Testimony of

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September 6, 2006

Statement

of the

American Medical Association

to the

Senate Committee on the Judiciary
United States Senate

Re: Examining Competition in Group Health Care

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September 6, 2006

The American Medical Association (AMA) appreciates the opportunity to present testimony to the Senate Judiciary Committee on competition in the health care industry. In particular, we are pleased to have been asked to discuss the AMA's study Competition in Health Insurance: A Comprehensive Study of US Markets (Competition Study), recent health plan mergers, and the uneven playing field that has developed between physicians and health plans. These issues are critical to the AMA because they bear directly upon physicians' ability to provide the best possible care to their patients.

The AMA believes that effective, efficient, high-quality medical care is only possible in a fully functional and competitive health care market. Growing consolidation and concentration in the health insurance market imperils the competitive process, threatening quality and access to care. The AMA has been cautioning about the long-term negative consequences of aggressive consolidation of health insurers for quite some time. We have watched with growing concern as large health plans pursue aggressive acquisition strategies to assume dominant positions in their markets, and we fear that this rapid consolidation will lead to a health care system dominated by a few publicly traded companies that operate in the interest of shareholders rather than patients.

The AMA's Competition Study, together with other key market characteristics, suggest that our worst fears are being realized in many markets across the country. It is the position of the AMA that the market dynamics as set forth in this testimony warrant the Federal Government, through the Department of Justice, exercising its subpoena power to determine whether health plans are, in fact, engaging in anticompetitive behavior to the detriment of consumers--our patients. In addition, the AMA believes that Congress must take steps to provide more protection to patients and physicians from the unfair practices of large, dominant health insurers.

AMA COMPETITION IN HEALTH CARE STUDY

The competitive health care market has been steadily eroding. Over the past 10 years there have been over 400 mergers involving health insurers and managed care organizations. In 2000, the two largest health insurers, Aetna and UnitedHealth Group (United) had a total combined membership of 32 million people. As a result of aggressive merger activity since 2000, including United's acquisition of California-based PacifiCare Health Systems, Inc., and John Deere Health Plan in 2005, United's membership alone has grown to 32 million. Similarly, WellPoint, Inc., (Wellpoint) the company born of the merger of Anthem, Inc. (originally Blue Cross Blue Shield of Indiana), and WellPoint Health Networks, Inc. (originally Blue Cross of California), now owns Blue Cross plans in 14 states. In 2005, WellPoint acquired the last remaining for-profit Blue Cross Blue Shield plan, the New York-based WellChoice. As a result of that acquisition and the many that preceded it, WellPoint now covers approximately 34 million Americans. Together, WellPoint and United control 33 percent of the U.S. commercial health insurance market.

The effects of consolidation, however, are even more striking at the local and regional levels, the focus of the AMA's Competition Study. Every year for the past five years, the AMA has conducted the most in-depth study of commercial health insurance markets in the country. The study, Competition in Health Insurance: A Comprehensive Study of US Markets, analyzes the most current and credible data available on health insurer market share for 294 Metropolitan Statistical Areas (MSAs) and 48 states.

In addition to its exhaustive geographic reach, the study considers both a broad and narrow definition of the product market. The product market represents all products that purchasers view as reasonable substitutes for the product in question. The broad product market analysis considered the combination of Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO) products; the narrow product analysis considered HMO and PPO market segments separately. Thus, the health insurance market was analyzed in three ways--including only HMOs; including only PPOs; and including both HMOs and PPOs. For each, the study calculated the Herfindahl-Hirschman Index ("HHI") of competition, which measures the competitiveness of a market overall, and, applying the 1997 Federal Trade Commission/ Department of Justice Horizontal Merger Guidelines (Merger Guidelines), classified them as "not concentrated," "concentrated," or "highly concentrated." The results form the most extensive and accurate portrayal of the health insurance market to date. And they confirm that in the majority of health care markets competition has been severely undermined.

