UNC SCHOOL OF LAW

NORTH CAROLINA LAW REVIEW

Volume 69 | Number 3 Article 2

3-1-1991

A Competitive Analysis of Most Favored Nations Clauses in Contracts between Health Care Providers and Insurers

Arnold Celnicker

A COMPETITIVE ANALYSIS OF MOST FAVORED NATIONS CLAUSES IN CONTRACTS BETWEEN HEALTH CARE PROVIDERS AND INSURERS

ARNOLD CELNICKER*

A most favored nations (MFN) clause is a contractual agreement between a buyer and a seller stating that the price paid by the buyer will be at least as low as the price paid by other buyers who purchase the same commodities from the seller. During the past decade the anticompetitive impact of MFN clauses in the health care industry has been challenged under federal antitrust laws. The cases have considered MFN clauses included in contracts between large third-party payers, specifically Blue Cross and Blue Shield (BCBS) plans, and providers of health care. The clauses prohibit providers from selling their medical services to BCBS's competitors at a price lower than the price at which they sell to BCBS. The cases have challenged these clauses on the grounds that they limit selective discounting to the competitors thereby making it difficult for the competitors to attract subscribers from dominant BCBS plans by lowering premiums. In this Article, Professor Celnicker asserts that MFN clauses have significant anticompetitive potential. The Article examines the competitive consequences of MFN clauses used in the health care industry. The Article's analysis draws heavily from the economic criticisms of the Robinson-Patman Act, which prohibits a seller from discriminating in price between customers in certain circumstances. The Article concludes that in certain circumstances, MFN clauses discourage discounting, facilitate oligopolistic pricing, and deter entry or expansion by more efficient distribution systems.

I. INTRODUCTION

A clause in the contract between Blue Cross and Blue Shield of Rhode Island (BCBSRI) and doctors prohibited the doctors from lowering their prices to any of their patients without also lowering their prices to BCBSRI subscribers. In *Ocean State Physicians Health Plan, Inc. v. Blue Cross and Blue Shield of Rhode Island*,[1] the doctors charged that this clause, called a "most favored nations" clause, was anticompetitive and violated the federal antitrust laws. The United States Court of Appeals for the First Circuit rejected the doctors' argument, characterizing it as "silly."[2]

---

* Assistant Professor, College of Business, and Adjunct Professor for Antitrust, College of Law, The Ohio State University. The author thanks Bruce Seaman for his valuable contributions to the economic analysis and David Leonard for his research assistance.

1. 883 F.2d 1101 (1st Cir. 1989), *cert. denied*, 110 S. Ct. 1473 (1990).

2. *Id.* at 1110 (quoting Ocean State Physicians Health Plan, Inc. v. Blue Cross and Blue Shield of R.I., 692 F. Supp. 52, 71 (D.R.I. 1988)).

This Article will analyze the competitive impact of most favored nations (MFN) clauses and establish that they do, in fact, have anticompetitive potential. This Article defines an MFN clause as a contractual agreement between a buyer and a seller that the price paid by the buyer will be at least as low as the price paid by other buyers who purchase the same commodities from the seller.[3] Only during the past decade has the possible anticompetitive impact of MFN clauses been challenged under federal antitrust laws.

In the early 1980s the Federal Trade Commission (FTC) brought a test case aimed at establishing that MFN clauses, accompanied by certain other practices, could facilitate tacit collusion in an oligopolistic industry.[4] The FTC found that MFN clauses facilitated oligopolistic pricing.[5] The Commission cited evidence that the clauses limited price discounting because the manufacturer would have to give any discount to all customers.[6] However, the United States Court of Appeals for the Second Circuit reversed the FTC's finding and labeled MFN clauses a legitimate business practice.[7]

Although the use of MFN clauses undoubtedly has continued in a number of industries, recent private antitrust litigation challenging the anticompetitive effects of these clauses has focused on the health care industry. The cases have considered MFN clauses included in contracts between large third-party payers, specifically Blue Cross and Blue Shield (BCBS) plans, and providers of health care, such as doctors, dentists, and hospitals. The clauses prohibit providers from selling their medical services to BCBS's competitors at a price lower than the price at which they sell to BCBS. The cases have challenged these clauses on the grounds that they limit selective discounting to the competitors and thus make it difficult for the competitors to attract subscribers from dominant BCBS plans by lowering premiums.[8]

During the 1980s, one federal circuit court,[9] two federal district courts,[10] and two state courts[11] rejected such antitrust attacks on MFN clauses. Moreover, both federal antitrust enforcement agencies, the FTC and the Antitrust

3. Other terms used to describe the same concept include "most favored customer," "most favored buyer," "price protection," and "nondiscrimination" clauses.

4. *In re* Ethyl Corp., 101 F.T.C. 425 (1983), *rev'd sub nom.* E.I. Du Pont de Nemours & Co. v. FTC, 729 F.2d 128 (2d Cir. 1984).

5. *Id.* at 625-26.

6. *Id.*

7. E.I. Du Pont de Nemours & Co. v. FTC, 729 F.2d 128, 139-40 (2d Cir. 1984).

8. *See* Baker, *Vertical Restraints Among Hospitals, Physicians and Health Insurers that Raise Rivals' Costs*, 14 AM. J.L. & MED. 147, 154-68 (1988); Note, *Most-Favored-Nation Clauses and Monopsonistic Power: An Unhealthy Mix?*, 15 AM. J.L. & MED. 111, 117-27 (1989).

9. Ocean State Physicians Health Plan, Inc. v. Blue Cross and Blue Shield of R.I., 883 F.2d 1101 (1st Cir. 1989), *cert. denied*, 110 S. Ct. 1473 (1990) For a discussion of this case, see *infra* text accompanying notes 73-87.

10. Kitsap Physicians Serv. v. Washington Dental Serv., 671 F. Supp. 1267 (W.D. Wash. 1987) (For a discussion of this case, see *infra* text accompanying notes 67-72.); Blue Cross and Blue Shield of Mich. v. Michigan Ass'n of Psychotherapy Clinics, 1980-2 Trade Cas. (CCH) ¶ 63,351 (E.D. Mich. 1980) (For a discussion of this case, see *infra* text accompanying notes 48-54.).

11. Michigan Ass'n of Psychotherapy Clinics v. Blue Cross and Blue Shield of Mich., 118 Mich. App. 505, 325 N.W.2d 471 (1982) (For a discussion of this case, see *infra* text accompanying note 54.); Madden v. California Dental Serv., 1986-1 Trade Cas. (CCH) ¶ 67,176 (Cal. Super. Ct. 1986) (For a discussion of this case, see *infra* text accompanying notes 55-66.).

Division of the United States Department of Justice, have indicated a general unwillingness to challenge the use of MFN clauses in the health care industry.[12] The support for MFN clauses is based primarily on the idea that requiring any lower price given to buyer *A* also be given to buyer *B* is not only fair to buyer *B*, but also leads to the spreading of lower prices throughout the market.

More recently, however, *Reazin v. Blue Cross and Blue Shield of Kansas, Inc.*[13] became the first court opinion to paint MFN clauses in an anticompetitive light. According to the court's analysis, MFN clauses create a disincentive for the provider to give a discount to a BCBS competitor because the discount would have to be given to BCBS also. The disincentive to discount, in turn, makes entry into the market by competitors more difficult.

This Article examines the competitive consequences of MFN clauses, focusing on their use in the health care industry. Part II of the Article reviews the FTC's test case, *In re Ethyl Corp.*[14] Part III provides background regarding the relevant economic changes that have been occurring in the health care industry since the 1970s and presents the cases that have challenged MFN clauses in that context. Part IV analyzes the competitive effects of MFN clauses. The analysis draws heavily from economic criticisms of the Robinson-Patman Act,[15] which prohibits a seller from discriminating in price between customers in certain circumstances. This analysis leads to the conclusion, presented in Part V, that MFN clauses have significant anticompetitive potential.

---

12. Between 1984 and 1986, the Antitrust Division of the United States Department of Justice conducted investigations involving MFN clauses in contracts between providers and Blue Cross of Idaho, Blue Cross of Kansas City, and Dental Service Corporation of North Dakota. (Documents obtained by the author pursuant to a Freedom of Information Act request.) No actions resulted. In 1988, the head of the Antitrust Division stated that the Division was "unlikely" to challenge MFN clauses between third-party payers and providers. He did state, however, that:

> when the third-party payer supplies at least 35 percent of the business of providers in the market—a function of the number of providers contracting with the payer and the importance of the payer to each provider—further analysis is warranted. Among the questions the Department is likely to ask in assessing such a clause's competitive effect are whether the imposition of the clause was motivated by factors other than the desire to get the best price possible and whether there is sufficient available capacity for a new third-party payer to enter the market.

Remarks at the Antitrust and Health Care Seminar of the Antitrust Section of the Connecticut Bar Association and the Connecticut Health Lawyers Association 24 (March 11, 1988) [hereinafter Remarks] (Statement by C.F. Rule).

Between 1984 and 1986, the Federal Trade Commission conducted at least two inquiries involving MFN clauses in provider contracts. (Documents obtained by the author pursuant to a Freedom of Information Act request.) No actions were taken. Moreover, the FTC declined to support Ocean State's petition for certiorari in *Ocean State*, where the First Circuit found MFN clauses to be procompetitive. *See infra* text accompanying notes 73-87.

13. 899 F.2d 951 (10th Cir.), *cert. denied*, 110 S. Ct. 3241 (1990) For a discussion of this case, see *infra* text accompanying notes 88-109.

14. 101 F.T.C. 425 (1983), *rev'd sub nom.* E.I. Du Pont de Nemours & Co. v. FTC, 729 F.2d 128 (2d Cir. 1984).

15. 15 U.S.C. § 13 (1988).

II. IN RE ETHYL CORP.[16]

In 1979, the Federal Trade Commission issued an administrative complaint against the only four manufacturers of antiknock compounds.[17] The complaint alleged that certain marketing practices used in an oligopolistic setting reduced uncertainty about prices, thereby facilitating price uniformity and reducing price competition.[18] One of these marketing practices was the use of MFN clauses.[19]

The Commission concluded that MFN clauses reduced the incentive to discount.[20] If the manufacturer provided a discount to one customer, it was contractually bound to give the discount to all its customers. The direct effect of discounting would be to reduce the manufacturer's profits, unless the lower prices attracted sufficient new customers to offset the reduced revenues caused by its lower prices. The prospect of that occurring is not great, however, if the other oligopolists learn of the discounting because they, too, would lower their prices. Given that MFN clauses require the discount be given to all customers, it is unlikely that such widespread discounting could be kept secret from the other oligopolists. Realizing this, the manufacturer is unlikely to discount in the first instance. Moreover, each oligopolist can be reasonably certain its rivals will view the situation the same way and opt not to discount. Therefore, the Commission concluded that price uncertainty, which can destabilize oligopolistic pricing, is reduced.[21]

The manufacturers argued that customers desired MFN clauses to ensure that they were not disadvantaged in relation to other customers.[22] They contended that MFN clauses actually were consistent with the policy of the Robinson-Patman Act,[23] which prohibits a seller from discriminating in price between

16. 101 F.T.C. 425 (1983), *rev'd sub nom.* E.I. Du Pont de Nemours & Co. v. FTC, 729 F.2d 128 (2d Cir. 1984).

17. *Id.* The four manufacturers were Ethyl, Du Pont, PPG, and Nalco. *Id.* at 426-27.

18. *Id.* at 427-28.

19. Ethyl's MFN clause stated: "If Ethyl sells a compound of equal quantity and quality at price lower than that provided for herein to any oil company in the United States, BUYER shall pay such lower price on all shipments of such compound made hereunder while such lower price is in effect." *Id.* at 471. Du Pont, and occasionally Nalco, had similar MFN clauses in their contracts, while PPG did not use MFN clauses. *Id.* at 471-72.

