Higher Ed. & Emp.	[681-682]	2
House	3846-3861	16
Insurance	2666-2669, 2681-2708, 2719-2781	95
Senate	6557, 6573-6578	7
		120

JOINT
STANDING
COMMITTEE
HEARINGS

HIGHER EDUCATION
AND
EMPLOYMENT ADVANCEMENT
PART 3
629 - 923

2011

I, myself, am former chair of the board of trustees of the law school and admission's council. It is an international legal organization. We do the dreaded LSAT. But among things, also offer a significant amount of counseling about things like: debt service and how to finance law schools.

I speak internationally about it at symposia. So I'm, you know, I'm the one in the bookstore shaking the credit card application out of the bottom of the bag. I think that's something that might be banned. I -- I want our students to tear up credit cards and get their credit scores up and all of that. So we do everything we can.

I would rather lose a student. Certainly, rather lose a student who couldn't afford to come and was going to make a mess of their lives, financially. They won't - they won't be accepted by the bar if they do that. So we're pretty cautious about it.

SENATOR BYE: Thank you. It is very heartening to hear your testimony. We're glad you're there, as a line of defense. I appreciate it.

ELLEN RUTT: Thank you.

REP. BOUCHER: Thank you, Ellen. It is interesting to hear all that you're doing. I mean you're doing a lot of, probably, what would be best practices anywhere, to protect the students from this. So I appreciate your testimony. Representative Dillon, do you have some questions?

REP. DILLON: Yes. Thank you very much, although I'm looking for your testimony, which I assume, is on-line. Is it? It's here. Okay.

[HB6477]
[HB5083]

As I mentioned to you when we spoke privately -- actually, I asked what the genesis of the bill was. That I asked the Commissioner of Higher Education, well over a year ago, almost two now, because I was concerned about the drop of -- in job availability, what kinds of supports there was?

There are a number of parents in my district, who had approached me to talk about the law school and their students, who were -- their kids who were saddled with debt. And my own son had graduated, although he had a job. So the -- there's -- there's also, sort of a companion bill in judiciary because a lot of -- one of the jobs that frequently a new graduate would do, would be document review, which is increasingly being outsourced to India and not performed by lawyers. So that that's a big change, and you and I discussed that.

[HB6477]
[HB5083]

I was really excited to hear the things that you're doing. And I -- I really did not know. And I must say that even though I assume the public expects us to file bills, I very often do not file bills, unless I feel that we have exhausted the ability to work things out otherwise, just because we have a lot to do here. But so I guess there was a communication problem. I think that's terrific.

But I'd like to talk a little bit later, not necessarily here, about things that we can do for some of our recent grads, because I don't know whether the change in this employment process is a temporary blitz, because of what happened in this -- in 2008, really, or whether there's a major restructuring going on, in terms of the way -- what job availability there will be for those who graduate. And I wonder if you thought about

H – 1103

CONNECTICUT
GENERAL ASSEMBLY
HOUSE

PROCEEDINGS
2011

VOL.54
PART 12
3772 – 4108

to the call of the calendar.

Will the Clerk please call Calendar 104.

THE CLERK:

On page 34, Calendar 104, Substitute for House Bill Number 6471, AN ACT PROHIBITING MOST FAVORED NATION CLAUSES IN HEALTH CARE PROVIDER CONTRACTS, favorable report of the Committee on Appropriations.

DEPUTY SPEAKER ARESIMOWICZ:

Representative Johnson of the 49th, you have the floor, madam.

REP. JOHNSON (49th):

Thank you, Mr. Speaker.

I move acceptance of the joint committee's favorable report and passage of the bill.

DEPUTY SPEAKER ARESIMOWICZ:

The question before the Chamber is on acceptance of the joint committee's favorable report and passage of the bill.

Will you remark, madam?

REP. JOHNSON (49th):

Thank you, Mr. Speaker.

This bill prohibits health plans from including most-favored-nations clause in a contract with health care providers. These clauses are typically used by

the largest health plans and they make sure they always get the best deals for their network providers.

Most-favored-nation clauses have a chilling effect on competition and that the provider cannot get a better deal to start up a small plan or help them get a leg up on a dominant plan. Most-favored-nation clauses are really designed to assure that the king of the hill stays the king of the hill. They can be expensive for a provider to prove compliance with most-favored-nation clauses' requirements and to satisfy their contractual obligations.

Mr. Speaker, the Clerk has an amendment, LCO Number 6154. I ask that the amendment be called and I be allowed to summarize.

LCO Number 6154. I ask that you call that amendment, please, and that I be allowed to summarize it, Mr. Speaker.

DEPUTY SPEAKER ARESIMOWICZ:

Will the Clerk please call LCO 6154, which will be designated House Amendment Schedule "A."

THE CLERK:

LCO Number 6154, House "A," offered by Representative Megna and Senator Crisco.

(Deputy Speaker Orange in the Chair.)

DEPUTY SPEAKER ORANGE:

Representative Johnson, please proceed.

REP. JOHNSON (49th):

Thank you, Madam Speaker.

The amendment simply changes the effective date to assure that existing contracts do not have to be opened up and that the most-favored-nation clauses take effect January 1, 2014 -- or any of the other contracts that expire between the time this bill passes and 2014 will actually not be able to include the most-favored-nation clauses.

(Deputy Speaker Aresimowicz in the Chair.)

DEPUTY SPEAKER ARESIMOWICZ:

Can you move adoption, madam?

REP. JOHNSON (49th):

Yes. Thank you, Mr. Speaker.

I move adoption of the amendment.

DEPUTY SPEAKER ARESIMOWICZ:

The question before the Chamber is adoption of House Amendment Schedule "A." Will you remark on the

amendment? Will you remark on the amendment?

Representative Coutu, you have the floor, sir.

REP. COUTU (47th):

Thank you. Thank you, Mr. Speaker.

Mr. Speaker, I just had a question through you. The date that we have effective prior to October 1, 2011, it will not affect those contracts. I just want to verify that we talked to all interested parties to determine that date.

Through you, Mr. Speaker.

DEPUTY SPEAKER ARESIMOWICZ:

Representative Johnson.

REP. JOHNSON (49th):

Thank you, Mr. Speaker.

And thank you for your question.

Yes. We have made agreements with all the interested parties and that none of the agreements will have to be touched until they expire and new ones are made.

DEPUTY SPEAKER ARESIMOWICZ:

Representative Coutu.

REP. COUTU (47th):

Thank you, Mr. Speaker.

DEPUTY SPEAKER ARESIMOWICZ:

Will you remark further on the amendment? Will you remark further on the amendment?

Representative Wright of the 77th, did you want to remark on the bill or the amendment, sir?

REP. C. WRIGHT (77th):

Thank you, Mr. Speaker.

On the bill, sir.

DEPUTY SPEAKER ARESIMOWICZ:

Thank you very much, sir.

Will you remark further on the amendment before us? If not, let me try your minds. All those in favor of the amendment, please signify by saying, aye.

REPRESENTATIVES:

Aye.

DEPUTY SPEAKER ARESIMOWICZ:

Those opposed, nay.

The ayes have it. The amendment is adopted.

Will you remark further on the bill as amended?

Representative Wright of the 77th, you now have the floor, sir.

REP. C. WRIGHT (77th):

Thank you, Mr. Speaker.

I rise in favor of the bill. This is a bill that would simply prohibit insurance companies from

requiring health care providers, doctors, hospitals from providing them with the lowest possible rate on any procedure.

I know that in my case, in my town, in Bristol Hospital there was a case where the hospital was negotiating a -- with one of the insurance companies who was insisting that they do this. And Bristol Hospital literally spent several months and at least a couple hundred thousand dollars auditing every single patient that they had had in the preceding year, proving that this insurance company was receiving the lowest rate on every single patient on every single case.

This is something that was a great hardship to Bristol Hospital and I just rise in support of this bill so that other hospitals don't have to go through this same procedure.

Thank you, Mr. Speaker.

DEPUTY SPEAKER ARESIMOWICZ:

Thank you very much, sir.

Will you remark further on the bill as amended?

Representative Coutu of the 47th, you have the floor, sir.

REP. COUTU (47th):

Thank you, Mr. Speaker.

Mr. Speaker, through you, a couple questions to the proponent of the bill.

DEPUTY SPEAKER ARESIMOWICZ:

Representative Johnson, please prepare yourself.

Representative Coutu, please proceed, sir.

REP. COUTU (47th):

I just want to verify if there are any other states in America that have this type of most-favored-nation provision.

Thank you, Mr. Speaker.

DEPUTY SPEAKER ARESIMOWICZ:

Representative Johnson.

REP. JOHNSON (49th):

Thank you, Mr. Speaker.

And thank you for your question.

Yes. All the surrounding states have the prohibition against the most-favored-nation and 13 other states in addition to that.

DEPUTY SPEAKER ARESIMOWICZ:

Representative Coutu.

REP. COUTU (47th):

I just couldn't hear, Mr. Speaker. Can you say that one more time, please?

DEPUTY SPEAKER ARESIMOWICZ:

I'd like to remind the Chamber that while we're asking the questions if we could please watch the noise. The Representative who was asking the question could not hear the response.

Representative Johnson, would you please repeat your reply?

REP. JOHNSON (49th):

Yes. Mr. Speaker. Thank you.

And yes. The surrounding states all have prohibitions against most-favored-nation clauses and 13 additional states in addition to the surrounding states.

DEPUTY SPEAKER ARESIMOWICZ:

Representative Coutu.

REP. COUTU (47th):

Thank you, Mr. Speaker.

And thank you for that answer.

I guess one other question is relating to in the situations where two separate parties are forming a contract, is this a situation where they can negotiate most-favored-nation within these contracts?

DEPUTY SPEAKER ARESIMOWICZ:

Representative Johnson.

REP. JOHNSON (49th):

Thank you, Mr. Speaker.

Through you, the most favored nation, this would be a situation where the most-favored-nation clauses would be removed from the contract so there would be no ability, if this bill passes, to have those kinds of clauses in the contract.

DEPUTY SPEAKER ARESIMOWICZ:

Representative Coutu.

REP. COUTU (47th):

Through you, Mr. Speaker.

I'm more trying to figure out currently without this piece of legislation, under current law the most favored nation, is it negotiated between two separate parties at this time?

DEPUTY SPEAKER ARESIMOWICZ:

Representative Johnson.

REP. JOHNSON (49th):

Could you ask the questioner to try and make it a little more clear for me so I can understand?

DEPUTY SPEAKER ARESIMOWICZ:

Representative Coutu, could you please reframe your question?

REP. COUTU (47th):

Mr. Speaker, what I'm trying to determine is, is most favored nation in every contract across the state of Connecticut? Or is this something that two separate parties can determine through the negotiation process?

DEPUTY SPEAKER ARESIMOWICZ:

Representative Johnson.

REP. JOHNSON (49th):

Yes. Thank you, Mr. Speaker. And thank you for your question.

I think, if I understand what you're saying is, can two parties alone make this, make this deal? The problem with the most-favored-nation agreements is that it tends to interfere with the contractual rights of the providers to make agreements with other providers because they crowd the field, so to speak.

So that's the problem. So that's why we need this, because it's actually anticompetitive.

And I thank you for your question.

DEPUTY SPEAKER ARESIMOWICZ:

Representative Coutu.

REP. COUTU (47th):

Mr. Speaker, there's many people on both sides of the aisle that would agree. Is most-favored-nation

fair? There's a lot of debate over that. And obviously across America there's also quite a bit of debate, because the minority of states only have a similar piece of legislation that supports no more most-favored-nation.

What I'm trying to determine is when a hospital and the potential insurance provider start negotiations, is it for the most part a guarantee that they will end up with the most-favored-nation clause in that contract?

Through you, Mr. Speaker.

DEPUTY SPEAKER ARESIMOWICZ:

Representative Johnson.

REP. JOHNSON (49th):

No.

DEPUTY SPEAKER ARESIMOWICZ:

Representative Coutu.

REP. COUTU (47th):

And I think that's where I have some concern, Mr. Speaker. When two people go into contract negotiations for anything, the question is always, how much should government get involved?

I'm not sure if this is negotiated and then results in a lower cost for the majority of hospitals.

We know of one situation where this individual hospital hired attorneys. The costs became excessive and it was brought to some of the Legislators in the Chamber that most-favored-nation hurt their hospital. But the question is always, how much government is too much government? And how much government should we have relating to contract law? In this case just a few state, 20 states give or take out of 50, have a situation where they don't have most favored nation anymore.

So through you, Mr. Speaker, relating to most favored nation, do we know if the reason people negotiate and accept that, is it because it decreased costs? Or is there any positives for most-favored-nation? Because it's been there for a while and its supported by some people.

Through you, Mr. Speaker.

DEPUTY SPEAKER ARESIMOWICZ:

Representative Johnson.

REP. JOHNSON (49th):

Thank you, Mr. Speaker.

Through you, Mr. Speaker, I think what -- there's only one insurance company that provided testimony during the whole hearing procedure that spoke in favor

of the most-favored-nation clauses. All the rest of the health insurance companies spoke against it because the one that spoke in favor of it actually was the largest provider in the state.

And so it was the reason the other insurance companies spoke against the most-favored-nation clauses is because it's anticompetitive and it's been closing the field out for these other health insurance companies.

But thank you for your question.

DEPUTY SPEAKER ARESIMOWICZ:

Representative Coutu.

REP. COUTU (47th):

Thank you, Mr. Speaker.

Mr. Speaker, I'll summarize. I know there's bipartisan support and we did have a lot of testimony in favor, supporting getting rid of most favored nation. I do believe -- for the most part I agree with many of those people who testified and said most favored nation is a challenge for hospitals like Bristol Hospital.

I do have a concern once again relating to the potential impact and the precedence that we are going to start and influencing contract negotiations between

two hospitals. As far as I know, even if this -- between two hospitals and an insurance provider -- as far as I know, there are many insurance companies across the State of Connecticut. We are the insurance capital of the world. And companies and hospitals have the option to get insurance plans and coverage through many different insurance companies. So while one company may have this, I believe often they have the option to purchase insurance from another company.

So with that, I have mixed feelings about this piece of legislation, but I will support this legislation, Mr. Speaker.

Thank you.

DEPUTY SPEAKER ARESIMOWICZ:

Thank you very much, Representative.

Representative Perillo of the 113th you have the floor, sir.

REP. PERILLO (113th):

Mr. Speaker, thank you very much.

I just rise very, very briefly in support of the bill before us. Essentially what MFN clauses have done here in the state of Connecticut, they have become very, very anticompetitive.

And I'll make a simple analogy. Imagine if the

one station, the largest gas station in your town required that regardless of what the price of their gasoline was, they made you pay the highest price in the State of Connecticut.

That is essentially what MFN does. It's anticompetitive and it leaves hospitals in a situation whereby they have no choice but to accept the lowest reimbursement in order to gain share of patients in their region. And for that reason I rise in support of the bill before us and I would urge my colleagues to support it as well.

Thank you, sir.

