S. HRG. 109–882

EXAMINING COMPETITION IN GROUP HEALTH CARE

HEARING

BEFORE THE

COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE

ONE HUNDRED NINTH CONGRESS

SECOND SESSION

SEPTEMBER 6, 2006

Serial No. J–109–106

Printed for the use of the Committee on the Judiciary

U.S. GOVERNMENT PRINTING OFFICE
35–140 PDF WASHINGTON : 2007

For sale by the Superintendent of Documents, U.S. Government Printing Office
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WEDNESDAY, SEPTEMBER 6, 2006

UNITED STATES SENATE,
COMMITTEE ON THE JUDICIARY,
Washington, DC

The Committee met, pursuant to notice, at 11:02 a.m., in room 226, Dirksen Senate Office Building, Hon. Arlen Specter, Chairman of the Committee, presiding.

Present: Senators Coburn and Durbin.

OPENING STATEMENT OF HON. ARLEN SPECTER, A U.S. SENATOR FROM THE STATE OF PENNSYLVANIA

Chairman SPECTER. Good morning, ladies and gentlemen. The Judiciary Committee will now proceed with our hearing on Examining Competition in Group Health Care.

The concern has arisen because there has been concentration of coverage by the health insurance industry and significant issues as to what the doctors may do by way of joint action without violating the antitrust laws.

We have seen a very substantial rise in health care costs. Some contend that the absence of the ability of physicians to negotiate with group health insurers is a significant factor leading to that rise.

We have had a considerable number of requests for an analysis by the Judiciary Committee on the antitrust aspects. In 2004, I convened a hearing in Philadelphia on the issue of the balance of negotiating power. This hearing of the full Committee is being held to pursue those issues further.

Our first witness could sit on either side of the dais today. Senator Tom Coburn has brought a level of expertise to the Committee on medical issues. He is very heavily involved in many, many of the complex questions which have come before the committee, most particularly in the asbestos field.

Senator Coburn has had over 20 years of practicing medicine in Muscogee, specializing in family medicine, obstetrics, and the treatment of allergies. He has a medical degree from the University of Oklahoma. He has served three terms in the House of Representatives.

We welcome you, Senator Coburn, Dr. Coburn, Witness Coburn. The floor is yours.

STATEMENT OF HON. TOM COBURN, A U.S. SENATOR FROM THE STATE OF OKLAHOMA

Senator COBURN. Thank you, Mr. Chairman. I appreciate you having this hearing. I am going to be rather brief this morning.

First of all, I can strongly identify with the physicians who are impacted by the market as we see it today and, I think, some insight into the frustration that is out there.

I do not necessarily agree that the answer of collective bargaining or forming is the answer to our health care problems, and let me explain that. But let me, first, also say how frustrating it is as a group of physicians to be in a box in terms of what you can charge.

Over 50 percent of our practice was Medicaid and Medicare, which means the remaining 50 percent is open to negotiation. Of that, 80 percent of that is fixed price, based on the fact that the only game in town is controlled by two or three groups of insurers.

That is significant in terms of any pricing flexibility. What you see as you look at physician practices, is rising expenses and lower revenues. At the same time, we are seeing health care costs go up, so something is wrong somewhere. Is there really a market out there? I would question that there is not really a market in health care in our country.

The second point I would make, is it not just about pricing, because the implied pricing comes along with rules and guidelines from the insurance companies that add significant costs to the individual practice or group practice in terms of following the rules and regulations, the permissions, the approvals, and the time costs associated with meeting the guidelines to be able to service a patient who is represented by a certain insurance group or company.

But more generally, I think we are fixing the wrong problem. I think we are tinkering around the edges with a problem on health care in our country, and I think if we continue to do it, we are going to get more of the same. It is like a balloon; you push in somewhere and it gets a bigger overall diameter because you pushed in somewhere. I do not think we can fix that.

I think we ought to ask ourselves the question, why is it that this Nation spends 16.2 percent of its GDP on health care, and yet we are not significantly healthier than anybody else, or countries that spend significantly less?

The average of the western world is less than 10 percent. So we are spending 50 percent more than the rest of the world, and yet we are not achieving a greater level of health care than the rest of the world. Some of those are free market, some of those are government controlled, and they control costs by rationing. So, I do not believe that is the answer either.

But fixing the problem, is creating a real market for health care. We have done it in every other area of our country. Every other area that we are extremely successful in, we have allowed the market to allocate resources.

When I am talking about a market, I am talking about a transparent, consumer-driven health care market where every person who is a consumer has skin in the game, where the tax benefit, where everybody who has health insurance, it is their health insur-

ance, it is not their employer's, where they own their health insurance and where they go, fixing it.

One of the things that I have noticed, is the specific case where the Department of Justice utilizes a 30 percent rule in terms of impact of group health insurance that did not really fit. The reason it does not really fit is because most practices have a large percentage of their income already fixed through Medicare and Medicaid.

So if you look at 30 percent of the market, you automatically cut out the 50 percent that the government controls. What you are really talking about is 60 percent of any individual physician's or group practices' income is controlled if you use 30 percent. So, I think that rule is erroneous. I saw the basis for how they came up with it.

I think the other important point that we miss, even though we have this big problem in terms of balance in what we call a market today, is the fact that there really is no leverage for physicians in terms of quality.

All you have to do is go and look at who all the large insurance groups contract with. They all say "board certified," but the bad physicians are getting paid the same as the good physicians.

So we do not have a market that says we are going to reward the best and we are going to disincentivize the worst. What we have is a fixed-price oligopoly in the health insurance market today that the physicians are frustrated with because they have no pricing leverage.

So I understand and identify with it, but I do not think fixing that problem by giving them more leverage in a false market will solve our greater problem.

As you know, Mr. Chairman, I have talked a long time about the unsustainability of our health care problems within the Federal Government in terms of the demographic shifts of Medicare and what is going to happen there, and in terms of the shifts in terms of health risk, especially obesity and diabetes, where we look at 2070 and 50 percent of every dollar spent on health care by the government will be spent on diabetes alone. I mean, this is a much larger problem. So, I am going to maintain myself on the dais today to hear the testimony.

But I think the more important question we ought to be asked is, how do we convert this one out of every three dollars that really is not given as health care to covering everybody in the country and making sure we spend money on prevention, and we truly create a transparent, consumer-driven health care system where markets actually allocate the scarce resources, where markets actually reward quality and punish poor quality, where markets reward innovation and punish duplication and waste? We do not have that.

Until we get that right in our country, working around the edges by giving pricing power to physicians may solve some of the short-term frustrations, but it will lead to increased costs—there is no doubt in mind that it will—and we will not solve the underlying problem that we have.

I would just make one point on that. And I am not picking on this particular thing. I had my staff pull all of the 10(k)s of all of the major insurers. It is interesting.

I am just going to use one, United Health Group. This is their 10(k) for last year. Twenty-two percent of the dollars that they took in did not go anywhere to help anybody get well. Now, that is one out of five. The national average is one out of three.

But here is a very profitable insurance company. If you look at their 10(k), 22.5 percent of every dollar that they took in did not go to help anybody to get well. And I am not against profit. I am all for profits.

But the point is, we have this fixed system that is not truly a market, and we are taking a lot of dollars out of the market and we have 16.2 percent of our GDP that we are spending on health care, and yet a third of that is not really going to health care.

So, fixing the problem around the edges I do not believe will ultimately solve the problem, and I am grateful that you are having this hearing. I agree with a lot about what the AMA says about this, and several others, but I do not think it is a solution to the problem. I think it is another fix in a bureaucratic maze that will relieve some tension, but will not ultimately fix the problem.

With that, I will end my testimony.

Chairman SPECTER. Well, thank you, Senator Coburn.

Do you have any suggestion as to how we reward the good physicians and treat the physicians who are not good, at a lower end of the financial scale?

Senator COBURN. Yes, sir, I do. I believe a market will do that, but you have to have transparency in it. You have to have price transparency that the President has asked for in terms of hospitals. There ought to be price transparency in terms of doctors. There ought to be outcome transparency. It ought to be weighted on the mix of patients that doctors see.

Performance ought to count in health care as much or more than anywhere else that we see in our country. The problem with a lot of the stuff that CMS is doing, is the best physicians get, routinely, our toughest patients.

I will give you examples. When I have very complicated obstetrical patients, the worst and the toughest I send to the one I trust the most. Well, if you measure his outcomes, his outcomes are going to be skewed because he has got all the tough patients. So how we measure outcomes becomes important.

But if you have transparency in a market where you know price and quality, and consumers get to choose rather than have an advocate who controls for them on the basis of profitability, not on the basis of quality—and as I said earlier, most physicians who are signed up with these insurance companies are board certified, but they are not all the best and they are not all the worst.

But we have a system that rewards them each the same. We ought to have a transparent system that says the best physicians are going to make more and the worst physicians are either going to get out or get better training.

Chairman SPECTER. Senator Coburn, in the written testimony the AMA urges Congress to require health insurers to publicly report additional enrollment and financial data. Do you think such reporting requirements will be helpful?

Senator COBURN. Well, I am not sure that it would be helpful or hurtful, because I do not think it solves the market problem. You

have got an agent for patients and you have got an intermediary between the patient and the provider. Their goal is not health care, it is profit.

I believe, whether they report that or not, what it ought to come down to is, what are the outcomes of the patients that are under their insurance? Do they fare better than under another insurance company?

In other words, we ought to look at outcomes and price, not enrollment. We ought to see what the outcomes are. We do that in every other area except health care and education in this country.

We are failing in education in K-12 in this country because we do not allocate dollars based on outcome and quality. We allocate dollars based on people. That is what we are trying to do in health care. If we change it, the innovation will be unbelievable, what will be happening with this excess amount of our GDP. We will markedly improve health care and we will markedly cut the cost.

Chairman SPECTER. Thank you very much, Senator Coburn. There are quite a number of other items that you and I could discuss, but we have some time constraints. After we scheduled this hearing, the Majority Leader announced a vote at 12:00. So, we are going to move to our second panel.

Senator COBURN. Thank you.

Chairman SPECTER. I would invite you to join us in your customary seat on the dais.

We turn, first, to Deputy Assistant Attorney General Bruce McDonald, who has a portfolio which includes regulated industries. He was previously at Baker Botts, where he practiced in the Antitrust Group, and before that he had antitrust experience with Jones Day. He has a bachelor's degree and a law degree with honors from the University of Texas.

Thank you for joining us, Mr. McDonald. We look forward to your testimony.

We have the clock set at 5 minutes, which is our customary time. We are going to have to stick very closely to the time limits because we are going to have to conclude this hearing shortly after 12:00 noon.

STATEMENT OF J. BRUCE MCDONALD, DEPUTY ASSISTANT ATTORNEY GENERAL, ANTITRUST DIVISION, DEPARTMENT OF JUSTICE, WASHINGTON, DC

Mr. MCDONALD. Mr. Chairman, Senator Coburn, thank you for the invitation to testify.

Every American knows the importance of affordable health care. For the DOJ Antitrust Division, that means working to ensure that health care markets are able to respond to consumer demand without interference from anticompetitive restraints. We use both enforcement actions and competition advocacy to protect and promote competition in health care markets.

Most of us rely on private health insurance to defray the cost of health care, and most of us are members of a group health plan. The group health care plan model involves transactions among several parties.

Individuals and families receive health care coverage through their employment or membership in an association. The employer

or association contracts with a group health plan, an insurer, to provide coverage for the members of the group.

Physicians, pharmacists, nurses, hospitals, equipment manufacturers, and other health care providers supply services and products to the insureds and receive payment from the insurer.

By joining together larger numbers of potential patients, group health plans obtain services and products on behalf of the subscribers at lower cost. Participating health care providers offering good quality and competitive rates are able to increase the number of patients they serve.

At any point in these arrangements, an anti- competitive restraint can interfere with competitive access or supply, ultimately harming consumers. If competing providers were to conspire to charge artificially high prices, for example, health plans could be forced to raise premiums or curtail service, restricting patient access to affordable health care.

Similarly, if competing health plans were to conspire to pay artificially low prices or engage in exclusionary conduct designed to obtain or maintain market power, then providers could be forced to curtail service or go out of business, restricting patient access to affordable health care.

The Department has brought enforcement actions to enjoin unlawful arrangements by, for example, insurance plans that impose anticompetitive agreements on providers, or providers that form group boycotts to obtain higher fees.

In addition to looking for anticompetitive conduct, the Department examines proposed mergers among hospitals, health plans, or provider groups that could reduce competition, restrict access and consumer choice, and dampen healthy incentives to provide quality health care at affordable prices.

The Department has brought actions to challenge mergers that lessen competition in health care markets, including mergers between insurance companies, and between medical equipment manufacturers.

In a competition advocacy role, the Department provides technical assistance advice to State regulators on how to avoid regulations that undercut competitive markets.

In 2003, the DOJ and FTC held lengthy hearings on competition in health care, after which we issued a report describing our findings. Some of my fellow panelists testified at those hearings. The report's recommendations reflect the fundamental antitrust principal that consumer welfare is best served by the operation of free and competitive markets.

Mr. Chairman, the Antitrust Division fully recognizes the critical important of a competitive health care marketplace to all Americans. We are committed to preserving competition in this marketplace through appropriate antitrust enforcement, and we will continue to monitor these markets closely.

Thank you for the opportunity to testify. I am happy to answer any questions.

[The prepared statement of Mr. McDonald appears as a submission for the record.]

Chairman SPECTER. Thank you very much, Mr. McDonald.

Our next witness is Mr. David Wales, Deputy Director of the Federal Trade Commission's Bureau of Competition. Previously, he was a partner of the Antitrust Group at Kedwalter, Wickersham & Taft. He also served as counsel to the Assistant Attorney General in the Antitrust Division of the Justice Department. He has an undergraduate degree from Penn State and a law degree from Syracuse.

Thank you for coming in today, Mr. Wales. The floor is yours.

STATEMENT OF DAVID P. WALES, DEPUTY DIRECTOR, BUREAU OF COMPETITION, FEDERAL TRADE COMMISSION, WASHINGTON, DC

Mr. WALES. Good morning, Mr. Chairman and Dr. Coburn. I appreciate the opportunity to appear today to discuss some of the Commission's activities to promote competition in health care markets.

Let me first start by saying that my oral presentation responses today are my own and do not necessarily reflect the views of the Commission or of any Commissioner.

The FTC has long been actively involved in health care markets and health care continues to be a high priority for the Commission. The Agency's fundamental goal has not changed: to ensure that health care markets operate competitively.

As in the past, the Agency will bring enforcement actions where necessary to stop activities that harm consumers by unreasonably restricting competition. At the same time, the FTC is not solely a vigilant cop on the beat out to protect consumers from anti-competitive conduct.

The Agency works to promote competition through a variety of other actions as well, including providing guidance to market participants to help them comply with the law, undertaking and publishing studies, public hearings and reports, and advising State and Federal policymakers on competition issues in health care.

Indeed, education explaining antitrust policy to the industry and the public, is a key part of our mission. There is a good deal of misapprehension and misinformation about the application of the antitrust laws to the health care marketplace and the FTC activities and policies in this area.

The Agency works hard to keep the lines of communication open and our guidance up to date as markets evolve, and to provide additional guidance as new market structures and new forms of competition develop.

As part of its law enforcement role for the past 25 years, the Commission has challenged naked price fixing agreements and coercive boycotts by physicians in their dealings with health plans.

These arrangements largely consist of otherwise competing physicians jointly setting their prices and collectively agreeing to withhold their services if health care payors do not meet their fee demands.

Such conduct is considered to be, per se, unlawful because it harms competition and consumers. Indeed, the anti-competitive effect from this conduct is not simply felt by health plans who are forced to pay more to the physicians. It extends to consumers, employers, and governments at the Federal, State, and local levels.

The effects include higher prices for health insurance coverage, increased out-of-pocket expenses such as co-payments, reduced benefits, fewer choices, and even loss of coverage.

Not all joint conduct by physicians, however, is improper. Physician network joint ventures can yield impressive efficiencies. Thus, the FTC committed long ago, using a balancing test called the "Rule of Reason" to evaluate those physician network joint ventures that involved significant potential for creating efficiencies through integration.

Physician joint ventures involving price agreements can avoid summary condemnation and merit the balancing analysis if: 1) the physician's integration is likely to produce significant efficiencies that benefit consumers; and 2) any price agreements are reasonably necessary to realize those efficiencies.

In this context, it is important to emphasize that collective setting of prices in negotiation with health plans by physicians does not assure quality health care, and there is no inherent inconsistency between vigorous competition and the delivery of high-quality health care services.

Theory and practice confirm that just the opposite is true. When vigorous competition occurs, consumer welfare is increased in health care, as in other sectors of the economy.

As noted above, however, it is also important to remember that much joint conduct by physicians can be pro-competitive, and that neither the antitrust laws nor the enforcement agency is treated as an antitrust violation.

As pressures to control health care costs continue and assure quality continues, there has been increasing effort in encouraging efforts to achieve the efficiencies that can come through cooperation and collaboration.

Practically every week FTC staff hear about new forms of collaborative arrangements in the health care field involving various combinations of providers, insurers, and other purchasers.

Although these cooperative efforts often involve factually novel arrangements, antitrust analysis is sufficiently flexible to distinguish innovative, pro-competitive market responses from collective efforts to resist competition.

The FTC supports initiatives to enhance quality of care, reduce or control escalating health care costs, and ensure the free flow of information in health care markets because such initiatives benefit consumers.

The Commission has no preexisting preference for any particular model for the financing and delivery of health care. Such matters are best left to the marketplace. The FTC's role is important, but limited to protecting the market from anti-competitive conduct that prevents it from responding freely to the demands of consumers.

The dynamics of evolving health care markets continue to pose challenges for market participants. The FTC is committed to working with physicians and other providers to give them guidance to avoid antitrust pitfalls as they respond to market challenges.

At the same time, collective action by health care providers to obstruct new models for providing or paying for care, or to interfere with cost-conscious purchasing remains a significant threat to con-

sumers and the Commission will continue to protect consumers from such conduct. Thank you.

[The prepared statement of Mr. Wales appears as a submission for the record.]

Chairman SPECTER. Thank you very much, Mr. Wales.

Our next witness is Dr. Mark Piasio, president of the Pennsylvania Medical Society. He practices in DuBois, a relatively small community, and is chief of the Department of Surgery at the DuBois Regional Medical Center.

He has his bachelor's degree from Johns Hopkins University, a master's in Psychology, and M.D. from Georgetown University.

We appreciate your coming down today, Dr. Piasio, and we look forward to your testimony.

STATEMENT OF MARK A. PIASIO, PRESIDENT, PENNSYLVANIA MEDICAL SOCIETY, HARRISBURG, PENNSYLVANIA

Dr. PIASIO. Thank you, and good morning, Mr. Chairman and members of the committee.

My name is Mark Piasio. I am an orthopedic surgeon practicing in Dubois, Pennsylvania, and president of the Pennsylvania Medical Society.

First, let me thank you for allowing me to speak with you this morning to examine competition in group health care. I would like to make it clear that our testimony is not intended as a corporate or personal attack on any of the market participants and the people who work for them; each of them is doing what they think is best. However, each is doing what comes naturally in failed markets.

This, we believe, is the fundamental cause of a host of problems and calls for extensive public policy analysis and response.

The lack of competition among health insurers and health delivery markets throughout the country and in Pennsylvania, as well as the consolidation of health insurers across the Nation, raises serious concerns for provision of quality patient care.

As patient advocates, physicians are often undermined by market-dominant insurers and prevented from providing necessary care through "take-it-or-leave-it" contracts and other insurer-imposed cost-cutting mechanisms.

These dysfunctional markets have produced annual double-digit health insurance premium increases, physician fee schedules that are unilaterally imposed, and have provided stagnant or declining compensation and substantial profit levels for health insurers.

In short, market consolidation is also detrimental to consumers from a financial perspective. While many large Pennsylvania insurers are posting huge profits and surplus reserves, premiums continue to skyrocket. Pennsylvania has some of the highest premiums in the Nation and patient cost sharing increases.

Physician payment, particularly in the Philadelphia market, continues to lag behind other geographic markets. For example, evaluation & management services, in some cases, are paying at 65 percent of the comparable Medicare rate.

In the meantime, operating costs increased. From 2000 to 2004, Pennsylvania health insurers increased premiums 40 percent per

enrollee, nearly double the U.S. average, while insurers' surplus reserves rose from $5 billion to $6.8 billion.

Total annual profits of Pennsylvania health insurers increased from $468 million in 2000 to $621 million in 2004. Overhead and profit percentages of Pennsylvania health insurers increased, despite the fact that much of the revenue increase was pure price level change.

One of the classic hallmarks of a firm with monopoly power is the erosion of administrative efficiency. There is no evidence that larger health insurers are more efficient. To the contrary, published studies show that health insurers exhaust their economies of scale at 100,000 to 150,000 enrollees. Insurers with 1, 2, 4, or 5 million enrollees are not any more efficient and may in fact be more inefficient than smaller ones.

So why are these dysfunctional markets not the subject of an antitrust investigation? The Sherman Act has two provisions that would appear to apply: prohibitions of 1) monopolization; and 2) contracts, combinations, and conspiracies in restraint of trade.

To prove monopolization or monopsonization, it is necessary to show that a firm has a dominant market share and has engaged in prohibited conduct. The dominant share test is met here.

The question is whether there is prohibited conduct. Conduct that might fall into this category includes: monopoly rents, diseconomies of scale, predatory pricing, product tie-ins, various contract provisions, including the combination of all products and most favored payor terms in the 75 percent rule.

Contracts, combinations and conspiracies in restraint of trade are evaluated under per se and Rule of Reason standards. There are four substantial Blue Cross firms that operate in Pennsylvania. Only Independence offers products in the Philadelphia region.

We understand that this is due to a Division of Markets Agreement and a non-competition agreement at the national level. If this is the case, the full ramifications of the agreement bear investigating.

There are, perhaps, reasonable arguments that the way southeast Pennsylvania markets are organized and operate does not violate antitrust law. We ask whether, as a matter of public policy, good medical care and sound economics, such organizations' operation is a public good. If the conclusion is that it is not, then changes in the antitrust law that restore competitive balance are warranted.

The AMA each year conducts a study looking at the competitive markets in the United States and health care. The Herfindahl-Hirschman Index for the national geographic markets is evaluated and 1,800 is considered "highly concentrated". The Philadelphia MSA area is approaching 6,000, four times the HHI indicator of little competition.

Entry into health care insurance markets is not easy. If it were easy, much more competition would exist. In large markets such as Philadelphia, entry is difficult even for larger players such as United.

As I see my time running short, what we are going to ask at this point in time is, there are several options that one can use to address failed markets.

We feel, in Pennsylvania, our markets are failing. Profits are increasing and compensation to physicians and hospitals is declining, who are bearing the full brunt of the cost drivers that are occurring in our health care marketplace.

We are asking, since health care is an extremely difficult commodity to measure with respect to a competitive market and countervailing power theories are debatable, we are asking the Department of Justice to look a little bit closer at the markets in Pennsylvania at least, and probably nationally as well, to be sure that competition is providing for good patient service and affordable health care for our businesses. Thank you.

[The prepared statement of Dr. Piasio appears as a submission for the record.]

Chairman SPECTER. Thank you very much, Dr. Piasio.

We now turn to Dr. Edward Langston, a family practitioner in LaFayette, Indiana. He serves on the AMA's Board of Trustees and will chair the board in 2007 and in 2008.

He has a medical degree from Indiana University, and has bachelor's degree in Pharmacy from Perdue. As a pharmacist, he also serves as Assistant Professor at Perdue's School of Pharmacy.

Thank you for being with us today, Dr. Langston. We look forward to your testimony.

STATEMENT OF EDWARD L. LANGSTON, CHAIR-ELECT, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION, CHICAGO, ILLINOIS

Dr. LANGSTON. Well, thank you very much, Mr. Chairman, and other members of the Senate Judiciary Committee.

My name is Edward Langston. I am a member of the Board of Trustees of the American Medical Association, and I do practice family and geriatric medicine in LaFayette, Indiana.

I want to thank you for inviting me to testify today, and for holding a hearing on this important subject, competition in group health care.

The AMA has been cautioning about long-term negative consequences of aggressive consolidation of health insurers for quite some time. We have watched with growing concern as large health plans pursue aggressive consolidation and we fear that this rapid consolidation will lead to a health care system dominated by a few publicly traded companies that operate in the interest of shareholders rather than patients.

The AMA's competition study suggests that our worst fears are being realized. Competition has been significantly undermined in the majority of markets across the country.

AMA's study is the largest and most comprehensive study of its kind. It has analyzed 294 metropolitan health insurance markets against an index used by Federal regulators for measuring market concentration. According to the Federal index, markets that are highly concentrated have a few competing health insurers.

