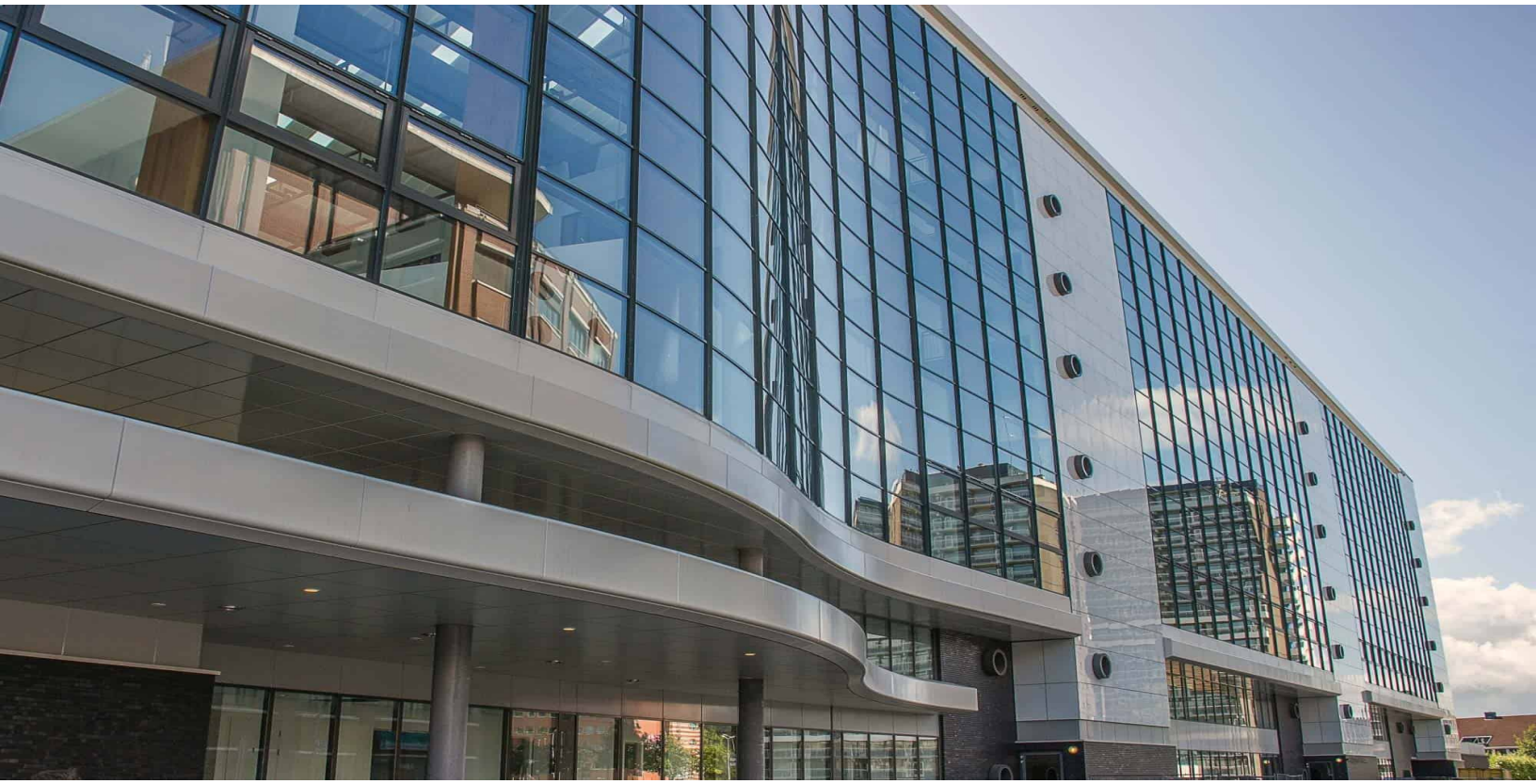
Research Report



Preventing Anticompetitive Contracting Practices in Healthcare Markets

Katherine L. Gudiksen, Alexandra D. Montague, Jaime S. King, Amy Y. Gu, Brent D. Fulton, and Thomas L. Greaney

September 2020

THE SOURCE
ON HEALTHCARE PRICE & COMPETITION
a project of the University of California Hastings College of Law

PETRIS CENTER

Table of Contents

ACKNOWLEDGMENTS

This report was funded by Arnold Ventures. We are grateful to them and to all our funders, who make it possible for the Source on Healthcare Price and Competition to advance its mission.

We thank Richard Scheffler and Daniel Arnold for their comments on an earlier draft. We thank Marty Gaynor, Paul Ginsburg, Chris Koller, Rachel Block, and Anna Sinaiko for sharing their comments and expertise on this project. We thank Patrick Crocker and Lizzie Jekanowski for their economic research and analysis of these contract terms and thank Alexandra Peltz and Ruhee Wadhwania for their research assistance.

The views expressed are those of the authors and should not be attributed to the Source on Healthcare Price and Competition or the Nicholas C. Petris Center on Health Care Markets and Consumer Welfare of the UC Berkeley School of Public Health, its trustees, or its funders. Funders do not determine research findings or the insights and recommendations of the Source on Healthcare Price and Competition.

EXECUTIVE SUMMARY

As unrelenting consolidation in healthcare provider and insurer markets continues, policymakers need additional options to protect the public from escalating healthcare prices and low-quality care. While restoring and sustaining competition in health care will require a multi-faceted approach, this report analyzes one potential facet of that broader approach – addressing the use of anticompetitive contract terms. This report examines the potential for policymakers, antitrust enforcers, and state officials to increase scrutiny over five contracting practices - most-favored-nations clauses, all-or-nothing provisions, exclusive dealing arrangements, anti-tiering and anti-steering clauses, and gag clauses – that have the potential to be used in anticompetitive ways. Unquestionably, vigorous antitrust enforcement can address anticompetitive contracting practices by dominant firms. Yet, cases can only be brought by antitrust enforcers and private litigants once they become aware of the harmful conduct, which is often challenging because little transparency exists into contracts between providers and payers. As a result, state legislatures have proposed legislation, and in some cases passed laws prohibiting the use of specific terms in contracts between healthcare providers and insurers. To prepare this report, we reviewed the legal and economic literature to determine the theoretical and empirical bases for arguments that these five contract terms can have pro- and anti-competitive effects in certain healthcare markets; analyzed state and federal antitrust enforcement activities challenging the use of these contract terms; and conducted a fifty-state survey of all proposed and enacted legislation restricting the use of these contract terms. This report identifies and describes the potential anticompetitive harms that can result from each of these contract terms. This report concludes with a range of legislative and regulatory recommendations for states seeking to mitigate potential harms arising from the anticompetitive use of these terms. While we make recommendations based on legal analysis and economic theory, more robust economic analysis is required to determine whether state laws to prohibit these contract terms reduce healthcare prices or improve quality.

Our recommendations include enacting legislation prohibiting or restricting the use of certain terms in contracts between healthcare insurers and providers. While these prohibitions may reduce harms by signaling to market participants and their advisors the anticompetitive nature of these terms, states cannot rely solely on legislation to remedy the healthcare market's deficiencies. Dominant firms may be able to garner similar benefits without inclusion of specific clauses in their written contracts through oral or other agreement. Therefore, legislative prohibitions targeting specific contract terms may fail to capture the potential cumulative anticompetitive effects of multiple contract terms used in combination. As a result, states searching for a more comprehensive solution to rising healthcare costs should also consider having a government agency oversee evolving contracting practices between healthcare payers and providers. States may create a new agency with oversight authority on healthcare costs and competition or may expand the authority of an existing state regulatory entity, like the Department of Insurance or Department of Justice. As consolidation of providers into health systems continues to increase, the potential for anticompetitive harms due to contracting practices also increases. As a result, states must consider all options to promote

and protect competitive markets including vigorous antitrust enforcement policies, legislative action, and increased oversight of insurance contracts by the state insurance commissioner, attorney general, or related agency.

Based on the research and analysis presented in this report, we make the following specific recommendations:

1) *Enact legislation banning most-favored-nation clauses and anti-steering/anti-tiering clauses in contracts between providers and insurers with a possible exception for companies with minimal market share.*

2) *Enact legislation banning gag clauses that prevent patients and employers from easily obtaining price and quality information from providers or insurers.*

3) *Enact legislation limiting all-or-nothing and exclusive contracting practices when their effect is likely to be anticompetitive*.

4) *Empower a state agency to monitor and oversee evolving healthcare contracting practices.*

I. Introduction

American healthcare prices have increased dramatically over the last thirty years, in large part due to consolidation of American healthcare provider and insurer markets.[1] This consolidation, which has occurred largely unchecked by federal regulators,[2] has allowed prices to skyrocket.[3] As a result, American businesses,[4] families,[5] and governments are foundering under the weight of providing meaningful health care to the American public.[6] The question facing many state policymakers is what can be done at the state level to address the effects of consolidation and bring the price of health care back to a sustainable level.

While states should consider many options to restore competition in health care markets, this report analyzes what policymakers can do to prevent insurers and providers from using contract terms that decrease competition and increase prices. This report examines the potential for policymakers, antitrust enforcers, and state officials to increase scrutiny over five contracting practices - most-favored-nations clauses, all-or-nothing provisions, exclusive contracting, anti-incentive clauses, and gag clauses – that have the potential to create anticompetitive harms when used in contracts between healthcare insurers and providers. In this report, Part I provides background information on healthcare markets in the United States, antitrust law, and the challenges of addressing consolidation in health care through litigation and federal antitrust enforcement. Analysis of each contract term and its competitive effects begins in Part II. Finally, Part III provides a range of legislative and regulatory recommendations for states seeking to mitigate potential harms arising from the anticompetitive use of these terms.

---

[1] Thomas L. Greaney & Barak D. Richman, *Part I: Consolidation in Provider and Insurer Markets: Enforcement Issues and Priorities*, AM. ANTITRUST INST. (June 12, 2018), https://www.antitrustinstitute.org/wp-content/uploads/2018/09/AAI_Healthcare-WP-Part-I_6.12.18.pdf.

[2] Cory S. Capps, *From Rockford to Joplin and Back Again: The Impact of Economics on Hospital Merger Enforcement*, 59 THE ANTITRUST L. BULL. 443, 449 (2014).

[3] Cory S. Capps, David Dranove & Christopher Ody, *The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending*, 59 J. OF HEALTH ECON. 139 (2018); Richard M. Scheffler, Daniel R. Arnold & Christopher M. Whaley, *Consolidation Trends in California's Health Care System: Impacts On ACA Premiums And Outpatient Visit Prices*, 37 HEALTH AFF. 1409 (2018); Martin Gaynor & Robert Town, *The Impact of Hospital Consolidation—Update*, THE SYNTHESIS PROJECT, ROBERT WOOD JOHNSON FOUND. (2012), www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261; Zack Cooper, Stuart V. Craig, Martin Gaynor & John Van Reenen, *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured*, 134 THE QUARTERLY J. OF ECON. 51 (2019); Hearing on Diagnosing the Problem: Exploring the Effects of Consolidation and Anticompetitive Conduct in Health Care Markets Before the Subcommittee on Antitrust, Commercial, and Administrative Law of the H. Committee on the Judiciary, 116th Cong. (2019) (statement of Martin Gaynor, E.J. Barone University Professor Economics and Public Pol'y, Heinz College, Carnegie Mellon University), https://www.congress.gov/116/meeting/house/109024/witnesses/HHRG-116-JU05-Bio-GaynorM-20190307.pdf [hereinafter Gaynor Statement 2019].

[4] Rhett Buttle, Katie Vlietstra & Angela Simaan, *Small-Business Owners' Views on Health Coverage and Cost*, THE COMMONWEALTH FUND (Sept. 2019), https://www.commonwealthfund.org/publications/issue-briefs/2019/sep/small-business-owners-views-health-coverage-costs.

[5] Amy E. Cha & Robin A. Cohen, *Problems Paying Medical Bills, 2018*, NAT'L CTR. FOR HEALTH STATISTICS: CENTERS FOR DISEASE CONTROL AND PREVENTION (Feb. 2020), https://www.cdc.gov/nchs/data/databriefs/db357-h.pdf?utm_source=newsletter&utm_medium=email&utm_campaign=newsletter_axiosvitals&stream=top.

[6] Office of the Assistant Secretary for Planning and Evaluation, *Effects of Health Care Spending on the U.S. Economy*, U.S. DEPT. OF HEALTH & HUMAN SERVICES (Feb. 2, 2005), https://aspe.hhs.gov/basic-report/effects-health-care-spending-us-economy.

A. Background

While preventing anticompetitive mergers may be the best way to ensure that healthcare markets operate competitively,[7] many markets are already so consolidated that preventing additional mergers, while important, will not curb dominant firms extant market power.[8] A recent analysis of metropolitan statistical areas found that 95 percent had highly concentrated hospital markets, 78 percent had highly concentrated specialist physician markets, 58 percent had highly concentrated insurance markets, and 41 percent had highly concentrated primary care provider markets in 2018.[9] Given the level of concentration throughout healthcare markets, antitrust enforcers and policymakers need to consider additional methods beyond merger review to address anticompetitive pricing and improve competition.[10]

B. Federal and State Antitrust Laws Governing Contract Clauses

At the federal level, anticompetitive contract clauses may violate both Sections 1 and 2 of the Sherman Act. Section 1 pronounces "[e]very contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade… is declared to be illegal."[11] To establish a violation of Section 1 of the Sherman Act, a plaintiff must prove that the parties entered into an agreement that affects interstate commerce and unreasonably restrains trade, which is decided through a rule of reason analysis.[12] To be found anticompetitive under the rule of reason, a vertical restraint, like a contract between an insurer and a healthcare provider, must have either collusive or exclusive effects. Collusive effects enable horizontal competitors to cooperate to raise prices, while exclusive effects foreclose rivals from entering the market or significantly raise their costs. Because contract clauses between payers and providers are vertical agreements, courts examine most such restraints under the rule of reason which

---

[7] See the companion paper in which we offer best practices to state policymakers seeking to improve merger oversight. Jaime S. King et al., *Preventing Anticompetitive Healthcare Consolidation: Lessons from Five States*, THE SOURCE ON HEALTH CARE AND COMPETITION (June 2020), https://2zele1bn0sl2i91io41niae1-wpengine.netdna-ssl.com/wp-content/uploads/2020/06/PreventingAnticompetitiveHealthcareConsolidation.pdf.

[8] Thomas L. Greaney, *Coping with Concentration*, 36 HEALTH AFF. 1564 (2017).

[9] King et al., *supra* note 7. The healthcare concentration measures for this article were provided by Brent Fulton, Daniel Arnold and Richard Scheffler at the Nicholas C. Petris Center on Health Care Markets and Consumer Welfare at the University of California, Berkeley. For more information, see Brent Fulton, Health Care Market Concentration Trends in the United States, Evidence and Policy Responses, 36 HEALTH AFF. 1530, 1534 (2017). The percentages represent the percentage of metropolitan statistical areas (MSAs) with an Herfindahl-Hirschman Index > 2,500 in the United States. *See also Donald Trump Wants Hospitals to be More Upfront About* Prices, THE ECONOMIST (Nov. 21, 2019), https://www.economist.com/business/2019/11/21/donald-trump-wants-hospitals-to-be-more-upfront-about-prices.

[10] Robert A. Berenson, Jaime S. King, Katherine L. Gudiksen, Roslyn Murray & Adele Shartzer, *Addressing Health Care Market Consolidation and High Prices*, URBAN INST. (Jan. 13, 2020), https://www.urban.org/research/publication/addressing-health-care-market-consolidation-and-high-prices.

[11] 15 U.S.C.A. § 1.

[12] Despite being vertical agreements, Herbert Hovenkamp has argued that these restraints also "have an implicit horizontal element, whether it be collusion or exclusion" that serves to increase prices. Herbert J. Hovenkamp, *The Rule of Reason*, 70 FLORIDA L. REV. 81, 160 (2018). For example, Blue Cross Blue Shield's use of MFNs in Michigan facilitated exclusion of other insurers and price increases both for providers which are passed on to consumers by insurers in the form of higher premiums. *See* United States v. Blue Cross Blue Shield of Mich., 809 F. Supp. 2d 665, 671 (E.D. Mich. 2011). *See also infra* II. A. 1. *Antitrust Enforcement and MFNs*.

requires proof of an anticompetitive effect.[13] This framework requires plaintiffs to prove either actual effects (such as price increases occurring after the contract term was adopted) or establish that the defendant possesses durable market power. The latter element is notoriously difficult to prove, requiring in-depth economic analysis to define the relevant product and geographic markets and establish sufficient market power. Further, under the burden shifting format of the rule of reason, defendants may rebut inferences of anticompetitive effects with evidence of substantial efficiency benefits. In any event, the standard is opaque, and the burden is substantial. As one commenter put it, the rule of reason is amorphous, "embrac[ing] antitrust's most vague and open-ended principles [and] making prospective compliance with its requirements extremely difficult."[14]

Anticompetitive contract clauses may also violate Section 2 of the Sherman Act if a firm with monopoly power uses or attempts to use them to stifle competition.[15] Here too, antitrust doctrine places a substantial burden on plaintiffs. Section 2 states "every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony."[16] When bringing a Section 2 case, the plaintiff must show both the possession of monopoly power in the relevant market and the willful acquisition or maintenance of that power, rather than growth due to a superior product or business acumen.[17] As discussed above, establishing market power is a complex undertaking. Moreover, Section 2 cases establish a higher threshold than found in Section 1 cases for the required showing of monopoly power. As to the second requirement, demonstration of improper conduct — typically defined as practices with unjustified exclusionary effects — is also a major hurdle.[18] Hence successful monopolization claims are rare.

Finally, state attorneys general may also deploy state antitrust laws to challenge anticompetitive contractual terms. Nearly all states have antitrust laws that prohibit anticompetitive conduct within the state and supplement enforcement of federal antitrust laws.[19] State antitrust laws can take a variety of forms, from those that essentially mirror federal antitrust laws, to those that only include certain prohibited acts, to those that add new substantive provisions.[20] In general, state antitrust laws that deviate from federal laws tend to prohibit more conduct than their federal counterparts,[21] yet few cases have demonstrated their broader reach.

---

[13] Although tying cases are still analyzed under a per se framework, that analysis has been called a "quasi-per se rule" in that it requires extensive proof beyond the mere existence of an agreement, e.g. market power in the tying product market and in many recent opinions, an anticompetitive effect in the tied product market. *See generally*, Hovenkamp, *supra* note 12, at 88.
[14] Maurice Stucke, *Does the Rule of Reason Violate the Rule of Law?* 43 U.C. DAVIS L. REV. 1375, 1379 (2009). *See also* Michael Carrier, *The Four-Step Rule of Reason*, 33 ANTITRUST 50 (2019) (criticizing recent court decisions and saying recent court decisions have "kneecapped" the rule of reason by extricating necessary balancing of harmful and beneficial effects from its framework).
[15] *See*, *e.g.,* U.S. v. Delta Dental of R.I., 943 F. Supp. 172, 175 (D.R.I. 1996).
[16] 15 U.S.C.A. § 2.
[17] Eastman Kodak Co. v. Image Tech. Services, Inc., 504 U.S. 451, 480 (1992) (quoting, United States v. Grinnell Corp., 384 U.S. 563, 570–71(1966)).
[18] *See* Andrew Gavil et al., ANTITRUST LAW IN PERSPECTIVE: CASES, CONCEPTS AND PROBLEMS IN COMPETITION POLICY 441 (3d ed. 2019) (stating that under the influence of the Chicago School "courts today tend to approach exclusion cases with skepticism").
[19] *Guide to Antitrust Laws*, WA. STATE, OFF. OF THE ATT'Y GEN., https://www.atg.wa.gov/guide-antitrust-laws.
[20] *Id*.
[21] *Id*.

C. Impediments to Effective Antitrust Enforcement

Unfortunately, both state and federal antitrust laws have thus far proven woefully inadequate to address the widespread use of anticompetitive contract terms between insurers and providers. While federal and state antitrust enforcers have brought and settled a few high-profile lawsuits against firms for using anticompetitive contract terms,[22] these cases required years and substantial resources to challenge the practices of only a few providers, paling in comparison to the number using them. Private litigants, such as employers or unions, are incentivized to challenge anticompetitive behavior through the opportunity to receive treble damages, yet private litigation has also failed to control the use of anticompetitive contract terms in a meaningful way.[23]

Many factors contribute to the inability of litigation to effectively control anticompetitive contract terms. First, as discussed above, antitrust case law in this area lacks clarity and places an enormous burden on plaintiffs to demonstrate market power and that the anticompetitive harms arising from the conduct outweigh any procompetitive benefits.[24] Second, case-by-case adjudication is an inefficient means of preventing widespread use of such contracts because each case consumes significant time and resources, preventing most state attorneys general from bringing multiple cases against multiple healthcare entities. Third, healthcare contracts often prohibit disclosure of their terms, which often leaves both antitrust enforcers, employers, and unions unaware of the existence of anticompetitive contract terms, unless notified by someone within the organizations. Fourth, while the potential for treble damages gives private plaintiffs an incentive to sue and may help protect the public from harms flowing from anticompetitive conduct, many private cases are settled confidentially for monetary damages, rather than injunctive relief, allowing the harmful behaviors to continue both by the defendant and other market participants.[25] As such, settlements without any public disclosure of terms may not benefit the public or improve overall market function. As a result, these limitations of antitrust law have prompted policymakers and antitrust enforcement agencies to consider alternative responses.

[22] United States v. Blue Cross Blue Shield of Mich., 809 F. Supp. 2d 665 (E.D. Mich. 2011); UFCW & Employers Benefit Trust, et al. v. Sutter Health, et al., No. CGC 14-538451 (Cal. Super. Ct. S.F. City and Cnty. 2019); United States v. Charlotte-Mecklenburg Hosp. Auth., 248 F. Supp. 3d 720, 724 (W.D.N.C. 2017).

[23] 15 U.S.C.A. § 15. Treble damages allow the court to award triple the amount actual or compensatory damages to the plaintiff. The Supreme Court called "[t]he treble-damages provision wielded by the private litigant…a chief tool in the antitrust enforcement scheme, posing a crucial deterrent to potential violators." Mitsubishi Motors Corp. v. Soler Chrysler-Plymouth, Inc., 473 U.S. 614, 635 (1985) (citing Perma Life Mufflers, Inc. v. Int'l Parts Corp., 392 U.S. 134, 138–139 (1968)). *See also* Directorate for Financial and Enterprise Affairs Competition Committee, *Relationship Between Public and Private Antitrust Enforcement*, ORG. FOR ECON. CO-OPERATION AND DEV. (June 15, 2019), https://www.justice.gov/atr/file/823166/download.

[24] *See generally* Ann Marie Helm, *Optimizing Private Antitrust Enforcement in Health Care*, 11 ST. LOUIS U. J. OF HEALTH L. & POL'Y 5 (2017); Hovenkamp, *supra* note 12.

[25] *But see* UFCW & Employers Benefit Trust, et al. v. Sutter Health, et al., No. CGC 14-538451 (Cal. Super. Ct. S.F. City and Cnty. 2019).

