Committee Minutes

Date: February 8, 2000
Time: 9:35am
Room: State House, Room 103

The Senate Committee on **Insurance** held a hearing on the following:

SB316 *relative to "most favored nation" or "equally favored nation" provisions in insurance provider contracts.*

Members of Committee present: *Senator Wheeler, Chairman*
Senator Fraser
Senator Squires

The Chair, Senator **Katie Wheeler**, opened the hearing.

Senator Katherine W. Wheeler, D. 21:
I will open the hearing on SB316, *"relative to "most favored nation" or "equally favored nation" provisions in insurance provider contracts"*, and call on the Prime Sponsor, Senator Fraser.

Senator Leo W. Fraser, Jr., D. 4:
Thank you, Madame Chairman. Good Morning again for the record I'm Senator Leo Fraser and I represent Senate District 4. What I will do, Madame Chairman, is just to give you, offer to the committee a definition of what "most favored nation" means.

(See attached written testimony, Document #1)

That is why Madame Chairman I bring 316 to the Committee this morning. Madame Chairman I would suggest that I defer to Alex from the Insurance Department so far as to speak next and I am sure he will be able answer any questions you may have about SB316.

Senator Katherine W. Wheeler, D. 21:
Thank you Senator Fraser. Is Legislation pending in Congress regarding this?

Senator Leo W. Fraser, Jr., D. 4:
I don't know, I know they are looking at it, but I don't know.

Palmer Jones:
Not at this time.

Senator Katherine W. Wheeler, D. 21:
So not at this time. Thank you Senator Fraser. I would announce to the, I just want to say that it's not lack of interest that the Committee isn't here. Some Senators are running late and some had other meetings, but as we know we have our crack secretary Linda Brosseau here and our crack aide Shannon so we'll get synopses and transcripts. No precious word will be lost. Thank you.

Senator Leo W. Fraser, Jr., D. 4:
Thank you Madame Chair.

Senator Katherine W. Wheeler, D. 21:
Alex would you like to go next? *(Yes).* I will call on Alex Feldvebel from the Department of Insurance.

Alex Feldvebel – New Hampshire Department of Insurance:
Thank you Madame Chairman, Members of the Committee my name is Alex Feldvebel I am appearing on behalf of the Insurance Department in support of this bill. Which focuses on the use of MFN and EFN clauses in contracts between health insurers and healthcare providers. MFN refers to, its an industry term of ours which is "most favored nation", EFN "equally favored nation".

They're similar provisions, which in essences put an obligation on the healthcare provider that contracts with health insurer #1. That if that provider subsequently offers terms of payment to health insurer #2, that are more favorable then the original contract with health insurer #1, that health insurer #1 will get the benefit of those new more favorable terms.

(Alex Feldvebel continues)

The Federal Department of Justice has begun, in the last few years, to bring enforcement action against the use of these clauses in contracts between insurers and healthcare providers, because of their anti-competitive effects. There are basically 2 ways in which the use of these clauses is believed to have anti-competitive effects.

Number 1, they intend to inhibit price competition and number 2 they tend to inhibit market entry of new insurers. In the absent of an MFN or EFN clause a provider may have an incentive to reduce its fees for a new insurer in order to be deemed an approved provider for that insurers members.

This would deem to be desirable both because it tends to decrease medical cost and because it enables new insurers to enter the market thus increasing competition generally. The effect of MFN and EFN clauses is to place a large penalty on this behavior. The provider who might otherwise want to offer a lower rate to an insurer is inhibited from that behavior because of the consequence that it has to give that rate also to the insurer who holds the MFN clause in the contract.

For this reason prices are kept artificially high and newer smaller insurers are discouraged from entering the market because they have a reduced ability to compete on price. Now, this issue is particularly important when you have a health insurance market such as the one we are coming to have now.

That is a market that is relatively consolidated and dominated by 2 major insurers. Because it's a combination of market power and the MFN, EFN clause that really creates the anti-competitive effect. And you can see this the situation, with the insurer with the MFN clause represents a large percentage of the providers business then complying with that MFN clause could have a dramatic impact on the provider. Forcing it discount a large block of business. So it's particularly appropriate, I think, that we have this Legislation given our current market structure.

One other point about these clauses, they're hard to enforce. If insurer #1 believes that the provider with whom it has contracted has actually offered a rate to another insurer that's lower, in violation of the MFN clause. How's that to be enforced? It's hard to get the evidence to determine that the clause has been violated.

(Alex Feldvebel continues)

The effect is that, basically it has to go into litigation. So these clauses have another defect is that they encourage litigation between carriers and buyers. That's all I have to say on this and I would be happy to answer any questions.

Senator Katherine W. Wheeler, D. 21:
Thank you very much. Senator Squires welcome. Any questions for Attorney Feldvebel? See none, thank you very much Alex. Lisa McGunnigle.

Lisa McGunnigle – VP, Health Law and Policy - NHHA:
(See attached written testimony, Document #2)

Senator Katherine W. Wheeler, D. 21:
Thank you very much. Any questions from the committee? See none, thank you so very much for testify. Palmer Jones.

Palmer Jones – New Hampshire Medical Society:
Good Morning committee members, my name is Palmer Jones with the New Hampshire Medial Society.
(See attached written statement, Document #3).

I wanted to take a little different tactical and try to explain why we're at this point. Both people have done a very, very good job of explaining the issue. We are at this point because during the negotiations by Anthem to acquire Blue Cross and Blue Shield this particular concept, or issue, was one that was talked about by the intervenors.

The reason it was discussed was because Anthem had used this contract in other States. And so the concern was that by doing and being allowed to do this, it would create a very, very big hardship on a number of the providers in the State of New Hampshire.

The reason we know there had been discussion about this is because in our discussions, with 13 or so intervenors, we were talking to our colleagues in other States where Anthem was at and Anthem at time used those as part of their contracts. So as a group we felt that would be unfair to the provider community.

(Palmer Jones continues)

We used that and asked that the Insurance Commissioner, in the final order, ban the use of these "most favored nation" clauses for a 2-year period. The Insurance Commissioner choice not to do that but however, she did, in the final memo make a reference to a 6-month period. With the understanding that we would bring this issue to the Legislature.

(Palmer asked Alex is that correct? He replied yes. I just wanted to make sure that I state that correctly.)

So, that is how Senator Fraser was approached, so that we would have a period to discuss this issue and take the opportunity to explain to Legislators that this whole concept and what this whole concept would do. Also the Insurance Commissioner made it very clear too, that it would be unfair in the final agreement with Anthem. Because you'd be placing upon them, as a sole, as an individual group, this particular clause where all the other health plans would not be required.

So, that would have been unfair to Anthem at the time. So the period was, look at it for a 6-month period, discuss it with the Legislature and see if we have a need in this particular area. The discussions are such that a small group, an individual doctor group, has no leverage what so ever. And basically they must take what contracts are presented to them because they don't have the ability to leverage against the bigger.

And as we consolidate here in New Hampshire as how it's indicating, it is going to be shifting a lot of that power to maybe 3 or more health plans. And if they are aloud to use these individual clauses the result could be disastrous for the entire provider community.

