REMARKS OF VINCENT SCICCHITANO

VYTRA HEALTH PLANS

JOINT FEDERAL TRADE COMMISSION /

DEPARTMENT OF JUSTICE HEARINGS ON

HEALTH CARE COMPETITION LAW AND POLICY

CONTRACTING PRACTICES

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Good afternoon and thank you for the opportunity to speak today.

My name is Vincent Scicchitano. I am currently Senior Vice President for Business Operations at Vytra Health Plans, located in Melville, NY. I joined Vytra in 1992 and have negotiated all of Vytra's hospital contracts since Vytra began contracting with hospitals in the early 1990s. Previously all hospital rates in New York were regulated.

Vytra was founded in 1986 as ChoiceCare, a not-for-profit health plan, established by two other not-for-profits. ChoiceCare changed its name to Vytra in 1996 and is now affiliated with HIP Health Plan of New York, who replaced our two founding corporate members in December 2001. Today Vytra provides insured benefits to over 130,000 members and administers third party benefits for approximately 70,000 members, almost exclusively in Nassau and Suffolk counties.

My remarks will focus on two ways that hospital negotiating practices are adversely impacting Long Island consumers and employers.

First, the current system of hospital contracting on Long Island, comprising Nassau and Suffolk Counties, has a negative impact on the percentage of Long Islanders that are able to purchase affordable health insurance.

Second, Long Islanders are paying higher rates to support more hospitals than the market place needs. The hospital systems, rather than closing inefficient or underutilized hospitals and/or beds, are causing consumers, employers, and health plans to pay more to sustain the status quo.

On Long Island, and across the region, we have experienced four consecutive years of double-digit premium increases. The cost of health insurance has risen at a rate several times higher than the rate of inflation. For the past two years, hospital rate increases have been the second highest (but fastest rising) component of the overall premium increase, exceeded only by pharmacy, alone rising at a rate more than three times the general inflation rate.

In order to fully understand the implications of Long Island's hospitals' negotiating practices, I need to spend a little time discussing the Long Island market and the challenges it presents.

When I say Long Island, I'm referring to Nassau and Suffolk counties, those counties which are not part of New York City and comprise the vast majority of the island. There are approximately 2.8 million people living in the two counties, with Suffolk, the easternmost and larger county, having a slightly higher population than Nassau. Of this 2.8 million, approximately 500,000 are covered by various government programs such as Medicare, Medicaid and Child Health Plus.

We estimate that between 350,000 - 400,000 Long Islanders are uninsured. This uninsured population is, for the most part, employed. Most do not have insurance because either they, their employer, or both, cannot afford the premiums. This leaves approximately 2 million people on Long Island with health care coverage, whether in managed care or in other indemnity-type arrangements.

Long Island is predominantly dominated by small businesses. According to the New York State Department of Labor, there are approximately 90,000 companies on Long Island. Of these, over 80% have ten or fewer employees. There are only 43 companies with over 1,000 employees on Long Island. None are in a dominant position to dictate to the market.

There are more than ten health plans serving Long Island, and again, none of which has a dominant market share. According to Sachs-Scarborough (an independent research firm), in 2001, the most recent year for which data is available, no plan had more than a 20% market share. There are seven plans, including Vytra, with market shares between 8% and 19%. These factors have changed little over the past few years. What has changed is the hospital environment.

In 1995, there were 27 hospitals in Nassau and Suffolk Counties. We negotiated rates with each individually and could make decisions about

which ones to include or not include in our networks. In addition, Vytra could negotiate favorable rates for specific hospital services by agreeing to drive volume into a "preferred" arrangement.

Today there are 25 hospitals in Nassau and Suffolk counties, with 21 of them grouped into three systems:

* The North Shore - Long Island Jewish System, with eight Long Island hospitals, and a very strong presence in Nassau County.

* The Long Island Health Network, with ten hospitals all on Long Island, and a significant presence in Suffolk County.

* The Peconic System, comprising the only three hospitals on Long Island's east-end.

Only four independent hospitals remain on Long Island. Of those, the two most significant (Nassau University Medical Center and Stony Brook University Hospital) are government affiliated and at this point precluded from joining networks.

The attached map shows the location of the various hospitals and their network affiliation, if any. If you look at the map, you can see that there is little overlap between coverage areas. A health plan needs all

three hospital systems in its network to be a viable competitor in the marketplace.

