



Competition in the Health Care Marketplace

by

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I. Introduction

Chairman Marino, Ranking Member Johnson, and members of the subcommittee, I am Dan Durham, Executive Vice President for Strategic Initiatives at America's Health Insurance Plans (AHIP), which is the national association representing health insurance plans. AHIP's members provide health and supplemental benefits to the American people through employer-sponsored coverage, the individual insurance market and the Exchanges, and public programs such as Medicare and Medicaid through localized networks that provide access to physicians and health care facilities in consumers' communities. Our members essentially act as the negotiators, on behalf of consumers, with health care providers, such as hospitals and pharmaceutical companies, to seek high quality services at the most competitive prices possible. 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.

Health plans are committed to ensuring that their enrollees receive high quality health care at competitive prices. As part of those efforts, health plans increasingly work with hospitals and providers to improve care coordination and deliver better value for patients. By advancing new and emerging models of payment and care delivery, health plans are taking a leading role in moving away from the antiquated fee-for-service model to a health system that promotes higher quality and more affordable care for consumers.

We appreciate this opportunity to testify on issues surrounding competition in the U.S. health care system. These issues have far-reaching implications for the cost of health care, quality improvement, consumer choice, and innovative approaches to the delivery of care. We applaud the subcommittee for holding this hearing to call attention to these important issues.

Our testimony today focuses on the following topics:

- The importance of continuing to ensure vigorous competition in local markets throughout the health care system;
- The fact that consolidation of some companies can have strong pro-competitive effects and is only harmful if anticompetitive effects can be demonstrated;

- The harmful impact of anticompetitive consolidation among hospitals and other health care providers; and
- The harmful impact of monopoly pricing in the pharmaceutical industry.

II. The Importance of Ensuring Vigorous Competition in the U.S. Health Care System

A competitive health care system is the best way to achieve innovative, high quality, affordable health care for all Americans. Vigorous competition in the marketplace creates incentives for all stakeholders to increase efficiency and hold down costs for consumers. Health plans operate in competitive markets and the Exchanges have demonstrated impressive growth in competitive options already. It is important to recognize that this competition among health plans occurs at the local level in specific geographic areas, and that new coverage options – including those resulting from collaboration between plans and providers – are emerging and evolving on an ongoing basis. The diversity of AHIP’s membership – which includes local, regional, and national insurers – reflects the many choices consumers have when shopping for health insurance coverage in their area.

The Department of Health and Human Services (HHS) has released a research brief¹ that highlights the broad range of choices that are available to consumers through the Exchanges established by the Affordable Care Act (ACA). The HHS research brief, focusing on 35 states, indicates that an average of 40 plan options are available per county in 2015 – up from an average of 30 plan options per county last year. The growth in choices and competition in the ACA Exchanges also is demonstrated in an analysis² by McKinsey & Company, which focused on 41 states and found that the number of insurers competing in the Exchanges increased by 26 percent between 2014 and 2015.

Similarly, for seniors and individuals with disabilities, a wide range of health plan choices are available in the Medicare Advantage (MA) program. According to an analysis³ by the Kaiser Family Foundation, Medicare beneficiaries were able to choose from an average of 18 MA plan options when making their enrollment decisions for the 2015 benefit year. In addition,

¹ U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Health Plan Choice and Premiums in the 2015 Health Insurance Marketplace, January 8, 2015

² McKinsey & Company, 2015 OEP: Emerging trends in the individual exchanges, November 2014

³ Kaiser Family Foundation, Medicare Advantage 2015 Data Spotlight: Overview of Plan Changes, December 10, 2014

beneficiaries were able to choose from an average of 30 stand-alone prescription drug plans (PDPs) under the Medicare Part D prescription drug program.⁴

Survey findings consistently show that a large majority of consumers are satisfied with their health plans. The Commonwealth Fund Affordable Care Act Tracking Survey,⁵ conducted in March-May 2015, found that 86 percent of enrollees in Exchange plans and newly enrolled Medicaid beneficiaries are satisfied with their health insurance. Similarly, a national survey of Medicare Advantage enrollees found that 90 percent of respondents were satisfied with their coverage.⁶

In the health insurance marketplace, competition is helping to drive innovative programs as health plans continually work – in collaboration with providers and other partners – to make their products more appealing to consumers and employers based on both quality improvements and cost savings. Our members have demonstrated strong leadership in developing and implementing initiatives in the areas discussed below.