So that is the background, that's why we've put through this Legislation. Senator Fraser also made a reference to something called an "all products clause". That is not part of this Legislation but it is also a concept that's being used by more and more of the health plans. By basically saying once you join our health plan you have to take all comers.

You have to take all our plans and more and more of the health plans are starting to use that. And it's a way to force provider communities into contracts that they normally might not sign. We have not introduced that as Legislation but we think that that is an important issue.

(Palmer Jones continues)

Again, as the market consolidates we have to look very carefully at the "all products clauses". Again, our approach is the "most favored nation" would be very unfair the provider community, that being the hospitals, that being the individual provider community of all different kinds. So were here to basically ask for your support in this area and I will try to answer any questions I can.

Senator Katherine W. Wheeler, D. 21:
Are there any questions for Palmer Jones? See none, thank you very much for your testimony. A number of people have signed up in favor and not wishing to speak. Yvonne Nanasi is the only person who has signed up in opposition. Yvonne would you like to testify now or do you like to go after? Tom seems to be moving forward.

Yvonne Nanasi:
I'll do whatever Tom wants to do.

Senator Katherine W. Wheeler, D. 21:
Tom you seem to be in position. Would you like to testify now? *(I'd be happy to).*

Tom Quarles – Aetna USHC:
Sorry for the ruckus, I am due over at House Commerce at 10:00. Tom Quarles appear on behalf of Aetna USHC, we support the bill. We have concerns in ever State we do business in with "most favored nations" clauses. They are not inherently anti-competitive but they can be and without belaboring the point, I think it's been made.

With a smaller market entrant, which is the position Aetna has in New Hampshire, if we want to cut a deal with a provider that is more generous than they might have been with a more dominant health plan. Then a "most favored nation" clause would automatically give that other health plan the better deal for the provider's that we've negotiated. Basically it prevents any advantage to being able to negotiate on the bases of volume and that is why we're in opposition. That's all I have unless there are any questions.

Senator Katherine W. Wheeler, D. 21:
Any questions for Mr. Quarles? Senator Squires.

Senator James W. Squires, D. 12:
Just for a clarification. I thought for awhile, Tom, you were in favor and then your last sentence was "that's why we are in opposition"?

Tom Quarles:
I'm sorry I miss spoke.

Senator Katherine W. Wheeler, D. 21:
In opposition to the clauses?

Tom Quarles:
Correct. We support the bill; we are against "most favored nation" or "equally favored nation" clauses in every instance. Sorry for any confusion.

Senator James W. Squires, D. 12:
Thank you.

Senator Katherine W. Wheeler, D. 21:
Thank you. Yvonne Nanasi.

Yvonne Nanasi – Anthem BC/BS of New Hampshire:
I'm Yvonne Nanasi I am the Director of Government Relations for Anthem Blue Cross/Blue Shield of New Hampshire.
(See first paragraph of attached written testimony, Document #4)

(Yvonne Nanasi continues)

I want to make a distinction here; we oppose prohibiting EFN's. We don't mind and certainly would encourage you to prohibit MFN's; there is a difference. Let me make that distinction as we see it. A MFN or MFR, "most favored rate contract" clause says that: xyz hospital agrees that no other insurance company will have as good a rate as the ABC insurance company.

Meaning that the same rate and anything better cannot be negotiated with another insurer. Meaning that another insurer could come in and negotiate the same rate; it just couldn't be better in a sense. We would have to be given what we will call "the same good rate". EFN's are different than MFN's and we certainly would support a prohibition of MFN's.

(Continues with written testimony, attached Document #4).

(Yvonne Nanasi continues)

A couple of things I need to clarify regarding Anthem's contracts in other States. Anthem in Cincinnati has an EFN contract that they negotiated with the hospitals. Anthem in Cincinnati has 13% market share; they're not the "big boy" in Cincinnati, for that matter in Ohio. In Rhode Island Ocean State BC/BS had 80% market share.

When the Ocean State case was decided the Court said, "it wasn't an anti-competed EFR". The fact didn't support that there was an adverse impact on commerce. These things are completed; it's best sometimes to look at them on a case by case bases. With that I will conclude my testimony, if you have any questions I would be happy to address them or provide you further information. Thank you.

Senator Katherine W. Wheeler, D. 21:
Any questions for Ms. Nanasi? Senator Fraser.

Senator Leo W. Fraser, Jr., D. 4:
Thank you Madame Chairman. Yvonne what's Anthem's market share in New Hampshire?

Yvonne Nanasi:
In New Hampshire, total, we pretty much have to take another look at this once the Tufts stuff all gets shaken out. But between us and Cigna, each of us share about 45% of the market.

Senator Katherine W. Wheeler, D. 21:
Each individually have 45%?

Yvonne Nanasi:
Right, not totally. We'd say somewhere between 40–45 and Cigna have between somewhere between 40-45. The other players do represent a very small portion of the market. That considering that it's mostly all in the Southern tier.

Senator Leo W. Fraser, Jr., D. 4:
So, the combination of Cigna and Anthem is 90%?

Yvonne Nanasi:
Just about.

Senator Leo W. Fraser, Jr., D. 4:
So, you heard Palmer when he spoke about anti-competitive environment here in New Hampshire? You don't believe that's true so far as EFR's are concerned? Would you explain again what, you keep using EFR, I use EFN what's the difference?

Yvonne Nanasi:
When we thinking, rate verses nation, because it is an equally favored rate.

Senator Leo W. Fraser, Jr., D. 4:
You explained what EFR's does, I not sure I understood.

Yvonne Nanasi:
An EFR means that the same rate and anything better can not be negotiated with another insurer. An EFR the other insurer could have the same rate that was negotiated. An MFR is much more "exclusive"; we would say more anti-competitive potential. And we mostly reflect on the Healthy Kids experience. Is that Healthy Kids in order to keep those premiums low, the reimbursement rate for those subscribers are considerable lower then some other plans.

Senator Leo W. Fraser, Jr., D. 4:
If I understand what you're saying, Yvonne if 316 should pass in its present form that would have a direct effect on programs such as Healthy Kids?

Yvonne Nanasi:
I want to make clear that I want to use the word "may", because Healthy Kids has been able to negotiate rates at this point and time without EFR's, because the program is so popular.

(Yvonne Nanasi continues)

We have some concern in the future that maybe desirable for that as well as the Medicaid program or Healthy Kids in order to insure that those premium rates remain low, especially if you get other competitors into the market.

Senator Leo W. Fraser, Jr., D. 4:
Thank you.

Senator Katherine W. Wheeler, D. 21:
Any other questions from the committee? Senator Squires.

Senator James W. Squires, D. 12:
Yvonne, I am interested in the second paragraph in the testimony where you say "the statutes give the Commissioner extensive authority to investigate and take action" etc. against any unfair method of competition. And as you know it's been suggested that some health plans in New Hampshire have entered the market with low rates that cannot be sustained. When I read that and I am well enough aware of that statute, when does a, in your opinion, does a low rate become an unfair method of competition? And would that be considered such and if it were why has there not been some attention given to that problem by the Insurance Department?

Yvonne Nanasi:
We would share your concern on that issue because we had been aware of what was happening with those rates. That they were not sustainable, well we believed they were not sustainable but we certainly did not have access to the same information. I wouldn't hazard a judgement on what's anti-competitive because it is so complicated. And basically the Insurance Statues give leave to the Commissioner to bring in the Attorney Generals office for assistance on those cases also.