DEPUTY SPEAKER ARESIMOWICZ:

Thank you very much, sir.

Will you remark further on the bill as amended? Will you remark further on the bill as amended? If not, will staff and guests please come to the well of the House. The members, please take your seats. The machine will be open.

THE CLERK:

The House of Representatives is voting by roll call. Members to the Chamber. Members to the Chamber. The House is voting by roll.

DEPUTY SPEAKER ARESIMOWICZ:

Have all the members voted? Have all the members voted? Will the members please check the board to determine if their vote has been properly cast. If all the members have voted the machine will be locked and the Clerk will take a tally. Will the Clerk please announce the tally.

THE CLERK:

House Bill 6471 as amended by House "A."

Total Number voting	140
Necessary for adoption	71
Those voting Yea	140
Those voting Nay	0
Those absent and not voting	11

DEPUTY SPEAKER ARESIMOWICZ:

The bill as amended is passed.

Are there any announcements or introductions? Are there any announcements or introductions?

Representative Nicastro of the 79th, for what purpose do you rise, sir?

REP. NICASTRO (79th):

Thank you, Mr. Speaker.

For purposes of introduction.

DEPUTY SPEAKER ARESIMOWICZ:

Please proceed, sir.

JOINT
STANDING
COMMITTEE
HEARINGS

INSURANCE AND
REAL ESTATE
PART 9
2658 – 2966

2011

CHAIRMEN: Senator Crisco
Representative Megna

VICE CHAIRMEN: Senator Hartley
Representative Johnson

MEMBERS PRESENT:
SENATORS: Kelly

REPRESENTATIVES: Alberts, Aldarondo, Altobello, Coutu Aresimowicz, Crawford, D'Amelio, Dargan, Hoydick, Nardello, Roldan, Sampson, Sanchez, Schofield, Yaccarino

REP. MEGNA: Speakers will be limited to three minutes of testimony, and we can ask questions. We have your testimony if you submitted it, and it will be posted online on the bill. With that, we're going to start off with Legislators, agencies, and municipalities. And the first person signed up is for House Bill 6471, and that is Representative Nicastro, who is right in front of the place, he's going to sit. How convenient.

REP. NICASTRO: Good afternoon, Chairman Megna. Good afternoon, Reps.

I will be brief. And if you believe that, you know, anyway. Anyway I'm here to talk about House Bill 6471, AN ACT CONCERNING MOST FAVORED NATION CLAUSES IN HEALTH CONTRACTS.

This is a bill that you really have to look at

and understand thoroughly. The adoption of this legislation prohibiting the use of most favored nations clauses in the health contracts is an important element to enhancing insurance competition in Connecticut.

Nineteen states have already enacted similar legislation. And in addition, the United States Department of Justice has enacted -- has attacked the MFN in litigation, which has commenced. And here's some of the reasons why.

Anticompetitiveness, you know, effects of MFN clauses, MFN clauses limit competition and allow large insurers to dictate terms and conditions. Think about that.

The way it is now, this -- it allows them to eliminate, and they will end up setting up the terms and conditions, and pervert -- perpetuate an enhanced market concentration. This is because MFN clauses limit and deter entry to the market by other insurers and payers. Even larger insurers, such as United Healthcare found that they cannot fairly compete in markets where an MFN clause are being used, also, costs associated with the negotiation and the enforcement of MFN clauses.

The existence of MFN clauses in contracts requires hospitals to continuously monitor for compliance, which involves a commitment of resource. Additionally, hospitals must participate in audits initiated by insurers, which may reveal pricing by competitors, which in itself is highly anticompetitive. Furthermore, the negotiation process may be more costly due to the amount of diligence and analysis required.

Increase in price terms: MFN clauses affect a provider's ability to negotiate terms with individual plans and prevent a provider from rewarding competitors who provide better service or less red tape in the process of claims. Preserving and enhancing the concentration results in higher prices across the board ultimately affects the amounts paid by consumers.

MFN clauses discourage innovation. MFN clauses discourage providers from entering into innovative payment methodologies with other insurers. The federal reform legislation and other -- agree that moving to nonfee for service payment methodologies, which create incentives to improve quality and reduce cost, is a key element of reform for the current legislation.

Last legislative session, Senate Bill 429, AN ACT CONCERNING MOST FAVORED NATION CLAUSES IN HEALTH CARE, was raised in the Public Health Committee -- other than Attorney General Richard Blumenthal submitted testimony in support of the bill. Okay?

Lastly, what I'd like to say, quite frankly and honestly, is that 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 appears that only one, Anthem, supports the use of MFN in health care contracts. The other three, Aetna, CIGNA, and United Healthcare have all indicated that the existence of an MFN in Anthem's contract with

providers has discouraged them -- that's Aetna, CIGNA, and United Health Care -- from entering or expanding in certain segments of Ohio's insurance market.

I think you have to understand that, Anthem, as we well know, is much larger, and that's why I'm here testifying today. And I'm sure that there's going to be plenty of other speakers here that -- Mr. Chairman, that will speak in regards to this bill. And I just want to thank you. If there's any questions, I'd be happy to honor them. If not, I'm heading into General Law.

REP. MEGNA: Yeah -- no. Thank you very much, Representative Nicastro. And I'm actually glad this issue is in front of us, and I think it's Bristol Hospital that brought it to our attention. And I -- as I look at the people that are going to give testimony, everybody is for it. I think it's applying to one insurer. And unfortunately, they are not here to testify against it, which I wish they were, to give us their side of the story. But I appreciate your -- your testimony.

REP. NICASTRO: I want to thank you, Mr. Chairman; I want to thank members of the board for hearing me out. And I think this is a step, a positive step, in the right direction. We need it with the way things are going on throughout this country right now. So I want to thank you very much.

REP. MEGNA: Oh, yeah. Okay. Thank you.

Are there any questions for Representative Nicastro?

No? No. Thank you very much (inaudible).

notice that the building is being foreclosed on, or lis pendens, or whatever, will that empower you to get off the risk -- not you, but the carrier? Is that what this is about? Does it change the risk, does it enable the carrier to -- to get out before the renewal? Is that what you're looking to do here with that part?

ROBERT KEHMNA: Honestly, I don't know. As the king of delegation in my office, I delegated this to Sue, and I haven't spent a minute on it. I will get you that answer.

REP. MEGNA: Okay. Thank you.

Are there any other questions? No?

Thank you very much, Bob.

ROBERT KEHMNA: Thank you.

REP. MEGNA: We're going to move on to 6471, Matt Katz.

MATTHEW KATZ: Since we're changing hair style, can I get some height? No? Okay. It's worth a try. I don't know. You know, I'm not sure which committee helps me with that.

Senator Crisco, Representative Megna, and members of the Insurance and Real Estate Committee, my name is Matthew Katz. I'm the Executive Vice President of the Connecticut State Medical Society.

On behalf of our members, thank you for the opportunity for allowing me to testify in front of you today in strong support of House Bill 6471, AN ACT CONCERNING MOST FAVORED NATION CLAUSES AND HEALTH CARE CONTRACTS.

This legislation, as you know and you've heard, will prohibit the use of contractual clauses by insurers and other contracting entities that are inherently unfair and currently gaining some national attention, as you heard, in places such as Michigan, because of the detrimental impact they have on physicians and on patient access to care.

CSMS believes that these most favored, or equal favored provisions of contracts should be expressly prohibited, as they are in most of our neighboring states, as well as in at least 13 additional states throughout the country.

Most favored nation clauses limit competition among insurers, and also limit the ability for physicians to negotiate on price, or any other term of importance to patients, such as quality, access, and even efficiency.

There are two main types of MFN, most favored nation clauses, generally, in effect, in contracts, those being comparable rate clauses or better than clauses. But, essentially, they do the same thing. They limit competition, allowing large insurers to dictate terms and conditions, preventing other insurers who are in the market from competing on price or other terms, and further limit access to this market for any insurers who wish to access or enter, who may offer benefits in lieu of payment rates to entice physicians to sign and offer further reductions in health insurance premiums to employers and employees.

When MFN clauses are in effect, providers, including physicians, cannot lower their

prices to attract more business, and cannot effectively negotiate with insurers on price. In addition, payers may be less aggressive in offering lower prices, if they know that an MFN is in effect. Now this doesn't disadvantage providers, physicians, however it does increase costs for consumers.

MFN clauses may also restrict the entry of small payers into the market who are looking for innovative ways to offer insurance within this state, looking at quality, looking at cost, looking at efficiency, reducing things such as abuse of unfair business practices, and offering a lower rate. But how, as a physician, would you accept a lower rate, if that means their dominant insurers in the state would, therefore, get that same rate within your practice? You can't negotiate. It limits your ability to do so, and it limits competition.

You heard the Ohio legislature looked at this, and their commission found that, in fact, the restrictive clauses on hospitals as well as insurers, essentially, the costs outweigh the benefits.

We ask for your support of this legislation. We ask that you look at this to recognize that it disadvantages consumers, providers, as well as insurers wishing to access the market, or those that do not have a current large market share in the state of Connecticut. Thank you very much, and we ask your support.

REP. MEGNA: Thank you, Matt. I apologize if I should already know this. So this -- this clause could also apply to any service provided?

MATTHEW KATZ: It is -- it is --

REP. MEGNA: Not only the hospitals?

MATTHEW KATZ: It is. And the bill that came up last year, there was a similar bill last year. We believe this one actually is more specific and more appropriately limiting of these clauses. But it can be any provider, and it is any provider of service in the health and health care arena that sees these in certain contracts that they have.

So they, therefore, any rate they offer the entity that has, you know, put this in their contract, they then have to offer the rate that they offer to anyone else that may be lesser of or, in some cases, it's even a greater percentage than lesser of, because you're being punished by offering a lesser rate.

Some insurers even require auditing of the physician practices to verify, in fact, that they are offering that lowest rate. Those audits cost the physician practices as well as the insurer money. This is not just in the hospital arena; it is throughout the health care system.

REP. MEGNA: Tell me, have you -- what other -- have other states addressed it or other states done away with it?

MATTHEW KATZ: Nineteen -- nineteen states have done away with it, in one form or another, some more limiting than others. We believe that many states have recognized, not just those that have already limited it, but many have recognized that this needs to be addressed simply because it limits

competition. We already have in Connecticut, more than most states, a consolidated market. We have few insurers left here that are providing insurance.

We want to incentivize or encourage other insurers to enter the market, or those that are smaller to grow. You can't do that with these kinds of contracts. It limits the ability for growth for those small insurers or anyone to enter.

And those states around us that have limited have done so because they found them to be problematic, and those states across the country that have done so have found it to be problematic, many having similar market dynamics as Connecticut when it comes to a consolidated market of insurance.

REP. MEGNA: Thank you very much.

Are there any questions? Thank you very much.

MATTHEW KATZ: Thank you.

REP. MEGNA: Dr. Bhaya? Deb Osborn?

HB6471

DEBBIE OSBORN: I was going to come up for Dr. Bhaya. He gives his apologies, he's in an emergency. So I'm going to -- we submitted testimony, so I'm not going to go through and take up my time reading the testimony.

We've also testified on this issue on the Standards and Contracting Bill that we asked to have inclusion of this language on. What I'd like to spend my time here today is discussing one of the attachments connected to our testimony, and that is a current contract that has the most favored nation language in

it, and that's a contract by Aetna. But it's not just Aetna. We're seeing this language surfacing in most, if not the majority of contracts. So we don't want to single out just Aetna. It's a problem throughout the state. It's a problem for physicians in every contract that they have.

And what I find very interesting and telling is the fact that the lobbyists, four, five, three years ago testified that when the settlements that were in place, that we didn't need to codify these provisions into state statute. And now that the settlements have expired and sunsetted, we're seeing that these provisions are once again resurfacing.

And we're dealing with the whole issues of bundling, and most favored nation clauses, and their unwillingness to preauthorize procedures for the physicians. So we're going -- we're reverting right back to where we were before the settlements were in place.

So we ask this committee to give careful consideration to this bill. It's a critical piece of legislation for my physicians, and I thank you for your time. If I can answer any questions, I will.

REP. MEGNA: Thank you very much.

Are there any questions? No.

Thank you very much for your testimony.

DEBBIE OSBORN: You're welcome.

REP. MEGNA: Kurt Barwis, from Bristol Hospital.

KURT BARWIS: Senator Crisco, Representative Megna,

HB6471

and the rest of the committee, thank you so much for giving me the opportunity to testify today.

I am Kurt Barwis, Chief -- President, Chief Operating Officer of Bristol Hospital, Bristol, Connecticut. And I'm here to testify in favor of House Bill 6471, AN ACT PROHIBITING MOST FAVORED NATIONS CLAUSES IN HEALTH CARE PROVIDER CONTRACTS.

The adoption of legislation prohibiting the use of most favored nations, MFN clauses, in health care provider contracts is important because it will enhance health care insurance competition in the State of Connecticut.

Currently, 19 states have already enacted similar legislation, and in addition, the United States Department of Justice has attacked MFNs in litigation in Michigan. A listing of all the states which have already enacted such legislation is attached in my testimony as exhibit one.

The existence of MFN clauses in health care provider contracts harms the public in the following ways.

First, any competitive effects, MFN clauses limit competition and allow large insurers to dictate terms, conditions, and perpetuate enhanced market concentration. This is because MFN clauses limit and deter entry to the market by other insurers and payers. Even large insurers, such as United Healthcare have found that they cannot fairly compete in markets where MFN clauses are being used by a competitor.

Specific to Bristol Hospital, with the

exception of the Charter Oak Health Plan, which Bristol Hospital could initially not participate with because it had an MFN clause in one of its largest payer contracts, and the Medicare/Medicaid managed care products, which have been brought to us, which are exempted from MFN clauses, Bristol Hospital has been approached only twice during the last four years, by a health insurance company covering, primarily, workers compensation. One of them also represented third-party administration services. So, essentially, in four years, very, very little activity in terms of new products coming by way of Bristol Hospital.

In terms of the cost associated, this is another way that they are damaging, costs associated with negotiating and enforcing these clauses, you've heard about audits from another testimony. The existence of MFN clauses and contracts requires health care providers to continuously monitor for compliance. It's a very complicated process which involves a commitment of resources. Additionally, health care providers must participate in audits initiated by insurers, which may reveal competitors pricing, which, in itself, is highly anticompetitive.

Furthermore, the negotiation process may be more costly due to the amount of diligence and analysis required as a result of accepting one of these provisions. Bristol Hospital spent $113,712 and over 376 hours responding to an MFN audit last year, and that's a fact.

Bristol Hospital has an MFN clause in one of its largest commercial health insurance contracts. That's a fact. Bristol Hospital would not have a contract with this payer if it had not continued to accept the MFN clause

in this payer contract. That is also a fact. Without this payer's contract, Bristol Hospital would likely go out of business. That is also a fact.

Another way they harm the market for commercial health insurance is increase in price terms. MFN clauses affect providers' ability to negotiate terms -- you've heard that from other folks that have testified -- (inaudible) plans and prevent a competitor from renewing competitors, rewarding competitors to provide better services or less red tape in the processing of claims. Preserving and enhancing the concentration results in higher prices across the board, ultimately affecting the amounts paid by consumers.

