Professional Examination Service in conjunction with the American Association of State Psychology Boards.

Ordinarily, psychology licensure is generic. That is, certificates or licenses issued by statutorily constituted examining boards refer to "psychology" and to "psychologists," not to any specialty grouping within the profession.<sup>16</sup>

<sup>14</sup> Sobel, *Freud's Fragmented Legacy*, New York Times, October 26, 1980 (magazine) at 102.

<sup>15</sup> LAHMAN, LICENSURE REQUIREMENTS FOR PSYCHOLOGISTS: USA AND CANADA (1978).

<sup>16</sup> To give consumers, third-party payers, and government planners a clear idea of which generically licensed or certified psychologists are specially trained and qualified to render health services, the *National Register of Health Service Providers in Psychology* was established in 1975. Approximately 13,000 providers

### 3. *Ethical Codes and Professional Standards*

To further ensure a high quality of professional practice, the states have adopted ethical codes identical or quite similar to the APA's *Ethical Principles of Psychologists*.<sup>17</sup> The *Ethical Principles* deals with a variety of professional and scientific issues such as confidentiality, utilization of assessment techniques, consumer welfare and professional relationships. The *Ethical Principles* also mandates that psychologists practice only within their areas of expertise and specifically states that the psychologist is to seek consultation when necessary.

In 1977 the APA Council of Representatives (the Association's policy making body) adopted a set of generic *Standards for Providers of Psychological Services*,<sup>18</sup> which specify minimally acceptable levels of performance for psychologists engaged in providing services.

The generic *Standards for Providers* are now supplemented by *Specialty Guidelines*<sup>19</sup> for clinical, counseling, industrial/organizational, and school psychology, adopted in 1980. These four areas constitute the principal fields of specialization in applied psychology.

### 4. *Peer Review*

Still another quality control mechanism which operates with respect to psychologists is peer review. As encouraged by the American Psychological Association, each

are listed in the most current edition of the *National Register*. The *Register* has been recognized as identifying qualified providers by the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), the Aetna and Blue Cross/Blue Shield Federal Employees Health Benefits Plans, and other groups.

<sup>17</sup> APA, *Ethical Principles of Psychologists*, 36 AMERICAN PSYCHOLOGIST 633 (1981) See e.g., Md. Code Ann. art. 43, § 627 (1980); Regulations of Virginia Board of Psychology § V, POR 5.1 (1979).

<sup>18</sup> APA, *Standards of Providers of Psychological Services*, 32 AMERICAN PSYCHOLOGIST 495 (1977).

<sup>19</sup> APA, *Specialty Guidelines for the Delivery of Services by Clinical Psychologists*, 36 AMERICAN PSYCHOLOGIST 640 (1981).

APA-affiliated state psychological association has established a Professional Standards Review Committee (PSRC) to provide consumers and third-party payers with a formal but readily accessible avenue of redress should a question arise regarding the customary, usual, and reasonable nature of any fee or service rendered. PSRC determinations are advisory in nature, and are based upon regional standards of practice as perceived by psychologist peers. The APA Committee on Professional Standards, which coordinates PSRC review activity nationwide, is also encouraging psychology's involvement in the implementation of the federal peer review and quality assurance program known as "PSRO."<sup>20</sup>

### C. *Recognition of Psychology as an Independent Profession*

Given their intensive training, the rigorous licensure/certification and ethical standards, and peer review, all of which ensure the quality of their work, it is not surprising

<sup>20</sup> Another development in the area of quality assurance and peer review is the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Peer Review Project. Under contract to CHAMPUS, a panel of psychologist consultants has engineered a system for retrospective review of claims for services provided to CHAMPUS beneficiaries to ensure that the services are appropriate and of high quality. The CHAMPUS Program, which provides health coverage for military dependents, military retirees, and some others, represents the largest unified group health plan in the country. Under the processing system which is now in operation, claims failing to meet the screening criteria developed by the CHAMPUS Project Panel of psychologists are subjected to "third-level" review by teams of local psychologists.

Claims screening systems drawing upon the experience of the APA CHAMPUS Project have been established by the APA in conjunction with the Aetna Life and Casualty, Provident Mutual and Prudential Insurance Companies.

that psychologists are viewed as leaders among mental health-care professionals. Recognition of psychology as an independent profession providing psychotherapy on a co-equal footing with psychiatry is expressed not only in public attitudes but also in federal and state statutory and regulatory law and in private sector practices.

