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Potential Anticompetitive Effects of Most Favored Nation Contract Clauses in Managed Care and Health Insurance Contracts

*Anthony J. Dennis**

INTRODUCTION

Most favored nation (MFN) contract clauses have been widely used in the health care industry by managed care organizations¹ and health insurers² in contracts with medical providers.³ An MFN contract clause consists of a promise by a seller of products or services, in the health care context a medical provider, to a purchaser of those products or services, an insurer,

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1. "Managed care plans offer pre-paid health insurance in which customers pay an up-front fee or premium in return for nearly unlimited access to a network of medical providers at little or no additional cost. Such plans include . . . HMOs, . . . PPOs and several variations on these two basic managed care entities." Anthony J. Dennis, *Hospitals, Physicians, and Health Insurers: Guarding Against Implied Agreements in the Health Care Context*, 71 WASH. U. L.Q. 115, 117 (1993) (footnotes omitted).

2. In contrast to managed care, indemnity insurance does not involve care rendered by a limited network of medical providers for a prepaid fee. Instead, the health insurer generally pays a set percent (typically 80%) of all billed charges while the insured pays the remaining amount. *Id.* at 116. For a general discussion of the different forms of health care financing and delivery and the success of each form in holding down medical costs and influencing physician behavior, see *id.* at 116-19.

3. See generally Arnold Celnicker, *A Competitive Analysis of Most Favored Nations Clauses in Contracts Between Health Care Providers and Insurers*, 69 N.C. L. REV. 863 (1991) (analyzing MFN provisions from the perspective of the Robinson-Patman Price Discrimination Act). Professor Celnicker stated that it is "not uncommon" for Blue Cross and Blue Shield plans to use MFN provisions. *Id.* at 869-70 n.44. Celnicker's belief parallels the author's own. At least two large managed dental plans, Delta Dental Plan of Arizona, Inc. and Oregon Dental Service Corporation, and the nation's largest vision care insurer, Vision Service Plan, have also used MFN clauses in contracts with dentists and optometrists, respectively. See *infra* note 7.

pursuant to which the seller agrees to give the purchaser as favorable a price as that seller is giving to any other purchaser.⁴

MFN contract clauses can be characterized as just another form of volume discount sale. Typically, only health insurers with substantial market strength representing a sizable book of business are able to induce providers to sign contracts containing MFN clauses.⁵ Indeed, one federal district court even went so far as to use the presence or absence of MFN clauses as part of a test for determining whether an insurer had substantial market power.⁶ If a given insurer does not have a substantial customer base representing a large volume of potential patients for medical providers, then providers have little or no reason to give that insurer their lowest available rates for rendering medical care. In the language of the health care industry, the larger the amount of patient "steerage" that insurers can deliver to providers, the more willing providers are to offer some form of volume discount. As a form of favorably low pricing typically granted to large buyers, MFN contract clauses are a form of volume discount.

MFN contract clauses are not "best price" clauses, since offering the best price means offering a price unique and lower than the price offered to any other third-party payer. Under an MFN contract clause, providers only promise to offer the lowest price offered to anyone else so that at least two purchasers will reap the lowest rate.

MFN contract clauses have been repeatedly challenged during the last 15 years under both federal and state antitrust laws.⁷ To

4. See, e.g., *Ocean State Physicians Health Plan v. Blue Cross & Blue Shield of R.I.*, 883 F.2d 1101, 1103-04 (1st Cir. 1989) (pursuant to Blue Cross's MFN clause, it would not pay "a physician more for any service or procedure than that physician was accepting from any other health care cost provider"), *cert. denied*, 494 U.S. 1027 (1990); see also JOHN J. MILES, *HEALTH CARE & ANTITRUST LAW* § 15.04[2] (1992).

5. In each of the proceedings challenging MFN clauses to date, the parties that extracted this kind of price protection provision had overwhelming market power as evidenced by market share. See cases cited *infra* note 7 and see section II below.

6. See *Reazin v. Blue Cross & Blue Shield of Kan., Inc.*, 663 F. Supp. 1360, 1418 (D. Kan. 1987), *aff'd*, 899 F.2d 951 (10th Cir.), *cert. denied*, 497 U.S. 1005 (1990). The district court and the Tenth Circuit Court of Appeals also looked at several other factors to assess the extent of Blue Cross's market power. It should be noted that *Reazin* did not directly confront the question of the legality of MFN clauses under the antitrust laws.