And then, also, you heard earlier that they -- they discourage innovation at a time when we really are being challenged to innovate, to come up with ways to enhance the quality and the safety of care and reduce costs. The payment mechanisms that we enter into, really do require innovation, and these clauses clearly limit our ability to do that.

You also heard about other states, and specifically, you heard about the -- the process that Ohio went through. And in -- in my exhibit, you'll see that I've attached an excerpt from that, which, essentially, Ohio put together a commission with approximately 16, 18 members. They actually put four of the largest insurers on that commission. And on page 30, 31 of that 172 page report, it says, and I'm going to quote this, "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 -- that being the four insurers that were on the committee. Of the four insurers on the commission, it appears that only one, Anthem, supports the use of MFNs in health care contracts". That, again, is specific to Ohio and their situation.

The other three, Aetna, CIGNA, United Healthcare have all indicated that the existence of an MFN in Anthem's contract with providers has discouraged them, Aetna, CIGNA, United Healthcare, from entering or expanding into certain segments of Ohio's market, and they went on to conclude that this was probably the most pervasive fact.

I really appreciate the opportunity to testify today on this bill, and I appreciate your support. Thank you very much.

REP. MEGNA: Thanks, Kurt.

Kurt, so in this contractual process between the hospital and the carrier, what -- when they come to you with this contract, do you tell them, hey, we'd like to do business with you, but we don't want that clause in there? What's their response? Take it or leave it? Do you have any kind of ability to negotiate that clause out of the contract?

KURT BARWIS: With respect to the contract that we -- where we went through this process, we have no ability to eliminate that clause. And we asked --

REP. MEGNA: You have no ability, why? Because the market power?

KURT BARWIS: The market power. Absolutely.

REP. MEGNA: So they literally make you an offer you can't refuse, you know, like the godfather?

KURT BARWIS: Well, I wouldn't characterize it that way. But I spoke to my contracting person this morning, and I know that we approach this language at least three times directly, maybe five times, and in every case that was a nonstarter.

REP. MEGNA: Does the -- does the hospital association have any bargaining power as an association with these clauses or --

KURT BARWIS: There's a -- there's multiple priorities for the hospital association, I'm not on board the hospital association. I'm not here representing the hospital association.

REP. MEGNA: Yeah, I understand that.

KURT BARWIS: I think, at one time, maybe 20 years ago, the hospital association actually negotiated these contracts. And that was about (inaudible) competitive, and they stopped that practice.

I think that the laws prevent them from actually entering into a collective process. I mean, certainly they could try to advance changes contractually, general changes like this, but they generally do not get involved in our contractual relationships.

REP. MEGNA: It's -- so it just seems amazing that a contract can get negotiated that way. What -- what -- is there a particular statute that allows that to happen?

KURT BARWIS: Well, it's interesting, because, you know, the health insurance plans are exempted from most of the federal antitrust laws unless specifically -- unless there's something that specifically addresses it. So it really falls to the states to enforce what they see as an antitrust violation or an issue where there's unfair competition in this particular respect. That's why you see 19 states passing legislation that specifically bans this activity.

Michigan took a very interesting approach, and one that, I think, is going to turn out to be quite costly, not only for the state, but the federal government. The situation there is so egregious that the Department of Justice and the State Attorney General filed suit.

I have no idea how much that costs, but I can only imagine that it's going to take them years and years to actually solve that problem before they actually enact legislation to -- to deal with this issue. So --

REP. MEGNA: So they filed suit, and -- and are also enacting legislation? Is that what you mean? They filed suit against these carriers?

KURT BARWIS: I believe they have legislation that -- and I'm going to be careful about this -- that limits, in some way, these kind of provisions, similar to Ohio, had a two years moratorium on them while the General Assembly commissioned a group to actually study the effects.

And then the two year moratorium had a -- the ability to go for one more year to allow the commission to actually study it. They actually have now officially banned, and it

was the conclusion of the committee. So I believe Michigan is in a similar situation.

REP. MEGNA: Okay, thank you very much.

Are there any questions?

Representative Johnson.

REP. JOHNSON: Thank you, Mr. Chair. Just quickly, I heard you say that it has cost you a lot of money to keep track of the costs of the different charges, and those sorts of things. And I just wondered, could you just explain in detail how that works for your finance department?

KURT BARWIS: Sure. Representative Johnson, that is a great question. Thank you very much. The -- it's -- it's a fairly complex process, but I'll try to make it very simple.

As you can imagine, a hospital charge master has tens of thousands of charges. And further complicating that is that each insurer brings to the hospital patients that are inherently different, more complex, less complex, getting different kinds of procedures, it may be specific age cohorts, and -- and so on.

So the only way to actually confirm that you've actually not given somebody a lower price, and this is -- this the hard part to think about, you take the insurer that has this provision, and what we did was essentially take 12 months of every patient, every claim, everything that was done, and you run them through a contracting system for every other single payer to see if, in fact, as a consequence, you gave them a lower price. It is a very long, arduous process.

And I can tell you, I wasn't surprised when we added up the costs, $117,000. Just legal costs and processing costs and consulting costs were $97,000. So it was -- it was quite expensive. We clearly would like to spend that money focused on delivering high quality patient care. So it was a great -- hopefully, I answered your question.

REP. JOHNSON: Yes, you did.

Thank you, Mr. Chair.

REP. MEGNA: Thank you, Representative Johnson.

Representative Schofield, did you have questions?

REP SCHOFIELD: So, you know, it's interesting because Deb Osborn showed us the Aetna contract. So at least in this state, Aetna is also using MFN language. But in Ohio, they're saying they can live without it. Am I understanding that correctly?

KURT BARWIS: That's correct.

REP. SCHOFIELD: Okay. You know, having worked in this industry, actually, on both sides of the equation, it always struck me that -- and this was years ago -- no one ever enforced it. You know, everybody had these -- and having been a consultant, I'd go around and see every company had MFN language. Every hospital said yes, and nobody ever double-checked. You're the first one I ever heard of who -- who actually had to go through that horrific process, and I know it would be, to try to document whether you were compliant or not.

So it strikes me, we ought to get rid of all those discounts, and just, this is your price and that's your price. It gets very complicated otherwise.

I guess I -- I am pretty sympathetic to the concerns that -- that you have here. Do you think that -- that it will result in -- in a change in how hospitals go about -- about doing their pricing, if -- if this change happened? What'll it do to the kinds of prices that you give payers?

KURT BARWIS: I think that that really gets to this question of innovation. So if someone were to approach me and say, you know, I'd like to work with you to create a unique product that may provide some incentives for my employees' use, you know, through a third party administrator, one of the payers who may provide that service, I would be more apt to do that, knowing that I don't have this provision in one of my contracts.

Because if you kind of play this forward, and you think about, well, if I innovate with a large employer, say the City of Bristol which has 2,000 employees on their health plan, the fear I always have in the back of my mind is that, let's say I'm successful in doing that, that we reduce some administrative work, we come up with a great opportunity to work together and partner but, inadvertently, 12 months after the fact, I'm challenged by this provision, and I find out that, in fact, because I innovated, I've actually provided somebody with a lower price now that, you know, this other provider who has this in their contract gets the benefit of that, it's a deterrent. It's clearly a deterrent to innovation and creating innovative products

that work together with, not only local employers, but insurers.

I mean, it's -- you have to be extremely careful. And as you just pointed out, these contracts are so complex, carve-outs, specific special situations based on the type of patients you have. I think the answer is -- that was the long part of the answer -- but the answer is yes, I think it will, in fact, improve innovation in the state, and improve the way we interact with payers and -- and, potentially, also employers throughout the state in a positive way.

REP. SCHOFIELD: Doesn't the MFN language usually have a caveat in there, though, that it's not just about price, but they have to offer the same circumstances? Because, you know, if you've got one payer who pays promptly, they don't hassle you a lot. You know, you don't have any difficulties with them. They work well with you. And another payer, with exactly, you know, the same kinds of patients, but they never pay on time, constant run around, a lot of hassles, you would -- I would not consider that they're paying under the same kind of circumstances, and that it would make sense for you to give more of a discount to the insurer that works well with you.

KURT BARWIS: Having gone through this last year, I would say that -- that seems obvious. I don't know that, in fact, the language provides for that. But I can tell you, it was all about price. And so, let's say you have a very small specialty insurer that just covers, say, some small segment of outpatient business.

REP. SCHOFIELD: Uh-huh.

KURT BARWIS: And you give them a pricing, or an arrangement, that is based on the facts and circumstances, and you inadvertently, in that little small thing, create a lower price than the insurer that has the MFN, the fear is that, why would you take the risk?

REP. SCHOFIELD: Right. Right.

KURT BARWIS: I mean, because you could basically go out of business if you had to, you know, reprice your, you know, one of your larger contracts.

REP. SCHOFIELD: Right. Okay. I have one last question. What was it? Oh, if -- if you could determine what, roughly, what would be the value of those better administrative behaviors, if you will, between payers, and assume that that would be the only basis for a discount, what would be the value?

I mean, already everybody has to live within prompt payment laws. But does it make it worth it, from an economic point of view, to deal with one payer, you know, to give them 2 percent, 10 percent, 20 percent discount because they're so much easier to deal with than another? What would -- how would you value that spread?

KURT BARWIS: I'm not sure that I could -- well, I'd have to process that a little bit more. I would say this. That, you know, I'm longing for the day where the cost, quality component of how we price -- we get priced, is the leading thing that occurs. Because that's not what's happening here. That is clear. I mean, if I looked at all my agreements, Medicare is the only real value-based purchaser of my services, at this point.

We all talk about quality. We all talk about quality incentives. But when it gets down to the table, that's not what you see. People are innovating now with quality products. But the evidence is that it's less than 2 percent, if that, of what a hospital provider gets. It's a very small component.

So I would love to see the whole negotiation process and pricing go into that direction. I think that would also help to reduce some of the other things that you're talking about, the administrative burden. I can tell you directly, $117,000 would be saved, if I was relieved from this particular administrative burden, so.

REP. SCHOFIELD: And -- and so what we do to give differential levels of -- of discounts of different payers? Is it only just how much fear you have that they'll throw you out of the network? Is that all it comes down to? How much clout they have?

KURT BARWIS: For our hospital, you know, I'll speak specifically for Bristol Hospital. I arrived a little over four years ago, and it was a distressed hospital. It had massive losses, three years of significant losses. It was a -- very much in trouble.

The easy thing for me to do, because there's really good state data that's published by OCA --

REP. SCHOFIELD: Uh-huh.

KURT BARWIS: -- is to actually look at the commercial reimbursement, what -- what the hospitals get paid, the actual cost rate. And

cost is different for every hospital in the state. It's -- it's clearly not a constant.

So when I looked at Bristol Hospital, that report suggested that Bristol Hospital is 106 percent of costs in its commercial contracts. The state average was running 118 to 120 percent and, currently, I think it's about 122 percent. So for every dollar expended, hospitals in the State of Connecticut are, on average, receiving a 22 percent margin on providing the services to commercial insurance.

So for us, to directly answer your question, our goal has been to get to the state average, to get at or above that state average, because, if we don't, we can't survive, because we lose money on taking care of the Medicare or Medicaid patients.

And I would -- I would like to tell you that the pricing is much more sophisticated for us, but we are emerging out of a very difficult and troubled time. And so our pricing is simply, you know -- and -- and it's your starting point too. If you're 106 percent cost, and you're asking an insurer for a 35 percent increase to get close to the state average, that is pretty tough to take.

REP. SCHOFIELD: Uh-huh.

KURT BARWIS: So most of the strategy is around -- we want to be treated like everybody else. We want to try to get to that average. I think, ultimately, as we get more sophisticated and the cost, quality, you know, programs start to kick in, I think you'll see more of that. And I, you know, I would certainly do -- I would

be -- welcome it today if I could do it that way.

REP. SCHOFIELD: And can you just tell us what you mean by a cost quality program?

KURT BARWIS: When you look at providers, the cost difference can be extreme from one hospital or one physician to another. In fact, if you look at Martha Coakley's report in Massachusetts, what she reported, having subpoenaed all the contracts, was that there was alarming disparities. You know, you could have a person -- and she even did it on a severity-adjusted basis -- you could have a person have the exact same procedure 20 miles apart from another person, with the exact same presentation of condition and comorbidities and, essentially, this one was paying 185 percent more than this one.

So the pricing, the way things are priced, isn't about costs and quality or outcome --

REP. SCHOFIELD: Right.

KURT BARWIS: -- and -- and you know, we're certainly moving in that direction. There's a lot of public reporting. The Connecticut Hospital Association is clearly working towards that, but we're not there yet.

REP. SCHOFIELD: Okay. Thank you very much.

KURT BARWIS: You're quite welcome.

REP. MEGNA: Thank you, Representative Schofield. It's interesting, I was talking to another hospital, and they mentioned -- they pointed out to me that a clause like this permits a carrier to achieve a disproportionate share,

not based on the level of service or price, which is what the real detriment of this clause is. And actually, while you were speaking, I looked online to see if any of the carriers submitted testimony.

One of them submitted 46 pages. And they actually make a statement that there that the proposed bill represents an inappropriate use of the legislative process, and the negotiations of a private contractual matter between sophisticated bargaining parties. I say that's interesting. The legislature should exercise restraint, and avoid interjecting itself into a private contractual negotiation.

But I can see in this issue that it almost goes beyond that. It goes into other people's contracts.

KURT BARWIS: It's -- it's a very interesting point you make. There is no level playing field. You know, if you call up and ask what our prices are, you know, we're in a place where we're becoming much more transparent in our prices.

In this negotiation process, I am not permitted to find out what another hospital gets paid by any of the payers, yet, every one of these payers knows what it's paying every other hospital. So there is absolutely no level playing field.

This bill, in a sense, gets it a little bit closer to even. It would be great to have the insurance companies post their payment rates to the providers in a transparent way, which is what is being asked of all the hospitals around the country.

REP. MEGNA: Yes, yes, yes. I totally agree.

Thank you very much.

Are there any other questions?

Thank you very much.

KURT BARWIS: Thank you very much.

REP. MEGNA: Oh, you're welcome.

KURT BARWIS: Thank you.

REP. MEGNA: Paul Knag? Paul Knag? Not here? There's also Mike Nicastro.

Any -- any relation?

MICHAEL NICASTRO: Yeah, unfortunately.

REP. MEGNA: That's not a bad thing. He's a good guy.

MICHAEL NICASTRO: You're not to repeat that, or I'll pay for it later.

Good day, Senator Crisco, Representative Megna, the rest of the committee. Thank you. My name is Mike Nicastro. I'm President and Chief Executive Officer of the Central Connecticut Chambers of Commerce. We're headquartered in Bristol. We're here in support of raised -- of the Bill 6471, AN ACT PROHIBITING THE MOST FAVORED NATIONS CLAUSES OF THE HEALTH CARE PROVIDER CONTRACTS.