The other three practices challenged in the complaint were the exclusive use of delivered pricing, the inclusion of clauses requiring 30-days advance notice of price changes in contracts, and the provision of more than 30-days advance notice of price changes through the press and to customers. *Id.* at 427-28.

20. *Id.* at 628-31.

21. *Id.* The Commission also noted that oligopolistic pricing would be stabilized by MFN clauses because the manufacturer could justify rejecting a customer's request for a discount by explaining to the customer that the MFN clause would require it to give the discount to all its customers. *Id.* at 630.

22. *Id.* at 632.

23. Subject to certain jurisdictional requirements and defenses, the Robinson-Patman Act makes it unlawful

> to discriminate in price between different purchasers of commodities . . . where the effect of such discrimination may be substantially to lessen competition or tend to create a monopoly in any line of commerce, or to injure, destroy, or prevent competition with any person who either grants or knowingly receives the benefit of such discrimination, or with customers of either of them . . . .

15 U.S.C. § 13(a) (1988).

customers in certain circumstances. The Commission, however, rejected the analogy to the Robinson-Patman Act. The Act bans only price discriminations that are not cost justified and that are not given in good faith to meet an equally low price of a competitor, whereas MFN clauses ban *all* price discriminations.[24] Moreover, the Commission dismissed the customers' desire for equal prices, finding that the benefits of a competitively performing market outweigh the customers' preference.[25]

On appeal, the Second Circuit reversed the Commission's finding of a violation.[26] Although the court's discussion of MFN clauses is terse, it indicates that the Commission's findings were not supported by record evidence.[27] According to the court's view of the evidence, MFN clauses were adopted simply to assure small customers that "they would not be placed at a competitive disadvantage to giants such as Standard Oil, Texaco and Gulf."[28] Although the court labeled this reason a "legitimate business reason,"[29] it did not address why, absent altruism, a profit-maximizing seller would adopt such a policy. The court failed to recognize that if a seller can engage in price discrimination, it can increase its profits.[30] Therefore, a seller contractually would not agree to MFN clauses and thus forego price discrimination, unless the MFN clauses enhanced profits more than the price discrimination would enhance profits. The only way MFN clauses might significantly enhance profits is by reducing discounting and price uncertainty, as explained by the Commission.[31]

Despite the court's conclusion that the Commission's analysis was not supported by evidence, the court recognized the potential anticompetitive effect of MFN clauses. The court stated that, "[e]ven though such clauses arguably reduce price discounting, they comport with the requirements of the Robinson-Patman Act, . . . which prohibits price discrimination between customers."[32] In the extreme, this sentence can be read as immunizing MFN clauses from antitrust attack as a matter of law because they comport with the Robinson-Patman Act. However, such a reading would make the court's consideration of the reason for the MFN clauses irrelevant. It is more likely that the court was simply bolstering its conclusion that, within the context of the instant case, there was no antitrust violation. The analogy between MFN clauses and the Robinson-Patman Act, which is central to this Article, is considered in Part IV.

The court's analysis of MFN clauses is not satisfying. Its brevity and weakness most likely reflect the legal context of the case. *Ethyl* was a test case on the reach of section 5 of the Federal Trade Commission Act, which prohibits "un-

24. *See infra* notes 159-68 and accompanying text.
25. *Ethyl*, 101 F.T.C. at 632.
26. E.I. Du Pont de Nemours & Co. v. FTC, 729 F.2d 128 (2d Cir. 1984).
27. *Id.* at 134.
28. *Id.*
29. *Id.*
30. *See* L. PHLIPS, THE ECONOMICS OF PRICE DISCRIMINATION 7 (1983).
31. For a discussion of the Commission's analysis, see *supra* text accompanying notes 20-21.
32. E.I. Du Pont de Nemours & Co. v. FTC, 729 F.2d 128, 134 (2d Cir. 1984).

fair methods of competition."[33] Unlike almost all other antitrust cases, there was no allegation of an "agreement" that unreasonably restrained trade, or of monopolization.[34] The court was unwilling to find that section 5 reaches unilateral practices engaged in for "legitimate business reasons" and without an anticompetitive purpose.[35] Although the policy concerns that shaped the court's view of the limits of section 5 are beyond the scope of this Article, the court's treatment of MFN clauses likely was tailored to fit within that view.

III. THE USE OF MOST FAVORED NATIONS CLAUSES IN THE HEALTH CARE INDUSTRY

With the exception of *Ethyl*, the major antitrust challenges to MFN clauses have been in the context of the health care industry. Before reviewing those cases in Part IIIB of the Article, Part IIIA summarizes some of the significant changes that have reshaped the health care delivery system over the past decade. A working knowledge of those changes is a prerequisite to understanding the role of MFN clauses in the industry.

A. The Changing Competitive Environment in Health Care

Historically, consumers have had to make two independent decisions regarding the purchase of health care services. First, they have had to choose a health insurance plan, often a BCBS plan, to reimburse the cost of specified expenses. Second, they have had to choose doctors, dentists, hospitals, and others to provide the health care itself. These providers then were reimbursed by the consumer's insurance plan based on the providers' fees for the services rendered.[36]

Starting in the 1970s, a consensus developed that this traditional insurance system not only failed to control the cost of health care, but actually fostered waste and inefficiency.[37] Moral hazard—"the higher costs that result when normal economizing incentives are diluted by the opportunity to risk or spend another's funds"[38]—was a major problem. It was in the subscriber's self-interest

33. 15 U.S.C. § 45(a)(1) (1988).

34. The Commission opted not to allege any "agreement" among the competing oligopolists in its *Ethyl* complaint. Instead, the case examined unilaterally adopted marketing practices that allegedly facilitated oligopolistic pricing. Professor Areeda has noted an alternative way to frame the antitrust issue. He states that MFN clauses "are embodied in a buyer-seller contract which has the effect of restraining the seller's freedom of action in other transactions. Such a contract might itself be examined under Sherman Act § 1 as an unreasonable restraint of trade." 6 P. AREEDA, ANTITRUST LAW ¶ 1435e, at 231 (1986). Therefore, rather than focusing on horizontal collusion among competitors, the vertical agreement embodied in the contract itself might be analyzed under the antitrust laws.

35. *Du Pont*, 729 F.2d at 139-40.

36. *See, e.g.*, Ball Memorial Hosp., Inc. v. Mutual Hosp. Ins., Inc., 784 F.2d 1325, 1329-30 (7th Cir. 1986); Baker, *supra* note 8, at 147-48; Frech, *Preferred Provider Organizations and Health Care Competition*, in HEALTH CARE IN AMERICA 353, 355 (H. Frech & R. Zeckhauser ed. 1988).

37. *See, e.g.*, Baker, *supra* note 8, at 152; Havighurst, *The Questionable Cost-Containment Record of Commercial Health Insurers*, in HEALTH CARE IN AMERICA 221, 248-49 (H. Frech & R. Zeckhauser eds. 1988); Pauly, *Overinsurance: The Conceptual Issues*, in NATIONAL HEALTH INSURANCE: WHAT NOW, WHAT LATER, WHAT NEVER? 201, 201 (M. Pauly ed. 1980).

38. Havighurst, *supra* note 37, at 222.

to seek out health care whenever the benefit to the subscriber was greater than the cost. The cost to the subscriber, however, was often minimal because the insurer reimbursed most expenses. Similarly, the provider's economic interests were served by providing more care, since the fees were paid by the insurer. Thus, neither the consumer-buyer nor the provider-seller had an incentive to economize.

Employers and the government primarily bore the ever-increasing costs of health care. Those paying the costs had few options, however, as long as the BCBS traditional insurance system was practically the only health care delivery system available. The search for options intensified as health care costs grew.[39] During the 1980s, the health maintenance organization (HMO)[40] and the preferred provider organization (PPO)[41] emerged as substantial alternatives to traditional insurance plans. Although HMOs and PPOs vary in organizational format, they all differ from traditional insurance in that they integrate, to varying degrees, the insurance function and the provider function into a single entity. For a predetermined fee, they provide specified medical services. Thus, HMOs and PPOs increase their profits by reducing their costs. One of the primary ways they reduce costs is by contracting with a limited number of providers who agree to provide services subject to peer review or other limiting mechanisms, and to do so at a reasonable or discounted fee.[42]

The emergence of HMOs and PPOs threatened, for the first time, BCBS's role in the health care delivery system. In response, many BCBS plans organized their own HMOs and PPOs.[43] However, they also continued to offer their traditional insurance plans. To ensure that those traditional plans did not pay

39. *See* Gabel, Jajich-Toth, Williams, Loughran & Haugh, *The Commercial Health Insurance Industry in Transition*, 6 HEALTH AFFAIRS 46, 47 (Fall 1987).

40. Professor Havighurst has noted:

> HMO arrangements with physicians vary widely. There are, however, three basic types of HMO: a "staff" model, a "group" model, and an "individual practice association" model. In the so-called staff model, the HMO employs physicians on a salaried basis; occasionally such physician/employees have organized a labor union for purposes of collective bargaining. In the group model, the HMO entity contracts for physicians' services with an independent physician-sponsored entity. In the individual practice association model, the HMO contracts with independent practitioners individually or in small groups. HMO arrangements with hospitals range from directly owning the hospital, to contracting with independent hospitals, to using hospitals selected by contracting physicians.

Havighurst, *Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships*, 1984 DUKE L.J. 1071, 1073 n.3.

41. Professor Frech has described the function of the PPO:

> A PPO provides a particular type of health insurance. It contracts with a limited number of providers—hospitals and/or physicians, to provide care for a particular group of consumers on preferential terms. The PPO stands between a specific, defined group of consumers and a specific, defined group of providers. Consumers are offered better terms (more complete insurance and possibly price discounts and/or utilization controls) if they patronize the preferred providers—hence the name. PPOs can be, and have been, organized by the providers, insurance companies, or employers.

Frech, *supra* note 36, at 354.

42. *See id.*; Rolph, Ginsburg & Hosek, *The Regulation of Preferred Provider Arrangements*, 6 HEALTH AFFAIRS 32, 34 (Fall 1987).

43. *See* Ball Memorial Hosp., Inc. v. Mutual Hosp. Ins., Inc., 784 F.2d 1325, 1329-31 (7th Cir. 1986).

more for provider services than competing HMOs and PPOs paid, some of the plans employed MFN clauses in their contracts with providers.[44] The MFN clauses prohibited providers from granting, and alternative delivery systems from receiving, select discounts. Providers and alternative delivery systems then challenged the legality of MFN clauses under the antitrust laws.

B. Health Care Cases Involving Most Favored Nations Clauses

In all five of the following cases, the basic issue is: What is the competitive impact of MFN clauses?[45] Three of these cases focus on BCBS's employment of MFN clauses in their traditional plans in response to the new competitive environment.[46] The two remaining cases focus on the use of MFN clauses by large dental service plans.[47]

1. The Michigan Mental Health Providers Cases[48]

In 1979, Blue Cross and Blue Shield of Michigan (BCBSM) proposed new

44. No data exists regarding the prevalence of MFN clauses in contracts between BCBS and providers. However, an April 18, 1984, letter from BCBS of Kansas City to hospitals states that " 'Most Favored Nation Clauses' are in many Blue Cross contracts across the country." Letter from Tom Bowser, Vice President, BCBS of Kansas City, to hospitals (April 18, 1984). (Documents obtained by the author pursuant to a Freedom of Information Act request.) Similarly, a July 23, 1990, letter from The Travelers Companies to the author claims that MFN clauses "are prevalent in Blue Cross contracts." Letter from James M. Michener to Arnold Celnicker (July 23, 1990) (discussing the use of the most favored nations clauses in provider contracts). This evidence, in addition to the cases discussed in the following section of this Article, indicates that MFN clauses are not uncommon in provider contracts with BCBS. Moreover, it recently was reported that BCBS plans in Connecticut and Ohio are moving to adopt MFN clauses in physician contracts in the wake of Ocean State Physicians Health Plan, Inc. v. Blue Cross and Blue Shield of Rhode Island, 883 F.2d 1101 (1st Cir. 1989), *cert. denied*, 110 S. Ct. 1473 (1990). *See Health Market Survey* 10 (April 20, 1990).

