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**STATEMENT OF DONALD S. SCHERZER,
PARTNER, ROETZEL & ADDRESS, LPA, CLEVELAND, OHIO, ON BEHALF OF
THE OHIO STATE MEDICAL ASSOCIATION IN SUPPORT OF HOUSE BILL 125,
THE HEALTH CARE SIMPLIFICATION ACT
BEFORE THE CIVIL AND COMMERCIAL LAW COMMITTEE
OF THE OHIO HOUSE OF REPRESENTATIVES**

MAY 16, 2007

I. INTRODUCTION

Mr. Chairman:

I very much appreciate the opportunity to appear before your Committee today to express my support for House Bill 125, the Health Care Simplification Act, and in particular, two key components of the Act: the prohibitions against "Most Favored Nations" and "All Products" clauses in contracts between health care providers and third-party payors.

Before beginning my formal remarks, I will tell you a little bit about my experience. I have practiced antitrust law for nearly 32 years. I spent the first seven years of my career as a Trial Attorney with the Antitrust Division of the United States Department of Justice. Since leaving the Department of Justice, I have represented clients throughout the United States in civil and criminal antitrust matters ranging from garden-variety criminal conspiracies to complex monopolization cases. Previously, I served as Chair of the Ohio State Bar Association's Antitrust Section and National Chair of the Federal Bar Association's Antitrust and Trade

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Regulation Section. I have been a member of several committees of the Antitrust and Trade Regulation Section of the American Bar Association for many years, and, in connection with that membership, I have contributed to several ABA publications. Through the years, I have lectured on numerous occasions about various antitrust topics.

II. BRIEF SUMMARY OF KEY PROHIBITIONS IN HOUSE BILL 125

From an antitrust perspective, the two key components of House Bill 125 are: (1) to prohibit what are known as a "Most Favored Nation" clauses in third-party payor/provider contracts; and (2) to prohibit so-called "All Products" clauses in third-party payor/provider contracts. The implementation of this legislation will serve to protect competition in the third-party payor market, and to increase price competition in the health care provider market. Ultimately, these changes will benefit consumers. In support of this proposition, I will address the harm House Bill 125 seeks to prevent through the prohibitions of both "All Products" clauses and "Most Favored Nation" clauses.

The bottom line is that the use of Most Favored Nation and All Products clauses effectively forecloses competition in both the health insurance and health care services markets. Why does foreclosure of competition matter? Most significantly, the foreclosure of competition results in higher prices to the consumers of health insurance and to the consumers of health care services. And, after all, the primary purpose of the antitrust laws is to insure that consumers get the very best products and services at the very lowest price. Most Favored Nation and All Products clauses contribute to higher prices because they allow dominant market players to preserve their market power, suppress competition, and therefore foreclose price competition.

III. "MOST FAVORED NATION" CLAUSE

The "Most Favored Nation" provision of the Bill is found on page 16 at line 450. A "Most Favored Nation" clause, also sometimes referred to as a "Most Favored Customer" clause, is a provision included in contracts between health care providers and insurers that requires providers of health care services to accept from a particular payor of these services the lowest price the provider accepts from any other payor. Put more simply, a Most Favored Nation clause requires the provider to give the insurer the lowest rate that it gives to any other insurer.

Market researchers and scholars have observed that Most Favored Nation clauses have served to (1) force smaller, less entrenched insurers out of business, and (2) prevent new, lower cost insurers from entering the market because the health care provider that might deal with these smaller, lower cost insurers is forced to charge all insurers the same price. If a provider wants to charge a lower price to a smaller insurer, doing so would activate the Most Favored Nation clause, thereby reducing that provider's income.

Despite insurers' arguments that these clauses serve to control rising health care costs, the actual anticompetitive effects of such clauses are wide and varying. The negative outcomes include: (1) suppression of new competitors in the third-party payor marketplace; (2) limitations on the prices health care providers may charge; (3) a negative effect on consumers due to the suppression of competition and the resultant higher insurance rates; and (4) the loss of provider autonomy. The United States Department of Justice, the Federal Trade Commission and scholars alike are in agreement regarding the negative competitive consequences that flow from Most Favored Nation clauses.

A. Foreclosure of Competition In the Third-Party Payor Market

From a legal standpoint, the suppression of new and existing lower cost third-party payors in the marketplace is perhaps the most significant anticompetitive impact of Most Favored Nation clauses. Most Favored Nation clauses facilitate marketplaces where new and existing low cost competitors are unable to survive because they cannot compete for new business by pricing below the dominant actor in the market. This is because the Most Favored Nation clause requires the provider to give the dominant insurer the lowest price that any new competitor can charge. Quite simply, The Most Favored Nation clause prevents smaller lower priced insurers from either entering the market or surviving in the market because providers have a disincentive to contract with these smaller, lower priced insurers.

Market researchers and scholars have observed that Most Favored Nation clauses have served to force smaller, less entrenched insurers out of business because a provider becomes forced to choose to do business solely with the dominant insurer, as opposed to a smaller insurer, so as to avoid activating the Most Favored Nation clause. By way of example, this is the typical scenario where a Most Favored Nation clause is in effect: If a provider lowers its price to any payor, it must then lower its price to the insurer with Most Favored Nation clause in its contract. This would result in a large penalty to the provider, so the provider will inevitably choose not to do business with a smaller insurer, thus facilitating barriers to entry for new competition.

These anticompetitive effects are even more pronounced in a concentrated marketplace, where only a few competitors comprise the majority of the market. This is precisely the state of the health care industry in Ohio today. A recent study by the American Medical Association found that competition in the health care industry on a national basis has been steadily eroding

over the past 10 years, since over this time, the industry has experienced more than 400 mergers involving health insurers and managed care organizations. On the regional level, these consolidations have severely eroded the number of competitors in the market. Ohio is no different. Today, Ohio has three dominant insurers—United, Medical Mutual and Anthem — that are estimated to collectively comprise nearly 70% of the health care market on the payor side. In addition, barriers to entry in the health care industry entry are great, particularly because in the health care industry, competitors cannot simply attract customers on the basis of the quality of the product or service they can provide.