(Tape Change).

Senator Katherine W. Wheeler, D. 21:
Any other questions for Ms. Nanasi? See none, thank you for your testimony. That concludes the list of people signed up to speak. Carol Workman, representing Concord Otolaryngology signed up in support not wishing to testify. If anybody wishes change his/her mind please speak up.

(Senator Wheeler continues)

Claudette Phelps, signed up in support but not wishing to testify. Betsey Andrews Parker, signed up in support but not wishing to testify. David Minnis representing the New Hampshire Pharmacists signed up in support but not wishing to testify. Is there any one else in the room wishing to testify on SB316?

Palmer Jones:
Are we allowed a second response?

Senator Katherine W. Wheeler, D. 21:
Yes, but let me call on Judy Ryan first.

Judy Ryan – Bi-State Primary Care:
I just want to say that Bi-State Primary Care Association supports the Legislation but will not testify we'll submit a letter.

Senator Katherine W. Wheeler, D. 21:
OK, Bi-State Primary Care supporting the bill with a letter. Yes, Palmer you may testify again.

Palmer Jones:
Just go back to, if you take the time one of the handouts we had was the most current response to this whole issue by the Justice Department.

(See attached, Documents #5 and #6).

It was release about 3 or 4 months ago, it is very complex but I think Senator Fraser hit upon it. The terms are very; it's clearly something you ought to take very careful look at. And what my point was is that there has been a shift in the anti-trust before they did support that and felt it would create competition.

They have changed their opinion at the National level based on the articles and material we've read. So you might want to, depending on if this goes to a subcommittee, you may want to talk to somebody in the Attorney General's office.

(Palmer Jones continues)

I had the impression that somebody might be here from the Attorney General's office this morning to discuss that. But I'd look very, very carefully at it. And the point I tried to make, and I think Yvonne did that very well, was that consolidation has occurred.

You have 2 players that control 90% of the business and we have to be careful that they offer to the provider community a fair reimbursement for their services. And that's they entire healthcare community, the hospitals, the provider community, everybody that's all we're asking for. Is that helpful?

Senator Katherine W. Wheeler, D. 21:
Thank you Palmer. Yvonne did you wish to testify again?

Yvonne Nanasi:
No, I'm happy, thank you.

Senator Katherine W. Wheeler, D. 21:
Would the Committee like the Attorney General's office give us something?

Senator Leo W. Fraser, Jr., D. 4:
I think so.

Senator Katherine W. Wheeler, D. 21:
Shannon would you mind requesting some information from them?

Shannon Gorrell:
Sure.

Senator Leo W. Fraser, Jr., D. 4:
Is the hearing closed?

Senator Katherine W. Wheeler, D. 21:
Oh, let me; Does anybody else in the room wish to testify on SB316? I will close the hearing on **SB316**.

Hearing on SB316 closed at 10:08am.

Respectively Submitted,
Linda Brosseau, Senate Secretary

Document #1

Document #1

What are they? MFN clauses require physicians (or providers) to agree to a reimbursement rate that is the lowest -- most favorable -- to the insurance plan; prohibits physician from offering a lower rate to anyone else. "All products/all-or-nothing" requires physicians to agree, as a condition of being in a plan's network, to participate in any/all of a plan's products. In other words, if you agree to see patients under a health insurer's indemnity plan or preferred provider program, you also have to take their HMO patients.

Originally the belief was that use of MFNs would create competition and lower insurance costs. But in reality, they have not lowered costs and they have decreased competition when utilized by plans with large market share. That is why the federal government is now taking a closer look.

Document #2

Testimony on SB 316, An Act Relative to "Most Favored Nation" or "Equally Favored Nation" Provisions in Insurance Provider Contracts.

Good morning Madame Chairwoman and members of the Committee. My name is Lisa McGunnigle and I am the Vice President for Health Law and Policy for the New Hampshire Hospital Association, representing New Hampshire's 26 acute care hospitals and most of its specialty care hospitals.

I am here today to express support for Senate Bill 316, An Act Relative to "Most Favored Nation" or "Equally Favored Nation" Provisions in Insurance Provider Contracts. "Most Favored Nation" clauses unfairly advantage the insurers who hold them and place a strain on the future contracting capabilities of other insurers and providers. In effect, an insurer who holds an "MFN" clause benefits from the future negotiations of other insurers, without putting time and effort into future negotiations themselves. Additionally, "MFN" clauses unfairly compromise the position of insurers who negotiate with the same provider in the future, because while that other insurer is not privy to the "MFN" clause, that "MFN" clause is driving up fees to a higher point than current market forces would otherwise dictate. Furthermore, if a hospital subsequently negotiates a lower fee with another insurer, the hospital is in effect required to share this sensitive contractual information to the insurer holding the "MFN" clause.

"MFN" clauses do not take into account changes in market conditions that may occur during the course of a contract, and produce results that would seem

ludicrous in any other setting. For example, "MFN" clauses are analogous to an insurer saying to a covered person, "If during the course of your contract with us, you become willing to pay a different ~~provider~~ insurer a lower premium for the same services, then you are required to pay us that lower premium". This would occur without allowing the current contract to expire or future negotiation to occur. Such an arrangement seems ludicrous and would not be tolerated in that scenario, and the parallel situation that "MFN" clauses create in insurer-provider contracts should not be tolerated either.

Thank you for your time this morning, and I am happy to answer any questions from the Committee.

Document #3

NEW HAMPSHIRE MEDICAL SOCIETY

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Palmer P. Jones

February 8, 2000

Senate Insurance Committee

The New Hampshire Medical Society supports SB 316. The bill would ban the use of most favored nation clauses by all health plans in New Hampshire. Most favored nation clauses are provisions in the providers contract that require a physician to give the health plan the benefit of any lower fee schedule, which the provider may subsequently agree to with other persons or entities.

Most favored nation ("MFN") clauses are intended to ensure that an insurance company will receive the benefit of any price concessions that a health care provider extends to other insurers for services provided to covered patients. A typical MFN clause states that the rates payable under the agreement between the provider and the insurer will at all times be equal to, or lower than, the most favorable rates available to any other payor. The effect is that the provider cannot offer lower rates to another insurance company without reducing its rates to the company enforcing the MFN clause.

MFN clauses have increasingly, and appropriately, come under attack in recent years because they inhibit price competition and market entry. In the absence of an MFN clause, a provider may have an incentive to reduce its fees for a new insurer in order to be deemed an approved provider for that insurer's members. Such conduct is desirable both because it tends to decrease medical costs and because it enables new insurers to enter the market, thus increasing competition generally. However, when an MFN clause is in place, the provider has a strong disincentive to offer such price concessions to the new insurer, because making such concessions to the new insurer would require it to do the same for the company benefiting from the MFN clause. The result is that prices are kept artificially high, and new or smaller insurers are discouraged from entering the market because they have no ability to compete on price.