Most relevant federal statutes require direct recognition of clinical psychologists as independent health-care providers, *i.e.*, as persons qualified to deliver services without mandatory referral or supervision by a physician.<sup>21</sup> Two notable examples of such statutes are the Federal Employees Health Benefits Program,<sup>22</sup> which covers approximately 10 million federal workers and their beneficiaries, and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS),<sup>23</sup> which covers both inpatient and outpatient services for approximately 7 million dependents of military personnel, retired military personnel, and other beneficiaries. In its 1978 report, The President's Commission on Mental Health recommended independent status for clinical psychologists under Medicare and under any future national health insurance program.<sup>24</sup>

<sup>21</sup> *E.g.*, Federal Employees Compensation Act, 5 U.S.C. § 8101(2) (1976); Vocational Rehabilitation Act, 29 U.S.C. § 723(a)(1) (1976); Health Maintenance Organization Act, 42 U.S.C. § 300e-1 (1976); 42 C.F.R. §§ 110.101, 110.104 (1980); Disaster Relief Act, 42 U.S.C. § 5183 (1976); 42 C.F.R. § 38.2(e) (1980); Veterans Health Care Expansion Act, 38 U.S.C. § 613(b) (1976); Comprehensive Employment and Training Act, 29 U.S.C. §§ 801 *et seq.* (1976); 29 C.F.R. § 94.4(bb) (1978).

<sup>22</sup> 5 U.S.C. § 8902(k) (1976).

<sup>23</sup> 10 U.S.C. §§ 1071 *et seq.* (1976); 32 C.F.R. § 199.12(c)(3) (iii) (a) (1981).

<sup>24</sup> 1 PRESIDENT'S COMMISSION REPORT, *supra* note 2, at 29-30.

Thirty states and the District of Columbia, representing more than 80 percent of the American population, have enacted laws establishing the direct recognition of psychological services for reimbursement purposes.<sup>25</sup> In effect, these laws allow consumers a "freedom of choice" among state licensed practitioners.<sup>26</sup> The Health Insurance Association of America, which represents more than 300 insurance companies that write approximately 80 percent of all health insurance contracts issued by United States companies, formally supports the introduction of such "freedom of choice" legislation in the remaining states and has endorsed a model statute.

In addition to "freedom of choice" legislation, many other state statutes recognize the expertise of psychologists in such areas as civil commitment proceedings,<sup>27</sup> participation in rehabilitation programs for convicts,<sup>28</sup> forensic examinations of criminal defendants,<sup>29</sup> service on community services boards,<sup>30</sup> and reports on incidents of child abuse.<sup>31</sup> A majority of the states provide that

<sup>25</sup> American Psychological Association State Association Bulletin, App. 4 (1982) (unpublished monograph in American Psychological Association Professional Affairs Office).

<sup>26</sup> *E.g.*, Ark. Stat. Ann. § 66-3212.6 (1980); Md. Code Ann. art. 48A, § 490A (Cumm. Supp. 1981); Miss. Code Ann. § 83-41-211 (Cumm. Supp. 1981); N.Y. Ins. Law §§ 164.7-d, 221.5(e), 250.1 (Supp. 1981); Tenn. Code Ann. § 56-7-108 (1980); Va. Code Ann. §§ 38.1-824, 38.1-347.1 (Cumm. Supp. 1979).

<sup>27</sup> *E.g.*, Va. Code Ann. § 37.1-65.1C2 (Cumm. Supp. 1981).

<sup>28</sup> *E.g.*, Md. Code Ann. art. 31B, § 5 (Cumm. Supp. 1980).

<sup>29</sup> *E.g.*, Ohio Rev. Code Ann. § 2947.06 (1975).

<sup>30</sup> *E.g.*, N.Y. Mental Hygiene Law § 41.11 (1978).