I'm going to come at this a little bit differently. I'm going to come at it as somebody who lived in -- in the corporate

world before taking over this chamber of commerce.

Just as background, I was the founder, and I was the Senior Vice President and Chief Marketing Officer for Open Solutions over in Glastonbury. It was a company that was founded here in Connecticut, has grown to a huge size, and is now the largest software company in the state, privately-owned software company in the state. And -- and just to digress for one second, we were also -- and I can answer these questions for you another time -- but we were also the largest data processer of retained asset accounts in the country. So we know a lot -- I know a lot about those.

But back to MFN, the MFN and 6471. In the Chief Marketing Officer role, I was in charge of third party arrangements, where we -- we sold our software through large distributors. Sometimes we worked with large distributors, big companies like Oracle, big companies like Microsoft. And starting out as a startup company here in Connecticut, there were many times we had to go to large companies to become our large distributor. And I can guarantee you, they had MFN clauses in their contract.

And as we grew, and when we became a publicly traded company, and we had size, we used MFN clauses in our contracts with smaller providers. So we used them. I can tell you that I understand where they are. And in a broad market, where there's many vendors and many players, whether -- no matter what that service might be, they have some value because they actually do create environments where small players can leverage large players for

growth. And they can be used, when used properly, as an advantage. But they can also be used as an offensive and defensive tool. There's just no question about it. So I understand that marketplace.

I also serve, though, as the chairman of the leadership cabinet of the chambers benefit centers, where those are the ten largest chambers in the State of Connecticut, and they run the insurance trust for the chambers, where we offer health insurance to our members.

And I can tell you, that looking at MFN and Bill 6471 with regards to health insurance, it is, even though it's counterintuitive to a businessperson, it is a challenge, and it is anticompetitive in this particular situation. So with that as background, I will more than happily answer any questions, and we support 6471.

REP. MEGNA: So what you're saying, in this sense, with regard to hospitals and health care carriers, it's not competitive, or it's anticompetitive?

MICHAEL NICASTRO: It is, Representative. You know, we look at this, and you get -- look, you've got -- you have the federal exemption on -- on insurance here. You have a very closed market here. You only have three or four real players in -- in the industry.

And when it comes to that, if you get one that has that controlling -- that controlling clause in there -- you know, even when we, on a national basis, coming from the software world, and we used it. We had many players (inaudible), we still had to watch out for

antitrust rules. We still had to be careful of all those kinds of environments where we weren't fixing pricing and all those kinds of things.

This environment is much tighter. And it does -- it does put our hospitals in an anticompetitive situation. And it really does not -- it tilts the playing field. It absolutely does.

So from what we can see, you know, especially for our small businesses here in this state, which we have thousands of them, we've got to -- we've got some things we have to work on for health care. And one of the things we can do is by leveling out this playing field.

REP MEGNA: Okay, thank you.
Are there any questions?

Representative Schofield.

REP SCHOFIELD: Thank you, Mr. Chair. You said that they can be -- that these MFNs can be used for good and also for bad. And so, you know, we always are worried about unintended consequences. If we eliminated the use of them, what good uses would we be throwing aside at the same time?

MICHAEL NICASTRO: This is a narrow bill. I don't know that you're throwing anything good out. You have a small playership here. And so it would be one thing if we had 10 or 15 players in this -- in this market space. Then I would be -- I honestly would be concerned that you are, maybe, tilting it too far in the opposite direction.

REP. SCHOFIELD: Well, what happens if we throw it

out and then there are 10 or 15 players?

MICHAEL NICASTRO: Well, I guess you'll have to -- you'll have to reevaluate it at that time, Representative. But I -- I don't anticipate that is going to happen anytime soon. And I think the immediate need, right now, is for the playing field to be leveled out, sooner than later.

REP. SCHOFIELD: And from your own industry, the nonhealth industry, can you tell us what -- how -- how MFNs were used that were helpful or good?

MICHAEL NICASTRO: Well, again, as a -- when we were a startup company, the reality was is we were able to go to some of the biggest players, and because MFN -- they would require an MFN in their clause, we were able to leverage them, and leverage them faster. We got growth there.

REP. SCHOFIELD: So it was because you had a relationship with a particular company.

MICHAEL NICASTRO: Correct.

REP. SCHOFIELD: So would you think it would make sense to have a carve-out here if -- I mean, I can think of examples of different kinds of insurers where they -- not that they exist here anymore -- but like a Kaiser Permanente, where they, you know, maybe own hospitals in some places, that they should get the best deal, if they have a business relationship, would you carve that out?

MICHAEL NICASTRO: I, you know, I would -- I'd have to see that. I wouldn't want to just say yes or no to that. I'd have to see what that --

what that would mean to the marketplace. But, again, I look at this as a -- as a contracted, controlled marketplace. And -- and these things can be very, very controlling.

REP. SCHOFIELD: Thank you.

REP. MEGNA: Thank you, Representative Schofield.

Representative -- Senator Kelly. I'm sorry.

SENATOR KELLY: Thank you very much. You indicated that leveling the playing field would be good for small business; can you explain how that would be?

MICHAEL NICASTRO: Well, I -- we certainly are -- we're putting our hospitals in position where they're having to -- to deal with these constraints. It's driving up their costs; it's driving up their environments. It all gets passed along to the consumer and the business, eventually.

And -- and, I think, by -- by doing so, we can put ourselves in a position where, if we level their playing field, we're -- we're hoping that that will then been passed along to the small business world and the consumers, ultimately.

The -- with the changes in -- in health care, and the things that we see coming, there's a huge consumerization of health care coming along here. We've talked about this at length. And in that, you know when we talk about some of the bills that are before you this year, with regards to exchanges in other programs, there is a drive toward consumerization with these products.

And -- and the things have to be level in a contracted market, or -- or the costs get passed on. If you get the big -- for lack of a better term -- 900-pound gorilla in the room, and they can tilt the room, that's got -- the losses have got to be passed somewhere, or the costs have to be passed somewhere. And -- and so we look at that as a concern.

SENATOR KELLY: Okay, thank you.

MICHAEL NICASTRO: You're welcome.

REP. MEGNA: Thank you, Senator Kelly.

Any other questions?

Thank you very much, sir.

That concludes everybody that has signed up for this public hearing. If there's anybody out there that would like to speak on any of the bills listed today, please come forward. Otherwise, that'll conclude this public hearing.

Anthem.

March 3, 2011

Statement
Of
Anthem Blue Cross and Blue Shield

HB 6471 An Act Prohibiting Most Favored Nation Clauses In Health Care Provider Contracts

Anthem Blue Cross and Blue Shield ("Anthem") *opposes* HB 6471 An Act Prohibiting Most Favored Nation Clauses In Health Care Provider Contracts and encourages the Insurance Committee to reject this bill. The compelling reasons in support of Anthem's opposition are described below.

A. Legal Considerations Support Most Favored Nation Clauses

No federal or Connecticut court has ever concluded that most favored nation clauses, as a purchasing practice, are either illegal or automatically anticompetitive. To the contrary, 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 sound economic sense. In fact, many courts have upheld the valid business reasons for having a most favored nation clause, explaining that such clauses are exactly the type of practice by buyers that the antitrust laws are intended to encourage since these clauses are designed to get the buyer price protection. The determination whether a particular most favored nation clause has an anticompetitive affect is fact specific, and can be adequately addressed under existing law. Consequently, not only is there no basis in law or fact to legislate against most favored nation clauses, but there already exists a legal framework within which the market affect of a particular clause can be assessed from an antitrust perspective.

This proposed bill represents an inappropriate use of the legislative process in the negotiations of a private contractual matter between sophisticated bargaining parties. The Legislature should exercise restraint and avoid interjecting itself into a private contractual negotiation.

B. Most Favored Nation Clauses Further Legitimate Business Purposes and Produce Pro-Consumer Benefits

Insurers and managed care organization that buy health care services have legitimate business reasons, just like any other buyer, to include most favored nation clauses in their health care provider contracts. A common type of most favored nation clause used in health care provider contracts is called an equal (or comparable) rate provision. An equal rate provision protects an insurer or managed care organization against price disadvantage if the provider offers a better discount, or price, to another payor; in such event, the insurer or managed care organization with an equal rate provision would likewise get the benefit of the better discount.

The equal rate provision is a prudent buying practice and produces real cost benefits and efficiencies for an insurer and its customers. For example, when an insurer negotiates with hospitals to obtain hospital services, the insurer is bargaining for the lowest possible cost of those services on behalf of its customers, both employer groups and members. An equal rate provision is a valuable cost-control device that can protect insurers from paying prices

that are over market rates. This cost protection also allows the insurer to enter into long-term provider contracts, thereby assuring network stability for the insurer's members. This price protection *directly and immediately benefits the insurer's self-funded employer groups*, which fund the cost of their employees' health care services. The price protection *also benefits the insurer's members* whose health benefit plan requires the member to pay a percentage of the price of their health care services (e.g., a coinsurance).

An equal rate provision can be advantageous for both the buyer (the insurer) and the seller (the provider). An equal rate provision enables an insurer to enter into long-term contracts for health care services since the equal rate provision ensures that the insurer will not be disadvantaged competitively with regard to the provider's price. Long-term contracts for health care services are beneficial to the consumer because they enable an insurer to control future costs, maintain stable provider networks for its members, and ensure that its members have participating providers readily accessible for the members' care. These long term contracts also benefit the seller of health care services (e.g., a hospital) because the seller is able to lock-in payment rate increases and assures a stable income stream.

As mentioned, most favored nation clauses are used by purchasers in many industries involving the sale of goods to ensure that the purchaser receives the lowest possible price. In fact, in the health care industry, hospitals commonly use most favored nation clauses when they purchase equipment, drugs and supplies. An insurer's use of a most favored nation clause is consistent with the use of such clauses by others in the health care industry, such as hospitals, as well as by purchasers in other industries.

C. There Is No Evidence That Justifies Interference With Freely Bargained Contracts

The health benefits market in Connecticut is a vibrant market with robust competition among many insurers, managed care organizations and third-party administrators. Most favored nation clauses have always been permitted, and there is no publicly available economic research that such provisions have produced any actual anticompetitive effects. In 2000, Dr. William Lynk, an economist, published an article which is the only published economic research to date on the effects of most favored nation clauses in health insurance contracts. This study titled "Some basics about most favored nation contracts in health care markets" is published in the Antitrust Bulletin/Summer 2000. The analysis and conclusions of this economic research study are extremely important for several reasons.

First, the article indicated that no empirical research had ever been done previously on the effects of most favored nation clauses in health care markets. This is critical because empirical economic evidence, not theory or assumptions, should be the basis for antitrust law and state law analysis of most favored nation clauses. As Dr. Lynk stated, "only factual investigation can determine whether in any actual market the balance of consumer benefits from MFNs [most favored nation clauses] is positive or negative." Dr. Lynk also explained that the relevant consideration is the effect on the average price paid by all consumers, not the effect on competitors.

Second, Dr. Lynk for the first time conducted an empirical study on most favored nation clauses in two markets and found that there were no anticompetitive effects. Rather, he found that the enrollment of the other plans increased and there were pro-competitive benefits because the most favored nation clauses caused a decrease in hospital prices.

Anthem.

In sum, the Lynk research study demonstrates that (i) there is no empirical economic evidence to date that most favored nation clauses in health insurance contracts produce anticompetitive effects; and, (ii) the only existing empirical evidence shows that most favored nation clauses are pro-competitive and beneficial, and are based on valid economic and business reasons. As a result, this economic research study concluded that "If there is one lesson that is warranted from this analysis, it is that across-the-board presumptions opposing MFNs are groundless." To Anthem's knowledge, no empirical economic analysis of most favored nation clauses in health insurance contracts has been conducted since 2000.

The opposition to the use of most favored nation clauses is fundamentally based on theories and assumptions, which, as Dr. Lynk's economic research study pointed out, cannot be relied upon. There is no valid economic evidence to justify a prohibition against the use of most favored nation clauses, especially when their purpose is to reduce costs for consumers.

In conclusion, Anthem submits that the use of most favored nation clauses by insurers who purchase health care services is good for the consumer and good for the Connecticut health benefits market. It is a prudent and legitimate buying practice that is used by insurers for the benefit of their employer groups and members. Since there is no empirical economic evidence of any adverse affects from the use of these clauses, there is no valid legal or economic basis for the Legislature to interfere in the contract negotiations of buyers and sellers in the health care market. The proposal in HB 6471 to prohibit insurers and managed care organizations from including a most favored nation requirement in provider contracts would create bad law and bad health care policy in Connecticut. We therefore urge the Committee to vote against this bill.

002722

Appendix B

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

* Senior Vice President and Senior Economist, Lexecon Inc., Chicago, Illinois.

© 2000 by Federal Legal Publications, Inc.

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

---

[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.

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

---

[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.

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

[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.

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]

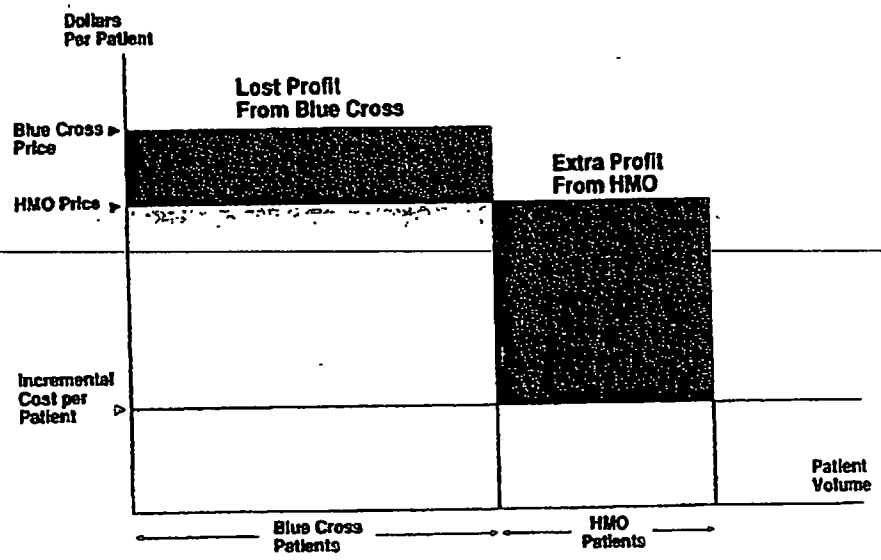
---

[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?

