Testimony of

Carolyn Scanlan

July 31, 2008

Statement of The Hospital & Healthsystem Association of Pennsylvania

Before the United States Senate Judiciary Committee

Subcommittee on Antitrust, Competition Policy and Consumer Rights

"Consolidation in The Pennsylvania Health Insurance Industry: The Right Prescription?"

Presented by

Carolyn F. Scanlan

President and Chief Executive Officer

The Hospital & Healthsystem Association of Pennsylvania (HAP)

Washington, D.C.

July 31, 2008

Introduction

Chairman Kohl, Senator Specter, and other members of the committee, I am Carolyn F. Scanlan, President and Chief Executive Officer for The Hospital & Healthsystem Association of Pennsylvania (HAP). HAP represents and advocates for the more than 250 acute and specialty care hospitals and health systems across the state of Pennsylvania, and the patients they serve. I appreciate the opportunity to present the views of hospitals and health systems across Pennsylvania regarding the proposed merger of Highmark, Inc. and Independence Blue Cross.

Over the past year, HAP has raised questions and concerns with both federal and state officials regarding the proposed merger of these two plans and has called for a thorough review by government. Through HAP's public policy development process, we have evaluated the information provided by the two plans to the Pennsylvania Insurance Department, reviewed other information publicly available about health insurance markets and practices, and carefully considered the hospital community position on the proposed merger of Highmark, Inc. and Independence Blue Cross.

Based on the available information and after thorough discussion, the hospital community in Pennsylvania opposes the merger of Highmark, Inc. and Independence Blue Cross as proposed. The current health insurance marketplace in Pennsylvania already is skewed toward Highmark, Inc.'s and Independence Blue Cross' advantage, and a merger would create a health plan with an overwhelming presence or "footprint" across the commonwealth.

Therefore, we believe that it is imperative that government not approve the merger as proposed. Should approval be granted, hospitals and health systems call for strong conditions and parameters, as well as strengthened state oversight and ongoing accountability be established to address market competition, fair and appropriate insurance contracting practices, and continued community and social commitments. To that end, we were disappointed that another early termination was granted to the plans under the Hart-Scott-Rodino Act, without the federal government establishing any parameters.

Because of the interrelationship of the issues in this merger, my written testimony includes a discussion of each of the four major areas of concern. However, my remarks today will primarily focus on those issues that we believed merited a more thorough review at the federal level.

Perspective on Pennsylvania's Health Insurance Market

Based on data from several public sources, including the Pennsylvania Insurance Department, the Pennsylvania Department of Health, the Pennsylvania Department of Public Welfare, and the Centers for Medicare and Medicaid Services, statewide Blue plans have an estimated total market share of 79.5 percent--that is, nearly 80 percent of Pennsylvanians with insurance coverage (such as commercial PPOs and point-of-service, HMOs, Medicare managed care, and Medicaid managed care) access care through a Blue plan. When looking closer at this data, the majority of this enrollment is in the state's two largest Blue Cross plans. If these two plans merge, their combined market share will be approximately 65 percent (see attached chart for more detail).

In addition, in looking at available public data across the three major types of managed care enrollment (commercial, Medicare, Medicaid), one also sees that the Pennsylvania's Blue plans have approximately 51 percent of the market share of commercial managed care enrollment; 60 percent of Medicare managed care enrollment; and 59 percent of Medicaid managed care enrollment. Thus, while there may be many types of managed care insurance products offered in Pennsylvania, enrollment is predominantly in Blue plans.

Therefore, the proposed merger of Highmark, Inc. and Independence Blue Cross will create the largest private health insurer in Pennsylvania. The resulting plan will have an even more dominant impact on health insurance practices across many product lines in communities across the commonwealth.

The triggering event for governmental review is the proposed merger of these two plans. It is imperative that government--both state and federal--carefully evaluate this merger, particularly the resulting market power that the merged plan will have, as well as the potential for future monopsonistic business practices given the size of the merged plan and its overwhelming market penetration across the commonwealth.

Market Competition

Market competition in health insurance is important in achieving competitive premiums for employed groups and competitive payments to health care providers. Both Highmark, Inc. and Independence Blue Cross already enjoy a dominant position in their respective service areas. In addition, the relationship between Highmark, Inc. and Blue Cross of Northeastern Pennsylvania would enable the merged plan to account for a majority of commercial premiums in the commonwealth, providing it with even greater market power. Such power could make it that much harder for existing health insurance competitors to expand their market share or for new competitors to enter Pennsylvania's health insurance market.