It is the combination of market power and an MFN clause that creates the anti-competitive effect. Enforcement of an MFN clause by a company that has only one percent of the relevant market may not inhibit price competition, or market entry, because there is less impact on the provider that is subject to the clause. If the provider offers price concessions to a new insurer, it will have to do the same for the insurer enforcing the MFN clause, but this may not present a problem if that insurer represents only a small amount of the provider's business. If, however, the latter insurer represents a large percentage of the provider's business, complying with the MFN clause could have a dramatic impact on the provider by forcing it to discount a large block of its business. Thus, the provider is likely to forgo the opportunity to do business with the new insurer.

It is because of these anti-competitive effects that the United States Department of Justice has, in recent years, regularly and successfully sought to enjoin the use and enforcement of MFN clauses. The Department of Justice obtained a consent order enjoining the use or enforcement of MFN clauses. The Department of Justice's argument was essentially as stated above: that enforcement of MFN clauses discouraged price competition and had the effect of preventing new insurers from entering the health care market.

Thank you,

Palmer P. Jones
Executive Vice President

bam

MFN2000.doc

Document 4

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February 8, 2000
Senate Insurance Committee
SB 316: Prohibiting MFN and EFN contract provisions

Anthem.

Anthem BCBSNH opposes a statutory prohibition of equally favored rate provisions in contracts between providers and health care plans. Such contract provisions are found in contracts between manufacturers and their suppliers, retailers and their suppliers and countries use them to establish tariff treaties. It is important to note that depending on the facts of any given situation most favored rate or equally favored rate provisions may or may not be anti-competitive.

Currently, Chapter 417 of the New Hampshire statutes gives the Commissioner of Insurance extensive authority to investigate and take action against an insurer that is deemed to be engaged in any unfair method of competition. Additionally, there are other governmental bodies that are able to determine whether or not a contract between a hospital and a health plan is anti-competitive. The U.S. Department of Justice, the Federal Trade Commission and the Attorneys' General all have authority to investigate alleged anti-competitive activity in the market place.

When Anthem BCBSNH negotiates a services contract with a hospital, large clinic or professional practice, we work with the provider to ensure that our subscribers will be provided high quality services at a fair rate. Does Anthem BCBSNH seek a contract at the best rate that a provider can afford to offer? Yes, Anthem BCBSNH subscribers deserve quality care at the best rate that we can negotiate that keeps their health insurance affordable and quality services accessible. In doing so, Anthem BCBSNH does not have most favored rate (MFR) provisions in any of its contracts with health care providers. Anthem is committed to serving every "inch" of New Hampshire, not bits and pieces based on market potential and our actions demonstrate it.

During your deliberations on whether to prohibit equally favored rate provisions in contracts, there are a few points that deserve attention.

- Examples of those who may benefit from equally favored rate (EFR) provisions are low income and uninsured residents who participate in Medicaid, NH Healthy Kids and any program that is developed for uninsured employed adults. Cost-effectiveness is an important tool in keeping benefits and insurance premiums affordable for these populations.

- One of the functions of EFR provisions are to protect a large third party payor from assuming more than their fare share of a large provider's operating costs. Without these clauses in their contracts, some health plans could be charged a higher rate for services than a smaller plan with which they compete.

* EFR provisions are entered into voluntarily during the negotiation process. They do not prevent a hospital, professional practice or clinic from giving a discounted charge to a competing payor. They simply require that as fair a discount be given to the payor who has an EFR contracting provision.

Anthem BCBSNH does not believe that prohibiting all EFR contract provisions adds value, nor does it work to solve the problems of the uninsured nor maintain affordable health care insurance premiums. The current law provides protection for consumers against unfair trade practices of insurers. Analysis of the facts in any given situation can occur under the present law to determine whether a contract is anti-competitive.

Anthem BCBSNH would appreciate an opportunity to assist in your deliberations on this bill and tap our extensive resources in New Hampshire and other states on this issue.

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Document #5

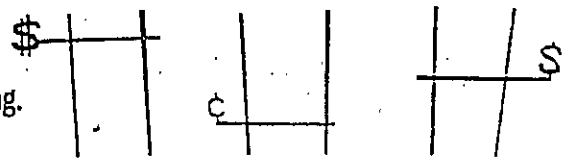
THE NATIONAL LAW JOURNAL

IN FOCUS

ealth Care

Antitrust enforcers step up scrutiny of MFN clauses

Insurers and health care providers should understand the competitive effects of 'most favored nation' pricing.



BY ERIK F. DYHRKOPP
AND ANDREW H. KIM
SPECIAL TO THE NATIONAL LAW JOURNAL

"GIVE ME THE lowest price you offer to my competitors." This simple approach for a buyer to negotiate a low price for goods or services that it purchases—the price given to a seller's most favored customer—is known as most favored nation (MFN) pricing. It is a feature of many agreements between health care providers and health insurers or prescription benefit managers (PBMs).[1] MFN clauses assure an insurance company that it will receive the benefit of any price concessions that a health care provider extends to other insurers for services provided to covered patients.

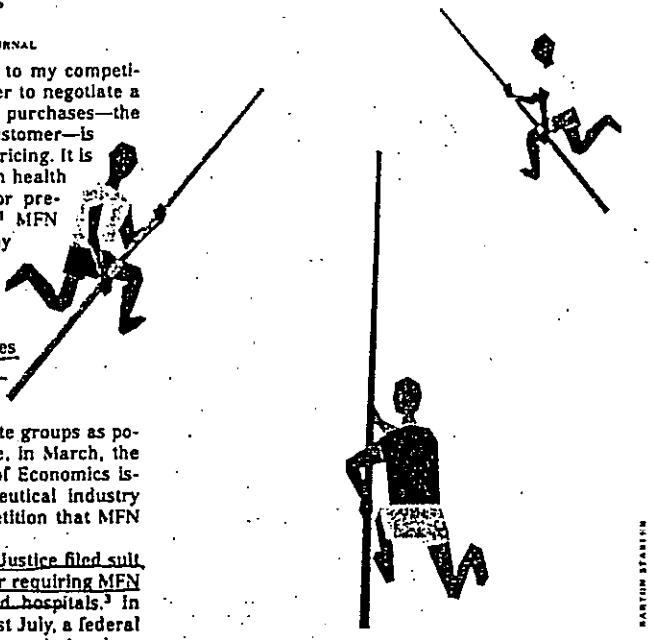
The seeming simplicity of MFN clauses masks the complex effects they may have on the market. MFN clauses increasingly are drawing fire from antitrust enforcement agencies and private groups as potentially anti-competitive. For example, in March, the Federal Trade Commission's Bureau of Economics issued a staff report on the pharmaceutical industry which set forth concerns about competition that MFN pacts raise.[2]

Last September, the Department of Justice filed suit against Ohio's largest health insurer for requiring MFN provisions in contracts with Cleveland hospitals.[3] In *FTC v. Cardinal Health Inc.*, decided last July, a federal court enjoined a merger of wholesale prescription drug distributors in part because they engaged in price coordination by agreeing to provide MFN status to a purchasing group.[4] In April, a society representing 6,800 doctors in Virginia protested an insurer's inclusion of an MFN clause in its standard provider contract.[5]

The FTC and DOJ have enunciated two principal theories behind their objection to MFN clauses: First, they can discourage price competition among health insurers and the entry of new insurers into a health care market. Second, they can facilitate price maintenance among health care providers. Given the increasing scrutiny from these agencies, insurers and health care providers should understand the pro- and anti-competitive tendencies of MFN clauses and evaluate which tendencies may prevail in their use of such provisions.