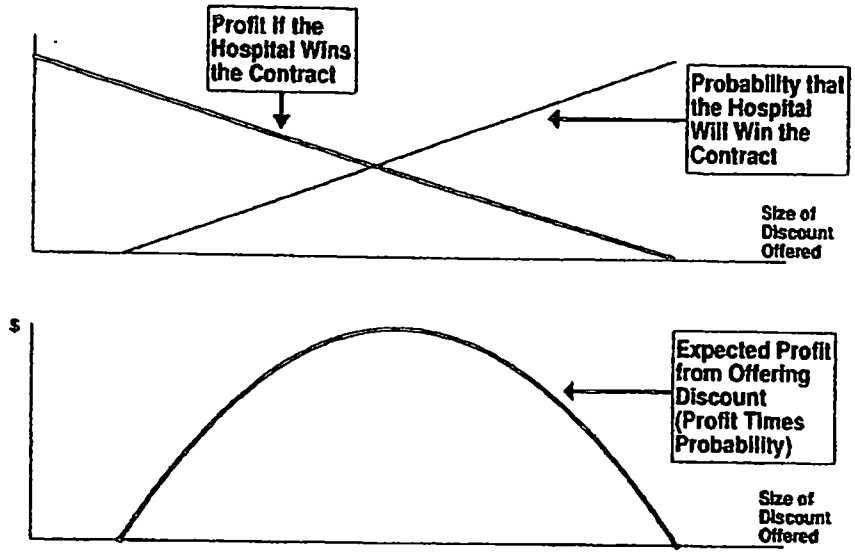
The size of the discount that is necessary to clinch the HMO's business is a key determinant of whether a deal is struck or not; the smaller the necessary discount (that is, the higher the HMO price), the likelier that the figure 1 "balance of rectangles" will favor granting a discount to the HMO. Figure 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?*

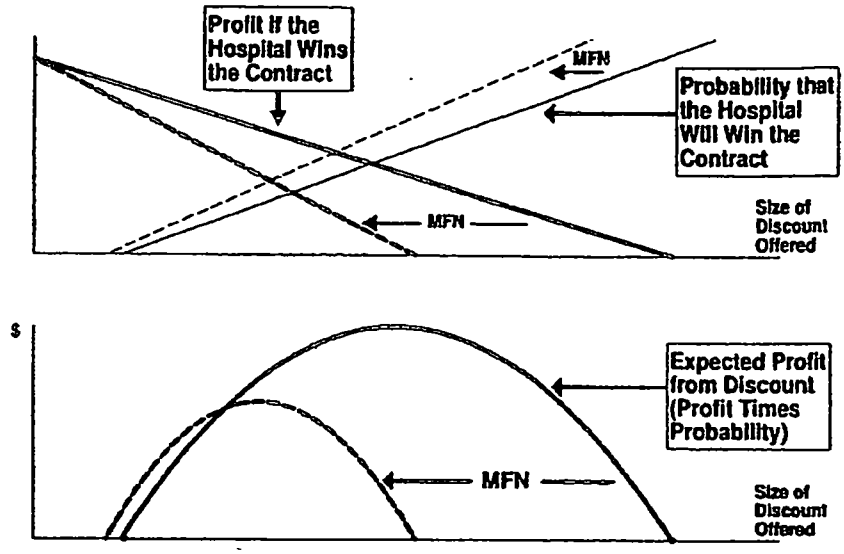
We now change the market environment of figure 2 by assuming that this hospital, and all or most of its competitors, has a contract with Blue Cross that contains an MFN provision. Figure 3 is structured like figure 2, and shows us how the MFN changes the expected profitability of offering discounts to 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.

---

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.

. MFN; but
r, are now
:y are now
O patients.
deeper dis-
, or we can
ts with the
ounting as
icing con-
increasing

:e question
l is funda-
ry can tell
ıple, with
ather than
;ation can
consumer

utterworth
aff'd, 121

ıe average
multiplied
of a prac-
the central
f discount-
eptance of
ies accep-
ng activity
ıunted and
ɔt, empiri-
dependent
mediating
:rage mar-

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

[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.

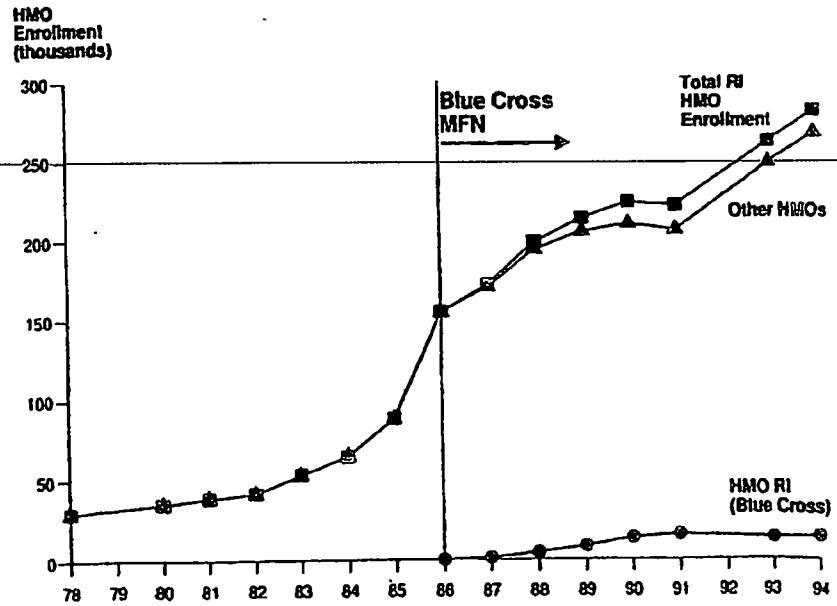
[23] Kramer, *supra* note 22.

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

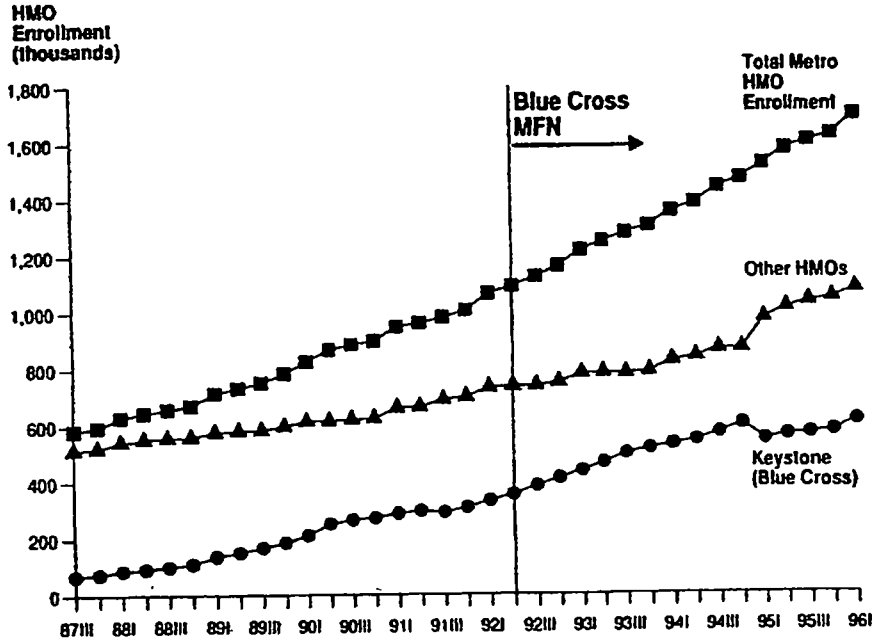


NOTE: HMO RI offered by Blue Cross-Blue Shield. Harvard Community RI members not broken out prior to 1/1/91. Some periods interpolated.

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),

tment,
rket at
'ant to

lverse
.e pre-
: their
lower
to see
:ffect?
:titive

should

grow,

'ant
:tatis-
based
icute-
rea.[28]

:ffect
er all
:ither
'enue
after
:rage

-er of
s not
hos-
area
, and

itient
:nts),

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)

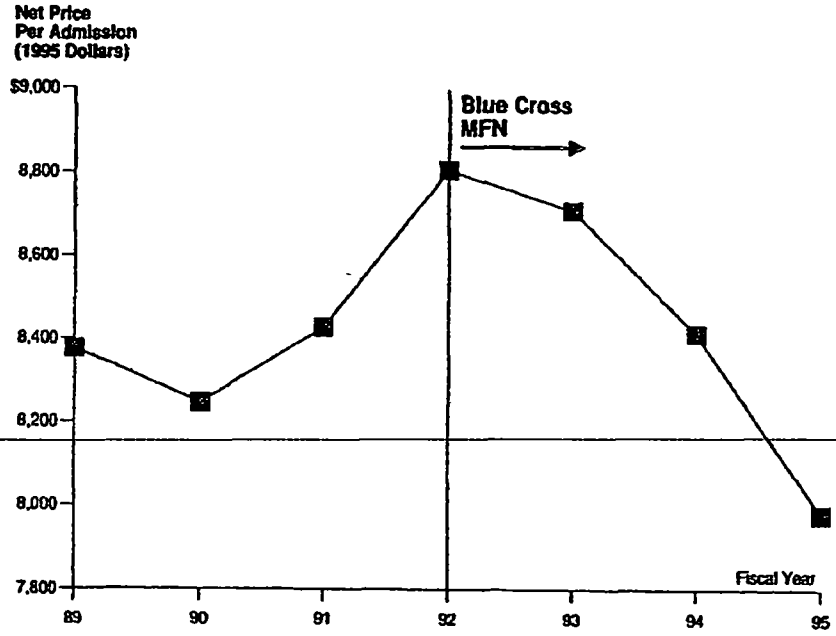
NOTE: N = 350 (50 hospitals, 7 years).
Prices deflated to 1995 dollars (Medical Care Component of Consumer Price Index).

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.

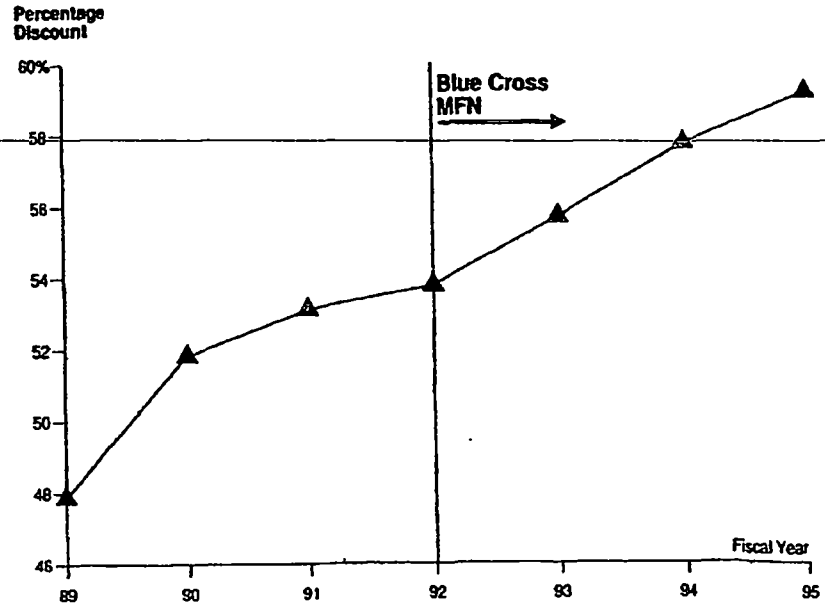
2. DISCOUNTS FROM LIST PRICE BEFORE AND AFTER THE MFN A subsidiary implication of the Justice Department's and QualMed's antitrust concerns is that the introduction of IBC's MFN should have brought with it a shrinkage of the overall discount. This we

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

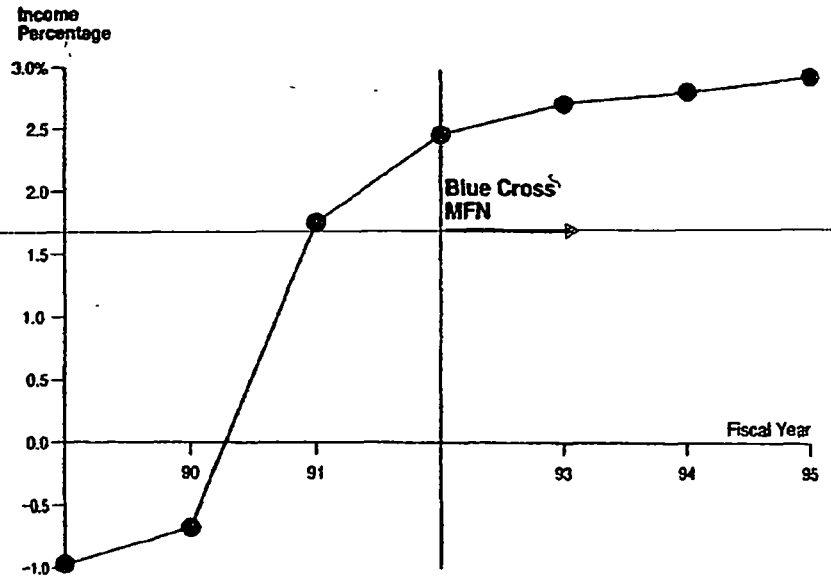


SOURCE: See table 2.

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.

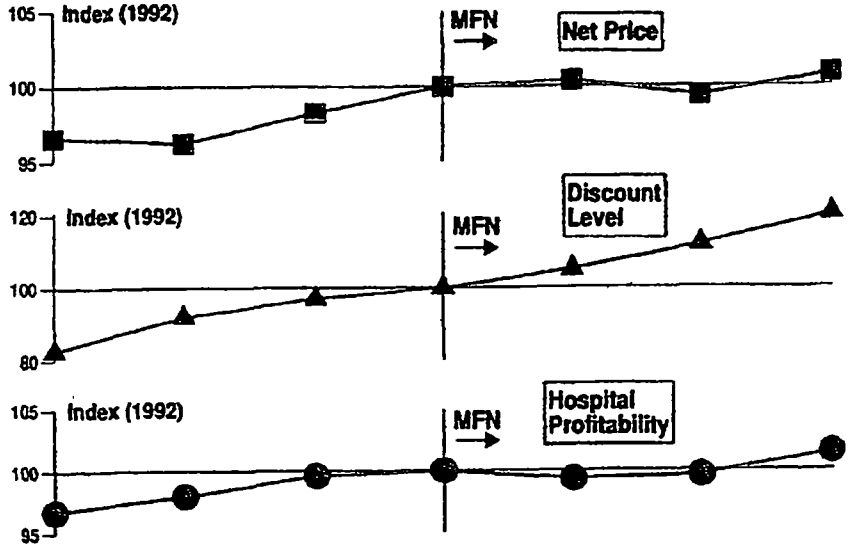
Those are the observable explanatory factors that, having controlled for their effects, we may then rule out as potential alternative causes of any remaining rise or fall in our variables of interest after the MFN begins to affect them.[31]

