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‘Most Favored Nations’ (MFN) Clauses under the Spotlight: U.S. v. Blue Cross Blue Shield of Michigan — When Might Otherwise Competitively Neutral or Procompetitive MFN Clauses Violate the Antitrust Laws?

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On October 18, 2010, the U.S. Department of Justice and the State of Michigan sued Blue Cross Blue Shield of Michigan (“Blue Cross”), a not-for-profit insurance provider, under Section 1 of the Sherman Act and analogous state law to enjoin Blue Cross from including most-favored-customer (aka, ‘most favored nation’ (MFN)) clauses in its contracts with hospitals in Michigan. *United States of America and the State of Michigan v. Blue Cross Blue Shield of Michigan*, 2:10-cv-15155-DPH-MKM, E.D. Mich. ([complaint](#) filed 10/18/10). (A follow-on private putative class action was filed several days later on behalf of a proposed class of purchasers of healthcare services and alleges violations of both Sections 1 and 2 of the Sherman Act (unlike the DOJ and State suit) and also the Michigan antitrust statute.) The governments’ suit highlights some of the ways in which MFNs, normally viewed as procompetitive or at least competitively neutral under the antitrust rule of reason, can draw scrutiny and perhaps even lead to liability in healthcare and other markets as well.

Renewed Emphasis by DOJ on MFNs in Context of Healthcare Legislation

With the recent passage of the federal Patient Protection and Affordable Care Act, the DOJ is stepping up and assiduously promoting competition policy in healthcare markets in order to ensure that such policy and the new law are mutually reinforcing. One such market is the health insurance industry, which of course figures prominently in the legislation.

Contractual MFN clauses guarantee a purchaser that it will receive terms at least as favorable as those provided to any other customer. MFN clauses are commonly used across a wide range of industries, including healthcare, and usually viewed as, at worst, competitively neutral under the antitrust rule of reason. The Blue Cross suit, however – the first by the government to target MFNs since the ‘90s – reflects a renewed focus by the DOJ (and interested States) on the use of MFNs by insurers with market power in discrete geographic markets allegedly to create barriers to entry, raise rivals’ costs and generally suppress competition in health insurance markets. It is therefore important for all market participants – whether healthcare providers, such as hospitals and physicians, or purchasers, including primarily insurers, with direct effects on consumers – to understand the possible economic dynamics of MFNs: how they work and the effects they may have on competition.

Indeed, DOJ Assistant Attorney General Christine Varney, Head of the Antitrust Division, stated last spring that the DOJ is focusing on the health insurance industry as part of its emphasis on antitrust enforcement and competition policy in healthcare, especially in the context of its efforts to help ensure that competition is maintained and consumers benefit amidst the significant federal legislative changes. AAG Varney singled out MFNs as potential obstacles to entry in health insurance markets, foreshadowing the DOJ's suit against Blue Cross, when she noted that "you should expect the Justice Department to carefully scrutinize and continue to challenge exclusionary practices by dominant firms – whether for-profit or non-profit – that substantially increase the cost of entry or expansion. This is particularly so with respect to most-favored-nations clauses and exclusive contracts between insurers and significant providers that reduce the ability or incentive of providers to negotiate discounts with aggressive insurance entrants." Assistant Attorney General Christine Varney, "Antitrust and Healthcare," Remarks as Prepared for the ABA/American Health Lawyers Assoc'n "Antitrust in Healthcare" Conference, Arlington, Va., May 24, 2010, *available at* <http://www.justice.gov/atr/public/speeches/258898.htm>.

MFNs Mostly Viewed as Procompetitive or Competitively Neutral – With Caveats

As noted, MFN clauses guarantee a purchaser that it will receive terms at least as favorable as those provided to any other customer. If the supplier lowers its price to another buyer, then the price offered to the buyer receiving the MFN will be lowered to match. The immediate effect of a MFN clause is uniformity in how one supplier treats different customers. Under U.S. law, MFN clauses are generally viewed as procompetitive or competitively neutral and unlikely to give rise to any antitrust violation in the absence of additional conduct or circumstances that, in the aggregate, may trigger liability for unilateral or joint conduct. MFN clauses have been challenged under the Sherman Act as unreasonable agreements in restraint of trade (Section 1) and as unreasonable exclusionary conduct (Section 2), and under Section 5 of the Federal Trade Commission Act. As vertical (distribution) arrangements, MFN clauses are judged under the rule of reason and their legality turns on weighing resulting procompetitive efficiencies against any anticompetitive effects.

