"Keeping You Active"

California Orthopaedic Association

5380 Elvas Avenue, Suite 221
Sacramento, CA 95819
Phone: 916-454-9884 Fax: 916-454-9882
E-mail: coa1@pacbell.net
Home Page: www.coa.org

Statement

Of the

California Orthopaedic Association

to the

Judiciary Committee Subcommittee on Courts and Competition Policy
United States House of Representatives

RE: H.R. 3596

Health Insurance Industry Antitrust Enforcement Act of 2009

Presented by: Peter J. Mandell, M.D.

October 8, 2009

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The California Orthopaedic Association (COA) represents over 75% of orthopaedic surgeons practicing in the state. Orthopaedic surgeons are integral to the health care delivery system treating patients with all types of musculoskeletal problems – hips, knees, shoulders, back, hands and wrists, and feet and ankles. As our population ages and as more individuals live longer active lifestyles, orthopaedic surgeons will become even more important in the management of musculoskeletal injuries and diseases through techniques such as joint replacement and ligament repair.

COA appreciates the opportunity to submit testimony before Chairman Johnson and other members of the Subcommittee on H.R. 3596, a bill which would remove anti-trust protections of health insurance issuers and medical liability carriers under the McCarran-Ferguson Act.

We appreciate and support the Subcommittee's interest in this issue; however, we respectfully would like to raise some concerns with H.R. 3596 as it is currently drafted.

We have consulted anti-trust experts and have failed to find any cases where the commercial health insurers have been charged with price-fixing or collusion in sharing price information. In fact, we believe the commercial health insurers moved past that business model many years ago and have little need to collude on pricing as they have consolidated and been able to control a larger part of the health insurance market.

In fact, during the last 10 years, there have been over 400 health insurer mergers. As a result, the payor market has become more concentrated, less diverse, and payors have enjoyed substantial negotiating leverage over patients and providers in most markets. For the last six years, the American Medical Association (AMA) has tracked and published a report entitled, "*Competition in Health Insurance: A Comprehensive Study of U.S. Markets.*" These reports have shown that the country's largest health insurers have continued to pursue aggressive acquisition strategies. The largest insurer, WellPoint, Inc. (formed from the merger of Anthem Inc. and WellPoint Health networks) has acquired 11 health insurers since 2000. The second-largest health insurer, UnitedHealth Group (United) has also acquired 11 health insurers since 2000.

To put this into perspective, in 2000, the two largest health insurers, Aetna and United, had a total membership of 32 million lives. As a result of mergers and acquisitions since 2000, the top two insurers in 2007, WellPoint and United, each have memberships, respectively, of 34 million and 33 million, totaling more than 67 million covered lives.

Together, WellPoint and United control 36 percent of the national market for commercial health insurers. *(AMA 2007, Competition in Health Insurance) (AMA Letter to the U.S. Assistant Attorney General for Antitrust, July, 2009)* In 2004 and 2005, 28 mergers valued at a total of $53.8 billion were completed or announced, which exceeded the value of all the deals completed in the previous eight years. (*Corporate Research Group, The Managed Care M&A Explosion, 2005).*

Instead of price fixing, we believe the larger problem is the virtual monopolies that the commercial health insurers have been able to form. In many areas of the country, there may be only one or two carriers in a particular region. There is no effective competition. Physicians are told to take-or-leave contracts and accept below market reimbursement rates. Patients' coverages are rescinded when they become ill and in most need of their insurance. These inappropriate activities and rescissions have been well documented in the media:

> "**Poizner: Blue Shield Canceled Policies – State Insurance Chief plans to pursue a $12.6 million fine for dropping patients**…Poizner accused a Blue Shield of California unit of committing more than 1,200 violations that resulted in some 200 people losing their medical insurance…Blue Shield was cancelling insurance after the fact…Blue Shield is the latest giant health plan caught in a state crackdown over policy cancellation practices. In recent years, consumer groups and regulators have contended that insurers wrongly revoked hundreds of policies after patients filed claims for costly medical care. Blue Cross of California, Health Net, Cigna, and Aetna have come under scrutiny." Sacramento Bee 12/2007
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> "**Calif. Blue Cross Stops Asking Doctors About Patients' Omissions** …. Blue Cross of California said it would stop sending letters to doctors asking them to help find patients who had failed to report pre-existing medical conditions to the insurance company…Schwarzenegger said the practice is akin to telling doctors to "rat out the patients …..so they have a reason to cancel the policy"." Wall Street Journal, 2/2008
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> **"Health Insurance Rescission Three Times More Likely Than Losing Russian Roulette**…every patient can be assured that, upon filing a major claim for chemotherapy or neurosurgery or the like, the insurance company will scour their medical records and application to find any excuse to deny coverage. The outrageous part is that **half** of these investigations of expensive claims result in rescission. Litigation and Trial, 8/2009
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> In 2004 in California, Blue Cross and the State Compensation Insurance Fund (SCIF) joined together to control, at the time, over 50% of the Workers' Compensation market in the state and a large part of group health coverage. **SCIF demanded that physicians contract with Blue Cross in order to be part of their Workers' Compensation medical provider network and Blue Cross required that physicians accept all of their products or they were completely dropped from the Blue Cross network as well as the network of all their affiliates.** Blue Cross has over 300 affiliates. This joining of markets has allowed Blue Cross in California to demand below cost reimbursements that have little basis in the actual costs of rendering the care, but rather are designed to utilize their market control to artificially drive down reimbursement rates.