D. Proposed Legislative or Regulatory Remedies

In response to the inadequacy of exclusive reliance on antitrust litigation, the Department of Justice (DOJ) and the Federal Trade Commission (FTC) held multiple workshops to consider alternative policies regarding anticompetitive contract terms.[26] While the DOJ and FTC aimed to create uniform enforcement policies for these contract provisions across industries, unique features of the healthcare market may require additional consideration. For example, highly consolidated provider and insurance markets, prices shrouded in secrecy, challenges in measuring healthcare quality, and health insurance that mutes the effect of price differences may all exacerbate the anticompetitive effects of these contract terms in ways not seen in other markets. As Professors Havighurst and Richman explain,

> "In health care, insurance puts the monopolist in an even stronger position by greatly weakening the constraint on its pricing freedom ordinarily imposed by the limits of consumers' willingness or ability to pay… The extraordinary profits that health insurance makes available to powerful sellers are earned mostly at the expense not of direct purchasers—insurers or patients—but of consumers bearing the cost of insurance… [Furthermore, f]or legal, regulatory, and other reasons, health insurers in the United States are in no position (as consumers themselves would be) to refuse to pay a provider's high price whenever it appears to exceed the service's likely value to the patient."[27]

These exceptional features of the healthcare market led some policymakers to consider passing legislation to prohibit the use of some contract terms, specifically in healthcare contracts. At the federal level, Congress considered the Lower Health Care Costs Act of 2019 (S.1895), which would ban most-favored-nation clauses, all-or-nothing contracting, anti-tiering or anti-steering provisions (except within value-based arrangements), and gag clauses.[28] To date, however, this bill appears to have stalled. In the absence of federal action to address escalating healthcare costs, some states enacted legislation to address specific anticompetitive contracting practices. While the number of states with laws banning many of these specific clauses in healthcare markets remains small, interest in these laws appears to be increasing. In the most recent legislative session, five states considered legislation to regulate the use of certain clauses in contracts between healthcare providers and payers.[29] As policymaker interest in addressing the anticompetitive potential of healthcare contracting practices grows, so does the need for legal and economic research on the possible legal and regulatory interventions and their impact on the market.

---

[26] *See Public Workshop: Examining Health Care Competition*, U.S. DEPT. OF JUST. (Feb. 24–25, 2015), https://www.justice.gov/atr/events/public-workshop-examining-health-care-competition; *Public Workshop: Most-Favored-Nation Clauses and Antitrust Enforcement and Policy*, U.S. DEPT. OF JUST. (Sept. 10, 2102), https://www.justice.gov/atr/events/public-workshop-most-favored-nation-clauses-and-antitrust-enforcement-and-policy.

[27] Clark C. Havighurst & Barak D. Richman, *The Provider Monopoly Problem in Health Care*, 89 OR. L. REV. 847, 862–863 (2011).

[28] S. 1895, 116th Cong. §§ 301–302 (2019).

[29] S.B. 5, 2020 Reg. Sess. (Ind. 2020); Assem. B. 9781 (N.Y. 2020); H.B. 1264, 72d Gen. Assem., 2nd Reg. Sess. (Colo. 2020); Assem. B. 3047/S.B. 1108, 2020-2021 Reg. Sess. (N.J. 2020); S.B. 977, 2019-2020 Reg. Sess. (Cal. 2020).

II. Potentially Anticompetitive Contract Clauses

This report, the second in a series, analyzes five specific clauses used in healthcare contracts – most-favored-nation clauses, all-or-nothing clauses, exclusive contracting, anti-tiering or anti-steering clauses, and gag clauses—with the potential to be used in anticompetitive ways. To prepare this report, we reviewed the legal and economic literature to determine the theoretical and empirical bases for these contract terms to have pro- and anti-competitive effects in healthcare markets; analyzed all state and federal antitrust enforcement activities challenging the use of these five contract terms; and conducted a fifty state survey of all proposed and enacted legislation restricting the use of these five contract terms. In each section, we provide: 1) a detailed description of the contracting practice and its potential for anticompetitive harm, 2) an analysis of lawsuits and enforcement actions to address the anticompetitive use of these provisions, 3) a discussion of how these terms may be used procompetitively, 4) a survey of state legislative efforts to regulate the use of these terms, and 5) best practices for states seeking to regulate the use of the contract clause. This report concludes with a range of legislative and regulatory options for states seeking to mitigate potential harms arising from the anticompetitive use of these terms. While we make recommendations based on legal analysis and economic theory, more robust economic analysis is required to determine whether state laws to prohibit these contract terms affect healthcare prices or insurance premiums.[30] We aim to provide this analysis in the future as part of this series.

A. Most-Favored-Nation Clauses

Of the contract provisions discussed in this report, most-favored-nation clauses (MFNs) have most frequently been prohibited via legislation. MFN clauses, sometimes called pricing parity or price protection clauses, are contractual agreements in which a provider or health system agrees not to give a lower provider payment rate to any other insurer or to give an insurer the best provider payment rate (sometimes called an MFN-plus).[31] MFNs can be contemporaneous – the provider agrees that the insurer[32] gets the best rate at the time the contract is signed – or retroactive – the provider agrees to refund the difference between the

[30] Researchers at UC Berkeley and UC Hastings are in the midst of conducting parts of this analysis, which will be forthcoming in future publications.

[31] The discussion here focuses on anticompetitive use of MFNs in healthcare. For a more complete discussion of anticompetitive uses of MFNs, see Steven C. Salop, *Practices that (Credibly) Facilitate Oligopoly Co-ordination*, *in* NEW DEVELOPMENTS IN THE ANALYSIS OF MARKET STRUCTURE, 265 (J. Stiglitz & F. Mathewson, eds., 1986) and Gönenç Gurkaynak et al., *Most-favored-nation Clauses in Commercial Contracts: Legal and Economic Analysis and Proposal for a Guideline*, 42 EUR. J. LAW ECON. 129 (2016).

[32] In this paper, we have used the term "payer" to include both insurers and employers. Unlike the other contract terms discussed in this paper, however, MFNs may be used by dominant insurers to exclude other insurers from the market. In addition, insurers may be willing to offer higher payment rates in exchange for an MFN because they know all other insurers must pay the higher payment rate and the cost can be passed on through higher premiums. Self-funded employers, however, must pay any health care costs directly, so their financial incentives differ from insurers. As a result, self-funded employers are less likely to use MFNs in anticompetitive ways. Furthermore, the federal Employee Retirement Income Security Act of 1974 ("ERISA") exempts self-funded employer plans from state insurance regulation. As a result, state laws banning MFNs are unlikely to apply to self-funded employer plans. For more discussion, see James Drew Young, Note, *Most Favored Nation Clauses in Self-Funded Health Insurance Policies: Useful Tool Still Available to Indiana Employers*, 49 IND. L. REV. 823 (2016).

current and future price if it offers a lower provider payment rate to another insurer during the term of the contract.[33] Both providers and insurers can use MFNs in anticompetitive ways, and such anticompetitive use of MFNs can create both exclusionary and collusive harms.

A dominant insurer may negotiate an MFN with providers to ensure that no other insurer can offer a novel insurance product (e.g. a narrow network) at lower rates and that no rival insurer can enter the market with lower provider payment rates. In this manner, MFNs can have exclusionary effects for market entrants seeking to create a new insurance product, such as a narrow or tiered network plan with a low premium. Insurers with a new product will struggle to compete effectively with existing insurers that have an MFN because they cannot negotiate lower payment rates to providers in exchange for a higher patient volume.[34] In addition, the insurer may agree to inflated prices with providers in exchange for this competitive advantage and pass the increased cost on to employers and consumers as premium increases. Consequently, MFNs may cause exclusionary and collusive harms when used by dominant insurers.

Similarly, MFNs may be used in both exclusionary and collusive ways in markets with dominant providers. A dominant provider may recognize that an MFN clause offers an insurer a competitive advantage and the health system may actually *increase* their prices in exchange for signing a contact with an MFN clause. Insurers can accept an anticompetitive price increase from a dominant provider without competitive disadvantage by passing the increase through to consumers in the form of higher premiums, as long as they know all competitors must also pay the same or higher rates. In this manner, MFNs may be used to coordinate pricing of premiums among insurers.

Perhaps the most concerning uses of MFNs result from agreements between a dominant provider and a dominant insurer. One particular agreement, reported by the Boston Globe, occurred as a handshake deal between Partners HealthCare and Blue Cross Blue Shield of Massachusetts, resulting in "the biggest insurance payment increase since Massachusetts General and Brigham and Women's hospitals agreed to join forces in 1993" in exchange for a "market agreement" in which Partners agreed not to allow other insurers to pay less for services.[35] While this "market agreement" did not appear as an MFN in contracts because the executives were wary of the legal risks, the MFN-like arrangement resulted in premium increases of almost 9 percent a year – more than double the annual rate that premiums increased in the years preceding the agreement.[36] In addition, MFNs may be particularly problematic when used in conjunction with exclusionary contracts in which an insurer agrees to

---

[33] James F. Nieberding, *The Anticompetitive Potential of MFNs*, CPI ANTITRUST CHRON. (Aug. 22, 2014*), https://dev.competitionpolicyinternational.com/the-anticompetitive-potential-of-mfns.*

[34] Providers often agree to discounts in reimbursement rates in narrow networks because those smaller networks typically increase patient volume. If a new insurer tries to enter the market with a narrow network product, any provider with an MFN agreement that contracts with an insurer in a narrow network plan must also give any reduced reimbursement rate to the broader network from the original insurer. As a result, MFNs may eliminate any premium savings from a narrow network plan thereby eliminating any incentive for patients and employers to choose the more cost-effective insurance option.

[35] Scott Allen & Marcella Bombardieri, *A Handshake That Made Healthcare History*, BOSTON GLOBE (December 28, 2008), https://www.bostonglobe.com/specials/2008/12/28/handshake-that-made-healthcare-history/QiWbywqb8olJsA3IZ11o1H/story.html.

[36] *Id*.

contract with only one hospital in a market and the hospital in turn agrees to an MFN assuring the insurer it will not give a lower price to any other competitor.[37]

The potential for both exclusionary and collusive harms clearly exists when dominant providers or insurers use MFNs, but these potential harms also exist in oligopolistic markets (those without a dominant provider or insurer).[38] Specifically, MFN clauses give providers little incentive to offer any insurer a lower price because that reduction must be passed on to all insurers, thereby acting as a penalty or tax on price discounts and making it impossible to offer selective discounts.[39] As MFNs give assurance to insurers that all rivals face the same costs, and insurers know that hospitals with MFNs are less likely to grant price reductions, each insurer has little incentive to negotiate strongly with a must-have provider. As a result, MFNs may soften price competition and may be anticompetitive even in markets without a dominant provider or insurer.[40] Widespread use of MFNs by insurers may also cause exclusionary harms as rival insurers face higher costs to enter the market, even when offering a novel insurance product in that geographic area. In addition, the anticompetitive effects of MFNs may be harder to remedy in relatively competitive markets because bringing a case under Section 1 of the Sherman Act requires proving actual anticompetitive effects or that the firm has market power, which may be very difficult to prove in court if no firm has a large market share.

Despite the potential of an MFN to create both collusive and exclusionary effects, enforcement actions against them have been limited. While some federal and state antitrust enforcers have obtained consent decrees curbing their use, the high burdens of proof associated with challenging anticompetitive behavior may chill some enforcement efforts.

1. Antitrust Enforcement and MFNs

As MFNs are vertical agreements with the potential for collusive or exclusionary effects, inappropriate use of MFNs may violate a range of federal and state antitrust laws.[41] In the early-1990s, multiple cases brought by the DOJ[42] and many private plaintiffs[43] claimed that MFNs used in dental and vision insurance markets led to anticompetitive harms that ultimately

[37] Steven C. Salop & Fiona Scott Morton, *Developing an Administrable MFN Enforcement Policy*, 27 ANTITRUST 15, 18 (Spring 2013).
[38] See discussion *infra* p. 15–16 in which lawmakers concluded widespread use of MFNs in Ohio by the insurer Anthem led to exclusionary harms even though Anthem did not have a majority of the market share in that state.
[39] Salop & Morton, *supra* note 37.
[40] *See infra* p. 15–16.
[41] *See* discussion *supra* Section I.A.
[42] *See, e.g.,* Final Judgment, U.S. v. Or. Dental Serv., No. C95 1211 FMS, 1995 WL 481363 (N.D. Cal. July 14, 1995); Final Judgment, U.S. v. Delta Dental Plan of Ariz., Inc., No.94-1793, 1995 WL 454769 (D. Ariz. May 19, 1995); U.S. v. Vision Serv. Plan, No. 1:94CV02693, 1996 WL 351147 (D.D.C. Apr. 12, 1996); Consent Order, Matter of Rxcare of Tenn., Inc., 121 F.T.C. 762, 763 (F.T.C. 1996); U.S. v. Delta Dental of R.I., 943 F. Supp. 172, 175 (D.R.I. 1996).
[43] *See, e.g.,* Blue Cross and Blue Shield of Mich. v. Mich. Ass'n of Psychotherapy Clinics, No. 9-71014, 1980 WL 1848,(E.D. Mich. Mar. 14, 1980); Kitsap Physicians Serv. v. Wash. Dental Serv., 671 F. Supp. 1267, 1270 (W.D. Wash. 1987); Reazin v. Blue Cross and Blue Shield of Kan., Inc., 899 F.2d 951 (10th Cir. 1990); Ocean State Physicians Health Plan, Inc. v. Blue Cross and Blue Shield of R.I., 883 F.2d 1101 (1st Cir. 1989), cert. den., 494 U.S. 1027 (1990); Nat'l Benefits Admin. v. Blue Cross & Blue Shield, 907 F.2d 1143 (11th Cir. 1990); Willamette Dental Group, P.C. v. Or. Dental Serv. Corp., 882 P.2d 637 (Or. App. 1994); Blue Cross & Blue Shield v. Marshfield Clinic. 65 F.3d 1406 (7th Cir. 1995).

ended in consent decrees.[44] More recently, in 2010, the DOJ brought the first major antitrust lawsuit challenging the use of an MFN clause in a contract between an insurer and a provider when it sued Blue Cross Blue Shield (BCBS) of Michigan for its use of MFN clauses in contracts with hospitals.[45] The DOJ alleged that the MFN clauses violated Section 1 of the Sherman Act by unreasonably restraining trade and Section 2 of the Michigan Antitrust Reform Act by reducing the ability of other health insurers to compete with BCBS and raising prices paid by BCBS's competitors and self-insured employers.[46] At the time, BCBS was the dominant insurer in Michigan, covering more than 60% of state residents with commercial insurance.[47] The insurer had MFN-plus agreements in contracts with 22 hospitals (which included 45 percent of the tertiary care hospital beds in Michigan) and Equal-to-MFN agreements in contracts with 40 smaller community hospitals.[48] The DOJ alleged that BCBS used MFNs in contracts to ensure that any hospital that agreed to a lower price with a rival insurer would need to offer the same or better terms to BCBS. As a result, any insurer attempting to build a narrow network plan by offering hospitals low prices in exchange for incremental volume would be unable to attract hospitals to its network, thereby securing BCBS's market dominance.

In addition to these exclusionary harms, the DOJ also alleged that BCBS's use of MFNs resulted in higher prices overall for hospital services.[49] Specifically, the DOJ asserted "Blue Cross' MFNs have caused many hospitals to raise prices to Blue Cross' competitors by substantial amounts"[50] and further, that BCBS did not use MFNs to lower their own costs, but instead offered higher rates to hospitals in exchange for an MFN agreement.[51] As Professors Salop and Scott Morton explained, "if Michigan hospitals were aware of the competitive advantage they were bestowing on BCBS, they rationally would seek a share of the resulting profit. That is, a hospital reasoning along these lines could 'sell' the MFN to the insurer in exchange for a higher price for hospital services. In this way, the protection from competition that the insurer obtains from the hospital would accrue to the benefit of the owners of the hospital as well as to BCBS."[52] In other words, in health insurance markets, MFN clauses can be

[44] The case law about the use of MFNs is far from settled. See BARRY R. FURROW ET AL., HEALTH LAW 772 n. 587 (3d ed. 2014) stating that "several courts have expressed the view that MFNs are procompetitive, [citing Blue Cross & Blue Shield v. Mich. Ass'n of Psychotherapy Clinics, 1980–2 Trade Cas. (CCH) ¶ 63351 (E.D. Mich.). The Seventh Circuit initially offered the view that MFNs are "standard devices" to minimize costs and constitute the "sort of conduct that the antitrust laws seek to encourage," but later amended this statement to make it clear that it was not ruling out the possibility the MFNs may lessen competition under some circumstances. Blue Cross & Blue Shield v. Marshfield Clinic, 65 F.3d 1406 (7th Cir.1995). Willamette Dental Group v. Or. Dental Serv., 882 P.2d 637 (Or. App. 1994)]. See also Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of R.I., 883 F.2d 1101 (1st Cir.1989) in which the "First Circuit affirmed a judgment notwithstanding the verdict, finding that the "most favored nations" clause was a legitimate competitive strategy to assure that the Blues could get the lowest price for services rather than an attempt to monopolize the health insurance market. As such, it held the conduct was not "exclusionary" as a matter of law and did not violate Section 2." BARRY R. FURROW ET AL., HEALTH LAW 772 (3d ed. 2014).

[45] United States v. Blue Cross Blue Shield of Mich., 809 F. Supp. 2d 665 (E.D. Mich. 2011).

[46] Complaint, United States v. Blue Cross Blue Shield of Mich., 809 F. Supp. 2d 665 (E.D. Mich. 2011) (No. 2:10-cv-14155), available at http://www.justice.gov/atr/cases/f263200/26.3235.pdf.

[47] *Id*. at 2.

[48] *Id*. at 3. In an MFN-plus agreement, the provider agrees not to accept rates from another insurer that are within a certain percentage of BCBS rates. The complaint alleges that in some cases, BCBS's MFN-plus clauses require that some hospitals charge other insurers as much as 40 percent more than they charge BCBS. In an Equal-to-MFN, BCBS requires the hospital to charge other insurers at least as much as they charge BCBS.

[49] *Id*. at 4.

[50] *Id*.

[51] *Id*.

[52] Salop & Morton, *supra* note 37, at 16.

used to reduce and eliminate competition for dominant insurers and facilitate supracompetitive price increases for providers.

Yet the case did not end with a victory in court. In 2013, the DOJ dropped the *BCBS* case after the Michigan legislature banned the use of MFN clauses in provider contracts by health insurers, health maintenance organizations, healthcare corporations, and any other entities providing health insurance.[53] Overall, federal and state antitrust cases challenging anticompetitive behavior are difficult to bring and win, as they often turn on complex economic testimony about the definition of the relevant market and the market share necessary to exert monopoly power.[54] As a result, legislative solutions, like the one found in Michigan, or regulatory solutions can provide additional protection against the anticompetitive effects of MFNs.

2. Use of Legislation to Address Harm from MFNs

In 2010, the Ohio legislature conducted one of the most extensive investigations of the use of MFNs by insurers and providers by creating a Joint Legislative Study Commission on Most Favored Nation Clauses in Healthcare Contracts to report on "the procompetitive and anticompetitive aspects of most favored nation clauses and the impact of such clauses on the availability of and accessibility to quality health care."[55] While the Commission did not quantitatively measure the effect of MFNs, the investigation provided a case study that widespread use of MFNs can weaken rivalry among insurers. The Commission sent surveys to all hospitals and insurers licensed in the state of Ohio asking whether they had MFN clauses in their contracts. Nearly half of the hospitals and hospital systems reported having at least one MFN in their insurer contracts, but fewer than 10% of the insurers reported having MFNs. Furthermore, 15 of the 20 hospitals with MFNs reported that the presence of an MFN in an existing contract prevented them from signing a new contract with a different insurer at a lower rate, presumably because the MFN would require them to extend that lower rate to the insurers with MFNs in their contracts.[56] Additionally, the surveys of insurance companies determined that only one insurer – Anthem – supported MFNs and the other three large insurers in Ohio at the time – Aetna, Cigna and UnitedHealthcare – reported that the existence of MFNs with hospitals discouraged them from expanding to other markets in the state.[57] The Commission report argues "[t]his may be the most persuasive fact that the Commission has

---

[53] Stipulated Motion and Brief to Dismiss Without Prejudice, United States v. Blue Cross Blue Shield of Mich., United States v. Blue Cross Blue Shield of Mich., 809 F. Supp. 2d 665 (E.D. Mich. 2011)
(No. 2:10-cv014155-DPH-MKM).

[54] TIM WU, CURSE OF BIGNESS (2018); Steven C. Salop, *Exclusionary Conduct, Effect on Consumers, and the Flawed Profit-Sacrifice Standard*, 73 ANTITRUST L.J. 311 (2006). U.S. DEP'T OF JUST., *Monopoly Power*, *in* COMPETITION AND MONOPOLY: SINGLE-FIRM CONDUCT UNDER SECTION 2 OF THE SHERMAN ACT 28–30 (2008), https://www.justice.gov/atr/competition-and-monopoly-single-firm-conduct-under-section-2-sherman-act-chapter-2#N_8.

[55] OHIO DEP'T OF INS., HOUSE BILL 125: JOINT LEGISLATIVE COMM'N ON MOST FAVORED NATION CLAUSES IN HEALTH CARE CONTRACTS REPORT (2010), https://insurance.ohio.gov/wps/portal/gov/odi/about-us/divisions/product-regulation-and-actuarial-services/resources/joint-legislative-study-comm-most-favored-nation-clauses [hereinafter JOINT LEGISLATIVE COMM'N REPORT]. House Bill 125 of the 127th General Assembly created the Joint Legislative Study Commission on Most Favored Nation Clauses in Healthcare Contracts. *See* H.B. 125, 127th Gen. Assemb., Reg. Sess. (Ohio 2008).

[56] JOINT LEGISLATIVE COMM'N REPORT, *supra* note 56, at 30.

[57] *Id*. at 31.

heard in assessing the anti-competitive effect of MFNs. If United Health Care [sic], the nation's largest insurer with $90 billion in revenue, believes it cannot fairly compete in a market where an MFN is being used, it seems patently obvious that MFNs are in fact anti-competitive because of its negative impact on the suppression of market competition."[58] Interestingly, in 2010, Ohio's insurance market was considered relatively competitive statewide,[59] which would have hindered antitrust enforcers ability to demonstrate that Anthem had the necessary market power to challenge this behavior as a violation of Section 1 of the Sherman Act. After hearing testimony from economic experts and considering the survey results, the Commission voted 8 to 3 to recommend that the Ohio Legislature prohibit or restrict MFN clauses in healthcare contracts. As a result of the Commission's conclusions, the Ohio legislature banned the use of MFNs in contracts between hospitals and insurers.

3. Economic Justifications or Procompetitive Use of MFNs

Legislative bans, however, can prove too broad if the contract terms at issue have potential procompetitive benefits that outweigh their potential harm to competition. Recognizing the complexity of antitrust enforcement and MFNs, the FTC and DOJ held a joint workshop on developing an administrable MFN enforcement policy.[60] During that workshop and in a companion paper, Salop and Scott Morton recognized that MFNs can be procompetitive or anticompetitive and their effects depend on a number of complex factors that are market-specific.[61] As a result, they acknowledge a detailed, fact-specific, competitive analysis is needed to determine anticompetitive harms, but provided a checklist of conditions to help antitrust enforcers identify when MFNs are less likely to raise antitrust concerns.[62] While economic theory suggests that in some instances MFNs could reduce healthcare prices,[63] most markets for health care are highly concentrated and have many of the characteristics Salop identifies as "worrisome."[64] As a result, plausible economic efficiency arguments for

---

[58] *Id*.