With regard to market concentration (HHI), the study found the following:

? In the combined HMO/PPO product market, 95 percent (279) of the MSAs are highly concentrated.
? In the HMO product market, 99 percent (290) of the MSAs are highly concentrated.
? In the PPO product market, 99 percent (293) of the MSAs are highly concentrated.

With regard to market share, the study found the following for each product market:

For the combined HMO/PPO product market:

? In 95 percent (280) of the MSAs, at least one health insurer has a market share of 30 percent or greater.
? In 56 percent (16) of the MSAs, at least one health insurer has a market share of 50 percent or greater.
? In 19 percent (56) of the MSAs, at least one health insurer has a market share of 70 percent or greater.
? In 4 percent (11) of the MSAs, at least one health insurer has a market share of 90 percent or greater.

For the HMO product market:

? In 96 percent (283) of the MSAs, at least one health insurer has a market share of 30 percent or greater.
? In 64 percent (188) of the MSAs, at least one health insurer has a market share of 50 percent or greater.
? In 34 percent (101) of the MSAs, at least one health insurer has market share of 70 percent or greater.
? In 17 percent (50) of the MSAs, at least one health insurer has a market share of 90 percent or greater.

For the PPO product market:

? In 99 percent (291) of the MSAs, at least one health insurer has a market share of 30 percent or greater.
? In 78 percent (230) of the MSAs, at least one health insurer has a market share of 50 percent or greater.
? In 36 percent (105) of the MSAs, at least one health insurer has a market share of 70 percent or greater,
? In 9 percent (26) of the MSAs, at least one health insurer has a market share of 90 percent or greater.

This year's study establishes, unequivocally, that competition has been undermined in hundreds of markets across the country. Sadly, the ultimate consumers of health care--patients--are not the ones benefiting from the consolidation. To the contrary, patient premiums have risen dramatically without any expansion of benefits, while many health insurers have posted record profits.

ADDITIONAL INDICATORS OF UNFAIR COMPETITION

In addition to high market share and market concentration, many health care systems across the country exhibit characteristics typical of uncompetitive markets and growing monopoly and monopsony power. There are significant barriers to entry for new health insurers in these markets. Large, entrenched health insurers are able to raise premiums without losing market share. And dominant health insurers are able to coerce physicians into accepting unreasonable contracts. Taken together these features confirm that competition in health care markets across the country is being significantly undermined.

Barriers to Entry into the Market

Barriers to entry are relevant when determining whether a high market share threatens competition in a specific market. Where entry is easy, even a high market share will not necessarily translate into market power, as attempts to increase price will likely be countered by entry of a new competitor. On the other hand, where entry is difficult, a dominant player is able to profitably sustain significant price increases without fear of competition.

Most markets across the country currently display substantial barriers to entry. Start-up health insurers must meet costly state statutory and regulatory requirements, including strict and substantial capitalization requirements. To do this, they must have sufficient business to permit the spreading of risk, which is difficult, if not impossible, in markets with dominant health insurers. Indeed, it would take several years and millions of dollars for a new entrant to develop name and product recognition with purchasers to convince them to disrupt their current relationships with the dominant health insurers. The Justice Department underscored the significant obstacles associated with entering certain health insurance markets in United States v. Aetna, when it noted, "[n]ew entry for an HMO or HMO/POS plan in Houston or Dallas typically takes two to three years, and costs approximately $50,000,000." These market conditions create insurmountable barriers for new entrants.

Premium Increases

The ability of dominant health insurers to profitably raise premiums is another sign of monopoly power. This practice exacerbates access to care problems and contributes to the alarming numbers of uninsured. When premiums rise, many employers stop providing coverage and/or reduce the scope of benefits provided. Even when employers offer health plans, increases in premiums, deductibles, and co-payments have led many workers to forego their employer-sponsored health insurance. In fact, according to a survey by the Agency for Healthcare Research and Quality, employee health plan participation at large companies declined from 87.7 percent to 81 percent between 1996 and 2004. This declining coverage puts an enormous strain on the health care system and leads to otherwise avoidable expenditures for emergency care and other medical services.