7. See, e.g., *Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of R.I.*, 883 F.2d 1101 (1st Cir. 1989) (challenging MFN clauses as illegal monopolization under section 2 of the Sherman Act), *cert. denied*, 494 U.S. 1027 (1990); *Kitsap Physician Serv. v. Washington Dental Serv.*, 671 F. Supp. 1267 (W.D. Wash. 1987) (challenging MFN clauses as unlawful attempted monopolization under section 2 of

date, these challenges have not succeeded,⁸ and the MFN clauses have been upheld every time. However, despite the well-developed case law on the subject, the legal status of MFN clauses is clearly still evolving.⁹

The Department of Justice under the Clinton Administration has taken a more skeptical view of and aggressive stance toward MFN clauses than have previous administrations. Assistant Attorney General Anne K. Bingaman, head of the Department of Justice's Antitrust Division, has been particularly vocal in this

the Sherman Act); *Blue Cross & Blue Shield of Mich. v. Michigan Ass'n of Psychotherapy Clinics*, 1980-2 Trade Cas. (CCH) ¶ 63,351 (E.D. Mich. 1980); *In Re Ethyl Corp.*, 101 F.T.C. 425 (1983), *rev'd sub nom. E.I. Du Pont De Nemours & Co. v. F.T.C.*, 729 F.2d 128 (2d Cir. 1984) (challenging defendant's use of MFN clauses as an unfair method of competition under section 5 of the Federal Trade Commission Act); *Michigan Ass'n of Psychotherapy Clinics v. Blue Cross & Blue Shield of Mich.*, 325 N.W.2d 471 (Mich. Ct. App. 1982) (challenging MFN clauses as unlawful price fixing under both section 1 of the Sherman Act and Michigan's state antitrust laws); *Willamette Dental Group, P.C. v. Oregon Dental Serv. Corp.*, 882 P.2d 637 (Or. Ct. App. 1994) (challenging MFN clauses as unlawful monopolization and attempted monopolization under Oregon state antitrust laws).

The Department of Justice and the Arizona Attorney General's Office filed a proposed settlement agreement in the federal district court in Phoenix, Arizona, on August 30, 1994, to settle antitrust charges against Delta Dental Plan of Arizona arising out of its use of MFN clauses in contracts with dentists. Under the settlement decree, which must still be formally accepted by the court, Delta Dental will make no admission of liability or wrongdoing but must renounce using MFN clauses in its contracts. See Press Release, Dep't of Justice (Aug. 30, 1994) (on file with author) [hereinafter Aug. 30, 1994 Press Release]; *Arizona Dental Plan Settles Federal, State Conspiracy Charges*, 67 Antitrust & Trade Reg. Rep. (BNA) No. 1679, at 277 (Sept. 1, 1994) [hereinafter Sept. 1, 1994 BNA]. The federal government had alleged that Delta Dental's MFN clauses constituted an unreasonable vertical restraint. *Id.* In contrast, the State of Arizona had been pursuing the theory that the MFN clauses in question constituted illegal price fixing and boycott activity. See *Arizona v. Delta Dental Plan of Ariz., Inc.*, No. CV 94-10142 (Ariz. Super. Ct. Maricopa County, July 1, 1994). The Department of Justice filed suit as well as a proposed settlement agreement on December 15, 1994, in the District Court of the District of Columbia against Vision Service Plan, the nation's largest vision care insurer. The suit alleged that Vision Service Plan's use of MFN clauses in contracts with optometrists violated section 1 of the Sherman Act. See Press Release, Dep't of Justice (Dec. 15, 1994) (on file with author) [hereinafter Dec. 15, 1994 Press Release].

8. The proposed settlement agreement, which would settle antitrust charges against Delta Dental Plan of Arizona by both the Department of Justice and the State of Arizona, does not involve any admission or finding of liability. The same holds true for the proposed settlement agreement involving Vision Service Plan. While these settlement decrees have no precedential value, they do underscore the federal government's enhanced enforcement activity in this area.

