American Academy of Pediatrics

TESTIMONY

BEFORE THE

FEDERAL TRADE COMMISSION

ON

HEALTH CARE AND COMPETITION LAW AND POLICY

PRESENTED BY

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ON BEHALF OF

THE AMERICAN ACADEMY OF PEDIATRICS

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The American Academy of Pediatrics is an organization of 57,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists dedicated to the health, safety and well being of infants, children, adolescents and young adults.

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The American Academy of Pediatrics is pleased to be able to present its testimony before the Federal Trade Commission and the Department of Justice. I am Dr. Tim Doran, a practicing pediatrician and chair of the Department of Pediatrics at the Greater Baltimore Medical Center in Baltimore, MD. The American Academy of Pediatrics is an organization of 57,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists dedicated to the health, safety and well being of infants, children, adolescents, and young adults. We are pleased that the Commission is conducting these hearings, and we appreciate the opportunity to speak on behalf of America's children and those who care for them.

The Health Insurance Picture for Children

There are 3 different health insurance markets for children: the commercial market, the public market, and the uninsured. The largest is the commercial market. According to Current Population Survey data, in 2001, 57 million children and young adults through age 21 were insured in the private market. The vast majority of these children receive their health coverage through the health insurance offered by a parent or guardian's employer. Coverage in this area has shown to be very elastic, increasing in strong economic times and decreasing with economic downturns.

Public programs, primarily Medicaid and the State Children's Health Insurance Program, or SCHIP, cover another 18.8 million children. Public programs play a vital role as a health care safety net for millions of low-income families that would not otherwise be able to afford health insurance. The majority of these children receive their care through managed care arrangements. A significant portion have special needs, and many have parents who work but whose employers do not offer insurance coverage. Others are not able to pay the extremely expensive premiums driven by the imperfections in the pricing structure of the individual or small group plan market.

Finally, a significant number of children are uninsured and must seek their health care through public health clinics, emergency rooms, and other providers of charity or low-cost care. 12.5 million children and young adults are estimated to be without health insurance. But this is an incomplete picture. Recent Academy analysis of data on monthly health insurance status

revealed that a significant number of children reported as insured had gaps in their insurance coverage that typically exceed 3 months. In 1998, for example, while 11 million children and young adults were uninsured throughout the year, an additional 12 million had bouts of uninsurance that averaged over 5 months. This latter group represents one-third of missing coverage and presents a sizable, and not commonly considered, challenge to providing health care for the needy. The high number of children who are uninsured part of the year signals significant rates of insurance turnover and churning that disrupt continuity of care and produce inefficiency in the health care system. Both uninsured and underinsured children are a costly problem. Without access to important preventive and comprehensive care, children are unnecessarily at risk of life-long health problems and catastrophic illness.

The type of coverage a child has influences the kind and choice of health care services available to them. In the private market, there is a noticeable imbalance: more out-of-pocket costs, less comprehensive coverage, but often greater choice of providers. With public coverage, there may be more comprehensive coverage and fewer out of pocket costs, but often much more restricted choice of providers. Finally, the uninsured face higher out of pocket costs and greater difficulty in obtaining services. These varying options in service and price of care are regulated by the economics of both the market and social policy. This fragile coexistence of market economics and social policy in defining the health care system for children also comes into play when describing pediatricians who provide their care.

Pediatricians That Care for Children

Pediatricians play a critical and growing role in providing health care to children. General pediatricians provided nearly 2/3 of children's office visits to primary care physicians. While these data show pediatricians provide the largest share of office-based visits to US children, especially younger children, data from AAP surveys of its members provides a picture of a changing pediatric workforce. The proportion of pediatricians in solo practice declined from 14.2% in 1993 to 10.6% in 2000. The proportion practicing in staff model health maintenance organizations (HMOs), medical schools and universities, and public hospitals also decreased. Over the same period, the proportion of pediatricians in pediatric group practices increased, as did those practicing in other settings, such as free-standing care centers, nonprofit community

health centers, and other patient and non-patient care employment. Now more than one fourth (28.5%) practice in group practice settings.

