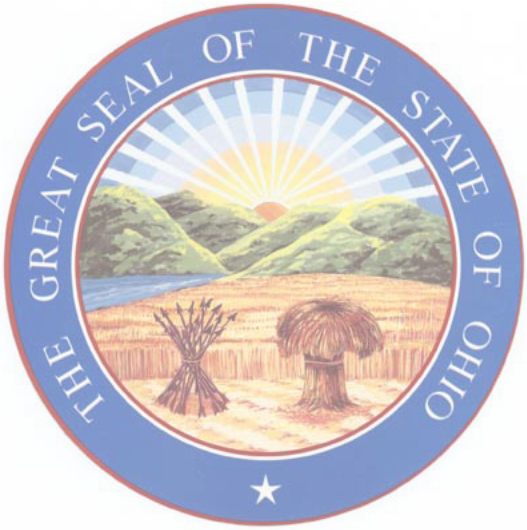
House Bill 125

Joint Legislative Commission on Most Favored Nation Clauses in Health Care Contracts Report

– 2010 –



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March 2010

House Bill 125 of the 127th General Assembly created the Joint Legislative Study Commission on Most Favored Nation Clauses in Healthcare Contracts. Section Six of House Bill 125 required the Commission to provide the General Assembly with a report of its findings and recommendations. The Commission convened its first meeting in January 2009, and held its last meeting on March 9, 2010.

The Commission was charged with studying the use and effect of most favored nation clauses in health care contracts, including the procompetitive and anticompetitive aspects of most favored nation clauses and the impact of such clauses on the availability of and accessibility to quality health care. After gathering the available information, the Commission reached consensus findings of fact and took votes on recommendations. The activities, findings and votes of the Commission are reflected in the attached Report.

Notably, HB 125 called for the Commission to issue a preliminary and final report. Instead of issuing two reports, the Commission decided to issue one report, which would represent both a preliminary and final report. With the issuance of the attached report, the work of the Joint Legislative Study Commission on Most Favored Nation Clauses in Healthcare Contracts is concluded.

I respectfully submit the Final Report of the Joint Legislative Study Commission on Most Favored Nation Clauses in Healthcare Contracts.

Sincerely,

Mary Jo Hudson
Superintendent
Ohio Department of Insurance

EXECUTIVE SUMMARY

House Bill 125 of the 127th General Assembly required the creation of the Joint Legislative Commission on Most Favored Nation (MFN) Clauses in Health Care Contracts (the Commission). The Commission was charged with examining several aspects of the effect of these clauses on health care in Ohio. The scope of the Commission's work included studying the procompetitive and anticompetitive aspects of MFN clauses; the impact of MFN clauses on health care costs and on the availability of and accessibility to quality health care; and the costs associated with the enforcement of MFN clauses.

The Commission consisted of members representing hospitals, insurers, providers, employers, antitrust attorneys, and the Ohio Department of Insurance. Members were appointed by the General Assembly. The Commission met regularly over a 13-month period to fulfill its charge.

In order to fulfill its charge, the Commission heard from two economists and an antitrust attorney with expertise in MFN clauses. The Commission also conducted two surveys of Ohio hospitals and insurers to collect Ohio specific information regarding the use of MFN clauses. While the surveys were not conducted using accepted statistical methods, they did provide information about the use of these clauses in Ohio.

After gathering the available information, the Commission came to unanimous consensus on a number of factual findings, which include the following:

a) Whether an MFN clause is pro or anti competitive depends on the facts of the specific situation.

b) The Commission is not aware of any information addressing whether or not MFN clauses have a market-wide economic impact on health care costs in Ohio.

c) The Commission is not aware of any information addressing whether or not MFN clauses have a market-wide impact on the availability of and accessibility to quality health care in Ohio.

d) The Commission conducted a survey of hospitals and insurers as to their experience with MFN clauses.

e) The surveys were not designed using accepted statistical methods. Responses were voluntary and blinded. Hospital respondents to the survey reported the following information:

1. Nine of the 13 large hospitals (which included hospital systems) and none of the six mid-size hospitals with MFN clauses reported that they would have given a lower price to another insurer in the absence of an MFN clause.

2. Six large hospitals or hospital systems and three mid-size hospitals reported that the existence of an MFN clause affected or discouraged them from entering into innovative payment methodologies with another insurer and six large hospitals or hospital systems and three mid-size hospitals reported that they did not.
3. 15 of 19 responding hospitals or hospital systems with MFN clauses use measures, such as price buffers, to ensure that an MFN clause is not violated.

f) There are costs to some insurers and hospitals associated with the enforcement of some MFN clauses.

The Commission also voted on the two recommendations required of it by the General Assembly. By a vote of 8 to 3, the Commission voted to recommend that the Ohio Legislature prohibit or restrict MFN clauses in health care contracts. Also, the Commission unanimously voted against recommending that the Ohio Legislature extend the two year moratorium on MFN clauses in health care contracts between hospitals and contracting entities. A listing of how members of the Commission voted is attached as Appendix A-2.

I. INTRODUCTION/BACKGROUND

The Joint Commission on Most Favored Nation (MFN) Clauses in Health Care Contracts (the Commission) was created by House Bill 125 (HB 125)[1] of the 127th Ohio General Assembly. Passed in 2008, the bill included restrictions on the use of MFN clauses in health care contracts between contracting entities[2] and providers[3]. House Bill 125 was subsequently amended by HB 493 of the 127th General Assembly. Together, these bills permanently banned the use of MFN clauses in health care contracts between contracting entities and providers that are not hospitals. With respect to hospitals, the bills placed a two-year moratorium on the use of MFN clauses subject to a possible one-year extension by the General Assembly.

In HB 125, the General Assembly defined MFN clauses as a provision in a health care contract that does any of the following:

a) prohibits, or grants a contracting entity an option to prohibit, the participating provider from contracting with another contracting entity to provide health care services at a lower price than the payment specified in the contract;

b) Requires, or grants a contracting entity an option to require, the participating provider to accept a lower payment in the event the participating provider agrees to provide health care services to any other contracting entity at a lower price;

c) requires, or grants a contracting entity an option to require, termination or renegotiation of the existing health care contract in the event the participating provider agrees to provide health care services to any other contracting entity at a lower price; or

d) requires the participating provider to disclose the participating provider's contractual reimbursement rates with other contracting entities.

MFN clauses emerged as an issue for providers during deliberation of the legislation. During testimony on the bill, some interested parties categorized MFN clauses as unfair and anticompetitive. Some interested parties characterized MFN clauses as fair and procompetitive.

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[1] For the entire text of Section Six of HB 125, see Appendix A-1.

[2] The term "contracting entities" means any person that has a primary business purpose of contracting with participating providers for the delivery of health care services.

[3] The term "providers" means a physician, podiatrist, dentist, chiropractor, optometrist, psychologist, physician assistant, advanced practice nurse, occupational therapist, massage therapist, physical therapist, professional counselor, professional clinical counselor, hearing aid dealer, orthotist, prosthetist, home health agency, hospice care program, or hospital, or a provider organization or physician-hospital organization that is acting exclusively as an administrator on behalf of a provider to facilitate the provider's participation in health care contracts.

Ultimately, HB 125, as amended by HB 493, prohibited contracting entities from doing any of the following: a) offering to a provider other than a hospital a health care contract that includes a MFN clause; b) entering into a health care contract with a provider other than a hospital that includes a MFN clause; and c) amending an existing health care contract previously entered into with a provider other than a hospital to include a MFN clause. With respect to a contracting entity and a hospital, no health care contract that includes a MFN clause shall be entered into, and no health care contract at the instance of a contracting entity shall be amended or renewed to include a MFN clause, for a period of two years after the effective date of HB 125 (i.e. June 25, 2008), subject to possible extension for one additional year by the General Assembly. The General Assembly included in HB 125 a study commission dedicated to examining the use and prevalence of MFN contracts. To fulfill the charge of HB 125, the Ohio General Assembly appointed seventeen individuals representing all sectors of the health care market to the Commission. Constituencies represented by Commission members include hospitals, insurance companies, providers, antitrust attorneys, and employers. The Commission was chaired by Mary Jo Hudson, the Superintendent of the Ohio Department of Insurance (ODI). ODI staff was responsible for providing administrative support to the Commission.

The Most Favored Nations Study Commission was charged with investigating the following:

1) The procompetitive and anticompetitive aspects of MFN clauses;
2) The impact of MFN clauses on health care costs and on the availability of and accessibility to quality health care;
3) The costs associated with the enforcement of MFN clauses;
4) Other state laws and rules pertaining to MFN clauses in their health care contracts; and
5) Other matters deemed relevant by the Commission.

In addition to studying MFN clauses, the Commission was charged with making recommendations to the General Assembly on whether to extend the two year moratorium on MFN clauses in health care contracts between hospitals and contracting entities for a period of up to one additional year; and whether to prohibit or restrict MFN clauses in health care contracts.

Members of the Commission

The Commission was comprised of the following individuals representing the following constituencies.

- Leigh Brock-Webster-Cleveland Clinic (representing hospitals)
- Senator Capri Cafaro-Ohio Senate (representing the minority party of the Senate)
- Dr. Stuart Chesky-KePRO (representing a provider who is an individual)
- Michelle Daniels-Aetna (representing contracting entities regulated by the Department of Insurance under Title XXXIX of the Revised Code)
- Philip Derrow-Ohio Transmission Corporation (representing an employer that pays for the health insurance coverage of its employees)
- Robert S. (Binem) Dizenhuz-Anthem Blue Cross and Blue Shield (representing contracting entities regulated by the Department of Insurance under Title XVII of the Revised Code)
- Representative Dan Dodd-Ohio House of Representatives (representing the majority party of the House of Representatives)
- Lisa Han-Squire, Sanders, and Dempsey (licensed attorney with an expertise in antitrust law who represents providers)
- Superintendent Mary Jo Hudson-Ohio Department of Insurance
- Representative Matt Huffman-Ohio House of Representatives (representing the minority party of the House of Representatives)
- Thomas Kniery-United Healthcare (representing contracting entities regulated by the Department of Insurance under Title XVII of the Revised Code)
- Dr. William Kose, Blanchard Valley Regional Health Center (representing a provider who is an individual)
- Laura Kuykendall-Vorys, Sater, Seymour and Pease (licensed attorney with an expertise in antitrust law who represents contracting entities that have used most favored nation clauses in their health care contracts and that are regulated by the Department of Insurance under either Title XVII or Title XXXIX of the Revised Code)
- Chad Matteson-CIGNA (representing contracting entities regulated by the Department of Insurance under Title XXXIX of the Revised Code)
- Michele Napier-Mercy Health Partners (representing hospitals)
- Senator Bill Seitz-Ohio Senate (representing the majority party of the Senate)
- Dr. Wayne Wheeler- Southern Ohio Medical Center (representing a provider who is an individual)

II. FINDINGS

After considering the available information, the Commission decided to develop findings upon which it could reach consensus. The following are the unanimous findings of the Commission.

1) Findings as to the procompetitive and anticompetitive aspects of MFN clauses

a) The available literature on the effects of MFN clauses in healthcare contracts includes theories of procompetitive market effects as well as theories of anticompetitive market effects.

b) There is little empirical evidence that supports either the procompetitive or anticompetitive market impact theory.

c) Enforcement actions by state and federal antitrust regulators do not lead to any overarching conclusions as to whether MFN clauses are always pro or anticompetitive. Each case is inherently fact specific.

d) Whether an MFN clause is illegal under state or federal antitrust laws depends on the facts of the case. Under antitrust laws, MFN clauses are not per se legal, but they are also not per se illegal.

e) Whether an MFN clause is pro or anticompetitive depends on the facts of the specific situation.

f) In order to determine with certainty whether MFN clauses have a market-wide pro or anticompetitive economic impact within Ohio, an empirical study would need to be performed.

g) An empirical economic study of MFN clauses in Ohio would need to include a comprehensive analysis of a defined market that isolates the effects of MFN clauses on that market, while controlling for all other factors.

h) Dr. William Lynk advised the Commission that conducting a proper economic study with respect to MFN clauses in Ohio would be a complicated undertaking that would take considerable time, expense and effort. The study would likely take over a year to perform and the costs would be significant.

i) The Commission decided not to undertake an empirical economic study of the market wide effects of MFN clauses in Ohio because of time and cost constraints.

j) The only empirical economic study discovered by the Commission as to the effects of MFN clauses on health care markets was performed by Dr. William Lynk and is entitled, “Some Basics About Most Favored

Nation Contracts in Health Care Markets," 45 Antitrust Bulletin 491 (Summer 2000).

k) As to his study, Dr. Lynk spoke to the Commission and stated the following:

i. MFN clauses in health care contracts are not automatically pro or anticompetitive.

ii. The findings of his study on the impact of MFN clauses involving hospitals in Philadelphia and physicians in Rhode Island approximately 15 years ago might or might not necessarily apply to the current market in Ohio.

iii. Dr. Lynk's study was designed to analyze the impact of MFN clauses on price and did not consider the impact of MFN clauses on non-price terms.

iv. Dr. Lynk was unaware of any study that considered the impact of MFN clauses on non-price terms.

v. Dr. Lynk's study did not consider the long term effects of MFN clauses on providers, employers or consumers.

vi. Dr. Lynk acknowledged his study took into account government payers without MFN clauses.

2) Findings as to the impact of MFN clauses on health care costs and on the availability of and accessibility to quality health care

a) The Commission is not aware of any information addressing whether or not MFN clauses have a market-wide economic impact on health care costs in Ohio.

b) The Commission is not aware of any information addressing whether or not MFN clauses have a market-wide impact on the availability of and accessibility to quality health care in Ohio.

c) The Commission conducted a survey of hospitals and insurers as to their experience with MFN clauses. The surveys were not designed using accepted statistical methods. Responses were voluntary and were blinded. The insurer survey was sent to all life and health insurers licensed to write health insurance in Ohio. 35 responses were received which represented over 90% of the insured lives in Ohio. The hospital survey was sent to 157 hospital chief financial officers representing 189 hospitals, which comprise approximately 96% of general medical surgical hospitals in Ohio. Responses were received from 60 hospitals or hospital systems to the initial survey and 44 hospitals or hospital systems to the follow-up survey. Hospital systems that responded

provided information as to multiple hospitals. Hospital respondents to the follow-up survey reported the following information:

i. Nine of the 13 large hospitals (which included hospital systems) and none of the six mid-size hospitals with MFN Clauses reported that they would have given a lower price to another insurer in the absence of an MFN clause.

ii. Six large hospitals or hospital systems and three mid-size hospitals reported that the existence of an MFN clause affected or discouraged them from entering into innovative payment methodologies with another insurer and six large hospitals or hospital systems and three mid-size hospitals reported that they did not.

iii. 15 of 19 responding hospitals or hospital systems with MFN clauses use measures, such as price buffers, to ensure that an MFN clause is not violated.

3) Findings as to the costs associated with the enforcement of MFN clauses

a) There are costs to some insurers and hospitals associated with the enforcement of some MFN clauses.

In response to the Commission surveys, some hospitals and insurers reported participating in audits to enforce some MFN clauses. Of the 27 responding hospitals with MFN clauses, 10 reported having been audited within the past 5 years. Responding insurers reported conducting 35 audits within the past 5 years.

b) Some hospitals reported both direct and indirect costs associated with audits initiated by insurers with MFN clauses.

c) Some hospitals reported costs related to enforcement of MFN clauses, and the reported costs varied from the costs associated with normal operations to an expense of $48,000 for third party services related to an audit.

d) Insurers with MFN clauses reported that they incurred less than $1 million in costs related to audits performed over the last 5 years.

e) Comments from some hospitals in response to the survey indicated that the presence of an MFN clause requires hospitals to continuously monitor for compliance, requiring additional staff which adds cost.

4) Findings as to other state laws and rules pertaining to MFN clauses in their health care contracts

a) The Commission has determined that 14 other states have passed laws to prohibit or restrict MFN clauses in healthcare contracts. Those states

are: Alaska, California, Idaho, Indiana, Kentucky, Maryland, Minnesota, New Hampshire, New Jersey, New York, Rhode Island, Vermont, Washington and West Virginia.

b) The Commission is not aware of any empirical evidence or analytical studies that address the market-wide effects of these laws in these other states.

5) Findings as to other matters deemed relevant by the Commission.

a) The insurer survey showed that two types of MFN clauses are being used in Ohio: (1) Comparable Rate – Under this type of clause, the provider would guarantee the contracting insurer that it would not charge a competitor a rate for a specified service that was less than the rate that it charged the insurer with the MFN clause. If the provider did negotiate a lesser rate, it would be obligated to offer a comparable rate to the insurer with the MFN clause. (2) Better Than Rate – Under this type of clause, the provider would guarantee the contracting insurer that any rate that was charged for a specific service would be a certain percentage below the lowest rate the provider charged a competing insurer for the same service.

b) The “comparable rate” was found to be the predominant type of MFN clause used in Ohio.

c) MFN clauses have supporters and opponents.

d) MFN clauses are one of many terms that are negotiated during negotiations between insurers and hospitals.

e) MFN clauses are used in a variety of circumstances, and are not necessarily exclusive to contracts between insurers and hospitals.

f) All members and stakeholders were provided opportunities to bring in witnesses and to present facts and opinions to the Commission.

g) Other than Dr. William Lynk and Dr. Michael Morrisey, no other economists were identified by the Commission as having published works on the economic impacts of MFN clauses. These were the only two economists to present to the Commission.

h) The Commission has decided to conclude its work with the issuance of this report.

IV. RECOMMENDATIONS OF THE COMMISSION

On February 26, 2010, the Commission met to vote on two recommendations.

First, by a vote of 8 to 3, the Commission voted in favor of recommending that the Ohio Legislature prohibit or restrict MFN clauses in health care contracts.

Second, the Commission unanimously voted against recommending that the Ohio Legislature extend the two–year moratorium on MFN clauses in health care contracts between hospitals and contracting entities.

A list of how each member of the Commission voted is attached as Appendix A-2.

V. ACTIVITIES OF THE COMMISSION

Meetings of the Commission

The Commission began its work in January 2009 and held regular meetings to conduct its work. These meetings are detailed below.

January 29, 2009 Meeting

At the first meeting, the Commission reviewed HB 125, including the definition of MFN clauses, the prohibitions and restrictions on MFN clauses, and the charge of the Commission.

The Commission discussed that the General Assembly in HB 125 and HB 493 instituted a permanent ban on MFN clauses with respect to providers that are not hospitals. As to hospitals, the General Assembly instituted a two-year moratorium and asked the Commission to make recommendations as to whether to extend the moratorium and whether to prohibit or restrict MFN clause permanently. As a result, the Commission decided to focus its study and analysis on MFN clauses involving hospitals.

The Commission also discussed how to complete its work. The Commission talked of investigating the prevalence, type, and use of MFN clauses in Ohio before making recommendations. The Commission discussed doing an Ohio-specific, market-wide, economic study of MFN clauses to determine whether the clauses are pro-or anticompetitive and their impact on the cost and quality of health care. The Commission decided to first conduct a survey of payors and providers in Ohio. The Commission asked ODI to begin work on a draft survey and decided to revisit the issue of an economic study after the survey was completed.

At the first meeting, Robert Jones, an antitrust attorney from the Chicago office of Jones Day, provided an overview of MFN clauses from an antitrust perspective and his testimony is detailed in Section Five of this report below.

March 12, 2009 Meeting

At the March 12, 2009 meeting, the Commission focused on developing the survey to payors and providers on the use, prevalence, and impact of MFN clauses in Ohio. In advance of the meeting, ODI staff completed a draft survey of survey questions. These initial drafts were reviewed and the Commission discussed what other issues should be addressed by the survey.

To continue work on the survey methodology and questions, the Commission decided to form three working groups and invited anyone who wanted to be involved to participate in drafting sessions. One working group was to draft the insurer survey, one was to draft the hospital survey, and one was to examine and address confidentiality issues. The working groups were to report back to the Commission at the next meeting.

May 14, 2009 Meeting

During the May 14 meeting, the Commission reviewed the work of the work groups. Questions on both surveys were reviewed and Commission members had the opportunity to comment on the surveys. The Commission decided to limit survey questions to MFN clauses currently in effect or in effect during the last five years. Likewise, questions about audits and enforcement were limited to the past five years.

It was determined that the ODI would send out both surveys under its authority under Section 3901.011 of the Ohio Revised Code. The individual survey responses are considered confidential market analysis work papers pursuant to Section 3901.48(C) of the Ohio Revised Code. ODI would review the responses and report the results on an aggregate basis with the individual information de-identified.

September 10, 2009 Meeting

On September 10, 2009, ODI reported back to the Commission on the survey.

On July 2, 2009, ODI distributed the surveys to all member hospitals of the Ohio Hospital Association (OHA). The chief financial officers of each hospital and hospital system received the survey. In total, the survey was sent to 157 individual hospitals and hospital systems. Hospital systems were asked to respond on behalf of all their member hospitals.

On July 2, 2009, the insurer surveys were sent to the 411 life and health insurers licensed to do business in Ohio. Insurers were not required to complete the survey if they did not contract with providers or they no longer wrote health insurance business in Ohio. Responses to the survey were requested by August 14, 2009.

ODI staff compiled the survey results. The de-identified results were presented to the Commission on September 10, 2009 and are detailed in Section Three of this report below. A Power Point presentation shown at the September 10th meeting is

also attached as Appendix A-3.

At this meeting, the Commission determined that follow-up surveys of both the hospitals and insurers were needed to obtain additional information. All Commission members and anyone else who wanted to participate were invited to work on the surveys.

November 12, 2009 Meeting

At the November 12, 2009 meeting, ODI reported back to the Commission on the follow up survey. ODI reported that the follow-up survey was sent out to the same recipients of the initial survey. Responses to the follow up survey were requested by October 23, 2009.

In the weeks following the survey response date, ODI staff compiled the results of the survey. The de-identified results were presented to the Commission on November 12, 2009, including a PowerPoint presentation which is attached to this report as Appendix A-4.The actual results of the follow up presentation are detailed in this report in Section Four below. Commission members were given an opportunity to discuss the results of the surveys and to make suggestions as to the next course of action.

At the November 12, 2009 meeting, Dr. Michael Morrisey testified to the Commission. Dr. Morrisey is an economics professor at University of Alabama at Birmingham who has written a text book that includes an overview of the economic principles and theories that apply to MFN clauses. Dr. Morrisey's testimony to the Commission is detailed in Section Five of this report below. Dr. Morrisey testified that MFN clauses can be procompetitive or anticompetitive depending on the situation. He gave an overview of the economic principles and theories that apply to MFN clauses, and answered the questions of Commission members.

January 10, 2010 Meeting

At the January 10, 2010 meeting, Dr. William Lynk testified to the Commission. Dr. Lynk is an economist with Compass Lexecon Services that authored an analysis of MFN clauses in 2000. Dr. Lynk's study came to the attention of the Commission and therefore he was invited to speak. Dr. Lynk spoke to the economic principles and theories that apply to MFN clauses and answered the questions about what it would take for the Commission to undertake an economic study of MFN clauses specific to Ohio. He testified that MFN clauses can be procompetitive or anticompetitive depending on the situation, and that a market-wide study of MFN clauses specific to Ohio would be complicated, lengthy and expensive. Dr. Lynk's testimony to the Commission is detailed in Section Five of the Report below.

The Commission met four additional times throughout January and March 2010. During these meetings, the Commission developed the findings of fact, as well as finalized the report to the General Assembly.

VI. Results of the Survey Sent to Payors and Providers on MFN clauses

Survey Methodology

The Commission prepared the surveys to determine the prevalence, type and impact of MFN clauses in Ohio. Separate surveys were sent to hospitals and insurers to gather information from both parties to MFN contracts. The surveys were developed with the input of all Commission members so that the survey questions would answer all their questions. It was a collaborative process in which all members of the Commission helped to prepare the survey.

The surveys were not designed using accepted statistical methods. Responses were voluntary. At the request of the OHA, the survey was designed to be a "blind survey" in which hospitals were not asked to identify themselves, only to indicate whether the response was on behalf of one hospital or more than one hospital (a hospital system). The hospital survey was sent to each hospital member of the OHA, which consisted of 157 hospital CFO's representing 189 hospitals, approximately 96% of general medical surgical hospitals in Ohio. ODI received sixty responses to the survey. Of the sixty responses, forty were on behalf of one hospital and twenty were on behalf of hospital systems which included more than one hospital. Because the survey was a "blind survey", it is not known exactly how many hospitals are represented in the twenty hospital system responses received.

A separate, but similar survey was designed and sent to all life and health insurers licensed to do business in Ohio. Insurers were not required to complete the survey if they did not contract with hospital providers, or if they did not write health insurance business in Ohio. ODI received thirty-five responses from insurers which collectively offer coverage to over 90% of the insured lives in Ohio. The following is a summary of the survey results.

Prevalence of MFN Clauses in Contracts between Insurers and Hospitals in Ohio

The survey collected information on the prevalence of MFN clauses in contracts between insurers and hospitals in Ohio. Both the hospital and the insurer survey asked whether the respondent had contracts with MFN clauses[4]. The results are as follows:

- Eleven of the 20 hospital systems responding to the survey reported having contracts with MFN clauses
- Sixteen of the 40 individual hospitals responding the survey had MFN clauses in their contracts.

[4]Not all survey respondents answered each question. Therefore, some categories may not total 100%.

- Of the 35 insurers responding to the survey, less than 10% reported using MFN clauses in their contracts.

As to respondent hospitals who indicated that they had contracts with MFN clauses, the survey asked questions about how many of the contracts these hospitals had with insurers had MFN clauses. Of the eleven hospital systems responding that they had MFN clauses, nine indicated that the hospital system negotiated contracts on behalf of the entire organization and two systems indicated that contracts were negotiated on a hospital by hospital basis. For purposes of determining the prevalence of MFN clauses, ODI aggregated the responses of the eleven systems and the sixteen individual hospitals with MFN clauses and then calculated an average. On average, the 27 hospital respondents with MFN clauses reported that:

- Each had an average of 29 different health insurers with whom they had a contract.
- Each had an average of 36 separate contracts with health insurers (some hospitals had more than one contract with the same insurer).
- Each had an average of 1.5 contracts that contained an MFN clause (18 of the respondents had only one contract with a MFN clause).

The hospital survey also asked for the percentage of the hospital patient population covered by contracts with MFN clauses. Hospital system respondents indicated on average that 23% of their patients were covered by contracts with MFN clauses. Individual hospitals responded that on average 13% of their patients were covered by contracts with MFN clauses. Individual hospitals reported that fewer of their patients were covered by contracts with health insurers than did hospital systems.

Characteristics of Hospitals and Hospital Systems with MFN Clauses in their Contracts

The hospital survey asked demographic questions related to the use of MFN clauses. All hospital respondents were asked to indicate their size by number of beds, but more specific demographic questions were limited to individual hospital respondents. To determine if there was a pattern of MFN clause use based on hospital type, the survey asked whether the hospital was a teaching hospital, a trauma center, or whether it held any special designation or certification. Of the 40 individual hospital respondents, we discovered that there was no significant difference as to the type of hospitals with MFN clauses and those without.

Of the 13 Teaching Hospitals

- 7 had contracts with MFN clauses
- 6 had no MFN clauses in their contracts.

Of the 14 Hospitals with special designation or classification:

- 8 had contracts with MFN clauses
- 6 had no MFN clauses in their contracts.

Of the 8 Hospitals with trauma centers:

- 5 had contracts with MFN clauses
- 3 had no MFN clauses in their contracts.

Size of Hospital or Hospital System with MFN Clauses in their Contracts

Both hospitals and hospital systems were asked to indicate their size by the total number of beds, broken down by organizations with 1-50 beds, 51- 250 beds, or more than 251 beds. All 11, of the 20 hospital systems with MFN clauses, reported having more than 251 beds. Of the nine hospital systems without MFN clauses, six reported having more than 251 beds and three reported having between 51-250 beds.

The responses from individual hospital showed that hospitals of every size had MFN clauses in their contracts. Of the 40 individual hospital responses, 16 had MFN clauses in their contracts. The 16 individual hospitals with MFN clauses break down as follows:

- One small hospital with 1-50 beds
- Ten medium hospitals with 50-250 beds
- Five large hospitals with more than 251 beds.

The 24 individual hospitals without MFN clauses in their contracts break down by size as follows:

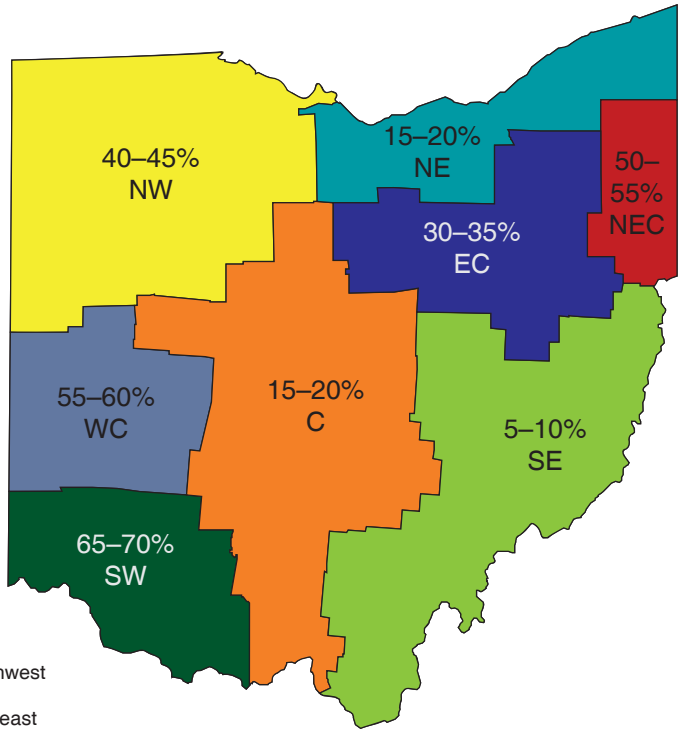
- 11 small hospitals with 1-50 beds
- Ten medium hospitals with 50-250 beds
- Three large hospitals with more than 251 beds.

Geographic location of Hospitals with MFN Clauses in their Contracts

The survey collected information regarding the location of hospitals with MFN, broken down by regions of the state. A map of the Ohio regions is included in Appendix A-5. From the insurer survey, we determined that insurers had contracts with hospitals that included MFN clauses in every region in Ohio. The following

chart shows the approximate percentage of hospitals within a region with at least one MFN clause in their contracts with insurers.

NW	40-45%
NE	15-20%
NEC	50-55%
WC	55-60%
C	15-20%
EC	30-35%
SW	65-70%
SE	5-10%



Ohio Regions

- WC – West Central
- C – Central
- SE – Southeast
- SW – Southwest
- NW – Northwest
- NE – Northeast
- EC – East Central
- NEC – Northeast Central

From the hospital survey, we discovered that MFN clauses are more likely to be found in contracts of urban hospitals:

- 17 urban Hospitals, nine have MFN clauses, eight do not
- 23 rural Hospitals, seven have MFN clauses, 16 do not.

Audits of Hospitals to Enforce MFN Clauses

The General Assembly asked the Commission to consider the costs associated with the enforcement of MFN clauses. In order to obtain information on the costs, the surveys included questions designed to collect information regarding whether hospitals are audited with regard to MFN clauses, how often that occurs, which hospitals are audited, and what are the costs.

The hospital survey asked whether hospitals had been audited with respect to an MFN within the past five years. Of the 27 hospital systems and individual hospitals reporting contracts with MFN clauses, ten reported being audited. The insurers reported having conducted 35 audits over the past five years.

Demographics of Audited Hospitals

The ten hospital respondents that reported having been audited over the previous

five years have the following characteristics:

- Three were individual hospitals
- One had 51-250 beds
- Two had more than 251 beds
- Seven were hospital systems
- All seven had more than 251 beds.
- The individual hospitals were located in the following regions: Northeast Central, Northeast, and Northwest Ohio

The 17 hospital respondents that reported not having been audited in the past five years had the following characteristics:

- Thirteen were individual hospitals
- Three had more than 251 beds
- Nine had 51-251beds
- One had 1-50 beds
- Four were hospital systems
- Four had more than 251 beds.
- The individual hospitals were located in the following regions: Northeast, West Central, East Central, Southwest, Northeast Central, Central, and Northwest Ohio.

Enforcement of MFN Provisions

Insurers reported that they have enforced MFN provisions a total of six times over the past five years.

Insurers reported that the consequences to hospitals or hospital systems of violating MFN provisions can include recovery of overpayment and or changes to other contractual terms, conditions or rates.

Cost of Audits

Both the hospital and insurer surveys asked respondents to report on the cost of the MFN audits. Hospitals were asked to describe the audit costs and to specify if the costs incurred were direct costs or indirect costs. Hospitals reported wide ranging results, from a high of $48,000 for an external audit to no cost at all. Some hospitals reported indirect costs including legal fees, auditor costs, labor estimated at 40-60 hours, and the use of IT resources.