Health plans are promoting quality and affordability by implementing a variety of provider-based strategies including:

- Rewarding quality and promoting evidence-based health care through payment and care delivery reforms, such as bundled payment and accountable care contracts, as part of an industry-wide effort to advance alternative payment models that align with, and laid the groundwork for, the new Medicare physician payment reform law;
- Partnering with primary care physicians to expand patient-centered medical homes that promote care coordination and accountability for clinical outcomes;
- Collaborating with physicians in their efforts at practice transformation, through activities such as direct clinical support and provision of meaningful and actionable data, to drive quality improvements, improved outcomes, and cost savings; and

⁴ Kaiser Family Foundation, Issue Brief: Medicare Part D: A First Look at Plan Offerings in 2015, October 2014

⁵ Commonwealth Fund Affordable Care Act Tracking Survey, March–May 2015

⁶ North Star Opinion Research, National Survey Of Seniors Regarding Medicare Advantage Plans, February 6-11, 2013

- Improving the flow of information between clinicians and plans by simplifying administrative processes and data exchange to improve care.

Similarly, health plans are driving value through programs and tools that promote patient-centered care and help consumers make value-based decisions, including:

- Offering a wide variety of provider networks for consumers and employers – integrated care delivery products, high performance networks based on cost and quality measures including health outcomes, tiered networks, and networks that offer the broadest possible selection of providers (In the 2015 Exchange market, 90 percent of consumers had access to both narrowed and broad-network plans, up from 86 percent in 2014);⁷
- Implementing standardized performance measures to provide consumers with better information about quality and costs to help them make value-based decisions about their medical treatments and how their health care dollars are spent;
- Providing disease management services to enrollees who stand to benefit the most from early treatment and care interventions;
- Offering personalized risk assessments, wellness programs, and consumer tools that provide information on the cost of health care services;⁸ and
- Encouraging electronic prescribing and consumer safety alerts.

These initiatives are being pioneered across the nation by health plans of all sizes, including local, regional, and nationwide insurers.

Plan-Specific Examples:

Independence Blue Cross in Pennsylvania has implemented patient-centered medical homes to improve patient health and lower costs through a team-oriented approach to primary care. Key components of this initiative include an emphasis on coordinated care among all health care professionals, electronic health records to better track care, open scheduling to allow for more

⁷ McKinsey Center for U.S. Health System Reform, Hospital networks: Evolution of the configurations on the 2015 exchanges, April 2015

⁸ AHIP Issue Brief, Health Plan Tools Empowering Consumers with Provider Price Information, August 2015

flexibility in seeing patients when they need care, and more interaction with the physician and staff between appointments to ensure that scheduled tests and consultations occur. Under this program, the transition to a medical home was associated with a statistically significant 5 to 8 percent reduction in utilization of Emergency Departments (ED) for patients with chronic illnesses who have one or more ED visits in any given year. The reduction in ED visits was most evident among patients with diabetes, who experienced a 9.5 to 12 percent reduction.^{9,10}

Blue Shield of California is collaborating with Dignity Health (formerly Catholic Healthcare West) and Hill Physicians on an accountable care model for members of the California Public Employees' Retirement System (CalPERS) in the greater Sacramento region. Each organization shares clinical and case management information to tightly coordinate care. By sharing data, the three organizations have been able to identify areas where costs are unduly high and implement solutions to bring those costs down. Results for 2010 included: a 15 percent reduction in inpatient readmissions; a 15 percent decrease in inpatient days; a 50 percent decrease in inpatient stays of 20 or more days; a half-day reduction in average patient length of stay; and \$15.5 million in savings.¹¹ Over three years, this initiative reduced premiums for CalPERS beneficiaries by \$59 million, or \$480 per member per year.¹²

Blue Cross Blue Shield of Michigan has implemented a Cardiovascular Consortium to facilitate better collaboration among health care providers to address the goals of: (1) improving care for patients with coronary disease undergoing angioplasty; and (2) decreasing complications and improving medical therapy for patients with severe peripheral arterial disease undergoing peripheral vascular intervention and open vascular surgeries. The first initiative achieved, from 2002 to 2011, a 20 percent reduction in hospital deaths, a 92 percent reduction in emergent coronary artery bypass grafts, and a 40 percent reduction in vascular complications. The second initiative achieved, from 2007 to 2011, a 25 percent reduction in the death rate, a 50 percent reduction in vascular complications, and a 22 percent reduction in the need for blood transfusions.