9. "The new antitrust [enforcement] environment is inherently more uncertain . . . than that of even 2 years ago." Joseph J. Kattan, *Beyond Facilitating Practices: Price Signalling and Price Protection Clauses in the New Antitrust Enforcement Environment*, 63 ANTITRUST L.J. 133, 150 (1994).

respect, indicating in a recent speech that the Antitrust Division is conducting several ongoing investigations into MFN clauses.¹⁰

Assistant Attorney General Bingaman also spoke out against an MFN clause in a 1993 letter to Cynthia M. Maleski, Commissioner of the Pennsylvania Insurance Department.¹¹ In the autumn of 1993, the Pennsylvania agency had before it a request from a state Blue Cross organization to use an MFN provision in its contracts with hospitals.¹² Assistant Attorney General Bingaman's letter expressed her concern that MFN clauses were being used by dominant insurers like Blue Cross of Western Pennsylvania with the intent or effect of smothering the competition, creating an artificial price floor in the health care and health insurance markets, and preventing or deterring the entry of competitors.¹³

The Antitrust Division has also investigated and brought charges against health care entities that use MFN clauses. On August 30, 1994, the United States Department of Justice simultaneously filed a lawsuit and a proposed settlement decree in the District Court of Arizona. The decree settled antitrust charges against a state dental plan, Delta Dental Plan of Arizona, Inc., which arose from Delta Dental's use of MFN clauses in contracts with dentists.¹⁴ Similarly, on December 15 of that year, the Department of Justice sued Vision Service Plan and simultaneously filed a proposed settlement decree. The case

10. Assistant Attorney General Bingaman made remarks to this effect in a speech she delivered to the Group Health Association of America on February 15, 1994. See 66 *Antitrust & Trade Reg. Rep. (BNA) No. 1651*, at 191 (Feb. 17, 1994).

11. See Letter from Anne K. Bingaman, Assistant Attorney General, Antitrust Division, United States Department of Justice to Cynthia M. Maleski, Commissioner, Pennsylvania Department of Insurance (Sept. 7, 1993) (on file with author).

12. The state insurance department ultimately denied Blue Cross of Western Pennsylvania's request to use an MFN clause in its hospital contracts. See Letter from Cynthia M. Maleski, Commissioner, Pennsylvania Department of Insurance to Mr. Eugene J. Barone, President and CEO, Blue Cross of Western Pennsylvania (Oct. 29, 1993) (on file with author). The insurance department does not have antitrust jurisdiction; it founded its decision on public policy grounds, not explicitly antitrust grounds. The outcome of this agency proceeding does not mean that MFN clauses are illegal under Pennsylvania's antitrust laws. Nonetheless, some of the public policy reasons articulated as the basis of the insurance department's decision appeared to indicate some level of discomfort with the potential anticompetitive effects of MFN clauses.

13. See Letter from Anne K. Bingaman to Cynthia M. Maleski, *supra* note 11.

14. See Aug. 30, 1994 Press Release, *supra* note 7; Sept. 1, 1994 BNA, *supra* note 7.

arose from the vision care insurer's use of MFN clauses in its contracts with optometrists.¹⁵

For the first time, a state agency prohibited the use of MFN clauses in the health care context expressly on antitrust grounds. The Washington Health Services Commission issued a permanent rule-making order on January 26, 1995, to become effective on October 1, 1995, banning the use of MFN clauses "in contracts between a health care provider or facility and a certified health plan."¹⁶ The state health commission adopted this rule in the belief that MFN provisions have "the potential to thwart . . . cost containment goals."¹⁷

These recent developments indicate that the legal status of MFN contract clauses under the antitrust laws is far from settled. It appears the Clinton Justice Department is determined to make new law in this area by challenging MFN clauses wherever and whenever it can find them in the health care marketplace.

This article will consider the anticompetitive effects of MFN contract clauses as well as the arguments in favor of these provisions. Although there are procompetitive justifications for using such clauses, MFN provisions appear to have a tendency to both force competitors from the health care market and set an artificial price floor in the health care marketplace. In light of the evolving case law and increasingly active enforcement environment, this article will also set forth several observations and recommendations for practitioners contemplating the use of contract MFN clauses.