45. Cases involving MFN clauses should be differentiated from cases in which BCBS and providers enter agreements limiting the charges that providers can collect for services rendered to the BCBS subscriber. *See* Barry v. Blue Cross of Cal., 805 F.2d 866, 867 (9th Cir. 1986); *Ball Memorial Hosp.*, 784 F.2d at 1330; Kartell v. Blue Shield of Mass., Inc., 749 F.2d 922, 923 (1st Cir. 1984), *cert. denied*, 471 U.S. 1029 (1985); Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross and Blue Shield of Conn., Inc., 675 F.2d 502, 503 (2d Cir. 1982); Travelers Ins. Co. v. Blue Cross of W. Penn., 481 F.2d 80, 82 (3d Cir.), *cert. denied*, 414 U.S. 1093 (1973); *see also* Chick's Auto Body v. State Farm Mut. Auto. Ins. Co., 401 A.2d 722, 725, 1979-1 Trade Cas. (CCH) ¶ 62,642 (N.J. Super. Ct. Law Div. 1979) (insurance company's refusal to pay auto repair shops more than a certain rate), *aff'd*, 176 N.J. Super. 320, 423 A.2d 311 (N.J Super. Ct. App. Div. 1980). Unlike MFN cases, these agreements do not tie the amount that BCBS or its subscriber will pay the provider to the amount paid by competing insurers to the same provider. Instead, BCBS refuses to pay more than a certain amount to any provider. This is analogous to a buyer deciding not to pay more than $X for a certain service. In the MFN situation, BCBS will pay more than $X, if others also pay more; the direct effect of MFN clauses is price uniformity rather than lower prices. *Cf.* United Mine Workers of Am. v. Pennington, 381 U.S. 657, 668 (1965) (An agreement between the United Mine Workers union and large coal producers to seek uniform labor terms throughout the industry violated antitrust policy by restraining the sellers of labor from acting "according to their own choice and discretion" in dealing with other employers.); Associated Milk Dealers, Inc. v. Milk Drivers Union, 422 F.2d 546, 552-53 (7th Cir. 1970) (Under *Pennington*, an MFN clause in a contract between the union and dairies might violate the antitrust laws if it were entered into for a predatory purpose.).

46. *See infra* texts accompanying notes 48, 73 & 88.

47. *See infra* texts accompanying notes 55 & 67.

48. Blue Cross and Blue Shield of Mich. v. Michigan Ass'n of Psychotherapy Clinics, 1980-2 Trade Cas. (CCH) ¶ 63,351 (E.D. Mich. 1980); Michigan Ass'n of Psychotherapy Clinics v. Blue Cross and Blue Shield of Mich., 118 Mich. App. 505, 325 N.W.2d 471 (1982).

contracts with providers of mental health services. One of the changes was the addition of an MFN clause. The clause, dubbed a price nondiscrimination clause, required that providers bill BCBSM at no more than their charges for non-BCBSM patients.[49] The changes generated two suits, one in federal court alleging price fixing under section 1 of the Sherman Act[50] and the other in state court alleging price fixing under Michigan's antitrust law.[51]

In the federal action, the court granted summary judgment in BCBSM's favor. The court reasoned that there was no price fixing because the price nondiscrimination clause did not dictate providers' fees. The court held that the clause "provides only that the provider cannot charge Blue Cross more for services rendered to its members than the provider charges non-members for similar services."[52] In the court's view, simply requiring that BCBSM be given the benefit of the lowest rate charged by the provider would not affect the providers' charges to others and, therefore, was not per se illegal price fixing.[53]

In the parallel action brought under Michigan's antitrust law, the Michigan Court of Appeals reversed the trial court's finding of price fixing. The appeals court labeled the price nondiscrimination clause as "only good business sense," and summarily concluded that there was no price fixing because the providers were "free to charge the public whatever they want, and BCBSM has no control over that."[54] Like the federal court, the state court ignored the possibility that the MFN clause would affect the providers' decision regarding the fees charged to non-BCBSM patients.

2. *Madden v. California Dental Service*[55]

The California Dental Service (CDS) is a dental service benefit plan established by California dentists. In return for a periodic premium, a subscriber can obtain specified services from a dentist.[56] Although the subscriber can obtain services from any dentist, there are incentives to obtain services from a dentist that participates in the plan.[57] Over ninety percent of California's dentists

49. Michigan Ass'n of Psychotherapy Clinics v. Blue Cross and Blue Shield of Mich., 118 Mich. App. 505, 508-10, 325 N.W.2d 471, 473-75 (1982). The price nondiscrimination clause stated: "Provider agrees to bill BCBSM for Covered Services at not more than the same level of charges which the Provider has in effect for patients who are not entitled to Covered Services but who receive services similar in character to Covered Services." *Id.* at 520, 325 N.W.2d at 482.

50. Blue Cross and Blue Shield of Mich. v. Michigan Ass'n of Psychotherapy Clinics, 1980-2 Trade Cas. (CCH) ¶ 63,351 (E.D. Mich. 1980). Section 1 of the Sherman Act states: "Every contract, combination . . ., or conspiracy, in restraint of trade or commerce . . ., is declared to be illegal." 15 U.S.C. § 1 (1988).

51. Michigan Ass'n of Psychotherapy Clinics v. Blue Cross and Blue Shield of Mich., 118 Mich. App. 505, 325 N.W.2d 471 (1982). Michigan antitrust laws are patterned after federal antitrust laws. *Id.* at 510, 325 N.W.2d at 475.

52. Blue Cross and Blue Shield of Mich. v. Michigan Ass'n of Psychotherapy Clinics, 1980-2 Trade Cas. (CCH) ¶ 63,351, at 75,794 (E.D. Mich. 1980).

53. *Id.*

54. *Michigan Ass'n of Psychotherapy Clinics*, 118 Mich. App. at 520, 325 N.W.2d at 482.

55. 1986-1 Trade Cas. (CCH) ¶ 67,176 (Cal. Super. Ct. 1986).

56. *Id.* at 63,043.

57. If services are obtained from a nonparticipating dentist, the patient must pay for the services and then obtain reimbursement from CDS, and the reimbursement cannot exceed the amount

participate.[58]

Under the plan, participating dentists agree not to charge CDS subscribers more than the dentists' "usual" fees. The usual-fee provision, which defines "usual fee" as the lowest fee that the dentist regularly charges for a particular service, is, in effect, an MFN clause.[59]

Plaintiffs were CDS subscribers. They claimed a violation of California's antitrust law based, in part, on the contractual prohibition preventing participating dentists from charging fees to others that were lower than their fees to CDS subscribers.[60] Plaintiffs' argument presumed that a dentist participating in CDS would not be willing to lower fees to a competing preferred provider organization (PPO) because the dentist would be required contractually to also lower fees to CDS.

The court ultimately granted CDS's motion for summary judgment because of plaintiffs' lack of evidence establishing how they, as CDS subscribers, would be injured by the MFN clause. The MFN clause required that any lower price to others also be given to plaintiffs. Therefore, the clause benefitted plaintiffs, unless they could show that the MFN clause prevented select discounts to others that eventually would bring down *all* dental fees. Although the court recognized that this was theoretically possible, the plaintiffs presented no such evidence.[61]

Although the suit was dismissed because CDS subscribers were not the appropriate plaintiffs to challenge any anticompetitive effects of MFN clauses, the court did discuss those possible effects. The court started with the proposition that, in most instances, a customer has a right to demand a price as low as the price offered by the dentist to any other customer.[62] The court claimed that such MFN agreements do not require the dentist to raise prices, but simply to charge the same prices to all. The court then stated that "[e]ven if the practice reduces discounting, and thus discourages price competition, this is an acceptable consequence of arms' length agreements negotiated between independent buyers and sellers for their respective advantages."[63] The court did not explain why reduced price competition was acceptable. It simply cited precedent[64] and

---

charged by 50% of all dentists for that procedure. By comparison, if services are obtained from a participating dentist, payment is made by CDS directly to the dentist, and the payment cannot exceed the amount charged by 90% of all dentists for that procedure. *Id.* at 63,043, 63,046.

58. *Id.* at 63,043.

59. *Id.*

60. *Id.* at 63,046. Plaintiffs' attack on MFN clauses was not central to their complaint. Their principal concern was a CDS rule prohibiting dentists from waiving collection of the patients' copayment. *Id.* at 63,049-52.

61. *Id.* at 63,053.

62. *Id.* at 63,052.

63. *Id.* (citations omitted).

64. In addition to *E.I. Du Pont de Nemours & Co. v. FTC*, 729 F.2d 128 (2d Cir. 1984), and *Blue Cross and Blue Shield of Michigan v. Michigan Association of Psychotherapy Clinics*, 1980-2 Trade Cas. (CCH) ¶ 63,351 (E.D. Mich. 1980), the court cited *Pennsylvania Dental Association v. Medical Service Association of Pennsylvania*, 745 F.2d 248 (3d Cir. 1984), *cert. denied*, 471 U.S. 1016 (1985). In *Pennsylvania Dental Association*, the contract between Blue Shield (Medical Service Association) and participating dentists limited the dentists to charging Blue Shield their "usual fees." The dentists challenged, *inter alia*, Blue Shield's practice of conducting reviews of the dentists' bill-

moved on to consider whether CDS should be treated like a typical buyer of dental services.

California Dental Services was controlled by its participating dentists, which included over ninety percent of California's dentists. Therefore, the court viewed the MFN clauses, which were ostensibly between CDS and the dentists, as horizontal agreements among the dentists not to lower prices, as opposed to simple arms-length agreements between independent buyers and sellers. In this context, the court stated that it would be necessary to determine whether the MFN clauses unreasonably restrained competition by weighing their benefits—minimizing CDS's costs and lowering its subscriber's premiums—against their competitive disadvantages—discouraging dentists from cutting fees to compete for new patients.[65] The *Madden* court avoided the weighing process, however, by holding that plaintiffs, CDS subscribers, had not established that they suffered any injury because of the alleged restraint on competition.[66]

3. *Kitsap Physicians Service v. Washington Dental Service*[67]

Washington Dental Service (WDS) offered prepaid dental service throughout the State of Washington. Kitsap offered the same service in a three-county area. Dentists initially charged less to Kitsap subscribers than to WDS subscribers. However, the contract between WDS and its participating dentists included an MFN clause, called a nondiscrimination clause in this instance, that prohibited the dentists from charging WDS subscribers more than they charged any other patients. Under the nondiscrimination clause, WDS lowered its payments to participating dentists who were also participants in Kitsap. Many of those dentists had more patients who were WDS subscribers than Kitsap subscribers; therefore, to avoid lowering their fees to WSD subscribers, twenty-six of sixty participating dentists left Kitsap.[68] Kitsap sued under section 2 of the Sherman Act,[69] alleging that WDS attempted to monopolize the prepaid dental insurance market. In denying Kitsap's motion for a preliminary injunction, the court held that the MFN clause "makes good business sense."[70] It is "pro-competitive"[71] because it "provides insurance companies with protection from (1) being overcharged by dentists, and (2) in the long term, being priced out of the highly competitive dental insurance market."[72]

---

ing records to ensure that the dentists were charging Blue Shield their usual fee. The court rejected the dentists' challenge because, although the dentists were ethically bound not to inflate their bills, many in fact did inflate their bills, and the reviews were approved by the state health department. *Id.* at 258-59.

