Most Favored Nation Clauses in Payor/Provider Agreements

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The use of "most favored nations" (MFN) clauses in agreements between third party payors and health care providers appears to be undergoing resurgence in some markets. These clauses traditionally required a provider to give the payor the lowest rate that it gave to any other comparable payor (referred to here as a "Floor MFN"). Payors tend to argue that these clauses are a legitimate and reasonable way to control rising health care costs and their impact on premiums. Providers and other opponents argue that they are anticompetitive and lead to informal provider collusion to create a price "floor" in a local market. The concept of MFN also appears to be evolving, and some recent contractual iterations involve a provider promising the payor demanding the MFN that the payor will not be paying *more* than any other comparable payor that the provider contracts with (referred to here as a "Ceiling MFN").

Although there are arguably some pro-competitive effects of MFN clauses, there are also potential legal consequences, which can result from their imposition. Due to the possible negative implications, payors and providers considering the implementation of MFN clauses should carefully consider the potential antitrust effects.

Traditional Most Favored Nation Clauses

MFN clauses typically,

> Require the provider to charge to the payer the provider's 'usual fee' with the 'usual fee' defined to be 'the lowest fee charged or offered and received as payment in full.' Similarly, a [MFN] clause may require that a provider not 'charge fees to an insurer higher than the fees the provider accepts from any other non-governmental group, group plan, or panel.'[1]

The availability of MFN clauses is somewhat limited because they are usually attainable only by large payors, in fact, "only payors with requisite market power in the form of patients can demand and receive MFN status from their service suppliers."[2]

A MFN clause "might be procompetitive because it ... [can] facilitate bargaining by eliminating the risk that the provider will be able to hold up the third party payor for more than the provider was willing to accept from the third party payor's competitors."[3] Another reason provided by proponents of MFN clauses is that they enable health insurers to lower the price of their own products. They reason that, "by reducing the purchase cost of medical care on behalf of its members, health insurers are able to reduce their own operating expenses. Presumably, this expense reduction is reflected in lower product prices."[4]

There are several arguments illustrating the potential negative competitive consequences of MFN clauses. These negative outcomes include: new competitors being discouraged from entering the payor/provider marketplace, providers limiting their payor mix, consumers being negatively affected by the suppression of competition and the resulting higher rates, and loss of provider autonomy.

A typical objection to MFN clauses is "that they produce marketplaces in which new competitors are simply unable to survive because they can't compete on price by pricing below the dominant player in the market. In turn, that permits sellers to maintain artificially high floor prices for goods or services."[5] This argument is significant in a health care context where "it is almost impossible for a competitor to attract customers on the basis of quality and

almost as hard to compete on the basis of product differentiation."[6] In fact, some smaller insurers,

> Have been forced out of business because the provider, when faced with the choice to do business solely with the dominant insurer or to do business with both the dominant insurer and other, smaller companies that can deliver less patient volume but can absorb the provider's excess capacity (thereby activating the MFN provision), choose to terminate or avoid relations with the other insurers to avoid activating the MFN provision.[7]

Not only may some new competitors be unable to survive, doctors and other medical professionals may be placed in the position of having to limit their payor mix if they cannot afford to provide discounts to small carriers, for fear they will in turn have to deal with the repercussions of having to further discount their services to their larger providers. An example of this was shared by a psychiatrist on his website where he stated,

> The "most favored nation" clause would have affected me in the following manner: If the big regional company paid me $75 for a service, but the official rate from a small Midwestern company I contracted with was $65 for that services, the big company expected me to tell them this, and to voluntarily accept a $10 cut in my fee. They expected this even though I'd never seen a client from the midwesten company...If I failed to voluntarily reveal a lower fee charged by another company I could be declared in breech of my contract and cut from the company's panel.[8]

Another argument against the usage of MFN clauses is that health care consumers are harmed by the suppression of competition and the higher rates, which result from the informal imposition of price floor. MFN clauses set price floors in the health care market in two different ways.