<sup>31</sup> *E.g.*, Del. Code Ann., tit. 16, §§ 902, 903 (1974 & Cumm. Supp. 1980).

communications between psychologists and their clients are privileged,<sup>32</sup> and numerous federal and state courts have recognized the competence of clinical psychologists to testify as expert witnesses in the field of mental disorders.<sup>33</sup>

These facts are consistent with the holding of the Fourth Circuit that clinical psychologists are equally qualified to provide mental health services and that under ordinary circumstances they compete with psychiatrists in the marketplace for the delivery of such services:

The record demonstrates that psychologists and psychiatrists do compete; indeed it is susceptible to judicial notice. Both provide psychotherapy, 469 F.Supp. at 560, and are licensed to do so by state law. See Va. Code §§ 54-273(10), -274, -309.1, -936 (1978 Replacement Vol.) Competition in the health care market between psychologists and M.D. providers of psychotherapy is encouraged by the legislature, see Va. Code § 38.1-824, and its existence is well documented. *Virginia Academy of Clinical Psychologists v. Blue Shield of Va.*, 624 F.2d 476, 485 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981) (footnote omitted) (incorporated by reference in *McCready v. Blue Shield of Va.*, 649 F.2d 228, 230 (4th Cir. 1981)).

<sup>32</sup> E.g., Ky. Rev. Stat. Ann. § 319.111 (1977); Tenn. Code Ann. § 63-1117 (1976); Va. Code Ann. § 8.01-399 (1977). See also Rule 501, Fed. R. Evid.

<sup>33</sup> E.g., *United States v. Riggleman*, 411 F.2d 1190, 1191 (4th Cir. 1969); *United States v. Brauner*, 471 F.2d 969, 994 (D.C.Cir. 1972) (*en banc*); *United States v. Portis*, 542 F.2d 414, 419 (7th Cir. 1976); *Hogan v. State*, 496 S.W.2d 594, 597 (Tex. Crim.), *cert. denied*, 414 U.S. 862 (1973); *Rollins v. Commonwealth*, 207 Va. 575, 580, 151 S.E.2d 622, 626 (1966), *cert. denied*, 386 U.S. 1026 (1967); *Roberts v. State*, 41 Wis.2d 537, 551, 164 N.W.2d 525, 532 (1969). See also Rule 702, Fed. R. Evid.

## II. PHYSICIANS AND BLUE SHIELD PLANS HAVE HISTORICALLY MADE AND CONTINUE TO MAKE ATTEMPTS TO DISCOURAGE COMPETITION FROM PSYCHOLOGISTS AND OTHER QUALIFIED PROVIDERS OF MENTAL HEALTH SERVICES, AND HAVE THEREBY INCREASED THE COST TO THE CONSUMERS OF SUCH SERVICES

### A. Anti-competitive Policies of Psychiatry

Recognition of psychologists as independent health care providers has met with strenuous opposition from physicians in general and psychiatrists in particular. Psychiatrists view their "territory" as being "assailed from every side" by psychologists and view the economic competition as threatening.<sup>34</sup>

The oft-stated policy of the American Psychiatric Association is to do everything possible to keep psychologists and other professionals in a subordinate role under the direction of physicians/psychiatrists.<sup>35</sup> The likely result of allowing psychiatrists to determine which competing psychotherapists will be reimbursed is indicated in an American Medical News article noting that "psychiatrists are declaring war on anyone trying to move in on their territory . . . [i]n the fight for professional

<sup>34</sup> *Province of Psychiatry Questioned, Said to Need Defining*, Clinical Psychiatry News, November 1977, at 1.

<sup>35</sup> E.g., *Position Statement on Hospital Privileges for Psychologists*, 128 AMERICAN JOURNAL OF PSYCHIATRY 1456 (1971); *Position Statement on Psychiatrists' Relationship with Non-Medical Mental Health Professionals*, 130 AMERICAN JOURNAL OF PSYCHIATRY 386 (1973); *Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry*, 130 AMERICAN JOURNAL OF PSYCHIATRY 1058 (1973); *Position Statement on Administration of Psychiatric Facilities*, 133 AMERICAN JOURNAL OF PSYCHIATRY 604 (1976); see also *Guidelines of Psychiatrists in Consultative, Supervisory, or Collaborative Relationships with Nonmedical Therapists*, 137 AMERICAN JOURNAL OF PSYCHIATRY 1489-90 (1980).

survival. . . ."<sup>36</sup> The president of the American Psychiatric Association is quoted in the same article as suggesting that psychiatrists should "push for treatment supremacy over allied health professionals practicing in the mental health field."<sup>37</sup>