The stimulation of health insurance market competition should be a top priority for government, particularly state legislative or regulatory approaches that enable small group market reform to foster growth of affordable health insurance options for smaller employed groups.

At the same time, the merged plan will account for a majority of the commercial revenues of most hospitals and physicians in the state. Given the resulting market power of the plan, it could drive provider reimbursement levels below competitive levels needed to sustain the provision of quality health care to the citizens of the commonwealth.

Based on publicly available data, experience has shown that in the regions of the state--the south central and Lehigh Valley areas--that have more robust health insurer competition (multiple Blue and commercial health insurer plans) there has been a more stable hospital financial picture over time. (See attached charts that compare hospital financial status by Blue Cross plan service areas.)

Certainly, health care providers recognize the inadequacies of governmental financing through Medicare and Medicaid, but in certain regions of the state the financial stability of hospitals also has been impacted by a less robust commercial health insurance market. A dominant plan can also cause payments to providers to be suppressed below an appropriate level, and particularly for hospitals, this suppression can impact payment by Medicare, particularly through Medicare's calculation of what is called an area wage index. Data that was recently released by the U.S. Labor Department showed that among similar sized metropolitan areas, salaries for nurses in the Pittsburgh area were generally much

lower. This type of factor impacts calculations for Medicare and creates a difficult cycle for providers seeking to recruit and retained qualified health care professionals.

Thus, a key policy question for government is how much of health care providers' (either facilities or practitioners) revenue should be controlled by one plan either directly or through such agreements that exist with Blue Cross of Northeastern Pennsylvania. We do not believe that this policy question has been addressed in the plans' filings regarding the Statement on Competitive Standards at the state level, and question whether this issue was addressed in the federal review.

The plans have stated that the change of control of the domestic insurer subsidiaries "will not substantially lessen competition or tend to create a monopoly in the lines of insurance in which those entities engage." However, this statement fails to address the potential for the Highmark, Inc./ Independence Blue Cross merger to create monopsony power in the market for the purchase of health care services, particularly hospital and physician services. This purchasing power could pose a risk that could adversely affect health care practitioners, hospitals--which in addition to providing needed care also significantly contribute to the economic vitality of community--and ultimately consumers seeking access to quality health care across the commonwealth.

Monopsony power is the ability to decrease prices paid to producers who have little opportunity to sell other than to the monopsonist. Most hospitals are confined to supplying services, as specified under their license, within a geographical area, and cannot do something else in response to reduced reimbursement other than to close services or close the hospital. Hospitals cannot move to more favorable markets.

Similarly, physicians are confined to supplying services within their training and scope of practice (licensure) laws and cannot do something else in response to reduced reimbursement other than relocating their practice.

This merger should raise competitive concerns--that is, whether the new company has a greater potential to eliminate rivals or competitors and/or whether through its new more dominant position it gains a greater ability to influence prices. Suppose the new plan reduces reimbursements to hospitals and/or physicians. Given the new plan's market share, do providers have the ability to terminate or even credibly to threaten to terminate the contractual relationship? That ability depends upon the provider's ability to replace the potential business/revenue that would be lost from contract termination and the time it might take to replace that loss. For physicians and hospitals this obviously would be quite difficult.

Further, monopsony power can harm consumers. If physicians, due to anticompetitive pressures, relocate to other markets outside of Pennsylvania, then access to physician care, which is already strained in many communities across the commonwealth, will be jeopardized. Further, physicians and hospitals that receive inordinately lower reimbursement may be forced to do more with less. This can result in longer waiting times, reduced staffing, or other cost reductions that could ultimately impact quality of care.

The concerns hospitals and physicians raise regarding monopsony power have not been properly analyzed and evaluated and serve as the center of HAP's concerns regarding the impact this merger will have on health care providers across the commonwealth.

The purpose of governmental oversight is to prevent the abuse of market power. Therefore, it is imperative that the government oversight properly evaluate the concern regarding monopsony power and take necessary actions, including:

? Explicitly prohibiting contractual provisions that raise competitive concerns--such as "most-favored" nation (or prudent purchaser, etc.) and/or "all products clauses" in any form that tie commercial, governmental (Medicare and/or Medicaid) and other product lines in a single contract.

? Review the existing agreement between Highmark, Inc. and Blue Cross of Northeastern Pennsylvania to limit control by the merged plan.

