American Medical Association
Physicians dedicated to the health of America

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Statement

to the

Federal Trade Commission and
the Department of Justice

Hearing on Health Care Competition Law and Policy

RE: **Perspectives on Competition Policy and the Health Care Marketplace**

Presented by: Jacqueline M. Darrah, MA, JD

February 27, 2003

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Good Morning. My name is Jacqueline M. Darrah, Director of Health Law in the Office of General Counsel of the American Medical Association (AMA). On behalf of the AMA, I would like to thank you for the opportunity to address the Federal Trade Commission and the Department of Justice on health care competition law and policy.

The issues raised today by the Commission and the Department, although quite broad, have very specific implications for this nation's patients. Indeed, the topic of market imperfections in health care is a timely one for the AMA. As you are aware, the AMA has recently expressed to your agencies a heightened concern that the dramatic consolidation in the market for health insurance has led to decreased competition among health insurers and increased problems for patients and physicians. We therefore commend the Commission and the Department for holding these hearings, which we hope will lead to productive discussions, as well as some concrete measures by your agencies to improve competition in the health care market.

We appreciate the acknowledgment by the Commission and the Department that the application of competition law and policy to health care is often controversial. As an organization, the AMA is committed to safeguarding the patient-physician relationship and to promoting high quality health care. From time to time we believe that these goals are hampered by antitrust enforcement policies that we view as contrary to the best interests of patients. But we place our trust in competition, and we recognize the important role that antitrust law has to play in ensuring free markets.

Today we are called upon to discuss: the AMA's perception of specific market imperfections in health care; what pro-competitive and anti-competitive responses (both public and private) have emerged in response to these imperfections; what specific challenges and complications arise in applying competition law and policy to health care; and what impact competition law and policy have had on health care markets.

As we stated to the Commission last September, we believe an imbalance exists in the health care market as well as the enforcement policies of the federal antitrust agencies. The federal antitrust agencies have placed physicians under a far higher level of scrutiny than is warranted by our comparative economic strength in today's health care system. In recent years physicians and physician organizations have been the subject of over fifty enforcement actions.[1] Virtually all of the physician organizations involved in these actions have been small in economic and practical terms. By contrast, despite the increasing size and power of health plans and insurers, we are not aware of a single FTC action against a health insurance company, HMO, health plan, or other third party payer.[2] We are aware of only one DOJ action against a health insurer.[3]

There are plenty of reasons to be concerned about the lack of competition in health insurance markets. In the latter half of the nineties, managed care organizations consolidated at a record pace - over 350 mergers and acquisitions took place in five years. Today, we are seeing double digit increases in health premiums and in health plan profits. At the same time, consumers have expressed deep dissatisfaction with managed care, and physicians have found themselves vastly overpowered in their dealings with insurers.

In any other industry, a merger wave followed by an abrupt rise in prices would cry out for an investigation. Yet ironically, there have been renewed calls by the Commission to "get tough" against physicians and other health care providers. To be sure, we are encouraged by the Department's recent declaration that health insurance companies have become an "area of primary concern" and that the DOJ will engage in renewed scrutiny of health insurers. The AMA strongly supports this initiative and we urge the Department to proceed with vigor.

As we explain the AMA's perception of market imperfections in health care, we arrive at the same conclusions we stated to the Commission last September. The AMA believes it is time to reexamine the legal and policy landscape that has resulted in aggressive antitrust enforcement actions against physicians. We also believe that the federal antitrust agencies should focus more intently on health insurance markets.

[1] See *FTC Antitrust Actions in Health Care Services and Products* (2002), available at www.ftc.gov.

[2] The only possible exceptions are the Commission's actions against health plans controlled by physicians or other health care providers. *See, e.g., RxCare of Tennessee, Inc. et al.*, 121 F.T.C. 762 (1996); *Medical Service Corp. of Spokane County*, 88 F.T.C. 906 (1976). For obvious reasons, however, we think these actions are more properly viewed as actions against providers rather than payers.

[3] As we discuss further below, the Justice Department brought a complaint challenging the national merger of two large payers as it affected two metropolitan markets in Texas. *United States v. Aetna,* No. 3-99CV1398-H (N.D. Tex.) (Complaint filed June 21, 1999; Revised final judgment entered Dec. 8, 1999).

Market Imperfections In Health Care

There are several characteristics of the health care market, considered "imperfections" or "distortions," that create unique problems for physicians and patients – the ultimate consumers of health care. To begin, the system of third party insurance in the United States places health insurers and employers directly between patients and those who provide health care services – physicians and other health care providers. These additional layers of decision-making interjected into the patient-physician relationship have a detrimental effect on patients and physicians.

Moreover, the recent consolidation of health insurers in the United States raises serious questions about the level of competition in the health insurance marketplace. This consolidation also exacerbates the problems created by the system of third party insurance. In addition, the Medicare system of payment for physician services imposes artificial constraints on physician payments for services provided to Medicare beneficiaries. This generally causes a distortion in the market prices of physician services, and it also has a spillover effect on private sector payment for physician services to commercial patients.

Combined, these market imperfections significantly reduce physicians' ability to act in the best interests of patients and generally undermine the practice of good medicine. We will discuss these market imperfections below and describe the procompetitive and anticompetitive responses that have emerged as a result of these imperfections. We will conclude with the specific challenges and complications that arise for physicians as a result of application of competition law to health care.

Insurer/Employer/Patient/Provider Relationships Create Unique Market Issues

The market for health care is directly linked to the market for health insurance. Physicians, hospitals and other health care providers are sellers in the market for health care goods and services. The vast majority of spending on health care flows through insurers to physicians and other health care providers. In other words, health insurers are purchasers of most of these goods and services. At the same time, health insurers are also sellers in the market for health insurance. They add administrative services to the health care goods and services they purchase and sell the combined product as health insurance coverage. Employers that offer health insurance benefits to their employees, as a group, are the largest purchasers in the market for private health insurance.

The phenomenon of third party insurance covering medical and other health care services began in the 1930s and accelerated rapidly in the 1940s when employers began offering health benefits in lieu of wage increases, which were strictly prohibited by wartime price stabilization efforts. What began as a wartime anomaly quickly became the centerpiece of health care financing in the United States. The purchaser of health care coverage – the employer – was (and is) distinct from the consumer of health care – the patient.

The emergence of sharply increasing costs and related financial pressures began in the 1970s and accelerated in the 1980s and 1990s. In the past decade, we have witnessed several important phenomena in our nation's health care finance and delivery systems:

- Employers embracing health plans that impose restrictions on patient demand for medical services.
- Employers limiting employee choice of health plans.
- The emergence of large publicly-traded health plans that have made clear their intent on dominating markets across the country and that approach health care providers as fungible goods.
- The emergence of health care as an attractive vehicle for Wall Street investors.

In no other industry are multiple parties with such conflicting interests interjected between consumers and providers of services. This has a direct impact on the market for health care services.

One mistaken assumption is that health insurers are simply purchasers of health care services, so their interests are closely aligned with consumers. Under this view, when insurers prevail in fee negotiations, the consumer is the ultimate winner.