Hospitals reported the cost of the audits to be:

- $48,000 cost of external audit
- Direct cost of audit $22,000, indirect cost $4,000
- Direct cost not specified, indirect cost included legal fees and

meeting time

- No cost, a small amount of time to copy contracts
- Annual report to auditors, estimated cost $1500. Estimate 46-56 hours of labor
- Annual audit – each hospital 40-60 hours labor
- Two routine audits, minimal costs (under $20,000) used existing resources, payer paid audit costs
- Annual audits create indirect costs to the system, time and IT resources

Insurers reported direct costs to enforce MFN clauses over the past five years of less than $1,000,000 dollars.

Written Comments

In response to the survey, some hospitals and insurers provided their comments as to their observations, opinions and experiences with MFN clauses. These comments are attached to this report as Appendix A-6.

VII. FOLLOW UP SURVEY RESULTS

Survey Methodology

The Commission authorized a follow-up survey in order to ask additional questions on the impact of MFN clauses on contract negotiations between insurers and hospitals as well as other possible impacts of MFN clauses. ODI sent the follow-up surveys to the same recipients as the initial survey.

Forty-four hospitals or hospital systems responded to the follow-up survey. These respondents were segregated by size and whether they had MFN clauses in their contracts. The respondents to the follow-up survey consisted of no small hospitals with MFN clauses and seven small hospitals without, six midsize hospitals (51 – 250 beds) with MFN clauses and 11 midsize hospitals without, and 13 large hospitals or hospital systems (over 251 beds) with MFN clauses and seven large hospitals or hospital systems without MFN clauses. [5]

Survey Results

Measures Taken by Hospitals to Prevent a Violation of a MFN Clause

The first area explored by the follow-up survey to hospitals inquired about measures taken by hospitals to prevent an inadvertent MFN violation. Because it is difficult to match up different payment methodologies in different contracts to

[5]Not all respondents answered each question. Therefore, some categories may not total 100%.

determine what the payment experience will be, some hospitals reported using measures such as establishing price buffers so as not to inadvertently accept a lower rate from an insurer that might violate a contract with another insurer with an MFN clause. Some hospitals also explained that they must perform internal analyses to quantify the net revenue of any new rate or payment methodology on a frequent basis to be certain they have not accepted a lower rate.

- Three of the six midsize hospital respondents with MFN clauses reported using measures such as price buffers and frequent internal analysis to protect themselves from violating an MFN clause.
- Twelve of the 13 large hospital respondents with MFN clauses reported using measures such as price buffers and frequent internal analysis to protect themselves from violating an MFN clause.

The Costs of Measures Taken to Prevent an MFN Clause Violation

Hospitals reported a range of costs associated with preventing an MFN clause violation. Midsize hospitals reported monetary costs ranging from $10,000 to $20,000. Large hospitals reported monetary costs of $1,500 to $30,000. Large hospitals also reported costs associated with internal and third-party audits, attorney fees, monitoring compliance, information technology, and staff time. Both groups of hospitals reported investing time in avoiding violations of MFN clauses.

The Effect of MFN Clauses on Negotiations

Hospitals - The hospital survey asked various questions regarding the effect of MFN clauses on negotiations with insurers, including:

- Would the hospital have given a competing insurer a lower rate but for the existence of an MFN? Nine of the 13 large hospitals or hospital systems with MFN clauses answered in the affirmative. None of the medium-size hospitals with MFN clauses answered that they would have.
- Are contracts with MFN clauses for a longer duration? Mid-size hospitals reported no difference, one large hospital reported shorter contracts with MFN clauses, and four large hospitals reported longer durations.
- Do MFN clauses simplify or complicate contract negotiations? Some hospitals reported that MFN clauses shorten negotiations because a price floor is set. Most hospitals reported that MFN clauses prolong negotiations because of the additional time for analysis and negotiations the clauses require.
- Do MFN clauses affect or discourage hospitals from entering into contracts with innovative payment methodologies with other insurers?

Three mid-size hospitals said yes, three said no. Six large hospitals said yes, six said no.

- Do MFN clauses affect or discourage hospitals from entering into non-fee schedule related contract terms? Six mid-size hospitals said no, seven large hospitals said no and five said yes.
- Has the hospital ever sought to amend or revise an MFN provision to allow it to use a different payment methodology with an insurer? Five mid-size hospitals said no, one said yes and ten large hospitals said no, two said yes.

Insurers - The insurer surveys asked various questions regarding the effects of MFN clauses on negotiations with hospitals, including:

Question: What are the effects on your company, customers, and members when your competitors are using or have used MFN clauses?

- **Response**: Part of the normal competitive process will undoubtedly involve situations where we engage in negotiations with a facility that has an MFN provision with a competitor. Overall we believe that MFN clauses are a benefit to the consumers in the health insurance marketplace.
- **Response**: Our experience has been that the use of MFN clauses in the Ohio marketplace results in insurers and hospitals being unable to reach agreement on terms that would otherwise result in lower prices to consumers. When negotiating with hospitals, we strive to achieve contract terms that are most beneficial to our customers, including terms on price. However, in many circumstances, we have been told by hospitals through the negotiating process that reaching such terms is not achievable due to the barrier that has been constructed through the use of MFN clauses by other insurers with those hospitals. Therefore, our experience has shown that our ability to independently negotiate contractual terms with a hospital in the best interest of our customers cannot occur in those circumstances where an MFN clause is in play.
- **Response**: Our company would pay a higher rate, causing higher premiums. While a plan with an MFN clause may see expenditures go down, others would see theirs go up.

Question: Has the existence of a competitor's MFN clause ever affected your ability to negotiate non-fee-schedule related contractual terms (such as outcome based reimbursement, quality incentives, administrative efficiency incentives or bundled payments) with a hospital?

- **Response**: If it impacts reimbursement in any way, providers with

MFN clauses are unwilling to alter any other provision that might impact rates as it might interfere with their existing MFN.

VIII. ANTITRUST AND ECONOMIC EXPERT PRESENTATIONS

Testimony of Robert Jones to the Commission on January 29, 2009

At the first meeting of the Commission, Robert Jones, an antitrust attorney from the Chicago office of Jones Day, provided an overview of MFN clauses from an antitrust perspective. Mr. Jones's attendance at the meeting was arranged by the Ohio Hospital Association. Mr. Jones testified that MFN clauses are used in a variety of situations, and they vary. There can be positive reasons for using MFN clauses. For example, MFN clauses reduce transactional costs because they can simplify contract negotiations about price. Further, MFN clauses can promote multi-year contracts by ensuring price. Additionally, MFN clauses can facilitate a concept of fairness by allowing purchasers to compete based on efficiency.

Mr. Jones identified concerns with MFN clauses. When MFN clauses are in effect, providers cannot lower price to attract more business. Payors may be less aggressive in offering lower prices if they know an MFN is in effect. This is not a disadvantage for providers; however, it may increase cost for consumers. MFN clauses may also restrict entry of small payors into the market. Fewer competitors may lead to less choice and higher prices. While less plausible, MFN clauses could facilitate collusion among providers by disallowing competition.

Mr. Jones explained that no court has explicitly determined MFN clauses to be illegal per se, but MFN clauses are not per se legal either. Courts and federal agencies treat MFN clauses under the rule of reason, which involves answering the question: is it likely to have anticompetitive effects? A few courts have held the clauses permissible. Some have permitted MFN clauses in situations where there is no market power. In those situations, courts have reasoned that MFN clauses may cause prices to decrease and companies that use them are trying to get the best price they can. No one knows if such a practice adversely affects consumers in such circumstances.

Mr. Jones also explained that the Antitrust Section of the Department of Justice (DOJ) has brought challenges against Delta Dental with respect to MFN clauses. The DOJ entered into consent agreements with Delta Dental prohibiting Delta's use of MFN clauses. The grounds for their decision were that the circumstances of the case showed that Delta's use of MFN clauses hindered competition and inhibited negotiations.

Testimony of Dr. Michael Morrisey to the Commission on November 12, 2009

Dr. Michael Morrisey, an economics professor at the University of Alabama at Birmingham, attended the November 12, 2009 Commission meeting. Dr. Morrisey was invited to speak by the Commission and his visit was paid for by the Department of Insurance. Dr. Morrisey authored a text book that included a discussion of the economic principles that apply to MFN clauses.[6]

During his presentation to the Commission, Dr. Morrisey reviewed the anticompetitive and procompetitive themes of MFN clauses. From an anticompetitive perspective, MFN clauses are initiated by competitive sellers to make it easier to detect deviations on price. MFN clauses can be initiated by dominant payors to hinder other payors from negotiating a lower price. MFN clauses deter price competition among payors.

Dr. Morrisey said MFN clauses can also be viewed as procompetitive under efficiency themes. From a procompetitive perspective, MFN clauses increase the efficiency of transactions by structuring contracts to assure low prices in the face of uncertainty about prices and costs.

Dr. Morrisey reviewed an example of how an MFN clause can affect patient volume and revenues for a hospital. In the example, a hospital entered into an MFN clause with a Blue Cross plan and sought to contract with a competing HMO at a lower price. If the hospital chose to contract with the HMO, there would be trade offs for the hospital. On the one hand, the lower HMO price would result in the Blue Cross plan's price being lowered, resulting in lower revenues to the hospital from the Blue Cross business. On the other hand, the hospital would gain additional patient volume from the HMO business which would result in additional revenues from that business. While the hospital's profits from contracting with the HMO would be lower because of these tradeoffs, the hospital's profits remained positive.

Dr. Morrisey theorized that if an MFN clause is harmful to insurance competitors, the following effects should occur: the average net price for hospital services should rise; the average hospital profits from operations should increase (due to less intense price discounting); the average discount should fall; and HMO enrollment should fall. However, Dr. Morrisey noted that Dr. Lynk found none of these effects in his case study on the effects of MFN clauses in a specific situation, and that HMO enrollment actually increased. Dr. Morrisey emphasized that MFN clauses may be procompetitive or anticompetitive depending on the circumstances.

On the procompetitive side, Dr. Morrisey noted MFN clauses can reduce uncertainty over price changes in long term contracts and across multiple payors. MFN clauses are more likely to occur when prices vary across payors, there are

[6] Morrisey, M. (2008) Health Insurance. Chicago: Health Administration Press, a copy of which is attached as Appendix A-7.

more payors in the market, and there are anticipated changes in the market.

In response to questions from the Commission, Dr. Morrisey provided feedback on what an Ohio-specific economic analysis of MFN clauses would require. Such an analysis would require a thorough review of hospital rates charged for specific procedures; hospital expenditures (controlling for individual factors of each hospital) and applicable provider laws. The analysis would require a vast amount of data, which hospitals would have to provide.

Testimony of Dr. William Lynk to the Commission on January 10, 2009

Dr. William Lynk, an economist with Compass Lexicon Services in Chicago, spoke at the January 10, 2009 meeting of the Commission via telephone. Dr. Lynk was invited by the Commission and his time speaking to the Commission was paid for by Anthem. Dr. Lynk came to the attention of the Commission because he conducted a case study of MFN clauses that included a discussion of the economic principles that applied to MFN clauses.[7]

Dr. Lynk testified that MFN clauses give a health care payor protection by ensuring the payor gets the best price. He said that although there is no shortage of economic theories, no theoretical model concludes there is an overall favorable or unfavorable effect of MFN clauses. He said that the level of discounts given by providers to payors tends to be less with MFN clauses. When an MFN is in effect, a hospital must consider whether a particular discount is too expensive because it must also be given to another payor.

Dr. Lynk said that his paper consisted of case studies in Rhode Island and Philadelphia. In those case studies, he found that MFN clauses did not affect the growth of an HMO. He also found no detectable effect on market characteristics. He said MFN clauses can be procompetitive or anticompetitive and broad generalizations cannot be made.

In response to questions about his case study, Dr. Lynk said that he found no empirical evidence of an effect of the MFN clause on the market, including no evidence the effect on hospital profitability. As to effects on consumers, Dr. Lynk said that he did not have any information on that subject. He also said that he did not do an analysis of the impact of MFN clauses on non-price terms because he did not go to that level of sophistication. In terms of his case study, Dr. Lynk said that any effect of MFN clauses was quite modest, and it appears that the effect was procompetitive.

On the broader issue of whether market conditions have worsened in states that have banned MFN clauses, Dr. Lynk said he had no information on that subject.

[7] Some Basics about Most Favored Nation Contracts in Health Care Markets, 45 Antitrust Bulletin 491, (Summer 2000), a copy of which is attached as Appendix A-8.

Dr. Lynk was unaware of anyone who has ever done a broad based economic study of MFN clauses. In response to a question about doing an Ohio specific economic study, Dr. Lynk said that a study is really a testing of cause and effect. He said a study could compare health plans with and without MFN clauses and the profitability of plans and providers. He thought it would be better to consider characteristics most directly affected by MFN clauses, such as price. Such a study would need reliable and comprehensive data from those involved in MFN clauses, and this is data that parties generally do not want to share. He also said that the study should be concerned with causality and other confounding factors that may affect hospital pricing. Pricing is affected by costs, payment mix, capabilities of the hospital and the hospital's market share. In order to evaluate the effect of one specific factor (i.e., MFN clauses), the study would need to control for the other factors. That is why time studies are preferable to regional studies.

In response to a question about the time and expense of conducting an Ohio specific study, Dr. Lynk said "staggering" would be a good term. He said it could take a few years. It is doable, but it would take a substantial amount of talented manpower.

In response to a question about whether there are any limitations on drawing conclusions from his case studies, which are 20 years old; Dr. Lynk said there is no good reason why the results would be invalid today.

Statement of Commission Members Wayne Wheeler, MD, JD, William Kose, MD, JD, and Stuart Chesky, DO, JD

The Joint Commission on Most Favored Nation (MFN) Clauses in Health Care Contracts met over the past year to examine the use, prevalence and market impact of MFN clauses in contracts between hospitals and contracting entities. During the Commission hearings, antitrust and economics experts were consulted in an effort to ascertain the pro-competitive or anti-competitive aspects of MFNs on health care contracts.

Two of the experts, Dr. Michael Morrisey, an economics professor at the University of Alabama at Birmingham, and Dr. William Lynk, an economist with Lexicon Services, provided a detailed academic overview of the economic principles of MFNs.

The analysis of MFNs by both Morrisey and Lynk acknowledged that MFNs can be either pro- or anti-competitive, depending on the factual circumstances. They further acknowledged that the only real way to get an answer to the question is to do an Ohio-specific market analysis, comparing hospital prices, insurance premiums and other market characteristics over a period of time.

The Commission concluded that such a study was not feasible due to cost and time restraints.

However, in an effort to assess the prevalence of MFNs in hospital/insurer contracts and the effects of MFNs on a hospital's ability to contract with third parties, the Commission did conduct a market survey of Ohio hospitals. This "market analysis," while not as scientifically persuasive as an extended market conduct examination, does provide compelling insights on how MFNs do in fact have an anti-competitive effect in Ohio. For example:

- 9 of 20 hospitals reported that an MFN clause discouraged entering into innovative payment methodologies with another insurer.
- 15 of 20 hospitals reported that they would have contracted with an insurer at a lower rate, if not for the presence of an MFN clause in another contract.
- Enforcement costs to hospitals can run as high as $30,000 for third party auditing services.

In addition to the hospital survey data, the Commission also gathered information from other states that restrict or prohibit MFNs in contracts between providers and insurers. In all, 14 states limit the use of MFNs in health care contracts. No data or study was presented to the Commission to suggest that the insurance markets in those states are experiencing any "anti-competitive" effects as a result of these state laws.

Another convincing detail that emerged from the Commission's discussion is that

there is a difference of opinion on the MFN issue within the insurance sector. Of the four insurers on the Commission, it is appears that only one, Anthem, supports the use of MFNs in health care contracts. The other three – Aetna, Cigna and United Health Care – have all indicated that the existence of an MFN in Anthem's contract with providers has discouraged them (Aetna, Cigna and United Health Care) from entering or expanding in certain segments of Ohio's insurance market.

This may be the most persuasive fact that the Commission has heard in assessing the anti-competitive effect of MFNs. If United Health Care, the nation's largest insurer with $90 billion in revenue, believes it cannot fairly compete in a market where an MFN is being used, it seems patently obvious that MFNs are in fact anti-competitive because of its negative impact on the suppression of market competition.

One final footnote - There was much discussion about the Lynk study and its value to the Commission as a gauge of the possible pro-competitive effects of MFNs. It was suggested by some on the Commission that the study was "the only empirical market analysis" of its kind in the nation, and the findings concluded that MFNs were not anti-competitive.

While the Lynk study does provide a snapshot of the pre-MFN and post-MFN markets in Rhode Island and Philadelphia from 1989 to 1995, and concludes that there was "no detectable" effect of MFNs as being anti-competitive, there was a great deal of concern raised by some Commission members as to the utility of the study's relevance to the market in Ohio today. Even the study's author, Dr. William Lynk, acknowledged in a conference call with the Commission that the model used in his analysis had "limitations in its implications" and was "not done as precisely" as he would have liked.

Consequently, the Lynk study - because it reviewed markets some 15 to 21 years ago, made no distinction between governmental and private insurers, and was limited to just two small geographic areas - appears to have limited utility to the Commission. Further, concern was raised by some Commission members about the potential bias of the Lynk study in that it was initially funded by a Blue Cross Blue Shield insurance plan.

Conclusion:

Since the only real factual Ohio information (from the hospital survey) indicates that the existence of MFNs in contracts between hospitals and insurers negatively impacts market competition, the Commission should recommend making the MFN ban for hospitals permanent, effective prior to the expiration of the two-year moratorium.

Respectfully submitted by:

Wayne Wheeler, MD, JD William Kose, MD, JD Stuart Chesky, DO, JD

Statement of Commission Member Philip Derrow
Opinion in dissent from the Majority | March 9, 2010

The Commission's majority vote recommending that the Ohio General Assembly prohibit or restrict Most Favored Nation (MFN) clauses in health care contracts is not supported by the evidence presented to the Commission. It appears instead to be a case of rent seeking; that is, using the power of government to tilt the playing field in favor of market players who have not otherwise been as successful as they would like in negotiating contract terms or earning greater market share through innovation.

The local National Federation of Independent Business (NFIB) office recommended me to the Commission. I have previously served on two committees related to Ohio's Medicaid program (Ohio Medicaid Administrative Study Council (OMASC) and the Medical Care Advisory Committee (MCAC)) and continue to serve on the MCAC. I believe my work on these committees is both well known and well regarded by the legislators and staff with whom I interacted. Although I am very well versed in a variety of health care policy issues, I knew nothing about MFN clauses relating to health care until my appointment to this Commission. Over the 13 months of Commission work, during which I attended all of the meetings and did independent research, not only did I become quite knowledgeable on the topic of MFN's, I changed my opinion of them.

Unlike the majority of other Commission members, I do not represent any insurance company or hospital. My work on the Commission therefore reflected the interests of Ohioans who are most directly affected by rising insurance costs – consumers in particular. As a business owner who provides health insurance coverage for 250 associates and their families, my goal is to provide the best possible health insurance at affordable rates. Together, we pay over $1.5 million for insurance premiums and health and wellness programs

My initial impression of MFN clauses after the first Commission meeting was that they sounded bad. If the facts presented to the Commission showed that MFN clauses raise the overall costs of health care in Ohio, I was inclined to recommend restricting them. But the facts presented to the Commission did not confirm my initial impression. Instead, they lead to a very different conclusion.

The studies and presentations by the only two PhD economists who are known to have studied the competitive and consumer effects of MFN clauses in health care contracts, although conducted many years ago in states other than Ohio, were voluminous. But their conclusions can be summarized with two words: It depends. Further, the information provided to the Commission regarding MFN's antitrust implications – the typical way of considering their competitive effects – can also be summarized in the same way: It depends.

The only other substantive evidence presented to the Commission included the results of two surveys conducted by the Ohio Department of Insurance (ODI). I

am confident that the ODI staff worked diligently to conduct the surveys, and they provided interesting feedback. But the survey results do not support a conclusion that MFN clauses are all bad. In fact, the worst "evidence" cited from the survey by proponents of banning MFNs was a $48,000 compliance cost reported by one respondent and a handful of respondents who asserted that they theoretically could have, would have or might have offered lower rates to some other payers were it not for an MFN clause from another payer.

Even though $48,000 is a lot of money, it represents little more than a rounding error on a hospital's financial statements. It is hardly cause for the State to step into contract negotiations between market players. As for lower rates that might have been offered, the survey was not designed to and so does not capture the lower rates that were actually charged to payers – and their customers – that benefited from using MFNs.

As these payers typically represent larger payers and therefore larger numbers of actual consumers, the potential for higher rates for these payers and consumers that might result from banning or restricting MFNs represents a powerful argument against banning or restricting them. It is in these lower rates and the certainty of obtaining them via an MFN clause that MFN clauses have been shown to be pro-competitive and pro-consumer. This is the central argument made by the PhD economists and by antitrust evaluations of MFNs. The majority ignores these facts.

The majority also chooses to gloss over the significant problems with the ODI surveys. This is not to disparage ODI staff, who I found to be supremely capable and professional. Rather, it is a function of the limitations of time and money necessary to perform statistically valid surveys of this sort. In short, because the surveys were only completed and returned by a self-selected small-minority sample of those to whom it was sent, and because the responses were anonymous and did not require supporting data for verification, there is no way to determine if the sample is representative of the whole or if the responses are based on hard data or anecdotes. The inability to determine the representativeness of the sample or the accuracy of the responses makes it improper to draw statistical conclusions from them. For example, the only conclusions that can be drawn from one respondent claiming compliance costs of $48,000 is that one respondent claimed compliance costs of $48,000. There is simply no way to know if that $48,000 is accurate, nor can that claim be multiplied by the total number of surveys sent to assert a total cost to the citizens of Ohio.

The evidence presented to the Commission regarding the impact of MFN clauses in health care contracts leads ultimately and inescapably to one conclusion (perhaps unsatisfying to some): It depends. Accordingly, the best place to determine when and if any particular MFN is anti-competitive or anti-consumer is the very same place such determinations have been made up to now – in the court system under the antitrust laws. Sorting out fact specific cases is what courts do

best.

The evidence presented to the Commission regarding banning or restricting MFNs in health care contracts does not make the case that they are always bad and should, therefore, be made per se illegal by legislative action. A recommendation to ban them anyway can only be explained by blind distaste for them or to advance parochial interests – rent seeking. Neither reason provides a legitimate basis for the legislature to ban or restrict MFNs.

I urge the members of the Ohio General Assembly to reject the majority vote of the HB 125 Joint Commission and allow the moratorium on MFN clauses in health care contracts to lapse.

Respectfully submitted,
Philip Derrow
Commission Member
Columbus, Ohio

Statement of Commission Member Robert (Binem) Dizenhuz

First and foremost, I would like to thank the Ohio Department of Insurance for its leadership and stamina over the past two years as it has dedicated an extraordinary amount of time and effort to keep the Commission focused and moving forward.

The task given to this Commission was to make recommendations to the Ohio General Assembly as to whether MFN contract provisions, as defined by the Ohio General Assembly, between hospitals and health insurers, are anti-competitive and should be prohibited in hospital contracts, thereby establishing a new public policy in Ohio.

Over the course of two years of meetings, all of which I attended, this Commission was never presented with any facts or evidence to support the conclusion reached by the eight members of this Commission who voted that MFN provisions are anti-competitive. I cannot support this conclusion based on the complete lack of any evidence presented to the Commission and therefore, I must dissent. In point of fact, the only study[1] presented to the Commission on the use of MFN provisions in the Hospital contracting context concluded that in that circumstance, MFNs had a pro-competitive effect. Additionally, the testimony of the two PhD economists who presented to the Commission was clear – to get the evidence needed to come to such a conclusion would require a complex in-depth study. The pro or anti-competitive impact of any condition depends on a host of market conditions which must be studied by experts. I have seen no current evidence to support a recommendation to the Ohio Legislature that these provisions are anti-competitive.

The Commission was provided with blinded information from a voluntary survey sent to most Ohio Hospital CFOs. While the responses are interesting, these responses did not provide any empirical or verifiable evidence to support the majority's conclusion. The survey received a limited response, mostly from what appears to be the larger hospital systems in the state. The Hospital survey is filled with anecdotes and opinions. Regardless of how many times the anecdotes are quoted, these anecdotes do not rise to the level of evidence that should be required to support a significant change to Ohio's public policy. The majority does not cite to any direct evidence that the provisions in question are anti-competitive because no such evidence was ever presented to the Commission.

What the survey did show was that, at least among the respondents, there was significant variation on whether there were these provisions in their contracts with insurers; that any exclusion or inclusion was part of the typical give and take found in all

[1] Dr. Lynk's peer reviewed and published study is included with the Commission's study. Dr. Morrisey, the other PhD economist who testified before the Commission called Dr. Lynk's study "the best one out there" in response to questions from the Commission regarding studies of MFN provisions between Hospitals and Insurers. See William Lynk, PhD, Some basics about most favored nations contracts in health care markets, The Antitrust Bulletin, Summer 2000.

complex negotiations involving many different components and priorities among the contracting parties.

The absence of MFN provisions in roughly half of the respondents contracts would certainly seem to indicate two key points that should not be ignored: 1) the inclusion of MFN provisions in an agreement is a matter of negotiation in the totality of the overall hospital contract and may or may not be included in any particular contract; and 2) the use of MFN provisions certainly has not been demonstrated to have the prevalence the proponents allege. It is simply not rational nor justifiable to base a recommendation of a significant change to public policy on a survey responses that may, or may not, represent the opinions of all involved.

In addition to the hospital survey, a Market Conduct Survey of Ohio Insurers was conducted by the Ohio Department of Insurance. As you can see from the Fact section of the Final Report, there is nothing in the responses to that survey which can be considered as factual data to support a recommendation to restrict or prohibit MFN provisions in hospital contracts. To the contrary, Ohio has a vibrant health insurance marketplace with vigorous competition among insurers.

The survey of insurers also confirms what I believe is a key point: the existence or absence of MFN clauses is a matter of negotiation as part of an overall Hospital/Insurer negotiation. The terms of MFN provisions vary by each contract.

Insurers also responded to the survey indicating in their opinion:

- The existence of a competitor's MFN clause has not affected insurers' ability to negotiate non-fee-schedule related contractual terms;
- The existence of an MFN clause has not deterred most insurers from contracting with a hospital or entering into a geographic market in Ohio;
- Other terms such as rates, location and other non-price terms have caused insurers not to contract with a particular hospital.

Neither the Hospital nor the Insurer survey presented any empirical data that I believe supports the majority's opinion.

Expert Witness Conclusions

The only existing study looking into the question presented to the Commission is a peer reviewed published article by Dr. William Lynk that is an Addendum to the Report. At the request of the Commission Dr. Lynk, participated in a telephone call and answered a variety of questions regarding his study and his opinions – questions from

members and non-members of the Commission. Dr, Lynk's conclusions were simple – there was no anticompetitive effect of MFN provisions to the Hospitals in the market he studied. In point of fact, he found some pro-competitive effects.

While some on the Commission took issue with his study methodology, no one could point the Commission to any other study to refute Dr.Lynk's conclusion. Both economists opined that to reach a conclusion of whether a particular circumstance was pro or anti-competitive depended on a host of fact-specific conditions. Regardless of whether one takes issue with Dr. Lynk's ultimate conclusions in his study, or with Dr. Morrisey's summary of the economics, both Economists, were consistent that whether a particular provision is pro or anti competitive in a particular market depends on the particular facts of that situation. It simply depends.

There is simply no empirical data to support that MFN provisions are anti-competitive in the contexts of Hospital contracts with health insurers in Ohio.

Stakeholder Participation

This Commission had input from a variety of interest groups. There has been ample, if not an overwhelming opportunity to present information of their choosing to support their position. Yet with so much opportunity to participate, the absence of any real proof to support their position is telling.

Howard Feller's Prior Testimony

Finally, I must point to Howard Feller, Esq.'s 2007 Presentation to the Ohio House of Representatives with regard to H.B. 125 which is included as a addendum and discussed during many Commission meetings. Mr. Feller demonstrated that MFNs known as comparable rate provisions provide a legitimate business function that is beneficial to Ohio Consumers by reducing costs and is pro-competitive. They are not only used in the health care arena but also by government agencies and by hospitals in the vendor contracts. Hospitals often have MFNs in their contracts with their suppliers – because in the right context they make sense for both parties.

Mr. Feller also points out that comparable rate provisions enable longer term contracts, which in turn increase stability for consumers and establish consistent income streams for the facilities. He also submitted that virtually every Court that has considered the effects of a most favored nation clause has found that it is a legitimate buying practice and makes economic sense.

In conclusion, I disagree with the conclusions of this Commission because there is no evidence to suggest that these provisions are uncompetitive. I cannot support any recommendation to the Ohio General Assembly that these provisions should be prohibited.

Statement of Commission Member Thomas Kniery
March 10, 2010

As a result of the enactment of House Bill 125 (127th General Assembly), Most Favored Nation (MFN) clauses were prohibited in health care contracts involving providers other than hospitals. In health care contracts that involve hospitals, a two year moratorium on MFNs was imposed by the Act. That moratorium is set to expire on June 25, 2010.

United Healthcare strongly urges the Ohio General Assembly to pass legislation prohibiting MFNs in health care contracts involving hospitals before the expiration of the moratorium.

During the past year that I have had the opportunity to participate in the deliberations of the Commission, new and compelling information regarding the prevalence and effects of MFNs in Ohio has been brought to light. This information, resulting from a survey of Ohio hospitals and insurers, is persuasive in illustrating that the existence of MFN clauses in hospital contracts serve to inhibit competition and stifle innovation in the health care marketplace. This information also demonstrates that unnecessary costs are being added to our health care system in Ohio and that availability of care is being negatively impacted.

Among the most compelling highlights of the survey results were the following:

1. *Nearly half of all hospital respondents with MFNs would have given a lower price to another insurer if not for the presence of an MFN clause*. The importance of this point cannot be overstated. Because of the MFN clauses that exist in contracts today between a particular dominant insurer and the hospitals with which it contracts, other insurers are being prevented from freely negotiating better discounted rates for their own customers. This increases costs for these other insurers and restricts their ability to compete in the health care market, thus preserving the dominant insurer's market share.

2. *Nearly half of all hospital or hospital system respondents reported that the existence of an MFN clause affected or discouraged them from entering into innovative payment methodologies with another insurer*. Hospitals, physicians, insurers and customers are actively working to develop contracting strategies that move away from fee for service reimbursement into more innovative strategies such as gain share models, case rates, accountable care organizations, medical home, etc. These type of new methodologies focus on rewarding providers for clinical outcomes rather than volume of services provided. However, MFN's prevent such forward thinking concepts because hospitals fear financial exposure tied to their MFN rate provisions.

3. *Over 75% of responding hospitals or hospital systems with MFN clauses use measures such as price buffers to ensure that an MFN clause is not violated.* This means that many hospitals with MFNs are establishing artificially higher rates for their services for other insurers in order to avoid incurring the harsh penalties associated with violating the MFN clause in their contract with the dominant insurer. When other insurers do not have the ability to negotiate prices that even approach those of the MFN insurer, their costs increase and their ability to compete in a particular market is restricted.

United Healthcare has found that where MFN clauses exist, we have been prevented time and again from freely negotiating favorable contractual terms with hospitals and other providers, especially financial terms, that are in the best interests of our customers. Onnumerous occasions right here in Ohio, we have been unable to negotiate reasonable terms with hospitals that would have otherwise been agreed to, but for the existence of an MFN. While some might seek to diminish the results of the Commission's survey or our own company's real world experiences for that matter, they are, in fact, representative of what is actually happening everyday in the health care market in Ohio.

Some might argue that Ohio law ought not to interfere with the ability of two parties to enter into a contract. However, I would respectfully submit that Ohio law ought not to protect an unfair business practice of one of those parties, especially when the net effect of that practice is to disadvantage all other competitors and their customers.

Through its work, the Commission learned that fourteen states (AL, CA, ID, IN, KY, MD, MN, NH, NJ, NY, RI, VT, WA, WV) have now prohibited or restricted the use of MFNs in health care contracts. Additionally, the Attorney General of Connecticut has initiated an investigation into potential anti-competitive effects of one company's (Anthem's) use of MFNs on the health insurance market in that state.

Thanks to the efforts of the General Assembly, Ohio has taken an important step in the right direction by permanently banning MFNs in physician contracts. United Healthcare believes it is time for the State to take the final step toward promoting a more competitive health insurance market in Ohio by imposing the same statutory prohibition MFNs in hospital contracts as well.

March 10, 2010

STATEMENT OF COMMISSION MEMBER LAURA G. KUYKENDALL

I appreciate the opportunity to serve on the Joint Legislative Study Commission on Most Favored Nation Clauses in Health Care Contracts. The Ohio Department of Insurance is to be commended for its work in leading this process. I do not, however, agree with the Commission vote as no justification for a legislative prohibition or restriction of rate provisions was demonstrated.