B. Foreclosure of Price Competition In Health Care Provider Market

Ultimately, it is the consumer who pays the price for the anticompetitive effects of a Most Favored Nation clause. As I have explained, providers have a disincentive to discount below the price that has been negotiated by the large insurer, which has the power to demand a Most Favored Nation clause in its contract. In the end, the suppression of competition through the Most Favored Nation clause leads to artificially high prices for consumers. This is achieved in two different ways. First, Most Favored Nation clauses set the minimum price for all medical services covered by that contract. More specifically, the charge for services that a provider charges to the dominant insurer that wields Most Favored Nation status becomes the price charged to all other insurers in the market by that provider. Second, Most Favored Nation clauses establish price floors as to the overall cost of all health insurance products in that market.

As an example, consider hospital costs, typically the largest single expense item from any health plan. The pricing that a health insurer can get from hospitals often drives the price of the overall health insurance product. So, when a Most Favored Nation clause causes hospital pricing to become rigid, the overall price structure in the health insurance market will also become fixed

at an artificially high price floor. These artificially high prices for health coverage, which are caused by Most Favored Nation clauses, limit consumers' access to coverage and increase co-payments and deductibles to patients.

While objections to Most Favored Nation clauses are strongest when insurers yield high percentage market shares, there is some evidence to suggest that inclusion of such clauses by insurers that have large, but not monopolistic, market share is also detrimental to competition. This is because the competitive impact of a Most Favored Nation clause is directly related to the perception by health care providers of the dominance of a particular insurer in the market, not the actual size. If providers perceive that it would not be in their economic best interests to terminate their relationship with these insurers, the same anticompetitive consequences will occur, even where the market share of the insurer is as low as 20%. Theoretically, even an insurer with a 20% share of the relevant market could adversely impact price competition when that insurer forces health care providers to refuse business with lower-priced insurers for fear of adversely impacting their income.

C. Other States' Regulations

Several states have recognized the anticompetitive effects of Most Favored Nation clauses in health care contracts and have affirmatively prohibited them through legislation. Washington State, Idaho, Alaska, Minnesota and New Hampshire all have statutes prohibiting Most Favored Nation clauses in health care contracts for the very reasons I have expressed to you here today.

D. DOJ and FTC Enforcement

In addition to legislative action by various states, the Justice Department and the FTC have vigorously challenged Most Favored Nation clauses in the health care industry since 1990.

During that time, virtually all of the Most Favored Nation clauses that have been challenged by either the DOJ or state antitrust authorities have ended in consent decrees whereby the use of Most Favored Nation clauses was expressly prohibited. While several of these cases involved third-party payors that possessed market shares of higher than 20%, none of the Complaints or Consent Judgments filed in these cases by the Department of Justice ever mentioned, let alone relied upon, market share data as justification for the government's enforcement action. As such, any effort to attack the 20% market share threshold in house Bill 125 would be unfounded.

Additionally, the FTC successfully challenged a Most Favored Nation clause in third-party payor contracts and obtained a consent judgment prohibiting the use and enforcement of Most Favored Nation clauses in those contracts.

IV. "ALL PRODUCTS" CLAUSE

The "All Products" provision of the Bill is found on page 15 at line 425. Turning now to another increasing trend that we are seeing in the health care industry that is causing anticompetitive effects--I will discuss "All Products" clauses. As I mentioned at the top of my discussion, House Bill 125 seeks to prohibit so-called "All Products" clauses. An All Products clause is a contractual provision in provider/insurer contracts that requires physicians to accept all present and future insurance plans and payment methods offered by a particular insurer as a condition of participating in any of the insurer's plans.

Insurers that force All Products clauses on providers can tie the participation of providers in health care plans that the providers actually want to their participation in health care plans that they don't want. These provisions compel providers to sign up with plans that they would never purchase on a stand-alone basis. The only bargaining power providers have when negotiating with insurers is the power to say "no." All Products clauses eliminate this bargaining power

because it forces upon a provider an all-or-nothing choice—providers must either accept all current and future products offered by the insurer, or get no contract for any of the insurer's products.

Given the proliferation of plan options being offered by insurers, combined with a highly concentrated market place, All Products clauses have become more standard. This is because insurers need to get their new products out in the market quickly without having to spend the time and resources recruiting new providers. Thus, the insurer uses the All Products clause in a coercive manner to force providers to participate in plans that they may otherwise not buy if they could freely choose. As a result, All Products clauses contribute to the uneven playing field that we are seeing in the health care industry today.

This particular problem is even more pronounced in markets in which one or more insurers enjoy dominant positions. A few health insurers with a large collective share of the market are likely to exert what is known as "Oligopsony" power. Oligopsony power is the power of a few dominant purchasers have to artificially influence prices for the purchase of goods or services when negotiating with sellers that wield less bargaining power. Where a few dominant health insurers exist, they are in a position to set the terms of participation for providers and force them to accept an All Products clause because the provider cannot commercially reject such clauses without risking the loss of a large percentage of their patients. Because the insurers operate from such a dominant position of bargaining power, providers simply cannot afford to reject the All Products clause.

As with any conduct that is anticompetitive, the anticompetitive effects caused by All Products clauses ultimately negatively impact consumers. These clauses distort the market for

provider services, eventually resulting in reduced patient access to the health care providers of their choice.

A. Other States' Statutes

State regulators and legislatures began recognizing the anticompetitive impact of All Products clauses in the late 1990s. Alaska, Kentucky, Virginia, Maryland, Minnesota and Nevada have all passed legislation prohibiting this anticompetitive behavior by banning the use of All Products clauses in provider/third-party payor contracts. Three other states also restrict All Products clauses under certain circumstances.

