ANTITRUST—NONPROFIT HEALTH MAINTENANCE ORGANIZATION PRICING POLICIES AND THE SCOPE OF THE ROBINSON-PATMAN PRICE DISCRIMINATION ACT—*De Modena v. Kaiser Foundation Health Plan*, 743 F.2d 1388 (9th Cir. 1984), *cert. denied*, 105 S. Ct. 1230 (1985).

In recent years, the health services industry has witnessed the growth and increasing public acceptance of the health maintenance organization (HMO).[1] For a monthly premium,[2] the HMO provides its subscribers and their dependent family members with all necessary health care, ranging "from a [tetanus] shot to brain surgery, at little or no additional charge."[3] Unlike traditional health insurance policies, however, the HMO provides the subscriber with direct health services, instead of reimbursements for medical services rendered.[4] The HMO thus incurs the largely open-ended contractual risk of satisfying all of the subscriber's health care needs.[5]

As both an insurer and provider of health care services, the HMO integrates two critical elements of health care into a solitary administrative structure,[6] thus further distinguishing it from the traditional "fee-for-service" system of medical care.[7] Its twofold nature controls rising health care costs by making health

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[1] The HMO concept is not of recent origin. *See* Note, *The Role of Prepaid Group Practice in Relieving the Medical Care Crisis*, 84 HARV. L. REV. 887, 890 (1971). First organized in a small rural health clinic during the 1920's, *id.*, by 1983, over 270 different HMOs served over 11.6 million people throughout the United States. *See* Kleinfeld, *The King of the H.M.O. Mountain*, N. Y. Times, Jul. 31, 1983, § 3, at 1, col. 2.

[2] This fixed monthly fee is actuarially established, much like any insurance premium. *See* Havighurst, *Health Maintenance Organizations and the Market for Health Services*, 35 LAW & CONTEMP. PROBS. 716, 718 (1970).

[3] Friedland, *Health Systems Said to Clash on Cost of Care*, N. Y. Times, Nov. 13, 1983, § 11, at 1, col. 1.

[4] *Id.*

[5] *See* Havighurst, *supra* note 2, at 718 & n. 9.

[6] Kissam, *Health Maintenance Organizations and the Role of Antitrust Law*, 1978 DUKE L.J. 487, 488.

[7] In the traditional fee-for-service method of medical services payment,

> each service is valued by the provider and billed separately. Insurance . . . covers specified incidents of care, and a third party then replaces the utilizer of medical services as payor. While some kinds of insurance place limits on the amounts providers can charge, the prevailing financing system involves individual agreement between the provider of services and the recipient as to the services to be received and the price to be paid.

Note, *supra* note 1, at 891-92.

care services more efficient.[8] In view of these benefits, the Federal Government[9] and a number of state legislatures [10] have enacted statutes specifically designed to facilitate the development of HMOs.

Due primarily to the long and vigorous opposition of organized medicine, it was only recently that the Government began to promote HMOs.[11] In fact, for nearly forty years, organized

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[8] *See generally* Havighurst, *supra* note 2, at 720-22 (advantages of HMOs). Havighurst identifies several other institutional features that enable HMOs to implement efficient management practices in order to control health care costs. *Id.* The fundamental principle encouraging cost control is that the HMO assumes the entire economic risk of a patient's health services because the fee the HMO charges is fixed. *See id.* at 718. For example, the healthier the patient, the less need for future expensive medical procedures to combat catastrophic illnesses. HMOs thus have a strong economic incentive to implement preventive care systems, an incentive lacking in the traditional fee-for-service system. *Id.* at 721. Because the HMO is responsible for all of the patient's medical expenses, it does not have the traditional tendency to provide unnecessary medical services. *Id.* at 720. Equally important, the HMO system encourages physicians and hospitals "to consider cost effectiveness and to avoid overusing expensive [medical] facilities." *Id.* It also allows the physician to spend more time caring for patients and less time dealing with incidental administrative activities such as billing. *Id.* at 721. This administrative structure, coupled with larger market strength, enables the HMO to analyze, select, and bargain for the most economical supplies, including pharmaceuticals. *See id.* An HMO also brings together physicians and health care specialists. *Id.* at 720-21. Because payment to the physician for services rendered is more certain in the HMO system, and because the HMO physician tends to consult with specialists more, the HMO physician has a greater incentive to refer patients to other doctors with more appropriate skills for curing their maladies, thus encouraging the early detection and cure of catastrophic illnesses and thereby reducing overall medical costs. *See id.* at 721-22.

[9] The Federal Health Maintenance Organization Act was proposed by President Nixon on February 18, 1971 as a comprehensive plan to provide the American people with "an alternative means of procuring health care." *Id.* at 716. The plan was approved by Congress and signed by the President on December 29, 1973. Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, 87 Stat. 914 (1982) (codified as amended at 42 U.S.C. §§ 300e to 300e-17). In the Act, Congress provided for over $300 million for the planning and development of HMOs and helped to remove some of the institutional impediments to development, including preempting state laws that were considered obstructive. Stern, *Health Care Expansion: Provisions of the Health Maintenance Organization Act of 1973*, 8 CLEARINGHOUSE REV. 89, 89 (1974). The legislation has not furnished the universal health care for the poor as promised by its promoters. *See* Schneider & Stern, *Health Maintenance Organizations and the Poor: Problems and Prospects*, 70 NW. U. L. REV. 90, 105 (1975); Rose-Ackerman, *Social Services and the Market*, 83 COLUM. L. REV. 1405, 1426-28 (1983).

[10] *See, e.g.*, N.J. STAT. ANN. §§ 26:2J-1 to -30 (West Cum. Supp. 1985-1986)(New Jersey's Health Maintenance Act, which was enacted two days before the Federal law became effective); CAL. HEALTH & SAFETY CODE § 437.03 (West Cum. Supp. 1986)(HMO defined for state health planning purposes); FLA. STAT. ANN. §§ 641.17-.39 (West Cum. Supp. 1985).

[11] *See* Kissam, *supra* note 6, at 492-93. Initially, organized medicine condemned

medicine, through political influence and control of the Government's regulation of the health care industry, effectively prevented the expansion of HMOs.[12] Despite this formidable opposition, the proponents of HMOs have successfully relied upon the Federal antitrust laws for protection.[13]

Recently, in *De Modena v. Kaiser Foundation Health Plan*,[14] the Ninth Circuit considered whether HMOs violate the Federal antitrust laws. Specifically, it examined the drug purchasing activities of nonprofit HMOs in light of the strict anti-price discrimination provisions of the Robinson-Patman Price Discrimination Act.[15] The court held that the purchasing activities of nonprofit HMOs were exempt from the Robinson-Patman Act by virtue of the Nonprofit Institutions Act of 1938.[16]

As of 1983, the defendant in *De Modena*, the Kaiser-Permanente Medical Care Program (Kaiser Program), was the largest HMO in the United States.[17] It consisted of three ele-

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HMOs as a form of "unethical medical practice." *Id.* at 492. In its view, the HMO system violated the long-standing public policy against the corporate practice of medicine by interposing impersonal clinical relationships between patients and doctors. *See id.* at 492-93.

[12] *See id.* at 495-99. Organized medicine historically utilized state legislatures as a tool to prevent HMO development. *Id.* at 495. Some of the tactics employed included requiring medical licensing boards to negate professional certification of physicians affiliated with HMOs on the ground that HMO practice was "unethical" and employing state insurance laws to prevent HMO development. *See id.* at 495-99.