One example of this effort is the attempted "remedicalization" of psychiatry, i.e., an attempt to define all treatment of mental health problems as "medical" treatments.<sup>38</sup> An official of the American Psychiatric Association has described the effects of the process as follows:

Medical care becomes equated with health care. This brings psychiatry back into the mainstream of the medical establishment, because the equation of medical care with health care is the basis on which organized medicine claims the right to exert control over the total health-care industry.<sup>39</sup>

#### B. Anti-competitive Policies of Blue Shield

This policy of "control by the medical profession" has long been the policy of Blue Shield of Virginia as well. Indeed, Blue Shield grew out of "medical service bureaus" organized by county medical societies to combat plans developed by employers to deliver medical care to their employees on a contract basis. The direct ancestors

<sup>36</sup> *Psychiatry Faces Survival Battle, Threats to Profession Seen*, May 26, 1978 at 1, col. 1.

<sup>37</sup> *Id.* at col. 2.

<sup>38</sup> For example, the fourth edition of A PSYCHIATRIC GLOSSARY (AMERICAN PSYCHIATRIC ASSOCIATION 1974) introduced a new term, "medical psychotherapy." Advertising material emphasized that this "new definition will be helpful to psychiatrists in relation to the third-party payment problem."

<sup>39</sup> *Tenson Rising Between Psychology, Psychiatry*, Clinical Psychiatry News, November 1977, at 1 (summarizing remarks of director of membership services and studies division of American Psychiatric Association).

of the present Blue Shield plan were established in the 1940s, offering prepaid coverage through medical societies and other physician-controlled organizations.<sup>40</sup> And as early as 1947, the medical profession's control over Blue Shield plans was being criticized, particularly because of the impact of that control on physicians' fees.<sup>41</sup>

Today, Blue Shield plans comprise by far the nation's largest source of private third-party payments for health services. During 1977, Blue Shield plans underwrote or administered coverage for approximately 85.3 million Americans, or about 39.5 percent of the nation's total population.<sup>42</sup> Physician dominance of Blue Shield has continued, as medical societies and other physician organizations "participate extensively in the control of most Blue Shield plans."<sup>43</sup> Many Blue Shield plans continue to act on the premise that physician organizations should control all aspects of health care, including the services of non-physicians.<sup>44</sup>

Although many Blue Shield plans extended coverage for mental health services in the 1960s, some—particularly in areas with high concentrations of psychiatrists—refused to recognize and reimburse clinical psychologists as independent providers, even though psychologists were

<sup>40</sup> FEDERAL TRADE COMMISSION, MEDICAL PARTICIPATION IN CONTROL OF BLUE SHIELD AND CERTAIN OTHER OPEN-PANEL MEDICAL PRE-PAYMENT PLANS 54-60 (1979) [FTC BUREAU OF COMPETITION].

<sup>41</sup> REED, BLUE CROSS AND MEDICAL SERVICES PLANS 236 (1947). For more recent criticism, see KENNEDY, IN CRITICAL CONDITION: THE CRISIS IN AMERICA'S HEALTH CARE 210 (1972).

<sup>42</sup> FTC BUREAU OF COMPETITION, *supra* note 40, at 80, quoting Blue Cross/Blue Shield Fact Book 1978, at 16.

<sup>43</sup> *Id.* at 87.

<sup>44</sup> *Id.* at 159.

licensed to practice independently in most states.<sup>45</sup> On the national level, Blue Shield refused to afford psychologists independent status in its program for federal employees until Congress mandated coverage for psychologists' services in 1974.<sup>46</sup> As explained in a staff report to the Federal Trade Commission, one of the

"... important decisions each Blue Shield plan must make in carrying on its business is determining which providers it will pay for supplying covered services to its subscribers. The decision as to which providers are eligible to receive reimbursement has a significant impact on competition in the health care services market. To the extent that providers' services are not covered by Blue Shield contracts, those providers may be virtually eliminated as competitors in the portion of the market represented by Blue Shield subscribers. If the plan in question has a substantial market share, such providers may in fact be seriously hampered in competing in the market as a whole."<sup>47</sup>

As a consequence of these decisions, "effective competition" from licensed non-physician health providers has been delayed and obstructed. Some professions have been excluded; others have been kept in a "complementary" or "physician-support" status, although their authority to practice independently has been recognized by state law.<sup>48</sup>

Such anti-competitive attitudes and practices are at issue in this case. As the court found in the companion

<sup>45</sup> *Id.* at 163.