I was appointed to the Commission for my expertise as an antitrust litigator and counselor for over 30 years. As such, I approach the Commission's task of determining whether "MFN" provisions are anticompetitive or procompetitive and the possible impact on costs and availability of health care from an antitrust perspective.

Antitrust analysis requires a very fact-specific study of the particular clause at issue and the surrounding circumstances, including the other provisions in the contract and how they relate to one another. Not all contract provisions that may be labeled generically as "MFN" are the same or operate in the same way. Many of the clauses do not require a "better" rate, but only a comparable one. The effect on competition of a comparable rate provision may be very different from that of a more favorable rate provision. A comparable rate provision is an anti-discrimination provision operating in much the same way as the Robinson-Patman Act prevents price discrimination by sellers to different buyers. The insurer is the buyer of the providers' services. A buyer bringing more customers, or in this instance patients, to the seller-provider should not have to pay a higher price than the insurer/payor bringing fewer. The larger volume provides fiscal stability and resources that others could then "free ride" on. Volume discounting and preventing free riding have consistently been accepted as business justifications for business practices that might otherwise be deemed unnecessarily restrictive in antitrust analysis.

Many, if not most, contract provisions restrict the freedom of parties to act as they may otherwise wish, but not all restrictive contract provisions are anticompetitive. "Anticompetitive" and "procompetitive" are defined terms in antitrust law. A provision is not anticompetitive simply because a party would conduct itself differently in its absence. The effect on individual sellers does not determine competitiveness of a clause nor does the loss of profits by the seller due to the clause. Whether or not rate provisions are legitimate business practices that are not prohibitively anticompetitive is determined by reference to cost savings to consumers in receiving lower premium costs passed on by payors.

Whether a particular clause is procompetitive, anticompetitive or competitively neutral can only be determined by an economic analysis of a multitude of factors, beginning with an economically determined market based on where consumers actually can or do go for services, and the effect on ultimate consumers—not the sellers of the services—in terms of output and prices. The impact of rate clauses on health care costs and accessibility and availability can only be determined by empirical economic analysis. There are theories and lay opinions about

whether such clauses are pro- or anticompetitive but there is very little in the way of empirical study that has been done in this area. Certainly the states which have passed legislation prohibiting or restricting rate clauses did not base that legislation on empirical studies. The Federal Trade Commission and Department of Justice, while voicing concerns about such clauses, have not undertaken any empirical analysis. There is no such empirical study in Ohio and it would be expensive and time consuming to do such a study. The only published empirical economic study in this area is that of Dr. William Lynk, a health care economist. This study was analyzed by Dr. Michael Morrisey, an economics professor at the Lister Hill Center for Health Policy at the University of Alabama, who wrote a textbook regarding health care, including a discussion of economic analysis of MFNs. Based on his case studies, Dr. Lynk concluded that any effect of MFNs in those markets was very modest but to the extent there was an effect, it was procompetitive. Dr. Morrisey opined that the real reason for these clauses is not anticompetitive or exclusionary but rather for resolution of uncertainty of future pricing and allowing for longer contracts. MFN clauses allow price to adjust naturally without the expense of constant renegotiation. Dr. Morrisey concluded that the empirical facts in an individual market must determine whether a particular clause is pro- or anticompetitive. Both Dr. Lynk and Dr. Morrisey stated that not all MFN clauses are the same and blanket statements as to these clauses are not informative. As Dr. Morrisey puts it: it all depends.

As part of the Commission's work, questionnaires were sent to hospitals and insurers in Ohio. Due to the nature of the questionnaires, however, the responses do not qualify as empirical evidence of the type that would allow conclusions to be drawn. The responses were mostly anecdotal and commentary. Little if any hard data resulted from the questionnaires. Due to the limitations of the methodology used, there is no statistical significance to the results and no hard conclusions can be drawn. To the extent any findings could be derived from the questionnaires, they are that MFNs are not widely used, have little effect and, while there are costs to both insurers and hospitals in using these clauses, they result in minimal expense in enforcement. While the responses indicate strongly held opinions and feelings on the provisions by some hospitals, these opinions and feelings do not rise to the level of evidence.

In conclusion, there is no empirical evidence that MFN provisions are always procompetitive or always anticompetitive. Even opponents of the clauses have conceded as much and no court has ever found a clause to be *per se* illegal. The questionnaire responses provided opinions, theories and feelings, but no hard data from which reasonable conclusions could be drawn. In sum, there was no empirical evidence presented to this Commission justifying legislative prohibition or restriction of most favored nation clauses or comparable rate clauses.

STATEMENT FROM COMMISSION MEMBER MICHELLE MATHIEU DANIELS

MARCH 5, 2010

I have been honored to serve on the Joint Commission on Most Favored Nation (MFN) Clauses in Health Care Contracts (the Commission). Based on our study I urge the Ohio General Assembly to pass legislation to prohibit the use of MFN clauses permanently for hospitals in the State of Ohio. In order to have an effect on the market, the legislation would need to be passed by June 25, 2010, as we have concluded our study and it is imperative that we not allow an open time period for their use since the General Assembly has prohibited their use in new hospital contracts since 2008 until we finished our report. Absent legislation in this time period, one, maybe two insurers will reconstitute their use, greatly affecting the discounts individuals and employers realize in Ohio.

The report the Commission is submitting highlights that fourteen other states (AL, CA, ID, IN, KY, MD, MN, NH, NJ, NY, RI, VT, WA, WV) have passed laws that prohibit or restrict MFN clauses in healthcare contracts. Since its writing at least one large insurer has announced that they will drop such language from their contracts. Specifically, last month Anthem Blue Cross and Blue Shield of Connecticut announced that it would drop controversial contract language that would have made it vulnerable to antitrust investigations. Previously, this insurer required hospitals to offer them the deepest discount available, which, in many cases, would be equal to the price paid by the state's subsidized insurance plan.

Summarized below are the reasons that bring me to a position to urge you to pass legislation to prohibit MFN use in any provider contract, in particular hospital contracts:

1) An Ohio survey conducted by the ODI showed two types of MFNs are being used in Ohio. The predominantly used clause guarantees the contracting insurer that the provider would not charge a competing insurer a rate for a specified service that was less than the rate the provider charged the insurer with the MFN clause.

2) Hospitals reported that on average they had 36 separate contracts with health insurers in Ohio. However, hospitals also reported that on average 1.5 contracts contained an MFN clause (over two-thirds of the respondents had only one contract with an MFN clause). We are aware that one dominant insurance company is using MFN clauses. This finding has market effects on all other insurers. If hospital MFN clauses were to be prohibited in Ohio, all insurers would be able to compete for hospital discounts, thereby allowing all individuals and employers to realize those discounts.

3) The Commission's survey of hospitals and insurers as to their experience with MFNs reported that: (1) 9 large hospitals would have given a lower price to another insurer in the absence of its MFN clause; (2) half of all responding hospitals/systems reported that the existence of an MFN clause affected or discouraged them from entering into innovative payment methodologies with another insurer; and (3) 15 of 19 hospitals/systems with MFN clauses use price buffers to ensure that the clause is not violated. These statistics bear out the fact that the MFN clause protects that insurer's market share and deters innovation.

4) The geographic location of hospitals with MFN clauses in their contracts is such that 40-70% of those contracts are located in the northwest, north east central, west central or southwest portions of Ohio. More MFN clauses exist in urban hospital contracts rather than rural. Generally, this finding zeroes in on MFN clause prevalence in our State.

These data lead me to conclude that MFN clauses are widely used in major sections of the Ohio market by one insurer, thereby adding to the cost of care and limiting the availability of care to those persons who are covered by most other insurers in this State. As individuals and employers face premium increases, passing legislation to prohibit MFN clauses would lessen their burden. The presence of MFN clauses in hospital contracts discourages not only new insurers from entering the market, but is extremely anticompetitive on the discounts other insurers provide. I respectfully urge you to ban clauses that provide a company an anti-competitive advantage in Ohio that would not be realized absent its MFN. Again, thank you for the opportunity to serve on the Commission.

Statement of Commission Member: Chad Matteson

The existence of Most Favored Nations (MFN) clauses in Ohio hospital contracts inhibits the ability of CIGNA Healthcare to compete in the marketplace. While some committee members have argued that these clauses are part of the contract language discussion, our experience in Ohio and in other states, has been that these clauses are almost exclusively tied to the reimbursement portion of the contract negotiation. Our ability to impact these discussions is severely limited by the existing MFNs present in the hospital contracts with other payors.

In attempting to determine the impact of MFNs, this Committee quickly concluded that a comprehensive economic study was not only a lengthy process, but one that was significantly cost-prohibitive and a Hospital and Payor Survey was the best alternative. The results of the survey illustrated the negative impact that MFNs represent in Ohio. It is clear that Hospitals would have contracted with insurers at a lower rate without the presence of a MFN and eliminated the barriers for hospitals to enter into innovative or creative arrangements with payors. Therefore, MFNs not only have a negative impact in the marketplace but force hospitals with MFNs to dedicate their entire payor strategy to managing their MFN contract –typically refusing to consider any other payor contract requests or creative solutions due to the fear of the potential impact to the MFN language. Although the findings presented by Dr. Lynk and Morrisey are compelling, the research is dated and, according to the authors, the impact of MFNs “depends on the situation.” The information collected by the survey is both representative and current. It represents this Committee’s best attempt to determine the Ohio-specific impact of MFN clauses in the marketplace and should not be ignored.

CIGNA Healthcare believes that MFN clauses hinder the ability of Payors to negotiate freely with Hospital providers. We respectfully recommend the General Assembly permanently ban MFN clauses in hospital contracts and join the 13 other states with a similar state statute.

March 9, 2010

Statement of Commission Member Michele Napier,

After 15 months and eight meetings, the Most Favored Nation (MFN) Study Commission has finalized a legislative recommendation that will reduce the cost of providing and purchasing health care in Ohio. The persistent work of both the individual commissioners and the staff at the Ohio Department of Insurance (ODI) made it possible to produce such a balanced report — a report that recommends the Ohio General Assembly permanently ban MFN clauses from health care contracts between hospitals and insurers.

The commission initiated the study of MFN clauses by conducting a survey of both insurers and hospitals. The goal of the survey was to gather information about the role MFN clauses play in contracts between insurers and hospitals. The results of the first survey were useful and informative on the prevalence of MFN clauses, but the commission conducted a second survey to collect detailed information about the negative impact of MFN clauses.

The surveys were sent to the hospital chief financial officers of 96 percent of all general medical surgical hospitals in the state of Ohio. The report indicates ODI received 60 hospital responses to the first survey, 20 of which came from hospital systems. It is important to note that the 22 hospital systems in Ohio represent 99 hospital facilities, meaning the survey responses represent approximately 139 facilities.

The General Assembly charged the commission with studying the pro-competitive and anti-competitive aspects of MFN clauses and the impact of MFN clauses on health care costs and on the availability of and accessibility to quality health care. The commission's surveys provide the only empirical data that speaks directly to these questions in Ohio. Other research conducted by Dr. William Lynk, senior vice president and senior economist at Lexecon Inc., was identified and considered by the commission; however, his case study research is over 20 years old and pertains to Philadelphia and Rhode Island.

The survey results speak strongly to the two previously mentioned requests from the General Assembly. Here is a summary of the survey results on these two points.

The pro-competitive and anti-competitive aspects of most favored nation clauses.

- Data from the two ODI surveys indicate that MFN clauses have significant anti-competitive effects.

- 9 of 19 hospitals with an MFN clause in their contracts said the MFN clause discouraged the hospital from entering into innovative payment methodologies with another insurer.

The impact of MFN clauses on health care costs and on the availability of and accessibility to quality health care.

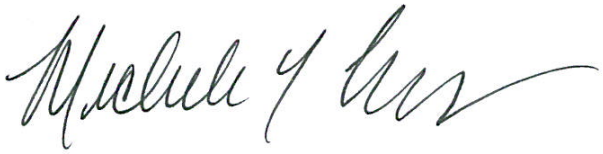
- Data from the two ODI surveys indicate that MFN clauses add to the cost of care and limit the availability of care.
  - 15 of 19 hospitals with an MFN clause use measures, such as price buffers, to ensure that the MFN clause is not violated, unnecessarily inflating the cost of care.
  - 9 of 13 large hospitals with an MFN clause reported they would have contracted with an insurer at a lower rate if not for the presence of an MFN clause in another contract.

Survey comments indicate the presence of an MFN clause requires hospitals to continuously monitor for compliance, requiring additional staff and again adding cost. The commission deliberated on the merit of the competing perceptions of MFN clauses, issues presented by Dr. Lynk and the negative effects revealed through the surveys. The debate was vigorous and resulted in a recommendation that the General Assembly permanently ban MFN clauses from health care contracts between health insurers and hospitals.

Critics of the study commission's recommendation failed to present any information to demonstrate any pro-competitive effects associated with the use of MFN clauses in Ohio. After two surveys and eight meetings, the closest proponents of MFN clauses have come to demonstrated pro-competitive aspects of MFN clauses is Dr. Lynk's antiquated and improperly designed case study. In fact, the insurer surveys conducted by ODI demonstrate no pro-competitive effects associated with the use of MFN clauses.

Thank you for taking the time to read the MFN study commission report. Ohio's hospitals look forward to working with the General Assembly in the coming months to implement the recommended prohibition on MFN clauses in health care contracts between insurers and hospitals.

Respectfully,



Appendix A – 1

House Bill 125 Joint Commission on Most Favored Nation Clauses in Healthcare Contracts

SECTION 5.

(A) As used in this section and Section 6 of this act:

(1) "Most favored nation clause" means a provision in a health care contract that does any of the following:

(a) Prohibits, or grants a contracting entity an option to prohibit, the participating provider from contracting with another contracting entity to provide health care services at a lower price than the payment specified in the contract;

(b) Requires, or grants a contracting entity an option to require, the participating provider to accept a lower payment in the event the participating provider agrees to provide health care services to any other contracting entity at a lower price;

(c) Requires, or grants a contracting entity an option to require, termination or renegotiation of the existing health care contract in the event the participating provider agrees to provide health care services to any other contracting entity at a lower price;

(d) Requires the participating provider to disclose the participating provider's contractual reimbursement rates with other contracting entities.

(2) "Contracting entity," "health care contract," "health care services," "participating provider," and "provider" have the same meanings as in section 3963.01 of the Revised Code, as enacted by this act.

(B) No health care contract that includes a most favored nation clause shall be entered into, and no health care contract at the instance of a contracting entity shall be amended or renewed to include a most favored nation clause, for a period of two years after the effective date of this act, subject to extension as provided in Section 6 of this act. This section does not apply to and does not prohibit the continued use of a most favored nation clause in a health care contract that is between a contracting entity and a hospital and that is in existence on the effective date of this act even if the health care contract is materially amended with respect to any provision of the health care contract other than the most favored nation clause during the two-year period specified in this section or during any extended period of time as provided in Section 6 of this act.

SECTION 6.
(A) There is hereby created the Joint Legislative Study Commission on Most Favored Nation Clauses in Health Care Contracts consisting of seventeen members as follows:

(1) The Superintendent of Insurance;

(2) Two members of the House of Representatives, one representing the majority party and one representing the minority party;

(3) Two members of the Senate, one representing the majority party and one representing the minority party;

(4) Three providers who are individuals;

(5) Two representatives of hospitals;

(6) Two representatives of contracting entities regulated by the Department of Insurance under Title XVII of the Revised Code;

(7) Two representatives of contracting entities regulated by the Department of Insurance under Title XXXIX of the Revised Code;

(8) One representative of an employer that pays for the health insurance coverage of its employees;

(9) A licensed attorney with an expertise in antitrust law who represents providers;

(10) A licensed attorney with an expertise in antitrust law who represents contracting entities that have used most favored nation clauses in their health care contracts and that are regulated by the Department of Insurance under either Title XVII or Title XXXIX of the Revised Code.

(B) The members of the Commission shall be appointed as follows:

(1) The Speaker of the House of Representatives shall appoint the two members of the House specified in division (A)(2) of this section.

(2) The President of the Senate shall appoint the two members of the Senate specified in division (A)(3) of this section.

(3) The Speaker of the House of Representatives and the President of the Senate jointly shall appoint the remaining members specified in divisions (A)(4) to (10) of this section.

(C) Initial appointments to the Commission shall be made within thirty days after the effective date of this act. The appointments shall be for the term of the Commission as provided in division (F)(2) of this section. Vacancies shall be filled in the same manner provided for original appointments.

(D)(1) The Superintendent of Insurance shall be the Chairperson of the Commission. Meetings of the Commission shall be at the call of the Chairperson. All of the members of the Commission shall be voting members. Meetings of the Commission shall be held pursuant to section 121.22 of the Revised Code.

(2) The Department of Insurance shall provide office space or other facilities, any administrative or other technical, professional, or clerical employees, and any necessary supplies for the work of the Commission.

(3) The Chairperson of the Commission shall keep the records of the Commission. Upon submission of the Commission's final report to the General Assembly under division (F) of this section, the Chairperson shall deliver all of the Commission's records to the General Assembly.

(E)(1) The Commission shall study the following areas pertaining to health care contracts:

(a) The procompetitive and anticompetitive aspects of most favored nation clauses;

(b) The impact of most favored nation clauses on health care costs and on the availability of and accessibility to quality health care;

(c) The costs associated with the enforcement of most favored nation clauses;

(d) Other state laws and rules pertaining to most favored nation clauses in their health care contracts;

(e) Matters determined by the Department of Insurance as relevant to the study of most favored nation clauses;

(f) Any other matters that the Commission considers appropriate to determine the effectiveness of most favored nation clauses.

(2) The Commission may take testimony from experts or interested parties on the areas of its study as described in division (E)(1) of this section.

(F)(1) Not less than ninety days prior to the expiration of the two-year period specified in Section 5 of this act, the Commission shall report its preliminary findings to the General Assembly and a recommendation of whether to extend that two-year period for one additional year. If the General Assembly does not grant the extension, the Commission shall submit its final report to the General Assembly not later than three months after the expiration of the two-year period specified in Section 5 of this act. If the General Assembly grants the extension, the extension shall be for not more than one year after the expiration of the two-year period specified in Section 5 of this act, and the Commission shall submit its final report to the General Assembly not later than six months prior to the expiration of the one-year extension.

(2) The final report of the Commission shall include its findings and recommendations on whether state law should prohibit or restrict most favored nation clauses in health care contracts. The Commission shall cease to exist upon the submission of its final report to the General Assembly.

House Bill 125 Joint Commission on Most Favored Nation Clauses in Healthcare Contracts

Appendix A – 2

Should the Commission recommend that the Ohio Legislature prohibit or restrict MFN clauses in health care contracts?

Member

Leigh Brock-Webster-Did not vote

Senator Capri Cafaro-Did not vote

Dr. Stuart Chesky-Yes

Michelle Daniels-Yes

Philip Derrow-No

Binem Dizenhuz-No

Representative Dan Dodd-Did not vote

Mary Jo Hudson-Abstained

Lisa Han-Did not vote

Representative Matt Huffman-Yes

Thomas Kniery-Yes

Dr. William Kose-Yes

Laura Kuykendall-no

Chad Matteson-Yes

Michele Napier-Yes

Senator Bill Seitz-Did not vote

Dr. Wayne Wheeler-Yes

Appendix A – 2

Should the Commission recommend that the Ohio Legislature extend the two year moratorium on MFN clauses in health care contracts between hospitals and contracting entities for a period of up to one additional year, from June 25, 2010 until June 25, 2011?

Member

Leigh Brock-Webster-Did not vote

Senator Capri Cafaro-Did not vote

Dr. Stuart Chesky-No

Michelle Daniels-No

Philip Derrow-No

Binem Dizenhuz-No

Representative Dan Dodd-Did not vote

Mary Jo Hudson-Abstained

Lisa Han-Did not vote

Representative Matt Huffman-No

Thomas Kniery-No

Dr. William Kose-No

Laura Kuykendall-No

Chad Matteson-No

Michele Napier-No

Senator Bill Seitz-Did not vote

Dr. Wayne Wheeler-No

Joint Legislative Study Commission on Most Favored Nation Clauses in Health Care Contracts

There is hereby created the Joint Legislative Study Commission on Most Favored Nation Clauses in Health Care Contracts…

The Commission shall study the following areas pertaining to health care contracts:

a) The procompetitive and anticompetitive aspects of most favored nation clauses;

b) The impact of most favored nation clauses on health care costs and on the availability of and accessibility to quality health care;

c) The costs associated with the enforcement of most favored nation clauses;

d) Other state laws and rules pertaining to most favored nation clauses in their health care contracts;

e) Matters determined by the Department of Insurance as relevant to the study of most favored nation clauses;

f) Any other matters that the Commission considers appropriate to determine the effectiveness of most favored nation clauses.

Confidentiality

The survey results were obtained by the Ohio Department of Insurance pursuant to Ohio Revised Code Section 3901.011.

The individual responses are considered confidential pursuant to Section 3901.48(C) of the Ohio Revised Code.

Results are reported in the aggregate with individual information de-identified, to maintain confidentiality

Who received a survey?

- All life and health insurers licensed to do business in Ohio
- Many were exempt because they do not write health insurance policies or do not contract with providers
- Members of the Ohio Hospital Association

Methodology

- There were separate surveys for hospitals and insurers.
- The surveys were created by two subcommittees of the Joint Commission.

- There was also a subcommittee to discuss confidentiality issues regarding the survey.

Who was surveyed?

- We sent the survey to 157 hospital chief financial officers.
- We received 60 hospital responses.
- 20 of those were from multi-hospital organizations.
- 40 of those were from individual hospitals.
- We sent the survey to 411 insurers.
- We received responses from 35 insurers.
- Caveat: survey did not apply to many insurance companies

Who has MFN Clauses in their Contracts?

- 11 out of 20 hospital systems reported that some of their hospitals had MFN clauses in their contracts.
- Of the 40 individual hospitals who responded, 16 had MFN clauses in their contracts.
- Of the 35 insurers who responded, less than 10% stated they used MFN clauses.

What We Found – Number of Contracts

For the hospitals that responded they had contracts with MFN clauses:

- Each hospital had an average of 29 health insurers with whom they had a contract.
- Each hospital had an average of 36 separate contracts with health insurers.
- Each hospital had an average of 1.5 contracts that contained MFN clauses. (Over 2/3 of the responding hospitals only had one contract with a MFN clause).

Geographic Region

- Hospitals in all regions of the state had contracts with MFN clauses.
- We did not notice any geographic pattern.

Hospital Systems with MFN Clauses

- 11 hospital systems have MFN clauses in their contracts.
- All had more than 251 beds.

Hospital Systems without MFN Clauses

- There are nine hospital systems without MFN clauses.
- Three have 51-250 beds.
- Six have more than 251 beds.

Individual Hospitals with MFN Clauses

- Hospitals of every size have MFN clauses.
- One small -1 to 50 beds.
- Ten medium-50 to 250 beds.
- Five large-251 or more beds.

Individual Hospitals without MFN Clauses

- 24 individual hospitals do not have MFN clauses in their contracts.
- 11 small -1 to 50 beds.
- 10 medium-50 to 250 beds.
- Three large-251 or more beds.

What We Found – Teaching Hospitals

- Thirteen hospitals classified themselves as teaching hospitals.
- Seven of 13 stated they had contracts with MFN clauses.

Designations

- Of hospitals that responded they had some sort of designation or classification, eight out of 14 stated they had contracts with MFN clauses.

Urban Vs. Rural

- Of hospitals that responded they were rural based, seven out of 23 stated they had contracts with MFN clauses.
- Of hospitals that responded they were urban based, 11 out of 22 stated they had contracts with MFN clauses.

Frequency of Audits

Of the 27 hospital responses we received with contracts containing MFN clauses:

- 10 hospital responses reported being audited within the past five years.
- 17 hospital responses reported not having been audited within the past

five years.

- Insurers reported conducting 35 audits over the past five years.

Demographics of Audits

Of the 27 hospital responses we received with contracts containing MFN clauses:

- 10 hospital responses reported being audited within the past five years.
- 17 hospital responses reported not having been audited within the past five years.
- Insurers reported conducting 35 audits over the past five years.

Demographics of Non–Audited Hospitals

Demographics of 17 non-audited hospital responses:

- 13 were individual hospitals.
- One had 1-50 beds.
- Nine had 51-251 beds.
- Three had more than 251 beds.
- Four of these were hospital systems.
- Four had more than 251 beds.

Liquidated Damages Provisions

Of the ten hospitals that responded that they had been audited, all had liquidated damage provisions in their contracts.

Cost of Audits to Hospitals

- Hospitals reported:
- $48,000 cost of external audit
- Direct cost of audit $22,000
- indirect cost $4,000
- Direct cost not specified
- indirect cost included legal fees and meeting time
- No cost, a small amount of time to copy contracts
- Annual report to auditors, estimated cost $1500. Estimate 46-56 hours of labor to prepare and go through audit.
- Annual audit-each hospital 40-60 hours labor
- Two routine audits, minimal costs (under $20,000) used existing resources, payer paid costs
- Annual audits create indirect costs to the system, time, and IT resources.

Cost of Audits to Insurers

Insurers reported direct costs to enforce MFN clauses over the past five years of less than $1 million.

Audits/Penalties/Sanctions

Of the ten audited respondents, five reported a penalty or sanction as a result of enforcement of the MFN provision.

Reported penalties include:

- $680,000 settlement
- $62,000 settlement
- Negative rate adjustment, financial penalty, amount not specified
- Payment to insurer, amount not specified
- No retrospective penalty, rates going forward were adjusted

Insurer Audit Enforcement

Insurers reported enforcing MFN provisions six times.

Insurers reported the consequences to hospitals or hospital systems for violating MFN provisions can include:

Recovery of overpayment and/or

Changes to other contractual terms, conditions, or rates.

Joint Legislative Study Commission on Most

Favored Nation Clauses in Health Care Contracts

There is hereby created the Joint Legislative Study Commission on Most Favored Nation Clauses in Health Care Contracts.

The Commission shall study the following areas pertaining to health care contracts:

a) The procompetitive and anticompetitive aspects of most favored nation clauses;

b) The impact of most favored nation clauses on health care costs and on the availability of and accessibility to quality health care;

c) The costs associated with the enforcement of most favored nation clauses;

d) Other state laws and rules pertaining to most favored nation clauses in their health care contracts;

e) Matters determined by the Department of Insurance as relevant to the study of most favored nation clauses;

f) Any other matters that the Commission considers appropriate to determine the effectiveness of most favored nation clauses.

Scope of Inquiry

The survey results were obtained by the Market Conduct Division of the Ohio Department of Insurance pursuant to Section 3901.011 of the Ohio Revised Code.

The responses are considered confidential as Market Analysis workpapers pursuant to Section 3901.48(C) of the Ohio Revised Code.

Who Received the Survey?

- All life and health insurers licensed to do business in Ohio
- Many were exempt because they do not write health insurance policies or do not contract with providers
- Members of the Ohio Hospital Association

Insurer Results

- The average duration of contracts with MFN clauses were no longer than those without MFN clauses.
- The responses did not indicate a significant difference.
- The existence of MFN clauses did not have a significant impact on negotiations.
- Five insurers said MFNs did have a significant impact.

- Five insurers said MFNs did not have a significant impact.
- Two said the question was not applicable.
- MFN clauses complicate and prolong negotiations.
- MFN clauses are only a single element in the negotiation.

What terms, other than MFN clauses, simplify, complicate, shorten, and prolong contract negotiations?

- Rates
- Duration of contract
- Medical necessity
- Retroactive denial concerns
- Incorporation of new and/or revised regulatory requirements
- Completion of credentialing and quality requirements

The existence of a competitor's MFN clause has not affected insurers' ability to negotiate non-fee-schedule related contractual terms.

The existence of a MFN clause has not deterred most insurers from contracting with a hospital or to enter into a particular geographic market in Ohio.

What are the reasons, other than the existence of a MFN clause, that have caused you not to contract with a hospital or enter into a geographic region?

- Rates
- Location
- Contract terms

Hospital Results (Revised March 8, 2010)

The results were tabulated separately based on hospital size.

Small hospitals (1-50 beds) reported having no MFN clauses.

Six midsize hospitals (51 to 250 beds) reported having MFN clauses.

Thirteen large hospitals (more than 251 beds) reported having MFN clauses.

Do you use any measures to ensure you do not inadvertently violate your MFN clause, such as a price buffer, with non-MFN insurers?

- Three midsize hospitals use measures, three do not.

- Twelve large hospitals use measures, one does not.

Do you use any measures to ensure you do not inadvertently violate your MFN

clause, such as a price buffer with non-MFN insurers?

Some measures used by hospitals include:

- Price buffers
- Internal analysis
- Monitor negotiated rate

What are the direct and indirect costs to your hospital of measures taken to prevent an MFN violation?

- Midsize hospitals: time; $10-20,000
- Large hospitals: $1500-$30,000; legal fees; internal annual audit; third-party audit; cost of monitoring compliance; IT costs, staff time

Have you ever been involved in negotiations where you would have given an insurer a lower rate but for the existence of an MFN?

- Six midsize hospitals would not have given a lower rate.
- Nine large hospitals would have given a lower rate.

Have you ever been involved in negotiations where you would have given an insurer a lower rate but for the existence of an MFN?

- Many responses indicated that hospitals were willing to give a lower rate, but could not due to an MFN clause.

For the midsize hospitals, there was no discernable difference in the duration of contracts between those with or without MFN clauses.

There was one large hospital that had, on average, a shorter duration, and four that had a longer duration of contracts between those with or without MFN clauses. The average difference was one year for both.

Does the existence of an MFN clause (either in the contract being negotiated or in another insurer's contract) simplify, complicate, shorten, or prolong contract negotiations?

- Some hospitals reported that MFN clauses shorten negotiations because a price floor is set.
- Most hospitals reported that MFN clauses prolong negotiations because of the extra attention the clauses require; additional time for analysis and negotiations.

Has the existence of an MFN clause in one of your contracts affected or

discouraged you from entering into innovative payment methodologies with a different insurer?

- Three midsize hospitals responded affirmatively, three responded negatively.
- Six large hospitals responded affirmatively, six responded negatively.

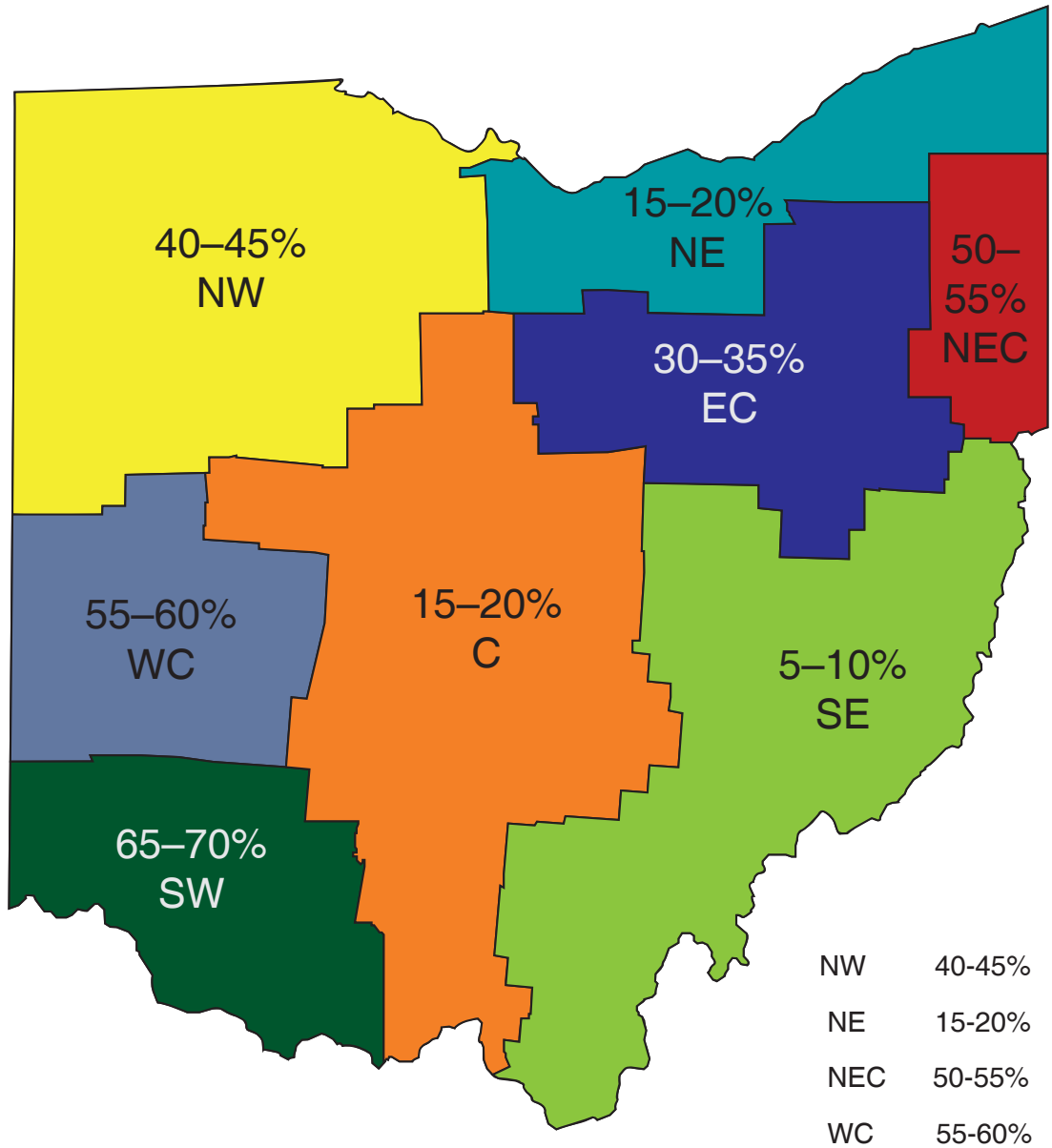
Have you ever sought to amend or revise an MFN provision to allow you to use a different payment methodology with an insurer?