Indeed, many of the initiatives noted above involve health plans partnering with providers in a manner that supports a comprehensive approach to improving quality and affordability. Health

⁹ Health Services Research, Do Patient-Centered Medical Homes Reduce Emergency Department Visits?, August 12, 2014

¹⁰ AJMC Managed Markets Network, Medical Homes and Cost and Utilization Among High-Risk Patients, March 24, 2014

¹¹ Fact Sheet: Blue Shield of California and Accountable Care Organizations (ACOs)

¹² The Commonwealth Fund, Hill Physicians Medical Group: A Market-Driven Approach to Accountable Care for Commercially Insured Patients, October 2014

plans have been leaders in the adoption of patient-centered medical homes, which replace episodic care with a sustained relationship between patient and physician. Similarly, health plans have been strong partners in many accountable care contracts, with promising early results in reducing preventable readmissions and total inpatient hospital days.¹³ The range of such efforts is vast, beginning with the point of contact with the patient and extending all the way to partnerships between plans and providers.

In this dynamic health care market, health plans are focused on tailoring these collaborations to their enrollees' health needs so that care is truly patient-centered. By supporting these efforts, policymakers will help quality improvement initiatives flourish in a variety of forms, with the benefits flowing to consumers and their employers as plans and providers work together to reduce costs and improve quality.

III. Consolidation of Companies Can be Pro-Competitive

The discussion of consolidation in the health care sector needs to begin with a clear understanding that many mergers and acquisitions are beneficial to consumers. They can be transformative, facilitate new and better products and services, and lead to efficiencies that reduce costs. The Federal Trade Commission (FTC) and the Department of Justice (DOJ), which have authority to enforce federal antitrust laws, have indicated that “a primary benefit of mergers to the economy is their potential to generate significant efficiencies and thus enhance the merged firm’s ability and incentive to compete, which may result in lower prices, improved quality, enhanced service, or new products.”¹⁴ Consolidation should be looked at on a case by case basis and is then problematic only when a transaction leads to anticompetitive effects, generally an increase in costs. The FTC and the DOJ, along with the 50 states Attorneys General, play an important role in reviewing proposed mergers and determining their potential impacts.

As has been reported, there is merger activity in the health insurance industry. The DOJ’s review of these proposed mergers will be, as with any such merger analysis conducted by the agencies, very fact intensive. While I cannot speak to the potential outcomes of these reviews, it is important to understand the broad framework that the antitrust agencies use to evaluate

¹³ *Health Affairs*, Early Lessons From Accountable Care Models in the Private Sector: Partnerships Between Health Plans and Providers, Aparna Higgins, et al. (commissioned by AHIP), September 2011

¹⁴ U.S. Department of Justice and the Federal Trade Commission, Horizontal Merger Guidelines, August 19, 2010

whether a particular transaction is pro-competitive or anticompetitive, and the evolving nature of the market for health coverage.

As the agencies review a proposed merger, they carefully evaluate a large body of data and other evidence to determine whether a merger would harm consumers by adversely impacting competition in specific products or specific geographic markets. It is important to note that there is no single national market for health coverage. Health insurance purchasers buy coverage in local markets, and for particular types of products, that differ widely from one another. Even the large national employers who buy coverage for employees across the country often offer their employees a range of choices from local, regional, and national plans (much as the federal government does for its employees).

The total size of the merging entities alone is not a determining factor. Rather, the agencies look at potential anticompetitive effects in particular markets regardless of size. This is true for mergers involving hospitals, insurers, and indeed any entity in any industry.