65. 1986-1 Trade Cas. at 63,053.

66. *See supra* text accompanying note 61.

67. 671 F. Supp. 1267 (W.D. Wash. 1987).

68. *Id.* at 1268.

69. 15 U.S.C. § 2 (1988).

70. *Kitsap Physicians Serv.*, 671 F. Supp. at 1269.

71. *Id.* at 1270.

72. *Id.* at 1269.

4. *Ocean State Physicians Health Plan, Inc. v. Blue Cross and Blue Shield of Rhode Island*[73]

Prior to 1984, Blue Cross and Blue Shield of Rhode Island (BCBSRI) was essentially the only provider of health care financing in Rhode Island.[74] Ocean State Physicians Health Plan, Inc. (Ocean State), an HMO organized in 1984, was eighty-percent owned by Rhode Island physicians.[75] From its inception, Ocean State offered better coverage for a lower premium than BCBSRI. By 1986, Ocean State's enrollment of 70,000 exceeded all expectations; in contrast, BCBSRI had lost 30,000 of its 543,000 subscribers.[76]

BCBSRI responded to its competitive and financial difficulties by establishing its own HMO,[77] revising its pricing policies to make its traditional coverage more expensive for employers that offered Ocean State's HMO to their employees,[78] and adopting a policy called the "Prudent Buyer" policy. The Prudent Buyer policy called for the inclusion of an MFN clause in contracts with providers. Under the MFN clause, if a physician lowered her fees for services rendered to an Ocean State subscriber, the physician was required to accept the same fees for services rendered to a BCBSRI subscriber.[79]

Ocean State's contracts with the physicians required Ocean State to with-

---

73. 883 F.2d 1101 (1st Cir. 1989), *cert. denied*, 110 S. Ct. 1473 (1990).

74. The district court commented that "[n]ot only did Blue Cross and Blue Shield have a better 'mousetrap,' it had the only 'mousetrap' in town." Ocean State Physicians Health Plan, Inc. v. Blue Cross and Blue Shield of R.I., 692 F. Supp. 52, 68 (D.R.I. 1988), *aff'd*, 883 F.2d 1101 (1st Cir. 1989), *cert. denied*, 110 S. Ct. 1473 (1990).

75. *Ocean State*, 883 F.2d at 1103.

76. *Id.*

77. BCBSRI's HMO, called HealthMate, was modeled after Ocean State and was marketed to employers who offered Ocean State to their employees. *Id.* Ocean State argued that the development of HealthMate was part of BCBSRI's willful actions to maintain its monopoly power. *Id.* at 1104. The First Circuit ruled that the McCarran-Ferguson Act, 15 U.S.C. §§ 1012(b), 1013(b) (1988), which under certain circumstances exempts the business of insurance from antitrust scrutiny, applied to HealthMate. *Ocean State*, 883 F.2d at 1107.

78. BCBSRI's new pricing policy was labeled "adverse selection." *Ocean State*, 883 F.2d at 1103. BCBSRI asserted that if an employer offered an HMO, the healthier employees would choose the HMO leaving relatively more unhealthy employees in BCBSRI's traditional plan. Therefore, BCBSRI's costs would be higher for its traditional plan when employers offered an HMO. BCBSRI thus adopted the following pricing policy for its traditional plan: The rate would be lowest if only its traditional plan were offered; the rate would be at an intermediate level if the employer also offered a competing HMO (*e.g.*, Ocean State) and HealthMate (BCBSRI's HMO); and the rate would be highest if the employer offered a competing HMO but did not offer HealthMate. *Id.* No explanation is given as to why BCBSRI's costs for its traditional plan would be lower when an employer offered two HMOs than when it offered only one HMO (Ocean State). Regardless, the First Circuit held that the adverse selection pricing policy was not subject to antitrust scrutiny because it was part of the "business of insurance" that satisfied the standards of the McCarran-Ferguson Act's exception from the antitrust laws. *Id.* at 1107.

Assuming that the court's holding that the adverse selection pricing policy and HealthMate, *see supra* note 77, are exempt under McCarran-Ferguson is correct, it does not follow that these activities are irrelevant to an analysis of nonexempt actions taken by BCBSRI. For example, if the purpose of the adverse selection pricing policy were to exclude Ocean State from the market, it would be a reasonable inference that other, nonexempt, policies adopted at the same time and under the same circumstances, such as the Prudent Buyer pricing policy, *see infra* text accompanying note 79, had the same purpose. The court did not address this possibility and ignored HealthMate and adverse selection when considering the competitive implications of the Prudent Buyer policy.

79. *Ocean State*, 883 F.2d at 1103-04.

hold twenty percent of the physicians' fees.[80] To the extent that the HMO was profitable, it would give the withheld fees to the physicians at the end of the year. If costs were greater than the subscribers' premiums, the twenty percent would be retained by Ocean State. This policy, not uncommon among HMOs, was designed to encourage physicians to be judicial in deciding what services to provide to a patient.

In 1985 and 1986, Ocean State operated at a loss and retained twenty percent of the physicians' fees.[81] Thus, the physicians in effect sold their services to Ocean State at a twenty percent lower fee than the services they sold to BCBSRI. BCBSRI then instituted its Prudent Buyer policy. The physicians thus were faced with the choice of either accepting a twenty-percent cut in fees paid by BCBSRI or abandoning Ocean State. About 350 of Ocean State's 1200 physicians chose to resign.[82]

Ocean State and a class of its participating physicians brought an action against BCBSRI claiming, inter alia, that BCBSRI was violating section 2 of the Sherman Act by monopolizing the health care insurance industry in Rhode Island.[83] The First Circuit listed the elements of a monopolization case as:

> (1) the possession of monopoly power in the relevant market and (2) the willful acquisition or maintenance of that power as distinguished from growth or development as a consequence of a superior product, business acumen, or historic accident.[84]

The parties did not dispute that BCBSRI had monopoly power and that its monopoly power was acquired legitimately.[85] The sole antitrust issue before the court was whether BCBSRI had maintained its monopoly power willfully.[86]

---

80. *Id.* at 1104.

81. *Id.*

82. *Id.*

83. Section 2 of the Sherman Act makes it a felony to "monopolize . . . any part of the trade or commerce among the several States." 15 U.S.C. § 2 (1982). The jury found a violation of § 2, although it awarded no damages on that count. *Ocean State,* 883 F.2d at 1105. Ocean State also alleged a pendent state law claim of tortious interference with the contractual relations between Ocean State and physicians. The tortious interference claim was based on the same acts as the § 2 claim. *Id.* at 1104-05. The jury found a violation and awarded approximately $3,000,000 in compensatory and punitive damages under the tortious interference claim. *Id.* at 1105. The district court then granted BCBSRI's motion for a judgment notwithstanding the verdict on both the § 2 and the tortious interference claims. *Id.* (citing Ocean State Physicians Health Plan, Inc. v. Blue Cross and Blue Shield of R.I., 692 F. Supp. 52 (D.R.I. 1988)). Regarding the § 2 count, the district court ruled that because the jury awarded no damages, Ocean State failed to prove injury caused by an antitrust violation and thus failed to establish a § 2 case. *Id.* at 1106. The First Circuit decided to avoid this issue and instead affirmed the judgment notwithstanding the verdict on the alternative ground that BCBSRI did not willfully maintain its monopoly power by adopting the Prudent Buyer policy. *Id.* at 1105-07, 1109-13. Because the Prudent Buyer policy was also the basis for the tortious interference claim, the First Circuit affirmed the district court's judgment notwithstanding the verdict on that count as well. *Id.* at 1113-14.

Ocean State had also alleged a violation of § 1 of the Sherman Act, 15 U.S.C. § 1 (1982), based on a 1982 agreement between Blue Cross and Blue Shield to merge and an agreement between BCBSRI and another entity regarding hospital discounts. *Id.* at 1104 n.3. The district court's directed verdict for BCBSRI on the § 1 count was not appealed. *Id.*

84. *Ocean State,* 883 F.2d at 1110 (quoting United States v. Grinnell Corp., 384 U.S. 563, 570-71 (1966)).

85. *Id.*

86. *Id.*

Specifically, the issue was whether adoption of the Prudent Buyer policy improperly excluded competition (*i.e.*, Ocean State) from the market and thereby allowed BCBSRI to maintain its monopoly power. In concluding that adopting the Prudent Buyer policy, as a matter of law, did not violate section 2 of the Sherman Act, the First Circuit stated that

> a policy of insisting on a supplier's lowest price—assuming that the price is not "predatory" or below the supplier's incremental cost—tends to further competition on the merits and, as a matter of law, is not exclusionary. It is hard to disagree with the district court's view:
>
> > As a naked proposition, it would seem silly to argue that a policy to pay the same amount for the same service is anticompetitive, even on the part of one who has market power. This, it would seem, is what competition should be all about.[87]

5. *Reazin v. Blue Cross and Blue Shield of Kansas, Inc.*[88]

Unlike each of the preceding cases, *Reazin* did not involve a challenge to the legality of MFN clauses under the antitrust laws. However, the court did have the opportunity to analyze the competitive impact of MFN clauses employed by Blue Cross and Blue Shield of Kansas (BCBSK) in the context of evaluating BCBSK's market power. To put the analysis of MFN clauses in context, it is necessary to consider first the facts and legal theory in *Reazin*.

Blue Cross and Blue Shield of Kansas was by far the largest health care insurer in Kansas. In the mid-1980s, it controlled between fifty and sixty percent of the market. No other company controlled more than five percent of the market.[89]

Through several acquisitions, Hospital Corporation of America (HCA) became a competitor of BCBSK. In 1985, HCA, which owns or manages more for-profit hospitals throughout the United States than any other company, purchased Wesley Medical Center, the largest hospital in Wichita. HCA also purchased an HMO and a health insurance company operating in Kansas.[90] Within a few months of these acquisitions, BCBSK announced that it would terminate its provider contract with Wesley hospital.[91] Wesley filed suit, claiming, *inter alia*, that BCBSK's termination of the provider contract would violate

87. *Id.* (quoting Ocean State Physicians Health Plan, Inc. v. Blue Cross and Blue Shield of R.I., 692 F. Supp. 52, 71 (D.R.I. 1988), *aff'd*, 883 F.2d 1101 (1989), *cert. denied*, 110 S. Ct. 1473 (1990)).

88. 899 F.2d 951 (10th Cir.), *cert. denied*, 110 S. Ct. 3241 (1990).

89. *Id.* at 969 & n.26.

90. *Id.* at 957.