A typical MFN clause in an agreement between an insurer and health care provider is: "[T]he aggregate rates of payment under this Agreement...between [Purchaser] and [Provider] shall be lower than or equal to the best, most favorable rates available to any non-governmental payer...."[6]

At first blush, MFN clauses appear to be no more than procompetitive efforts by buyers to reduce health care costs. Some courts have focused on this point in validating the use of MFN clauses.



BARTON STABLER

In *Ocean State Physicians Health Plan v. Blue Cross & Blue Shield*, the U.S. Court of Appeals for the 1st Circuit rejected a challenge to Blue Cross' MFN agreements, stating that "it would seem silly to argue that a policy to pay the same amount for the same service is anticompetitive, even on the part of one who has market power. This, it would seem, is what competition is all about."[7] In 1995, the 7th Circuit remarked that "'[m]ost favored nations' clauses are standard devices by which buyers try to bargain for low prices, by getting the seller to agree to treat them as favorably as any of their other customers....[T]hat is the sort of conduct that the antitrust laws seek to encourage."[8]

Economic theory provides additional explanation of MFN clauses' procompetitive benefits: They can enable purchasers to avoid search-and-transaction costs in securing the best available price.[9] Instead of costly comparison shopping to determine whether a health care provider is charging a fair price for a service, a buyer

[SEE 'MFN' PAGE B12]

Mr. Dyhrkopp is a partner, and Mr. Kim an associate, at

Inside:
It's becoming easier to tout virtues
...dictum supplements Page B8

MF[illegible] pricing clauses are attracting agency scrutiny

['MFN' FROM PAGE B7]

instead can rely on an MFN arrangement to assure fair pricing, based on the presumption that the provider would not survive long in the marketplace if its lowest price to customers was significantly above market.

MFN clauses can also facilitate pricing flexibility in long-term contracts. Parties to a long-term contract often want agreed-upon prices to respond to changes in market conditions but want to ensure that any price-adjustment mechanism is fair to both buyer and seller. An MFN clause can meet this need, and avoid significant renegotiation costs, by allowing a seller to adjust prices in a contract to the lowest price it offers other customers.[10] This gives the seller freedom to adjust contract prices in response to market conditions, but the seller's ability to abuse this freedom by charging above-market prices is limited because it can do so only if it does not charge a lower price to any of its other customers.

Antitrust concerns

The government believes that MFN clauses may suppress price competition among insurers by discouraging health care providers from offering selective discounts to insurers. A provider desiring to reduce its fees for a new insurer in order to be deemed an approved provider of services for that insurer's customers must offer the same price reduction to all other insurers protected by MFN clauses.

If patients covered by these MFN-protected insurers account for a large portion of the provider's sales, the extension of the price reductions to services performed on them could result in significant revenue losses for the provider. A provider may decide that these losses offset gains that could result from sales of services to additional patients covered by the new insurer. In such a situation, the MFN clause in the provider's existing agreements with insurers may deter the offering of discounts to a smaller, newcomer insurer.[11] If so, the smaller insurer will have no discount to pass on to its customers in the form of lower fees, thereby reducing price competition between such insurers and larger insurers already established in a market.

This can place smaller insurers at significant competitive disadvantage. Smaller insurers, often possessing a limited pool of providers approved for use by customers, may need to compete on price to attract customers from larger rivals. As explained, however, MFN clauses with large, dominant insurers can discourage providers from offering lower prices to smaller insurers, thus impairing the ability of these insurers to offer competitive pricing to consumers. For this reason, small insurers may decline to enter a market in which a large insurer covers many of the patients in the market and has MFN arrangements with many health care providers.

Such a scenario is described in *U.S. v. Delta Dental of Rhode Island*.[12] In that case, the DOJ alleged in part that Delta Dental's MFN agreement with Rhode Island dentists blocked the entry of a rival insurer, Dental Blue PPO, a nascent PPO (preferred provider organization) of Blue Cross and Blue Shield of Massachusetts. Dental Blue PPO had recruited a number of dentists in Rhode Island, securing rates some 14% below those of Delta Dental on average.

Delta Dental responded by threatening to enforce its MFN agreements against those dentists. Specifically, it demanded to be charged the same fees the dentists charged Dental Blue. Not surprisingly, Dental Blue's dentists deserted and returned to Delta Dental, and Dental Blue PPO was unable to establish itself as a lower-priced alternative dental insurance plan in Rhode Island.[13]

MFN agreements may also inhibit innovation in the provision of services and management of costs. Because their rivals are unable to obtain selective price discounts from providers, insurers lack incentive to develop cost-reducing strategies, such as narrow-panel health plans and efficient case management.[14]

Finally, MFN pacts may spark concern that they discourage price competition among providers. In *Cardinal Health*, the FTC targeted drug distributors who entered into an MFN agreement with a single pharmaceutical purchasing organization, VHA.[15] The FTC charged that "in practice, the [MFN] clause functioned to guarantee that no other customer would be charged a price lower than the VHA. In other words, the agreement served to police the [drug distributors] from trying to undercut one another in the competitive marketplace."[16]

A similar problem involving a provider-owned insurer was manifested in the FTC's complaint and consent decree with RxCare of Tennessee Inc. and the Tennessee Pharmacists Association (TPA) in the RxCare proceeding.[17] RxCare was a pharmacy network that included at least 95% of all chain and independent pharmacies in Tennessee, and was owned by TPA, Tennessee's largest association of pharmacists. RxCare filled prescriptions on behalf of insurers and PBMs, and its contracts with member pharmacies included MFN clauses requiring that, if a network member accepted a reimbursement rate that was lower than RxCare's rate for filling drug prescriptions from anyone else, the member thereafter would accept this lower rate as RxCare's new rate.

The FTC charged that the MFN clause had the effect of deterring pharmacists from accepting lower reimbursement rates because they did not want to extend the same discounts to their RxCare business. Both TPA and RxCare entered into a consent order forbidding MFN clauses in contracts with pharmacies.

Assessing the risks

In assessing the antitrust exposure faced by health care purchasers and providers, certain red flags may warn against the use or enforcement of MFN clauses. First, if the insurer covers a high percentage of patients in a particular area, and has contracts with a high percentage of providers or accounts for a high percentage of payments to them, use of MFN agreements in that area may give rise to concerns about anticompetitive effects.

The antitrust authorities have not specified thresholds for these factors.[18] In practice, however, the DOJ has pursued MFN agreements when market presence was very clear. In *Medical Mutual of Ohio*, for example, the DOJ noted that Medical Mutual covered over 730,000 enrollees, constituting about 36% of the commercially insured local population.[19]

> In assessing the potential antitrust risks, certain red flags may warn against the use or enforcement of an MFN clause.