- One midsize hospitals responded affirmatively, five responded negatively.
- Two large hospitals responded affirmatively, twelve responded negatively.

Has the existence of an MFN clause in one of your contracts affected or discouraged you from entering into non-fee schedule-related contract terms?

- Six midsize hospitals responded negatively.
- Seven large hospitals responded negatively.

Percentage of Hospitals within a Region with At Least One MFN Clause in their Contracts with Insurers



NW	40-45%
NE	15-20%
NEC	50-55%
WC	55-60%
C	15-20%
EC	30-35%
SW	65-70%
SE	5-10%

Ohio Regions

- WC – West Central
- C – Central
- SE – Southeast
- SW – Southwest
- NW – Northwest
- NE – Northeast
- EC – East Central
- NEC – Northeast Central

HOSPITAL SURVEY RESPONSES

10) How many separate contracts does your organization have with health insurers?

- It could be up to 2 to 3 depending upon if insurer has a Medicare Advantage product or if they contract for our home health separately.

17) Please describe the circumstances that prompted the audit. Please also describe the cost of the audit using the following categories to calculate the costs: direct and indirect. Please be as specific as possible.

- Routine audit, one in 2005-6 and recently 2008-9. Costs were minimal (under $20,000) using existing resources. The auditor costs were covered by the payer.
- No cost, a small amount of time to copy contracts.
- Our contract requires that each year we submit a report to X's independent auditors on previous years managed care performance at our hospital. This report allows them to compare X's rate of payment in aggregate to that of our other managed care payors. The auditor then requests samples of bills and EOB's that they test to determine if our report appears plausible and no MFN violation is expected. Our financial analysis area prepares the initial report that requires approximately 8 hours of labor. We then spend an additional 8-10 hours interacting with the auditors answering questions, etc. Our patient financial services area provides the requested claims and EOB samples which represent several hundred copies. This takes approximately 30-36 man hours as well as the copy expense to compile. It is estimated that each audit costs our facility approximately %1500 to comply with the actual audit.
- Routine audit. Direct cost of $680,000. Indirect costs of several meetings to discuss and prepare, legal fees.

19) Has your organization ever used the existence of a MFN clause in a contract with a health insurer to successfully negotiate a higher rate with another health insurer?

- In order to not have a violation with our MFN language we had to insist on higher rates from several payors. We never intentionally used the MFN language as a tactic to gain higher rates.

20) Has your organization ever had to reject a contract with a lower rate of reimbursement due to the existence of a MFN clause in a competing health insurer's contract?

- But we have been cautious in developing products for the working poor.
- It has gotten in the way of negotiating and caused issues in getting deals done but in the end after much deliberating, we reached common ground.

21) Has your organization ever had to negotiate a contract for the same reason?

- We had to negotiate a few contracts because of the MFN language.

22) Do you feel that the existence of a MFN clause in a contract between your organization and a health insurer limits your flexibility to negotiate contracts with other health insurers due to concerns about violating the existing MFN clause?

- Yes. MFN clauses limit our contracting flexibility. We now have to ensure that all services paid at a rate higher than the contract with MFN clause because the carrier with the clause has the ability to claim a violation for specific procedures. For example, even though the contract reads that on a percent of charge basis the MFN has to be the lowest in the aggregate, they can claim that other carriers pay less for MRI services and then take back the difference for just MRIs, even though in total or, in the aggregate of their business, they pay less. For example, if the MFN pays the hospital at a rate 45% of charges and all other carriers pay on average, 49% of the charges, but the MFN carrier discovers that another carrier pays $500 for an MRI and the MFN carrier pays $600 ($1333 * 45%) then the MFN carrier can recoup the $100 difference, even though in the aggregate they pay less. Because the MFN carrier has a large market share, we are less flexible to other carriers when negotiating rates, especially new entrants to the market. New market entrants are almost guaranteed to pay higher rates and their ability to grow will be limited.
- At times it does.
- Somewhat limits.
- Yes. Currently renegotiating with a major payor. MFN creating obstacles.
- No, I believe that the MFN concept is a legitimate one as I believe that health insurers should only get discounts based on the volumes that they bring to the hospital. Thus larger volume insurers should get the better discounts.
- Yes, but we have used it to increase rates with other payers.
- Yes. The existence of MFN clauses in our agreements with certain

payers has impacted our negotiations with other payers due to concerns about violating the MFN clause. The financial penalties for violating MFN with the largest payers are significant. Since it is our objective to negotiate similar reimbursement levels for the top payers in the market, a MFN clause forces us to include a buffer of several percent so that minor unanticipated changes do not put us in violation. The buffer generally ends up disadvantaging the other smaller, but significant payers. Also, smaller payers may then experience market entry barriers because of the higher reimbursement levels required by providers.

- Yes.
- Yes. Each contract should stand alone.
- MFN language limits the provider's ability to strategically work with a smaller more regional payors. Larger companies that have large market share in an area get dangerously close to monopolizing the market and ultimately have a stranglehold on it. once they have a critical mass they can shadow price incrementally just below where employers would move their business. In addition, larger payors answer to their investors and regional players are more centric to the region they exist in.

As a provider, I would like to be able to work with other payors strategically to bring product(s) into the market that provides the plan designs our employers are looking for and competitive premium rates. Working with regional and local payors allows us as a hospital to have a more transparent relationship with payors that is more flexible for both parties. In my opinion being hamstrung with MFN language only limits creativity and competitive products from reaching local markets.

- Yes. It limits flexibility. Other payers want the same rate as the ones with MFNs. They presume to know the rate from "internal intelligence". Some plans have strategies to "steal" business from the large plans so they are asking for rates within a few points of the large payers. Also, payers don't pay the same way, so not comparing apples to apples. And with the variance of patient utilization, it's difficult to predict how rates negotiated one year will translate to reimbursement rate for next year based on utilization.
- The existence of MFN in contracts has limited our flexibility to negotiate contracts with other health insurers due to concerns about violating the existing MFN clause. We have been hesitant about exploring different types of reimbursement methodologies with "other carriers" that could positively impact cost and quality for fear of violating the MFN clause. There are also times that a new insurer enters that market and they would like to effectively compete against the incumbents. There may be relatively little volume with the new carrier; consequently the financial risk to the hospital is relatively minimal. The hospital may believe that increased competition between the insurers' carriers would be good

for the community as well as for the hospital. The MFN clause would prohibit such an initiative that would be a win for the hospital and a win for the business community, etc.

- Yes, an MFN provision requires that we contract with non-MFN health insurers at rates that will not create an MFN violation. Given that the various health insurers are on vastly different payment methodologies, it limits our flexibility in terms of how competitively we can position non-MFN health insurer effective rates. In other words, we have to build in a cushion to be certain that we have avoided a future violation.
- Yes. It is a constant battle to monitor these provisions. It is especially difficult when two of these provisions are active at the same time and each provision is written and audited differently. If you have two active provisions, unless a "corridor" is in place, one provision will most likely be in violation.
- It absolutely would.
- The existence of an MFN clause does not influence our flexibility to negotiate contracts as our organization's position has been that we negotiate the reimbursement terms and discounts based on the relative volume of business provided to us by the respective payer. We have followed such strategy of stratifying payers and their respective discount for many years.
- Absolutely. MFN clauses limit the ability to negotiate special arrangements with payors or businesses for discount rates that may be above average and that may be in the hospital's best interests, such as in providing for a community benefit to a particular group of enrollees (low income, etc.) or in meeting competitive offers requested by local businesses who are trying to reduce/minimize their health care costs.
- Yes, the existing MFN gives the managed care company a pricing advantage in the community and forces other payers out, giving the MFN payer more leverage to lower payments to the provider. If not for the MFN, we could offer a lower [r]ate to other payers and level the playing field which would reduce the cost shifting impact.
- Not currently
- Yes-any price concessions to a non-MFN insurer are magnified, as we would have to be {not legible}.
- MFN insurer's book of business is enormous when compared to any other managed care payors or the others as a whole. The risk of an inadvertent MFN violation has a chilling effect on competitive pricing. A small violation may become a huge penalty when applied to the MFN's insurer's volume.
- Yes and no-while we honor the MFN provision, we strive to keep all payor's reimbursement at similar levels, and thus while the MFN is

occasionally a factor in our contracting strategy, it is not the main driver.

- Yes-it inhibits leverage.
- Yes. Payor with MFN sets the floor.
- Yes
- Yes

23) Do you believe that MFN clauses in contracts have increased or decreased competition among payers?

- MFN clauses have certainly decreased competition in the market. Because pricing is the single most important part of healthcare selection process, the lower price compared to the competition, the greater market share one will capture. For example, X, which is a large company doing business in nearly every state, they are not able to compete in the NW Ohio market, in fact, they have lost market share over the last few years because one of their competitors required an MFN clause at almost every hospital.
- Decreased
- Decreased
- Decreases competition. Automatically gives larges payor best deal.
- I do not believe they have had any effect.
- Possibly decreased competition. Since they have a lower rate, companies will go to them before going to payer whose rates are higher.
- We believe that MFN clauses have had an impact on competition. It would not be our business practice to give a smaller or new payer in the market a better rate than the largest payer. However, as noted in Response 22, the existence of an MFN clause with the largest payer does force a somewhat higher reimbursement to protect ourselves against potential and unintentional violations. Such higher reimbursement would cause premiums to be higher and make it difficult for a new entry into the market to be successful. As a provider we do not have sufficient market data to reach conclusion as to the direct impact of the MFN clauses. However, based upon our claims volume, we do note that the largest payer, the payer with the most significant clause, has been able to significantly increase its market share over the past five years.
- Decreased competition-obvious reasons.
- Decreased development of new products for concern of impact on MFN contract.
- To my knowledge there has been only 2 such agreements in our area since I came here in 1995. X and Y were the only HICs that had MFN in their deals. X lost a case in the Cleveland market years ago making

the MFN clause obsolete for them. It is my understanding that Z was asking for the lowest rate by a fixed number under the best rate at that provider.

Y takes what they think is a more passive position by asking for equal to or better than the best rate a provider has. This still limits competition and the provider's ability to get creative in their market.

- Decreased competition with small plans. Large plans have the majority of businesses. Smaller plans/networks continue to lose groups to these large plans.
- As noted above, in the examples under #22, the existence of MFN clauses have limited flexibility, creative reimbursement methodologies, and the growth of new insurers, which all have had a negative impact on competition among payers.
- Yes. By its very nature, the MFN provision provides the largest payer with a medical cost differential that allows it to grow at the expense of other competing health insurers.
- Inconclusive. However, if you ever did want to offer a payor a "preferred" rate in order to steer business to them, the existence of a MFN provision would not allow you to do so. So, your options are limited before you even begin negotiations.
- The organization feels the existence of a MFN clause has had little to no effect on competition. We are able to provide competitive reimbursement structures with multiple payers and contract with new payers to gain entry to the market by providing discounts based on relative volume and if needed able to provide rates close enough to the MFN payer to ensure parity.
- Decreased. Competition in our region is relatively low in that there are only 6 major payors that have significant market penetration. Our MFN contract represents one of those six, and essentially, it prohibits us from negotiating contractual arrangements (with higher discounts than the MFN discount) with other non-major payors. As such, this situation severely limits the small MCO in their attempt to enter into our market and compete on an equal footing with the existing 6 major payors.
- Decreased.
- In our market, the MFN clause has decreased competition. Our highest volume payer (with the MFN) should always be able to win an employer's health insurance business as he is guaranteed the best price.
- Competition has decreased as the large payors dominate the market. To prevent further domination, again, we strive to keep all payors at similar reimbursement levels.

- Decrease-add advantage to the one payer and allows them to grow.
- Decreased-the largest payers who have the most leverage and have been the most aggressive use the MFN to “lock in” their advantage.
- Decreased-MFN sets a “floor” for pricing.
- Decrease
- Decrease

24) What effect do you believe that MFN clauses in contracts have had in holding down health care costs?

- I do not believe MFN clauses hold down costs for healthcare, they actually increase costs and move market share to the carrier that has the MFN. We now require a minimum of 5% increases from all other carriers to ensure there is not an MFN violation. In prior years, we made sure our pricing was in line with cost increases.
- None
- I do not believe MFN clauses have any effect on health care costs as it is only a contractual concept. The way to hold down health care costs by insurance companies is to make them manage the patient and their care, not try to penalize the hospital by non-payment for services provided.
- I don’t believe an MFN clause holds healthcare costs down.
- None, in fact it might have the opposite effect. The MFN provisions are used by providers to negotiate higher reimbursement with the largest payers with MFN provisions. The MFN rate then operates at a floor. The existence of an MFN makes it more comfortable for the larges payer with the MFN protection to agree to higher reimbursement because they are guaranteed not to be disadvantaged. The providers are then forced to negotiate even higher reimbursement with the competitors. Accordingly, the MFN clause is more likely to increase overall healthcare costs and make it more difficult for new payers to successfully enter the market.
- None.
- As I mentioned previously that MFN language limits flexibility and creativity in a market. Providers cannot easily create strategic alliances with payors that would allow products to be developed that are specific to the community they serve and are very cost effective to the provider, payor and most importantly the community. MFN protects the larger company that does not have the ability to be flexible, creative or responsive to local markets.
- 67% of our commercial patients have large discounts. Contracts with MFN provision at least sets a floor for all other payer rates.

- MFN clauses may have reduced healthcare costs for the applicable insurance carrier, but in turn it has increased healthcare costs for their competition and the business community at large. It has also forced the hospital, because of concerns of violating the MFN clause, to increase rates to other carriers by even a higher percentage by adding a "cushion" as a protection against a possible MFN violation.
- None. Questions 19-21 allude to the fact that the MFN provision may end up establishing a 'floor' level of reimbursement and a non-competitive playing field that is otherwise necessary to control costs and expand employer access to competitive rates and premiums.
- None. Only those with market clout can negotiate these provisions into contracts. These payors don't care what the rate is…only that they are receiving the best rate. If you did want to offer another payor a better rate (thereby lowering healthcare costs), you are prohibited to do so.
- The organization believes the existence of an MFN clause has had little to no effect in holding down health care cost. The reimbursement terms negotiated are not influenced by the presence of a MFN clause therefore the existence of an MFN clause has not had a significant influence on our reimbursement terms and the payer's reimbursement terms would be similar with or without such a clause.
- None. We believe that the MFN clauses really only serve to benefit the interest of the contracting MCO and provide no real benefit to the contracting provider. The constant threat of an MCO audit and the additional efforts to ensure compliance with the MFN clause, considering the various forms of contractual payment arrangements that need to be monitored, add to the level of effort, and costs, of the contracting provider. In our market, we do have to worry about the effects that having only 6 major MCO players has on our competitive environment. If our MFN contract proves unfavorable, options are limited in business shifting to other MCOs.
- None. It requires other payers to lose market share and requires providers to insist on very high rates from the non-MFN payers in order to compensate…at the end of the day the providers must negotiate rates that in the aggregate will sustain the costs to provide care…MFN doesn't lower health care costs, it simply determines who will pay a disproportionate share of those costs.
- The MFN clause has had no effect in holding down health care costs. The MFN provision in our area's largest insurer's contract has had the effect of cost shifting. The system's costs have increased as a result of the cost of business increasing as labor, drugs, supplies, technology, etc. have increased in cost. Insurers without the MFN provision have born more than their fair share of cost increases through rates that are

contained in their contracts that must cover a greater share of increased costs. On the national and state level, as Medicare and Medicaid fail to pay the cost of providing care, these costs are shifted to those who can pay (the commercial/managed care payors). Within our system, the costs must be and are shifted to other payers. Over time, this dynamic has resulted in our market being dominated by the insurer with the MFN, and fewer lower volume other payers to shift costs to.

The situation as relates to competition is worsened once again as the managed care payer with the MFN, and the largest book of business is then leveraging its market power by converting retirees to its MA plan.

- Some small effect, but not a key driver in holding down healthcare costs.
- Mix-on one hand we have had to increase rates with non-MFN payers but it allows that payer with MFN to keep rates down in area. Also the MFN payer is in NE Ohio and they add value to the economy.
- None. This is a red herring. If a hospital must leverage other payers to advantage one over the others, then it drives costs up in the short to midterm. The payer with the MFN can actually become lazy in negotiations as they know they will always have the best price regardless of how high costs or rates go.
- None. It benefits only the payor with the MFN.

25) Please provide any other information you would like to present to the Commission.

- We are a relatively small business compared to the size of the insurance carrier requiring an MFN clause. About 4 years ago, this carrier terminated their contract with our hospital and signed an exclusive contract with our competitor, who also owns a HIC. Our prior contract with this insurance carrier did not have an MFN. This carrier approached us 3 weeks before the moratorium was to start in 2008 and said if you want to back in the network, sign this MFN clause or you will probably not be considered to be a network provider in the future. This carrier's market share has steadily grown in NW Ohio since the year 2000.
- Our hospital has chosen not to enter into contracts containing MFN clauses as we feel the financial risk and bureaucratic hassle is too great. The presence of MFN clauses in contracts proposed by some major health insurers in the past has been a barrier to us contracting with them.
- MFN clauses are not permitted in other states where I have worked-deemed anti-competitive.

- We are totally against MFN clauses. We need to have the ability to individually determine payment rates based on size of the plans in our market, timeliness of payments, and the administrative burden of the plans.
- The main issues with MFN clauses in today's environment are: a) the rate buffer described in item 22 above which is required to protect providers from violating the MFN clauses. The existence of MFN provisions makes it less flexible for providers to negotiate pricing with smaller payers for fear of violating the MFN clauses; b) because of the higher rates, the MFN clauses make it harder for smaller payers to enter the market; c) the administrative hassle related to monitoring and actual audits. Providers are forced to spend valuable resources to monitor compliance with the MFN clauses and to deal with audits; d) if a provider is found to have violated the MFN clauses, the penalty is grave and not proportionate to the benefit (if any) realized by the provider. More specifically, if a provider violates the MFN clauses, the usual penalty is for the larger payer to apply the lower rates to the larger payer's business, which would be more substantial than that of the smaller payer. Also, any penalty would likely be applied both prospectively and retrospectively; e) it is difficult to predict if a provider will violate the MFN clauses, especially new payers with no record as to volume of services. In the Ohio market, certain large payers started using the MFN clauses about 20 years ago. back then, the reimbursement was primarily based upon a percentage of charge. However, in today's managed care environment, payer are using diverse reimbursement methodologies, which are often complex. Providers often have issues with how payers determine whether a provider has violated the MFN and the MFN penalty amount; f) the main MFN provisions were implemented by X about 20 years ago. X was known by the name Y. The decision to implement the MFN provisions was based upon factors that are not relevant today. Back then, Y experienced significant pressure from physician-owned Z that was demanding much lower reimbursement. Also, AA had its own MFN clause and X did not want to be disadvantaged as both plans expanded statewide. These factors are either no longer relevant or less relevant today. In fact, some later development has proven that MFN clauses are not essential in protecting a payer's competitive position. In late 1990s, AA entered into a consent decree with the US Dept. of Justice whereby AA agreed not to use the MFN clauses. Not using MFN clauses in AA's provider agreements has not affected AA's market position. Today, AA remains one of the largest payers in Ohio.

In conclusion, it has been proven that payers and providers can reach fair and reasonable reimbursement rates without the MFN clauses. The MFN clauses are no longer appropriate in today's market because of the anti-competitive effect in the marketplace, the health care resources providers are forced to spend to deal with compliance and audit, and the unpredictable and disproportionate penalties to providers if the providers are found to have violated the MFN clauses. Instead of their competitive value, the MFN clauses have been used by large payers to sustain their dominant market position. Because of the concerns outlined above, many states have passed laws to ban the use in an effort to promote an environment which allows more competition among payers.

- MFN clauses are outdated. Especially when you try to convert a DRG to a percentage of charge. You are at the mercy of your patient mix. Compare that to a percentage of charge contract and you may find out the MFN was violated. All parties should be free to negotiate their rates.
- MFN, pure and simple, is the way the large insurer keeps competition out of a marketplace.
- X's corporate headquarters is located in Indianapolis, IN. in 2007 the state of Indiana passed regulations outlawing MFN. I attached a few documents from this action.
- 1) Although we have responded to the above that we are currently in one MFN contract, we have another contract where the MFN provision exists but has "gone silent" due to HB 125. Although that payor does not have audit rights today, that provision could "turn on" later. The payor refuses to remove the provision in hopes that they are able to reenact it after the state's study. So we need to monitor that contract as well as if it did have MFN. 2) The MFN provision we currently have guarantees that payor the lowest rate by x%. At the time, the payor had significant leverage to negotiate that provision into a long term deal. That provision is truly anti-competitive and we are stuck in a long term contract with that provision. If the state determines to do away with MFN, it should also end these provisions in all EXISTING contracts, too. 3) Only payors with a lot of market leverage can achieve these provisions. Achieving these provisions can make their sales job easy because they can go out locally and say they are contractually guaranteed the best rate. (Even though other payors may have an equivalent discount rate, they cannot tout the MFN provision). Having MFN provisions gains the significant payors even more business making the big payors even bigger and giving them even more leverage over the providers. 4) Systems that also own healthplans typically get their owned healthplan as an exclusion when participating in these provisions. When the local owned healthplan is excluded from these provisions, it allows that healthplan tied to that one hospital system to price lower in the market and have a pricing advantage (although they also have a network disadvantage

as both local systems are not participating). Regardless, the system without the owned healthplan has no options to offer lower pricing when constrained by MFN provisions with no exceptions.

- We support the continued prohibition of most favored nation provisions in healthcare contracts.
- Although my organization does not hold any contracts that contain MFN clauses, I believe MFN clauses can lead to higher prices. In addition, an MFN clause can ensure that the largest insurer in a given market is able to maintain that status while removing incentives to hold down health care costs as a result of competition from other insurers. These observations are based on actual experiences as described below.

I have previous experience working on the insurance side of the managed care industry. I worked in hospital contracting for a medium sized insurer. On a number of occasions I was told by hospitals "I cannot agree to that rate because it will violate my MFN provision with another insurer." One hospital even confided that they will like their MFN provision because it set a floor as to how low they could go on rates with other insurers.

As most are aware, medical costs account for 80-85% of the spend on health insurance. If an insurer (typically the largest insurer(s)) can guarantee that it has the lowest rate on these medical costs through an MFN provision then the insurer will have a competitive advantage over other insurers. In this case, the primary incentive of the insurer with the MFN clause is to maintain and enforce the MFN provision as opposed to negotiating competitive rates between providers and offering innovative approaches in holding down healthcare costs. This has the effect of preventing competition and eliminating the possibility of new savings to the employers/consumers.

On the provider side, I have witnessed this phenomenon. Although we do not have an MFN provision, one large insurer suggested that they could agree to a certain rate level as long as they were assured that the other insurers were at a higher level. The suggestion was made that we should raise our rates with other insurers which would then enable this insurer to agree to our desired rates. The insurer's concern in this case was to maintain a competitive advantage over other insurers vs. holding down health costs. This logic is indicative of how large insurers use their MFN status to maintain their competitive advantage and market share without a true goal of holding down costs.

Another important point for those providers who do not have the leverage to refuse MFN provisions is the need for flexibility in negotiating rate levels by insurer based on factors other than just the insurer's size. Many times low denial rates, payment turnaround and administrative ease are just as important as the insurer's market size. A provider should have the ability to negotiate rates based on these factors as opposed to a simple measurement of the insurer's size.

- Insurers use MFN clauses as a sales tool to employers, purporting to have best pricing, but failing to fully disclose other elements of pricing such as “percentage of savings” arrangements wherein the payor keeps a portion of a discount.

INSURER SURVEY COMMENTS

8) Explain the business reason for using MFN clauses.

- Our MFN clause is in only one hospital contract. This particular clause was at the request of the hospital which wanted to ensure that case volumes with their facility remained intact. It was only agreed to since the hospital, from which we purchased their HMO and health insurer, required us to agree not to contract with any other hospitals in that geographic area, other than the ones our (and their) HMO and health insurer already contracted with. As a negotiation tactic, then we required them (the hospital) not to contract with any other carriers other than those they already contracted with. It had very little, if any impact since they already contracted with a multitude of carriers. 8a)
- No
- Our comparable rate provisions provide for a comparable, not a better rate. We typically only use comparable rate provisions in long term contracts. The use of these provisions: 1) encourages long term contracts-which provides long term stability for both the facility (they can plan on revenue levels over a number of years) and provides us with a stable network over a number of years; 2) provides long term network stability giving our members consistent access to a wide range of facilities; 3) helps to reduce the ultimate costs of insurance to Ohio consumers by preventing X from having to pay higher rates than other plans. This benefits many consumers since these cost savings are passed on to them, particularly in the context of self-funded plans where they are directly responsible for each bill; 4) prevents X from paying unnecessarily higher rates, over the market rate, subsidizing the activities of competing plans. Without comparable rate provisions, we will likely enter into shorter term contracts with facilities, which could lead to network instability or other disruptions to both the facility and us. The comparable rate provisions do not prevent hospitals from accepting either higher payments or lower payments. Please see the attached documents for further clarification, evidence and support.
- Yes. In most cases, MFN clauses are designed to ensure that insurers and employer groups pay a market rate for health care services. MFN clauses can stabilize health care costs by ensuring that hospitals charge a consistent reimbursement rate. An MFN clause in a contract between

a hospital and an insurer can assure a hospital that its reimbursement rates of other insurers. In this way, MFN clauses can be an efficient contract mechanism for hospitals.

8b)

- No
- The question of whether an activity is pro-competitive or anti-competitive is fundamentally an antitrust analysis. As such, it is one that must be viewed from the consumer's perspective and with the input of an antitrust economist. Neither hospitals nor insurers are consumers of the product here-it is the end consumer-the insureds-where the analysis must be made. There has only been one analysis of comparable rate provisions in the health care marketplace that has the performed by an antitrust economist using standards generally acceptable and applicable to an antitrust inquiry. This article, published by William Lynk, which looked at two marketplaces, concluded that provisions like comparable rate provisions are in fact pro-competitive and help to reduce health care costs for consumers. A copy of Dr. Lynk's study is provided, as well as a summary of that study that was prepared by Howard Feller. Please see the attached materials from Howard Feller's presentation for additional information and evidence supporting the broad legal and public policy support to comparable rate provisions in the healthcare marketplace.
- MFN clauses may provide a competitive advantage in certain situations where a hospital agrees to provide X with its best rate. In certain cases, however, and MFN clause provides no specific advantage to X. X is unable to identify any specific evidence to support the foregoing statement.

9b) What were the direct costs of auditing or enforcing the MFN clause to your company?

- $971,124.71 was spent auditing 1/1/2004 through 12/31/2008 (2009 figures have not yet been determined as those audits are still in progress).

9c) Within the past 5 years, how many times have you audited hospital MFN clauses for compliance?

- 35 hospital system audits have been made since 1/1/2004.

9d) Within the past five years, how many times have you enforced hospital MFN clauses?

- From 1/1/2004 through 12/31/2008 there have been 6 hospital system violations. 2009 figures not yet determined as those audits are still in

progress

9e) What are the consequences to a hospital for violating an MFN provision?

- Breach of contract
- Resolution of a contract violation can include recovery of the overpayment and/or changes to other contractual terms, conditions, or rates.

11) For each CFC geographic region, check what kinds of hospitals you have MFN clauses with, broken down into the following categories.

- The response to this question represents each individual hospital facility rather than an alliance or group of hospitals under a single contract with us. As a result, the response to this question could include a smaller hospital individually where it is in reality part of a larger negotiating entity under a single contract which would also be separately represented. In addition, the larger negotiating entities can cover multiple regions, particularly given hospital consolidation over the past five years. We are reluctant to provide information to the following subparts (kinds of hospitals, rural or urban) based on the categories that have been provided to us (e.g. we were unsure how Lima Hospitals should be categorized). We also found the categories of the kinds of hospitals to be vague and difficult to categorize in a consistent manner.

13) What are the effects on your company, customers, and members when your competitors are using or have used MFN clauses? Please explain the effects and identify the CFC geographic region/counties where these effects have occurred.

- We believe that MFNs are an unfair business practice that are only used by larger companies that hold a strong market share in an area and are able to use that strength to influence a provider to sign the MFN. Its intent is to make the company which is probably already on top with its market share to stay on top by always having the best contract. MFNs stifle competition by making it impossible to compete fairly based upon the quality of the service that we offer. Ultimately, it works toward attempting to eliminate the smaller companies by helping the bigger companies maintain or expand their market share.
- In the major metropolitan areas, some of the competition has years to get by before renegotiating will not be affected by MFN. It definitely put us to some disadvantage until the requirements of those old contracts have been completed to get beyond the maximum year that some of those contracts are still in effect if the competition isn't doing an active MFN contract.
- We have no particular opinion about the impact of MFN clauses on our business in Ohio to report.

- Our company would pay a higher rate, causing higher premiums. While a plan with an MFN clause may see expenditures go down, others would see theirs go up.
- We are unaware of this type of clause.
- We have encountered MFN language with providers throughout the state but it is particularly prevalent in the southern part of the state (Cincinnati and Dayton) as well as the more rural areas.
- Our experience has been that the use of MFN clauses in the Ohio marketplace results in insurers and hospitals being unable to reach agreement on terms that would otherwise result in lower prices to consumers. When negotiating with hospitals, X strives to achieve contract terms that are most beneficial to our customers, including terms on price. However, in many circumstances, we have been told by hospitals through the negotiating process that reaching such terms is not achievable due to the barrier that has been constructed through the use of MFN clauses by other insurers with those hospitals. Therefore, our experience has shown that our ability to independently negotiate contractual terms with a hospital in the best interest of our customers cannot occur in those circumstances where an MFN clause is in play. This experience doesn't vary by region. In other words, wherever a MFN clause is in existence, we typically experience similar affects. In terms of where we see MFN clauses being used most prevalently, it is in SW Ohio.
- X believes MFN contracting stifles competition as smaller carriers are not able to obtain the same levels of discounts as the larger carriers who are able to negotiate MFN contracts.
- Unknown-we don't know the status of competitor contracts with or without MFN.
- Although our intermediary provider network does not have specific information in its possession regarding CFC geographic regions/ counties, most favored nation clauses tend to negatively impact and/or limit a network's ability to negotiate rates with providers.
- MFNs obviously restrict our company's ability to compete, in a given market place, on price (premiums). With hospitals accounting for 35-40% of the medical costs, if a payer's rates at a given hospital are 10% higher than the MFN rates, that translates into a 4% higher premium. Obviously, the customers (employer groups) and members feel the impact on their premiums. Not all hospitals openly admit they have MFNs, they don't want to breach their contract terms. Therefore, we don't know the extent of existing MFNs and associated geographic distribution within our current service area.
- At this time, we do not know the effects on our company or customers

when our competitors are using or have used MFN clauses.

- There is one specific instance in which Ohio law governing MFN clauses has had an anticompetitive effect. HB 125 established a two-year moratorium on the use of MFN clauses and precluded any existing health care contract from being amended to include an MFN clause. Yet HB 125 specifically provides that the moratorium does not apply to and does not prohibit the continued use of a MFN clause in an existing health care contract. This provision in Ohio law is anticompetitive because it locks in a competitive advantage for those insurers with existing MFN clauses, but prohibits insurers from seeking new MFN clauses in health care contracts.
- X believes MFN clauses to be anti-competitive. Only large insurers with substantial market share can demand MFN clauses from providers. Once in place, the MFN clauses limit the ability of insurers with lesser market share from competing on price because providers cannot, or effectively cannot, offer larger discounts to other, possibly lower-priced, health benefit plans. Moreover, employers are driven to larger insurers because the only way the employer can be sure to get the best pricing is to go through the insurer with the MFN clause. This discourages other potential insurers from entering the marketplace and limits the ability of existing insurers to grow.
- Our company would pay a higher rate, causing higher premiums. While a plan with an MFN clause may see expenditures go down, others would see theirs go up.
- MFN clauses typically require the hospital not to enter into a contract with another insurer for rates less than or within 1-3% of the MFN contracting insurer. This corridor potentially causes hospitals to be overly conservative to guarantee non-violation of the MFN clause in order to avoid financial penalties. The hospital could then require other insurers to contract for at least 2% higher rates. In tougher economic times differentials of more than 1-3 percentage points could force a plan sponsor to choose another insurer for their employees. It also can potentially cause plan sponsors and ultimately members to pay higher premiums based on the higher contracted rate with the hospital.
- None to my knowledge.
- Although X does not have specific information in its possession regarding CFC geographic regions/counties, MFN clauses tend to negatively impact and/or limit a network's ability to negotiate rates with providers.
- Part of the normal competitive process will undoubtedly involve situations where we engage in negotiations with a facility that has an MFN provision with a competitor. Overall we believe that MFN clauses

are a benefit to the consumers in the health insurance marketplace.