91. *Id.* at 957-58. One of the oddities complicating the *Reazin* case was that BCBSK never actually terminated Wesley hospital. After the suit was filed, the parties agreed to maintain the status quo pending its resolution. *Id.* at 957-58 n.7. A year later, HCA sold the HMO it had purchased and withdrew from the health care financing field in Kansas. *Id.* BCBSK then signed a new provider contract with Wesley. *Id.* Therefore, the case was akin to a declaratory judgment action and BCBSK argued that Wesley could not prove damages. *Id.* at 972 & n.34. The court rejected BCBSK's argument, stating that:

> Wesley introduced evidence at trial that, because of Blue Cross' *announced* termination of Wesley as a contracting provider hospital, it (1) spent money on advertisements to reassure

sections 1 and 2 of the Sherman Act.[92]

Wesley contended that BCBSK had entered into an agreement with two other Wichita hospitals whereby BCBSK was to terminate Wesley's status as a participating hospital in consideration for the two other hospitals significantly lowering their prices to BCBSK.[93] The alleged anticompetitive effect of the agreement was to reduce the competitive significance of Wesley-HCA and to allow BCBSK to maintain its dominant position.[94] In addition to the direct effect on Wesley-HCA, Wesley's threatened termination allegedly sent a message to other hospitals that might have considered entering into agreements with HMO-insurers offering alternative delivery systems in competition with BCBSK. Unfortunately for BCBSK, a letter from BCBSK's president to all Kansas hospitals made that message explicit by threatening to terminate any hospital that joined an HMO in competition with BCBSK.[95] A number of Kansas hospital administrators testified that in response to the threatened termination of Wesley's participating status and this letter, they chose not to enter into alliances that would compete with BCBSK.[96]

In defending its actions, BCBSK argued that to prove a violation of section 1 of the Sherman Act, plaintiffs had to establish that it had market power.[97] In the Tenth Circuit, "market power" is defined as "*either* 'power to control price' *or* 'power to exclude competition.' "[98] Without deciding whether a showing of market power was necessary under the facts of this case,[99] the Tenth Circuit examined plaintiff's evidence of BCBSK's market power. That evidence included the competitive effects of MFN clauses in the contracts between BCBSK and all of the hospitals in Kansas.

In 1984, BCBSK revised its contracts with all of the hospitals in Kansas, adding MFN clauses.[100] The district court found that at least one of the reasons

---

patients that Blue Cross subscribers were still welcome at Wesley, (2) reduced its prices in order to retain its market share, and (3) lost patients.

Id. at 962 (emphasis added).

92. *Id.* at 955.

93. *Id.* at 960.

94. *Id.* at 964.

95. The letter stated:

> We cannot stand idly by and watch insurance-hospital corporations, such as HCA, monopolize the delivery and financing of care by seeking to enroll Blue Cross and Blue Shield subscribers in their insurance programs. Vertical integration is a strategy some hospitals may feel to be in their best interest. However, if hospitals decide to compete with Blue Cross and Blue Shield in the manner that HCA is competing, Blue Cross and Blue Shield must make a business decision about its future relationship with these entities. Hospitals that wish to continue their current relationship with Blue Cross and Blue Shield, that do not seek to enroll subscribers in other programs, and that wish to cooperate with Blue Cross and Blue Shield as a major marketing arm of the hospital, will experience no change in the contractual relationship that has historically served Kansans well.

Id. at 958 n.8.

96. *Id.* at 966 & n.21.

97. *Id.* at 966.

98. *Id.* (quoting Westman Comm'n Co. v. Hobart Int'l, Inc., 796 F.2d 1216, 1225 n.3 (10th Cir. 1986), *cert. denied*, 486 U.S. 1005 (1988)).

99. *Id.* at 968 n.24.

100. *Id.* at 957 n.7.

BCBSK adopted MFN clauses was "to forestall other insurance companies from receiving any better prices from a hospital, which would enable competitors to offer lower rates to subscribers for medical insurance."[101] The Tenth Circuit affirmed the district court's holding, concluding that there was "considerable testimony on the effect of Blue Cross' most favored nations clause, and the jury could reasonably have concluded that that clause contributed to Blue Cross' power over price."[102] In drawing this conclusion, the Tenth Circuit noted the First Circuit's opinion in *Ocean State* about the antitrust consequences of MFN clauses:

> The fact that the First Circuit has recently concluded that, as a matter of law, a "Prudent Buyer" policy utilized by Blue Cross and Blue Shield of Rhode Island, essentially identical to the most favored nations clause in this case, did not constitute monopolization in violation of section 2 does not alter our conclusion on the existence of Blue Cross' monopoly power here. In *Ocean State*, Blue Cross conceded its monopoly power. The only question was whether Blue Cross violated section 2. By contrast, the most favored nations clause here is not itself challenged as unlawful monopolization. Rather, it is only considered as evidence of, or as contributing to, Blue Cross' market or monopoly power. We need not reach the question addressed in *Ocean State* of whether use of the most favored nations clause could itself violate section 2.[103]

Thus, the Tenth Circuit took the position that MFN clauses can contribute to market or monopoly power—the power to control price or exclude competition. Although MFN clauses have this anticompetitive potential, the Tenth Circuit was correct in asserting that its position was not necessarily inconsistent with the First Circuit's conclusion in *Ocean State* that MFN clauses are "not exclusionary." The First Circuit stated that, for purposes of section 2 of the Sherman Act, "exclusionary conduct" is " 'behavior that not only (1) tends to impair the opportunities of rivals, but also (2) either does not further competition on the merits or does so in an unnecessarily restrictive way.' "[104] The First Circuit held that MFN clauses "tended to further competition on the merits"[105]

---

101. Reazin v. Blue Cross and Blue Shield of Kan., Inc., 663 F. Supp. 1360, 1376 (D. Kan. 1987), *aff'd*, 899 F.2d 951 (10th Cir.), *cert. denied*, 110 S. Ct. 3241 (1990).

102. *Reazin*, 899 F.2d at 971. The district court had capsulized the testimony as showing that the MFN clauses could have

> effectively prevented discounting to other insurers, and since the price of hospital care is the single largest element of health care financing companies' costs, the "most favored nations" clause effectively prevents competing insurance companies from offering more favorable insurance rates to consumers. This clause gives defendant the ability to prevent insurance prices from falling, thus providing it the ability to effectively control insurance prices.

Reazin v. Blue Cross and Blue Shield of Kan., Inc., 663 F. Supp. 1360, 1418 (D. Kan. 1987) (citation to record omitted), *aff'd*, 899 F.2d 951 (10th Cir.), *cert. denied*, 110 S. Ct. 3241 (1990).

103. *Reazin*, 899 F.2d at 971 n.30 (citations omitted).

104. Ocean State Physicians Health Plan, Inc. v. Blue Cross and Blue Shield of R.I., 883 F.2d 1101, 1110 (1st Cir. 1989) (quoting 3 P. AREEDA & D. TURNER, ANTITRUST LAW ¶ 626b, at 78 (1978), *quoted in* Aspen Skiing Co. v. Aspen Highlands Skiing Corp., 472 U.S. 585, 605 n.32 (1985)).

105. *Id.*

and, therefore, could not be exclusionary under section 2.[106] For the Tenth Circuit's purpose of determining whether BCBSK had market power in connection with a section 1 allegation, it was sufficient that MFN clauses could exclude rivals, thus contributing to BCBSK's market power.[107] Therefore, the Tenth Circuit feasibly could hold that MFN clauses exclude rivals and lead to market power without reaching "the question addressed in *Ocean State* of whether use of the most favored nations clause could itself violate section 2."[108]

Although the Tenth Circuit neatly avoided explicit conflict with the First Circuit, implicit conflict was unavoidable. Throughout the district court's and the Tenth Circuit's opinions, MFN clauses were characterized in anticompetitive tones. At no point did the opinions indicate that MFN clauses are procompetitive or, as stated in *Ocean State*, " 'what competition should be all about.' "[109] Moreover, if MFN clauses were simply a legitimate, procompetitive strategy, like charging a price equal to marginal cost, or efficiently managing a company, it seems unlikely that the court would have concluded that they gave BCBSK the power to raise prices and thereby supported a finding of a section 1 violation. Nevertheless, the key question for antitrust purposes remains: Are MFN clauses anticompetitive or procompetitive?

IV. COMPETITIVE ANALYSIS OF MOST FAVORED NATIONS CLAUSES

The preceding health care cases posit two potentially anticompetitive effects of MFN clauses: (1) the reduction or elimination of discounting by providers because they would have to give the discount to *all* customers;[110] and (2) the inhibition of entry of alternative delivery systems, such as HMOs and PPOs,

106. The First Circuit ignored the second half of its own test: whether MFN clauses further competition on the merits in an unreasonably restrictive way.

107. Concerning the § 2 allegation in *Reazin*, the Tenth Circuit found consideration of the effects of MFN clauses unnecessary because BCBSK engaged in other actions that the Tenth Circuit considered illegitimate and anticompetitive: "threatening to terminate Wesley's contracting provider agreement and reducing the maximum allowable payments for the remaining [Wichita] hospitals, thereby coercing other hospitals into not doing business with Blue Cross competitors." *Reazin*, 899 F.2d at 973.

108. *Id.* at 971 n.30. *See generally* Baker, *supra* note 8 (analyzing, prior to the courts of appeals' opinions, possibility that actions of BCBSRI and BCBSK could raise rivals' costs and thus be anticompetitive).

109. *Ocean State*, 883 F.2d at 1110 (quoting Ocean State Physicians Health Plan, Inc. v. Blue Cross and Blue Shield of R.I., 692 F. Supp. 52, 71 (D.R.I. 1988), *aff'd*, 883 F.2d 1101 (1989), *cert. denied*, 110 S. Ct. 1473 (1990)).

110. An early case that involved the health care industry but was unrelated to the line of cases discussed in the text nicely illustrates the effect of MFN clauses on discounting. *See* United States v. Eli Lilly & Co., 1959 Trade Cas. (CCH) ¶ 69,536 (D.N.J. 1959). In *Lilly*, five manufacturers were charged with horizontal price fixing in the sale of polio vaccine to public agencies. The court held that the government failed to prove a conspiracy among the manufacturers to fix prices. Instead, the court found that the uniform prices were the result of MFN clauses included in contracts between the government and the manufacturers. The MFN clauses would have required any discount that was given to the federal government also be given to state governments. This led to each manufacturer unilaterally deciding not to give any discounts. Moreover, the court noted that foreign governments received lower and varying prices because the MFN clauses did not apply to such sales. This fact bolstered the court's conclusion that the absence of discounting in the United States was because of the MFN clauses, not collusion among manufacturers. Once the MFN clauses expired, selective discounts appeared in domestic bids. *Id.* at 76,152-53.

because they would not be able to entice providers to give them a discount. In addition, the FTC's analysis in *Ethyl*[111] indicates that MFN clauses, in the context of an oligopolistic industry, can facilitate tacit collusion by reducing uncertainty regarding pricing. The cases also present two potentially procompetitive effects of MFN clauses: (1) lower prices overall because discounts will be given to *all* buyers; and (2) a guarantee to buyers that they all are receiving the same price.

With the exceptions of the FTC's opinion in *Ethyl* and the Tenth Circuit's opinion in *Reazin*,[112] the preceding cases concluded that the procompetitive effects of MFN clauses prevail over the anticompetitive effects. None of those cases, however, provides an analytical framework for judging the economic effects of MFN clauses. This part of the Article provides such a framework. A close analogy exists between the Robinson-Patman Act and MFN clauses—both prohibit selective discounting or price discrimination.[113] Therefore, it is possible to gain an understanding of the competitive effects of MFN clauses by applying what has been learned from studying the Robinson-Patman Act's prohibition of price discrimination. First, however, it is useful to consider why a provider would discriminate in price against BCBS subscribers if not prevented from doing so by an MFN clause.

A. The Basis for Provider Discrimination Against BCBS

Providers working at full capacity serving BCBS subscribers (or other patients who pay full price) have nothing to gain by lowering their price and, therefore, would not price discriminate. If, however, the provider has excess capacity, it can increase its profits by serving additional patients at a lower price so long as that price exceeds its marginal opportunity cost. The situation is analogous to any supplier deciding whether to engage in price discrimination. Assuming it is practical, price discrimination always will increase a supplier's profit, unless the supplier can sell all its capacity at the relatively high price.[114]

---

111. *In re* Ethyl Corp., 101 F.T.C. 425, 628-32 (1983), *rev'd sub nom.* E.I. Du Pont de Nemours & Co. v. FTC, 729 F.2d 128 (2d Cir. 1984).

112. Reazin v. Blue Cross and Blue Shield of Kan., Inc., 899 F.2d 951 (10th Cir.), *cert. denied*, 110 S. Ct. 3241 (1990).