The agencies also consider the nature of the market itself and whether it is undergoing changes that are relevant to their analysis of the transaction. For example, the highly regulated nature of health insurance markets is relevant to an analysis of the potential competitive effects of transactions. Medicare Advantage plans are subject to extensive federal regulation and Medicaid plans are subject to extensive federal and state regulation. Commercial health insurance plans are highly regulated at both the national level (e.g., medical loss ratio requirements) and the local level (e.g., rate filing and rate review), with the U.S. Department of Health and Human Services and other government agencies exercising oversight over such entities. Such regulation is relevant to the analysis of health insurance mergers and distinguishes health insurance markets from many other, less regulated markets.

Another relevant factor to such review is the nature of the markets themselves. Health insurance markets are in a highly dynamic period and this change is relevant to the analysis of the transactions as well. Competition within local markets is evolving with a variety of entities entering health insurance markets and expanding from one product area into another (e.g., Medicaid plans expanding into commercial markets through Exchange offerings).

Additionally, any analysis of mergers must consider the potential pro-competitive effects that can be generated. In the context of health care, this might include a circumstance when an insurance entity with strength in one particular area is able to offer a better product because it is

joined with an entity that offers complementary strengths. For example, a merger might join an entity with a strong track record of managing chronic conditions in the Medicare Advantage program with another entity that has strengths in meeting the health care needs of beneficiaries who are financially vulnerable through its Medicaid products. The combined entity may be able to leverage these complementary strengths to benefit all of its members. Further, the entity may be able to offer such combined competencies in innovative products on the growing Exchange markets.

In some instances, a merger may help facilitate investments in, and the implementation of, payment and delivery system reforms and streamlined quality measures, all of which support the broader use of value-based initiatives that ultimately benefit consumers.

Other important considerations include the expectation that, following a merger, economies of scale will allow fixed costs to be spread across a larger customer base and that unit costs per customer for medical care and pharmaceuticals will be lower for the merged entity, compared to what they would have been for the original two entities.

IV. The Harmful Impact of Anticompetitive Consolidation Among Hospitals and Other Health Care Providers

Leading up to the passage and implementation of the ACA, our members repeatedly emphasized that affordability of care must be a central objective of health reform. Halting harmful and anti-competitive consolidation that results in higher health care costs in provider markets is an important part of achieving this goal.

Provider-related costs are a significant portion of total medical costs, and the growth in such costs has had a critical, and detrimental, effect on consumers. Consumers benefit when health care providers compete to offer them lower costs, higher quality services, and innovative approaches to delivering care. There are situations in which provider consolidation does not impede these benefits or may even enhance them. In other situations, however, consolidation diminishes competition among providers and leaves consumers with higher costs, diminished quality, and a reduced prospect of innovation or improvement.

The federal antitrust agencies have selectively and carefully challenged mergers of hospitals and provider systems that hold a significant prospect of causing such harm to consumers. While such

challenges represent a relatively small percentage of the total number of hospital mergers, they are of great importance to consumers. Not only do such challenges, and the investigations that preceded them, prevent harm in specific markets, they also deter other anticompetitive transactions by signaling to market participants that anticompetitive transactions will be challenged.

A recent analysis¹⁵ by Kaufman, Hall & Associates found that hospital mergers and acquisitions increased 44 percent between 2010 and 2014, with a total of 442 transactions occurring during this time frame. Moreover, an analysis of provider consolidation by Bates White Economic Consulting¹⁶ found that hospital ownership in 2009 was “highly concentrated” in more than 80 percent of the 335 areas studied. The current wave of provider mergers and the general lack of competitive entry suggests that concentration levels have increased each year since that 2009 study.

A new AHIP data brief¹⁷ highlights research showing a statistically significant positive correlation between increases in health insurance premiums and the degree of hospital concentration in Exchange markets in three states. The findings of this research, based on an analysis of monthly premium data from October 2014, demonstrate that:

- In Georgia, insurance premiums were 35 percent to 52 percent higher in highly consolidated hospital markets compared to premiums for plans offered to residents in markets having less provider consolidation.
- In Missouri, people living in highly consolidated hospital markets paid 31 percent to 46 percent more than those living in areas of the state with greater levels of hospital competition.
- In Ohio, premiums were 9 percent to 13 percent higher in the least competitive hospital markets compared to premiums in more competitive markets.

