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S. HRG. 108–699

THE HEALTHCARE CRISIS IN SOUTHEASTERN PENNSYLVANIA: THE ROLE OF THE HEALTH INSURANCE INDUSTRY

HEARING

BEFORE THE

SUBCOMMITTEE ON ANTITRUST, COMPETITION POLICY AND CONSUMER RIGHTS

OF THE

COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE

ONE HUNDRED EIGHTH CONGRESS

SECOND SESSION

PHILADELPHIA, PENNSYLVANIA

APRIL 12, 2004

Serial No. J–108–67

Printed for the use of the Committee on the Judiciary

U.S. GOVERNMENT PRINTING OFFICE

96–925 PDF WASHINGTON : 2004

For sale by the Superintendent of Documents, U.S. Government Printing Office
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THE HEALTHCARE CRISIS IN SOUTHEASTERN PENNSYLVANIA: THE ROLE OF THE HEALTH INSURANCE INDUSTRY

MONDAY, APRIL 12, 2004

UNITED STATES SENATE,
SUBCOMMITTEE ON ANTITRUST,
COMPETITION POLICY, AND CONSUMER RIGHTS,
COMMITTEE ON THE JUDICIARY,
Washington, D.C.

The Subcommittee met, pursuant to notice, at 9:04 a.m., in the Maris Courtroom, 601 Market Street, Philadelphia, Pennsylvania, Senator Arlen Specter, presiding.

Present: Senator Specter.

OPENING STATEMENT OF HON. ARLEN SPECTER, A U.S. SENATOR FROM THE STATE OF PENNSYLVANIA

Senator SPECTER. Good morning, ladies and gentlemen. The field hearing of the Antitrust Subcommittee of the Senate Committee on the Judiciary will now proceed.

This morning we will make an inquiry into the health care situation in Southeastern Pennsylvania with particular focus on the role of the health insurance industry.

There have been recurrent comments, really complaints, about what many consider to be an overconcentration of Blue Cross and Blue Shield. This issue has come to our attention recurrently discussions with doctors, discussions with hospital officials, and most recently when Governor Rendell and I convened a meeting of a number of hospitals in the Philadelphia area on the efforts to keep the Medical College of Pennsylvania open. There the point was made about the very low reimbursements from Blue Cross and Blue Shield. And the comment was made that the reimbursement by Blue Cross Blue Shield was lower even then what is provided by Medicare.

There has been very substantial concern expressed by small businessmen and small businesswomen about the high cost of health care. And the issue has arisen as to whether there ought to be an exemption under the antitrust laws to allow some to bargain collectively to try to reduce the rates on the approach that a larger number in the insured group would provide lower rates.

House Bill 1247 provides for such legislation and I concluded that I would not introduce legislation at least until we had this hearing and had some further insights into the issue.

We have also noted a number of lawsuits filed against Blue Cross Blue Shield which have been settled with allegations of practices which are highly questionable if not unlawful and noted that a number of these lawsuits were settled with confidentiality agreements which precluded individuals from testifying before this Subcommittee because they are barred from doing so under those confidentiality agreements.

I have long been concerned with such confidentiality agreements on the issue as to whether they are contrary to public policy, if there are allegations of impropriety and they are settled whether there is a right by the community to know.

To deal with this issue the Judiciary Committee issued subpoenas. One of the parties subject to subpoena asked to be relieved of the obligation to testify at this hearing today because the settlement with Blue Cross Blue Shield was almost completed. And we decided to honor that request. Apparently there has not been a final preparation and execution of all the papers. We may revisit that depending upon what happens.

With a very brief introduction and the addendum of my thanks to Senator DeWine of Ohio, who is the Chairman of the Subcommittee, I am senior to Senator DeWine on the full Committee but I chair the Subcommittee on Labor, Health, Human Services and Education and he chairs this Subcommittee, we will now proceed.

Under the standard rules of the Committee and Subcommittee, we have allocated five minutes for opening statements to allow the maximum amount of time for dialogue for question and answer. You might think five minutes is insufficient. We recently had a memorial service for Ambassador Annenberg. And the speakers included the Secretary of State, Colin Powell and former President Gerald Ford and a number of other officials, governor, myself and others. And were allocated three minutes to speak. So I want you to know how generous the five minute allocation is.

Our first witness is Dr. David Badolato, a member of the Family Practice Associates of Upper Dublin and a senior physician in the Department of Family Practice at Abington Memorial Hospital. He is a member of the Pennsylvania Medical Society and the Pennsylvania Academy of Family Practice, certified by the American Board of Family Practice, completed his residency at Abington Memorial Hospital, a graduate of La Salle College and Hahnemann University School of Medicine.

Thank you very much for joining us, Dr. Badolato, and we look forward to your testimony.

STATEMENT OF DAVID BADOLATO, M.D., FAMILY PRACTICE ASSOCIATES OF UPPER DUBLIN, FORT WASHINGTON, PENNSYLVANIA

Dr. BADOLATO. Thank you, Senator. Good morning to all. I will do less than the three pages of testimony to honor the five minutes.

I come to you this morning as the senior physician of Family Practice of Upper Dublin, as you mentioned. We are eight physicians and 26 staff, care for 15,000 patients who mostly reside in eastern Montgomery County.

I am in my 26th year of practice and I love what I do. In our practice we have a passion for excellence, and are committed to quality and safety in the medical care of our patients. Our practice has been recognized for leadership in quality by the two major insurance companies of Southeastern Pennsylvania. And in almost every measurement for both companies we rank in the top 1 percent.

Unfortunately, the financial condition of our practice continues to deteriorate and our ability to continue to practice is imminently threatened. We are in serious financial debt as a result of extreme reductions imposed by the two dominant health insurance companies of Pennsylvania. They are IBC and Aetna. We have 10 years of data pertaining to our quality and our decreasing reimbursements.

Senator SPECTER. You say IBC, Independence Blue Cross?

Dr. BADOLATO. Yes.

We have 10 years of data pertaining to our quality and the decreasing reimbursements. We welcome an in-depth analysis by appropriate professionals of the microeconomics within our practice. We believe that such a study will reveal the truth and define the equitable reimbursements required to support and sustain 99th percent performing practices who have achieved quality and safety outcomes for our patients.

It appears that the two dominant health insurance companies of Southeastern Pennsylvania have been able to proceed with reimbursement reductions unchecked by any outside entity during the past 10 years. It appears in contracting that the market dominance leads to a take it or leave it contracting. Sadly, too often, one can say take it or leave the state.

In addition, the less 10 years have seen a dramatic increase in the insurance company requirement for administrative resources required at the practice level. The resource consumption and barriers, such as preauthorization and precertification mechanisms, have placed roadblocks even in the delivery of gold standard diagnostic test and treatments.

There is a problem. Our medical school graduates have serious debt load, $200,000-plus, and appear to no longer be able to afford to enter the specialty of family practice.

But let us look at the outcomes. 25 percent vacancy upon entry into the residency programs nationally. 58 percent of those entering family practice residencies in the United States are graduates of foreign medical schools.

