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Statement by

LAWRENCE WU

Vice President

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On Health Insurance: Payor/Provider Issues

Prepared for the

Federal Trade Commission Workshop on

Health Care and Competition Law and Policy

Washington, D.C.

September 9, 2002

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Introduction

I want to thank the FTC for hosting this workshop and for inviting me to speak. I am encouraged to see the FTC's continuing interest in fostering competition in health care markets. Competition is not just an antitrust issue; I believe competition can help us control the rise in health care costs, which has long been an important public policy goal.

My perspective is a little bit different from the others on this panel. As an antitrust economist, I am interested in understanding the sources of market power in an industry and in

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measuring its effects. As a health economist, I am interested in the public policy questions related to health care cost containment. And, as an empirical economist, I have a natural interest in numbers—and when it comes to health care, there are some pretty big numbers that have caught my interest:

- A recent survey found that employers' health insurance premiums increased 12.7 percent from 2001 to 2002, the largest increase since 1990. This is higher than the general inflation rate (i.e., the consumer price index), which was 1.6 percent. Increases in premiums for small employers were even higher.[2] Experts also believe that the average premium will rise anywhere from 12 to 15 percent from 2002 to 2003.[3]

- Spending on health care services and prescription drugs has increased at around seven percent per year recently. Sound small? Not compared to the two percent growth rates that we had in the mid-1990s.[4] To give you a little more perspective, spending on hospital inpatient care actually *declined* from 1994 to 1998. That is not the case any more.[5]

By most accounts, we are headed for significant increases in health care spending. As a result, the demand for cost containment will be stronger than ever. So, what can we do to control costs? In broad terms, we have three strategies: 1) we can reduce the prices paid to

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[2] The Kaiser Family Foundation and Health Research and Educational Trust Survey of Employer-Sponsored Health Benefits: 2002. See "Employer Health Benefits: 2002 Annual Survey," p. 12-15.

[3] See, for example, Ian Reed, "U.S. Health Insurance Outlook Midyear 2002: Consumer Demand Underpins Stability," Report by Standard & Poor ("According to a Mercer Human Resources Consulting study, employer costs increased 12.7 percent for 2002 and will likely go up a further 12%-15% for 2003."). Also see Catherine Arnst, "Health Care: Costs Will Stay Feverish," *BusinessWeek Online*, January 14, 2002 ("An annual survey of large companies by the consulting firm Towers Perrin indicates that health-plan costs will increase an average of 14% in 2002—the largest annual hike since the survey started a decade ago, and the third consecutive year of double-digit increases.").

[4] See Bradley C. Strunk, et al., "Tracking Health Care Costs," *Health Affairs – Web Exclusive*, September 26, 2001, p. W41 ("Health care spending per privately insured person increased 7.2 percent in 2000, which represents the largest year-to-year increase since 1990 and marks the third straight year of significantly high growth.") and the data in Exhibit 1 on p. W42.

[5] *Ibid*, p. W42 ("Hospital inpatient spending increased at a rate of 2.8 percent in 2000—a 1.2 percentage point increase over 1999. More importantly, however, this finding signals a dramatic departure from the trend in 1994-1998, when hospital inpatient spending was actually declining year to year by as much as 5.3 percent.").

providers; 2) we can manage health care utilization better; and/or 3) we can accept a lower quality of care.[6]

I want to talk briefly about each of these cost containment tools, but more importantly, I want to talk about the role that competition can play and has played in developing innovative ways to control the rise in costs. And because competition is so important, I will conclude with a few observations on the vital role that the FTC has and will continue to have in preserving competition in this industry.