? Advance legislation that permits joint negotiation by providers through state action exemption to ensure Pennsylvanians continued access to quality health care.

Provider Contracting

Hospitals and health systems, as well as groups and/or individual practitioners, negotiate contracts with health insurers. These contracts cover many provisions affecting the purchase of health care, including quality, payment, credentialing, etc.

A dominant plan can deploy a "take it or leave it" approach with little or no opportunity for meaningful negotiations between individual providers--either facilities or practitioners. Given the market power and

vast footprint that the merged plan will have, it is unlikely that hospitals or physicians who serve patients could "walk away" from the terms dictated by the plan.

Therefore, given the magnitude of market power of the merged plan, there need to be appropriate parameters--e.g., checks and balances--so that there isn't unchecked use of market power in these negotiations. Failure to establish effective parameters could unduly drive down provider reimbursement to inadequate levels, thus jeopardizing access to quality health care and the long-term financial sustainability of essential community health care services.

To enable a balance in the important partnership that exists between health insurers and the providers serving patients in communities across the commonwealth, government should consider the following parameters:

? Prohibition of use of unilaterally imposed contract terms by the merged plan, including use of most-favored nation or similar clauses that require the largest volume plan to be given the lowest rate by a provider, and/or contracts that require acceptance of all product lines sold by the merged plan. These prohibitions must include both commercial and public sector product lines.

? Allowance for a provider-initiated, binding, mandatory independent alternative dispute resolution process (such as arbitration) between health care facilities and/or provider practices and the merged plan to resolve contract disputes. Such an approach should specify the basic criteria that would be used and include confidential review by the third-party of data regarding payments to comparable providers (by size, service area, and/or nature of service of services provided) during the relevant time period during which the contract is in dispute, and the structure and process of the dispute resolution process. In addition, certain key financial indicators (such as margins, burden of indigent and uncompensated care, dependence on public payors--such as Medicare and Medicaid, capital investment support, quality and patient safety initiative support, etc.) must be considered during the dispute resolution process. Financial indicators used should be based on valid and reliable sources, such as data collected by state agencies.

? Enabling clinically and financially integrated organizations (either currently in existence or in the future as consistent with federal law) to negotiate as a unit with the merged plan. Federal authorities (Department of Justice and Federal Trade Commission) have long recognized the ability of financially integrated organizations to jointly negotiate contracts with health plans provided that the financial integration provided strong incentives for the providers involved to control costs and improve quality. More recently, federal authorities through the 1996 Statements of Antitrust Enforcement Policy in Health Care have been evaluating clinical integration in matters related to antitrust policy. Clinical integration involves providers working together in an interdependent fashion so that they can pool infrastructure and resources, and develop, implement, and monitor protocols, "best practices," and

various other organized processes that can enable them to furnish higher quality care in a more efficient manner than they likely could achieve working independently.

Criteria for clinical integration can include:

? Selectively choosing program physicians who are likely to further the

program's efficiency objectives;

? Establishing mechanisms to monitor and control utilization of health care

services that are designed to control costs and assure quality of care; and

? Significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies.

Hospitals and health systems appreciate the letter sent by several members of this committee in June 2007 (attached) to the Federal Trade Commission and the Department of Justice urging them to work with the hospital field to develop better guidance on clinical integration. It is imperative that federal officials continue to advance these discussions and we would request that this committee seek clarification on the status of these discussions with officials at the Federal Trade Commission.

Social and Community Mission

Pennsylvania's hospital plan and professional health service plan corporations were created by state statute in the late 1930s, for the purposes of enabling all Pennsylvanians to have access to coverage for hospital care and physician and other related services. Hospital plan corporations (e.g., Blue Cross plans) in Pennsylvania are statutorily mandated to be "benevolent and charitable" organizations and the professional health service plan corporation (e.g., Blue Shield plan) is statutorily mandated to have a "social mission," including meeting requirements for open enrollment, continuity of coverage, and low-income programs.

Continued fulfillment of the social mission and community obligation by the merged plan remains as important to Pennsylvanians today in assuring access to health coverage as it was when the plans were established in the late 1930s. Therefore, it is imperative that the continuation of these obligations be clearly specified in any state level agreement that permits the merger of these two plans. These specifications should address:

? Maintenance of not-for-profit status for a mandated period of time--ideally 20 years--to assure continued social and community mission and opportunity for plan/provider relationships/partnerships that are focused on improving the quality, safety, and affordability of care.