<sup>46</sup> 5 U.S.C. § 8902(k) (1976). See S.REP. No. 93-961, 93d Cong., 2d Sess. 3 (1974) ("no justification" for requiring supervision of psychologists by physicians).

<sup>47</sup> FTC BUREAU OF COMPETITION, *supra* note 40, at 210-211. See also FEDERAL TRADE COMMISSION, ENFORCEMENT POLICY WITH RESPECT TO PHYSICIAN AGREEMENTS TO CONTROL MEDICAL PREPAYMENT PLANS (September 25, 1981).

<sup>48</sup> FTC BUREAU OF COMPETITION, *supra* note 40, at 161-162.

case *Virginia Academy of Clinical Psychologists v. Blue Shield of Va.*, 624 F.2d 476, 485 n.11 (4th Cir. 1980), "one could scarcely find a more revealing statement of competitive conditions than the statement of [the medical director of the Richmond plan] concerning the need to stop 'encroachment' by non-M.D. providers of therapy." That statement appeared in the May 25, 1972 minutes of the Committee on Mental Health of the Medical Society of Virginia, which read as follows:

Dr. Hulley assured the Committee of the interest of Blue Cross/Blue Shield where psychiatric services are concerned and discussed a report prepared under the direction of Dr. Wingfield and a special committee of the Neuropsychiatric Society.

The report is concerned with services provided by psychiatrists and charges involved. It has been referred to the Blue Shield Board for consideration and final disposition.

It was brought out that a number of groups, which have a part in the overall mental health picture, are little-by-little working their way into the therapy field. It seemed to be the consensus that the Medical Society of Virginia should take a firm stand on this encroachment and seek to stop it once and for all.

It was brought out that psychotherapy apparently means different things to different people and it was agreed that it should be defined as that performed by psychiatrists or under the direct supervision of psychiatrists. 624 F.2d at 481 n.6.

That evidence, which is incorporated by reference into the Fourth Circuit's decision in this case (649 F.2d at 230), shows with shocking clarity the extent to which petitioners were motivated by a wish to stamp out free competition in the marketplace for psychotherapy services and to preserve as much as possible their domination and control of the field.

### C. The Effects of Such Illegal Practices on the Cost of Services to Consumers

The elimination of psychologists and other non-physician providers from the marketplace of mental health services leads inevitably to higher costs for such services.<sup>49</sup> And from a cost perspective, the requirement that psychologists bill through physicians is little better than the practice of excluding psychologists from the market entirely. As a Senate committee has concluded, "there is little if any benefit derived from the practice of [physician] supervision of [mental health] service other than the earning of money by doctors . . . ." <sup>50</sup>

When such anti-competitive practices as have been alleged here and proved in the companion case are allowed to persist, the real victims are persons such as respondent and the class she seeks to represent who must pay artificially high prices for artificially scarce mental health services. Persons in need may even be denied such services entirely because the existing supply of qualified psychotherapists will be grossly inadequate if non-physician providers have been driven from the marketplace.

Noting that "[t]he Blue Shield plans are a dominant source of health care coverage in Virginia" and that "[t]heir decisions as to who will be paid for psychotherapy necessarily dictate, to some extent, which practitioners will be chosen from among those competent under the law to provide such services," the Fourth Circuit found the plans' requirement that psychologists' fees be billed through physicians to be illegal. *Virginia Academy of Clinical Psychologists v. Blue Shield of Va.*, 624 F.2d 476, 485 (4th Cir. 1980). "The Blue Shield policy forces the two independent economic entities to act as

<sup>49</sup> Frank, *Pricing and Location of Physician Services in Mental Health*, 1 HEALTH POLICY QUARTERLY 3 (1982) (in press).

<sup>50</sup> S.REP. No. 92-861, 92d Cong., 2d Sess. 5 (1972). See also S.REP. No. 93-961, 93d Cong., 2d Sess. (1974).

one, with the necessary result of diminished competition in the health care field." *Id.* As the Fourth Circuit held, the elimination of the bill-through-provision would *not* preclude a variety of other cost control and quality control measures by Blue Shield. But it would "expand consumer and provider alternatives" and would be likely to "result in lower costs." *Id.* at 486.

