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UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
DALLAS REGIONAL OFFICE

COMMISSION AUTHORIZED

Office of the Regional Director

May 18, 1993

The Honorable John Smithee
Chairman, Insurance Committee
House of Representatives
P. O. Box 2910
Austin, TX 78768-2910

Dear Chairman Smithee:

The staff of the Federal Trade Commission[1] is pleased to submit this response to your request for views on the possible competitive effects of legislative proposals that would limit the ability of several kinds of health benefit plans to arrange for services through contracts with providers, by requiring that services be available through any provider willing to meet the plan's terms. The proposals bill would prevent limiting the panel of providers, and thus would discourage contracts with providers in which lower prices are offered in exchange for the assurance of higher volume. The proposals also could inhibit the realization of cost savings, such as reduced transaction and auditing costs, made possible by the ability to contract selectively. Although the proposals may be intended to assure consumers greater freedom to choose where they obtain services, they appear likely to have the unintended effect of denying consumers the advantages of cost-reducing arrangements and limiting their choices in the provision of health care services.

I. Interest and experience of the Staff of the Federal Trade Commission.

The Federal Trade Commission is empowered to prevent unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.[2] Pursuant to this statutory mandate, the Commission encourages competition in the licensed professions, including the health care professions, to the maximum extent compatible with other state and federal goals. For several years, the Commission and its staff have investigated

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[1] These comments are the views of the staff of the Federal Trade Commission, and do not necessarily represent the views of the Commission or any individual Commissioner.

[2] 15 U.S.C. § 41 et seq.

the competitive effects of restrictions on the business practices of hospitals and state-licensed health care professionals.

The Commission has observed that competition among third-party payors and health care providers can enhance the range of services available to consumers in the market and can reduce health care costs. In particular, the Commission has noted that the use by prepaid health care programs of limited panels of health care providers is an effective means of promoting competition among such providers.[3] The Commission has taken law enforcement action against anti-competitive efforts to suppress or eliminate health care programs, such as health maintenance organizations ("HMO's"), that use selective contracting with a limited panel of health care providers.[4] The staff of the Commission has submitted, on request, comments to federal and state government bodies about the effects of various regulatory schemes on the competitive operation of such arrangements.[5]

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[3] Federal Trade Commission, Statement of Enforcement Policy With Respect to Physician Agreements to Control Medical Prepayment Plans, 46 Fed. Reg. 48982, 48984 (October 5, 1981); Statement of George W. Douglas, Commissioner, On Behalf of the Federal Trade Commission, Before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce, United States House of Representatives, on H.R. 2956: The Preferred Provider Health Care Act of 1983 at 2-3 (October 24, 1983); Health Care Management Associates, 101 F.T.C. 1014, 1016 (1983) (advisory opinion). See also Bureau of Economics, Federal Trade Commission, Staff Report on the Health Maintenance Organization and Its Effects on Competition (1977).

[4] See, e.g., Medical Service Corp. of Spokane County, 88 F.T.C. 906 (1976); American Medical Association, 94 F.T.C. 701 (1979), aff'd as modified, 638 F.2d. 443 (2d Cir. 1980), aff'd by an equally divided court, 455 U.S. 676 (1982); Forbes Health System Medical Staff, 94 F.T.C. 1042 (1979); Medical Staff of Doctors' Hospital of Price George's County, 110 F.T.C. 476 (1988); Eugene M. Addison, M.D., 111 F.T.C. 339 (1988); Medical Staff of Holy Cross Hospital, No. C-3345 (consent order, Sept. 10, 1991); Medical Staff of Broward General Medical Center, No. C-3344 (consent order, Sept. 10, 1991); see also American Society of Anesthesiologists, 93 F.T.C. 101 (1979); Sherman A. Hope, M.D., 98 F.T.C. 58 (1981).

[5] The staff of the Commission has commented on a prohibition of exclusive provider contracts between HMO's and physicians, noting that the prohibition could be expected to hamper pro-competitive and beneficial activities of HMO's and deny consumers the improved services that such competition would stimulate.

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Several of these comments have addressed "any willing provider" requirements for pharmacy and other health care service contracts.[6]

II. Description of Proposals.

One of these proposals would require that any professional health care provider be permitted to participate in the preferred or contract provider program of an HMO or health insurance plan if the provider is willing to accept the program's terms.[7] Those terms could not include limitations on the number of participating providers. The other proposal would apply a similar requirement to pharmacy services.[8]

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[5](...continued)
See, e.g., letter from Bureau of Competition to David A. Gates, Commissioner of Insurance, State of Nevada (November 5, 1986).