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-

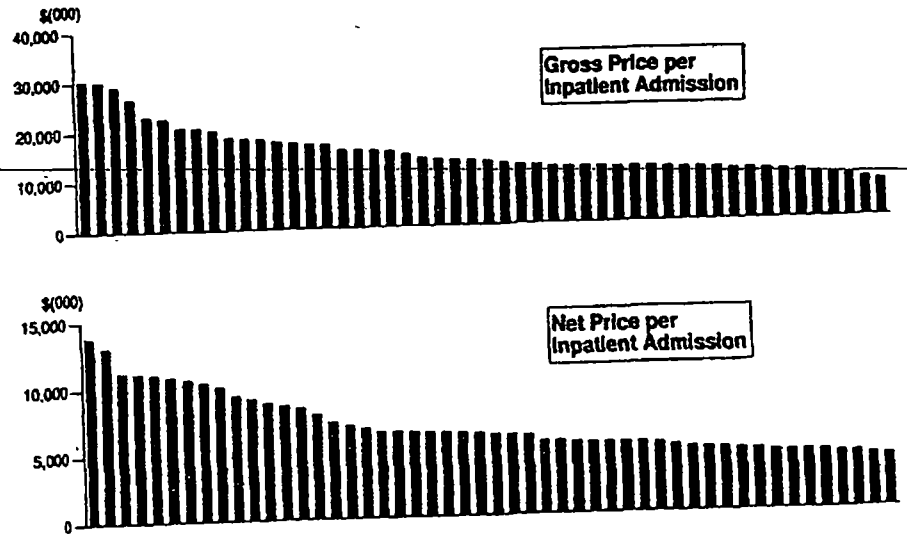
[33] Although it is not worth developing at length here, I note that had market risk been more the concern of the seller than of the buyer, the MFN clause could have been written in reverse, at least for a nonrequirements contract: for example, if the buyer later bought at a higher price from any other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



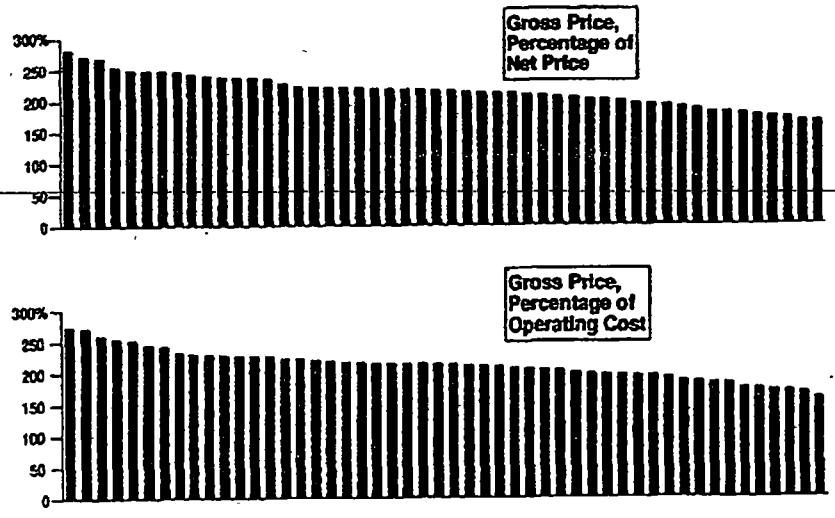
SOURCE: See table 2.

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.

[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.

a deal to
ogous to
c though

s not by
r by dis-
general-
conomic
stead to
ctual or
n of the

sis, it is
ground-
exam-
equally
lizations
fects of
l studies
employ
work to
eraliza-
nitiated
vorable
do not
ch.

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.

---

[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.

002758

inally,
licator
-1995.
line of
ctable
1989–

ters of
ics in
iables
—the
ber of
on net
on to
semix
d less
t care
sitive
dis-
l pro-
icant.
ortion
n this
ee of
atient
ffects
gnifi-

ferred
five-

sions
onate
small
ssen-
ation

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.

[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

002761

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.

CONNECTICUT ACADEMY OF
FAMILY PHYSICIANS
CARING FOR CONNECTICUT'S FAMILIES

Statement in support of House Bill 6471 –

An Act Concerning Most-Favored-Nation Clauses in Health Care Contracts

Insurance and Real Estate Committee

March 3, 2011

We would like to take this opportunity to commend this Committee for the steps that it has taken this year and in past years, in helping physicians level the playing field with managed care companies. We hope that you will continue to help us put a level of fairness in contracting with health insurers by passing House Bill 6471.

As you are well aware, the past decade has brought numerous changes to the health care industry. More and more patients are covered by a managed care plan. In order to treat these patients, physicians must sign contracts with managed care companies. However, these contracts often contain provisions that are incredibly unfair to patients and physicians. One such provision is a most favored nation clause. Such clauses require providers to allow health care plans to match any lower reimbursement rate from another insurer. The plan does not have to beat the lower reimbursement, just match it. In effect, these clauses require providers to give the payor the lowest rate that it gives to any other comparable payor this can even include public payors. Such clauses discourage a competitive market and are unfair.

We have heard the argument that physicians have a choice whether to accept clauses such as most-favored nation or to whether to sign these contracts or not, but we really have no choice. Because of the MCOs strong market power, they have been able to virtually dictate the terms and conditions they offer physicians. In addition, because of federal anti-trust laws, physicians are unable to collectively negotiate the terms and conditions of these contracts.

Presently, physicians have no choice but to sign all or nothing agreements and have no power to remedy payment problems. We hope that this Committee will recognize the unfairness that currently exists and amend and pass this bill to afford protection from these practices.

For more information, please call:

Mark Schuman, Executive Vice President
Melissa Dempsey, Government Relations Director
860-243-3977

ConnectiCare
You know us by ♥.

Written Testimony of ConnectiCare, Inc.

Submitted to
The Insurance and Real Estate Committee
Connecticut General Assembly

March 3, 2011

Testimony in Support of
HB 6471 An Act Prohibiting Most Favored Nation Clauses in Health Care Provider Contracts

Senator Crisco, Representative Megna and members of the Insurance and Real Estate Committee, my name is Janice Perkins and I am Director of Government Relations for ConnectiCare Inc. ConnectiCare is a health plan based in Farmington, Connecticut and part of the Emblem Health family with over 200,000 commercial and Medicare members. For many years, ConnectiCare has been ranked in service and quality as one of the best health plans in America. We are a local health plan with 500 employees who reside primarily in the Hartford area. Thank you for the opportunity to testify in support of HB 6471 An Act Prohibiting Most Favored Nation Clauses in Health Care Provider Contracts.

A most favored nation clause (MFN) is a provision in a provider agreement in which the parties agree that the provider will charge the payer no more than the lowest prices the provider charges any other payer. Payers with large market share often negotiate most favored nation clauses in their contracts. The bill before you would prohibit managed care organizations and preferred provider networks from including such clauses in their provider agreements.

Most Favored Nation Clauses benefit large payers that have predominant market share (see attached chart). Connecticare objects to MFN clauses in provider contracts because MFNs create an uneven playing field in the market and an unfair advantage for large health plans. MFNs are anti-competitive and actually do harm to a smaller, high quality health plan like ConnectiCare in Connecticut. The following is a true story that illustrates our concern.

Several years ago, in a nearby state, the following scenario played out. Two major hospitals in a city merged and as a result attained substantial market power. The new hospital organization got together with the biggest health plan in the area and made a deal: The health plan agreed to give the hospital a large pay increase, and the hospital agreed to require all other health plans with which it had contracts to pay at least as much as those new higher rates. Several months later, a smaller health plan negotiated a contract renewal with the hospital. The hospital demanded the higher rates from the smaller health plan. The smaller health plan would not agree to the increased fees. The hospital launched a public campaign to tell its patients that it would no longer accept the smaller health plan coverage. The smaller health plan's employer and individual customers threatened the smaller health plan with policy cancellations. Result: The smaller health plan relented and agreed to increase its rates. The risk of policy terminations threatened the very viability of the smaller health plan.

This is an example of the damage that can be done by a Most Favored Nation or MFN clause in a provider-payer contract. A payer with sufficient market clout to obtain an MFN clause in a provider contract benefits by ensuring that its competitor health plans will have to pay at least as much for medical services as the big health plan will pay. However, the overall health plan market is the big loser: Other payers find that they are unable to bargain for better provider rates because providers are not willing to violate the MFN provisions in their agreement with the big health plan. There is only one result: higher costs for health plans and higher premiums for the employers and individuals they serve. MFN clauses in provider contracts act as "floor pricing" in the health care industry: No matter what the true costs of providing coverage really are, pricing will never fall below the artificial floor set by the one contract with the MFN clause. This is clearly not in the best interests of health plan customers, particularly as we seek to make insurance more affordable.

MFN clauses provide a substantial disincentive for providers to even consider accepting lower rates from other payers because to do so will decrease the provider's compensation in a disproportionate matter. If a provider agrees to perform a service for $100 under a contract with an MFN clause, and then agrees to perform the same service for $90 under a contract with another payer (without an MFN clause),the provider must then notify the payer with the MFN clause of the new $90 fee arrangement, and also must accept a $10 pay cut for that service from the payer with the MFN clause. Such a situation poses a barrier for providers that might want to consider new and innovative payment arrangements, since they may be unable to afford to accept an across-the-board pay cut to enter into a lower-priced contract. The obvious effect on the overall health care market is to stifle competition and innovation in payment practices, to hinder cost containment efforts and to harm consumers.

It is in all of our interests to control costs. Let's do it in a way that that supports fair competition among all the payers. Anything less removes our ability to compete on a level playing field and to succeed in our efforts to lower the costs of health insurance premiums for the people of Connecticut. For this reason we urge your support of HB 6471.

(continued)

TOTAL HMO and Indemnity	Insured	ASO	Total	Market Share of State Total Insured
Aetna	223,566	352,114	575,680	18.5%
Anthem (WellPoint)	536,728	814,246	1,350,974	43.4%
CIGNA	75,277	59,540	134,817	4.3%
ConnectiCare	176,502	42,653	219,155	7.0%
Health Net	113,646	92,911	206,557	6.6%
Oxford (United)	91,818	1,866	93,684	3.0%
United Healthcare (incl. Golden Rule)	130,622	139,862	270,484	8.7%
SUBTOTAL	1,348,159	1,503,192	2,851,351	
Other (Indv) Indemnity less Golden Rule	4,385	0	4,385	0.1%
Other: Community Health Network (Medicaid)	257,039	0	257,039	8.3%
Total Insured	1,609,583	1,503,192	3,112,775	
CT Uninsured			380,400	
CT Total Population (approximate)			3,500,000	

Sources:
- *CT Insurance Department (CID), Released Oct. 2010 (YE 2009 Data)*
- *ConnectiCare January 2011 membership 224,714 (29,603 ASO); Market Share of CT Insured 7.2%*
- *Community Health Network membership from CT Dept. of Social Services, Dec. 2010*
- *Current Uninsured and Total Population data from U.S. Census, Kaiser*

Quality is Our Bottom Line

Insurance Committee Public Hearing

March 3, 2011

Connecticut Association of Health Plans

Testimony in Support of

HB 6471 An Act Prohibiting Most Favored Nation Clauses in Health Care Provider Contracts

The Connecticut Association of Health Plans is pleased to support HB 6471. Assuring that Connecticut's health insurance marketplace remains competitive is critical to the health of the overall delivery system. Most Favored Nation Clauses create an unlevel playing field among the carriers and should be prohibited allowing health plans to compete on the basis true cost and quality. Currently, Connecticut has the benefit of five major health insurers in the state which gives our employers and consumers real choice among products. Practices that have the potential to destabilize the market should be discontinued.

Thank you for your consideration.

280 Trumbull Street | 27th Floor | Hartford, CT 06103-3597 | 860.275.8372 | Fax 860 541 4923 | www.ctahp.com

State of Connecticut

HOUSE OF REPRESENTATIVES
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

REPRESENTATIVE ELIZABETH B. RITTER
THIRTY EIGHTH ASSEMBLY DISTRICT

LEGISLATIVE OFFICE BUILDING
ROOM 3004
HARTFORD, CT 06106-1591
HOME: (860) 444-1700
CAPITOL: (860) 240-8585
TOLL FREE. 1-800-842-8267

E-MAIL Elizabeth Ritter@cga.ct gov

CHAIRMAN
PUBLIC HEALTH COMMITTEE

MEMBER
APPROPRIATIONS COMMITTEE
ENERGY AND TECHNOLOGY COMMITTEE

TESTIMONY TO THE COMMITTEE ON INSURANCE AND REAL ESTATE
HB 6471 AN ACT PROHIBITING MOST FAVORED NATION CLAUSES IN HEALTH CARE PROVIDER CONTRACTS
March 3, 2011

Good morning Senator Crisco, Representative Megna, and the members of the Committee on Insurance and Real Estate. I am Elizabeth Ritter and I am the State Representative from the 38th District, representing the Towns of Waterford and Montville. I am testifying in support of HB 6471 AN ACT PROHIBITING MOST FAVORED NATION CLAUSES IN HEALTH CARE PROVIDER CONTRACTS.

This bill prohibits any provision in any contract between a health insurer and a hospital or health care provider that prohibits the hospital or provider from contracting with another insurer at a lower payment or reimbursement rate. It also prohibits these contracts from containing provisions requiring provider disclosure of the rates paid by other insurers or a mandatory renegotiation option if a lower rate is agreed to between the provider and another insurer.

These "most favored nation" clauses require providers to give payers the lowest rate that it gives to any other payer, are inherently anti-competitive, and are simply not fair to providers. They have been allowed to exist because the health insurance industry is exempt from federal trade laws. They present huge barriers to new market entrants; and they greatly serve the interests of the insurance company over the consumer, leaving the healthcare provider in the middle of the transaction with no alternatives other than to take the insurer's policy in the fear of losing a substantial portion of their patients.

Thank you for your careful consideration of this bill. I urge you to add Connecticut to the growing list of states learning the dangers of these clauses by supporting this bill.

Sincerely,

Betsy Ritter

State Representative
38th District

did not speak

FTR

Testimony of Paul Knag in Support of Senate Raised Bill 6471

I am a partner of the firm of Murtha Cullina LLP. I am Chair of its Health Care Group.

Prior to joining Murtha, I served as Chair of the Health Care Group at Cummings and Lockwood. I represent numerous hospitals and other health care providers. However, I am not here today representing any client, but rather am here to express my personal views

I am in support of view taken in this bill that insurers should be prevented from unduly leveraging their market share by requiring providers to agree to a so called "most favored nation" ("MFN") clause. Under an MFN clause, hospitals are required to charge other payors an amount equal to or more than they charge the payor which has the MFN clause.

For many years, providers in this state have sought to end this practice of payors demanding MFN clauses. There are many circumstances which might warrant a hospital charging less in a particular circumstance For example, a competing plan might cost less to administer.

By eliminating these MFN clauses, hospitals will be free to negotiate freely with all payors, and will be able to charge lower fees than may be permitted by the anti-consumer, anti-competitive MFN clauses.

Furthermore, it should be noted that to enforce this clause, the payor with the clause in the contract may attempt to require the hospital or other provider to disclose the rates it is charging other payors. This itself is highly uncompetitive.

It is my understanding that twenty other states have already passed similar legislation. It makes sense to obtain this result through legislation, rather than to leave it to court battles with the attendant high costs.

Therefore, I believe this legislation is in the public interest and should be enacted as law.

Date: March 1, 2011

Paul E. Knag

Paul E. Knag, Esq.

