Health Insurance/Providers – Countervailing Market Power

Presentation to Joint FTC/DOJ Hearings

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May 7, 2003

Overview

Summarize CRA analysis of potential costs of allowing physicians to negotiate collectively

Review current market conditions relevant to negotiations between providers and plans

CRA Analysis of "National Costs of Physician Antitrust Waivers"

Study done on behalf of Health Insurance Association of America in 2000

Analysis precipitated by "Quality Health-Care Coalition Act of 1999" (HR 1304)

Findings

- Personal health care expenditures likely to increase by 2.5-8 percent
- Private health insurance premiums likely to increase by 5-13 percent
- Effects stem from increases in provider fees and relaxed utilization controls

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Potential Costs of Physician Collective Bargaining: Underlying Model

Managed care has reduced rate of expenditure growth by

- Reducing prices by encouraging competition (threats of selective contracting)
  - Previous analyses found provider discounts ranging from 6-25%
- Managing utilization, much of which is directed by physicians
  - Previous analyses found UR/UM savings ranging from 8-22%
  - Utilization increases occur in all services to some extent given physician role as agent

Competition among managed care organizations ensures that savings are passed on to employers in contract pricing

Potential Costs of Physician Collective Bargaining: Data and Estimation

Data

- HCFA
  - National Health Expenditure projections - Expenditures for physician, dental and other professional services
  - Profile of Medicare Chartbook
- KKF/HRET Employer Health Benefits Survey

Estimation

- Range of scenarios with alternate assumptions
  - 50-100% of discounts would be reversed
  - Utilization would increase expenditures by 3-10% (in comparison to 8-22% savings achieved from UR/UM)
- Effect on private payers more substantial than on public payers, but spillover effect does exist

Results

- Total effect is 2.5-8.3 percent
- Utilization effect is 2/3 of total

Current market conditions suggest that market has led to same place….

Managed care has become "kinder and gentler"*

- Significant decrease in health plan use of capitation to pay physicians (57.4% of physicians in 1997 to 48.6% in 2001 derive some revenue from capitation)
- 51 –77 percent of physicians affected by care management tools (guidelines, patient satisfaction surveys, profiling) report positive effects
  - Younger physicians both more affected and more positive
- Less emphasis by managed care to influence ***physician*** behavior and control fees → more emphasis on controlling ***patient*** behavior through cost sharing

*Center for Studying Health System Change: Kinder and Gentler: Physicians and Managed Care, 1997-2001 (Tracking Report : 11/02); Physicians and Care Management: More Acceptance than You Think (Issues Brief: 01/03)