B. DOJ Enforcement

The Department of Justice has also been concerned by the impact of All Products clauses on the health care industry in concentrated markets. Recently, the Department of Justice recognized the anticompetitive impact of All Products clauses when it filed suit in December, 2005 challenging a merger of third-party payors. The settlement in that case requires that third-party payor no longer utilize an All Products clause in its contracts with providers, thereby ensuring doctors will be free to choose whether to participate in the third-party payors networks for its commercial plans, its networks for its Medicare plans, or both.

Mr. Chairman, I thank you and the other members of your Committee for your time this afternoon. I will be pleased to answer any questions that you may have at this time.

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MEMORANDUM

TO: File (OSMA – H.B. 125 – MFN Testimony)

FROM: Lisa G. Han, Esq.
Schottenstein, Zox & Dunn, LPA

DATE: December 6, 2007

RE: Antitrust Implications of Most Favored Nation ("MFN") Clause

Summary of Antitrust Implications Concerning MFN

This memorandum provides a summary of the antitrust implications of MFN provisions in providers' agreements with health plans.

Definition. A "most favored nation" ("MFN") clause is generally referred to as a contractual agreement between a supplier and a customer that requires the supplier to sell the customer on pricing terms at least as favorable as the pricing terms on which the supplier sells to other customers. MFN clauses are frequently found in contracts between health insurers and hospitals or physicians, allowing the insurer to ensure that the rates it pays to providers are not greater than the rates negotiated by its competitors.

Court Opinions. MFN clauses have been challenged under §1 of the Sherman Act (prohibiting unreasonable restraint of trade)¹, §2 of the Sherman Act (prohibiting monopolization or attempted monopolization)² and §5 of the Federal Trade Commission Act ("FTC Act").³

Courts have traditionally viewed the MFN provisions as a pro-competitive tool to control hospital costs rather than being anti-competitive. Viewed as "buyers" of health care services (instead of sellers), insurers have been supported for exercising their fundamental right to bargain with whomever they choose at whatever price they choose.⁴ The rationale is that if

¹ Section 1 of the Sherman Act, 15 U.S.C. §1, provides: "every contract, combination in the form of trust or otherwise, or conspiring, in restraint of trade or commerce among the several states, or with foreign nations, is declared to be illegal."

² Section 2 of the Sherman Act, 15 U.S.C. §2, prohibits monopolization, attempted monopolization and conspiracy to monopolize.

³ Section 5 of the Federal Trade Commission Act, 15 U.S.C. §45(a)(1), proscribes any "unfair methods of competition" and any "unfair or deceptive acts or practices."

health insurers are able to obtain favorable prices from providers, then these lower prices will be passed onto consumers in the form of lower health insurance premiums. In essence, the argument is that the MFN provision facilitates the sharing of sellers' cost savings or efficiencies.

MFNs can also raise anti-competitive concerns. Under certain market conditions, MFNs can discourage providers from discounting their rates to other insurers, deter innovation, and reduce meaningful consumer choices in health plans. These anti-competitive effects include setting a price floor (because providers are not willing to offer lower prices to rival plans for fear of violating the MFN provisions), creating a market entry barrier to competing insurers, allowing dominant payers to maintain large market share, and eventually reducing consumer choices in health plans. MFN clauses tend to be viewed to have serious anti-competitive effects when the insurers have a substantial market share.

The following is a summary of the court decisions involving the MFN clause:

- In Blue Cross & Blue Shield of Michigan v. Michigan Association of Psychotherapy Clinics, 1980-2 Trade Cas. (CCH) P63, 352 at 75,792 (1980), MFN provisions were held not to constitute price fixing and restraint of trade under Sections 1 and 2 of the Sherman Act. The court stated that *per se* restraint of trade by price-fixing refers to competitors agreeing on prices to be charged to third parties, not a price between two contracting parties in a vertical relationship who ordinarily do not compete with one another. Because health care providers and insurers are not competing with one another, the court held that BCBSM's MFN provision does not *per se* restrain trade in violation of §§ 1 and 2 of the Sherman Act.⁵
- In Ocean State Physicians Health Plan v. Blue Cross and Blue Shield of Rhode Island,⁶ Ocean State, a physician-owned HMO, sued Blue Cross and Blue Shield of Rhode Island ("BCBSRI") for monopolization of Rhode Island's health insurance market in violation of § 2 of the Sherman Act.

⁴ Courts have viewed insurers as buyers of health care services who, thus, should have the right to negotiate for the best price. In Kartell v. Blue Shield of Massachusetts, 749 F.2d 922 (1st Cir. 1984), the First Circuit Court of Appeals upheld a Blue Cross "ban on balance billing" i.e. accepting Blue Cross' payment as payment in full, and promising not to bill the patient a supplementary fee. The First Circuit Court considered Blue Cross the buyer of the medical services for purposes of antitrust analysis and allowed a buyer to freely negotiate prices with sellers for the lower prices offered by sellers to other buyers.

⁵ A commentator criticized this view as naïve because it overlooked the fact that BCBSM's MFN clause consequently sets a minimum price, as the outpatient clinics could not give other insurers a lower price than BCBSM was paying. See Susan E. Stenger, "Note and Comment: Most Favored Nation Clauses and Monopsonistic Power: An Unhealthy Mix?" 15 Am. J. L. and Med. 111 (1989).

⁶ 883 F.2d 1101 (1st Cir. 1989), *cert. denied*, 494 U.S. 1027 (1990).

BCBSRI, which owned both an HMO and other insurance plans, had a dominant share of that market. Ocean State HMO caused BCBSRI to lose 30,000 of its 543,000 subscribers.

In response, BCBSRI set up its own HMO and adopted an MFN policy called the "prudent buyer policy." Under this policy, BCBSRI refused to pay a provider more than the lowest price accepted by that provider from any other plan.