This view is terribly naïve. Health plans are not surrogates for patients. They may drive down payments, — often by sacrificing quality of patient care, and seldom reflected in lower health insurance premiums. As the size of plans grow, and as plans consolidate, the decision-making power over the health care of millions of people is being controlled by fewer and fewer managers of large health plans. Instead of individual physicians determining what is in the best interests of a given patient, a small number of health plan managers decide what is best for hundreds of thousands of patients at a time. While health plans' power has been used in positive ways to encourage physicians, hospitals, and other providers to find ways to appropriately reduce costs, the degree of leverage now held by health plans has become overwhelming.

Health plan medical decisions are often driven by the financial bottom-line, not the best interests of the patient. Health plans are under financial pressure, especially if they are for-profit entities. Plans have to do more than show a positive return, they must demonstrate earnings growth for their stock prices to increase. This often results in cut-backs on health care expenses by finding ways to deny more and more medically necessary covered services. At the same time, health plans frequently seek to avoid accountability for negligent decisions to deny care under ERISA. *Because their primary legal obligation is to shareholders and they escape accountability to patients, their bottom line is always boosted by a determination of non-coverage of medical services.* Clearly, the health plan cannot be viewed as a patient advocate.

Consumers have become fully aware that their interests are not aligned with those of their health plan – witness the "managed care backlash" of recent years. Patients, of course, share

their health plan's interest in avoiding unnecessary expenses. But patients also have an intense interest in receiving high quality medical care – an interest that their health plans do not necessarily share. Judge Richard Posner, a leading antitrust jurist and scholar, put the point this way: "the HMO's incentive is to keep you healthy if it can but if you get very sick, and are unlikely to recover to a healthy state involving few medical expenses, to let you die as quickly and cheaply as possible."[4] Whatever else one may say about this observation, it would seem to reflect at a minimum the understanding of one particularly sophisticated consumer that his interests are not aligned with those of insurers.

In addition, a perspective that equates the interests of the health insurers with those of consumers omits the fact that insurers are not merely purchasers; they are also sellers. Employers who negotiate group health premiums with their health insurers know this fact all too well. Health insurers do not simply pass through expenses that originate with physicians and health care providers. Health insurance premiums reflect administrative expenses and profit, not just claims expenses.

Employers are also under tremendous pressure to reduce costs associated with health insurance for their employees, particularly recently because of successive years of double-digit premium increases. Many employers are under increasing economic pressure to limit patient choice to one or two plans and to increase the portion of the patients' share of premium or co-payments or to drop coverage altogether.

In contrast, physicians have ethical and legal obligations to act in the best interests of their patients. In addition, clinical decisions are made in the course of the patient-physician relationship, not the insurer/insured relationship. Consequently, physicians will always play a critical role as patient advocate in an increasingly financially driven health care system. This role can be easily undermined when a physician has no leverage to negotiate with a large health plan.

Physicians have responded to these market dynamics by pursuing a number of strategies in an attempt to increase their power to act on behalf of patients. Some are practicing in groups, but these groups remain generally small – 80 percent of self-employed physicians are in practices with less than 9 physicians while only 4.5 percent practice in a group of 50 or more physicians.[5] Other physicians join physician networks and independent practice associations. However, due in part to antitrust constraints, these entities still have little economic power when faced with essentially monolithic health plans.

Joining together to form larger group practices or network joint ventures that would enable physicians to jointly negotiate is extremely capital intensive and is simply not an option for many physicians. Physician practices currently face tremendous economic pressures (as we discuss below) from a range of sources. It is an economic reality that the majority of physicians

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[4] *Marshfield Clinic v. Blue Cross & Blue Shield United of Wisconsin,* 65 F.3d 1406, 1410 (7th Cir. 1995).

[5] Kane, Carol K., *The Practice Arrangements of Physicians 1999* (American Medical Association). See Figure 1 (attached), "Distribution of Self-Employed Physicians and Physicians Employed in Physician Owned Groups by Practice Size, 1999."

do not have the time and capital necessary to integrate with other physicians, nor are they in a position to take on substantial financial risk.

High Levels of Health Plan Concentration Is Evidence of Lack of Competition in the Market for Health Insurance

The latter half of the 1990s was a period of unprecedented consolidation among health insurance companies. Between 1995 and 2000, there were over 350 mergers involving health insurers and managed care organizations.[6] Between 1994 and 1999, mergers and acquisitions of managed care and benefit companies affected over 130 million Americans.[7] Today, over 50% of commercially insured persons are covered by one of the ten largest national health plans.[8]

But the effects of consolidation are most clearly seen at the local and regional levels. In 2001, the AMA completed a comprehensive study of competition in health insurance, based on 2000 health insurance enrollment data.[9] The AMA continues to strive to develop the most accurate possible picture of competition in the market for health insurance. In December 2002, the AMA published its second study of competition in the commercial health insurance industry based on 2001 health insurance enrollment data.[10] Because of improvements in the available data, we were able to look at significantly more markets than we did in our first study.

We looked at HMO and PPO market share, based on 2001 enrollment, for 70 metropolitan areas. We also looked at state level health insurance market concentration, including 22 less populated states where metropolitan area-level data were not available. To date, these studies represent the most extensive effort ever undertaken to paint an accurate picture of the markets for health insurance.

These studies confirmed what patients and physicians and employers around the country already knew: In many parts of the country, health insurance markets are dominated by a few companies that have significant power in the market. In other words, the insurers in these markets may have the ability to profitably raise premiums to employers, and to profitably depress physician payments.

In our most recent study, we looked at health insurance markets in three ways: First, we included only HMOs (as the Justice Department did in its challenge to the Aetna/Prudential

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[6] Levin Associates, *The Health Care Acquisition Report* (8th ed. 2002).

[7] June 23, 1999 Press Release from Levin Associates, *Managed Care Consolidation Affecting More than 50% of the U.S. Population.*

[8] Kaiser Family Foundation, *Trends and Indicators in the Changing Health Care Marketplace* (May 2002), at 58.

[9] *See* American Medical Association, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets* (2001).

[10] *See* American Medical Association, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets* (Second Edition, 2002).

merger in Texas); second, we included only PPOs; and, third, we included both HMOs and PPOs. Next, we calculated the Herfindahl-Hirschman Indices ("HHI") for each market area and – applying the *Merger Guidelines* – classified each market as "unconcentrated," "concentrated," or "highly concentrated."[11]

What we found was staggering. For the 70 metropolitan areas, 100% of the PPO product markets were highly concentrated, 90% of the HMO markets were highly concentrated, and 87% of the combined HMO/PPO product markets were highly concentrated. In 89% of the highly concentrated markets, there was at least one insurer with a market share in excess of 30%, and in 40%, a single insurer had a market share in excess of 50%.