The past five years have been marked by increasing health plan premiums and profits. In 2005, premiums for employment-based insurance policies increased by 9.2 percent --outpacing overall inflation by a full 5.7 percent. In 2003 and 2004, premiums again increased by 14 and 11 percent respectively. Cumulatively, the premium increases during the last six years have exceeded 87 percent, with no end in sight. This is more than three times the overall increase in medical

inflation (28 percent) and more than five times the increase in overall inflation (17 percent) during the same period.

Health insurers seek to deflect attention from their huge profits by falsely asserting that physician payments are driving recent premium increases. Such claims are baseless. While premium levels have risen by double-digit amounts, physician revenues have fallen. The median real income of all U.S. physicians remained flat during the 1990s and has since decreased. The average net income for primary care physicians, after adjusting for inflation, declined 10 percent from 1995 to 2003, and the net income for medical specialists slipped two percent. In contrast, recent reports on health insurer profits show that the profit margins of the major national firms have experienced double-digit growth since 2001. In fact, United and WellPoint have had seven years of consecutive double-digit profit growth that has ranged from 20 to 70 percent year-over-year. Thus, it is shareholders and health insurance executives, not physicians, who are profiting at patients' expense.

Physician Bargaining Power

Growing market domination of health insurers is undermining the patient-physician relationship and eviscerating the physician's role as patient advocate. Physicians have little-to-no bargaining power when negotiating with dominant health insurers over contracts that touch on virtually every aspect of the patient-physician relationship. This is particularly troublesome given physicians' critical role as patient advocates in an environment where health insurers have increasing control and limited accountability regarding decisions that affect patient treatment and care.

Many health insurer contracts are essentially "contracts of adhesion." Contracts of adhesion are standardized contracts that are submitted to the weaker party on a take-it or leave-it basis and do not provide for negotiation. Many contracts of adhesion contain onerous or unfair terms. In the health insurer context, these terms may include provisions that define "medically necessary care" in a manner that allows the health plan to overrule the physician's medical judgment and require the lowest cost care, which may not be the most optimal care for the patient. They also frequently require compliance with undefined "utilization management" or "quality assurance" programs that often are nothing more than thinly disguised cost-cutting programs that penalize physicians for providing care that they deem medically necessary.

In addition to interfering with the treatment of America's patients, many health insurer contracts make material terms, including payment, wholly illusory. They often refer to a "fee schedule" that can be revised unilaterally by the health insurer, and do not even provide such a schedule with the contract. In fact, many contracts allow the health insurer to change unilaterally any term of the contract. In addition, these contracts frequently contain such unreasonable provisions as "most favored payer" clauses and "all products" clauses. "Most favored payer" clauses require physicians to bill the dominant health insurer at a level equal to the lowest amount the physician charges any other health insurer in the region. This permits the dominant health insurer to guarantee that it will have the lowest input costs in the market, while creating yet another barrier to entry.

Similarly, "all products clauses" require physicians to participate in all products offered by a health insurer as a condition of participation in any one product. This often includes the health insurer reserving the right to introduce new plans and designate a physician's participation in those plans. Given the rapid development of new products and plans, the inability of physicians to select which products and plans they want to participate in makes it difficult for physicians to manage their practices effectively.

Despite the improper restrictions and potential dangers these terms pose, physicians typically have no choice but to accept them. Any alleged "choice" they have is effectively a Hobson's choice, given that choosing to leave the network often means destroying patient relationships and drastically reducing or losing one's practice. Physicians simply cannot walk away from contracts that constitute a high percentage of their patient base because they cannot readily replace that lost business. In addition, physicians are limited in their ability to encourage patients to switch plans, as patients can only switch employer-sponsored plans once a year, during open enrollment, and even then, they have limited options, and could incur considerable out-of-pocket costs.

