Federal Trade Commission and
U.S. Department of Justice
Joint Hearing on
Health Care and Competition Law and Policy

Health Insurance Monopoly Issues –
Competitive Effects

Statement of Fred Dodson

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April 23, 2003

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

My name is Fred Dodson. I am Vice President of Network Management for PacifiCare of California, the largest operating entity within PacifiCare Health Systems. PacifiCare serves more than 3 million health plan members in Arizona, California, Colorado, Nevada, Washington, Oregon, Texas and Oklahoma. Approximately 700,000 of our members are in the Medicare+Choice program. PacifiCare also serves an additional 9 million members nationwide through our dental, vision, behavioral health and pharmacy specialty companies.

From the perspective of a large health insurer, I will attempt to address several of the questions posed in your agenda for today. I would like to frame my discussion based on four factors that influence health plans' participation in the marketplace. These include:

- Market Concentration;
- Purchaser Product Preferences;
- Provider Market Tensions; and,
- Regulatory and Political Environment

I will address these factors and provide several data points salient to the questions at hand; suggest other data analysis for your consideration; and finally attempt to provide

a broader assessment of the present dynamics and challenges presented for companies such as PacifiCare.

First, I would like to address **market concentration**. In all of the geographic markets in which PacifiCare operates health plans, there are multiple health insurer competitors and several product options, including HMO, PPO, POS and consumer directed health plans. Additionally, competitors within specific markets vary, including regional and local plans serving specific needs and geographies. There is a wealth of competition for employers' business. Additionally, employers can opt to self-fund their insurance.

Most markets have experienced shifts over time with the departure of players and occasional acquisitions, but the net effect of healthy competition remains in place today. While there have been several mergers over the past decade, a "unilateral competitive effect" is an unlikely outcome. From our review of data from Lehman Brothers, the largest and most significant recent activity appears to be the acquisition of plans in markets in which the purchaser had no previous market share. Only three of the thirty-two mergers and acquisitions highlighted by Lehman Brothers were within the same service area. My own company's acquisition of FHP, International in 1997 may have been one of the last mergers of "equals", at least in California, and yet PacifiCare did

not significantly shift its market share over time or geography and in fact divested itself of several smaller regional operations in the years immediately after the merger[1].

Even when clear opportunities to increase market position occur, the outcomes may be contrary to conventional wisdom. For example, provider demands in contract negotiations led to two health plan failures in the San Francisco Bay Area. HealthPlan of the Redwoods was one of the top three plans in market share and had the highest consumer satisfaction levels of any plan serving Sonoma, Napa, and Lake counties. HealthPlan of the Redwoods was financially successful until the provider community aligned to increase payment demands. Despite the opportunity to buy the plan for a "song" no insurer was willing to undertake the business risk in such a rural area and the plan dissolved. As a result of the decrease in choice, insurance rates increased, but in direct proportion to the increases in payment rates required by the providers from all other insurers in the market. While competition remains among the five major and several smaller insurers competing in the market, those health plans serve overlapping but more variable geographic areas. In San Jose, a similar result occurred when Lifeguard with nearly 150,000 members failed, and as a result, its membership was assimilated into other plans.

[1] Ohio, Utah and New Mexico (originally FHP)

Second, **purchaser product preferences** are a significant factor in the development of products and health plan networks. The expectations of both the employer who purchases the insurance and the consumer of the health care service/product have driven insurers to become "sufficiently close substitutes for each other". Insurers still attempt to distinguish themselves based on product choice, brand, cost and other factors including quality in order to increase membership and market share, but these distinctions are not fundamental.

Health insurers today find themselves at the intersection of competing interests. Employers expect broad provider coverage at the best price and service levels with numerous choices to provide those capabilities. Their expectations are the same for the desirable hospitals. High levels of quality are appropriately assumed and expected. As consumers shift from a preference for traditional managed care to more open PPO networks, all insurers shift their product offerings and network contracting to respond to their customers' demands.