I would like to highlight a few of those numbers to illustrate our concern. Most notably, the AMA competition study found that in the combined HMO-PPO markets, 95 percent of the metropolitan areas have few competing health insurers. For example, in 78 per-

cent of the markets, a single PPO has a market share of 50 percent or greater.

This alarming reduction in competition is extremely troubling, not only because competition does drive innovation and efficiency in the health care system, but because it does not appear to be benefitting patients. Health insurers are posting high profit margins, yet patient health insurance premiums continue to rise without a corresponding expansion of benefits.

In addition to the compelling results of our study, many health care systems across the country exhibit characteristic, typical, uncompetitive markets and barriers to entry for new health insurance carriers: the ability of large, entrenched health insurers to raise premiums without losing market share and the power of dominant health insurers to coerce physicians into accepting unreasonable and unjust contracts.

We believe there are significant, immediate steps Congress can take to inform the debate about excessive health insurance market power and its effects on cost and patient care. For instance, we believe that current market distortions warrant Congress directing the Department of Justice to exercise its investigation power to determine whether plans are, in fact, engaging in anti-competitive behavior to the detriment of consumers—our patients, your constituents.

To gauge the severity of the problem, there should be public reporting of health insurer enrollment numbers by county, by MSA, and by product line. There should be standardized reporting of medical loss ratios for nonprofit, mutual, and for-profit insurers by State and product line. Health insurers should be required to report their financial information, including total revenue, premium revenue, profit, and administrative expenses.

Now, all of this information is critical in assessing efficiencies and determining how much of the premium dollar is going toward actual patient care.

It is time to address the serious public policy issues raised by unfettered consolidation of health insurance markets. The AMA study demonstrates the competition has been undermined in markets across the country.

This has real, lasting consequences for the delivery of health care and it is time to halt the march toward a marketplace controlled by a few health insurance conglomerates. It is time to encourage meaningful competition that will truly benefit America's patients. Thank you very much, Mr. Chairman, for this opportunity.

[The prepared statement of Dr. Langston appears as a submission for the record.]

Chairman SPECTER. Thank you very much, Dr. Langston.

Our next witness is Ms. Stephanie Kanwit, Special Counsel to America's Health Insurance Plans, a national association representing more than 1,300 member companies which provide a variety of health care insurance. She was formerly a partner at Epstein Becker & Breen, and spent 6 years as head of Health Litigation for Aetna. She is a graduate of the Columbia University Law School.

We appreciate your being here, Ms. Kanwit, and the floor is yours.

STATEMENT OF STEPHANIE W. KANWIT, SPECIAL COUNSEL, AMERICA'S HEALTH INSURANCE PLANS, WASHINGTON, DC

Ms. KANWIT. Thank you so much. Good morning, Chairman Specter and other members of the committee.

America's Health Insurance Plans' testimony this morning focuses on two main topics. First, the fact that vigorous competition does exist in the health care industry, including how that competition has spurred the introduction of new products that benefit consumers, and, second, on the issue that Senator Coburn addressed, the issue of increasing quality and transparency, how we are working with practitioner and employer groups to maintain a competitive marketplace.

Health insurance plans operate in one of the most highly competitive industries in this country. The Department of Justice and the Federal Trade Commission, in their recent landmark report, explored the issue of whether payors, such as health insurance plans, possess monopsony, or buyer side power, in the U.S. health care market. The resounding conclusion was that they do not, nor do they possess monopoly power.

In fact, employer groups testified repeatedly at those hearings that health insurance markets in most areas of the country enjoy robust competition, with multiple insurers offering multiple product options to employers on behalf of their employees.

Such vigorous competition is critical for all stakeholders, including health insurance plans and health care practitioners, to increase efficiency and improve patient care and ultimately reduce costs for consumers.

Consumers benefit from that competition. They have wide choices in the U.S. health care markets. I cite some of those choices in my testimony, including how every major metropolitan area in the U.S. has multiple competing health care plans purchasing physicians' services, and each of those plans offering multiple products to consumers and employers.

In addition, new types of products, such as consumer- directed health plans, which many of you know are HSAs, continue to be introduced into the marketplace, affording consumers additional choices to the HMO, PPO, and indemnity options that we are all familiar with, thus demonstrating the vitality of the marketplace.

Senator Coburn spoke this morning of the need to promote greater transparency in health care. We support that goal totally. Our members are currently working with a 125-member coalition.

This coalition consists of more than 35 physician groups, just for one, the American Medical Association, as well as the American Board of Internal Medicine, the American College of Cardiology, the American Academy of Pediatrics, as well as other provider groups like the American Hospital Association, and government agencies like CMS, the Centers for Medicare and Medicaid Services.

What are we doing with this group? We are working to develop uniform processes for performance measurement and reporting. Two goals. First, to allow patients and purchasers to evaluate the cost, quality, and efficiency of health care. Second, to enable practitioners to determine how their performance compares with others in similar specialties.

Senator Coburn spoke of the need to improve outcome measurement. Exactly right. Toward that end, the AQA, this coalition, has endorsed a set of clinical physician-level performance measures that are already being incorporated in provider contracts.

Over the next few months, the AQA is working toward identifying a set of efficiency measures. We are also receiving report from CMS, as well as the Agency for Healthcare Research and Quality, and we are carrying out pilot programs in six areas of the country.

Secretary of Health and Human Services Michael Leavitt has applauded our efforts on these pilots and he has expressed interest in creating more throughout the country. The results of this pilot program are going to lead to a national framework for measurement and reporting of physician performance.

Finally, I want to note that health insurance plans are designing products to carry out one of the key recommendations of the FTC/DOJ health care report, and that is to promote incentives for providers to deliver high-quality and efficient care.

We are working with stakeholders across the health care community, particularly health care professionals who work on the front lines, to develop and improve incentive programs, as well as an overall strategy with accountability for the quality of care delivered to providers.

Thank you so much for this opportunity to testify.

[The prepared statement of Ms. Kanwit appears as a submission for the record.]

Chairman SPECTER. Thank you very much, Ms. Kanwit.

Our final witness is Professor David Hyman. He is a professor at the University of Illinois College of Law, School of Medicine. He previously served as Special Counsel at the FTC. Before teaching at Illinois, he was a professor at the University of Maryland Law School. He has a medical degree and law degree from the University of Chicago.

We appreciate your being here, Professor Hyman, and we look forward to your testimony.

STATEMENT OF DAVID A. HYMAN, PROFESSOR OF LAW AND MEDICINE, GALOWICH-HUIZENGA FACULTY SCHOLAR, COLLEGE OF LAW, UNIVERSITY OF ILLINOIS AT URBANA-CHAMPAIGN CHAMPAIGN, ILLINOIS

Mr. HYMAN. Thank you, Mr. Chairman. Thank you for appearing, Ranking Member Durbin, from my home State of Illinois.

Let me start just by echoing Senator Coburn's remarks at the outset about the importance of relying on markets and health care, and strengthening and improving them. Let me just flag a volume that has been mentioned several times over the course of this morning, the joint report of the Federal Trade Commission and Department of Justice, Improving Health Care: A Dose of Competition, issued in 2004, which comprehensively surveys the performance, both good and bad, of the financing and delivery sides of the health care market, and offers a series of recommendations for ways of strengthening and improving the performance of the market.

My academic interests focus on the financing and regulation of health care, and I have written a number of articles on that sub-

ject, including one on the specific issue that we are going to be talking about this morning, monopsony power in health care financing markets. There is a 2004 Health Affairs article on that subject that I would be happy to provide.

Now, obviously the backdrop for this hearing is the complaints of health care providers about disparities in bargaining power in dealing with insurance companies. The fact that the complaints come from health care providers should give us pause for two distinct reasons.

First, disparities in bargaining power are simply not the same thing as monopsony, or buyer side monopoly. Indeed, equal bargaining power is very much the exception in most markets. But as long as those markets are reasonably competitive, you do not need equal bargaining power to get efficient outcomes.

I can give plenty of examples, including car rental and purchase, retail consumer goods and air travel, where there are huge disparities in bargaining power, but reasonably efficient outcomes.

Second, is the context of this is that the sellers of a service, any service or good, have a natural tendency to conflate what is good with them with what is good for society. But the interests of consumers and patients do not map perfectly onto the interests of health care providers, so we should generally discount complaints from providers of services.

We should pay close attention to complaints from consumers of services, but discount complaints from providers of services, consistent with the maxim that the purpose of antitrust is to protect competition, not competitors.

Now, we have heard a certain amount this morning about the emergency of national insurers and the significance of high Herfindahl-Hirschman indices in individual States and metropolitan areas.

On the emergence of national insurers, this actually marks a deconcentration, not an increased concentration, in the markets in many States as we have gotten new entrants from national insurers.

Second, the raw numbers of people covered by national insurers is not really important. What is important, is their percentage in any given market.

Now, when you analyze market power, if you do not have direct evidence of anti-competitive effects, you usually start by trying to identify a relevant product and geographic market and calculate the shares of market participants and concentration ratios.

So, let us talk about the HHI in the minute and 43 seconds that I have remaining. HHI is a mechanical calculation which you do after you have determined the relevant product and geographic market.

HHIs determined in the absence of a sensible market are essentially meaningless. I closed my written statement with the example that I am the only person at the University of Illinois College of Law that does empirical research on medical malpractice.

That means the HHI for researchers in medical malpractice there is 10,000, a completely monopolized market, but I can assure you, I do not have any monopoly power whatsoever in dealing with

my dean on any subject. So, you basically have to get the market right in order to come up with a sensible HHI. That is part one.

Part two is, even if you have defined the market properly, an HHI is simply a screening tool which creates both false positives and false negatives for the kinds of things we are interested in.

So all it does, in the context of merger analysis which is where it was developed, is mark areas where our index of suspicion should be higher or lower for whether there are monopoly or monopsony problems.

It does not define them, it does not identify them. All it does is say you should not worry about these sorts of transactions, and these other transactions you might want to look further in order to determine whether there are monopoly, monopsony, and market power problems.

The final point that I want to make, is the importance of factoring in false positives and false negatives in an analysis of monopoly and monopsony power. It is not a trivial proposition to determine when there is, and the more aggressively we look for it, the fewer false negatives we end up with. But the more false positives we have, the cost of false positives are borne by consumers quite directly.

Thank you very much.

[The prepared statement of Mr. Hyman appears as a submission for the record.]

Chairman SPECTER. Thank you, Professor Hyman.

Senator Durbin, would you care to make an opening statement?

STATEMENT OF HON. RICHARD J. DURBIN, A U.S. SENATOR FROM THE STATE OF ILLINOIS

Senator DURBIN. Thanks, Mr. Chairman. I will make it very brief. I thank this panel for gathering today, and I thank you for calling this hearing.

I listened to the testimony that was given, and as I was listening to it I was thinking about how lucky we are on this side of your microphones, because we are Federal employees. We have a Federal Employees Health Benefit Program and we have an agency that sits down with these insurers and bargains with them before they can have a chance to sell to 8 million Federal employees and their businesses. It turns out that they are pretty good negotiators.

In 2005, the Federal Employees Health Benefit Program offered 249 plans. In 2006, it was up to 278 plans, exactly the opposite of the experience you are describing; where many of your health care providers are finding fewer and fewer insurers, we are finding more and more who want to do business with us.

The Office of Personnel Management has the responsibility to negotiate with hundreds of insurance companies on our behalf. Tom Bernatavitz, vice president of Aetna Insurance, recently said pretty tough negotiators are at OPM.

He said that OPM experts were "much tougher" in negotiations with insurance companies, which has more than 250,000 Federal enrollees. Bernatavitz says, "In general, we wanted some more benefit enhancements at some additional premium costs that they really wouldn't allow....There was definitely a lot of rigor about keeping our premiums down."

So, it turns out that we have a pretty good model here, and some of us believe that it is a model that ought to be expanded. It ought to be expanded so that small businesses all across America can have the same basic common market of private insurance companies. There are four or five States in this country where there is one dominant health insurance company that sells to over 70 percent of the market.

I do not want to dwell on this, Mr. Chairman, other than to suggest to Dr. Coburn and my colleague, Senator Specter, that if you take a look at what we are doing effectively here to represent Federal employees and their families, we do not have the problems that they are just describing in the open market outside. I hope that you all will take a look at Senator Lincoln's bill that I am cosponsoring.

Thank you.

Chairman SPECTER. Thank you, Senator Durbin.

We now will turn to the panelists for a five-minute round of questioning.

Ms. Kanwit, I was disappointed that we asked five health insurers to testify today and none would agree to do so: United, Aetna, Independence Blue Cross, Highmark, and Wellpoint.

So let me ask you, what is wrong with an antitrust exemption for doctors to be able to negotiate with these companies which have had such an enormous number of mergers, some 400 in the last 12 years?

Ms. KANWIT. Well, a couple of points, Senator Specter. The idea of physician collective bargaining has been condemned by the Federal Trade Commission and the Department of Justice over the course of the last 10 or 15 years for a very good reason, the reason being that allowing physician collective bargaining or an exemption from the antitrust law allowing them as horizontal competitors to bargain collectively with health plans, without clinical or financial integration, will inevitably raise prices while doing absolutely nothing to increase the quality of health care that consumers enjoy.

Congress, in the last 10 years, has looked at numerous bills on collective bargaining and rejected every one of them, as, by the way, have many, many States. There are just a handful of States that allow physicians, under very strict rules, to collectively bargain. That is because it is a bad idea.

Chairman SPECTER. Let me turn to Mr. McDonald. We only have a few minutes, so we are going to have to be brief on the responses.

Only two challenges over 400 mergers in the past 12 years. Is there not some suggestion of not quite enough scrutiny, Mr. McDonald?

Mr. MCDONALD. Mr. Chairman, antitrust analysis is very fact-specific. We have investigated a large number of mergers and found reason to challenge the ones that you have mentioned.

Chairman SPECTER. You have investigated all 400?

Mr. MCDONALD. Likely not, Mr. Chairman. But we have investigated all those that had any significant possibility of presenting an anticompetitive problem.

Chairman SPECTER. Dr. Piasio, the Daily and Sunday Review from Towanda, Pennsylvania has noted the Pennsylvania Medical Society recently cautioned against the impending merger, as they

put it, of two of Pennsylvania's largest health insurers, Independence Blue Cross and Highmark, two companies who have an enormous share of the Pennsylvania market. Would you be apprehensive or opposed to such a merger?

Dr. PIASIO. Well, certainly we have not seen any information yet as to what efficiencies that merger is going to bring. Contrary to some of the things you have heard earlier though, there may be markets in the country that are working competitively. Pennsylvania certainly is not. We enjoy the highest premiums, the lowest reimbursement, and the highest profit margins and reserves of most insurers in the country.

I think if you look at the contract provisions under the Rule of Reason, we are meeting those requirements of at least questionable behavior on the part of our large players.

But what we would much prefer to see in Pennsylvania are the four Blues competing in each other's market as opposed to having one Blue now. We do not have national players in Pennsylvania. Aetna and United represent extremely minor players in our entire State, and even less so.

So from our perspective, until we see some evidence that a merger of that nature is going to bring some level of consumer benefit as well as provider and quality benefits, we are looking at it extremely cautiously. But as they are operating now, we do not particularly see where there is going to be any efficiency that the market is going to enjoy.

Chairman SPECTER. Professor Hyman, do you not think that Dr. Piasio has a point, that all of these mergers have to have an impact of lessening competition?

Mr. HYMAN. The question is, who is merging, and are they combining market shares in the same market or are they, as the rise of national firms would suggest, buying shares in different markets? You have to look at them individually. I do not know enough about the Pennsylvania market to have an informed opinion on that subject.

Chairman SPECTER. Mr. Wales, in your written testimony you said that "the antitrust laws allow physicians to act jointly, including agreeing on fees, so long as their efforts produce significant efficiencies and price agreement is reasonably necessary to achieve those efficiencies."

Absent that standard, physicians cannot act jointly on agreeing on fees. Is that not an extraordinarily difficult standard for physicians to try to achieve, putting themselves at risk of violating the antitrust laws?

Mr. WALES. Mr. Chairman, what we have found is that when you do not have collective bargaining that is associated with pro-competitive benefits and integration, that you do find clear consumer harm, whether it be increased prices for health care, higher out of pocket expenses for consumers, reduced benefits and choices. So I guess we do find that, without that integration, that there are clear harms in place.

What we have tried to do is be very clear with doctors as to what types of integrative efficiencies we think would be permissible, and have done that through not only guidance with our colleagues at Department of Justice in statements, but also in advisory opinions

and other fora, including our web site and enforcement actions, where we try to explain where that line is that we do not think doctors should cross.

Chairman SPECTER. Well, thank you, Mr. Wales. The red light was on during your testimony and I will conclude, and yield to the Democratic side, as our alternation provides.

Senator Durbin?

Senator DURBIN. Thank you, Mr. Chairman.

So Ms. Kanwit, let me make sure I understand here. By your answer to Senator Spector's question about collective bargaining as an antitrust exemption for doctors, I take it that you are opposed to exemptions for the antitrust law.

Ms. KANWIT. We are, Senator.

Senator DURBIN. How about the McCarran-Ferguson Act which applies to your industry which gives you an exemption so that you can share pricing information which some say may lead to higher prices and collusion by your own industry? That has been on the books a long time.

Ms. KANWIT. It has.

Senator DURBIN. Do you support that exemption?

Ms. KANWIT. Senator, the McCarran-Ferguson Act has been on the books for about 60 years and it has worked very well. But it is not an antitrust exemption. It does allow insurers to gather, collectively, actuarial information in the interest of consumers. But it specifically does not allow boycotts or collusive pricing, so it is not exactly an analogy to physician collective bargaining.

Senator DURBIN. But it clearly is an exemption for your industry that most businesses do not enjoy. If all of the automobile manufacturers had the ability to do what the insurance industry has under McCarran-Ferguson, some would suggest that it would not be in the best interest of consumers. Do you understand that?

Ms. KANWIT. It is, but it is a very, very narrow exemption for rate setting, actuarial rate setting. But the real purpose of McCarran-Ferguson, as everyone knows, was to give the States authority over the business of insurance, an issue that has been litigated over and over for 60 years. This was a minor point on it, but it is an extraordinarily narrow exemption.

Senator DURBIN. But it is an exemption.

Ms. KANWIT. It is.

Senator DURBIN. Thank you.

Dr. Piasio, so if you were allowed to collectively bargain, which many doctors have been seeking for a long time so they have some power to bargain as the Federal Government does for 8 million employees, what is the protection for consumers, I mean, in terms of whether or not individual doctors and practitioners are going to charge reasonable rates for their services?

Dr. PIASIO. I think, first and foremost, we need to distinguish, in terms of collective bargaining, it is allowed if you are going to be at risk, such as taking risk as an insurer, but not in a fee-for-service system.

I am not sure there are good studies out there that show it does not work. I think when you look at what that does, it kind of goes into that countervailing power theory of how to balance a market

competitively that cannot be done economically or through political processes.

At least that seems to work in other markets. If you look at the western part of Pennsylvania where there are some competitive insurers, we enjoy slightly lower premiums and slightly higher reimbursement. At this point, I am not here to say that collective bargaining is the solution. It is just one of the potential solutions in trying to bring back competition to a market that does not seem to exist, at least in my State.

Whether it will work or not, I leave it up to the gentleman to the right to study and get back to us as to whether they can make it work. Certainly when you are looking at trying to put in efficiencies such as electronic records and quality and value metrics, which we have not even started discussing yet as to how you can do that, it is difficult to integrate, but you can do it unless you are at risk. That is just something that we are not experienced enough to do.

Senator DURBIN. Professor Hyman, thank you from being here from Illinois. But let me ask you this question. You seem to be skeptical about whether or not there is a concentration of power here to the disadvantage of these providers and consumers.

But most people you speak to would agree with the following statement: "It seems like every year the premium costs for health insurance goes up and the coverage goes down. I have to pay more out of pocket for less coverage each year." So, this is a consumer's point of view in this picture.

Then when you step back and you look at it in a global context, you say the end result here, the health care result that comes out of this, is not as good as we might expect. There are countries that spend a lot less per capita on health care and get a lot better results, in terms of life expectancy, for example.

Do you quarrel with those conclusions?

Mr. HYMAN. Well, I certainly would quarrel with drawing a causative line from one to the other. I think the quality issue, which I touch on very briefly at the end of my written statement, is a very important issue.

I do not see, even if we by fiat de-concentrated the insurance market, we would see the kinds of quality improvements that we would want to buy and that we, in fact, are already paying for. I think that is something we need to go after directly.

It is certainly clear that the costs of health care have gone up, and go up every year. But drawing a causative line between that market concentration, actually, there are a bunch of other things going on. There is an increase in the number of elderly people receiving care. They have higher intensity of services.

We can do more things for more people that cost more. The retail prices of some things have gone up. You have seen consolidation on the provider side as well, something we have not mentioned so far, and then you can get the sort of bilateral monopoly problems. There are a lot of things going on, would be my short answer.

Senator DURBIN. Thank you.

Thanks, Mr. Chairman.

Chairman SPECTER. Thank you, Senator Durbin.

They have started the vote, but we are going to complete the round of questioning with Senator Coburn.

Senator COBURN. Thank you, Mr. Chairman.

I just would wonder, how many of you all really think there is insurance out there versus pre-paid expense that is paid for by an agent? How many really believe there is an insurance market in this country? I am talking, risk spreading market versus pre-paid health care expense. Does anybody want to answer that?

Mr. HYMAN. I guess my short answer is, there is a huge amount of pre-payment, but there is some risk pooling for catastrophic expenditures.

Senator COBURN. But the vast majority is pre-paid medical expense.

Mr. HYMAN. I would probably say a majority. I am not sure "vast".

Senator COBURN. The point is, we are paying a very expensive fee to have pre-paid health care expense. The other question that I had, for anybody that wants to answer it, who is the consumer? I have heard the word wielded about a bunch. The consumer I see is not my patients or the individual. The consumer is whoever has the power.

Senator Durbin talked about the FEHBP that went up 6.7 percent this year, versus 8 percent last year. That is the largest purchaser in the country, 8 million people, and it still went up that much. Yet, the costs to the providers, the reimbursement to the providers who are caring for the people, is not rising at all in terms of numbers.

So the question goes back to the 16.2 percent of our GDP. What are we getting for it? Doctor?

Dr. LANGSTON. Yes, Dr. Coburn. It is not necessarily a free market because there are middlemen involved. Our concern is that we are raising the red flags on some of these issues because we are seeing the change in the number of coverage and the increase of 6.8 to 8.6, yet premiums are rising in the double-digit areas.

All we know is, in 2004 and 2005, the insurance industry spent nearly $55 billion in consolidating and in acquisition, so there is something going on. We know the profits are higher. As a physician, our reimbursement is not changing.

I think we are unjustly accused of being the driver, which indirectly says we are getting more payment for what we are providing, where in fact what we are doing is providing, I believe, increased quality of care because of technology, drug expenses, and other institutional and system expenses.

So we are raising the red flags and we really appreciate the opportunity to talk about that because we think it needs to be explored. We, too, call for transparency. That is why we said we need the data, just as you do, to make public policy decisions on what are the real costs within that industry, and is there really any risk there. We certainly advocate the quality measures because that is ingrained in us as professionals, and we support that, quite frankly.

Senator COBURN. Let me go to one other point. We have almost 47 percent of our health care paid for by the government.

Dr. LANGSTON. Right.

Senator COBURN. That is off the table. So that leaves 52 percent, of which about 12 percent is not covered through some type of insurance program. What do we get for the one in four dollars of that? That is $1.9 to $2.3 trillion, somewhere between that. There is 45 percent of that, so you have got $1 trillion.

For the $250 billion that does not ever get into health care at a minimum, what are we getting for that in terms of quality? And the reason I raise that question, is Mr. McDonald's statement said that doctors can increase the patients that they serve. Well, they cannot. They are maxxed out.

What is happening, is the arc of medicine is declining and the quality of medicine—the first thing you are taught in medical school is to listen to your patient.

That is not happening any more because doctors cannot afford to pay for the receptionist, the insurance filing clerks, and their malpractice, and at the same time see the same number of patients.

So what is happening, one of the reasons we are with the 16.2 percent, we are not seeing this markedly increasing quality that we should be because we are spending 50 percent more than anybody else in the world, is because we are jamming the very people.

So what is the response? The response is, well, I will order a test rather than listen to the patient. What we do know, is about a quarter of a trillion dollars of tests are ordered every year that are not necessary. That is one of AMA's own studies. They are not necessary because they do not have the time to listen to the patient.