[13] *See, e.g.*, American Medical Ass'n v. United States, 317 U.S. 519 (1942). In *American Medical*, the Supreme Court held that the American Medical Association (AMA) was not exempt from the provisions of § 3 of the Sherman Act, which prohibits the restraint of trade or commerce. *Id.* at 528-29. The Court stated, therefore, that the AMA could be held liable and criminally responsible for participation in an illegal, anticompetitive scheme against a prepaid group practice, a forerunner of today's HMO. *See id.* at 532. The Supreme Court found this anticompetitive behavior to include the exclusion of HMOs and their physicians from medical societies and hospital medical staffs, the refusal of fee-for-service physicians to consult with or accept referrals from HMO physicians, and the spreading of false information about HMOs designed to discourage patients from using their services. *Id.; see also* Kissam, *supra* note 6, at 493-95 (discussing trade restraint practices employed by fee-for-service physicians).

[14] 743 F.2d 1388 (9th Cir. 1984), *cert. denied*, 105 S. Ct. 1230 (1985).

[15] *Id.* at 1390. The Robinson-Patman Price Discrimination Act is discussed *infra* at notes 54-61 and accompanying text.

[16] *De Modena*, 743 F.2d at 1396. For a general discussion of the Nonprofit Institutions Act, see *infra* notes 62-67 and accompanying text.

[17] Kleinfeld, *supra* note 1, at 1. In 1983, the Kaiser Program had over 4.3 million members in 10 states and the District of Columbia. *Id.* at 1, 23. This accounted for over 36 % of the nation's entire HMO membership. *Id.* Its revenues in 1982 totaled $2.44 billion. *Id.* at 23. Its market penetration was such that in northern

ments.[18] The regional Kaiser Health Plans, which were organized as nonprofit institutions, formed the first component of the Kaiser Program.[19] Their function was to enroll consumers who wished to become members of the HMO.[20] The second part was composed of eight corporate, regional Permanente Medical Groups, consisting of doctors who contracted with the Kaiser Program to render medical care to subscribing members.[21] The Kaiser Foundation Hospitals, a nonprofit corporation of California, constituted the final segment of the Kaiser Program.[22] This entity operated the various hospitals that provided HMO members with extensive health care services.[23]

In addition to prepaid medical care, the Kaiser Health Plans offered their members an elective drug plan.[24] For an extra fee, participants could obtain pharmaceuticals at little or no charge.[25] The drug plan participant, however, could only obtain drugs from either a Kaiser hospital pharmacy or a nonhospital pharmacy operated by a Kaiser Health Plan.[26]

Several retail pharmacies located in Oregon and California, as well as their trade association, filed suit against the Kaiser Program.[27] They claimed that the Kaiser Program knowingly induced or received discriminatorily low prices from pharmaceutical suppliers in violation of section 2(f) of the Robinson-Patman Price Discrimination Act.[28]

California, one of four people was enrolled in the Kaiser Program. *Id.* Membership is expected to grow at a rate of 5 % per year. *See id.* at 1.

18 *De Modena*, 743 F.2d at 1390.

19 *Id.* at 1391.

20 *Id.* at 1390.

21 *See id.* at 1390, 1391.

22 *Id.* at 1390. The Kaiser Foundation Hospitals also controlled one of the Permanente Medical Groups. *Id.*

23 *See id.*

24 *Id.*

25 *Id.*

26 *Id.*

27 *Id.* The Portland Retail Druggists Association, the trade association, filed a separate action against the Kaiser Health Plans that was joined to the complaints brought by the individual pharmacies. *See* Portland Retail Druggists Ass'n v. Kaiser Found. Health Plan, 662 F.2d 641, 643 (9th Cir. 1981).

28 *De Modena*, 743 F.2d at 1390. The Robinson-Patman Price Discrimination Act provided in part: "It shall be unlawful for any person engaged in commerce, in the course of such commerce, knowingly to induce or receive a discrimination in price which is prohibited by this section." 15 U.S.C. § 13(f)(1976).

The pharmacies also alleged that the Kaiser Program, by offering the drug plan, "attempt[ed] to monopolize the retail drug market in violation of . . . the Sherman Act," and that it created an unlawful tying arrangement of drug sales to other health services in violation of the Clayton Act. *De Modena*, 743 F.2d at 1390.

The district court granted the Kaiser Program's motion for summary judgment on the basis that the defendant was a charitable, nonprofit institution.[29] The court determined that the Nonprofit Institutions Act exempted the purchasing activities of nonprofit institutions from the strict anti-price discrimination provisions of the Robinson-Patman Act.[30] The Ninth Circuit agreed and affirmed the district court's decision.[31] The circuit court held that nearly all of the Kaiser Program's activities associated with the drug plan were within the express exemption to the Robinson-Patman Price Discrimination Act.[32]

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29 *See De Modena*, 743 F.2d at 1390.

30 *Id.* In addition, the district court found that the pharmacies failed to show sufficient causal connections to sustain the burden of pursuasion both on the attempted monopolization claim and the tying claim. Portland Retail Druggists Ass'n v. Kaiser Found. Health Plan, 662 F.2d 641, 645 (9th Cir. 1981); *see supra* note 28.

31 *De Modena*, 743 F.2d at 1396. The *De Modena* decision marked the second time the Ninth Circuit considered the district court's decision to grant the Kaiser Program's motion for summary judgment on the pharmacies' Robinson-Patman Act claim. *Id.* at 1390 n. 2. In its first decision, the appellate court concluded that the district court had prematurely granted the Kaiser Program's motion for summary judgment. Portland Retail Druggists Ass'n v. Kaiser Found. Health Plan, 662 F.2d 641, 646 (9th Cir. 1981). The court reasoned that the district court did not provide sufficient time to the pharmacies within which to challenge the Kaiser Program's affirmative defense that its purchasing activities were exempt from the Robinson-Patman Act. *Id.* In addition, the court remanded the case to the district court to consider the alternative defense that by offering its drug plan, the Kaiser Program was engaged in the "business of insurance" within the meaning of the McCarran-Ferguson Act. *Id.* at 647. The court concluded that this defense had to be reexamined in light of the United States Supreme Court's intervening decision in Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205 (1979). *Portland Retail Druggists*, 662 F.2d at 646-47.

The McCarran-Ferguson Act states:

> (a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.
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> (b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: Provided, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance *to the extent that such business is not regulated by State Law.*

15 U.S.C. § 1012 (1982) (emphasis added). In *Group Life*, the Supreme Court found that a drug plan offered by a health insurance company, similar in form and operation to that offered by the Kaiser Program, was not within the "business of insurance" exception of the McCarran-Ferguson Act, and that therefore the insurer was not exempt from the Federal antitrust laws. *Group Life*, 440 U.S. at 232-33.

32 *De Modena*, 743 F.2d at 1396. The court reversed the district court's finding

The underlying principle of the American economic system is faith in free enterprise with minimal governmental interference.[33] Even the most ardent free market advocates realize, however, that the market can be abused by the concentration of economic power.[34] Nevertheless, the concentration of economic power by itself is not an economic evil.[35] Free market micro-economic theory[36] has long supposed that by employing the economies of scale,[37] larger economic entities may actually reduce unit costs and thereby benefit consumers with lower competitive prices.[38] Over the long run for the overall economy, however,

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that drug sales to nonparticipating customers were de minimis, however, and remanded the issue to the district court. *Id.*

33 *See* Standard Oil Co. v. Federal Trade Comm'n, 340 U.S. 231, 248 (1951) (Justice Burton stating that "[t]he heart of our national economic policy long has been faith in the value of competition"). *See generally* McAllister, *Price Control by Law in the United States: A Survey*, 4 LAW & CONTEMP. PROBS. 273, 285 (1937)("[T]he basic faith in . . . anti-trust legislation was a faith in the automatism of free competition.").