14) Do you believe MFN clauses have had an effect on holding down health care costs? Please explain your answer and include evidence to support your conclusion, if available.

- MFNs do just the opposite of holding down health care costs. In one instance, they are used when a provider sets an expectation of a level of reimbursement that they want is higher than what the payor is willing to pay. After negotiating unsuccessfully, the payor gives in to the reimbursement rates the provider wants under the condition that the provider does not give better rates to anyone else. Once the MFN agreement is in place, the provider now tells the other payors that they cannot contract below a specified rate. When the hospital negotiates with other payors/carriers, they usually do not initially announce that they have an MFN clause, but as the negotiations go on and the provider is not willing to contract at rates that are considered reasonable by the payor, it will often come out that they cannot (or will not) go lower because they have an MFN with another payor. In other circumstances, a large payor/carrier will offer a very attractive (high) reimbursement rate to a large hospital and use an MFN clause. Then no other carrier can negotiate below that rate which drives up healthcare costs to consumers and stifles competition. In addition, in Ohio there are integrated systems whereby the hospital, doctors and many of the ancillary services are owned by the system or foundation which do not use MFNs, but do not contract with any other carrier. Competition has been eliminated, but not by use of an MFN. Also, in Ohio there are other integrated systems (provider owned) that do not contract with other payors, but refuse to sign an MFN because they want their own HMO or insurance company to have the best rates in order to keep the business within the system. Again, an MFN clause is not used but competition is stifled because the best rates are given to its own HMO or insurance company.
- We have no particular opinion or evidence to present regarding the impact of MFN clauses on overall health care costs relative to the Ohio marketplace.
- We have no data to support either issue.
- We do not use MFN clauses.
- No, not in the aggregate.
- Unknown
- To the contrary, MFN clauses have done nothing more than hasten the advance of medical costs by establishing an anti-competitive environment. The inability of a provider to negotiate freely with payors (due to restrictive MFN clauses), pre-empts natural market forces and stifles competition. Ultimately, depending on the size or location of such

provider, the lack of competitive pricing can preclude payors from 1) entering certain geographic markets or 2) if the payor enters the market, serves to make the payor's products financially uncompetitive. Such a scenario restricts competition and access, leading to higher health care costs for payors, customers, and consumers.

- No, all they do is advantage the carrier that has the MFN contractual language. In many conversations we have had with providers, we have consistently heard feedback that they could not/would not negotiate any more favorable rates due to contractual language with the largest carrier in the market.
- It is unlikely that most favored nation clauses hold down health care costs. Most favored nation clauses tend to limit payors, networks and health plans from entering into more favorable financial arrangements with providers.
- No-they potentially hold down the costs for that subset of the market controlled by those with the MFN, but those with the MFN incur "higher costs" via enhanced/creative broker commissions and margins they have to return to shareholders. Further, the MFNs preclude another payer and the hospital working together as partners on new and innovative models of care and financing to drive better quality and cost effective outcomes for the patients/members/communities. All other payers are at the mercy of the negotiating skills of the payer that has the MFN. Finally, the MFN is used to drive all payers higher when and how the hospital deems appropriate.
- In theory, it would appear that MFN clauses are intended to hold down health care costs. It remains to be seen if this is actually the case.
- Yes. MFN clauses can hold down health care costs because they tend to create greater consistency in pricing by maintaining reimbursement rates at a particular level until a significant percentage of the insurers and other payers in the market are willing to raise the market rate for health care services.
- We do not believe MFN clauses hold down health care costs. Even without MFN clauses, insurers with size, reputation and market share will still be able to negotiate competitive rates with providers; the market will remain open and attractive to a variety of other carriers giving employers more choice in selecting who administers their health plan; and, most importantly, consumers will have access to the best pricing from providers without artificial restriction.
- No, not in the aggregate.
- X believes MFN clauses do not always hold down cost, in fact, they may potentially increase cost depending on the market facts (e.g., number of market participants, their relative bargaining strength, actual language

of the MFN clause in question). If insurer "A" has an MFN with a hospital that is set unreasonably low due to that insurer having large volume in the market place and the hospital's belief that it has no other significant revenue source besides Insurer "A" and therefore must deal with Insurer "A" at any cost, the hospital may need to make up overall revenue by negotiating higher reimbursement rates with Insurer "B" to cover expected revenue. In turn, Insurer "B" may be placed in the position of having to charge higher rates to plan sponsors and ultimately members in order to cover its higher provider costs. Again, depending on the strength, number of participants in the market and the exact language of the MFN clause, MFN clauses tend to establish a price floor on reimbursement rates. The Dayton market may be one to explore for this phenomenon.

- Don't have an opinion.
- It is unlikely that MFN clauses hold down health costs. MFN clauses tend to limit payors, networks, and health plans from entering into more favorable financial arrangements with providers.
- The only empirical economic analysis of MFN provisions in the health care marketplace, a study prepared by Dr. William Lynk (copy attached) concluded that MFN clauses produced lower prices from providers which would result in lower premium rates to consumers. There are no comparable economic studies to the contrary, only conjecture from hospitals upset that they cannot keep overpayments. Please see the attached materials from Howard Feller's presentation for additional information and evidence.

15) Please provide any other information you would like to present to the Commission.

- The MFN is a tool that is used by some payors and serves the payor who uses it in their contract and it serves the provider who signs it. it is not much different than price fixing because the provider and one payor are controlling the cost of health care. Neither the provider nor the payor who sign an agreement with an MFN clause wish to admit that it was their choice to do it, but in the end both of the parties of the MFN contract benefit from its existence. In the current healthcare crisis with costs spiraling out of control, MFNs only help contribute to the problem by limiting competition. Historically, it is known that the primary means of defining the true cost of a product or service is competition. When competition exists, the competitors are driven by trying to provide their product or service at the lowest possible cost, and best possibly quality.
- MFNs are only good for the company that can get away with it.
- The opposition to comparable rate provisions in hospital contracts is based on theories and assumptions, which Dr. Lynk's economic

research study pointed out, cannot be relied upon.

- The only way to determine what the effect of a comparable rate provision has been on an actual market is to conduct an empirical economic study that focuses on the impact on consumers.
- The only economic study on this topic concluded that comparable rate provisions were in fact, pro consumer.
- The use, terms and conditions of a comparable rate provision are the subject of negotiations. The use of these provisions in Ohio hospital contracts should be left to the market to determine.
- Please see the attached materials from Howard Feller's presentation for additional information and evidence.

HOSPITAL FOLLOW-UP SURVEY COMMENTS

2) Do you use any measures to ensure you do not inadvertently violate your MFN clause, such as a price buffer with non-MFN insurers?

- Monitor negotiated rate
- Make sure percentage of charge for non-MFN is higher. Need to convert MFN contract to percentage (i.e. same DRG).
- Percentage of charge for all services must be at a minimum threshold
- We must attempt to quantify the net revenue effect of any new rates or payment methodology to assure as much as possible, that we have not accepted a lower rate. We do use a buffer, so as not to commit a MFN violation.
- Yes-unless contracts are all reimbursed at a percentage of billed charges, you need to have "cushion" to account for case mix changes from year-to-year between the contracts. Even with the best intent, two contracts on different methodologies with different patients running through them, will not match up exactly from year to year.
- We utilize semi-annual review of all payers and their payment experience over prior periods to ensure compliance.
- Awareness
- Frequent analysis, monthly reporting price buffer
- Internal analysis
- Yes, we do have to build some conservatism into our pricing models in order to protect ourselves from an MFN audit for the following reasons: 1) each payer's contracted reimbursement methodology and reimbursement policy although similar in some respect has enough nuances that differ to make an apple to apple comparison difficult; 2) there are some provisions within payer's reimbursement methodology

and policy that are difficult to model. For example, claims bundling software and reimbursement hierarchy methodologies; and 3) contract interpretation issues. If the MFN auditor chooses to interpret a provision of a competitors contract in a way that is not accurate it could skew the audit results. So, for these main reasons we always build some level of conservatism (i.e. higher levels of reimbursement) into our models and negotiation.

- During rate discussions with new payors we diligently analyze the impact on the rates being discussed and make sure that they are in the range that is allowable per our MFN language.
- We try to insure a buffer since it is difficult to remove the risk of a violation by pricing too close to MFN level.

3) What are the direct and indirect costs to your hospital of measures taken to prevent a MFN violation?

- There are no direct costs associated with preventing a MFN violation except for legal costs to review MFN provisions; such costs are between $1500 and $2000. The payment stratification mentioned in the previous response provides the necessary protection with or without existence of a MFN clause.
- Nothing is out of beyond normal rate monitoring procedures
- Costs include the cost of monitoring compliance, and the costs of an annual compliance audit required by the insurer benefiting from the MFN. Compliance is monitored as contracts are negotiated and when contractually-provided rate changes take effect. Direct costs associated with the MFN are approximately $15,000 to $20,000 and include financial modeling time and it system utilization.
- Time
- No MFN clauses exist in our agreements
- We have one payor that has a better discount than the other payors. It is this payor that has MFN-type language in their agreement. We frankly do not have a need to monitor this discount in a way greater than we do with any other payor so I wouldn't say there is an incremental cost to us. It is something I'm very cognitive of when negotiating new rates with other payors.
- Generally hiring a third-party auditor, $25-30,000, staff time of $20-30,000
- We have a market dominated by the company with the MFN. In the past, there has been a MFN violation with payback in cash and lower rates.
- Direct cost: we had to terminate a major payor contract about 10 years

ago due to a violation of a MFN provision with another payor. It was "cheaper" to terminate the smaller contract than to lower the rate on the larger MFN contract. We were out of network for several years and it cost the hospital about $5 million/year at the time. In the meantime, the larger payors were able to gain more business and become even larger.

- None
- Direct: staff's time to run analysis=every month, biannual review
- Estimated at $10,000 to $20,000 (analyst's time)
- There are two most notable costs associated with our efforts to prevent MFN violation: 1) as mentioned above building some level of conservatism in our rate negotiations as a cost of doing business"; 2) all FTE costs associated with managing the actual MFN audit process.
- We perform an annual audit for X (the only payor that has MFN). That process costs in staff time approximately $1500-2000 to complete. We then must have executive phone calls discussing any items that may have been red-flagged by the audit company or if we disagree with their findings. This could mount up to 10 to 20 hours in additional staff and executive time. In addition, as contracts end each year on their anniversary there would be staff time involved with all of the rate discussions to ensure MFN is not violated. This could mount up to 20 more additional hours of staff and executive time. If MFN was not involved our discussions could be more strategic rather than defensive.
- Costs have not been documented to date, however, an inordinate amount of operational resources has been used to evaluate the modified rate clause exposure to date.
- $5000 in resource time

5) Details of "Have you ever been involved in negotiations where you would have given an insurer a lower rate but for the existence of a MFN?"

- Some insurer agreements include less business risk than the business risks inherent in the MFN insurer's agreement. We might also want to stimulate market competition by agreeing to equal or better rates with a competitor of the MFN insurer.
- We did get clearance from a MFN payor to offer low-income insurance product in our community as they indicated that it was not a competing product.
- We had a small payor that was willing to do some innovative programs for local payors in partnership with the hospital. In order for this payor to even get a chance at this new business, they needed competitive pricing. We were unable to provide that pricing due to MFN contract provisions.

- As is inherent in every payer negotiation, we set targets for improvements with each payer. If an MFN exists for a particular hospital or market, this information is incorporated into the objectives of the negotiation so as not to inadvertently negotiate a violation. It stands to reason that other payers without MFNs are forced above the MFN to avoid violations.
- Some insurance companies have tried to get MFR
- We were negotiating a deal with a payer for a three year term. We wanted to help the payer offset part of the increase in year one by spreading it into year two and three at higher increases. The problem is in "year 1" of that three year deal we would have been in violation of our MFN (with the MFN payer). For illustrative purposes only: the hospital needed 7%, 7%, 7% (year 1, 2, 3) the payer agreed to the overall increase but needed some relief in year one to make it work so we wanted to agree to 2%, 10% 10%. The problem was that agreeing to 2% in year one put us in violation of the MFN when rates were compared. In the end we ended up agreeing to a lesser deal in order to get it done and no one was happy… well except of the MFN payer of course.
- There have been several situations that payors wanted to create very specific plans that would allow us and the plan to become more transparent in their relationship but it would have required rates that may have violated the MFN. So there have been opportunities in the past that were impeded by the one contract with the MFN (X).
- There are situations where we would have otherwise priced a product lower but since the MFN is a by-product, we have to exceed the threshold.

10) Details of "Does the existence of a MFN clause (either in the contract being negotiated or in another insurer's contract) simplify, complicate, shorten, or prolong contract negotiations?

- The existence of the MFN clause complicates and prolongs negotiations. Other contracts must be considered in light of the MFN. This requires additional modeling and planning. We must balance our interest in a competitive market with our need to cover costs. If the MFN rates are at or below cost, we must consider demanding higher rates from competitors. However, we want to promote a competitive market. The MFN distorts the market. Negotiations might take weeks or months longer as we work to craft a deal that complies with MFN and meets our other objectives. That the MFN is causing an impasse cannot be disclosed to the other party. Stalemates sometimes result from limited contractual options created by the MFN.
- Simplifies-as it gives me a floor for negotiations.

- If we were approached now by a payer with a MFN clause, we would not agree to this. As such, it would likely complicate and lengthen the negotiations.
- Add 3 to 6 months for contracts
- Payors seem to know what deals each payor has due to coordination of benefit issues. It is common for a payor to tell me that they know what discount I'm giving another payor.
- We give similar discounts to all insurance companies
- We will not accept MFN language in our contracts.
- Every time rates are negotiated, we must calculate the possible MFN violation each time.
- Prolong-more complicated modeling of rates and payment methodologies is required.
- As we are always attempting to get these provisions out of the contracts, this provision always lengthens the contract negotiation time. One year, we debated with a payor for over a year about having this in the contract. We could not afford to terminate. So, for over a year as we debated, we received a 0% increase. We could not afford no increase into a second year so we agreed to the MFN language. We also spend an inordinate amount of time discussing the methodology for MFN measurement and audit. We always need this to be as specific as possible so we can monitor our compliance.
- Complicate & prolong. Although each negotiation has its own personality due to many variables both at the payer and facility level, the existence of a MFN clause complicates negotiation. In the case of a payer insistent on an MFN, much additional due diligence is required in order to ensure that contract terms surrounding the MFN would be achievable or conversely, proving to the payer that the MFN is unreasonable. Negotiations with other payers can also be impacted when rates are within a range that could trigger another payer's MFN.
- One payor tried to get us to agree to MFN/access to our other rates. The negotiations went on for more than a year, which was past the expiration date of the contract.
- Not applicable, but I would think that if it were that it would add to the length.
- Need to do careful analysis with larger population/database, then specific payers historical claims data. Have to run multiple payer rates through same data field since we don't have a system that can handle this, it's a manual process creating huge Excel files. Since payer's rates aren't the same, sometimes we are unable to simulate the exact payment method, so in the end, we're creating our best guess and

hope that future utilization doesn't change much, which would result in potential MFN violation.

- It varies
- It complicates more than prolongs a negotiation. What I can say is that it doesn't simplify or shorten the process. The complication factor is having a conversation with a payer as to why we cannot accept their offer because we have already promised the best deal to someone else and that we have no ability to accept anything less.
- Sometimes the rate increase required of payers without MFN clauses exceed what they are initially willing to agree to and extend negotiations to 30-60 days.
- MFN does not simplify or shorten negotiations but rather complicates and prolongs it. Negotiations take time going back and forth so adding MFN language to contend with just makes the talks less flexible. A provider may like the reimbursement model being proposed as a creative, innovative and fair model but because of the threat of MFN cannot agree to it because of possible penalties related to MFN. MFN restricts creativity and innovation which we believe hurts each market where is in force.
- The presence of a favored nations clause in a contract that is being negotiated results in the following: a) increase in expense and time relating to the financial modeling that would be part of any due diligence relating to potential financial exposure, etc. relating to possible violations; b) increase expense and time relating to attorney involvement relating to the legal implications of a favored nations clause; c) impact on time relating to meetings, etc. that need to occur since MFN has a major impact on the strategic initiatives of the hospital.
- MFN clauses cause us to have to perform more extensive analyses and contract simulations.

11) Describe the terms, other than MFN clauses, that simplify, complicate, shorten or prolong contract negotiations.

- The reimbursement terms are inevitably the issue that causes prolonged contract negotiations. In addition to rates the things that would simplify contract negotiations would be more standardization of contract terms, such as medical necessity, billing and payment timeframes, COB, utilization management and payment policies and procedures,

Interference with Medical Judgment, exclusion of services, change in status and extending the contract terms to self-funded clients without explicitly binding them to the contract terms. The more such terms can be standardized across all payers the less administrative cost that would be expended by hospitals in negotiating and administering such terms on a payer by payer basis. Payers are constantly trying to change the intent of contract terms including statutorily defined contract terms to either lessen their affect or to their favor (i.e. HB 125).

- Rate levels, administrative burden demanded by payor.
- Increasingly insurers do not wish to disclose essential terms of the agreement such as operating policies, descriptions of their insurance products, and care management guidelines. We must be creative to minimize the risks, both to ourselves and to patients, of these uncertainties in the financing scheme.
- Rates, charge master caps
- Simplify: contract provisions are equal on both sides for the payer, and the provider; reasonable termination clause such as 180 days or less with notice. Complicate: contract provisions are extremely one sided in favor of the payer; no termination without cause clause; contract allows for most issues to be addressed by the manual, and notice of changes are sent via email. Prolong-unwillingness of payer to move from a position; arrogance of payer; contracts that have to be sent to "corporate" for approval of changes; contracts that have egregious provisions that the payer knows are such, yet they require you to go through and ask for revisions of each provision. It is apparent when you see one of these because there is NO pushback when you request a change.
- MFN clauses restrict our ability to negotiate a better deal. And, if you have this clause with a major payor, it is impossible to get out without terminating the agreement which has huge ramifications with local employers.
- Payment methodologies
- Most of the language is one-sided. Most insurance carriers won't budge in negotiations. For example, unilateral changes, reference to provider manuals, utilization review, complication of benefits.
- MVN auditing provisions also negotiated
- Other contract terms that are discussed at length include ability to audit claims, ability to make retrospective payment adjustments and ability to change policies and procedures. However, the MFN provision discussion always extends far beyond any discussion on these other provisions.
- Generally speaking, language negotiations are often the most time

consuming aspects of negotiations. Hospitals and providers must be very cognizant of each payer's rules, regulations and provider manual provisions in order to avoid being "stuck". Items such as payment for any medically necessary services provided or prompt payment terms, to name only a few are often sticking points that require ongoing discussions and consultation with respective legal counsels.

- Term clause, payment rates
- Insurance companies prolong negotiations beyond contract date to save them money.
- Rate caps and outlier provisions as well as exclusions
- Fee schedules complicate
- Payment method is always easier/quicker when it's a percentage off arrangement. Termination, claims payment, time to appeal, and steerage.
- Annual allowable price increase
- Rates/language
- Usually reimbursement rates. Sometimes it's difficult to reach an amicable solution.
- Complicate and prolong. All the commercial payers want to negotiate lower reimbursement rates.
- Any contractual clause or reimbursement item has the potential to complicate or prolong a contract negotiation. Every provider has a slightly different risk tolerance level and/or operational focus. The issue here is the MFN payer influences every negotiation/discussion in their favor with this provision and it is that complicating factor that contributes to prolonging a discussion.
- I think this questions should be restated as "Describe any other terms and conditions other than MFN clause, which allows a payer to influence (in their favor) all negotiations/discussions between their (the MFN payer) competitors and the hospital." The answer…none.
- There are contracts out there that are very fair for both insurance companies and providers. In most cases this makes negotiations go more smoothly and quickly. However, most of the larger payors have language that cause issues such as but not limited to: timely filing; policies and procedures (billing, medical utilization review, precertification, prior authorization, notification); termination language; audits; provider obligations; insurance's ability to re-coop monies and provider ability to collect).
- There are numerous terms that require language negotiation and revisions. MFN language is just more extensive.

12) Has the existence of a MFN clause in one of your contracts affected or discouraged you from entering into innovative payment methodologies (such as outcome-based reimbursement rather than fee-for-service reimbursement) with a different insurer?

- Trading off a per-determined rate increase for an increase based on pay-for-performance or similar, would likely result in a MFN violation since there is a risk to the MFN insurer that the pay-for-performance increase might not take effect. Our experience is that the MFN insurer's auditor will side with the MFN insurer in disputes.
- Because after you convert the actual payments to a percentage, if it is less than the MFN number, than you are in violation.
- We would like to move to a pay for performance model but the MFN prohibits us from doing that.
- We must be able to audit rates provided to others to compare.
- Yes – we have not even explored these options due to the existence of these provisions.
- Our concern around this issue is more future related. Today innovative payment methodologies are not the norm. However, it is very clear that health care reform will require innovative payment methodologies and there will be early adopters and late adopters. Our concern is if the MFN payers are the late adopters this could severely limit our ability to partner with other payers in efforts to reduce cost and share in the savings generated.
- It would, but has not yet been an issue.
- The existence of MFN in contracts has limited our flexibility to negotiate contracts with other health insurers due to concerns about violating the existing MFN clause. We have been hesitant about exploring different types of reimbursement methodologies with "other carriers" that could positively impact cost and quality of fear of violating the MFN clause. There are also times that new insurer enters that market and they would like to effectively compete against the incumbents. There may be relatively little volume with the new carrier; consequently the financial risk to the hospital is relatively minimal. The hospital may believe that increased competition between insurers' carriers would be good for the community as well as for the hospital. The MFN clause would prohibit such an initiative that would be a win for the hospital and a win for the business community, etc.

13) Other than fee-for-service and DRG reimbursement, what other payment methodologies does your hospital currently use to obtain reimbursement from insurers?

- Per diem/per case
- Percentage of charges and Medicare costs
- None
- Per diem and case rates
- Capitation-fixed payment per member per month
- Per diems
- No other reimbursement arrangements
- Percent of billed charges
- Only fee for service
- Percentage of billed charges, per diems
- Percentage of charge
- Case rates, fee schedule percentage of change, fixed fees, carve outs, outliers, etc. all affect comparability of rates for MFN comparisons.
- Per diems-daily rate of payment; case rates-fixed rate per DRG or CPT; surgery case rates-based on Medicare groupers; APGs-one insurer's version of outpatient APCs, we must use an outside vendor that the insurer works with to obtain software to allow us to model and track these payments; outlier thresholds-triggered at either a dollar amount or a day limit, then pay either first dollar, second dollar, or per diem.
- Percentage of total charges
- Although this question is somewhat vague, some of our agreements are paid at a percent of charge and others at per diems. If this question is asking whether we have developed a "novel" or new approach to reimbursement other than traditional methods, at the present time, we have not.
- Percent of charges; per diem; case rates
- 1) carve out rates based upon ICDQ/CPT codes; 2) outliers based upon maximum charges; 3) per diems; 4) percentage of charge to max charge
- Percent of charge in some cases
- Also have percentage of charge arrangements
- Per diems, ASC fixed rates for CT, MRI, Mammo, ER case rates carve out payment for implants, pacemakers, and prosthesis.
- Critical access rates
- Per diem, per visit, per test discount
- Percentage of billed charges
- Percent of charges
- Percent of billed charges

- We are a critical access hospital. We negotiate contracts with insurers by either per diem/per service or percent of charges.
- Per day
- Percentage off billed charges, per diem
- Percent of charge; percent of charge with a limit on the charge increase that is accepted; case rates not DRG based e.g. maternity, NICU, medical, surgical; visit rates such as emergency room, OP surgery; per diems; outlier case based on charges or length of stay reimbursed at a percent of charge or per diem; carve outs for high costs implants or drugs.
- We consider fee for service to include per diems, case rates, fee schedules, carve outs and percent of charge so we do not at this time have any other type of reimbursement model other than DRG and fee for service.
- Per diems, per case, percentage of charge, APC, APG

14) Have you ever sought to amend or revise an MFN provision to allow you to use a different payment methodology with an insurer?

- We were forced into the agreement or we would not be in the network.
- Sought to eliminate MFN when HB 125 was being finalized. Payer used HB 125 as rationale not to remove or modify the provision.
- Different rates, but not different methodology
- We have tried to get the MFN language our agreement every chance we could but too date X will not budge. We even asked that X provide us with an MFN guarantee as well that would ensure that we would not be getting paid any less than any other provider in our market but to no avail. X did allow some concessions in our language that excludes (name removed-we are part owners) and limits the plans being watched for MFN to those that produce $5 million a year or more. However, even with those concessions if we enter into an aggressive deal with a payor and it suddenly grows which was our intent it could quickly produce an MFN violation. MFN restricts creativity and innovation.

15) Has the existence of a MFN clause in one of your contracts effected or discouraged you from entering into non-fee-schedule related contract terms (such as administrative efficiency incentives) with a different insurer?

- Any payment arrangement that might be difficult to model, or that deviates from standard payment methodologies, might be difficult for the MFN auditor to understand and model. Such risks are considerations when negotiating agreements with other insurers.
- We try to avoid complicated reimbursement scenarios due to the cost of

managing and monitoring the terms.

- Too complex to audit
- We have not even explored these options due to the existence of these provisions.
- At the present time, other reimbursement methods have not been offered.

16) Other than contracts with health insurers, do you have MFN or similar provisions in any other contracts (i.e. supplier or service contracts)?

- With a service vendor
- Other than the modified rate clause with X, we do not have MFN.

INSURER FOLLOW-UP SURVEY COMMENTS

2) What is the average duration or term of your contracts that contain MFNs? Please break out responses into contracts with "evergreen clauses" and contracts without "evergreen clauses".

- All of our hospital contracts have evergreen provisions (contracts with an initial term that automatically renew). Near the close of the initial term of this contract, either party can open up negotiations or terminate. Of the hospital contracts that have MFNs, the average initial term is a slightly more than 2 and ½ years; and nearly 2/3 of our contracts with MFN are at 3 years or more.

3) What is the average duration or term of your contracts that do not contain MFNs?

- Most our contracts include a clause where either party may terminate agreement, "without cause" in a 30-90 day notice period.
- All of our hospital contracts have evergreen provisions (contracts with an initial term that automatically renew). Of the hospital contracts that do not have MFNs, the average initial term is 2 years; and over 2/3 of our contracts without MFN are at 1 year or less.

5) Does the existence of an MFN clause (either in the contract being negotiated or in another insurer's contract) simplify, complicate, shorten or prolong contract negotiations?

- An MFN can simplify negotiation when X has an MFN in place. It can complicate the negotiation process when another insurer has a MFN in place.
- Obviously the majority of negotiation time is spent around rates; however there are other contract provisions that, in some instance,

require a great deal of discussion/negotiation. In general, the time is shortened and the process simplified, but to what degree is dependent on other factors.

- It makes it virtually impossible to negotiate as the provider negotiating parameters are focused solely on managing their existing MFN contracts. We are unable to improve our deals and are typically notified that our contracts need to be worsened due to their MFNs with other carriers.
- MFN clauses in other insurer's contracts add greater complexity and length to the negotiation process for all. As healthcare providers are left with little ability and/or flexibility to negotiate in good faith, fair & equitable term [based on any relevant merits] are often difficult to achieve. MFN clauses impose arbitrary parameters around a healthcare provider's ability to negotiate with an unrelated third party, thereby stifling free market competition.
- Complicates
- We cannot isolate any single element, whether an MFN provision, length of a term, reimbursement rate or any other contract term, to respond to this question. Each contract negotiation is a complex multifaceted process with give and take by both sides concerning many contributing factors unique to that particular negotiation. The terms of a contract are ultimately the product of extensive negotiation.

6) Describe the terms, other than MFN clauses, that simplify, complicate, shorten, and prolong contract negotiations?

- Rates & duration of the contract.
- We aim to have the easiest contract for providers to sign. We don't have pre-authorizations for hospital admissions or specialty referrals.
- Typical issues that delay negotiations include rate discussions, medical necessity language, & retroactive denial concerns.
- None
- A few contracts are renegotiated every year.
- The simplification, complication, shortening or prolonging of negotiations with hospitals varies with each contract negotiation.
- There are various factors within the context of a negotiation between parties that serve to simplify, complicate, shorten, or prolong discussions. However, MF is the most polarizing of all issues encountered since healthcare providers are left with little ability and/or flexibility to negotiate, in good faith, fair and equitable terms based solely on free market, competitive principles. Instead, healthcare providers are forced to purvey another payors artificial doctrine around what they deem competitive.

- Shorten-continued communication during contract timeframe minimize or eliminate delays at the time of renewal discussions. Prolong-ensuring new/revised regulatory requirements are incorporated into agreement and properly implemented. Prolong-ensuring credentialing and quality requirements are completed.
- Reimbursement rates, separating obligations of payers vs. non payer such networks.
- We cannot isolate any single element, whether an MFN provision, length of a term, reimbursement rate or any other contract term, to respond to this question. Each contract negotiation is a complex multifaceted process with give and take by both sides concerning many contributing factors unique to that particular negotiation. The terms of a contract are ultimately the product of extensive negotiation.

7) Other than fee-for-service and DRG reimbursement, what other payment methodologies do you currently use with hospitals to reimburse them for services? Please describe the methodology and specify where and how those terms have been used.

- All inpatient services are paid at a DRG, a per diem, or a percentage of charge rate. Outpatient services are paid at a percentage of charge, a fee schedule, an ambulatory payment group (APG) rate, or an ambulatory surgical categories rate (ASC) rate.
- Percent of billed charges.
- 1) Per diem-daily rate for inpatient care; 2) Flat Rate-fixed fee for specified services; 3) Discount with a maximum payment rate or cap amount; 4) Medicare APC and/or ASG or RBRVS methodologies. All have been used with a number of contracting hospitals.
- We also implement per diem rates, outlier provisions, and occasionally case rates.

Per Diems: We have a number of commercial contracts with per diem rates. Examples include Medical Center inpatient psych and rehab services. The per diem rates are all inclusive for any facility service. Other examples of per diems include: 1) LTAC & SNF rates at X hospital; 2) Inpatient AD/TC, psych, and dual diagnosis at X Behavioral Health; 3) SNF rates at Y hospital. Additionally our transplant agreements with certain hospitals include per diems once day outlier status has been reached.

Outliers: Commercial contracts with several hospitals have inpatient outlier provisions. These contracts have charge thresholds where specific outlier rates apply. We also have many (Advantage) Medicaid contracts that mirror ODJFS rate methods where charge and day outlier thresholds exist for each DRG number. We have Elite (Medicare Advantage) contracts that mirror CMS outlier methods, where each service has day & charge outlier provisions. The intent of outlier threshold is

to provide a specific rate for high cost service.

Case Rates: We use case rates in the following two scenarios: 1) for inpatient transplant services; 2) for direct negotiation with non-par facilities. Our transplant agreements with some hospitals have fixed case rates for the inpatient transplant service. These case rates are all inclusive and have outlier provisions. Pre- and post-transplant services fall outside the case rate. When direct negotiation with non-par providers occurs typically case rates are established. Any service rendered by that provider falls under the case rate.

- Discount from charges-primarily used as a "catch all" for services that do not have a specific rate. This methodology is primarily used for outpatient services. Case rates-emergency room services & transplants. Cost plus-implantables & high cost drugs.
- Our hospital discounts include discount from billed charges, per diem, and DRG rates. All contracts include "lesser of" language. 54% of hospital contracts include discounts from billed charges. 39% include per diem rates and 9% include DRG rates. Note that discounts/DRG/ per diem rate types vary by contract; some contain more than one methodology.
- Percent discount off billed charges.
- Case rates, POC, per diems.
- Similar to DRG, we also employ case rate methodologies for inpatient services where a flat rate is paid for an entire admission.
- Our fully insured product does have a capitation agreement for one network hospital. This includes a fixed payment per enrollee/month and additional compensation for achieving quality goals established each year.
- Per diem and percent of billed charges
- We generally reimburse most our contracted Ohio hospitals through the DRG method. In some circumstances however, often in conjunction with the DRG method, hospitals may also be reimbursed on a per diem (a set rate per day regardless of charges billed) basis or a case rate (a set rate per admission regardless of charges billed) basis for certain specialty or carve-out services such as newborn care, neonatal care or mental health/substance abuse services. In limited circumstances, generally for those rural or children's hospitals, a straight percentage discount (reimbursed a percentage of eligible charges billed) on charges is reimbursed.