Ocean State paid providers a certain level of reimbursement with 20% risk withholds to be refunded to providers if Ocean State turned a profit. Since Ocean State was operating at a loss, Ocean State retained the 20% risk withholds. Such retention, in effect, caused the providers to be actually reimbursed at a rate 20% lower than the rates charged BCBSRI. BCBSRI enforced the prudent buyer policy and caused many providers to drop out of the Ocean State plan.

The issue in dispute was whether BCBSRI maintained its monopoly position through improper means in violation of §2 of the Sherman Act. The First Circuit Court held that as a matter of law, insisting on a supplier's lowest price is not exclusionary conduct in violation of §2 of the Sherman Act.

- In Blue Cross and Blue Shield United of Wisconsin v. Marshfield Clinic,⁷ Marshfield Clinic's HMO subsidiary, Security, was the largest HMO in the 14-county north central region of Wisconsin with approximately 90% of the "HMO market." Security required its member physicians and contracting providers to agree to an MFN provision. Blue Cross' HMO sought to enter into capitated contracts with Marshfield Clinic, but was refused. Blue Cross sued, alleging that Security had illegally monopolized the market and had enforced its MFNs in a collusive manner to exclude competition.

The court held that HMO is not a separate market, but simply another financing vehicle competing with standard indemnity insurance and PPOs. As such, even though Marshfield Clinic had more than 90% of the HMO market, Marshfield Clinic's market share did not support a finding of monopolization in the broader health care/insurance market. Also, other mitigating factors included the facts that contracting physicians did not work exclusively for Security and that the work for Security generated only 6% of these doctors' income.

- The only decision condemning the MFN clauses is the Tenth Circuit Court's decision in Reazin v. Blue Cross and Blue Shield of Kansas, Inc., 663 F. Supp. 1360 (d. Kan. 1987), *aff'd on other grounds*, 899 F.2d 951 (10th Cir. 1990), *cert. denied*, 497 U.S. 1005 (1990). In this case, the Tenth Circuit Court found that the use of an MFN clause was a component of barriers to market entry by competitors of Blue Cross. In

⁷ 65 F.3d 1406 (7th Cir., 1995), *cert. denied*, 516 U.S. 1184 (1996).

Reazin, the court held that when MFN clauses are insisted upon by a payer with market power, these clauses may be exclusionary and could give rise to an action under §2 of the Sherman Act. The court remarked in dicta that the MFN provision was anti-competitive, decreasing competitors' ability to compete and erecting entry barriers for potential competitors.

It is worth noting that a hospital recently filed a law suit against a Blue Cross plan, alleging that the use of MFN provisions in provider contracts violated the antitrust laws. Chester County Hospital, a suburban Philadelphia hospital, filed a \$60 million antitrust suit against Independent Blue Cross ("IBC") and its subsidiaries and affiliates. The complaint alleged that IBC discouraged hospitals from dealing with competitors by employing MFN requirements that force the hospital to give IBC the lowest prices the hospital affords to any other payer.⁸ The hospital alleged that the IBC group is the primary payor of 44% of its inpatients admissions, and 50% of its outpatient volume, so the hospital cannot realistically refuse to do business with IBC. Also, the hospital stated that if it had no IBC contract at all, it would have to close its doors.

Enforcement Actions. Compared with courts, the DOJ has been aggressive in challenging MFN provisions. DOJ's Antitrust Division has filed five (5) law suits and FTC, one, challenging the MFN provisions in provider agreements as unreasonable restraint of trade. DOJ has urged at least one state insurance commissioner to disapprove the inclusion of MFNs in the provider agreements used by a Blue Cross plan with a large market share.⁹

According to DOJ, it continues to receive and evaluate complaints about managed care plans' use of MFN clauses to determine if they merit more complete investigation, and ultimately, any enforcement actions.¹⁰ For example, DOJ closed an investigation of MFN provisions used by a Blue Cross plan in Alabama upon confirmation that the plan had abandoned its MFN policy; DOJ forced Highmark (an insurer with significant market share in western Pennsylvania) to abandon its proposed use of MFN clause in its hospital contracts.¹¹

⁸ Chester County Hospital v. Independence Blue Cross et al., No. 02-cv-2746, complaint filed (E.D. Pa., May 8, 2002).

⁹ This refers to the letter from Anne K. Bingaman, Assistant Attorney General, Antitrust Division, to Hon. Cynthia M. Maleski, Pennsylvania Insurance Commissioner (Sept. 7, 1993). In its letter, the DOJ stated that MFN clauses were being used by dominant insurers like Blue Cross with the intent or effect of "smothering the competition, creating an artificial price floor in the health care and health insurance markets, and preventing or deterring the entry of competitors." The Pennsylvania Insurance Commissioner ultimately disapproved the use of the MFN provision.

¹⁰ See the Presentation by Deborah Platt Majorae, Deputy Assistant Attorney General, Antitrust Division, U.S. Department of Justice for Health Care and Competition Law and Policy Workshop, Federal Trade Commission, Washington, D.C., dated September 9, 2003.

¹¹ In 1996, the Pennsylvania Insurance Commissioner approved the consolidation of the Blue plans forming Highmark, contingent on a three year moratorium on using the MFN clause. In 2002, Highmark requested the state insurance regulators to bless a "fair payment rate provision" that would force hospitals to always give Highmark their lowest rates. Highmark has 65% to 70% of the health insurance market.