34 Adam Smith, the eighteenth century economist who had an unquestioned faith in the ability of the market to take care of society's needs if it was left alone free of governmental interference, *see* R. HEILBRONER, THE WORLDLY PHILOSOPHERS 66 (4th ed. 1972), and the staunchest opponent of government regulation of the economic market place, conceded that monopolies and conspiracies designed to control markets were economic evils, which necessitated an exception to his laissez faire attitude to government intervention in the markets. *See* A. SMITH, THE WEALTH OF NATIONS 232 (1776, reprint 1982); *see also* R. HEILBRONER, *supra*, at 67-68.

35 This is because larger economic entities may be more efficient than smaller ones, thereby reducing long run costs. *See* R. LEFTWICH, THE PRICE SYSTEM AND RESOURCE ALLOCATION 417 (7th ed. 1979).

36 *See id.* at 11.

> Microeconomic theory is concerned with the economic activities of such individual economic units as consumers, resource owners, and business firms. It is concerned with the flow of goods and services from business firms to consumers, the composition of the flow, and the evaluation of pricing of the component parts of the flow.

Id.

37 "Economies of scale" refers to the economic phenomenon that the larger the plant, the lower the unit costs become. *See* Jefferson County Pharmaceutical Ass'n v. Abbott Laboratories, 460 U.S. 150, 158 n.17 (1983). This occurs because of inherent improvements in the efficiencies of operation on a larger scale and increased productivity that allow a producer to reduce costs. *See id.* These reduced costs, in turn, can be passed on to consumers in the form of lower prices. *Id.* As Justice Powell stated, "[v]olume purchasing permits any large, relatively efficient, retail organization to pass on cost savings to consumers, and, to that extent, consumers benefit merely from *economy of scale*." *Id.* (emphasis added).

38 *See* R. LEFTWICH, *supra* note 35, at 471 (economies of size defined as "the forces causing a firm's long run average costs to decrease as the output level and size of the plant are increased. These are usually thought to be (1) increasing possibilities of division and specialization of labor and (2) increasing possibilities of using more efficient technology").

the growth of larger economic entities can cause a competitive "shake-out," which reduces the number of competing firms in an industry.[39] This occurs when larger, established producers gain control of the market and thus acquire the ability to manipulate prices.[40]

The price manipulator not only gains from monopolistic profits, but acquires the power to undercut his competitors' prices.[41] Competitors are forced either to meet the manipulator's price, or to go out of business, thereby reducing competition and strengthening monopolistic power.[42] Price manipulation thus is the economic evil that Congress sought to regulate by enacting the Federal antitrust laws, the purpose of which was "to buttress the traditional system of free competition, free markets and free enterprise."[43]

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39 *See generally* R. LEFTWICH, *supra* note 35, at 316-17 (discussing long run industry "shake-outs" as a result of competitive forces). "Shake-outs" can best be explained by imperfections in the free market system. *See id.* at 316. Artificial barriers to the entry of new firms can allow the dominant producers to control the pricing system. *Id.* "[L]imit pricing policies of established firms may be used to bar the door [to entry into an industry]. Established firms may deliberately produce outputs [of products] greater than those that maximize profits, lowering price sufficiently so that it is not profitable for a potential newcomer to enter." *Id.* at 317 (footnote omitted).

40 *See, e.g.*, Standard Oil Co. v. United States, 221 U.S. 1, 32-43 (1911)(classic description of monopolistic activities of large economic entities). By offering preferential rates and rebates, Standard Oil was able to drive out many of its competitors from the petroleum business or to coerce them into joining with it in a conspiracy to control the market for petroleum products. *Id.* at 32-33. The Court found that Standard Oil had controlled over 90% of the petroleum business and was able to fix the price of all petroleum products and otherwise restrain trade. *Id.* at 33.

Some of the adverse consequences of monopolistic activity identified by economic theoreticians include: (1) generally higher consumer prices; (2) the misallocation of societal resources; (3) reduced output; (4) the loss of overall societal resources; and (5) the inefficient operation of plants. *See* E. MANSFIELD, MICROECONOMICS: THEORY AND APPLICATIONS 238-41 (3d ed. 1979); R. LEFTWICH, *supra* note 35, at 277-79.

41 *See supra* note 40.

42 *See id.*

43 *See* Tigner v. Texas, 310 U.S. 141, 145 (1940). In United States v. Topco Assocs., 405 U.S. 596 (1972), the Court stated:

> Antitrust laws . . . are the Magna Carta of free enterprise. They are as important to the preservation of economic freedom and our free-enterprise system as the Bill of Rights is to the protection of our fundamental personal freedoms. And the freedom guaranteed each and every business, no matter how small, is the freedom to compete—to assert with vigor, imagination, devotion, and ingenuity whatever economic muscle it can muster.

Id. at 610.

The first Federal antitrust laws enacted did not expressly regulate anticompetitive pricing practices.[44] Nevertheless, price manipulation and local price cutting were soon recognized as the customary symptoms of anticompetitive behavior, necessitating Federal regulation.[45] Consequently, Congress enacted section 2 of the Clayton Act in 1914, which made price discrimination in commerce unlawful if it lessened competition or created a monopoly.[46]

Although this section[47] was expected to have a strong deterrent effect on price discrimination, the inclusion of a proviso that permitted quantity discounts without regard to actual cost savings[48] negated the Act's desired effect.[49] Small businesses were unable to exact quantity discounts from suppliers and thus were prevented from competing with large national firms. These larger firms possessed the economic might to bargain for lower prices from their suppliers and then pass on the lower prices to their customers.[50] As a result, many small businesses closed, thereby reducing the number of competitors in the industry and

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[44] *See* Sherman Act, ch. 647, 26 Stat. 209 (1890)(codified as amended at 15 U.S.C. §§ 1-7 (1982)).

[45] *See* McAllister, *supra* note 33, at 285. One commentator stated that subsequent legislation was enacted by Congress after the Sherman Act because of the following reasons:

> It was believed that certain practices were so generally the tools of incipient monopoly that the proscription of those practices would halt the fruition of monopoly and restraint of trade. It was believed that government would act more effectively if it could step in and check certain practices than if it must wait until its only recourse was to seek to dissolve the trust at the height of its power. It is in this connection that the prohibition against the discriminatory price first made its appearance in federal anti-trust law in Section 2 of the Clayton Act. It was designed to check the elimination of a competitor by local price cutting.

Id.

[46] Clayton Act, ch. 323, § 2, 38 Stat. 730, 730-31 (current version at 15 U.S.C. § 13 (1982)).

[47] *See id.* Section 2 of the Act stated "[t]hat nothing herein contained shall prevent discrimination in price . . . on account of differences in the grade, quality, or *quantity* of the commodity sold, or that makes only due allowance for difference in the cost of selling or transportation." *Id.* (emphasis added).

[48] *See id.*; Federal Trade Comm'n v. Morton Salt Co., 334 U.S. 37, 43 (1948). The Supreme Court stated that the "section has been construed as permitting quantity discounts . . . without regard to the amount of the seller's actual savings in cost attributable to quantity sales or quantity deliveries." *Id.* (citation omitted).

[49] *See* Federal Trade Comm'n v. Morton Salt Co., 334 U.S. 37, 43 (1948)(quantity discount provision of Clayton Act rendered Act inadequate); *see also* Rosoff & Dunfee, *A "Fix" for the Retail Pharmacy: The Supreme Court Redefines Application of the Robinson-Patman Act to Drug Sales by Nonprofit Hospitals*, 13 CAL. W.L. REV. 195, 243 (1977)(quantity discounts negatively affect competition).