Controlling the Rise in Health Care Costs

What can health plans do to control costs? First, health plans could continue to try to reduce the prices that are paid to providers. In the past, this has come about through HMOs, who have used selective contracting with providers as a way to negotiate lower provider reimbursement rates. Will this continue to work? Not without some change because the HMOs have lost quite a bit of bargaining power recently.[7] If the past five years are any indication, employers and employees have shown that they prefer PPOs (i.e., preferred provider organizations) and health plans that do not limit coverage to certain hospitals and

[6] The adoption of new technologies is another important dynamic in the cost containment equation. For example, Henry J. Aaron concludes that, "More than any other factor, the proliferation of medical technology explains the growth of health care spending. The development of medical technology affects outlays in two distinct ways: by adding to the menu of feasible treatments and by reducing the invasiveness of existing interventions, thereby increasing the number of patients who stand to enjoy net gains from diagnosis or treatment." (See Henry J. Aaron, *Serious and Unstable Condition*, The Brookings Institution, Washington, D.C., 1991, p. 48.) Of course, innovation also can lower costs. The demand for health care cost containment favors innovations that improves efficacy and/or reduces the cost of treatment (e.g., outpatient surgery and other less invasive treatment options).

[7] See, for example, Debra A. Draper et al., "The Changing Face of Managed Care," *Health Affairs*, Vol. 21, No. 1, January/February 2002, p 11 ("Consumers' and purchasers' preferences for broad and stable networks give providers the upper hand in contract negotiations with plans.") and p. 20 ("As plans move to less restrictive managed care products, they lose their ability to control costs. This trend is likely to contribute to further premium increases....").

physicians.[8] But limiting coverage is the backbone of selective contracting.

Health plans also could reduce costs by managing health care utilization better or by reducing the quality of care that is provided or covered by the plan. But if the past five years are any indication, it is not clear that employers and employees will embrace more controls that restrict the amount of medical care that is provided and paid for. Consumer concerns about the quality of care supplied to HMO enrollees already have made HMOs reluctant to further manage the access to and use of health care services.[9]

If we cannot count on the traditional tools of managed care, and if consumers are not willing to accept more restrictions on their choice of provider or their access to health care services, are we destined for double-digit inflation? Probably not for the long term, but we have to allow competition to take its course.

The Role of Competition in Controlling the Rise in Health Care Costs

If we go back to the basics, it is clear that managed care was able to reduce the rise in health care spending by doing two things: encouraging competition among providers and encouraging consumers to shop for a health plan on the basis of price. What happened? The market evolved.

Using selective contracting, HMOs negotiated low reimbursement rates with providers. With lower costs, the HMOs went to the marketplace and sold lower-priced health insurance compared to PPO and indemnity coverage. Employers and employees loved the low premiums

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[8] *Ibid*, p 11 ("Managed care plans – pressured by a variety of marketplace forces that have been intensifying over the past two years – are making important shifts in their overall business strategy. Plans are moving to offer less restrictive managed care products and product features that respond to consumers' and purchasers' demands for more choice and flexibility.").

[9] See Bradley C. Strunk, et al., "Tracking Health Care Costs," *Health Affairs – Web Exclusive*, September 26, 2001, p. W47 ("…health plans, in an effort to quell the managed care backlash, are reducing their reliance on other cost-control mechanisms such as gatekeepers, preauthorization requirements, and capitation.").

and enrolled by the millions.[10] This only served to give HMOs even more leverage to negotiate even lower prices with providers. In this way, managed care changed the nature of competition so that market forces could be used to control costs.[11] Managed care involved some tradeoffs, but it worked as promised. Total health care spending stabilized as a percent of the gross domestic product, and the rise in premiums and provider costs slowed.[12]

Consumers then started to express their demand for less restrictive managed care. We wanted more freedom of choice, and we did not want to have to get a referral before we were allowed to see a specialist. What happened? The market evolved, and we saw the introduction and proliferation of numerous types of health plans that varied in terms of copayment rates, the benefits that were covered, and access to care.[13] In the last half of the 1990s, enrollment in HMOs started to fall and HMOs began to lose their ability to negotiate low rates with

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[10] See Jon Gabel, "Ten Ways HMOs Have Changed During the 1990s," *Health Affairs*, Vol. 16, No. 3, May/June 1997, p. 134 ("Between 1990 and the end of 1995, the number of Americans enrolled in a health maintenance organization (HMO) grew from 36.5 million to 58.2 million.").