So I want to go back to my opening statement and just let people comment. Why do we not take and let consumers, the real consumer, be the decider of value about their health care, and why do we not let everybody own their own health insurance rather than their employer own it? Why do we not give the tax benefit to the individual rather than to the employer? Any comments on that?

Ms. KANWIT. Senator, I would like to comment on that. We are working hard, as I mentioned in my comments here, to make value-based information available to consumers so that they can make choices. You raise an excellent point. The Federal Trade Commission and Department of Justice, in their recent study, said exactly the same thing.

Senator COBURN. Well, the problem with that is, most people who come under one of your insurance companies do not have that choice because their employer made that choice for them. They do not get to make that choice, so they have a proxy making that choice.

What I am saying is, why would we not want individuals to make that value judgment rather than their employer, and let individuals decide what is in their best interests in terms of their care rather than some proxy for them? Let them squeeze out this one in three dollars out of the health care system to either increase quality and lower premiums.

Somebody else? Yes, sir. Doctor?

Dr. PIASIO. Yes. I would also just like to comment. At least in Pennsylvania, when you are looking at trying to get the transparency with respect to the quality, and now the new value metric, those are going to be determined by the sole insurer.

We do not have the bargaining power to even participate in those discussions as to even determine what those metrics may be. So in the transparency issue of what is quality and what is value, we have very little input on exactly how we are even going to measure what we are doing.

Senator COBURN. All right. Thank you.

Chairman SPECTER. We have only nine minutes left on the vote.

Well, thank you all very much for coming in. This is a panel to be continued.

In concluding the hearing, let me call to the attention of the regulators, Mr. McDonald and Mr. Wales, the impending merger of the two big companies in Pennsylvania. Independence Blue Cross collected 28 percent of the $28 billion spent on health insurance premiums; Highmark collected 27 percent of the $28 billion.

I would join Dr. Piasio and Dr. Langston—even an Indiana AMA guy speaks for Pennsylvania, in part—in taking a very close look at that situation. When they talk about efficiencies, one last question. I would like you to provide it in writing for me.

They talk about efficiencies. Why not hold them to a specific determination of what those efficiencies are, pulling down cost and the commitment that they are going to reduce premiums by that amount? Let me address that to the regulators, the Department of Justice and the FTC.

But let me ask that of you, too, Ms. Kanwit, since you are here representing all of these companies. We only surveyed five of them, who would not come in. That is not a very good sign if the Senate Judiciary Committee wants to have an antitrust hearing on this issue not to have companies be willing to come in and respond to some questions.

Chairman SPECTER. But this is a big, big issue. We all know the costs of health care. Everywhere I go, it is a question. I spent last week traveling in Pennsylvania, and everywhere I went the question comes up repeatedly, especially among small business men and women, what are we going to do?

Thank you all very much. Sorry the vote intervenes, but I think we pretty much covered the ground.

That concludes our hearing.

[Whereupon, at 12:11 p.m. the hearing was concluded.]

[Questions and answers and submissions for the record follow.]

QUESTIONS AND ANSWERS

UNIVERSITY OF ILLINOIS
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September 29, 2006

The Honorable Arlen Specter
Chairman of the Judiciary Committee
United States Senate
Washington, DC 20510

Dear Chairman Specter:

Thank you for giving me the opportunity to testify before the Committee earlier this month. Enclosed are my responses to the follow-up written questions I received after testifying on September 6, 2006 at a hearing titled "Examining Competition in Group Health."

Please feel free to contact me if you have additional questions.

Sincerely,

David A. Hyman

DAH:mp

Questions from Senator Specter:

Question 1: The AMA has urged Congress to require health insurers to publicly report additional enrollment and financial data. In your testimony, you advocate greater transparency. Do you believe such a reporting requirement would be helpful in this market?

Answer 1: I believe greater transparency with regard to the cost and quality of health care services has the potential to improve the performance of the health care marketplace. The FTC/DOJ report, *Improving Health Care: A Dose of Competition*, similarly calls for greater transparency with regard to this type of information. Good, reliable information about the cost and quality of health care services provides patients with the information they need to make their own decisions.

I am not convinced that compelled disclosure of the information sought by the American Medical Association (AMA) has the potential to improve the health care marketplace – particularly given the amount of such information that is already available. Information on enrollment and financial data on insurers is unlikely to be of interest to the relevant consumers (i.e., the purchasers of health care coverage and the recipients of health care services).

Question 2: You suggest that the AMA concentration study is flawed because its conclusions are based on the use of metropolitan statistical areas ("MSAs") as the appropriate geographic markets. However, in reviewing mergers between health insurers, the Department of Justice has relied upon MSAs to assess the effect of a merger on particular geographic markets. Why do you say that the use of MSAs is a weakness in the study?

Answer 2: The AMA study treats each MSA as a geographic market for purposes of calculating the Herfindahl-Hirshman Index (HHI). One simply can not assume that an MSA is equivalent to a geographic market without extensive analysis. It is always possible to disagree about the definition of a specific geographic market, but it is not correct to simply assume that an MSA is co-extensive with a geographic market.

Furthermore, when the DOJ uses MSAs, it does so as a starting point for analysis – not the end-point.

Question 3: You suggest that the antitrust enforcement agencies must show not only the ability to exercise market power, but also that such power was obtained or maintained through improper means, but that is not true for merger analysis is it? Merger analysis is designed to prevent an exercise of market power that would be legal if such market power was acquired other than through a merger, correct?

Answer 3: The statements in this question correctly describe antitrust law with regard to merger analysis. However, the AMA study was not about how to use HHIs to perform

merger analysis. Instead, the AMA used the HHI in each MSA as the basis for its analysis, without regard to the fact that it was not dealing with a prospective challenge to a merger. My point (against the backdrop of the AMA study) was that in a retrospective analysis, you cannot just look at market power – you also need to look at how that power was acquired.

Question 4: Do you believe that additional mergers among health insurers would enable the merged firm to exercise market power in at least some markets? As more mergers occur, would you oppose having the Justice Department take a closer look at health insurer mergers?

Answer 4: As I mentioned in my testimony, the question is whether the mergers are within geographic and product markets or across such markets. As long as the mergers are across markets, they are unlikely to raise issues of market power. Within-market mergers, on the other hand, require analysis to determine whether they raise issues of market power or not. I assume that in evaluating all such mergers, the Department of Justice will properly follow the enforcement policy set forth in the Horizontal Merger Guidelines that were jointly issued by the Department of Justice and the Federal Trade Commission.

Question from Senator Schumer:

Question 5: At the hearing, we examined the impact of consolidated health insurance companies on physicians. We did not, however, carefully examine the effect on hospitals. In New York, the consolidation of health insurers has been dramatic. We have recently seen the acquisition of Empire Blue Cross/Blue Shield by WellPoint, the acquisition of Oxford by United Health Group, and the proposed merger of the HIP Health Plans with Group Health Incorporated.

This activity exacerbates a disequilibrium, at least in my State, between the bottom lines of the health insurers and the bottom lines of our not-for-profit and public hospitals. For instance, last year the health insurance plans in New York State enjoyed a profit of $1.3 billion, while the hospitals have been in the red for seven consecutive years. Hospitals are held captive by huge national health plans, which need to sign contracts with plans like WellPoint, which has 34 million customers. And yet, our anti-trust laws prohibit hospitals from banding together to negotiate prices.

How can we expect a hospital to negotiate a fair deal with a behemoth like WellPoint?

Should we amend our antitrust laws to allow struggling hospitals that serve our inner city, suburban, and rural communities to band together and negotiate fair payment terms with these huge national companies?

Answer 5: As noted above, the issue is not how many customers any given insurer has across the country, but whether its market share in a specific geographic and product market is likely to result in the exercise of market power. So, the fact that Wellpoint represents 34 million customers nationwide does not indicate it has market power in any given geographic and product market.

More generally, consumers do not benefit when health care providers seek to "band together and negotiate fair payment terms" – and consumer welfare is the touchstone for our antitrust laws. Indeed, allowing physicians or hospitals to collectively fix prices will harm consumers – not help them. I do not believe it is necessary to amend the antitrust laws to address these concerns. If Congress wants to aid struggling hospitals in the inner city, suburban and rural communities, it should provide direct subsidies to the particular institutions that need assistance.

America's Health Insurance Plans

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September 29, 2006

Senator Arlen Specter
United States Senate
SR 259, Russell Senate Office Building
SH-711
1st and C Street, NE
Washington, DC 20510-3802

Dear Senator Specter:

Please find attached the answers to written questions on behalf of America's Health Insurance Plans (AHIP) from members of the United States Senate Judiciary Committee, transmitted to us on September 18, 2006. We are sending an electronic version, as you requested, to Barr Huefner as well.

Thank you for your consideration. Please do not hesitate to call me with any questions or further concerns.

Sincerely,

Stephanie W. Kanwit
Special Counsel

cc: Barr Huefner

Enclosure

Senate Judiciary Committee

Responses of Stephanie W. Kanwit, Special Counsel America's Health Insurance Plans (AHIP)

Question #1: How do you respond to the allegation that health insurers have lowered payments to doctors without passing the savings on to consumers, enabling insurers to earn substantial profits?

First, the assertion that "health insurers have lowered payments to doctors" is not supported by the data. In fact, as detailed below, numbers from the Centers for Medicare and Medicaid Services (CMS) indicate private health insurance payments for physicians and clinical services have actually *increased* in both absolute dollar numbers and in terms of percentage of total private health insurance benefits in the recent past and are likely to do so in the future. Moreover, AHIP's members are working with physicians and other stakeholders to develop strategies that pay more for quality performance, as well as to establish processes to report meaningful quality information for physicians, hospitals, and health professionals. The result has been both increased payments to doctors who practice high quality medicine, as well as better health care outcomes for consumers.

Second, the data also show that health plans are in fact "passing the savings on to consumers." Health benefit costs are moderating for the third consecutive year, as we detail below.

Third, in response to the allegation that insurers reap "substantial profits," it should be noted that margins tend to be relatively low in the health insurance industry. In fact, PricewaterhouseCoopers in a recent report, "The Factors Fueling Rising Healthcare Costs 2006," has calculated that health plan profits are in the range of 3 percent.[1] Those profits are available to meet risk-based capital needs, to support continued reinvestment into the system, and to provide a reasonable return to attract investors. The fact is that profit margins outside healthcare are many multiples higher than the profits of companies in the healthcare arena.

Physician Payments Are Increasing, Not Decreasing:

Private health insurance payments to physicians amounted to $136.8 billion in the year 2000, but by 2004 had increased to $194.0 billion---an increase of $57.2 billion over that short period. Indeed, the trend is expected by government actuaries to continue into the future,

[1] PricewaterhouseCoopers Report prepared for AHIP, at p. 7 (2006) (hereafter PWC Report). That Report is based on data including Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits, 2004", Sept. 2004; Mercer Human Resource Consulting, "US health benefit cost rises 7.5% in 2004"; The Segal Group, Inc., "2005 Segal Health Plan Cost Trend Survey," August 2004; Towers Perrin HR Services, "2005 HR Health Care Cost Survey," Dec. 2004.

with private health insurance payments to physicians expected to increase from $209.6 billion in 2005 to a projected estimate of $227.2 billion in 2006 and to $313.5 billion in 2010.

Private Health Insurance Payments for Physician and Clinical Services

Year	Physician Payments ($ billions)	Total Private Health Insurance Benefits ($ billions)	Physician Percentage
2002	$ 162.7	$ 552.2	33.8%
2003	$ 177.5	$ 606.3	34.1%
2004	$ 194	$ 658.5	34.4%
Estimated:			
2005	$ 209.6	$ 706.4	34.5%
Projected:			
2006	$ 227.2	$ 745	35.4%
2007	$ 246.6	$ 806.2	35.6%
2008	$ 268.3	$ 875.5	35.8%
2009	$ 290.7	$ 950.5	35.9%
2010	$ 313.5	$ 1,017.70	36.0%

Source. CMS National Health Expenditures Data and Projections.

Moreover, the largest share of the consumer's and employer's premium dollar-- fully 24 percent --goes towards payments to physicians for their services, according to the PWC Report, "The Factors Fueling Rising Healthcare Costs." That Report determined that the rest of premium dollar goes to outpatient costs including free-standing facilities and outpatient departments of hospitals (22%), to inpatient hospital costs (18%), and to pay for prescription drugs (16%). In addition, fully 6% of the premium dollar goes to government payments, compliance, claims processing, and administration.[2]

"Paying for Quality" Is Working:

Rather than lowering payments to physicians, as the Committee's question posits, our health insurance plan members are in the forefront of working collaboratively with physicians to design and implement a range of "paying for quality" arrangements that reward physicians who practice high quality medicine. Those ongoing efforts are proving successful. The National Committee for Quality Assurance (NCQA) just this week, on September 27, 2006, issued a report indicating that the quality of health care provided to millions of Americans improved last year across several dozen categories. For patients in private insurance plans, there was improvement in 35 of 42 measurements, including such categories as cervical cancer screening, colorectal cancer screening, and the control of high blood pressure.

[2] PWC Report at p. 7.

Traditionally, practitioners including doctors have not been paid based on the quality of care they deliver, but rather on the volume and technical complexity of services rendered. This approach has rewarded the over-utilization and misuse of services, resulting in higher payments when health care complications arise, and creating disincentives to improve quality and efficiency. The effort to implement paying for quality initiatives is consistent with the recommendation of the Department of Justice and Federal Trade Commission in their ground-breaking report, "Improving Health Care: A Dose of Competition," which stressed that "private payors, governments, and providers should experiment further with payment methods for aligning providers' incentives with consumers' interests in lower prices, quality improvements, and innovation."[3]

Physicians want to be recognized and rewarded for high quality care. A survey conducted for AHIP in 2004, for example, found that 86 percent of the physicians surveyed were concerned that the current payment system does not reward physicians for providing high quality medical care, and 71 percent of the physicians queried favored payments based on the quality of care they provide.[4]

Our members have clinicians --including physicians --actively involved in key aspect of rewarding quality performance programs, including program development, selection of performance measures, and determination of how rewards are linked to provider performance. Achieving clinical goals plays the most significant role in the formula for determining financial rewards. Other plans link awards, for example, on the ability of physician groups to create registries for patients with particular medical conditions (like diabetes and coronary heart disease), provide performance feedback to individual physicians, promote consistent delivery of care pursuant to evidence-based guidelines, and refer to care management programs.

The Federal Medicare program as well has embarked on a demonstration program to reward physicians for improving the quality and efficiency of health care services delivered to Medicare fee-for-service beneficiaries. Under the Benefits Improvement and Protection Act of 2000, the Physician Group Practice (PGP) Demonstration seeks to reward physicians for improving health outcomes, especially those groups that can retain and coordinate care for chronically ill and high cost beneficiaries and promote active use of utilization and clinical data for purposes of improving efficiency and outcomes. It should be noted that the measures used to evaluate the physician groups and reward quality under the program were developed by CMS working in conjunction with the American Medical Association.

Finally, as we noted briefly in testimony before this Committee on September 6, 2006, our health insurance plan members are currently working to develop a uniform, coordinated strategy for measuring, aggregating and reporting physician performance called the AQA. That ongoing work is a highly collaborative effort along with a large coalition of more than 35 physician groups including the American Medical Association, the American College of Cardiology, the American Board of Internal Medicine, and the American Academy of

[3] FTC/DOJ Report, July 2004, Executive Summary, at 21.
[4] "National Survey of Physicians Regarding Pay-for-Performance," Ayres, McHenry & Associates, Inc., September/October 2004.

Pediatrics. The input of those medical groups is key to developing a common set of performance measures and a strategy to implement them so that "paying for quality" results in engaging physicians, hospitals, and other health care professionals who work hard to improve the quality of health care delivery.

Premium Increases Are Moderating:

Not only is quality up, but health plans are in fact "passing the savings on to consumers," in the words of the Committee's query. First, premium increases very closely follow healthcare spending increases. According to PricewaterhouseCoopers, "over the most recent ten-year period (1993-2003) for which data are available, premiums grew at an annual rate of 7.3 percent, while the cost of healthcare services grew at an annual rate of 7.2 percent." [5]

Moreover, both private and government actuaries at the Centers for Medicare and Medicaid Services (CMS) have found that health benefit costs are indeed moderating. CMS has reported that in 2005, national health spending growth is expected to decelerate to 7.4 percent from 7.9 percent in 2004. This is the third consecutive year of slowing spending growth since 2002.[6]

In sum, health insurance plans have continuously raised payments to physicians across the board, with a special emphasis on increases to those who practice high quality and efficient medicine; any "savings" have in fact been passed on to consumers, since premium increases very closely follow healthcare spending; and those savings are passed on to consumers in the form of both moderating premiums as well as higher quality health care.

Question # 2. The AMA has urged Congress to require health insurers to publicly report additional enrollment and financial data. In your testimony, you advocate greater transparency. Would your members object to such reporting requirements? If so, on what grounds?

Health insurance plans strongly believe that consumers should have access to reliable and useful information to enable them to make informed value-based decisions about the care they receive. Moreover, physicians, hospitals and other health care professionals should have access to actionable information to enable them to improve health care delivery. Our community is already providing or making available such critical information – which includes enrollment and financial data as well as quality information – to enrollees, network providers, employers they contract with, and others. Before proposing disclosure of additional enrollment and financial data, we urge policymakers to consider: (1) the extensive amount of enrollment and financial information which is already currently available, as

[5] PWC Report at 3.

[6] C. Borger, S. Smith, C. Truffer, et al., "Health Spending projections through 2015: Changes on the Horizon," Health Affairs (Feb. 2006) at W61. See also the National Survey of Employer-Sponsored Health Plans 2005, Mercer Human Resources Consulting, available at http://www.mercerhr.com/pressrelease/details.jhtml/dynamic/idContent/1202305

described below; and (2) how additional enrollment and financial data would in fact be useful to stakeholders and further the goal of improving quality or value in the health care system.

Enrollment Data:

There are a number of resources which providers, consumers and other stakeholders can access to obtain enrollment information on particular health insurance plans. For example, AIS's Directory of Health Plans contains detailed national and state-level enrollment data by company.[7] Additionally, many individual plans have different types of enrollment data (e.g., enrollment data by product) on their websites. And finally, all health insurers include enrollment numbers in their annual statements to state regulators. Providers, consumers and other stakeholders can access those annual statements through the National Association of Insurance Commissioners (NAIC) website. Consumers can access up to five free annual statements at the website, at https://external-apps.naic.org/insData/index.jsp, and researchers can purchase whole data sets from the NAIC if they seek to review more than five insurers at a time.

Financial Data:

Health insurance plans also currently disclose different types of financial data to various stakeholders. For example, in their extensive oversight of health plan activities, which include ensuring that health plans meet solvency requirements and monitoring plan premiums and rating practices, state regulatory agencies already require health plans to disclose extensive financial data. A significant amount of this information, including annual financial statements information, is available to the public.

Additionally, health insurance plans are working with various stakeholders to increase the types and quantity of information that is currently available to inform consumers about the relative cost of services provided by network physicians, hospitals and other health care professionals. Individual plans, for example, currently are pioneering and considering tools and resources which will help consumers, including:

- Estimates of average in-network and out-of-network costs in the member's zip code for 25 common office procedures;
- Access to a hospital buyer's guide that displays a quality rating and a cost range using dollar signs; and
- Use of a treatment cost estimator to project costs for management of conditions, diagnostic tests, office visits, and select procedures.

Linked to financial data is the critical issue of reporting quality data that is useful to consumers and other stakeholders. As we pointed out in our testimony to the Committee on September 6, 2006, health insurance plans are currently working with the AQA coalition alongside physician organizations, employer groups, and governmental organizations to explore strategies for reporting reliable and useful quality information to consumers,

[7] More information is available at www.aishealth.com.

providers, and other stakeholders. AQA recently developed fundamental principles for reporting with the objectives of facilitating more informed decision-making about health care treatments and investment and facilitating quality improvement.

In sum, any additional reporting requirements relating to enrollment, financial and quality data would have to be useful and create value for beneficiaries, and not result in unintended consequences, including confusion (particularly among consumers), or unnecessary burdens which divert limited resources and focus away from quality improvement activities. While consumers need accurate information to empower them to make effective and efficient decisions, reporting of specific financial data (such as health plan payments to physicians) must operate within antitrust guidelines to ensure that vigorous competition continues to thrive in the marketplace, resulting in lower prices. [8]

Question #3. Your members contend that mergers can generate efficiencies and reduce the cost of health care. Do you believe it would be appropriate for the Department of Justice and Federal Trade Commission to hold companies to their promises – decreased premium growth rates, increased payments to physicians, and so on – as a condition of merger approval?

We believe that the Federal antitrust agencies, the Department of Justice and the Federal Trade Commission, should continue to fulfill their statutory mandate, pursuant to the current Merger Guidelines, [9] to investigate and evaluate appropriate mergers, whether by hospitals, health insurance plans, practitioner groups, or other entities in the health care system. Those agencies have expressed clearly their continuing commitment to monitor the healthcare sector of the economy.

As the agencies made clear in their healthcare Report, "Improving Health Care: A Dose of Competition," the antitrust laws are designed to ensure that markets operate competitively in order to maximize consumer welfare. In the healthcare arena, those laws ensure that competition will achieve the goal of promoting lower prices, higher quality, greater innovation, and enhanced access to healthcare at a price and quality level that fit the consumer's needs.[10]

The DOJ has in fact reviewed a number of health plan mergers, looking at whether they promote efficiency and affordability for consumers. After an extensive review of recent healthcare mergers, its investigations have been closed after finding that the mergers were helpful to consumers in that they afforded consumers enhanced access to provider networks and benefit programs, were not likely to raise prices post-merger because of vigorous

[8] See, for example, the FTC's *MedSouth* opinion, setting parameters on physician clinical integration; www.ftc.gov/bc/adops/medsouth.htm.
[9] U.S. Dept. of Justice & Federal Trade Commission, Horizontal Merger Guidelines § 0.1 (1992 rev. 1997), available at www.ftc.gov/bc/docs/horizmer.htm.
[10] AHIP's position has been consistent: for example, in its testimony before the FTC and DOJ at their healthcare hearings, it asked that mergers be analyzed through the prism of the following: whether the impact of a merger or proposed merger is positive or negative for *health care consumers*.

competition in their competitive areas, and were *unlikely* to enable the merged firm to reduce payments to practitioners through "monopsonistic" behavior.

Each of those investigations, of course, was highly fact-specific, dependent on the particular facts relating to the merging parties as well as the particular markets in which they operate. As the healthcare Report notes, "[t]he agencies will continue to follow the merger guidelines in health insurance mergers and conduct a factually intensive, case-specific assessment of whether a particular transaction under review will allow health plans to exercise market power with regard to their customers."[11]

In terms of the question whether it would be appropriate to "hold companies to their promises" subsequent to a merger, we believe it to be extremely unwise under a competitive market system for merging health care companies or any other merger partners to make specific commitments regarding what premiums or practitioner payments will be in the future post-merger. First, no other segment of the economy, and no other industrial or financial consolidation, has ever been held to that standard, nor should it be. It is impossible for anyone to look into a crystal ball so accurate that it can allocate resources in an ever-changing marketplace. Competition should determine the appropriate cost/quality trade-offs, not promises made prior to a merger that may not accord with the operation of an efficient marketplace subsequent to the merger.

Payments to Physicians:

The Committee's query asks about possible promises of increased physician payments as a condition to a proposed merger. Surely the Committee is not suggesting that consumers pay more in terms of health care premiums, which could be the inevitable consequence of any such requirements. If markets including health care markets operate properly, competition determines the appropriate prices for payments to physicians rather than specific companies. Payments to physicians, for example, currently depend on many factors, including the particular geographic area where the physician or group practices, the specialty of the practice, and whether the physician or physician group has a national reputation for quality within a particular field. Consumer demand is also critical, and drives the payment rate for certain physicians or other practitioners (such as those at well-known medical centers like the Mayo Clinic) or for certain medical services. The payment rates to a particular physician may also depend on other pro-competitive factors, such as whether the physician is part of a "paying for quality" initiative whereby he or she is paid additional increments to practice high quality medicine, as noted above in answer to question #1.

Payments to physicians in a particular area may, of course, decrease after a merger, but those payments would be set by operation of the marketplace, not by an agreement that may result in anticompetitive consequences, such as stifling innovation, or eliminating pricing and product flexibility. Again, across the country, as we noted in answer to question #1, the trend is for private health insurance payments to physicians *to increase*, not decrease, often by substantial amounts. We also pointed out that those fees, based on government data, are likely to increase in the future. (See Chart attached as answer to Question #1).

[11] "Improving Healthcare: A Dose of Competition," Ch. 6, at 13.

