Testimony of

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I. Introduction

Good morning, Chairman Specter, Ranking Member Leahy, and members of the committee. I am Stephanie Kanwit, Special Counsel for America's Health Insurance Plans (AHIP), which is the national association representing nearly 1,300 health insurance plans providing coverage to more than 200 million Americans.

We appreciate this opportunity to testify on the challenges and complexities associated with ensuring vigorous competition in group health care. The basic purpose of the antitrust laws and antitrust enforcement in the health care industry, as in other industries, is to promote and preserve competition for the benefit of consumers, not individual competitors. Competition promotes quality improvement, cost containment, consumer choice, and the expansion of innovative approaches to health care delivery that benefit consumers.

Our testimony today will focus on two main topics:

? The fact that vigorous competition exists in the health care industry, including how that competition has spurred the introduction of new products beneficial to consumers; and

? How health insurance plans are working with practitioner and employer groups to maintain a competitive health care market by promoting quality and transparency through such measures as improving physician performance measurement and rewarding quality performance, while providing consumers with information allowing them to make value-based decisions.

II. Vigorous Competition in the Health Care Marketplace

Our health insurance plan members operate in one of the most highly competitive industries in the country, according to the two Federal antitrust agencies, the Department of Justice and the Federal Trade Commission. Those agencies in their landmark report last summer summarized twenty-seven days of hearings exploring the issue of whether payors, such as health insurance plans, possess monopsony (buyer-side) power in U.S. health care markets. This in-depth exploration came to the resounding conclusion that they do not. Nor do they possess monopoly (seller-side) power; in fact, representatives from our members' customers - employer groups - testified repeatedly at those hearings that health insurance markets in most areas of the country enjoy robust competition, with multiple insurers offering multiple product options to employers on behalf of their employees. Such vigorous competition creates incentives for all stakeholders, including health insurance plans and health care practitioners, to increase efficiency and reduce costs for consumers.

Unfortunately, there is misinformation regarding the nature of that competition, based on the argument that the health insurance marketplace is dominated by a few companies with "market power," and that the recent consolidation of some health insurance plans has somehow led to purported higher health care premiums. For example, the American Medical Association just released the fifth edition of its report, "Competition in Health Insurance," claiming that alleged health insurer consolidation is creating "near-monopolies in virtually all reaches of the U.S." and that such consolidations have raised prices for consumers. These conclusions are not supported by the data.

Specifically, empirical data show that consumers currently benefit from vigorous competition, and have wide choices among multiple competing health insurers in their areas. For example, there are multiple competing health plans purchasing physician services in every major metropolitan area in the United States, each offering multiple products to consumers and employers. As the following chart shows, there are 16 HMOs in Los Angeles, 20 in Miami, 12 in Boston, 13 in Baltimore, 14 in Philadelphia, and 11 in Pittsburgh.

In addition, new types of products - such as consumer-directed health plans or Health Savings Accounts (HSAs) - continue to be introduced in the marketplace, affording consumers additional choices to the many varied HMO, PPO and indemnity options and demonstrating the vitality and innovation typical of a highly competitive marketplace. According to a January 2006 AHIP census, HSA-compatible high deductible health plans (HDHPs) covered approximately 3.2 million people. This reflects a more than three-fold increase in enrollment in HSA products since AHIP conducted an earlier census in March 2005 - a strong showing for a health care option that did not even exist as recently as three years ago.

Second, the thesis that health care markets are concentrated, thus creating higher prices, also is not borne out by the data, since growth in national health spending has been slowing down, not increasing. According to actuaries at the Centers for Medicare & Medicaid Services (CMS) in Baltimore, private health insurance premiums were estimated to grow by 6.8% in 2005, down from 8.4% in 2004 - "the third consecutive year in which premium growth will have slowed" since 2002. Non-government estimates already have indicated that 2006 will be the fourth consecutive year in which premium growth has slowed. In charging undue "concentration," studies have inappropriately employed a Department of Justice benchmark, the Herfindahl-Hirschman Index (HHI). This index normally is used by the FTC and the Justice Department to assess concentration within a particular market when a merger is proposed. But the regulatory agencies do not stop with an analysis of market concentration; the key antitrust question is "whether market power exists or is being exercised," in the words of a former General Counsel of the FTC. Market power means the ability of sellers or buyers to profitably maintain prices above or below competitive levels, not simply market concentration.

Studies claiming that health insurance plans as purchasers of health care "dictate" prices and coverage terms to physicians cannot be accurate when the average physician: (1) contracts with about thirteen health plans, as noted in the chart below, and (2) receives about only half of his or her practice revenues from health plan contracts. Physicians can and do provide services to other purchasers, such as public programs including Medicare and Medicaid; workers' compensation systems; and TRICARE, the Government health care program for the military. In addition, there

are self-insured plans through which employers work with health plan administrators to contract for the services of physicians and other practitioners.