I. COMPETITIVE IMPACT OF MFN CONTRACT CLAUSES

The primary reason that MFN contract clauses have withstood antitrust scrutiny may possibly stem from the fundamental right of buyers to bargain with whomever they choose at whatever price they choose. A buyer's right to bargain has been enshrined in the antitrust laws by the *Colgate* doctrine, derived from a 1919 United States Supreme Court decision of the same name.¹⁸ The doctrine has reverberated in several antitrust cases that arose over the years that challenged contracts between

15. See Dec. 15, 1994 Press Release, *supra* note 7.

16. See Rule-Making Order, Wash. Health Servs. Comm'n (Jan. 26, 1995) (on file with author). See also WASH. ADMIN. CODE §§ 245-02-010, -045 (1995).

17. Rule-Making Order, *supra* note 16.

18. *United States v. Colgate*, 250 U.S. 300, 307 (1919) (stating the buyer has the right under the antitrust laws to "exercise his own independent discretion as to parties with whom he will deal").

health insurers and providers.¹⁹ Most recently, this venerable principle found expression in the First Circuit Court of Appeals' 1989 decision in *Ocean State Physicians Health Plan v. Blue Cross and Blue Shield of Rhode Island*.²⁰ Despite overwhelming evidence of anticompetitive conduct by the defendant Blue Cross and the anticompetitive effect that Blue Cross's MFN clause had on competitors like Ocean State, the court found in favor of Blue Cross when it concluded that the MFN clause at issue did not constitute illegal monopolization in violation of section 2 of the Sherman Act.²¹

The court was able to overcome and essentially brush aside abundant evidence of anticompetitive impact and intent by founding its decision on the right of buyers to bargain for the lowest obtainable price. The First Circuit stated:

We agree with the district court that such a policy of insisting on a supplier's lowest price—assuming that the price is not “predatory” or below the supplier's incremental cost—tends to further competition on the merits and, as a matter of law, is not exclusionary. It is hard to disagree with the district court's view: [“]As a naked proposition, it would seem silly to argue that a policy to pay the same amount for the same service is anticompetitive, even on the part of one who has market power. This, it would seem, is what competition should be all about.[”]²²

Thus, the First Circuit Court of Appeals, like the federal district court before it, actually characterized Ocean State's anti-trust complaint as “silly.”²³

19. See, e.g., *Travelers Ins. Co. v. Blue Cross of W. Penn.*, 481 F.2d 80 (3d Cir.) (holding Blue Cross's contracts with hospitals prohibiting them from shifting certain overhead costs to Blue Cross to the disadvantage of other insurers like Travelers did not violate sections 1 and 2 of the Sherman Act), *cert. denied*, 414 U.S. 1093 (1973). Finding in favor of Blue Cross, the Third Circuit stated:

In its negotiating with hospitals, Blue Cross has done no more than conduct its business as every rational enterprise does, i.e., get the best deal possible. . . . To be sure, Blue Cross[s] initiative makes life harder for commercial competitors such as Travelers. The antitrust laws, however, protect competition, not competitors; and stiff competition is encouraged, not condemned.

Id. at 84; *Kartell v. Blue Shield of Mass.*, 749 F.2d 922 (1st Cir. 1984) (holding Blue Shield contracts requiring physicians to accept Blue Cross reimbursement as payment in full for services rendered and prohibiting those providers from billing patients, i.e., a ban on “balance billing,” do not violate sections 1 and 2 of the Sherman Act), *cert. denied*, 471 U.S. 1029 (1985).

20. 883 F.2d 1101 (1st Cir. 1989), *cert. denied*, 494 U.S. 1027 (1990).

21. *Id.* at 1110-13.

22. *Id.* at 1110 (quoting *Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of R.I.*, 692 F. Supp. 52, 71 (D.R.I. 1988)).

23. *Id.*

The First Circuit, affirming the Rhode Island District Court, like other courts that have heard antitrust cases challenging MFN clauses and other types of contractual provisions, essentially dismissed such challenges because of the well-established right of a buyer to bargain with or “get the best deal possible”²⁴ from sellers. Although the courts have not expressly dwelled on the point, there appears to be an unstated rationale for upholding the buyer’s right to bargain: if health insurers are able to obtain favorable prices from providers, then these lower prices will be passed on to consumers in the form of lower health insurance premiums.