[50] *See* Rosoff & Dunfee, *supra* note 49, at 243.

ultimately harming free markets.[51]

With the occurrence of the Great Depression and the continuing decline in economic activity in the 1930's, public sentiment prompted Congress to strengthen the ineffective protections of section 2 of the Clayton Act.[52] Congress was expressly concerned with limiting the Clayton Act's quantity discount defense to actual cost differences.[53] Thus, in 1936, Congress passed the Robinson-Patman Price Discrimination Act.[54] This Act amended and strengthened the Clayton Act provisions.[55] Unlike the Clayton Act, the Robinson-Patman Act prohibited all price discrimination,[56] except when justified by cost savings.[57] Moreover, if the complainant demonstrated price discrimination, the Robinson-Patman Act shifted the burden to the defendant, who then had to justify the price discrimination within the constraints of the Act.[58] Finally, the Robinson-Patman Act imposed liability upon buyers who knowingly engaged in illegal price discrimination.[59] Violators of the Act were subjected to criminal penalties,[60] as well as

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51 *See* Federal Trade Comm'n v. Anheuser-Busch, Inc., 363 U.S. 536, 543-44 (1960) (description of Congressional concern at time of enactment of Robinson-Patman Price Discrimination Act); *see also* Bacco, *Depression Tale: Putting the Chain Stores in a Cage*, Wall St. J., Mar. 5, 1985, at 30, col. 3 (public protests by small businessmen in the 1930's sought passage of Federal and state laws to protect them against competition from large chain stores).

52 *See* Bacco, *supra* note 51, at 30.

53 Federal Trade Comm'n v. Morton Salt Co., 334 U.S. 37, 43-44 (1948)(discussing Congressional purpose "to limit 'the use of quantity price differentials to . . . actual cost differences' " to protect against competitive oppression)(citations omitted).

54 Ch. 592, 49 Stat. 1526 (1936)(codified as amended at 15 U.S.C. §§ 13-13b, 21a (1982)).

55 *See* Federal Trade Comm'n v. Anheuser-Busch, Inc., 363 U.S. 535, 544 (1960).

56 *See* Robinson-Patman Price Discrimination Act, ch. 592, § 2(c)-(f), 49 Stat. 1526, 1527 (1936)(current version at 15 U.S.C. § 13(c)-(f)(1982)). The Robinson-Patman Act defined price discrimination as including not only actual price differentials, but also ancillary favors—such as paying commissions in connection with the sale of goods, paying for facilities or services at prices different than those charged to other purchasers in connection with the sale of goods, or rendering services in connection with the sale of goods on terms different from all other purchasers. *See id.*

57 *See id.* § 2(a)-(b), 49 Stat. at 1526 (current version at 15 U.S.C. § 13(a)-(b)(1982)). Cost savings refer both to quantity and transportation discounts. *See id.*; *see also* Standard Oil Co. v. Federal Trade Comm'n, 340 U.S. 231, 250 (1951)(description of reasons for quantity discount defense).

58 Robinson-Patman Price Discrimination Act, ch. 592, § 2(b), 49 Stat. 1526, 1526 (1936)(current version at 15 U.S.C. § 13(b)(1982)).

59 *Id.* § 2(f), 49 Stat. at 1527 (current version at 15 U.S.C. 13(f)(1982)); *see supra* note 28 (setting forth text of § 13(f)).

60 *Id.* § 3, 49 Stat. at 1528 (current version at 15 U.S.C. § 13a (1982)). This sec-

the traditional treble damages afforded by civil antitrust remedies.[61]

Shortly after its enactment, the deficiencies of the Robinson-Patman Price Discrimination Act became evident. In particular, nonprofit institutions were adversely affected by the stringent anti-price discrimination provisions of the Act.[62] Historically, nonprofit institutions, such as hospitals, educational facilities, and other chartiable agencies, were routinely granted price breaks unavailable to other customers.[63] The Robinson-Patman Act, however, appeared to prohibit such price concessions to nonprofit institutions.[64] Congress responded to this dilemma by enacting the Nonprofit Institutions Act of 1938.[65] This Act exempted supply purchases by nonprofit institutions from the Robinson-Patman Act.[66] It permitted the exemption only to the extent that the purchased supplies were for the nonprofit institutions' own use.[67]

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tion states: "Any person violating any of the provisions of this section, shall, upon conviction thereof, be fined not more than $5,000 or imprisoned not more than one year, or both." *Id.*

61 *See* Clayton Act § 4, 15 U.S.C. § 15(a)(1982). This section states: "[A]ny person who shall be injured . . . shall recover threefold the damages by him sustained." *Id.*

62 *See generally* Abbott Laboratories v. Portland Retail Druggists Ass'n, 425 U.S. 1, 12 (1976) ("[T]he legislative history of the Nonprofit Institutions Act indicates clearly that that Act was concerned with the suspicion that Robinson-Patman, at the time just recently enacted, actually might operate to outlaw price favors that sellers would wish to grant to eleemosynary institutions.")(citations omitted).

63 *See* H.R. REP. No. 2161, 75th Cong., 3d Sess. 1 (1938) (letter by John H. Hayes, President of the Hospital Bureau of Standards and Supplies, dated Dec. 18, 1937).

64 *See id.* at 1.

65 Ch. 283, 52 Stat. 446 (codified at 15 U.S.C. § 13c (1982)).

66 *Id.* This Act stated: "Nothing in . . . the Robinson-Patman Antidiscrimination Act . . . shall apply to purchases of their supplies for their own use by schools, colleges, universities, public libraries, churches, hospitals, and charitable institutions not operated for profit." *Id.*

67 *Id.* An organization may qualify as a nonprofit institution under the Act, but its sales may not qualify for the exemption. *See* 3 E. KINTNER & J. BAUER, FEDERAL ANTITRUST LAW § 25.9 (1983). In Students Book Co. v. Washington Law Book Co., 232 F.2d 49 (D.C. Cir. 1955), *cert. denied*, 350 U.S. 988 (1956), the court dismissed a claim by a self-sustaining university bookstore for the exemption. *Id.* at 50 & n.5, 51. Although some of the purchases by the bookstore were found to be for the university's own use, the court found that the bookstore was actually reselling the books at a profit. *Id.* at 50 n.5. The court concluded that such resale activities did not fall within the provisions of the exemption. *Id.*

In contrast, the Ninth Circuit upheld the exemption as it applied to the sale of bowling lanes to a state university athletic facility. Logan Lanes, Inc. v. Brunswick Corp., 378 F.2d 212, 217 (9th Cir.), *cert. denied*, 389 U.S. 898 (1967). The court concluded that the term "supplies" expressed in the Act's exemption meant "any-

Few recorded cases have construed the exemption provided by the Nonprofit Institutions Act.[68] In the context of health care services, only one case, *Abbott Laboratories v. Portland Retail Druggists Association*,[69] has addressed the scope of the Act's exemption. In *Abbott Laboratories*, the pricing policies of several retail pharmaceutical companies were challenged by an association of retail pharmacies.[70] The pharmacies alleged that local hospitals were purchasing drugs at prices that were lower than those being offered to the pharmacies in violation of the Robinson-Patman Act.[71] In construing the exemption to this Act contained in the Nonprofit Institutions Act, the Supreme Court concluded that it was limited to certain sales made by pharmaceutical companies to nonprofit hospital pharmacies.[72] The Court expanded a sales categorization scheme earlier formulated by the appellate court.[73] The *Abbott Laboratories* Court classified ten categories of sales into two groups[74]—those eligible for the exemption and

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thing required to meet the institution's needs." *Id.* at 216. This included both consumable items and permanent material installations. *Id.* Although the bowling facility was available and open to the public for a fee, *id.* at 214, the court concluded that the supply purchases were nevertheless exempted from the Robinson-Patman Act because its "primary purpose . . . was to fulfill the needs of the University in providing bowling facilities for its students, faculty and staff." *Id.* at 217. For a discussion of the *Logan Lanes* and *Students Book* decisions, see generally Note, *The Proper Scope of the Non-Profit Institutions Exemption:* Abbott Laboratories v. Portland Retail Druggists Association, 31 Sw. L.J. 606, 609 (1977).