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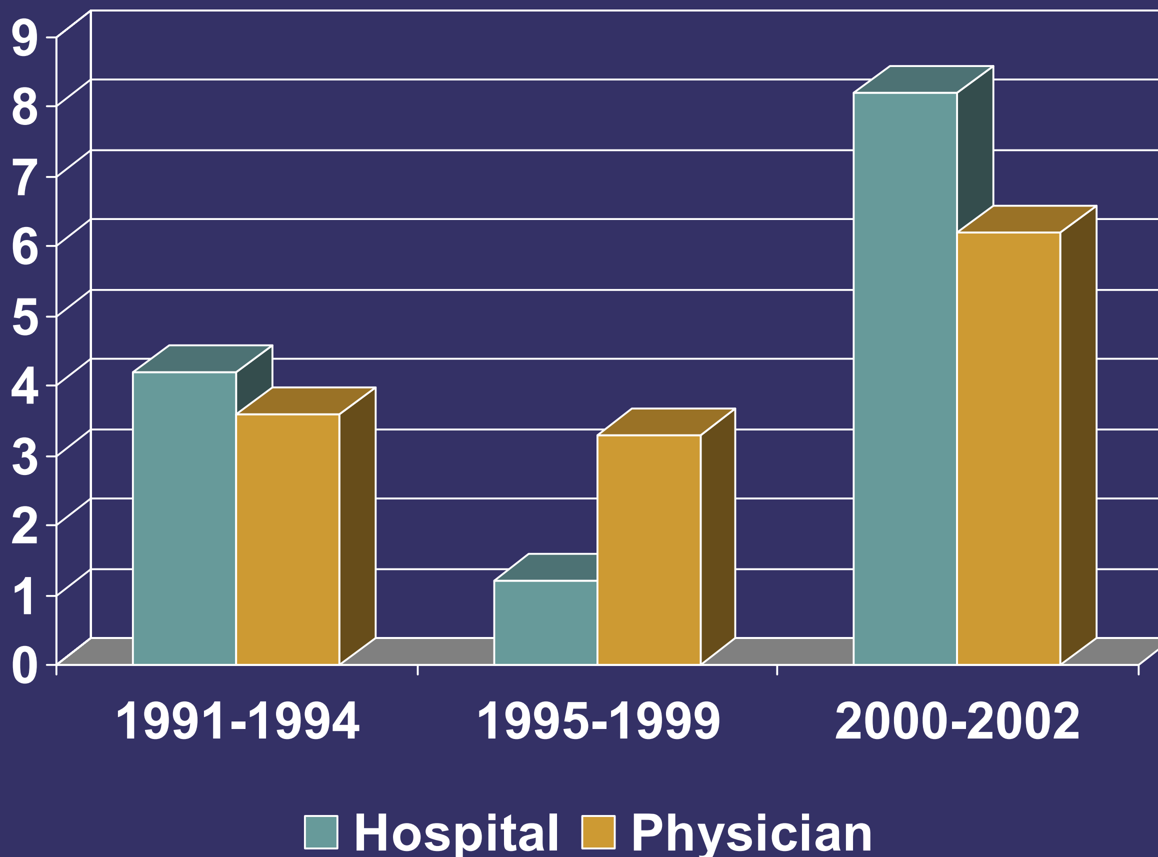
Current market conditions suggest that market has led to same place….

Providers often have substantial clout in their negotiations

- Less than half of physician revenues stem from managed care (AMA and Center for Studying Health System Change)
- No single MCO generally accounts for substantial portion of private revenue: average physician contracts with 13 plans (CSHSC)
- “Physicians adding fees for services that once were free” (American Medical News, March 24/31, 2003)
- Per capita spending on provider services has increased at a more rapid rate in the last few years than in the late 90s…

Average Annual Percent Change in Per Capita Spending on Providers



Hospital data are weighted average of inpatient and outpatient spending increases, weighted by respective national gross revenue shares, as recorded in American Hospital Association's *Hospital Statistics*, 2001 edition, Table 3.

Sources: Milliman USA Health Cost Index ($0 deductible); Kaiser/HRET survey of employer-based health plans for 1999-2002; and KPMG survey for 1991p1998. Downloaded from http://www.kaisernetwork.org/health_cast/uploaded files/DB22_FINAL_pdf.

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Where we are today…health care costs have risen (Employers)

Costs to employers have increased by double digit rates in the last 3 years

- Premiums in 2003 are 12.8% higher than in 2002 and the average employee will spend 16% more in out-of pocket expenditures (Fidelity Investments survey of 30 large companies and their 100 plan offerings)
- Comparable premium increases occurred in 2001 and 2002 (Kaiser Family Foundation/Health Research and Education Trust Survey)
- Costs of services to self-insured employers are similar, suggesting most of increases attributable to increase in provider costs