I, the physicians, the staff, and the patients invite you to the practice for a collaborative analysis of quality and what the reimbursements are that are required to sustain such quality. We welcome Government, corporate America, medical academic institutions, business leadership, et cetera, to such a platform.

I urge you to stop the increasing damage to the medical infrastructure. If we continue on this path, it may take an entire generation to rebuild the quality components which have been destroyed due to our neglecting to act responsibly as guardians and stewards of the essential social good of quality health care.

I reinforce three final points. A top 1 percent performing practice is unable to continue to practice with the current conditions.

Secondly, the national outcomes of vacancies in our residencies and the overwhelming majority of foreign medical graduates filling those positions is of concern.

And lastly, please, I ask for responsible guardians to use our practice to discover the truth without the negative influence of market dominance.

I thank you for the opportunity to speak today.

[The prepared statement of Dr. Badolato appears as a submission for the record.]

Senator SPECTER. Thank you very much Dr. Badolato.

We turn now to Dr. L. Robert Burns, James Joo-Jin Kim Professor and Professor of Health Care Systems at the University of Pennsylvania's Wharton School of Business, Director of Research at the Leonard Davis Institute of Health Economics and Visiting Professor to the Department of Preventive Medicine, University of Wisconsin.

Thank you for joining us, Dr. Burns, and we welcome your testimony.

STATEMENT OF L. ROBERT BURNS, PH.D., MBA, JAMES JOO-JIN KIM PROFESSOR AND PROFESSOR OF HEALTH CARE SYSTEMS, UNIVERSITY OF PENNSYLVANIA, WHARTON SCHOOL OF BUSINESS, PHILADELPHIA, PENNSYLVANIA

Mr. BURNS. Thank you Senator. I appreciate the opportunity to present testimony about the market structure for health insurance in Southeastern Pennsylvania and some of its observed effects.

My remarks are drawn from research I am now conducting on the history of the Southeast Pennsylvania insurer and hospital markets during the 1980s and 1990s.

Senator SPECTER. Dr. Burns, as Senator Thurmond always used to say, pull the machine closer.

Mr. BURNS. Is that better?

Senator SPECTER. I do not know, I have not heard either from you or Senator Thurmond.

[Laughter.]

Mr. BURNS. My remarks are drawn from research I am now conducting on the history of the insurer and hospital markets in Southeastern Pennsylvania during the 1980s and 1990s. They are based on several years of research data analysis and interviews with major stakeholders in the market.

However, I should point out I have not had as much access to the executives of Independence Blue Cross as I would have liked and thus, my remarks may not fully reflect their side of the story.

For purposes of my remarks, the Southeast Pennsylvania market includes Philadelphia County and the four suburban counties: Bucks, Montgomery, Delaware and Chester.

Also for purposes of definition, I define market structure in terms of the number of competitors in the market and their relative share of the market. These two components are often summarized as the Herfindahl-Hirschman Index, HHI, which measures how much market share is concentrated in one or a few firms. The higher the HHI, the more concentrated the market and the more powerful are one or a small number of firms.

The five county area in Southeastern Pennsylvania exhibits a big contrast in insurer and hospital market structures. During the 1990s, the hospital market featured lots of competition between lots of hospitals. The HHI for hospital services in Southeastern Pennsylvania ranged from 185 to 654, depending on the year of measurement and how one assessed market share in terms of beds or patient days.

But regardless of the measure one used, this was a very competitive hospital market with very low concentration. Philadelphia consistently ranked among the top five most competitive hospital markets, i.e., low Herfindahl Index, in the United States with 1 million or more population. And all of the hospital system formations during the 1990s barely raised the HHI in Southeast Pennsylvania.

On the other hand, the health insurance market in Southeast Pennsylvania is quite concentrated. According to data from InterStudy, the HHI for health maintenance organizations or HMOs operating in the Philadelphia market was 4,134 in 1999 and 4209 in the year 2000. Data from the Pennsylvania Department of Insurance indicates similar figures, rising steadily since 1994 through 2000.

Depending on which data source you use, this places Southeast Pennsylvania in the top five percent most concentrated insurer markets in the United States with 1 million or more population.

To be sure, HMOs are only one part of the insurer market. One also needs to consider preferred provider organization, PPO, and point of service plans, POS. A recent report that analyzes the market structure of large U.S. metropolitan areas with 1 million or more population found that Philadelphia had the fifth most concentrated market for PPO enrollment and the highest, the number one most concentrated market for combined HMO and PPO enrollment.

For both HMO and PPO products, Independence Blue Cross, IBC, is the market leader in Southeast Pennsylvania. In 1997, for example, IBC had captured 41 percent share of the HMO market through its Keystone Health Plan East subsidiary, and 68 percent share of the PPO market.

In sum, Southeast Pennsylvania features two contrasts with other large cities, a very competitive hospital market with low HHI and a very concentrated insurer market with high HHI. This type of situation may lead to high levels of insurer market power over hospitals and consumers of health insurance. I consider some of the evidence for this below.

This research on the Philadelphia market did not concentrate on Independence Blue Cross or its potential market power. However, in conducting my research I came across several studies conducted during the 1990s by the Delaware Valley Hospital Council that suggest that Independence Blue Cross utilized its market power in ways detrimental to the cash flow of hospitals in the area.

For example, among commercial insurers during the mid-1990s, IBC exhibited the highest denial rate for hospital inpatient services both in terms of the percentage of patients denied and the percentage of inpatient days denied. Similarly, IBC and its HMO subsidiary Keystone exhibited the highest median payment denial rate for emergency room services. Finally, IBC exhibited the lowest ac-

cess to acute rehab services for its Medicare managed care enrollees.

Other data collected by the Pennsylvania Medical Society and the American Hospital Association provide additional evidence for the exercise of market power by IBC. During the mid to late-1990s, IBC featured the largest number of unpaid claims for Philadelphia providers in terms of dollar volume among all insurers.

Hospital payment-to-cost ratios for privately insured patients also began to fall by the mid-1990s through the end of the decade. These decreases were more pronounced in Southeast Pennsylvania than in other metropolitan areas. And as mentioned before, IBC dominated this market.

Nationally, there is also evidence that HMOs that have attained market power have exercised it over both consumers and providers. For example, HMOs that enjoy high HHI sell their managed care products at higher premium levels to employers and other buyers. Similarly, they have found that HMOs that account for a larger share of all inpatient days in the market can force down hospital prices per days paid.

The research has not investigated whether HMOs attempt to exercise market power simultaneously both upstream with employers and buyers and downstream with hospital suppliers.

The typical U.S. metropolitan area has a concentrated HMO market. Across all metropolitan areas with 1 million or more population, the median HHI for HMO insurance is 2,291. Although this value is higher than the cutoff point used by the Department of Justice to define a highly concentrated market, it does not include competition from other types of insurance. It is thus unclear whether the effects described are widely found in other parts of the country. However, Philadelphia appears to be an outlier compared to the rest of the country.

In conclusion, the data suggests that Philadelphia is a unique market when one considers both the insurer market and the hospital market. There seems to be a huge imbalance of bargaining power between insurers and hospitals due to the high concentration in the former and the low concentration in the latter.