Why the DOJ Views Blue Cross's Conduct as Harming Competition

In the general case, an MFN clause guarantees a health insurer, as the purchaser, the same lowest price as obtained by any of its competitors. Here, Blue Cross, as the insurer, purchases health care services on behalf of its subscribers from hospitals as the sellers of such services. In the complaint, the DOJ and the State allege that Blue Cross's use of MFNs has reduced competition in the sale of health insurance in markets throughout Michigan by inhibiting hospitals from negotiating competitive contracts with its competitors. In particular, according to the complaint, the MFNs have harmed competition by (1) reducing the ability of other health insurers to compete with Blue Cross, or actually excluding its competitors in certain markets, and (2) raising prices paid by Blue Cross's competitors and by self-insured employers.

MFNs are generally viewed by courts and enforcers to be procompetitive and consumer welfare-enhancing – to the extent they are scrutinized at all – because typically they promote competition and yield lower costs to purchasers, who in turn can then provide lower prices to consumers. The thrust of the government's complaint here, however, is that as a result of Blue Cross's market power in the sale of commercial health insurance in each of the alleged relevant geographic markets, and by intent and effect, the MFNs suppress competition in the sale of health insurance and harm consumer welfare. Through vertical agreements, in other words, Blue Cross allegedly is suppressing horizontal competition. *See also* Dpty Ass't Attorney General for Economics Carl

Shapiro, “Update from the Antitrust Division,” Remarks as Prepared for the ABA Sect. of Antitrust Law Fall Forum, Washington, D.C., Nov. 18, 2010, at 5-6 (commenting on suit), available at <http://www.justice.gov/atr/public/speeches/264295.pdf>.

The Complaint

Salient features of Blue Cross’s conduct and dominant role in the relevant markets, as alleged in the complaint, include the following:

- Its commercial health insurance policies cover more than three million Michigan residents – or more than 60% of the commercially insured population of the state;
- It insures more than nine times as many Michigan residents as its next largest commercial health insurance competitor, and it is the largest non-governmental purchaser of health care services, including hospital services, in the state;
- It purchases hospital services on behalf of its insureds from all 131 general acute care hospitals in the state, totaling more than \$4 billion in 2007;
- Blue Cross currently has MFNs, or MFN-type arrangements, with at least 70 of Michigan’s general acute care hospitals, accounting for more than 40% of the state’s acute care hospital beds;
- Blue Cross generally enters into either of two types of MFN clause – “Equal To” MFNs or MFNs-Plus:

? The *Equal-to MFNs* guarantee that hospitals will charge Blue Cross prices that are equal to the lowest prices charged to its competitors. Blue Cross has such clauses in contracts with some 40 small, community hospitals. This is the standard type of MFN, in the general case. Here, however, a community hospital that declines to enter into such agreements is paid about 16% less by Blue Cross than if it accepts the MFN. Thus, the MFN, rather than lowering prices, raises the price floor for all purchasers, making it harder for Blue Cross’s rivals to compete and likely resulting in higher prices for consumers.

? The *MFN-Plus* clauses guarantee that hospitals will charge Blue Cross lower prices for services than those charged to its competitors. Its MFN-Plus contract clauses with some 22 hospitals (which operate 45% of the state’s tertiary care hospital beds) typically specify the greater percentage amount that they must charge to competing insurers, requiring some to charge as much as 40% more than they charge Blue Cross. The percentage increment – the “Plus” factor – guarantees that Blue Cross’s competitors cannot obtain hospital services at prices comparable to those Blue Cross pays and this limits other health insurers’ ability to compete, according to the complaint.

- As noted above, in many cases Blue Cross has sought and obtained MFNs from hospitals in exchange for increases in the prices it pays for the hospitals’ services, according to the complaint. Whereas the normal, generally accepted procompetitive purpose behind MFNs is to ensure that the purchaser pays the lowest price paid by its competitors, the intent and effect of Blue Cross’s

strategy here, the government contends, is just the opposite – to cause hospitals to raise the minimum charges they can charge to Blue Cross’s competitors. In other words, the logic goes, Blue Cross viewed the extra money it paid in exchange for the MFN as an acceptable price for obtaining protection from competition, and the only difference between deployment of the Equal-to MFN versus the MFN-Plus in these circumstances is that the latter raises the costs to Blue Cross’s rivals even beyond the higher price floor that Blue Cross has accepted for itself. Thus, in the case of the Equal-to MFN, given the defendant’s market power in the specified geographic markets, the calculus presumably is that it might hurt Blue Cross somewhat to be charged higher prices, but setting these as the price floor through the use of Equal-to MFNs will at the very least hurt its smaller rivals even more. And the cost burden to those rivals will be that much greater when Blue Cross’s contracts with hospitals contain MFN-Plus clauses.