Our data brief also highlights research from other studies showing, for example, that: (1) physician prices increased, on average, by 14 percent for medical groups acquired by hospital

¹⁵ Kaufman, Hall & Associates, LLC, Number of Hospital Transactions Remains High in 2014, February 9, 2015

¹⁶ Bates White Economic Consulting, Cory Capps, PhD, David Dranove, PhD, Market concentration of hospitals (commissioned by AHIP), June 2011

¹⁷ AHIP Data Brief, Impact of Hospital Consolidation on Health Insurance Premiums, June 2015

systems; (2) hospital mergers in already concentrated markets could result in hospital price increases of as much as 20 percent, without any corresponding improvement in the quality of care; and (3) local hospital ownership and multi-hospital health system ownership of provider groups resulted in per patient expenditures that were 10 percent to 20 percent higher than for patients seen at independently owned groups.

The findings of our data brief are reinforced by numerous other research studies which demonstrate that anticompetitive consolidation in provider markets is resulting in higher health care costs for consumers and employers:

- A January 2015 study,¹⁸ commissioned by AHIP and published by the *Antitrust Health Care Chronicle*, examined the impact of hospital concentration on premiums in California and provides clear evidence that consumers living in regions with many hospital competitors have substantially lower premiums compared to those in regions with highly consolidated hospital markets. This analysis found that more competitive hospital markets had implied premium reductions of more than 8 percent, translating into savings of more than \$20 a month for consumers in markets with less hospital concentration.
- A June 2012 study published by the Robert Wood Johnson Foundation (RWJF)¹⁹ found that “increases in hospital market concentration lead to increases in the price of hospital care,” and that “when hospitals merge in already concentrated markets, the price increase can be dramatic, often exceeding 20 percent.” This study further cautions that “physician-hospital consolidation has not led to either improved quality or reduced costs” and, additionally, points out that consolidation “is often motivated by a desire to enhance bargaining power by reducing competition.” An earlier RWJF research project,²⁰ focusing on hospital consolidation in the 1990s, stated: “Studies that examine consolidation among hospitals that are geographically close to one another consistently find that consolidation leads to price increases of 40 percent or more.”

¹⁸ Bates White Economic Consulting, *ACA Exchange Premiums and Hospital Concentration in California*, January 2015

¹⁹ Martin Gaynor, PhD and Robert Town, PhD, Robert Wood Johnson Foundation, *The impact of hospital consolidation—Update*, June 2012

²⁰ William B. Vogt, PhD and Robert Town, PhD, Robert Wood Johnson Foundation, *How has hospital consolidation affected the price and quality of health care?*, February 2006

- An article published in June 2011 by the *American Journal of Managed Care*²¹ found that “hospitals in concentrated markets were able to charge higher prices to commercial insurers than otherwise-similar hospitals in competitive markets.”
- An issue brief published in July 2011 by the National Institute for Health Care Management Foundation²² found that one of the factors contributing to higher prices is “ongoing provider consolidation and enhanced negotiating strength vis-à-vis insurers, resulting in an ability to extract higher payment rates from insurers.”
- A 2013 report by the Massachusetts Center for Health Information and Analysis²³ included a discussion about the impact of provider consolidation, noting that the highest priced 25 percent of providers in Massachusetts received over 50 percent of commercial payments made to acute hospitals and physician groups in 2012. A *Boston Globe* article²⁴ pointed out that the report’s findings show that as hospitals and provider groups consolidate, “larger groups often have the leverage to demand higher prices from insurers.”
- A September 2013 research brief by the Center for Studying Health System Change²⁵ reported that “it is clear that provider market power is key in price negotiations and that certain hospitals and physician groups, known as ‘must-haves,’ can extract prices much higher than nearby competitors.” This study also concludes that “increases in provider prices explain most if not all of the increase in premiums” in recent years.

V. The Harmful Impact of Monopoly Pricing in the Pharmaceutical Industry

The pharmaceutical industry is another area where lack of competition has resulted in monopoly pricing – leading to exorbitant costs for consumers. This problem is particularly evident with high-priced specialty drugs. While innovations and breakthroughs in the pharmaceutical field are leading to promising new treatments for serious and life-threatening diseases, the costs associated with these drugs are a source of major concern.