Evidence also seems to suggest that IBC has exploited this differential market power. Moreover, at least nationally there has been a tendency to allow insurers to amass more market power than providers in order to allow them to extract lower prices for inpatient and outpatient care with the hope of lowering rate of increase in health care spending.

I am not aware of the increase in health care spending in Southeast Pennsylvania and thus cannot comment on what overall effects may have been asserted or achieved by IBC's dominance in the market. The available evidence suggest the welfare of hospitals may have been hurt, as reflected in past statistics on denial rates, slow payment of claims and low payment-to-cost ratios. Thank you for this opportunity.

[The prepared statement of Mr. Burns appears as a submission for the record.]

Senator SPECTER. Thank you, Dr. Burns.

Before proceeding, I think it would be useful for those hearing your testimony to define a couple of your terms. Would you define what an HMO is, contrasted with a PPO?

Mr. BURNS. Yes. HMO is a health maintenance organization where there are two sets of things to consider. One is the insurers will contract with an employer for a predefined premium called a capitated premium, which covers a defined set of benefits or services for the enrollees, the employees in that company.

And then the HMO insuring will turn around and then contract with hospitals and doctors in any number of ways. In this market, it has typically been on a discounted fee-for-service basis, although during the 1990s they experimented with capitation.

The other interesting characteristic about the HMO is that you are required to use the panel of providers that contract with the HMO. So it is sort of a closed network of providers.

The PPO, the preferred provider organization, allows the enrollees to seek a broader panel of hospitals and doctors. They pay a differential, though, in using those hospitals and doctors. But it is a less restrictive network, a little bit more of an open network.

Senator SPECTER. You used the term upstream and downstream. I think it would be useful to define those terms. There are people following these hearings, lay people who will not know all of the technicalities and so that they can follow it and have an understanding as to what is involved here, would you define upstream and downstream?

Mr. BURNS. Sure. The insurance companies, Independence Blue Cross being one of them, are intermediaries between the buyers or the employers on one side and the providers, the hospitals and the physicians, on the other side. The HMOs, when they amass market power with this high HHI have the potential of exerting market power upstream towards the buyers of health care as well as downstream towards the suppliers or the providers of health care.

And so on either side of their bargaining relationship, going to the people who pay or to the people who provide health care, they have the potential to exercise bargaining power over them.

Senator SPECTER. Thank you, Dr. Burns.

Our next witness is Dr. I. Stephen Udvarhelyi, Senior Vice President and Chief Medical Officer for Independence Blue Cross and its affiliated companies, Keystone Health Plan East and AmeriHealth.

Independence Blue Cross and its affiliate provide health coverage, according to the information provided to this Subcommittee, to over 4 million individuals with approximately 3 million of these members residing in the Greater Philadelphia area.

In his role as Chief Medical Officer, Dr. Udvarhelyi has overall responsibility for medical management programs and policies and is the chief medical spokesperson for the company.

He is a board-certified internist and completed his residency in internal medicine at the University of Minnesota, fellowship in general medicine at Brigham and Women's Hospital in Boston and a graduate of Harvard University and the Johns Hopkins School of Medicine with a master's degree in health services administration from Harvard.

Mr. G. Fred DiBona, who is the Chief Executive Officer of Independence Blue Cross wanted to be here this morning, but could not be. So we welcome you here, Dr. Udvarhelyi.

STATEMENT OF I. STEVEN UDVARHELYI, M.D., SENIOR VICE PRESIDENT AND CHIEF MEDICAL OFFICER, INDEPENDENCE BLUE CROSS, PHILADELPHIA, PENNSYLVANIA

Dr. UDVARHELYI. Thank you, Senator and good morning. Thank you for the opportunity to participate in the hearing.

From my perspective, there are two critical health care issues facing our region. First is the cost crisis that is making health care increasingly unaffordable. And the other is the perpetuation of misinformation about what is causing the crisis.

The fact is, health care costs in this region are skyrocketing and are higher than almost any other region in the country. It is also a fact that when health care costs increase, so do health insurance premiums.

From our perspective, here is the bottom line. The most common commercial policy we sell at Independence Blue Cross is our Personal Choice PPO family plan. Today it costs over $15,000 per year, including drug coverage. Four years ago, in 2000, the same coverage cost $8,000 per year. That is an increase of almost 90 percent in four years.

Most employers have responded to the increase costs by sharing the cost of health care with their workers. But many employers are buying fewer benefits. Some only pay for the worker's insurance, leaving the employee to pay for the rest of the family, which could cost almost $9,000 per year out of pocket after taxes with the product I just referenced.

We should not wonder why so many workers cannot afford to cover their spouses and children, who are now becoming part of the growing ranks of the uninsured. And even more concerning, some employers are no longer providing any coverage at all.

This is a crisis, Senator. And behind the increases in health insurance premiums are skyrocketing health care costs. At Independence Blue Cross our overall medical costs per member, like our premiums, have increased almost 90 percent over a four year period. There are several reasons for this increase in medical cost.

First, Independence Blue Cross has increased fees to hospitals and physicians. Over a 19 month period, through March of 2003, we increased physician fees by more than 22 percent, worth over $300 million. We have also increased rates to hospitals which have resulted in renegotiated agreements with virtually every hospital in our network, over 55 hospitals and 25 health systems, during the last four years.

Second, payments to doctors and hospitals increased due to both an increase in the use of services and an increase in the use of more expensive services and technology. Here are the numbers about how that plays out. In just five years our payments to hospitals have more than doubled from $1.1 billion to $2.4 billion. Per hospital, payments over that same period have risen 109 percent from $19 million to $39 million per hospital. Total physician payments are up 92 percent, with the average annual payment per

physician—this is just from Independence Blue Cross—an increase from about $85,000 per year to almost $145,000 per year.

A major driver of these increases is that almost no city in America uses medical services at the rate we do in Philadelphia. Philadelphia's overall medical costs are the fifth highest in the country for large metropolitan areas, more than 40 percent higher for example than Chicago. Our rate of hospital care is the third-highest in the Nation. Philadelphia has 46 percent more hospital beds per capita than the national average and actually 24 percent more than the Pennsylvania average. We make 38 percent more visits to physicians than the national average and have higher rates of outpatient surgery than two-thirds of the country, and we are second in the Nation for both radiology visits and cardiovascular visits.

This list could go on, but the fact is that for almost every type of medical service, Philadelphia ranks as one of the highest areas in the country.

It is also worth nothing what is not driving our cost and utilization. The increases are not due to increases in our membership. Since January 1st of 2000, our membership in Southeastern Pennsylvania has grown by just 1.7 percent. That is less than .5 percent a year. In fact, over the last two years, our membership has declined. Our medical costs, however, show no sign of falling.

Let us make no mistake, the hospitals and physicians of Southeastern Pennsylvania are facing extremely difficult financial issues, as are our customers and their employees. But Independence Blue Cross cannot solve the pressures facing hospitals and physicians. For example, we represent only 26 percent of the average hospital revenue in this marketplace. And the increases I shared a moment ago hardly support our critics' notion that Independence Blue Cross's market position forces hospitals and physicians to accept inadequate levels of reimbursement.