Moreover, the DOJ noted that 25% to 30% of the commercial payments to local hospitals came from Medical Mutual.[20] In *Vision Service Plan*, 98% of all licensed optometrists in Nevada and 90% in California participated in Vision Service Plan's program, which also covered 57 million enrollees in California.[21]

In *Delta Dental of Rhode Island*, Delta Dental had recruited about 90% of dentists practicing in Rhode Island, and covered 35% to 45% of the people in the state with dental insurance.[22]

Second, an insurer should evaluate whether its use of an MFN clause has had the intended effect of lowering the fees it must pay to health care providers for services performed on covered patients. In *Delta Dental*, DOJ charged that Delta Dental had acknowledged that its MFN had not generated any meaningful savings for dental services, and the court relied on this assertion in denying Delta Dental's motion to dismiss.[23]

Third, government suspicion is particularly apt to be aroused if an MFN clause is imposed by an organization that itself is controlled by health care providers, as was true in *RxCare*. In such cases, providers have an incentive to use MFN clauses as a mechanism for discouraging each other from discounting prices.[24]

Fourth, if there is evidence that [illegible]

tered into an MFN arrangement with a buyer to limit competition among themselves, as in *Cardinal Health*, they risk being challenged by antitrust enforcers.

Insurers and providers should carefully weigh potential procompetitive and anti-competitive effects of using MFN clauses in their contracts. Antitrust enforcers are carefully scrutinizing such arrangements, so it is important that entities fully understand these effects and whether the procompetitive effects outweigh the anti-competitive ones, before DOJ or the FTC come knocking.

(1) For ease of reference, the term "insurer" shall refer to both third-party payers for health care services and prescription benefit managers.

(2) Ron Levy, FTC, The Pharmaceutical Industry: A Discussion of Competitive and Antitrust Issues in an Environment of Change 101-04 (1999) (Staff Report).

(3) Complaint, U.S. v. Medical Mutual of Ohio, No. 1:98-CV-2172 (N.D. Ohio Sept. 23, 1998).

(4) 12 F. Supp.2d 34, 65 (D.D.C. 1998).

(5) Bob Rayner and Deborah Kelly, "Doctors, Trigon at Odds over Pact; Fee Changes, Timing Drawing Criticism," Richmond Times-Dispatch, April 7, 1999, at A1.

(6) See Exhibit 1 to Petition and Complaint of Health Systems International Inc. and Qualmed Plans for Health of Pennsylvania Inc., In re Independence Blue Cross, Docket No. M95-06-024 (June 13, 1995).

(7) 692 F. Supp. 52, 71 (D.R.I. 1988).

(8) 65 F.3d 1406, 1415 (7th Cir. 1995).

(9) Joseph Kattan and Scott A. Stempel, "Antitrust Enforcement and Most Favored Nation Clauses," Antitrust, Summer 1996, at 20.

(10) See id.

(11) As an illustration, DOJ noted in its challenge to an MFN clause between an insurer, Vision Service Plan, and its participating optometrists and ophthalmologists, that prices charged for services in areas where VSP had substantial market presence ranged from $95 to $110, in contrast to $70 to $80 in areas where it had a smaller presence. Competitive Impact Statement, U.S. v. Vision Service Plan, 1996-1 Trade Cas. (CCH) ¶ 71,404, at ¶ 77,042 (Jan. 26, 1995) (Vision Service Plan CIS). Health care providers may also suffer a direct penalty for offering lower prices to other purchasers. See Competitive Impact Statement at 4, Medical Mutual, No. 1:98-CV-2172 (Sept. 23, 1998) (Medical Mutual CIS).

(12) Complaint at ¶¶ 19-25, U.S. v. Delta Dental of Rhode Island, No. CA 96-113 (D.R.I. Feb. 29, 1996).

(13) Id.

(14) See Medical Mutual CIS, supra n.11, at 10.

(15) 12 F. Supp.2d at 65.

(16) Id.

(17) Complaint and Decision and Order, In re RxCare, docket C-3664 (FTC proceeding June 10, 1996).

(18) Kattan and Stempel, supra n.9, at 24.

(19) Medical Mutual CIS, supra n.11, at 3.

(20) Id.

(21) Vision Service Plan CIS, supra n.11, at 77,041.

(22) Delta Dental Complaint, supra n.12, at ¶ 8.

(23) U.S. v. Delta Dental of Rhode Island, 1996-1 Trade Cas. (CCH) 71,609, at ¶ 78,316 (D.R.I. 1996).

Document 6

2ND CASE of Level 1 printed in FULL format.

UNITED STATES OF AMERICA, Plaintiff, vs. DELTA DENTAL OF RHODE ISLAND, Defendant.

Civil Action No. 96-113P

UNITED STATES DISTRICT COURT FOR THE DISTRICT OF RHODE ISLAND

1997 U.S. Dist. LEXIS 11239; 1997-2 Trade Cas. (CCH) P71,860

July 2, 1997, Decided

July 2, 1997, Entered

CORE TERMS: dentist, dental, reimbursement, non-delta, patient, certification, provider, issue of fact, participating, distributed, distribute, notice, Delta's Rules, principal office, duly authorized, designated, referenced, monitoring, customary, enforcing, revised

COUNSEL: [*1] For UNITED STATES OF AMERICA, plaintiff: Anthony C. DiGioia, US Attorney's Office, Providence, RI. Anne K. Bingaman, Joel I. Klein, Rebecca P. Dick, Gail Kursh, David C. Jordan, Steven Kramer, Paul J. O'Donnell, Michael S. Spector, U.S. Dept.. of Justice, Antitrust Division, Washington, DC.

For DELTA DENTAL OF RI, defendant: William R. Landry, Michael W. Carroll, Blish & Cavanagh, Providence, RI. William Kopit, Esq., Epstein, Becker & Green, P.C., Washington, DC.

JUDGES: Raymond J. Pettine, UNITED STATES DISTRICT JUDGE

OPINIONBY: Raymond J. Pettine

OPINION: FINAL JUDGMENT

Plaintiff, United States of America, filed its Complaint on February 29, 1996. Plaintiff and Defendant, by their respective attorneys, have consented to the entry of this Final Judgment without trial or final adjudication of any issue of fact or law. This Final Judgment shall not be evidence against or an admission by any party of any issue of fact or law, nor a determination that any violation of law has occurred. Therefore, before the taking of any trial testimony and without trial of any issue of fact or law, and upon consent of the parties, it is

ORDERED, ADJUDGED, AND DECREED, as follows:

I.

JURISDICTION

This [*2] Court has jurisdiction over the subject matter of this action and over each of the consenting parties. The Complaint states a claim upon which relief may be granted against Delta under Section 1 of the Sherman Act, *15 U.S.C. § 1.*

II.

DEFINITIONS

As used herein, the term:

(A) "Defendant" or "Delta" means Delta Dental of Rhode Island.

(B) "Participating Dentist's Agreement" means Delta's agreement with dentists for the provision of dental services to Delta's subscribers, including Delta's Rules and Regulations referenced in the agreement, and all amendments and additions to any such agreement.

(C) "Participating Dentist" means any dentist who has agreed to comply with the terms of the Participating Dentist's Agreement.

(D) "Most Favored Nation Clause" means:

(1) paragraph 10 of Delta's Rules and Regulations, sometimes characterized as Delta's "Prudent Buyer Policy," pursuant to which:

Delta Dental reserves the right to limit reimbursements to dentists to such levels as such dentists have agreed to accept as reimbursement from other non-governmental dental benefits reimbursement programs;" or

(2) any contractual provision, policy, or practice

which requires [*3] a dentist to charge Delta no more than the lowest fee charged by that dentist to any non-Delta plan or patient.