The antitrust cases brought by the DOJ were under §1 of the Sherman Act, alleging that the health plans' use of MFNs in their provider agreements constituted agreements unreasonably restraining competition. In 1996, Gail Kursh, then Chief of the Health Care Task Force of DOJ's Antitrust Division, stated that a law suit would be strongly considered "when a plan imposing an MFN on a provider constitutes the substantial share of the provider's income and has a significant share of the industry's market in relation to others, and providers bound by the MFN are a high percentage of providers in the market, and can impede entry of other providers."¹²

Although DOJ's consent decrees usually do not involve admission or finding of liability and have no precedential value, they do underscore and signify the federal government's enforcement direction in this area. The following is a summary of the enforcement agencies' actions:

- U.S. v. Vision Service Plan¹³ In December, 1994, DOJ's Antitrust Division filed a suit against Vision Service Plan ("VSP"), the largest national vision care insurer, for enforcing MFN clauses in contracts with its member optometrists. VSP was a not-for-profit company that controlled the operation of vision care plans in 46 states and the District of Columbia and covered more than 15 million people. VSP clearly had a dominant position in many markets and a substantial position in others. During the relevant period of time, 98% of Nevada optometrists and 90% of California optometrists were VSP providers and had to agree to an MFN provision. VSP controlled a substantial share of the relevant insurance market. The alleged anti-competitive effects included the fact that optometrists had to resign to avoid the MFN violation and substantial penalty as a result of VSP's enforcement of MFN provisions. According to the government's competitive impact statement, claims were on average \$25 - \$30 higher in parts of the state where VSP had a substantial presence when compared with parts of the states in which VSP was a minor player.

VSP entered into a settlement agreement which enjoined VSP from continuing to use MFNs in its contracts with member optometrists and from engaging in various other anti-competitive activities.

- U.S. and Arizona v. Delta Dental Plan of Arizona¹⁴ The key factors in this case include: (a) Delta Dental had provider contracts with approximately 85% of the dentists in the State of Arizona, (b) most of the dentists received a significant part of their income from Delta Dental, (c) Delta Dental's enforcement of MFN provisions was found to have effectively stopped provider discounting in the market, and (d)

¹² Health Care: DOJ Cites Industry Practices as Continuing Antitrust Concerns, Daily Rep. For Executives (BNA), at A-6 (Apr. 30, 1996).

¹³ 1996-1 Trade Cas. (CCH) ¶ 71,404 (D.D.C. 1996)(consent decree).

¹⁴ 1995-1 Trade Cas. (CCH) ¶ 71,048 (D. Ariz. 1995)(consent decree).

most dentists had resigned from competing dental plans. The government found that the enforcement of the MFN had restricted competition and Delta Dental controlled the Arizona dental insurance market.

- U.S. v. Oregon Dental Service.¹⁵ In this case, Oregon Dental Service (“ODS”) had over 90% of the dentists in Oregon and most of these dentists received a significant part of their income from ODS. The enforcement of MFN provisions caused most Oregon dentists to refuse to discount fees and thus made it impossible for other dental plans to compete in the market. MFNs also caused a significant number of dentists to drop out of competing dental plans, resulting in stabilizing prices for dental services and dental insurance at levels higher than they might otherwise have been. This case was settled by entering into a consent decree with DOJ whereby ODS agreed not to enforce MFN provisions in its provider contracts.
- U.S. v. Delta Dental of Rhode Island.¹⁶ In 1996, the DOJ Antitrust Division sued to stop Delta Dental of Rhode Island (“Delta Dental”) and unnamed co-conspirators from engaging in unlawful agreements that discouraged dentists from offering fees lower than those paid by Delta Dental to patients covered by other insurance companies and to uninsured patients. Delta was the largest dental insurer in Rhode Island and contracted with more than 90% of dentists in the state. Delta administered 35-40% of Rhode Island’s dental insurance plans.

Fees from dental services provided to Delta enrollees represented a substantial portion of most dentists' income. Almost all of the Delta dentists agreed to comply with MFN clause and refused to contract with limited panel dental insurance plans that were trying to enter the Rhode Island market as prices below Delta's.

DOJ alleged that the MFN provisions reduced competition in the dental services and dental insurance markets in Rhode Island because they inhibited participating dentists from lowering their fees to other competing plans as well as uninsured patients.

Prior to going to trial, Delta Dental entered into a settlement agreement whereby Delta Dental agreed to remove the MFN provisions in its agreements with its participating dentists and be enjoined from engaging in other actions that would limit future discounting by its participating dentists.

- U.S. v. Medical Mutual of Ohio.¹⁷ On September 23, 1998, the DOJ sued Medical Mutual of Ohio (“MMO”) to prohibit MMO from enforcing or reinstating MFN

¹⁵ 1995-1 Trade Cas. (CCH) ¶ 71,062 (D. Or. 1995)(consent decree).

¹⁶ 943 F. Supp. 172 (D.R.I. 1996)(denying defendant’s motion to dismiss for failure to state a claim).

provisions in its contracts with hospitals in the Cleveland, Ohio area.¹⁸ DOJ claimed that MMO's MFN clauses in provider contracts violate §1 of the Sherman Act. MMO demanded hospitals agreeing to MFN provisions, which required hospitals to charge MMO's competitors 15%-30% more than they charged MMO. This "price buffer" insulated MMO's health plans from competition, substantially increasing the costs of hospital services and health insurance for businesses and consumers, while suppressing innovation. The complaint also alleged that MMO's MFN provisions reduced hospital discounting and price competition among hospitals and health plans. Under the settlement between the parties, MMO was enjoined from adopting or enforcing any MFN provision or engaging in other activities leading to similar anti-competitive effect in the 7-county area around Cleveland ("Cleveland Region").

Several factors have contributed to the DOJ's investigation and prosecution of MMO.

- MMO's market share – MMO had about 36% of the commercial insurance market in the Cleveland Region.
- All of the general acute care hospitals in the Cleveland Region contracted with MMO for its traditional indemnity plan, approximately 75% of the hospitals were also in MMO's PPO panel, and 45% to 60%, in the HMO panel.
- MMO's MFN provisions result in 15% to 30% of pricing differential between MMO and rival managed care payers. This price buffer has insulated MMO from competitors' price competition.
- MMO's aggressive enforcement of MNF provisions and retrospective audits result in millions of dollars of penalties and the auditing firm is often the consulting firm designing the MNF provisions for MMO.