[59] Calcuations by researchers at the Petris Center determined Ohio was the 10th lowest among states in insurer concentration in 2010 (HHI=2,154). Other research has shown that the largest insurance carrier had between 35 and 45 percent market share in the individual market in 2010. *Market Share of Largest Insurance Carrier in the Individual Insurance Market, 2010*, KAISER FAMILY FOUND. (2013), https://www.kff.org/health-reform/slide/market-share-of-largest-insurance-carrier-in-the-individual-insurance-market-2010/. Additionally, the top 3 insurers in the large group market in 2011 were Wellpoint (now named Anthem) with 41 percent, UnitedHealth with 21 percent, and Medical Mutual with 16 percent. *Market Share and Enrollment of Largest Three Insurers — Large Group Market*, KAISER FAMILY FOUND., https://www.kff.org/other/state-indicator/market-share-and-enrollment-of-largest-three-insurers-large-group-market/?currentTimeframe=7&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[60] *Public Workshop: Most-Favored-Nation Clauses and Antitrust Enforcement and Policy*, *supra* note 26.

[61] Steven C. Salop, Presentation for the DOJ/FTC Workshop on Most-Favored-Nations Clauses and Antitrust Enforcement and Policy (Sept. 20, 2012), https://www.justice.gov/sites/default/files/atr/legacy/2012/09/11/286834.pdf [hereinafter Salop DOJ/FTC Presentation]; Salop & Morton, *supra* note 37, at 16.

[62] Salop & Morton, *supra* note 37, at 18.

[63] Economic theory suggests that MFNs may be used procompetitively in certain market conditions. Consider an example in which two insurers negotiate with a hospital and Insurer A has an MFN in the contract while Insurer B does not. In year one, both insurers agree to a fair price of $100, but hospital costs go up in year two and the competitive price (with a fair return on investment) rises to $105. If the hospital charges $105 to Insurer B, but tries to charge $107 to Insurer A, then theoretically at least, the MFN is procompetitive because it reduces the $107 rate for Insurer A to $105 (the competitive price). Furthermore, the MFN reduced Insurer A's negotiating costs and time.

[64] Salop DOJ/FTC Presentation, *supra* note 61.

MFNs in health insurance markets typically follow more intricate rationale than the straightforward argument that price matching will lead to lower prices. As a result, the procompetitive arguments for MFNs in contracts between insurers and providers generally fall into three categories: 1) reducing transaction costs and uncertainty, 2) encouraging investment by preventing opportunism, and 3) reducing delays in contracting or purchasing.[65] While MFNs may create procompetitive benefits in competitive markets, in highly-concentrated markets many of these benefits no longer outweigh the competitive harms. We discuss each potential procompetitive benefit and its applicability to health care in turn below.

First, MFNs can reduce transaction costs and uncertainty by streamlining the contracting process. Specifically, in markets with large numbers of provider groups, insurers may find contracting with individual provider groups to be resource intensive, and small provider groups may want assurances from the insurer that their competitors are getting the same rate. In theory, an efficiency enhancing MFN would allow insurers to simplify the negotiating process in these markets by offering a contract with standardized rates and terms. The MFN gives providers the assurance that competitors will not get more advantageous terms. This efficiency, however, only exists in fragmented provider markets, which does not exist in most hospital markets and only exists in some physician markets. Furthermore, these contracts might cause exclusionary harms if used by a dominant insurer as they may prevent other insurers from creating narrow network products by negotiating lower provider payment rates in return for higher patient volumes.

Second, MFNs may encourage investment when one party to a contract must make substantial investments specific to the other party.[66] Once a purchaser makes investments specific to the relationship, it would be highly susceptible to price increases by the seller and may be unlikely to make the initial investment. For example, an insurer may form an accountable care organization with a provider and make an investment in information technology that is compatible with a specific provider's electronic medical record or patient monitoring system to help the insurer track and optimize continuity of care services for particular patients, especially those with chronic conditions.[67] Insurers may be more willing to invest the time and energy to implement a new system or transfer their insureds to a new electronic monitoring system if the provider guarantees them that they will not face price increases relative to other insurers. In this hypothetical example, an MFN enables the insurer to invest in infrastructure that will improve the efficiency of the healthcare delivery and payment system, while remaining confident that it will reap rewards from its investment. However, the use of an MFN is only justified economically to the extent that it protects investments specific to the relationship between a specific insurer and a specific provider group. Furthermore,

---

[65] For a more complete discussion of the potential efficiencies of MFNs in healthcare, including "ratcheting down" effect of dynamic bidding, strategic effects of targeting individual rivals, see BARRY R. FURROW ET AL., HEALTH LAW 772 (3d ed. 2014); Arnold Celnicker, *A Competitive Analysis of Most Favored Nations Clauses in Contracts Between Health Care Providers and Insurers*, 69 N.C. L. REV. 863 (1991). For a discussion of how MFNs operate in additional industries, see Jonathan B. Baker & Judith A. Chevalier, *The Competitive Consequences of Most-Favored-Nation Provisions* 27 ANTITRUST 20 (Spring 2013); Salop & Morton, *supra* note 37, at 16; Jonathan B. Baker, *Vertical Restraints with Horizontal Consequences: Competitive Effects of "Most Favored Nations Clauses,"* 64 ANTITRUST L. J. 517 (1996).

[66] For an example of MFNs increasing efficiency, see the discussion of a brewer and bottle maker in Baker & Chevalier, *supra* note 65.

[67] Brystana Kaufman et al., *Impact of Accountable Care Organizations on Utilization, Care, and Outcomes: A Systematic Review*, 76 MED. CARE RESEARCH AND REV. 255 (2019).

efforts by the federal government to encourage integration and standardization of electronic health records[68] may reduce the procompetitive justification for MFNs.

Finally, a third contention is that MFNs may counteract delays in contracting by encouraging longer-term contracts where price can fluctuate with market demand. For example, some large purchasers may want to sign a long-term contract with a supplier to ensure stability in the supply chain. Agreeing to a contract with an MFN allows the supplier to offer the best price to the large purchaser while still allowing that price to fluctuate due to changes in the cost of production and market demand. For example, some economic research finds that MFNs have led to more efficient contracts in the natural gas industry, where fuel price indices fluctuate more rapidly relative to the length of the contract.[69] In health care, hospitals may face unknown costs from changing healthcare technologies, labor negotiations, and new obligations arising from legislation and regulation, but these prices do not fluctuate rapidly. Increases in costs to providers may be reflected in future contracts and the procompetitive justification of MFNs as protection against price fluctuations, may not outweigh potential anticompetitive harms.

In sum, consolidation, federal regulation, and costs that do not fluctuate rapidly relative to the contract period in healthcare markets minimize the procompetitive justifications for MFNs that apply in other industries. In addition, the potential for MFNs to weaken price competition, exclude competitors, and drive up prices for healthcare services is amplified by third-party insurance and a lack of price transparency. As a result, regulating or banning the use of MFNs in contracts between healthcare providers and payers may be beneficial, particularly when there is a dominant insurer.

4. Which States Have Restricted MFNs in Healthcare Contracts?

Realizing that MFNs represent an area of concern, many lawmakers at both the state and federal level have introduced bills to prohibit their use in health care. In particular, Congress is currently considering the Lower Health Care Costs Act, which would eliminate MFNs in insurance contracts by prohibiting an insurer from "enter[ing] into an agreement with a provider, network or association of providers… if such agreement, directly or indirectly… restricts other group health plans or health insurance issuers not party to the contract from paying a lower rate for items or services than the contracting plan or issuer pays for such items or services."[70] This bill, however, appears to have stalled.

---

[68] *See e.g.,* 21st Century Cures Act, Pub. L. No. 114-255, 130 Stat. 1033 (2016); *ONC's Cures Act Final Rule*, THE OFFICE OF THE NAT'L COORDINATOR FOR HEALTH INFO. TECH., https://www.healthit.gov/curesrule/ (last visited Aug. 28, 2020).

[69] *See* W. Robert Majure & Andrew Sfekas, *Revisiting Guidance on MFN Terms* NAT'L L. REV. (April 16, 2020), https://www.natlawreview.com/article/revisiting-guidance-mfn-terms. "When renegotiation is costly, but long-term contracts are desirable, MFNs may make contracts possible that would otherwise require exclusive arrangements or would simply not occur. For example, MFNs have been common in natural gas contracts, where producers and pipeline owners typically commit to contracts with very long terms. In these markets, a typical MFN would guarantee that a pipeline operator will pay the best price in a region to a wellhead producer… neither side wants to be locked into a contract that pays less than the market rate, which will likely vary over time as market conditions fluctuate in unpredictable ways. MFNs allow pipeline operators and producers to address this uncertainty of future market conditions within the long-term contract that they both desire." *See also* 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. LAW & ECON. 297 (1994).

[70] S. 1895, 116th Cong. § 302(b)(1)(D) (2019).

In the decades of federal inaction, nineteen states have passed laws restricting the use of MFNs in contracts between insurers and providers, suggesting an evolving consensus that the use of MFN clauses in healthcare contracts is, on balance, anticompetitive. While considerable variation exists in the statutory language used by the states to restrict the use of MFNs (see Table 1), additional economic research is required to determine the relative effectiveness of these restrictions. Seventeen states specify that no contracts may require that the provider give the insurer the best price. Alternatively, Massachusetts' law broadly bans contract provisions that establish prices paid to providers, including hospitals, based on the rates paid in contracts with other insurers or medical service corporations.[71] Kentucky's law provides that "[n]o insurance contract with a provider shall contain a most-favored-nation provision" but does not define the specifics of that provision. Of the seventeen states that ban best-price requirements, eleven states also prohibit restricting the provider from contracting with another plan for lower provider payment rates, a second set of eleven states also prohibit a plan from requiring that the provider renegotiate the contract if they subsequently contract with another plan for lower rates, and a third set of eleven states also prohibit a plan from requiring a participating provider to disclose the rates a provider negotiates with any other plan. Connecticut, Maryland, and New Jersey prohibit a contractual term requiring the provider to certify to the plan that the negotiated provider payment rate is the best rate available. In addition, New York requires the insurance commissioner to review MFN clauses in contracts with managed care organizations.[72]

One of the most comprehensive bans is in Arkansas' MFN ban, which became effective on September 1, 2019. This law prohibits insurers from offering or entering into contracts with providers that include an MFN, which the law defines broadly as "a provision in a healthcare contract that:

> (A) Prohibits or grants a contracting entity an option to prohibit a participating healthcare provider from contracting with another contracting entity to provide healthcare services at a lower price than the payment specified in the healthcare contract;
>
> (B) Requires or grants a contracting entity an option to require a participating healthcare provider to accept a lower payment in the event the participating healthcare provider agrees to provide healthcare services to another contracting entity at a lower price;
>
> (C) Requires or grants a contracting entity an option to require termination or renegotiation of an existing healthcare contract if a participating healthcare provider agrees to provide healthcare services to another contracting entity at a lower price; or
>
> (D) Requires a participating healthcare provider to disclose the participating healthcare provider's contractual reimbursement rates with other contracting entities."[73]

[71] MASS. GEN. LAWS ch.176D, § 3(4).

[72] In addition to these nineteen states, three states have statutes that address the use of MFNs in healthcare contracts without prohibiting their use generally. West Virginia exempts rates negotiated in the small group market from triggering MFN clauses (W. VA. CODE § 33-16D-16); CA exempts any cash payments from uninsured patients from triggering MFN clauses (CAL. HEALTH & SAFETY CODE § 1371.22); and Washington prohibits the use of MFNs with certified health plans, but the statutes defining certified health plans have been repealed (WASH. ADMIN. CODE 246- 25-045).

[73] ARK. CODE ANN. § 23-99-1202(10).

Table 1: Statutes Banning MFNs by State, August 2020[74]

	Date Effective (hospitals)	Best Price	Prevent contracting with other entities at lower rate	Contract Re-negotia-tion	Required disclosure of rival's rates	Certifi-cation of Best Price	Unfair trade practice/ Unenforce-able contract provision
Alaska	7/1/2001	✓	-	-	-	-	⊗
Arkansas	9/1/2019	✓	✓	✓	✓	-	⚖
Connecticut	10/1/2011 for new contracts; 1/1/2014 for existing contracts	✓	✓	✓	✓	✓	⊗
Georgia	3/2/2012	✓	✓	✓	✓	-	⊗
Idaho	7/1/1998	✓	-	✓	✓	-	⊗
Indiana	4/26/2007	✓	✓	✓	✓	-	⊗
Kentucky	4/10/1998	-	-	-	-	-	⊗
Maine	Any contract executed or renewed on or after 1/1/2012	✓	✓	✓	✓	-	⊗
Maryland	10/1/2006	✓	✓	-	✓	✓	⊗
Massachusetts [75]	10/1/2010	-	-	-	-	-	⚖
Michigan	2/1/2013	✓	✓	✓	✓	-	⊗
Minnesota	Applies to contracts entered, renewed, or amended on 5/19/1991	✓	✓	✓	-	-	⊗
New Hampshire	1/1/2001	✓	-	-	-	-	⚖

[74] ALASKA STAT. § 21.07.010 (b)(3); ARK. CODE ANN. § 23-99-1204; CONN. GEN. STAT. § 38a-479b(d); GA. COMP. R. & REGS. 120-2-20-.03 IDAHO CODE § 41-3927 (managed care plans); IDAHO CODE § 41-3443 (hospitals); IND. CODE § 27-8-11-9; IND. CODE § 27-13-15-4; KY. REV. STAT. § 304.17A-560; ME STAT. tit. 24-A, § 4303(17); MD. CODE ANN., INS. § 15-112 (2009); MASS. GEN. LAWS ch. 176D § 3(4); MASS. GEN. LAWS ch. 176O § 9A(b); Mich. Insurance Commissioner Order No. 12-035-M; MICH. COMP. LAWS § 550.1400; MINN. STAT. § 62A.64; N.H. REV. STAT. ANN. § 417:4; N.J. ADMIN. CODE § 11:24C- 4.3(c)(2) (managed care); N.Y. COMP. CODES R. & REGS., tit. 10 §§ 98-1.2 & 98-1.5; N.C. GEN STAT. § 58-50-295; N.D. CENT. CODE § 26.1-04-03(19); OHIO REV. CODE § 3963.11; 23 R.I. GEN. LAWS § 23-17.13-2, 3 (2009); 27 R.I. GEN. LAWS § 27-18.8-3 (d)(8); VT. STAT. ANN. tit. 18, § 9418e.

[75] Massachusetts' law broadly bans contracts that reference rivals, which includes MFNs. The statutory language is broader than the specific bans listed as columns in this chart." MASS. GEN. LAWS ch.176D, § 3(4).

New Jersey	1/1/2014	✓	-	-	-	✓	⊗
New York	Pre-2007	-	-	-	-	-	⊗
North Carolina	10/1/2013	✓	✓	✓	✓	-	⊗
North Dakota	8/1/1999	✓	-	-	-	-	⚖
Ohio	6/25/2010 (6/25/2008 for all providers except hospitals)	✓	✓	✓	✓	-	⊗
Rhode Island	1/1/2004	✓	-	-	-	-	⊗
Vermont	7/1/2009	✓	✓	✓	✓	-	⊗

Source: Authors' analysis of statutes and regulations using searches of Westlaw and state legislative and regulatory websites.

⚖ = Unfair trade practice

⊗ = Unenforceable contract provision

Most states that ban MFNs do so for all provider contracts, but Kentucky permits them where the Insurance Commissioner determines the insurer has "nominal" market share[76] and New York[77] only requires that the Insurance Commissioner reviews them in contracts with managed care organizations.[78] Procedurally, most states that ban MFN clauses do so by defining MFN clauses as prohibited or unenforceable contractual terms in managed care or insurance contracts. Some states — Arkansas, Massachusetts, New Hampshire, and North Dakota — ban the clauses by defining them as unfair and deceptive trade practices. Whether limiting MFNs as an unenforceable contractual provision or labeling them a deceptive trade practice is a more effective method for enforcement has not been determined.

5. Summary

In health care, the anticompetitive harms of MFNs frequently outweigh any procompetitive justifications, especially in markets with a dominant insurer or provider. Yet challenging MFNs in court for violating antitrust statutes is difficult and resource intensive, providing strong justification for states to consider legislative bans on MFNs. While procompetitive justifications for use of MFN clauses in contracts between providers and payers remain relatively weak, states might consider allowing MFNs in situations when both parties lack market power.[79] In states that decline to prohibit MFNs, antitrust enforcers should continue to bring cases to clarify case law on this issue.

[76] KY. REV. STAT. ANN. § 304.17A-560.

[77] N.Y. COMP. CODES R. & REGS., tit. 10 §§ 98-1.2 and 98-1.5.

[78] Michigan law allowed the use of MFNs with the approval of the Insurance Commissioner between February 1, 2013 and January 1, 2014, when the law first took effect.

[79] Salop & Morton, *supra* note 37; Gönenç Gurkaynak et al., *Most-favored-nation Clauses in Commercial Contracts: Legal and Economic Analysis and Proposal for a Guideline*, 42 EUR. J. L. ECON. 129 (2016).

B. All-or-nothing Clauses

Dominant providers may exert market power through the use of all-or-nothing clauses, which require a health plan that wants to contract with a particular provider or affiliate in a provider system to contract with all other providers in that system. Providers typically use all-or-nothing provisions to leverage the status of their "must-have" providers or facilities in highly concentrated markets to demand higher payment rates for the entire system, including those providers in more competitive locations and specialties.[80] A "must-have" provider is one a health plan must have within its network to be commercially viable because of geographic proximity, referrals, legal obligations, reputation, specialized services, or a lack of an alternative in a geographic location.[81] In order to contract with the "must-have" provider in a system, an all-or-nothing provision would require the health plan to contract with all providers in that system.

Network adequacy laws contribute significantly to enabling providers to mandate all-or-nothing clauses in contracts with health plans. Network adequacy laws aim to ensure that health plans can deliver the benefits included in the insurance contract by providing adequate access to in-network providers and services.[82] For example, California's Knox-Keene Health Care Services Plan Act of 1975 requires health maintenance organization plans offered by commercial insurance companies to provide their enrollees with access to at least one hospital that is no more than 15 miles or 30 minutes away from the enrollee's residence or workplace.[83] If a provider's hospital is the only hospital in an area that satisfies that requirement, a health plan must contract with that provider to avoid violating the Knox-Keene Act. Furthermore, some providers have such a strong reputation that insurers cannot credibly exclude them from the network, even if they could do so legally. In either instance, if a health plan must include a provider in its network, the provider's bargaining power is enhanced, and it can demand higher prices.[84]

All-or-nothing clauses compound the leverage held by a must-have hospital or physician group by extending it out to all other commonly controlled providers within a health system. As a result of the must-have status of individual hospitals or providers, a health system can demand supracompetitive rates for all providers and facilities within the system. The use of all-or-nothing clauses also highlights the anticompetitive dangers of the unilateral effects resulting

---

[80] Robert A. Berenson, Paul B. Ginsburg, Jon B. Christianson & Tracy Yee, *The Growing Power of Some Provider to Win Steep Payment Increases from Insurers Suggests Policy Remedies May Be Needed*, 31 HEALTH AFF. 973 (2012).
[81] *Id*. at 973–975.
[82] Sally McCarty & Max Ferris, *ACA Implications for State Network Adequacy Standards*, THE STATE HEALTH REFORM ASSISTANCE NETWORK 1 (Aug. 2013), https://www.rwjf.org/en/library/research/2013/08/aca-implications-for-state-network-adequacy-standards.html.
[83] CAL. HEALTH & SAFETY § 1340, et seq.; CAL. CODE REGS. tit. 28, § 1300.51; *Provider Network Adequacy*, CALIFORNIA DEPT. OF INSURANCE, http://www.insurance.ca.gov/01-consumers/110-health/10-basics/pna.cfm#:~:text=An%20adequate%20provider%20network%20must,physician%20per%202%2C000%20covered%20persons (last visited Aug. 20, 2020).
[84] Berenson, Ginsburg, Christianson & Yee, *supra* note 80.

from mergers.[85] When two hospitals that patients view as substitutes merge, a health plan can no longer use one hospital as a threat to negotiate lower rates with the other, and the newly merged provider entity has increased bargaining leverage over the health plan. If the merged provider entity then implements all-or-nothing provisions, the health plan must either have both facilities in their network or neither. As a result, the bargaining power of each hospital is heightened, and the merged system can command higher prices.[86]

All-or-nothing clauses are an extreme form of a concept known as tying, or the practice of a dominant provider utilizing their market power over services in one market (the tying product) to pressure health plans to buy their services in other markets (the tied product). Under antitrust law, tying is unlawful if a seller with significant market power in the tying market coerces a buyer to purchase the tied product or services and thereby forecloses competition in the tied market. While all-or-nothing clauses force health plans to choose between contracting with all or none of a health system's providers or facilities, dominant providers can still demand higher prices in more competitive markets by effectively tying a "must-have" provider or facility to just some, or even just one other, of the provider's products in other markets.

1. Antitrust Enforcement and All-or-Nothing Clauses

The most prominent examples of legal challenges to the use of all-or-nothing clauses in healthcare contracts are the dual state and federal lawsuits against Sutter Health. Both suits challenged the health system's use of all-or-nothing clauses in conjunction with other anticompetitive terms to maintain—and gain—market dominance, and command higher prices in violation of both state and federal antitrust laws.[87] In the state suit, two consolidated cases, *UFCW & Employers Benefit Trust v. Sutter Health* and *People of the State of California ex rel Xavier Becerra v. Sutter Health* (hereinafter "*Sutter"*),[88]alleged Sutter Health used all-or-nothing

[85] *See e.g.*, FTC v. Penn State Hershey Med. Ctr., 185 F. Supp. 3d 552 (M.D. Pa. 2016), rev'd, 838 F.3d 327, 343 (3d Cir. 2016); FTC v. Advocate Health Care, No. 15 C 11473, 2016 WL 3387163 (N.D. Ill. June 20, 2016), rev'd, 841 F.3d 460 (7th Cir. 2016), on remand 2017 WL 1022015 (N.D. Ill. Mar. 16, 2017);
Saint Alphonsus Med. Ctr.-Nampa Inc. v. St. Luke's Health Sys., Ltd., No. 1:12-cv-00560, 2014 WL 407446 (D. Idaho Jan. 24, 2014), aff'd, 778 F.3d 775 (9th Cir. 2015).

[86] Martin Gaynor, *Competition Policy in Health Care Markets: Navigating the Enforcement and Policy Maze*, 33 HEALTH AFF. 1088 (2014); Martin Gaynor & Robert J. Town, *Competition in Health Care Markets, in* HANDBOOK OF HEALTH ECONOMICS, VOLUME 2 499–638 (eds. Mark V. Pauly, Thomas G. McGuire & Pedro P. Barros (2012); *Special Commission on Provider Price Variation Report*, MASSACHUSETTS HEALTH POL'Y COMM'N 63 (March 15, 2017), https://www.mass.gov/news/special-commission-on-provider-price-variation-report.

[87] *See* Complaint, UFCW & Employers Benefit Trust, et al. v. Sutter Health, et al., No. CGC 14-538451 (Cal. Super. Ct. S.F. City and Cnty. 2019) [hereinafter UEBT Complaint]; Complaint, People of the State of California ex rel Xaviar Becerra v. Sutter Health., CGC 18-565398 (Cal. Super. Ct. S.F. City and Cnty. 2019) [hereinafter California AG Complaint], Third Amended Complaint, Sidibe v. Sutter Health, 4 F.Supp 3d 1160 (N.D. Cal. 2013) (No. C 12–04854 LB) [hereinafter *Sidibe* Third Amended Complaint].