113. The Robinson-Patman Act makes it unlawful, under certain circumstances

> to discriminate in price between different purchasers of commodities . . . where the effect of such discrimination may be substantially to lessen competition or tend to create a monopoly in any line of commerce, or to injure, destroy, or prevent competition with any person who either grants or knowingly receives the benefit of such discrimination, or with customers of either of them . . . .

15 U.S.C. § 13(a) (1988). On its face, the Robinson-Patman Act does not apply to the sale of medical services because medical services are not "commodities." *See* Ball Memorial Hosp., Inc. v. Mutual Hosp. Ins., Inc., 784 F.2d 1325, 1340 (7th Cir. 1986).

The term "price discrimination" as used in the Robinson-Patman Act simply means a price difference. *See* Texaco Inc. v. Hasbrouck, 110 S. Ct. 2535, 2544 (1990). In economics, however, the term "price discrimination" means selling a product to different customers either at different price-to-marginal-cost ratios or at different per-unit profits. *See* Celnicker & Seaman, *Functional Discounts, Trade Discounts, Economic Price Discrimination and the Robinson-Patman Act*, 1989 UTAH L. REV. §13, 816-17. This Article uses the term price discrimination in its legal sense and assumes, unless stated otherwise, that the price differences referred to are also economic price discriminations.

114. *See* L. PHLIPS, *supra* note 30, at 7.

There are four conditions that must be satisfied before a provider can price discriminate: (1) the provider must have some market power; (2) the buyers must have differing elasticities of demand; (3) the provider must be able to segregate the buyers based on their differing elasticities of demand; and (4) profitable arbitrage must not be possible.[115] In the context of providers selling to BCBS and HMO or PPO enrollees, all four conditions are satisfied.

The first condition necessary for price discrimination is that the provider must have some market power, though it need not be significant market power. In the context of price discrimination, market power simply means that the provider faces a downward sloping—rather than horizontal—demand curve.[116] If the patient is considered the buyer (ignoring the effect of insurance), then it is well-established that few providers face a horizontal demand curve. A five percent rise in price would not lead to a loss of all patients.[117] The presence of insurance, however, complicates the market power issue.

Market power is a prerequisite to price discrimination because, without it, if a provider attempted to charge a relatively high price to certain customers, rival providers would compete for that profitable business. Therefore, competition would bid the price back down to the competitive level. When the patient's insurance plan effectively controls which providers its subscribers frequent, the provider's market power might be curtailed. If the plan serves as an informed agent of its subscribers and limits the subscribers' choice to a relatively small portion of providers chosen by the plan based on price, providers may lose much of their market power. This process, however, does not apply to providers selling to a traditional BCBS plan.

Under the traditional BCBS plan, BCBS aims to contract with practically all providers in the market. This policy dates back to the origins of BCBS. In the 1930s, Blue Cross plans were developed under the auspices of the American Hospital Association (AHA) as a mechanism for hospitals to obtain prepayment for their services.[118] The "Essentials of an Acceptable Plan for Group Hospitalization" adopted by the AHA included the notions that "[t]he subscriber should have free choice of hospital" and "[a]ll recognized hospitals in the community should participate."[119] Similarly, state and county medical societies established

115. *See* A. ALCHIAN & W. ALLEN, EXCHANGE AND PRODUCTION: THEORY IN USE 136-37 (1969); E. MANSFIELD, MICROECONOMICS: THEORY AND APPLICATIONS 286 (2d ed. 1975); L. PHLIPS, *supra* note 30, at 16. *See generally* W. BAUMOL, ECONOMIC THEORY AND OPERATIONS ANALYSIS 347-48 (3d ed. 1972) (discussing discriminating monopoly). "Profitable arbitrage" occurs when a buyer purchases a commodity at a low price and then profitably resells the commodity at a higher price.

116. *See* M. ADELMAN, A & P: A STUDY IN PRICE-COST BEHAVIOR AND PUBLIC POLICY 220 (1959); L. PHLIPS, *supra* note 30, at 16.

117. *See* Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S. 2, 27-28 (1984); Frech, *supra* note 36, at 361-62. In a perfectly competitive market where providers have no market power, MFN clauses would be redundant. All identical transactions would occur at the same price because no buyer need pay more than the competitive prices (which equals marginal cost) and no provider could sell for less than the competitive price and earn a normal return. Therefore, the use of MFN clauses itself indicates that we are not dealing in a perfectly competitive market.

118. *See* H. SOMERS & A. SOMERS, DOCTORS, PATIENTS, AND HEALTH INSURANCE 292, 295 (1961); *The Blue Cross and Blue Shield Fact Book 1979* 2; Havighurst, *supra* note 37, at 248-49.

119. H. SOMERS & A. SOMERS, *supra* note 118, at 292; *see also* L. REED, BLUE CROSS AND

Blue Shield plans during the Depression to help doctors collect their fees.[120] The American Medical Association's "Seal of Acceptance" for Blue Shield plans included the requirement that "[t]here should be no regulation which restricts free choice of a qualified doctor of medicine in the locality covered by the plan who is willing to give services under the conditions established."[121] In fact, many of the statutes establishing Blue Shield plans require that all licensed physicians in the area be allowed to participate.[122]

The principles underlying BCBS include the subscriber's freedom to choose any doctor or hospital in the community and the concomitant right of all doctors and hospitals to participate in the plans. Data collected by the FTC in 1978 regarding sixty-five Blue Shield plans showed that for twenty-nine of the plans, over ninety percent of the community's doctors participated, and for fifty-two of the plans, over seventy percent of the community's doctors participated.[123] Moreover, in areas where it has a large subscriber base, BCBS could not significantly limit the number of participating providers and still provide good service to its customers.[124] With essentially all providers in a market who wish to participate in a BCBS plan doing so, a high price to BCBS will not lead to other providers competing for that profitable business; they *all* can have access to the profitable BCBS business. Therefore, providers have market power when dealing with BCBS.

The second condition necessary for price discrimination is that buyers must have different elasticities of demand. As discussed above, BCBS plans generally are open to all providers and indeed have contracted with a large proportion of the providers in their markets to service their subscribers. Conversely, a relatively small HMO or PPO can adequately serve its subscribers with relatively few providers. Therefore, the HMO or PPO can select only those providers that have excess capacity and are willing to discount their fees to obtain additional patients. BCBS does not have that ability.[125] Therefore, BCBS has a less elastic

---

MEDICAL SERVICE PLANS 47 (1947) ("[T]the great majority of plans have contracts with all the eligible general hospitals of their area."); Frech, *supra* note 36, at 357 (Shortly after Blue Cross plans were formed in the early 1930s, "the Blue Cross plans began to contract with all or most area hospitals.").

120. *See* H. SOMERS & A. SOMERS, *supra* note 118, at 317-19; *The Blue Cross and Blue Shield Fact Book 1979* 2; Havighurst, *supra* note 37, at 249.

121. H. SOMERS & A. SOMERS, *supra* note 118, at 319.

122. R. EILERS, REGULATION OF BLUE CROSS AND BLUE SHIELD PLANS 134 (1963).

123. Bureau of Competition, FTC, *Medical Participation in Control of Blue Shield and Certain Other Open-Panel Medical Prepayment Plans* B-3 to B-11 (1979); *see also* L. REED, *supra* note 119, at 170-72 (indicating substantial participation in most plans and discussing reasons for some doctors' choosing not to participate).

124. A study based on BCBS of Michigan noted: "It is entirely possible that, in the absence of enough participating physicians, the Insurance Commissioner could revoke Blue Shield's right to sell service contracts, the only type it is authorized to sell, on the grounds of fraud." 2 W. MCNERNEY, HOSPITAL AND MEDICAL ECONOMICS 1362 (1962).

125. This difference between the traditional BCBS plan and alternative delivery systems allows the alternatives to be more efficient. *See* Frech, *supra* note 36, at 359-64. A small number of states have enacted statutes or regulations requiring PPOs to contract with "any willing provider" meeting predetermined criteria. Any-willing-provider provisions threaten the ability of the PPO to exclude providers who practice in a costly manner or who do not provide quality care. The provisions may also limit the bargaining power of the PPO in negotiating discounts in exchange for a certain volume of business from PPO subscribers. *See* Rolph, Ginsburg & Hosek, *supra* note 42, at 38-39.

demand for provider services.

The third condition for price discrimination is that the provider must be able to differentiate between buyers with relatively elastic demand curves and buyers with relatively inelastic demand curves. Buyers with relatively elastic demand curves are sensitive to price and, in response to a price change, will change their buying decisions to a greater degree than buyers with relatively inelastic demand curves. Therefore, the discriminating seller needs to be able to differentiate among buyers based on their demand elasticity. This problem is often significant for a vendor selling to huge numbers of anonymous consumers.[126] A provider dealing with a handful of third-party payers in a local market, however, easily should be able to differentiate between a price-sensitive HMO or PPO that will eschew high-priced providers and a BCBS plan that will contract with practically all providers in the market.

The final condition necessary for price discrimination is that profitable arbitrage must not be possible. Price discrimination cannot persist if those who pay less can profitably resell to those who pay more. Arbitrage is not possible, however, when dealing with services such as health care.[127] A patient who pays a provider a low fee for an appendectomy, nevertheless, will be unable to resell that appendectomy to another patient who is being charged a high fee by the provider.

Providers with excess capacity have both the financial motivation and the ability to price discriminate against BCBS.[128] Because such price discrimination would put BCBS at a competitive disadvantage, BCBS can be expected to try to prevent the price discrimination. Thus, the MFN clause becomes BCBS's weapon to prevent being victimized by price discrimination. The question then becomes: Is the prevention of price discrimination procompetitive or anticompetitive?

B. The Competitive Effects of Prohibiting Price Discrimination

In considering the effects of the Robinson-Patman Act,[129] which prohibits price discrimination in certain circumstances, antitrust analysts have dealt at length with the competitive effects of prohibiting price discrimination. That work, reviewed next, establishes that the legal prohibition of price discrimina-

126. When dealing with large numbers of anonymous consumers, sellers have devised various indirect ways to gauge each one's elasticity of demand. For example, airlines try to differentiate business travelers, who have a relatively inelastic demand, from vacationers, who have a more elastic demand, by requiring advanced reservations and a Saturday stayover. Another example is consumer products companies that try to differentiate customers who have relatively elastic demand by lowering price to those customers who will search out discount coupons.

127. *See* W. BAUMOL, *supra* note 115, at 347.

128. The foregoing analysis assumes that the lower price charged to the HMO is a price discrimination in the economic sense of that term. *See supra* note 113. It is interesting to note that if the HMO is a more efficient system for delivering medical service, *see infra* text accompanying notes 153-58, a lower price to the HMO might not be an economic price discrimination but simply a reflection of the lower cost of selling medical services through the HMO. The MFN clause, like the Robinson-Patman Act, prohibits price differences regardless of whether they are price discriminations in an economic sense.

129. 15 U.S.C. § 13(a) (1988).

tion is often anticompetitive.[130] Although the Supreme Court has stated that "[t]he determination whether to alter the scope of the Act must be made by Congress, not this Court,"[131] the Court has warned that the Act's ban on certain price discriminations has anticompetitive potential.[132] Rather than recount all of the economic criticisms of the Robinson-Patman Act,[133] the major criticisms particularly germane to the issues in this Article are reviewed. Preventing price discriminations may: (1) eliminate a dynamic mechanism by which prices are racheted down to the competitive level; (2) reduce output; and (3) prevent the market from rewarding more efficient distribution systems. Although these criticisms also apply to MFN clauses, there are differences between the Robinson-Patman Act and MFN clauses that make the anticompetitive potential of MFN clauses greater. These differences are addressed in Part IVC.