The situation was even worse in the 22 states where no metropolitan area-level data was available. All of the 22 states had highly concentrated PPO product markets, and 21of the 22 states had highly concentrated HMO product markets and highly concentrated combined HMO/PPO product markets. In 20 of the 22 states, a single health insurer had a market share in excess of 30% in each of these three product markets. In two-thirds or more of the 22 states, for both the HMO and PPO product markets, a single insurer had a market share in excess of 50%. And, in nearly half of the 22 states, in the PPO product market, there was one insurer with more than 70% of the market -- a dominating share by any measure.[12]

Indications of Monopoly Power

The high levels of health plan concentration described in the market study raise serious questions about the level of competition in the markets for health insurance. We recognize, however, that market concentration is not the only measure by which the competitiveness of markets is assessed. So we also look at other characteristics of these markets. In doing so, we find further cause for concern. To begin, because significant regulatory barriers restrict entry into health insurance markets, dominant firms currently in the market are able to more easily maintain their monopoly power. In addition, physicians' unique legal and ethical responsibilities enhance the ability of dominant insurers to exercise market power.

Entry into a market requires investing millions of dollars to comply with state regulations governing insurance companies. New health plans in the market must also invest time, labor, and money to establish relationships with physicians and health care providers in the market. In its challenge to the Aetna/Prudential merger in Texas (the only health plan merger ever challenged by either federal antitrust agency), the Department of Justice noted that "effective

[11] U.S. Dep't of Justice & Federal Trade Commission, *Horizontal Merger Guidelines* (1992; revised 1997) ("*Merger Guidelines*"). Under the *Merger Guidelines*, markets with an HHI below 1000 are considered unconcentrated; markets with an HHI between 1000 and 1800 are considered moderately concentrated; and markets with an HHI above 1800 are considered highly concentrated.

[12] Because this portion of our 2002 market analysis was done on a state-wide basis, these market share estimates may significantly understate the market power of some payers in some local markets. (See footnote 10)

new entry for an HMO or HMO/POS plan in Houston or Dallas typically takes two to three years and costs approximately $50,000,000."[13]

Monopoly power is perpetuated by barriers to entry in health plan markets because the costs and regulatory hurdles facing a new entrant make it possible for an insurer that currently has a large market share to increase premiums without concern that it will lose market share. Even worse, large insurers may use contractual devices such as "most-favored nation" clauses or "all-product" clauses to lock in physicians and keep out new rivals. The large companies are clearly in the driver's seat.

On the other hand, physicians face unique legal and ethical responsibilities that enhance the ability of health plans to exercise market power.[14] In most sectors of the economy, if a customer does not pay in a timely fashion, the supplier will simply cease providing goods or services. This is not the case in medicine. If a health plan presents physicians with a reduced fee schedule or unfair contract terms, physicians typically do not switch health plans. Physicians' decisions are driven by their relationships with patients. The Justice Department acknowledged this in the *Aetna* case, noting that physicians have a limited ability to encourage patients to switch plans because the patients would have to switch to another employer-sponsored plan in which the physicians participate (which might not be an option), or pay considerably higher out-of-pocket costs.[15] As a consequence, physicians are often unable to reject unfair demands by a dominant health plan without losing patients and harming their practice.[16]

Combined, these conditions enable an insurer with a large market share to increase its premiums while also reducing physician payments without losing market share – a clear indication of monopoly power. Consider, for example, the California situation: As of 2000, five health plans in California accounted for 90% of HMO patients and three plans represented 67% of all patients.[17] These plans wield enormous bargaining power, driving payment rates well below the level needed to provide medically necessary care and forcing dozens of medical groups and IPAs into bankruptcy.[18] From the consumer's perspective, the result has been chaos – higher out-of-pocket costs, longer waiting times, and reduced access to the patient's physician or to any physician at all. Worse still, these conditions have driven a wedge between physicians

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[13] *United States v. Aetna,* No. 3-99CV1398-H (N.D. Tex.) (Revised Competitive Impact Statement filed August 3, 1999).

[14] *See* Herndon, "Health Insurer Monopsony Power: The All-Or-None Model," 21 *Journal of Health Economics* 197-206 (2002).

[15] *See supra* n. 3.

[16] Id.

[17] *See* Bodenheimer, "California's Beleaguered Physician Groups – Will They Survive?" 342 *New England Journal of Medicine* 1064 (April 6, 2000).

[18] Robinson, "Physician Organization in California: Crisis and Opportunity," *Health Affairs* (July/August 2001), at 85 ("Low payments, expressed most clearly in dismal per member per month capitation rates, are the proximate cause of the difficulties inflicting medical groups and IPAs in California."); Lentz, "Closure Count: Report Enumerates California Medical Group Failures," *Modern Physician* (Aug. 1, 2001).

and their patients, and contributed to an atmosphere of distrust and acrimony among patients, their health plan, and physicians.

Rising Health Premiums

Clear indications of monopoly power exist when dominant insurers have the ability to profitably raise premiums to employers, and to profitably depress physician payments. As we explain below, that seems to be the case. In addition, the number of uninsured individuals is increasing as premiums rise.

If the late '90s were a period of mergers and acquisitions in managed care, the years since have been characterized by increasing health plan premiums and profits. Again, let's take a look at the facts: From 2000 to 2001, premiums for employment-based insurance policies increased by 11%.[19] Premium increases outpaced overall inflation of 3.3% by a wide margin.[20] From 2001 to 2002, premiums increased by 12.7%, the highest rate of increase since 1993.[21] The increase marked the sixth consecutive year of accelerating premium increases. Overall, health insurance premiums increased 42% from 1998 through 2002.[22] This is more than double the overall increase in medical inflation (17%) and more than triple the increase in overall inflation (10%) during the same time period.

The recent premium increases have not been driven solely, or even primarily, by increases in underlying medical costs.[23] Data indicate that private health insurance administrative costs (which include profits) rose steadily from 1997 to 2000.[24] Data also indicate that premiums have been rising at a substantially faster rate than claims expenses.[25]

Further, recent reports on corporate profits in the insurance industry refute any notion that claims expenses are driving premium increases. Profit margins of the major national firms have been steadily rising. Despite a slowdown in the general economy since 2001, the managed care

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[19] Strunk, et al, "Tracking Health Care Costs," *Health Affairs* (Sept. 26, 2001), at W45.

[20] Jon Gabel, et al, "Job-Based Health Insurance in 2001: Inflation Hits Double Digits, Managed Care Retreats," *Health Affairs* (Sept./Oct. 2001), at 180.

[21] *See* Figure 2 (attached), "Increase in Health Insurance Premiums Compared to Other Indicators (1988-2002)."

[22] Id.

[23] To the extent that premium increases may be attributable to rising costs of health products or services, physician costs have not been one of the major drivers. *See* Figure 3 (attached), "Annual Percentage Change in National Spending for Selected Health Services 1998-2002, Office of the Actuary, Centers for Medicare and Medicaid Services."

[24] Kaiser Family Foundation, *supra* n. 6, at 73 (from $208 per person in 1997 to $270 per person in 2000.)