- In sum, the complaint alleges, the MFNs have caused many hospitals to (1) raise prices to Blue Cross’s competitors by substantial amounts, or (2) demand prices that are too high to allow rivals to compete, thereby excluding them from the market. According to the government, Blue Cross has effectively denied competitors access to competitive hospital contracts: it has used its market power to impose MFNs which have deterred or prevented competitive entry and expansion in health insurance markets in Michigan, and these MFNs have likely increased prices for health insurance sold by Blue Cross and its competitors and also prices for hospital services paid by insureds and self-insured employers.

Blue Cross Responds; Files Motion to Dismiss

Soon after the complaint was filed, Blue Cross denied the charges in the press and explained that the MFNs were a tool to secure the lowest possible hospital costs and the deepest possible discounts for the more than four million people it serves in the state. Also, in a press release responding to the suit, it stated: “Our hospital discounts are a vital part of our statutory mission to provide Michigan residents with statewide access to health care at a reasonable cost . . .] Because Blue Cross is the only nonprofit healthcare corporation that is regulated by Michigan Public Act 350, it is the only Michigan insurer that is required to meet the cost, quality, and access goals required by statute.”

Sounding some of these same themes, on December 17th Blue Cross filed a Motion to Dismiss, setting forth four principal reasons why the complaint fails to state a claim. First, it contends, dismissal is compelled by the doctrine of state action immunity under *Parker v. Brown*, 317 U.S. 341 (1943), “which bars antitrust challenges to conduct of state-created corporations – such as Blue Cross – that foreseeably flows from a comprehensive state regulatory scheme such as Michigan’s.” (Brief at 4.) Second, under principles of federal abstention announced in *Burford v. Sun Oil Co.*, 319 U.S. 315 (1943), “federal courts must abstain from cases that interfere with state agencies’ regulation of substantial policy issues.” (Id.) Third – as a matter of substantive antitrust law, and unrelated to the first two grounds – dismissal is required under *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544 (2007), and *Ashcroft v. Iqbal*, 129 S.Ct. 1937 (2009), Blue Cross asserts, because, principally, (1) plaintiffs plead product and geographic markets in only conclusory terms, (2) their allegations of market power and anticompetitive effects fail to cross the *Twombly-Iqbal* plausibility threshold, and (3) their attack on the MFNs is essentially a claim that Blue Cross has sought to obtain price discounts for its insureds, and no claim for violation of the antitrust laws due to discounting can be stated without a showing that it constitutes predatory pricing, with a dangerous possibility of recoupment of losses – and the plaintiffs make no such plausible allegation. Fourth, Blue Cross asserts, the state claims must also be dismissed for the same reasons,

as they track federal antitrust law.

State Action Immunity: First, although a detailed analysis of *Parker* state action immunity and *Burford* abstention, with subsequent case law refinements, and their application in this case, are beyond the scope of this comment, they merit some attention here. Blue Cross’s arguments on these grounds are compelling on their face and the challenge to the plaintiffs – which surely will not have been caught unawares – to surmount them appears significant. In brief, Blue Cross contends that its price negotiations and MFN contracts with hospitals in Michigan – the subject of the complaint – satisfy each of the two independent prongs of the test for determining whether conduct overlapping state regulation is immune: first, that its actions as a “quasi-public, state-created health care corporation,” Brief at 17, are the foreseeable result of a clearly articulated state policy to displace unfettered competition with a regulatory structure, *Town of Hallie v. City of Eau Claire*, 471 U.S. 34 (1985); and second, that even considered as a private entity, its actions satisfy the ‘clearly articulated state policy’ requirement and are actively supervised by the state, *Cal. Retail Liquor Dealers Ass’n v. Midcal Aluminum, Inc.*, 445 U.S. 97 (1980).