MFN clauses represent more than just the fruit of hard bargaining between buyers and sellers. In extracting an MFN guarantee from a seller, a dominant buyer has done more than bargain for the lowest obtainable price: it has in fact linked its price with the most favorable price any other buyer receives over the life of the contract. Thus, the idea that an MFN contract clause falls neatly under the rubric of the *Colgate* doctrine—an agreement between a buyer and seller who engaged in hard bargaining—is not entirely accurate. MFN contract clauses take as their frame of reference the price deals obtained by third parties. By implicating the commercial relationships of other buyers, MFN clauses can indirectly affect the price structure of the entire marketplace as well as everyone in it.

A. Forcing Competitors From the Market

The First Circuit Court of Appeals in *Ocean State* was not able to step back from the *Colgate* doctrine; it turned a blind eye to the anticompetitive effect of Blue Cross’s MFN clause on the competition.²⁵ A look at the actual market effects of MFN contract clauses clearly reveals the power of these provisions to affect the behavior of providers and the economic fortunes of competitors. Health insurers that have persuaded providers to accept an MFN clause in their contracts typically possess significant market power, with market shares ranging in some cases

24. See *Travelers*, 481 F.2d at 84; see also *Kartell*, 749 F.2d 922.

25. 883 F.2d 1101.

from 75% to 85%.²⁶ These health plans may sometimes concede that they possess monopoly power.²⁷

Some smaller insurers who compete with these dominant insurers have been forced out of business because the provider, when faced with a choice to do business solely with the dominant insurer or to do business with both the dominant insurer and other, smaller companies that can deliver less patient volume but can absorb the provider's excess capacity (thereby activating the MFN provision), choose to terminate or avoid relations with the other insurers to avoid activating the MFN provision. The large book of business that providers enjoy courtesy of the dominant insurer is economically more valuable than realizing an increase in patient volume originating from a competing plan. The latter has the effect of activating the MFN clause, which forces the providers to lower their prices across the board. As a result, competitors of the dominant health plan may eventually be forced out of the market because they are unable to develop and retain a viable provider network to service their customers. The facts of actual cases demonstrate this phenomenon in action.

The *Ocean State* case involved a small, provider-owned HMO, Ocean State, that entered the health care financing market in Rhode Island in competition with the state's largest insurer, Blue Cross and Blue Shield of Rhode Island. Ocean State's entrance into the market appeared to benefit Rhode Island consumers as it "provided more coverage and charged lower premiums" than Blue Cross.²⁸ As a result, the Ocean State HMO initially enjoyed great commercial success. The federal appellate court noted that "[b]y the spring of 1986, Blue Cross had lost approximately 30,000 of its 453,015 enrollees, while Ocean State's enrollment had exceeded all expectations, growing to 70,000."²⁹ Blue Cross implemented a three-part strategy, which included the insertion of MFN clauses in each of its pro-

26. Blue Cross of Western Pennsylvania had a market share of approximately 75% as of the fall of 1993. See Letter from Anne K. Bingaman to Cynthia M. Maleski, *supra* note 11. As of August 30, 1994, Delta Dental Plan of Arizona had contracts with 85% of all dentists in Arizona and was acknowledged as the largest dental insurer in the state. See Aug. 30, 1994 Press Release, *supra* note 7. Precise figures on Delta Dental's actual market share were not available.

27. For example, Blue Cross and Blue Shield of Rhode Island conceded the point, so the parties never argued it in *Ocean State*. 883 F.2d at 1110.

28. *Id.* at 1103.

29. *Id.*

vider contracts.³⁰ The impact of Blue Cross's MFN clause was immediate. To avoid having to lower their fees to Blue Cross in accordance with the MFN clause, "approximately 350 of Ocean State's 1200 physicians resigned."³¹ Ocean State no longer had a viable provider network with which to attract and retain clients.³²

Similarly, in the Arizona dental insurance market, the United States Department of Justice found that the dominant dental insurer's use of an MFN clause in its contracts with area dentists essentially forced those dentists to avoid dealing with competing dental plans.³³ With the MFN clause in place, dentists in that state found that it no longer made any economic sense to deal with any insurers other than Delta Dental. According to the federal complaint filed by the United States Department of Justice in the District Court of Arizona, literally "hundreds" of state dentists terminated their relationships with Delta Dental's competitors after the imposition of the MFN clause, rather than risk activating their MFN obligation under their contracts with Delta Dental.³⁴

This mass exodus by hundreds of providers demonstrates the awesome power that MFN clauses can have in affecting provider behavior and undermining competitors in the health insurance market. When the dust settled in both Rhode Island and Arizona after the dominant insurer in each state instituted an MFN contract obligation, competing health and dental plans were left bleeding and wounded on the floor. It is clear that MFN contract clauses, coupled with significant market power, can serve as a powerfully effective tool to undermine or even destroy existing competitors as well as prevent new market entrants from gaining a foothold in the health insurance market.

