Senate Judiciary Committee

Responses of Stephanie W. Kanwit, Special Counsel
America's Health Insurance Plans (AHIP)

<u>Question #1</u>: How do you respond to the allegation that health insurers have lowered payments to doctors without passing the savings on to consumers, enabling insurers to earn substantial profits?

First, the assertion that "health insurers have lowered payments to doctors" is not supported by the data. In fact, as detailed below, numbers from the Centers for Medicare and Medicaid Services (CMS) indicate private health insurance payments for physicians and clinical services have actually *increased* in both absolute dollar numbers and in terms of percentage of total private health insurance benefits in the recent past and are likely to do so in the future. Moreover, AHIP's members are working with physicians and other stakeholders to develop strategies that pay more for quality performance, as well as to establish processes to report meaningful quality information for physicians, hospitals, and health professionals. The result has been both increased payments to doctors who practice high quality medicine, as well as better health care outcomes for consumers.

Second, the data also show that health plans are in fact "passing the savings on to consumers." Health benefit costs are moderating for the third consecutive year, as we detail below.

Third, in response to the allegation that insurers reap "substantial profits," it should be noted that margins tend to be relatively low in the health insurance industry. In fact, PricewaterhouseCoopers in a recent report, "The Factors Fueling Rising Healthcare Costs 2006," has calculated that health plan profits are in the range of 3 percent.[1] Those profits are available to meet risk-based capital needs, to support continued reinvestment into the system, and to provide a reasonable return to attract investors. The fact is that profit margins outside healthcare are many multiples higher than the profits of companies in the healthcare arena.

Physician Payments Are Increasing, Not Decreasing:

Private health insurance payments to physicians amounted to $136.8 billion in the year 2000, but by 2004 had increased to $194.0 billion---an increase of $57.2 billion over that short period. Indeed, the trend is expected by government actuaries to continue into the future,

[1] PricewaterhouseCoopers Report prepared for AHIP, at p. 7 (2006) (hereafter PWC Report). That Report is based on data including Kaiser Family Foundation and Health Research and Educational Trust, "Employer Health Benefits, 2004", Sept. 2004; Mercer Human Resource Consulting, "US health benefit cost rises 7.5% in 2004"; The Segal Group, Inc., "2005 Segal Health Plan Cost Trend Survey," August 2004; Towers Perrin HR Services, "2005 HR Health Care Cost Survey," Dec. 2004.

with private health insurance payments to physicians expected to increase from $209.6 billion in 2005 to a projected estimate of $227.2 billion in 2006 and to $313.5 billion in 2010.

Private Health Insurance Payments for Physician and Clinical Services

Year	Physician Payments ($ billions)	Total Private Health Insurance Benefits ($ billions)	Physician Percentage
2002	$ 162.7	$ 552.2	33.8%
2003	$ 177.5	$ 606.3	34.1%
2004	$ 194	$ 658.5	34.4%
Estimated:			
2005	$ 209.6	$ 706.4	34.5%
Projected:			
2006	$ 227.2	$ 745	35.4%
2007	$ 246.6	$ 806.2	35.6%
2008	$ 268.3	$ 875.5	35.8%
2009	$ 290.7	$ 950.5	35.9%
2010	$ 313.5	$ 1,017.70	36.0%

Source. CMS National Health Expenditures Data and Projections.

Moreover, the largest share of the consumer's and employer's premium dollar-- fully 24 percent --goes towards payments to physicians for their services, according to the PWC Report, "The Factors Fueling Rising Healthcare Costs." That Report determined that the rest of premium dollar goes to outpatient costs including free-standing facilities and outpatient departments of hospitals (22%), to inpatient hospital costs (18%), and to pay for prescription drugs (16%). In addition, fully 6% of the premium dollar goes to government payments, compliance, claims processing, and administration.[2]

"Paying for Quality" Is Working:

Rather than lowering payments to physicians, as the Committee's question posits, our health insurance plan members are in the forefront of working collaboratively with physicians to design and implement a range of "paying for quality" arrangements that reward physicians who practice high quality medicine. Those ongoing efforts are proving successful. The National Committee for Quality Assurance (NCQA) just this week, on September 27, 2006, issued a report indicating that the quality of health care provided to millions of Americans improved last year across several dozen categories. For patients in private insurance plans, there was improvement in 35 of 42 measurements, including such categories as cervical cancer screening, colorectal cancer screening, and the control of high blood pressure.

[2] PWC Report at p. 7.