First, "MFN contract rates can set the minimum price for all medical services covered by the contract. Thus, the cost of such services incurred by a dominant insurer with an MFN clause can become the price for all other competitors in the market that deal with those same providers."[9] A second way that MFN clauses set price floors in the health care market is that

they "establish a price floor with respect to the overall cost of all health insurance products offered in that market."[10] An example of this is,

> The largest single expense item for any health plan is typically hospital costs. Thus, the kind of pricing that a health insurer is able to obtain from hospitals in large part drives the price of the overall health insurance product. If hospital pricing in the market has become rigid due to the existence of an MFN clause, then the price structure in the health insurance market will also become similarly fixed at an artificial price floor.[11]

In fact, "artificially high prices for health coverage limit access to such coverage... moreover, the maintenance of a non-competitive marketplace may have the effect of artificially increasing co-payments and deductibles to patients."[12] Thus, the suppression of competition imposed by MFN clauses may ultimately influence the affordability of quality health insurance for consumers.

Another alleged negative result of MFN clauses is that providers feel that if they are "stuck in a marketplace with an overwhelmingly dominant payor they are forced to agree to 'take it or leave it' pricing policy with the dominant payor."[13] This agreement to accept the terms of the MFN, results in the attainment of patient volume, however, it may result in the inability of providers to expand their payor mix because of their commitment to the MFN clause with the dominant payor. The most serious anti-competitive effects occurs when the dominant payor "has a significant market share...30%-40%, ... there is a high likelihood that the use of MFN clauses in that situation could have an anti-competitive effect. [There is] less concern about their use if ... [they are] a relatively small purchaser of services."[14]

Federal Case Law and Regulatory Guidance

There are three key cases which discuss the federal response to the use of MFN clauses prior to 1990, *Kitsap v. Washington Dental* (1987), *Ocean State v. Blue Cross Blue Shield* (1989) and *Reazin v. Blue Cross Blue Shield* (1990). In both *Kitsap* and *Ocean State,*

the court held that the MFN clause was not anti-competitive, however in the *Reazin* case, the court recognized the anticompetitive potential of the MFN due to BCBS market power.

In *Kitsap v. Washington Dental*[15] there were two dental care service providers operating in Kitsap, Jefferson and Mason Counties in Washington.[16] Kitsap Physicians Service (KPS) and Washington Dental Service (WDS) both had nondiscrimination clauses in their contracts with their respective member dentists. The clause ensured that,

> WDS will not be charged more than the general public or other providers are charged for the same service... if WDS [discovers]... that a member dentist is charging a lower fee for the same service to another patient, WDS will reduce its payments to the member dentist to this lower fee.[17]

This lawsuit ensued after WDS became aware that "its member dentists were charging KPS less than WDS [they then] reduced its payments to member dentists accordingly. As many of WDS's member dentists had more WDS than KPS patients, they cancelled their contract with KPS rather than accept the reduced rate for their WDS patients."[18] As a result of the dentists' actions, KPS lost 26 of its 60 member-dentists and filed a lawsuit. The court after examining the "(1) specific intent to control prices or destroy competition; (2) predatory or anti-competitive conduct directed toward accomplishing an unlawful purpose (3) a dangerous probability of success; and (4) causal anti-competitive injury,"[19], determined that WDS's practices were not anticompetitive.

Regarding the intent to control prices or destroy competition, the court found that, "the nondiscrimination clause, far from being a price control measure, 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."[20] The Court also found that the antidiscrimination policy was not "predatory", since "predatory conduct exists if the disputed practice is not 'justified by any normal business purpose'...the nondiscrimination

clause [is not predatory because it] makes good business sense. KPS has a similar clause in their own contract."[21]

In terms of the third factor, the court found that WDS did not have a dangerous probability of success. The court found that the "Defendant's relevant market share in this case is 13%,... a 13% market share (or even a 22% market share, excluding commercial insurers) is not enough market power to give rise to a prima facie case of dangerous probability of success of monopolization."[22] The fourth factor was also not met because the court found that no causal anticompetitive injury would result from the MFN clause since the "defendant's practices are in fact pro-competitive."[23]

In *Ocean State Physicians Health Plan, Inc., Et al., v. Blue Cross Blue Shield of Rhode Island*[24], the court found the plan was legitimately competitive and did not violate Section 2 of the Sherman Act.[25] Both Blue Cross and Ocean State contracted with physicians to provide medical care to its subscribers and then paid its contracted physicians on a fee-for-service basis. Due to Ocean State's ability to provide more coverage and charge lower premiums, many subscribers switched from Blue Cross to Ocean State, resulting in Blue Cross losing 30,000 of their 543,015 enrollees over a period of two years.[26]