8) Has the existence of a competitor's MFN clause ever affected your ability to negotiate non-fee schedule-related contractual terms (such as outcome based reimbursement, quality incentives, administrative efficiency incentives or bundled payments) with a hospital?

- We don't know when there are issues in negotiations if they are the result of MFN or not. Often we don't know if a hospital has MFN or not.
- No-we've not attempted to do so.
- If it impacts reimbursement in any way, providers with MFNs are unwilling to alter any other provision that might impact rates as it might interfere with their existing MFN.

9) Have you ever sought to amend or revise and MFN provision to reflect a different payment methodology?

- We have tried multiple creative ways to negotiate with providers that have MFNs in an effort to improve our deal without the provider interfering with their MFNs. Again, providers are unwilling to look at anything creative due to fear associated with infringing on their MFN contracts.

11) Has the existence of a competitor's MFN ever caused you not to contract with a hospital or to enter into a particular geographic market in Ohio?

- We have gone OON with multiple facilities due to MFN, particularly in SW Ohio.
- It should be made known that the existence of MFN has placed undue burden on the healthcare system in Ohio. Healthcare providers are left with little ability and/or flexibility to negotiate, in good faith, fair & equitable terms based solely on free market, competitive principles. Instead, healthcare providers are forced to purvey another payors artificial doctrine around what they deem competitive.
- As we understand it, a hospital in a contiguous county has (or recently had) a clause in their contract with a specific Ohio insurer, stating the hospital is not allowed to contract with us, nor allow any leased/ rental network to offer its specific hospital discount arrangement with us, or any organization related to us. Because of this, we only have a network contract with one of the two large hospitals in that geographic region and are not competitive. Most all other carriers have network agreements with both large hospitals in the community.

12) What are the reasons, other than the existence of an MFN clause, that have caused you not to contract with a hospital or enter into a geographic region?

- Non-competitive rates, strategic partnerships, & market differential.
- The hospitals we have not contracted with have asked for rates that are too high for the market.
- Failure to agree to rates or terms.
- Reimbursement rate barriers occasionally exist in our core market or in

the regional market.

- The primary reason for not contracting with a hospital or entering into new geographic regions is rates. This means the rates hospitals and other large providers are willing to extend to us as a new partner do not translate into premiums that are attractive to purchasers of health care. Many providers talk about diluting and modifying their payer mix, but clearly are afraid of the consequences associated with giving competitive rates to plans that do not have the volume of membership/ patients flowing through their facilities. We would like to see a level playing field from a rate perspective and let service be the basis upon which we compete.
- Other than the existence of an MFN clause, not being able to get a reasonable discount has been why we do not contract with a hospital or enter a geographic region.
- Rates, difficult language requests.
- There are various business reasons, outside of the scope of this survey that could impact an organization's decision to either expand or contract their operations in a given geography. In the end, however, MFN continues to be the most polarizing of all issues encountered given the unreasonable influence it has over discussions. Healthcare providers are left with little ability and/or flexibility to negotiate, in good faith, fair and equitable terms based solely on free market, competitive principles. Instead, healthcare providers are forced to purvey another payors artificial doctrine around what they deem competitive.
- Non-contracting hospitals decision NOT to contract with our network; final contract terms were not deemed sufficient from one or both parties; adequate or excess capacity in a geographic region; business decision not to expand into a specific geographic location.
- We will negotiate with all willing hospitals unless another hospital contract has language that prohibits us from negotiating.
- There are innumerable reasons that have caused us not to contract with a hospital such as contract terms, location, the needs of our network, or unrealistic demands from the hospital to name just a few. Over the course of time, we typically have contracts with almost every acute care hospital in Ohio.

HEALTH INSURANCE

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AUPHA

significant effect on hospital days. This means that hospital use increased with HMO buying power, results consistent with Figure 11-3*a*. This is a clear refutation of the monopsony model and suggests that, rather than anticompetitive behavior, managed care plans appear to enhance competition in the hospital market. Feldman and Wholey also examined the effects of HMO buying power on hospital ambulatory service prices and utilization but found no statistically significant evidence in either direction. This may have been the result of methodological difficulties in analyzing the ambulatory sector.

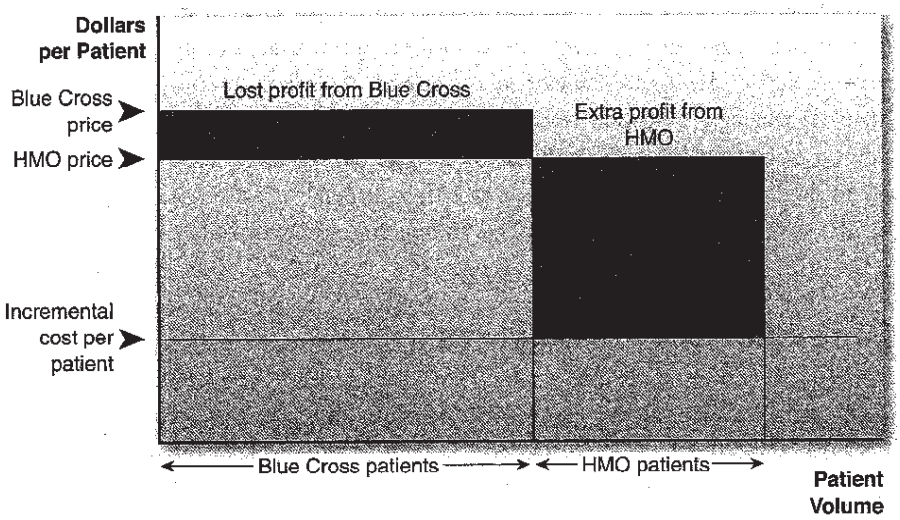
Most Favored Nation Clauses

One of the more interesting contract features in some insurer-provider contracts is the "most favored nation" (MFN) clause. The term stems from international trade agreements in which countries are assured that they will not pay any higher import or export taxes than those paid by the "most favored nation." In healthcare, the contract term says that the buyer of hospital (or physician) services gets the benefit of the lowest price that has been given to any other buyer. The provision is controversial because it is said to be anticompetitive. Perhaps surprisingly, some claim that most favored nation clauses benefit the healthcare provider, and others claim that the clauses benefit the insurer.

The first view argues that all hospitals in a market would gain if they would agree to charge a common monopoly maximizing set of prices for their services. This sort of "cartel" arrangement is inherently unstable. Each hospital in the cartel has an incentive to cheat. If it can secretly cut the price to some buyers, it can attract considerably more volume at the expense of its sister institutions. The other hospitals would observe lower utilization, but it would be difficult to determine if this was anything other than random fluctuation. The MFN clause provides an additional set of eyes at every hospital in the form of buyers with this contract provision. If a hospital is secretly giving a discount, the MFN buyer will see the lower price when it exercises its right to examine the hospital books and determine that it is indeed getting the lowest price. In this view, the MFN clause is a mechanism to enforce the provider cartel.

Alternatively, and more commonly, the MFN clause is viewed as a means whereby a large local insurer is able to keep other insurers from negotiating lower hospital prices. In this view, a large insurer insists that it be given the lowest price the hospital gives to any other buyer. If , say, a new managed care plan seeks to selectively contract with a hospital, promising volume in exchange for price, the hospital must give the large insurer the same lower price that it gives the new managed care plan. Alternatively, the hospital must give up its contract (and patients) with the large insurer and cast its lot more

FIGURE 11-4
The Arithmetic of Discounting with a Most Favored Nation (MFN) Clause



SOURCE: Lynk (2000), "Basics about Most Favored Nation Contracts in Health Care Markets," *Antitrust Bulletin* 45(2): 491–530, Figure 1. Reprinted with permission.

or less with the new managed care plan. This obviously undercuts the ability of the managed care plan to compete on a premium basis with the large local insurer and may keep the managed care plan from entering the market at all.

Finally, there is a view that the MFN clause is not anticompetitive at all but, rather, is simply a mechanism to help an insurer get the best possible price in a world of complex and very diverse hospital prices and costs.

Bill Lynk (2000) provided perhaps the only empirical investigation of the effects of the MFN clause on hospital and insurer markets. The economics of the contract are straightforward (see Figure 11-4). In this model, a hypothetical Blue Cross plan is the large local insurer; it is initially charged the "Blue Cross price" shown in the figure. A new HMO that would provide new patient volume to the hospital asks for the "HMO price" in the figure. The marginal or incremental costs are assumed to be equal per patient to keep the analysis focused on the pricing issues. The shaded area labeled "Extra profit from HMO" indicates profits that the hospital would gain by entering into the new HMO contract. However, with an MFN clause, there is a cost to this new contract. The hospital must give Blue Cross the same lower price. The shaded area labeled "Lost profit from Blue Cross" indicates the magnitude of this cost. It is easy to see from the figure that, depending on the prices negotiated by Blue Cross and the HMO and their respective patient volumes, the hospital may gain or lose as a result of executing the new HMO contract, even in the presence of the MFN clause.

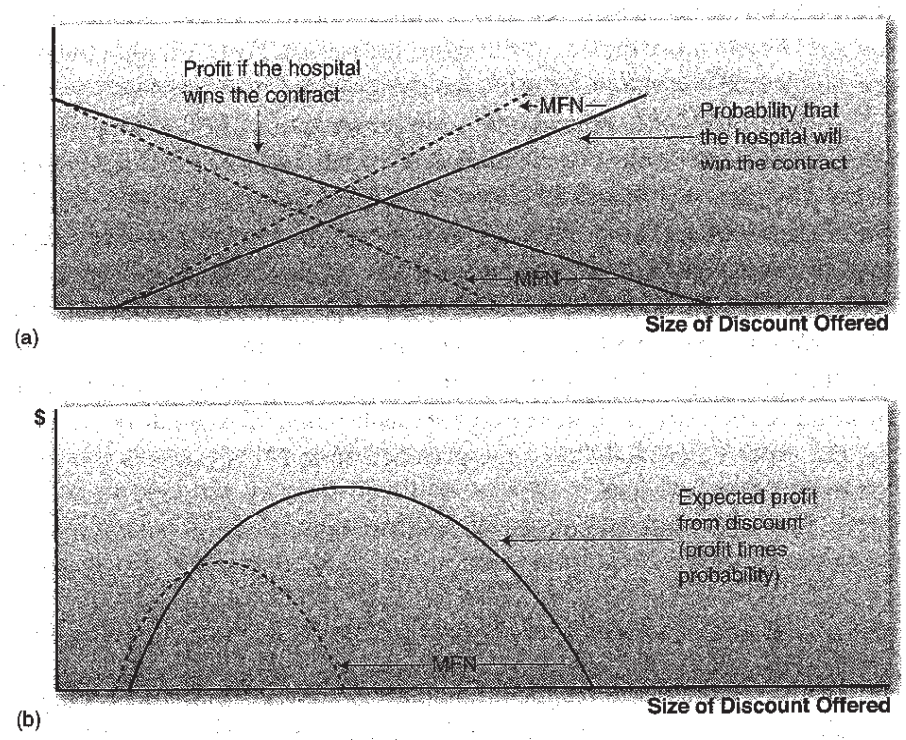


FIGURE 11-5 The Effect of a Most Favored Nation (MFN) Clause on the Expected Profitability of Discounting

SOURCE: Lynk (2000), "Some Basics about Most Favored Nation Contracts in Health Care Markets," *Antitrust Bulletin* 45(2): 491–530, Figure 3. Reprinted with permission.

This intuition can be easily formalized. See Figure 11-5*a*. The graph has the size of any discount, relative to the Blue Cross price, along the horizontal axis. As you move from left to right, the discount gets larger. The vertical axis has two scales: profit (from an executed contract) on the left and the probability (of winning a contract) on the right. The dark lines represent the market in the absence of an MFN clause. Consider the downward-sloping line. If the hospital gave the HMO no discount (the point at the far left), the hospital would obtain the largest profit. As it gives increasingly large discounts, the profit from the contract declines and ultimately reaches zero if the discounted price was equal to the costs of providing the service. The upward-sloping dark line represents the probability of winning the HMO contract at any size discount. Notice that, as drawn, the hospital has no chance of winning the contract at very small discounts. However, as the size of the discount increases, the probability of winning the contract increases substantially.

Figure 11-5*b* multiplies the profit from the contract by the probability of winning the contract at each potential price discount. The dark line shows the expected profit from various discount levels for the

no-MFN-clause scenario. The expected profit is maximized somewhere in the midlevel of potential discounts, at the point where the "hump" is the highest. As you move further to the right, the probability of winning the contract is greater, but the profit is less, so the expected profit declines.

Figure 11-5 also presents the scenario when an MFN clause is present and applies to all or most of the providers in the market. This is represented in both Figures 11-5*a* and 11-5*b* by the dashed lines. In Figure 11-5*a*, an MFN clause causes the profitability line to shift in (downward) because, at each discount, the Blue Cross plan must also be given the new lower price, reducing overall profits. The profitability line shifts out (upward) because the MFN clause applies marketwide. Profitability of an HMO contract declines for all of the hospital's competitors, so at any given discount, the probability of winning the contract is increased for this hospital. The result of computing the expected profitability in the presence of an MFN clause is shown by the dashed line in Figure 11-5*b*.

Several hypotheses emerge from this simple theory:

- The MFN clause reduces the size of optimal discount to the HMO. (The peak of the expected profit curve is to the left of where it was without the MFN clause.)
- The MFN clause reduces the profitability of entering into discounting at all. (The peak of the expected profit curve is lower under the MFN clause.)
- Although the profitability of discounting is lower, it is still positive, and therefore, discounting should be seen.

Thus, in some sense, MFN clauses establish a social tradeoff between deep discounts for some and shallow discounts for many.

Lynk (2000) provided two case study evaluations of the effects of MFN clauses. In the first, Blue Cross/Blue Shield of Rhode Island (BCBS) had a large insurance market share. It discovered that it was paying more for physician services than a new insurer, Ocean State HMO. In 1986, it initiated an MFN in its physician contracts. Ocean State sued, but BCBS prevailed in court, and the clause continued intact. In the second, Independence Blue Cross (of Philadelphia) added an MFN clause to its hospital contracts in mid-1992, requiring each hospital to give it as low a price as it gave any nongovernmental purchaser. The Department of Justice investigated but withdrew, and the clause remained intact.

Lynk argued that if an MFN clause is harmful to the large insurer's competitors, then (1) the MFN clause should result in lower HMO enrollment, (2) the average net price for hospital services should increase, (3) the average discount should decrease, and (4) average hospital profits should increase due to less-intense discounting.

Lynk compared the trends in non-BCBS HMO enrollment before and after the enactment of the MFN provision in both Rhode Island and Philadelphia. In both instances, he found that enrollment continued upward at essentially the same rates as they had prior to the introduction of the MFN clause, suggesting that the provisions did not lower HMO enrollment. Next, only for the Philadelphia case where the data were available, Lynk reported that hospital net prices were virtually unchanged after the introduction of an MFN. Discount levels increased after the MFN clause was introduced, and average hospital profits were virtually unchanged in the two years following the introduction of the MFN and rose only slightly in the third year. In each instance, the evidence presented suggested that the MFN clause did not do what the anticompetitive theory predicted.

So, if MFN clauses do not keep out HMO competitors, why do large insurers impose the provision? Lynk (2000) argued that they do so to enable them to obtain a more-competitive price from each provider in a market characterized by great uncertainty about price, cost, and quality. He showed that average full billed charges per admission in the Philadelphia market varied by hospital from less than $10,000 to nearly $30,000. Net prices (adjusted for contractual discounts) varied by about half that amount. Billed charges as a percentage of net prices and billed charges as a percentage of operating costs also varied substantially across hospitals.

Under these circumstances, simple price rules can have undesirable effects. If the insurer decided to pay one fixed price to all hospitals, it would find that it was overpaying some hospitals that had lower prices (and costs) and that other, potentially excellent, high-quality hospitals would reject the contract because the offer was below the price that would cover their costs. Alternatively, the insurer could pay a fixed discount on the hospital's charges. Again, this would have the effect of overpaying for services at some hospitals and of having the contract rejected at others. A third approach would require the insurer to obtain detailed cost and quality data from each hospital with which it potentially wished to contract. Aside from the expense of this approach, it is not clear that many hospitals would allow a buyer to rummage through their cost data.

We can liken the problem to buying a new car. Everyone knows that no one pays the sticker price, and no one expects the dealer to actually sell the car below cost. You can go to "Blue Books" and Internet guides, and you can ask to see the invoice. However, the surest way to get a good price is to get information on the lowest price the dealer has accepted from others. That, Lynk says, is a most favored nation clause!

MFN clauses continue to be controversial. As we have seen, there are compelling theories arguing for the anticompetitive and the efficient price explanations, but a theory is only as good as its ability to predict behavior

correctly. Lynk's tests refuting the anticompetitive theory are not as strong as they might appear. The two case studies provide pre-post comparisons. While these are informative, they are not the gold standard. We would like to know what happened to enrollment, prices, and profits in otherwise similar markets over the same time period. Further, Lynk has provided no test supporting the efficient pricing theory. Nonetheless, based on his analysis, it is not obvious that MFN clauses necessarily make new insurance entrants worse off.

Chapter Summary

- There are two principal explanations for why health insurance premiums increased in the last decade: a backlash against managed care and a reduction in competition among providers.
- The backlash argument holds that physicians were opposed to restrictions on their practice styles imposed by utilization management techniques and objected to the lower prices negotiated by the plans. Patients were concerned about utilization restrictions, as well as the limited choice of providers in managed care networks. This increased insurance premiums because wider provider choice implies that plans cannot assure sufficient volume to get the lowest prices. Evidence from the late 1990s failed to find much evidence of switching to less-restrictive plans. More recent data suggest much more shifting.
- The reduction in competition argument holds that a wave of hospital mergers and consolidations reduced the number of competitors and allowed hospitals to raise prices to managed care plans. Physicians have been accused of entering into marketing networks that collusively raise the price of their services to insurers. Evidence is mixed on the effects of managed care growth on consolidation among providers. However, there is little research on the effects of the wave of mergers on prices paid by providers. The FTC and the Department of Justice continue to have an active interest in anticompetitive behaviors in the healthcare industry.
- Physicians and hospitals have argued that they have banded together to fight the market power of large insurers. Recent research, however, fails to find evidence of such "monopsony" power. Rather, the pattern of evidence suggests that selective contracting by managed care plans has reduced provider market power.
- "Most favored nation" clauses allegedly harm competition by either enforcing a cartel arrangement among providers that keeps prices high or by restricting the ability of new managed care plans to negotiate lower prices with providers, which benefits large, entrenched local insurers. Alternatively, the clauses are mechanisms to allow insurers to obtain

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APPENDIX C

Some basics about most favored nation contracts in health care markets

BY WILLIAM J. LYNK*

I. Introduction

A most favored nation (MFN) provision is a condition in a contract between a buyer and a seller, specifying that the buyer gets the benefit of the lowest price that the seller charges to other buyers. So if Smith, a seller, and Jones, a buyer, enter into a contract with an MFN provision under which Jones initially gets a price of $10, and Smith later sells the same product to another buyer at a price of $9, then Jones also gets the same lower $9 price. Or, to rearrange the emphasis, Smith had better not offer the $9 price to the other buyer unless he is prepared to cut his price to Jones as well.

MFN provisions affect prices, and so it is not surprising that their use has attracted the attention of the federal antitrust agencies. Their earliest litigated assault on this practice was 20 years

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ago, when in 1979 the Federal Trade Commission brought the *Ethyl* case against the sellers of gasoline additives.[1] The Commission found MFNs to be anticompetitive and enjoined their further use, but it was reversed soundly by the Second Circuit Court of Appeals.[2] Since then, virtually all MFN cases brought by the federal agencies have involved contracts in the health care industry, generally between providers of medical services (e.g., physicians, dentists, hospitals) and purchasers of those services (e.g., health insurers, including health maintenance organizations [HMOs]).[3] In addition to the federal antitrust agencies' challenges to health care MFN contracts, the practice has been attacked frequently by private health care antitrust litigants, in which typically a health care purchaser with an MFN provision is sued by either a provider or a competing purchaser (usually a managed care payor such as an

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[1] *In re* Ethyl Corp., 101 FTC 425 (1983). A prior Justice Department investigation of MFNs in the electrical equipment industry ended in settlement with a consent decree; U.S. v. General Electric Co., 1977-2 Trade Cas. (CCH) ¶61,660 (E.D. Pa. 1977) (consent decree).

[2] E.I. du Pont de Nemours & Co. v. FTC, 729 F.2d 128 (2d Cir. 1984).

[3] "With the exception of *Ethyl*, the major antitrust challenges to MFN clauses have been in the context of the health care industry." Arnold Celnicker, *A Competitive Analysis of Most Favored Nations Clauses in Contracts Between Health Care Providers and Insurers*, 69 N.C. L. REV. 864, 868 (1991). *See, e.g.*, United States v. Oregon Dental Service, 1995-2 Trade Cas. (CCH) ¶71,062 (D. Or. 1995) (consent decree); United States v. Delta Dental Plan of Arizona, 1995-1 Trade Cas. (CCH) ¶71,048 (D. Ariz. 1995) (consent decree); United States v. Vision Service Plan, 1996-1 Trade Cas. (CCH) ¶71,404 (D.D.C. 1996) (consent decree); RxCare of Tennessee, Dkt. C-3664 (FTC June 10, 1996) (consent order); and United States v. Delta Dental Plan of Rhode Island, 943 F. Supp. 172 (D.R.I. 1996), 1997-2 Trade Cas. (CCH) ¶71,860 (D.R.I. 1997) (consent decree). *See also* United States v. Medical Mutual of Ohio, N.D. Ohio No. 1:98-CV-2172 (September 23, 1998), a proposed consent decree eliminating the use of MFNs by Medical Mutual, the largest commercial health care insurer in the Cleveland metropolitan area and until recently a Blue Cross plan, described in 75 Antitrust & Trade Reg. Rep. 374 (BNA) (October 1, 1998), and Erik F. Dyhrkopp & Andrew H. Kim, *Antitrust Enforcers Step Up Scrutiny of MFN Clauses*, NATIONAL L. J., July 5, 1999, at B7.

HMO).[4] When the providers sue, they typically complain that the prices that they must accept from the defendant purchaser are too low; when the competing purchasers sue, they typically complain that the prices that they must pay to providers are too high.

The recent antipathy of the federal antitrust agencies toward the practice of MFN provisions in health care contracts is unmistakable. As the Department of Justice recently explained in urging the Pennsylvania insurance commission to disallow the use of an MFN provision:

> [W]here sellers (hospitals) and buyers (health plans) negotiate price and a large buyer asks sellers for a guarantee of the best rate given to any other purchaser, anticompetitive results can occur. . . . [T]he cost to a hospital of granting a price concession . . . increases dramatically because this same price must be given to the larger buyer. . . . This reduces the incentive of a hospital to grant price concessions to [managed care plans] and thus helps the hospital negotiate a higher price with [managed care plans].[5]

The timing of this emerging enforcement posture in the 1990s is puzzling for at least three reasons. One is that this contractual feature is not a recent development; MFNs have been around for a long time. Second, the economic theory on MFNs is remarkably ambiguous in terms of its economic welfare implications; even analyses that fall generally into the anti-MFN camp usually note

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[4] *For example*, Blue Cross & Blue Shield v. Michigan Association of Psychotherapy Clinics, 1980-2 Trade Cas. (CCH) ¶63,351 (E.D. Mich. 1980); Kitsap Physicians Service v. Washington Dental Service, 671 F. Supp. 1267 (W.D. Wash. 1987); Reazin v. Blue Cross & Blue Shield, 663 F. Supp. 1360 (D. Kan. 1987), 899 F.2d 951 (10th Cir.); Ocean State Physicians Health Plan v. Blue Cross & Blue Shield, 692 F. Supp. 52 (D.R.I. 1988), 883 F.2d 1101 (1st Cir. 1989); National Benefits Administrators v. Blue Cross & Blue Shield, 1989-2 Trade Cas. (CCH) ¶68,831 (M.D. Ala. 1989), 907 F.2d 1143 (11th Cir. 1990); Willamette Dental Group, P.C. v. Oregon Dental Service, 882 P.2d 637 (Or. App. 1994); and Blue Cross & Blue Shield v. Marshfield Clinic, 65 F.3d 1406 (7th Cir. 1995).

[5] Letter from Anne K. Bingaman, Assistant Attorney General, Antitrust Division, to Hon. Cynthia M. Maleski, Pennsylvania Insurance Commissioner (Sept. 7, 1993), concerning an MFN provision adopted by Blue Cross of Western Pennsylvania in its contracts with hospitals.

that there exist circumstances under which MFNs can be efficient and procompetitive, and vice versa for analyses that fall generally into the pro-MFN camp.[6] And third, there is virtually no published empirical economic research on the actual, rather than theoretical, effects of MFNs on the health care markets in which they are used, empirical evidence that is ordinarily our guide to antitrust policy in circumstances in which theoretical predictions cut both ways.[7]

To recap quite lightly some of the insights from previous literature on the MFN issue, two themes seem to predominate. The principal anticompetitive theme is that MFNs are initiated by otherwise competitive sellers in a market because MFNs make it easier to detect secret deviations from explicit or implicit agreements on price.[8] A related anticompetitive subtheme is that MFNs are initiated by dominant purchasers, because MFNs disadvantage any rivals who might otherwise dicker for a lower price than the

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[6] *See, e.g.*, Steven C. Salop, *Practices That (Credibly) Facilitate Oligopoly Coordination*, *in* New Developments in the Analysis of Market Structure 265 (Joseph E. Stiglitz & G. Frank Mathewson eds., 1986); Celnicker, *supra* note 3; Joseph Kattan, *Beyond Facilitating Practices: Price Signaling and Price Protection Clauses in the New Antitrust Environment*, 63 ANTITRUST L.J. 133, 146–50 (1994); Anthony J. Dennis, *Most Favored Nations Clauses Under the Antitrust Laws*, 20 U. DAYTON L. REV. 1 (1995); Joseph Kattan & Scott A. Stempel, *Antitrust Enforcement and Most Favored Nations Clauses*, ANTITRUST, Summer 1996, at 20; and Jonathan B. Baker, *Vertical Restraints with Horizontal Consequences: Competitive Effects of "Most-Favored-Customer Clauses,"* 64 ANTITRUST L.J. 517 (1996).

[7] Most of the empirical literature on MFNs concerns natural gas contracts; *see* Keith J. Crocker & Thomas P. Lyon, *What Do "Facilitating Practices" Facilitate? An Empirical Investigation of Most-Favored-Nation Clauses in Natural Gas Contracts*, 37 J. L. & ECON. 297 (1994); and David A. Butz, *Most-Favored Treatment Provisions as Nondiscrimination Guarantees*, 2 INT'L J. ECON. BUS. 65 (1995), and references cited therein.

[8] Ironically, they do so by enlisting the unwitting assistance of the customer, who in a typical MFN arrangement has the right to audit the seller's records to guarantee that no other customer is getting a lower price.

dominant purchaser's price (in which circumstance the MFN will also be applauded by sellers who hope to escape the competitive pressures associated with an environment of rampant discounting). The principal procompetitive or efficiency-related theme is that an MFN is one of many available features in supply contracts that, depending upon market characteristics, will permit some buyers and some sellers to achieve their competitive objectives more effectively.[9] In this event MFNs will ordinarily receive mixed reviews from market participants: favorable from those who find them competitively useful, and unfavorable from their competitors who don't.

In this article I have several contributions to offer to the evolving antitrust attitude toward the use of MFN provisions in health care provider contracts. The first is to outline a simple economic model of the effects of MFNs on provider incentives to reduce price, a model that demonstrates why the apparent general intuition—that MFNs can be neither condemned nor commended by theory alone—is correct. The second is to examine empirically the actual effects of the adoption of MFN provisions that were incorporated into the provider contracts of two health care purchasers—Blue Cross plans in Rhode Island and in Philadelphia—an examination that may contribute to the empirical basis for antitrust judgment that has, so far, been scarce in this area of inquiry. And finally, I provide some statistics on the remarkable degree of price dispersion in health care markets, a fact that may help explain why MFNs can be economically efficient and attractive to cost-conscious health care purchasers.

II. Price discounting with and without MFNs

To telegraph one of the conclusions of this section, the net overall effect of MFNs on average market price is fundamentally ambiguous; economic theory provides no universally applicable proof that MFNs always raise price on balance, or always lower

[9] Chief among those market characteristics is uncertainty over the distribution of prevailing or future market prices, a characteristic that I discuss at greater length in section III below.

price on balance.[10] As a very broad generalization, hostile antitrust verdicts on MFNs are generally grounded in hypotheses that sellers use them to help enforce explicit or tacit collusion by making price cuts more detectable and more expensive, or that purchasers use them to help prevent their competitors from buying inputs more cheaply. Conversely, benign verdicts on MFNs are typically grounded in hypotheses that they increase the efficiency of transacting through contract, by creating a means of structuring an enforceable agreement to guarantee low prices. It is for that reason that establishing even the direction—pro or con—of the competitive effects of an MFN in any actual market is an empirical question. In this section, I sketch out some of the basic mechanics of price discounting with MFNs to demonstrate intuitively why we need more than a theory to either denounce or endorse MFNs.

A. *When is a discount proposal profitable?*

Assume that a hypothetical insurer—call it Blue Cross—contracts with all of the hospitals in its service area to purchase inpatient hospital services for its members. The contracts have MFN provisions of the sort described above; if any one hospital gives a lower price to another purchaser than it is currently giving to Blue Cross, then when this happens Blue Cross will get the same low ("discounted") price.[11]

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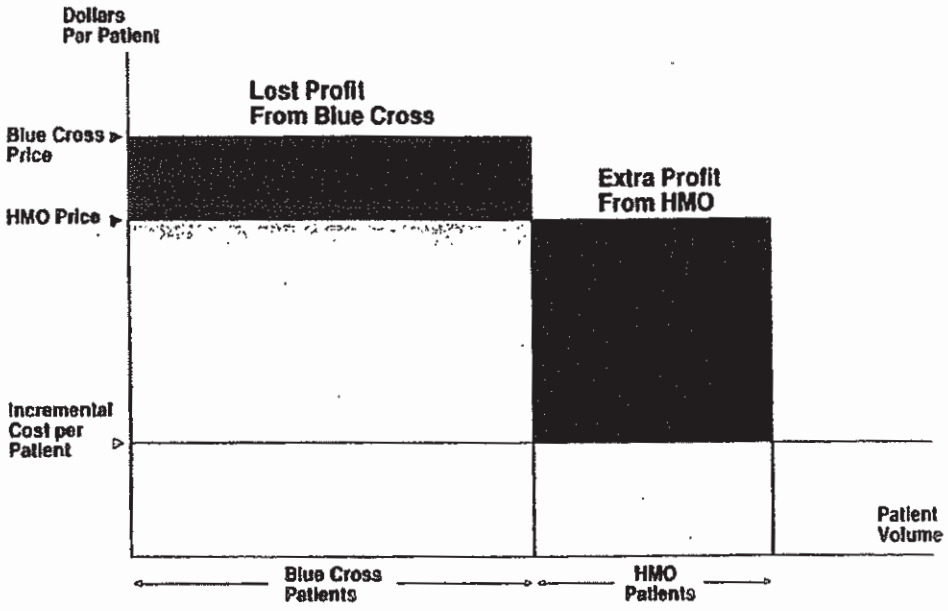
[10] This should not be surprising. It is well known in the economics literature that the welfare implications of price discrimination are ambiguous; depending on the elasticities of consumer demand and the structure of the price schedule, there can be circumstances under which price discrimination either increases or decreases consumer welfare. *See generally* LOUIS PHILIPS, THE ECONOMICS OF PRICE DISCRIMINATION (1983). Since MFNs affect the degree of price discrimination within a market, it is unremarkable that their welfare implications also are ambiguous.

[11] To keep this description manageably simple, I assume throughout that, in the absence of an MFN provision, hospitals would charge only two classes of prices to their private-pay patients. One is the hospital's "standard" or undiscounted price, which all indemnity payors, including Blue Cross, pay. The other is an array of discounted prices that the hospi-

Figure 1 shows us how this arrangement looks to a hospital when it contemplates a discount proposal to an HMO. The hospital has a substantial volume of Blue Cross patients, as shown on the horizontal axis of the figure.[12] Blue Cross's contract provides for a price substantially in excess of the hospital's incremental cost per patient, so each Blue Cross patient provides a significant incremental profit. An HMO offers the hospital the usual pitch, under which the HMO, which currently does not deal with the hospital, will begin sending it a specified number of patients ("HMO patients" on the horizontal axis), but only if the hospital gives it a discounted "HMO price," which is below the price that the hospital charges Blue Cross. Although the proposed HMO price is discounted, it is still comfortably above the hospital's

Figure 1
The Arithmetic of Discounting With an MFN Contract



tal offers to HMOs, generally in return for the HMOs' promises of incremental patient volume.

[12] The hospital also has many patients covered by other payors, all of whom I omit from the graph for simplicity.

incremental cost, and so landing the deal would add to the hospital's bottom line.