The hospital systems are leveraging their implied authority to negotiate on behalf of the "system," and to the detriment of consumers, employers, and insurers. The following is a short list of some of the practices utilized by the three systems:

* Health plans must negotiate with the system, and cannot negotiate with individual hospitals

* Health plans must contract with all hospitals in a system, unless it's to the system's betterment not to.

Let me illustrate with three examples:

1. One hospital system requires that we contract with all their hospitals except one, which we may choose not to. This hospital is the only one in that particular geographic area of Long Island. So it is impractical to believe that a health plan could exclude that hospital from its network.

2. Another system requires that we contract with all its hospitals except the one which the system won't let us contract with. That particular hospital enjoys an excellent reputation in a particular

specialty and has occupancy rates equal to or above capacity, perhaps the only hospital on Long Island that can make that claim. Even though we are not contracted with them, it was our 13th highest hospital in terms of dollars in 2002, exceeding over twenty other hospitals on Long Island and in New York City where we have contracts. Because the hospital system excludes that particular hospital from our contracting arrangement, we are at a competitive disadvantage and are forced to pay charges for those members who are admitted.

3. A third hospital system unilaterally notified a local newspaper that they had issued a notice of termination to Vytra, when in fact they never had. This prompted an inquiry from the New York State Department of Health regarding how we would meet the access standards for members in that area. It is, in fact, impossible to meet the standards without that hospital system in our network. Needless to say this hospital system's action did initiate a negotiation process far in advance of the expiration of the existing contract.

The reality is that to compete effectively on Long Island, a health plan needs all systems in its network to meet service and access standards, as well as consumer demand. If any health plan does not contract with a particular system that plan will be unable to serve a significant portion of the market.

This dynamic affects consumers, employers, and health plans by severely limiting competitive pricing opportunities that are normally available, such as requests for proposal, carveout agreements, and preferred provider arrangements. It also limits efforts to improve the quality of care members receive by preventing health plans from making greater use of centers of excellence as well as hampering employer efforts to improve quality such as the Leapfrog Group.

From that advantaged position, hospital systems are proposing even more unreasonable terms designed to bolster themselves. The following are actual examples of clauses that Long Island hospital systems have or are attempting to negotiate into agreements:

"Vytra or Vytra's agents shall not restrict by co-pay, deductible, pre-authorization, network design, plan design or any other method to prevent access to . . . hospitals." This would, among other things, prevent health plans from creating benefit plans that would encourage patients to use a particular hospital with more favorable pricing or considered to be of higher quality.

"If as a result of any significant changes to any individual hospital's operating costs, the individual hospital may propose a renegotiation of rates." If this is allowed what is the point of agreeing to rates in the first place?

"There shall be no carveout of services to subcontractors after January 1, 2004 during the term of this agreement other than those in effect prior to January 1, 2004." This is an attempt to tie in other ancillary hospital and physician services for which health plans may have more cost effective arrangements and to restrict surgery in non-hospital settings.

"Rates for mental health and substance abuse are conditioned upon an increase of x% for all services covered in the agreement." One hospital system held these services as "hostage" in order to obtain an off-cycle rate increase.

"*During the course of this agreement, Vytra shall not implement any policy, rule, or procedure, that reduces . . . hospital income.*" I'm not sure what this last one means but it's hard to see how this would benefit consumers.

The impact of imposing these conditions on payors is that Long Islanders are paying higher rates to support more hospitals than the market needs. The hospital systems, rather than closing inefficient or underutilized hospitals and/or beds, are causing consumers, employers, and health plans to pay more to sustain the status quo.

To date, our data does not demonstrate any evidence of the "clinical integration" that one would expect from a system approach to the delivery of hospital services. There has been no measurable reduction in length of stays while cost per admission continues to rise at rates far greater than overall medical inflation.

By inflating the cost of health coverage, the current system of hospital contracting does ultimately have a negative impact on the percentage of Long Islanders that are able to purchase affordable health insurance.

Thank you for the opportunity to speak with you today, and I would be happy to answer any questions that you may have.

Vytra's Network Hospitals
Nassau and Suffolk

- NS-LIJ
- Peconic
- LIHN
- St. Francis Hospital
- Long Beach Med Ctr
- Nassau University Medical Ctr
- Brunswick Hospital
- Stony Brook University Hospital

2/20/03