The presentation of evidence of Blue Cross’s status as a quasi-public entity and of the clearly articulated state policy is thoroughgoing and rigorous. That policy is embodied in Michigan Public Act 350, which provides a comprehensive statutory and regulatory structure for ensuring that “the health care financing system is an essential part of the general health, safety, and welfare of the people of [Michigan],” Mich. Comp. Laws § 550.1102(1); furthermore, it charges Blue Cross with serving as “the primary tool for ensuring comprehensive health care access at reasonable cost.” Brief at 11 (citing Mich. Comp. Laws §§ 550.1101-1704. And, in particular, the Act “specifically contemplates,” as one of the means at Blue Cross’s disposal to fulfill its role, that it “may enter into reimbursement arrangements that ‘include financial incentives and disincentives’ even if those incentives might mean that some share of hospital costs are borne by other health care purchasers.” Brief at 16 (citing Mich. Comp. Laws § 550.1516(2)(b)).

Even assuming Blue Cross did not qualify as a public entity and satisfy the first prong of the test, however, and even though all reasonable inferences on a motion to dismiss are drawn in favor of the plaintiffs, the thoroughgoing, detailed legislative and judicial evidence of the state’s active supervision of Blue Cross, considered as a private entity, looms as a significant obstacle for the plaintiffs to defeat the second prong of the defense. Nonetheless, the defendant’s burden, to satisfy the ‘active state supervision’ requirement, especially on a motion to dismiss, is also quite high: among other things, the mere potential for supervision is inadequate – there must be active state supervision in fact. Active state supervision of the anticompetitive acts of private entities that further state regulatory policies, as required under *Patrick v. Burget*, 486 U.S. 94 (1988), means in this case, Blue Cross asserts, that the state Insurance Commissioner “has and exercises the power to review and disapprove conduct of the nature at issue in this case.” Brief at 23. Blue Cross easily satisfies this test, it contends: it enters into contracts with hospitals under state-mandated “provider class plans” which contain reimbursement arrangements – such as pursuant to the MFNs – and which the Commissioner reviews for their compliance with Public Act 350 pursuant to a set of detailed criteria. Even more particularly, though, it goes on, it submitted such provider plans for 2006 and 2007 containing “the exact model hospital agreements [with] ‘equal to’ MFNs at issue in the present case” to the Commissioner, who issued an order in 2009 specifically recognizing that under Blue Cross’s provider agreements, “[h]ospitals must attest that their rates are at least as favorable as those for other non-governmental commercial insurers’.” Brief at 24 (citing order). Furthermore, Blue Cross adds, commercial health insurers have directly complained to the Commissioner about both types of MFNs, raising “the very issues presented in the Complaint.” *Id.*

Review by the state under the active supervision test has thus been highly detailed and explicit, Blue Cross asserts.

Next, *Burford* abstention may afford a court more discretion than the state action immunity defense, as a practical matter, but the policy bases for each are substantially similar, and Blue Cross's abstention arguments are rooted in essentially the same principles as its state action argument.

'Complaint Does Not State Viable Theory of Antitrust Harm': More interesting from the substantive antitrust perspective is Blue Cross's argument that the pleading does not cross the plausibility threshold of *Twombly* and *Iqbal*. If, as Blue Cross asserts, fault can be found in the plaintiffs' relevant product and geographic market definitions, or allegations of anticompetitive harm (e.g., on the tenuous grounds, *inter alia* – to this observer – that Blue Cross does not have market power in the sale of commercial health insurance because as a nonprofit entity, it does not compete in that market), it may be rectifiable by amended pleadings.

But the Motion is most provocative, and creative, in challenging antitrust attacks on MFNs head-on by asserting that the complaint fails plausibly to allege facts supporting a viable legal theory of harm – in other words, that no showing of anticompetitive harm can be made based on the MFNs at issue in this case (or indeed, any case based on a similar use of MFNs). Here, Blue Cross returns to its central point regarding the legality of MFNs – that they are, at bottom, discounts (and whether they are a *quid pro quo* for a price increase by the hospitals, as alleged, or not, is immaterial to the assertion that they constitute discounts in any case). Indeed, other courts, as Blue Cross notes, have so characterized MFNs. If they are discounts, however, it contends, then sanctioning them would appear to fly in the face of antitrust law and policy promoting price competition, including by dominant firms. In other words, a complainant would have to show that they satisfy the criteria for anticompetitive predatory pricing.