### III. IN THE CIRCUMSTANCES OF THIS CASE, RESPONDENT AND OTHER CONSUMERS HAVE STANDING TO ASSERT ANTITRUST VIOLATIONS WHICH DIMINISH THEIR PROPERTY BY INCREASING THE NET COST OF PSYCHOTHERAPEUTIC MENTAL HEALTH SERVICES

It is undisputed that respondent and other consumers of psychological services have standing, in the constitutional sense, to assert antitrust violations which diminish their property by increasing the net cost of such services.<sup>51</sup> The question, therefore, is not whether Congress has the power to confer standing in these circumstances, but whether it has done so. In *amicus'* view, Congress manifestly intended for consumers to have standing in cases such as this.

#### A. Standing Will Further the Purposes Underlying the Antitrust Laws and Will Ensure the Delivery of Necessary Psychological Services at Reasonable Cost

Several important points relating to consumer standing are by now well-settled. First, as this Court unanimously ruled in *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 486 n.10 (1977), the treble-damages

<sup>51</sup> See Berger and Bernstein, *An Analytical Framework for Antitrust Standing*, 86 Yale L.J. 809, 813 n.11 (1977); and Comment, *Closing the Door on Consumer Antitrust Standing*, 54 N.Y.U. L.Rev. 237 n.6 (1979); and the cases and authorities cited therein.

provision of the Clayton Act was intended by Congress primarily as a remedy for individuals, "especially consumers."

Second, as this Court unanimously ruled in *Reiter v. Sonotone Corp.*, 442 U.S. 330, 339 (1979), a "consumer whose money has been diminished by reason of an antitrust violation has been injured 'in his . . . property' within the meaning of Section 4" of the Clayton Act, even if the consumer has suffered no "business" or "commercial" injury.

Third, as commentators and this Court have acknowledged after reviewing the legislative histories of the Sherman and Clayton Acts, the "private treble-damages remedy was enacted to achieve two real public purposes: compensation for private harm and enforcement of the national economic policy in favor of competition." Berger and Bernstein, *supra* note 51, at 845.<sup>52</sup>

Both of these Congressional objectives would be furthered by allowing consumer standing in the circumstances of this case. And because the injuries to psychologists and to consumers of psychological services are quite distinct, the first objective—compensation for private harm—can be furthered *only* by allowing consumer standing.

Petitioners contend that since psychologists do have standing to assert antitrust claims against them, granting standing to consumers "advances no rational goal of the antitrust laws," Cert. Pet. at 20, and "the policies of

<sup>52</sup> See also, *Branswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. at 485-486 ("... the treble-damages provision . . . is designed primarily as a remedy."); *Reiter v. Sonotone Corp.*, 442 U.S. at 344 ("Congress created the treble-damages remedy of Section 4 precisely for the purpose of encouraging private challenges to antitrust violations. These private suits provide a significant supplement to the limited resources available to the Department of Justice for enforcing the antitrust laws and deterring violations.") (emphasis in original).

the antitrust laws can be fully vindicated" by psychologists. Cert. Pet. at 9. But that contention overlooks the very different economic injuries which psychologists and consumers of psychological services suffer by reason of the same antitrust violation. The economic injury to psychologists consists of the income they would have received from potential clients who would have chosen their services but who chose instead the services of psychiatrists in order to obtain reimbursement from petitioners. If, as in this case, a client nevertheless chooses and pays a psychologist, the psychologist will have "suffered no damage in this respect," because the consumer will have "already paid" the psychologist in full. *McCready v. Blue Shield of Va.*, 649 F.2d 228, 232 (4th Cir. 1981). The only economic injury, in this circumstance, is to the consumer.<sup>53</sup> Accordingly, unless consumers who do choose psychologists are granted standing to sue for the particular economic injury they and they alone suffer by reason of the antitrust violation, the Congressional objective of ensuring compensation for every private harm will be completely frustrated.