FTC Action. The one notable enforcement action by FTC is the 1996 consent agreement with RxCare of Tennessee.¹⁹ RxCare was the leading pharmacy network which includes more than 95% of chain and independent pharmacies in the State of Tennessee. FTC claimed that the use of the MFN clauses violated Section 5 of the FTC Act prohibiting unfair acts or methods of competition. The MNF provision discouraged the pharmacies from discounting fees and limited price competition among the pharmacies in their dealings with pharmacy benefits managers and third party payers. The consent agreement bars RxCare and its parent company from using MFN clauses in its pharmacy participating agreements.

State Actions. In addition to the enforcement agencies by DOJ and FTC, various states have either considered legislation or have taken actions to prevent implementation of MFN

¹⁷ 63 Fed. Reg. 52,764 (October 1, 1998). See also 1999-1 Trade Cas. (CCH) ¶ 72,465 (N.D. Ohio, 1999)(consent decree and competitive impact statement).

¹⁸ MMO had previously announced that it would cease enforcing its MFN clauses. However, the DOJ determined that MMO's verbal commitment alone did not sufficiently protect consumers, and that injunctive relief was needed.

¹⁹ See In re RxCare of Tenn., 121 F.T.C. 762 (1996) (consent order).

provisions. As of today, the states that have enacted laws to ban MFN include: Alaska, California, Idaho, Indiana, Kentucky, Minnesota, New Hampshire, Washington, Idaho and Rhode Island.

For Ohio, H.B. 125 is the first try. On or about September 8, 1999, the so-called MFN bill was introduced into the 123rd General Assembly. The Bill prohibits insurers, HMOs or TPAs from using MFN clauses requiring providers to charge any other payors a rate equal to or more than the rate the provider charges the payor or requiring the providers to charge a payor a rate that is equal to or less than the lowest that the provider or health care facility charges any other third party payor.

Other states' actions:

- o **New York** - In a letter dated June 5, 1998, the Executive Deputy Health Commissioner of New York asked Blue Cross and Blue Shield of Rochester, NY to delay or suspend implementation of MFN clauses and to submit contract information to the Department of Insurance for approval.²⁰ The letter stated that the inclusion of a MFN clause "may blunt competition and hinder customer choice."
- o **Pennsylvania** - In May, 1994, the Pennsylvania Attorney General sued two health care systems that created a single corporation (hereinafter referred to as "Alliance") to manage and coordinate the delivery of health care services to residents of north central Pennsylvania.²¹ The two health systems were the sole members of Alliance. The law suit resulted in a consent decree which prohibited Alliance from entering into any provider contracts with any health plans on terms which include a MFN clause to the benefit of the Alliance or any health care plan.
- o **Tennessee** - In March, 1999, Blue Cross and Blue Shield of Tennessee dropped its MFN clause in its hospital contracts and proposed set fee schedules for all hospital charges.
- o **New Hampshire** - As a condition to the approval of the sale of Blue Cross & Blue Shield of New Hampshire to Anthem, the New Hampshire Insurance Commissioner prohibited Anthem from demanding MFN exclusive discounts from health care providers based upon Anthem's volume until July 1, 2001 (but refused to enforce it on a permanent basis).
- o **Virginia** - Because of the medical community's strong opposition to the MFN provisions, in May of 1999, Trigon Blue Cross & Blue Shield (the largest managed

²⁰ See BNA Health L. Rep. Vol. 7, No. 28 (July 9, 1998).

²¹ Commonwealth of Pennsylvania v. Providence Health System, Inc. and North Central Pennsylvania Health System, CV-94-772 (May 26, 1994).

care plan in Virginia) announced its decision to drop the MFN provisions from its physician agreements.²²

- o **California** - In approving the merger of PacifiCare of California with FHP, Inc. in 1997, the California Department of Corporation restricted the plans' use of MFN clauses in the Medicare HMO products in the State of California.
- o **Washington** - In 1997, Washington passed a new law authorizing the Department of Health to promulgate rules governing MFN clauses. The Department of Health adopted rules prohibiting the use of MFN clauses in provider contracts with health carriers. Also, in 1997, Washington State antitrust authorities negotiated a consent decree with Washington Dental Service to stop enforcing the MFN clause.²³

Conclusion

Based upon the enforcement actions and DOJ's informal guidance, DOJ and FTC are likely to target its investigation if the following suspect factors are present:

- The health insurance plan has a significant share of the market. For example, Oregon Dental Service had 90% of the dental insurance market. Vision Service Plan had 98% of the market in Nevada and 90% in California. MMO had 36% of the health insurance market in the Cleveland Region.
- The health plan using the MFN clause must be such an important factor in the market that almost all providers believe that they must participate in that payer's plan.
- A high percentage of providers in the market are bound by the MFN provisions.
- The health plans implementing the MFN clauses represent a significant percentage of providers' income. (As such, it would be unprofitable for those providers to contract with another plan paying less and thus have to lower its price to the payer using the

²² See Roanoke times & World News (May 6, 1999).

²³ See BNA Health L.Rep. Vol. 6, p. 174 (January 30, 1997).

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MFN clause. DOJ Antitrust Division has indicated that when the payer supplies at least 35% of the business of providers in the market, further analysis is warranted.)²⁴

➤ There are anti-competitive effects resulting from the enforcement of MFNs.

These factors are not exclusive nor exhaustive, but merely suggest the likelihood of investigation or enforcement actions by DOJ and FTC. As noted above, MFNs remain an area of interest to DOJ and FTC, which will certainly continue to monitor and evaluate the anti-competitive effect of MFNs.