For a claim of anticompetitive predatory pricing to be viable under the law of *Brooke Group Brooke Group Ltd. v. Brown & Williamson Tobacco Corp.*, 509 U.S. 209 (1993), the complainant must show below-cost pricing followed by recoupment. And a claim of predatory pricing in the hands of a dominant buyer (rather than seller, as in *Brooke Group*), as the Supreme Court recently explained in *Weyerhaeuser Co. v. Ross-Simmons Hardwood Lumber Co.*, 549 U.S. 312 (2007), requires an analogous showing that a dominant buyer overpaid for critical inputs, driving competitors out of business, and that there is a dangerous probability that it will then recoup its losses through the overpayments by buying or paying less than before. In effect, then, Blue Cross contends, the plaintiffs have to allege predatory monopsony pricing, with the effect of driving competitors out of the relevant market. But, it goes on, plaintiffs cannot plausibly make such a claim: first, "competitors are ready and willing to purchase hospital services at prices comparable to the purportedly elevated prices Blue Cross pays now," Brief at 45 (citing Complaint at Para. 56) – and this undercuts the argument that any overpayment by Blue Cross would drive its competitors out of business; and second, plaintiffs make no showing that, even if Blue Cross did drive competing insurers out of the market, it could keep them out long enough to recoup its losses (i.e., that they could not re-enter and increase their purchases of hospital services if Blue Cross tried to recoup by buying or paying less, thereby undermining its recoupment).

Blue Cross's MFNs-as-discounts theory, triggering the need for an assessment under predatory pricing antitrust analysis, prompts several observations. First, query whether it takes full account of the effect of the MFN-Plus clause: The competing insurer cited (as an example) in the

mentioned Para. 56 of the Complaint indeed allegedly was “ready and willing to purchase hospital services at prices comparable to” those paid by Blue Cross to the hospital in question – even accepting the elevated prices; but the playing field was no longer level, because the competing insurer would have been required to pay even higher rates than those paid by Blue Cross, thanks to the operation of its MFN-Plus clause, thereby suppressing competition from that insurer. And once driven out of the market, re-entry would quite plausibly be difficult and time consuming – at the very least, certainly a matter of factual dispute (*if* properly pleaded). Also, if, as Blue Cross broadly asserts, courts are “nearly unanimous in holding that MFNs do not violate the antitrust laws,” Brief at 8, it is *typically* only after a balancing of procompetitive and anticompetitive factors under the rule of reason, and not based on a theory of predatory buying and recoupment. (At the same time, however, in at least one case, the suggestion has been made – by the Court of Appeals for the First Circuit – that in order to state a claim under antitrust law regarding a standard MFN clause, the complainant must allege predatory pricing and recoupment. See discussion of *Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of Rhode Island*, below.) Furthermore, even Chief Judge Posner himself, in one of the leading cases upholding MFNs, acknowledged that perhaps such clauses can be misused in some cases (i.e., by a buyer with monopoly power) (see discussion below).

The Judicial Landscape on MFNs is Perhaps More Nuanced than Blue Cross’s “Near Unanimous” Characterization Would Suggest

A review of the relatively small number of cases and consent decrees since the ‘90s finds an acceptance of MFNs as competitively neutral or procompetitive in the general case, but a rejection of such clauses on antitrust grounds when the buyer has market power and especially if the MFN clause results in rivals having to pay more than the MFN buyer for the services. (And although consent decrees do not constitute precedent, they reflect both the DOJ’s enforcement priorities regarding MFNs and the defendants’ risk analysis.) In particular, the price-floor phenomenon – which can raise rivals’ costs, driving them from the market or deterring entry – is likeliest to occur where the buyer is dominant, as allegedly is the case with Blue Cross in the relevant geographic markets specified in the DOJ and State’s complaint. Also, a previous consent decree between the DOJ and a commercial health insurer – Medical Mutual of Ohio – sheds light on the government’s analysis of contractual healthcare payment obligations containing both standard MFN and MFN-Plus components.

Marshfield Clinic: In an often-cited case, *Blue Cross & Blue Shield of Wis. v. Marshfield Clinic*, a Seventh Circuit panel found a medical clinic’s most-favored-customer clause in contracts with affiliated physicians insufficient to support an inference of an anticompetitive, collusive agreement to fix prices by setting a price floor. 65 F.3d 1406, 1415 (7th Cir. 1995) (Posner, C.J.), *cert. denied*, 116 S.Ct. 1288 (1996). The court, which found that the clinic lacked monopoly power in the relevant market, described such clauses as “standard devices by which buyers try to bargain for low prices” and dismissed the collusion theory, based on the MFN – on which basis in part a jury had awarded judgment for the plaintiffs – as an “ingenious but perverse argument.” Critically, however, Chief Judge Posner acknowledged that “[p]erhaps, as the Department of Justice believes, these clauses are misused to anticompetitive ends in some cases,” but the panel found no such evidence on the allegations presented.