68 Rosoff & Dunfee, *supra* note 49, at 200.

69 425 U.S. 1 (1976).

70 *See id.* at 1. The plaintiff pharmacy association in *Abbott Laboratories*, the Portland Retail Druggists Association, was a party to the *De Modena* case. *See De Modena*, 743 F.2d at 1388.

71 *Abbott Laboratories*, 425 U.S. at 5.

72 *See id.* at 14.

73 *Id.* at 8; *see* Portland Retail Druggists Ass'n v. Abbott Laboratories, 510 F.2d 486, 489 (9th Cir. 1974) (appellate court's enumeration of sales categorization scheme), *vacated*, 425 U.S. 1 (1976).

74 *Abbott Laboratories*, 425 U.S. at 9. The 10 categories included the following:

1. To the inpatient for use in his treatment at the hospital. For present purposes, we define an inpatient as one admitted to the hospital for at least overnight bed occupancy.
2. To the patient admitted to the hospital's emergency facility for use in the patient's treatment there. A patient in this category may or may not become an inpatient, as defined in the preceding paragraph.
3. To the outpatient for personal use on the hospital premises. For present purposes, we define an outpatient as one (other than an inpatient or a patient admitted to the emergency facility) who receives treatment or consultation on the premises.
4. To the inpatient, or to the emergency facility patient, upon his discharge and for his personal use away from the premises.
5. To the outpatient for personal use away from the premises.

those ineligible.[75] In the Court's view, a hospital drug purchase qualified for the exemption if it was for the hospital's own use.[76]

This ten-part categorization scheme, according to the Court, was the "definitive construction of [the] language in the Nonprofit Institutions Act."[77] The Act, the Court stated, did not provide an exemption for every activity undertaken by a nonprofit institution.[78] Instead, the Court held that an activity qualified for the exemption only if it was within the basic institutional purpose of the nonprofit agency.[79] The Court stated that certain activities, such as *dispensing* drugs to inpatients, emergency room patients, and even outpatients while on hospital premises, may properly be considered "traditional" hospital activities within the scope of the exemption provided by the Act.[80] The Court found that hospital pharmaceutical sales to walk-in customers were not protected by the Act, however.[81]

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6. To the former patient, by way of a renewal of a prescription given when he was an inpatient, an emergency facility patient, or an outpatient.

7. To the hospital's employee or student for personal use or for the use of his dependent.

8. To the physician who is a member of the hospital's staff, but who is not its employee, for personal use or for the use of his dependent.

9. To the physician, who is a member of the hospital's staff, for dispensation in the course of the physician's private practice away from the hospital.

10. To the walk-in customer who is not a patient of the hospital.

Id. at 9-10 (footnotes omitted). The Supreme Court qualified its categorization scheme by noting that it was not meant to be "exhaustive." *Id.* at 10 n.8.

75 *Id.* at 14-19.

76 *Id.* at 14.

77 *See id.* at 6.

78 *Id.* at 14. Justice Blackmun, writing for the majority, recognized the legal "line-drawing" undertaken by the Court. *Id.* at 10. He noted, however, that the test as to whether a particular purchase qualified for the exemption was an "obvious one," *id.* at 14, determined solely upon whether the hospital could properly be considered the consumer of the drug. *See id.* at 10-12.

The Court noted that the role of the nonprofit hospital had broadened dramatically since the passage of the Nonprofit Institutions Act—from an institution serving the sick and the poor to a modern community health center. *Id.* at 13. The expansion of the nonprofit hospital, the Court opined, did not, however, justify an automatic extension of the exemption to every new responsibility assumed by a nonprofit hospital. *Id.* The Court held that purchases that "promote[d] the hospital's intended institutional operation" qualified for the Act's exemption. *Id.* at 14.

79 *Id.*

80 *Id.* at 10-11.

81 *Id.* at 18. The Court observed, however, that certain infrequent emergency sales to walk-in customers when other pharmacies are closed may prove to be de minimis and too infrequent to cause noticeable injury. *Id.*; *see also infra* notes 114-116 and accompanying text (discussing *De Modena's* reasoning of same issue).

In applying this newly articulated "basic institutional purpose" test, the *Abbott Laboratories* Court concluded that *sales* to patients who received treatment on hospital premises were also within the scope of the exemption.[82] The Court opined that if the patient were merely returning to the hospital to refill a prescription, however, the exemption would be inapplicable.[83] Similarly, the Court applied the exemption to drug sales to hospital employees, students, or physicians for their own use or for their dependents' use, but not for resale by the hospital staff in their medical practice.[84] The Court reasoned that sales to hospital employees were exempt because they constituted fringe benefits necessary to satisfy collective bargaining provisions, which in turn served the institutional purpose of the hospital.[85]

For the Ninth Circuit in *De Modena*, the Supreme Court's *Abbott Laboratories* decision was the only relevant precedent.[86] Judge Norris, writing for a unanimous court, first considered the three elements comprising the Nonprofit Institutions Act's exemption.[87] To be eligible for the exemption, the court stated that the Kaiser Program had to show that it was a nonprofit institution, that it was an eligible institution under the Act, and that the drugs were purchased for its "own use."[88]

The court approached the first statutory element by recognizing that both the Kaiser Health Plans and the Kaiser Foundation Hospitals were organized as nonprofit institutions.[89] Judge Norris rejected the pharmacies' contention that because the Kaiser Health Plans and the Kaiser Foundation Hospitals were controlled by the for-profit Permanente Medical Groups, they had

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82 *Abbott Laboratories*, 425 U.S. at 14-15.

83 *Id.* at 15.

84 *Id.* at 16-17.

85 *See id.* at 16 & n.9. The Court argued that the fringe benefits were necessary to retain employees for long-time assignments in order to maintain high quality health care. *Id.* For a comparison of the positions taken by the trial court, the Ninth Circuit Court of Appeals, and the United States Supreme Court in *Abbott Laboratories*, see Rosoff & Dunfee, *supra* note 49, at 209-17. The trial court adopted a de minimis test approach—if resales were insignificant so as not to cause injury, the plaintiff could not recover. *Abbott Laboratories*, 425 U.S. at 7. The Ninth Circuit adopted an approach that focused upon where the sale was made—a simple geographic proximity test. *Id.* at 7-8. The Supreme Court rejected both views and held in favor of an elaborate examination of the institutional nature of the sales by the hospital. *Id.* at 8-10; *see supra* note 74 and accompanying text.

86 *De Modena*, 743 F.2d at 1392.

87 *Id.* at 1391.