[88] The state suit, *UFCW & Employers Benefit Trust v. Sutter Health*, was filed in 2014 by UFCW & Employers Benefit Trust, one of the largest union benefit trusts in California, and a class of California self-funded payers. In 2018, the California Attorney General filed a similar suit after an investigation into the practices of health systems that led to significant price disparities in healthcare between Southern and Northern California. The cases were later consolidated as both complaints alleged that Sutter had violated the Cartwright Act, the primary antitrust law in California, by engaging in price tampering and fixing, unreasonable restraint of trade (unlawful tying), and combination to monopolize. The complaints laid out how Sutter used a combination of all-or-nothing, anti-steering/anti-tiering, and gag-clauses to insulate itself from price competition for healthcare services.

clauses in conjunction with anti-steering or anti-tiering clauses[89] and gag clauses provisions,[90] in violation of the state antitrust statutes to charge anticompetitive prices and hide these higher prices from those ultimately responsible for paying those costs.[91] In particular, the complaints alleged that Sutter used all-or-nothing clauses to require health plans that offer their enrollees the services and products available at a specific Sutter provider to also offer the services available at every other Sutter provider. Because Sutter is a "must-have" provider in several markets in Northern California,[92] health plans had little choice but to include all of Sutter's providers at the rates demanded by Sutter, even when the providers were in more competitive markets.[93] By effectively tying these "must-have" providers to the entire system, Sutter enhanced its bargaining power and could demand higher prices from health plans, which largely lost their negotiating powers. The complaints alleged that the all-or-nothing clauses prevented health plans from building networks to exclude Sutter hospitals, even in the geographic areas where it would be economically feasible, and preferable, to assemble networks with high-quality, lower-priced alternative providers.[94]

In addition to the explicit all-or-nothing clauses, the attorney general's complaint alleged that Sutter also effectuated its all-or-nothing position by using excessive out-of-network pricing, as well as other punitive pricing mechanisms.[95] The attorney general alleged that the out-of-network rates set by Sutter were excessive and rendered any narrow networks that excluded Sutter uneconomical because of its exorbitant out-of-network rates.[96] Further, the Attorney General contended that if a health plan wanted to exclude a Sutter provider, Sutter would significantly raise the rates for their other contracted providers, making it more economically viable for the health plan to include that provider rather than pay the higher prices.[97] Both of these pricing schemes made it difficult to escape agreeing to Sutter's all-or-nothing clause.

Because the state has agreed to settle its case against Sutter, no binding precedent will arise from the litigation. However, the terms of the settlement target the anticompetitive features of Sutter's scheme to maintain its monopoly power. Specifically, the proposed consent decree: 1) bars Sutter from requiring all-or-nothing clauses, allowing health plans to pick and choose hospitals within and outside the system;[98] 2) prohibits Sutter from conditioning the pricing of its "must-have" hospitals on the inclusion of its other providers in the network;[99] and 3) limits Sutter's out-of-network rates by imposing caps for certain services and hospitals.[100] In

[89] *Infra* Section II. D. Anti-Steering or Anti-Tiering Clauses.
[90] *Infra* Section II. E. Gag Clauses.
[91] UEBT Complaint, *supra* note 87, at 33, 38.
[92] Specifically, Sutter Coast Hospital in Crescent City, Sutter Lakeside Hospital in Lakeport, Sutter Memorial Hospital in Los Banos, Sutter Amador Hospital in Jackson, Sutter Auburn Faith Hospital in Auburn, Sutter Tracy Hospital in Tracy, and Sutter Solano Hospital in Vallejo. *Id*. at 26.
[93] *Id*. at 29; California AG Complaint, *supra* note 87, at 33.
[94] UEBT Complaint, *supra* note 87, at 28; California AG Complaint, *supra* note 87, at 31.
[95] California AG Complaint, *supra* note 87, at 34.
[96] *Id*.
[97] *Id*. at 35.
[98] Notice of Motion and Motion for Preliminary Approval of Settlement; Memorandum of Points and Authorities, UFCW & Employers Benefit Trust, et al. v. Sutter Health, et al., No. CGC 14-538451 13 (Cal. Super. Ct. S.F. City and Cnty. 2019 [hereinafter UEBT Motion for Preliminary Approval of Settlement].
[99] *Id*. at 13.
[100] *Id*. at 14.

effect, the decree recognizes the principle established in a number of cases under Section 2 of the Sherman Act cases that when a "monopoly broth" of restraints support a monopoly, they must be enjoined.[101]

While these conduct remedies are a step in the right direction, they do not directly address the underlying issue of market consolidation in Northern California and Sutter's resultant market power. Although the terms of the proposed consent decree may curb Sutter's dominance over time, Sutter may still be able to leverage its several "must-have" hospitals in creative ways. As a Massachusetts judge noted in denying a consent decree for a proposed health system merger, using the proposed conduct remedies to address all-or-nothing contracting is "like putting a band-aid on a gaping wound that will only continue to bleed (perhaps even more profusely) once the band-aid is taken off."[102] While conduct remedies, such as prohibiting the use of all-or-nothing clauses, is a useful tool in addressing anticompetitive behavior, antitrust enforcers prefer structural remedies, such as mandated divestiture, as a mechanism to restoring competition in a market.[103]

In *Sidibe v. Sutter Health*, a federal suit with similar claims as the state antitrust lawsuit against Sutter, the plaintiffs alleged that Sutter's use of all-or-nothing, anti-steering or anti-tiering, and gag clauses led to violations not only of California's state antitrust laws but also federal antitrust laws, specifically both Sections 1 and 2 of the Sherman Act.[104] The plaintiffs in *Sidibe*, enrollees of various health plans, directly alleged that the all-or-nothing clauses amounted to illegal tying under the Sherman Act. The plaintiffs contended that if a health plan wanted to include any of the nine Northern California health markets where Sutter wielded a one-hundred percent share of the relevant inpatient hospital services, they would also have to include providers in five more competitive "tied markets."[105] By utilizing this practice, Sutter

---

[101] The term "monopoly broth" arises from a Seventh Circuit decision in which the judge stated, "It is the mix of various ingredients of. . . behavior in a monopoly broth that that produces the unsavory flavor." City of Mishawaka, Ind. v. Am. Elec. Power Co., Inc., 616 F.2d 976, 986 (7th Cir. 1980). The court relied on the rule elaborated in Continental Ore Co. v. Union Carbide & Carbon Corp., 370 U.S. 690, 698–99 (1962), "plaintiffs should be given the full benefit of their proof without tightly compartmentalizing the various factual components and wiping the slate clean after scrutiny of each." *See also* United States v. Microsoft Corp., 253 F.3d 34, 78 (D.C. Cir. 2001) (en banc) ("Because the District Court identifies no other specific acts as a basis for "course of conduct" liability, we reverse its conclusion that Microsoft's course of conduct separately violates § 2 of the Sherman Act"); City of Groton v. Conn. Light & Power Co., 662 F.2d 921, 929 (2d Cir. 1981) ("The proper inquiry is whether, qualitatively, there is a 'synergistic effect."'); MCI v. AT&T, 708 F.2d 1081, 1177 (7th Cir. 1983) ("If you really wanted to know what caused the unsavory flavor of the monopoly broth, you would not just audit the chef's books of account; you would also take a look at his recipe."); City of Anaheim v. S. Cal. Edison Co., 955 F.2d 1373, 1378 (9th Cir. 1992) ("[I]t would not be proper to focus on specific individual acts of an accused monopolist while refusing to consider their overall combined effect."); LePage's Inc. v. 3M, 324 F.3d 141, 171, 181-82 (3d Cir. 2003) (declining monopoly broth claim). For more discussion on various monopoly broth theories, see Daniel A. Crane, *Does Monopoly Broth Make Bad Soup?*, 76 ANTITRUST L.J. 663 (2010); 2 PHILLIP E. AREEDA & HERBERT HOVENKAMP, ANTITRUST LAW: AN ANALYSIS OF ANTITRUST PRINCIPLES AND THEIR APPLICATION §310c (3d ed. 2008).

[102] Commonwealth v. Partners Healthcare System, Inc., SUCV2014-02033-BLS2, 2015 WL 500995, at *2 (Mass. Super. Jan. 30, 2015). The consent decree in the Partners and Southshore case proposed requiring component contracting wherein payers would be able to negotiate with Partners and choose to purchase only certain components of services in Partners' network rather than being required to contract with the entirety of Partners' network. For further discussion of component contracting, see *Special Commission on Provider Price Variation Report*, *supra* note 86, at 63–67.

[103] *See Antitrust Division Policy Guide to Merger Remedies*, U.S. DEPT. OF JUST. 8 (Oct. 2004), Ihttps://www.justice.gov/atr/page/file/1175136/download.

[104] *Sidibe* Third Amended Complaint, *supra* note 87, at 33–38.

[105] *Id*. at 2. The nine "tying markets" included the hospital service areas in Antioch, Berkeley, Burlingame, Castro Valley, Davis, Roseville, San Leandro, Tracy, and Vallejo. In the San Leandro market, Sutter only has 78 percent market share of inpatient hospital services. The five "tied markets" included the hospital service areas in San Francisco, Oakland, Sacrament, Modesto, and Santa Rosa.

would force the health plans to contract for services in the tied markets, and then would charge the plans the same high prices it charged in the tying markets. Crucial to the designation of the "tying" and "tied" markets, is the plaintiffs' definition of the geographic markets and the establishment of market power. The district court dismissed plaintiffs' case on the grounds that the plaintiffs failed to allege plausible geographic markets.[106] However, the Ninth Circuit recently disagreed with the district court and granted an appeal. As of this writing, the case remains in active litigation.

Although neither *Sutter* case has resulted in a final court opinion, the use of the tying legal analysis in the context of a provider tying different geographic markets under the Cartwright Act and the Sherman Act is a relatively novel use of the doctrine.[107] A claim for tying, such as the one illustrated in both *Sutter* cases, would have to overcome several hurdles under the quasi-*per se* tying analysis.[108] Plaintiffs must prove four elements to establish an unlawful tie: 1) two separate products or services; 2) the tying arrangement coerced the buyer to purchase the tied product or service; 3) the seller's market power for the tying product or service restrains competition in the market of the tied product or services; and 4) the tying arrangement foreclosed a substantial amount of competition.[109]

These elements may be quite challenging to prove within the context of the complex markets for healthcare services. Under the first element, if the plaintiff is trying to establish a tie between two acute care hospitals in different geographic areas, the analysis would need to focus on the insurer's need to build provider networks in all the geographic markets where their enrollees reside, even though a particular enrollee usually only demands a provider network in the geographic market where he or she resides. In this scenario, the insurer would be the "common customer" across markets.[110] While patient demand, rather than insurer demand, for hospital services in different geographic markets could demonstrate that two hospitals that are part of one system and satisfy the separate products test, this argument is less persuasive and less reflective of how the tie actually functions. Some courts may be reluctant to distinguish two hospitals in different geographic areas as separate products if they operate under a single system, however this view would fail to recognize the impact of the tying of healthcare service providers and hospitals through the eyes of the insurer.

---

[106] Sidibe v. Sutter Health, 4 F. Supp. 3d 1160, 1175 (N.D. Cal. 2013).

[107] Morgan A. Muir, Stephanie A. Alessi & Jaime S. King, *Clarifying Costs: Can Increased Price Transparency Reduce Healthcare Spending?*, 319 WILLIAM & MARY POL'Y REV. 43 (2013).

[108] Unlike a pure *per se* analysis where an arrangement would be automatically invalidated if the plaintiff could prove that an agreement ties two products, in modern tying cases the plaintiff must also prove market power and illustrate the effect of the tying in the tied product market. Construction Aggregate Transport, Inc. v. Florida Rock Industries, Inc., 710 F.2d 752 (11th Cir. 1983). These additional requirements make the quasi-*per se* rule less forceful than the other restraints under Section 1 of the Sherman Act. Additionally, in her concurrence in Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S. 2 (1984), Justice O'Connor suggests that the procompetitive effects of such arrangements should be weighed as well, suggesting an analysis more akin to the rule of reason.

[109] JOHN J. MILES, HEALTH CARE AND ANTITRUST LAW, § 11:3 (2020). "If the tying arrangement fails to meet the requirements for unlawfulness. . . .it still may fail full-blown rule-of-reason analysis. This requires the plaintiff prove that the arrangement had an actual unreasonable anticompetitive effect in the market for the tied product or service. Few decisions, however, have analyzed tying arrangements under this standard, and it is difficult to prove that a tying arrangement actually unreasonably restrained competition without prove the elements. . ."

[110] Leemore Dafny, Kate Ho & Robin S. Lee, *The Price Effects of Cross Market Mergers: Theory and Evidence from the Hospital Industry*, 50 THE RAND J. OF ECON. 286 (2019) (also providing some evidence indicating that cross-market mergers have led to higher prices); Matthew S. Lewis & Kevin E. Pflum, *Hospital Systems and Bargaining Power: Evidence from Out-of-Market Acquisitions*, 48 THE RAND J. OF ECON. 579 (2017).

Under the second element of coercion, the plaintiffs must show that the health plan would not have contracted with the Sutter providers in the tied markets but for the tying arrangement. If the health plan may have contracted with the hospital in the tied market in the absence of the tie, this element would be difficult to establish. However, if the tied product or provider offered healthcare services in a more competitive market, the tie could be more easily established.

The last two elements—market power and foreclosure of a substantial amount of competition—require a significant amount of economic analysis that depends on a complex and fact-dependent inquiry.[111] As illustrated by the district court's dismissal of the plaintiffs' complaint for an insufficient geographic market definition in *Sidibe* and the subsequent disagreement by the Ninth Circuit, establishing the existence and parameters of market power can be difficult.[112] The back and forth within the federal courts on this issue reveals both the challenges of establishing geographic markets in health care and the potential for the courts to establish new precedent on this issue. Foreclosure also largely depends on an acceptable market definition to establish the market where the tying arrangement foreclosed competitors. Additionally, the amount of foreclosure required to establish an anticompetitive tie is also often contested, and courts have varied on what constitutes sufficient foreclosure and the factors that can impact that determination.[113]

The state and federal lawsuits against Sutter illustrate the ability of dominant health systems to use all-or-nothing clauses to enhance their negotiating power by leveraging must-have providers throughout the system and the subsequent anticompetitive harms that arise from doing so. The lawsuits also illuminate the difficulty in successfully disciplining these contracting practices through litigation because of the complexity and largely unsettled nature of tying law under state and federal antitrust laws. As many health systems currently have must-have providers, lawmakers should consider implementing other methods in addition to litigation to minimize anticompetitive harms arising from all-or-nothing contracting, including laws banning those provisions or making them presumptively illegal when used by firms with market power.

2. Economic Justification or Procompetitive Use of All-or-Nothing Clauses

As with bans on MFN clauses, policymakers considering sweeping bans on all-or-nothing contracting should examine whether any reasonable justification supports their use by health system. The main arguments in support of the use of all-or-nothing clauses revolve around

---

[111] MILES, *supra* note 109.

[112] *Sidibe* Third Amended Complaint, *supra* note 87, at 19–20. The district court found that the geographic markets should be defined by where enrollees *could* go in response to an increase in price, not where they *actually* go, and ultimately dismissed the case. On appeal, the Ninth Circuit disagreed with the district court and found that the plaintiffs' market definitions were sufficient.

[113] Some courts have held that short duration contracts are less problematic because competitors are not foreclosed for a significant period of time and can compete when the contract has expired, see Methodist Health Services Corp. v. OSF Healthcare System, 859 F.3d 408, 410 (7th Cir. 2017). On the other hand, other courts have held that a plaintiff must show that the purchaser subjected to the tying arrangement would have purchased the product or service from another seller in the absence of the tie. *See* Sidibe v. Sutter Health, 4 F. Supp. 3d 1160, 1178 (N.D. Cal. 2013). The district court in *Sidibe* initially dismissed the case in part because the complaint did "not plead facts showing any negative impact on competition in the tied markets.

efficiency and integration. For example, Sutter began utilizing all-or-nothing contracting in 1994 under the pretext that if they were going to create an integrated system, then it should operate as such.[114] For instance, patients should move freely from Sutter providers to Sutter laboratories to Sutter hospitals without concern that certain Sutter providers were not in their insurance network. Sutter also contended that having to execute only one contract for all hospitals at one price improved efficiency and saved administrative costs for both Sutter and the health plans.[115] Sutter additionally argued health plans find all-or-nothing contracting attractive because they prefer providers that can offer complete health services under a single contract.[116] The health system largely argued that all-or-nothing clauses are necessary to maximize the potential of the system to provide integrated care.

While these arguments show all-or-nothing contracting can generate some benefits, in practice, these benefits have not outweighed the harms in the context of health care when there is a health system with market power. Rather, the use of all-or-nothing contracting helps health systems, like Sutter, which has acquired market power through consolidation, both maintain and enhance that power. Importantly, acquiring another firm or contracting as a whole system does not in and of itself equate to meaningful clinical integration, nor is financial integration achieved through a merger or an acquisition always necessary to achieve the benefits of clinical integration. [117] As Martin Gaynor notes, "consolidation is not integration . . . Integration, if it happens, is a long process that occurs after an acquisition."[118] Consolidation overwhelmingly leads to decreased competition, higher prices, and decreased quality.[119] In the case of Sutter, the Petris Center at the University of California, Berkeley, found that Northern California is considerably more concentrated than Southern California across most measures of healthcare market concentration.[120] These higher levels of concentration were associated with higher prices—"inpatient prices were 70% higher, outpatient prices were 17–55% higher (depending on the specialty of the physician performing the procedure), and ACA premiums

[114] Michelle Conklin, *Sutter Begins All-or-Nothing Contracting*, 12 HEALTH CARE STRATEGIC MGMT. 12 (1994).
[115] *Id*.
[116] *Id*.
[117] Elliott S. Fisher et al., *Financial Integration's Impact on Care Delivery and Payment Reforms: A Survey of Hospitals and Physician Practices*, 39 HEALTH AFF. 1302, 1310 (2020); Hannah T. Neprash, Mechael E. Chernew, Andrew L. Hicks, Teresa Gibson & Michael McWilliams, *Association of Financial Integration Between Physicians and Hospitals with Commercial Health Care Prices*, 175 JAMA INTERNAL MED. 1932 (2015); Jeff Goldsmith, Lawton R. Burns, Aditi Sen & Trevor Goldsmith, *Integrated Delivery Networks: In Search of Benefits and Market Effects*, NAT'L ACADEMY OF SOCIAL INS. (Feb. 2015), https://www.nasi.org/sites/default/files/research/Integrated_Delivery_Networks_In_Search_of_Benefits_and_Market_Effects.pdf; Erin C. Fuse Brown & Jaime S. King, *The Double-Edged Sword of Health Care Integration: Consolidation and Cost Control*, 92 INDIANA L. J. 55 (2016).
[118] Gaynor Statement 2019, *supra* note 3, at 15.
[119] *See e.g.*, *Id*. at 2; Cooper, Craig, Gaynor & Van Reenen, *supra* note 3; Erin C. Fuse Brown & Jaime S. King, *The Double-Edged Sword of Health Care Integration: Consolidation and Cost Control*, 92 INDIANA L. J. 55 (2016); Fisher et al., *supra* note 117; Brady Post, Tom Buchmueller & Andrew M. Ryan, *Vertical Integration of Hospitals and Physicians: Economic Theory and Empirical Evidence on Spending and Quality*, 75 MEDICAL CARE RESEARCH AND REV. 399 (2018); Robert A Berenson, Paul B. Ginsburg & Nicole Kemper, *Unchecked Provider Clout In California Foreshadows Challenges to Health Reform*, 29 HEALTH AFF. 699 (2010).
[120] The impetus for the California Attorney General to file his separate complaint on behalf of the people of California against Sutter in 2018 involved a several-year investigation as well the publication of studies and analyses illustrating the immense price disparities between Northern and Southern California, including this report. *Consolidation in California's Health Care Market 2010-2016*, NICHOLAS C. PETRIS CENTER ON HEALTH CARE MARKETS AND CONSUMER WELFARE, SCHOOL OF PUBLIC HEALTH, U.C., BERKELEY 1, 9 (March 26, 2018), https://petris.org/wp-content/uploads/2018/03/CA-Consolidation-Full-Report_03.26.18.pdf.

were 35% higher than they were in Southern California."[121] The Petris Center attributed these higher prices primarily to Sutter and its market dominance.[122]

Apart from increased prices, scant evidence finds an association between quality improvements and consolidation.[123] Further, the level of quality improvement necessary to outweigh potential anticompetitive harms in the case of a dominant health system should be significant and not merely speculative. On the other hand, extensive research shows that consolidation between close competitors can cause serious harm to the quality of care received by patients.[124] A number of studies have shown that health outcomes are substantially worse at both the hospital and physician level when providers face less competition.[125] From the perspective of patients, at least one study found that providers that are more integrated do not systematically provide care that patients perceive as integrated.[126] While it may be true that there are some efficiencies associated with providers who can complete health services under a single contract, financial integration has not led to the promise of improvements in quality or coordination of care. In short, the expediency of all-or-nothing contracting does not outweigh the anticompetitive harm caused by these terms that help dominant providers preserve their market power.

3. Which States Have Restricted All-or-Nothing Clauses in Healthcare Contracts?

Despite overwhelming evidence that some health systems may use all-or-nothing contracting to expand their market power, no state has passed a law to broadly prohibit the use of all-or-nothing clauses. To date, only Massachusetts has prohibited all-or-nothing clauses, but only in the context of limited- and tiered-network plans.[127] Specifically, the statute prohibits a contract between an insurer and a provider that contains a provision that "requires the carrier to include all members of a provider group, whether local practice groups or facilities, in a

---

[121] *Id*.; Duke Helfand, *Hospital Stays Cost More in Northern California Than Southern California* L.A. Times (March 6, 2011), https://www.latimes.com/health/la-xpm-2011-mar-06-la-fi-hospital-cost-20110306-story.html.

[122] *Consolidation in California's Health Care Market 2010-2016*, *supra* note 120.

[123] *See* Gaynor Statement 2019, *supra* note 3, at 13; Fisher et al., *supra* note 117; Nancy D. Beaulieu et al., *Changes in Quality of Care after Hospital Mergers and Acquisitions*, 382 N. ENG. J. OF MED. 51 (2020); Vivian Ho et al, *Annual Spending per Patient and Quality in Hospital-Owned Versus Physician-Owned Organizations: an Observational Study*, 35 J. GENERAL INTERNAL MED. 649 (2020); J. Michael McWilliams et al., *Delivery System Integration and Health Care Spending and Quality for Medicare Beneficiaries*, 173 JAMA INTERNAL MED. 1447 (2013); Kirsten W. Scott et al., *Changes in Hospital–Physician Affiliations in U.S. Hospitals and Their Effect on Quality of Care*, 166 ANNALS OF INTERNAL MED. 1 (2017).

[124] *See* Gaynor Statement 2019, *supra* note 3.