[11] For additional background, see David Dranove, Mark Shanley, and William D. White, "Price and Concentration in Hospital Markets: The Switch from Patient-Driven to Payer-Driven Competition," *Journal of Law and Economics*, Vol. 36, No. 1, Part 1, April 1993, p. 180 ("Skepticism about the effects of competition in health-care markets is based largely on the assumption that purchasing power rests with poorly informed and price-insensitive patients and their physicians. Recent institutional changes have shifted purchasing power toward well-informed and price-sensitive insurers and employers. This shift from 'patient-driven' to 'payer-driven' competition began with the growth of health maintenance organizations (HMOs) in the 1970s and has continued with the emergence of preferred provider organizations (PPOs) in the 1980s.").

[12] See, for example, Jon Gabel, et al., "Job-Based Health Insurance in 2000: Premiums Rise Sharply While Coverage Grows," *Health Affairs*, Vol. 19, No. 5, September/October 2000, p. 144 ("...health care spending in 1998 constituted only 13.5 percent of GDP, two-tenths of a percentage point lower than in 1993.") and Jon Gabel, "Ten Ways HMOs Have Changed During the 1990s," *Health Affairs*, Vol. 16, No. 3, May/June 1997, p. 134 ("In 1995 and 1996 overall premium increases in employer-based plans were 2.5 percent and 0.5 percent, respectively—lower than any other years since researchers began measuring them.").

[13] See Jon Gabel, "Ten Ways HMOs Have Changed During the 1990s," *Health Affairs*, Vol. 16, No. 3, May/June 1997, p. 136-137 ("Over the past ten years, employers increasingly have chosen to offer hybrid health plans: point-of-service (POS) plans and preferred provider organizations (PPOs). As more employees have enrolled in POS plans and PPOs, HMOs have responded by expanding their offerings to cover services provided outside the plan....Today, most HMOs do not view themselves as HMOs, but as managed care organizations that offer an array of managed care plans.").

providers.[14] Not surprisingly, provider costs and premiums are again rising at levels not seen since 1990.

Where will it end? I do not know because the market is still evolving. For example, more and more health plans are exploring the use of "triple-tiered pricing," which is a fancy word for charging consumers different copayment rates depending on their choice of provider.[15] The hope is that by charging consumers different copayment rates for, say, different hospitals, consumers will pay more attention to price.

Just as important, the expectation is that tiered pricing to consumers will lead to tiered provider pricing and an improvement in insurers' negotiating position relative to providers, which should help stimulate price competition among providers for contracts with health plans.[16] This is old-fashioned competition, but as the financial incentives become more complicated, it is likely that the contracting and reimbursement arrangements between payors and providers also will become more complicated.

Providers, of course, have not been and will not be standing still. To make themselves attractive to health plans, hospitals and physicians have tried, with varying degrees of success, to find new ways to reduce and control the rise in costs. MedSouth Inc., a physician IPA in south Denver that was the subject of a recent FTC staff advisory opinion, is a great example of a physician group that is trying to find innovative solutions that will help patients and lower costs.[17]

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[14] The drop in HMO enrollment from 1996 to the present can be seen in Exhibit 5.1 on p. 69 of the report, "Employer Health Benefits: 2002 Annual Survey," which is based on data from the Kaiser Family Foundation and Health Research and Educational Trust Survey of Employer-Sponsored Health Benefits. Also see the references in footnote 7 above.

[15] The Kaiser Family Foundation and Health Research and Educational Trust Survey of Employer-Sponsored Health Benefits: 2002. See "Employer Health Benefits: 2002 Annual Survey," p. 92.

[16] Debra A. Draper et al., "The Changing Face of Managed Care," *Health Affairs*, Vol. 21, No. 1, January/February 2002, p 20 ("The option of less expensive products is already evident in the use of cost-sharing tiers for pharmacy benefits, and the option is likely to be applied to provider network structures (such as tiered provider networks) and other benefits in the future.").