[25] Claims expenses rose 9.5% in 2001, but premiums increased 12.3 percent for fully insured plans "For self-insured firms, changes in premium equivalents are a proxy for trends in expected claims expenses. Premium equivalents rose 9.5 percent in 2001 . . . Premiums increased 12.3 percent for fully insured plans, which indicates that insurers are raising their prices faster than claims expenses are growing." Gabel, *supra* n. 16, at 181-82.

industry has posted consistent profits during that time. The industry posted a 16% increase over its profits for the first half of 2000.[26] HMOs and health insurers reported a 25 percent increase in profits for 2001, rising from $3.3 billion in 2000 to $4.1 billion in 2001.[27] In 2002, most health insurers were able to boost profits by raising premiums higher than the rate of medical inflation for the third year in a row. Some also cut money-losing business and saw a drop in enrollment as a result.[28] Third-quarter earnings were up 47% on average for 11 major insurers, and good fourth-quarter results are also expected.[29] It was recently noted that "premiums are expected to rise an average of 15.4% this year, while underlying health costs to insurers are expected to grow 12%, allowing insurers to add the difference to the bottom line."[30]

According to financial analysts, the increases in managed care profits are the result of three things: premium increases, plan mergers, and withdrawals from unprofitable markets.[31] As one analyst put it, "there's very little pricing competition for employers right now and that allows HMOs to get the premiums they need to see to be profitable."[32] Another analyst explained the industry's profits as follows: "What's driving it is very simple: We finally have premium increases outpacing medical inflation."[33] Another analyst stated "it has become very apparent that in the past few years, 10% to 40% premium increases are indeed pushing up premium revenue. It helps that fewer insurers are controlling more local markets—as seen, for example, with recent mergers establishing dominant companies like WellPoint and Anthem." [34] Wall Street certainly does not view the premium increases as a mere pass through of costs.

When premium hikes by dominant payers appear to reflect more than just marginal costs, it raises concerns of monopoly power. This is especially disturbing when it appears that the

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[26] These statistics are from Weiss Ratings Inc., an independent ratings agency. *See* Jacob, "HMO profits rose overall last year: Higher premiums and exits from unprofitable markets helped improve insurers' bottom line," amednews.com (March 4, 2002). *See also* October 31, 2001 Press Release from InterStudy Publications, at 6.

[27] September 3, 2002 Press Release from Weiss Ratings, Inc., *HMOs' and Health Insurers' Profits Increase 25% to $4.1 Billion in 2001.*

[28] Appleby, *USA Today*, "Managed care Insurer Profits Up" (Jan. 2, 2003).

[29] Id.

[30] Id.

[31] *See generally* Wholey, et al, "The effect of market structure on HMO Premiums," 14 *Journal of Health Economics* 81-105 (1995).

[32] Brent Layton, of consulting firm Layton & Associates, quoted in Bryant, "HMO profits rise in first quarter," *Atlanta Business Chronicle* (May 31, 2002).

[33] Joel Ray, an analyst with Wheat First Union in Richmond, Va., quoted in New York Associated Press, "HMOs profiting from higher premiums" (Feb. 26, 1999); *see also* Jacob, "HMO profits rose overall last year: Higher premiums and exits from unprofitable markets helped improve insurers' bottom line," amednews.com (March 4, 2002).

[34] "Managed Care's Profits Come From Physician Pockets," *American Medical News* (September 2, 2002).

dominant companies and their top management have been richly rewarded for these results, potentially at the expense of patients and physicians.

The stock of the largest publicly-held insurers increased in value by 76% in 2001 and by 48% in 2002,[35] while the overall stock market posted significant losses. Concurrently, the CEOs of at least 14 managed care companies all received salaries and bonuses in excess of $1 million -- in some cases quite a bit more.[36]

When health premiums rise due to a lack of competition, some employers will cease providing coverage or will reduce the scope of benefits provided. Lack of coverage for uninsured and underinsured individuals places enormous pressures on other segments of the health care system – particularly physicians and hospitals. It also leads to otherwise avoidable expenditures for emergency treatment and medical services that could have been prevented. Competition among health insurers helps to avoid these results.

While health plans power is increasing, physicians' payments are decreasing[37] as well as their ability to influence health plans in general. As the Justice Department recognized in the *Aetna* matter, a lack of competition among health insurers may also lead to anticompetitive effects in the health care provider markets. A dominant insurer exercising monopsony power, can drive down physician fees below competitive levels. Over time, these fee reductions can lead to reduced physicians' patient care hours, physician departures from the market, and hence, reduced access to care for patients. Indeed, these are precisely the effects that are currently being observed in a number of markets that are dominated by large firms.

<u>Physicians Decreasing Ability to Act in the Best Interests of Patients</u>

The presence of monopoly and monopsony power is also suggested by physicians' decreased ability to negotiate effectively on behalf of patients. In many markets, physicians have virtually no bargaining power with dominant health plans that refuse to negotiate any terms of their contracts – including terms which directly affect patient care. Some examples include:

- *Undisclosed fee schedules.* Many contracts provide that the health plan will not disclose its fee schedule. Without access to fee schedules, physicians are unable to determine whether plans are making payment errors or to engage in budgeting for their practices.

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[35] Stacey Bradford, "What Health Care Crisis?" *SmartMoney* (April 29, 2002).

[36] "CEO Bonuses Tied to Performance," *Managed Care Week* (May 6, 2002). The fourteen companies are WellPoint, United, CIGNA, Anthem, Oxford, Sierra, Aetna, Coventry, First Health, Trigon, Humana, Mid-Atlantic, Amerigroup, and PacifiCare. The CEOs of the top five publicly traded health insurers in 2001 (UnitedHealthcare, WellPoint, Aetna, Cigna, and Health Net) received total compensation ranging from $8,156,452 - $27,549,675.

[37] In the early to mid-90s, growth in spending for physician services decreased, from 5.4% in 1991 to 1.6% in 1996. After years of reductions in physician payment rates from private insurers, physician payments started to increase in 1997. The increase in physician payment rates leveled off in 2000. Strunk, *supra* n. 18, at W41-W42.

- *Unilateral amendment by payer.* Many contracts allow the plan to change not only physician fee schedules but also contract terms that govern whether and under what circumstances patients are able to obtain medically necessary services.

- *Slow Pay.* Health plans often do not reimburse physicians in accordance with their contractual and other legal requirements, yet physicians often have no cost-effective recourse available. Slow pay problems may result from coordination of benefits issues, requests for additional documentation from physicians, improper denials, and other reasons.

- *Restrictive Definitions of Medical Necessity.* Many contracts include overly restrictive definitions of medical necessity that prevent physicians from recommending proven treatments.

- *All products" clauses* that require physicians to participate in a less attractive health plan as a condition of participating in a more attractive plan.

- *"Most-favored nation" clauses* that require physicians to give a dominant health plan the benefit of the physicians' most favorable discount of any plan.

- *Indemnification Clauses for Patient Privacy Violations.* Many contracts require physicians to provide confidential patient information to the health plan for utilization management and other purposes. These contracts frequently require the physicians to indemnify the plan for legal claims brought against the plan for its misuse of that information.

No reasonable businessperson would accept these terms if he or she had any leverage to negotiate. The egregious nature of many of these terms, such as the assumption of liability by physicians for improper conduct by the health plan, reflects poorly on the state of competition in the health care market and is substantial evidence that something is amiss. Unfortunately, because these terms directly affect patient care, patients will suffer until physicians can negotiate better contract terms.

