HIAA®

Health Insurance Association of America

Presentation by

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On

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I am Henry R. Desmarais M.D., M.P.A., Senior Vice President of Policy and Information for the Health Insurance Association of America (HIAA). HIAA is the nation's most prominent trade association representing the private health care system. Its nearly 300 members provide the full array of health insurance products, including medical expense, long-term care, dental, disability, and supplemental coverage to more than 100 million Americans. HIAA is also the nation's premier provider of self-study courses on health insurance and managed care.

The nature of this panel addresses questions that are the subject of great dispute between providers, health plans, and non-physician providers.

HIAA is committed to working with the physician community. HIAA has focused on working with physicians and other providers with the hope of addressing problems before they become the subject of bitterly divisive legislative proposals or lawsuits. On November 5, 2001, the HIAA Board of Directors approved a resolution strongly supporting open communication and collaborative working relationships between HIAA and organizations representing physicians and other health care professionals. In approving this resolution, the Board held that such relationships are necessary to establish trust and to further the shared goals of strengthening the physician and patient relationship and encouraging high quality, affordable health care. They also help to identify areas to simplify administrative procedures and improve efficiencies for consumers, physicians, other health professionals, and insurers.

HIAA has supported legislation to reduce medical errors through a ***non-punitive environment***, in which error-related information would be strictly confidential and non-discoverable. Physicians and hospitals cannot be expected to improve patient safety without

having adequate protections from the fear of lawsuits. Furthermore, HIAA is a member of the Coalition for Affordable Quality Healthcare (CAQH), which has worked to develop uniform health plan credentialing standards for providers in order to reduce the administrative burden that physicians and other providers face in becoming credentialed under numerous plans and networks.

It is important to note that the role of the Federal Trade Commission (FTC) on any issues discussed in this panel dealing with competition and antitrust is ultimately to protect and benefit the consumer. The FTC is charged with ensuring a functioning marketplace that achieves this goal. If relationships between physicians, health insurance plans, and employers are not functioning appropriately, consumers will be the ones affected the most. If access to needed physician services is compromised or health insurance coverage becomes unaffordable for employers, individual consumers will be the ones left without access to health care services or health insurance coverage.

The issue of affordability is certainly an important one, especially at this time of rising health care costs. A recently published report, based on a national survey, revealed that the cost of employer-based health insurance rose 12.7 percent from spring 2001 to spring 2002.[1] This was the highest rate of growth since 1990. The survey also showed that monthly employee contributions for health insurance rose from $30 to $38 for single coverage and from $150 to $174 for family coverage. The study also found that employers responded to rising health care costs by increasing employee cost sharing (i.e., higher deductibles and copayments), reducing covered benefits, and even dropping health insurance coverage altogether. In this context, then,

[1] Jon Gabel et al., "Job-Based Health Benefits In 2002: Some Important Trends," *Health Affairs* (Sep/Oct 2002): 143-151.

it is important to consider the implications of potential changes in public policy on health care access, cost and quality.

The issue of whether consumers benefit when providers combine to form a "countervailing balance" is one that is brought to the forefront by physicians seeking to bypass antitrust law and form cartels to collectively bargain with health plans on fees. HIAA is strongly opposed to any federal or state effort by physicians to gain such an exemption. As mentioned above, consumers would ultimately be affected by any consolidated activity or "countervailing balance" by providers through increased costs of health care and decreased access. For example, a recent study showed that enacting physician antitrust legislation would increase health care costs by 5-7 percent.[2] In addition, an April 2002 study by Charles River Associates states that "there are no economic principles that support the argument that bargaining between two parties that both possess market power leads to a superior outcome for ultimate consumers (in this case patients) than bargaining between one party with market power and one without."[3] The argument that quality will be improved by allowing physicians to collectively negotiate is simply false. In fact, under the recent Barr/Conyers bill H.R. 3897 introduced this year, which HIAA actively opposed, physicians would have the ability to refuse to enter into contracts that contain clauses related to quality activities that plans may have in place, including participating in the collection of data needed for quality reporting such as HEDIS.[4] Furthermore, in the state of Washington where physicians have had the right to collectively bargain on quality – but NOT on fees – since 1993, there has not been a single application from a physician entity since enactment.

[2] Charles River Associates, LLP. "The National Costs of Physician Antitrust Waivers." March 2000.
[3] Monica Noether, Peter Rankin, Rhett Johnson, "Competition in Health Insurance and Physician Markets: A Review of "Competition in Health Insurance: A Comprehensive Study of US Markets" by the American Medical Association." Charles River Associates, April 2002.

Physicians and providers currently have significant market power and the ability to legally negotiate with health plans. Through the use of the "messenger model," or by creating qualified risk-sharing or clinically integrated joint arrangements, physicians can legally negotiate with health plans.

In addition, employers have expressed the desire for less restrictive managed care plan designs and access to large provider networks for their employees. This puts physicians and other providers in a position of power in negotiations with health insurance plans, that need to contract with large numbers of physicians or with specific physicians in order to satisfy customer demands. "Consumers' and purchasers' preferences for broad and stable networks give providers the upper hand in contract negotiations with plans."[5] It is also true that health plans wish to avoid lengthy and contentious contract negotiations since they are expensive and unpredictable and could result in dissatisfied consumers.

Testimony by Paul Ginsburg, President of the Center for Studying Health Care System Change (HSC), shows that one likely factor resulting in an increase in the cost of health insurance is increased consolidation of hospitals and the subsequent increase in their bargaining clout with insurers.[6] This is significant since hospitals undergo stringent merger and acquisition scrutiny and yet still have significant *legal* market power. If physicians were to gain such ability with *no* merger and acquisition scrutiny, the resulting increase in cost and the effect on the health care market would be significant.