30. *Id.* at 1103-04. The other parts of the strategy involved the introduction of its own HMO known as HealthMate and the use of an "adverse selection" pricing policy, which lowered prices for those commercial customers that solely offered Blue Cross products to their employees rather than competitors' health insurance products.

31. *Id.* at 1104.

32. Ocean State sued, alleging unlawful monopolization under section 2 of the Sherman Act. Despite substantial evidence that Blue Cross's conduct was "willful" and "exclusionary" within the meaning of *United States v. Grinnell*, 384 U.S. 563, 570-71 (1966) and *Aspen Skiing Co. v. Aspen Highlands Skiing Corp.*, 472 U.S. 585, 605 n.32 (1985), the First Circuit found in favor of the defendant Blue Cross. 883 F.2d at 1110-13.

33. See Aug. 30, 1994 Press Release, *supra* note 7; Sept. 1, 1994 BNA, *supra* note 7.

34. See Aug. 30, 1994 Press Release, *supra* note 7; Sept. 1, 1994 BNA, *supra* note 7.

B. *Setting a Price Floor*

MFN contract clauses also have the potential to set a price floor in the health care market. When providers do not want to contract with additional health plans for a lower price for fear of activating an MFN clause, then the MFN contract rate in effect becomes the standard price for the entire market. MFN contract clauses can operate to set a price floor in the health care market in two respects.

First, since they are found in service contracts between various types of medical providers and health insurers, MFN contract rates can set the minimum price for all medical services covered by the contract. Thus, the cost of such services incurred by a dominant insurer with an MFN clause can become the price for all other competitors in the market that deal with those same providers. No one is able to obtain a better price for medical services than the dominant insurer—the MFN clause thus establishes a price floor in the health care delivery market.

Second, MFN contract clauses can establish a price floor with respect to the overall cost of all health insurance products offered in that market. A health plan's overall expenses determine in large part the price it will charge for all of its health insurance products. The cost of delivering medical care constitutes most of a health plan's costs in offering health insurance products. If an MFN clause sets a price floor for a particular type of medical service, then it also indirectly operates to establish a price floor with respect to the ultimate price of all products. For example, the largest single expense item for any health plan is typically hospital costs. Thus, the kind of pricing that a health insurer is able to obtain from hospitals in large part drives the price of the overall health insurance product. If hospital pricing in the market has become rigid due to the existence of an MFN clause, then the price structure in the health insurance market will also become similarly fixed at an artificial price floor. Thus, competing insurers will be unable to offer, and thus consumers will be unable to buy, insurance below a set price because of the artificial price floor in the health insurance marketplace.

The District Court of Kansas recognized this pernicious effect of MFN contract clauses in the *Reazin* case. The Tenth Circuit stated:

[S]ince the price of hospital care is the single largest element of health care financing companies' costs, the "most favored

nations" clause effectively prevents competing insurance companies from offering more favorable insurance rates to consumers. This clause gives defendant the ability to prevent insurance prices from falling, thus providing it the ability to effectively control insurance prices.³⁵

The current Department of Justice apparently perceives similar anticompetitive effects. In Assistant Attorney General Bingaman's September 7, 1993, letter to Pennsylvania Insurance Commissioner Cynthia Maleski, she expressed concern about the anticompetitive effects of Blue Cross of Western Pennsylvania's MFN clause in its hospital contracts:

Based on our review, we conclude that implementation of the [MFN clause] likely would result in higher hospital prices to [Blue Cross of Western Pennsylvania's] competitors. The cost to hospitals of making price concessions to competitors would increase because the same price concessions would have to be granted to [Blue Cross of Western Pennsylvania]. It is unlikely that any savings to [Blue Cross of Western Pennsylvania] from the [MFN provision] would benefit western Pennsylvania health plan purchasers. The increase in competitors' costs likely would cause their health plan prices to rise, which would enable [Blue Cross of Western Pennsylvania] to increase its health plan prices. Finally, there are other means available to accomplish such cost savings, used by Blue Cross plans elsewhere in the country, that would not impede competition.³⁶

Thus, both the Department of Justice and the District Court of Kansas perceive MFN contract clauses as creating an artificial price floor in the health care marketplace. The facts in the above-described cases and agency proceedings themselves speak eloquently of this pernicious effect.