So while we do not question the right for physicians and hospitals to request increased reimbursements, here is our dilemma. Every time we increase our payment rates to physicians, to hospitals, to pharmacies, and to any other entity that provides health care to our members, the people who buy our health insurance policies end up paying for it with higher premiums.

The truth is, the crisis will not be solved by allowing hospitals and physicians to engage in collective bargaining. This will only increase costs at a faster rate and exacerbate the cost crisis. This is not only view. For years the FTC has clearly taken a position against allowing physicians and hospitals to engage in collective bargaining. And as you will read in the letter attached to my written testimony from Dr. Anthony Coletta, physicians have been able to partner effectively with Independence Blue Cross without any exemptions from the Nation's antitrust laws.

Senator it is time for people like those gathered here today to get serious about the real issue threatening our health care system, which is that Americans are losing their access to health care because they simply cannot afford it. And getting serious means focusing on how to reduce the systems cost.

How bad is the crisis? Well, let us look at the number of uninsured Pennsylvanians has increased 36 percent from 1999 to 2002 to a number of over 1.4 million people. So bad that labor leaders

like you will hear from Pat Gillespie will tell you that the number one position in negotiations is no longer salary. It is health benefits. And at $15,000 for just one family's health insurance policy, how much higher can we go before we address the real issues.

Thank you for the opportunity to share my views.

[The prepared statement of Dr. Udvarhelyi appears as a submission for the record.]

Senator SPECTER. Thank you very much, Mr. Udvarhelyi.

Our next witness is Mr. Joseph Chip Marshall, III, Chairman and CEO of the Temple University Health System which encompasses academic and community hospital, medical school and community-based physician and home care services.

He is a member of the Board of Trustees of Temple Board of Hospital and Health System Association of Pennsylvania and the Pennsylvania College of Optometry, the Greater Philadelphia Chamber of Commerce and has served as Chairman of the Pennsylvania State Ethics Commission and has a B.A. and law degree from Temple University.

Thank you for joining this morning, Mr. Marshall and we look forward to your testimony.

STATEMENT OF JOSEPH CHIP MARSHALL, III, CHAIRMAN AND CEO, TEMPLE UNIVERSITY HEALTH SYSTEM, PHILADELPHIA, PENNSYLVANIA

Mr. MARSHALL. Thank you, Senator. And thank you for the opportunity to testify today and for holding this hearing to consider whether antitrust law should allow collective bargaining among physicians to enable them to negotiate with health insurers and to consider the role of large health insurers in the Southeast Pennsylvania health care market.

I last testified before you in March of 2003 at another Senate hearing on Medicare outlier payments and appreciate your leadership in helping health care providers receive fair and adequate reimbursement to ensure quality and accessible health care for all Pennsylvanians.

The Temple University Health System is comprised of a major academic teaching hospital, three community hospitals, one pediatric hospital, a ground transport team and a network of more than 1,500 physicians. TUHS is a cornerstone of the health care delivery system in Philadelphia and the surrounding region.

On any given day, approximately 500 people utilize the services of TUHS emergency rooms and an additional 1,700 people present for non-emergency ambulatory surgery and services. As one of the largest private employers in the city of Philadelphia, TUHS entities employ approximately 7,000 people, pay nearly $300 million annually in salaries, and an additionally $73 million annually in benefits.

As CEO of this comprehensive health system which is faced daily with numerous complex issues, I view the physician bargaining question from a unique vantage point. It would be a great relief if this were the only challenge before us. Every day we struggle with rising pharmaceutical, medical supply and technology costs, workforce issues and escalating malpractice premiums.

Compounding this, we are faced with a rising tide of patients without health insurance. Last year alone TUHS provided nearly $63 million in charity care to the communities we serve.

We must strive to mend the health care delivery system in urgent need of repair. In so doing we must work collaboratively to promote improvements in the health care delivery system to benefit hospitals, physicians, insurers, employers and above all, our patients.

I know that collective bargaining among physicians is offered as a solution to Pennsylvania's health care delivery problems. Some see this as a way to help balance competing interests of physician and insurers, encourage physicians to practice in our region and improve quality and continuity of health care. Others believe that insurers will simply pass along higher costs to employers and other consumers who continue to strive to meet rising insurance costs, ultimately causing an increase in the number of patients who present to hospitals without health insurance.

Clearly, the question of collective bargaining is difficult but is only one of many that must be answered in resolving the health care crisis in Southeast Pennsylvania.

There is no doubt that as the region's leading health care insurer, Independence Blue Cross casts a giant shadow over health care providers in this region. In fact, a little over a year ago we locked horns with IBC during arduous contract negotiations. We even had to implement determination procedures in the contract before we finally resolved the matter of our contract with IBC.

Did IBC give us all that we asked? Certainly not. Did IBC take our concerns seriously? I sincerely believe so. Did we negotiate a fair contract? Ultimately, yes.

Together we issued a joint press release and TUHS placed a full-page newspaper advertisement marking the successful completion of negotiations that marked the beginning of a new five year agreement.

Make no mistake, however. Neither TUHS nor any hospital in the region can say all is perfect in payer relations. We would love for IBC and other insurers to pay us more. Our costs are rising but we cannot pass them on. We need to either lessen demand or increase the number of dollars in our system. We recognize, however, that there is no single cure for our region's health care problems and finger-pointing will not provide the solutions.

Looking around this room I see many stakeholders in the health care delivery system. We have labor leaders, business leaders, Government leaders, physicians, health care administrations and consumers. it is only by working collaboratively that we can fix our region's health care system to improve deliveries, enhance quality, ensure affordability, and increase accessibility to all.

We at TUHS are committed to working with all stakeholders to build a sturdy health care system to meet current needs and to assure a stable delivery system for the next generation.

Senator Specter, thank you for the opportunity to testify on this matter and for your leadership on this very important issue.

[The prepared statement of Mr. Marshall appears as a submission for the record.]

Senator SPECTER. Thank you very much, Mr. Marshall.

Our next witness is Mr. Robert Ballou, President and CEO of CDI Corporation which provides engineering and information technologies, staffing, outsourcing and consulting services to a wide range of Fortune 400 customers.

Prior to joining CDI, Mr. Ballou held positions at Global Vacation Group, Thayer Capital Partners and Alamo Rent-a-Car. A graduate of the University of Pennsylvania's Wharton School and from Dartmouth College's Amos Tuck School of Business.

Thank you for joining us, Mr. Ballou, and we look forward to your testimony.

STATEMENT OF ROGER BALLOU, PRESIDENT, CHIEF EXECUTIVE OFFICER AND DIRECTOR, CDI CORPORATION, PHILADELPHIA, PENNSYLVANIA

Mr. BALLOU. Thank you, Senator Specter and good morning.

My name is Roger Ballou and I am President and CEO of CDI Corporation, a $1.1 billion publicly traded outsourcing and professional staffing company headquartered in Philadelphia. Thank you for inviting me to this hearing today to discuss a topic of great importance to CDI and its 16,600 staff and contract employees, the rising cost of health care and specifically provider collective-bargaining.