1. Eliminating a Dynamic Mechanism by which Prices are Racheted Down to the Competitive Level

A market is a dynamic process. Individual sellers regularly adjust price and buyers provide feedback through their purchasing decisions. A restriction on pricing flexibility strikes at the heart of the market system. Judge Easterbrook of the United States Court of Appeals for the Seventh Circuit has noted that "the control of price discrimination poses substantial risks to competition, which often works through 'discriminatory' chiseling down of prices."[134] Leading commentators in this area have made similar observations. Morris Adelman has stated that "under competition, [price] discriminations are always being created and always being destroyed. To block either the creative or the destructive part of the process is to block competition."[135] Similarly, Frederick Rowe has explained that:

> Blanket illegality of selective price discrimination cements rigid prices that antitrust policy aims to loosen. . . . [S]elective price reduction[ ] to "divert trade" . . . *is* competition. Prices reduced to gain new trade symptomize a competitive system's effective functioning. Prohibiting selective price reductions "low enough to get the business" comes close to outlawing price competition itself. If a seller by law must lower all

130. *See, e.g.*, R. BORK, THE ANTRITRUST PARADOX 382-401 (1978); R. POSNER, THE ROBINSON-PATMAN ACT: FEDERAL REGULATION OF PRICE DIFFERENCES 49 (1976); F. ROWE, PRICE DISCRIMINATION UNDER THE ROBINSON-PATMAN ACT 24-29 (1962).

131. Falls City Indus., Inc. v. Vanco Beverage, Inc., 460 U.S. 428, 436 (1983).

132. *See* Great Atl. & Pac. Tea Co. v. FTC, 440 U.S. 69, 80-81 (1979); United States v. United States Gypsum Co., 438 U.S. 422, 458 (1978); Automatic Canteen Co. of Am. v. FTC, 346 U.S. 61, 63 (1953).

133. *See, e.g.*, AMERICAN BAR ASSOCIATION SECTION OF ANTITRUST LAW, 1 THE ROBINSON-PATMAN ACT: POLICY AND LAW 27-37 (1980) (summarizing the economic criticisms and marshalling the sources of the criticisms); Kintner & Bauer, *The Robinson-Patman Act: A Look Backwards, A View Forward*, 31 ANTITRUST BULL. 571 (1986) (summarizing criticism and acclamation of the Act).

134. Ball Memorial Hosp., Inc. v. Mutual Hosp. Ins., Inc., 784 F.2d 1325, 1340 (7th Cir. 1986).

135. Adelman, *Price Discrimination as Treated in the Attorney General's Report*, 104 U. PA. L. REV. 222, 224 (1955).

his prices or none, he will hesitate long to lower any.[136]

Finally, the *Report of the Attorney General's National Committee to Study the Antitrust Laws* concluded that "a seller constrained by law to reduce prices to *some* only at the cost of reducing prices to *all* may well end up by reducing them to *none*."[137]

These authorities support the proposition that if a provider is not free to charge a lower price to the members of an HMO or PPO without also lowering prices to BCBS, the provider will be inhibited from lowering prices at all. The resulting price rigidity undermines the central role prices should play in a market and prevents movement toward a competitive equilibrium. This is the primary criticism of the Robinson-Patman Act. It is equally applicable to MFN clauses and supports the proposition that MFN clauses are the antithesis of competition, and will inhibit discounting and facilitate tacit collusion.

This analysis could be read to imply that providers should welcome MFN clauses because MFN clauses diminish downward pressure on provider prices by preventing discriminatory discounts. However, a provider with excess capacity can increase profits at least in the short run by price discriminating,[138] which the MFN clause prevents. Thus, some provider opposition to MFN clauses would appear reasonable. In the long run, however, as Easterbrook, Adelman, and Rowe have suggested,[139] if MFN clauses were abolished, the ensuing price discriminations could create competitive pressures that would lower the whole provider price structure.

Alternatively, it is possible that the market for medical services could accommodate discriminatory provider pricing over the long run. There is no certainty in predicting the long-run effect of allowing discriminatory pricing because, as the leading authority on price discrimination has stated: "The conditions under which a market equilibrium with price discrimination is possible are not yet fully understood."[140] From a societal perspective, the possibility that allowing providers to price discriminate ultimately could put downward pressure on the price of medical services is a powerful argument against MFN clauses. Even if the price discriminations ultimately did not cause a lowering of medical service prices, the price discriminations still would be desirable if they increased the output of medical services. Therefore, the Article turns to the

---

136. Rowe, *Price Discrimination, Competition, and Confusion: Another Look at Robinson-Patman*, 60 YALE L.J. 929, 956 (1951).

137. *Report of the Attorney General's National Committee to Study the Antitrust Laws* 335 (1955). Similarly, Nelson and Keim wrote:

> To the extent to which sellers are required to maintain uniform prices to all buyers, they are rendered unable to seek particular sales by cutting prices. If they choose to rely upon price competition as their primary sales argument, they must cut prices simultaneously to all comers. Naturally, many sellers are far more reluctant to take such a broad step than to reduce prices on individual transactions.

NELSON & KEIM, PRICE BEHAVIOR AND BUSINESS POLICY 62 (1940).

138. *See supra* text accompanying note 114.

139. *See supra* notes 134-36 and accompanying text.

140. L. PHLIPS, *supra* note 30, at 16.

question of whether MFN clauses, by preventing provider price discrimination, reduce medical service output.

2. Reducing Output

Robert Bork has argued that the effect price discrimination has on output should be the criteria for judging the impact on consumer welfare of a ban on price discrimination.[141] Unfortunately, judging output effects of MFN clauses in provider contracts is not without its problems. The issue normally would be framed in terms of whether price discrimination between BCBS and a competing HMO would increase the amount of medical services provided to the public.[142] The answer would appear to turn on whether the MFN clause's ban on price discrimination would lead to providers charging the high (BCBS) price and foregoing sales to the HMO, or, alternatively, charging the low (HMO) price to everyone.[143] The provider would choose the HMO price, thereby lowering its price to BCBS, only if the increased profits from HMO patients were greater than the reduced profits from BCBS patients.

For example, assume the provider's marginal cost to provide medical service is a constant $55 per unit; BCBS pays $100 per unit; the HMO pays $80 per unit; and the provider sells 1000 units per year to BCBS patients.[144] The provider's profit on sales to BCBS patients is $45,000.[145] If the provider could sell

141. R. BORK, *supra* note 130, at 395. The preceding section focused on the possibility that discrimination, over time, will result in enhanced competition lowering prices and increasing output in the medical service market. The focus of the instant section is that output may be increased by a provider utilizing price discrimination as compared to a provider charging a single, profit-maximizing price. Here, the output effects are not caused by price discrimination unraveling supracompetitive pricing through the dynamic market process, but by the possibility that the discriminating provider will produce more medical service output than the provider who is prevented from discriminating by an MFN clause.

142. The moral hazard caused by comprehensive health insurance, such as traditional BCBS plans, leads to greater health care output than is optimal. *See* Feldstein, *The Welfare Loss of Excess Health Insurance*, 81 J. POL. ECON. 251, 252-53 (1973); *supra* text accompanying notes 36-38. If there is too much health care output already, and if provider price discrimination increases output, it may seem anomalous to equate an increase in output with an increase in social welfare. However, the increase in output caused by provider price discrimination manifests itself as more patients being served through HMOs and PPOs, which, compared to traditional BCBS plans, reduce moral hazard and socially wasteful care. If, instead, the price discrimination produced more patients served by traditional health insurance, serious questions could be raised about equating increased output and increased social welfare.

143. Note that the choice facing the provider is fundamentally different from the choice facing most sellers who would price discriminate but for a legal prohibition. For most sellers, the profit-maximizing single price would be between the high price and the low price. That is not a rational option for health care providers because any rise above the HMO price will result in the loss of all the HMO's business, while any price below the BCBS price will not result in more BCBS business. Thus, the provider prohibited from discriminating is likely to choose either the HMO price or the BCBS price.

144. In this context, the term "unit" means a standardized measure of output. Although measuring provider output in the health care industry is very difficult, the economic analysis does not differ from factories producing widgets. The presumption that the same basic economic model used for other industries applies to the health care industry is consistent with Supreme Court analysis in antitrust health care cases. *See* FTC v. Indiana Fed'n of Dentists, 476 U.S. 447 (1986); Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S. 2 (1984); Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332 (1982).

145. $(1000 \times \$100) - (1000 \times \$55) = \$45{,}000$.

an additional 200 units per year by joining the HMO, but because of the MFN clause would receive the $80 per unit price (or $25 per unit profit) from both BCBS and the HMO, then its total profit would fall from $45,000 to $30,000.[146] Therefore, the provider would choose not to increase its output because of the MFN clause.

Alternatively, even with the MFN clause the provider might still choose to join the HMO if the added profits were great enough. If the preceding example were changed by assuming that the HMO generated an additional 900 units per year, then the provider would join the HMO because its profit would increase from $45,000 to $47,500.[147] In this situation, the MFN clause would have no effect on the provider's output because the provider would join the HMO regardless of the presence of the MFN clause. The clause would result in a lower price paid by BCBS to the provider. The lower price, however, is simply a rent transfer from the provider to BCBS. Ignoring, for now, any effect on the price of insurance, there is no direct effect on the provider's output because the provider would produce the same number of units regardless of whether or not the provider contract contained an MFN clause. Thus, the MFN clause's prohibition of price discrimination would appear to either reduce provider output or leave it unchanged. In no case does the MFN clause appear to increase provider output.

Factoring the insurance market into the analysis complicates matters. To the extent that MFN clauses deter providers from participating in the HMO, many would-be HMO patients presumably subscribe to BCBS instead. Output effects in the medical service market may result from differences in the insurance premium and the product sold by BCBS and the HMO. The issue, therefore, becomes how the MFN clause affects output in the insurance market, which, in turn, affects output in the medical service market. If the MFN clause deters providers from joining the HMO, then the higher premiums for BCBS insurance may reduce output in the insurance market, thereby reducing output in the medical service market. Alternatively, if providers join the HMO despite the MFN clause and then lower prices to BCBS, lower insurance premiums may follow and lead to increased output in the insurance market and the medical service market. Thus, the output effects of MFN clauses will depend not only on how providers respond to the presence of the MFN clause, but also on how the insurance market responds to the providers' decisions, and how consumers' choices would be affected by changes in the insurance market.

If providers were discouraged from joining HMOs, the likely result would be lessened competition in the insurance market and reduced provider output. If providers joined the HMOs despite the MFN clause, the result might be lower provider prices to BCBS, lower insurance premiums, and increased provider output. Alternatively, lower provider prices to BCBS caused by the MFN clause might enhance BCBS's profits by lowering its costs without leading to

146. $[(1000 \times \$80) - (1000 \times \$55)] + [(200 \times \$80) - (200 \times \$55)] = \$30{,}000.$
147. $[(1000 \times \$80) - (1000 \times \$55)] + [(900 \times \$80) - (900 \times \$55)] = \$47{,}500.$

lower insurance premiums and higher output if BCBS retains substantial market power.

This result was observed in *Ocean State Physicians Health Plan, Inc. v. Blue Cross and Blue Shield of Rhode Island.*[148] In *Ocean State*, although physicians lowered their fees to BCBSRI because of the MFN clause, BCBSRI did not lower its premiums.[149] Therefore, the MFN clause produced a rent transfer from those physicians to BCBSRI, but no positive output effects. The First Circuit concluded that "nothing turns on whether Blue Cross in fact lowered its rates. The fact remains that achieving lower costs is a legitimate business justification under the antitrust laws."[150] The notion that output effects and consumer welfare are irrelevant to an antitrust analysis is not only extreme, but also inconsistent with the court's subsequent argument that one of the reasons for not interfering with BCBSRI's provider contracts was that MFN clauses benefit consumers by lowering prices.[151] Regardless, *Ocean State* illustrates that even where the MFN clause leads to some providers lowering their prices to BCBS, there will not necessarily be a positive output effect. To the extent that the MFN clause caused physicians to abandon the HMO,[152] it had a negative output effect and reduced the competitive significance of a more efficient distribution system. The latter effect is the focus of the third criticism of the Robinson-Patman Act's ban on price discrimination.