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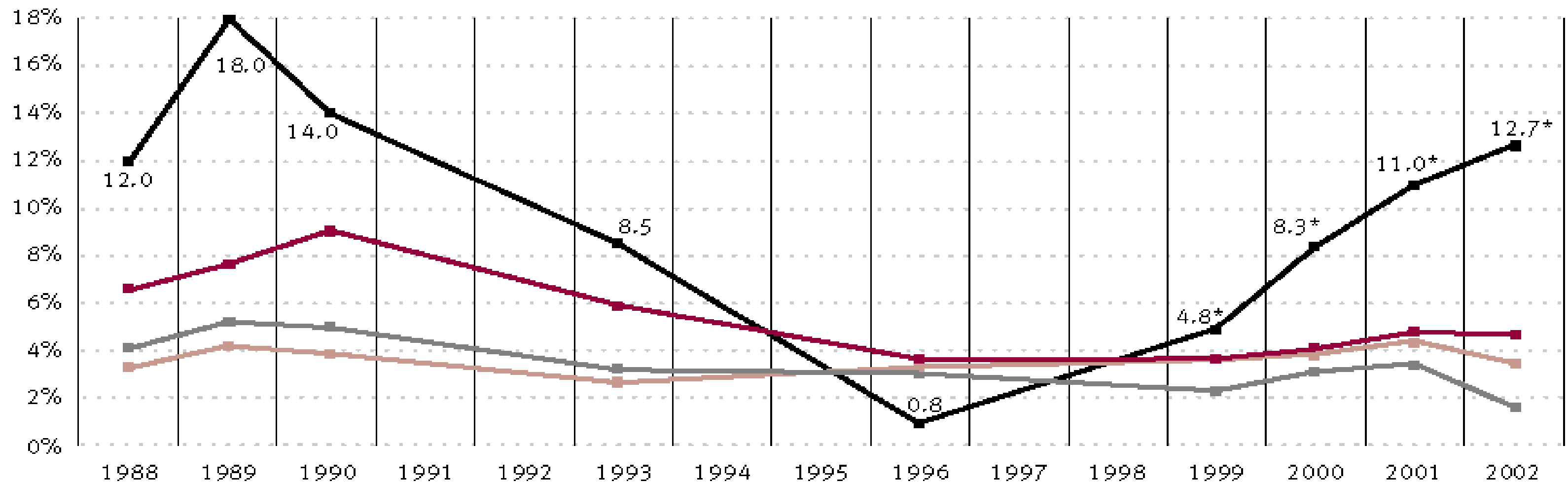
Increases in Private Premiums: 1988-2002



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 1999, 2000, 2001, 2002; KPMG Survey of Employer-Sponsored Health Benefits: 1993, 1996; The Health Insurance Association of America (HIAA): 1988, 1989, 1990; Bureau of Labor Statistics, Consumer Price Index, US City Average of Annual Inflation (April to April), and Medical Inflation, 1988-2002; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1988-2002.

*Estimate is statistically different from the previous year shown: 1996-1999, 1999-2000, 2000-2001, 2001-2002.

Note: Data on premium increases reflect the cost of health insurance premiums for a family of four.

HEALTH INSURANCE PREMIUMS
MEDICAL INFLATION
OVERALL INFLATION
WORKERS' EARNINGS

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Where we are today…Employees are paying more out-of-pocket as labor market softens

Average Annual Deductible by Plan Type, 2001 - 2002

	Single Coverage Preferred Provider			Family Coverage Non-Preferred Provider		
	2002	2001	Percent Change	2002	2001	Percent Change
PPOs (50%)	$276	$201	37%	$488	$407	20%
POS (19%)	$59	$84	(30%)	$413	$406	2%

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2001 and 2002.

Where we are today…Employees are paying more out-of-pocket as labor market softens

Typical HMO Copayments For Physician Visits have Increased

	2002	2001
$10+ Per Visit	89%	76%
$15+ Per Visit	40%	26%

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2001 and 2002

Summary of World Today

In balance of power between plans and providers, providers do not appear to be at disadvantage overall

- Circumstances in particular markets may vary, but these are situations in which antitrust authorities should intervene to restore competitive behavior on both sides

Demand based pressures have largely benefited providers in recent years - Tight labor market in healthy economy made employers want to meet employee demands for:

- Broader networks: has taken away primary tool of managed care - ***selective contracting***
- More freedom of choice – has led to ***reduction in access restrictions***

Result

- Premiums have increased in last 3 years at 7.5% higher rate than had in 90s → this is comparable to prediction made on effects of collective bargaining

Where do we go from here?

Situation

- Employers feeling crunch of higher premiums
- Managed care plans currently meeting employer concerns through direction of cost-sharing toward ultimate consumers (employee patients)
- Could also lead to re-acceptance of limited networks and utilization controls
  - Selective contracting or, at least, tiered networks
  - UR/UM

Question: Does this revitalize issues relating to need to sanction countervailing provider market power?

Answer: No, antitrust agencies need to use appropriate enforcement to ensure that monopsony power is not exercised by plans in situations in which providers cannot walk away

- Not necessarily relevant even if plan has seller market power
- Situations in which monopsony power exists and is likely to result in reduction in consumer welfare are rare

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