

**Health Care Workshop, Project No. P131207**

**Submission of America's Health Insurance Plans to the Federal Trade Commission on  
Health Care Competition**

**April 30, 2014**

America's Health Insurance Plans (AHIP) would like to thank the Federal Trade Commission (FTC) for hosting its workshop on Examining Health Care Competition and for the opportunity to provide comments on the important issues covered in the workshop. AHIP's members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. AHIP advocates for public policies that expand access to affordable health care coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation.

AHIP appreciates, and supports, the FTC's longstanding efforts to promote competition in health care markets. We agree with the FTC that the workshop and comments submitted in conjunction with the workshop will support its enforcement, advocacy, and consumer education efforts related to health care. AHIP wishes to assist the FTC in these efforts by providing its comments on the five topics addressed in the workshop, and AHIP's comments on each are provided below. More generally, AHIP's members are continually working to provide increased value to their members and have taken leadership roles in delivering actionable information on provider price and quality to consumers, utilizing health information technology, and finding innovative ways

to work with providers and health care organizations to deliver high quality, lower cost, and more accessible care to consumers.

We would like to highlight our perspective, and the common themes through our comments, that: (1) consumers benefit from more, not less, competition in health care markets and (2) the FTC's efforts are vital to ensuring that consumers receive such benefits. Impediments to competition can arise either from entities within markets or from external sources, such as government regulations that, often without the intention of doing so, create impediments to competition. The FTC has done commendable work in addressing both categories of impediments, by coupling its enforcement activities with advocacy efforts designed to ensure that the competitive implications of legislation and regulation are known, understood, and considered. Both categories of FTC work will continue to be of critical importance as health care markets continue to go through a period of tremendous change. We appreciate the opportunity to offer our comments to the FTC on these subjects and stand ready to assist it in future activities to deliver the benefits of competition to health care consumers.

## **I. Professional Regulation of Health Care Providers**

AHIP shares the FTC's concern that some professional regulations of health care providers "unnecessarily restrict the ability of non-physician health care professionals to practice to the full extent of their training, imposing costly limitations on professional services without well-founded consumer safety justifications or other consumer benefits to offset those costs."<sup>1</sup> Thus,

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<sup>1</sup> 79 F.R. 10153.

AHIP has recommended modernizing scope of practice requirements for key personnel, such as nurses to encourage the development of innovative, cost-saving models of care. The record on the savings available to consumers from modernizing scope of practice requirements is well-developed and convincing.<sup>2</sup> Equally significant is the record on the quality impact of such modernization, which indicates that quality will not decrease when professionals such as nurse practitioners are allowed to practice to the "top of their licenses."<sup>3</sup>

Modernizing scope of practice requirements will lead to additional benefits as well. First, removing unnecessary restrictions on nurse practitioners and physician assistants can greatly increase access to primary care. This access is important everywhere, but is particularly critical in areas in which such access to primary care services has been challenging to maintain. In addition, such an increase in access to primary care will be timely as it will help ensure that the millions of previously uninsured persons now covered by health insurance have access to high quality and accessible primary care services.

Second, modifying such requirements can enable a greater range of delivery system reforms to emerge as physicians, nurse practitioners, plans, and others will have greater flexibility to create models that best utilize their training and experience. Thus, for example, states can facilitate

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<sup>2</sup> See, e.g., Joanne Spetz et al., *Scope of Practice Laws for Nurse Practitioners Limit Cost Savings that Can be Achieved in Retail Clinics*, Health Affairs (November 2013) (estimating savings from retail clinic use would be \$810 million greater if all states allowed Nurse Practitioners (NPs) to practice independently and \$472 million greater if NPs could both practice and prescribe independently).

The possibility for such consumer savings would be reduced, of course, were there prohibitions imposed (as suggested by some) on varying payment levels among different categories of providers.

<sup>3</sup> See *id.* (discussing studies of quality of care provided by NPs relative to quality of care provided by physicians).

greater use of nurse practitioners in coordinating care for individuals with complex, chronic conditions-through their state-based patient-centered medical home and/or disease management programs. In addition, states can also permit nurse practitioners to order in-home care for Medicare and Medicaid patients-as a way to encourage more effective primary care and care coordination.