In order to combat Ocean's success, Blue Cross instituted a three-pronged approach. One of the policies implemented was called the "Prudent Buyer" policy, which meant that Blue Cross would not pay "a physician more for any service or procedure than that physician was accepting from any other health care cost provider (such as Ocean State)."[27] This policy was instituted because Blue Cross realized that Ocean State's contracting physicians were accepting almost 20 percent less for their services from Ocean State than they received from Blue Cross.[28]

To implement this policy Blue Cross "required each of its participating physicians to certify that he or she was not accepting any lower fees from other providers than he or she was receiving from Blue Cross for the same service. If the provider [did not sign this]... Blue Cross reduced the physician's fees by 20 percent."[29] This policy resulted in significant cost savings for Blue Cross and after implementation "350 of Ocean State's 1200 physicians resigned, in many cases apparently in order to avoid a reduction in their Blue Cross fees."[30] Ocean State subsequently filed suit against Blue Cross alleging violations of antitrust law. The court found that,

> The record amply supports Blue Cross's view that Prudent Buyer was a bona fide policy to ensure that Blue Cross would not pay more than any competitor paid for the same services...such 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.[31]

The court found that this MFN clause was not an antitrust violation.

In the Tenth Circuit decision of *Reazin v. Blue Cross Blue Shield*[32], the court recognized the anticompetitive potential of a MFN clause. In this case, plaintiffs brought suit against Blue Cross alleging violations of sections 1[33] and 2 of the Sherman Act. Blue Cross Blue Shield Kansas (BCBSK) provided private health care financing to businesses and individuals in Kansas. It also operated an HMO in Kansas through HMO Kansas, Inc. (HMOK). BCBSK and HMOK competed with Health Care Plus (HCP- Plaintiff) in the private health care finance markets in the State of Kansas and Sedgwich County.[34]

In one of BCBSK's contracting provider agreements there was a MFN clause, which stated, "if a hospital decides it can provide services at charges less expensive than the MAP's [Maximum Allowable Payments- established by BCBS for various services] BCBSK subscribers will have the benefit of the less expensive charges."[35] Therefore, "this clause

requires a contracting hospital to give BCBSK the most economical rate the provider can charge, whether or not that rate is given to competing third party payors. BCBSK does not want other insurance companies receiving lower rates from its contracting hospitals."[36]

In this case, there was evidence that 60% of all medically insured Kansans were insured with BCBSK.[37] In fact, "Blue Cross is by far the largest private source of health care financing in its service area. By virtue of its size, Blue Cross has economic leverage over hospitals."[38] The court here found antitrust violations "because Blue Cross was in a position to use its leverage over hospitals to exclude or slow down the development of alternative delivery systems, it thereby had power to exclude competition"[39] and based on substantial testimony, found that the effect of Blue Cross' MFN clause "contributed to Blue Cross' power over price."[40]

Since 1990, there have been various U.S. Department of Justice (DOJ) Consent Settlements, Federal Trade Commission (FTC) Consent Settlements, and Court decisions, which have considered the legality of MFN clauses. In 1994, the DOJ filed a civil antitrust suit and proposed settlement against Delta Dental Plan of Arizona, Inc. accusing them of "eliminating discounts and reducing price competition under an agreement that had the effect of preventing dentists from cutting fees below those offered in the Delta plan."[41] Anne K. Bingaman, Assistant Attorney General in charge of the Antirust Division at the time, stated, "The use of the most favored nation clause by Delta facilitated anticompetitive behavior by reducing or eliminating discounts and limiting competition."[42] The Department indicated since, "so many Arizona dentists participate in the Delta plan, and because Delta patients account for a significant part of the dentists' income, the [MFN clauses]... have led many dentists to stop discounting and severely restricted competing dental plans' ability to attract

and retain enough dentists to serve their members."[43] A consent decree was filed with the U.S. District Court in Phoenix prohibiting Delta from "maintaining, adopting or enforcing a most favored nation provision in its agreements with dentists.[44]