[17] Letter from Jeffrey W. Brennan (FTC Assistant Director for Health Care Services & Products) to John J. Miles, February 19, 2002, regarding the proposal of MedSouth, Inc., a physician independent practice association located in Denver, Colorado. MedSouth proposed to implement a program that would integrate the provision of primary and specialty physician services mainly through the development and implementation of 1) a clinical

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Will tiered pricing and provider integration eliminate concerns about cost containment? I do not know, but the market will evolve, and we should allow competition to determine the outcome. The solutions that will survive will not be driven by what the health plans want or what the providers want. Instead, the solutions will be driven by what *employers* and *employees* want and by the tools that *consumers* want to put in the hands of the health plans.

Implications for the Federal Trade Commission and the Antitrust Division of the Department of Justice

What does this mean for the federal antitrust enforcement agencies? First, the agencies will probably have an important role in commenting on physician collective bargaining laws and legislation such as the Patients' Bill of Rights. Many, if not all, of the proposals for collective bargaining have included provisions that would allow some physicians to price jointly without integration. In my view, these proposals should be strongly discouraged, which is a position that the FTC and the Antitrust Division have taken already.[18] Political appeals for such legislation only serve to undercut the competitive process.

Second, the agencies will continue to play an important role in evaluating the competitive effects of mergers, joint ventures, contractual arrangements, and other changes in ownership and organizational form. These organizational changes will likely affect the way

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data record system that would permit MedSouth's physicians to access and share clinical information relating to their patients, and 2) clinical practice guidelines and performance goals. As stated in the letter, "With these systems, MedSouth believes it will be able to improve and standardize members' treatment of specific diagnoses and their fulfillment of standards of care; reduce medical errors and improve patient care outcomes; permit its members to provide their services more efficiently and to reduce the aggregate long-term cost of physician services; and demonstrate to payers, employers, and others that the integrated and coordinated delivery of services by primary care and specialist physicians can improve the quality and delivery of physician services."

[18] See the "Statement by Joel I. Klein" and the "Prepared Statement of the Federal Trade Commission" (presented by FTC Chairman Robert Pitofsky), which describe the views of the Antitrust Division and the Federal Trade Commission, respectively, regarding H.R. 1304, "The Quality Health-Care Coalition Act of 1999." The statements were made before the House Judiciary Committee in Washington, D.C., on June 22, 1999.

contracts between payors and providers are written, which will change the way health care is delivered, priced, and paid for.

The task facing the agencies will not be an easy one. It is likely that the responses of health plans and providers to consumer demands for cost containment could have procompetitive, as well as potentially anticompetitive, consequences. For example, when evaluating the buyer power of a health plan, we will need to be careful to distinguish sensible and procompetitive cost controls (which could lead to lower payments to providers) from the exercise of market power that also lower the amount that is paid to providers.[19] It is not always easy to separate the two theories.

The dynamics of competition also complicates matters by making it harder to conduct a forward-looking antitrust analysis. In this context, I like the FTC's recent initiative to take a retrospective look at consummated hospital mergers because this approach to merger analysis is premised on the belief that, in the first instance, the market is likely to be capable of sorting things out. Post-merger reviews – if they can be done well and if we have the patience to let the market try to sort things out – lessens the pressure to forecast the future, which is probably helpful in a complicated industry that needs extra understanding and flexibility during times of change.

In summary, competition is an important part of the cost containment process. It is the dynamic that has encouraged providers to find new ways to deliver high-quality, cost-effective medicine. It also is the dynamic that has encouraged payors to find ways to slow the rise in the health care costs of employers and employees. The challenge will be to protect and preserve competition without discouraging the marketplace incentives that are needed to help payors, employers, and consumers control the rise in health care costs.

[19] For a discussion of monopsony power and many of the other antitrust issues involving health plans and providers, see Thomas McCarthy and Scott Thomas, "Antitrust Issues Between Payers and Providers," prepared for the ABA-AHLA Health Care Antitrust Meetings, Washington D.C., May 17-18, 2001. (The article was reprinted in two parts in the *Antitrust Health Care Chronicle*, Vol. 16, No. 1, Spring 2002, pp. 2-12; and Vol. 16, No. 2, Summer 2002, pp. 3-13.)