Health insurers have also employed certain tactics to coerce non-contracted physicians who have managed to preserve some level of bargaining power, into signing contracts. For example, a number of large health insurers are refusing to honor valid assignments of benefits executed by a patient who receives care from a non-contracted physician. This means that health insurers, rather than pay the non-contracted physician directly, pay the patient for the services provided. Similarly, many health insurers engage in the practice of "repricing" of physician claims (including proprietary claims edits and the use of rental network PPOs), which results in non-contracted physicians receiving less than contracted physician for the same service. These and other manipulative practices are clearly designed to undermine any residual bargaining power a physician practice might have, and further depress physician payments.

Monopsony Power

In a substantial number of markets across the country, dominant health insurers have the potential to exercise monopsony power over physicians to the detriment of consumers. Monopsony power is the ability of a small number of buyers to lower the price paid for a good or service below the price that would prevail in a competitive market. When buyers exercise monopsony power in the labor market, they exploit workers in the sense of decreasing fees below their true market value. Monopsony power also has an adverse impact on the economic well being of consumers as it results in a reduced quantity of the firms' products available for purchase.

In the health insurance industry, health insurers are both sellers (of insurance to consumers) and buyers (of, for example, hospital and physician services). As buyers of physician services, health insurers are acting as monopsonists--lowering the prices they pay to a point at which physicians may be forced to supply fewer services to the market. Moreover, because health plans have posted considerable profits without decreasing premiums, the benefits of their ability, as a buyer of services, to lower the prices they pay suppliers (physicians), have not been passed on to consumers.

In fact, the US Department of Justice has recognized that a health plan's power over physicians to depress reimbursement rates can be harmful to patients--the ultimate consumers of health care. Such was the basis for the DOJ's recent decision requiring United to divest some of its business in Boulder as a condition of approving its merger with PacifiCare. Specifically, the DOJ noted that because physicians cannot replace "lost business" quickly, the point at which physicians are locked-into a managed care contract is significantly lower than for other businesses. In the case of the United/PacifiCare merger, the DOJ found that where the merged company would control 30 percent of physician revenues, the plan could exercise monopsony power over physicians in a manner that would lead to a "reduction in the quantity or quality of physician services provided to patients."

Health insurers with monopsony power can use the economic benefits of reduced prices in medical care to protect and extend their monopoly position and increase barriers to entry into the market. Thus, rather than producing "efficiencies," increasing monopsony power in health care markets across the country causes a number of distortions in the market that harm patients by reducing access to care.

Any one of these characteristics individually--market share, barriers to entry, premium increases, monopsony power, and disparity in bargaining power--should send a strong warning that competition in the health care market is being compromised. The simultaneous existence of all of these features is nothing short of alarming. The current health care market exhibits all the symptoms of an ailing system that, absent intervention, has a dire prognosis.

ANTITRUST LAW AND POLICY RESTRICTIONS ON PHYSICIANS

Ironically, rather than focus on the health insurance industry, which, as noted, has boasted record profits and increased premiums corresponding to recent waves of consolidation, regulators have focused on physicians, the least consolidated segment of the health insurance industry. This is confounding given the current health insurer environment. Since April 2002, the FTC has brought at least 25 cases against physician groups based upon contracting arrangements with health insurers. All but one of the groups chose to settle with the FTC rather than engage in a protracted, financially devastating legal battle. These actions have had a chilling effect on physician efforts to create joint ventures that could result in lower cost, higher quality care.

Short of forming a fully integrated group practice, the only option currently available to physicians is so-called "clinical integration," as described by the DOJ/FTC in their 1996 Statements of Antitrust Enforcement Policy in the Health Care Area. The agencies, however, have provided little guidance on what exactly constitutes clinical integration, other than to make it clear that meeting the standard requires several years of development and millions of dollars of infrastructure investment; an option which is simply not feasible for the vast majority of physicians.