In my testimony, I will first discuss the importance of physicians' ability to effectively negotiate with health plans in order to receive adequate payment for services**.** I will then discuss other market distortions that lead to benefits packages that don't match the needs of children, costs that outstrip many parents' ability to pay, and limited information about quality.

Limited Ability to Negotiate

This imbalance of power is evident in health plan contracting practices. As a practical matter, while physicians may have the flexibility to set what they charge, this often has little or no correspondence to the payment level they actually receive. Because of their size, the vast majority of physician groups do not have an ability to negotiate with health plans. Most express that they are in the position of having to accept what the insurance companies will pay. Further, the payment that they receive may be entirely unrelated to the value of the service being provided. A primary example is the relatively low reimbursement received for arguably the most socially beneficial service: vaccine administration.

In actuality, many physicians report that there is no negotiating; they are expected to sign the contract as is. Physicians may not always be allowed to see fee schedules before signing contracts. Equally troubling, health plans' coding and bundling practices are usually not made available. In some cases, contract language eliminates a physician's right to appeal such decisions. In others, health plans reserve the right to change the fee schedules. Some contracts even include " most favored nation" clauses that require physicians to "give" the health plan the lowest rate it accepts from any other health plan. Some contracts limit physicians' grievance and appeal rights. All-products clauses require physicians to participate in all of a health insurance plan's products – they must sign-up with a plan's HMO for example, in order to participate with that plan's preferred provider organization (PPO). As the market becomes more consolidated, rather than the physicians "selling services" it more resembles the health insurance plan "selling" access to its covered lives.

While federal and state laws consider physicians to be independent contractors who might then be in a position to collude to set prices, this is far from the case. Rather, health plans are in a much stronger position. According to analysis by the American Medical Association (AMA) in 2001, in 61 of the 70 metropolitan areas the health insurance market was highly concentrated (AMA, Competition in Health Insurance: A Comprehensive Study of US Markets.). Where in simple economic theory one would expect investments to stream to resources that represent the greatest potential for productivity, this is not the scenario in pediatric care. In the case of children, the market appears to be in a state of confusion, because it undervalues and under invests in their role as the future agents of social and economic productivity. Pediatricians, along with other physicians, have had to resort to the courts to attempt to address some of these issues.

Lack of Information

Another factor that undermines pediatricians' ability to negotiate is that there is very limited information available on the provision of health care for children. Access to information is a key attribute to an effective market. It drives allocation of resources, promotes innovation and invention, and brings parity to those at the negotiating table. The Medicare program provides a national database of utilization of services for adults. Physicians use this database to identify the need for new billing codes, to gauge their billing profiles against an average, and to determine if their case mix is different than the average. There is no such database for the utilization of services for children. When pediatricians and policymakers want to look at children, they have no place to turn; there is an information void. States have databases for Medicaid, but those are often not easily accessible and there are concerns about the reliability of the information. For example, the data on preventive care screens through the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program is widely recognized to be inaccurate – either understating or overstating the number of screens. In the commercial market, much of this data is proprietary. Without access to information, pediatricians become as disadvantaged as some of the children they care for. The market discriminates against both children and pediatricians.

The Impact of Medicare RBRVS

While health plans are free to make decisions about coverage and reimbursement, the Medicare Resource Based Relative Value Scale (RBRVS) fee schedule does serve as a national standard. Once values and policies are set, private health plans generally move to adopt or adapt those standards. Yet, children are often left out of this system. The Centers for Medicare and Medicaid Services (CMS) make decisions about the schedule, what is published and what is valued, based on the budgetary and policy implications for the Medicare program. Unfortunately, CMS is not able to take into account the needs of both the Medicare program and the host of non-Medicare payers who follow RBRVS. While it is true that RBRVS was originally intended as a tool for the Medicare program, the fact that more non-Medicare payers are using it to establish their fee schedule requires that CMS develop policies that are socially responsible. Without the "approval" of the Medicare system, it is often much harder to get private insurance plans to adopt specific policies.