Ocean State: In *Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of Rhode Island*, Blue Cross, the Court of Appeals for the First Circuit concluded that “a policy of insisting on a supplier’s lowest price – *assuming that the price is not predatory or below the supplier’s*

incremental cost – tends to further competition on the merits and, as a matter of law, is not exclusionary.” 883 F.2d 1101, 1110 (1st Cir. 1989), *cert. denied*, 494 U.S. 1027 (1990) (emphasis added). This would appear to offer some support for Blue Cross (Michigan)’s reasoning that the DOJ does not state an antitrust claim because it does not allege predatory pricing with a dangerous likelihood of recoupment – although Blue Cross does not cite *Ocean State* in support of this proposition. On the other hand, Blue Cross & Blue Shield of Rhode Island, the defendant in this case, did not seek to impose price differentials on the suppliers (physicians), analogous to the MFN-Plus clauses in the Michigan case, and this distinction may be critical.

Here, BCBS Rhode Island (“Blue Cross-RI”), the largest health insurer in Rhode Island, demanded most-favored-customer (“Prudent Buyer”) terms from physicians who also affiliated with plaintiff Ocean State, a new health maintenance organization (HMO). The HMO’s payment schedule to physicians contemplated sharing profits, if any. If the HMO was not profitable, its effective payment rate to physicians was lower than what Blue Cross paid. Under the most-favored-customer contracts, the HMO’s physicians would then have to accept lower payment from Blue Cross-RI as well. Hundreds of doctors terminated their affiliation with the HMO after Blue Cross-RI insisted on these terms. Plaintiff alleged that Blue Cross-RI maintained its monopoly position through improper means – the MFN Prudent Buyer terms – in violation of Section 2, and, specifically, that defendant instituted the MFN not in order to save money but in order to induce physicians to resign from Ocean State. A jury found for the plaintiff (although it awarded no damages on the Section 2 claim).

The district court granted defendant’s motion for judgment notwithstanding the verdict and the Court of Appeals affirmed, holding that the Prudent Buyer policy as a matter of law did not violate Section 2. The Court of Appeals explained that as the purchaser of the doctors’ services, Blue Cross-RI sought to limit the fees to be charged by the physician to the subscriber and, thus, the price it pays to the physician for services it is purchasing. In a previous First Circuit case involving Blue Shield of Massachusetts, on similar facts, the plaintiffs argued that Blue Shield’s pricing policy enabled it to attract more subscribers, thus “increasing its dominance in the health insurance business.” *Kartell v. Blue Shield of Massachusetts*, 749 F.2d 922, 929 (1st Cir. 1984), *cert. denied*, 471 U.S. 1029 (1985). There, as in *Ocean State*, the court rejected this argument, noting that it “comes down to saying that Blue Shield can attract more subscribers because it can charge them less,” which clearly has no antitrust significance. *Id.* at 929. Similarly, in *Ocean State*, the court found that the record “amply supports Blue Cross’s view that [the MFN] was a bona fide policy to ensure that Blue Cross would not pay more than any competitor paid for the same services” and that “a policy of insisting on a supplier’s lowest price – assuming that the price is not predatory or below the supplier’s incremental cost – tends to further competition on the merits and, as a matter of law, is not exclusionary.” 883 F.2d at 1110.

Ocean State contended that, even assuming the MFN policy was neutral on its face, defendant applied it only to Ocean State physicians, i.e., to smother the competition from Ocean State. The court found that even if this were true, defendant’s conduct was legitimate: Blue Cross simply offered to Ocean State physicians payment schedules that matched what they were currently accepting from Ocean State, and “[t]he antitrust laws do not prevent a purchaser from making such an obviously reasonable and obtainable price bargain with a provider.” *Id.* at 1112. The court determined that, first, (standard) MFNs are facially procompetitive, and second, the defendant’s use of the MFN in question was supported by legitimate efficiency justifications (namely, lower costs). Thus, it found, the policy was not primarily aimed at the illegitimate goal of destroying Ocean State but aimed instead at the legitimate goal of lowering costs.