Thus, AHIP encourages the FTC to continue to advocate for a modernization of scope of practice laws, to allow health care professionals to practice to the top of their licenses. AHIP commends the FTC for its advocacy on this issue over the years and, in particular, for its recent report, "Policy Perspectives: Competition and the Regulation of Advanced Practice Nurses." As recognized by the FTC, many barriers to the full practice of health care professionals are unnecessary to protect patient quality and safety, and removing these barriers can bring consumers greater access, lower costs, and sustained quality. Further, removing such barriers will have indirect benefits as well, increasing the variety of new models of care delivery, unencumbered by unnecessary restrictions on practice, that can compete to bring patients lower cost, high quality, and accessible health care.

**Recommendations: State laws should be modernized to allow advanced practice nurses and other health care practitioners to practice to the top of their licenses, to bring consumers the benefits of lower costs, greater access, and innovative delivery models. The FTC should continue its excellent educational and advocacy work in this area.**

## **II. Innovations in Health Care Delivery**

In parallel with increased access to individual health care providers, consumers would benefit from an increase in access to the models in which care is delivered. Unfortunately, just as scope of practice limitations can prevent consumers from realizing such benefits, similar restrictions can prevent consumers from fully realizing the benefits of innovations such as retail clinics and telemedicine. AHIP believes that making such options available to consumers will help control costs, improve access, and sustain or even improve quality. We are encouraged by the FTC's advocacy work in this area, helping to ensure that laws do not unnecessarily prevent consumers from realizing the benefits from such innovations.

Health plans have embraced such innovations, recognizing the tremendous benefits that consumers can receive in terms of high quality, more accessible and convenient, and lower cost care. Plans have not only included retail clinics in their networks, but have provided members with tools to locate such options when their primary care physician is not available. Such options can not only provide improved access and convenience, but can reduce unnecessary visits to the emergency room and help members lower costs.

Plans have also embraced telemedicine in a variety of ways. From the widespread use of nurse hotlines, to remote monitoring services, to electronic office visits, plans are using telemedicine to provide value to their enrollees. Plans have also worked outside of their benefit structures to expand access through telemedicine, for example committing funding to telemedicine initiatives to bring behavioral health to underserved areas.

AHIP's members will continue to innovate in ways that bring consumers the benefits of developments such as retail clinics, virtual clinics, and telemedicine.<sup>4</sup> By adding to the options for high quality care available, such innovations can both help reduce the growth of health care costs and can make health care more accessible. Both developments were needed even before the Affordable Care Act, and have become even more critical as more people receive health insurance and use it to access the health care system. We ask that the FTC continue its important work in this area, educating legislators and others on the benefits to consumers from such innovations and the unnecessary harm that comes when they are impeded.

**Recommendations: States should reject laws and regulations that would prevent, restrict, or slow the development of innovative delivery options such as retail clinics, virtual clinics, and telemedicine. As technological and other changes make more such options available to consumers, the FTC should ensure that such innovations are not unnecessarily chilled by outdated or unnecessary regulatory approaches.**

### **III. Advancements in Health Care Technology**

AHIP has long advocated for the increased use of health care technology for decreasing the fragmentation of care delivery, improving the efficiency of the health care system, and

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<sup>4</sup> Mandates with respect to such delivery models, however, reduce the benefit and the promise of them. By reducing the ability of plans to structure networks and benefits in a manner best suited to their members, such mandates lead to higher prices and reduced incentives to provide higher quality and greater access. Similarly, by reducing the ability of plans to pursue varying approaches to the use of such models, such mandates reduce the ability of plans to innovate and compete to best use such models to the benefit of their members.

empowering consumers to make well-informed decisions about their health care. AHIP's members have embraced the challenge of using technology to meet these goals. Indeed, health plans have been on the cutting edge of using technology to empower consumers with information about their health care through electronic health records and with information about the price of health care services through cost calculators. Plans have also used health information technology to make interactions between health plans and providers faster, less costly, and more efficient. For example, in Ohio, health plans sponsored a successful information technology initiative to provide one-stop service in electronic billing transactions for physicians.

The power of health information technology will be muted, however, if such information sits in silos, inaccessible to those on the outside. Thus, it is important that health information technology not only be widely and well used, but that it be interoperable. Different providers and types of providers should be able to access health information across settings and institutions, with the common purpose of improving the quality and efficiency of care delivered.