As a businessman running an international company, I tend to try to break things down into the simplest of terms, cost and benefits, assets and liabilities. The issues I face day-to-day vary in complexity, but in reality most can be solved by the application of basic principles learned in economics 101.

I have learned that same approach in evaluating the cost benefits of provider collective bargaining. I can unequivocally say it just does not add up.

Fundamentally, it is an issue of supply and demand. A basic truth of our economic system is that there exists a right price in which all those who wish to buy can find sellers willing to sell and all those who wish to sell can find buyers willing to buy. Provider collective-bargaining would alter this equation by exempting physicians from Federal antitrust laws and enable them as a group to demand higher costs from the buyers.

But these higher prices simply translate into higher cost ultimately for the buyers, in this case health care insurers, who would be forced to buy at artificially inflated market prices.

As we all know, however, price increases are passed along in the market economy and ultimately end up with the consumer. In the health care market, that means businesses and employees would be stuck with the bill, a bill that is already onerous and getting worse every year.

To give you an idea of the dramatic increase in pricing, from 1998 to 2003 the health care premiums paid by CDI and its employees increased more than 60 percent. Last year alone premiums paid by CDI and CDI employees jumped more than 13 percent, and that is below the national average.

Every year we competitively shop around for the best rates for our employees and have remained with Independence Blue Cross because they offer the best rates, rates that would surely go up if

physicians were permitted to collectively bargain with health plans over fees and other contract terms.

Provider collective bargaining would not only drive up health care costs in Pennsylvania as a matter of course, it would also most likely impede job growth in the State. As CEO of a publicly traded company I have a fiduciary duty to my shareholders. I must make sure that the company runs efficiently and turns a profit or I am out of a job.

When making a decision on where to locate or relocate a business function, health care costs enter the equation. I can tell you that in the past two years we have moved a back office operation from Philadelphia to Charleston, West Virginia in part due to lower health care costs in that State. I know other Pennsylvania businesses grapple with the same issues.

Simply put, if health care costs in Pennsylvania continue to rise, it would further erode the State's competitiveness and ability to attract and retain businesses.

In short, provider collective bargaining would accelerate the already spiraling cost of health care in Pennsylvania and the country, which in turn would increase the number of uninsured and underinsured employees and further drain business capital that could be better spent on investment and job creation. This is the exact opposite of what needs to be done. We should be taking costs out of health care, not increasing the cost of health care services.

It is for this reason that we need to explore real solutions to contain health care costs, such as health savings accounts and medical malpractice tort reform that would cap non-economic damages. These solutions, especially tort reform, should be actively pursued on a national and state level. Physicians must have their insurance burden eased. The health insurance industry needs to make a profit and Pennsylvania businesses and employees need relief from out-of-control health care costs.

These are not necessarily competing interests. There are solutions but provider collective bargaining is not one of them.

Senator Specter, thank you for allowing me to share my experience with you at this forum and I will be happy to answer any questions you may have later.

[The prepared statement of Mr. Ballou appears as a submission for the record.]

Senator SPECTER. Thank you very much, Mr. Ballou.

Our next witness is Mr. Patrick B. Gillespie, Business Manager of the Philadelphia Building and Construction Trades Council since 1982. The Council represents approximately 70,000 union members in the construction industry in the Philadelphia region. He served as a member of the Pennsylvania House of Representatives in 1975 and 1976, and is a member of the Board of Directors of Independence Blue Cross.

Mr. Gillespie, that is what my notes tell me here, but were you in the House of Representatives?

Mr. GILLESPIE. Yes, Senator. When I was a child, yes, sir. In 1976.

Senator SPECTER. then it is accurate. I have known you for a long time but I did not know of your background in the house. Thank you.

Mr. GILLESPIE. Certain things I am not proud of, Senator.

[Laughter.]

Senator SPECTER. I thought I had a pretty comprehensive knowledge of your background, Pat, but not that.

Thank you for joining us and the floor is yours.

STATEMENT OF PATRICK B. GILLESPIE, BUSINESS MANAGER, PHILADELPHIA BUILDING AND CONSTRUCTION TRADES COUNCIL, PHILADELPHIA, PENNSYLVANIA

Mr. GILLESPIE. Thank you, Senator.

As you stated, my name is Pat Gillespie. I am the Business Manager of the Philadelphia Building Trades Council.

It is my understanding that the primary issue you wanted to discuss today is collective bargaining for physicians and hospitals and whether that would represent a positive change for consumers of health care in Pennsylvania. As a person who believes in the sanctity of collective bargaining with their employer, this is kind of an interesting dilemma that I have.

At the outset I want to state for the record that in addition to my role as manager of the Philadelphia Building Trades, I am a member of the Independence Blue Cross Board of Directors. And the reason I am on that board is absolutely germane to the subject of today's gathering.

The workers who I represent, and there about 70,000 of them, care very much about their health care coverage. Right now it is running about $15,000 a year to cover each member. They care about the quality and quantity of their benefits and increasingly they are very concerned about the cost of those benefits.

That is why it is important for me to sit on the Independence Blue Cross is Board because there I hear firsthand why my member's health insurance premiums are going up. I ask the questions that my members ask me and I can better understand the factors that are driving up the cost of their health care coverage.

In other words, I am there to represent people who work hard every day to provide for families that count on them. One of the things that they want to provide for their families is health insurance, obviously. As a result, I have learned a whole lot about the health insurance business and I have learned one lesson well. The costs of my member's health insurance is tied directly to the amount of health insurance paid out for health care. When the cost of medical care goes up, our premiums go up.

That is what has me worried about today's subject, Senator, because no matter how I look at the idea of paying still more to physicians and hospitals it comes out the same way, higher insurance costs for my members. These days, I guarantee you that will mean loss of jobs because companies that employ our members are having a harder and harder time finding health care benefits for their workers and my members.

That is why these companies cannot believe it when they hear the Government might step in and artificially alter the balance between an insurer like IBC strikes between their financial needs for providers and members.

The issue is not about contracting leverage or bargaining power. The real issue is how to assure affordable health care to as many

people as possible while still compensating providers fairly. That is what IBC does. Day in and day out it strikes a balance between those needs of my members, your constituents, and the providers of medical care.

Let me tell you why companies buy health insurance from IBC. They do it because IBC's long history, sound reputation, strong network of hospital and physician competitive prices. That is why those companies expect, no they insist, that IBC negotiate on their behalf with physicians and hospitals to ensure that quality care is provided at a reasonable price.

Those companies have no interest in Government making it more difficult for IBC to negotiate a deal which are fair to both members and providers because they know full well that can lead to higher health care costs.

I have been seeing a disturbing trend lately. It involves the Government stepping in and ordering health insurance companies to provide additional benefits, adopt new rules or implement new programs. People call them mandates and I guess that is what they are, well intended. But let me tell you who pays for those mandates each and every time they are enacted is our members.