An interesting example of employer purchasing power and the effect on health plan choice is CalPERS in California. CalPERS purchases health care on behalf 1.3 million employees of municipal, State, and other public entities and may be the second largest purchaser of health care in the United States after the Federal government. As a result of a bidding process in 2002, CalPERS elected to provide health insurance through a single insurer, Blue Shield of California, whose bid was significantly lower than the bids

of the other two primary competitors for the business but still represented a double-digit increase in premiums. Due to the highly similar hospital and physician networks affiliated with the three plans, CalPERS estimated that 90 percent of the more than 300,000 members who were required to switch to Blue Shield would be able to stay with their primary care doctors and hospitals in 2003.

Has the fact that Blue Shield now has 300,000 additional members as a result of CalPERS increased their purchasing power to a meaningful degree with providers and decreased the price they pay to providers? I do not believe that is the case. The power of large provider groups may increase with the reduction of plan choice.

Which leads my to my third point, the **market power of hospital and physician networks**. In California, PacifiCare faces this reality every day. A single hospital and physician network receives approximately $500 million per year, or over 40 percent of the dollars we expend on all healthcare services in Northern California. When wielding the purchasing power of $500 million dollars and over 400,000 health plan members, one might assume that the insurer commands the purchasing decision. The fact is quite the opposite. Let me expand on this.

As the supplier of the service, this provider system commands the relationship with the health plans using a single contract on an "all or none" basis for twenty-six hospitals and thirteen medical groups, in addition to ancillary medical services. The provider

system speaks in terms of its "demands" and "benchmark" requirements, off of which it rarely negotiates. A health plan or insurer in Northern California simply isn't able to offer an insurance product without this healthcare system and if the insurer was naïve enough to assume it could, it would face full billed charges for the thousands of patients who would use the provider system on an emergency basis every year. The premium impact of full bill charges events would outweigh any pricing benefit that might be obtained by dropping this higher cost system.

How is such a market position possible? First, there is the expectation of the employer that "you must have this provider system, or we will be unable to offer you to our employees". Second, there is the expectation of the consumer that "my physician" be covered under the plan. Given that this provider system now employs 3,600 physicians and represents other groups on an "all or none" with the entire provider system the only way to access many physicians is through contracting with this provider system. There are no adequate substitutes to meet consumer and employer expectation. This provider system does not afford us the opportunity to contract with only a portion of their organization or negotiate price with the individual operating entities. Third, there are the state and federal regulatory requirements. Without this provider system, we simply cannot meet the regulatory requirements for access and capacity for our membership. The provider system knows this and uses this knowledge to its advantage.

The provider system also impacts product offerings. In contract negotiations, we face requirements that the level of member co-pay cannot be higher for the dominant provider system, regardless of the fact that the price paid by the insurer to that system is often higher. Quite simply, this contract requirement obscures the consumer's awareness of price, and since the consumer's co-pay would be the same, this negates the reason consumers might select a lower priced facility of equal or higher quality. The assumption should be made that the provider system does this deliberately to secure patient volumes at higher prices.

This provider organization's prohibition on a higher out-of-pocket payment for consumers using its provider system has an additional perverse effect in the market. Since the consumer is isolated from the true cost of health care, the competing provider systems no longer have a reason to discount their price to the insurer below the level of the more dominant system. Since there is no reason for the consumer/employer to select wisely based upon price, the less dominant provider systems now seek the same prices as their more dominant competitor. Thus, we now see the effect that the rising tide (price) driven by this dominant provider system boat is raising all boats, and health care costs are being driven up.

This dominant provider system also leverages its position across many urban areas in Northern California. As I noted before, a-la-carte purchasing from this provider system is not an option. You purchase the entire prix fixe meal, regardless of your appetite.