Anticompetitive Practices: Physician Collective Bargaining and Provider Contracting Practices

As part of the committee's discussion of health care competition, we hope that the recommendations in the recent FTC/DOJ report will be closely studied with respect to the consideration of physician collective bargaining. Unlike trade unions that are subject to the rules and requirements of the Taft-Hartley legislation, proposals for physician collective bargaining would have none of these requirements. Indeed, one of the FTC and DOJ's six key recommendations coming out of their joint health care hearings was the following: "Governments should not enact legislation to permit independent physicians to bargain collectively." Authorizing physicians, hospitals, pharmacists and other providers to engage in collusive conduct never serves the interest of consumers. Instead, such legislation is likely to increase substantially the cost of health care services, thus increasing costs and reducing access to insurance, while not improving the quality of patient care. Physicians and other practitioners already have the ability to collectively negotiate with health insurance plans under guidelines issued in 1996, when the goal is increasing efficiencies and improving patient care.

What practitioners cannot do under current law is create cartels that restrict consumer choice and hinder the ability of health insurance plans to manage health care costs. The FTC, for example, has been very active in policing provider conduct that unreasonably restrains competition. Just last week it settled a complaint against two independent practice associations (IPAs) and their 127 physician members, charging that their conduct toward health insurers unreasonably restrained competition by fixing prices. The FTC has also been active in scrutinizing provider-side mergers, especially hospitals. Indeed, in an initial decision by an FTC law judge issued last

fall and now under appeal, an Illinois hospital merger was found to reduce competition when the merged entity exercised its enhanced post-merger market power to obtain price increases significantly above its pre-merger prices, and substantially larger (as much as 48%) than price increases obtained by other hospitals in the area. The FTC/DOJ report and agency officials have highlighted anti-competitive contracting practices, including full-system or all-or-nothing contracting, whereby hospital systems with market power demand inclusion of all hospitals in a network - regardless of need.

III. Health Insurance Plans' Efforts to Promote Quality and Transparency

The FTC/DOJ report on health care competition emphasizes improving measures of both price and quality, and the importance of empowering consumers with information as well as incentives to use that information. Our members are committed to working to maintain a competitive health care market through a number of initiatives and strategies which improve physician performance measurement as well as provide consumers with information that helps them make informed, value-based decisions. I describe two examples below.

A. Promoting Quality and Transparency through the AQA

There is a major push by both public and private stakeholders to promote greater transparency and value-based competition throughout the U.S. health care system, through empowering consumers to be more actively engaged in making decisions - based on reliable, user-friendly data - about their medical treatments and how their health care dollars are spent. Last month, for example, President Bush signed an executive order requiring agencies that administer federal health programs to take steps to make price and quality information available to consumers, and implement pay-for-performance incentives. Simultaneously, the Administration has been urging the states and major employers to take similar steps through their leverage as health care purchasers on behalf of private sector employees, state employees, and Medicaid beneficiaries.

The antitrust agencies, the FTC and DOJ, also have long promoted disclosure to consumers and other interested parties of information regarding prices and quality of health care services. In their 2004 report, the antitrust agencies touted "increased transparency" as the key means "to implement strategies that encourage providers to lower costs and consumers to evaluate prices." They specifically recommended that private payors, governments, and providers "should furnish more information on prices and quality to consumers in ways that they find useful and relevant."

We are pleased to note that health insurance plans are currently working collaboratively towards that same goal with a large coalition of more than 35 physician groups (including the AMA, the American College of Cardiology, the American Board of Internal Medicine, and the American Academy of Pediatrics), as well as hospitals, accrediting organizations (like NCQA, JCAHO, and URAC), private sector employers and business coalitions (like AARP, the Pacific Business Group on Health, and the Leapfrog Group), and employers and government representatives, to meet this challenge by developing uniform processes for performance measurement and reporting. Those processes are ongoing, and would first, allow patients and purchasers to evaluate the cost, quality and efficiency of care delivered, and second, enable practitioners to determine how their performance compares with their peers in similar specialties. This effort, called by the acronym AQA, has grown and now consists of more than 125 organizations joined in a broad-based coalition.

The AQA has endorsed a "starter set" of 26 clinical performance measures for the ambulatory care setting that are already being incorporated into provider contracts. The uniform starter set includes preventive measures for cancer screening and vaccinations; measures for chronic conditions including coronary artery disease, heart failure, diabetes, asthma, depression, and prenatal care; and two efficiency measures that address the overuse and misuse of health care services. The AQA also has adopted new sets of measures for practitioners in the areas of cardiology (eight measures) and cardiac surgery (fifteen measures). These measures represent an important first step in establishing a broad range of quality standards to give consumers the information they need to make informed health care decisions.