Further, the 2006 PricewaterhouseCoopers study found that spending on physician fees is not only the largest share of health spending, but that it grew by 7.8 percent in 2005. [12] That pricing increase was *in excess of inflation*. Again, because the cost of health insurance premiums is a reflection of the overall cost of healthcare services, any higher payments to physicians will be reflected in higher premiums to consumers and an increase in the number of consumers who become uninsured.

Post-merger review:

Rather than insisting on promises that may be anticompetitive as a condition for merger approval, the antitrust agencies always retain the ability to review, after the fact, consummated mergers. An example is the recent Evanston Northwestern Healthcare case, where the FTC brought an administrative proceeding against a group of hospitals, contending that after the acquisition and merger, the combined entity was able to raise prices considerably.[13] The Law Judge, in a decision now on appeal to the full Commission, held that both contemporaneous and post-acquisition evidence indicated that the merger was anti-competitive for three reasons: (1) the three merged hospitals bargained as a single entity with managed care organizations and obtained post-merger price increases that were significantly above premerger prices; (2) the merged entity's prices were substantially higher than price increases obtained by other comparison hospitals, sometimes even three times as large; and (3) there were no other explanations for the price increases, such as higher wage costs, changes in regulations, or changes in consumer demand. Further, the Law Judge found that the merger created "an appreciable danger of anticompetitive consequences and will substantially lessen competition and harm consumer welfare in the future."

In terms of one example of possible efficiencies you cite, "decreased premium growth rates," in fact government actuaries at the Centers for Medicare and Medicaid Services (CMS) have found that health benefit costs are indeed moderating. CMS has reported that in 2005, national health spending growth is expected to decelerate to 7.4 percent from 7.9 percent in 2004. This is the third consecutive year of slowing spending growth since 2002.[14]

In sum, we believe that consumers will benefit in terms of lower healthcare costs and higher quality when the marketplace works efficiently, and that no changes are needed in current merger policy.

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[12] PWC Report at12.
[13] *In re Evanston Northwestern Healthcare Corp.*, FTC, No. 9315, 10/20/05.
[14] C. Borger, S.Smith, C. Truffer, et al., "Health Spending projections through 2015: Changes on the Horizon," Health Affairs (Feb. 2006) at W61.

Edward L. Langston, MD, Member, Board of Trustees

November 6, 2006

The Honorable Arlen Specter
Chairman
Senate Committee on the Judiciary
United States Senate
Washington, D.C. 20510

Dear Chairman Specter:

On behalf of the physicians and student members of the American Medical Association (AMA), I am sending to you answers to questions you submitted to the AMA after the September 6, 2006 hearing in your Committee entitled "Examining Competition in Group Health Care." We appreciated the opportunity to testify at this hearing on this important subject.

We look forward to working with you and your staff on this issue in the future.

Sincerely,

Edward L. Langston, M.D.

American Medical Association 515 North State Street Chicago Illinois 60610
phone: 312 464 4467 fax: 312 464 5543 edward.langston@ama-assn.org

Written Questions
"Examining Competition in Group Health"
September 6, 2006

Dr. Edward L. Langston

1. Are there changes that the AMA would recommend making to the FTC/DOJ Health Care Policy Statements?

The AMA believes that the FTC/DOJ Health Care Policy Statements offer virtually no realistic avenues for leveling the playing field between physicians and health plans, because they offer no means for physicians to joint contract and thereby obtain some modicum of bargaining power. Without such bargaining power, physicians in markets across the country are unable to negotiate with health insurers on behalf of their patients over contracts that touch on virtually every aspect of care.

Physicians, their patients, and the health care system as a whole are severely disadvantaged because the acceptable "joint ventures" outlined in the FTC/DOJ Health Policy Statements discourage physicians from working together on efficiency-enhancing physician joint ventures. They are unrealistic and overly burdensome, and do not provide adequate legal avenues for physicians to work together to address concerns over unfair contracts and restrictions on their ability to provide the best possible care to their patients. .

For example, the FTC's "messenger model," despite health insurer assertions to the contrary, has primarily resulted in confusion and fear of prosecution. Similarly, "clinical integration," another arrangement permitted by the FTC, is simply out of reach and is impractical for the vast majority of physicians. The FTC/DOJ Policy Statements make it clear that the only physician organizations that can realistically engage in clinical integration are those that have extremely sophisticated infrastructures, large numbers of physicians, and significant financial resources.

The AMA believes that these policies and restrictions are unwarranted and ineffective. We believe that they should be revisited and guidelines should be put in place that will realistically allow physicians to joint contract. We are confident that developing less restrictive approaches to physician joint contracting will have pro-competitive benefits, such as greater flexibility, further innovation, and ultimately a lower cost, higher quality health care system.

2. Do you believe that consumers would be seeing such significant increases in their health insurance premiums if insurers were passing along the savings from lower payments to physicians?

The AMA does not have access to information regarding how health insurance companies price their premiums. From the information available, however, it is clear that there are dangerous trends in the health insurance market, including, highly concentrated markets, increasing premiums, depressed reimbursement rates, and a lack of new entrants into the health insurance market despite significant profit incentives.

3. Why do you think the Justice Department has not challenged more mergers among health insurers?

The AMA believes that the U.S. Department of Justice (DOJ) and the Federal Trade Commission (FTC), with appropriate Congressional oversight, should re-examine their guidelines for challenging mergers among health insurers in today's markets. The current environment has produced market distortions to the detriment of health care consumers. For example, health plans have been able to raise premiums without losing market share, exacerbating access to care problems and contributing to the alarming numbers of uninsured. When premiums rise, many employers stop providing coverage and/or reduce the scope of benefits provided. Even when employers offer health plans, increases in premiums, deductibles, and co-payments have led many workers to forego their employer-sponsored health insurance. This declining coverage puts an enormous strain on the health care system and leads to otherwise avoidable expenditures for emergency care and other medical services.

In addition, the growing market domination of health insurers is undermining the patient-physician relationship. Because physicians have little-to-no bargaining power when negotiating with dominant health insurers over contracts that touch many aspects of patient care, existing imbalances in the market are virtually eviscerating the physician's role as patient advocate. As noted in our testimony, this is particularly troublesome given that health insurers have increasing control and limited accountability regarding decisions that affect patient treatment and care.

In addition, the AMA believes that the DOJ and FTC should not limit their review of health insurers to merger investigations. The red flags we have identified, market concentration, record profits that have failed to attract new entrants to the market, and premium increases outpacing inflation, warrant the DOJ and FTC investigating whether health insurers in some of these markets are exercising monopsony or monopoly power. Only the federal government can undertake this task because private parties cannot access the proprietary pricing information that is fundamental to making this determination.

4. Do you have an idea of how much the concentration level would increase in Pennsylvania as a result of a merger between Highmark and Independence Blue Cross?

If a merger between Highmark and Independence Blue Cross (IBC) occurs, this new plan will dominate the two largest metropolitan areas in the state, Philadelphia and Pittsburgh with a 68% and 74 percent (according to a 2002 analysis of the Pittsburgh market by the Pennsylvania Medical Society) combined HMO/PPO market share respectively. At the September hearing, Pennsylvania Medical Society presented testimony highlighting some of the troubling statistics relating to the IBC. Statistics such as these are becoming more and more common in health insurance markets across the country, and thus we believe that this merger would be an ideal place for the Justice Department to begin investigating whether monopolistic/monopsonistic power is being exercised by dominant health plans.

Notably, the American Health Insurance Plans (AHIP) claim that there are "multiple competing health plans in every major metropolitan market," is exceedingly misleading. In Pennsylvania and in other markets across the country, there may be multiple plans licensed to do business in the market, but the market is nonetheless not competitive. In fact, nearly all of the markets AHIP cites as being "competitive," have multiple plans, but under the DOJ/FTC horizontal merger guidelines, are highly concentrated. This is because, despite having multiple plans, in the vast majority of these markets, one insurer has a market share over 30 percent.

The Philadelphia and Pittsburgh markets provide an example of this lack of competition, even where multiple health plans exist. AHIP supports its claims of multiple competing health plans in Pennsylvania by noting that there are 14 HMOs in Philadelphia and 11 in Pittsburgh. As noted, however, the number of entities licensed as HMOs in a given market does not determine whether these markets benefit from "vigorous competition." For example, Philadelphia, a market dominated by IBC, has a Herfindahl-Hirchman Index (HHI) (a commonly used measure of competition in a market) of 5129, far in excess of the highly concentrated mark of 1800>. With IBC holding a 68 percent market share, the remaining 13 plans (assuming they exist) clearly have insignificant market shares in terms of generating competition for IBC. The reality is that one health insurer dominates each of those markets.

U.S. Department of Justice

Office of Legislative Affairs

Office of the Assistant Attorney General

Washington, D.C. 20530

February 12, 2007

The Honorable Patrick J. Leahy
Chairman
Committee on the Judiciary
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Please find enclosed the Department of Justice's responses to questions directed to J. Bruce McDonald, Deputy Assistant Attorney General for the Antitrust Division. The questions arose after Mr. McDonald's testimony at the Committee's hearing on September 6, 2006 entitled "Examining Competition in Group Health Care." We hope that this information is helpful to the Committee.

The Office of Management and Budget has advised us that from the perspective of the Administration's program, there is no objection to the submission of these responses. Please do not hesitate to call upon us if we may be of additional assistance.

Sincerely,

Richard A. Hertling

Richard A. Hertling
Acting Assistant Attorney General

Enclosure

cc: The Honorable Arlen Specter
Ranking Member

Questions for the Record for
Deputy Assistant Attorney General J. Bruce McDonald
Hearing on "Examining Competition in Group HealthCare"
Senate Committee on the Judiciary
September 6, 2006

Question from Senator Schumer

At the Hearing, we examined the impact of consolidated health insurance companies on physicians. We did not, however, examine the effect on hospitals. In New York, the consolidation of health insurers has been dramatic. We have recently seen the acquisition of Empire Blue Cross/ Blue Shield by WellPoint, the acquisition of Oxford by United Health Group, and the proposed merger of the HIP Health Plans with Group Health Incorporated.

This activity exacerbates a disequilibrium, at least in my State, between the bottom lines of the health insurers and the bottom lines of our not-for-profit and public hospitals. For instance, last year the health insurance plans in New York State enjoyed a profit of $1.3 billion, while the hospitals have been in the red for seven consecutive years. Hospitals are held captive by huge national health plans, which need to sign contracts with plans like WellPoint, which has 34 million customers. And yet, our antitrust laws prohibit hospitals from banding together to negotiate prices.

a. How can we expect a hospital to negotiate a fair deal with a behemoth like WellPoint?

b. Should we amend our antitrust laws to allow struggling hospitals that serve our inner city, suburban, and rural communities to band together and negotiate fair payment terms with these huge national companies?

Answer: Although the hearing may have emphasized the potential effects of health insurance mergers on competition for the purchase of physician services, the potential effects on competition for the purchase of hospital services are no less important. When the Department investigates a health insurer merger, we focus on the effects in all relevant markets. As with physician services, if a merger would result in the price paid for hospital services being depressed below competitive levels, consumers are deprived of quality and choice and an enforcement action would be warranted to prevent that from occurring.

We do not believe creating an antitrust exemption to allow competing hospitals to jointly negotiate reimbursement rates is an effective answer to any concerns one may have regarding the size of health insurers. Experience has repeatedly demonstrated that consumers benefit from competition in obtaining lower prices, better quality, and more choices. The antitrust laws are the primary protector of competition, and while an antitrust exemption may work to benefit the

select group that gets license to disregard those laws, it generally does so at a cost to competition and consumers. Markets benefit from more competition, not less. Rather than alleviate the adverse effects of any existing market power, an antitrust exemption is likely to increase those adverse effects and shift them even more onto consumers. Accordingly, we believe the better approach is to be vigilant in investigating health insurer mergers so as to prevent the unlawful acquisition of monopsony power, and to investigate reports of potential collusive or exclusionary conduct by health insurers and bring enforcement action where warranted.

Questions from Senator Specter

Question 1: The Justice Department ordered divestitures in several geographic markets as a condition of approving United Health's recent acquisition of PacifiCare. Do you believe that the market for the purchase of physician services by health insurers has become highly concentrated in some geographic markets? Do you think that the Department is likely to take a more aggressive posture toward future mergers involving the market for physician services?

Answer: The Department reviews each merger, and each affected market, on a case-by-case basis. In our investigation of the UnitedHealth/PacifiCare merger, we determined that the merger as proposed would result in competitive harm with regard to reimbursement rates for physicians in certain markets, and therefore we insisted on divestitures to preserve competition in those markets. It is not possible to make general statements about whether mergers that have not yet been proposed will have such anticompetitive effects, but the Department will closely investigate mergers that raise any such competitive issues.

Question 2: In 2004, the Justice Department approved United health's acquisition of Oxford Health and Anthem's merger with WellPoint. Has the Department done any follow-up analysis to determine what the effect of those mergers has been? If so, has the Department noted either lower reimbursement rates or higher premium rates in the affected markets?

Answer: The Department remains on the lookout for potentially anticompetitive conduct that might warrant further investigation or enforcement action in these markets. We encourage individuals and businesses who believe they have evidence of a possible antitrust violation to bring that information to the Department for our review. With respect to the particular mergers in your question, the Department has not performed any post-merger analysis of the type you identified. The Department will continue to be vigilant in monitoring the health insurance marketplace for mergers and other activity that could potentially harm competition.

Question 3: Insurers assert that mergers generate efficiencies and reduce the cost of health care. Has the Department of Justice considered holding companies to their promises – decreased premium growth rates, increased payments to physicians, and so on – as a condition of merger approval?

Answer: Mergers often do generate efficiencies, and the Department takes efficiencies into account as appropriate in evaluating a proposed merger, provided the merging parties can show that the efficiencies likely will result from the merger and are not reasonably achievable absent the merger.

It is generally not practical or desirable to impose price regulation or other market regulation that would require prolonged interference in the marketplace. Government regulation of prices is inconsistent with the primary goal of antitrust, to let market forces determine pricing and output decisions. Furthermore, such regulation can often be subject to evasion that is hard to identify and police. For example, a merged firm that has agreed not to raise price may instead reduce service. Consumers in such situations are no less harmed, but proving that lower quality service was provided likely is more difficult and would require more substantial regulatory oversight. For these reasons, the strongly preferred approach is to identify structural problems with a proposed merger that are likely to substantially lessen competition, and to insist on structural remedies – *i.e.*, divestitures – that fix those structural problems, instead of seeking conduct remedies that may prove harmful or ineffectual.

Pennsylvania
MEDICAL SOCIETY®

September 28, 2006

Senate Judiciary Committee
224 Dirksen Senate Office Building
Washington, D.C. 20510
Attn. Barr Huefner

Dear Chairman Specter:

Thank you again for providing the opportunity for the Pennsylvania Medical Society to participate in the hearing regarding "Examining Competition in Group Health Care," held on September 6, 2006. Your office has forwarded five questions to my attention as a follow-up to that hearing. Found below are our responses to those questions.

Q1. Do you believe that doctors in Pennsylvania could simply refuse to treat patients from a health insurer with very low reimbursement rates, or does each company insure so many patients that no doctor can refuse?

A1. The answer to this question will vary depending on the physicians geographic location in the Commonwealth, physician specialty, size of the physician practice, service mix, and their ability to cost shift to other health insurers.

For example, a physician practicing in the Philadelphia MSA will almost certainly have to participate with Independence Blue Cross and Aetna due to the overwhelming number of lives that these two payers either insure directly or serve as a third-party administrator. These two health insurers cover more than 90 percent of the commercial health insurance market and a large part of the publicly financed health insurance market (Medicare & Medicaid) in the Philadelphia MSA. Having an inability to capture a share of the product market created by these two health plans would almost certainly lead to the demise of a physician practice in Southeastern Pennsylvania. As physician payment is currently structured, it has become very difficult to survive even participating with both health plans.

In Central Pennsylvania where a limited level of competition still exists, physicians would have a greater ability to say no to participation with certain health insurers. Although several payers with significant market share exist, none are so dominant as to control the market. The combined market share of Highmark Blue Shield and Capital Blue Cross constitutes approximately 60 percent of the product market for Central Pennsylvania. It would be difficult to

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survive in the Central Pennsylvania market if a physician practice could not participate with both of these two plans.

Q2. How would the potential merger between Highmark and Independence Blue Cross affect your practice?

A2. In analyzing health care markets it is important to distinguish between the geographic and product markets involved. A product market is defined to include all products that purchasers view as reasonable substitutes for the product in question. Although there is little evidence regarding the substitutability of various forms of health insurance, most would agree that PPO and HMO products are interchangeable. After determination of the relevant product market, the second element in market definition is a determination of the geographic area where the market participants operate. The geographic market is the area where consumers can practically turn for alternative products if a competitor increases price.

Based on a 2005 update by the American Medical Association, the Pennsylvania statewide Herfindahl-Hirschman Index (HHI) for all HMO and PPO products is 1513. This would make the market "concentrated" based on the 1997 Federal Trade Commission/Department of Justice Horizontal Merger Guidelines (FTC/DOJ guidelines). This number is probably low since it is very difficult to obtain accurate PPO numbers. Under the guidelines, a merger in these markets that raises the HHI by more than 100 points may raise significant competitive concerns. If the market has an HHI above 1800, which the Pennsylvania statewide market probably is if accurate PPO numbers were known, the market is considered "highly concentrated" under the guidelines. A merger in these markets that raises the HHI more than 50 points may raise significant competitive concerns and mergers that raise the HHI more than 100 points are presumed to be anti-competitive. **It is therefore imperative that the FTC/Justice Department collects accurate HMO/PPO numbers to determine the correct HHI for the Pennsylvania statewide market. If the HHI were found to be above 1900, a combination of Highmark and IBC would not be permitted under existing FTC/DOJ merger guidelines.**

We have so far identified two areas of concern with the potential merger. First, the merger would eliminate any competition between the two plans in the future. After merger talks between Highmark and Capital Blue Cross failed, the two plans opted to compete against each other. Even if Highmark and IBC legitimately do not compete under the "Blues" label due to the national franchise restrictions, they could compete under a different brand. IBC now competes with the New Jersey Blues plan under a different brand outside of Pennsylvania. It may be pertinent for the FTC/DOJ to examine the Blue Cross Blue Shield Association franchise agreements to determine if it impermissibly restricts competition among the Blues plans. Highmark and IBC should not be able to defend their merger on the basis of no current competition if in fact the lack of current competition is due to an impermissible agreement.

The second area of concern is that the merger would eliminate the ability of physicians who can currently draw patients from both insurers (due to their practice location near the border of the two insurer's territories) to elect to participate in just one, but not both of the insurers. For example, an IBC Member lives in Reading, Berks County. They commute to an employer based in Norristown, Montgomery County. Because the employer is located in Montgomery County the Blue product would be purchased from IBC due to franchise restrictions. The patient sees physicians located in Reading, who currently participate in both Highmark Blue Shield and IBC "Blues branded" products. After the merger, the physicians in Reading would only have the ability to participate in one Blue firm's products.

Q3. You testified that you would like to see competition between the Blues in Pennsylvania. Do you believe that competition would be restored if the Justice Department ordered significant divestitures before approving the merger of two large insurers?

A3. Given the market problems in Pennsylvania, which include its structure, market conduct and at least an implication of market power, what public policy response would produce a welfare-improving outcome? A first best response would be to restore full and open competition in the markets. Simply put, the FTC/Justice Department could bring actions to "break up" concentrated firms such as IBC and Highmark and to limit market-enhancing conduct. For example, IBC could be forced to divest its subsidiary Keystone Healthplan East and Highmark could be forced to divest its subsidiary Keystone Healthplan West. Ironically, the very premise of using antitrust enforcement action to restore competition to these markets presumes that they can be competitive.

If you cannot accomplish a "first-best" (perfectly competitive) solution for whatever reason, an effective "second-best" solution may be to develop a countervailing power response. The basic idea is to give countervailing power to a party dealing with a monopolist or monopsonist, which can be welfare improving. For example, if an employer purchaser is given countervailing power (either through size or joint purchasing) the health insurer will no longer have the power to fix price in a unilateral manner. We see the operation of countervailing power theory in the creation of employer bargaining cooperatives. Employer buying coalitions improve public welfare when they provide countervailing power to sellers of health insurance who enjoy market power.

Unlike health insurers and employer coalitions, physicians do not generally have market power and many attempts to develop countervailing power through collective action have been opposed by the health insurance industry and the FTC. This opposition has not assessed the full extent to which countervailing power has the potential to be welfare improving. Revisiting this opposition could help improve antitrust enforcement theory.

A third intervention, failing federal intervention to restore competition or an effective countervailing power response, may be to encourage state government to regulate the industry. State government regulation can take a number of forms including state countervailing power legislation, regulation of industry prices (profit levels and levels of reserves), and regulation of conduct by industry participants. While the drawback to a state specific approach is that it provides differing responses in different areas of the country, major advantages include the fact that state regulation at least provides some response to the problem. State intervention in problem markets also gives an opportunity for them to act as laboratories to invent and measure the effectiveness of solutions for a persistent nationwide problem.

Q4. It is my understanding that the Pennsylvania Medical Society's statistics show a significant drop—nearly 10 percent over the past 5 years—in the number of doctors practicing in the state. Have you seen physicians leave Pennsylvania, or even the practice of medicine, in response to the terms contained in physician contracts with insurers?

A4. Absolutely. From statements made by physicians who have left the Commonwealth to practice medicine elsewhere, who have retired early, or who have eliminated performing certain services in their practice, the two primary reasons are the cost of professional liability insurance and the low payment rates from health insurers. This second reason would be tied directly to the physicians contract with a health insurer.

In addition to the low reimbursement rates there are also a number of one-sided contract terms (unfair business practices) imposed upon the practicing physician by health insurers that further erodes the level of payment and/or increases costs to operate the practice.

There are two major problems underlying these unfair practices. The first is the inherent disparity in bargaining power between health plan payers and physicians. While ostensibly physicians have the right to agree only to the contract terms and reimbursement levels that benefit them, in Pennsylvania as well as other areas of the country, this is not realistic. The root of the problem often lies in the provider contract, which is typically a form contract imposed upon physicians by health plans with little opportunity for amendment. Artfully drafted, these contracts and related business practices often put physicians' offices at the mercy of payers in terms of reimbursement. Because of the imbalance in negotiating power between these organizations and physicians, physicians wind up forfeiting a considerable percentage of charges for services they provide.

In the Pittsburgh and Philadelphia MSAs for example, a health plan's market dominance makes it infeasible for a physician to not participate in the network. More over, health plans are moving aggressively to restrict reimbursement for

out-of-network physicians in an effort to force these physicians to participate in their networks. As a result, physicians often feel coerced into signing provider agreements that include provisions that are inequitable and often detrimental to them and their patients. Even when egregiously treated, physicians often fail to seek redress because of time and money involved in legal actions.

The second underlying problem is the pervasive refusal of health plans to disclose information regarding what they pay and how they pay. This systematic effort to obfuscate payment has made it extremely difficult for physicians to dispute the amounts they are paid.

In most industries, businesses are able to set the price of the services they provide or goods they sell based on costs incurred and a reasonable profit margin. For the vast majority of physician offices, which represent a major small business interest and employer base in Pennsylvania, reimbursement is nowhere near this straightforward. Instead it is based on a complex array of factors, most of which are largely outside of physicians' control. In recent years, physicians have faced increasingly aggressive strategies by health plans to contain costs through systematic reductions in reimbursement. The AMA has calculated that physicians receive only 40 cents out of every dollar of billed charges. The other 60 cents is eaten by authorized and unauthorized discounts and various code editing practices by health insurers.

Q5.You suggest that providing doctors with an antitrust exemption might counter the market power that health insurers currently exercise. What is your response to the assertion that an antitrust exemption would increase the amount that consumers pay for health insurance?

A5. The health insurance lobby argues stridently that countervailing power legislation will increase health care costs between 5 and 25 percent. Interestingly enough, our data shows that Pennsylvania health insurers for the period 2000 to 2004:

- Increased premiums per enrollee 40 percent, and we believe, would have raised them even more if employers would have been willing to pay the increase,
- Increased total annual profits from $468 million to $621 million,
- Increased their surplus reserves from $5 billion to $6.8 billion, and
- Increased their annual administrative costs per member from $132 to $270.

These increases had nothing to do with countervailing physician or other provider power.

Creating a level playing field for physicians does not need to result in increased premiums, even if the net result is fair market physician reimbursement. Physician reimbursement levels could be enhanced through increased efficiencies with

physicians, hospitals, and health plans working together to create these efficiencies, and a fairer distribution of the premium dollar between administrative costs, insurer profits, and provider reimbursement. The current process is not structured to permit reasonable people to come together to develop reasonable solutions to the current health system cost crisis. If not altered, dominant health insurers will continue to be "price makers." Physicians should be permitted to negotiate contract terms that increase patient choice, improve quality of care, and empower patients and their physicians to make informed decisions about health care needs.