Other Market Distortions

Another distortion in the market for health care occurs as a result of Medicare payment policies. The federal government purchases a large portion of health care services for the nation's population. Because of budgetary constraints and price controls, Medicare payments are not derived from natural market forces that would normally occur as a result of competition. Public sector budgetary issues, statutory limitations, and price controls drive physician reimbursements down (and keep them low) yet practice costs continue to increase, adding to physicians' growing economic pressures.

The artificial constraints on physician payments imposed by the government distort market prices of physician services. In addition, because numerous private sector health plans and state Medicaid programs tie their physician fee schedules to the Medicare rates, the Medicare payment schedule affects the entire health sector. For example, statutory reductions in

Medicare payments translate into automatic price deductions throughout the industry where private sector health plans tie fees to the Medicare fee schedule.

At its inception, physician payment for services covered by Medicare was based on a system of "customary, prevailing and reasonable" (CPR) charges. The CPR system was designed to pay for physician services according to their actual fees, with some adjustments to keep government outlays predictable.[38] Yet in the late 1980s, due to various distortions in physician payments, the CPR system was changed to the Resource Based Relative Value System (RBRVS), whereby payment is based on the relative value of the service multiplied by a conversion factor.

When the RBRVS was enacted, the legislation created an automatic budget control mechanism for physician services by capping any annual revisions to relative values to $20 million over the spending level that would have occurred without the adjustments. Every year since its implementation, "budget neutrality" adjustments have been required because of projected net expenditure increases exceeding this limitation. The law also established a target setting mechanism now called the sustainable growth rate (SGR). The SGR sets limits on the rate of increase in Medicare spending on physicians' services. [39] Under this system, physician payment updates are tied to growth of U. S. gross domestic product (GDP) even though there is little relationship between GDP growth and utilization of health care services. No other Medicare provider group is subject to payment reductions when GDP growth declines.

The distortions in the Medicare fee schedule are particularly problematic for physicians. Many private health plans rely on the RBRVS and tie their conversion factor to the Medicare conversion factor to establish physician payments.[40] Even though many pay physicians according to a higher conversion factor, if it is tied to the Medicare conversion factor, the flawed formula and any negative updates end up factored in to those payments. The ultimate result is a downward trend in payments – potentially below medical inflation.[41] Even if health plans provide an annual increase in the conversion factor, if the Medicare payment update reduces the Medicare conversion factor, private sector payments may effectively be reduced as well.

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[38] Medicare defined "customary" charges as the median of an individual physician's charges for a particular service for a defined period of time. The "prevailing" charge for this service was set at the 90th percentile of the customary charges of all peer physicians in a defined payment area. The "reasonable" charge was the lowest of the actual fee, the customary charge or the prevailing charge in the area.

[39] Under the SGR system, the government annually establishes allowed expenditures for physicians' services based on a number of factors including changes in Medicare spending on physicians' services due to changes in (i) inflation, (ii) Medicare fee-for-service enrollment, (iii) gross domestic product (GDP), and (iv) laws and regulations. If actual expenditures exceed allowed expenditures, then Medicare payment updates may be reduced by as much as 7 percent below the MEI. Conversely, if allowed expenditures are less than actual expenditures, payment updates may increase up to 3 percent above the MEI.

[40] According to a November 2001 AMA survey, out of 176 private payer respondents that use the RBRVS, approximately 26% volunteered that they tie their conversion factor to the Medicare conversion factor for physician payments. It is possible that some of the 74% that did not volunteer this information also tie their conversion factor to the Medicare conversion factor.

[41] From 1991 to 2001, Medicare payment levels had dropped 13% behind inflation in medical practice costs.

The problem with the "spillover" of Medicare payment rates and schedules into the private sector is compounded by the increasing power of health plans. In addition, if one factors in the current environment for physicians - dramatically increasing practice costs as a result of evolving technology, excessive administrative burdens, unfunded mandates imposed by federal laws and regulations, and increasing costs of medical liability premiums in many areas - the result will likely be reduced access for patients. If physicians were better able to negotiate with private payers, the effects of the spillover would be less drastic. Yet when individual physicians are faced with monolithic health plans, the result is most often a take-it-or-leave-it situation.

Challenges and Complications Arising from Application of Competition Law to Health Care:

Physicians have limited financial resources and capabilities to undertake successfully the financial and/or clinical integration necessary to effectively deal with health insurers. The most obvious way in which independently practicing physicians can improve their ability to deal with health plans is to form a large multispecialty group practice such as the Mayo Clinic or the Cleveland Clinic. This type of large multispecialty group practice often owns all of the assets required for the spectrum of health care delivery such as hospitals, outpatient facilities and physician offices. These group practices are extremely difficult to form and require significant amounts of time, capital and infrastructure.

As an alternative, the 1996 Statements of Antitrust Enforcement Policy in Health Care address the ability of physicians to form joint ventures that would be allowed to negotiate with health plans. Although the Statements were an important step in recognizing the realities of the health care marketplace, in practical terms their usefulness has proven limited for most physicians.

Antitrust Law and Policy Restrict Physicians' Ability to Respond To Health Plan Leverage

The Statements describe three ways in which physicians can join together in their dealings with health plans other than forming a large group practice. These three types of arrangements are referred to as "provider networks." These networks must 1) share substantial financial risk; 2) substantially merge their clinical practice; or 3) use the messenger model. All three types of arrangements fall short of realistic, practical remedies for many physicians.

Substantial Financial Risk

According to the Statements, independent physicians may form a network where the physicians share substantial financial risk. "Substantial financial risk" means accepting payment by capitation or a percent of the premium, or by accepting substantial fee withholds or bonuses. If a network intends to accept one of these forms of payment it may then negotiate such a contract with health plans. However, there are significant barriers to forming these networks. Formation of a network capable of assuming substantial financial risk is a major undertaking, and can require hundreds of thousands of dollars to pay for legal counsel, consultants, and the infrastructure necessary to manage risk. Moreover, the size limits place physician networks at a

disadvantage against other networks formed by non-physicians. For example, a health plan can form a non-exclusive PPO with 70% of physicians in the market.[42]

An additional cost is that of physician bankruptcies resulting from inadequate capitation rates. In California, where risk contracting is the norm rather than the exception, dozens of medical groups and IPAs have declared bankruptcy since 1999, and dozens more face the prospect of doing so.[43] Together, these groups and IPAs were responsible for providing medical care for over 2.5 million people. These groups were simply not being paid enough to cover the costs of the medical care required by their patient populations.[44] Their bankruptcies caused enormous disruptions in care and dislocations in the market, with many individuals losing access to their physician of choice – or, indeed, to any physician at all. Similar circumstances have unfolded in other states.[45] Risk contracting, as its name suggests, inherently involves the possibility of a downside – the costs of which must be taken into account.