Traditionally, practitioners including doctors have not been paid based on the quality of care they deliver, but rather on the volume and technical complexity of services rendered. This approach has rewarded the over-utilization and misuse of services, resulting in higher payments when health care complications arise, and creating disincentives to improve quality and efficiency. The effort to implement paying for quality initiatives is consistent with the recommendation of the Department of Justice and Federal Trade Commission in their ground-breaking report, "Improving Health Care: A Dose of Competition," which stressed that "private payors, governments, and providers should experiment further with payment methods for aligning providers' incentives with consumers' interests in lower prices, quality improvements, and innovation."[3]

Physicians want to be recognized and rewarded for high quality care. A survey conducted for AHIP in 2004, for example, found that 86 percent of the physicians surveyed were concerned that the current payment system does not reward physicians for providing high quality medical care, and 71 percent of the physicians queried favored payments based on the quality of care they provide.[4]

Our members have clinicians --including physicians --actively involved in key aspect of rewarding quality performance programs, including program development, selection of performance measures, and determination of how rewards are linked to provider performance. Achieving clinical goals plays the most significant role in the formula for determining financial rewards. Other plans link awards, for example, on the ability of physician groups to create registries for patients with particular medical conditions (like diabetes and coronary heart disease), provide performance feedback to individual physicians, promote consistent delivery of care pursuant to evidence-based guidelines, and refer to care management programs.

The Federal Medicare program as well has embarked on a demonstration program to reward physicians for improving the quality and efficiency of health care services delivered to Medicare fee-for-service beneficiaries. Under the Benefits Improvement and Protection Act of 2000, the Physician Group Practice (PGP) Demonstration seeks to reward physicians for improving health outcomes, especially those groups that can retain and coordinate care for chronically ill and high cost beneficiaries and promote active use of utilization and clinical data for purposes of improving efficiency and outcomes. It should be noted that the measures used to evaluate the physician groups and reward quality under the program were developed by CMS working in conjunction with the American Medical Association.

Finally, as we noted briefly in testimony before this Committee on September 6, 2006, our health insurance plan members are currently working to develop a uniform, coordinated strategy for measuring, aggregating and reporting physician performance called the AQA. That ongoing work is a highly collaborative effort along with a large coalition of more than 35 physician groups including the American Medical Association, the American College of Cardiology, the American Board of Internal Medicine, and the American Academy of

[3] FTC/DOJ Report, July 2004, Executive Summary, at 21.
[4] "National Survey of Physicians Regarding Pay-for-Performance," Ayres, McHenry & Associates, Inc., September/October 2004.

Pediatrics. The input of those medical groups is key to developing a common set of performance measures and a strategy to implement them so that "paying for quality" results in engaging physicians, hospitals, and other health care professionals who work hard to improve the quality of health care delivery.

Premium Increases Are Moderating:

Not only is quality up, but health plans are in fact "passing the savings on to consumers," in the words of the Committee's query. First, premium increases very closely follow healthcare spending increases. According to PricewaterhouseCoopers, "over the most recent ten-year period (1993-2003) for which data are available, premiums grew at an annual rate of 7.3 percent, while the cost of healthcare services grew at an annual rate of 7.2 percent." [5]

Moreover, both private and government actuaries at the Centers for Medicare and Medicaid Services (CMS) have found that health benefit costs are indeed moderating. CMS has reported that in 2005, national health spending growth is expected to decelerate to 7.4 percent from 7.9 percent in 2004. This is the third consecutive year of slowing spending growth since 2002.[6]

In sum, health insurance plans have continuously raised payments to physicians across the board, with a special emphasis on increases to those who practice high quality and efficient medicine; any "savings" have in fact been passed on to consumers, since premium increases very closely follow healthcare spending; and those savings are passed on to consumers in the form of both moderating premiums as well as higher quality health care.

Question # 2. The AMA has urged Congress to require health insurers to publicly report additional enrollment and financial data. In your testimony, you advocate greater transparency. Would your members object to such reporting requirements? If so, on what grounds?

Health insurance plans strongly believe that consumers should have access to reliable and useful information to enable them to make informed value-based decisions about the care they receive. Moreover, physicians, hospitals and other health care professionals should have access to actionable information to enable them to improve health care delivery. Our community is already providing or making available such critical information – which includes enrollment and financial data as well as quality information – to enrollees, network providers, employers they contract with, and others. Before proposing disclosure of additional enrollment and financial data, we urge policymakers to consider: (1) the extensive amount of enrollment and financial information which is already currently available, as

[5] PWC Report at 3.

[6] C. Borger, S. Smith, C. Truffer, et al., "Health Spending projections through 2015: Changes on the Horizon," Health Affairs (Feb. 2006) at W61. See also the National Survey of Employer-Sponsored Health Plans 2005, Mercer Human Resources Consulting, available at http://www.mercerhr.com/pressrelease/details.jhtml/dynamic/idContent/1202305

described below; and (2) how additional enrollment and financial data would in fact be useful to stakeholders and further the goal of improving quality or value in the health care system.