Unfortunately, such interoperability is not always the rule. This is doubly pernicious. First, as noted, it limits the potential benefits to patients of having their medical information available to each of their providers across settings. Second, non-interoperable technology has the effect of reducing competition in provider markets, as providers become locked-in to certain systems by virtue of technology. Thus, physicians who might normally direct their referrals to more than one hospital based on obtaining the highest quality, lowest cost option for their patients, can essentially become locked into a particular hospital by virtue of using the same, non-

interoperable, technology. To avoid this scenario, and to fully benefit consumers, interoperability must be available in fact as well as name.

An example of the benefits of increased health information technology – and the potential of a silo-based approach to such technology to mute those benefits – can be found in the realm of new payment and delivery models. Many such models are emerging, some in the context of government initiatives, but many more as the result of innovative collaborations between health insurance plans, hospitals, physicians, and others. The initiatives have benefit in themselves, but the greater benefit is in the variety of approaches being explored, based on factors specific to markets, providers, and other stakeholders. Non-interoperable health information technology can prevent certain types of approaches, such as physician-led collaborations, from being attempted in the first place. Equally harmful to consumers, locking in providers through non-interoperable health IT can ossify existing silos, ensuring that current market structures live on, unchallenged by new ideas, developments, or entrants.

Thus, AHIP believes that enabling interoperable health information technology is an important component of transitioning to a twenty-first century system of care in which consumers benefit from the best ideas, innovations, and technologies. We have noted that, "successful transition to new payment and delivery models . . . requires effective use of health information technology and the ability to share information across providers."<sup>5</sup> Health information technology is, has, and will bring benefits to consumers and health plans have been leaders in delivering these benefits. If the technology is not interoperable, however, consumers will end up with health

<sup>5</sup> AHIP, A Roadmap to High Quality Affordable Health Care for All Americans, November 2013, at 16.

options somewhat akin to having a Betamax in 2014: reflecting a portion of the very best technology of the very last century. AHIP asks that the FTC help consumers avoid this result and that it utilize all of the advocacy and enforcement tools at its disposal to ensure that non-interoperable technology does not create market power or otherwise lead to consumer harm.

**Recommendations: Public and private stakeholders should embrace and utilize twenty-first century technologies to deliver better, more efficient care to consumers. At the same time, the FTC and other government agencies should remain vigilant to ensure that such technologies are not being used to create or enhance market power, to the detriment of consumers. When such a negative effect on consumers is found, the FTC and other government agencies should challenge the relevant private conduct and address any regulatory structures that may be, in part, enabling such conduct.**

#### **IV. Measuring and Assessing Quality of Health Care**

AHIP supports the FTC's interest in ensuring that consumers have access to, and are empowered to use, information about the quality of health care providers. The FTC's comments about this topic will be of tremendous value to all health care stakeholders. In addition, the FTC's enforcement and advocacy work also plays a critical role in the quality of care patients receive, since "competition law affects quality of care by influencing the conduct of providers and the institutional and structural arrangements through which health care is financed and delivered."<sup>6</sup> Some have suggested a reversal of this relationship, suggesting that the prospect that certain

<sup>6</sup> William M. Sage et al., *Why Competition Matters to Health Care Quality*, Health Affairs (March/April 2003).

transactions or activities might improve quality of care should affect (in this case, diminish or completely deter) the application of competition law to such arrangements. This suggestion is, of course, incorrect and not in the interest of consumers, who benefit when competition and quality are both pursued, rather than viewed as alternatives. In fact, on this issue, it would be helpful for the FTC to share any additional information it may have about: (1) information sharing approaches that are likely to improve quality and value for consumers without eroding competition; (2) information sharing approaches that are likely to erode competition; and (3) indicators of quality, value and cost efficiency in a provider organization that appear likely to be understood and utilized by consumers, improve healthcare outcomes for patients, and increase competition in provider markets.