[125] *See* Daniel P. Kessler & Mark B. McClellan, *Is Hospital Competition Socially Wasteful?*, 115 Q. J. OF ECON. 577 (2000); Martin Gaynor, Rodrigo Moreno-Serra & Carol Propper, *Death by Market Power: Reform, Competition and Patient Outcomes in the National Health Service*, 5 AM. ECON. J.: ECON. POL'Y 134 (2013); David J. Balan & Patrick S. Romano, *A Retrospective Analysis of the Clinical Quality Effects of the Acquisition of Highland Park Hospital by Evanston Northwestern Healthcare*, 18 INT'L J. OF THE ECON. OF BUS. 45 (2010); Tamara B. Hayford, *The Impact of Hospital Mergers on Treatment Intensity and Health Outcomes*, 47 HEALTH SERV. RESEARCH 1008 (2012); Marah Noel Short & Vivian Ho, *Weighing the Effects of Vertical Integration Versus Market Concentration on Hospital Quality*, MED. CARE RESEARCH AND REV. (Feb. 2019), https://journals.sagepub.com/doi/pdf/10.1177/1077558719828938; Thomas Koch, Brett Wendling & Nathan E. Wilson, *Physician Market Structure, Patient Outcomes, and Spending: An Examination of Medicare Beneficiaries*, 53 HEALTH SERV. RESEARCH 3549 (2018); Kirstin W. Scott, E. John Orav, David. Cutler & Ashish K. Jha, *Changes in Hospital-Physician Affiliations in U.S. Hospitals and Their Effect on Quality of Care*, 168 ANNALS OF INTERNAL MED. 156 (2018).

[126] Michaela M. Kerrissey et al, *Medical Group Structural Integration May Not Ensure That Care Is Integrated, From the Patient's Perspective*, 36 HEALTH AFF. 885, 889 (2017).

[127] MASS. GEN. LAWS ch.176O, § 9A (2016).

select network plan on an all-or-nothing basis."[128] While the statute does ban all-or-nothing provisions in some plans, the language potentially does not address the central issue of anticompetitive tying. By only prohibiting clauses that require an insurer to contract with *all* members of a provider group, providers may be able to circumvent the prohibition by continuing to tie their "must-have" providers to *some* of their other providers and demanding higher prices for the tied providers.[129] The law also does not apply to the majority of plans with broad networks.

New York and Colorado had bills in the most recent legislative session that attempted to prohibit all-or-nothing contracting. New York's bill would prohibit an insurer that offers a managed care plan health product or a policy that utilizes a network of providers from entering into a contract that "requires an insurer to include all members of a provider group, including medical practice groups and facilities, in its network of participating providers."[130] Similarly, Colorado's bill would have prohibited health systems from entering into contracts with insurers that require the insurer to "enter into a contract with each hospital or outpatient health care facility, if any, within the health system."[131] Similar to the statute in Massachusetts, both bills would prohibit providers from forcing health plans to contract with *all* members of a provider system and do not account for potential tying arrangements with "must-have" affiliates that contribute to higher prices.

Additionally, California has recently considered but failed to pass three different bills that attempted to restrict all-or-nothing contracting.[132] S.B. 932 (2016) would have prohibited agreements between a hospital and a health plan or payer that contained "a requirement that the network vendor or payor includes in its network any one or more providers owned or controlled by, or affiliated with, the contracting provider."[133] S.B. 538 (2017) similarly tried to prohibit contracts between a hospital and insurer that "require the health insurer to contract with any one or more of the hospital's affiliates."[134] Although neither passed, the language in both of these bills would have been a more effective route to prohibiting the use of tying arrangements, thereby also prohibiting all-or-nothing contracting. Additionally, in the most recent session, California considered S.B. 977, which took a slightly different approach by not prohibiting tying arrangements altogether, but instead would have created a legal presumption that such arrangements are unlawful unless the defendant provider can prove otherwise.[135]

Lastly, on the federal level, The Lower Health Care Costs Act of 2019 would prohibit health plans from entering into contracts with providers if the contract directly or indirectly "requires the group health plan or health insurance issuer to enter into any additional contract with an affiliate of the provider as a condition of entering into a contract with such provider."[136]

---

[128] *Id*.

[129] Alternatively, there has been speculation that a health system with market power can effectively game individuated contracting by using its knowledge of which providers in its system an insurer has contracted with and using that knowledge to manipulate the prices it charges for other providers.

[130] Assem. B. 9781 (N.Y. 2020).

[131] H.B. 1264, 72nd Gen. Assem., 2nd Reg. Sess. (Colo. 2020).

[132] *See* S.B. 538, 2017–2018 Reg. Sess. (Cal. 2017) and S.B. 932, 2015–2016 Reg. Sess. (Cal. 2016).

[133] S.B. 932, 2015–2016 Reg. Sess. (Cal. 2016).

[134] S.B. 538, 2017–2018 Reg. Sess. (Cal. 2017).

[135] While S.B. 977 was not brought to a vote in this legislative session, the bill may be reintroduced in 2021. For further discussion of S.B. 977, see *infra* Section II. C. 3. *Which States Have Restricted Exclusive Contracting?*

[136] S. 1895, 116th Cong. (2019).

Although the bill appears to be currently stalled, like the language in the California bills, the language here would prohibit all-or-nothing contracting as well as tying arrangements between "must-have" providers and any other provider or affiliate within the system.

4. Summary

While all-or-nothing provisions can lead to antitrust scrutiny, achieving effective remedies through antitrust litigation is time-intensive, costly, and complex. Additionally, the results of such claims are unpredictable given the unsettled state of tying law. Furthermore, contracts with all-or-nothing provisions often include non-disclosure provisions that prevent antitrust enforcers and private firms from discovering the harm and filing suit.[137] As a result, state legislation prohibiting all-or-nothing contracting between providers with market power and insurers, including tying arrangements, is likely to be a more effective tool in preventing dominant providers from leveraging their market power to raise prices. State legislators should try to prevent creative health systems from tying "must-have" providers to others, even if it is not to every provider in the system. To address this concern, state legislatures may also consider instilling power in the state's insurance commissioner or other state agency the ability to review insurance contracts and reject them if they contain explicit all-or-nothing or tying provisions or other provisions that have similar effects, such as excessive out-of-network pricing or other punitive pricing schemes.

C. Exclusive Contracting

While all-or-nothing provisions require insurers to contract with all of a health system's providers, exclusive contracting provisions prevent the insurer from contracting with other competitive providers. Under the umbrella of exclusive contracting are exclusive dealing provisions and tying arrangements, both of which can produce anticompetitive results. The two practices can have similar exclusionary effects (and in fact can apply to the same conduct), but they are judged under different antitrust standards. Exclusive dealing provisions require a purchaser to only purchase a product from one seller and none of the seller's competitors. An exclusive-dealing arrangement can also flow in the other direction in which a seller agrees only to sell its products to one purchaser.[138] Exclusive dealing agreements may foreclose other sellers or purchasers from the market, allowing one entity to obtain market power. In exclusive dealing contracts between insurers and providers, a health system or other provider will require that the insurer only contract with the provider, and not any of its competitors, or an insurer will require that the provider only offer its services to the health plan. This type of arrangement can be especially anticompetitive when a particular provider is needed for a health plan to meet network adequacy requirements, essentially foreclosing all other health plans from building a viable network. On the hospital-physician level, many hospitals enter into contracts with physician groups, such as anesthesiologists, radiologists, pathologists, or emergency room physicians, wherein only that group will provide services at a particular

[137] *See infra* Section II. E. Gag Clauses.
[138] MILES, *supra* note 109, at § 4:1.

hospital. These types of contracts deny clinical privileges to competing physicians and prevent them from providing those services at that hospital.

Tying arrangements exist when a seller conditions the sale of one product (the tying product) on the purchaser's agreement to purchase another product (the tied product) from the seller. As illustrated in the discussion of all-or-nothing clauses,[139] tying agreements have the potential to foreclose the seller's competitors in the tied market, allowing the seller to obtain or maintain market power in that market. Tying can also occur either between insurers and providers or between physicians and hospitals. Tying between insurers and providers often manifests as geographic tying as discussed in the all-or-nothing section and illustrated by Sutter's anticompetitive behaviors in Northern California.[140] However, tying arrangements are also common between physicians and hospitals and often involve an exclusive contract between a physician group and hospital, where the tying product is the service offered by the hospital, while the tied products are offered by the exclusive physician group. For example, if the exclusive contract is with a group of anesthesiologists, the tied product is the anesthesiology services, while the tying product is the surgical services offered by the hospital, such that a patient who chooses that hospital must also choose that anesthesiology group. In this case, the plaintiff, a foreclosed anesthesiologist, can allege that the hospital refused to permit surgical patients to use its operating room unless they agree to purchase anesthesia services from the exclusive physician group.[141]

1. Antitrust Enforcement and Exclusive Contracting

Courts analyze exclusive dealing claims under both Sections 1 and 2 of the Sherman Act and will condemn such agreements if they are found to unreasonably restrain trade or are used by an entity with sufficient monopoly power to stifle competition.[142] Whether an exclusive dealing provision unreasonably restrains trade depends on whether the contract results in substantial foreclosure of competition.[143] Under the rule of reason analysis, courts have identified four factors to determine whether the conduct will cause anticompetitive harm: "1) the degree of market foreclosure resulting from the contract;[144] 2) the duration of the contract; 3) the effect of the foreclosure on the market power of the contracting provider; and 4) the

[139] *Infra* Section II. B. All-or-Nothing Clauses.
[140] *Id*.
[141] Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S. 2, 45 (1984).
[142] 15 U.S.C.A. § 1–2.
[143] Roland Machinery Co. v. Dresser Indus., Inc., 749 F.2d 380, 393 (7th Cir. 1984); Tampa Electric Co. v. Nashville *Coal Co.*, 365 U.S. 320, 333–35 (1961). *See also*, Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S. 2, 45 (1984) (O'Connor, J., concurring) ("Exclusive dealing is an unreasonable restraint on trade only when a significant fraction of buyers or sellers are frozen out of a market by the exclusive deal."); United States v. Dentsply Inter., Inc., 399 F.3d 181, 191 (3d Cir. 2005).
[144] Courts' analyses around the substantiality of the foreclosure have both a quantitative as well as qualitative analysis. Quantitatively, courts have required a plaintiff to show that the challenged contracts foreclose competition in at least 30 percent of the market. Stop & Shop Supermarket Co. v. Blue Cross & Blue Shield of R.I., 373 F.3d 57, 68 (1st Cir. 2004); Drs. Steuer & Latham v. National Med. Enters., Inc. 672 F.Supp. 1489 (D.S.C. 1987), aff'd 846 F.2d 70 (4th Cir.1988) (market share of less than 15% inadequate market power); Burnham Hosp., 101 F.T.C. 991 (1983) (FTC advisory opinion) (hospital with 11% market share lacks sufficient market power). However, some courts have found illegality on less, see e.g., Am. Motor Inns, Inc. v. Holiday Inns, Inc., 521 F.2d 1230 (3d Cir. 1975) (foreclosure of 14.7 percent not necessarily unlawful if other factors indicate no substantial impact on competition). Qualitatively, courts also consider the other factors such as whether another an alternative means of distribution.

procompetitive efficiencies flowing from the contracts." [145] As illustrated by the cases discussed in this section, cases pursued against entities employing exclusive dealing provisions are difficult to win because proving the factors listed above is challenging, and courts have established varying parameters for proving them.[146]

In *Methodist Health Services Corp. v. OSF Healthcare System*, Saint Francis, the largest and a "must-have" hospital in Peoria, Illinois, entered into contracts with commercial health insurance companies that required those insurers to exclude other providers from those insurer's provider markets.[147] Methodist Hospital, the second-largest hospital in the area, alleged that these contracts violated both sections of the Sherman Act by unreasonably restraining trade, unlawfully maintaining monopoly power, and seeking that monopoly power through unlawful means through the use of exclusive contracts.[148] Saint Francis's exclusive contracts covered more than half of all commercially-insured patients in the area. Methodist consequently contended that "it could not obtain a sufficiently high volume of patients to enable it to invest in quality-improving projects it otherwise would have undertaken."[149] However, the district court found that Methodist failed to make its case as it was unable to show that it had been substantially foreclosed from the market as a result of the exclusive dealing contracts and granted Saint Francis its motion for summary judgment.[150]

In his final opinion as a judge on the Seventh Circuit, Judge Posner affirmed the district's court decision, explicitly noting that the contracts did not significantly foreclose competition "since most of the contracts expire every year or two, giving other hospitals, such as Methodist, a shot at obtaining the next contract by outbidding Saint Francis."[151] The Seventh Circuit additionally found that although Methodist claimed that the exclusive contract caused prices to rise, it did not have a theory as to how the exclusive contracts contributed to that rise and failed to show that the behavior harmed competition and not just a competitor.[152] Applying

---

[145] MILES, *supra* note 108, at § 4:7. "It is not clear whether the requisite anticompetitive effect, and thus unlawfulness, can be inferred from substantial foreclosure by itself, or whether the plaintiff must prove an actual adverse effect on competitive variables such as the level of output, price, or quality. Some courts seem to indicate that exclusive contracts are unlawful when they foreclose a substantial share of the market, while most indicate that substantial foreclosure is merely a threshold requirement and require the plaintiff to go further, perhaps so far as to prove an actual adverse effect on market performance. But substantial foreclosure is an essential element of the violation."

[146] *See* Bocobo v. Radiology Consultants of South Jersey, P.A., 477 F.App'x 890 (3d Cir. 2012) (a radiologist's claim of exclusionary conduct failed because he could not show anticompetitive effects); William M. Sage, *Judge Posner's RFP: Antitrust Law and Managed Care*, 16 HEALTH AFF. 44 (1997) (addresses the assumptions and gaps in understanding that can occur when courts are asked to evaluate the health care industry without the benefit of sound empirical research through the lens of *Blue Cross and Blue Shield United of Wisconsin v. Marshfield Clinic*, 65 F.3d 1406 (7th Cir. 1995), *cert denied*, 116 S.Ct. 1288 (1996); Mark A Patterson, *The Market Power Requirement in Antitrust Rule of Reason Cases: A Rhetorical History*, 37 SAN DIEGO L. REV. 1 (2000); Roger D. Blair & D. Daniel Sokol, *The Rule of Reason and the Goals of Antitrust*: *An Economic Approach*, 78 ANTITRUST L.J. 471 (2012).

[147] Methodist Health Services Corp. v. OSF Healthcare System, No. 113CV01054SLDJEH, 2016 WL 5817176, at *6 (C.D. Ill. Sept. 30, 2016), *aff'd*, 859 F.3d 408, 410 (7th Cir. 2017).
Saint Francis is a "must have" hospital because it provides services not offered by other hospitals in the area such as solid-organ transplants, neonatal intensive care and other pediatric care, and a Level 1 trauma center.

[148] Methodist Health Services Corp. v. OSF Healthcare System, No. 113CV01054SLDJEH, 2016 WL 5817176, at *5 (C.D. Ill. Sept. 30, 2016).

[149] Methodist Health Servs. Corp. v. OSF Healthcare Sys., 859 F.3d 408, 409–10 (7th Cir. 2017).

[150] Methodist Health Services Corp. v. OSF Healthcare System, No. 113CV01054SLDJEH, 2016 WL 5817176, at *11–14 (C.D. Ill. Sept. 30, 2016).

[151] Methodist Health Servs. Corp. v. OSF Healthcare Sys., 859 F.3d 408, 410 (7th Cir. 2017).

[152] *Id*. at 411.

one of the most lenient standards for reviewing exclusive contracts, Judge Posner noted that "competition-for-the-contract is a form of competition that antitrust laws protect rather than proscribe,"[153] and contended that such competition can keep markets competitive by requiring providers to lower their prices to be more attractive to insurers.[154] Examined under this rather extreme application of the competition-for-the-contract theory, the court upheld the exclusive contracts on the basis that Methodist was "simply an unsuccessful competitor" because it lacked the services required by patients and health plans.[155]

While *Methodist* is an example of a *de facto* exclusive dealing arrangement, there are other types of contracting arrangements that can achieve similar exclusive effects. For example, some "must-have" providers offer discounts to payers in exchange for the payer excluding the provider's competitors from its network. In 2011, the DOJ and the Texas Attorney General's Office filed a complaint against United Regional Health Care System, claiming its exclusive contract provisions with commercial health insurers violated Section 2 of the Sherman Act.[156] Specifically, the government contended that United Regional effectively bought exclusivity with commercial insurers by offering a substantial discount to insurers if United Regional was the only local hospital or outpatient surgical provider in the insurer's network.[157] The pricing in the absence of the discount created a significant enough price differential to induce insurers into entering into the exclusive contracts. United Regional is also a "must-have" provider as it is the largest hospital in the area and the only provider of certain essential services, such as cardiac surgery, obstetrics, and high-level trauma care.[158] The combined effect of the punitive pricing and United Regional's "must-have" status meant that insurers had little choice but to contract with United Regional exclusively.[159]

The government subsequently argued that the effect of these contracts was to foreclose other hospitals and outpatient surgery centers from a large percentage of all area patients by preventing United Regional's rivals from obtaining contracts with most insurers, resulting in the

---

[153] *Id*. at 411 (quoting Paddock Publ'ns, Inc. v. Chicago Tribute Co., 103 F.3d 42, 45 (7th Cir. 1996)).

[154] McWane, Inc. v. F.T.C., 783 F.3d 814, 834 (11th Cir. 2015) ("courts often take a permissive view of [exclusive dealing] contracts on the grounds that firms compete for exclusivity by offering procompetitive inducements (e.g., lower prices, better service)"); Nilavar v. Mercy Health System-Western Ohio, 244 Fed. App'x. 690 (6th Cir. 2007) (noting that the evidence showed the challenged exclusive contract resulted from a competitive process).

[155] Methodist Health Servs. Corp. v. OSF Healthcare Sys., 859 F.3d 408, 411 (7th Cir. 2017). The use of this more lenient standard created a troubling precedent for subsequent cases. In a more recent and similar case, the defendant hospital attempted to argue in a motion to dismiss that the 7th Circuit held in *Methodist* that short-term exclusive contracts are not unlawful and therefore the claims against the defendant should be dismissed as their contracts were of similar duration to *Saint Francis's*. In response to this argument, the DOJ filed a "Statement of Interest" (a rare occurrence on the district court level) refuting the defendant's argument and stated that "the formal duration of a contract is not dispositive." The DOJ stated that, in its view, a fact-specific inquiry into the effect of the alleged agreement is required in all cases, regardless of the duration of the exclusivity. *See* Statement of Interest on Behalf of the United States of America, Marion Healthcare, LLC v. S. Illinois Healthcare, No. 12-CV-871-SCW, 2018 WL 1318054 (S.D. Ill. Mar. 14, 2018), https://www.justice.gov/atr/case-document/349521.

[156] Complaint at 3, United States and State of Texas v. United Reg'l Health Care System, No. 7:11–cv–00030 (N.D.Tex.2011), available at https://www.justice.gov/atr/case-document/file/514171/download.

[157] Competitive Impact Statement at 3, United States and State of Texas v. United Reg'l Health Care System, No. 7:11–cv–00030 (N.D.Tex. 2011), available at https://www.justice.gov/atr/cases/f267600/267653.pdf.
"In general, the contracts offer a substantially larger discount off billed charges (*e.g.*, 25%) if United Regional is the only local hospital or outpatient surgical provider in the insurer's network; and the contract provide for a much smaller discount (*e.g.,* 5% off billed charges if the insurer contract with one of United Regional's rivals.")

[158] *Id*.

[159] *Id*. at 3–4.

system's ability to receive substantially higher prices than it would have otherwise.[160] In the complaint, the government contended that the amount of foreclosure was approximately 35 to 40 percent, and later explained that those amounts were likely an underestimate of the foreclosure caused by the contracting practices.[161] In determining foreclosure, the government asked whether the discount resulted in United Regional pricing below cost, not for the competitive services, but for the patients that United Regional would risk losing if it was not the exclusive provider.[162] Using this test, the government determined that the discounting was below cost and would exclude an equally efficient competitor. This method for determining disclosure has been criticized because it fails to explain how the strategy would result in a return on investment for lost profits required under predatory pricing analysis established in other cases.[163] However, as Professor Steven Salop explains, when analyzed under a raising rivals' costs framework,[164] this kind of exclusive dealing is plainly exclusionary and lacks procompetitive justifications.[165] The parties ultimately reached agreement in a consent decree that forbids United Regional from prohibiting commercial health insurers to contract with their competitors.[166]

Like exclusive dealing, the primary crux of the tying analysis is whether the behavior forecloses competitors. However, tying arrangements have been analyzed under a quasi-*per se* analysis that involves the examination of whether there are two separate products or services, the tying arrangement coerced the buyer to purchase the tied product or services, the seller had significant market power, and the tying arrangement foreclosed a substantial amount of competition.[167] As discussed in the all-or-nothing section, these elements can be challenging for a plaintiff to show.

---

[160] *Id.* at 8. United Regional's average per-day rate for inpatient hospital services offered to commercial health insurers under the exclusive contract was around 70 percent higher than the rate charged by its closest competitor for the same services.
[161] *Id*. at 11.
[162] *Id*. at 14–15.
[163] For an in-depth discussion of the DOJ's predatory pricing theory used in the case, see David A. Argue & John M. Gale, *A Closer Look at the Bundled Discounting and Predation in United Regional*, ECONOMISTS INC. (2012), https://ei.com/economists-ink/winter-2012/a-closer-look-at-bundled-discounting-and-predation-in-united-regional-by-david-a-argue-and-john-m-gale/.
[164] Raising rivals' costs generally describes conduct aimed at raising the costs of competitors with the purpose and effect of causing them to raise their prices and allowing the excluding firm to profit by setting a supracompetitive price. "[Raising rivals' costs] conduct can be evaluated effectively with a consumer welfare effect standard that evaluates whether the conduct harms competitors by raising their costs and whether those higher costs harm consumers and competition by allowing the defendant to achieve, maintain, or enhance monopoly power. In carrying out this analysis, the procompetitive rationales for the conduct would be taken into account in evaluating the overall competitive impact of the conduct on consumers." Steven C. Salop, *Exclusionary Conduct, Effect on Consumers, and the Flawed Profit-Sacrifice Standard*, 73 ANTITRUST L. J. 311, 318 (2006).
[165] *See* Steven C. Salop, *The Raising Rivals' Costs Foreclosure Paradigm, Conditional Pricing Practices, and the Flawed Incremental Price-Cost Test*, 81 ANTITRUST L. J. 371 (2017); Thomas G. Krattenmaker & Steven C. Salop, *Anticompetitive Exclusion: Raising Rivals' Costs to Achieve Power over Price*, 96 YALE L. J. 209 (1986); Steven C. Salop, *Exclusionary Conduct, Effect on Consumers, and the Flawed Profit-Sacrifice Standard*, 73 ANTITRUST L. J. 311, 318 (2006).
[166] Final Judgment, United States and State of Texas v. United Reg'l Health Care System, No. 7:11–cv–00030 (N.D.Tex.2011), available at https://www.justice.gov/atr/case-document/file/514136/download. In particular, United Regional is prohibited from conditioning the prices or discounts that it offers to commercial health insurers based on whether those insurers contract with other health-care providers and from inhibiting insurers from entering into agreements with United Regional's rivals. United Regional is also prohibited from taking any retaliatory actions against an insurer that enters into an agreement with a rival provider.
[167] Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S. 2 (1984). See also discussion the of tying *infra* Section II. B. All-or-Nothing Clauses.