Enrollment Data:

There are a number of resources which providers, consumers and other stakeholders can access to obtain enrollment information on particular health insurance plans. For example, AIS's Directory of Health Plans contains detailed national and state-level enrollment data by company.[7] Additionally, many individual plans have different types of enrollment data (e.g., enrollment data by product) on their websites. And finally, all health insurers include enrollment numbers in their annual statements to state regulators. Providers, consumers and other stakeholders can access those annual statements through the National Association of Insurance Commissioners (NAIC) website. Consumers can access up to five free annual statements at the website, at https://external-apps.naic.org/insData/index.jsp, and researchers can purchase whole data sets from the NAIC if they seek to review more than five insurers at a time.

Financial Data:

Health insurance plans also currently disclose different types of financial data to various stakeholders. For example, in their extensive oversight of health plan activities, which include ensuring that health plans meet solvency requirements and monitoring plan premiums and rating practices, state regulatory agencies already require health plans to disclose extensive financial data. A significant amount of this information, including annual financial statements information, is available to the public.

Additionally, health insurance plans are working with various stakeholders to increase the types and quantity of information that is currently available to inform consumers about the relative cost of services provided by network physicians, hospitals and other health care professionals. Individual plans, for example, currently are pioneering and considering tools and resources which will help consumers, including:

- Estimates of average in-network and out-of-network costs in the member's zip code for 25 common office procedures;
- Access to a hospital buyer's guide that displays a quality rating and a cost range using dollar signs; and
- Use of a treatment cost estimator to project costs for management of conditions, diagnostic tests, office visits, and select procedures.

Linked to financial data is the critical issue of reporting quality data that is useful to consumers and other stakeholders. As we pointed out in our testimony to the Committee on September 6, 2006, health insurance plans are currently working with the AQA coalition alongside physician organizations, employer groups, and governmental organizations to explore strategies for reporting reliable and useful quality information to consumers,

[7] More information is available at www.aishealth.com.

providers, and other stakeholders. AQA recently developed fundamental principles for reporting with the objectives of facilitating more informed decision-making about health care treatments and investment and facilitating quality improvement.

In sum, any additional reporting requirements relating to enrollment, financial and quality data would have to be useful and create value for beneficiaries, and not result in unintended consequences, including confusion (particularly among consumers), or unnecessary burdens which divert limited resources and focus away from quality improvement activities. While consumers need accurate information to empower them to make effective and efficient decisions, reporting of specific financial data (such as health plan payments to physicians) must operate within antitrust guidelines to ensure that vigorous competition continues to thrive in the marketplace, resulting in lower prices. [8]

Question #3. Your members contend that mergers can generate efficiencies and reduce the cost of health care. Do you believe it would be appropriate for the Department of Justice and Federal Trade Commission to hold companies to their promises – decreased premium growth rates, increased payments to physicians, and so on – as a condition of merger approval?

We believe that the Federal antitrust agencies, the Department of Justice and the Federal Trade Commission, should continue to fulfill their statutory mandate, pursuant to the current Merger Guidelines, [9] to investigate and evaluate appropriate mergers, whether by hospitals, health insurance plans, practitioner groups, or other entities in the health care system. Those agencies have expressed clearly their continuing commitment to monitor the healthcare sector of the economy.

As the agencies made clear in their healthcare Report, "Improving Health Care: A Dose of Competition," the antitrust laws are designed to ensure that markets operate competitively in order to maximize consumer welfare. In the healthcare arena, those laws ensure that competition will achieve the goal of promoting lower prices, higher quality, greater innovation, and enhanced access to healthcare at a price and quality level that fit the consumer's needs.[10]

The DOJ has in fact reviewed a number of health plan mergers, looking at whether they promote efficiency and affordability for consumers. After an extensive review of recent healthcare mergers, its investigations have been closed after finding that the mergers were helpful to consumers in that they afforded consumers enhanced access to provider networks and benefit programs, were not likely to raise prices post-merger because of vigorous

[8] See, for example, the FTC's *MedSouth* opinion, setting parameters on physician clinical integration; www.ftc.gov/bc/adops/medsouth.htm.

[9] U.S. Dept. of Justice & Federal Trade Commission, Horizontal Merger Guidelines § 0.1 (1992 rev. 1997), available at www.ftc.gov/bc/docs/horizmer.htm.

[10] AHIP's position has been consistent: for example, in its testimony before the FTC and DOJ at their healthcare hearings, it asked that mergers be analyzed through the prism of the following: whether the impact of a merger or proposed merger is positive or negative for *health care consumers.*

competition in their competitive areas, and were *unlikely* to enable the merged firm to reduce payments to practitioners through "monopsonistic" behavior.