²⁴ See Charles F. Rule, Assistant Attorney General, Antitrust Division, "Antitrust in the Health Care Field: Distinguishing Resistance from Adaptation," text of remarks before the Antitrust & Health Care Seminar of the Antitrust Section of the Connecticut Bar Association and the Connecticut Health Lawyers Association (March 11, 1988), cited in 2 Health Care and Antitrust L. § 15A:6 (2003).



*Advancing a Counterattack on Managed Care Payment Practices:
Most Favored Nation Clauses*

STATE STATUTORY ANALYSIS

Legislative restrictions on most favored nation ("MFN") clauses remain an area of interest for physician advocates. The dramatic inadequacy in many physician reimbursement rates, and the growing market power of managed care organizations, will probably nourish a continued interest in the physician community to advocate for restrictions in MFN clauses. The Advocacy Resource Center ("ARC") hopes that this report will be a useful tool for those states who may want to push for MFN restrictions.

The ARC will monitor state legislative activity on this subject and notify the federation when any MFN bills are introduced in state legislatures, as appropriate.

For ease of reference, attached to this report is the relevant text of the state statutory restrictions on most favored nation provisions. We have included citation information to assist states who wish to locate the text of a statute in an official source.

GENERAL SUMMARY

The ARC has identified seven states that have restrictions on most-favored nation clauses in managed care contracts. These laws can differ significantly in their content and scope.

Alaska has an outright prohibition against MFN clauses. The law prohibits a managed care entity that offers a group insurance plan from requiring a provider to be paid at the same rate that the provider has contracted to receive from another managed care entity.

In **California**, the law does not actually prohibit most favored nation clauses. It does, however, state that if a contract between a health care service plan and a provider requires that the provider accept the lowest payment rate charged to a patient or third party, the contract cannot apply to any cash payments made by individual patients who do not have private or public forms of health care coverage.

Idaho has an extensive MFN prohibition comprised of three elements:

- (1) a managed care organization cannot contractually require a provider to agree to the unnegotiated adjustment by the managed care organization of the provider's lowest reimbursement rate paid by any other payor;

(2) a managed care organization cannot require a provider to adjust his or her charges to a managed care organization if the provider subsequently agrees to charge another payor lower rates; or

(3) a managed care organization cannot require that a provider disclose the contractual reimbursement rates he/she has agreed to receive from other payors or managed care organizations.

Indiana has an outright MFN clause prohibition, consisting of four parts:

- (1) an agreement between an insurer and provider cannot prohibit, or grant the insurer an option to prohibit, the provider from contracting with another insurer to accept lower payment for health care services than the payment specified in the agreement;
- (2) the agreement cannot require, or grant the insurer an option to require, the provider to accept a lower payment from the insurer if the provider agrees with another insurer to accept lower payment for health care services;
- (3) the agreement cannot require, or grant the insurer an option of, termination or renegotiation of the agreement if the provider agrees with another insurer to accept lower payment for health care services; or
- (4) the agreement cannot require the provider to disclose the provider's reimbursement rates under contracts with other insurers.

In **Kentucky**, MFNs are not absolutely prohibited. An insurance contract cannot contain a MFN clause, *unless* the insurance commissioner determines that the insurer's market share is nominal.

Minnesota has an outright MFN clause prohibition, which is made up of three parts:

- (1) an agreement between an insurer and a provider cannot prohibit, or grant the insurer an option to prohibit, the provider from contracting with other insurers or payors to provide services at a lower price than provided in the agreement;
- (2) the agreement cannot require, or grant the insurer an option to require, the provider to accept a lower reimbursement rate if the provider subsequently agrees to a lower rate with another insurer or payor; or
- (3) the agreement cannot permit the insurer to terminate the agreement or call for contract renegotiation if the provider agrees to a lower reimbursement rate with another insurer or payor.

In **New Hampshire**, using MFN clauses or "Equally Favored Clauses" is an unfair method of competition, and an unfair and deceptive act and practice, in the business of insurance.

Washington's Washington Health Department's administrative rules state that MFN clauses are prohibited.

SPECIFIC STATUTORY LANGUAGE

ALASKA

TITLE 21, CHAPTER 07, Sec. 21.07.010. Patient and health care provider protection

(b) A contract between a participating health care provider and a managed care entity that offers a group managed care plan may not contain a provision that

(3) requires the health care provider to be compensated for health care services performed at the same rate as the health care provider has contracted with another managed care entity.

CALIFORNIA

HEALTH AND SAFETY CODE, DIVISION 2. Licensing Provisions, CHAPTER 2.2. Health Care Service Plans, ARTICLE 5. Standards § 1371.22

Acceptance of lowest payment rate charged by provider to patient or third-party; Inapplicability of policy provision to cash payments made to provider by patient without private or public health care

If a contract between a health care service plan and a provider requires that the provider accept, as payment from the plan, the lowest payment rate charged by the provider to any patient or third party, this contract provision shall not be deemed to apply to, or take into consideration, any cash payments made to the provider by individual patients who do not have any private or public form of health care coverage for the service rendered by the provider, as described in subdivision (c) of Section 657 of the Business and Professions Code. This section shall apply to a provider contract that is issued, amended, or renewed on or after the effective date of this section.

IDAHO

GENERAL LAWS, TITLE 41. INSURANCE, CHAPTER 39. MANAGED CARE REFORM

§ 41-3927. Health care providers -- Participation by any qualified, willing provider -- Contracts -- Grievance procedure

(4) No managed care organization may require as an element of any provider contract that any person agree:

(c) To the unnegotiated adjustment by the managed care organization of the provider's contractual reimbursement rate to equal the lowest reimbursement rate the provider has agreed to charge any other payor;

(d) 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

(e) To a requirement that the provider disclose his or her contractual reimbursement rates from other payors.

INDIANA

TITLE 27. INSURANCE, ARTICLE 8. LIFE, ACCIDENT AND HEALTH, CHAPTER 11. ACCIDENT AND SICKNESS INSURANCE – REIMBURSEMENT AGREEMENTS IAC 27-8-11-9. Agreement between insurer and provider may not contain certain provisions pertaining to contracts or agreements by provider with other insurers.