The seminal case that examined tying on the physician-hospital level is *Jefferson Parish Hospital District No. 2,* where a hospital denied an anesthesiologist admission to the hospital's medical staff because the hospital had already entered into an exclusive contract with a separate anesthesiology group.[168] The excluded anesthesiologist argued that the hospital had tied its acute care hospital services to the provision of anesthesiology services by exclusively contracting with an anesthesiology group so that patients needing to utilize the hospital's operating rooms (the tying product) were also compelled to purchase the hospital's selected anesthesia service (the tied product).[169] The Court ultimately upheld the arrangement, finding that the plaintiff anesthesiologist had failed to show that there had been sufficient market power to force patients to buy products they otherwise would not have purchased.[170] Most of the cases that have followed in the wake of *Jefferson Parish* have resulted in similar conclusions, such that failure to show market power has been the downfall of several other cases like *Jefferson Parish*.[171]

Plaintiffs also face several other hurdles in establishing a case for unlawful tying in this context. The first being the failure of plaintiffs to convince a court that two different hospital services constitute separate products under the quasi-*per se* tying analysis. While the Court in *Jefferson Parish* held that anesthesiology and general acute care hospital services constituted separate products, not all courts have held similarly. For example, one court found that pathology services did not constitute a separate product from other hospital services because there was no distinct demand from consumers.[172] Another significant hurdle is that some courts have followed Justice O'Connor's concurrence in *Jefferson Parish,* where she suggests that the procompetitive effects of such arrangements should be weighed against the anticompetitive effects, in an analysis more akin to the rule of reason.[173] In her concurrence, she found that there were significant benefits to the hospital exclusively contracting with the anesthesiology group and having those services tied to general acute care hospital services. She found that these benefits enabled the hospital to run more efficiently and safely and urged these benefits should be considered in addition to the anticompetitive effects.[174] This type of weighing of benefits of these arrangements makes it more difficult for plaintiffs to prevail in these cases. As illustrated by the cases above, the complex realm of law governing exclusive dealing and tying arrangements creates a number of hurdles for plaintiffs attempting to challenge these contract provisions under the Sherman Act.

---

[168] *Id.* at 5.
[169] *Id.* at 8.
[170] *Id*. at 26–27.
[171] *See, e.g.,* Drs. Steuer & Latham v. Nat'l Med. Enters., Inc. 672 F.Supp. 1489 (D.S.C.1987), aff'd 846 F.2d 70 (4th Cir.1988) (market share of less than 15% inadequate market power); Burnham Hosp., 101 F.T.C. 991 (1983) (advisory opinion) (hospital with 11% market share lacks sufficient market power); but cf. McMorris v. Williamsport Hosp., 597 F.Supp. 899 (M.D.Pa.1984) (market share of 55–60% and evidence that some procedures were not provided elsewhere posed genuine issue of fact).
[172] Collins v. Associated Pathologists, Ltd., 844 F.2d 473 (7th Cir.1988).
[173] *Jefferson Parish Hosp. Dist. No.* 2, 466 U.S. at 43 (O'Connor, J., concurring).
[174] *Id*. at 43–44.

2. Economic Justification or Procompetitive Use of Exclusionary Contracting

Exclusive contract terms can have meaningful procompetitive effects in competitive markets, but these benefits can be outweighed by anticompetitive effects if used by a dominant provider in a non-competitive market. These potential procompetitive effects significantly contribute to the difficulty of proving a case against the use of these contract terms. The procompetitive effects of exclusive contracting between providers and payers include ensuring health plan enrollees have steady access to the necessary range of providers, protecting payers from price increases during the contract, and reducing administrative and operational hurdles from dealing with multiple providers.[175] Additionally, as suggested by the court in *Methodist*, competition for the exclusive contract itself in certain situations can create competition among providers, encouraging them to lower their prices to gain an exclusive contract with an insurer.[176] This means a payer may receive better rates from a provider in exchange for an exclusive contract, as the exclusivity will drive a higher volume of business to the provider.[177] However, these benefits are limited to circumstances where a party does not have market power and largely do not outweigh the potential anticompetitive effects of these arrangements in situations where a dominant provider leverages that status to pressure payers into contracts that affect the competition in the market. Yet one exception may be Kaiser Permanente, an organization that uses mutually exclusive contracts between its health plan and physician and hospital providers. In this case, the procompetitive benefits have largely prevailed because it has allowed these organizations to make investments to improve patients' health and health care, including care management processes and electronic medical records.

On the physician-hospital level, the procompetitive benefits of exclusive contracting and tying are more persuasive. As mentioned above, in her concurrence in *Jefferson Parish*, Justice O'Connor recognized that an exclusive contract between physicians and a hospital could provide a host of benefits, including ensuring 24-hour coverage of services, standardization of procedures, allowing hospitals to monitor the quality of those procedures and services effectively, placing the responsibility of selecting a provider for particular services on the hospital rather than the patient, in addition to the hospital assuming responsibility that the provider will be available and will be an acceptable provider.[178] While these contracts may also

---

[175] *See* Geneva Pharmaceuticals Tech. Corp. v. Barr Laboratories Inc., 386 F.3d 485 (2d Cir. 2004) ("such agreements may also, however, have procompetitive purposes and effects, such as assuring steady supply, affording protection against price fluctuations, reducing selling expenses, and promoting long-term business relationships"); TCA Bldg. Co. v. Northwestern Resources Co., 873 F. Supp. 29 (S.D. Tex. 1995) (explaining that procompetitive effects of exclusive contracts include ensuring the purchaser an adequate and reliable source of supply, protecting against price increases during the contract, and reducing administrative and operational difficulties from dealing with multiple sources of supply).

[176] Methodist Health Servs. Corp. v. OSF Healthcare Sys., 859 F.3d 408, 411 (7th Cir. 2017).

[177] *Id*. at 410.

[178] *Jefferson Parish Hosp. Dist. No.* 2, 466 U.S. at 43–44. *See also*, Burnham Hospital, 101 F.T.C. 991, 1983 WL 486340 (1983)(FTC Advisory Opinion) (exclusive contracts can facilitate efficient delivery of services, increase hospital's control over department's operations, lower costs through standardization of procedures, permit better scheduling, facilitate maintenance of equipment, improve supervision of staff, improve working relationships, and improve quality by ensuring that physicians do sufficient number of procedures to maintain and upgrade skills); William M. Sage, David A. Hyman & Warren Greenberg, *Why Competition Law Matters to Health Care Quality*, 22 HEALTH AFF. 31, 36–37 (2003) (". . . competition law concluded that, in part for quality reasons, interbrand competition between hospitals for patients was more beneficial to consumers than was intrabrand competition between doctors working in a single hospital.").

have anticompetitive effects, in many ways, they help ensure hospitals are appropriately staffed to provide necessary levels of care.

Despite the benefits of exclusive contracts or tying arrangements in either the context of provider/payer contracts or physician/hospital contracts, exclusive contracts or tying arrangements can be used as tools by a dominant provider to maintain their market power and increase prices by excluding competition and should not be overlooked by antitrust enforcers.

3. Which States Have Restricted Exclusive Contracting in Healthcare Contracts?

The potential procompetitive benefits associated with exclusive dealing and tying make prohibiting or restricting the practices legislatively precarious. However, some states have addressed exclusive practices under their general regulation of trade laws. Generally under these laws, it is unlawful for a seller to condition the price of a service or good on the requirement that the purchaser shall not do business with a seller's competitors if the agreement lessens competition or tends to create a monopoly.[179] Several states have recognized the issue with exclusive contracts in health care specifically and have prohibited the use of these practices between managed care organizations or health cooperatives and healthcare providers.[180] Through its insurance regulations, New York requires that managed care organizations that wish to add an exclusivity clause between the managed care organization and a healthcare provider to obtain prior approval from the insurance commissioner.[181] Lastly, Wisconsin has explicitly prohibited insurers from entering into contracts for exclusive services of a healthcare provider subject to some exceptions.[182]

In a different approach, California tried to curb the practice through proposed legislation that would create a legal presumption that a healthcare system with market power acts unlawfully if the system engages in tying or exclusive dealing.[183] Under S.B. 977 "Health Care System Consolidation: Attorney General Approval and Enforcement," that presumption can be rebutted if the conduct "directly and significantly benefits consumers of any services in that same market in which the conduct is taking place or the health system, and the conduct that it is committing, [is] located entirely within a rural area."[184] The bill permits the attorney

---

[179] *See, e.g.,* LA. STAT. ANN. § 51:124; MASS. GEN. LAWS ch. 93 § 6; MO. REV. STAT § 416.031; R.I. GEN. LAWS § 6-36-6.

[180] *See, e.g.*, MINN. STAT. § 62R.08 ("It shall be unlawful for any health care network cooperative, other than a health care network cooperative operating on an employed, staff model basis, to require that its participating providers provide health care services exclusively to or through the health care network cooperative"); N. H. REV. STAT. ANN. §§ 420-I:1–420-I:5 ("No managed care insurer may enter into any new exclusive arrangement or renew any exclusive arrangement with any person on or after the effective date of this act.").

[181] N.Y. COMP. CODES R. & REGS., tit. 10 §§ 98-1.2 and 98-1.5 (an exclusivity clause is explicitly a material change in a managed care contract that must be approved by the commissioner before it takes effect).

[182] WIS. STAT. § 628.35. There are some exceptions to this including if the health care provider is an employee of the insurer, the provider is a corporation owned by the insurer, the provider uses the insurer's name under a franchise agreement, or the insurance commissioner has granted an exception.

[183] S.B. 977, 2019-2020 Reg. Sess. (Cal. 2020). The bill defined "tying" as the "seller coercively conditioning the sale of one or more services on the sale of a second distinct service or services if the arrangement affects a more than trivial amount of sales of the second distinct service or services. The conditioning can be explicit, implicit, or as an economic imperative based on the pricing of those services." Exclusive dealing is defined as "an agreement in which a health plan or employer who buys health care services agrees implicitly or explicitly, whether coerced or voluntarily, to buy services exclusively from a health care system for a period of time."

[184] *Id*.

general to bring a civil action on behalf of the state against entities in violation of the section. While S.B. 977 was not brought to a vote in this legislative session, the bill may be reintroduced in 2021. Nonetheless, this tipping of the scales can help the attorney general successfully challenge and curb the use of exclusive dealing and tying clauses in dominant provider/insurer contracts by reducing some of the hurdles illustrated in the cases above.

4. Summary

Unlike some of the other contract terms discussed in this report, exclusive dealing and tying do not lend themselves well to blanket legislative bans because of the array of potentially procompetitive effects they can create. On the other hand, while litigation may be a useful tool in particularly egregious cases where the offending entity has evident market power and has engaged in several anticompetitive behaviors, many cases under the rubric of the rule of reason or quasi-*per se* analysis will likely fail due to the uncertainty and complexity of the economic analysis necessary to support a claim under Section 1 or 2 of the Sherman Act.[185] Passing legislation like California's S.B. 977 would be an effective way to help make litigation a more potent tool by facilitating the attorney general's ability to challenge the use of exclusive contract terms.

D. Anti-Tiering or Anti-Steering Clauses

Health systems with market power can also use anti-incentive clauses, also known as anti-steering and anti-tiering clauses, to hinder competition on price and quality. In competitive contracting, payers' negotiating power is limited to two options - threatening to exclude the provider from the network or placing incentives on consumers to choose the more cost-effective alternative. Because exclusion is often impractical in concentrated hospital markets, steering patients to lower-cost, higher-value providers has become a primary mechanism by which payers control costs.[186] When using tiered networks, insurers group providers into tiers based on price and quality and then offer financial incentives, typically through lower co-payments or co-insurance, to patients when they choose providers from a lower-cost, higher-value tier. A forthcoming study found that enrollees selected lower-tiered hospitals for inpatient services, resulting in projected baseline spending to be 8 to 17 percent lower after three years (but the study emphasized each tier's patient cost-sharing was transparent and

[185] The DOJ and FTC have recognized the potential harms of exclusive contracting as well as tying and have tried to address these concerns in their Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program. The statement sets forth policies guiding the agencies' review of ACOs to prevent ACOs from enhancing provider market power. The statement identifies tying sales of an ACO's services to the private payer's purchase of other services from providers outside the ACO (and vice versa) and exclusive dealing as behaviors that "may raise competitive concerns" for an ACO with a certain level of market power. *See* FTC & U.S. Dep't of Justice Statement of Antitrust Enforcement Policy Regarding Accountable Care Organization Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67,026 (Oct. 28, 2011).

[186] James C. Robinson, *Hospital Tiers in Health Insurance: Balancing Consumer Choice With Financial Motives*, 22 HEALTH AFF. W3-135 (2003); Dennis P. Scanlon, Richard C. Lindrooth & Jon B. Christianson, *Steering Patients to Safer Hospitals? The Effect of a Tiered Hospital Network on Hospital Admissions*. 43 HEALTH SERV. RESEARCH 1849 (2008); Matthew B. Frank, John Hsu, Mary Beth Landrum & Michael E. Chernew, *The Impact of a Tiered Network on Hospital Choice*, 50 HEALTH SERV. RESEARCH 1628 (2015).

easy to understand).[187] Outside of strict tiering, insurers may also try to steer patients to lower-cost or higher-value providers by giving preferred providers a specific designation or offering other incentives for patients to seek care from them.[188]

Additionally, the use of tiering and steering mechanisms can also incentivize providers to lower prices or provide better quality care in exchange for placement in the preferred group or tier.[189] As a result, tiering and steering can have procompetitive effects on both the demand side, as patients choose higher-value providers, and on the supply side, as providers reduce their prices and improve their quality. A study by Sinaiko, Landrum, and Chernew found that enrollees in plans with a tiered network had a 5% decrease in medical spending relative to enrollees in similar plans without a tiered network.[190] While the authors found that tiered networks had minimal effects on enrollee's relationships with their existing providers, when enrollees chose a new doctor, they rarely selected one from the lowest-value tier.[191] Furthermore, tiered networks preserve consumer choice by including most facilities in-network at some tier, while decreasing premiums and cost-sharing by shifting patient demand to higher-value providers. Specifically, tiered networks may be an attractive alternative to narrow networks for insurers and employers because any high-cost providers with market power will likely still be included in the network, albeit in a lower-value tier.[192] For example, academic medical centers often have higher costs than similar community hospitals, and tiered networks allow insurers to include them in network for highly specialized care, while reducing their utilization for more routine care.[193] Overall, tiering and steering provides payers with strong mechanisms to guide patients to higher-value providers.

Recognizing the power of steering provisions, courts have even allowed questionable mergers to proceed based on the ability of payers to steer patients away from higher-cost, lower-value providers. These merger approvals, however, ignored the possibility that dominant health systems may use market power to insert anti-tiering or anti-steering clauses in the majority of contracts. Specifically, in 1999, the California attorney general challenged the

---

[187] Elena Prager, *Health Care Demand Under Simple Prices: Evidence From Tiered Hospital Networks*, AM. ECON. J.: APPLIED ECON (forthcoming), https://www.aeaweb.org/articles?id=10.1257/app.20180422.

[188] Sunita M. Desai et al., *What Are The Potential Savings From Steering Patients To Lower-Priced Providers? A Static Analysis*, 25 AM. J. MANAGED CARE e204-e210 (July 1, 2019), https://www.ajmc.com/view/what-are-the-potential-savings-from-steering-patients-to-lowerpriced-providers-a-static-analysis.

[189] Gaynor Statement 2019, *supra* note 3.

[190] Anna D. Sinaiko, Mary Beth Landrum & Michael E. Chernew, *Enrollment in a Health Plan With A Tiered Provider Network Decreased Medical Spending By 5 Percent*, 36 HEALTH AFF. 870 (2017).

[191] *Id*. Similarly, calculations by economist Elena Prager, based on hospital and insurance rates in Massachusetts from 2009 to 2012, estimated that tiered networks could lead to a moderate decrease in hospital spending (1% to 8% decrease), and also have an effect on negotiated rates for hospital services (2% to 4% savings), with a possible 12% overall decline. Elena Prager, Tiered Provider Networks in Health Insurance (Jan. 1, 2016) (Ph.D. dissertation, University of Pennsylvania), https://repository.upenn.edu/cgi/viewcontent.cgi?article=3739&context=edissertations.

[192] *2019 Employer Health Benefits Survey*, KAISER FAMILY FOUND. (Sept. 25, 2019), https://www.kff.org/report-section/ehbs-2019-section-14-employer-practices-and-health-plan-networks/#:~:text=TIERED%20NETWORKS,of%20the%20care%20they%20deliver; Paul Fronstin, *Tiered Networks for Hospital and Physician Health Care Services*, EMPLOYEE BENEFIT RESEARCH INST. (August 2003), https://www.ebri.org/docs/default-source/ebri-issue-brief/0803ib.pdf?sfvrsn=a2d9292f_0.

[193] *February 24, 2015 Workshop Transcript: Examining Healthcare Competition*, F.T.C. AND U.S. DEP'T OF JUST., ANTITRUST DIVISION 1, 44 (Feb. 24, 2015), https://www.ftc.gov/system/files/documents/public_events/618591/transcript-day1.pdf [hereinafter *February 24, 2015 Workshop Transcript*].

merger of Sutter Health's Alta Bates Medical Center with Summit Medical Center.[194] The court, however, noted that the health plans could "discipline" hospitals by steering patients to lower-cost health providers. "When faced with rising prices, [managed care organizations] MCOs can attempt to steer patients to lower cost health care providers and away from the hospital imposing a price increase, thereby pressuring the hospital to eliminate the price increase."[195] The court allowed the merger to proceed, making Sutter the largest provider of hospital services in the area. Perhaps recognizing the potential for steering to reduce their market share, Sutter Health began including anti-tiering and anti-steering provisions in their contracts with insurers. Nearly twenty years later, alleged anticompetitive use of these anti-incentive provisions formed part of the basis of the claims against Sutter in *UEBT v. Sutter Health.*[196]

Anti-tiering or anti-steering provisions prohibit an insurer from placing a health system on a lower-value tier or, in some cases, from even signaling to patients that there are higher-value alternatives to that health system. In highly consolidated markets, health systems with market power may demand anti-tiering or anti-steering provisions in contracts as a condition of participating in any network offered by that insurer.[197] These anti-incentive provisions cripple insurers' ability to direct patients to higher-value providers or have patients pay a higher co-pay for seeing such providers, and gag clause provisions may hide any overall price difference from patients. Additionally, insurers often pass these increased costs onto patients and their employers through increased premiums. As a result, the anticompetitive use of anti-tiering and anti-steering clauses may harm both patients and payers.

1. Antitrust Enforcement and Anti-tiering and Anti-steering Provisions

Recognition of the potential for anticompetitive harms arising from the use of these terms led antitrust enforcers to a file a groundbreaking civil suit against a dominant health system in North Carolina. Specifically, in 2016, the DOJ and the North Carolina attorney general filed suit alleging that North Carolina's largest health system, Atrium Health (formerly Carolinas HealthCare System, aka "CHS") used anti-steering and anti-tiering clauses in healthcare contracts to unreasonably restrain trade in violation of Section 1 of the Sherman Act.[198] Atrium was a dominant provider with more than 50 percent share of the relevant market in the Charlotte area[199] and was considered a "must-have" provider.[200] Leveraging that market power, Atrium allegedly forced major commercial insurers, including Aetna, Blue Cross, Cigna, and UnitedHealthcare, to enter one-sided, anticompetitive contracts that restricted steering and tiering. [201] In particular, Atrium used contract clauses that required insurers to place Atrium in the most favorable tier with the lowest cost-sharing rate. At the same time, Atrium prevented insurers from allowing competing providers to use and benefit from similar tiering and steering

[194] California v. Sutter Health Sys., 130 F. Supp. 2d 1109, 1117 (N.D. Cal. 2001).
[195] *Id*. at 1130.
[196] *See* UEBT Complaint, *supra* note 87.
[197] *See, e.g.,* UEBT Complaint, *supra* note 87; California AG Complaint, *supra* note 87.
[198] United States v. Charlotte-Mecklenburg Hosp. Auth., 248 F. Supp. 3d 720, 724 (W.D.N.C. 2017).
[199] Department of Justice Complaint at 2, United States v. Charlotte-Mecklenburg Hosp. Auth., 248 F. Supp. 3d 720, 724 (W.D.N.C. 2017).
[200] *Id.* at 7.
[201] *Id*. at 5.

mechanisms.[202] In addition, Atrium allegedly used gag clauses to ensure that the insureds would not have access to information about the price and quality of Atrium's healthcare services compared to its competitors.[203]

Proving a claim of unreasonable restraint of trade under the rule of reason standard requires a showing of anticompetitive effect from the anti-steering and anti-tiering provisions, either directly or indirectly.[204] In this case, the DOJ alleged anticompetitive harm via both direct and indirect methods. Under the direct approach, evidence of increased prices, reduced output or quality, or interference with the competitive process constitute anticompetitive harm. The DOJ alleged that Atrium's anti-steering clauses resulted in actual anticompetitive harm in the form of higher out-of-pocket costs for Charlotte area patients. Alternatively, the DOJ also alleged anticompetitive harm under the indirect method, which requires (a) sufficient market power to harm competition, and (b) grounds for believing that the anti-steering restrictions could harm competition.[205] The DOJ argued that Atrium acted as a one-sided market provider of hospitals services in the relevant market of the sale of general acute care inpatient hospital services.[206] In that market with a high entry barrier, Atrium had sufficient market power with approximately 50% market share. Moreover, regardless of *how* or *why* the market power came into existence, Atrium's substantial market power allowed it to affect prices and harm competition in that market.[207]

While the Supreme Court decision in *Ohio v. American Express* (hereinafter *Amex*)[208] arguably muddied the steering analysis in Atrium by raising the question of whether healthcare markets constitute so-called "two-sided markets" that require analysis of the combined effect of transactions, [209] the DOJ dismissed the applicability of the *Amex* "two-sided market" analysis to healthcare contracts.[210] Importantly, the Supreme Court ruling in *Amex* is limited in scope to platforms involving simultaneous one-on-one transactions, such as credit card networks. This limitation effectively excludes markets where the relationship between the transactions is actuarial, "where the buyer and seller do not engage in simultaneous transactions on a per-

[202] *Id*. at 4.
[203] *Id.*
[204] Plaintiffs' Opposition to Defendant's Rule 12(c) Motion for Judgment on the Pleadings at 8, United States v. Charlotte-Mecklenburg Hosp. Auth., 248 F. Supp. 3d 720, 724 (W.D.N.C. 2017).
[205] *Id.*
[206] Plaintiffs' Response to Defendant's Supplemental Briefing on *United States v. American Express* at 5, United States v. Charlotte-Mecklenburg Hosp. Auth., 248 F. Supp. 3d 720, 724 (W.D.N.C. 2017) [hereinafter Plaintiffs' Response to Defendant's Supplemental Briefing on *United States v. American Express*].
[207] *Id.* at 9.
[208] Ohio v. American Express Co., 138 S. Ct. 2274 (2018).
[209] In the 2018 decision, the Supreme Court used a novel analysis that found insufficient evidence under a rule of reason analysis that American Express' anti-steering provisions had a substantial anticompetitive effect to the credit card market as a whole. Ohio v. American Express Co., 138 S. Ct. 2274 (2018) [hereinafter *Amex*]. In a dissenting opinion joined by Justices Ginsburg, Sotomayor, and Kagan, Justice Breyer argued that the majority's opinion erroneously rested on the market definition requirement and that direct measures of American Express's conduct indicated significant market power and anticompetitive harm. *Id*. at 2297 (Breyer, J., dissenting). Antitrust experts also attacked the core economics of the Supreme Court's logic, asserting that the court "lost sight of the fact that coherent economic analysis of any antitrust issue requires assessment of marginal rather than total effects," and erroneously assumed that harm on one side of the platform could be offset by benefits on the other side of the market. Herbert Hovenkamp, *The Looming Crisis in Antitrust Economics*, (U. of Penn, Inst. for Law & Econ, Research Paper No. 20-15, Jan. 30, 2020), https://ssrn.com/abstract=3508832. *See also* Brief of Amici Curiae The American Medical Association and Ohio State Medical Association in Support of Petitioners, Ohio v. Am. Express Co., 138 S. Ct. 2274 (2018).
[210] Plaintiffs' Response to Defendant's Supplemental Briefing on *United States v. American* Express, *supra* note 206, at 8.

service basis," which would include health insurance networks.[211] Accordingly, the North Carolina district court's opinion in denying Atrium's motion for summary judgment clearly distinguished *Amex*, holding that credit cards are an entirely "different product and a different market" from health care,[212] and that Atrium must consider "facts peculiar to the health care industry, the effect of the activities on health providers, and the impact of the activities on costs to the ultimate consumer."[213] Following the district court ruling, Atrium settled out of court in November 2018, a mere five months after the Supreme Court decision in *Amex*. The settlement agreement prohibits Atrium from using or enforcing anti-steering provisions in its contracts with insurers.[214] Together with key differences between healthcare contracting and the credit card market at issue in *Amex*, the settlement suggests that the *Amex* decision should not be a barrier to future antitrust challenges to anti-tiering or anti-steering provisions involving dominant health systems.