(E) "Usual and customary fees" means the fees for services and material that dentists usually charge, before any discounting, to their patients.

III.

APPLICABILITY

This Final Judgment applies to Delta and to its successors and assigns, and to all other persons (including Participating Dentists) in active concert or participation with any of them, who have received actual notice of the Final Judgment by personal service or otherwise.

IV.

PROHIBITED CONDUCT

Delta is enjoined and restrained from:

(A) maintaining, adopting, or enforcing any Most Favored Nation Clause or similar provision in any Participating Dentist's Agreement, or by any other means or methods;

(B) maintaining, adopting, or enforcing any policy or practice varying Delta's payments to, or other treatment of, any dentist because the dentist charges any non-Delta patient or plan a fee lower than the fee the dentist charges Delta;

(C) taking any action to discourage any dentist from participating in any non-Delta plan or from offering or charging to any non-Delta patient, or any non-Delta plan, [*4] any fee lower than that paid to the dentist by Delta; and

(D) monitoring, auditing, or obtaining from any dentist the fees a particular dentist charges any non-Delta patient or any non-Delta plan, except as provided in Section V.

V.

PERMITTED ACTIVITIES

Nothing herein shall be construed so as to preclude Delta from:

(A) establishing preferred provider networks or other forms of limited panels of providers, including discounted fee panels, recruiting dentists who are participating with other dental plans in similar panels, and negotiating bi-lateral fee arrangements with such dentists, provided that such activity does not violate any provision of Section IV;

(B) establishing provider reimbursement levels as may be reasonable and necessary to respond to market conditions and having different reimbursement levels for different categories or panels of providers, provided that Delta's criteria for differentiation in reimbursement among categories or panels of dentists are not based on their participation in other dental plans, on fees those dentists offer other dental plans or persons, or on fees those dentists agree upon with other dental plans or persons; and

(C) collecting [*5] through otherwise lawful means, including use of a survey sent to all Participating Dentists, (1) Participating Dentists' usual and customary fees for each applicable service, provided that such information is collected uniformly from all Participating Dentists; and (2) data and information, including reimbursement levels, regarding other dental plans.

VI.

NULLIFICATION

Delta's Most Favored Nation Clause shall be null and void and Delta shall impose no obligation arising from it on any Participating Dentist. Within 90 days of entry of this Final Judgment, Delta shall disseminate to each Delta participating Dentist revised Rules and Regulations, referenced in the Participating Dentist's Agreement, that omit the Most Favored Nation Clause. Delta shall eliminate the Most Favored Nation Clause from all Participating Dentist's Agreements entered into after entry of this Final Judgment.

VII.

COMPLIANCE MEASURES

The Delta shall:

(A) distribute, within 60 days of the entry of this Final Judgment, a copy of this Final Judgment to: (1) all Delta officers and directors; and (2) all Delta employees who have any responsibility for approving, disapproving, monitoring, recommending, [*6] or implementing any provisions in agreements with Participating Dentists.

(B) distribute in a timely manner a copy of this Final Judgment to any officer, director, or employee who succeeds to a position described in Section VII(A)(1) or (2);

(C) obtain from each present or future officer, director, or employee designated in Section VII(A)(1) or (2), within 60 days of entry of this Final Judgment or of the person's succession to a designated position, a written certification that he or she: (1) has read, understands, and agrees to abide by the terms of this Final Judgment; and (2) has been advised and understands that his or her failure to comply with this Final Judgment may result

in conviction for criminal contempt of court;

(D) maintain a record of persons to whom the Final Judgment has been distributed and from whom, pursuant to Section VII(C), the certification has been obtained;

(E) distribute, within 60 days of the entry of this Final Judgment, a copy of the attached letter, which has been approved by the Antitrust Division, by first-class mail to all currently Participating Dentists; and

(F) report to the Plaintiff any violation of the Final Judgment.

VIII.

CERTIFICATION [*7]

(A) Within 100 days of the entry of this Final Judgment, Delta shall certify to the Plaintiff whether it has: (1) disseminated revised Rules and Regulations pursuant to Section VI; (2) distributed the Final Judgment in accordance with Section VII(A); (3) obtained certifications in accordance with Section VII(C); and (4) distributed copies of the attached letter in accordance with Section VII(E).

(B) For ten years after the entry of this Final Judgment, on or before its anniversary date, Delta shall file with the Plaintiff an annual Declaration as to the fact and manner of its compliance with the provisions of Sections IV, V, VI, and VII.

IX.

PLAINTIFF'S ACCESS TO INFORMATION

(A) To determine or secure compliance with this Final Judgment, duly authorized representatives of the Plaintiff, upon written request of the Assistant Attorney General in charge of the Antitrust Division and on reasonable notice to Delta made to its principal office, shall be permitted, subject to any legally recognized privilege:

(1) access during Delta's office hours to inspect and copy all documents in the possession or under the control of Delta, who may have counsel present, relating to any matters [*8] contained in this Final Judgment; and

(2) subject to the reasonable convenience of Delta and without restraint or interference from it, to interview officers, employees or agents of Delta, who may have Delta's counsel and/or their own counsel present, regarding such matters.

(B) Upon the written request of the Assistant Attorney General in charge of the Antitrust Division made to Delta's principal office, Delta shall submit such written reports, under oath if requested, relating to any matters contained in this Final Judgment as may be reasonably requested, subject to any legally recognized privilege.

(C) Delta shall have the right to be represented by counsel in any process under this Section.

(D) No information or documents obtained by the means provided in Section IX shall be divulged by the Plaintiff to any person other than duly authorized representatives of the Executive Branch of the United States, except in the course of legal proceedings to which the United States is a party, or for the purpose of securing compliance with this Final Judgment, or as otherwise required by law.

(E) If at the time information or documents are furnished by Delta to Plaintiff, Delta represents [*9] and identifies in writing the material in any such information or documents to which a claim of protection may be asserted under Rule 26(c)(7) of the Federal Rules of Civil Procedure, and Delta marks each pertinent page of such material, "subject to claim of protection under Rule 26(c)(7) of the Federal Rules of Civil Procedure," then 10 days' notice shall be given by Plaintiff to Delta prior to divulging such material in any legal proceeding (other than a grand jury proceeding) to which Delta is not a party.

(F) Nothing in this Final Judgment prohibits the Plaintiff from using any other investigatory method authorized by law.

X.

FURTHER ELEMENTS OF THE FINAL JUDGMENT

(A) This Final Judgment shall expire ten years from the date of its entry.

(B) Jurisdiction is retained by this Court for the purpose of enabling either of the parties to this Final Judgment, but no other person, to apply to this Court at any time for further orders and directions as may be necessary or appropriate to carry out or construe this Final Judgment; to modify or terminate any of its provisions, based on changed circumstances of fact or law warranting such action; to enforce compliance; and to punish [*10] violations of its provisions.

(C) This Court finds that this Final Judgment is in the public interest as it effectively eliminates the Most Favored Nation Clause. For the reasons set forth in the Competitive Impact Statement, which is attached, eliminating the Most Favored Nation Clause dismantles a significant barrier to the entry of new dental insurance plans into the Rhode Island market. This Final Judgment will open the Rhode Island market to other dental insurance plans, which ultimately should provide

Rhode Island consumers with increased dental insurance options.