An agreement between an insurer and a provider under this chapter may not contain a provision that:

(1) prohibits, or grants the insurer an option to prohibit, the provider from contracting with another insurer to accept lower payment for health care services than the payment specified in the agreement;

(2) requires, or grants the insurer an option to require, the provider to accept a lower payment from the insurer if the provider agrees with another insurer to accept lower payment for health care services;

(3) requires, or grants the insurer an option of, termination or renegotiation of the agreement if the provider agrees with another insurer to accept lower payment for health care services; or

(4) requires the provider to disclose the provider's reimbursement rates under contracts with other insurers.

KENTUCKY

TITLE XXV. BUSINESS AND FINANCIAL INSTITUTIONS, CHAPTER 304. INSURANCE CODE, SUBTITLE 17A. HEALTH BENEFIT PLANS, KENTUCKY GUARANTEED ACCEPTANCE PROGRAM § 304.17A-560. Most-favored-nation provision

(1) No insurance contract with a provider shall contain a most-favored-nation provision except

where the commissioner determines that the market share of the insurer is nominal.

(2) Nothing in this section shall be construed to prohibit a health insurer and a provider from negotiating payment rates and performance-based contract terms that would result in the health insurer receiving a rate that is as favorable, or more favorable, than the rates negotiated between a provider and other health insurance issuers.

MINNESOTA

CHAPTER 62A. ACCIDENT AND HEALTH INSURANCE, PROHIBITED AGREEMENTS

§ 62A.64 Health insurance; prohibited agreements

An agreement between an insurer and a health care provider may not:

- (1) prohibit, or grant the insurer an option to prohibit, the provider from contracting with other insurers or payors to provide services at a lower price than the payment specified in the contract;
- (2) require, or grant the insurer an option to require, the provider to accept a lower payment in the event the provider agrees to provide services to any other insurer or payor at a lower price; or
- (3) require, or grant the insurer an option of, termination or renegotiation of the existing contract in the event the provider agrees to provide services to any other insurer or payor at a lower price.

NEW HAMPSHIRE

TITLE XXXVII. INSURANCE. CHAPTER 417. UNFAIR INSURANCE TRADE PRACTICES, GENERAL PROVISIONS

§ 417:4. Unfair Methods, Acts, and Practices Defined

The following are hereby defined as unfair methods of competition and unfair and deceptive acts and practices in the business of insurance:

XXI. "Most Favored Nation" or "Equally Favored Nation" Provisions. -- Using or enforcing any "most favored nation" or "equally favored nation" provision in any contract for medical care provider services. For the purposes of this paragraph "most favored nation" or "equally favored nation" provisions mean a requirement that a provider give the insurer the benefit of any lower fee schedules or charges for services which the provider may subsequently agree to with other persons or entities.

WASHINGTON

TITLE 43. STATE GOVERNMENT – EXECUTIVE, CHAPTER 43.72. HEALTH SYSTEM REFORM -- HEALTH SERVICES COMMISSION

**§ 43.72.310. Managed competition -- Competitive oversight -- Attorney general duties --
Anti-trust immunity -- Fees**

(2) After obtaining the written opinion of the attorney general and consistent with such opinion, the department of health:

(b) Shall adopt rules governing conduct among providers, health care facilities, and health carriers including rules governing provider and facility contracts with health carriers, rules governing the use of "most favored nation" clauses and exclusive dealing clauses in such contracts, and rules providing that health carriers in rural areas contract with a sufficient number and type of health care providers and facilities to ensure consumer access to local health care services...

**TITLE 246. DEPARTMENT OF HEALTH, AGENCY DESCRIPTION, CHAPTER
25. ANTITRUST IMMUNITY AND COMPETITIVE OVERSIGHT SUBSTANTIVE
RULES**

WAC 246-25-010. Definitions.

Unless the context requires otherwise, the definitions contained in this section apply throughout this chapter.

(9) "*Most favored nations clause*" means terms in a contract between a certified health plan and a health care provider or facility by which the provider or facility agrees they will not charge other plans a lower price than the price charged the plan instituting the clause.

WAC 246-25-045. "Most favored nations clauses"--Policy statement.

"Most favored nations clauses" may discourage discounting by the affected seller, may facilitate oligopolistic pricing and deter entry by more efficient competitors. "Most favored nations clauses" are often used as a replacement for innovation or efficiency by large competitors and act as a disincentive for creativity by small competitors. The commission finds that the use of "most favored nations clauses" in contracts between a health care provider or facility and a certified health plan create the potential to thwart the cost containment goals of health care reform. For these reasons, the use of "most favored nations clauses" in contracts between a health care provider or facility and a certified health plan is prohibited.



*Advancing a Counterattack on Managed Care Payment Practices:
All Products and Most Favored Nation Clauses*

RELATED AMA POLICY

All Products Clauses

H-285.989 AMA Opposition to Requiring Physician Participation in Health Maintenance Organizations in Order to Join Preferred Provider Organization Panel

Our AMA will seek legislative action to prohibit tying a physician's membership in a managed care panel (e.g., a PPO) to that physician's participation in any other managed care panel (e.g., an HMO). (Res. 109, I-93; Reaffirmation I-99; Reaffirmation A-00)

Most Favored Nation Clauses

H-385.938 Most Favored Nation Clause within Insurance Contracts

Our AMA opposes the inclusion of "Most Favored Nation Clauses" into insurance contracts that require a physician or other health care provider to give a third party payor his most discounted rate for medical services. (Res. 712, I-98)

D-180.992 Most Favored Nation Clauses

Our AMA shall prepare model legislation to eliminate the use of "Most Favored Nation" clauses in insurance contracts as barriers to offering affordable medical care. (Res. 701, A-02)