In December of 1994, the DOJ filed another civil antitrust suit and proposed settlement, this time in the U.S. District Court in Washington, D.C. against Vision Service Plan. The Justice Department stated that Vision Service Plan was "reducing discounting and price competition through a contract provision known in the industry as a 'most favored nation' clause, that inhibited doctors from reducing their fees to competing vision care insurance plans and to individual patients."[45] Anne K. Bingaman, speaking on behalf of the Antitrust Division stated, "as a result of the most favored nation clause, vision care insurance plans that had previously contracted with doctors at discounts between 20 and 40% were no longer able to obtain discounts at that level."[46] The Justice Department felt that Vision Service Plan's use of the MFN clause in their provider agreements "facilitated anticompetitive behavior by providing a strong disincentive to optometrists' discounting of fees for vision care services and by impairing entry and competition from competing vision care insurance plans."[47] At the time of the suit, a consent decree was filed with the court requiring the elimination of the MFN clause and preventing Vision Service Plan from limiting future discounting by its participating doctors.

In *United States of America v. Delta Dental of Rhode Island*[48], the DOJ alleged violations of section 1 of the Sherman Act. In this case, the US DOJ found that Delta Dental was engaging in unlawful agreements, which discouraged dentists from offering lower fees to other insurance companies. In a 1994 letter Delta wrote to participating dentists it made "clear to participating dentists that the only way to avoid the risk of lower Delta fees is to refuse to

accept any fees lower than Delta's fee schedule...pursuant to this contractual clause [MFN] Delta dentists are well aware that charging lower fees may result in Delta lowering their reimbursement rate."[49]

Here the court stated that, "the issue presented here is an alleged violation of § 1 of the Sherman Act, which requires a showing of: 1) concerted activity which 2) unreasonably restrains trade."[50] Delta Dental was the largest dental insurer in Rhode Island and fees from dental services provided to Delta enrollees comprised a substantial portion of most dentists' incomes.[51] The Government found evidence to show that "Delta's Prudent Buyer policy adversely affects not just one existing competitor, but numerous existing and potential competitors."[52] They went on to say that the MFN clause "prevents many Rhode Island dentists from participating in lower cost programs"[53] for fear that Delta would reimburse them at a lower rate if they accept lower rates from these other programs. Therefore, the Government argued, "Delta's Prudent Buyer clause has negative impact on all existing and potential competing plans, and ultimately, the consumer."[54] The Court sided with the DOJ and the case was eventually settled via a consent decree.[55]

The FTC also became involved in challenging MFN clauses. RxCare in their reimbursement agreements had a MFN clause which required that "if a pharmacy in the RxCare network accepts a reimbursement rate from any other third party payor that is lower than the RxCare rate, the pharmacy must accept the lower rate for all RxCare care business in which it participates."[56] In the FTC's complaint against RxCare of Tennessee, Inc. it was alleged that RxCare "required pharmacies to agree to the MFN clause in order to participate in its network, that it has enforced the clause, and that it has urged pharmacies to refrain from participating in networks that offer lower reimbursement rates."[57]

Of most concern to the FTC was that RxCare's pharmacy network comprised more than 95% of all chain and independent pharmacies in Tennessee.[58] This market power combined with the MFN clause caused much concern for the FTC because "an MFN clause imposed by a dominant group of competing sellers can establish a price floor and restrict competition that otherwise would allow prices to go below that floor."[59] There was evidence, which showed that the MFN clause had resulted in "managers of pharmacy benefit plans in Tennessee [being] forced to pay higher prices for prescription drugs."[60] RxCare agreed to a proposed consent agreement, which would prohibit it from maintaining or enforcing a MFN clause and would also require them to remove the clause from existing contracts.

In addition to the DOJ's and FTC's criticisms of MFN clauses in the 1990's the courts continued to weigh in on the legality of these clauses. In *Blue Cross Blue Shield of Ohio v. Bingaman*[61], Blue Cross and Blue Shield of Ohio (BCBSO) brought a petition against the United States and Anne K. Bingaman, Assistant Attorney General in charge of the Antirust Division of DOJ, to set aside a investigative demand by DOJ in connection with alleged BCBSO violations of sections 1 and 2 of the Sherman Antitrust Act.