As an example, back in 1999 the Pennsylvania Legislature, such an August body, decided as part of Act 68 to order health insurers to pay for emergency room visits if a prudent layperson would agree that the situation was an emergency. At that time, Independence Blue Cross already was paying 98 percent of all emergency room claims. So how much more could another 2 percent amount to?

Well, Senator, today IBC's emergency from costs just for its HMOs has increased 154 percent. Why? Because people use the ER as a doctors office. I am sure no legislator ever intended that to happen, but it did and my members are paying for it.

And how about the HIPAA—this is my favorite one—the Federal initiative that was designed to protect all of us and our health information. It was a high and lofty intent and a good deal. Independence Blue Cross spent more than $40 million to implement that Federal mandate. Did any legislator intend for that to happen? I do not think so. But it did and my members will end up paying that $40 million, along with everyone else who buys Independence Blue Cross insurance.

I am not sure I can think of a Federal, State or local mandate that ever resulted in a decrease of health insurance cost, which brings me back to the subject of today's session, whether the Government should step in so physicians and hospitals can get paid more. I think we have to go very slowly with this and very carefully. A friend of mine said one time on this issue that we should not be looking for villains. There are plenty of them out there. What we should be looking for is solutions.

Thank you, Senator.

[The prepared statement of Mr. Gillespie appears as a submission for the record.]

Senator SPECTER. Thank you very much, Mr. Gillespie.

We now turn to Dr. Stephen Foreman, Vice President of Research and Director of the Pennsylvania Medical Society Health Services Research institute. A student of the Pennsylvania health

insurance markets for more than six years, he has prepared reports on the dynamics of Philadelphia, Pittsburgh, Central Pennsylvania and the Northeastern Pennsylvania area. He provides consulting services to the American Medical Association for issues relating to health insurance markets.

A Ph.D. in health economics from the University of California at Berkeley, a law degree from the University of North Carolina and a master's in public administration from Harvard's Kennedy School of Government.

Thank you for being with us today, Dr. Foreman, and we look forward to your testimony.

STATEMENT OF STEPHEN FOREMAN, PH.D., J.D., VICE PRESIDENT OF RESEARCH AND DIRECTOR, PENNSYLVANIA MEDICAL SOCIETY HEALTH SERVICES RESEARCH INSTITUTE, HARRISBURG, PENNSYLVANIA

Mr. FOREMAN. Thank you, Senator.

We also appreciate the opportunity to present testimony about the Southeast Pennsylvania health insurance markets.

I would like to make it clear at the outset that our testimony is not intended as a corporate or personal attack on any of the market participants or the people who work for them. Each of them is doing what they think best.

However, each is doing what comes naturally in what we call a failed market. This, we believe, is the fundamental cause of a host of problems and calls for extensive public policy analysis.

First, let us look at the market. Clearly, Independence Blue Cross has a dominant share. In 2002 Independence had an 85 percent share and Aetna about 13 percent.

What about employers, hospitals and physicians? Basically they are fragmented. What does such market produce? Annual double-digit health insurance premium increases, unilateral decisions about payment fee schedules that are unilaterally imposed or stagnant or declining compensation, despite the fact that physician fees have been raised 20 percent recently, leaving physician payment substantially below Medicare levels.

Health insurers with high profit levels also exist.

How did this market evolve? Not by skilled foresight in the industry. Independence's overhead costs are good but not remarkably better than any other firms. Indeed, there is no published evidence that larger health insurers are any more efficient. To the contrary, they exhaust their economies of scale at about 100,000 to 150,000 enrollees.

The Health Insurance Industry Association contends that competition is robust and that market entry is easy. This is certainly not the case. Nor can employer's self-insurance provide effective competition because dominant insurers demand and receive lower hospital and physician prices. Market entry barriers are high and they are rising higher.

Indeed the best evidence of barriers is that despite high profit levels in this market, there has been no substantial new entry for the past 10 years.

So why is not this market the subject of antitrust investigation? The Sherman Act has two provisions that would appear to apply.

For the reasons that we described in our written comments, conduct in this market may bear further study. There are perhaps reasonable arguments that there are no antitrust violations here. If so, we would then ask is this market good for the public? If not, then market restoring changes in the antitrust laws may well be warranted.

So that brings us to a closer look at public policy concerns. AHIP, the insurance industry trade association argues that dominant health insurers are needed to pull down health care costs. You have already heard that in some great detail. You will hear today that Independence needs its size and that physicians and hospitals must stay fragmented in order to hold down health care costs.

For the reasons described in our written comments, this is not true nor does it make for sound public policy. Despite the strenuous assertions of well-meaning health insurers, private monopoly and monopsony enforcement is not in the public interest here. If markets cannot work toward competition, then public and not private regulation of price is required.

Cost containment presumes that insurers pass their savings along through to employers and to the public through reduced premiums. However, double digit premium increases over the last 10 years suggest that this may not be occurring.

Indeed, the whole notion that rising health care costs can be dealt with through a simplistic cost reduction imposed on providers is misplaced. Rising costs are a function of a complex host of factors. You have already heard a lot about the utilization issue in Southeast Pennsylvania. There are many others.

Imposing cost containment on hospitals and physicians solely is unfair, improper and does not deal with the underlying causes of medical care cost inflation. It will destroy medical care and will drastically reduce patient access.

So where does that leave us? The evolution of the Southeast Pennsylvania health insurance market puts us squarely at a crossroad. Is a competitive private commercial health insurance market the best way to allocate scarce medical care resources? If so, then steps need to be taken to restore competition here. If we believe that competition cannot work, we should not lightly conclude that private commercial health insurers are the best entities to administer a single-payer system and dictate price. Effectively that is what we have here now.

Pennsylvania's physicians believe that the current situation is untenable and growing worse. Physicians are integral participants in a failed market.

As our elderly population increases rapidly, we will need to provide ever-increasing amounts of medical care here. Pennsylvania physicians urge appropriate action now so that they can continue to deliver the best possible medical care for each of their patients.

Thank you very much.

[The prepared statement of Mr. Foreman appears as a submission for the record.]

Senator SPECTER. Thank you very much, Dr. Foreman.

Our next witness is Dr. Martin D. Trichtinger, a board-certified physician in internal medicine. For years an active member and leader in both the Pennsylvania Medical Society and the Mont-

gomery County Medical Society. In 2003, he acted as vice-speaker of the Pennsylvania Medical Society's House of Delegates and is currently a member of the Society's Council on Policy and Governmental Affairs.

In 1998 he served as the president of the Montgomery County Medical Society and is currently a board member delegate and executive committee member.

Dr. Trichtinger is a graduate of the Jefferson Medical College in Philadelphia and I believe also the chairman of the Political Action Committee of the Pennsylvania Medical Society.

Thank you for joining us and the floor is yours.

STATEMENT OF MARTIN D. TRICHTINGER, M.D., INTERNIST, MONTGOMERY COUNTY, PENNSYLVANIA

Dr. TRICHTINGER. Thank you, Senator Specter.

As you have said, my name is Marty Trichtinger, M.D. I am an internist practicing in Jenkintown, Pennsylvania. I come before you to speak on behalf of the physicians of Southeastern Pennsylvania.