STATE OF CONNECTICUT)
) ss: New Haven, CT
COUNTY OF NEW HAVEN)

On this the 1st day of March, 2011, before me, Heather Bachun, personally appeared Paul E Knag, Esq., satisfactorily proven to be the person whose name is subscribed to the within instrument and acknowledged that he executed the same for the purposes therein contained.

In witness whereof I hereunto set my hand.

Commissioner of the Superior Court

Didn't speak FTR

Testimony of the
Connecticut Society of Eye Physicians
Connecticut ENT Society
Connecticut Dermatology and Dermatologic Surgery Society
Connecticut Urology Society
Connecticut Chapter of the American College of Surgeons
Connecticut Oncology Association
CT Orthopaedic Society
on
HB 6471, AN ACT PROHIBITING MOST FAVORED NATION CLAUSES IN HEALTH CARE PROVIDER CONTRACTS
Before the Insurance and Real Estate Committee
March 3, 2011

Good Morning Senator Crisco, Representative Megna and other distinguished members of the Insurance and Real Estate Committee For the record, my name is Mahesh Bhaya, M.D., I am a board certified otolaryngologist practicing in Waterbury, CT, and I am here representing over 2000 medical doctors in the specialties of dermatology, eye, orthopaedics, oncology, otolaryngology, general surgery and urology to support HB 6471, An Act Prohibiting Most Favored Nation Clauses In Health Care Provider Contracts.

Healthcare Providers in Connecticut are beginning to see a recurrence of a behavior, like the inclusion of Most Favored Nations(MFN) clauses, that was prohibited by legal settlements between the insurers and organized medicine, now that those settlements have expired. In light of this, I am here to ask this committee to follow the example of Rhode Island, New Hampshire, Vermont and New York, among others, to statutorily prohibit "Most Favored Nations" (MFN) clauses from inclusion in Physician/ Managed Care Organization Contracts.

A Most Favored Nations clause allows an insurer to demand the lowest price for any procedure that a provider has agreed to in any other contract, regardless of what company issued it, or what other terms may be contained in that contract which might make it possible for the provider to accept that price. This clause inclusion severely limits the doctor's ability to selectively contract with third party payors based on specific circumstances important to the doctor, such as whether or not the payer makes payments in a timely fashion, whether they represent a significant market share, or if the rest of the payment schedule can balance the losses on a given procedure. It effectively negates any negotiating power or skill a practice might have, and gives the insurer complete control to fix prices. This puts the doctor at a huge disadvantage, especially if the MFN clause is in a contract that represents a large portion of the practices patients and revenue. Connecticut is already experiencing a drain of providers. This loss of market forces, keeping artificially low prices on goods and services, will make an already adverse practice environment worse.

MFN clauses are also anti-competitive, in that they produce marketplaces in which new competitors are simply unable to survive because they can't compete on price. There are several examples that illustrate the potential negative competitive consequences of MFN clauses. New competitors may be discouraged from entering the payor/provider marketplace, or providers may limit their payor mix. Consumers may be negatively affected by suppression of competition and resulting higher rates, as well as the loss of provider and patient autonomy. MFN clause also have the unintended consequences of restricting access to physicians in lower paying programs, such as Medicare, Medicaid (Husky), SAGA, and Charter Oak or other such programs.

In closing, we have attached some of the actual MCO/physician contract language for your review and appreciate the time and consideration this committee has given us today.

One example of a MFN clause from an actual contract offered this year:

AGREEMENT

This Agreement confirms the understanding between _____and Aetna Health Inc. ("Aetna") regarding rates payable under the Physician Group Agreement which will be effective _____ (referred to hereinafter as "Agreement").

1. Physician Group warrants and covenants that the rates payable under the Physician Group Agreement for Covered Services are and will remain at least as favorable as those granted or to be granted by Group to any other health maintenance organization, insurer, network or third party administrator ("Other Carrier").

2. Should Physician Group grant any Other Carrier more favorable rates and terms than those provided in the Physician Group Agreement, then Physician Group will notify Aetna in writing within (30) days and Aetna will thereupon receive the more favorable prices and terms effective as of the date that Physician Group granted such more favorable prices and terms to such Other Carrier. If requested by Aetna in writing, Physician Group will execute an Amendment to the Physician Group Agreement to contain the more favorable prices and terms effective as of the date that Physician Group granted such more favorable prices and terms to such Other Carrier.

3. Aetna will have the right, upon ninety (90) days prior written notice, to secure (at its own expense) a confidential audit for the sole purpose of determining if the rates and terms payable under the Physician Group Agreement are at least as favorable as those granted by Physician Group to any Other Carrier. The auditor will have the skills and qualifications reasonably required to perform its duties hereunder. In the event that either Physician Group or the auditor confirms that the rates and terms under the Physician Group Agreement are not at least as favorable as those granted by Physician Group to any Other Carrier, then the reimbursement rates and terms that Aetna pays Physician Group under the Physician Group Agreement will be adjusted to match the more favorable rates and terms effective as of the date that Physician Group had granted such more favorable rates and terms to such Other Carrier.

4. Under either (2) or (3) above, to the extent that Aetna has paid Physician Group monies in excess of that which would have been paid had the more favorable rates and terms been in place as of the date the services were rendered, Aetna will calculate the amount of the overpayment made by Aetna, will notify Physician Group of the overpayment, and Physician Group will reimburse Aetna for such overpayment within thirty (30) days following receipt of Aetna's notice of the overpayment.

AGREED AND ACCEPTED:	AGREE AND ACCEPTED
PHYSICIAN GROUP	AETNA
By:_____	By:_____
Title:	Title:
Date:	Date:

P5
L1

Opening Remarks Regarding Raised Bills 6471
Insurance and Real Estate Committee

Good day Senator Crisco, Representative Megna, vice chairs, ranking members and members of the Insurance & Real Estate Committee.

My name is Michael Nicastro and I am the President & Chief Executive Officer of the Central Connecticut ~~Chambers~~ of Commerce headquartered in Bristol.

I appear before you in support of Raised Bill 6471, An Act Prohibiting Most-Favored-Nation (MFN) Clauses in Health Care Provider Contracts. Prior to taking on my current role leading the Central Connecticut Chamber I was the Senior Vice President and Chief Marketing Officer of Open Solutions Inc, Connecticut's largest state based software company.

During the 14 years with Open Solutions one of my primary responsibilities as CMO was to oversee all third party contractual relationships. As such I am very familiar with Most-Favored-Nations clauses and how they can be used both effectively and in some cases detrimentally in business situations.

With that as background let me provide you with an example from my experience. When Open Solutions was in its early stages as a company we entered into a reseller arrangement with one of our largest competitors. Through this arrangement we were able to leverage the size and distribution strength that this competitor could deliver which we as a start-up company lacked.

Contained in the initial drafts of the agreement was both exclusivity and MFN clauses. To avoid both of these clauses from becoming a method of suffocating our young company we modified the language to provide for both exceptions to the exclusivity and MFN status.

This was done by developing a set of performance metrics that the reseller needed to attain in order to maintain not only their exclusivity but the MFN status as well. Failure to meet set sales goals resulted in either offsetting royalty payments or the loss of MFN status. These goals were annualized but also had quarterly benchmarks and reviews.

Throughout the process we needed to take great care to balance the need of the company with the opportunity that a large partner could provide while at the same time not compromising our business model or federal anti-trust laws.

In that case where we were selling software and services across all states in some cases globally the process worked well. It was for the most part a business to business sales model and all prospective clients had a meaningful choice of providers and simply could have gone elsewhere for service.

While this is an example of an effective use of a MFN there are circumstances where the use does not translate well. One area for certain is that of Health Care Providers and their agreements with Medical Service providers.

As a business person I can tell you that at first blush not using an MFN is counter intuitive. But as a matter of public policy the use of MFN in some cases just does not work. With current legal constraints on cross border insurance sales and the anti-trust exception enjoyed by the industry the medical providers are placed at clear competitive disadvantage. Contracting health organizations that garner and control the highest percentages of market share can use MFN as tool to further erode competition.

The end result is a lack of competitive pricing that ultimately gets passed along to businesses and individuals. By restricting the use of MFN under this very narrowly drafted bill the legislature can provide a competitive protection that the anti-trust exception has inadvertently created.

As a Chamber of Commerce we are very concerned with overall tenor and discussion of the healthcare debate. One thing we can agree on is that improving the competitive nature of the market can help. Certainly the prohibition of MFN clauses in these contracts is a positive step and one our Chamber can support in Bill 6471.

Thank you for the opportunity to speak before you this morning and I am happy to answer any questions that you may have regarding this issue.

P 3
L 2

Testimony of the
Connecticut Society of Eye Physicians
Connecticut ENT Society
Connecticut Dermatology and Dermatologic Surgery Society
Connecticut Urology Society
CT Orthopaedic Society
Connecticut Oncology Association
Connecticut Chapter of the American College of Surgeons
on
HB 6471, AN ACT PROHIBITING MOST FAVORED NATION CLAUSES IN HEALTH CARE PROVIDER CONTRACTS
Before the Insurance and Real Estate Committee
March 3, 2011

Good Morning Senator Crisco, Representative Megna and other distinguished members of the Insurance and Real Estate Committee For the record, my name is Debbie Osborn, I am the executive Director of the Connecticut Society of Eye Physicians, CT ENT, CT Dermatology and CT Urology Society and I am here representing over 1500 medical doctors in the specialties of dermatology, eye, orthopaedic, otolaryngology, general surgery, oncology and urology to support HB 6471, An Act Prohibiting Most Favored Nation Clauses In Health Care Provider Contracts.

Healthcare Providers in Connecticut are witnessing a recurrence of a behavior. The inclusion of Most Favored Nations (MFN) clauses, that were previously prohibited by legal settlements between the insurers and organized medicine, are resurfacing now that those settlements have expired. In light of this, I am here to ask this committee to follow the example of Rhode Island, New Hampshire, Vermont and New York, among others, to statutorily prohibit "Most Favored Nations" (MFN) clauses from inclusion in Physician/ Managed Care Organization Contracts.

A Most Favored Nations clause allows an insurer to demand the lowest price for any procedure that a provider has agreed to in any other contract, regardless of what company issued it, or what other terms may be contained in that contract which might make it possible for the provider to accept that price. This clause inclusion severely limits the doctor's ability to selectively contract with third party payors based on specific circumstances important to the doctor, such as whether or not the payer makes payments in a timely fashion, whether they represent a significant market share, or if the rest of the payment schedule can balance the losses on a given procedure. It effectively negates any negotiating power or skill a practice might have, and gives the insurer complete control to fix prices. This puts the doctor at a huge disadvantage, especially if the MFN clause is in a contract that represents a large portion of the practices patients and revenue. Connecticut is already experiencing a drain of providers. This loss of market forces, keeping artificially low prices on goods and services, will make an already adverse practice environment worse.

MFN clauses are also anti-competitive, in that they produce marketplaces in which new competitors are simply unable to survive because they cannot compete on price. There are several examples that illustrate the potential negative competitive consequences of MFN clauses. New competitors may be discouraged from entering the payor/provider marketplace, or providers may limit their payor mix. Consumers may be negatively affected by suppression of competition and resulting higher rates, as well as the loss of provider and patient autonomy. MFN clauses also have the unintended consequences of restricting access to physicians in lower paying programs, such as Medicare, Medicaid (Husky), SAGA, and Charter Oak or other such programs.

In closing, we have attached some of the actual MCO/physician contract language for your review and appreciate the time and consideration this committee has given us today.

One example of a MFN clause from an actual contract offered this year:

AGREEMENT

This Agreement confirms the understanding between _____and Aetna Health Inc. ("Aetna") regarding rates payable under the Physician Group Agreement which will be effective _____ (referred to hereinafter as "Agreement").

1. Physician Group warrants and covenants that the rates payable under the Physician Group Agreement for Covered Services are and will remain at least as favorable as those granted or to be granted by Group to any other health maintenance organization, insurer, network or third party administrator ("Other Carrier").

2. Should Physician Group grant any Other Carrier more favorable rates and terms than those provided in the Physician Group Agreement, then Physician Group will notify Aetna in writing within (30) days and Aetna will thereupon receive the more favorable prices and terms effective as of the date that Physician Group granted such more favorable prices and terms to such Other Carrier. If requested by Aetna in writing, Physician Group will execute an Amendment to the Physician Group Agreement to contain the more favorable prices and terms effective as of the date that Physician Group granted such more favorable prices and terms to such Other Carrier.

3. Aetna will have the right, upon ninety (90) days prior written notice, to secure (at its own expense) a confidential audit for the sole purpose of determining if the rates and terms payable under the Physician Group Agreement are at least as favorable as those granted by Physician Group to any Other Carrier. The auditor will have the skills and qualifications reasonably required to perform its duties hereunder. In the event that either Physician Group or the auditor confirms that the rates and terms under the Physician Group Agreement are not at least as favorable as those granted by Physician Group to any Other Carrier, then the reimbursement rates and terms that Aetna pays Physician Group under the Physician Group Agreement will be adjusted to match the more favorable rates and terms effective as of the date that Physician Group had granted such more favorable rates and terms to such Other Carrier.

4. Under either (2) or (3) above, to the extent that Aetna has paid Physician Group monies in excess of that which would have been paid had the more favorable rates and terms been in place as of the date the services were rendered, Aetna will calculate the amount of the overpayment made by Aetna, will notify Physician Group of the overpayment, and Physician Group will reimburse Aetna for such overpayment within thirty (30) days following receipt of Aetna's notice of the overpayment.

AGREED AND ACCEPTED:	AGREE AND ACCEPTED
PHYSICIAN GROUP	AETNA
By:_____	By:_____
Title:	Title:
Date:	Date:

P. 3
L-5

TESTIMONY OF KURT BARWIS
PRESIDENT & CHIEF EXECUTIVE OFFICER
BRISTOL HOSPITAL, INC.
BEFORE THE COMMITTEE ON INSURNACE AND REAL ESTATE
Thursday March 3, 2011

H.B. No. 6471, An Act Prohibiting Most Favored Nation Clauses in Health Care Provider Contracts

My name is Kurt A. Barwis and I am the President & Chief Executive Officer of Bristol Hospital. On behalf of Bristol Hospital I appreciate the opportunity to testify in support of H.B. No. 6471, *An Act Prohibiting Most Favored Nation Clauses in Health Care Provider Contracts.*

The adoption of legislation prohibiting the use of most-favored nations ("MFN") clauses in health care provider contracts is important because it will enhance health care insurance competition in Connecticut. Nineteen (19) states have already enacted similar legislation and in addition, the United States Department of Justice has attacked MFN's in litigation which has been commenced. A listing of all states which have already enacted such legislation is attached hereto as EXHIBIT I. The existence of MFN clauses in health care provider contracts harms the public in the following ways:

- **Anti- Competitive Effects of MFN Clauses:** MFN clauses limit competition and allow large insurers to dictate terms and conditions, and perpetuate and enhance market concentration. This is because MFN clauses limit and deter entry to the market by other insurers and payers. Even large insurers, such as United Health Care, have found that they cannot fairly compete in markets where MFN clauses are being used by a competitor.
    - With the exception of the Charter Oak Health Plan which Bristol Hospital could not initially contract with due to the existence of an MFN clause in its largest payer contract, and Medicaid/Medicare Managed Care Plans which are exempted from MFN clauses, Bristol Hospital has been approached twice during the last four (4) years, both by a health insurance companies covering primarily workers compensation, one also provided Third Party Administration "TPA" services.
- **Cost Associated with the Negotiation and Enforcement of MFN Clauses:** The existence of MFN clauses in contracts requires health care providers to continuously monitor for compliance, which involves a commitment of resources. Additionally, health care providers must participate in audits initiated by insurers which may reveal competitor's pricing, which in itself is highly anti-competitive. Furthermore, the negotiation process may be more costly due to the amount of diligence an analysis required as a result of accepting an MFN.
    - Bristol Hospital spent approximately $113,712 and over 376 hours responding to an MFN audit last year.
        - Bristol Hospital has an MFN clause in one of its largest commercial health insurance contracts.
        - Bristol Hospital would not have a contract with this payer if it did not continue to accept the MFN clause in this payer contract.