BCBSO had regularly included MFN clauses in their contracts with hospitals. These MFN clauses required "the hospital to give BCBSO the hospital's most favorable rates, i.e. to charge no other insurance company less than it charges BCBSO for the same services."[62] BCBSO in their lawsuit contended that the "Antitrust Division cannot legitimately pursue an investigation of its use of MFN clauses because its use of MFN clauses is indisputably legal under the Sherman Act."[63] In support of its argument, that the use of MFN clauses in their contracts was not a violation of the Sherman Act, BCBSO argued that the "government uses similar clauses in its procurement of goods and services."[64] The court dismissed this argument

because "the Sherman Act does not apply to the federal government."[65] The court in its opinion stated, "while no courts have held that the use of MFN clauses violates the Sherman Act, courts have noted the anticompetitive effects that MFN clauses may have...[these] suggest that in appropriate circumstances, the use of MFN clauses could violate the Sherman Act by restraining competition."[66] The court indicated it could not "find that BCBSO's use of MFN clauses is so clearly legal as to foreclose the government's investigation of that use."[67]

In *Blue Cross & Blue Shield United of Wisconsin v. Marshfield Clinic*, the Seventh Circuit Court of Appeals considered the issue of MFN clauses. In this case, Blue Cross & Blue Shield United of Wisconsin (BCBSW) and its subsidiary Compcare Health Services Insurance Corporation (Compcare) sued Marshfield Clinic and its HMO subsidiary, Security Health Plan of Wisconsin, Inc. (HPW) alleging violations of the Sherman Act §§ 1 & 2. Specifically, BCBSW and Compcare claimed that Marshfield Clinic "has a monopoly which it acquired and has maintained by improper practices that have excluded Compcare from the HMO 'market' in the counties of north central Wisconsin in which the Marshfield Clinic and its HMO subsidiary (Security) operate."[68] BCBSW also claimed that Marshfield, "partly through its own monopoly power and partly by collusion with other providers of medical services, charged supracompetitive prices to patients insured by Blue Cross."[69]

BCBSW was most concerned that the "Clinic [had] colluded with competitors to raise prices, above competitive levels."[70] BCBSW had numerous insureds that lived in north central Wisconsin that received healthcare at the Marshfield Clinic. BCBSW would pay the Clinic directly the portion of the fee that BCBSW had agreed with its enrollees to cover. Here the court found that the Clinic,

> When buying services from the affiliated physicians either directly or through Security, [Marshfield Clinic] would not pay them more than what these

> physicians charge their other patients. This is said to set a floor underneath these physicians' prices, since if they cut prices to their other patients their reimbursement from the Clinic will decline automatically.[71]

The Court here stated that, "'Most favored nations' clauses are standard devices by which buyers try to bargain for low prices, by getting the seller to agree to treat them as favorably as any of their other customers."[72] The court went on to say that, "the Clinic did this to minimize the cost of these physicians to it, and that is the sort of conduct that the antitrust laws seek to encourage, it is not price-fixing."[73]

"Ceiling" Most Favored Nation Clauses

An emerging trend is for payor and provider agreements to include "Ceiling" MFN clauses, which do not guarantee lowest price, but instead guarantee that the payor demanding the MFN is not paying reimbursement above the rates of any other payor. Payors engaging in these contracts appear to believe that they will be subject to less scrutiny because they do not encourage the establishment of price floors, and the auditing process used to determine whether a provider is compliant with the terms of the MFN are typically done through a non-competing third party who does not share actual payor pricing date with the payor enforcing the MFN. Also, there tends to be no retroactive pricing adjustments in Ceiling MFN terms. Traditionally, a payor would be entitled to the contractual remedy of repricing any claims paid to the provider during a period where another payor had a more favorable rate. The Ceiling MFNs appear to be most typically tied to an increase in rates requested by the provider, and the remedy for a violation is generally prospective reversion to the payor's standard rates. Although "Ceiling" MFN clauses have been structured to appear facially legitimate, they are new enough that their actual impact on competition and pricing in specific markets has yet to be established or challenged on antitrust grounds.

State Action

Some states have taken affirmative steps to ban all MFN clauses. Both Washington State and Idaho have established strict laws preventing the use of MFN clauses in health care. Washington prohibits MFN clauses in health care agreements because they, "discourage discounting by the affected seller... facilitate oligopolistic pricing and deter entry by more efficient competitors... [they] are often used as a replacement for innovation or efficiency by large competitors... act as a disincentive for creativity by small competitors... [and] create... potential to thwart... cost containment goals of health care reform."[74] This statute became effective in October of 1995.