AHIP's members have been leaders in the effort both to improve the quality of care delivered and to provide consumers and providers with actionable information on quality. For example, AHIP members have used innovative approaches to improve medication therapy management to reduce complications, preventable emergencies, hospital admissions, and readmissions. Such approaches vary by plan, but often involve using advancements in health information technology, evolutions in care delivery models, and innovations in the role of pharmacists. With respect to improving information, health plans have engaged in innovative efforts to increase the consistency of physician performance measurement, by using performance measurement data compiled from multiple plans.<sup>7</sup> More importantly, many AHIP members publish physician quality and cost efficiency information for their members along with relevant consumer

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<sup>7</sup> Aparna Higgins et al., *Measuring The Performance Of Individual Physicians By Collecting Data From Multiple Health Plans: The Results Of A Two-State Test*, Health Affairs (April 2011).

experience information, and have made such information available in connection with cost estimator tools they have made available to their membership.<sup>8</sup>

We believe, however, that more can be done to improve both the *quality* of quality data and the *accessibility* of such data to consumers. First, current quality measures over-emphasize process and volume, at the expense of patient outcomes and value. Quality measures need to shift to better reflect patient outcomes and value. Second, too often consumers can't obtain information about provider quality because of contractual terms and other practices that prevent such information from being shared. Such contractual terms and practices should be eliminated so that consumers can become better informed about provider quality and better empowered to use such information.

Public and private quality measures also should become much more aligned. Plans and providers currently are subject to hundreds of quality measures from both private and public accrediting bodies. The resulting lack of uniformity has created a serious impediment to quality improvement. It is very important that public payers, private payers, and providers work together to better align performance measures, to improve quality results and reduce redundancy and inefficiency. Several such efforts are underway to further such alignment, both within the public sector through the Measure Applications Partnership, and between the public and private sectors.

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<sup>8</sup> See, for example, HarvardPilgrim's online cost and quality tool, [NowiKnow](#). For additional discussion of health plan cost estimator tools, see footnote 10 and accompanying text.

It is equally important that once such alignment is achieved, it be maintained. This will require regular re-evaluation by relevant stakeholders and revisions based on the most current research and on the lessons learned from application of the measures. This process should be an objective and nimble one, removed from political considerations and informed only by the best evidence and the collective desire of all involved to use quality metric data to improve the quality of care delivered.

As efforts to measure and report on quality progress, it is important that the FTC continue its efforts to demonstrate the consistency, at a fundamental level, of competition (protected by vibrant antitrust law) and quality (protected by vibrant competition). Similarly, it is important that the FTC continue to challenge transactions in which assertions of quality improvements are counterbalanced by likelihoods of higher prices for consumers. Too often anticompetitive transactions are justified by speculative assertions that quality will be improved and incorrect assumptions that the transaction is the only way to achieve quality improvements. It is important that such assertions and assumptions are challenged, as they were in the FTC's suit to block St. Luke's acquisition of Saltzer Medical Group, so that quality can be improved in a way that does not entail market power or higher prices. Ultimately, these two aspects of the FTC's work on quality, advocacy and enforcement will ensure that *improved reporting on the quality of care* will lead to reports that themselves demonstrate *improved quality of care delivered to patients*.

**Recommendations: Stakeholders should continue their work on improving quality measures to better reflect outcomes and value. The FTC should work both to: (1) remove impediments to consumers receiving quality information and (2) challenge anticompetitive**

**transactions, including those based on the assertion that quality improvement can only be achieved by obtaining market power.**

## **V. Price Transparency of Health Care Services**

AHIP's members have embraced the suggestion of the FTC and the DOJ that "[p]rivate payors, governments, and providers should furnish more information on prices and quality to consumers in ways that they find useful and relevant, and continue to experiment with financing structures that give consumers greater incentives to use such information."<sup>9</sup> Thus, health insurance plans have designed innovative products, such as high performance and tiered networks, that use information about both provider cost and quality in their formation and empower consumers to use this information in deciding where to receive care. In addition, health plans offer cost calculators, which include quality information, to estimate the following:

- Out-of-pocket costs for specific services;
- Cost sharing obligations under the plan (e.g., a dollar co-pay amount versus a percentage co-insurance amount), including incorporating deductible information;
- Estimated costs associated with a likely "service bundle," rather than simply for an isolated service (e.g., with respect to a surgery, including the costs of anesthesia and blood work, as well as the surgery itself);
- Where consumers can find the health care service, by local area and network; and

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<sup>9</sup> *Improving Health Care: A Dose of Competition*, FTC and U.S. Dep't of Justice, Executive Summary, available at: [Improving Health Care: A Dose of Competition - A Report by the Federal Trade Commission and the Department of Justice \(07/2004\)](#).