? The continuation of financial support for health insurance programs for the uninsured for the same period of time.

? Clarification that community mission includes reinvesting in the community through use of accumulated reserves to assure that assets stay in the region in which they are created and that

community reinvestment includes partnerships with hospitals and practitioners in improving quality, safety, effectiveness, and health information technology.

Health Insurer Accountability

I'd also like to provide the policy framework by which the hospital community evaluates insurer accountability. Hospitals and health systems recognize that having health care coverage assures better access to care for individuals. We also believe that fair competition in health insurance:

? Enables consumers to have choice.

? Fosters affordability and innovation of employment-based insurance at reasonable premium prices.

? Enables fair and appropriate payments to providers delivering cost-effective, quality health care.

The Pennsylvania Insurance Department is responsible for oversight of Pennsylvania-domiciled insurers and must maintain the confidence and trust of Pennsylvania citizens that such oversight assures access to affordable health care coverage, as well as assuring that health insurers engage in appropriate and fair insurance practices.

Hospitals and health systems believe that there is compelling public policy interest for the state, through the Insurance Department, to assure that:

? There is a competitive insurance market that enables broad access to coverage.

? Health insurance practices foster efficient utilization and stewardship of limited resources.

? Health insurance practices enable access to high quality health care.

? There can be innovation in health insurance to respond to purchaser and subscriber needs.

We also believe that health insurer accountability, like delivery system accountability, requires greater openness, including public reporting of data that enables better information for consumers, purchasers, government, and health care providers. There need to be clear reporting requirements to enable ongoing review of the merged plan, including performance by product lines and evaluation of surplus and reserves. Reporting by health insurers needs to be consistent across plans and provide a complete picture of the financial and enrollment performance of all plans.

I might note that in our efforts to evaluate the proposed merger, it was quite difficult to evaluate data that is publicly available regarding health insurers. We have learned that there is not necessarily consistent or complete information across all types of health insurers or across the various product lines (commercial, Medicare, and Medicaid) that is available publicly for independent analysis of a consolidated entity's financial performance, enrollment, and utilization.

Therefore, we have called on the state to require the merged plan, as well as all other health insurers, to report in a consistent and complete manner to the Pennsylvania Insurance Department as part of accountability and transparency. In addition, average provider payments should be reported to the state's central health care data repository (hopefully a reauthorized Pennsylvania Health Care Cost

Containment Council). Clear reporting requirements that are adhered to will support improved information for employers, consumers, labor, and others seeking to improve purchasing of coverage.

Also, while we applaud the Insurance Department's approach to making as much information about the proposed merger available to the public, it is unclear how and whether the department determined information deemed "confidential and proprietary" by Highmark, Inc. and Independence Blue Cross merited such secrecy and privacy. This flies in the face of consumers' desire for greater transparency and information. All assertions by the plans that the merger will create savings for the citizens of the commonwealth must be documented, and the use of those savings must be defined and documented as well.

In addition, accountability should exist across all types of health insurers and all product lines. The state's Quality Health Care and Protection and Accountability Act (Act 68 of 1998) defines payment policies across managed care plans (e.g., HMOs) regardless of ownership, which use primary care gatekeepers. Importantly for providers, this act established timely claims payment and utilization review standards. However, this type of managed care plan is not how most Pennsylvanians access health care and these accountabilities are not necessarily required across the other types of insurance products used in our state. Hospitals believe these accountabilities need to exist across all types of health insurers, including the proposed merged plan, to ensure timely payment to providers and that there are fair standards for utilization review of claims.

Finally, should state government approve the proposed merger, there need to be clear criteria and/or methodologies for ongoing monitoring and evaluation of the merged plan's compliance with commitments stipulated in any agreement reached with the Pennsylvania Insurance Department and/or the state Attorney General. This would include clear requirements for the plans in documenting that the savings attributed to the proposed merger were achieved and validating such documentation through an audit under state agency control.

Conclusion

A vibrant insurance market, which offers an array of affordable health plans to employers and consumers, supports access to quality health care for patients, and enables fair and appropriate payment practices for providers, is important. These are the issues that hospitals and health systems in Pennsylvania believe need to be balanced in evaluating potential changes to insurance in our state, including the proposed merger of the state's two largest Blue Cross plans.

Thank you for this opportunity to testify and to provide the Pennsylvania hospital and health system community's perspective on the proposed merger of Highmark, Inc. and Independence Blue Cross. I welcome your questions.

# # #