Three years later, Idaho signed into law a bill prohibiting managed care organizations from using MFN clauses. The law states that a managed care organization may not require as part of a provider contract that any person agree, "to a requirement that the provider adjust, or enter into negotiations to adjust, his or her charges to the managed care organization if the provider agrees to charge another payor lower rates; or to a requirement that the provider disclose his or her contractual reimbursement rates from other payors."[75]

Conclusion

The key factors that courts and federal officials focus on when evaluating the legality of MFN clauses is the market share that the payor controls. If there is sufficient market share/market power, the impact on competition, consumer choice and pricing will be examined. The Tenth Circuit in *Reazin v. Blue Cross & Blue Shield, Inc.*[76] showed concern that the payor, BCBSK, insured 60% of the entire state's population. The DOJ has also shown concern when the payor controls a large market share and proceeds to require a MFN clause in their contracts, as was evidenced in the Delta Dental case. Market share has also posed

concern for the FTC and was evidenced when they prosecuted Rx Care for their use of a MFN clause when they comprised 95% of the market.[77]

Attorneys counseling health plans and providers need to remain mindful of the applicable antitrust constraints on MFN arrangements and the practical and economic impact of these provisions on their clients.

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[1] Wiggins and Dana, *Enforcement by Antitrust Division Suggests New Attitude Toward Most-Favored National Clauses, at* http://www.wiggin.com/pubs/articles_template.asp?ID=1113218242000 (last visited November 7, 2005).

[2] Federal Trade Commission, *Joint DOJ-FTC Hearings on Healthcare Antitrust: Testimony of Robert M. McNair, Jr. on Most Favored Nation Clauses, at* http://www.ftc.gov/ogc/healthcarehearings/docs/030507mcnair.pdf (last visited November 1, 2005).

[3] Wiggins and Dana, *Enforcement by Antitrust Division Suggests New Attitude Toward Most-Favored National Clauses, at* http://www.wiggin.com/pubs/articles_template.asp?ID=1113218242000 (last visited November 7, 2005).

[4] Anthony J. Dennis, *Potential Anticompetitive Effects of Most Favored Nation Contract Clauses in Managed Care and Health Insurance Contracts*, 4 Ann. Health L. 71, 81-82 (1995).

[5] Federal Trade Commission, *Joint DOJ-FTC Hearings on Healthcare Antitrust: Testimony of Robert M. McNair, Jr. on Most Favored Nation Clauses, at* http://www.ftc.gov/ogc/healthcarehearings/docs/030507mcnair.pdf (last visited November 1, 2005).

[6] Federal Trade Commission, *Joint DOJ-FTC Hearings on Healthcare Antitrust: Testimony of Robert M. McNair, Jr. on Most Favored Nation Clauses, at* http://www.ftc.gov/ogc/healthcarehearings/docs/030507mcnair.pdf (last visited November 1, 2005).

[7] Anthony J. Dennis, *Potential Anticompetitive Effects of Most Favored Nation Contract Clauses in Managed Care and Health Insurance Contracts*, 4 Ann. Health L. 71, 78 (1995).

[8] Mental Health Resources, *A New Strategy for Managed Care, at* http://mentalhealth.about.com/library/weekly/aa051099.htm (last visited November 5, 2005).

[9] Anthony J. Dennis, *Potential Anticompetitive Effects of Most Favored Nation Contract Clauses in Managed Care and Health Insurance Contracts*, 4 Ann. Health L. 71, 80 (1995).

[10] *Id.*

[11] *Id.*

[12] Federal Trade Commission, *Joint DOJ-FTC Hearings on Healthcare Antitrust: Testimony of Robert M. McNair, Jr. on Most Favored Nation Clauses, at* http://www.ftc.gov/ogc/healthcarehearings/docs/030507mcnair.pdf (last visited November 1, 2005).

[13] *Id.*

[14] State of Maine Department of Professional and Financial Regulation Bureau of Insurance, *Prefiled Testimony of David Cluchey, at* http://www.state.me.us/pfr/ins/bcdoc617.htm (last visited November 8, 2005).

[15] 671 F. Supp. 1267 (W.D.W.A. 1987)

[16] *Kitsap v. Washington Dental*, 671 F. Supp. 1267 (W.D.W.A. 1987)

[17] *Id.* at 1268.