To that end the American Medical Association has drafted legislation that among other things would create a minimum of six demonstration projects, limited to one project per state, which would allow two or more physicians or other health care professionals to engage in negotiations with health plans under the antitrust laws. These projects are to be established "for the purpose of testing various options in the health care market to allow negotiations and agreements by health care professionals that will enhance efficiency, quality, and availability of health care, while promoting competition in the health care market." The demonstration projects would be conducted in conjunction with a study on the impact of the negotiations, and an advisory committee would be established to assist the Attorney General with implementation of the projects and the study.

In short, policy makers concerned with rising health care costs ought to carefully consider the role of monopoly health insurers in the cost increases in addition to the responsibility of other industry participants.

Thank you again for the opportunity to provide additional information regarding these issues. The Pennsylvania Medical Society believes that the foundation of good health care is the patient-doctor relationship, and that the answers provided in this letter to your questions are in the best interest in strengthening the health care Americans receive. If you should have questions, feel free to contact me or Dennis Olmstead at the Society.

Sincerely,

Mark A. Piasio, MD
President

Responses to Written Questions for
FTC Bureau of Competition Deputy Director David Wales

Hearing on "Examining Competition in Group Health Care"
Senate Committee on the Judiciary
September 6, 2006

Questions from Senator Specter

1. **You indicated in your testimony that the antitrust laws allow physicians to act jointly, including by agreeing on fees, so long as their efforts produce significant efficiencies and the price agreement is reasonably necessary to achieve those efficiencies. What types of efficiencies would be significant enough? Under what circumstances would a price agreement be necessary to achieve those efficiencies? Have there been any cases in which the FTC has found such efficiencies?**

The FTC applies the same antitrust principles to arrangements in the health care industry as it does to arrangements in other industries. Accordingly, in evaluating joint pricing by competing health care providers, there are two threshold questions. First, have competitors economically integrated to create efficiencies, and second, is the joint pricing reasonably necessary to achieve those efficiencies? If so, then the joint price setting is evaluated under a relatively detailed rule-of-reason analysis to assess the net competitive effects of the arrangement.

With regard to the first question, the focus is on whether the competitors are engaged in a joint undertaking that is likely to enhance competition by, for example, reducing costs or improving quality. That is what is meant by an "efficiency-enhancing integration." Integration means a joint undertaking in which the competitors together can achieve something that they could not do individually.

The joint FTC/DOJ Statements of Antitrust Enforcement Policy in Health Care and the FTC advisory opinions provide examples of some types of physician networks in which joint bargaining over fees has been deemed to be reasonably necessary to achieve significant efficiencies. These include various arrangements in which the network members share financial risk for the performance of the group as a whole, as well as arrangements involving what is sometimes called "clinical integration," in which the participants undertake various joint clinical activities to control costs and improve quality for the group as a whole. Moreover, the Health Care Statements emphasize that the examples are not meant to exclude other forms of integration that might also create efficiencies and justify joint pricing.

One example, a 2002 advisory opinion on a proposal by a physician group in Denver, Colorado, involved an arrangement designed to integrate the provision of primary and specialty services so that they are delivered in a coordinated fashion. It reflected a significant investment of time, effort, and other resources, and included the

collective development and implementation of protocols and benchmarks with the potential to create significant interdependence among the physicians in their rendering of medical services. The physicians would pool their resources and expertise to identify common standards of care, and, through their agreement to abide by those standards, the physicians subjected themselves to the collective judgment of the group with respect to their patterns of practice.

The staff advisory opinion concluded that joint pricing was reasonably necessary to achieve the benefits of the arrangement because the key element of the arrangement for consumers was significantly dependent on the doctors being able to function as a group within which patients are commonly referred. The price for professional services rendered under health plan contracts needs to be established, and if it were done through individual negotiation and contracting, then no one could count on the full participation of the group's members.

Finally, the staff considered the extent to which the size of the group would create competitive concerns. It concluded that, as long as doctors were, in fact, willing to deal individually on competitive terms with payers who did not want the package product, as the group had represented, significant anticompetitive effects appeared unlikely.

2. You suggest that collective action by physicians would increase the cost of health insurance for consumers, but wouldn't a lack of competition among health insurers do the same?

Yes. Every effort should be made to ensure that both provider markets and insurer markets function competitively. Competition is fundamental to the nation's free-market economy, and it is an important tool for stimulating innovative strategies to control costs, increase quality, and provide consumer choice in health care. And antitrust enforcement plays a critical role in helping to assure that new and potentially more efficient ways of delivering and financing health care services can arise and compete in the market for acceptance by consumers. Allowing anticompetitive collective action by physicians is not the way to address competitive concerns regarding health insurers.

3. You mentioned that the Health Care Policy Statements issued by the Department of Justice and Federal Trade Commission are intended to provide doctors with guidance regarding collaborative activities by doctors. Do you believe that there are any changes that could be made to the Health Care Policy Statements to help clarify when collaborative activity, particularly involving fees, is acceptable?

While we are always willing to consider suggestions, the staff has no current plans to propose revisions to the Health Care Statements. I note that the Statements are only one form of guidance that the Commission provides to the public. The agency communicates in various other ways, including enforcement actions, advisory opinions, and speeches. Since antitrust analysis is inherently fact-intensive, looking at the way the agency applies established antitrust principles in specific, concrete fact settings can be the most informative. The staff is also mindful of the risk that greater specificity in the

Statements might serve to channel market behavior toward particular structures and discourage innovative, alternative approaches to health care delivery that might offer equal or greater efficiencies.

4. Insurers assert that mergers generate efficiencies and reduce the cost of health care. Has the Federal Trade Commission considered holding companies to their promises – decreased premium growth rates, increased payments to physicians, and so on – as a condition of merger approval?

Historically, health insurance mergers have been within the particular expertise of the DOJ Antitrust Division, so the FTC would defer to the DOJ on the subject of efficiencies generated by health insurance mergers. As a general matter, however, the Commission seeks structural remedies, such as divestiture, when it finds reason to believe that a merger poses a threat to competition. Remedies that rely on enforceable commitments to hold prices down, and similar regulatory decrees, are unlikely to adequately protect consumers, because they either can be evaded or can have unintended consequences. Moreover, a regulatory approach to an anticompetitive merger can present particular risks in the health care industry, because of the critical role that competition can play in prompting market participants to devise innovative strategies to address the cost and quality challenges facing the health care system today.

Questions from Senator Schumer

At the hearing, we examined the impact of consolidated health insurance companies on physicians. We did not, however, carefully examine the effect on hospitals. In New York, the consolidation of health insurers has been dramatic. We have recently seen the acquisition of Empire Blue Cross/Blue Shield by WellPoint, the acquisition of Oxford by United Health Group, and the proposed merger of the HIP Health Plans with Group Health Incorporated.

This activity exacerbates a disequilibrium, at least in my State, between the bottom lines of the health insurers and the bottom lines of our not-for-profit and public hospitals. For instance, last year the health insurance plans in New York State enjoyed a profit of $1.3 billion, while the hospitals have been in the red for seven consecutive years. Hospitals are held captive by huge national health plans, which need to sign contracts with plans like WellPoint, which has 34 million customers. And yet, our anti-trust laws prohibit hospitals from banding together to negotiate prices.

- **How can we expect a hospital to negotiate a fair deal with a behemoth like WellPoint?**
- **Should we amend our antitrust laws to allow struggling hospitals that serve our inner city, suburban, and rural communities to band together and negotiate fair payment terms with these huge national companies?**

An antitrust exemption to permit competing hospitals to engage in joint price negotiations with health plans is not the way to address any concerns about either the

financial condition of hospitals or consolidation among insurers. Giving special antitrust treatment to price fixing by hospitals would raise costs to employers, patients, and health plans (both public and private); increase the ranks of the uninsured; and would not ensure better quality health care.

Many of the financial challenges facing hospitals today, particularly rural and inner city hospitals, are due to factors other than the payment rates offered by private health plans. Chief among these are: budget constraints on hospital rates paid by Medicare, Medicaid, and other public programs, which typically account for over half of a hospital's revenues; the costs of uncompensated care to uninsured individuals, now roughly 45 million people nationwide; and changes in health care delivery as more services are delivered outside of hospitals, in physician offices, diagnostic centers, and ambulatory care facilities. An antitrust exemption for collective fee bargaining would impose additional costs on the health care system while doing nothing to alter these fundamental underlying conditions.

With regard to disparities in bargaining power between hospitals and health plans, relative bargaining power varies from situation to situation, even when the plan is a large national company. In fact, in many instances it is the hospitals, not the health plans, that have greater bargaining power, because the plans need access to good, cost-effective hospitals in their networks in order to offer a product that is attractive to employers and consumers. Health plans' contract offers to hospitals must be sufficiently attractive that enough high-quality hospitals are willing to agree to the terms offered. Unless a health plan can assemble a network of providers willing to contract with the plan that is attractive to employers and consumers, the plan will have nothing to sell in the marketplace.

Anticompetitive aggregations of power on the buying side can be addressed under existing antitrust law. Promotion of competition at all levels of health care financing and delivery will serve the interests of consumers far better than antitrust exemption.

SUBMISSIONS FOR THE RECORD

Statement of David A. Hyman
Professor of Law and Medicine
University of Illinois

Hearing on
"Examining Competition in Group Health Care"
U.S. Senate Committee on the Judiciary
September 6, 2006

Thank you for inviting me to speak with you today. I am a professor of law and medicine and the Galowich-Huizenga Faculty Scholar at the University of Illinois, where I direct the Epstein Program in Health Law and Policy. I spent three years as Special Counsel at the Federal Trade Commission ("FTC"), where I coordinated and was principal author of the joint report issued by the FTC and Department of Justice on health care and competition law and policy.[1] My academic interests focus on the financing and regulation of health care, and I have written numerous articles on these subjects – including several on the specific issues that you are considering today.

The title of today's hearing – "Examining Competition in Group Health Care" actually encompasses a wide array of issues. These issues include:

- The role of federal and state regulation of health care delivery;
- The role of federal and state regulation of health insurance;
- The role of the federal tax subsidy for employment-based health insurance;
- The role of employers in structuring the marketplace for health care financing and delivery;
- The role of Medicare in structuring the marketplace for health care delivery – and to a lesser extent, the marketplace for health care financing;
- The extent to which information is available to consumers and policy makers about the cost and quality of health care services;
- The optimal strategy for addressing agency problems in employer-based health insurance;
- The role of antitrust law as applied to health care providers and insurers

Given our time constraints, I will focus on a much narrower subject – whether there is evidence of market power in health insurance markets – and what, if anything, we should do about it. My remarks are informed by the several days of hearings we devoted to this subject when I was at the FTC, and the two chapters in the final report on health insurance and competition law.[2] They are also informed by the academic literature that has appeared on the subject, and the multiple reports that the American Medical Association has issued decrying consolidation in the market for health insurance – most recently in April, 2006 (using 2005 data).[3] I should note that my views on this specific subject are laid out in some detail in my 2004 Health Affairs article, titled *Monopoly, Monopsony and Market Definition: An Antitrust Perspective on Market Concentration Among Health Insurers.*[4] The article was co-authored with Bill Kovacic – then General Counsel, and now a Commissioner on the Federal Trade Commission.[5]

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[1] Federal Trade Commission and Department of Justice, Improving Health Care: A Dose of Competition (2004).
[2] Id.
[3] American Medical Association, Competition in Health Insurance: A Comprehensive Study of U.S. Markets – 2005 Update (April, 2006), available at http://www.ama-assn.org/ama1/pub/upload/mm/368/compstudy_52006.pdf.
[4] David A. Hyman & William Kovacic, *Monopoly, Monopsony and Market Definition: An Antitrust Perspective on Market Concentration Among Health Insurers*, 24 Health Affairs 25-29 (Nov./Dec. 2004).
[5] Of course, in writing this article, Commissioner Kovacic was conveying his own views, and not those of the Commission, or of individual Commissioners.

Obviously, the backdrop for this hearing is the complaints of health care providers about disparities in bargaining power in dealing with insurance companies. This setting should give pause, for two distinct reasons. First, disparities in bargaining power are simply not the same thing as monopsony (buyer-side monopoly) power. Indeed, equal bargaining power is very much the exception in most markets. However, as long as those markets are reasonably competitive, there is no particular reason to get unduly exercised about bargaining disparities. Indeed, markets can work well with significant disparities in bargaining power, as long as they are reasonably competitive. To pick a few non-random examples, there are huge bargaining disparities in the markets for retail consumer goods, car rental and purchase, and air travel, but these markets are all sufficiently competitive that these bargaining disparities just don't matter to consumers – nor should they.

Second is the simple fact that the complaints come from providers -- and not consumers. In health care, providers have long set the terms of trade, including generous compensation without regard to the quality or value of the services they provide. There has been a dramatic shift in bargaining power over the past several decades in many markets away from health care providers and toward purchasers. It is far from clear the rest of us should be much concerned with that trend – again, as long as the market for health insurance is reasonably competitive. The sellers of a service have a natural tendency to conflate what is good for them with what is good for society – but the interests of consumers are sufficiently at odds with those of providers that we should generally discount provider complaints about disparities in bargaining power – an insight that flows naturally from the maxim that the purpose of antitrust is to protection competition, not competitors.[6]

Let me now turn to the evidence offered by providers in support of their position. Essentially, they make two claims: there have been a host of mergers among insurance companies that have resulted in the emergence of insurers with a national presence; and there are high Herfindahl-Hirshman ("HHI") indices in individual states and metropolitan areas.[7] I address each of these points in turn.

Over the past several decades, health insurance markets have moved from markets overwhelmingly dominated by nonprofits (primarily Blue Cross) that operated only in single states to a market with several large national insurers that operate in multiple states, and nonprofits that continue to operate in single states. These national insurers cover millions of Americans in multiple states. Does the emergence of national insurers indicate that we have a problem in the market for health insurance?

The short answer to that question is no. Understanding why requires a brief review of some basics of economics and antitrust law. Antitrust law focuses on the problem of market power. Market power is when sellers (or buyers) have the ability to profitably maintain prices above (or below) competitive levels for a significant period of time. When sellers exercise market power, it is called "monopoly." When buyers exercise market power, it is called "monopsony." Both monopoly and monopsony decrease consumer welfare. Health insurers are both buyers of medical services (from

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[6] Brown Shoe Co. v. United States, 370 U.S. 294, 320 (1962) ("Taken as a whole, the legislative history illuminates congressional concern with the protection of competition, not competitors, and its desire to restrain mergers only to the extent that such combinations may tend to lessen competition.")

[7] *See* AMA, *supra* note 3, at 1.

providers) and sellers of insurance (to consumers), so they can raise both monopsony and monopoly concerns. Absent direct evidence of anticompetitive effects (*e.g.,* higher prices, lower outputs, and lower quality), antitrust analysis of market power generally begins with the identification of relevant product and geographic markets and calculation of the shares of market participants and concentration ratios.

With this background, it is easy to see why the raw number of Americans that are covered by a particular national insurer is effectively irrelevant to an inquiry into market power. The starting point for analysis should be the market share of these insurers in particular geographic markets – not the total number of Americans who receive health insurance from national insurers.

What of the HHI indices, the second basis for the AMA's position? The HHI, which forms the analytical foundation for the FTC/DOJ merger guidelines, represents the sum of the squares of the market share of individual competitors in the market. In a market with a single seller, the HHI is 10,000. The FTC/DOJ merger guidelines provide that an HHI below 1000 corresponds to an "unconcentrated" market; an HHI between 1000 and 1800 corresponds to a "moderately concentrated" market, and a HHI above 1800 corresponds to a "highly concentrated" market.

The HHI is used as a screening tool to assess whether a proposed merger is more or less likely to have anticompetitive consequences. The merger guidelines provide that different presumptions apply, depending on the extent of post-merger market concentration and the increase in HHI that will result from the merger. For example, a merger that results in an unconcentrated market "ordinarily require no further analysis" because it is unlikely to have adverse competitive effects, but where the post-merger HHI exceeds 1800, it is "presumed that mergers producing an increase in the HHI of more than 100 points are likely to create or enhance market power or facilitate its exercise."[8]

There is no question that the reports prepared by the AMA have gotten much more sophisticated and more comprehensive over time.[9] Unfortunately, these reports fail to address the fundamental problems that have beset their analysis from the outset.

The first problem is that high HHIs do not demonstrate that market power exists or is being exercised. HHIs are a screening tool. The purpose of the HHI is to raise or lower our index of suspicion about the likelihood of market power being created or exercised in the context of evaluating a proposed merger – not to establish that market power exists or will exist.

Second, even if it could be shown that a health insurer actually has market power, the issue for antitrust purposes is whether the insurer has obtained or maintained that power through improper means. Absent such evidence, the sole fact that a market is concentrated is unlikely to attract the interest of an antitrust enforcer. With one exception, high levels of concentration have never been thought sufficient, taken by themselves, to merit an antitrust challenge. In the late 1970s, the FTC briefly flirted with using a "no-fault" theory of antitrust liability to de-concentrate various industries without proof of improper conduct. The FTC dropped this approach after developments in the case law and overwhelming criticism from antitrust experts led the FTC to conclude that

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[8] FTC/DOJ Merger Guidelines, 1.51 (1992), available at http://www.ftc.gov/bc/docs/horizmer.htm.

[9] For example, the first study analyzed 40 metropolitan areas, while the latest study analyzes almost 300 metropolitan areas. AMA, *supra* note 3, at 1.

no-fault cases would receive a hostile reception in the courts.[10] No competition agency has sought to revive this strategy in the intervening twenty-odd years.

Third, the HHI is used to calculate market concentration only *after* the scope of the product and geographic market is determined. The validity of the HHI as a screening tool depends entirely on proper definition of the relevant market. As Judge Richard Posner has observed, "the definition of the market in which to measure the market shares of the merging parties and their competitors is critical; given enough flexibility in market definition a surprising number of innocuous mergers can be made to appear dangerously monopolistic."[11] Similarly, Robert Pitofsky, former Chairman of the FTC, has observed that "knowledgeable antitrust practitioners have long known that the most important single issue in most enforcement actions - because so much depends on it - is market definition."[12] The market definition process was farcically described by Professor (and Nobel laureate) George Stigler:

> Consider the problem of defining a market within which the existence of competition or some form of monopoly is to be determined. The typical antitrust case is an almost impudent exercise in economic gerrymandering. The plaintiff sets the market, at a maximum, as one state in area and including only aperture-priority SLR cameras selling between $ 200 and $250. This might be called J-Shermanizing the market, after Senator John Sherman. The defendant will in turn insist that the market is worldwide, and includes not only all cameras, but also portrait artists and possibly transportation media because a visit is a substitute for a picture. This might also be called T-Shermanizing the market, this time after the Senator's brother, General William Tecumseh Sherman. Depending on who convinces the judge, the concentration ratios will be awesome or trivial, with a large influence on his verdict.[13]

At first glance, it might seem intuitively appealing to use states and metropolitan areas as geographic markets. An individual state is clearly a relevant parameter for regulatory purposes, and a considerable amount of data is available on a state-by-state basis. However, there is no evidence that individual states constitute relevant geographic markets for health insurance – and there is considerable evidence to the contrary. Indeed, the AMA's study of market concentration expressly cautions that "state-level data can be very misleading because in many states, health insurers do not compete on a statewide basis."[14] It is much more plausible to evaluate markets at the metropolitan level, but once again one must demonstrate that a particular metropolitan area is a market, and not simply assume it. Bluntly stated, if an entire state or metropolitan area is not a relevant

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[10] Timothy J. Muris, Improving the Economic Foundations of Competition Policy, Jan. 15, 2003, available at http://www.ftc.gov/speeches/muris/improveconfoundatio.htm

[11] RICHARD A. POSNER, ANTITRUST LAW: AN ECONOMIC PERSPECTIVE 125 (1976).

[12] Robert Pitofsky, *New Definitions of Relevant Market and the Assault on Antitrust*, 90 COLUM. L. REV. 1805, 1807 (1990).

[13] George J. Stigler, *The Economists and the Problem of Monopoly*, in THE ECONOMIST AS PREACHER AND OTHER ESSAYS 38, 51 (1982).

[14] AMA, *supra* note 3, at 3.

geographic market, the existence of high HHIs in that state or metropolitan area has no competitive (or probative) significance.

Fourth, it is important to distinguish lawful managed care contracting from unlawful monopsony behavior. It is common for providers to treat disparities in bargaining power as prima facie evidence of anticompetitive behavior. This is silly. Managed care plans and other health insurers can legitimately lower provider prices by increasing competition among providers or engaging in other activities that lower the costs of provider services. By engaging in hard bargaining, insurers lower the cost of coverage – which directly benefits consumers.

Because one purpose of managed care is to lower prices closer to a competitive level, it can be extremely difficult to determine when a managed care purchaser is exercising monopsony power – necessitating a lengthy, fact-intensive investigation that is prone to error. The more general point, as Table 1 reflects, is that any system for deciding whether monopsony power is being exercised will generate four kinds of the results: true positives (cell 1), false positives (cell 2), false negatives (cell 3), and true negatives (cell 4).

Table 1: A Typology of Monopsony Evaluation

Was There Monopsony?	Did the Enforcer Determine There Was Monopsony?	
	Yes	No
Yes	True Positive (1)	False Negative (3)
No	False Positive (2)	True Negative (4)

True positives and true negatives occur, respectively, when an enforcer correctly determines that there was monopsony, or correctly determines that there was not monopsony. False positives and false negatives occur, again respectively, when an enforcer determines there was monopsony even though there wasn't, or determines there wasn't monopsony even though there was. True positives and true negatives are correct results. False positives and false negatives are mistakes.

The goal for an antitrust enforcer is to maximize the number of cases in cells 1 and 4, and minimize the number of cases in cells 2 and 3, while simultaneously minimizing the costs associated with the system of antitrust enforcement. The more difficult it is to distinguish between true positives and true negatives (let alone false positives and false negatives), the more expensive and error-prone the system is likely to prove. The AMA is understandably interested in minimizing the number of false negatives – but doing so is likely to increase the number of false positives – and consumers will directly bear the costs of those erroneous decisions. Before starting down this path, we should ask ourselves whether the game is worth the candle – particularly when there is precedent (written by then-Judge and now Supreme Court Justice Stephen Breyer) indicating that "a legitimate buyer is entitled to use its market power to keep prices down," as long as the prices are not below incremental cost or predatory.[15]

[15] *Kartell v. Blue Shield of Massachusetts*, 749 F.2d 922, 927-931 (1st Cir. 1984).

Finally, for all the complaints we have heard from providers about monopsony power and market concentration, it is striking how little we have heard from employers on the subject. At the FTC/DOJ health care hearings, panelists representing employers testified that health insurance markets in most geographic areas enjoy healthy competition, with multiple health insurer competitors offering multiple product options.[16] Most employers can self-insure, and avoid most of the problems that might otherwise result from health insurance market concentration. Of course, these hearings were held several years ago, and it is certainly possible that employers in particular markets in particular states might express different views now – but that is where we should be looking if we want to get a reading on the likelihood insurers are exercising monopsony power.

Where Should We Go From Here?

My skepticism about the issue of monopsony does not mean that I think all is well in the health care sector of the economy. Let me summarize a few specific reforms that would help improve the status quo.

- Improve transparency of price and quality information, and use incentives to improve quality

The quality of American health care is not what it should be.[17] One important step in addressing this problem is improving the transparency of price and quality information. There have been promising preliminary steps in this direction, but there is much more to be done. The same goes for payment-for-performance ("P4P").[18]

- Fix the tax subsidy

The tax subsidy for employment-based health insurance is the source of considerable horizontal and vertical inequity.[19] Although we need to be careful not to destabilize the existing system, it is long past time to experiment with various ways of eliminating these inequities.