Even if physicians have the time, energy and capital to establish such a network, in many markets, health plans resist or choose not to enter into risk arrangements with physicians. Their reasons may include business considerations, pressures from employers, lack of confidence in the physicians' ability to manage risk, or concerns regarding legal liability. [46]

In addition to the financial concerns involved with taking on insurance risk, many physicians have ethical concerns about such financing mechanisms as well. These types of arrangements inevitably involve incentives to reduce or limit care. Even though the idea is to reduce care that is not necessary, if the capitated payment levels are too low or the withholds/bonuses significant, a physician can be placed in an untenable position and his or her practice could be placed in jeopardy. There has also been a heightened level of consumer suspicion surrounding these arrangements based on perceived abuses. Patients have turned

[42] The Statements limit a non-exclusive network to 30% of physicians in the market to fall within a "safety zone." If the network is exclusive they can include just 20% of physicians in the market.

[43] J. Robinson, "Physician Organization in California: Crisis and Opportunity," *Health Affairs* 81, 85 (July/August 2001) ("Low payments, expressed most clearly in dismal per member per month capitation rates, are the proximate cause of the difficulties inflicting medical groups and IPAs in California."); Lentz, "Closure Count: Report Enumerates California Medical Group Failures," *Modern Physician* (Aug. 1, 2001).

[44] "It is clear that plan payment rates have to meet provider expenses over time to sustain risk transfer arrangements, but that has not been the case in may instances for a number of reasons. Some providers have been overly optimistic about their ability to manage care. Others may have been naïve in rate negotiation and actuarial estimation. Still others accepted risk for costs they could not be expected to control, or they encountered unexpectedly large cost increases. In other situations, plans may have used the threat of exclusion from their networks to gain providers' acceptance of what provide to be inadequate rates, or refused to include realistic updates to reflect changing conditions." R. Hurley, J. Grossman, T. Lake, & L. Casalino, "A Longitudinal Perspective on Health Plan-Provider Risk Contracting," *Health Affairs* 144, 152 (July/August 2002).

[45] *See, e.g.,* Letter from Jeffrey W. Brennan, Asst. Director, Bureau of Competition, to John J. Miles (Feb. 19, 2002) (*"MedSouth"*) (noting that many IPAs in Denver "experienced significant financial difficulties under [capitation] contracts, and a number of the organizations declared bankruptcy.").

[46] *See* R. Hurley, *et al., supra* n. 6, at 149.

against the concept of financial incentives offered to physicians to reduce or limit care.

Substantial Clinical Integration

Physicians who do not share substantial financial risk may also be able to negotiate with health plans if they coordinate their practices to such an extent that they become "clinically integrated." This level of clinical integration also requires a substantial level of investment, management and infrastructure that is likewise out of reach for many physicians.

In 2002, the Commission issued its first staff advisory letter approving such a joint venture to MedSouth, Inc., an IPA of over 400 physicians based in Denver, Colorado.[47] The *MedSouth* letter is notable in a number of respects, demonstrating how daunting a project clinical integration really is. For most physician groups, the level of investment called for in *MedSouth* is simply not an option. Moreover, the Commission's letter is laced with caveats which seem to indicate that even a physician network with an extraordinarily high level of integration will continue to be exposed to significant antitrust risk.

Here are just a few of the critical facts. MedSouth worked for over a year with a health care information technology firm and a national clinical laboratory company to develop a program with two major parts: (1) a web-based electronic clinical data record system designed to permit the physicians to share clinical information on their patients and to monitor data relating to utilization, adverse drug reactions, medical errors, and medical outcomes, and (2) the development of over 100 clinical practice guidelines and the implementation of performance goals linked to those guidelines. Although the staff letter does not indicate precisely how much time and money was invested in this project, there can be little doubt that the physicians' investment was sizeable. In addition to requiring the purchase of sophisticated information technology, the *MedSouth* project required the physicians to hire numerous advisors, including lawyers, health care consultants, and an information technology firm.

A few other facts about *MedSouth* are worth noting. First, the physicians assured the staff that they intended to contract on a non-exclusive basis – *i.e.*, they would continue to make their services available outside the network. One might have thought that this fact alone – even without clinical integration – would have substantially assuaged any concern about the physicians' ability or desire to harm competition.[48] Second, it appears that MedSouth planned to wall off its physicians from direct involvement in contracting. The letter indicates that the physicians proposed to use an outside consultant to develop a fee schedule and, if necessary, gather information from each MedSouth physician on a confidential basis. This approach sounds like a miniature version of the "messenger model" (although it dispenses with some of that model's most burdensome features).

[47] *See,* Letter from Jeffrey W. Brennan, Asst. Director, Bureau of Competition, to John J. Miles (Feb. 19, 2002) (*"MedSouth"*).

[48] *See* H. Hovenkamp, Federal Antitrust Policy: The Law of Competition and Its Practice § 5.6 (1994) (a non-exclusive physician network is "absolutely inconsistent with the economics of cartelization: no cartel could restrict its output and raise price if it permitted its members freely to come and go, or to make unlimited 'non-cartel' sales.").

Third, the letter notes that MedSouth proposed to take a fee-for-service approach only after disastrous experiences with risk contracting. Specifically, MedSouth and other IPAs in the market accepted capitation until "[m]any of these groups experienced significant financial difficulties under those contracts, and a number of the organizations declared bankruptcy." In light of this experience, "payers and most physician groups, including MedSouth terminated their capitated contracts." It is truly disheartening that such language seems to suggest that the Commission would be less tolerant of a physician network that was just starting out on a fee-for-service basis, before trying capitation and meeting market resistance.

For all their efforts to invest, innovate, and implement appropriate safeguards, the MedSouth physicians received a go-ahead from the Commission staff that can best be described as tepid. The letter concludes with remarks that leave one pondering whether the undertaking and "approval" from the Commission will ultimately be any practical protection for the physicians.[49] The message from the Commission appears to be this: "You may proceed, but at your own risk. And we will be watching you."

MedSouth represents a thoughtful attempt by the Commission staff to deal with an innovative effort by physicians to improve quality, coordinate care, and provide new services within the confines of antitrust restrictions. But it demonstrates how high the bar has been set. After years of work, a very substantial investment, and lots of physician and consultant time, the IPA walked away with a lukewarm, conditional go-ahead - and a pointed reminder that the Commission may change its mind at any time.

Messenger Model

When all else fails, the final option for a physician network that is not sufficiently integrated to negotiate prices is to adopt the "messenger model." Under the messenger model, a third party – the messenger – receives offers from payers and conveys them to each physician practice in the network. It then surveys the practices, and conveys the individual response of each practice to the payer. If the payer is not satisfied with the level of acceptance in the first round, the parties start over and do it again.[50]

The messenger model is purely a device for maintaining antitrust compliance, with no independent business justification. It is cumbersome and difficult to administer. Not surprisingly, it is often despised by physicians, hospitals, and – to our understanding – even payers. Moreover, the messenger model leaves physicians exposed to charges of boycott whenever a large number of physicians in the network view a payer's offer as inadequate.

[49] "Based on all the factors discussed above, we have concluded that we would not recommend a challenge to MedSouth fully implementing the program and then offering it to payers on a collective basis. As long as doctors are, in fact, willing to deal individually on competitive terms with payers who do not want the package price, as you represent will be the case, significant anticompetitive effects appear unlikely. . . . If, however, MedSouth's member physicians are able to use collective power to force payers to contract with the network or to pay higher prices, then absent evidence that substantial efficiency benefits outweighed likely anticompetitive effects, we likely would recommend that the Commission bring an enforcement action. . . . This office will monitor MedSouth's operations and the behavior of its physician members for indications that the proposed conduct is resulting in significant anticompetitive effects."