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[4] H.R. 3897. "Health Care Antitrust Improvement Act of 2002," U.S. House of Representatives, 107th Congress, 2nd Session.
[5] Debra A. Draper, Robert E. Hurley, Cara S. Lesser, and Bradley C. Strunk. "The Changing Face of Managed Care," *Health Affairs* 21(1), January/February 2002, p. 11.
[6] "Statement of Paul G. Ginsburg, PhD., President of the Center for Studying Health System Change." U.S. House of Representatives, Committee on the Education and the Workforce, Subcommittee on Employer-Employee Relations. June 18, 2002.

Physicians argue that health insurers that have a significant health insurance market share possess monopsony power, or the power to suppress the purchase of physician services and therefore suppress physician fees. While the insurance and physician service markets are interrelated, they are not identical and the competitive characteristics of each market must be analyzed separately. There is a great deal of competition among health insurers in purchasing physician services. As noted in one recent report, "any attempt by a single plan to decrease the rates it pays providers below the competitive level would be offset by its competitors taking the opportunity to augment their preferred provider panels and thereby grow their businesses at the expense of the plan attempting to reduce its fees paid to providers."[7]

Even if health insurers possessed significant market power in selling health insurance, they may not have market power in purchasing physician services. "Physician groups can consolidate to increase their bargaining power. Physicians can capitalize on their good reputations or powerful presence in local geographic areas to achieve leverage with health insurers."[8] In addition, physicians have other significant sources of income including Medicare, Medicaid, Federal and State employee plans, and self-insured plans. And, the average physician has contractual or other business arrangements with multiple private plans. As health economist Mark Pauly notes:

"Market power in selling insurance need not imply monopsony power since market-level input supply curves might be highly elastic…So it is quite possible for local health plans to have seller

[7] Charles River Associates, April 2002.
[8] Charles River Associates, April 2002.

(monopoly) power but not buyer (monopsony) power…measuring the concentration of buyers in the market is not, in itself, sufficient to establish the existence or extent of monopsony power."[9]

It is also important to recognize that insurers are subject to intense governmental scrutiny of their business practices. Federal and state governments exercise shared and sometimes overlapping jurisdiction over the various operations of health insurers. Some examples of regulatory oversight include the following:

- Regulation of insurers' financial statements;
- Regulation of insurers' investments (permissible and non-permissible);
- Financial examinations;
- Review and approval of premium rates and policy forms;
- Regulation of form and substance of disclosures;
- Regulation of discontinuance and replacement of policies;
- Investigation of consumer complaints;
- Performance of market conduct examinations;
- Investigation and prosecution of insurance fraud; and
- Regulation of trade and claim payment practices.

Indeed, there are few business activities that an insurer can undertake without having to consider compliance with an existing law or regulation. This includes issues relating to mergers, acquisitions and antitrust. While actions taken by federal authorities (DOJ and FTC) against insurers for antitrust concerns are not common, this lack of activity is not attributable to a lack of scrutiny. In addition to the national antitrust enforcement agencies, state Attorneys General, who once waited for federal enforcers to address issues of competition, often seek out and prosecute anticompetitive behavior in advance or in tandem with their federal counterparts.[10]

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[9] Pauly, Mark V. "Managed Care, Market Power, and Monopsony," *Health Services Research*, December 1998, Part 11, p. 1443.

[10] Seven states have pursued actions against HMOs since 1998. See Laura B. Benko, "Attorneys General Take On HMOs," *Modern Healthcare*, February 18, 2002, p. 24. In addition, the Texas Attorney General worked in collaboration with the DOJ to contest the Aetna-Prudential transaction, resulting in divestitures in Dallas and Houston; see Revised Competitive Impact Statement, *United States of America and the State of Texas v. Aetna Inc.*

There is a perception among some that, as a result of passage of the McCarran Ferguson Act in 1946, insurance companies are exempt from antitrust scrutiny. This is not the case. Insurance companies cannot enter into agreements with other insurers in the market place to set prices or boycott or coerce providers. They are subject to both federal and state antitrust laws.

The Supreme Court pointed this out in the Royal Drug case decision, drawing a distinction between ***"the business of insurers"*** and ***"the business of insurance."*** The former is subject to both federal and state antitrust oversight, the latter, "the business of insurance" or the mechanics of insurance if you will, is subject to state oversight.[11]

McCarran-Ferguson only protects insurers from antitrust violations if the concerted activity that they are engaged in is regulated by the state – only then can insurers be considered "exempt" from certain antitrust restrictions. This exception was included in the law to protect the property and casualty (P&C) rating bureaus that then existed to share information subject to state oversight. These bureaus are no longer in operation, and buying a policy from an insurance company is no longer the only source of insurance available to purchasers. In both the P&C and health insurance markets, a large number of purchasers self-insure.

Once again, I'd like to thank the Commission for providing HIAA the opportunity to participate in this important forum. As I tried to emphasize at the outset, we are not interested in having an adversarial relationship with physicians and other practitioners but in finding ways to work together to meet the health care needs of the American public. In saying this, however, we cannot ignore the implications of rising health care costs and their impact on the availability and affordability of health insurance.

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and The Prudential Insurance Company of America, Civil Action No. 3-99CV1398-H, p. 1 (at http://www.usdoj.gov/atr/cases/f2600/2648.pdf).

[11] *Group Life & Health Insurance Co., aka Blue Shield of Texas, et al. v. Royal Drug Co., Inc., dba Royal Pharmacy of Castle Hills, et al.,* 440 U.S. 205.