Medicare payment policies mandated by CMS have a significant impact on the Medicaid program and its reimbursement policies. When the Physician Payment Review Commission (PPRC) was replaced with the Medicare Payment Advisory Commission (MedPac), a crucial site for the formal discussion of Medicaid payment and other programmatic issues disappeared. A new forum has to be developed to discuss key Medicaid payment and operational issues and to advise CMS and Congress on physician coding and payment policies related to State Medicaid Programs.

Rising Costs to Provide Care

At a time when many pediatricians are unable to negotiate appropriate reimbursement, they are also experiencing factors that increase the cost of providing care – rising medical malpractice premiums and rising costs associated with regulatory compliance. In recent years physicians have also come under greater scrutiny for fraud and abuse. Many states and the federal government have seen this as a way to find "excess funds" in the system. Yet, physicians are audited for fraud in an environment where there are no clear guidelines.

The concept of compliance is based on the notion that there is universal agreement on what constitutes "accurate and appropriate" coding, billing, and reimbursement. This is simply not the case in Medicaid and other federal health programs. The CMS proposed and then suspended updated documentation guidelines for evaluation and management. There are also no set payment guidelines. While the Health Insurance Portability and Affordability Act (HIPAA) requires that health plans accept all Current Procedural Terminology (CPT) codes, it does not require that they follow the guidelines.

Limited Ability to Exit the Market

It is also important to note that physicians have a limited ability to exit a market because of their commitment to their patients. Many would consider it unethical to stop seeing their patients. With pediatricians, this is most evident in the Medicaid market. Medicaid reimbursement rates are about 64% of Medicare rates nationally. To be sure, the Academy has found a relationship between reimbursement level and pediatrician participation in Medicaid. Those with the lowest rates have the lowest participation. However, even when Medicaid reimbursement is just half of Medicare, more than half of pediatricians accept all Medicaid patients who contact their practices. I have spoken with many physicians who are anguished as they begin to think about the possibility of closing their office to Medicaid patients.

Impact on Children

The Academy is concerned that these factors are making it more difficult to provide high quality care to children. The number of solo practitioners has decreased, and we now routinely hear from members who are retiring early or have chosen to get out of direct patient care because of the increased expenses, decreased revenue and increased hassles of providing care. This also may jeopardize the number of medical students who elect to enter pediatric residency programs. If these forces persist, the pipeline of future pediatricians will become thin.

There are certain foundations of health care that should not be in dispute. Certainly, ensuring that infants, children and adolescents have medications that are properly studied and labeled for their use must be won. When the market does not fully respond to a need, it is appropriate and necessary for the government to provide the impetus to ensure that the public health is protected.

Pediatric drug testing is an example. Approximately 75 percent of all drugs prescribed for children are not tested for use in children. The Pediatric Rule, issued by the FDA in 1998, required drug companies to conduct pediatric studies on drugs and biologics that are important to children. The Pediatric Rule works in conjunction with a voluntary law, the Best Pharmaceuticals for Children Act (BPCA), which provides the pharmaceutical industry incentives to conduct pediatric studies. Of the approximately 130 applications containing pediatric studies that have been received by the FDA since the Rule was put in place, half are attributed to the Rule and half to the BPCA. And yet, in October 2002, the US District court struck down the 1998 Pediatric Rule, stating the FDA did not have the statutory authority to require pediatric drug testing. This court decision rendered the Pediatric Rule mute. The American Academy of Pediatrics has appealed the court's decision and is working with Congress to pass legislation that will restore the Pediatric Rule.