While not binding precedent, the settlement in Atrium helped support the challenge brought by the California Attorney General and UEBT alleging Sutter Health's use of anti-tiering and anti-steering clauses in combination with other contract provisions violated state antitrust law.[215] In *Sutter,* the parties reached a tentative settlement in which Sutter agreed not to "engage in any action, direct or indirect, to prevent the introduction of new narrow, tiered, or steering [networks]… or value-based designs of any kind…[including] benefit designs that attempt to reward providers for affordability and/or quality."[216]

The settlement in *Atrium* and the proposed settlement in *Sutter* indicate the potential for successful antitrust enforcement actions against the use of anti-tiering and anti-steering provisions. As discussed in the introduction, however, enforcement actions are time and resource intensive and can only be brought after antitrust enforcers or private firms become aware of the anticompetitive harm. As a result, state and federal policymakers may choose to pass laws prohibiting the use of anti-tiering or anti-steering clauses, at least for health systems with market power, depending on their potential procompetitive justifications.

2. Economic Justification or Procompetitive Use of Anti-tiering and Anti-steering Provisions

As with other provisions, lawmakers considering sweeping bans on anti-tiering and anti-steering provisions should examine possible offsetting efficiencies in specific markets for these terms. In health care, there are two potential justifications for these anti-incentive terms. First, an anti-steering provision might incentivize a health system to offer more significant price discounts because it would provide assurance that the insurer would not steer patients away from its providers and facilities.[217] A health system or provider group may offer more significant discounts to be included in the highest-value tier knowing that they will not be undercut by

[211] Herbert J. Hovenkamp, *Platforms and the Rule of Reason: The American Express Case*, 2019 COLUM. BUS. L. REV. 35 (2019).
[212] Order Re Defendant's Motion for Judgment on the Pleadings, United States v. Charlotte-Mecklenburg Hosp. Auth., 248 F. Supp. 3d 720, 724 (W.D.N.C. 2017).
[213] *Id.* at 13.
[214] Proposed Final Judgment, United States v. Charlotte-Mecklenburg Hosp. Auth., 248 F. Supp. 3d 720, 724 (W.D.N.C. 2017) [hereinafter Atrium Proposed Final Judgment].
[215] UFCW & Employers Benefit Trust, et al. v. Sutter Health, et al., No. CGC 14-538451 (Cal. Super. Ct. S.F. City and Cnty. 2019).
[216] UEBT Motion for Preliminary Approval of Settlement, *supra* note 98, at 13.
[217] *February 24, 2015 Workshop* Transcript, supra note 193, at 37.

another provider. Second, anti-steering clauses may allow health systems to spread fixed operating costs across more services and reduce the costs of highly specialized services. For example, Fiona Scott Morton, economist and former Deputy Assistant Attorney General for Economics at the Antitrust Division of the U.S. Department of Justice, discussed a hypothetical efficiency hospitals systems may use to justify an anti-steering clause when describing how an orthopedic department may use anti-steering to reduce costs for specialized care and increase referrals.[218] An academic medical center may offer highly specialized orthopedic surgeries not available at other hospitals in an area, but the orthopedics department also offers more routine services, like setting a broken leg, that can be provided at another hospital at a lower cost. If an insurer uses steering provisions to direct most of the routine broken legs to another provider, the academic medical center must allocate fixed costs across fewer patients. The academic medical center may also lose referrals for more specialized care that would come if the broken legs were set at their facility. As a result, the academic medical may consider increasing the cost of highly specialized services or demanding anti-steering provisions in their contracts.[219]

On the surface, then, anti-steering and anti-tiering provisions appear to have some procompetitive justifications. Specifically, the anti-incentive provisions might allow health systems to offer larger discounts in exchange for guaranteed patient volumes and to spread fixed costs across more patients. As Scott Morton notes, however, anti-steering provisions used in this manner blunt clear price signals and suppress competition on both price and quality.[220] High-value health systems are unlikely to benefit from these anti-incentive terms because they are already likely to be included in a high-value tier. In addition, in highly concentrated markets, dominant providers, including academic medical centers, may use anti-steering clauses to prevent smaller competitors from gaining market share or opening new centers to deliver basic healthcare services at a discounted price. As such, anti-incentive clauses pose few procompetitive benefits in healthcare markets that are unlikely to outweigh the potential for abuse by dominant healthcare systems.

3. What States Have Restricted Anti-tiering and Anti-steering Clauses in Healthcare Contracts?

Recognizing the potential for anticompetitive harms from anti-tiering and anti-steering provisions, Massachusetts passed a law in 2010, prohibiting anti-tiering or anti-steering clauses in contracts between healthcare providers and health insurance carriers.[221] As part of a second

[218] *Id*. at 35.

[219] *Id*. at 34. Additional justifications for anti-tiering provisions dismissed by Fiona Scott Mortan include the argument that patient find tiered networks confusing and that hospitals do not know the profitability of each healthcare service and therefore must negotiate in bundles or as whole departments, saying "cost accounting is a well-developed field."

[220] *Id*. "If [a specialty service] is expensive, we sort of need to know it is expensive, and then we can design public policy to subsidize it, or to raise money for it, or to tax people to provide it. And if broken legs are cheap, we should pay a low price for broken legs." Fiona Scott Morton acknowledges that providers may need referrals from one service to another to keep economies of scale.

[221] MASS. GEN. LAWS ch. 176O, § 9A provides "A carrier shall not enter into an agreement or contract with a health care provider if the agreement or contract contains a provision that:
(a)(i) limits the ability of the carrier to introduce or modify a select network plan or tiered network plan by granting the health care provider a guaranteed right of participation; (ii) requires the carrier to place all members of a provider group, whether

set of sweeping healthcare reforms,[222] the law also prohibits contract terms that require all members of a provider organization to be included in the same tier, so payers may include different facilities and practice groups in different tiers. In addition to prohibiting contracting practices, the law also requires all large insurers to offer at least one narrow or tiered-network plan in at least one geographic area.[223] Even before the regulation went into effect, the three largest insurers in the state – Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care, and Tufts Health Plan – offered both tiered and narrow network plans and, as of 2016, between 10-35 percent of their commercial enrollees were in tiered network plans.[224] Enrollment in tiered networks appears to be steady at approximately 20 percent statewide.[225] As a result, other states passing anti-tiering or anti-steering laws may consider incentivizing the use of tiering or narrow networks to maximize the impact of a law prohibiting anti-tiering or anti-steering provisions.

To date, Massachusetts is the only state with a law prohibiting anti-tiering or anti-steering clauses. Nonetheless, other legislatures have considered similar prohibitions. As mentioned earlier, the federal Lower Health Care Costs Act of 2019 includes provisions prohibiting anti-steering clauses,[226] and in 2016, California considered S.B. 932 that included a prohibition on anti-tiering clauses. In testimony before the California Legislature's Senate Committee on Health related to this bill, Paul Ginsberg, director of the USC-Brookings Schaeffer Initiative for Health Policy, asserted that this legislation to address anticompetitive contracting practices should be a top priority for California: "In many markets, dominant providers have blocked the offering of tiered networks by refusal to contract with insurers that do not place them in the preferred tier. This phenomenon was seen in Massachusetts, where 2010 legislation prohibiting this practice led to rapid growth in insurance products with tiered networks."[227] While the California bill did not pass, other states have considered legislation,

---

local practice groups or facilities, in the same tier of a tiered network plan; (iii) requires the carrier to include all members of a provider group, whether local practice groups or facilities, in a select network plan on an all-or-nothing basis."

[222] In 2006, Massachusetts passed the Health Care Reform Act (Ch. 58 of the Acts of 2006, An Act Providing Access to Affordable, Quality, Accountable Health Care) to expand health insurance coverage that became a blueprint for the ACA. However, per capita spending continued to exceed and continue to grow faster than the national average, so in 2010 the Massachusetts legislature passed Ch. 288 of the Acts of 2010, Health Insurance – Cost Containment – for Individuals and Small Businesses). *See* Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 118G, § 6½(b) Report for Annual Public Hearing, OFF. OF THE ATT'Y GEN. MARTHA COAKLEY (March 16, 2010), https://www.mass.gov/doc/2010-examination-of-health-care-cost-trends-and-cost-drivers-with-appendix/download. These reforms included, among other provisions, the creation of the All-Payer Claims Database, requirements for insurers to offer value-based insurance designs, and the anti-tiering and anti-steering provisions discussed here. For more information see Prager, *supra* note 191.

[223] MASS. GEN. LAWS ch. 176J, § 11.

[224] Prager, *supra* note 191.

[225] *2018 Annual Health Care Cost Trends Report*, MA. HEALTH POL'Y COMM'N 70 (Feb 2019), https://www.mass.gov/files/documents/2019/02/20/2018%20Cost%20Trends%20Report.pdf; *Performance of the Massachusetts Health Care System Annual Report 2019*, MA. CENTER FOR HEALTH INFO. AND ANALYSIS 48 (Oct. 2019), https://www.chiamass.gov/assets/2019-annual-report/2019-Annual-Report.pdf.

[226] "A group health plan or a health insurance issuer offering group or individual health insurance coverage shall not enter into an agreement with a provider, network or association of providers, or other service provider offering access to a network of service providers if such agreement, directly or indirectly—(A) restricts the group health plan or health insurance issuer from—(i) directing or steering enrollees to other health care providers; or (ii) offering incentives to encourage enrollees to utilize specific health care providers" S. 1895, 116th Cong. §302(b)(1) (2019).

[227] Informational Hearing Health Care Market Consolidations: Impacts on Costs, Quality and Access Before California Senate Committee on Health, 2015–2016 Reg. Sess. (March 16, 2016) (statement of Paul B. Ginsburg, University of Southern California: Professor and Director of Public Policy, Schaeffer Center for Health Policy and Economics).

including New Jersey, where an anti-tiering bill has been introduced in every legislative session since 2014.[228] While Massachusetts stands alone with an existing legislative ban on anti-tiering and anti-steering provisions, momentum may be building for other states to pass similar bans on those contract terms. Other states may be encouraged to ban these provisions due to the lack of procompetitive justifications that outweigh the anticompetitive effects of those provisions, as evidenced by the *Sutter* and *Atrium* consent decrees prohibiting enforcement of those terms in existing contracts and prohibiting their use in future contracts.[229]

4. Summary

The ability of insurers to steer patients to higher-value providers, including hospitals, is one of the primary mechanisms by which they control healthcare costs. Steering and tiering promotes competition by giving providers an incentive to reduce prices or provide better quality or service to be in the preferred group. Anti-incentive provisions insulate providers from market forces by eliminating price signals that encourage patients to choose higher-value care. Furthermore, few procompetitive explanations justify the use of anti-tiering and anti-steering provisions in healthcare markets. In both *Atrium* and *Sutter*, antitrust enforcers negotiated settlement terms prohibiting enforcement of these clauses in existing contracts or their use in future contracts.[230] Nonetheless, these lawsuits took years to work their way through the court and took significant resources, so antitrust enforcers are likely to prosecute only the most egregious abuses. As a result, states should strongly consider passing legislation to prohibit anti-tiering and anti-steering clauses.

---

[228] Assem. B. 3527 / S.B. 1108, 2020-2021 Reg. Sess. (N.J. 2020); Assem. B. 3047 / S.B. 1008, 2018-2019 Reg. Sess. (N.J. 2018); Assem. B. 3266/S.B. 1312, 2016-2017 Reg. Sess. (N.J. 2016); Assem. B. 3686 / S.B. 2603, 2014-2015 Reg. Sess. (N.J. 2014).

[229] As of this writing, the consent decree in *Sutter* is still pending. *See supra* Section B. 1. *Antitrust Enforcement and All-or-Nothing Clauses*.

[230] *See* UEBT Motion for Preliminary Approval of Settlement, *supra* note 97, at 7–8 (stating "Defendants may not veto, interfere with, or otherwise engage in any action, direct or indirect, to prevent the introduction of new narrow, tiered, or steering Commercial Products or value-based designs of any kind for Commercial Products (i.e., benefit designs that attempt to reward providers for affordability and/or quality), including reference pricing. Defendants shall not penalize Insurers and/or Self-Funded Payers for selecting some but not all of Defendants' Providers for participation in Commercial Products. Defendants shall not impede Insurers' and/or Self-Funded Payers' use of differences in co-payments, co-insurance, and information as to quality, certification, ratings, and cost-effectiveness to incentivize patients to select the providers that are preferred by the Insurers and/or Self-Funded Payers for Commercial Products, provided that these policies and practices are disclosed to Defendants during the negotiation of a new contract or renewal of a contract and not changed during the term of that contract. b. Defendants shall not require that Insurers and/or Self-Funded Payers include any or all Group A Providers or Group B Hospitals in the preferred tier(s) of tiered networks for Commercial Products, or designate them centers of excellence, or require that these Providers or Hospitals be included in any or all of an Insurer and/or Self-Funded Payer's narrow or tiered network Commercial Products. Defendants shall not require that any sub-set of services provided by a Group A Provider or Group B Hospital be included in the top tier of any Commercial Product."); Atrium Proposed Final Judgment, *supra* note 214, at 6–8 (stating "For Healthcare Services in the Charlotte Area, Defendant will not seek or obtain any contract provision which would prohibit, prevent, or penalize Steered Plans or Transparency including: 1. express prohibitions on Steered Plans or Transparency; 2. requirements of prior approval for the introduction of new benefit plans (except in the case of Co-Branded Plans); and 3. requirements that Defendant be included in the most-preferred tier of Benefit Plans (except in the case of Co-Branded Plans)").

E. Gag Clauses

Finally, gag clauses, or price secrecy contract provisions, prohibit a contractual party from disclosing price or other information to a third party. By 2000, fear that managed care organizations were restricting physicians from discussing all treatment options with patients led nearly every state to pass a law banning any gag clause that limited a physician's ability to discuss all relevant treatment options.[231] However, contracts between providers and insurers continue to include pricing gag clauses that prevent patients, competing providers, and employers from knowing the negotiated provider payment rates.[232] This section focuses only on gag clauses that prohibit the contracting parties from disclosing negotiated rates to third parties, including patients, employers, and government entities. Furthermore, gag clauses may perpetuate the erroneous assumption that provider payment rates are trade secrets[233] and contribute to the shroud of secrecy that prevents the public and policymakers from understanding and evaluating the cost of healthcare services.

Pricing gag clauses prevent interested third parties from obtaining necessary information to assess the relative value of healthcare services from competing providers. All patients should have access to information about all aspects of their care, including the cost, as a matter of basic transparency in health care. Nevertheless, multiple studies demonstrate that patients have not used price transparency tools at high enough rates to significantly impact healthcare spending, although some evidence exists that financial incentives to choose higher-value care can improve patient engagement.[234] Increasing price transparency for employers, however, may have a much larger impact on healthcare markets than measures aimed at patients.[235] Specifically, if employers are able to assess the relative price and quality of the providers in a network, they may implement mechanisms to steer patients to higher-value care or remove low-value providers from their network. Furthermore, employers need to compare

---

[231] Bryan A. Liang, *The Practical Utility of Gag Clause Legislation*, 13 J. GEN. INTERNAL MED. 419 (1998); Carol O'Brien, *Background on Gag Clause Issues/Ethical Issues in Managed Care*, AMERICAN HEALTH LAWYERS ASS'N (Dec. 11, 1996). *But see* GAO report saying "A commonly understood definition of a gag clause is a contract provision that limits physicians' ability to advise patients of all medically appropriate treatment options. There is little consensus, however, about whether certain clauses that may appear in HMO contracts meet this definition." U.S. GOV'T ACCOUNTABILITY OFF., GAO HEHS -97-195, MANAGED CARE: EXPLICIT GAG CLAUSES NOT FOUND IN HMO CONTRACTS, BUT PHYSICIANS RAISE CONCERNS 5 (1997); U.S. GOV'T ACCOUNTABILITY OFF., GAO/ -03-1133, PRIVATE HEALTH INSURANCE FEDERAL AND STATE REQUIREMENTS AFFECTING COVERAGE OFFERED BY SMALL BUSINESSES 26 (2003)("Forty-seven states prohibited "gag clauses" (restrictions on certain communications) in insurers' contracts with health care providers. These laws enable physicians to speak openly with their patients about treatment options not covered by the health insurance policy").

[232] Alessi & King, *supra* note 107.

[233] Katherine Gudiksen, Samuel L. Chang & Jaime S. King, *The Secret of Health Care Prices: Why Transparency is in the Public Interest*, CAL. HEALTH CARE FOUND. (July 16, 2019), https://www.chcf.org/publication/secret-health-care-prices/; Robin Feldman & Charle Graves, *Naked Price and Pharmaceutical Trade Secret Overreach*, YALE J. OF L. & TECH. (forthcoming), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3426225.

[234] Christopher M. Whaley et al., *Paying Patients to Switch: Impact of a Rewards Program on Choice Of Providers, Prices, And Utilization*, 28 HEALTH AFF. 440 (2019); Sunita Desai et al., *Offering A Price Transparency Tool Did Not Reduce Overall Spending Among California Public Employees and Retirees*, 36 HEALTH AFF. (2017); Sunita Desai, Laura A. Hatfield, Andrew L. Hicks, *Association Between Availability of a Price Transparency Tool and Outpatient Spending*, 315 JAMA 1874 (2017); Hearing on Examining State Efforts to Improve Transparency in Healthcare Costs for Consumers before the Subcommittee on Oversight and Investigations of the H. Committee on Energy and Commerce, 115th Cong. (2018) (testimony of Jaime S. King), https://docs.house.gov/meetings/IF/IF02/20180717/108550/HHRG-115-IF02-Wstate-KingJ-20180717.pdf [hereinafter King Testimony 2018].

[235] Brian Blase, *Make Transparent Health Care Prices A Price of Any Future Aid to The Health Care Industry*, HEALTH AFF. BLOG (June 16, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200615.566069/full/.

price and quality measures among providers for many of their efforts to control the cost of employee healthcare services, including direct contracting and Centers of Excellence.[236] Gag clauses may also hinder employers from effectively using outside firms to analyze their claims for waste or low-value care.[237] As a result, gag clauses that prevent employers from learning negotiated payment rates from third-party administrators or vendors acting on their behalf may be particularly problematic. Finally, gag clauses may be especially insidious when used in conjunction with other contract term provisions discussed in this report to hide their impact. For example, gag clauses can conceal the magnitude of variation in provider rates so that the effects of an anti-steering clause remain hidden. As a result, gag clauses may be used to both hide and amplify the effects of other potentially anticompetitive contract terms.

1. Antitrust Enforcement and Gag Clause Provisions[238]

In particular, the use of gag clauses in combination with other anticompetitive provisions formed the basis of the complaint in *Sutter*. In that complaint, the plaintiffs claimed that contracts used by Sutter Health prevented insurers acting on behalf of self-funded employers from disclosing both contract provisions and the cost of hospital and ancillary services to the employers before those services were utilized and billed.[239] The plaintiffs alleged that these secrecy terms insulated Sutter from competition based on price and quality that would be present in an unfettered free market.[240] Specifically, "[b]ecause the price secrecy terms prevent the self-funded payors from determining what they will be obligated to pay Sutter for the hospital health care services and products included in their health plans (and how much those prices exceed the prices charged by Sutter's competitors) they are less able to exert commercial pressure on Sutter to moderate its inflated pricing."[241] Furthermore, as the California attorney general asserted in a companion complaint, Sutter's " Price Secrecy Terms reinforced the anticompetitive effects of Sutter's All-or-Nothing Terms and Anti-Incentive Terms. Together, these terms effectively eliminated price competition for Sutter's healthcare services throughout Northern California."[242]

While the court did not rule on whether Sutter's use of gag clauses amounted to anticompetitive conduct, the proposed final judgement requires Sutter to allow insurers to

---

[236] Gary Claxton et al., *Employer Strategies to Reduce Health Costs and Improve Quality Through Network Configuration*, PETERSON-KFF HEALTH SYS. TRACKER (Sept. 25 2019), https://www.healthsystemtracker.org/brief/employer-strategies-to-reduce-health-costs-and-improve-quality-through-network-configuration/; Emily Curran, *Large Employer Strategies to Combat Increasing Healthcare Costs: Trends in Direct Contracting, On-Site Clinics and More*, CTR. ON HEALTH INS. REFORMS BLOG (Dec. 8, 2018), http://chirblog.org/; *Sixth Annual Transamerica Center for Health Studies Employers Survey: U.S. Businesses Remain Committed to Employee Healthcare Benefits*, TRANSAMERICA CTR. FOR HEALTH STUDIES (November 2018), https://www.transamericacenterforhealthstudies.org/docs/default-source/research/tchs-employer-survey-2018.

[237] See Brian Blase, *Transparent Prices Will Help Consumers and Employers Reduce Health Spending*, GALEN INST. 15 (Sept. 27, 2019), https://galen.org/assets/Blase_Transparency_Paper_092719.pdf. (stating "Most employers, however, do not know the rates that insurers are negotiating for their employees' care, and many of these employers have difficulty obtaining this information if they try.")

[238] For a discussion of legal considerations for treatment-based gag clauses, see Gordon S. Brand et al., *The Two Faces of Gag Provisions, Patients and Physicians in a Bind*, 17 YALE L. & POL'Y REV. 249 (1998).

[239] UEBT Complaint, *supra* note 87, at 7.

[240] *Id*.

[241] *Id*. at 33.

[242] California AG Complaint, *supra* note 87, at 37.

provide self-funded payers with their own claims data "for any purpose subject to reasonable protections against further disclosure of price information."[243] Furthermore, the proposed final judgement allows insurers and/or employers to provide enrolled members with access to pricing, quality, and/or cost information concerning Sutter providers.[244] While the proposed final judgment may allow payers to gain some pricing information, it falls short of efforts to allow employers to gain access to information about negotiated provider payment rates at the time they sign a contract. Employers may not find the information about after-the-fact paid claims sufficient to establish programs to steer patients to higher-value care or to assess any discounts or the relative value of facilities included in their network. While the court did not rule on whether gag clauses were used by Sutter in an anticompetitive way, few procompetitive justifications support their use in contracts to hide prices from payers, patients, and other providers.