But with an MFN, the hospital must balance the incremental gain from the HMO's business against the corresponding incremental loss of some of its Blue Cross revenues when it gives Blue Cross the same low price that it gives to the HMO. If the "extra HMO profit" rectangle is larger than the "lost Blue Cross profit" rectangle (as it is in figure 1) then the hospital offers the discounted price to the HMO and grants it to Blue Cross as well. Under other circumstances—a lower HMO price necessary to do the deal, lower HMO patient volume, or higher Blue Cross patient volume—the lost Blue Cross profit rectangle would swamp the extra HMO profit rectangle, and the hospital would decline to deal with the HMO.

B. What determines the size of the discount offer?

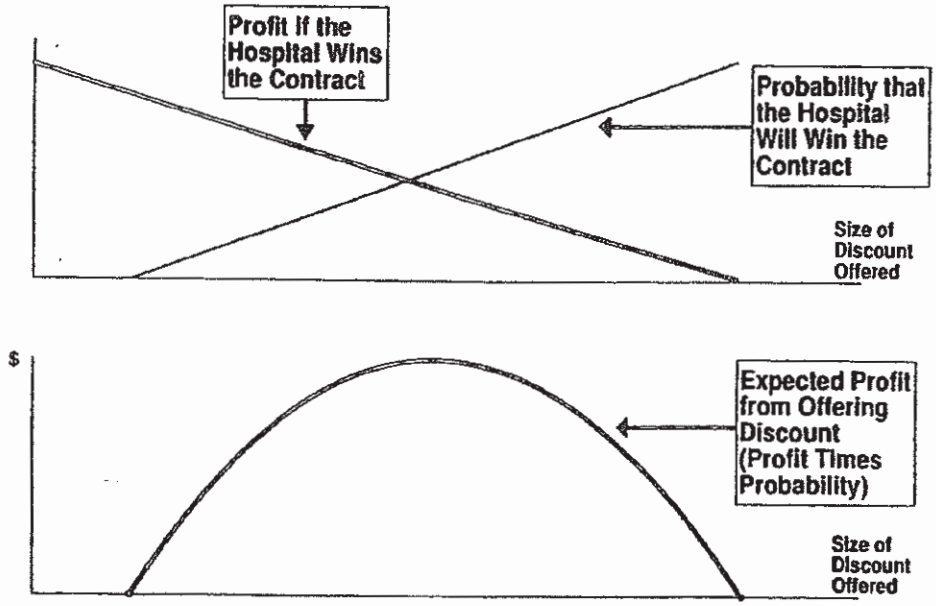
The size of the discount that is necessary to clinch the HMO's business is a key determinant of whether a deal is struck or not; the smaller the necessary discount (that is, the higher the HMO price), the likelier that the figure 1 "balance of rectangles" will favor granting a discount to the HMO. Figure 2 puts a little structure on the concept of determining the size of the discount that the hospital will offer in the absence of an MFN provision with Blue Cross.

Start with the upper panel of the figure. The horizontal axis reflects the percentage discount that a hospital might offer to an interested HMO; moving from left to right represents a greater discount (that is, a lower price) offer.[13] As the proffered discount gets deeper, two things happen. The first is that the profitability of the HMO contract—*if* the hospital wins it—declines.[14] The second

[13] At a discount of zero, the hospital offers the HMO the same price that Blue Cross pays.

[14] At a zero discount, the HMO contract would be exactly as profitable, per patient, as the Blue Cross business. As the discount offer becomes deeper, profitability falls, eventually to zero.

Figure 2
The Profitability of Obtaining an HMO Contract by Offering Discounts: No MFN



is that the probability that the hospital's offer will be attractive enough to actually win the HMO contract rises.

The profit from the contract *if* it is won, times the probability that the contract *will* be won, equals the expected profitability of the contract. Both of these factors vary with the level of the offered discount. That multiplicative function is shown in the lower panel of figure 2. Intuitively, expected profit is low at low discount levels because, although such a contract would be lucrative if won, the odds of actually winning it are slim. Conversely, the expected profit is also low at high discount levels because, although the odds of winning the contract are high, the profits from performing such a contract are low. The hospital finds its highest expected profit by offering the HMO an intermediate-level discount, one with an appreciable chance that the offer will be spurned but with appreciable profits realized if it is accepted.

C. How does an MFN affect the size of the discount offer?

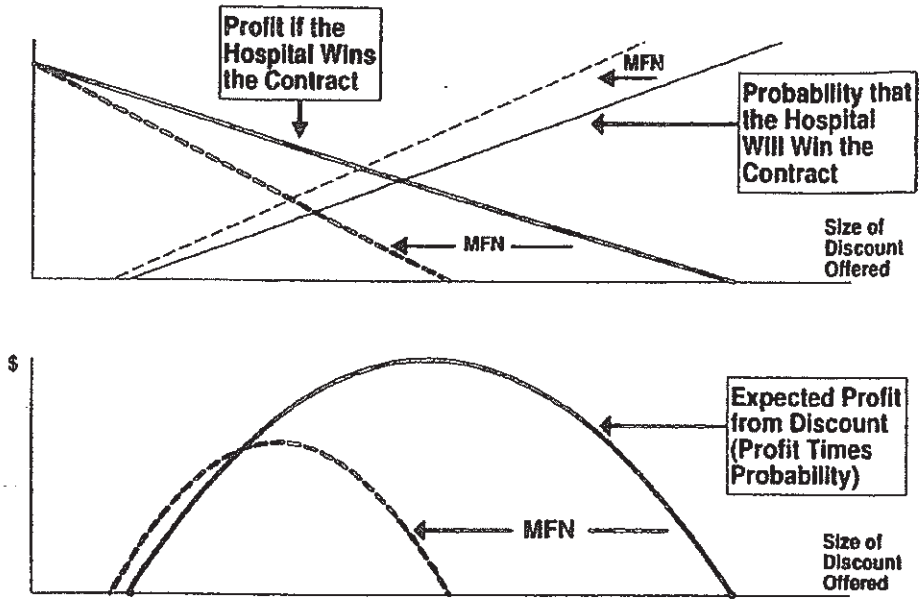
We now change the market environment of figure 2 by assuming that this hospital, and all or most of its competitors, has a contract with Blue Cross that contains an MFN provision. Figure 3 is structured like figure 2, and shows us how the MFN changes the expected profitability of offering discounts to HMOs. There are two MFN effects, shown in the upper panel. The first is that the MFN reduces the profitability of any HMO contract that the hospital wins, because the hospital's profit from the HMO contract is now offset by the "hit" that it takes from granting the same discount on its existing Blue Cross business.[15] The second effect is that the MFN increases the hospital's probability of actually winning the contract at any given level of discount. The reason for this is that if the marketwide MFN feature reduces the profitability of a discounted HMO contract for *this* hospital, it also necessarily reduces the profitability of discounting to win the HMO's business for all of the hospital's *competitors*. This means that the distribution of competing hospitals' bids for the HMO's business will reflect lower levels of discounts (that is, higher prices), which in turn means that any particular level of discount that this hospital offers now has a higher chance of being good enough to win the HMO contract.

The bottom line (in the bottom panel) is that the expected-profitability-of-discount relationship shifts as a result of the MFN provision. There are three qualitative points about the effects of the MFN on the hospital's discount strategy that emerge from this simple theoretical model. First, the model implies that MFNs reduce the hospital's optimal discount offer to the HMO, which is to say that they reduce the spread between the HMO price and the Blue Cross price.[16] Second, it implies that MFNs reduce the over-

[15] Note that this effect is zero for an HMO discount of zero, because in that case no adjustment to the Blue Cross price is required. The MFN effect on foregone profits from Blue Cross business becomes greater as the HMO discount becomes greater, because the "foregone profit" rectangle in figure 1 becomes greater as the HMO price becomes lower.

[16] Which we see because the expected profitability curve peaks at a lower level of discount with MFNs in place.

Figure 3
The Effect of an MFN Contract on the Expected Profitability of Discounting



all profitability to the hospital of engaging in HMO discounting at all.[17] And third, although with MFNs the hospital's optimal profitability from discounting is lower, it is nevertheless positive; even with the MFN provision, discount offers to HMOs are still profitable, and will still be made.

D. Are MFNs procompetitive or anticompetitive?

In health care antitrust assessment we are ordinarily concerned with overall, marketwide effects, not with effects on HMOs considered in isolation from the rest of the market.[18] On the one hand,

[17] Which we see because the peak of the expected profitability curve is lower with MFNs.

[18] "Viewing the managed care discounts in light of their impact on the welfare of consumers as a whole exposes them as illusory. Such selective price advantages are hardly the sort of benefit the antitrust laws

we might expect smaller HMO discount offers with an MFN; but on the other hand, those discounts, although smaller, are now extended to a larger number of patients, because they are now extended to the Blue Cross patients as well as the HMO patients. The terms of the MFN tradeoff are these: we can have deeper discounts to a smaller number of patients without an MFN, or we can have shallower discounts to a greater number of patients with the MFN. If we adopt the aggregate dollar amount of discounting as an operational criterion of the marketwide effect on pricing conduct, then by that criterion MFNs are as capable of increasing aggregate discounting as reducing it.[19]

The simple analytic point of this derivation is that the question of MFN effects on aggregate discounting in the market is fundamentally empirical rather than wholly theoretical. Theory can tell us what effects to expect and to look for—for example, with MFNs we will see shallow discounts for the many, rather than deep discounts for the few—but only factual investigation can determine whether in any actual market the balance of consumer benefits from MFNs is positive or negative.

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are designed to protect." Federal Trade Commission v. Butterworth Health Corp., 946 F.Supp. 1285, 1299 (W.D. Mich. 1996), *aff'd*, 121 F.3d 708 (6th Cir. 1997).

[19] By aggregate dollar amount of discounting I mean the average per-patient discount (for those patients receiving a discount) multiplied by the number of patients receiving a discount. It is the effect of a practice on the average price paid in the market that is ordinarily the central antitrust criterion of consumer welfare effects, not the details of discounting by which that average price is arrived at. Therefore, acceptance of "aggregate discounting" as a practical welfare criterion implies acceptance of the untested assumption that high levels of discounting activity are associated empirically with low levels of average—discounted and undiscounted—price. Whether we accept that assumption or not, empirical examination of the aggregate extent of discounting has independent relevance in its own right, because discounting is the intermediating mechanism through which the MFN may potentially affect average market price.

III. Some evidence to go with the theory

Compared to other topics in antitrust and industrial organization—the relationship between market structure and price, for example—there is very little published empirical research on the actual effects of MFN provisions, and virtually none that concerns health care markets, the one industry in which recent government and private attacks on this practice have so predominantly focused. I summarize here the available basic economic evidence on market effects in two recent challenges to Blue Cross MFN provisions, one in Rhode Island involving physicians and the other in Philadelphia involving hospitals.[20] The available evidence is limited to two instances of the introduction of MFNs in health care provider contracts, but the fact that each of them had enough "bite" to provoke litigation by competing health insurance plans suggests that they may be particularly instructive examples of the MFN phenomenon more generally.

I examine below three observable market characteristics that are relevant to the introduction of these MFN provisions. One is the growth rate of the discount-seeking HMOs. The adoption of the MFN should have improved Blue Cross's competitive position, and worsened the HMOs' position, each relative to the other. This is not exactly shocking; competitors (like Blue Cross) generally don't take competitive initiatives of any sort in which they hope to worsen their position. Thus it is plausible to suspect that even in instances where MFNs do not injure competition itself—that is, do not increase average market price or reduce total market output—they may still have the potential to injure one category of competitors (the discount-seeking HMOs). The second inquiry that I make with data available for the *QualMed* case (though not available for *Ocean State*) is the effect of the MFN on

[20] Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of R.I., 692 F. Supp. 52 (D.R.I. 1988), 883 F.2d 1101 (1st Cir. 1989) (physicians); and Petition and Complaint of Health Systems International and QualMed Plans for Health of Pennsylvania regarding: Independence Blue Cross Filing No. 1-P-92 and Subsequent Blue Cross Hospital Contracts, Dkt. No. M95-06-024 (Insurance Commissioner of the Commonwealth of Pennsylvania) (June 13, 1995) (hospitals).

hospital pricing, specifically on the average level of net price (that is, after all discounts). It is this effect on consumers generally, and not the effect on the HMO competitors particularly, that is the pertinent test of antitrust injury from MFNs. I also examine in that inquiry both the degree to which net price is discounted from list price (an indirect indicator of hospital pricing conduct) and also the level of hospital profitability (an indirect indicator of the effects of hospital pricing). And finally, I examine (again for the *QualMed* market) some characteristics of hospital pricing that may help explain the reasons for Blue Cross's adoption of the MFN provision.

A. *The MFN effect on HMO enrollment*

The contention that Blue Cross MFNs injured the entire class of HMO health care purchasers was central both in *Ocean State* (which appears to be the most cited litigated case on MFN issues) and in *QualMed*. I will not rehash here the fact finding in *Ocean State*, since there is no shortage of law review articles that handle that task ably.[21] The essential, simplified fact relevant to my purposes is that Blue Cross-Blue Shield of Rhode Island (BCRI), despite the possession of monopoly power in Rhode Island health care financing (which BCRI conceded at trial), was concerned with rising competition from the Ocean State HMO. Upon investigation, BCRI discovered that it was effectively paying more for the services of Rhode Island physicians than the upstart Ocean State HMO was. In response, BCRI in 1986 initiated (among other things, including starting its own HMO) an MFN provision in its physician service contracts. Ocean State sued, claiming antitrust injury, but BCRI prevailed. The Blue Cross MFN provision survived intact.

The relevant stylized facts are roughly similar in *QualMed*. Independence Blue Cross (IBC), which services the greater Philadelphia metropolitan area, added an MFN provision to its

[21] For a starting point, *see* Anthony J. Dennis, *Potential Anticompetitive Effects of Most Favored Nation Contract Clauses in Managed Care and Health Insurance Contracts*, 4 ANNALS HEALTH L. 401 (1995), and the references cited therein.

hospital contracts effective as of mid-1992, which required each contracting hospital to offer IBC a price as low as the lowest price that the hospital gave to any other nongovernment payor. In response, the Justice Department in 1993 opened "a civil investigation . . . to assess the competitive effects of IBC's [MFN provision] and to determine whether it violates the federal antitrust laws."[22] The Justice Department eventually dropped its investigation, but only because the issue would likely be exempt from federal antitrust scrutiny under the state-action doctrine, and suggested on its way out that the state insurance commission should be the agency to investigate "whether [IBC's MFN] has, in fact, reduced health-care costs" based upon "information now available . . . about the policy's actual effects."[23] Also in response, QualMed, one of the potentially adversely affected HMOs, brought an action against IBC through the Pennsylvania Insurance Commission, which had the legal authority to enjoin the MFN provision. That case was eventually resolved through a 1998 settlement agreement between IBC and the Insurance Commission.

Although the simple economic model sketched in the previous section is ambiguous with respect to consumer injury, it does imply that the MFN should have injured the competitive position of HMOs. Based upon theory alone, we might well predict that both of these Blue Cross MFNs would have stopped the HMO movement cold. After all, if HMOs offer subscribers only a limited panel of health care providers, yet have no provider discounts

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[22] Letter from Steven Kramer, Attorney, Antitrust Division, to Hon. Cynthia M. Maleski, Pennsylvania Insurance Commissioner (May 5, 1994). This investigation of Blue Cross contracting practices in eastern Pennsylvania was conducted in parallel with the overlapping similar investigation in western Pennsylvania, *supra* note 5. Both of these Blue Cross plans were reported in the general press to have had high enough shares of their respective service areas' health insurance business to raise competitive concerns with the Antitrust Division: A share of 70% for Blue Cross of Western Pennsylvania, and over 50% for IBC. Marc Metzer, *Blue Cross Practice Eyed*, PHILADELPHIA DAILY NEWS (P.M. ed.), Sept. 15, 1993, at B21.

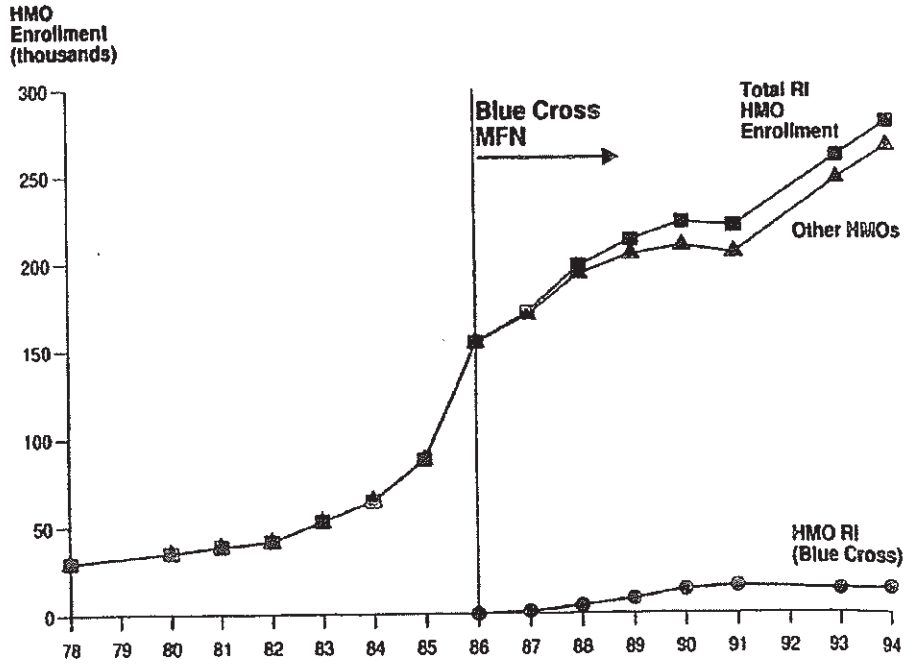
[23] Kramer, *supra* note 22.

to be passed along in the form of offsetting lower health insurance premiums, how could HMOs possibly offer a product that consumers would choose over conventional (Blue Cross) health insurance? As one antitrust expert put the facts in *Ocean State*:

> The impact of Blue Cross's MFN clause was immediate. . . . When the dust settled . . . , competing health and dental plans were left bleeding and wounded on the floor.[24]

With a description like that, it's hard to resist an autopsy of the casualties. Figure 4 provides a look at the HMO enrollment statistics that are relevant to *Ocean State*, and figure 5 does the same for *QualMed*; the underlying data are summarized in table 1.

Figure 4
The Growth of HMO Enrollment in Rhode Island Before and After the Blue Cross MFN

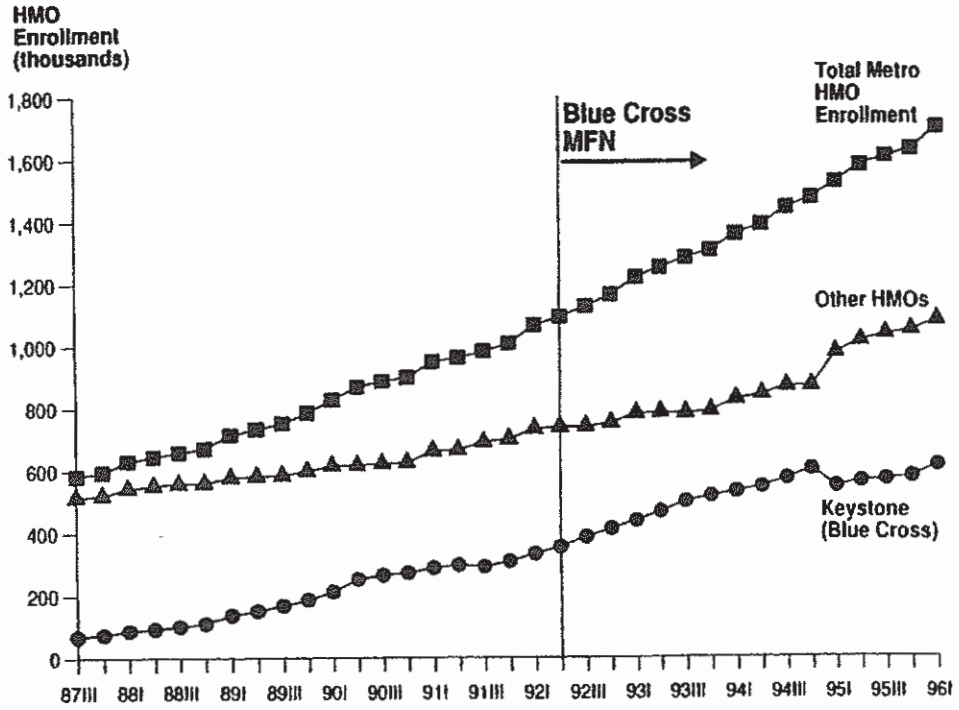


NOTE: HMO RI offered by Blue Cross-Blue Shield. Harvard Community RI members not broken out prior to 1/1/91. Some periods interpolated.

SOURCE: See table 1.

24 Dennis, *supra* note 21, at 409 (footnote omitted).

Figure 5
The Growth of HMO Enrollment in the Philadelphia Metro Area Before and After the Blue Cross MFN



SOURCE: See table 1.

The figures and table reflect the published statistics on Rhode Island (*Ocean State*) and Philadelphia metropolitan area (*Qual-Med*) enrollment in HMOs both before and after Blue Cross initiated its physician MFN provision. These data speak fairly plainly, and what they say is that there is no indication that the Blue Cross MFN provision halted the HMOs' long-run growth within the MFN-affected areas.[25] In a period of fairly stable areawide popu-

[25] A study of similar but less-recent Rhode Island HMO data observed that "[t]hese data make it difficult to conclude that the actions undertaken by [BCRI] seriously injured Ocean State," inferring that "[t]he existence of Ocean State allowed [BCRI] to pinpoint those physicians who were willing to accept lower fees. By reducing reimbursement to these physicians, [BCRI] was able to lower physician input costs. . . . [A] policy that can reduce input costs should be encouraged from a public policy viewpoint." Lawrence G. Goldberg & Warren Greenberg, *The*

lation, in each case HMOs added more enrollment in the years following the inception of the Blue Cross MFN than they had in the corresponding number of years prior to it.[26] Based on these data, it's hard to see (with the benefit of hindsight) what the competitive concern was.

Table 1

Total HMO Enrollment Before and After the Blue Cross MFN: State of Rhode Island (*Ocean State*), 1978–1994 and Philadelphia Metropolitan Area (*QualMed*); 1987 III–1996 I

HMO enrollment prior to MFN	*HMO enrollment at adoption of MFN*	*HMO enrollment after MFN*	*Average annual enrollment growth*	
			Prior period	*Subsequent period*
		RHODE ISLAND		
29,419 (1978)	154,184 (1986)	279,466 (1994)	15,596	15,660
		PHILADELPHIA METRO AREA		
582,785 (1987 III)	1,093,686 (1992 II)	1,694,391 (1996 I)	107,558	160,188

NOTES: Rhode Island: Enrollment figures are for mid-year. Harvard Community RI members not broken out prior to 1991.

Philadelphia Metro: Metro Area enrollment calculated as the sum of Keystone (KHPE, DVHMO, and Vista), Aetna (Aetna C&E and Freedom), U.S. Healthcare (USHC Philadelphia), CIGNA, Greater Atlantic/QualMed, Health Partners, Oaktree/Oxford, and Prucare of Philadelphia (plus several others with negligible enrollment). Includes Medicare and Medicaid. Excludes PPOs, and POS plans (except CIGNA).

SOURCES: Rhode Island: Interstudy publications (1978–1990); GHAA directories (1991–1994); and RI DBR Enrollment Reports (HCHP 6/30/94).

Philadelphia Metro: Pa. Dept. Health, HMO Quarterly Reports (1987 III through 1996 I).

Response of the Dominant Firm to Competition: The Ocean State Case, 20 HEALTH CARE MGMT. REV. 65, 73 (1995).

[26] The first-quarter 1995 shift of enrollment away from Keystone (IBC's HMO) that we see in figure 5 was the result of Keystone's sale of its Medicare HMO business to a competing HMO.

The demonstration in figures 4 and 5 does not, of course, translate automatically to the facts of MFNs in operation elsewhere. Different cases will have different facts, and those facts may lead to different competitive conclusions. Nevertheless, the lesson that *Ocean State* and *QualMed* teaches is that theoretical predictions about the actual magnitude of any competitor injury—much less of any competitive injury—are not worth much unless they are informed by empirical evidence.

B. The MFN effect on hospital prices, discounts, and profitability

As I noted earlier, an adverse MFN effect on the relative competitive position of HMOs is not sufficient, by itself, to imply competitive injury, in the usual sense of injury to consumer welfare. We expect the MFN to reduce the price paid by the purchaser employing the MFN, and to increase at least some prices paid by other purchasers; it is the net effect on average price, aggregated over all of the affected purchasers, that is the ultimate economic test of consumer injury or benefit. Although data are lacking on the Rhode Island physicians' fees that would be relevant to an examination of *Ocean State*, I have assembled and analyzed a large body of data on hospital financial and operating characteristics in the Philadelphia metropolitan area for the 7 years (1989–1995) straddling the 1992 introduction of the MFN provision in IBC's hospital contracts.[27] These data allow us to test for consumer welfare effects in *QualMed*.

IBC negotiated new MFN-inclusive contracts with its participating hospitals, made effective as of approximately mid-1992. Thus the pre-1992 period reflects the market environment that motivated IBC to adopt the MFN, and the post-1992 period reflects any effects of the MFN on hospital pricing and discounting. In this section I spell out what we would expect to see if, as

[27] These data were obtained from HCIA, a major health care data vendor, and are derived from the Medicare Cost Reports that virtually all hospitals submit annually to the U.S. Health Care Financing Administration. My initial investigation of these data was undertaken at the invitation of counsel for IBC, who had requested an independent economic analysis and assessment of the IBC MFN provision.

claimed by QualMed and suspected by the Justice Department, IBC's MFN had a competitively adverse effect on the market at large, and then report my analysis of the data that are relevant to each of these hypothesized effects.

Assume as a hypothesis that the IBC MFN had an adverse effect on consumer welfare: specifically, that on balance the predominant effect of the MFN was to cause hospitals to raise their prices to IBC's competitors, more so on balance than to lower their prices to IBC. If this were so, what would we expect to see in consequence as evidence of this competitively adverse effect? The chief empirical implications of the hypothesized competitive injury conjecture are that, after the MFN is initiated:

1. The average net price for hospital services should rise;
2. The average discount (of net prices relative to list prices) should shrink; and
3. The average profitability of hospital operations should grow, thanks to less intense price discounting.

I present below descriptive summaries of the data that are relevant to each of these implications, followed by a more extensive statistical analysis of the same data. My empirical analysis is based upon 7 years of annual data (1989–1995) for essentially all acute-care inpatient hospitals in the Philadelphia metropolitan area.[28] The relevant underlying data are summarized in table 2.

1. NET HOSPITAL PRICES BEFORE AND AFTER THE MFN If the effect of the MFN were to elevate average net hospital prices, after all discounts, and if all other relevant factors were stable (in either their levels or trends), then we would expect average net revenue per inpatient admission to rise, relative to any existing trend, after 1992.[29] But as we see in figure 6, the affected hospitals' average

[28] The principal exclusions from this definition are a number of long-term psychiatric and rehabilitation hospitals, and hospitals not reporting for some or all of the 1989–1995 period. This results in 50 hospitals for which I have data for all 7 years. The Philadelphia metro area consists of five counties: Bucks, Chester, Delaware, Montgomery, and Philadelphia.

[29] Net inpatient price must be approximated. I calculate net inpatient revenue as net patient revenue (from both outpatients and inpatients),

Table 2
Philadelphia Area Hospital Data Summary

1989–1995

Variable	*Mean (standard deviation)* 1989	1992	1995
Net inpatient price per admission	$7,606 (2,589)	$7,929 (2,966)	$7,062 (2,868)
Percentage discount, net from gross	44.14% (8.54)	52.79% (6.11)	58.21% (7.83)
Operating revenue, percent of operating cost	97.32% (9.52)	101.94% (6.00)	102.05% (5.72)
Inpatient admissions	10,184 (6,008)	10,680 (6,028)	10,710 (6,429)
Inpatient days	67,270 (43,024)	69,302 (43,448)	55,386 (36,895)
Casemix severity index	1.30 (.20)	1.35 (.23)	1.39 (.25)
FTEs per patient	6.42 (1.83)	6.75 (1.80)	8.18 (2.62)
Percent nursing home beds	1.35% (3.47)	1.16% (3.51)	5.69% (11.58)
Percent Medicare days	49.55% (13.04)	52.47% (12.46)	52.52% (12.33)
Percent Medicaid days	12.45% (12.91)	13.34% (12.66)	13.40% (11.23)
Percent private-pay days	38.00% (10.27)	34.19% (9.95)	34.08% (11.02)

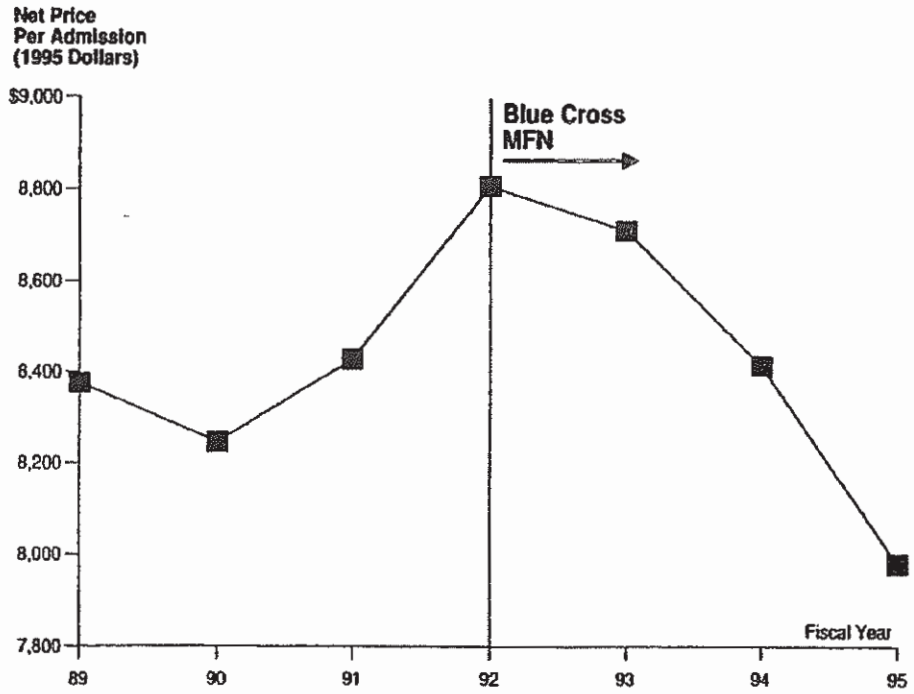
NOTE: N = 350 (50 hospitals, 7 years).
Prices deflated to 1995 dollars (Medical Care Component of Consumer Price Index).

SOURCE: HCIA; American Hospital Association, AHA Guide (1990–1996); Economic Report of the President (1996).

times the ratio of gross inpatient charges divided by the sum of gross inpatient and outpatient charges. Dividing through by patient admissions gives us average net price per inpatient admission. For purposes of analysis, I then deflate these revenues by converting all of them to 1995 dollars using the medical care component of the Consumer Price Index; Economic Report of the President (1996), at table B 56.

net inpatient price had been rising slightly in the years leading up to the adoption of the MFN in 1992. After the MFN was initiated, the average price declined, not increased, contrary to the competitive injury conjecture.

Figure 6
Net Price per Inpatient Admission for Philadelphia Area Hospitals Before and After the Blue Cross MFN



SOURCE: See table 2.

If any adverse market price effects of IBC's MFN exist and are important, we would expect them to leave some visible tracks in the pertinent data on net price. No such tracks are apparent, and so the competitive injury conjecture gets no support in this area of investigation.

