Written Questions
"Examining Competition in Group Health"
September 6, 2006

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1. Are there changes that the AMA would recommend making to the FTC/DOJ Health Care Policy Statements?

The AMA believes that the FTC/DOJ Health Care Policy Statements offer virtually no realistic avenues for leveling the playing field between physicians and health plans, because they offer no means for physicians to joint contract and thereby obtain some modicum of bargaining power. Without such bargaining power, physicians in markets across the country are unable to negotiate with health insurers on behalf of their patients over contracts that touch on virtually every aspect of care.

Physicians, their patients, and the health care system as a whole are severely disadvantaged because the acceptable "joint ventures" outlined in the FTC/DOJ Health Policy Statements discourage physicians from working together on efficiency-enhancing physician joint ventures. They are unrealistic and overly burdensome, and do not provide adequate legal avenues for physicians to work together to address concerns over unfair contracts and restrictions on their ability to provide the best possible care to their patients. .

For example, the FTC's "messenger model," despite health insurer assertions to the contrary, has primarily resulted in confusion and fear of prosecution. Similarly, "clinical integration," another arrangement permitted by the FTC, is simply out of reach and is impractical for the vast majority of physicians. The FTC/DOJ Policy Statements make it clear that the only physician organizations that can realistically engage in clinical integration are those that have extremely sophisticated infrastructures, large numbers of physicians, and significant financial resources.

The AMA believes that these policies and restrictions are unwarranted and ineffective. We believe that they should be revisited and guidelines should be put in place that will realistically allow physicians to joint contract. We are confident that developing less restrictive approaches to physician joint contracting will have pro-competitive benefits, such as greater flexibility, further innovation, and ultimately a lower cost, higher quality health care system.

2. Do you believe that consumers would be seeing such significant increases in their health insurance premiums if insurers were passing along the savings from lower payments to physicians?

The AMA does not have access to information regarding how health insurance companies price their premiums. From the information available, however, it is clear that there are dangerous trends in the health insurance market, including, highly concentrated markets, increasing premiums, depressed reimbursement rates, and a lack of new entrants into the health insurance market despite significant profit incentives.

3. Why do you think the Justice Department has not challenged more mergers among health insurers?

The AMA believes that the U.S. Department of Justice (DOJ) and the Federal Trade Commission (FTC), with appropriate Congressional oversight, should re-examine their guidelines for challenging mergers among health insurers in today's markets. The current environment has produced market distortions to the detriment of health care consumers. For example, health plans have been able to raise premiums without losing market share, exacerbating access to care problems and contributing 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. 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.

In addition, the growing market domination of health insurers is undermining the patient-physician relationship. Because physicians have little-to-no bargaining power when negotiating with dominant health insurers over contracts that touch many aspects of patient care, existing imbalances in the market are virtually eviscerating the physician's role as patient advocate. As noted in our testimony, this is particularly troublesome given that health insurers have increasing control and limited accountability regarding decisions that affect patient treatment and care.

In addition, the AMA believes that the DOJ and FTC should not limit their review of health insurers to merger investigations. The red flags we have identified, market concentration, record profits that have failed to attract new entrants to the market, and premium increases outpacing inflation, warrant the DOJ and FTC investigating whether health insurers in some of these markets are exercising monopsony or monopoly power. Only the federal government can undertake this task because private parties cannot access the proprietary pricing information that is fundamental to making this determination.

4. Do you have an idea of how much the concentration level would increase in Pennsylvania as a result of a merger between Highmark and Independence Blue Cross?

If a merger between Highmark and Independence Blue Cross (IBC) occurs, this new plan will dominate the two largest metropolitan areas in the state, Philadelphia and Pittsburgh with a 68% and 74 percent (according to a 2002 analysis of the Pittsburgh market by the Pennsylvania Medical Society) combined HMO/PPO market share respectively. At the September hearing, Pennsylvania Medical Society presented testimony highlighting some of the troubling statistics relating to the IBC. Statistics such as these are becoming more and more common in health insurance markets across the country, and thus we believe that this merger would be an ideal place for the Justice Department to begin investigating whether monopolistic/monopsonistic power is being exercised by dominant health plans.

Notably, the American Health Insurance Plans (AHIP) claim that there are "multiple competing health plans in every major metropolitan market," is exceedingly misleading. In Pennsylvania and in other markets across the country, there may be multiple plans licensed to do business in the market, but the market is nonetheless not competitive. In fact, nearly all of the markets AHIP cites as being "competitive," have multiple plans, but under the DOJ/FTC horizontal merger guidelines, are highly concentrated. This is because, despite having multiple plans, in the vast majority of these markets, one insurer has a market share over 30 percent.

The Philadelphia and Pittsburgh markets provide an example of this lack of competition, even where multiple health plans exist. AHIP supports its claims of multiple competing health plans in Pennsylvania by noting that there are 14 HMOs in Philadelphia and 11 in Pittsburgh. As noted, however, the number of entities licensed as HMOs in a given market does not determine whether these markets benefit from "vigorous competition." For example, Philadelphia, a market dominated by IBC, has a Herfindahl-Hirchman Index (HHI) (a commonly used measure of competition in a market) of 5129, far in excess of the highly concentrated mark of 1800>. With IBC holding a 68 percent market share, the remaining 13 plans (assuming they exist) clearly have insignificant market shares in terms of generating competition for IBC. The reality is that one health insurer dominates each of those markets.