88 *Id.*

89 *Id.*

lost their nonprofit status.[90] Rather, he agreed with the findings of the Internal Revenue Service and the district court that, because the for-profit Permanente Medical Groups did not exert control over the Kaiser Health Plans or the Kaiser Foundation Hospitals, these entities had retained their nonprofit status.[91] Although the Kaiser Health Plans and the Kaiser Foundation Hospitals contracted with the Permanente Medical Groups' doctors for the delivery of certain medical services, the court observed that the doctors did not set their own fees.[92] Judge Norris noted that the Permanente Medical Groups instead were paid an agreed amount by the Kaiser Health Plans for each member, regardless of the particular services provided by the doctors to each member.[93]

The court next addressed the eligibility of both the Kaiser Foundation Hospitals and the Kaiser Health Plans under the Nonprofit Institutions Act.[94] Because hospitals are expressly eligible under this Act, the court held that the Kaiser Foundation Hospitals were exempt from the Robinson-Patman Act.[95] The court also held that the Kaiser Health Plans were exempt from the Robinson-Patman Act.[96] The court reasoned that although they were not expressly included within the language of the Nonprofit Institutions Act, they nevertheless fell within the Congressionally intended scope of that Act's exemption provisions.[97] The court recognized that the drafters of the Nonprofit Institutions Act, in explicitly exempting "charitable institutions,"[98] sought "to protect the same eleemosynary institutions that are given special consideration under the tax and charitable trust laws."[99] Lending support to its conclusion, the court noted that since the passage of the Act in 1936, the nature and responsibilities of charitable institutions have expanded dramatically, to the extent that today all nonprofit organizations delivering health services are considered charitable.[100] The court was also per-

90 *Id.*
91 *Id.*
92 *Id.*
93 *Id.*
94 *Id.*
95 *Id.*
96 *Id.* at 1392.
97 *Id.* at 1391-92.
98 *See supra* note 66 (setting forth applicability of the Act to charitable institutions).
99 *De Modena*, 743 F.2d at 1391 (citations omitted).
100 *Id.* at 1391-92 (citations omitted).

suaded by the rulings of other courts that had deemed the Kaiser Health Plans charitable institutions for tax purposes.[101]

Judge Norris lastly addressed whether the pharmaceutical purchases made by the Kaiser Health Plans and the Kaiser Foundation Hospitals were "for their own use" within the meaning of the Nonprofit Institutions Act.[102] The court acknowledged that the categorical rules test established by the Supreme Court's decision in *Abbott Laboratories* was its only relevant precedent.[103] In discussing that decision, however, the court concluded that it could not literally apply the categorical rules test to the circumstances presented by the Kaiser Health Plans' practices.[104] The court thus stated that *Abbott Laboratories* stood for the proposition that the overriding determinative factor for defining "own use" was the "basic institutional function" of the nonprofit entity claiming the Act's exemption.[105]

In applying this test, the circuit court stated that an HMO has an extraordinarily "broad institutional function" designed "to provide a complete panoply of health care to [its] members."[106] The court reasoned that, unlike fee-for-service hospitals, which provide temporary and usually remedial health care to their patients, the HMOs provide "continuing and often preventive health care for their members."[107] Therefore, the Ninth Circuit held that drugs purchased by the Kaiser Health Plans for resale to its members were within its "basic institutional function," and as such they were purchased "for their own use" within the meaning of the Nonprofit Institutions Act.[108]

The *De Modena* court believed that its holding fell firmly within "the primary Congressional purpose of the exemption to the Robinson-Patman Act, which is to aid nonprofit institutions

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101 *Id.* at 1392; *see, e.g.*, Sound Health Ass'n v. Commissioner, 71 T.C. 158, 177-81 (1978)(HMO is nonprofit institution for tax purposes).

102 *De Modena*, 743 F.2d at 1392.

103 *Id.*; *see supra* notes 70-85 and accompanying text (discussing *Abbott Laboratories* decision).

104 *De Modena*, 743 F.2d at 1393; *see supra* notes 74-75 and accompanying text (discussing categorical rules test).

105 *De Modena*, 743 F.2d at 1393.

106 *Id.*

107 *Id.* The court clearly distinguished between the purchases by a hospital and those by an HMO. *See id.* The distinguishing feature, the court stated, is that "the relationship between the HMO and its members is ongoing, not temporary," while the relationship between a hospital and its patient terminates when the patient is discharged from the hospital. *Id.* at 1393 n.7 (citation omitted); *see also supra* notes 1-9 and accompanying text (general description of HMO services).

108 *De Modena*, 743 F.2d at 1394.

by lowering their operating expenses."[109] The court also maintained that its decision was in accordance "with national health care policy."[110] The court observed that in 1976 Congress passed the Health Maintenance Organization Act[111] in order to provide consumers with a free choice among the various methods of health care delivery, thus lowering the costs of medical care.[112] Moreover, the refusal to extend the exemption to HMOs, the court stated, would undermine Congressional intent by providing hospitals with a market advantage over HMOs.[113]

Although the *De Modena* court ruled that all sales to the Kaiser Health Plans' members through the drug plan were exempt from the Robinson-Patman Act, the court remanded the case to the trial court to determine whether the Kaiser Health Plans' sales to nonmembers were also exempt because they were so minor as to be de minimis.[114] The Ninth Circuit opined that the de minimis issue could not be decided solely upon the relative percentages of such sales to the total sales of the Kaiser Health Plans.[115] Instead, the circuit court directed the trial court to reconsider the overall impact of such sales on the competing pharmacies and not merely upon the Kaiser Health Plans' total sales.[116]

The Ninth Circuit was confronted with several complicating factors in arriving at its decision in *De Modena*. Because of the admitted lack of precedent, [117] the court had to reason by analogy to divergent areas of the law.[118] Furthermore, the Ninth Circuit had been overturned recently by the Supreme Court in the hospital pharmacy case of *Abbott Laboratories*,[119] and thus seemed

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109 *Id.* (quoting *Abbott Laboratories*, 425 U.S. at 23 (Marshall, J., concurring)). The *De Modena* court acknowledged, however, that the legislative history of the Act was "less than crystal clear." *Id.*

110 *Id.*

111 *See supra* note 9 (discussing the Federal Health Maintenance Organization Act).

112 *De Modena*, 743 F.2d at 1394.

113 *Id.*

114 *Id.* at 1394-95.

115 *Id.* at 1394.

116 *Id.* at 1394-95. The Ninth Circuit briefly considered the pharmacies' appeals of the attempted monopolization and tying claims, and it subsequently affirmed the district court's granting of summary judgment in favor of the Kaiser Program. *Id.* at 1395-96; *see supra* notes 28 & 30.

117 *De Modena*, 743 F.2d at 1391.

118 *See supra* notes 96-101 and accompanying text.

119 *See* Portland Retail Druggists Ass'n v. Abbott Laboratories, 510 F.2d 486 (9th Cir. 1974), *vacated*, 425 U.S. 1 (1976); *see also supra* notes 70-85 and accompanying text (discussing *Abbott Laboratories* decision).

constrained not to stray far from the structured "basic institutional function" test laid down by the Supreme Court in that case.[120]

The *Abbott Laboratories* "definitive construction" of the Nonprofit Institutions Act[121] was criticized by commentators for imposing excessive administrative costs upon the nonprofit institutions that the Act was specifically adopted to benefit.[122] In fact, one commentator has predicted that some nonprofit hospitals might forego the Act's exemption rather than submit to the onerous procedures necessary to withstand the scrutiny of the test laid down by the *Abbott Laboratories* Court.[123] This author contends that regardless of which alternative a nonprofit hospital chooses to take—either implement the expensive accounting and drug segregation procedures necessary to comply with the *Abbott Laboratories* decision, or forego the Act's exemption entirely—its patients would nevertheless face a significant increase in their health care costs.[124]

The *De Modena* court recognized the shortcomings of the *Abbott Laboratories* strict categorical scheme, but was compelled to follow it.[125] The effects of the *De Modena* decision upon the purchasing activities of HMOs, however, are very different from the impact upon hospital pharmacies as a result of *Abbott Laboratories*. In fact, the result reached in *De Modena* resembles more closely the less restrictive district court ruling in *Abbott Laboratories*[126] than the Supreme Court's decision that "categorically" re-

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120 For an analysis of the ideological differences between the Ninth Circuit and the United States Supreme Court, see Stewart, *Ninth Circuit's Judges Frequently Run Afoul of the Supreme Court*, Wall St. J., Dec. 19, 1984, at 1, col. 1.