Raymond J. Pettine

UNITED STATES DISTRICT JUDGE

DATED: 7/2/97

Speakers

SENATE INSURARNCE COMMITTEE

Date February 8, 2000 Time 9:30am Public Hearing on SB316

Appearing in FAVOR: (Please print) Please check box at left to speak.

Speaking?	Name	Address	Representing
☒	Lisa McGunnigle	125 Airport Rd Concord	NH Hospital Association
☒	PALMER P. JONES	7N State St.	N.H. Medical Society
☐	Carol A. Workman	194 Pleasant St	Concord Otolaryngology
☐	CLAUDETTE PHELPS	241 BROCKWAY RD HOPKINTON NH	
☒	Sen Lou Fraser	Dist 4	Sponsor
☐	Betsey Andrews Parker	[redacted], 4 Park st, Concord	NH Citizens Alliance
☐	DAVID MINNIS	228-8191	NH PHARMACISTS
☒	Alex Feldvebel	56 Old Suncook Rd Concord	NH DOI
☒	~~Yvonne Nanasi~~:	~~Anthem BCBS~~	
☒	Tom Quarles	Aetna USHC	
	Judy Ryan	Bi-State Primary Care (Submitted letter)	

Appearing in OPPOSITION: (Please Print) Please check box at left to speak.

☒	Yvonne NANASI	Anthem BCBSNH
☒	Tom Quarles	
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SENATE INSURARNCE COMMITTEE

Date **February 8, 2000** Time **9:30am** Public Hearing on **SB316**

Appearing in FAVOR: *(Please print)* ***Please check box at left to speak.***

Speaking?	*Name*	*Address*	*Representing*
☐ →	Judith Ryan	3 South St Concord	B. STATE Primary Care Assn.
☐			
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Appearing in OPPOSITION: *(Please Print)* ***Please check box at left to speak.***

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Testimony

YOUNG ANALYSIS

FORMULA

For Q&A on 2/8/00

MFN contract clause: xyz hospital agrees that no other insurance company will have as good a rate as the ABC insurance company. Meaning that same rate and anything better cannot be negotiated with another insurer.

EFN contract clause: xyz hospital agrees that no other insurance company will get any better rate than ABC insurer. Meaning that other insurers can negotiate the same rate but if it is less than the ABC rate then the lower rate will be afforded to ABC.

X

Document #1

What are they? MFN clauses require physicians (or providers) to agree to a reimbursement rate that is the lowest -- most favorable --.to the insurance plan; prohibits physician from offering a lower rate to anyone else. "All products/all-or-nothing" requires physicians to agree, as a condition of being in a plan's network, to participate in any/all of a plan's products. In other words, if you agree to see patients under a health insurer's indemnity plan or preferred provider

program, you also have to take their HMO patients.

Originally the belief was that use of MFNs would create competition and lower insurance costs. But in reality, they have not lowered costs and they have decreased competition when utilized by plans with large market share. That is why the federal government is now taking a closer look.

For: Lee Fraser

Anthem Update

MFNs & All Or Nothing

"Most Favored Nation" (MFN) and "all-products" clauses have been the topic of discussions between NHMS, the NH Insurance Dept. and Anthem -- the company in the process of acquiring NH Blue-Cross. Both clauses have received increased attention of late because of the potential anti-trust implications. The AMA House of Delegates has adopted policy statements opposed to both clauses; the US Dept. of Justice has been investigating the use of such clauses; several states have either enacted laws or are in the process of adopting legislation prohibiting them; and there have been court cases outlawing the use of MFNs.

American Medical Assoc. →

another health plan or to an individual patient. MFNs prevent physicians from offering a discount to a small not-for-profit health plan that may be trying to get into the NH market.

In Anthem's business plan, they state: " 5.0 ... Anthem's N-H's contracting philosophy will be to secure contracting terms and arrangements that are at least as favorable as those obtained by competitors."

The Medical Society will continue to work with Anthem and with the NH Insurance Dept. to try to eliminate the two clauses from any future NH insurance contracts. (Watch for updates.)❖

The wording of the MFN clause can be subtle. In one company contract, NHMS found this wording under a section on physician compensation, "... such charge not to exceed the charge made by Primary Care Physician to non-Member patients." That wording prevents the physician from charging a lower price to

Palmer Jones from the NH Medical Society will go into more detail and answer your questions.

Senator Fraser's Testimony

Alex Feldvebel
NH Insurance Department

SB 316

- MFN and EFN clauses in health carrier provider contracts have an anti-competitive effect

- They inhibit price competition and market entry

- In the absence or an MFN or EFN clause, a provider may have an incentive to reduce it fees for a new insurer in order to be deemed an approved provider for that insurer's members. This is desirable both because it tends to decrease medical costs and because it enables new insurers to enter the market, thus increasing competition generally.

- The effect of MFN and EFN clauses is that prices are kept artificially high and new or smaller insurers are discouraged from entering the market because they have reduced ability to compete on price.

- It is the combination of market power and MFN or EFN clauses that creates the anti-competitive effect. If the insurer with the MFN clause represents a large percentage of the provider's business, complying with the MFN clause could have a dramatic impact on the provider by forcing it to discount a large block of business.

- Also, such clauses are hard to enforce without litigation.

Committee Report

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE

Date:

THE COMMITTEE ON Insurance

to which was referred Senate Bill 316

AN ACT relative to "most favored nation" or "equally favored nation" provisions in insurance provider contracts.

VOTE: 4-0

Having considered the same, report the same without amendment and recommend that the bill: **OUGHT TO PASS.**

Senator Leo W. Fraser, Jr.
For the Committee

SB316 Docket

Next|Previous|Results List|Bill Status|Main

Bill Title: relative to "most favored nation" or "equally favored nation" provisions in insurance provider contracts.

Date	Body	Description
1/5/2000	S	Introduced and Ref. to Insurance; SJ Convening Day, Pg. 7
1/6/2000	S	Hearing , Feb. 8 , Room 103 , SH , 9:30 a.m.; SC1, Pg.7
3/13/2000	S	Committee Report Ought to Pass; 3/16/00, SC17, Pg.3
3/16/2000	S	Ought to Pass, MA, VV; OT3rdg, MA,VV; SJ 6, Pg.179
3/21/2000	H	03/09/2000 Introduced and ref to Commerce; HJ26, p795
3/21/2000	H	Copy to Chairman on 3/21/2000
4/4/2000	H	Hearing Apr 12 1:30 RM302,LOB
4/18/2000	H	Subcom Work Session May 9 10:00 RM302,LOB
4/19/2000	H	(Subcom: Reps McGough, Kenney & Taylor)
5/9/2000	H	Maj Report OTP for May 17 (vote 18-1;CC)
5/17/2000	H	Passed; Reps Chandler & Burling Susp Rules for 3rd reading, MA 2/3VV; HJ45, p1366 + 1394
5/18/2000	S	Enrolled Bill, Adopted; SJ 15, Pg.495
5/18/2000	H	Enrolled; HJ$6, p1497
5/30/2000	S	Signed by the Governor on 5/30/2000 Eff: 1/1/2001 Chap: 0206

Next|Previous|Results List|Bill Status|Main