The AMA believes that given the increasing power and size of health insurers and the corresponding decrease in the bargaining power of physicians, it is time to reexamine the policy landscape that has resulted in aggressive antitrust enforcement actions against physicians. First, we believe that the Rule of Reason, rather than the per se rule, should apply to the creation of physician networks. Second, we would like to reopen discussions with the DOJ and FTC on

more flexible approaches to physician joint ventures that recognize the benefits to physician joint contracting. For health insurers, physician joint contracting can make it possible to obtain ready access to a panel of physicians offering broad geographic and specialty coverage. In fact, in a number of the cases settled by the FTC, health plans had voluntarily contracted with physician networks for several years before calling the FTC to initiate an investigation.

Non-exclusive physician networks pose no threat to competition. Physicians can independently consider contracts presented from outside the network. Likewise, health insurers that cannot reach a "package deal" with a physician network can contract directly with its physicians or approach a competing network. Rather than restraining trade, the physicians will have created an additional option for purchasers--a pro-competitive result. Thus, the AMA believes that application of the Rule of Reason to the creation of physician networks, as well as less restrictive approaches to physician joint contracting will have pro-competitive benefits such as greater flexibility, more innovation, and ultimately a better health care system.

SUGGESTIONS AND SOLUTIONS

Absent antitrust relief, we believe there are a number of interim steps Congress could take immediately to inform the debate about health insurance market power and its effects on costs and patient care.

? We believe that Congress should instruct the Department of Justice to exercise its subpoena power to investigate whether the record profits and increased premiums posted by health plans are the result of monopoly power. Only the government can undertake this task since private parties cannot access the proprietary health plan pricing information that is fundamental to making this determination. Americans deserve to know whether continuing consolidation in the health insurance market is resulting in "efficiencies" that will benefit consumers, or whether the real beneficiaries are shareholders and highly compensated executives.

? Congress should require health insurers to report enrollment numbers for all product lines by market, preferably at the county level, but at least at the MSA level, to a designated Federal agency. Currently, health insurers are only required to report HMO enrollment, and only at the state level. This reporting is problematic for two reasons. One, PPO enrollment constitutes more than 69 percent of the commercially insured population. And two, markets for health insurance are typically local rather than state-based. Requiring reporting of all product lines at the local level would ensure reporting of true enrollment numbers, information that is currently unattainable without time-consuming extrapolation from multiple sources. Public reporting of enrollment numbers by county or MSA, and by product line, would greatly enhance the health research community's ability to evaluate and report on health insurance markets.

? Congress should require reporting of health insurers' financial information, including total revenue, premium revenue, profit, and administrative expenses, in each state by product line. This information is necessary for calculating economic efficiency measures and comparing the profitability of separate product lines.

? We believe Congress should require standardized reporting of medical loss ratios for non-profit, mutual, and for-profit health insurers by state and product line, again to a designated

Federal agency. Medical loss ratios, also referred to as medical cost ratios, medical expense ratios, medical care ratios, and medical ratios, provide a measure of how much of the premium dollar is going to patient care. Currently, medical loss ratios are not provided for each state of operation, and a number of different formulas are utilized to calculate them, making it virtually impossible to accurately compare health insurance plans. Standardized reporting would go a long way toward informing the public debate on health insurer market power and would provide the public with information on how much of their premiums are actually being spent on medical care.

? Congress should evaluate the need for the development and enforcement of Federal prompt payment standards.

CONCLUSION

It is time for Congress, as well as Federal regulatory agencies, to address the serious public policy issues raised by the unfettered consolidation of health insurance markets. The AMA's Competition Study shows unequivocally that competition has been undermined in markets across the country. This has real, lasting consequences for the delivery of health care. It is time to halt the march toward a marketplace controlled by a few health insurance conglomerates focused solely on profits, not patients.