121 *See supra* notes 72-79 and accompanying text.

122 *See, e.g.*, Rosoff & Dunfee, *supra* note 49.

123 *See generally id.* at 217-30 (discussing problems of complying with *Abbott Laboratories* decision).

124 *See id.* at 219. The *Abbott Laboratories* Court anticipated and rebutted the challenges of its critics. *See Abbott Laboratories*, 425 U.S. at 19-21. The hospitals in *Abbott Laboratories* argued that the application of the Court's categorization of purchases would either cause drug suppliers to end the nonprofit discounts offered to hospitals, or require each hospital to institute complicated and expensive drug segregation and accounting schemes to assure that the drugs purchased under the exemption were distributed only to exempt categories of customers. *Id.* at 19-20. The Court concluded, however, that this was "the price the Congress has exacted for the benefits bestowed by the [Nonprofit Institutions Act]." *Id.* at 20.

125 *See De Modena*, 743 F.2d at 1392-94. The Ninth Circuit's analysis in *De Modena* is a virtually verbatim recapitulation of the Supreme Court's analysis of the Nonprofit Institutions Act found in *Abbott Laboratories*. *Compare id.* at 1391-92 *with Abbott Laboratories*, 425 U.S. at 11-14.

126 *See* Portland Retail Druggists Ass'n v. Abbott Laboratories, 510 F.2d 486, 488

jected the less rigorous analysis.[127]

In *De Modena*, as in the district court's decision in *Abbott Laboratories, all* sales by the HMO to its members through its drug plan—and those to nonmembers found to be de minimis[128]—qualified for the express exemption contained in the Nonprofit Institutions Act.[129] Conversely, in the Supreme Court's *Abbott Laboratories* decision, only certain sales that fit within very structured categories were eligible for the exemption.[130] The drugs distributed and the health services offered by the Kaiser Program in *De Modena*, however, are no different from the drugs and health services rendered by the hospitals in the *Abbott Laboratories* decision.[131] Nevertheless, the Ninth Circuit's decision in *De Modena* has afforded the Kaiser Program, as well as other HMOs, a cost advantage unavailable to competing nonprofit hospitals under the *Abbott Laboratories* decision. *De Modena* essentially eliminates the need to create a strict drug accounting program to comply with the Court-imposed drug sale categorization scheme.[132]

(9th Cir. 1974) (discussion of unpublished district court ruling of summary judgment for the pharmaceutical companies), *vacated*, 425 U.S. 1 (1976).

127 *See Abbott Laboratories*, 425 U.S. at 7-11; *supra* note 85.

128 *See supra* notes 114-116 and accompanying text (discussing de minimis sales issue).

129 *See De Modena*, 743 F.2d at 1393.

130 *See supra* notes 70-85 and accompanying text.

131 *See supra* notes 1-7 and accompanying text (explaining services offered by HMOs).

132 *See Abbott Laboratories*, 425 U.S. at 19-20 (establishing record keeping requirement to segregate nonexempt sales from exempt sales). The cost impact upon hospitals of the *Abbott Laboratories* scheme has not yet been calculated. It has been suggested that the decision will result in both an increase in health care costs to the public and perhaps "an increased profit margin for the large corporations which make and sell drugs." *See* Rosoff & Dunfee, *supra* note 49, at 228-29.

HMOs are not the exclusive purveyors of drug plans based upon periodic subscriber fees. Indeed, in its initial remand to the district court, the Ninth Circuit specifically directed that the parties consider the Supreme Court's holding in Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205 (1979), wherein the Court denied an antitrust exemption for a health insurance company's drug plan that operated like the Kaiser Program's plan. Portland Retail Druggists Ass'n v. Kaiser Found. Health Plan, 662 F.2d 641, 647 (9th Cir. 1981). The McCarran-Ferguson Act, 15 U.S.C. § 1012 (1982), provides an exemption for insurance company actitivies regulated by the states from all Federal antitrust laws. *See Group Life*, 440 U.S. at 210-11. Although *Group Life* did not involve the Robinson-Patman Act, but rather § 1 of the Sherman Act, the insurers claimed that their drug plan was eligible for the McCarran-Ferguson Act exemption. *See id.* at 207. The *Group Life* Court, however, concluded that the exemption was inapplicable to contractual arrangements that extend beyond the insurance company-policyholder relationship. *See id.* at 217. According to the Court, the "business of insurance" exemption contained in the McCarran-Ferguson Act was unavailable to health insurers unrecog-

When Congress passed the Nonprofit Institutions Act in 1938, it provided virtually no legislative history revealing its motives.[133] The Act's very existence, however, is wholly dependent upon the continued enforcement of the Robinson-Patman Price Discrimination Act.[134] Therefore, some insight regarding the exemption contained in the Nonprofit Institutions Act may be gleaned from the wealth of legislative materials concerning the Robinson-Patman Act.[135] Perhaps the most enlightening analysis of the Congressional intent underlying the enactment of the Robinson-Patman Act was undertaken by the Supreme Court in 1983 in *Jefferson County Pharmaceutical Association v. Abbott Laboratories*.[136] In *Jefferson County*, the Court held that sales by several large pharmaceutical companies to state hospitals in Alabama were not exempt from the provisions of the Robinson-Patman Act.[137] The Court rejected the pharmaceutical companies' argument that purchases by the state hospital pharmacies were exempt entirely from the Robinson-Patman Act by virtue of the

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nized as engaged in the "business of insurance." *See id.* at 225-27 & n. 33; *see also supra* note 31 (discussing McCarran-Ferguson Act). Presumably, the *De Modena* court expected this issue to be considered on remand. The Ninth Circuit, however, did not address the McCarran-Ferguson Act exemption as it applied to the Kaiser Program. *See De Modena*, 743 F.2d at 1390-96.

Just as similarities exist between HMOs and hospitals, HMOs are also admittedly quasi-insurers offering services similar to and in competition with those of traditional health insurers. *Compare De Modena*, 743 F.2d at 1396 (HMO sales exempt from antitrust provisions of Robinson-Patman Act) *with Group Life*, 440 U.S. at 232-33 (insurer sales not exempt from antitrust laws). Despite these similarities, the Ninth Circuit opinion in *De Modena* offers HMOs an express statutory exemption from the antitrust laws that almost certainly will provide them with a significant cost advantage unavailable to competing health insurers. *See De Modena*, 743 F.2d at 1391-92 (holding HMOs to be nonprofit institutions for purposes of Nonprofit Institutions Act).

133 *See De Modena*, 743 F.2d at 1394; Rosoff & Dunfee, *supra* note 49, at 203 n. 35.

134 *See* Nonprofit Institutions Act, 15 U.S.C. § 13c (1982).