3. Preventing the Market from Rewarding More Efficient Distribution Systems

The third major criticism of the Robinson-Patman Act's ban on price discrimination is that the Act prevents the market from rewarding more efficient distribution systems. The HMO and PPO are alternative forms of delivering health care. Their greater efficiency, when compared to a traditional BCBS plan, stems partly from the creation of incentives to eliminate the moral hazard that leads to unnecessary care.[153] One of the mechanisms used is to tie the provider's compensation to the HMO's profit. For example, twenty percent of the provider's compensation may be withheld and paid only if the HMO's costs are less than revenues.[154] If the MFN clause prevents such mechanisms from being used, it prevents the establishment of a more efficient distribution system.

Similarly, an HMO or PPO may reduce informational costs, transactional costs, and the risk associated with the consumer's choice of providers.[155] Alternative delivery systems can reduce these costs by acting as an informed purchas-

148. 883 F.2d 1101 (1st Cir. 1989), *cert. denied*, 110 S. Ct. 1473 (1990).

149. *Id.* at 1111 n.11.

150. *Id.*

151. *Id.* at 1111. In fact, lower costs unaccompanied by lower prices is a manifestation of market power. *See* P. AREEDA & L. KAPLOW, ANTITRUST ANALYSIS ¶ 338 (4th ed. 1988).

152. *See supra* text accompanying note 82.

153. *See* Frech, *supra* note 36, at 355; Havighurst, *supra* note 37, at 248-49.

154. *See* Ocean State Physicians Health Plan, Inc. v. Blue Cross and Blue Shield of R.I., 883 F.2d 1101, 1104 (1st Cir. 1989), *cert. denied*, 110 S. Ct. 1473 (1990).

155. *See* Frech, *supra* note 36, at 361-64; Havighurst, *supra* note 37, at 230-31.

ing agent for consumers. Rather than each consumer shopping for providers who will offer the desired level of care at a competitive price, it may be more efficient to have the HMO or PPO act as the consumer's centralized purchasing agent. In contrast, the traditional BCBS plan requires each consumer to choose providers.

The HMO or PPO also may offer advantages from the provider's perspective. It may reduce risk by guaranteeing a certain volume of patients. Furthermore, it may reduce costs by limiting paperwork or otherwise reducing the time the provider must spend on each patient.[156] An MFN clause, however, prevents such efficiencies from being transformed into lower costs and negates any marketing advantage due to the more efficient distribution system.

By preventing more efficient distribution systems from being rewarded by free market forces, MFN clauses prevent competition on the merits. Ironically, the First Circuit in *Ocean State* concluded that prohibiting price discrimination "tends to further competition on the merits."[157] The court failed to recognize that some distribution systems may be more efficient than others. This failure is particularly perplexing given the court's finding that "Ocean State provided more coverage and charged lower premiums" than BCBSRI.[158] Just as chain stores may be more efficient buyers and distributors of groceries, HMOs and PPOs may be more efficient buyers and distributors of health care services. Any legal requirement that all buyers invariably must pay the same price to suppliers or providers prevents competition on the merits from rewarding the more efficient system.

C. *The Anticompetitive Potential of Most Favored Nations Clauses Compared to the Robinson-Patman Act*

Although criticisms of the Robinson-Patman Act's ban on price discrimination can be applied to an MFN clause's ban on price discrimination, the anticompetitive potential of the MFN clause is far greater than the anticompetitive potential of the Robinson-Patman Act. Unlike the MFN clause, the Robinson-Patman Act is not a per se ban on all price discrimination. First, section 2(a) of the Act bans price discrimination only if "the effect of such discrimination may be . . . to injure, destroy, or prevent competition . . . ."[159] As the United States Court of Appeals for the Eleventh Circuit recently noted: "A controversy has raged (and continues to rage) over the meaning of 'competition' as used in the so-called 'competitive injury' phrase of section 2(a)."[160] For purposes of this Article, it is unnecessary to review that controversy.[161] Regardless of the exact

156. *See* Remarks, *supra* note 12, at 22.

157. *Ocean State*, 883 F.2d at 1110.

158. *Id.* at 1103.

159. 15 U.S.C. § 13(a) (1988).

160. Alan's of Atlanta, Inc. v. Minolta Corp., 903 F.2d 1414, 1418 n.6 (11th Cir. 1990) (citing Boise Cascade Corp. v. FTC, 837 F.2d 1127, 1143 (D.C. Cir. 1988); *id.* at 1148-52 (Williams, J., concurring); *id.* at 1152-63 (Mikva, J., dissenting)).

161. For a discussion of the issues, see AMERICAN BAR ASSOCIATION SECTION OF ANTITRUST LAW, *supra* note 133, at 72-74, 97-105.

contours of the competitive injury element, it is undisputed that, unlike MFN clauses, the Robinson-Patman Act's reach is limited to price discriminations that may injure competition.

Second, the Act includes a defense for cost-justified price differentials.[162] For example, if one customer buys products from a manufacturer in large quantities, thereby reducing per-unit shipping costs, the manufacturer may lower the price to that customer accordingly. Under an MFN clause, however, price differences that reflect cost differences are prohibited. Thus, even if it costs a provider less to deal with an HMO or PPO than with BCBS, an MFN clause prevents price differences that simply reflect that cost savings.[163]

A third provision of the Robinson-Patman Act that diminishes its anticompetitive potential is the defense for the good-faith meeting of competition.[164] The meeting-competition defense allows a seller to offer lower prices to select customers if those lower prices were offered in response to "an equally low price of a competitor."[165] For example, if hospital *A* offered a twenty percent discount to an HMO, then, consistent with the Robinson-Patman Act, hospital *B* could also offer a twenty percent discount to the HMO without also offering the discount to BCBS. Under an MFN clause, however, hospital *B* would have to forego competing for the HMO's business unless it chose to also give the twenty percent discount to BCBS. Therefore, compared to the Robinson-Patman Act, an MFN clause places greater limitations on competitive pricing responses and is more likely to lead to price uniformity.

The competitive injury requirement, the cost-justification defense, and the meeting-competition defense are only three of the many ways in which the reach of the Robinson-Patman Act has been limited.[166] No such limits apply to MFN clauses.[167] Moreover, in enacting the Robinson-Patman Act, Congress was driven by the desire to provide fairness and equality of opportunity to small business.[168] While there is room for disagreement as to how much, if any, weight society should give to such goals, it is appropriate for Congress to make such judgments. Thus, criticism of the anticompetitive effects of limiting price

162. 15 U.S.C. § 13(a) (1988) ("differentials which make only due allowance for differences in the cost of manufacture, sale, or delivery resulting from the differing methods or quantities in which such commodities are to such purchasers sold or delivered").

163. *See supra* text accompanying note 156.

164. 15 U.S.C. § 13(b) (1988).

165. *Id.* For a discussion of the defense, see Falls City Indus., Inc. v. Vanco Beverage, Inc., 460 U.S. 428, 438-47 (1983).

166. Other limitations on the Act's reach include requirements that the transactions involved be "sales" to "two different purchasers" of "commodities" of "like grade and quality" in "interstate commerce" and that the lower price be "unavailable" to the disfavored customer. 15 U.S.C. § 13. For a discussion of these and other limits on the Act, see Scher, *How Sellers Can Live With the Robinson-Patman Act*, 41 BUS. LAW. 533 (1986).

167. *See* 6 P. AREEDA, *supra* note 34, at 230.

168. *See* FTC v. Sun Oil Co., 371 U.S. 505, 520 (1963); FTC v. Morton Salt Co., 334 U.S. 37, 46 (1948); Silcox & MacIntyre, *The Robinson-Patman Act and Competitive Fairness: Balancing the Economic and Social Dimensions of Antitrust*, 31 ANTITRUST BULL. 611 (1986). It is also the prerogative of Congress to enact special interest protectionist legislation, while private conduct with similar results may be illegal. *See* Premier Elec. Constr. Co. v. National Elec. Contractors Ass'n, Inc., 1987-1 Trade Cas. (CCH) ¶ 67,462, at 59,936-38 (7th Cir. 1987).

discrimination under the Robinson-Patman Act must be tempered by the Act's fostering of other social values. No such tempering of criticism is appropriate for privately imposed MFN clauses.

V. CONCLUSIONS

When the FTC challenged the use of MFN clauses in the *Ethyl* case,[169] the defendants argued that MFN clauses were consistent with the Robinson-Patman Act.[170] It is not surprising that the FTC, which is charged with enforcing the Robinson-Patman Act, would be reluctant to say that the Act often has anticompetitive consequences and that the similarity between the Act and MFN clauses may indicate that MFN clauses also have anticompetitive consequences.[171] Instead, the FTC rejected the defendant's argument because, unlike MFN clauses, the Robinson-Patman Act's reach is limited in various ways, including cost-justification and meeting-competition defenses.[172]

In reversing the FTC, the Second Circuit used the Robinson-Patman Act's prohibition of price discrimination to give legitimacy to MFN clauses.[173] It is perplexing, however, that the Second Circuit summarily concluded that the similarity of the Act and MFN clauses conferred competitive legitimacy on MFN clauses. Also baffling is the failure of subsequent cases in the health care industry to transfer the economic criticism of the Robinson-Patman Act's ban on price discrimination to MFN clauses. In fact, there is no indication that the courts were even aware of the extensive literature critical of the Robinson-Patman Act.[174]

It is possible that, in certain circumstances, MFN clauses will result in lower prices spreading to those who otherwise would pay more. However, it is also possible that, in certain circumstances, MFN clauses will discourage discounting, facilitate oligopolistic pricing, and deter entry or expansion by more efficient distribution systems. With the exceptions of the FTC in *Ethyl*[175] and the Tenth Circuit in *Reazin*,[176] the courts have held that MFN clauses are not anticompetitive as a matter of law. Although there is a compelling simplicity to the argument that lower prices will flow from MFN clauses, extensive economic analysis of the Robinson-Patman Act indicates that MFN clauses have substan-

169. *In re* Ethyl Corp., 101 F.T.C. 425 (1983), *rev'd sub nom.* E.I. Du Pont de Nemours & Co. v. FTC, 729 F.2d 128 (2d Cir. 1984).

170. *See supra* text accompanying notes 23-24.

171. The FTC, however, has "declined to use Section 5 [of the FTC Act] to extend the [Robinson-Patman] Act's reach, where the effect would be in conflict with the competition goals of the antitrust laws." *In re* Boise Cascade Corp., 107 F.T.C. 76, 205 (1986) (citing *In re* General Motors Corp., 103 F.T.C. 641, 700-01 (1984)), *rev'd on other grounds and remanded*, 837 F.2d 1127 (D.C. Cir. 1988).

172. *See supra* text accompanying note 24.

173. *See supra* text accompanying note 32.

174. *See supra* notes 130 & 133.

175. *In re* Ethyl Corp., 101 F.T.C. 425 (1983), *rev'd sub nom.* E.I. Du Pont de Nemours & Co. v. FTC, 729 F.2d 128 (2d Cir. 1984).

176. Reazin v. Blue Cross and Blue Shield of Kan., Inc., 899 F.2d 951 (10th Cir.), *cert. denied*, 110 S. Ct. 3241 (1990).

tial anticompetitive potential. In an era when economic analysis has reshaped much of antitrust law, the treatment of MFN clauses stands out as an anomaly.