Each of those investigations, of course, was highly fact-specific, dependent on the particular facts relating to the merging parties as well as the particular markets in which they operate. As the healthcare Report notes, "[t]he agencies will continue to follow the merger guidelines in health insurance mergers and conduct a factually intensive, case-specific assessment of whether a particular transaction under review will allow health plans to exercise market power with regard to their customers."[11]

In terms of the question whether it would be appropriate to "hold companies to their promises" subsequent to a merger, we believe it to be extremely unwise under a competitive market system for merging health care companies or any other merger partners to make specific commitments regarding what premiums or practitioner payments will be in the future post-merger. First, no other segment of the economy, and no other industrial or financial consolidation, has ever been held to that standard, nor should it be. It is impossible for anyone to look into a crystal ball so accurate that it can allocate resources in an ever-changing marketplace. Competition should determine the appropriate cost/quality trade-offs, not promises made prior to a merger that may not accord with the operation of an efficient marketplace subsequent to the merger.

Payments to Physicians:

The Committee's query asks about possible promises of increased physician payments as a condition to a proposed merger. Surely the Committee is not suggesting that consumers pay more in terms of health care premiums, which could be the inevitable consequence of any such requirements. If markets including health care markets operate properly, competition determines the appropriate prices for payments to physicians rather than specific companies. Payments to physicians, for example, currently depend on many factors, including the particular geographic area where the physician or group practices, the specialty of the practice, and whether the physician or physician group has a national reputation for quality within a particular field. Consumer demand is also critical, and drives the payment rate for certain physicians or other practitioners (such as those at well-known medical centers like the Mayo Clinic) or for certain medical services. The payment rates to a particular physician may also depend on other pro-competitive factors, such as whether the physician is part of a "paying for quality" initiative whereby he or she is paid additional increments to practice high quality medicine, as noted above in answer to question #1.

Payments to physicians in a particular area may, of course, decrease after a merger, but those payments would be set by operation of the marketplace, not by an agreement that may result in anticompetitive consequences, such as stifling innovation, or eliminating pricing and product flexibility. Again, across the country, as we noted in answer to question #1, the trend is for private health insurance payments to physicians *to increase*, not decrease, often by substantial amounts. We also pointed out that those fees, based on government data, are likely to increase in the future. (See Chart attached as answer to Question #1).

[11] "Improving Healthcare: A Dose of Competition," Ch. 6, at 13.

Further, the 2006 PricewaterhouseCoopers study found that spending on physician fees is not only the largest share of health spending, but that it grew by 7.8 percent in 2005. [12] That pricing increase was *in excess of inflation*. Again, because the cost of health insurance premiums is a reflection of the overall cost of healthcare services, any higher payments to physicians will be reflected in higher premiums to consumers and an increase in the number of consumers who become uninsured.

Post-merger review:

Rather than insisting on promises that may be anticompetitive as a condition for merger approval, the antitrust agencies always retain the ability to review, after the fact, consummated mergers. An example is the recent Evanston Northwestern Healthcare case, where the FTC brought an administrative proceeding against a group of hospitals, contending that after the acquisition and merger, the combined entity was able to raise prices considerably.[13] The Law Judge, in a decision now on appeal to the full Commission, held that both contemporaneous and post-acquisition evidence indicated that the merger was anti-competitive for three reasons: (1) the three merged hospitals bargained as a single entity with managed care organizations and obtained post-merger price increases that were significantly above premerger prices; (2) the merged entity's prices were substantially higher than price increases obtained by other comparison hospitals, sometimes even three times as large; and (3) there were no other explanations for the price increases, such as higher wage costs, changes in regulations, or changes in consumer demand. Further, the Law Judge found that the merger created "an appreciable danger of anticompetitive consequences and will substantially lessen competition and harm consumer welfare in the future."

In terms of one example of possible efficiencies you cite, "decreased premium growth rates," in fact government actuaries at the Centers for Medicare and Medicaid Services (CMS) have found that health benefit costs are indeed moderating. CMS has reported that in 2005, national health spending growth is expected to decelerate to 7.4 percent from 7.9 percent in 2004. This is the third consecutive year of slowing spending growth since 2002.[14]

In sum, we believe that consumers will benefit in terms of lower healthcare costs and higher quality when the marketplace works efficiently, and that no changes are needed in current merger policy.

[12] PWC Report at12.
[13] *In re Evanston Northwestern Healthcare Corp*., FTC, No. 9315, 10/20/05.
[14] C. Borger, S.Smith, C. Truffer, et al., "Health Spending projections through 2015: Changes on the Horizon," Health Affairs (Feb. 2006) at W61.