[50] *Health Care Policy Statements,* Statement 9.

Consider the following scenario: A payer offers a contract to the network messenger. The messenger takes the contract to the individual physicians, each (or many) of whom reject it as unacceptable. The payer, who views its offer as eminently reasonable, concludes that the physicians must have colluded – so it contacts the FTC.

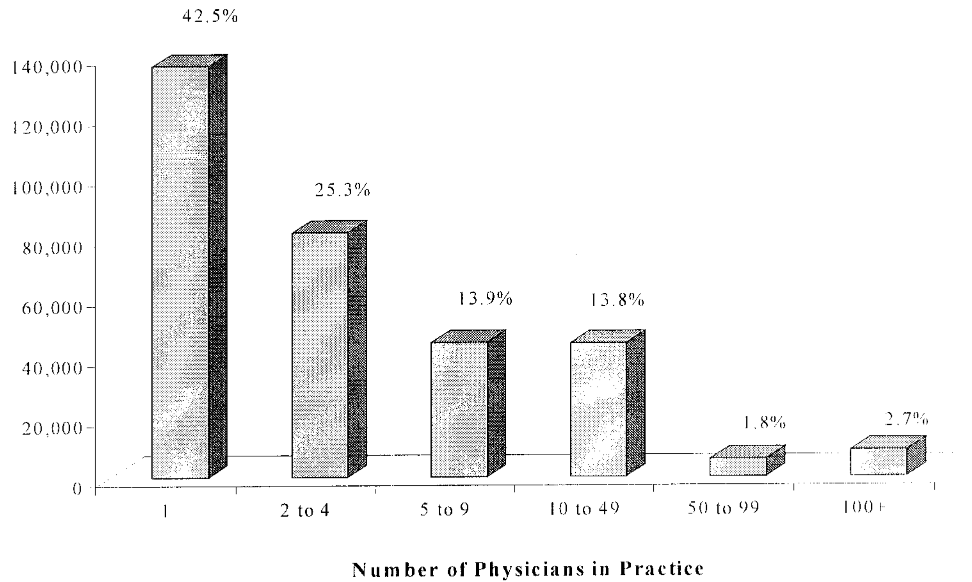
The lawfulness of the physician's conduct should not depend on whether they accept the payer's proposal. As a practical matter, however, whenever a payer's offer is rejected by a significant number of physicians, a factual question will arise as to whether the physicians acted in a truly independent fashion. The presence of that factual question creates antitrust risk for the physicians. And it gives the payer an upper hand in the contracting process, regardless of whether the Commission agrees to bring a complaint or even to open an investigation.

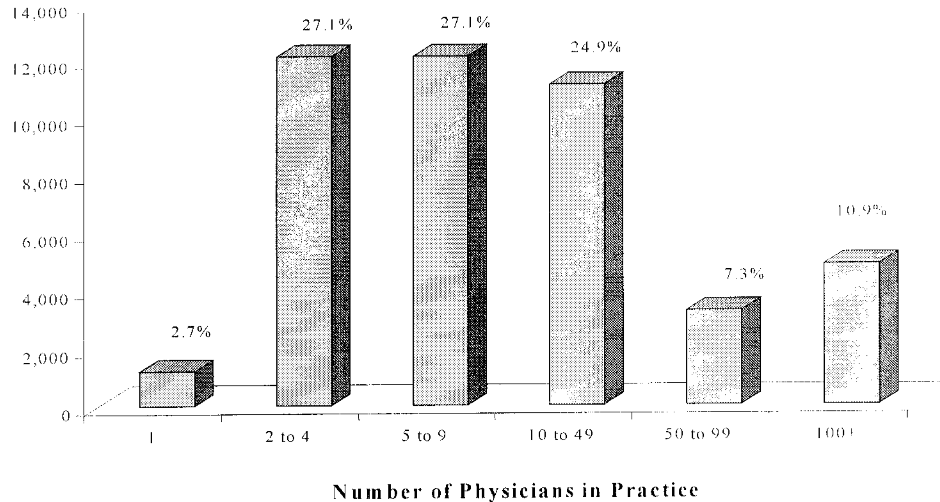
In the end, the machinations of the messenger model provide little in the way of antitrust protection for physicians while imposing significant administrative costs on all parties. Because fee-for-service contracting is not inherently anticompetitive – and because the Rule of Reason can sufficiently guard against competitive abuses – the messenger model is at best unnecessarily restrictive and, at worst, an obstacle to competition by legitimate physician networks.

Conclusion

In closing, we believe that the Commission has spent too much of its time tracking down physician groups, while looking the other way when payers engage in activities that have real and widespread effects on the cost and quality of patient care. We respectfully ask that the Commission reconsider its approach, and take a serious look at competition on the payer side. We also take very seriously the Department's intention to pay closer scrutiny to health insurers and we stand ready to assist the Department in its efforts. Thank you for the opportunity to participate in these hearings.