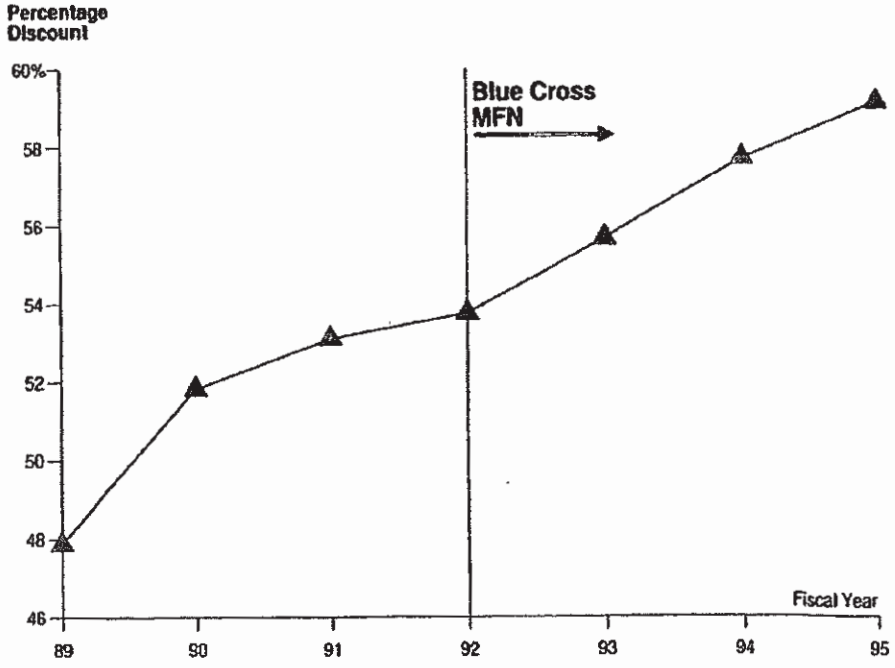
2. DISCOUNTS FROM LIST PRICE BEFORE AND AFTER THE MFN A subsidiary implication of the Justice Department's and QualMed's antitrust concerns is that the introduction of IBC's MFN should have brought with it a shrinkage of the overall discount. This we

can observe by measuring the overall average percentage discount, which is calculated as the percentage by which net patient revenue (based on net prices received after all discounts) is less than gross patient revenue (based on list prices charged before any discounts). The chronology of the average percentage discount is recorded in figure 7.

The data show no sign whatsoever of any post-MFN shrinkage in the overall discount level; there is *more* discounting, not less, after IBC introduces its MFN. More to the point; there is no post-MFN break in the continuous trend toward more discounting over time. Here too, the competitive injury conjecture receives no support from the data on overall discounting activity.

3. HOSPITAL PROFITABILITY BEFORE AND AFTER THE MFN The final empirical implication that I draw from the antitrust theory behind

Figure 7
Discounts as a Percentage of Gross Charges for Philadelphia Area Hospitals Before and After the Blue Cross MFN

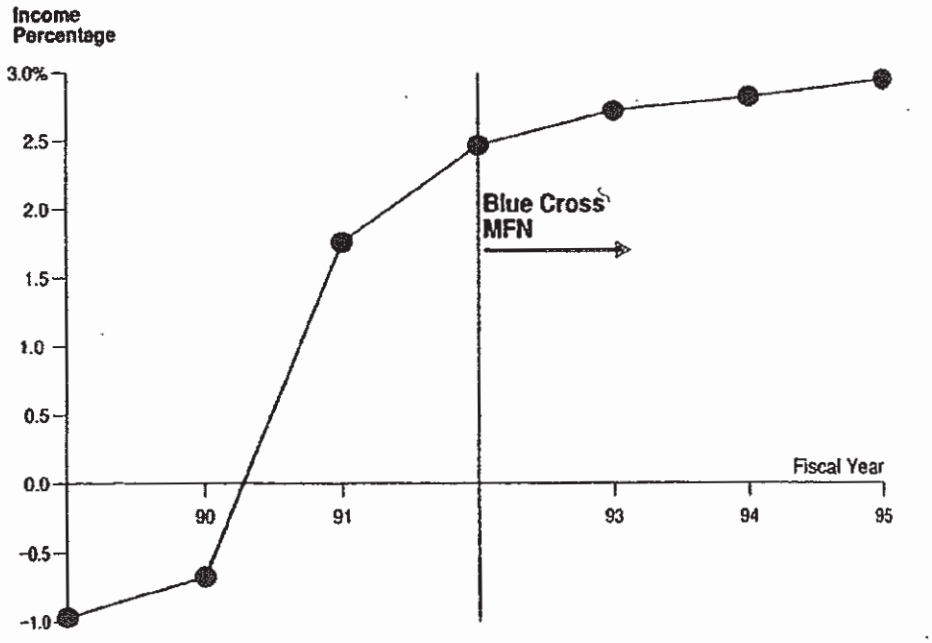


SOURCE: See table 2.

QualMed is that, if IBC's MFN discouraged aggressive "dog-eat-dog" hospital price discounting, and as a result the MFN cooled the intensity of competition in the hospital services market, then hospital profitability should have been buoyed as a consequential result.[30] We can study that proposition by examining hospital profitability, measured by operating income expressed as a percentage of operating revenue.

Figure 8 tells the story, and it is not favorable to the competitive injury conjecture. There is no sign of a significant upturn, rel-

Figure 8
Operating Income as a Percentage of Operating Revenue for Philadelphia Area Hospitals Before and After the Blue Cross MFN



SOURCE: See table 2.

[30] As noted earlier, much of the theory under which MFNs can have anticompetitive effects characterizes MFNs as contractual features that are fostered by the sellers (here, the hospitals), rather than the buyers, as a way to prop up explicit or implicit price collusion by making secret price discounts easier to detect.

ative to the pre-MFN upward trend, in hospital profitability after the introduction of the MFN. Profitability grew sharply (from an obviously abnormally low base) before the MFN, but after the adoption of the MFN the growth of profitability flattens out at a level of less than three percent of revenues. This finding is not consistent with a substantial post-1992 reduction in competitive price pressure. Here as before, the facts on hospital profitability fail to provide support for the competitive injury conjecture about adverse market effects of MFNs.

4. STATISTICAL ANALYSIS OF HOSPITAL PRICES, DISCOUNTS, AND PROFITABILITY I recognize that more is going on in this hospital market than just the MFN. Suppose that the effect of the MFN under study here was actually to elevate average net hospital prices, but that coincidentally at the same time there were other independent market factors that changed after 1992 in a way that would tend to reduce prices. If so, then such a confounding price-reducing event might offset and thus mask a hypothetical price-increasing effect of the MFN. The same possibility is true for a hypothetical MFN-induced reduction in the overall level of price discounting, or a hypothetical MFN-induced elevation of hospital profitability.

The usual approach to ruling out other potential causes is to identify at least the most important of those causes, and control for their effects on the variable of interest through multivariate regression analysis. This is my approach here. We have three variables of interest: (1) net price per inpatient admission, (2) discount of net price relative to list price, and (3) hospital profitability. I estimate an economic model under which each of these dependent variables is potentially influenced by several important explanatory variables. Those explanatory variables include:

The overall scale of the hospital's operations (measured on two dimensions: the number of admissions, and the number of patient days);

The severity of medical treatment for the mix of patients that the hospital admits;

The amount of labor that the hospital applies to patient care, measured by full-time-equivalent employees per patient;

The fraction of the hospital's total beds that is devoted to long-term nursing care rather than short-term acute care; and

The fractions of the hospital's inpatient census that are reimbursed under Medicare and under Medicaid.

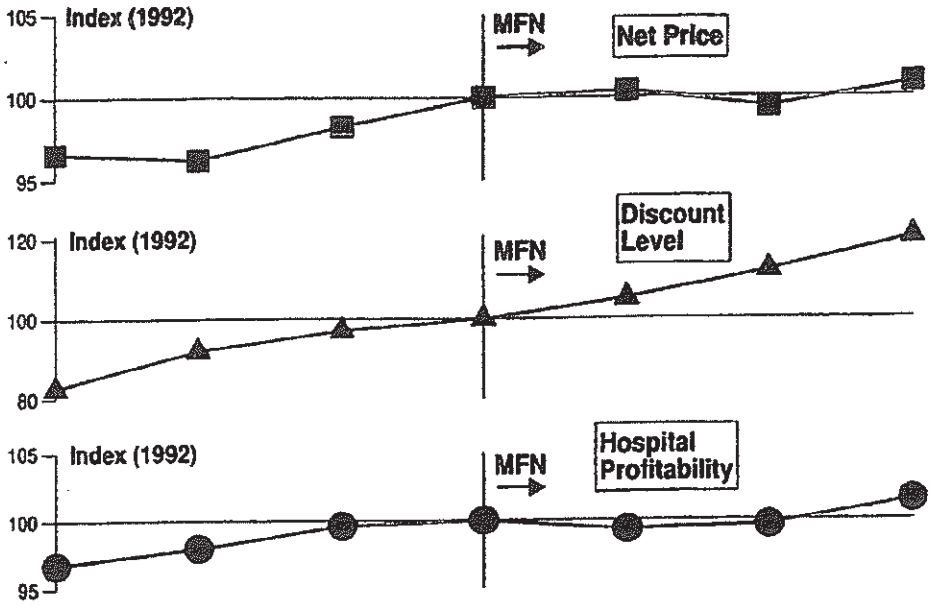
Those are the observable explanatory factors that, having controlled for their effects, we may then rule out as potential alternative causes of any remaining rise or fall in our variables of interest after the MFN begins to affect them.[31]

Finally, to estimate the MFN effect, the model also includes six "year variables" that measure any remaining differences in the dependent variables in each of the three pre-MFN years (1989–1991) and the three post-MFN years (1993–1995), each year relative to the transition year 1992. The interpretive sense of these year variables is that, if there are no important omitted or unobserved explanatory variables that change materially over time in ways that are strongly correlated with any MFN effect, then the pattern of the post-MFN year differences, relative to the pattern of the pre-MFN year differences, captures the effects of the adoption of the MFN.

The details of this statistical analysis are described in the appendix, and the results are summarized in appendix tables A.1 and A.2. The pertinent time patterns of the year variable effects on hospital net price, overall discount level, and hospital profitability are summarized in figure 9. Each variable in the figure—

[31] Each of these seven explanatory variables is observable, and varies from hospital to hospital within each year and from year to year within each hospital. In addition to these variables, my empirical model also includes binary "hospital fixed-effect" variables, one variable for each hospital. This empirical approach—called a "fixed-effects model"—accounts for differences across hospitals that are common to the entire time period but are not accounted for by the explanatory variables that my model includes explicitly. Illustrative examples of such unobserved influences on (say) net price might include a hospital's teaching (or nonteaching) status; its outstanding (or abysmal) reputation; its location in a safe (or crime-infested) neighborhood; and the excellence (or mediocrity) of the doctors on its staff. The fixed-effect formulation implicitly accounts for across-hospital variation in all of this, and leaves the explicitly measured variables to explain variation over time for each hospital.

Figure 9
Price, Discount Level, and Profitability, Net of Effects of Explanatory Variables (Percentage of 1992 Level)



NOTE: Deviations from 1992 index calculated from table A.1 coefficients of year variables.

SOURCE: See figures 6–8 and table A.1.

price, discount, and profitability—is indexed; that is, each year effect is shown as the percentage by which the variable of interest deviates from its 1992 level.[32] To the extent that the inferences that we might draw from figures 6–8 are qualified by concerns that those movements in price, discounting, and profitability might be influenced by extraneous, non-MFN causal factors, figure 9 addresses, and for the most part obviates, those concerns. The central results survive the statistical analysis: controlling for other causal factors (1) net price, which had been rising prior to

[32] Mechanically, the differences from the base year 1992 in each year of figure 9's plots equal the estimated coefficients of the year variables in table A.1's regression estimates, exponentiated to percentage differences. I also estimated the same model with the hospital fixed-effect variables omitted; the results of those estimates are slightly less favorable to the hypothesis of competitive injury than are the results reported here.

the MFN, is held in check after the MFN; (2) discount levels, which had been rising prior to the MFN, continue to rise after the MFN; and (3) hospital profitability, which had been rising prior to the MFN, is roughly stable after the MFN. In other words, the data analyzed here provide no support for the MFN competitive injury conjecture, and are if anything more consistent with a pro-competitive assessment.

IV. Price negotiations and MFNs in heterogenous markets

The preceding sections of my empirical analysis of MFN contracts have concentrated on *what* these contracts have done, either to health insurance market competitors or to hospital market competition. I now turn to a different question and ask *why* a health care purchaser might have initiated an MFN policy in the first place, if in the cases that I have examined it evidently was not to successfully injure competition. At the highest level of generality, the answer is simply that a purchaser of health care proposes an MFN in order to improve its profitability or its competitive position, relative to its rivals. But that level of generality, as noted earlier, does not tell us much about why an MFN is important to that objective.

Prior research has identified many purposes that might be served by MFNs, but one of the simplest of the benign explanations is that MFNs are a tool with which to deal with uncertainty and reduce risk. To illustrate, suppose that a buyer and a seller want to deal with each other through a long-term requirements contract rather than in spot transactions, for all the usual reasons. However, neither the buyer nor the seller knows what market conditions will be like in the future. Because of this uncertainty, the buyer is unwilling to commit now to a fixed price that may prove to be significantly above the prevailing spot price later. If the contractual relationship is valuable enough to the seller, then he can solve this information problem by offering the buyer an MFN provision. In this setup, the operative evidence of changed market conditions is the seller's own subsequent pricing to other buyers. If the market price falls, as reflected in the seller's own prices,

then the buyer gets the benefit of that development. With this reduction in risk, the buyer is more willing to enter into a mutually beneficial long-term contract with the seller.[33]

That illustration concerned uncertainty between two parties over many time periods, but MFNs can also deal with uncertainty between many parties within a single time period. Again to illustrate, suppose that the buyer (e.g., Blue Cross) wants to buy a product from many sellers (e.g., hospitals)—rather than just from just one seller as in the previous example—but the sellers have substantially different costs and therefore may sell profitably at substantially different prices. In the first illustration, the buyer had intertemporal uncertainty about getting the best prices from a given seller over multiple years; here, the buyer has contemporaneous uncertainty about getting the best prices over multiple sellers in a given year. All of the parties, let us suppose, place some value on a contractual relationship, but the buyer has a concern about locking in a disadvantageous price. That concern may lead him to contract with fewer sellers than would be the case without this uncertainty. Here too MFNs can help overcome a barrier to contract. By pledging to grant to the contracting buyer the lowest prices at which they have in fact sold to other buyers, each of the sellers can provide the strongest evidence practicably available that their promise to the buyer of a low price is genuine. With this assurance, the buyer may enter into contracts that, without this credible "best price" guarantee, uncertainty might have prevented.

Thus MFNs are useful in situations where buyers don't know just how low the lowest available price actually is. One general manifestation of such market ignorance is the dispersion of prices within the market; a high degree of ignorance and a high degree of price dispersion go hand-in-hand.[34] To enlighten the price dis-

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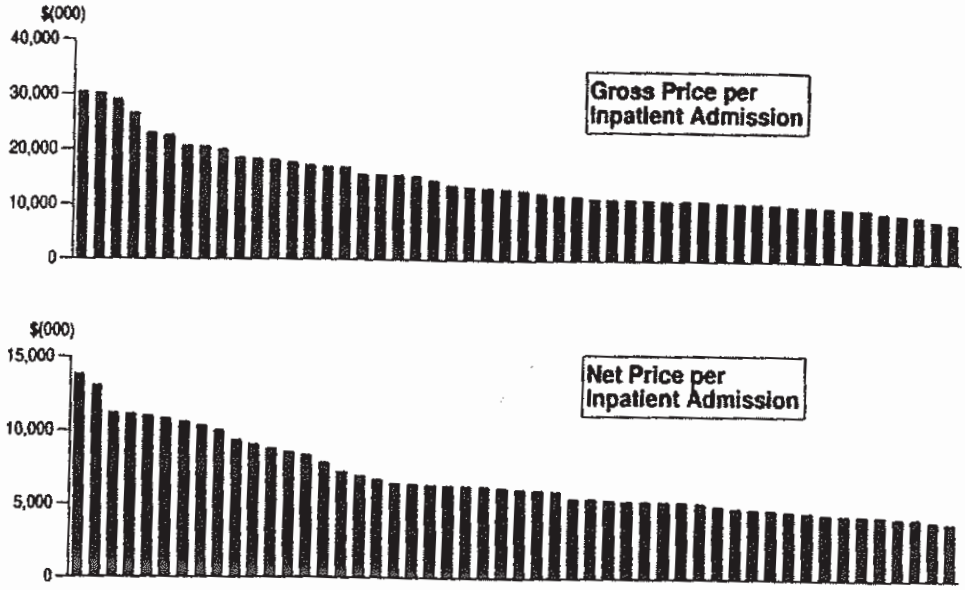
[33] Although it is not worth developing at length here, I note that had market risk been more the concern of the seller than of the buyer, the MFN clause could have been written in reverse, at least for a nonrequirements contract: for example, if the buyer later bought at a higher price from any other seller, then the seller with the MFN contract would receive the benefit of that higher price.

[34] *See* George J. Stigler, *The Economics of Information*, 69 J. Pol. Econ. 213 (1961) and subsequent derivative research. For applications in

persion issue empirically, I examine the distribution of Philadelphia metropolitan area hospitals' average list prices (that is, before any discounts) and average transaction prices (that is, net of all discounts). These are the prices that reflect the market environment within which IBC adopted its MFN provision in 1992.

List prices for Philadelphia metropolitan area hospital services have a huge degree of variation; see figure 10 (upper panel) for the 1992 average gross charge per inpatient admission, which ranges from a high of $30,392 to a low of $7262. Since it is the common wisdom that "nobody" pays list price, we might ask

Figure 10
Average Gross and Net Prices for Philadelphia Area Hospitals—1992



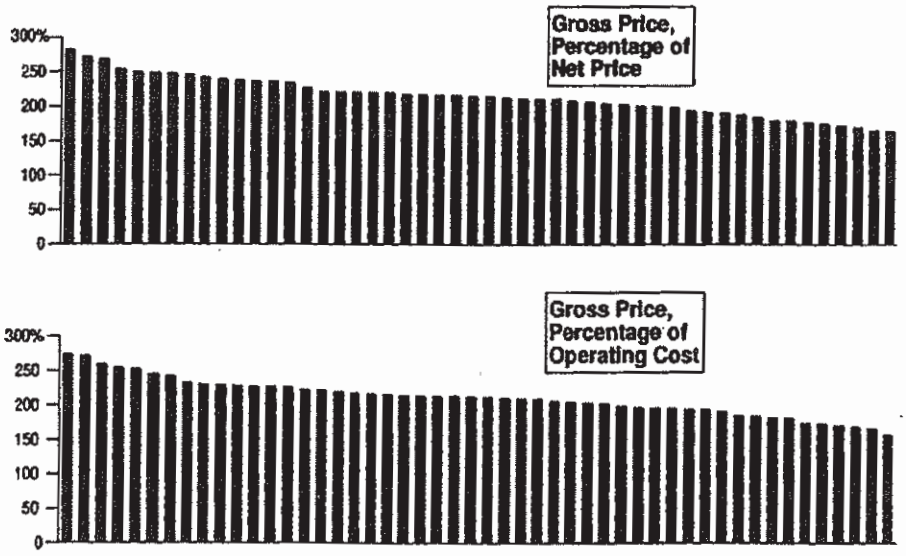
SOURCE: See table 2.

health care markets, *see, e.g.*, Barry S. Eisenberg, *Information Exchange Among Competitors: The Issue of Relative Value Scales for Physicians' Services*, 23 J. L. & ECON. 441 (1980); William J. Lynk, *Physician Price Fixing Under the Sherman Act: An Indirect Test of the* Maricopa *Issues*, 7 J. HEALTH ECON. 95 (1988); and Martin Gaynor & Solomon W. Polachek, *Measuring Information in the Market: An Application to Physician Services*, 60 S. ECON. J. 815 (1994).

whether the "real" price—net price after discounts—has significantly less variability across hospitals than list price does. It doesn't: figure 10 (lower panel) shows us that the average net charge after all discounts has nearly as much dispersion as list price, ranging from a high of $13,818 to a low of $3912.[35] Thus we see tremendous price variability in both list and net prices.

In this environment, it is a problem for a purchaser of hospital services to figure out how low a price it can realistically negotiate with each of the individual hospitals in the area. A single, flat price won't work, because the metro area hospitals vary greatly in their list and net prices. If a "flat price" approach won't work, then maybe a "flat discount" approach would, in which the purchaser demands the same percentage discount from gross charges from all of the metro area hospitals. For this to result in a net

Figure 11
Gross Price Percentage Multiples for Philadelphia Area Hospitals—1992



SOURCE: See table 2.

[35] More formally, the coefficient of variation of the distribution of prices (i.e., the standard deviation expressed as a percentage of the mean) is 39.6% for list price, while for net price it is 37.4%.

price to the purchaser that is, say, the same as the average net price that the hospital receives from all other purchasers, it would have to be the case that all hospitals' nominal (i.e., list) prices are marked up by roughly the same percentage over their real (i.e., net) prices. But figure 11 (upper panel) reveals no market uniformity on that pricing characteristic; list price is marked up to anywhere from 281.5% of net price to 165.7% of net price, which is to say equivalently that net price is discounted from list price by anywhere from 64.5% to 39.6%.[36]

As an alternative and more aggressive strategy, the purchaser might seek a single pricing formula that results in a discount from list price that achieves a net price roughly equal to the hospital's operating costs. For this to work, it would have to be true that all hospitals had roughly the same percentage markup of list price over operating costs.[37] But they don't; as we see in figure 11 (lower panel), list price is marked up to anywhere from 273.1% to 157.4% of operating cost. For a purchaser to attempt to negotiate a discount from list price that gave it a net price equal to each hospital's operating costs, those discounts would range from a high of 63.4% to a low of 36.5%. Based on both types of figure 11's markup percentages, a flat-discount approach would not be materially more effective than a flat-price approach would be.

We see from this high degree of observed pricing heterogeneity in the hospital market that a "one size fits all" approach to price negotiation won't work well. Moreover, these broad all-payor hospital-average price and markup statistics are too crude to be a particularly useful guide to specific private-pay price discounting possibilities, because every one of these figures reflects not only a hospital's HMO and other private-pay discounts but also substantial discounts forced upon it by Medicare and Medicaid, a burden that varies greatly from one hospital to another.

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36 The percentage price ratios shown in the figure are calculated as total gross patient revenues (inpatient plus outpatient) as a percentage of the corresponding net patient revenues.

37 That markup percentage is defined for these purposes as total gross patient revenues as a percentage of total operating costs.

Nevertheless, the variation in even these figures' aggregated statistics is highly suggestive of why an MFN provision would seem to a health care purchaser like a prudent approach to bargaining for the best price that it could realistically obtain. We see an immense spread within the metro area of hospitals' average list prices, net prices, markups of list price to net price, and markups of list price to operating cost. There is every reason to expect a roughly similar spread in the corresponding figures for specific purchasers' private-pay prices, but that measure cannot be teased out of the available data (which are averaged over all of the hospital's payors). Failing that, one available alternative in the effort to pay no more than must be paid is the focused price inquiry that is the defining element of an MFN provision.[38]

A health care purchaser's objectives in this effort are no different than those of any other buyer who wants the best available prices from multiple sellers in a market where actual prices are confidential. By simple analogy, a consumer in the market for a new car faces much the same problem when canvassing multiple dealers offering multiple makes of cars. The buyer knows that ordinarily he should hold out for a purchase price less than list price, but knows also that if he insists on a price that is less than the dealer's actual cost he won't get an offer. Services like dealer cost guidebooks, and tactics like demanding to see the dealer's factory invoice, help somewhat; but because of practices like off-invoice factory rebates these resources are at best only a rough and upward-biased guide to the dealer's wholesale acquisition cost, and are no guide at all to the dealer's own costs of distributing the product. Under these circumstances, the best and most relevant guide that the price-conscious consumer could seek would be information on the lowest actual prices that these heterogeneous dealers have in fact accepted for their products. These are

[38] All of the relevant research of which I am aware (*see, e.g.*, note 34 *supra* and references cited therein) has confirmed that price heterogeneity is strikingly high in markets for health care services generally. It may be a promising speculation that, because of that fact, MFNs are more common in health care markets than in most other markets, and that that commonality is what explains the antitrust enforcement agencies' apparent focus on the health care industry when pursuing MFN investigations.

the lowest prices that are demonstrably not too low for a deal to be struck. This information is, of course, precisely analogous to the pricing information that health care purchasers seek though the mechanism of an MFN.

V. Conclusions

The applicable economic theory on MFNs assists us not by proving generalizations that must always be so, but rather by disproving false generalizations about that which cannot be generalized. Here, as in most of economic analysis, the role of economic theory is not to single-handedly prove a result. It is instead to point us more specifically to the relevant areas of factual or empirical investigation, and to guide our interpretation of the results of such investigations.

If there is one lesson that is warranted from this analysis, it is that across-the-board presumptions opposing MFNs are groundless. I suspect, but cannot prove with the cases that I have examined, that the opposite consumer welfare presumption is equally groundless. A corollary of this lesson is that any generalizations that eventually do emerge about the consumer welfare effects of MFNs will emerge only through a succession of empirical studies of their circumstances and consequences, studies that may employ a common theoretical framework but that apply that framework to divergent sets of facts. It may be that there are such generalizations to be discovered—for example, that purchaser-initiated MFNs are likelier than provider-initiated MFNs to have favorable consumer welfare effects—but hypotheses like these do not become empirical generalizations without empirical research.

APPENDIX

My objective is to explain the variation that we see across hospitals and over time in (1) net hospital price per inpatient admission; (2) the overall hospital discount (average net price reduction, relative to list price); and (3) hospital operating profitability. To do so, I account for the following explanatory variables that potentially may have a causal influence on each of these three variables of interest:

1. the number of patients admitted;
2. the total number of days of inpatient care received by the admitted patients;
3. the casemix severity index, a measure of the severity of medical condition or treatment of the hospital's average Medicare patient;
4. the number of full-time-equivalent employees per patient, as a measure of quality or intensity of care;
5. the fraction of the hospital's beds that are devoted to long-term nursing care, rather than short-term acute care;
6. the fraction of the hospital's patient days that are provided to Medicare patients, and reimbursed at Medicare rates; and
7. the fraction of the hospital's patient days that are provided to Medicaid patients, and reimbursed at Medicaid rates.

As for the variables to be explained, (1) net price (that is, net inpatient revenue per inpatient admission) is deflated to 1995 dollars using the Medical Care Component of the CPI, and then converted to logarithms; (2) average discount is expressed as the difference between dollars of gross patient charges minus dollars of net patient revenues, divided by gross charges and then converted to logarithms; and (3) hospital profitability is measured by net operating revenues divided by operating costs, then converted to logarithms. As for the explanatory variables, the Medicare, Medicaid, and long-term beds percentages are expressed as fractions, and the other explanatory variables are converted to logarithms. In addition, I add binary "hospital fixed effect" variables to the model, one for each hospital, to capture the overall full-period effects of any hospital-specific factors that are not accounted

for by the explicitly included explanatory variables. Finally, I append to the explanatory model 6 year-specific binary indicator variables, one for each of the years 1989–1991 and 1993–1995. The pattern of these "year effects," each relative to a baseline of 1992—the MFN transition year—is the measure of any detectable effect of the MFN in 1993–1995 relative to trends seen in 1989–1991.

Table A.1 reports the regression estimates of the parameters of my explanatory model, with the corresponding *t*-statistics in parentheses.[1] The results for most of the explanatory variables provide no surprises. The composition of hospital output—the number of admissions, given patient days, and the number of patient days, given admissions—has a significant effect on net price and degree of discounting, supporting the decision to include both output measures in the model.[2] Higher casemix severity of hospital output is reflected in a higher price, and less discounting, for that output. Higher labor intensity of patient care (more specifically, for my rough FTE proxy for it) has a positive effect on net price, with no statistically significant effect on discounting or profitability. The effect of the long-term-care bed proportion is economically negligible and statistically insignificant. Finally, as for payor composition, the Medicare patient proportion has, surprisingly, no effect on a hospital's average net price in this model, but a strong positive effect on both the overall degree of discounting and the level of profitability. The Medicaid patient proportion has, as expected, large and significant negative effects on average net price and profitability, and a positive and significant effect on the degree of discounting.

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[1] In samples of this size, *t*-statistics above roughly 2.0 are referred to as statistically significant by conventional standards (that is, a five-percent confidence level, two-tailed test).

[2] I note that the sum of the price coefficients on admissions (–.7762) and days (.7561) is –.0201, implying that an equiproportionate increase in both variables, all else equal, is associated with a very small decrease in net price. The same arithmetic implies that size has essentially no effect on the degree of discounting, and a positive association with profitability.

Table A.1
Regression Estimates of Net Price, Average Discount, and Operating Profitability
1989–1995

Explanatory variable	*Dependent variable* Net price	Average discount	Operating profitability
Log admissions	–.7762	–.4125	.0756
	(–9.62)	(–4.17)	(1.18)
Log days	.7561	.4180	.0245
	(9.52)	(4.29)	(.39)
Log case severity	.5171	–.4655	.1557
	(3.80)	(–2.79)	(1.45)
Log FTE per patient	.1175	.0642	–.0481
	(2.55)	(1.14)	(–1.32)
Nursing bed fraction	–.0088	.1089	–.0184
	(–.12)	(1.23)	(–.32)
Medicare fraction	.0081	.5326	.4455
	(.04)	(2.36)	(3.06)
Medicaid fraction	–.5258	1.0260	–.3330
	(–3.24)	(5.15)	(–2.59)
1989 effect	–.0346	–.1899	–.0332
	(–1.87)	(–8.37)	(–2.27)
1990 effect	–.0384	–.0834	–.0204
	(–2.12)	(–3.76)	(–1.43)
1991 effect	–.0178	–.0307	–.0040
	(–1.06)	(–1.49)	(–.30)
1993 effect	.0036	.0484	–.0070
	(.22)	(2.35)	(–.52)
1994 effect	–.0062	.1120	–.0041
	(–.32)	(4.70)	(–.26)
1995 effect	.0080	.1832	.0143
	(.33)	(6.21)	(.75)
R^2	.954	.743	.441

NOTE: N = 350 (50 hospitals, 7 years). *T*-ratios in parentheses. Coefficients of 50 hospital fixed effect variables not reported. All revenues and costs converted to 1995 dollars.

SOURCE: See table 2.

Examining the estimated coefficients and significance levels of the year variables (which are all that we are ultimately really interested in here), we may say that prices, discounting, and hospital profitability had all risen by 1992, and that these increases were statistically significant relative to at least some of the pre-MFN years. After the introduction of the MFN, the level of discounting in subsequent years is greater than it had been in 1992, and the differences in discounting are all statistically significant. For both net price and hospital profitability, there were no statistically significant differences between the 1992 transition year and any of the subsequent post-MFN years.

Together, all of these variables, including the hospital fixed-effect variables, account for 95.4% of the total variation in hospital net inpatient price, 74.3% of the variation in overall average discount, and 44.1% of the variation in hospital profitability.

I have described the interpretation of the data in terms of comparing post-MFN trends to pre-MFN trends, and to carry that descriptive theme through to the empirical work I also estimate an explicit trend model. In lieu of the discrete pre-MFN and post-MFN year variables, the model now has a log-linear pre-MFN trend line from 1989 to 1992, joined to a post-MFN trend line from 1992 to 1995.[3] The results from this pretrend and posttrend model are reported in table A.2.

These results confirm, with additional precision, the inferences that I drew from table A.1. There is a statistically significant growth trend of about 1.24% per year in real net hospital prices prior to the MFN; afterward there is essentially no trend in prices. There is statistically significant growth in the degree of discounting both before and also after the MFN; the differential between the two estimated rates of growth is not statistically significant.

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[3] Specifically, this is a regression on a 1989–1995 trend variable (trend = –3, –2, –1, 0, 1, 2, 3) plus a post-MFN trend differential variable (differential = 0, 0, 0, 0, 1, 2, 3). The net effect is a trend line with a kink (but not a discontinuous jump) at 1992. The *t*-ratios for the level of the post-MFN trend are calculated for the sum of the coefficients of the trend and the trend differential variables.

Table A.2
Regression Estimates of Net Price, Average Discount, and Operating Profitability

1989–1995

Explanatory variable	*Dependent variable* Net price	Average discount	Operating profitability
Log admissions	–.7724	–.3809	.0965
	(–9.82)	(–3.90)	(1.55)
Log days	.7557	.3754	.0009
	(9.83)	(3.93)	(.01)
Log case severity	.5188	–.4904	.1506
	(3.85)	(–2.94)	(1.41)
Log FTE per patient	.1218	.0422	–.0546
	(2.68)	(.75)	(–1.52)
Nursing bed fraction	–.0099	.1048	–.0222
	(–.14)	(1.17)	(–.39)
Medicare fraction	.0108	.3998	.3917
	(.06)	(1.81)	(2.79)
Medicaid fraction	–.5194	.9484	–.3619
	(–3.24)	(4.77)	(–2.86)
Pre-MFN trend	.0124	.0612	.0102
	(2.16)	(8.61)	(2.26)
Differential in trend	–.0100	–.0072	–.0083
	(–.98)	(–.57)	(–1.03)
Post-MFN trend	.0024	.0540	.0019
	(.32)	(5.83)	(.33)
R^2	.953	.735	.435

NOTE: N = 350 (50 hospitals, 7 years). *T*-ratios in parentheses. Coefficients of 50 hospital fixed effect variables not reported. All revenues and costs converted to 1995 dollars.

SOURCE: See table 2.

And finally, the trends in hospital profitability mirror those for price; positive and significant at about 1.02% per year prior to the MFN, and essentially flat afterward. Both here and in table A.1, there is no empirical support whatsoever for the proposition that

the introduction of IBC's MFN injured competition in the affected market for hospital services. To the contrary, the increasing pace of discounting continued unabated, and the prior uptrends in hospital price and profitability were extinguished.