- Lower barriers to entry in health insurance

The AMA believes that state regulation is an important barrier to entry in the health insurance market.[20] I concur with that assessment. The question is how best to fix the problem. One possible strategy is to allow small businesses to form Association Health Plans in order to get the benefit of ERISA preemption. Another possible strategy is to use regulatory federalism to create a national market in health insurance. As with the tax

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[16] Hyman & Kovacic, *supra* note 4, at 27.
[17] David A. Hyman & Charles Silver, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?*, 95 CORNELL L. REV. 893-993 (2005)
[18] David A. Hyman & Charles Silver, *You Get What You Pay For: Result-Based Compensation for Health Care*, 58 WASHINGTON & LEE L. REV. 1427-1490 (2001); Arnold M. Epstein, *Paying For Performance in the United States and Abroad*, 355 NEW ENGL. J. MED. 406 (2006); Robert Galvin, *Pay For Performance: Too Much of A Good Thing? A Conversation with Martin Roland*, Health Affairs Web Exclusive (2006), *available at* http://content.healthaffairs.org/cgi/content/abstract/hlthaff.25.w412.
[19] David A. Hyman & Mark Hall, *Two Cheers For Employment-Based Health Insurance*, 2 YALE J. HEALTH POL'Y, L. & ETHICS 23-57 (2001).
[20] *See* AMA, *supra* note 3, at 2.

subsidy, although we need to be careful not to destabilize the existing system, it is long past time to experiment with various ways of addressing unnecessary state-created barriers to entry in the markets for health insurance and health care delivery.

- Malpractice Reform

The academic consensus on the performance of the malpractice system is considerably at odds with the terms of the political debate that has been waged over the issue in the past few years.[21] Although there is certainly a broad range of views on the best way to fix the malpractice system, no serious academic thinks that a cap on non-economic damages is going to address the pathologies of the existing system. If we want to improve the performance of the health care system, malpractice reform needs to be part of the discussion.[22]

Conclusion

Let me close with a concrete example of the problem with the AMA's approach to the issue of monopsony power. I am one of two people at the University of Illinois College of Law that teaches health law, and the only person who does empirical research on medical malpractice. If one treats the College of Law as the relevant geographic market (and we are the only law school within 125 miles), the HHI for health law is 5,000 and the HHI for medical malpractice is 10,000. These are staggeringly high – but utterly meaningless HHIs. I can assure you that I don't have any market power in dealing with my dean with regard to my salary and teaching package.

The obvious point is that unless the product and geographic market is correctly defined, high HHIs are simply irrelevant to what we actually care about – and even if these markets are properly defined, the HHI is only a screening test that calls for further investigation. For these reasons, the kindest thing one can say about the charge of monopsony, at least based on the current record, is the old Scottish verdict, "not proven."

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[21] David A. Hyman & Charles Silver, *Medical Malpractice Litigation and Tort Reform: It's the Incentives, Stupid*, VAND. L. REV. (forthcoming, 2006).

[22] I note that the Senate Committee on Health, Education, Labor, and Pensions held a hearing on "Medical Liability: New Ideals for Making the System Work Better For Patients" on June 22, 2006. *See* http://help.senate.gov/Hearings/2006_06_22/2006_06_22.html.

Testimony on

Examining Competition in Group Health Care

By

Stephanie W. Kanwit
Special Counsel
America's Health Insurance Plans

Before the Senate Judiciary Committee

September 6, 2006

I. Introduction

Good morning, Chairman Specter, Ranking Member Leahy, and members of the committee. I am Stephanie Kanwit, Special Counsel for America's Health Insurance Plans (AHIP), which is the national association representing nearly 1,300 health insurance plans providing coverage to more than 200 million Americans.

We appreciate this opportunity to testify on the challenges and complexities associated with ensuring vigorous competition in group health care. The basic purpose of the antitrust laws and antitrust enforcement in the health care industry, as in other industries, is to promote and preserve competition for the benefit of consumers, not individual competitors. Competition promotes quality improvement, cost containment, consumer choice, and the expansion of innovative approaches to health care delivery that benefit consumers.

Our testimony today will focus on two main topics:

- The fact that vigorous competition exists in the health care industry, including how that competition has spurred the introduction of new products beneficial to consumers; and

- How health insurance plans are working with practitioner and employer groups to maintain a competitive health care market by promoting quality and transparency through such measures as improving physician performance measurement and rewarding quality performance, while providing consumers with information allowing them to make value-based decisions.

II. Vigorous Competition in the Health Care Marketplace

Our health insurance plan members operate in one of the most highly competitive industries in the country, according to the two Federal antitrust agencies, the Department of Justice and the Federal Trade Commission. Those agencies in their landmark report last summer summarized twenty-seven days of hearings exploring the issue of whether payors, such as health insurance plans, possess monopsony (buyer-side) power in U.S. health care markets. This in-depth

exploration came to the resounding conclusion that they do not. [1] Nor do they possess monopoly (seller-side) power; in fact, representatives from our members' customers – employer groups – testified repeatedly at those hearings that health insurance markets in most areas of the country enjoy robust competition, with multiple insurers offering multiple product options to employers on behalf of their employees. Such vigorous competition creates incentives for all stakeholders, including health insurance plans and health care practitioners, to increase efficiency and reduce costs for consumers.

Unfortunately, there is misinformation regarding the nature of that competition, based on the argument that the health insurance marketplace is dominated by a few companies with "market power," and that the recent consolidation of some health insurance plans has somehow led to purported higher health care premiums. For example, the American Medical Association just released the fifth edition of its report, "Competition in Health Insurance," claiming that alleged health insurer consolidation is creating "near-monopolies in virtually all reaches of the U.S." and that such consolidations have raised prices for consumers. These conclusions are not supported by the data.

Specifically, empirical data show that consumers currently benefit from vigorous competition, and have wide choices among multiple competing health insurers in their areas. For example, there are multiple competing health plans purchasing physician services in every major metropolitan area in the United States, each offering multiple products to consumers and employers. As the following chart shows, there are 16 HMOs in Los Angeles, 20 in Miami, 12 in Boston, 13 in Baltimore, 14 in Philadelphia, and 11 in Pittsburgh.

In addition, new types of products – such as consumer-directed health plans or Health Savings Accounts (HSAs) – continue to be introduced in the marketplace, affording consumers additional choices to the many varied HMO, PPO and indemnity options and demonstrating the vitality and innovation typical of a highly competitive marketplace. According to a January 2006 AHIP census, HSA-compatible high deductible health plans (HDHPs) covered approximately 3.2

[1] FTC/DOJ Report, "Improving Health Care: A Dose of Competition," (2004) at p. 27; ch. 2 at p. 21; see generally ch. 6. Health insurance plans are both buyers of medical services (from providers) and sellers of insurance (to consumers and employers).

million people. This reflects a more than three-fold increase in enrollment in HSA products since AHIP conducted an earlier census in March 2005 – a strong showing for a health care option that did not even exist as recently as three years ago.

Second, the thesis that health care markets are concentrated, thus creating higher prices, also is not borne out by the data, since *growth in national health spending has been slowing down, not increasing*. According to actuaries at the Centers for Medicare & Medicaid Services (CMS) in Baltimore, private health insurance premiums were estimated to grow by 6.8% in 2005, down from 8.4% in 2004 – "the third consecutive year in which premium growth will have slowed" since 2002.[2] Non-government estimates already have indicated that 2006 will be the fourth consecutive year in which premium growth has slowed. In charging undue "concentration," studies have inappropriately employed a Department of Justice benchmark, the Herfindahl-Hirschman Index (HHI). This index normally is used by the FTC and the Justice Department to assess concentration within a particular market when a merger is proposed. But the regulatory agencies do not stop with an analysis of market concentration; the key antitrust question is "whether market power exists or is being exercised," in the words of a former General Counsel of the FTC.[3] Market power means the ability of sellers or buyers to profitably maintain prices above or below competitive levels, not simply market concentration.

Studies claiming that health insurance plans as purchasers of health care "dictate" prices and coverage terms to physicians cannot be accurate when the average physician: (1) contracts with about thirteen health plans, as noted in the chart below, and (2) receives about only half of his or her practice revenues from health plan contracts. Physicians can and do provide services to other purchasers, such as public programs including Medicare and Medicaid; workers' compensation systems; and TRICARE, the Government health care program for the military. In addition, there are self-insured plans through which employers work with health plan administrators to contract for the services of physicians and other practitioners.

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[2] C. Borger, S. Smith, C. Truffer, S. Keehan, et al., "Health Spending Projections Through 2015: Changes on the Horizon," *Health Affairs*, DOI 10.1377/hlthaff.25.w61 (Feb. 2006).

[3] Kovacic, W. and Hyman, D., "Monopoly, Monopsony and Market Definition," 23 *Health Affairs* 25 (2005).

Anticompetitive Practices: Physician Collective Bargaining and Provider Contracting Practices

As part of the committee's discussion of health care competition, we hope that the recommendations in the recent FTC/DOJ report will be closely studied with respect to the consideration of physician collective bargaining. Unlike trade unions that are subject to the rules and requirements of the Taft-Hartley legislation, proposals for physician collective bargaining would have none of these requirements. Indeed, one of the FTC and DOJ's six key recommendations coming out of their joint health care hearings was the following: "Governments should not enact legislation to permit independent physicians to bargain collectively." Authorizing physicians, hospitals, pharmacists and other providers to engage in collusive conduct never serves the interest of consumers. Instead, such legislation is likely to increase substantially the cost of health care services,[4] thus increasing costs and reducing access to insurance, while not improving the quality of patient care. Physicians and other practitioners already have the ability to collectively negotiate with health insurance plans under guidelines issued in 1996, when the goal is increasing efficiencies and improving patient care.[5]

What practitioners cannot do under current law is create cartels that restrict consumer choice and hinder the ability of health insurance plans to manage health care costs. The FTC, for example, has been very active in policing provider conduct that unreasonably restrains competition. Just last week it settled a complaint against two independent practice associations (IPAs) and their 127 physician members, charging that their conduct toward health insurers unreasonably restrained competition by fixing prices.[6] The FTC has also been active in scrutinizing provider-side mergers, especially hospitals. Indeed, in an initial decision by an FTC law judge issued last

[4] The Congressional Budget Office in 2000 estimated that one such piece of Federal legislation, HR 1304, would increase private health care costs by 2.6%, even assuming that only 30% of physicians took advantage of the bill's exemption. Another report by LECG/Navigant Consulting estimated that the same Federal bill would increase health care expenditures by $141 billion over a five-year period, and cause approximately 3 million more individuals to be uninsured.

[5] The DOJ and FTC in their recent report on health care competition specifically affirmed that physician networks can enter into joint negotiations with health insurance plans consistent with the *1996 Antitrust Guidelines* so long as the networks are either (1) financially integrated, like IPAs formed to accept risk, or (2) clinically integrated. Providers are experimenting with different types of clinical integration, including banding together to institute mechanisms to control costs and ensure quality, or share electronic clinical data systems, or reward those physicians in the group who meet performance goals.

[6] *In re New Century Health Quality Alliance, Inc.* FTC, File No. 051-0137, 8/24/06.

fall and now under appeal, an Illinois hospital merger was found to reduce competition when the merged entity exercised its enhanced post-merger market power to obtain price increases significantly above its pre-merger prices, and substantially larger (as much as 48%) than price increases obtained by other hospitals in the area.[7] The FTC/DOJ report and agency officials have highlighted anti-competitive contracting practices, including full-system or all-or-nothing contracting, whereby hospital systems with market power demand inclusion of all hospitals in a network – regardless of need.[8]

III. Health Insurance Plans' Efforts to Promote Quality and Transparency

The FTC/DOJ report on health care competition emphasizes improving measures of both price and quality, and the importance of empowering consumers with information as well as incentives to use that information. Our members are committed to working to maintain a competitive health care market through a number of initiatives and strategies which improve physician performance measurement as well as provide consumers with information that helps them make informed, value-based decisions. I describe two examples below.

A. Promoting Quality and Transparency through the AQA

There is a major push by both public and private stakeholders to promote greater transparency and value-based competition throughout the U.S. health care system, through empowering consumers to be more actively engaged in making decisions – based on reliable, user-friendly data – about their medical treatments and how their health care dollars are spent. Last month, for example, President Bush signed an executive order requiring agencies that administer federal health programs to take steps to make price and quality information available to consumers, and implement pay-for-performance incentives. Simultaneously, the Administration has been urging

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[7] *In re Evanston Northwestern Healthcare Corporation* (ENH), FTC, 10/17/05. The three merged hospitals, the Law Judge found, "decided that all three hospitals would operate under one contract, with one price, and one chargemaster, even though other multi-hospital systems in the Chicago area charged different rates for different hospitals." Id. At 158.

[8] See FTC/DOJ Report at pp. 31-55. See also testimony of Stephanie Kanwit before the FTC on Sept. 9, 2002, "Health Care Services: Provider Integration", asking that Commission evaluate huge increases in hospital charges as a result of mergers; the strategy of hospital systems sending termination letters to health plans as part of their efforts to obtain higher rates; all-or-nothing contracting; and increased leverage as a result of hospitals forming joint arrangements with physician groups. See http://www.ftc.gov/ogc/healthcare/kanwit1.pdf

the states and major employers to take similar steps through their leverage as health care purchasers on behalf of private sector employees, state employees, and Medicaid beneficiaries.

The antitrust agencies, the FTC and DOJ, also have long promoted disclosure to consumers and other interested parties of information regarding prices and quality of health care services. In their 2004 report, the antitrust agencies touted "increased transparency" as the key means "to implement strategies that encourage providers to lower costs and consumers to evaluate prices." They specifically recommended that private payors, governments, and providers "should furnish more information on prices and quality to consumers in ways that they find useful and relevant."

We are pleased to note that health insurance plans are currently working collaboratively towards that same goal with a large coalition of more than 35 physician groups (including the AMA, the American College of Cardiology, the American Board of Internal Medicine, and the American Academy of Pediatrics), as well as hospitals, accrediting organizations (like NCQA, JCAHO, and URAC), private sector employers and business coalitions (like AARP, the Pacific Business Group on Health, and the Leapfrog Group), and employers and government representatives, to meet this challenge by developing uniform processes for performance measurement and reporting. Those processes are ongoing, and would *first,* allow patients and purchasers to evaluate the cost, quality and efficiency of care delivered, and *second,* enable practitioners to determine how their performance compares with their peers in similar specialties. This effort, called by the acronym AQA, has grown and now consists of more than 125 organizations joined in a broad-based coalition.

The AQA has endorsed a "starter set" of 26 clinical performance measures for the ambulatory care setting that are already being incorporated into provider contracts. The uniform starter set includes preventive measures for cancer screening and vaccinations; measures for chronic conditions including coronary artery disease, heart failure, diabetes, asthma, depression, and prenatal care; and two efficiency measures that address the overuse and misuse of health care services. The AQA also has adopted new sets of measures for practitioners in the areas of cardiology (eight measures) and cardiac surgery (fifteen measures). These measures represent an important first step in establishing a broad range of quality standards to give consumers the information they need to make informed health care decisions.

Over the next few months, the AQA will be working toward identifying a starter set of efficiency measures. These measures will assess physicians' resource utilization when treating select conditions over a period of time. The AQA will seek to align these measures with existing clinical quality measures and ensure that they are appropriately adjusted for risk and case mix.

Most importantly, the AQA is receiving support from the Centers for Medicare & Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ) to carry out a pilot program in six sites across the country to combine public and private sector quality data on physician performance. This pilot program is testing various approaches to aggregating and reporting data on physician performance, while also testing the most effective methods for providing consumers with meaningful information that they can use to make choices about which physicians best meet their needs.

This pilot program is being implemented in areas and through organizations that have a history of collaboration on quality and data initiatives among health plans and physician groups:

- California Cooperative Healthcare Reporting Initiative, San Francisco CA;
- Indiana Health Information Exchange, Indianapolis IN;
- Massachusetts Health Quality Partners, Watertown MA;
- Minnesota Community Measurement, St. Paul MN;
- Phoenix Regional Healthcare Value Measurement Initiative, Phoenix AZ; and
- Wisconsin Collaborative for Healthcare Quality, Madison WI.

A highly respected advisory committee of leaders in quality and performance design selected these six entities because they have the infrastructure and experience needed to support the combination of public and private data and, additionally, are positioned to implement the pilots within a short timeframe. Ultimately, we anticipate that the results of this pilot program will lead to a national framework for measurement and public reporting of physician performance, which is an important step toward improving transparency and consumer decision-making. Secretary of Health and Human Services Michael Leavitt has applauded the efforts of the pilot and expressed interest in creating more pilots throughout the country, constructing a national effort in support of quality performance measurement.

B. Promoting Quality and Transparency Through Rewarding Quality Performance

Health insurance plans continue to lead efforts to design products that offer comprehensive coverage, broad choice of providers, and greater information on provider performance. Increasingly, these products are incorporating incentives for providers to promote high quality and efficient care. Such products aim to meet yet another recommendation of the FTC/DOJ, calling for private payors, governments, and providers to "experiment further with payment methods for aligning providers' incentives with consumers' interests in lower prices, quality improvements and innovation."

AHIP's members are committed to working with stakeholders across the health care community, particularly health care professionals who work on the frontlines every day, to develop and improve incentive programs and an overall strategy that accounts for the quality of care delivered to patients. In November 2004, AHIP's Board of Directors demonstrated this commitment by approving principles for guiding the development and implementation of programs that advance a quality-based payment system. They include eight key elements:

- Programs that reward quality performance should promote medical practice that is based on scientific evidence and aligned with the six aims of the IOM for advancing quality (safe, beneficial, timely, patient-centered, efficient, and equitable).

- Research is urgently needed to inform clinical practice in priority areas currently lacking a sufficient evidence-based foundation.

- The involvement of physicians, hospitals and other health care professionals in the design and implementation of programs that reward quality performance is essential to their feasibility and sustainability.

- Collaboration with key stakeholders, including consumers, public and private purchasers, providers, and nationally recognized organizations, to develop a common set of performance measures – process, outcome and efficiency measures – and a strategy for implementing

those measures will drive improvement in clinically relevant priority areas that yield the greatest impact across the health care system.

- Reporting of reliable, aggregated performance information will promote accountability for all stakeholders and facilitate informed consumer decision-making.

- The establishment of an infrastructure and appropriate processes to aggregate – across public and private payers – performance information obtained through evidence-based measures will facilitate the reporting of meaningful quality information for physicians, hospitals, other health care professionals, and consumers.

- Disclosure of the methodologies used in programs that reward quality performance will engage physicians, hospitals, and other health care professionals so they can continue to improve health care delivery.

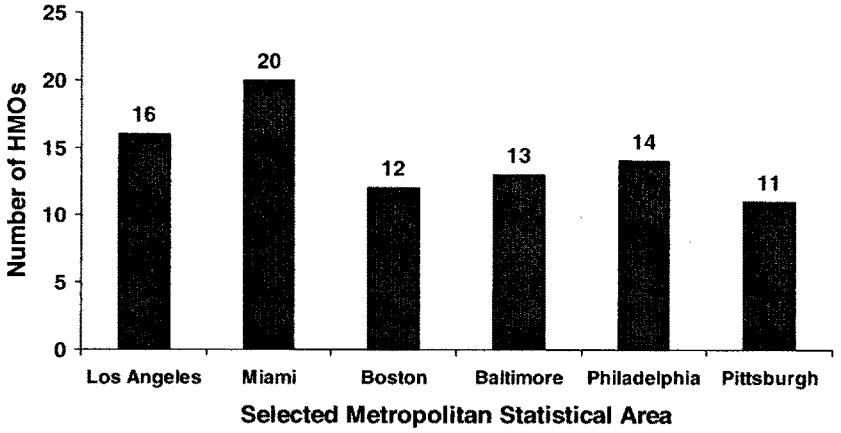
- Rewards, based upon reliable performance assessment, should be sufficient to produce a measurable impact on clinical practice and consumer behavior, and result in improved quality and more efficient use of health care resources.

IV. Conclusion

AHIP and its member health insurance plans strongly support both competition and cooperation among all the participants in the health care delivery system. We commend the Federal antitrust agencies for their comprehensive and landmark report, "Improving Health Care: A Dose of Competition," as well as their law enforcement initiatives in those instances where provider networks, whether comprised of hospitals or physicians, engage in anti-competitive conduct.

Thank you for this opportunity to testify, and we look forward to continuing to work with this committee and the antitrust agencies to promote and preserve competition with the goal of further expanding access to high quality, affordable health care.

Multiple Competing Health Insurance Sellers Exist in Every Major Metropolitan Area



Source: HealthLeaders / Interstudy: *The Competitive Edge, Part III: Managed Care Regional Market Analysis*, data from July 1, 2005

Statement

of the

American Medical Association

to the

Senate Committee on the Judiciary
United States Senate

RE: Examining Competition in Group Health Care

Presented by Edward L. Langston, MD

September 6, 2006

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Statement

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Re: Examining Competition in Group Health Care

Presented by: Edward L Langston, MD

September 6, 2006

The American Medical Association (AMA) appreciates the opportunity to present testimony to the Senate Judiciary Committee on competition in the health care industry. In particular, we are pleased to have been asked to discuss the AMA's study *Competition in Health Insurance: A Comprehensive Study of US Markets* (Competition Study), recent health plan mergers, and the uneven playing field that has developed between physicians and health plans. These issues are critical to the AMA because they bear directly upon physicians' ability to provide the best possible care to their patients.

The AMA believes that effective, efficient, high-quality medical care is only possible in a fully functional and competitive health care market. Growing consolidation and concentration in the health insurance market imperils the competitive process, threatening quality and access to care. The AMA has been cautioning about the long-term negative consequences of aggressive consolidation of health insurers for quite some time. We have watched with growing concern as large health plans pursue aggressive acquisition strategies to assume dominant positions in their markets, and we fear that this rapid consolidation will lead to a health care system dominated by a few publicly traded companies that operate in the interest of shareholders rather than patients.

The AMA's Competition Study, together with other key market characteristics, suggest that our worst fears are being realized in many markets across the country. It is the position of the AMA that the market dynamics as set forth in this testimony warrant the Federal Government, through the Department of Justice, exercising its subpoena power to determine whether health plans are, in fact, engaging in anticompetitive behavior to the detriment of consumers—our patients. In addition, the AMA believes that Congress must take steps to provide more protection to patients and physicians from the unfair practices of large, dominant health insurers.

AMA COMPETITION IN HEALTH CARE STUDY

The competitive health care market has been steadily eroding. Over the past 10 years there have been over 400 mergers involving health insurers and managed care organizations.[1] In 2000, the two largest health insurers, Aetna and UnitedHealth Group (United) had a total combined membership of 32 million people. As a result of aggressive merger activity since 2000, including United's acquisition of California-based PacifiCare Health Systems, Inc., and John Deere Health Plan in 2005, United's membership alone has grown to 32 million. Similarly, WellPoint, Inc., (Wellpoint) the company born of the merger of Anthem, Inc. (originally Blue Cross Blue Shield of Indiana), and WellPoint Health Networks, Inc. (originally Blue Cross of California), now owns Blue Cross plans in 14 states. In 2005, WellPoint acquired the last remaining for-profit Blue Cross Blue Shield plan, the New York-based WellChoice. As a result of that acquisition and the many that preceded it, WellPoint now covers approximately 34 million Americans.[2] Together, WellPoint and United control 33 percent of the U.S. commercial health insurance market.

The effects of consolidation, however, are even more striking at the local and regional levels, the focus of the AMA's Competition Study.[3] Every year for the past five years, the AMA has conducted the most in-depth study of commercial health insurance markets in the country. The study, *Competition in Health Insurance: A Comprehensive Study of US Markets*, analyzes the most current and credible data available on health insurer market share for 294 Metropolitan Statistical Areas (MSAs) and 48 states.[4]

In addition to its exhaustive geographic reach, the study considers both a broad and narrow definition of the product market. The product market represents all products that purchasers view as reasonable substitutes for the product in question.[5] The broad product market analysis considered the combination of Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO) products; the narrow product analysis considered HMO and PPO market segments separately. Thus, the health insurance market was analyzed in three ways—including only HMOs; including only PPOs; and including both HMOs and PPOs. For each, the study calculated the Herfindahl-Hirschman Index ("HHI")[6] of competition, which measures the competitiveness of a

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[1] Irving Levin Associates. *The Healthcare Acquisition Report*, 2001-2206 Editions.

[2] WellPoint Health Networks and Anthem, Inc., merged in 2004. The merged entity, WellPoint, Inc., is nearly double the size of either entity.

[3] The AMA focused on state and MSA markets because health care delivery is local, and health insurers focus their business and marketing practices on local markets.

[4] Significantly, state-level data is often misleading because in many states health insurers do not compete on a statewide basis.

[5] The AMA considered both a broad and narrow definition of product market because there is little evidence regarding substitutability of various forms of health insurance and therefore no consensus as to whether some products are or are not substitutable for others.

[6] The HHI is the sum of the squared market shares of each firm in the market. The more competitive the health insurance market, the lower the HHI. The less competitive the health insurance market, the higher the HHI. The largest value the HHI can take is 10,000 when there is a single insurer in the market. As the number of firms in the market increases, however, the HHI decreases. For instance, if a market has four

market overall, [7] and, applying the 1997 Federal Trade Commission/Department of Justice Horizontal Merger Guidelines (Merger Guidelines), classified them as "not concentrated," "concentrated," or "highly concentrated."[8] The results form the most extensive and accurate portrayal of the health insurance market to date. And they confirm that in the majority of health care markets competition has been severely undermined.