C. Procompetitive Justifications

Defendants that have had their MFN clauses challenged in court have used a variety of arguments to defend the clauses, depending on the nature of the antitrust violation alleged. The primary rationale for using such provisions is that MFN clauses enable health insurers to lower the price of their own products. By reducing the purchase cost of medical care on behalf of its members, health insurers are able to reduce their own operating expenses. Presumably, this expense reduction is reflected in

35. *Reazin v. Blue Cross & Blue Shield of Kan.*, 663 F. Supp. 1360, 1418 (D. Kan. 1987), *aff'd*, 899 F.2d 951 (10th Cir.), *cert. denied*, 497 U.S. 1005 (1990).

36. See Letter from Anne K. Bingaman to Cynthia M. Maleski, *supra* note 11.

lower product prices. However, as the Department of Justice recently noted, this is not always the case. In her letter to the Pennsylvania Insurance Commissioner, Assistant Attorney General Bingaman stated in part that it would be unlikely that health plan purchasers in Western Pennsylvania would benefit from any savings to Blue Cross of Western Pennsylvania that resulted from its MFN clause. Rather, MFN clauses can help dominant insurers establish a price floor.³⁷ As the Department of Justice recognized, there is no guarantee that an insurer using an MFN clause will pass on to consumers the cost savings it reaps.³⁸

II. OBSERVATIONS AND RECOMMENDATIONS

No court to date has concluded that MFN contract clauses are illegal. The Pennsylvania Insurance Department proceeding disallowed use of an MFN contract clause for public policy reasons, not specifically for antitrust reasons. Furthermore, the Department of Justice's proposed consent settlements involving Delta Dental Plan of Arizona, Inc. and Vision Service Plan do not include any admission or finding of liability or wrongdoing. The federal district courts in those cases were not given an opportunity to judge the MFN contract clause at issue under the antitrust laws.³⁹ Thus, the Delta Dental and Vision Service Plan settlement decrees do not stand for the proposition that MFN clauses are illegal under the federal antitrust laws. Instead, those investigations and subsequent proposed settlements merely indicate that the federal government is aggressively pursuing such cases.

Given the increased scrutiny of these provisions over the last two years, federal antitrust enforcement authorities, and at least some states, will most likely continue to closely scrutinize, and challenge where appropriate, health insurers' use of MFN contract clauses. Given the foregoing observations about the quickening pace of recent enforcement activity in this area, health

37. *Id.*

38. In the absence of internal cost data from various health insurers, this is a hard point for anyone, including the Department of Justice, to prove or disprove. The result depends on whether the individual insurer passes on its cost savings in the form of lower prices, which would make the health plan more price competitive in the market, or retains the savings, adds the savings to reserves, or passes the savings on to stockholders in the form of higher stock dividends.

39. Aug. 30, 1994 Press Release, *supra* note 7; Sept. 1, 1994 BNA, *supra* note 7; Dec. 15, 1994 Press Release, *supra* note 7.

care providers must be aware of whether and under what circumstances MFN contract clauses can safely be used in their contracts.

A. Market Strength

A client's risk of investigation and possible suit for using MFN clauses is a function of that client's market strength. All of the cases, agency proceedings, and investigations mentioned or discussed in this article make it clear that health insurers with substantial market strength are particularly vulnerable to investigation and suit.⁴⁰ As previously stated, only health insurers with a commanding position in the market typically utilize MFN clauses. However, it is conceivable that insurers with sizable but not dominant or commanding market shares might be capable of negotiating MFN arrangements with local providers. Thus, the risks of investigation and suit must be weighed against the potential benefits of using such provisions in contracts with providers.