- The relative cost of receiving care at different providers, through comparison features.<sup>10</sup>

At the same time, AHIP has concern about two related categories of proposals. First, AHIP disagrees with the assertion by some that so-called all payer claims databases are a panacea and, instead, would suggest that such databases are neither necessary to obtain the benefits of transparency nor wise as a matter of public policy. Collecting large amounts of data without a specific purpose puts unnecessary burdens, and costs, both on the governments that must collect the data and the health care plans (and their members) who must provide it. The gathering and maintenance of such large amounts of data also raises the possibility, and risk, that data will be made public without appropriate consideration of the potential anticompetitive consequences of releasing some types of data. This relates to the second type of proposal that raises concerns.

AHIP also has significant concerns about proposals that states broadly disseminate the specific payment rates negotiated between providers and health plans, whether the data are gathered from all payer claims databases or otherwise. Rather than benefitting consumers, such proposals could have the result of forcing consumer costs higher. This risk is heightened by the current, high degree of concentration in many provider markets. AHIP appreciates, and strongly supports, the FTC's efforts to inform policymakers of this potential unintended consequence of certain transparency initiatives.<sup>11</sup> Similarly, we appreciate the guidance provided by the agency

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<sup>10</sup> See, for example, Aetna's [Member Payment Estimator](#) and UnitedHealthcare's [myHealthcare Cost Estimator](#), [Health4Me Mobile App](#), and [UnitedHealth Premium Program](#).

<sup>11</sup> See, for example, Letter of FTC to New Jersey Assemblywoman Nellie Pou (2007).

on the ways in which transparency initiatives can be structured to mitigate the possibility of consumer harm.<sup>12</sup>

We encourage the FTC to continue its efforts here, to help policymakers understand the ways in which the important policy goals underlying transparency initiatives can be pursued without the initiatives themselves undermining these goals. AHIP believes that both the policy discussion and individual decisions can be improved through information about provider price and quality. The policy discussion will be best served through information that is aggregated, such that important information about provider pricing can be understood, without the competitive harm that could be created from broad dissemination of disaggregated data. Individual decisions will be best served through member cost calculators and other tools that help consumers understand the cost to them of various providers and services, and through products, such as tiered and high value networks, that use information on provider price and quality to deliver lower cost, higher quality care to consumers.

**Recommendations: Consumers should continue to receive actionable information on the cost of health care services from their health insurance plans. Stakeholders also should identify and offer useful measures of provider pricing to further policy discussions and enable policy solutions. Approaches to collection of data should be focused and efficient, rather than the costly and burdensome approaches of all payer claims databases. The FTC should both: (1) ensure that price transparency initiatives are structured in a way that does**

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<sup>12</sup> See, for example, Statement 6 of Statements of Antitrust Enforcement Policy in Health Care, U.S. Dep't of Justice and FTC (1996), available at: [http://www.justice.gov/atr/public/guidelines/1791.htm#CONTUM\\_49](http://www.justice.gov/atr/public/guidelines/1791.htm#CONTUM_49).

**not harm consumers and (2) help stakeholders more fully understand the linkage between provider market power and increased provider pricing.**

## **VI. Conclusion**

We appreciate the opportunity to provide the FTC with comments on these five areas in which health care policy intersects with competition law. As noted above, we believe that good health care policy and strong competition policy are well-matched, not in tension. Quality can be improved, access increased, and the cost curve bent, not by allowing anti-competitive transactions or reducing the competitive field through regulations, but by protecting and enhancing competition. Allowing medical professionals to practice to the scope of their licenses, allowing innovative structures to increase access and convenience, and allowing technology to be a bridge across entities, rather a ladder up and down a silo, holds tremendous promise for consumers. Equally important, the empowerment of consumers, through access to actionable information on provider price and quality can lead to a virtuous cycle in which the decisions of consumers, providers, and plans, reinforce one another to provide relevant data, improve quality, and reward those who have created such improvement.

AHIP and its members stand in favor of all of these developments and are interested in working with providers and consumers to accelerate such developments and in working with the FTC to ensure that barriers to competition do not slow them.