For example, to access the system's hospitals and physicians in Sacramento, where the system is clearly dominant, plans must also contract with the system's hospitals in the San Francisco Bay area. This allows the system to leverage the impact of its dominant sub-markets to the benefit of its entire system, and the provider system can drive much higher price expectations in its sub-markets of less dominance.

It is a supplier's market. As this dominant provider system in Northern California has acquired physician groups, either through ownership or contractual representation, it has captured the portion of the provider marketplace that most heavily impacts demand, the physician. It has also made that physician available to the insurer only when the insurer contracts with all components of the provider organization. The insidious nature of driving demand and price is in play. This provider system enhances the effect with the contractual limitation prohibiting us from encouraging referral to non-system competing hospitals.

Hospitals leveraging physician group ownership to the benefit of the provider system is a fairly recent development in this industry. Ten years ago, the interests of physician groups were often much more aligned with keeping healthcare costs contained. The groups were independent of hospitals and competition was supported through capitation arrangements and programs that existed to encourage physician groups to use efficient and reasonably priced hospitals. Those controls are typically absent today as the structure has changed and groups have aligned with hospitals.

Unfortunately, this single provider system is not the only example of these practices in California, nor are these practices limited only to California.

Finally, I would like to describe how the **regulatory and political environment** shapes the competitive market and the products. Health plan operations and benefit mandate regulations do protect consumers. However, if the delicate balance is tipped towards a negative regulatory environment for health plans and insurers, the net result can be a lack of choice for consumers.

As a result of numerous benefit and operational mandates, the minimum coverage levels and services covered are typically the same across competing plans. This regulated similarity in plans assures comparability of health plans within the marketplace, but this comparability does come in the form of increased premiums for consumers.

This mandated similarity and the desire of health plans to differentiate their products vis-a-vis competitors and manage health care costs has taken insurers into products such as PPO, ASO, and consumer directed health plans. Competitive advantage however is short lived as insurers respond to these competitive forays with similar products of their own.

Regulations also limit the choices available to insurers with respect to provider networks. In California, before we can terminate one of our medical groups, we are required to demonstrate that alternative physician groups have capacity to assimilate health plan membership that would move to them following a termination. Standards for geographic accessibility exist in such cases, which further limit insurer options. As a result, there are times when the insurer is essentially unable to terminate a large provider group contract due to the absence of an alternative provider group to provide services within the state mandated levels of availability. Provider groups know this and it gives them increased bargaining power.

The regulatory atmosphere is especially challenging in Texas. Health plans, including PacifiCare, have faced marketplace and regulatory problems, especially with Medicare+Choice products. Over the last several sessions of the Texas Legislature there have been approximately 70 mandate bills passed and written into law. Since the first prompt pay bill was signed into law in 1999, there have been numerous attempts to pass "prompter pay" legislation and add more extreme requirements for plans, medical groups, and TPAs doing business in the state.

Between 2000 and 2002, Texas health plans, IPAs, and TPAs experienced severe financial problems resulting from insufficient Medicare payment levels, provider insolvency, large hospital systems' market influence, and a confusing and intricate regulatory atmosphere. In the Houston market, seven health plans were forced to

withdrawal from the Medicare+Choice program. The Dallas-Fort Worth Metroplex also experienced a severe withdrawal of Medicare+Choice programs. These market and regulatory challenges have also caused health plans to experience similar problems on the commercial side, with increases in commercial premiums adding significant numbers to the uninsured in Texas.

In closing, given the consolidated provider market and employer expectations, the balance of power is now heavily weighted to the provider in many markets. Regulatory requirements further moderate health plans' leverage in the market.

I would also like to observe that there have been wonderful improvements in health and treatment of injuries and ailments in this system. We transplant organs and treat illness and injury that only a few years ago were not within the realm of the possible. At the same time the system has been impacted by subtle changes that in many markets have shifted the balance of power substantially to large provider systems with the resulting impacts summarized above.

Thank you for the opportunity to address these issues. I will happy to answer questions as part of the panel discussion.