I do want to thank you again particularly for holding these hearings.

I wanted to give you some perspective in terms of the view of a physician in an attempt to provide a high level quality of care to patients who are obviously your constituents.

Basically there have been many wedges that have been driven into the doctor-patient relationship and Southeastern Pennsylvania has some of the highest practice costs in the Nation. These are driven obviously by the professional liability crisis, and some of the worse reimbursement levels nationally for health care delivery.

I wanted to begin on the contracting process. You have already heard Mr. Gillespie talk about negotiation within the market. However, based on some of the prior testimony you have heard, there are essentially two giant insurers operating within this market, and essentially one being bigger than the other.

Neither I nor the group of physicians that I participate in have the ability to negotiate with these insurers to amend our contracts with either of the two predominant payers. Both Aetna and IBC presently have 95 percent of the private commercial patients in this region.

They are able to dictate the terms of the contract, including the level of reimbursement and the cost of the patient care.

I have no ability to change this dilemma. In fact, in 1998 IBC unilaterally decreased its fees for many of its services. In some cases, this decrease was more than 60 percent of what they were previously paying. Since that time some of these fees have been increased, but many of the current fees still remain below 1998 levels.

So you may ask why would I continue to participate or accept a contract on such unfavorable terms? Unfortunately, the answer is all too simple. Unless I plan to leave the State, I have no choice if I wish to take care or continue to provide the care of the patients that I have seen for greater than 20 years.

In addition to these low levels of reimbursement, both fee-for-service and capitation contracts also allow insurers to pay claims processing and perform other insurance games. This further

tightens the vice grip of escalating costs and unfair reimbursement. These games include bundling of services into a single-payer system.

Insurance company play another destructive game when they do not recognize the entirety of the CPT coding system, the system that was initially developed by the AMA. And it effectively provides a wide range of looking at all aspects of health care. If you have the ability to pick and choose certain aspects of this coding system that favor the insurer and electing not to adopt coding provisions that favor patient care, I find this patently unfair.

Ultimately the tight vise grip that squeezes physicians hurts patients as well. In some instances, because of this tight vice grip, patients do not have the access to cutting edge technology in the doctor's office due to these financial constraints that are placed upon us.

Also, retention and recruitment of quality staff at the doctor's office and even other quality physicians to join the practices is inhibited by this fee scale system.

My practice at Abington Hospital admits patients to the hospital and cares for these patients while they are hospitalized. And hospital admissions can occur at any hour of the day or night, and care is demanding both clinically and emotionally. Our group believes that it is in the patient's best interest to be there when the patients are hospitalized. We provide a very important role in terms of advocacy, safety and quality.

Unfortunately, under the present system, in August of 2001, IBC terminated its episode of care payment leaving us with the dilemma to either accept seeing patients at no reimbursement versus turning the care over to hospitalists who do not know the patient. Ironically, these payments to the hospitalist provide them with even more reimbursement than what we were receiving under the episode of care.

That seems particularly wasteful that IBC would pay another physician to take care of my hospitalized patient, and it makes little sense in terms of the quality and the continuity of care that we are not able to take care of our own hospitalized patients.

No one knows my patients better than I do, and I feel that it is inappropriate that IBC puts us in this sort of Faustian dilemma of either accepting the care of the patients for free or handing it over to a hospitalist to provide the care.

I wanted to thank you for the opportunity to provide this testimony today. I am hopeful that you will be able to have the appropriate Federal regulatory agencies review the health care delivery system dynamics in the Philadelphia area. We definitely need to bring the best and the brightest physicians into the Philadelphia area and we need to be able to keep them here so that our patients benefit.

We believe that now is the time to come to terms with this very serious problem.

Thank you.

[The prepared statement of Dr. Trichtinger appears as a submission for the record.]

Senator SPECTER. Thank you very much for your testimony, Dr. Trichtinger.

We have one additional witness on the list and that is Mr. Stuart H. Fine, Chief Executive Officer of Grand View Hospital and affiliate entities in Sellersville. And we will come back to Mr. Fine in just a moment or two.

Dr. Udvarhelyi, with respect to the reserve which Blue Cross Blue Shield, Independence Blue Cross is alleged to have, that figure has been estimated as high as $5 billion. Is that a correct figure?

Mr. UDVARHELYI. No, Senator, that is not a correct figure.

Senator SPECTER. What is the correct figure?

Mr. UDVARHELYI. I believe our reserve level now is—I do not have the exact number. We can certainly get it for you. I believe it is just a little over $800 million.

Senator SPECTER. A little over what?

Mr. UDVARHELYI. $800 million.

Senator SPECTER. $800 million?

Mr. UDVARHELYI. Yes, and our reserves, Senator, represent on average the ability to pay about 40 days of claims on hand. We pay $660 million of claims each and every month, about $8 billion in claims a year. So our reserves represent a little bit more than one month's claim payment ability in the event of an emergency.

Senator SPECTER. There has been a contention by some of the officials of the Commonwealth of Pennsylvania that they have the authority under the Insurance Department rules to assess funds against Independence Blue Cross to, in effect, take those funds to help with the malpractice problem. Does any such authority reside in the Commonwealth of Pennsylvania, in your opinion?

Mr. UDVARHELYI. Senator, I could not comment on what authority the State has. What I can say is that the State did hold hearings in the fall of 2002 into the are of reserves. Testimony was given by Independence Blue Cross as well as some outside experts and the result, I think, of that investigation is that our level of reserves is entirely appropriate.

In fact, some of the experts would say if anything we are underreserved. And I believe Dr. Foreman of the Medical Society has looked at that and would concur that, at least in our case, our reserves are not excessive.

Senator SPECTER. Mr. Fine, we turn to you at this point. You are the Chief Executive Officer of Grand View Hospital and affiliated entities in Sellersville, Pennsylvania. It is my understanding that there has been litigation between your hospital and Independence Blue Cross; is that correct?

Mr. FINE. Yes, it is, Senator.

Senator SPECTER. And that litigation was settled subject to a confidentiality agreement?

Mr. FINE. Yes, sir.

Senator SPECTER. What are the essential terms of the confidentiality agreement?

STATEMENT OF STUART H. FINE, CHIEF EXECUTIVE OFFICER, GRAND VIEW HOSPITAL AND AFFILIATED ENTITIES, SELLERSVILLE, PENNSYLVANIA

Mr. FINE. According to a letter received from Independence Blue Cross by my counsel earlier this month, I am to, if I can find the

correct section here, I am not to voluntarily disclose in testimony anything that need not be voluntarily disclosed. Blue Cross has not waived any of its rights or remedies relating to the settlement agreement or the mutual release of provider contracts.

I understand that I am able to respond to direct questions put to me.

Senator SPECTER. Dr. Udvarhelyi, what is the purpose of such a restrictive confidentiality agreement?

Mr. UDVARHELYI. Senator, our contract negotiations and certainly settlement discussions are considered confidential from a business standpoint and hence, we do not permit them in the public domain.

Senator SPECTER. Why confidential? Why should not the public have a right to know what the charges were made in litigation and what the terms of a settlement are?