The arguably critical distinction between *Ocean State* and the allegations in the Blue Cross Michigan case therefore lies in the fact that in the latter case Blue Cross allegedly has demanded that the hospitals charge higher rates to rival insurance companies, through the use of the MFN-Plus clause, whereas in *Ocean State* the defendant was only insisting on the supplier-physicians' lowest cost – and on those facts, the First Circuit suggested, the plaintiff would need to show predatory pricing in order to make out a claim. If the First Circuit's reference to predatory pricing analysis in *Ocean State* – although it is only a bare reference, and not an extended analysis – indeed lends support to Blue Cross Michigan's argument, then the question of the proper characterization of the MFN-Plus clause, in particular, is drawn into tighter focus: is it merely a discount, as Blue Cross contends, or is it more properly analyzed through a wider antitrust lens, as the DOJ and State will contend?

Recent Consents with the DOJ – Shedding Light on its Analysis: Among some of the more recent government suits, first, in 1996, in *U.S. v. Vision Services Plan*, the DOJ obtained a consent enjoining defendant (VSP), the largest national vision care insurer, from enforcing MFN clauses in contracts with its member optometrists. 1996 U.S. Dist. LEXIS 20930, 1996-1 Trade Cas. (CCH) ¶ 71,404 (D.D.C. 1996). The government alleged that the clauses restricted the willingness of VSP's members to provide discounted fees for vision care services to non-VSP patients – on plans providing discounts of 20-40 percent below VSP's rates – and that prices for vision care and vision care insurance were thus higher than they might otherwise have been. The DOJ further alleged that in all or parts of many states where VSP operates, a high percentage of an area's optometrists participated in the plan, and because VSP's patients accounted for a significant part of its participating doctors' professional income, the MFN clause inhibited many of its doctors from discounting and severely restricted the ability of competing vision care insurance plans to attract and retain enough doctors to serve their members. DOJ Press Release, Dec. 15, 1994, available at http://www.justice.gov/atr/public/press_releases/1994/211949.htm.

Next, in *U.S. v. Delta Dental of Rhode Island*, the defendant was the largest dental insurer in Rhode Island and had contracts with some 90 percent of the dentists in the state, covering 35-45 percent of the state's residents. 1997 U.S. Dist. LEXIS 11239, 1997-2 Trade Cas. (CCH) ¶ 71,860 (consent decree) (D.R.I. 1997). Fees from dental services provided to Delta enrollees represented a substantial portion of most dentists' income. Delta entered into agreements that discouraged dentists from charging fees to patients covered by other insurance companies (and to uninsured patients) that were lower than those paid by Delta patients under reduced-cost plans. Almost all of the Delta dentists agreed to comply with the MFN clause, leading them to refuse to contract at prices below Delta's with limited-panel dental insurance plans that were trying to enter the Rhode Island market. Basing its claim on Section 1, the DOJ explained that “[b]ecause few dentists in Rhode Island are not under contract with Delta, and because Delta's MFN clause gives its participating dentists strong disincentives to contract with dental managed care plans at fees below Delta's, other plans have been unable to form a competitively viable panel. By thus excluding from the dental insurance market reduced-cost plans that many consumers view as an important option, Delta's MFN clause has protected Delta from competition from such lower-cost plans at the expense of consumers.” *Id.* (Competitive Impact Statement). The government further alleged that “Delta's approach suggests that Delta applied its MFN clause to prevent the entry of a new, low-cost rival, not just to ensure that it obtained the lowest prices available.” *Id.* The government also noted that the MFN clause had not, by Delta's own admission, generated any meaningful savings or procompetitive benefits but instead had “eliminated most discounting by dentists below Delta's fees . . . and set a floor on dental fees, thus raising the costs of dental services and dental insurance to Rhode Island consumers.” *Id.*

The district court first denied a motion to dismiss, rejecting Delta’s argument that most MFN clauses are per se legal and agreeing with the DOJ that under certain conditions, including these, MFNs may have substantial anticompetitive effects and are properly analyzed under the rule of reason. *U.S. v. Delta Dental of Rhode Island*, 943 F. Supp. 172 (D.R.I. 1996). The case was settled by consent decree, with Delta agreeing to drop the MFN, which was declared null and void. See also *U.S. v. Oregon Dental Serv.*, 1995 U.S. Dist. LEXIS 21042, 1995-2 Trade Cas. (CCH) ¶71,062 (N.D. Ca. 1995), and *U.S. v. Delta Dental Plan of Ariz., Inc.*, 1995 U.S. Dist. LEXIS 9752, 1995-1 Trade Cas. (CCH) ¶ 71,048 (D. Ariz. 1995) (consent judgments enjoining enforcement of standard MFNs imposed by dominant dental insurers, on Section 1 grounds, as deterrents to dentists’ providing discounts on fees).