2. Economic Justifications or Procompetitive Use of Gag Clauses

Economic experts have debated the impact of price transparency on prices and whether price transparency reduces costs depends on specific market conditions.[245] Some economists have warned that increased transparency may lead to increased prices. As Cutler and Dafny explain, mandated transparency may have the same effect as a most-favored-nation clause. Specifically, a hospital may be less likely to offer a discount to an insurer knowing that it must publicly reveal that price discount to other insurers, who may use that knowledge to demand a lower rate.[246] Furthermore, increased transparency may allow non-dominant providers to "shadow price" a higher priced dominant provider. In particular, once the prices of the dominant provider are disclosed, other providers may be able to increase their prices to slightly below that of the dominant provider, without significant risk of losing market share.[247] Economists also note that increased transparency has led to tacit collusion in other markets, including Danish concrete and Australian gasoline, where prices increased following government mandates to increase transparency.[248] However, healthcare markets are very different from these commodity markets where prices fluctuate frequently for a product with little quality variation among suppliers.[249] To our knowledge, no research has documented an increase in healthcare prices following an increase in transparency.

On the other hand, research has found an association between increased price transparency in healthcare markets and reductions in providers' prices.[250] After New Hampshire required most payers to disclose their paid claims information to a state all-payer claims

---

[243] UEBT Motion for Preliminary Approval of Settlement, *supra* note 98, at 21–22.
[244] *Id*. at 22.
[245] Gudiksen, Chang & King, *supra* note 233; King Testimony 2018, *supra* note 234; Anna D. Sinaiko & Meredith B. Rosenthal, *Increased Price Transparency in Healthcare-Challenges and Potential Effects*, 364 N. ENG. J. MED. 891, 891 (2011); David M. Cutler & Leemore Dafny, *Designing Transparency Systems for Medical Care Prices*, N. ENG. J. MED 894 (2011).
[246] Cutler & Dafny, *supra* note 245, at 894.
[247] Alessi & King, *supra* note 107, at 329–30.
[248] D. Andrew Austin, Jane G. Gravelle*, CRS Report for Congress: Does Price Transparency Effect Market Efficiency? Implications Of Empirical Evidence In Other Markets For The Healthcare Sector*, FEDERATION OF AMERICAN SCIENTISTS (Apr. 29 2008), https://fas.org/sgp/crs/secrecy/RL34101.pdf; Gudiksen, Chang & King, *supra* note 233; Cutler & Dafny, *supra* note 245.
[249] Gudiksen, Chang & King, *supra* note 233.
[250] Zach Y. Brown, *Equilibrium Effects of Health Care Price Information*,101 REV. OF ECON. AND STATISTICS 699 (2019).

databases (APCD), the state experienced a decrease in the prices of many healthcare services.[251] While gag clauses prevent providers or insurers from disclosing rates, APCDs affirmatively promote transparency by compiling the amounts paid by both public and private insurance plans for healthcare services.[252] While some state APCDs report only aggregated or median paid amounts, New Hampshire disclosed provider-specific pricing information on its consumer-facing website, HealthCost.[253] Analysts credit the state APCD with a shift in negotiating power as the database highlighted a wide variation in hospital prices, and especially the outlier prices charged by one hospital system.[254] Zach Brown, an economist at the University of Michigan, found that New Hampshire's APCD saved individuals $7.9 million and insurers $36 million on imaging services in the five years following the launch of the HealthCost website.[255] The savings came both from a small number of patients choosing lower-cost providers and a "significant reduction in negotiated prices" for high-priced providers in concentrated markets (those with a Herfindahl-Hirschman Index above the fourth quartile).[256] Specifically, Brown's study indicates that the highest cost providers of imaging services reduced their prices to avoid losing market share after their prices were revealed. Furthermore, another study that included 8 million consumers across the United States who had access to an Internet-based price transparency platform similarly found this access was associated with 1 to 4 percent lower prices for laboratory services but no price reduction for office visits, which are more highly differentiated across providers than laboratory tests.[257] While studies of the market effects of these initiatives demonstrate that increased price transparency may lead to decrease in prices, the effects are relatively small.[258]

While experts may debate the impact of public disclosure of all negotiated rates, the potential for an increase in prices following a ban on gag clauses is negligible. Gag-clause bans only *allow* insurers and providers to disclose price information to patients, their providers, and employers. Hence, arguments about tacit collusion and price shadowing among competitors are unlikely to apply. Nonetheless, allowing patients and employers to access cost and quality information when they choose a health plan, a provider, and which providers to include in a network, is a modest step towards increasing transparency. Allowing employers to obtain information about provider payment rates from insurers increases the employer's bargaining power and may allow them to negotiate price discounts from highly priced providers or create Centers of Excellence to steer patients to higher-value care.[259] Increased knowledge about

---

[251] *Id*. Due to ERISA preemption, self-insured employers are not required to submit their claims data to the state APCD. Gobeille v. Liberty Mutual Ins. Co., 136 S. Ct. 936 (2016).

[252] Gudiksen, Chang & King, *supra* note 233; *Frequently Asked Questions*, ALL-PAYER CLAIMS DATABASE COUNCIL, https://www.apcdcouncil.org/frequently-asked-questions (last visited Aug. 30, 2020). While the Supreme Court ruling in Gobeille v. Liberty Mutual Insurance Co., Inc. held that the Employee Retirement Income Security Act (ERISA) prevented states from requiring all payers to submit information to APCDs, self-funded employers may choose to contribute claims data to a state APCD.

[253] Gudiksen, Chang & King, *supra* note 233.

[254] T. Tu & Rebecca Gourevitch, *Moving Markets: Lessons from New Hampshire's Health Care Price Transparency Experiment*, CAL. HEALTH CARE FOUND. (2014), https://www.chcf.org/wp-content/uploads/2017/12/PDF-MovingMarketsNewHampshire.pdf.

[255] Brown, *supra* note 250, at 710.

[256] *Id*. at 709.

[257] Christopher Whaley, *Provider Responses to Online Price Transparency*, 66 J. OF HEALTH ECON. 241 (2019).

[258] *Id*.; Tu & Gourevitch, *supra* note 254; Brown, *supra* note 250, at 710.

[259] Gary Claxton et al., *supra* note 236; Curran, *supra* note 236; *Sixth Annual Transamerica Center for Health Studies Employers Survey: U.S. Businesses Remain Committed to Employee Healthcare Benefits*, *supra* note 236.

prices may increase the bargaining leverage of other insurers and allow other providers to offer competitive provider payment rates.[260]

3. What States Have Restricted Pricing Gag Clauses in Healthcare Contracts?

Since 2004, five states – California, Connecticut, Indiana, Massachusetts and Minnesota – passed laws banning price gag clauses.[261] While a few of the treatment gag-clause bans passed earlier may be interpreted to allow providers to disclose negotiated rates to patients as part of a treatment decision,[262] none of them allow insurers or providers to disclose negotiated rates to employers or plan sponsors. Even the more recent price gag-clause bans are relatively limited in scope. Specifically, Massachusetts, Minnesota, and California only prohibit contract provisions that limit providers or insurers from disclosing pricing information or allowed amounts to patients upon request.[263] The laws passed in Connecticut and Indiana are much broader, and both states passed their gag-clause bans as part of a larger bill creating a new state APCD. In particular, Indiana's law requires contracts to allow disclosure of healthcare claims data to employers providing the coverage, as long as the disclosure is in compliance with the privacy requirements of the federal Health Insurance Portability and Accountability Act (HIPAA).[264] Connecticut's law provides the most protection by banning contracts between insurers and providers from containing "a provision prohibiting disclosure of billed or allowed amounts, provider payment rates or out-of-pocket costs" or any data from being disclosed to the state APCD.[265]

Standing alone, most gag-clause prohibitions passed by state legislatures are fairly weak as they only allow patients and, in some cases employers, to get paid claim amounts, but fall short of providing them information about negotiated rates or discounts offered to the payer.[266] Nonetheless, nearly all of the gag-clause bans passed by state legislatures were part of larger price transparency efforts, which included the creation of an APCD, that may give payers,

---

[260] Alessi & King, *supra* note 107, at 5.

[261] CAL. HEALTH & SAFETY CODE §§ 1367.49, 1367.50; CONN. GEN. STAT. § 38a-477f(a), (b); IND. CODE § 27-1-37-7; MASS. GEN. LAWS ch. 176O, § 9A(d), (e); MINN. STAT. § 62J.81.

[262] *See, e.g.,* N.H. REV. STAT. ANN. § 420-A:19 (1998) saying "No contract between a health service corporation and a health care provider shall limit what information such health care provider may disclose to patients or to prospective patients regarding the provisions, terms, or requirements of the health service corporation's products as they relate to the needs of such provider's patients except for trade secrets of significant competitive value."

[263] California also prohibits contracts between providers and insurers that "in any way restrict the disclosure of claims data related to health care services provided to an enrollee or subscriber of the health care service plan or beneficiaries of any self-funded health coverage arrangement administered by the health care service plan, to a qualified entity." CAL. HEALTH & SAFETY CODE § 1367.50 (2013).

[264] Pub. Law No. 104-191, 110 Stat 1936 (1996).

[265] CONN. GEN. STAT. § 38a-477f.

[266] Paid claims allow employers to know the amount they paid for a particular service, but do not provide information about rates paid by other employers to a provider for the same service or what the employer would have paid if the patient choose another provider. Furthermore, large quantities of paid claims may be difficult for many employers to analyze. As a result, paid claim amounts are not as useful as data from APCDs that allow employers to compare their claims against median amounts or to assess any discounts that the insurer negotiates on their behalf. *See* Sara Hansard, *Hospital Price Transparency Rules Arms Employers Seeking Savings*, BLOOMBERG L. (Nov. 25, 2019), https://news.bloomberglaw.com/health-law-and-business/hospital-price-transparency-rules-arm-employers-seeking-savings. Negotiated rates are more meaningful than discounts off charges "Making negotiated rates transparent 'will help point out that the discounts really aren't all that meaningful,' Smith said. 'We need to quit negotiating on these nebulous discounts from charges, and let's force price competition.'"

policymakers, and the public access to additional price information. As broader transparency initiatives, like the creation of an APCD, require significant financial resources and an oversight agency to assess disclosure and compliance,[267] state lawmakers could consider passing legislation banning pricing gag clauses as the necessary first step in an attempt to increase transparency for healthcare costs in the state.

4. Summary

As illustrated in *Sutter,* gag clauses that prevent insurers from disclosing price information to patients and employers have the potential for anticompetitive effects, especially when used in conjunction with other contract provisions. Dominant firms may use gag clauses to allow anticompetitive conduct to continue unnoticed and, therefore, unchallenged. In addition, gag clauses may insulate dominant providers from competing with other providers on price to maintain market share. While some economists expressed concern about price transparency increasing prices, all studies to date suggest that increased transparency decreases prices in healthcare markets. As a result, states may consider passing legislation banning gag clauses to allow providers and insurers to disclose both paid amounts and negotiated rates to patients and employers providing insurance coverage. States seeking to improve upon existing statutes should consider requiring disclosure of the information to employers with minimal procedural barriers and allowing employers to give the information to other firms operating on their behalf. Further, allowing insurers or providers to demand confidentiality of provider payment rates reinforces the misconception that negotiated provider rates are trade secrets.[268] Robust gag-clause bans allow employers and patients to use pricing information to make more informed decisions when choosing which providers to use for both health care and network inclusion. Multiple studies demonstrate modest savings from price transparency targeted to consumers.[269] However, increased transparency that allows policymakers and the public to assess the functioning of healthcare markets and the impacts of particular policy interventions likely has much larger and more widespread impact. As a result, while preventing dominant providers from using gag clauses to shield themselves from competition is an important first step, states seeking to improve the functioning of healthcare markets through transparency should consider implementing an APCD to provide policymakers and the public with additional information on healthcare pricing in the state.

---

[267] Jo Porter et al., *All-Payer Claims Database Development Manual: Establishing a Foundation for Health Care Transparency and Informed Decision Making*, APCD COUNCIL AND WEST HEALTH POL'Y CTR. (Feb. 2015), https://www.apcdcouncil.org/manual.

[268] *See* Feldman & Graves, *supra* note 231, at 30 ("the idea that pricing information should qualify for trade secret protection does not fit a traditional justification for intellectual property laws: that they exist to encourage and incentivize spending and research to develop useful commercial information."); Gudiksen, Chang & King, *supra* note 233.

[269] Sinaiko & Rosenthal, *supra* note 243; Cutler & Dafny, *supra* note 243; Desai et al, *supra* note 235; Desai, Hatfield & Hicks, *supra* note 233; Anna Sinaiko, Karen E. Joynt & Meredith B. Rosenthal, *Association Between Viewing Health Care Price Information and Choice of Health Care Facility*, 176 JAMA INTERN MED. 1868 (2016); Katherine Hempstead & Chapin White, *Plain Talk About Price Transparency*, HEALTH AFF. BLOG (March 25, 2019), https://www.healthaffairs.org/do/10.1377/hblog20190319.99794/full/; Christopher Whaley, Timothy Brown & James Robinson, *Consumer Responses to Price Transparency Alone versus Price Transparency Combined with Reference Pricing*, 5 AMERICAN J. OF HEALTH ECON. (2019); Anna D. Sinaiko, Shehnaz Alidina & Ateev Mehrotra, *Why Aren't More Employers Implementing Reference-Based Pricing Benefit Design?*, 25 THE AMERICAN J. OF MANAGED CARE 85 (2019); James C. Robinson, Timothy T. Brown & Christopher Whaley, *Reference Pricing Changes "Choice Architecture" of Healthcare for Consumers*, 36 HEALTH AFF. 524 (2017).

III. Recommendations and Conclusion

All of the contract clauses discussed in this report – most-favored-nation clauses, all-or-nothing contracting, exclusive contracting, anti-steering and anti-tiering clauses, and gag clauses– may be used in ways that increase healthcare prices and lower quality. As unrelenting consolidation in provider and insurer markets continues, policymakers need additional options to protect the public from escalating prices. Unquestionably, vigorous antitrust enforcement can address the use of these provisions when used by dominant firms.[270] Yet, cases can only be brought by antitrust enforcers and private litigants once they become aware of the harmful conduct, which is often challenging as little transparency exists into contracts between providers and payers. Furthermore, cases may take years to reach a resolution and are often inefficient at addressing widespread contracting practices because they are filed against individual companies. As Emilio Varanini, Deputy Attorney General in the antitrust section of the California Department of Justice, has argued, "while litigation can blaze the way for addressing such anti-competitive conduct, ultimately legislation may be a far more effective tool for carrying out competition as a policy goal."[271]

Recognizing that legislation may be an effective tool at promoting competition, Congress is considering banning some of the contract terms detailed in this report, as many states have done. As discussed above, many of the procompetitive justifications for these terms are unlikely to apply to or outweigh the anticompetitive harms in healthcare markets, making them strong candidates for legislative prohibition.

While enacting legislation prohibiting or restricting the use of certain terms in contracts between healthcare insurers and providers has the potential to reduce harms by sending a clear signal that lawmakers presume their use to be anticompetitive, states cannot rely solely on legislation to remedy the healthcare market's deficiencies. Enacting legislation can be politically challenging, especially if state hospital and medical associations take a strong stance against such bills. Even if a state does pass legislation, it cannot then rest on its laurels. Dominant firms may be able to garner similar benefits without inclusion of specific clauses in their written contracts through oral or other agreements. For example, Indiana passed a state-wide ban on MFNs in 2007, but a dominant insurer appeared to continue to impose best-rate requirements on hospitals without an explicit MFN in the contracts.[272] In addition, antitrust enforcement measures and legislative prohibitions targeting specific contract terms fail to capture the cumulative anticompetitive effects of use of a variety of contract terms used in combination. As argued in the complaints against Sutter Health, the anticompetitive effects of these contract provisions can be mutually reinforcing.[273] In consolidated healthcare provider markets, an amalgam of restraints—what some antitrust cases call a "monopoly broth"[274]—may allow a health system to exert market power through a collection of smaller actions that, on their own,

---

[270] *See* Emilio Varanini, *Competition as Policy Reform: The Use of Vigorous Antitrust Enforcement, Market Governance Rules, and Incentives in Health Care*, 11 ST. LOUIS U. J. HEALTH L. & POL'Y 69 (2018).
[271] *Id*. at 86.
[272] Berenson, Ginsburg, Christianson & Yee, *supra* note 80, at 978.
[273] UEBT Complaint, *supra* note 85; California AG Complaint, *supra* note 87.
[274] For discussion, see *supra* note 101. City of Mishawaka v. Am. Elec. Power Co., 616 F.2d 976, 986 (7th Cir. 1980) (characterizing a mix of exclusionary conduct as a "monopoly broth").

might not be deemed anticompetitive. As a result, states searching for a more proactive solution to rising healthcare costs should also consider ways to have a government authority oversee evolving contracting practices between payers and providers.

State legislatures may consider requiring a state agency to monitor contracts between insurers and providers for provisions that create a risk of anticompetitive harm. States could accomplish this in several ways. They could assign an existing state regulatory entity, like the Department of Insurance, or a new independent state commission to oversee healthcare costs and competition in the state. Part of the regulatory entity's responsibilities could be to review contracts between healthcare providers and payers, especially those with market power, for potentially anticompetitive terms. For instance, Rhode Island created a separate Health Insurance Department to address concerns associated with health insurance markets. Rhode Island law authorizes the Health Insurance Commissioner to review provider payment rates in certain contracts between insurers and providers and reject any contracts that increase the total cost of services above a threshold.[275] State legislatures could build upon Rhode Island's approach by creating a new health insurance commission or granting the existing insurance commissioner the ability to review insurance contracts for competitive concerns, including the anticompetitive use of contract terms.

Alternatively, states could broaden the existing authority of the attorney general to review and challenge anticompetitive practices, especially by health systems and insurers with market power. First, to facilitate review, a state could have the attorney general's office review contracts involving dominant providers or insurers for potentially anticompetitive terms. Second, as proposed in California's S.B. 977, states can ease the ability of the state attorney general to successfully challenge anticompetitive contracting practices. S.B. 977 would have created a rebuttable presumption that the use of exclusive dealing and tying provisions in contracts involving health systems, those with three or more hospitals, is anticompetitive.[276] Further, the bill also would have make it unlawful for a health system with market power to engage in conduct that "has a tendency to cause anticompetitive effects," which includes any conduct that has a "substantial likelihood of raising market prices, diminishing quality, reducing choice, increasing total cost of care, or diminishing availability of diminishing access to hospital or nonhospital health services."[277] The bill would have also included civil fines for violations.[278]

Lawmakers could also consider specifically including all of the contract terms described in this report – MFNs, all-or-nothing clauses, anti-tiering or anti-steering clauses, gag clauses, and exclusive contracting provisions – as material changes that must be approved by the commission, insurance commissioner, or the attorney general before the contract is executed. New York, for example, requires the insurance commissioner to approve any "material changes" in the contract between a managed care organization and a provider before

[275] The threshold is 1.5% + the US All Urban Consumer All Items Less Food and Energy Percentage Increase ("CPI-Urban"). The threshold is set annually by the Commissioner on October 1 based on the most recently published United States Department of Labor data. 230 R.I. CODE R. 20-30-4.10.

[276] Unfortunately, the bill was not brought to a vote in this legislative session, however the bill may be reintroduced in 2021. S.B. 977, 2019-2020 Reg. Sess. § 1191 (Cal. 2020).

[277] S.B. 977 2019-2020 Reg. Sess. § 1191(b)(1) (Cal. 2020) (defining a substantial likelihood of anticompetitive effects to include "raising market prices, diminishing quality, reducing choice, increasing total cost of care, or diminishing the availability of, or diminishing access to, hospital or nonhospital health care services.").

[278] S.B. 977, 2019-2020 Reg. Sess. (Cal. 2020).

implementation.[279] The New York law then explicitly defines a material change to include the proposed addition of an exclusivity or most-favored-nation clause in a managed care contract with a provider other than a management contract.[280] Legislatures could consider only requiring review of certain contracts, such as those challenged on appeal by one of the parties, those with health insurance premiums or premium rate increases that exceed a certain threshold, or those involving entities of a certain size or level of market power.

Once the selected state entity identifies potentially anticompetitive contract terms, states could follow a variety of protocols to resolve the question of whether the harms outweigh the benefits of including the contract terms. First, the state could grant the reviewing state entity, whether it is a new commission, the department of insurance, or the attorney general's office, the ability to approve or reject the contract based on its potential to impact competition following a comprehensive review. If oversight authority is not granted to the state attorney general, policymakers could also consider requiring the commission or insurance commissioner to refer any contract with potentially anticompetitive contracting practices to the attorney general for an administrative opinion on its competitive effects. Alternatively, states may simply require the state entity to refer potentially anticompetitive cases to the state attorney general for review to determine whether to challenge use of such contract terms in a lawsuit.[281] As healthcare consolidation of providers into health systems continues to increase[282] and evidence mounts that the financial harms from integration are not offset by increases in quality,[283] states must consider all options to promote and protect competitive markets including vigorous antitrust enforcement policies, legislative action, and increased oversight of insurance contracts by the state insurance commissioner, attorney general, or related agency.

Based on the research and analysis presented in this report, we make the following specific recommendations:

1) *Enact legislation banning most-favored-nation clauses and anti-steering/anti-tiering clauses in contracts between providers and insurers with a possible exception for companies with minimal market share*.

   Most-favored-nation clauses and anti-tiering and anti-steering clauses offer scant procompetitive justifications, especially when used by firms with market power. As a result, state lawmakers should enact legislation prohibiting these terms in contracts between providers and insurers. States may consider including an exception for contracts in which both parties lack market power. For example, Kentucky's law prohibiting MFNs permits the clause when the Insurance Commissioner determines the insurer has "nominal" market share.[284]

[279] N.Y. COMP. CODES R. & REGS., tit. 10 § 98-1.5.
[280] N.Y. COMP. CODES R. & REGS., tit. 10 § 98-1.2.
[281] *See, e.g.,* S.B. 977 § 1191(b)(1), 2019-2020 Reg. Sess. (Cal. 2020).
[282] Michael F. Furukawa, Laura Kimmey, David J. Jones, Rachel M. Machta, Jing Guo & Eugene C. Rich, *Consolidation of Providers into Health Systems Increased Substantially*, 39 HEALTH AFF. 1321 (2020).
[283] Fisher et al., *supra* note 117.
[284] KY. REV. STAT. ANN. § 304.17A-560.

2) *Enact legislation banning gag clauses that prevent patients and employers from easily obtaining price and quality information from providers or insurers.*

   At a minimum, states should allow employers and patients to easily access both their own claims data and negotiated provider payment rates. States wanting to meaningfully improve price transparency should also consider implementing an APCD that would provide policymakers and the public access to healthcare claims data that includes information on negotiated prices, utilization, expenditures, and quality, as well as the equity of the provision and quality of services.

3) *Enact legislation limiting all-or-nothing and exclusive contracting practices*.

   States should enact legislation banning all-or-nothing contract provisions and practices that amount to anticompetitive product or geographic tying, while allowing waivers or a de minimis exception for entities with limited market power. Additionally, states may consider passing legislation to make exclusive contracting presumptively unlawful when used by a provider with significant market power in any market.

4) *Empower a state agency to monitor and oversee evolving healthcare contracting practices.*

   As described above, state legislatures should consider granting a state agency the responsibility of monitoring contracts between insurers and providers for provisions that create a risk of anticompetitive harm. States could accomplish this in several ways, including through the creation of an independent commission, or vesting more authority in existing agencies, such as the insurance commissioner or the state attorney general. States could either grant the oversight agency the ability to approve or reject the use of potentially anticompetitive contract terms or require that such contracts be referred to the attorney general for review and potential challenge if they remain in the contract.