[6] The staff has submitted similar comments to Massachusetts (letter from Bureau of Competition to Representative John C. Bartley (May 30, 1989)), New Hampshire (letter from Office of Consumer and Competition Advocacy to Paul J. Alfano (March 17, 1992)), California (letter from Office of Consumer and Competition Advocacy to Senator Patrick Johnston (June 26, 1992)), Montana (letter from Office of Consumer and Competition Advocacy to Montana Attorney General Joseph P. Mazurek (February 4, 1993)), New Jersey (letter from Office of Consumer and Competition Advocacy to New Jersey Assemblyman E. Scott Garrett (March 29, 1993)), Pennsylvania (letter from Office of Consumer and Competition Advocacy to Pennsylvania Senator Roger Madigan (April 19, 1993)), and South Carolina (letter from Office of Consumer and Competition Advocacy to Representative Thomas C. Alexander (May 10, 1993)).

[7] Proposed new Subsection 4 to Insurance Code, Article 21.52. The kinds of providers covered would include physicians, physician's assistants, advanced nurse practitioners, podiatrists, optometrists, chiropractors, dentists, audiologists, speech-language pathologists, social workers, dieticians, professional counselors, psychologists, and marriage and family therapists.

[8] Proposed amendment to Tex. Ins. Code Art. 21.52B, § 2(b), 2(c). This requirement would replace a provision that was adopted in 1991 and is set to expire August 31, 1993, that applies an "any-willing provider" requirement to pharmacy services through health insurance plans, but not through HMO's.

This comment will focus on the "any willing provider" aspects of the proposals, that is, their requirement that all providers be permitted to participate in contracts to provide services, and on their effective prohibition of exclusive contracting for services. Our concern here is principally with the ultimate effects on the consumer that result from competition, or lack of it, among providers of health care services. This comment addresses the effects on consumers of the regulation of contracts in which insurance companies and health care plans such as HMO's act as purchasers of health care services.[9]

III. Competitive importance of programs using limited provider panels.

Over the last twenty years, financing and delivery programs that provide health care services through a limited panel of health care providers have proliferated, in response to increasing demand for ways to moderate the rising costs associated with traditional fee-for-service health care. These programs may provide services directly or arrange for others to provide them. The programs, which include HMO's and preferred or contract provider panels under other kinds of plans, typically involve contractual agreements between the payor and the participating health care providers. Many sources now offer limited-panel programs. Even commercial insurers, which in the past did not usually contract with providers, and Blue Cross or Blue Shield plans, which do not usually limit severely the number of providers who participate in their programs, now frequently also offer programs that do limit provider participation.

The popular success of programs that limit provider participation appears to be due largely to their perceived ability to help control costs. Economic studies have confirmed that, under health care arrangements that permit selective contracting, competition helps to moderate cost increases.[10]

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[9] The Commission has no jurisdiction over the business of insurance. Contracts between health plans and service providers, and regulations of those contracts, do not involve the "business of insurance" for purposes of the antitrust exemption of the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-15, and the exclusion from Federal Trade Commission jurisdiction, 15 U.S.C. §46. <u>See Group Life & Health Ins. Co. v. Royal Drug Co</u>., 440 U.S. 205 (1979).

[10] Studies have examined the competitive effects of selective contracting, in particular California's experience with

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Competition among different kinds of arrangements for providing services, including those that limit provider participation and those that do not, would tend to ensure that the gains from these cost savings would be passed on to consumers of health care services, either as lower out-of-pocket costs or improved services.[11] This principle would apply to all types of health care payment programs and health care providers.

Providers compete, ultimately, for the business of patients. A pharmacy or other provider may pursue the business of subscribers to PPO or HMO programs by seeking access to those subscribers on a preferential, or even an exclusive, basis. The provider may perceive several advantages to such arrangements. A preferential or exclusive arrangement may assure the provider of enough business to make possible savings from economies of scale, for example, by spreading fixed costs over a larger volume of sales. At a minimum, it could facilitate business planning by making sales volumes more predictable. The arrangement may reduce transaction costs by reducing the number of third-party payors with whom the provider deals, and may reduce marketing costs that would otherwise be incurred to generate the same business. To get access to the business and the advantages represented by these programs, providers compete with each other, offering lower prices and additional services, to get the payors' contracts.