B. Volume Discounts and "Notice"-Type MFN Clauses

Another way to reduce the legal risks associated with MFN contract clauses is to use a variation of the MFN concept that serves the client's business interest in obtaining a favorable price but does not raise as much antitrust concern. One obvious alternative is a simple volume discount deal based on the number of patients that the health insurer can send to the provider. The larger the volume, the lower the price per head or capitation rate.⁴¹

Another option is to institute a "notice"-type MFN clause much like the one at issue in *National Benefit Administrators v. Blue Cross*.⁴² In that case, a third-party administrator of em-

40. See also Anthony J. Dennis, *Proposed Arizona Settlement Sheds More Light on Most Favored Nation Clauses*, 1 HEALTH CARE ANTITRUST MANUAL, Nov. 1994, at 5, 6; Kattan, *supra* note 9, at 150-51:

Large buyers who negotiate price protection clauses must now be concerned with the prospect of a government investigation, notwithstanding the First Circuit's clear endorsement of contracting "to get the lowest possible price." . . . Buyers with dominant market shares now face a threat of antitrust enforcement when they engage in the sensible practice of securing the best prices for their inputs.

41. See generally NAT'L HEALTH LAWYERS ASS'N, THE INSIDER'S GUIDE TO MANAGED CARE (Susan K. Chambers ed., 1990).

42. 1989-2 Trade Cas. (CCH) ¶ 68,831, at 62,370 (M.D. Ala. 1989), *aff'd*, 907 F.2d 1143 (11th Cir. 1990).

ployee benefit programs, National Benefit Administrators and Goff Agency, sued Blue Cross and Blue Shield of Alabama, Inc. under sections 1 and 2 of the Sherman Act for, among other practices, Blue Cross's use of a "notice"-type MFN clause in its contracts with hospitals.⁴³ The clause was not a standard MFN clause, but merely required a given hospital to give Blue Cross "notice" and an opportunity to renegotiate if the hospital gave equal or better rates to a third party.⁴⁴ The clause stated:

If at any time Hospital contracts or agrees with any other third party health benefit plan payor . . . to provide health care services . . . at payment amounts which are equal to or less than those applicable to [Blue Cross] Members under this Contract, Hospital shall immediately give written notice of the fact of such contract . . . to [Blue Cross]. Such notice shall be *for the sole purposes of affording [Blue Cross] opportunity to evaluate the advantages and consideration expected to inure to Hospital from such other payor and to renegotiate the terms of this Contract*. No provision of this Contract shall be construed or applied as limiting in any way either Hospital's or [Blue Cross's] right to engage freely in agreements with other competing [payors or providers].⁴⁵

The federal district court concluded that this provision differed from the MFN clause at issue in *Ocean State*⁴⁶ and did not raise similar antitrust concerns. The court rejected the plaintiff's antitrust allegations and found in favor of the defendant.⁴⁷

As indicated by the decision in *National Benefit Administrators*, a "notice"-type MFN contract clause apparently passes muster under the federal antitrust laws. Although one can never rule out an investigation or frivolous lawsuit, it appears that such provisions can be safely utilized under the antitrust laws.

CONCLUSION

MFN clauses can result in lower or higher health care costs, depending on the conditions in any particular market. Pursuant

43. *Id.* at 62,371, 62,374-75.

44. *Id.* at 62,375.

45. *Id.* (emphasis in original).

46. Compare *supra* notes 20-32, and accompanying text.

47. The federal district court noted that if the MFN clause at issue in *Ocean State* was held not to violate the federal antitrust laws, certainly the watered-down version at issue in *National Benefit*, "which entitles [Blue Cross] only to notice and an opportunity to renegotiate," did not violate these laws. 1989-2 Trade Cas. (CCH) ¶ 68,831, at 62,375.

to an MFN clause, providers may end up lowering the prices they charge to any insurer who negotiates an MFN clause to equal the lowest price providers charge other insurers, or providers may raise the prices charged insurers to meet the cost charged to the insurer with the clause. The only certainty is that the charges will be the same, not necessarily lower.

However, doubt has been expressed about the benefits consumers will ever see. More troubling, competing insurers may be squeezed out of the marketplace in the short term, leading to less competition and higher costs in the long run.

It remains to be seen whether these clauses will continue to pass antitrust scrutiny given the anticompetitive effects indicated by the current administration.