Health care is one of the only non-regulated markets where prices are not set by the relationship between supply and demand. This imperfect market continues to be perpetuated by the fact that third parties have the ability to set prices based on factors irrelevant to the value of the service being provided. The outcome of this flawed market is a product and price that does not account for children's needs. As has been written by many, one of the primary distortions of the health market is that those who use the services do not purchase them. The product and price are determined generally by employers. For children, this is distorted even further because the health insurance that is purchased is primarily purchased for a working adult. The benefits that are purchased do not always reflect a true understanding of the importance of comprehensive well child care, nor the unique developmental and health needs of children. As employers look to cut costs, decisions about benefits are made based on the adult. Thus employers may purchase health plans that cover limited numbers of visits to physical or occupational therapists or no coverage of family therapy, etc. They may purchase plans that require high out-of-pocket expenditures for preventive health care. Making the case to cover preventive care can be difficult because it generally has a limited "pay-off" in the short term, yet it can be critical to ensuring a healthy future for a child.

RECOMMENDATIONS

There are a number of things that the American Academy of Pediatrics recommends to begin to rebalance the relationship between health plans, pediatricians, and the children they care for.

Greater Scrutiny of the Health Insurance Industry and the Impact on Children's Access to Service

We urge the Federal Trade Commission (FTC) and the Department of Justice (DOJ) to bring greater scrutiny to the health insurance industry and its contracting practices. The continued consolidation of the health insurance market through mergers and acquisitions poses a risk to a market operating through healthy competition. Health plans leverage their command of information and access to dollars at the expense of playing "fair" with providers. It is incumbent upon the FTC and the DOJ to monitor them closely and diligently.

Joint Negotiation for Physicians

The Academy calls for legislation that would allow physicians to negotiate jointly with health plans. By definition, negotiation implies equal opportunity to a fair and reasonable outcome based on parity in access to information and control of resources. However, this is not the case for providers as they attempt to secure financially sound contracts from health plans that do not constrain access to care for children. As the payer market further consolidates, the scale of fair negotiation will tip more heavily in favor of the payors. We ask for the FTC and DOJ to provide clearer guidance on what is currently allowed and to take a leadership role in helping to initiate such discussions between health plans and groups. Pediatricians are the conduit for care for children, and the FTC and the DOJ should examine the market deficiencies as they relate to the healthcare needs of children.

Reinstate Pediatric Rule

Securing safe and appropriate drugs for use by children has had a long and laborious history. Significant progress toward pediatric drug studies and labeling has been made over the last five years. The Academy believes the Pediatric Rule must be preserved and enhanced. It is an essential tool in ensuring that children have the quality and quantity of drugs they need. The

Pediatric Rule makes medications for children a certainty, not an option. We can not overstate the importance of having the Pediatric Rule permanently in place as a therapeutic foundation for children.

Enact Medical Liability Reform

The Academy supports medical liability insurance reform that would cap non-economic damages at $250,000, allow for periodic payment of future damages over $100,000; include mandatory offsets for collateral sources (with credit for out-of-pocket costs of collateral source); and limit plaintiff lawyer fees through the use of a sliding scale. The professional liability coverage marketplace is undergoing significant stress and strain. Over 40 states are in medical liability crisis or on the verge of crisis. Without reform, the increased costs of professional liability insurance will result in increased costs of health care.

Creation of a National Medicaid Database and Payment Commission

The Academy supports the creation of a national Medicaid database similar to the Medicare Part B Database (BMAD). To ensure pediatricians have parity in transaction costs, and choice of contractual arrangements, this information is essential. The Academy also supports the creation of a National Medicaid Payment Advisory Commission to address the many physician payment issues related to the Medicaid program.

Strengthening of the Public Market

The Academy is deeply committed to protecting the 18.8 million children who receive health care through Medicaid and SCHIP. Efforts to strengthen these programs through enhanced funding and simplified and continuous enrollment policies will remedy much of the problem of uninsurance and underinsurance in children.

Thank you for the opportunity to speak to you today. The American Academy of Pediatrics stands ready to assist you as you examine these issues in more detail.