- Without this payer's contract Bristol Hospital would likely go out of business.

- **Increase in Price Terms:** MFN clauses affect a provider's ability to negotiate terms with individual plans, and prevent a provider from rewarding competitors who provide better service or less red tape in the processing of claims. Preserving and enhancing the concentration results in higher prices across the board, ultimately affecting the amounts paid by consumers.

- **MFN Clauses Discourage Innovation:** MFN clauses discourage providers from entering into innovative payment methodologies with other insurers. The federal reform legislation and other commentators agree that moving to non-fee for service payment methodologies which create incentives to improve quality and reduce cost is a key element to reforming the current system.

Last Legislative Session, Senate Bill 429, An Act Concerning Most-Favored Nations Clauses in Health Care Contracts was raised in the Public Health Committee – Our then Attorney General Richard Blumenthal submitted testimony in support of the bill. Attorney General Richard Blumenthal's Testimony is attached hereto as **EXHIBIT II.**

Finally below, is an excerpt from the Ohio 127th General Assembly House Bill 125 Joint Legislative Commission on Most Favored Nation Clauses in Health Care Contracts Report 2010, Statement of three (3) Commission Members, pages 30-31 which state:

> "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 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 MFN's. 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 MFN's are in fact anti-competitive because of its negative impact on the suppression of market competition."

In closing, Bristol Hospital, Inc. appreciates the opportunity to present its testimony in support of H.B. 6471.

Testimony of Kurt Barwis, President & Chief Executive Officer
Bristol Hospital, Inc.
Committee on Insurance and Real Estate
H.B. 6471 An Act Prohibiting Most Favored Nation Clauses in Health Care Provider Contracts
March 3, 2011

AN ACT CONCERNING MOST-FAVORED-NATIONS CLAUSES IN HEALTH CARE CONTRACTS - EXPLANATORY STATEMENT
EXHIBIT I

- **States that have either banned or restricted the use of MFN clauses in health care contracts:**

1. **ALABAMA** – Reference, Ohio report states they ban MFN
2. **ALASKA** – Bans clauses or place restriction on which plans may use MFN clauses
3. **CALIFORNIA** – Bans clauses or place restriction on which plans may use MFN clauses
4. **COLORADO** – Banned MFN in 2007
5. **IDAHO** – Banned MFN clauses in 1998
6. **INDIANA** – Banned MFN in 2007
7. **KENTUCKY** – Bars insurer with a local market share of more than 20% from putting a MFN clause in contracts with physicians
8. **MARYLAND** – Banned MFN in 2006
9. **MASSACHUSETTS** – Banned in 2010
10. **MINNESOTA** – Bans clauses or place restriction on which plans may use MFN clauses.
11. **NEW HAMPSHIRE** – Bans clauses or place restrictions on which plans may use MFN clauses
12. **NEW JERSEY** – Reference, Ohio report states they ban MFN
13. **NEW YORK** - Reference, Ohio report states they ban MFN
14. **OHIO** – Banned for hospitals in 2008
15. **ORGEGON** – Bans practices injurious to free competition
16. **RHODE ISLAND** – Bans clauses or place restrictions on which plans may use MFN
17. **VERMONT** – Banned MFN in 2009
18. **WASHINGTON** – Bans clauses or place restrictions on which pans may use MFN clauses
19. **WEST VIRGINIA** – Reference, Ohio report states they ban MFN

- **Pending states in litigation**

20. **MICHIGAN** – United States of America and the State of Michigan VS. Blue Cross Blue Shield of Michigan, complaint filed in October 2010 citing egregious anticompetitive activities

p2

L18

State Medical Society

(203) 865-0587 FAX (203) 865-4997

Matt K.

Connecticut State Medical Society Testimony in support of
House Bill 6471 An Act Concerning Most-Favored Nation Clauses in Health Care Contracts
Insurance and Real Estate Committee
March 3, 2011

Senator Crisco, Representative Megna and Members of the Insurance and Real Estate Committee , my name is Matthew Katz and I am the Executive Vice President of the Connecticut State Medical Society (CSMS). On behalf of our more than 7,000 physicians and physician in training members thank you for the opportunity to present this testimony to you today in support of House Bill 6471 An Act Concerning Most-Favored Nation Clauses in Health Care Contracts

This legislation will prohibit the use of a contractual clause by insurers and other contracting entities that are inherently unfair and currently gaining national attention for the detrimental impact they have on physicians and on patient access to care.

"Most favored nations" clauses, though not as common as they once were, limit competition among and between insurers, and also allow for the continuation of health insurer monopolistic and monopsony related behavior to further limit a physician's ability to effective negotiate contractual terms, including rates and related issues or even unrelated issues such as quality, access and efficiency.

There are two main types of MFN clauses generally in effect in contracts.

- Comparable Rate clauses – 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.
- 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.

These clauses are fundamentally unfair and limit, if not prohibit a physician from negotiating not only rates, but other terms of their contract in a fair and open marketplace. This limits competition and allows large insurers to dictate terms and conditions, preventing other insurers who are in the market from competing on price or other terms of negotiation and further limit access to this market by other insurers, who may offer other benefits in lieu of payment rates to entice physicians to sign contracts.

When MFN clauses are in effect, providers, including physicians, cannot lower price to attract more business and they cannot effectively negotiate with insurers on areas other than price or cost. In addition, 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, especially if the market is already concentrated or highly concentrated, as is Connecticut (looking at local and statewide markets). Fewer competitors may lead to less choice and higher prices. While less plausible but possible in the extreme, MFN clauses could facilitate collusion among providers, such as hospitals, by disallowing competition on price.

CSMS believes that "most favored" or "equally favored" provisions of contracts for medical services should be expressly prohibited as they are in most neighboring states; including Rhode Island, New Hampshire, Vermont and New York, as well as in at least 13 other states across the country.

The Ohio legislature last year formed a Commission to review the matter of MFNs and after an extensive and lengthy review voted to recommend that the Ohio Legislature prohibit or restrict MFN clauses in health care contracts. They based this recommendation on an investigation of both the impact on these restrictive clauses on insurers, as well as hospitals, and found that there are costs to insurers and hospitals associated with the enforcement of MFN clauses, including both direct and indirect costs associated with audits initiated by insurers, and that some of these costs to institutions can be substantial.

CSMS believes that any legislation designed to address this situation of unfair contracting should:

(1) prohibit an insurer or other entity from granting itself, or its affiliates or subsidiaries, the ability to limit or otherwise restrict the physician from agreeing to accept payment of equal to or lower than received from said insurer or entity;

(2) prohibit and insurer or other entity from requiring or granting itself the option to require the physician from accepting lower payment from said insurer if the physician accepts lower payment from another contracting or non-contracting entity;

(3) prohibit the insurer or other entity from restricting or limiting a physician from charging a lower price or fee than the price or fee the physician charges said insurer;

(4) prohibit the insurer or other entity from requiring the physician to certify that payment is not higher or lower than the payment rate that the physician receives from any other insurer or entity; and

(5) prohibit the insurer or other entity from requiring termination or renegotiation of the physician agreement if the physician has agreed to accept payment lower than the rate from the said insurer for the provision of medical services.

We ask for your support of this legislation and recognize that when these "most favored" or "equal to" clauses are in physician contracts, they limit a physician's ability to negotiate on rates as well as other terms and have the unintended consequences of restricting access to physicians in lower paying programs, such as Medicare, Medicaid (Husky), SAGA, and Charter Oak or other such programs.

Physicians should be allowed to negotiate on price, but also on cost, quality and efficiency. These contractual clauses do nothing more than limit a physician's ability to negotiate and further limits competition in an already highly concentrated market.

Please Support House Bill 6471.

S – 632

CONNECTICUT
GENERAL ASSEMBLY
SENATE

PROCEEDINGS
2011

VOL. 54
PART 21
6546-6914

Move to place this item on the Consent Calendar.

THE CHAIR:

So ordered.

SENATOR LOONEY:

Thank you, Madam President.

The final item on calendar page 18, Calendar 548, House Bill Number 6471.

Move to place this item on the Consent Calendar.

THE CHAIR:

So ordered.

SENATOR LOONEY:

Thank you, Madam President.

Moving now to calendar page 19, where we also have several items. First: Calendar 550, House Bill Number 6, excuse me, House Bill Number 5802.

Madam President, move to place this item on the Consent Calendar.

THE CHAIR:

So ordered.

SENATOR LOONEY:

Thank you, Madam President.

Calendar 551, House Bill Number 6433.

Mr. Clerk.

THE CLERK:

Immediate roll call's been ordered in the Senate on the Consent Calendar. Will all Senators please return to the Chamber. Immediate roll call's been ordered in the Senate on the Consent Calendar. Will all Senators please return to the Chamber.

THE CLERK:

Madam President, the items placed…

THE CHAIR:

I would ask the Chamber to be quiet please so we can hear the call of the Calendar for the Consent Calendar.

Thank you.

Please proceed, Mr. Clerk

THE CLERK:

Madam President, the items placed on the first Consent Calendar begin on calendar page 5, Calendar 336, House Bill 5697.

Calendar page 7, Calendar 421, Substitute for House Bill 6126.

Calendar page 8, Calendar 449, Senate Bill 1149.

Calendar page 10, Calendar 470, Substitute for House Bill 5340. Calendar 474, Substitute for House Bill 6274. Calendar 476, House Bill 6635.

Calendar page 12, Calendar 499, Substitute for House Bill 6638. Calendar 500, House Bill 6614. Calendar 508, House Bill 6222.

Calendar page 13, Calendar 511, House Bill 6356. Calendar 512, Substitute for House Bill 6422. Calendar 514, House Bill 6590. Calendar 515, House Bill 6221. Calendar 516, House Bill 6455.

Calendar page 14, Calendar 517, House Bill 6350. Calendar 519, House Bill 5437. Calendar 522, House Bill 6303.

Calendar page 15, Calendar 523, Substitute for House Bill 6499. Calendar 524, House Bill 6490. Calendar 525, House Bill 5780. Calendar 526, House Bill 6513. Calendar 527, Substitute for House Bill 6532.

Calendar page 16, Calendar 528, House Bill 6561. Calendar 529, Substitute for House Bill 6312. Calendar 530, Substitute for House Bill 5032. Calendar 532, House Bill 6338.

Calendar page 17, Calendar 533, Substitute for House Bill 6325. Calendar 534, House Bill 6352.

Calendar 536, House Bill 5300. Calendar 537, House Bill 5482.

calendar page 18, Calendar 543, House Bill 6508. Calendar 544, House Bill 6412. Calendar 546, Substitute for House Bill 6538. Calendar 547, Substitute for House Bill 6440. Calendar 548, Substitute for House Bill 6471.

Calendar page 19, Calendar 550, Substitute for House Bill 5802. Calendar 551, House Bill 6433. Calendar 552, House Bill 6413. Calendar 553, Substitute for House Bill 6227.

Calendar page 20, Calendar 554, Substitute for House Bill 5415. Calendar 557, Substitute for House Bill 6318. Calendar 558, Substitute for House Bill 6565.

Calendar page 21, Calendar 559, Substitute for House Bill 6636.

Calendar page 22, Calendar 563, Substitute for House Bill 6600. Calendar 564, Substitute for House Bill 6598. Calendar 566, House Bill 5585.

Calendar page 23, Calendar 568, Substitute for House Bill 6103. Calendar 570, Substitute for House Bill 6336. Calendar 573, Substitute for House Bill 6434.

Calendar page 24, Calendar 577, Substitute for House Bill 5795.

Calendar page 25, Calendar 581, House Bill 6354.

Calendar page 26, Calendar 596, Substitute for House Bill 6282. Calendar 598, Substitute for House Bill 6629.

Calendar page 27, Calendar 600, House Bill 6314. Calendar 601, Substitute for House Bill 6529. Calendar 602, Substitute for House Bill 6438. Calendar 604, Substitute for House Bill 6639.

Calendar page 28, Calendar 605, Substitute for House Bill 6526. Calendar 608, House Bill 6284.

Calendar page 30, Calendar number 615, Substitute for House Bill 6485. Calendar 616, Substitute for House Bill 6498.

Calendar page 31, Calendar 619, Substitute for House Bill 6634. Calendar 627, Substitute for House Bill 6596.

Calendar page 32, Calendar 629, House Bill 5634. Calendar 630, Substitute for House Bill 6631. Calendar 631, Substitute for House Bill 6357. Calendar 632, House Bill 6642.

Calendar page 33, Calendar 634, Substitute for House Bill 5431. Calendar 636, Substitute for House, correction, House Bill 6100.

Page 34, Calendar 638, Substitute for House Bill 6525.

Calendar page 48, Calendar 399, Substitute for Senate Bill 1043.

Calendar page 49, Calendar 409, Substitute for House Bill 6233. Calendar 412, House Bill 5178. Calendar 422, Substitute for House Bill 6448.

Calendar page 52, Calendar 521, Substitute for House Bill 6113.

Madam President, that completes the item placed on the first Consent Calendar.

THE CHAIR:

Thank you, sir.

We call for another roll call vote. And the machine will be open for Consent Calendar number 1.

THE CLERK:

The Senate is now voting by roll on the Consent Calendar. Will all Senators please return to the Chamber. The Senate is now voting by roll on the Consent Calendar, will all Senators please return to the Chamber.

Senator Cassano, would you vote, please, sir.

Thank you.

Well, all members have voted. All members have voted. The machine will be closed, and Mr. Clerk, will you call the tally?

THE CLERK:

Motion is on option Consent Calendar Number 1.

Total Number Voting	36
Those voting Yea	36
Those voting Nay	0
Those absent and not voting	0

THE CHAIR:

Consent Calendar Number 1 has passed.

Senator Looney.

SENATOR LOONEY:

Thank you, Madam President.

We might stand at ease for just a moment as we prepare the next item…

THE CHAIR:

The Senate will stand at ease.

(Chamber at ease.)