American Association of
HEALTH PLANS

Federal Trade Commission and U.S. Department of Justice

Joint Hearing on Health Care and Competition Law and Policy

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Perspectives on Competition Policy and the Health Care Marketplace
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Introduction

Good morning. My name is Stephanie Kanwit, and I am General Counsel and Senior Vice President, Public Policy and Research, for the American Association of Health Plans (AAHP). AAHP is the principal national organization representing HMOs, PPOs, and other network-based health plans. Our member organizations provide health care coverage to approximately 170 million individuals nationwide. AAHP member health plans contract with large and small employers, state and local governments, as well as with public programs, including the Medicare, Medicaid, Federal Employee Health Benefits Plan (FEHBP), and State Children's Health Insurance (SCHIP) programs.

We appreciate the opportunity to participate in this discussion of the challenges and complexities associated with applying competition law and policy to health care. In my statements at the workshops that the Federal Trade Commission and Department of Justice held in September 2002, I noted that competition and collaboration are key ingredients in a health care system that puts consumers' needs first. Competition in the health care market creates incentives for health care providers to increase efficiency and reduce costs for consumers. Health plans and health care providers are working collaboratively to promote improvements in the care delivery process in a variety of ways. For example, in several markets around

the country, health plans and hospitals are pursuing initiatives to reduce medical errors and improve performance in achieving quality goals. Health plans are working with medical societies and public health departments to distribute common guidelines on how to improve care for patients with chronic health conditions such as diabetes and asthma. In addition, to help make the health care system more efficient, health plans and providers are working together to promote proper submission of claims and timely payment for services. Clearly, when hospitals, health plans, and physicians work collaboratively to solve problems in the health care system, consumers benefit.

All stakeholders in the health care system have a common interest in achieving three interrelated goals: promoting patient quality and safety; maintaining a competitive health care market that provides consumers with a broad range of choices; and keeping health care affordable for the next generation. In my testimony today, I will discuss trends that are cause for concern due to their potential implications for affordability and competition in a number of key health care markets, and I will suggest steps that the Agencies can take to restore affordability, competition, and choice in the health care system.

Disproportionate Increases in Charges

As I noted in September, consolidation in the health care market has the potential to make the health care system more efficient and thus keep health care affordable for consumers. However, published evidence has suggested that in some markets, consolidation is having unintended, negative consequences.

In site visits to 12 nationally representative communities in 2001, the Center for Studying Health Systems Change found that consolidation has given hospital systems significantly more leverage in contract negotiations – making it possible for them to gain substantially higher payments from health plans.[i] The *New York Times* has reported that as a growing number of hospitals have gained market power through consolidation, they have demanded rate increases as high as 40 to 60 percent for some services.[ii] These rate increases ultimately are passed on to employers, consumers, and governments in the form of higher health care costs. Recently, the GAO cited provider consolidation as a leading factor contributing to the 11.1% growth in premiums in the Federal Employee Health Benefit Program (FEHBP) in 2003 – a significant increase over previous years, in which premium increases averaged 5.9% annually from 1991-2002.[iii]

In the current environment, it appears that in some markets, consolidation is not working to increase efficiency and affordability in the health care system, but rather, is having the opposite effect. Throughout much of the 1990s, health plans were able to keep care affordable for consumers by contracting with high-quality providers at a negotiated payment rate. But in the past several years, in some markets, as a direct result of the market leverage that large hospital systems have gained through consolidation, many are refusing to contract at negotiated rates. Instead, they are seeking to set prices unilaterally and, in some cases, they are refusing to participate in health plan networks at all. This trend hinders health plan efforts to offer consumers products with a broad choice of providers, and it reduces the ability of health plan networks to keep health care affordable.

Extension of All-or-Nothing Contracting

In my testimony in September, I noted that in some markets, hospital systems were forcing health plans to contract with every facility affiliated with their system, even if some facilities filled no real need in the health plan's network. What we are seeing now is an extension of that trend. Dominant hospital systems in some markets have purchased freestanding facilities – such as home infusion centers, home health agencies, and ambulatory surgery centers – and are requiring all-or-nothing contracts with health plans that previously could negotiate separately with

these centers. In addition, in some regions, dominant systems have demanded contract provisions that essentially require health plans to contract with their labs and radiology facilities, even if these facilities' costs are higher than those for freestanding facilities.

This trend is reducing consumer choice and adding unnecessary costs, not only in the hospital sector but throughout the health care system. Furthermore, this all-or-nothing approach to contracting appears contrary to the intent of current competition law and policy -- specifically, Statement 9 of the 1996 Statements of Antitrust Enforcement Policy in Health Care -- which establishes rules for operating multi-provider networks.