Finally, the MFNs at issue in *U.S. v. Medical Mutual of Ohio, Inc.*, by operation and effect, most closely resemble those utilized by Blue Cross Blue Shield of Michigan. 1998 U.S. Dist. LEXIS 21508, 1999-1 Trade Cas. (CCH), ¶72,465 (N.D. Ohio, E. Div. 1999) (final judgment). Defendant Medical Mutual (formerly known as Blue Cross Blue Shield of Ohio), the largest health care insurer in Ohio, required a ‘most favorable rate’ (MFR) clause as a precondition for entering into any agreement with hospitals in the Cleveland area. It also required that the hospitals maintain certain percentage differentials – or price buffers, similar to Blue Cross’s MFN-Plus – between the rates charged to itself and all other smaller commercial insurers. This differential was in the range of 15-30 percent more than the rates charged to Medical Mutual. Furthermore, Medical Mutual imposed a financial penalty against a hospital if its actual price to another payer was below the MFR benchmark for any reason.

The DOJ alleged that the requirement that hospitals charge Medical Mutual’s rivals substantially more than the MFR or else suffer significant penalties substantially increased the cost of hospital services for rival plans, because hospitals were deterred from offering significant additional discounts to them; it forced hospitals to manipulate their contractual arrangements with other payers to avoid incurring an MFR penalty; and it hindered innovation in the delivery of health care insurance. With respect to this last allegation – that the MFR suppressed innovation – the DOJ stated: “The result was to force hospitals to raise all rates to Medical Mutual’s level (or above), removing the principal incentive for other payers to invest in more efficient case management. Unable to obtain the benefits of more efficient case management, rival payers declined to invest in less costly methods and consumers were deprived of the choice of alternative plans.” Competitive Impact Statement, available at <http://www.justice.gov/atr/cases/f1900/1958.htm>.

In a similar vein, in the Blue Cross complaint, the DOJ alleged that the MFNs “effectively create a large financial penalty for hospitals that do not accept them. [. . .] A hospital that would otherwise contract with a competing insurer at lower prices than it charges Blue Cross would have to lower its prices to Blue Cross pursuant to the MFN if it sought to maintain or offer lower prices in contracts with other commercial insurers. The resulting financial penalty discourages a hospital with a Blue Cross MFN from lowering prices to health insurers competing with Blue Cross. Blue Cross’s MFNs have caused hospitals to raise prices charged to other commercial health insurers, rather than lower prices to Blue Cross.” *U.S. v. Blue Cross Blue Shield of Michigan*, Complaint at ¶ 45.

Medical Mutual consented to “fencing in” relief, prohibiting it for a period of ten years from using a MFR clause which either requires a hospital to charge any third party payer as much as or more than the rate charged to Medical Mutual, or requires a hospital to charge Medical Mutual rates equal to or lower than the lowest rate it charges any third party payer.

In sum, although the cases reflect a general tolerance of MFNs, DOJ enforcement has focused on instances where the provisions operate as more than mere discounts and by intent and/or effect allegedly tend to suppress competition from rival purchasers of health services. The DOJ's strongest case for that argument would appear to be where the insurer imposes a price differential, such as Medical Mutual of Ohio did with its price-buffer most favorable rate clauses.

Conclusion

If MFNs have previously been floating in a backwater of antitrust scrutiny, the DOJ and State's action against Blue Cross, and its vigorous defense so far, may herald renewed attention to this commonly used contractual provision. The legality of MFNs may be a closer question than often assumed and at the very least, they should be used with caution, as their possible anticompetitive effects may prompt challenges from the federal antitrust agencies, the States and private plaintiffs alike.

The bottom line:

? In healthcare as in other industries, both purchasers and sellers of services should carefully scrutinize even standard MFNs. If such clauses are challenged, the procompetitive effects should usually outweigh anticompetitive effects, although the DOJ has obtained a number of consents enjoining standard MFNs when the buyer is deemed dominant in a relevant market.

? MFN-Plus or price-buffer MFN clauses, whether standing alone or in combination with standard MFNs, are likely to be harder to defend as mere price discounts or through a balancing of procompetitive and anticompetitive factors, and thus may create particular challenges – or opportunities – depending on one's vantage point.

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