<sup>53</sup> Petitioners stress that "there is no allegation in the complaint that the alleged boycott increased the price of clinical psychologists' services or that the alleged boycott hindered McCready in finding a clinical psychologist to treat her." Cert. Pet. at 4. Both of those points are irrelevant. But for the antitrust violation, respondent would have been reimbursed for 80 percent of the cost of her psychologist's services. McCready Deposition Transcript at 67; *McCready v. Blue Shield of Va.*, 649 F.2d at 231. Thus, even if the violation did not increase the gross cost of psychological services, it very substantially increased respondent's *net* or out-of-pocket cost, and substantially diminished the money she would have had but for the violation. Similarly, the fact that respondent was able to purchase the services of a psychologist, although at an increased cost to her, is no more relevant than the fact that the plaintiffs in *Reiter v. Sonotone Corp.*, 442 U.S. 330, were able to purchase hearing aids, although at an increased cost to them. The fact that goods or services are available at *some* price does not preclude suit under the antitrust laws if, because of an antitrust violation, the cost of those goods or services to the consumer is increased.

In addition to furthering this nation's economic objectives, granting standing to consumers of psychological services will further other equally important societal objectives. As we have demonstrated above, there is an enormous and unmet need for psychological services in this country. 1 PRESIDENT'S COMMISSION REPORT 2-10; see generally discussion *supra* at 5-7. Increasing the pool of therapists available to meet that need will directly and substantially benefit individuals, and will indirectly benefit the national economy by reducing the time employees are absent from work because of psychological problems.

In sum, recognition of respondent's standing in this case will further important societal objectives as well as the purposes of our anti-trust laws, the essence of [which] is to ensure fair price competition in an open market." *Reiter v. Sonotone Corp.*, 442 U.S. 330, 342 (1979).

**d. In the Circumstances of This Case, Standing Will Not Result in Duplication of Recovery, Speculative Damages, or any of the Other Problems Which Have Persuaded Courts, in Other Circumstances, to Deny Standing<sup>24</sup>**

Petitioners contend that "this case presents exactly the situation of multiple lawsuits against the same defend-

<sup>24</sup> Although respondent will discuss the cases relied upon by petitioners in more detail, *amicus* simply wishes to state that all of the cases cited by petitioners in support of their argument that respondent should be denied standing are readily distinguishable. Indeed, some of them are not "standing" cases at all. For example, petitioners assert that the "standing" principle of *Hawaii v. Standard Oil Co.*, 405 U.S. 251 (1972), "was elaborated" in *Illinois Brick Co. v. Illinois*, 431 U.S. 720 (1977). Cert. Pet. at 16. But in *Illinois Brick* this Court expressly did "not address the standing issue . . ." 431 U.S. at 728 n.7. Rather, the Court "stressed the difficulties of proving passing-on of overcharges in the course of holding that indirect purchasers could not recover treble damages under Section 4," Berger and Bernstein, *supra* note 51, at 855. The "direct-purchaser rule of *Illinois Brick*," as this Court phrased it in *Reiter v. Sonotone Corp.*, 442 U.S. at 337 n.3, is thus a substantive rule fashioned to

ants that the 'target area' rule was designed to prevent." Cert. Pet. at 9. But since the economic injuries to psychologists and consumers are quite distinct, granting standing to both will not result in "multiple" or "duplicative recoveries," which was the "central premise" and reason for denying standing in *Hawaii v. Standard Oil Co.*, 405 U.S. 251 (1972). See *Reiter v. Sonotone Corp.*, 442 U.S. 330, 342 (1979).

The economic injuries suffered by consumers are not at all speculative. They are fixed by the terms of their Blue Shield contracts, and "can be readily ascertained to the penny." *McCready v. Blue Shield of Va.*, 649 F.2d 228, 231 (4th Cir. 1981).

