Testimony before the Senate Financial Institutions and Insurance Committee
SB 382
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Madam Chair and Members of the Committee, I am Keith Barnes, Market President for Aetna, Inc for Kansas, Missouri and Oklahoma.

Thank you for the opportunity to provide this testimony in support of Senate Bill 382, which would prohibit the use of "Most Favored Nations" (or MFN) clauses. Aetna is a national health insurance plan operating in all fifty states. We have approximately 100,000 residents of the state of Kansas insured. We believe that the existence and use of MFN clauses in contracts between health insurers and medical providers has an anti-competitive effect on the healthcare market place in Kansas.

Background

A most favored nation ("MFN") clause is a contractual provision requiring a provider of health care services to accept from a particular insurer the lowest price the provider accepts from other insurers.

Aetna's Position

Aetna believes that MFN clauses should be prohibited when used by insurers possessing significant market share. Use of MFN clauses by dominant insurers can dissuade providers from doing business with competing plans and sometimes result in a price floor for health care services to the detriment of consumers.

Discussion

MFN contract clauses can have pro-competitive or anti-competitive effects, depending on the market facts. When used by a market dominant health plan responsible for the majority of dollars flowing in to a provider's practice or facility year in and year out, that provider can be understandably reluctant and even unwilling to give competing health plans a better price for fear of triggering the MFN guarantee. In this way, when used by a market dominant health plan with commanding market strength, a MFN clause can tend to set a price floor for covered services. Competing health plans which may have received a lower price from the provider in the absence of the MFN clause are now prevented from obtaining one, thus preventing a reduction in the cost of health care services which ultimately harms consumers.

Fear of inadvertently triggering an MFN provision can also lead providers to create a "price buffer" between the MFN rate that the dominant payer has extracted from it and the next best price. A provider subject to an MFN rate guarantee may actually deal with competing payers on a somewhat less favorable price basis (particularly when an array of services or a combination of care is involved) to ensure that they can never be accused by the dominant health plan of violating the MFN provision, either intentionally or

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unintentionally. This drives up the cost of health care services charged to competing health plans and can increase the cost of health insurance over time.

We have empathy for provider systems that may feel uneasy about speaking up against MFN clauses. Understanding that so much of their revenue is at stake by a market dominant carrier, it is no wonder they feel a lack of control. As a national carrier, Aetna has chosen to not use them in favor of allowing the competitive market to foster innovation. Dominant plans that use MFNs can use them as a weapon to stifle vigorous competition, ensure that the dominant plan receives the best price and retains the power to establish that price year over year, and prevent attempts by both providers and competing payers to reduce health care costs. By banning MFNs allows providers to contract at market competitive rates with other carriers and enables the competitive market to work and gives the citizen's of Kansas greater choice.

Twenty states nationwide (AK, CA, CO, CT, GA, ID, IN, KY, MD, ME, MA, MN, NH, NJ, OH, OR, RI, VT, WA, WV) have now enacted some form of ban on the use of MFN clauses in the health care context and seven states (MI, MO, NJ, NY, NC, PA, SC) are either considering additional or initial restrictions or prohibitions on their use. We believe that MFNs which give non-dominant health plans a foothold in the marketplace by allowing providers to contract with them at market-competitive rates can be pro-competitive. However, when used by dominant plans possessing significant market share, MFNs have the anticompetitive effects noted above.

Ohio is one of the states most recently to ban the use of these clauses. In 2008 the Ohio General Assembly enacted HB 125, which banned the use of MFN clauses in health care contracts between insurers and physicians, but left open the question of whether to permanently ban them in hospital contracts. It also created the Joint Commission on MFN Clauses in Health Care Contracts, a study commission to further examine MFN clause effects, and ultimately make a recommendation to the legislature on whether state law should ban MFN clauses in contracts between hospitals and health insurers.

The Ohio Commission met to study the issue and complete its charge. They heard from two economists, an antitrust attorney, and conducted two surveys of hospitals and insurers. Some of the key findings included in their report included:

- 9 of the 13 large hospitals with MFNs reported that they would have given a lower price to another insurer in the absence of an MFN clause.

- Half of all responding hospitals reported that the existence of an MFN clause affected or discouraged them from entering into innovative payment methodologies with another insurer;

- 15 of 19 responding hospitals with MFN clauses use measures such as price buffers to ensure that an MFN clause is not violated.

In summary, Aetna believes that if healthcare reform is to be successful in this country, we must do everything possible to get at the actual cost drivers within the system. The use of MFN clauses is one of those cost drivers that can be eliminated by the Legislature. For this reason and the reasons mentioned above, we support the passage of Senate Bill 382. Thank you and I'll be happy to answer questions.

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