With regard to market concentration (HHI), the study found the following:

- In the combined HMO/PPO product market, 95 percent (279) of the MSAs are highly concentrated.
- In the HMO product market, 99 percent (290) of the MSAs are highly concentrated.
- In the PPO product market, 99 percent (293) of the MSAs are highly concentrated.

With regard to market share,[9] the study found the following for each product market:

For the combined HMO/PPO product market:

- In 95 percent (280) of the MSAs, at least one health insurer has a market share of 30 percent or greater.
- In 56 percent (16) of the MSAs, at least one health insurer has a market share of 50 percent or greater.
- In 19 percent (56) of the MSAs, at least one health insurer has a market share of 70 percent or greater.
- In 4 percent (11) of the MSAs, at least one health insurer has a market share of 90 percent or greater.

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firms, each with a 25 percent share, the HHI would be 10,000 divided by 4, which equals 2500. The HHI would continue to decrease with additional firms in the market.

[7] The HHI is not a measure specific to any one firm, although it is a function of each firm's market share. The U.S. Department of Justice (DOJ) uses the HHI when evaluating the impact of a merger or acquisition on the competitiveness of a market.

[8] Markets with an HHI of less than 1000 are classified as "not concentrated." The DOJ and FTC will generally not restrict merger activities in these markets. Markets with an HHI between 1000 and 1800 are classified as "concentrated." Under the Merger Guidelines, a merger in one of these markets that raises the HHI by more than 100 points may raise significant competitive concerns. Markets with an HHI above 1800 are classified as "highly concentrated." A merger in a "highly concentrated" market that raises the HHI by more than 50 points may raise significant competitive concerns, and a merger that raises the HHI more than 100 points is presumed to be anti-competitive.

[9] The AMA measures market shares of health insurers by enrollment. The combined HMO/PPO market share of an insurer is the sum of that insurer's HMO and PPO enrollment, divided by the total HMO and PPO enrollment in the market, multiplied by 100. HMO market share is that HMO's enrollment, divided by total HMO enrollment in the market, multiplied by 100. Similarly, a PPO's market share is that PPO's enrollment, divided by total PPO enrollment in the market, multiplied by 100.

For the HMO product market:

- In 96 percent (283) of the MSAs, at least one health insurer has a market share of 30 percent or greater.
- In 64 percent (188) of the MSAs, at least one health insurer has a market share of 50 percent or greater.
- In 34 percent (101) of the MSAs, at least one health insurer has market share of 70 percent or greater.
- In 17 percent (50) of the MSAs, at least one health insurer has a market share of 90 percent or greater.

For the PPO product market:

- In 99 percent (291) of the MSAs, at least one health insurer has a market share of 30 percent or greater.
- In 78 percent (230) of the MSAs, at least one health insurer has a market share of 50 percent or greater.
- In 36 percent (105) of the MSAs, at least one health insurer has a market share of 70 percent or greater,
- In 9 percent (26) of the MSAs, at least one health insurer has a market share of 90 percent or greater.

This year's study establishes, unequivocally, that competition has been undermined in hundreds of markets across the country. Sadly, the ultimate consumers of health care—patients—are not the ones benefiting from the consolidation. To the contrary, patient premiums have risen dramatically without any expansion of benefits, while many health insurers have posted record profits.

ADDITIONAL INDICATORS OF UNFAIR COMPETITION

In addition to high market share and market concentration, many health care systems across the country exhibit characteristics typical of uncompetitive markets and growing monopoly and monopsony power. There are significant barriers to entry for new health insurers in these markets. Large, entrenched health insurers are able to raise premiums without losing market share. And dominant health insurers are able to coerce physicians into accepting unreasonable contracts. Taken together these features confirm that competition in health care markets across the country is being significantly undermined.

Barriers to Entry into the Market

Barriers to entry are relevant when determining whether a high market share threatens competition in a specific market. Where entry is easy, even a high market share will not necessarily translate into market power, as attempts to increase price will likely be countered by entry of a new competitor. On the other hand, where entry is difficult, a

dominant player is able to profitably sustain significant price increases without fear of competition.

Most markets across the country currently display substantial barriers to entry. Start-up health insurers must meet costly state statutory and regulatory requirements, including strict and substantial capitalization requirements. To do this, they must have sufficient business to permit the spreading of risk, which is difficult, if not impossible, in markets with dominant health insurers. Indeed, it would take several years and millions of dollars for a new entrant to develop name and product recognition with purchasers to convince them to disrupt their current relationships with the dominant health insurers. The Justice Department underscored the significant obstacles associated with entering certain health insurance markets in *United States v. Aetna*, when it noted, "[n]ew entry for an HMO or HMO/POS plan in Houston or Dallas typically takes two to three years, and costs approximately $50,000,000."[10] These market conditions create insurmountable barriers for new entrants.

Premium Increases

The ability of dominant health insurers to profitably raise premiums is another sign of monopoly power. This practice exacerbates access to care problems and contributes to the alarming numbers of uninsured. When premiums rise, many employers stop providing coverage and/or reduce the scope of benefits provided. Even when employers offer health plans, increases in premiums, deductibles, and co-payments have led many workers to forego their employer-sponsored health insurance. In fact, according to a survey by the Agency for Healthcare Research and Quality, employee health plan participation at large companies declined from 87.7 percent to 81 percent between 1996 and 2004.[11] This declining coverage puts an enormous strain on the health care system and leads to otherwise avoidable expenditures for emergency care and other medical services.

The past five years have been marked by increasing health plan premiums and profits. In 2005, premiums for employment-based insurance policies increased by 9.2 percent[12]—outpacing overall inflation by a full 5.7 percent.[13] In 2003 and 2004, premiums again increased by 14 and 11 percent respectively. Cumulatively, the premium increases during the last six years have exceeded 87 percent, with no end in sight. This is more than three times the overall increase in medical inflation (28 percent) and more than five times the increase in overall inflation (17 percent) during the same period.[14]

Health insurers seek to deflect attention from their huge profits by falsely asserting that physician payments are driving recent premium increases. Such claims are baseless.

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[10] *United States v. Aetna*, No. 3-99CV1398-H (N.D. Tex.) (revised Competitive Impact Statement filed August 3, 1999).
[11] Fuhrmans, Wall Street Journal, 8-25-06.
[12] Strunk, et al, "Tracking health Care Costs," *Health Affairs* (Sept. 26, 2001), W45.
[13] Jon Gabel, et al, "Job-Based Health Insurance in 2001: Inflation Hits Double digits, Managed Care Retreats," *Health Affairs* (Sept/Oct. 2001), at 180.
[14] Kaiser/HRET: Employer Health Benefits Survey, 2005 Annual Survey.

While premium levels have risen by double-digit amounts, physician revenues have fallen. The median real income of all U.S. physicians remained flat during the 1990s and has since decreased.[15] The average net income for primary care physicians, after adjusting for inflation, declined 10 percent from 1995 to 2003, and the net income for medical specialists slipped two percent.[16] In contrast, recent reports on health insurer profits show that the profit margins of the major national firms have experienced double-digit growth since 2001. In fact, United and WellPoint have had seven years of consecutive double-digit profit growth that has ranged from 20 to 70 percent year-over-year. Thus, it is shareholders and health insurance executives, not physicians, who are profiting at patients' expense.

Physician Bargaining Power

Growing market domination of health insurers is undermining the patient-physician relationship and eviscerating the physician's role as patient advocate. Physicians have little-to-no bargaining power when negotiating with dominant health insurers over contracts that touch on virtually every aspect of the patient-physician relationship. This is particularly troublesome given physicians' critical role as patient advocates in an environment where health insurers have increasing control and limited accountability regarding decisions that affect patient treatment and care.

Many health insurer contracts are essentially "contracts of adhesion." Contracts of adhesion are standardized contracts that are submitted to the weaker party on a take-it or leave-it basis and do not provide for negotiation. Many contracts of adhesion contain onerous or unfair terms. In the health insurer context, these terms may include provisions that define "medically necessary care" in a manner that allows the health plan to overrule the physician's medical judgment and require the lowest cost care, which may not be the most optimal care for the patient. They also frequently require compliance with undefined "utilization management" or "quality assurance" programs that often are nothing more than thinly disguised cost-cutting programs that penalize physicians for providing care that they deem medically necessary.

In addition to interfering with the treatment of America's patients, many health insurer contracts make material terms, including payment, wholly illusory. They often refer to a "fee schedule" that can be revised unilaterally by the health insurer, and do not even provide such a schedule with the contract. In fact, many contracts allow the health insurer to change unilaterally *any* term of the contract. In addition, these contracts frequently contain such unreasonable provisions as "most favored payer" clauses and "all products" clauses. "Most favored payer" clauses require physicians to bill the dominant health insurer at a level equal to the lowest amount the physician charges any other health insurer in the region. This permits the dominant health insurer to guarantee that it will have the lowest input costs in the market, while creating yet another barrier to entry.

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[15] Physician Income: A Decade of Change, Carol K. Kane, PhD, Horst Loeblich, Physician Socioeconomic Statistics (2003 Edition) American Medical Association).

[16] Losing Ground: Physician Income, 1995-2005, Ha T. Tu, Paul B. Ginsburg, Center for Studying Health Systems Change Tracking Report No. 15 (June 2006).

Similarly, "all products clauses" require physicians to participate in all products offered by a health insurer as a condition of participation in any one product. This often includes the health insurer reserving the right to introduce new plans and designate a physician's participation in those plans. Given the rapid development of new products and plans, the inability of physicians to select which products and plans they want to participate in makes it difficult for physicians to manage their practices effectively.

Despite the improper restrictions and potential dangers these terms pose, physicians typically have no choice but to accept them. Any alleged "choice" they have is effectively a Hobson's choice, given that choosing to leave the network often means destroying patient relationships and drastically reducing or losing one's practice. Physicians simply cannot walk away from contracts that constitute a high percentage of their patient base because they cannot readily replace that lost business.[17] In addition, physicians are limited in their ability to encourage patients to switch plans, as patients can only switch employer-sponsored plans once a year, during open enrollment, and even then, they have limited options, and could incur considerable out-of-pocket costs.[18]

Health insurers have also employed certain tactics to coerce non-contracted physicians who have managed to preserve some level of bargaining power, into signing contracts. For example, a number of large health insurers are refusing to honor valid assignments of benefits executed by a patient who receives care from a non-contracted physician. This means that health insurers, rather than pay the non-contracted physician directly, pay the patient for the services provided. Similarly, many health insurers engage in the practice of "repricing" of physician claims (including proprietary claims edits and the use of rental network PPOs[19]), which results in non-contracted physicians receiving less than contracted physician for the same service.[20] These and other manipulative practices are clearly designed to undermine any residual bargaining power a physician practice might have, and further depress physician payments.

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[17] The DOJ, in its 1999 challenge of the Aetna/Prudential merger recognized that there are substantial barriers to physicians expeditiously replacing lost revenue by changing health plans. It also noted that this imposes a permanent loss of revenue. *See U.S. v. Aetna* (ND TX, June, 21, 1999) (Aetna Complaint). The DOJ reiterated this position in its challenge to the UnitedHealth Group/PacifiCare merger. *See U.S. v UnitedHealth Group, Inc.* (DDC Dec. 20, 2005) (United Complaint).

[18] *See* Aetna Complaint, United Complaint

[19] A "rental network PPO" exists to market a physician's contractually discounted rate primarily to third-party payers, such as insurance brokers, third-party administrators, local or regional PPOs, or self-insured employers. Rental network PPOs may also rent their networks and associated discounts to entities such as "network brokers" or "repricers" whose sole purpose is finding and applying the lowest discounted rates, often without physician authorization

[20] "Repricing" practices and rental networks also deprive contracting physicians of the benefits of their contracts when they result in payment below the contracted fee schedule. These tactics make it difficult for physicians to administer their practices and undercuts efforts to make the health care system more transparent.

Monopsony Power

In a substantial number of markets across the country, dominant health insurers have the potential to exercise monopsony power over physicians to the detriment of consumers. Monopsony power is the ability of a small number of buyers to lower the price paid for a good or service below the price that would prevail in a competitive market. When buyers exercise monopsony power in the labor market, they exploit workers in the sense of decreasing fees below their true market value. Monopsony power also has an adverse impact on the economic well being of consumers as it results in a reduced quantity of the firms' products available for purchase.

In the health insurance industry, health insurers are both sellers (of insurance to consumers) and buyers (of, for example, hospital and physician services). As buyers of physician services, health insurers are acting as monopsonists—lowering the prices they pay to a point at which physicians may be forced to supply fewer services to the market. Moreover, because health plans have posted considerable profits without decreasing premiums, the benefits of their ability, as a buyer of services, to lower the prices they pay suppliers (physicians), have not been passed on to consumers.

In fact, the US Department of Justice has recognized that a health plan's power over physicians to depress reimbursement rates can be harmful to patients—the ultimate consumers of health care. Such was the basis for the DOJ's recent decision requiring United to divest some of its business in Boulder as a condition of approving its merger with PacifiCare.[21] Specifically, the DOJ noted that because physicians cannot replace "lost business" quickly, the point at which physicians are locked-into a managed care contract is significantly lower than for other businesses.[22] In the case of the United/PacifiCare merger, the DOJ found that where the merged company would control 30 percent of physician revenues, the plan could exercise monopsony power over physicians in a manner that would lead to a "reduction in the quantity or quality of physician services provided to patients." [23]

Health insurers with monopsony power can use the economic benefits of reduced prices in medical care to protect and extend their monopoly position and increase barriers to entry into the market. Thus, rather than producing "efficiencies," increasing monopsony power in health care markets across the country causes a number of distortions in the market that harm patients by reducing access to care.

Any one of these characteristics individually—market share, barriers to entry, premium increases, monopsony power, and disparity in bargaining power—should send a strong warning that competition in the health care market is being compromised. The simultaneous existence of all of these features is nothing short of alarming. The current health care market exhibits all the symptoms of an ailing system that, absent intervention, has a dire prognosis.

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[21] United Complaint.
[22] *See id.*
[23] *Ibid.*

ANTITRUST LAW AND POLICY RESTRICTIONS ON PHYSICIANS

Ironically, rather than focus on the health insurance industry, which, as noted, has boasted record profits and increased premiums corresponding to recent waves of consolidation, regulators have focused on physicians, the least consolidated segment of the health insurance industry. This is confounding given the current health insurer environment. Since April 2002, the FTC has brought at least 25 cases against physician groups based upon contracting arrangements with health insurers. All but one of the groups chose to settle with the FTC rather than engage in a protracted, financially devastating legal battle. These actions have had a chilling effect on physician efforts to create joint ventures that could result in lower cost, higher quality care.

Short of forming a fully integrated group practice, the only option currently available to physicians is so-called "clinical integration," as described by the DOJ/FTC in their 1996 *Statements of Antitrust Enforcement Policy in the Health Care Area.* The agencies, however, have provided little guidance on what exactly constitutes clinical integration, other than to make it clear that meeting the standard requires several years of development and millions of dollars of infrastructure investment; an option which is simply not feasible for the vast majority of physicians.

The AMA believes that given the increasing power and size of health insurers and the corresponding decrease in the bargaining power of physicians, it is time to reexamine the policy landscape that has resulted in aggressive antitrust enforcement actions against physicians. First, we believe that the Rule of Reason, rather than the *per se* rule, should apply to the creation of physician networks.[24] Second, we would like to reopen discussions with the DOJ and FTC on more flexible approaches to physician joint ventures that recognize the benefits to physician joint contracting. For health insurers, physician joint contracting can make it possible to obtain ready access to a panel of physicians offering broad geographic and specialty coverage. In fact, in a number of the cases settled by the FTC, health plans had voluntarily contracted with physician networks for several years before calling the FTC to initiate an investigation.

Non-exclusive physician networks pose no threat to competition. Physicians can independently consider contracts presented from outside the network. Likewise, health insurers that cannot reach a "package deal" with a physician network can contract directly with its physicians or approach a competing network. Rather than restraining trade, the physicians will have created an additional option for purchasers—a pro-competitive result. Thus, the AMA believes that application of the Rule of Reason to the

[24] Legally, there are two types of antitrust violations. There is certain conduct that is considered so detrimental to the market that it is seen as being without possible redeeming merit. Engaging in this type of conduct is considered a *per se* antitrust violation, since it is considered inherently antisocial. Where conduct is not *per se* violative, it is evaluated pursuant to the Rule of Reason standard, which requires a determination as to whether the conduct is pro-competitive and/or likely to bring efficiency to the market and provide improvements for consumers. In accordance with the Rule of Reason, courts may exonerate defendants where the conduct results in more choice for patients, more competition, and better health care.

creation of physician networks, as well as less restrictive approaches to physician joint contracting will have pro-competitive benefits such as greater flexibility, more innovation, and ultimately a better health care system.

SUGGESTIONS AND SOLUTIONS

Absent antitrust relief, we believe there are a number of interim steps Congress could take immediately to inform the debate about health insurance market power and its effects on costs and patient care.

- We believe that Congress should instruct the Department of Justice to exercise its subpoena power to investigate whether the record profits and increased premiums posted by health plans are the result of monopoly power. Only the government can undertake this task since private parties cannot access the proprietary health plan pricing information that is fundamental to making this determination.[25] Americans deserve to know whether continuing consolidation in the health insurance market is resulting in "efficiencies" that will benefit consumers, or whether the real beneficiaries are shareholders and highly compensated executives.

- Congress should require health insurers to report enrollment numbers for all product lines by market, preferably at the county level, but at least at the MSA level, to a designated Federal agency. Currently, health insurers are only required to report HMO enrollment, and only at the state level. This reporting is problematic for two reasons. One, PPO enrollment constitutes more than 69 percent of the commercially insured population. And two, markets for health insurance are typically local rather than state-based. Requiring reporting of all product lines at the local level would ensure reporting of true enrollment numbers, information that is currently unattainable without time-consuming extrapolation from multiple sources. Public reporting of enrollment numbers by county or MSA, and by product line, would greatly enhance the health research community's ability to evaluate and report on health insurance markets.

- Congress should require reporting of health insurers' financial information, including total revenue, premium revenue, profit, and administrative expenses, in each state by product line. This information is necessary for calculating economic efficiency measures and comparing the profitability of separate product lines.

[25] The AMA is aware that in December 2006, the DOJ filed a civil lawsuit to block the United/PacifiCare merger unless United agreed to certain conditions set forth in a proposed consent decree. The conditions included divestiture of some of PacifiCare's business in other areas and a requirement that United modify and cease within one year its network access agreement in California with a subsidiary of Blue Shield of California. While the AMA was pleased with this action, we do not think that it is sufficient to limit inquiries into merger investigations.

- We believe Congress should require standardized reporting of medical loss ratios for non-profit, mutual, and for-profit health insurers by state and product line, again to a designated Federal agency. Medical loss ratios, also referred to as medical cost ratios, medical expense ratios, medical care ratios, and medical ratios, provide a measure of how much of the premium dollar is going to patient care. Currently, medical loss ratios are not provided for each state of operation, and a number of different formulas are utilized to calculate them, making it virtually impossible to accurately compare health insurance plans. Standardized reporting would go a long way toward informing the public debate on health insurer market power and would provide the public with information on how much of their premiums are actually being spent on medical care.

- Congress should evaluate the need for the development and enforcement of Federal prompt payment standards.

CONCLUSION

It is time for Congress, as well as Federal regulatory agencies, to address the serious public policy issues raised by the unfettered consolidation of health insurance markets. The AMA's Competition Study shows unequivocally that competition has been undermined in markets across the country. This has real, lasting consequences for the delivery of health care. It is time to halt the march toward a marketplace controlled by a few health insurance conglomerates focused solely on profits, not patients.

Statement Of Senator Patrick Leahy,
Ranking Member, Judiciary Committee
"Examining Competition in Group Health Care"
September 6, 2006

This hearing on health care provider and insurance issues is important, but only if it is a first step towards actually doing something about our health care system. The United States spends more per capita on health care than other developed countries. Yet last year 46.6 million people in the United States had no health insurance and the percentage of people covered by employment-based plans dropped for the fifth consecutive year. Just yesterday, *The Washington Post* reported that the number of children without health coverage was increasing; about 8.3 million children – more than 11 percent -- had no health care coverage in 2005, up from 10.8 percent from 2004. This is simply unconscionable. In my home state of Vermont, we have implemented programs to try to combat this problem, and Vermont has been a leader in providing health care to children through the Dr. Dynasaur program that helps cover the costs of doctor visits, prescriptions, dental care, and hospital care among other services. But there is more to be done, and many other states lack such programs. Congress must do a better job of understanding the health care provider and health care insurance markets, and taking aggressive steps to ensure quality treatment is more accessible.

There is little disagreement that the health insurance industry is an increasingly concentrated one. The American Medical Association asserts that the market for HMOs and PPOs is "highly concentrated" in 99 percent of markets around the country. Concentration does not necessarily equal market power, and it does not necessarily mean the Justice Department should have prevented consolidation.

I have long been a proponent of competition among insurers, and indeed I am the principal sponsor of the Medical Malpractice Insurance Antitrust Act of 2005, which would remove the malpractice insurers' antitrust exemption for the most egregious kinds of anticompetitive behavior. This bill is narrow, focusing only on a segment of the health care system with particularly difficult problems. But were Congress truly committed to assisting health care consumers, we would enact not only this bill. We would eliminate the antitrust exemption for insurers entirely. Then, even were our federal enforcers to abdicate their responsibilities to the public, state authorities could step in to protect consumers. The response we should make to insurers with market power, and with immunity from antitrust prosecution, is not to arm the physicians with similar exemptions and power. The response should be to strip the insurers of those protections, and make them obey the rules of competition.

But a concentrated market does reduce competition and puts control in the hands of only a few powerful players. Consumers – in this case patients – are ultimately the ones who suffer from this concentration. As consumers of health care services, we suffer in the form of higher prices and fewer choices. This Committee, and this Congress, would be serving Americans better by working to ensure competition both in the purchase of services from health care providers and in the sale of insurance to employer groups.

The AMA asserts that the answer to the insurance industry's increased market share is to give physicians more market power. The voice left unheard in negotiations between big health insurance companies and physicians permitted to collude would be the consumer's.

To be sure, health care providers operate under an ethical obligation to deliver quality care. The recent Federal Trade Commission and Department of Justice report on improving health care noted, however, that providers' financial incentives do not directly promote performance goals. Needless to say, that is not good for patients. Ultimately, the objective of this hearing, and any congressional action, should be to promote more, affordable, quality health care choices for consumers. If the insurance industry is consolidating to the point where insurance companies can exercise market power, the government's role is to address that concentration – not add to the problem by creating market power on the other side, leaving consumers out of the equation.

The Department of Justice and Federal Trade Commission should be vigorously enforcing the antitrust laws not just against physician groups, as it has, but against insurance companies engaging in anticompetitive behavior. They should be just as diligent in detecting and prosecuting fraud in the health care system, which costs American taxpayers billions of dollars a year, and deprives American patients of the quality health care they deserve.

Department of Justice

STATEMENT

OF

J. BRUCE MCDONALD
DEPUTY ASSISTANT ATTORNEY GENERAL
ANTITRUST DIVISION

BEFORE THE

COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE

CONCERNING

"EXAMINING COMPETITION IN GROUP HEALTH CARE"

PRESENTED

SEPTEMBER 6, 2006

Mr. Chairman and Members of the Committee, I am pleased to be here to discuss the Antitrust Division's work to protect competition in the health care marketplace. Every American knows the importance of affordable health care, and for us that means ensuring that health care markets are able to respond to consumer demand without interference from anticompetitive restraints. The Antitrust Division utilizes both enforcement actions and competition advocacy to protect and promote competition in health care markets.

The Health Care Marketplace

Most of us rely on private health insurance to help defray the cost of health care, particularly catastrophic expenses that can arise unexpectedly and for which it is difficult for individual families to plan. Group health plans have developed as a means for employers and other associations to contract for health insurance on behalf of a large group of individuals, so that individuals in the group can better obtain health insurance at more affordable rates.

The group health care plan model involves transactions among a number of parties. Individuals and families receive health care coverage through employment or membership in an association. The employer or

association contracts with a group health plan – an insurer – to provide coverage for members of the group. Health care providers – physicians, pharmacists, nurses, hospitals, clinics, equipment suppliers, and others – supply services and products to the insured individuals and families and receive some or all of the payment from the group plan, with any remaining amount generally coming from the individual or family or, in some cases, the employer.