Petitioners also assert that respondent should "not be accorded standing, because her alleged 'injury' results from the independent decision of her employer to purchase a group contract that did not cover psychologists' services." Cert. Pet. at 17; see also, *Id.* at 20. That assertion is irrelevant, and seriously misleading, in several respects. First, if it were true that respondent's injury was caused not by petitioners but solely by her employer, that factual issue could not be resolved on standing grounds, but only on the merits. Second, the assertion is not factually accurate. "Between 1962 and 1972, Richmond Plan coverage included direct payment to psychologists for psychotherapy rendered to subscribers." *Virginia Academy of Clinical Psychologists v. Blue Shield of Va.*, 624 F.2d 476, 478 (4th Cir. 1980). In 1972, petitioners decided, apparently without changing the wording of the plans, to re-interpret the plans so that payment would be allowed for the services of psychologists only if those services were billed through a physician. *Id.* But in 1973, Virginia enacted a statute

to avoid the special and complex problems of proof of damages in chain-of-distribution cases. But none of those proof problems is present in the circumstances of this case, and *Illinois Brick* is therefore irrelevant on substantive grounds, as well as on the issue of standing.

which required the plans "to pay directly for services rendered by licensed psychologists." *Id.*<sup>55</sup>

As petitioners know, respondent sues on her own behalf and on behalf of a not yet certified class of consumers who incurred unreimbursed costs for services by licensed clinical psychologists "since 1973." Cert. Pet. at 3; *McCready v. Blue Shield of Va.*, 649 F.2d 228, 229 (4th Cir. 1981). Thus, at all times relevant to this suit, state law required petitioners to reimburse directly for services rendered by psychologists. Given this history of direct reimbursement and a state law requiring direct reimbursement in 1973 and thereafter, it is certainly not unreasonable for respondent to believe that it had contracted for a plan which would provide direct reimbursement.<sup>56</sup>

Petitioners contend that the "target area" rule "was rejected by the majority" below, and they stress that point repeatedly. Cert. Pet. at 7-8; see also *Id.* at 10-19. *Amicus* is puzzled by that contention. Far from "rejecting" the rule, the majority squarely held that both psychologists and consumers "were in the target area." *McCready v. Blue Shield of Va.*, 649 F.2d 228, 231 (4th Cir. 1981). Moreover, in explaining its ruling, the majority indicated that the target area rule should be applied to deny standing "only when the underlying purposes of the phrase are served"; surely petitioners do not quarrel with that qualification. Petitioners may disagree with the majority whether the target area rule permits or prohibits standing in the particular factual circumstances presented by this case; but to suggest that the majority below rejected the target area rule as a matter of law, thus creating a supposed conflict with

<sup>55</sup> Va. Code § 32-195.10:1 (now amended and codified at § 38.1-824 (1978)).

<sup>56</sup> Of course state law did not preclude petitioners from raising the cost of the plans they offered, if they had chosen to do so.

other circuits, is disingenuous. Because there is no true conflict between the decision below and other circuits on this point, it would be appropriate to dismiss the writ of *certiorari* as improvidently granted on that question.<sup>57</sup>

### CONCLUSION

The writ of *certiorari* should be dismissed; or, in the alternative, the judgment of the United States Court of Appeals for the Fourth Circuit should be affirmed.

Respectfully submitted,

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<sup>57</sup> The remaining question raised by petitioners was resolved against them in the related case of *Virginia Academy of Clinical Psychologists v. Blue Shield of Va.*, 624 F.2d 476 (4th Cir. 1980), cert. denied, 450 U.S. 916 (1981). As petitioners note, that case involved "a similar complaint" "filed in the same court against the same defendants . . . . The material allegations in the two complaints are identical." Cert. Pet. at 8-9. In that case, as in this, petitioners contended unsuccessfully that their plans were exempt from the antitrust laws as part of the "business of insurance" under Section 2 of the McCarran-Ferguson Act. Petitioners were represented by the same lawyers, for the most part, in both cases. In our view, petitioners are collaterally estopped from attempting here to relitigate that issue. Accordingly, the writ should be dismissed as improvidently granted on that question as well.

### CERTIFICATE OF SERVICE

I, Paul R. Friedman, Counsel for *Amicus Curiae* and a member of the bar of this Court, certify that on January 18, 1982, I served by mail three copies of the foregoing Motion for Leave to File Brief *Amicus Curiae* and Brief of *Amicus Curiae* on Griffin B. Bell, Esquire, King & Spalding, 1915 I Street, N.W., Washington, D.C. 20006, Counsel of Record for Petitioner; and on Timothy J. Bloomfield, Esquire, Dunnells, Duvall, Bennett & Porter, 1220 19th Street, N.W., Washington, D.C. 20036, Counsel of Record for Respondent.

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PAUL R. FRIEDMAN