Information-Sharing Should Promote Consumer Choice, Not Physician Cartels

At the same time that disproportionate price increases and all-or-nothing contracting are increasing health care costs and reducing consumer choice, policymakers are being encouraged -- and in some cases are establishing rules -- to allow information-sharing among physicians that inevitably will drive costs even higher. While certain types of information-sharing in the health care system benefits consumers and should be encouraged, information-sharing in other contexts ultimately hurts consumers and thus is cause for concern.

Health plans have led the way in promoting safe and effective health care by collecting and reporting information on health care quality and performance. We believe that all stakeholders in the health care system should make information about health care quality available to patients and their families, to allow them to make informed health care decisions and safe and effective choices.

We are concerned, however, that a trend toward broad publication of other types of health information – specific information about the payments made to individual health care practitioners – offers no benefit to consumers yet opens the door to cartel activity. A Business Review Letter issued by the Department of Justice in September 2002 authorized the Washington State Medical Society to collect and publish annual statistics on the average health plan payment to physicians for specific services. This information is of no use to consumers, but it makes it possible for physicians to determine the contract terms negotiated by their peers. As a result, the decision could lead to an unanticipated and anticompetitive rate-setting process in which payment information published each year establishes a higher floor, beyond which providers can seek collectively to drive up rates to the highest possible level.

The Washington State Medical Society's activities in the aftermath of this ruling demonstrate that these concerns are warranted. The medical society has established a new unit to conduct the annual survey on health plan payments to physicians and another unit that helps providers bargain with health plans to obtain higher rates. This arrangement has the appearance of creating a physician cartel – an activity that both the FTC and DOJ consistently have opposed. Likewise, in Texas, Louisiana, Minnesota, and New York, policymakers have proposed or required broad publication of payment information that has the potential to lead to collusion among providers to increase rates.

Earlier this month, the Federal Trade Commission allowed a Dayton, OH physician group to form an organization that will publish fees that health plans pay for certain physician services in the Dayton market. The organization pledged that it would not negotiate on behalf of its member physicians and that it would not publish information suggesting how individual physicians should negotiate payments. The FTC concluded that, to the extent that the venture helps inform patients, employers, and payors, and physicians better about the operation of Dayton's health care market, it is likely to promote competition. However, the FTC cautioned that the antitrust laws prohibit concerted action among competitors to set prices or to determine the quality and output levels of the products and

services available to consumers.[iv] Thus, the FTC warned the group that if it uses this fee information as the basis for collective action that unreasonably limits competition, the organization may be subject to law enforcement action.

Recommendations

We encourage the Agencies to watch these developments closely and take enforcement action where appropriate. When consolidation and broad distribution of data on provider charges have the effect of increasing costs and reducing choice for consumers, competition policy should work to achieve the following objectives:

*1) **Prevent cartel activity among physicians.*** Broad publication of information on individual health plan payments to physicians does not help consumers in their search for affordable, quality health care. Instead, it establishes an anti-competitive ratesetting process in which published information on payments creates a floor beyond which providers can seek to drive charges steadily higher. As a result, it creates an environment conducive to collusion. Therefore, we recommend that the Agencies refuse to authorize disclosure of health plans' specific physician payment rates to anyone other than the physician being paid or the individuals authorized to receive such information.

2) Ensure that the activities of multi-provider networks fall within the parameters of current antitrust policy. As dominant hospital systems enter the markets for allied health services, it is important to ensure that the competitiveness of markets for ambulatory surgery, laboratory, radiology, and home health services is not diminished. Recent actions by some hospital systems raise questions about compliance with the 1996 Statements of Antitrust Enforcement Policy in Health Care. Therefore, we encourage a renewed focus on the activities of multi-provider networks.

3) Evaluate the impact of consummated mergers. Given the press reports about how hospital consolidation is affecting health care negotiations, we believe it is prudent for the Agencies to proceed with plans to evaluate the impact of consummated mergers. Such an analysis is critical to determine whether existing mergers meet the test of benefiting consumers by promoting efficiency and affordability in health care markets rather than adding another administrative layer for negotiating purposes.

Thank you for providing the opportunity for us to participate in this hearing.

[i] Strunk, B., Ginsburg, P., & Gabel, J. (2001). Tracking health care costs: Hospital care surpasses drugs as the key cost driver. *Health Affairs*. Web Exclusive. W39-W50.

[ii] Freudenheim, M. Medical costs surge as hospitals force insurers to raise payments. *New York Times*. May 25, 2001.

[iii] U.S. General Accounting Office (December 2002). *Federal Employees' Health Plans: Premium Growth and OPM's Role in Negotiating Benefits.* Report to the U.S. Senate Committee on Governmental Affairs, Subcommittee on International Security, Proliferation, & Federal Services. GAO-03-236. Washington, D.C.

[iv] Assam, C. (2003). FTC advisory opinion OKs proposed Ohio physicians' advocacy organizations. *BNA Health Plan and Provider Report.* Vol. 9, No. 7, p. 158. Washington, D.C.