²¹ *American Journal of Managed Care*, Hospital Market Concentration, Pricing, and Profitability in Orthopedic Surgery and Interventional Cardiology, James C. Robinson, PhD, June 24, 2011

²² National Institute for Health Care Management Foundation, Understanding U.S. Health Care Spending, July 2011

²³ Massachusetts Center for Health Information and Analysis, 2013 Annual Report on the Massachusetts Health Care Market, August 2013

²⁴ *The Boston Globe*, Partners hospitals, doctors top health-payment list, August 14, 2013

²⁵ Center for Studying Health System Change, High and Varying Prices for Privately Insured Patients Underscore Hospital Market Power, September 2013

One notable case study involves Sovaldi and Harvoni, two specialty drugs sold by the same manufacturer that have been approved by the Food and Drug Administration (FDA) for treating patients with the Hepatitis C virus. Both of these drugs have price tags of \$1,000 or more per pill. Together, they generated a combined total of \$4.55 billion in worldwide sales in the first quarter of 2015.²⁶

The high cost of these drugs is placing a heavy burden on public programs. In 2014, Medicare spent a combined total of \$4.5 billion on Sovaldi, Harvoni, and Olysio (which is often taken in conjunction with Sovaldi) to treat patients who have Hepatitis C.²⁷ This represents a 15-fold increase relative to the amount Medicare spent on the previous generation of Hepatitis C drugs in 2013. This dramatic increase in costs has significant implications for the long-term financial stability of Medicare. The 2015 annual report²⁸ of the Medicare Board of Trustees cautioned that “a continuing increase in the use and price of specialty drugs” is a key factor behind the trustees’ projection that the growth rate in per capita drug costs will exceed the growth rate of other categories of medical spending in the future. Other public programs – including Medicaid, the Department of Veterans Affairs (VA) health care system, and the Federal Employees Health Benefits Program – also are impacted by these high costs. Additional specialty drugs in the pipeline, including recently approved PCSK9 inhibitors for managing high cholesterol (at an annual cost²⁹ of \$7,000 to \$12,000), are poised to have a similar impact on future costs in public programs and in the private marketplace.

Sovaldi originally was researched and developed by Pharmasset, which was planning to market the drug at a cost of \$36,000 per treatment course.³⁰ However, after Pharmasset was purchased by Gilead Sciences, Sovaldi was launched with a price of \$84,000 per treatment course – more than double the price envisioned by the developer of the drug. This clear example of monopoly pricing raises serious questions about whether the manufacturer is abusing consumers. In addition, consolidation among drug manufacturers, as well as practices such as pay-for-delay and product hopping, has led to price increases, delays in the availability of generic drugs, and drug shortages.

²⁶ *New York Times*, Gilead Hepatitis Drugs Brought In \$4.55 Billion in First Quarter, April 30, 2015

²⁷ *ProPublica*, The Cost of a Cure: Medicare Spent \$4.5 Billion on New Hepatitis C Drugs Last Year, March 29, 2015

²⁸ 2015 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, July 22, 2015

²⁹ *Health Affairs*, In The Debate About Cost And Efficacy, PCSK9 Inhibitors May Be The Biggest Challenge Yet, William Shran, Alan Lotvin, Surya Singh, and Troyen Brennan, February 17, 2015

³⁰ *The Fiscal Times*, The \$1,000 Pill That Could Cripple the VA’s Budget, Erik Pianin, October 8, 2014

A recently updated AHIP issue brief³¹ focuses on the challenges posed by high-priced specialty drugs. Our brief explains that brand-name biologics have a 12-year exclusivity period following FDA approval, and that this government-approved monopoly “removes the economic benefits of price competition, resulting in higher prices relative to what they would be in a perfectly competitive market.” Our brief also cites data showing that specialty drugs accounted for only 1 percent of prescriptions in 2014, but 32 percent of all prescription drug spending, and that specialty drug spending is projected to increase by 16 percent annually for the 2015-2018 period, with total spending projected to reach \$235 billion by 2018.

VI. Conclusion

Thank you for holding this hearing and for considering our perspectives on these important issues. We appreciate this opportunity to testify about competition in the health care marketplace. We look forward to continuing to work with the subcommittee and other stakeholders to further our shared goal of expanding patient access to high quality, affordable health care.

³¹ AHIP Issue Brief, Specialty Drugs—Issues and Challenges, July 2015