135 It is well-recognized that legislative construction is a part of the judicial process. It is not based on fixed rules of law, "but merely [on] axioms of experience" in order to determine Congressional intent in enacting legislation. United States v. Universal C.I.T. Credit Corp., 344 U.S. 218, 221 (1952). Reliance upon the legislative history of prior legislative acts that affect the operation of subsequent acts is one method accepted by the courts to interpret the legislative intent of later laws. *See* Piper v. Willcuts, 64 F.2d 813, 815-16 (8th Cir. 1933)(using legislative history from 1921 tax law to support interpretation of 1932 Tax Code).

Although the views of draftsmen are not generally considered appropriate grounds upon which to base the interpretation of a statute, an exception is available where it is clear that the draftsman's views were communicated to the legislature and there is reason to believe that the legislators were influenced by his views. *See* Zuber v. Allen, 396 U.S. 168, 192 (1969).

136 460 U.S. 150 (1983).

137 *Id.* at 153.

tenth amendment's prohibition against Federal regulation of the sovereign activities of the states.[138] The Court stated that only the purchases for state "consumption in traditional governmental functions" were intended by Congress to be exempt from the Act.[139] It noted that the one express exemption to the Act applied only to nonprofit institutions.[140] Thus, the Court reasoned that Congress intended the Robinson-Patman Act to apply to a state that chose to compete in the private retail market.[141]

In several extensive footnotes, Justice Powell quoted at length from the legislative history of the Act as presented by H.B. Teegarden, the chief draftsman of the original bill.[142] According to Justice Powell, "Teegarden clearly assumed that governmental purchasing would not compete with private purchasing."[143] The inference that Congress never intended a governmental exemption to the Robinson-Patman Act to apply where the benefactor of the exemption is in competition with private purchasers thus becomes quite clear. Unfortunately, no similar legislative history exists either to buttress or refute a similar inference in interpreting the Nonprofit Institutions Act.[144] The striking similarities of the market positions between governmental activities and nonprofit activities, however, lends credence to the view that Congress, by analogy, did not intend the Nonprofit Institutions Act to apply where the benefactor of the exemption elected to compete in activities traditionally left to private enterprise.

A comparison of any of the decisions rendered by the courts in cases involving the Robinson-Patman Act and the Nonprofit Institutions Act demonstrates the contradictory and confusing results that can be reached, even in cases that are as similar as *De Modena* and *Abbott Laboratories*.[145] The courts, faced with almost indistinguishable fact situations, have rendered different deci-

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138 *Id.* at 154 n.6.

139 *Id.* at 154.

140 *Id.* at 154-55.

141 *Id.* at 154.

142 *See id.* at 160-64 nn.19-23.

143 *Id.* at 162 n.21. Justice Powell subsequently stated, however, that the assumption was inapplicable to the *Jefferson County* case. *Id.* In response to questioning from Representative Hancock, Mr. Teegarden stated:

> If the two hospitals are in competition with each other, I should say then that the fact that one is operated by the city does not save it from the bill, [the Robinson-Patman Act]. If they are not in competition with each other, then they are in a different sphere.

Id. at 160 n.19 (citation omitted).

144 *See supra* note 133 and accompanying text.

145 *Compare Abbott Laboratories*, 425 U.S. at 19-21 (some, but not all, hospital sales

sions, a situation that calls once again for legislative reform of the Robinson-Patman Act.[146]

The analysis of the Nonprofit Institutions Act furnished by the *De Modena* court is consistent with the fundamental purposes of this Act. On the other hand, it offers little solace to those small proprietors who have relied upon the protections of the Robinson-Patman Act.[147] Even though the court exercised care in its interpretation of the exemption to the Act, the vastly changed circumstances in which the Act operates today, as compared with the conditions in existence when it was first enacted, have surely broadened the scope of the Act beyond what Congress may have ever intended. Thus, it is not only judicial interpretations of the Act that have adversely affected small proprietors, but also the operations of an antiquated antitrust exemption ill-suited to present day realities.

For small proprietors, such as the retail pharmacies in *De Modena*, the Ninth Circuit's recognition of an exemption for an institution as large and financially well endowed as the Kaiser Program[148] will most certainly have devastating effects on the former's ability to compete absent the protections of the Robinson-Patman Act. While exercising their market power unrestricted by the Robinson-Patman Act, the Kaiser Program and other large nonprofit HMOs will be able to offer services at much lower prices.[149] The size of nonprofit institutions when the exemption was first enacted was small in comparison to the nonprofit agencies in existence today.[150] Whether Congress

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exempt) *with De Modena*, 743 F.2d at 1396 (all HMO sales exempt) *and Jefferson County*, 460 U.S. at 171 (government sales not exempt).

146 *See* Rosoff & Dunfee, *supra* note 49, at 242-49. The Robinson-Patman Act was passed during a different era than the other antitrust laws. During the Great Depression, smaller proprietors, who already faced hard economic times due to the generally failing economy, sought and received from Congress protection from larger enterprises that could use their market strength to exact lower prices from their suppliers. *Id.* at 243. This relief came in the form of the Robinson-Patman Act, which has sometimes been called the "Anti-Chain Store" Act. *Id.* The Act has been termed by one Justice of the Supreme Court as "a singularly opaque and elusive statute." Federal Trade Comm'n v. Sun Oil Co., 371 U.S. 505, 530 (1963)(Harlan, J., concurring). In a nation that promotes the ideal of a free market economy, it seems contradictory to have a law such as the Robinson-Patman Act, which controls the pricing decisions of suppliers. *See generally* Comment, *Eine Kleine Juristische Schlummergeschichte*, 79 HARV. L. REV. 921 (1966)(Robinson-Patman Act is illogical and does not fit with United States free market economy).

147 *See supra* notes 47-51 and accompanying text.

148 *See supra* note 17.

149 *See supra* note 37.

150 In a letter to Congress from John H. Hayes, President of the Hospital Bureau

envisioned nonprofit institutions of such magnitude that they would rival some of America's largest corporate giants in market power,[151] and whether an exemption from antitrust laws should be available to these institutions, will forever remain uncertain. In any event, the sheer market power of the Kaiser Program and other nonprofit institutions similarly situated should serve as a signal to Congress that the principles underlying the Robinson-Patman Act are being frustrated to the detriment of the proprietary activities of the small businesses that the Act was designed to protect. Moreover, this insidious erosion of the Act's legislative prohibitions is occuring through the invocation of the very exemption to the Robinson-Patman Act that Congress itself created. The solution to this dilemma, however, is not within the province of the courts, but with Congress. Congress should reexamine the Act's depression era prohibitions in order to update them to the realities of the 1980's.

Steven N.J. Wlodychak

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of Standards and Supplies, which advocated passage of the Nonprofit Institutions Act, the author noted that in 1937, 2700 nonprofit hospitals throughout the United States spent over $150 million on food and supplies for the needy sick. H.R. REP. No. 2161, 75th Cong., 3d Sess. 2 (1938). In 1983, the Kaiser Program had gross revenues of *$2.44 billion*. *See supra* note 17. The Kaiser Program alone thus had a greater market strength than all the nonprofit hospitals operating in the United States combined when the bill was passed. It is unclear that the Nonprofit Institutions Act exemption for the Kaiser Program is the occasional price favor that Congress contemplated would not interfere with "the wholesome purpose of the Robinson-Patman Act." *See* H.R. REP. No. 2161, 75th Cong., 3d Sess. 1 (1938).

[151] In fact, if the Kaiser Program were a profit making enterprise, its available 1983 gross revenue figures of $2.44 billion would rank it number 152 on the 1985 Fortune 500 list of the largest American corporations, above such recognized corporate giants as Uniroyal, Wang Laboratories and Mack Trucks. *See generally The Fortune 500*, FORTUNE, Apr. 29, 1985, at 270, 270-72 (listing largest revenue corporations).