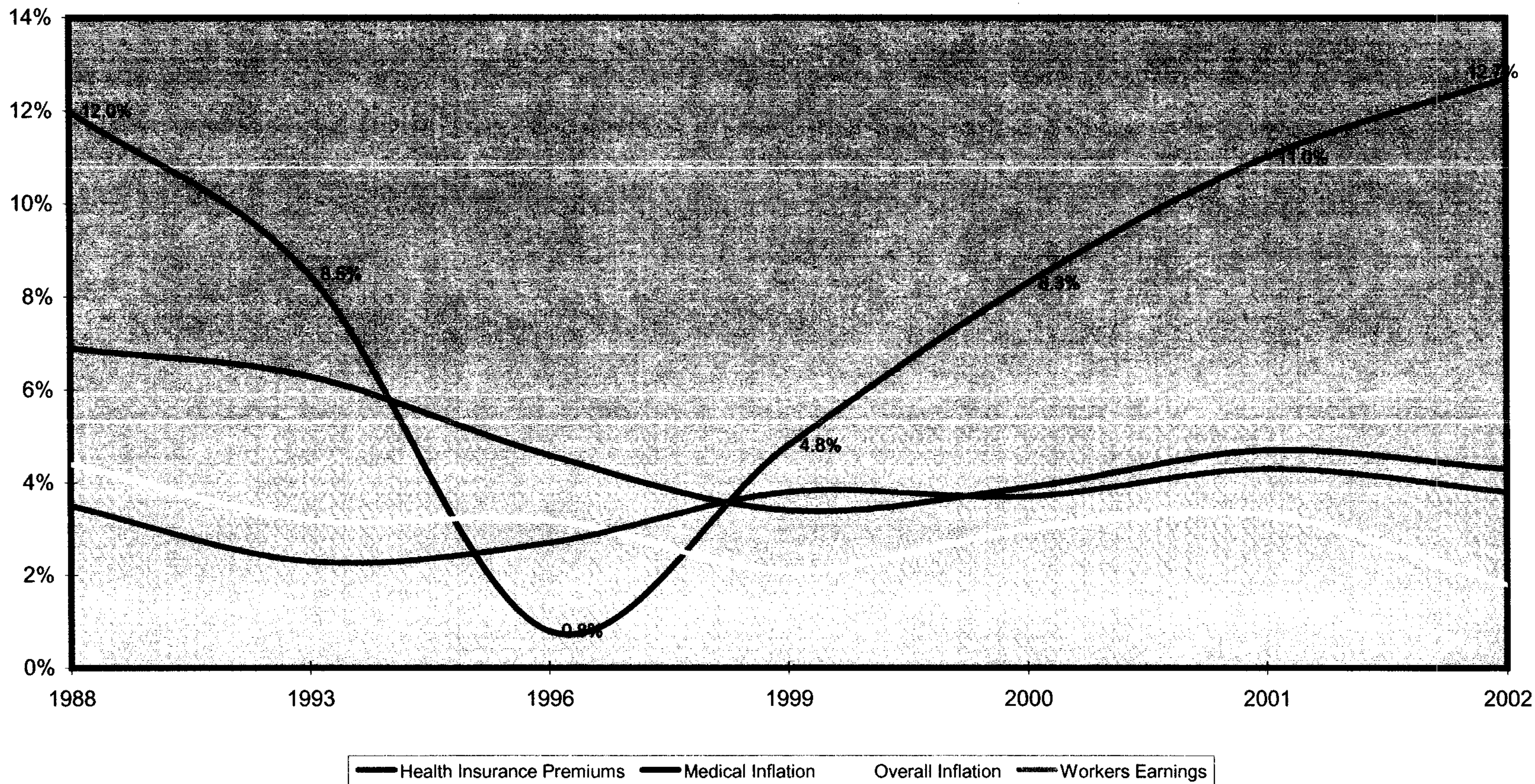
Figure 1





Note: Approximately 62.0% (321, 281) of non-federal, post residency patient care physicians are self-employed, and approximately 8.6% (44,565) are employed by physician-owned groups.

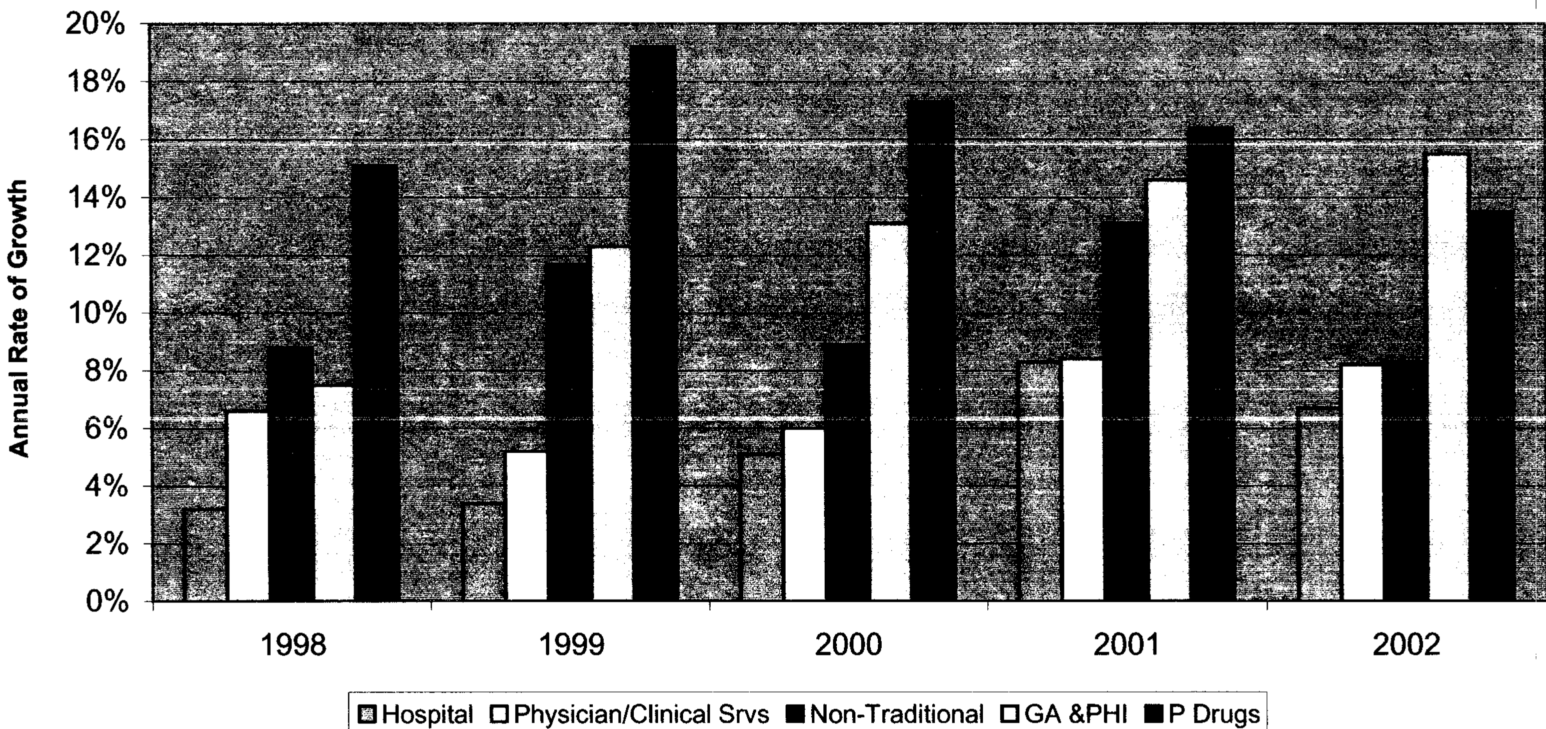
Figure 2
Increase in Health Insurance Premiums Compared to Other Indicators (1988-2002)



AMA Note: Health insurance premiums increased 42% overall from 1998 to 2002.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits: 1999, 2000, 2001, 2002;
KPMG Survey Employer-Sponsored Health Benefits: 1988, 1993, 1996.

Figure 3
Annual Percentage Change in National Spending for Selected Health Services 1998-2002*



**Source:* *Office of the Actuary, Centers for Medicare and Medicaid Services. Figures for 1998-2000 are actual; 2001&2002 are projected.*

1. Hospital: total net revenue received by U.S. hospitals.
2. Physician & Clinical Services: physician (M.D. & D.O.) business receipts for outpatient care centers, and the proportion of billed services from independent medical laboratories.
3. Non-Traditional: Government expenditures for medical care not delivered in traditional medical setting; e.g., community centers, senior citizen centers, schools, military field stations, and home visits by various kinds of medical personnel. Also includes industrial-inplant services based on a 1984 survey, extrapolated forward by using the medical care component of the consumer price index, and adjusted by changes in the number of employed civilians.
4. GA &PHI: administrative expenses of government programs and philanthropic organizations, and the net cost of private health insurance (premiums less benefits, which includes profits and additions to reserves)
5. P Drugs: prescription drug purchases by consumers from retail establishments, less manufacturers' rebates to insurers.