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[10](...continued) permitting hospitals to contract selectively. See, e.g., J. C. Robinson and C. S. Phibbs, An Evaluation of Medicaid Selective Contracting in California, 8 J. Health Econ. 437 (1989). This study found that shifting from cost-reimbursement to permitting selective contracting moderated increases in hospital costs, particularly in more competitive local markets. This study concentrated on Medicaid experience; however, further studies based on private health insurance experiences confirm these findings. See, e.g., D. Dranove et al., Price and Concentration in Hospital Markets: The Switch from Patient-Driven to Payor-Driven Competition, forthcoming in J. of Law & Economics (April 1993); see also D. Dranove et al., Is Hospital Competition Wasteful? 23 RAND J. Econ. 247 (1992); G. Melnick et al., The Effects of Market Structure and Bargaining Position on Hospital Prices, 11 J. of Health Econ. 217 (1992).

[11] In addition, employers that realize savings in their health care costs may pass those savings on to buyers of their firms' goods and services, or to their employees in the form of higher wages. These effects would depend on the nature of product and labor market competition.

Third-party payors may find such arrangements attractive because they would benefit from the providers' competition. Lower prices paid to providers could mean lower costs for the third-party payor. Not only might the amounts paid out for services be lower, but in addition administrative costs might be lower for a limited-panel program than for one requiring the payor to deal with, and make payments to, all or most of the providers doing business in a program's service area. A payor might find it easier to implement cost-control strategies, such as claims audits and utilization review, if the number of providers whose records must be reviewed is limited. And lower prices and additional services would help make the payor's programs more attractive in the prepaid health care market.

Consumers too may prefer programs with limited or preferred provider panels, if the competition among providers leads to lower prices (which may take the form of lower premiums or deductibles) or other advantages. Consumer preference for such programs would presumably mean that, in the consumers' view, these advantages would outweigh the disadvantages of limiting the choice of providers, such as reduced convenience or the occasional need to use a provider that is not part of the payor's contracted service. Limitations on choice are unlikely to be so severe that consumers' access to providers is inadequate. For just as competitive forces encourage providers to offer their best price and service combination to a payor in order to gain access to its subscribers, competition would also encourage payors to establish service arrangements that offer the level of accessibility that subscribers want. To the extent that consumers can change programs or payors if they are dissatisfied with service availability, payors have an incentive to assure that the arrangements they make for delivery of covered health care services satisfy consumers.[12]

IV. Effects of "any willing provider" requirements on limited-panel programs.

"Any willing provider" requirements and bans on exclusive or preferential contracting may limit firms' ability to reduce the cost of delivering health care without providing any substantial public benefit. They may make it more difficult for third-party payors to offer programs that have the cost savings and other advantages discussed above.

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[12] For consumers in employer-provided health care programs that offer no choices of different levels of service availability, changing programs could require changing jobs. But employers have an incentive to add options if their employees are dissatisfied.

Because the proposals would require that services be available from any provider willing to meet the plan's terms, it would make it impracticable to enter exclusive contracts with a panel of particular providers. Thus the bill would deny a means of ensuring that a contracting provider would obtain a substantial portion of subscribers' business. Without that volume, a would-be contracting provider may be unable to achieve economies of scale and offer lower price terms or additional services.

Even in the absence of economies of scale, requiring that programs be open to all providers wishing to participate on the same terms could discourage efforts to offer lower prices or additional services. Since any provider would be entitled to contract on the same terms as other providers, there would be little incentive for providers to compete in developing attractive or innovative proposals. Because all other providers can "free ride" on a successful proposal formulation, innovative providers may be unwilling to bear the costs of developing a proposal. Thus "any willing provider" requirements may substantially reduce provider competition for this segment of their business.

Reduced competition among providers for access to the business represented by limited panel programs can result in higher prices for services through those programs. The higher prices for services, as well as the increased administrative costs associated with having to deal with many more providers, may mean that subscribers to prepaid health care programs could face higher prices or reduced services.

Moreover, requiring programs to be open to more providers may not give the consumer any additional advantages of greater choice, if consumers may already choose other types of prepayment programs with fewer limits on the providers from which they may obtain covered services. Indeed, requiring open participation may reduce the options available to consumers without providing any additional consumer benefit.

Dampening of competition for service contracts could cause third party payors to pay higher prices for services and incur the higher administrative costs of dealing with a large number of providers. Facing these higher costs, third party payors may decide not to make these services available. Thus a result of these proposals may be to limit consumers' ability to select among alternative delivery systems for health care services.

V. Conclusion.

In summary, we believe that "any willing provider" requirements may inhibit competition among providers, in turn raising prices to consumers and unnecessarily restricting consumer choice without providing any substantial public benefit. We hope these comments are of assistance.

Sincerely,

Thomas B. Carter
Director