Even when Members of Congress demand that the carriers cease and desist their inappropriate rescission activities, commercial health insurers such as UnitedHealth, Assurant Health, and Wellpoint Blue Cross, say they will not.

> **"Insurers Not Committing to End Rescission**" A Congressional investigation into UnitedHealth, Assurant Health and Wellpoint Blue Cross found that they cancelled the coverage of more than 20,000 people in a five-year period, allowing the companies to avoid paying $300 million in claims. In spite of these findings, executives from these companies said that they would <u>not</u> pledge to limiting the practice of dropping coverage

to [only] cases of policy holders who lied or committed fraud to get policies. Wall Street Journal, 6/2009.

The power garnered by health insurers through rapid, large-scale consolidation has not been used to the advantage of consumers or providers. Patient premiums have soared in this increasingly consolidated market and physician reimbursement has decreased. As premiums have risen, many employers have stopped providing coverage, substantially limited or reduced the scope of benefits provided, and/or asked employees to pay a higher share of the overall premium.

Nor have physicians benefited from these premium increases. To the contrary, powerful insurers have depressed physician revenues. This reduction in physician income has not benefited patients, and indeed may have harmed them.

Health plan executives and shareholders, on the other hand, have reaped enormous monopoly profits. The bottom lines of the major national health firms experienced double-digit growth between 2001 and 2008. United and WellPoint, specifically, had 7 years of consecutive double-digit growth that ranged from 20% to 70% year after year through 2003. *(Health Affairs, Consolidation and the Transformation of Competition in Health Insurance)*

The Federal Trade Commission and the Department of Justice have shown little interest in restricting additional mergers and no interest in addressing complaints of monopolization by dominant health insurers.

To have a meaningful impact on the anti-competitive activities of commercial health insurers, we would urge members of the Subcommittee to relax the anti-trust restrictions on health care providers instead of removing the anti-trust protection on carriers. This would allow providers to collectively share electronic medical records to improve patient care, to monitor data relating to utilization and medical outcomes, to form accountable care organizations that add value to health care delivery, and to come together to work with commercial health insurers in their communities to ensure that patients receive appropriate medical care.

We would also urge the Subcommittee to consider some real enforcement of the merger laws and a break-up of the commercial health insurers who have these virtual monopolies.

We believe these activities, relaxing the anti-trust restrictions on providers and a break-up of the commercial health insurers' monopolies, would have a more meaningful impact on reining in the problems felt by patients and physicians in the commercial health care market.

In addition, a repeal of the anti-trust protections afforded to commercial insurance carriers under the McCarran-Ferguson Act, could have a negative impact on health care cooperatives that may be formed under the health care reforms being considered by Congress. New companies would likely benefit from anti-trust protections under the Act. Repealing the carriers' protections will make it more difficult for these small companies to gain market share. Passage of H.R. 3596 in its current form, could potentially protect even more the monopolies enjoyed by the existing commercial health insurers allowing them to continue their anti-competitive activities, which could be an unintended consequence of this legislation.

Finally, we oppose the inclusion of the medical liability carriers in this bill. In California, many of the medical liability carriers were created in the mid-1970s to bring stability, availability, and affordability to the medical malpractice market. In our opinion, they have achieved those goals without engaging in anti-competitive activities and price fixing. We see no evidence that medical liability carriers share data or drop physicians from coverage should malpractice claims be filed against them. We would urge that the medical liability carriers be excluded from the bill

Thank you for the opportunity to present these views to the Subcommittee.

We appreciate your consideration of our comments and we look forward to working with you and your staff in this important effort. If you have any questions or would like any additional information, please do not hesitate to contact Diane Przepiorski, Executive Director, California Orthopaedic Association, (916) 454-9884 or e-mail her at: coa1@pacbell.net.

References

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