



**Federal Trade Commission Workshop on Health Care and
Competition Law and Policy**

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**Panel 2
Health Insurance: Payor/Provider Issues
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I. Introduction

Good afternoon, I'm Stephanie Kanwit, and I am General Counsel and Senior Vice President, Public Policy and Research, for the American Association of Health Plans (AAHP). AAHP is the principal national organization representing HMOs, PPOs, and other network-based health plans. Our member organizations provide health care coverage to approximately 170 million individuals nationwide. AAHP member health plans contract with large and small employers, state and local governments, as well as with the Medicare, Medicaid, Federal Employee Health Benefits Plan (FEHBP), and State Children's Health Insurance (SCHIP) programs.

In terms of the payor/provider issues that are the subject of this panel, AAHP and its member plans strongly support both *competition* and *cooperation* among all participants in the health care delivery system. Competition creates incentives for health care providers to increase their efficiency, lower their costs, and improve quality. Competition among health plans spurs them to be innovative and efficient, and assures that the savings they obtain through their negotiations with health care providers will be passed on to consumers — through lower prices to employers which pay for the bulk of the premiums, and ultimately to their employees.

Cooperation between health plans and providers promotes payments for services

that are timely and appropriate for properly submitted claims, as well as a better system-wide integration of evidence-based standards into the practice of medicine.

Simply put, competition and cooperation each are necessary ingredients for a health care system that ultimately puts consumers first, so that as many as possible have access to affordable health care that is of the highest quality. When standards for competition are loosened, or when cooperative efforts are hindered, consumers lose -- their health care costs rise, ability to afford access to the system declines, while quality and safety improvement efforts are undermined.

Any consideration of altering existing antitrust laws or the Statements of Antitrust Enforcement Policy in Health Care should start with one key question: Does this change help consumers, or does it hurt consumers?

With health care costs now rising at the fastest rate in a decade, consumers today view affordability as the single most important problem in health care today. The second most important problem, according to consumers, is the high number of uninsured – which tends to rise and fall with the cost of health care. In fact, one recent study suggests that with every one percent rise in health care costs, 300,000 more Americans lose access to health insurance.

All of us, whether representing providers or payors, have a crucial task to accomplish in the immediate future – to work together to address these very serious concerns, while continuing our efforts to better integrate the latest and best medical science into the practice of medicine. Recent information regarding hormone replacement therapy and arthritic surgery are examples of two areas where assumptions about medical efficacy were simply proven wrong, to the detriment of patients and the healthcare system as a whole. Preserving standards for healthy market competition among all members of the health care community is an indispensable part of these efforts.

II. Health Care Antitrust Guidelines

You have asked for our views on the current Statements of Antitrust Enforcement Policy in Health Care issued by the Commission and the Department of Justice. First, we reject the contention that the Guidelines need to be amended to allow providers to collectively negotiate regarding price. The current Guidelines provide flexibility for providers to create new and alternative ways of creating delivery networks to provide patients quality care. At the same time, the Guidelines unfortunately may have had the unintended consequence of giving providers more opportunity to form market cartels. Several years ago, when changes were made to

the guidelines, we raised this concern. Unfortunately, the activities we are beginning to see in certain parts of the country now suggest that these concerns were warranted.

The FTC's recent MedSouth advisory opinion allows flexibility to create new alternatives that can lead to improved quality of care. Notwithstanding the MedSouth opinion, some physicians have continued to argue that the Guidelines and current antitrust laws prevent them from communicating about such issues as quality, utilization management, or contract terms. This rhetoric doesn't match reality, and moreover, it continues to be used as a device to justify a long-standing effort to seek changes to the antitrust laws in the form of exemptions or other special treatment for providers. Were the FTC to provide this type of special treatment to providers, consumers would certainly pay the price.

The antitrust laws always have permitted health care providers to join together to provide more efficient health care and negotiate with health plans. By forming group practices, which often include groups of 100 and even 1000 or more, physicians create substantial economies of scale. These arrangements provide a lawful means by which physicians can achieve efficiencies and negotiate collectively with health plans.

While providers have argued that alternatives to these arrangements are needed to create a more level playing field for competition, in fact their proposals would do just the opposite: They would create large, powerful provider cartels which would both restrict consumer choice, and hinder the ability of health plans and employers to manage health care costs.

In 2000, the consulting firm LECG estimated for AAHP that enactment of physician collective bargaining legislation would increase health expenditures by \$141 billion over a five year period, or 8.6 percent of private health care costs during its peak year. According to a separate LECG study, that would result in almost 17 million people losing insurance over the next five years, and 855,000 people even losing their jobs. For consumers, that is simply too high a price.

There have been several recent settlements between provider groups and the FTC that highlight these concerns regarding collective bargaining and the harm that befalls consumers when providers are allowed to negotiate for terms that include price-fixing. One example is the recent Dallas-Fort Worth Physician Group Settlement. Genesis Physicians Group (GPG), comprised of approximately 1,250 members, contracted with System Health Providers (SHP) for management services. SHP actively bargained with payors, often proposing and counter-

proposing fee schedules. SHP discouraged the individual physicians who participated in GPG from entering into unilateral agreements with payors. SHP had a practice of not conveying to GPG physicians (even when the payor explicitly requested it to be conveyed) payor offers that SHP deemed deficient. Rather than acting as a third-party negotiator as allowed under FTC Guidelines, the management company set its own criteria for the terms of physician contracts. The FTC determined that SHP's actions restrained price and other forms of physician competition. As a result, physician fees rose significantly, and health care costs for consumers, employers, and payors in the public and private sectors increased.

These activities by providers reveal the significant problems that anticompetitive activities cause for consumers. We commend the FTC and the Department of Justice for their consistent opposition to any special exemption for physicians or other health professionals, and we continue to believe that providers should be allowed to negotiate as permitted under the existing laws and guidelines.

III. Uniform Model Contracting and Class-Action Litigation

Two additional strategies that providers currently are using to advance their arguments on the need of a more level playing field are: (1) advocating for a

“uniform” contract with all payors; and (2) joining with plaintiffs’ attorneys in filing class action lawsuits to force disclosure of health plan fee schedules and rate payment information. In fact, disclosure of contract terms and payment rates to all players in a market would eliminate the opportunity for negotiating to keep prices affordable for consumers. Essentially such disclosure would lead to a rate-setting process in which providers have the opportunity collectively to drive rates to the highest possible level. As a result, competition in the market would be eliminated, and consumers would pay more for health care.

IV. Recommendations

The purpose of antitrust laws is to promote and preserve competition for the benefit of consumers, not individual competitors. To that end, the Agency can make a positive contribution by:

- (1) Continuing its work in the active enforcement of existing antitrust laws;
- (2) Working with other federal authorities and at the state and local levels, in a unified, collaborative approach to antitrust enforcement throughout the health care system; and

(3) Facilitating an open dialogue about what are and are not permissible negotiating parameters under the existing Statements of Antitrust Enforcement Policy in Health Care.

It is time to build bridges, not fences, and to work together in addressing the problems facing our health care system in the interest of consumers, not suppliers of care.