Over the next few months, the AQA will be working toward identifying a starter set of efficiency measures. These measures will assess physicians' resource utilization when treating select conditions over a period of time. The AQA will seek to align these measures with existing clinical quality measures and ensure that they are appropriately adjusted for risk and case mix.

Most importantly, the AQA is receiving support from the Centers for Medicare & Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ) to carry out a

pilot program in six sites across the country to combine public and private sector quality data on physician performance. This pilot program is testing various approaches to aggregating and reporting data on physician performance, while also testing the most effective methods for providing consumers with meaningful information that they can use to make choices about which physicians best meet their needs.

This pilot program is being implemented in areas and through organizations that have a history of collaboration on quality and data initiatives among health plans and physician groups:
? California Cooperative Healthcare Reporting Initiative, San Francisco CA;
? Indiana Health Information Exchange, Indianapolis IN;
? Massachusetts Health Quality Partners, Watertown MA;
? Minnesota Community Measurement, St. Paul MN;
? Phoenix Regional Healthcare Value Measurement Initiative, Phoenix AZ; and
? Wisconsin Collaborative for Healthcare Quality, Madison WI.

A highly respected advisory committee of leaders in quality and performance design selected these six entities because they have the infrastructure and experience needed to support the combination of public and private data and, additionally, are positioned to implement the pilots within a short timeframe. Ultimately, we anticipate that the results of this pilot program will lead to a national framework for measurement and public reporting of physician performance, which is an important step toward improving transparency and consumer decision-making. Secretary of Health and Human Services Michael Leavitt has applauded the efforts of the pilot and expressed interest in creating more pilots throughout the country, constructing a national effort in support of quality performance measurement.

B. Promoting Quality and Transparency Through Rewarding Quality Performance

Health insurance plans continue to lead efforts to design products that offer comprehensive coverage, broad choice of providers, and greater information on provider performance. Increasingly, these products are incorporating incentives for providers to promote high quality and efficient care. Such products aim to meet yet another recommendation of the FTC/DOJ, calling for private payors, governments, and providers to "experiment further with payment methods for aligning providers' incentives with consumers' interests in lower prices, quality improvements and innovation."

AHIP's members are committed to working with stakeholders across the health care community, particularly health care professionals who work on the frontlines every day, to develop and improve incentive programs and an overall strategy that accounts for the quality of care delivered to patients. In November 2004, AHIP's Board of Directors demonstrated this commitment by approving principles for guiding the development and implementation of programs that advance a quality-based payment system. They include eight key elements:

? Programs that reward quality performance should promote medical practice that is based on scientific evidence and aligned with the six aims of the IOM for advancing quality (safe, beneficial, timely, patient-centered, efficient, and equitable).

? Research is urgently needed to inform clinical practice in priority areas currently lacking a sufficient evidence-based foundation.

? The involvement of physicians, hospitals and other health care professionals in the design and implementation of programs that reward quality performance is essential to their feasibility and sustainability.

? Collaboration with key stakeholders, including consumers, public and private purchasers, providers, and nationally recognized organizations, to develop a common set of performance measures - process, outcome and efficiency measures - and a strategy for implementing those measures will drive improvement in clinically relevant priority areas that yield the greatest impact across the health care system.

? Reporting of reliable, aggregated performance information will promote accountability for all stakeholders and facilitate informed consumer decision-making.

? The establishment of an infrastructure and appropriate processes to aggregate - across public and private payers - performance information obtained through evidence-based measures will facilitate the reporting of meaningful quality information for physicians, hospitals, other health care professionals, and consumers.

? Disclosure of the methodologies used in programs that reward quality performance will engage physicians, hospitals, and other health care professionals so they can continue to improve health care delivery.

? Rewards, based upon reliable performance assessment, should be sufficient to produce a measurable impact on clinical practice and consumer behavior, and result in improved quality and more efficient use of health care resources.

IV. Conclusion

AHIP and its member health insurance plans strongly support both competition and cooperation among all the participants in the health care delivery system. We commend the Federal antitrust agencies for their comprehensive and landmark report, "Improving Health Care: A Dose of Competition," as well as their law enforcement initiatives in those instances where provider networks, whether comprised of hospitals or physicians, engage in anti-competitive conduct.

Thank you for this opportunity to testify, and we look forward to continuing to work with this committee and the antitrust agencies to promote and preserve competition with the goal of further expanding access to high quality, affordable health care.