[18] *Id.*

[19] *Id.* at 1269.

[20] *Id.*

[21] *Id.*

[22] *Id.* at 1270.

[23] *Id.*

[24] 883 F. 2d 1101 (1st Cir. 1989)

[25] 15 USCS § 2 (2005)-" Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding $ 100,000,000 if a corporation, or, if any other person, $ 1,000,000, or by imprisonment not exceeding 10 years, or by both said punishments, in the discretion of the court."

[26] *Ocean State Physicians Health Plan, Inc., Et al., v. Blue Cross Blue Shield of Rhode Island*, 883 F. 2d 1101, 1103 (1st Cir. 1989).

[27] *Id.* at 1103-04.

[28] *Id.* at 1104.

[29] *Id.*

[30] *Id.*

[31] *Id.* at 1110.

[32] 899 F. 2d 951 (10th Cir. 1990)

[33] 15 USCS § 1 (2005)- "Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is hereby declared to be illegal. Every person who shall make any contract or engage in any combination or conspiracy hereby declared to be illegal shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding $

100,000,000 if a corporation, or, if any other person, $ 1,000,000, or by imprisonment not exceeding 10 years, or by both said punishments, in the discretion of the court."

[34] *Reazin v. Blue Cross & Blue Shield, Inc.*, 635 F. Supp. 1287 (D. K. S. 1986)

[35] *Id.* at 1295.

[36] *Id.* at 1295.

[37] *Reazin v. Blue Cross & Blue Shield, Inc.*, 899 F. Supp. 951, 969 (10th Cir. 1990)

[38] *Id.* at 969.

[39] *Id.* at 970.

[40] *Id.* at 971.

[41] DOJ, *Department of Justice and Arizona State Attorney General Break Up Dental Group's Conspiracy to Eliminate Discounting, at* http://www.usdoj.gov/opa/pr/Pre_96/August94/azdental.txt.html (last visited November 11, 2005).

[42] *Id.*

[43] *Id.*

[44] *Id.*

[45] DOJ, *Justice Department Stops Agreements That Inhibited Vision Care Discounting Nationwide, at* http://www.usdoj.gov/opa/pr/Pre_96/December94/702a.txt.html (last visited November 11, 2005).

[46] *Id.*

[47] *Id.*

[48] 943 F. Supp. 172 (R.I. 1996)

[49] *United States of America v. Delta Dental of Rhode Island*, 943 F. Supp. 172, 175 (R.I. 1996)

[50] *Id.* at 178.

[51] John Miles, Health Care and Antitrust Law, 4 Health Care and Antirust L. Appendix E95 (2005).

[52] *Delta Dental*

[53] *Id.* at 179.

[54] *Id.*

[55] John Miles, Health Care and Antitrust Law, 4 Health Care and Antirust L. Appendix E95 (2005).

[56] Federal Trade Commission, *FTC Challenges 'Most Favored Nation' Clause in Tennessee Pharmacy Network Contract, at* http://www.ftc.gov/opa/1996/01/rxcare.htm (last visited November 12, 2005).

[57] *Id.*

[58] *Id.*

[59] *Id.*

[60] *Id.*

[61] (N.D.O.H 1996)

[62] *Blue Cross Blue Shield of Ohio v. Bingaman, 1996 U.S. District. LEXIS 17091, 2* (N.D.O.H 1996).

[63] *Id.* at 5.

[64] *Id.* at 6.

[65] *Id.* at 7.

[66] *Id.* at 10-11.

[67] *Id.* at 13.

[68] *Blue Cross Blue Shield of Wisconsin v. Marshfield Clinic*, 65 F. 3d 1406, 1408 (7th Cir. 1995).

[69] *Id.*

[70] *Id.* at 1415.

[71] *Id.*

[72] *Id.*

[73] *Id.*

[74] WASH. ADMIN. CODE § 246-25-045 (1995).

[75] 1998 Idaho Sess. Laws S1458.

[76] 899 F. Supp. 951, 969 (10th Cir. 1990)

[77] Federal Trade Commission, *FTC Challenges 'Most Favored Nation' Clause in Tennessee Pharmacy Network Contract, at* http://www.ftc.gov/opa/1996/01/rxcare.htm (last visited November 12, 2005).