Employers and other associations are attractive to insurers because they bring numerous customers into a group health plan. The group offers its employees or members to the insurer in exchange for the insurer providing better coverage at lower premium costs. Likewise, a group health plan offers its subscribers to providers as potential patients in exchange for the providers agreeing to care for them at lower rates. With competition at every level, everyone benefits. The insured individuals and families obtain better and more affordable coverage. The health plans obtain health care services and products on behalf of their subscribers at lower cost. Participating health care providers offering good quality and competitive rates are able to increase the number of patients they serve.

At any point in these arrangements, however, an anticompetitive restraint can interfere with efficient access or supply and can drive prices away from competitive levels. If that occurs, consumers are harmed. For example, if competing providers were to conspire with each other to insist on artificially high prices, health plans could be forced to raise premiums, curtail service, or even leave the market, restricting patient access to affordable health care. Similarly, if competing health plans were to conspire with each other to pay artificially low prices, providers could be forced to curtail service or go out of business, also restricting patient access to affordable health care services.

Those are examples of the kinds of anticompetitive restrictions we are on the lookout for as we monitor health care markets. In addition to looking for anticompetitive conduct, the Department also examines proposed mergers among hospitals, health plans, or provider groups that could have the effect of reducing competition, restricting access and consumer choice, and dampening healthy incentives to provide quality care at affordable prices.

Recent Enforcement Activity

Although the Federal Trade Commission and the Antitrust Division

have a long-standing process for allocating our shared antitrust enforcement authority between ourselves so as to avoid duplication of enforcement effort, health care is a sector in which both agencies are active, depending on the particular markets involved. While many of the Antitrust Division's recent health-care-related investigations and enforcement actions have been in the markets for group health plans and health insurance, we have also been active in a variety of other health care markets. Let me turn now to a description of some of our recent activities.

This past April, the United States District Court for the District of Delaware entered its final judgment in favor of the Department in our case against Dentsply, after Dentsply's unsuccessful appeals had run their course. The Department had filed suit to stop the defendant -- Dentsply International, a corporation which provides 70% to 80% of the prefabricated artificial teeth used in the United States -- from enforcing unlawful restrictive dealing agreements and engaging in other unlawful conduct designed to restrict most of the tooth distributors in the United States from selling products made by Dentsply's competitors. The Department alleged that Dentsply's actions both deprived its competitors

of the opportunity to distribute their products efficiently and deterred potential new entrants from the market for prefabricated artificial teeth.

This past February, the Division sued a West Virginia hospital, Charleston Area Medical Center, which had made an agreement preventing a nearby competing hospital from developing a cardiac surgery program in the neighboring county, thereby preventing competition between them for cardiac surgery. The case was settled with a consent decree terminating the anticompetitive agreement.

This past December, the Division challenged the merger of UnitedHealth Group and PacifiCare Health Systems, two of the nation's largest health insurers, on the grounds the merger would reduce competition for health insurance in Tucson, Arizona and Boulder, Colorado. We alleged that the merger would lead to inflated premium prices and reduced quality of coverage in Tucson, and would lead to artificial depression of reimbursement rates for physicians in Boulder, resulting in reduced availability and quality of medical care. The case was settled with a consent decree that required divestitures in these two areas.

In 2005, the Division investigated a territorial market allocation

arrangement among the twelve Medicare-approved home health agencies in Vermont. Under this agreement, the agencies did not compete, leaving Medicare and Medicaid beneficiaries in Vermont without any competition in home health services. While our investigation was underway, the State of Vermont enacted legislation mandating separate territories for the home health agencies as part of an overall regulatory scheme, and we subsequently closed our investigation.

In 2005, the Division brought an action against two hospitals in southern West Virginia, Bluefield Regional Medical Center and Princeton Community Hospital Association. The hospitals had entered into an illegal market allocation agreement under which Princeton would provide cancer services (but not cardiac surgery services) and Bluefield would provide cardiac surgery services (but not cancer services), eliminating competition between them in these areas. The case was settled with a consent decree requiring the hospitals to abandon their agreement and requiring that they obtain our approval before entering into any new agreement regarding cancer services or cardiac surgery.

In 2005, we sued the Federation of Physicians and Dentists, which had orchestrated a boycott of health plans by competing OB/GYNs in

Cincinnati. Our motion for summary judgment is pending, and the case has been referred for mediation.

In 2004, we conducted extensive investigations into two mergers among group health insurers – UnitedHealth Group with Oxford Health Plans, and Anthem Inc. with WellPoint Health Networks – to determine whether the merger might give the combined firm market power either in the provision of health insurance services, or on the buyer side, as payors for health care services. As explained in the closing statements we issued, we ultimately concluded that neither competitive problem was likely and closed the investigations.

In 2003, we challenged the G.E./Instrumentarium merger regarding its likely harm to competition for critical care monitors and for mobile C-arm x-ray machines used in surgery. The case was settled with a consent decree requiring G.E. to divest Instrumentarium's critical care monitor and mobile C-arm x-ray operations before the two firms could merge.

In 2002, we sued Mountain Health Care, a North Carolina physician organization with over 1000 members, for restraining competition by adopting joint fee schedules for its members and negotiating with health plans on their behalf, which had resulted in

patients paying inflated prices for medical care. That case was settled by a consent decree requiring Mountain Health Care to cease operations.

Joint Hearings on Health Care Antitrust Issues

In 2003, the Division and the FTC hosted a series of hearings on a full range of health care competition law and policy issues, to increase our knowledge about health care antitrust issues, and to educate policymakers and the public about antitrust issues and enforcement in this area. In 2004, the Division and the FTC issued an extensive joint report on those hearings.[1] The Report covers a variety of issues, including issues relating to physicians, hospitals, pharmaceuticals, and insurance.

Among its recommendations, the Report encourages payors and providers to continue innovating to increase incentives for providers to lower costs and enhance quality, and to improve incentives for consumers to seek these improvements. The report also counsels against relying on community commitments for resolving competitive concerns with hospital mergers, or looking to "countervailing power" for an effective response to disparities in bargaining power between payors and providers,

[1] The report, "Improving Health Care: A Dose of Competition," can be found at www.usdoj.gov/atr/public/health_care/204694.htm.

specifically recommending against legislation to immunize collective bargaining among competing physicians.

The report also urges that the role of subsidies and mandates be re-examined for distorting effects on competitive efficiency, and that unnecessary regulatory barriers to entry into provider markets be reduced. The health care marketplace is extensively regulated – not only in terms of rules imposed by government as a large third-party payor, but also in terms of the variety of mandates and restrictions enacted to protect patients and subscribers. Some of these regulations can create their own anti-competitive inefficiencies and barriers to entry, and we have been examining some of these regulations in our competition advocacy role.

One such barrier to entry is the certificate of need, under which providers need state regulatory authority before they can enter a market -- for example, by building a new facility. The restrictive effect of certificates of need was a factor in our investigations into the Vermont home health care agencies and into the market allocation agreement between the Bluefield and Princeton hospitals.

We believe this Report will continue to be a useful resource for the health care community and the antitrust bar on these issues, and it will

inform our antitrust investigations and enforcement actions into the future.

Conclusion

Mr. Chairman, the Antitrust Division fully recognizes the critical importance of a competitive health care marketplace to all Americans. We are committed to preserving competition in this marketplace through appropriate antitrust enforcement, and we will continue to monitor this marketplace closely.

Thank you for the opportunity to testify. I would be happy to answer questions

Good morning Senator Specter and members of the Committee. My name is Mark A. Piasio, MD, MBA. I am an orthopedic surgeon practicing in Dubois, Pennsylvania and President of the Pennsylvania Medical Society.

First, let me thank you for allowing me to speak with you this morning.

I would like to make it clear that our testimony is not intended as a corporate or personal attack on any of the market participants and the people who work for them. Each of them is doing what they think is best. However, each is "doing what comes naturally" in failed markets. This, we believe, is the fundamental cause of a host of problems and calls for extensive public policy analysis and response.

The lack of competition among health insurers in health delivery markets throughout the country and in Pennsylvania, as well as the consolidation of health insurers across the nation, raises serious concerns for the provision of quality patient care. As patient advocates, physicians are often prevented by market dominant insurers from providing necessary care through "take-it-or-leave-it" contracts and other insurer imposed cost cutting mechanisms.

Market consolidation does not benefit consumers from a financial perspective either. While many large Pennsylvania insurers are posting huge profits and surplus reserves, premiums continue to skyrocket (Pennsylvania has some of the highest premiums in the nation), and patient cost shares continue to increase without any increased benefit. Additionally, physician payment, particularly in the Philadelphia market, continues to lag behind other geographic markets. For example, evaluation and management services in some cases are paying at 85% of the comparable Medicare rate. In the meantime, physician operating costs continue to escalate, driven primarily by professional liability and employee (?) costs.

From 2000 to 2004, Pennsylvania health insurers increased premiums 40 percent per enrollee, from $2,161 to $3,022, nearly double the U.S. average, while insurer surplus reserves rose from $5 billion to $6.8 billion. Total annual profits of Pennsylvania health insurers increased from $468 million in 2000 to $621 million in 2004. This translates to an annual per enrollee profit for Pennsylvania health insurers in 2004 of $93.45. The equivalent average annual per enrollee profit for health insurers in the rest of the country, as reported to the National Association of Insurance Comissioners was $79.79 in 2004.

Overhead and profit percentages of Pennsylvania health insurers increased despite the fact that much of the revenue increase was pure price level change. Annual health insurer administrative costs per member more than doubled from $132 in 2000 to $270 in 2004. One of the classic hallmarks of a firm with monopoly power is the erosion of administrative efficiency. It is quite possible that the loss of administrative cost efficiency seen among Pennsylvania's health insurers relates directly to the loss of incentive to maintain administrative cost efficiency in the presence of market power.

Physician practices located in the Philadelphia and Pittsburgh markets as well as a number of other Pennsylvania health delivery markets depend heavily on patients covered by market dominant insurers, which can and have provided unreasonable contract terms and anti-competitive reimbursement rates. These physicians have little bargaining power with those insurers that exert monopsony power.

The American Medical Association each year conducts a study focused on health insurance competition in the U.S. One aspect of this study is a determination of the Herfindahl-Hirschman Index (HHI) for each of the national geographic markets. Simply put, the HHI is a measure of competition of an overall market. The Federal Trade Commission (FTC) and the Department of Justice (DOJ) consider an HHI of over 1800 as a "highly concentrated" market, therefore little competition. The HHI for the Philadelphia MSA is 5129, four times the HHI indicator of little competition.

It was recently announced in the news media that the two largest Pennsylvania-based health insurers—Highmark and Independence Blue Cross—are merging. It is unclear what ultimate impact this merger will have on the geographic and product markets, but what is clear is that the statewide market share for commercial health insurance as well as the statewide HHI will increase to levels that would not be permitted under existing Department of Justice and Federal Trade Commission merger guidelines.

Entry into health insurance markets is not easy. If it were easy, much more competition would exist in large markets such as Philadelphia. Instead for example, even large national payers like United Healthcare gained entrance into the Philadelphia market by acquiring Fidelity Insurance, Oxford and Health Net as opposed to developing their own physician network and products.

Given the problems identified above, we believe a first response would be to restore full and open competition in these markets. However, this will produce substantial economic and political issues. The next optional response would be to develop countervailing power intervention. Third, would be regulatory oversight of market participants that hold and exercise market power. We recommend that the FTC and the DOJ develop a comprehensive research agenda that will provide greater insight into the issue of insurer market power.

Let me add that today, investigating this situation may be more important than ever before. The impact of the proposed merger between IBC and Highmark may impact more Pennsylvanians than any other healthcare transaction in the state's history, perhaps more than any other business transaction that has occurred in the Commonwealth. Certainly, such a transaction would have a profound impact on physicians and the Medical Society. Consumers, other providers, employers and unions, the Medicare and Medicaid programs, regulators, the uninsured and many other interest groups would be equally affected.

In conclusion, thank you for the opportunity to provide testimony today. I an hopeful that you will be able to have the appropriate federal regulatory agencies review the health delivery dynamics in the country, the Commonwealth as well as the impending merger of Highmark and Independence Blue Cross.

I'd be glad to answer any questions that members of the subcommittee may have.

PREPARED STATEMENT OF THE FEDERAL TRADE COMMISSION

Presented by
David P. Wales
Deputy Director
Bureau of Competition
Federal Trade Commission

before the

COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE

on

EXAMINING COMPETITION IN GROUP HEALTH CARE

September 6, 2006

Mr. Chairman and members of the Committee, I am David Wales, Deputy Director of the Federal Trade Commission's Bureau of Competition. I appreciate the opportunity to appear today to discuss some of the Commission's activities to promote competition in health care markets.[1]

The FTC has long been actively involved in health care markets, and health care continues to be a high priority for the Commission.[2] The agency's fundamental goal has not changed: to ensure that health care markets operate competitively. As in the past, the agency will bring enforcement actions where necessary to stop activities that harm consumers by unreasonably restricting competition.

At the same time, the FTC is not solely a vigilant "cop on the beat" out to protect consumers from anti-competitive conduct. The agency works to promote competition through a variety of other actions, as well, including: providing guidance to market participants to help them comply with the law; undertaking and publishing studies, public hearings, and reports; and advising state and federal policymakers on competition issues in health care.[3]

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[1] This written statement represents the views of the Federal Trade Commission. My oral presentation and responses are my own and do not necessarily reflect the views of the Commission or of any Commissioner.

[2] Actions to promote a competitive health care marketplace have enjoyed bipartisan support within the Commission. *See, e.g.*, Deborah Platt Majoras, Chairman, Federal Trade Commission, "The Federal Trade Commission: Fostering a Competitive Health Care Environment that Benefits Patients," Remarks before World Congress Leadership Summit, New York, N.Y. (February 28, 2005); Timothy J. Muris, Chairman, Federal Trade Commission, "Everything Old is New Again: Health Care and Competition in the 21st Century," Remarks before the 7th Annual Competition in Health Care Forum, Chicago, Illinois (November 7, 2002); Robert Pitofsky, Chairman, Federal Trade Commission, Testimony before the Committee on the Judiciary, United States House of Representatives, Concerning H.R. 1304, the "Quality Health Care Coalition Act of 1999."

[3] For example, the Commission currently is undertaking an industry-wide study of the competitive effects of the use of authorized generic drugs in the prescription drug

Indeed, education – explaining antitrust policy to the industry and the public – is a key part of our mission. There is plenty of misapprehension and misinformation about the application of the antitrust laws to the health care marketplace, and the FTC activities and policies in this area. The agency works hard to keep the lines of communication open and our guidance up-to-date as markets evolve, and to provide additional guidance as new market structures and new forms of competition develop.

As part of its law enforcement role, for the past 25 years, the Commission has challenged naked price fixing agreements and coercive boycotts by physicians in their dealing with health plans.[4] These arrangements largely consist of otherwise competing physicians jointly setting their prices and collectively agreeing to withhold their services if health care payers do not meet their fee demands. Such conduct is considered to be "*per se*" unlawful because it harms competition and consumers – raising prices for health care services and health care insurance coverage, and reducing consumers' choices.

Not all joint conduct by physicians, however, is improper. Physician network joint ventures can yield impressive efficiencies. Thus, the FTC (together with DOJ) committed long ago to using a balancing test (in our legal parlance, the "rule of reason") to evaluate those physician network joint ventures that involve significant potential for creating efficiencies through integration. Physician joint ventures involving price agreements can avoid summary condemnation, and merit the balancing analysis, if the physicians' integration is likely to produce

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marketplace. *See* 71 Fed. Reg. 16779 (April 4, 2006).

[4] *See* Overview of FTC Antitrust Actions in Health Care Services and Products, available at http://www.ftc.gov/bc/0608hcupdate.pdf.

significant efficiencies that benefit consumers, and any price agreements (or other agreements that would otherwise be *per se* illegal) are reasonably necessary to realize those efficiencies.

It is important to consider what can happen when health plans are forced to accept the collective demands of health care providers for higher fees that are not reasonably necessary to achieving significant efficiencies. The effect is not simply on the health plans that must pay more. Experience with antitrust enforcement over the years shows that the effects can extend to various parties, and in various ways, throughout the health care system:

- Consumers and employers face higher prices for health insurance coverage, potentially forcing some employers to reduce or drop health benefits for their employees.
- Consumers also face higher out-of-pocket expenses, such as increased co-payments.
- Senior citizens participating in Medicare HMOs (health maintenance organizations) may face reduced benefits, because Medicare pays HMOs a fixed amount per enrollee. Higher fees for professional services mean that health plans will have fewer dollars available to pay for benefits that are not available under traditional Medicare, but currently are provided by many Medicare HMOs.
- The federal government may pay more for health coverage for its employees through the Federal Employees Health Benefits Program and military health care programs.
- State and local governments may incur higher costs to provide health care benefits to their employees.
- State Medicaid programs attempting to use managed care strategies to serve their beneficiaries may have to increase their budgets, cut optional benefits, or reduce the

number of beneficiaries covered.

- State and local programs providing care for the uninsured may be further strained because making health insurance coverage more costly can be expected to increase the already sizable portion of the population that is uninsured.[5]

For example, just two weeks ago, the Commission accepted for public comment a consent agreement involving two IPAs (independent practice associations) representing approximately 127 primary care physicians in the Kansas City area.[6] The consent agreement settles charges that the physicians refused to sell their medical services to certain health plans, except on jointly agreed-upon terms, including price terms, and that the physicians' actions were intended to raise or maintain higher fees. Further, according to the Complaint, the physicians' agreement and refusal to deal regarding their individual medical services were not reasonably related to any productive cooperative activity among them, or the IPAs that acted on their behalf.

This matter may be of particular interest to those who are concerned about the Medicare program because, according to the Complaint, the threatened boycott by the physicians of one health plan that opposed their contract demands would have prevented that plan from offering its Medicare HMO program in two counties. The federal government has authorized the establishment of Medicare HMO programs that may provide more extensive benefits than

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[5] *See generally* U.S. DEP'T OF JUSTICE & FEDERAL TRADE COMMISSION, IMPROVING HEALTHCARE: A DOSE OF COMPETITION (2004) (*hereinafter* "IMPROVING HEALTHCARE").

[6] In the Matter of New Century Health Quality Alliance, Inc., Prime Care of Northeast Kansas, L.L.C., et al. FTC File No. 051-0137, *available at* http://www.ftc.gov/os/caselist/0510137/0510137.htm.

traditional Medicare coverage, as an alternative for elderly consumers. In one of the counties, the plan was the only Medicare HMO available to elderly consumers. Thus, the physicians' actions would have eliminated any opportunity for consumers there to choose a Medicare HMO option. In the other county, the plan was one of only two that were available to consumers. The challenged activity would have eliminated consumers' opportunity to choose between the Medicare HMO alternatives for their coverage.

The FTC's experience teaches that this type of physician price-fixing and coercive collective activity in dealing with health plans – without any accompanying pro-competitive benefits – raises consumer health care costs considerably, without benefitting consumers. Unfortunately, this sort of harmful and unjustified behavior continues in the health care area, which is why the agency has been active in challenging this type of activity.

It is important to emphasize that collective setting of prices and negotiation with health plans by physicians does not assure quality health care, and there is no inherent inconsistency between vigorous competition and the delivery of high quality health care services. Theory and practice confirm that just the opposite is true – when vigorous competition occurs, consumer welfare is increased in health care, as in other sectors of the economy.[7] Interference with competition is far more likely to decrease consumer welfare. As the Supreme Court observed in *Indiana Federation of Dentists*, such interference necessarily and improperly preempts "the working of the market by deciding . . . that customers do not need that which they demand."[8]

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[7] *See generally*, Paul J. Feldstein, HEALTH CARE ECONOMICS (6th ed. 2004).

[8] *Indiana Fed'n of Dentists v. FTC*, 476 U.S. 447, 459 (1986).

As noted above, however, it also is important to remember that much joint conduct by physicians can be pro-competitive, and that neither the antitrust laws, nor the enforcement agencies treat it as an antitrust violation.[9] As pressure to control health care costs and assure quality continues, there has been increasing interest in encouraging efforts to achieve the efficiencies that can come about through cooperation and collaboration. Practically every week FTC staff hear about a new form of collaborative arrangement in the health care field, involving various combinations of providers, insurers, or other purchasers. Developments in information technology, for instance, present new opportunities for efficiency-enhancing integration among health care providers that are likely to increase efficiency and help assure high quality. Although these cooperative efforts often involve factually novel arrangements, antitrust analysis is sufficiently flexible to distinguish innovative, pro-competitive, market responses from collective efforts to resist competition. Indeed, potential efficiencies are one of the core issues in contemporary antitrust analysis, and this is true in health care, as in all sectors of the economy.

The FTC supports initiatives to enhance quality of care, reduce or control ever-escalating health care costs, and ensure the free flow of information in health care markets, because such initiatives benefit consumers. The Commission has no pre-existing preference for any particular model for the financing and delivery of health care. Such matters are best left to the marketplace, with physicians and other health care providers, and health plans offering alternatives that they

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[9] *See, e.g.*, Letter from Jeffrey W. Brennan, Assistant Director, Bureau of Competition, Federal Trade Commission to Gregory G. Binford (February 6, 2003) (staff advisory opinion stating that staff would not recommend that the Commission pursue law enforcement action with regard to a proposed program by physicians to publicize their concerns about the effects of reimbursement levels and other policies of health plans in the Dayton, Ohio, area.

hope consumers and other purchasers will find attractive, based on cost, quality, convenience, and other factors consumers consider important. The FTC's role is important – but limited: to protect the market from anti-competitive conduct that prevents it from responding freely to the demands of consumers.

To help allay physicians' and other health care providers' concerns about potential antitrust issues regarding collaborative activity, and to encourage the development of potentially pro-competitive and lawful arrangements, the Commission has undertaken a broad and proactive effort to inform and educate participants in the health care area. For example, the FTC and the Department of Justice jointly developed and published Statements of Antitrust Enforcement Policy in Health Care.[10] These Statements describe and explain at length how otherwise competing physicians may collaborate through arrangements that have the potential to lower costs, improve quality, and benefit consumers, without running afoul of the antitrust laws.[11] The two agencies, consistent with antitrust law generally, have long recognized the importance of not summarily condemning physician and other health care provider network joint ventures that have the potential to create efficiencies through integration of the participants.

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[10] Department of Justice & Federal Trade Commission, Statements of Antitrust Enforcement Policy in Health Care (1996), available at http://www.ftc.gov/reports/hlth3s.htm. Previous editions of such joint enforcement policy statements in the health care area were issued in 1993 and 1994. *See also* IMPROVING HEALTHCARE at ch. 2, 40-41.

[11] For example, through formation of efficiency-enhancing, integrated joint arrangements involving physicians and other health care providers who: share financial risk regarding the efficiency with which they together provide care through the arrangement; who are "clinically integrated" to together improve the quality and efficiency of the care they provide; or who otherwise are integrated in ways that jointly increase their efficiency and benefit consumers; or through arrangements that avoid horizontal agreement among the participants on prices or other competitively significant terms of dealing. *See* Statements of Antitrust Enforcement Policy in Health Care at Statement 8 and Statement 9.

The Commission staff also has provided considerable detailed guidance about potentially pro-competitive forms of physician integration. For example, over the years it has issued numerous advisory opinions concerning physician networks. In one notable instance, the staff issued a favorable advisory opinion to MedSouth in Denver,[12] a multi-specialty physician initiative involving "clinical integration" among the participants. This year, the staff issued another lengthy advisory opinion with detailed guidance about how such arrangements are analyzed,[13] and currently is considering other requests for guidance regarding multi-provider arrangements involving clinical integration or other forms of collaboration.

Conclusion

The dynamics of evolving health care markets continue to pose challenges for market participants. The FTC is committed to working with physicians and other providers to give them guidance to avoid antitrust pitfalls as they respond to market challenges. At the same time, collective action by health care providers to obstruct new models for providing or paying for care, or to interfere with cost-conscious purchasing, remains a significant threat to consumers, and the Commission will continue to act to protect consumers from such conduct.

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[12] Letter from Jeffrey W. Brennan, Assistant Director, Bureau of Competition, to John J. Miles, Ober , Kaler, Grimes & Shriver (Feb. 19, 2002) (staff advisory opinion re: MedSouth, Inc.), available at <http://www.ftc.gov/bc/adops/medsouth.htm>.

[13] Letter from David R. Pender, Acting Assistant Director, Bureau of Competition, to Clifton E. Johnson and William H. Thompson, Hall Render, Killian, Heath & Lyman (March 28, 2006) (staff advisory opinion letter re: Suburban Health Organization, Inc.), available at http://www.ftc.gov/os/2006/03/SuburbanHealthOrganizationAdvisoryOpinion03282006.pdf.

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