Mr. UDVARHELYI. Senator, I cannot comment on the legal aspects of the agreement, although we would be happy to get back to you on that. I believe, like many settlements which are settled in a legal manner, the terms of that are frequently kept confidential between the parties to protect both parties' interests.

Senator SPECTER. Mr. Fine, the Morning Call on July 17th, 2001 reported that you had stated that Grand View Hospital "loses millions of dollars each year because IBC does not reimburse Grand View for the entire cost of its care of Blue Cross patients." The Morning Call then added that "Fine estimated that Grand View would likely lose $5 million in the next 12 months if it continues to be reimbursed under the terms of the expiring contract." Are those quotes accurate, Mr. Fine?

Mr. FINE. Yes, sir, they are.

Senator SPECTER. It was reported that in July of 2001 while your contract negotiations were ongoing, you made some comments to the press about your difficulties with Independence Blue Cross. And in response Independence Blue Cross sued you and your hospital for libel.

According to the Morning Call of July 17th, 2001 your attorney referred to the suit as a "fairly heavy-handed negotiating tactic." Is all of that accurate?

Mr. FINE. I believe it to be accurate, Senator.

Senator SPECTER. Do you agree with the comment attributed to your attorney that the purpose of the suit was to pressure you and your hospital to agree to IBC's terms?

Mr. FINE. Yes, sir, I do.

Senator SPECTER. Dr. Udvarhelyi, are you familiar with that lawsuit?

Mr. UDVARHELYI. Senator, I am not familiar with the details of that lawsuit.

Senator SPECTER. Is there anybody hear from IBC who is familiar with that lawsuit? Anybody in the room?

Would you step forward please? Would you identify yourself for the record, please?

Mr. TUFANO. Sure, Senator. I am Paul Tufano. I am the General Counsel for IBC.

Senator SPECTER. Are you familiar that lawsuit?

Mr. TUFANO. I am, Senator but I did not know you would be asking about it today and so I did not get a chance to review the pleadings from that. I would be happy to and follow up with you and your staff, if you would like.

Senator SPECTER. It is a pretty unusual lawsuit. do you know about it in a general way?

Mr. TUFANO. I recall that there were some statements made by the hospital and Dr. Fine at the time in connection with the negotiations about Independence Blue Cross. And I recall that the litigation was filed. I do not have the exact details of what the statements were handy right now.

Senator SPECTER. Has Independence Blue Cross filed lawsuits under similar circumstances?

Mr. TUFANO. Not that I recall, at least in my four-and-a-half years with the company, Senator.

Senator SPECTER. If you would supplement your answers to both questions, I would appreciate it. We had not anticipated calling you as a witness and I can understand you would not be familiar with it. But since the witness for Independence Blue Cross did not know, thank you.

Mr. TUFANO. I will certainly supplement that after today's hearing. Thanks, Senator.

Senator SPECTER. We would appreciate that.

Mr. Gillespie, when we talk about collective bargaining and you are concerned that if there was collective bargaining that there might be the intervention of another insurance company into the field. And you were concerned that that would cause your union members to pay more dues.

There has been a counter argument offered that if there was another insurer in the field that that competition between some other insurer and Independence Blue Cross might tend to drive costs down. Do you think there is any merit to that?

Mr. GILLESPIE. I think that what drives costs up is the utilization. I think that however you slice it or dice it. My concern about collective bargaining is who is the employer? Who becomes the employer? Does the agent, the indemnifier that our members select is Independence Blue Cross. They do not have to select them. They select them because that is where we get the best rates.

If those Independence Blue Cross rates go up, then people will look at Aetna, as they have. Or they will look at other indemnifiers in the area. It is kind of like shifting the chairs on the Titanic.

We have a serious health care cost problem and I do not think that problem gets settled by—I mean, the reason Independence Blue Cross enjoys the market share that they have here in the five county area is that they tend to their knitting. They are pretty aggressive when it comes to maintaining their costs.

And by the way, I believe their administrative costs are about nine cents on the dollar, which is pretty good in this day and age.

So the idea of saying that we could get better health care, we can contain costs, we can provide a better service if we allow a condition in the antitrust law that allows our doctors to act as employees and our insurance companies to act as employers.

I can understand the doctors saying we have to band together and say this is what we are going to charge. And they can very

well do that. And Independence Blue Cross can just say okay, we will just pass that on.

But what happens then when they just pass the costs through, when they just pass the costs through, then the people that have to pay that cost are our members who either A, will not continue to buy that service; or B, just look somewhere else where they can get it cheaper.

And what has happened in the marketplace is, as people will say here, all these lofty folks around, I feel a little inadequate talking about economics here. But what happens in the marketplace is if you do not have the money then you just cannot buy the service.

In Pennsylvania we have well over 1 million people now who work for a living. These are not poor folks. These are people who work who just decided not to have health care coverage.

The other dilemma that is going to be a tragedy is people who are just buying health care coverage for themselves and not for their families.

We are headed for a catastrophe and we have to find the solution as to containing costs for our health care, whether we overutilize it or whether it is just too expensive or whether society has to come forward and say okay, we have to pay. And instead of paying $15,000 a year, it is $30,000 a year. That is the number we have to pay.

But then where do we find that? The average salary for a building tradesman in my territory, the five County area, the average salary is $65,000 or $70,000 a year. It varies. And these are the good jobs in the blue-collar realm. The construction industry has always been a good job, $65,000 or $70,000 is good.

$15,000 going to health care, that is an awful lot of money. That is a big percentage.

Senator I wish I had an answer. But I do not see how making Independence Blue Cross or Aetna or other insurance companies an employer in the scenario of collective bargaining with doctors resolves it.

Senator SPECTER. Mr. Gillespie, that is the issue we are wrestling with. And your perspective for collective bargaining is a very unique perspective because there is no doubt that labor could not deal with management when each employee was looking out for himself. It was the collective bargaining aspect which gave the members the strength in combination.

But I understand your point.

Mr. Marshall, you have testified in favor of the benefit of collective bargaining. If there were to be an exemption under the antitrust laws for communities where there is a certain market share dominated by one firm what do you think the consequence of that would be? Would it necessarily drive up health care costs? Or would there be an opportunity for another insurer to come into the field which might provide competition illustratively for IBC?

Mr. MARSHALL. I am not sure, Senator, that I testified for or against the concept because I am not even sure I understand—

Senator SPECTER. Okay, if you are not sure, then what do you think?

Mr. MARSHALL. What I have wrestled with, and whether the issue is malpractice or—it is like Jell-O. You push in one direction

and it pops out another. What I am really hoping is we can get a comprehensive solution. If collective bargaining—

Senator SPECTER. What would you suggest for a comprehensive solution? I think everybody would like that, Mr. Marshall. But what is it?

Mr. MARSHALL. That is why I preface that by saying I wrestle with this all the time. I guess what I am saying is that we have to make sure that if we rob Peter to pay Paul, you are going to be back here with one of the apostles a year from now.

Senator SPECTER. Mr. Marshall, we do not want to rob anybody, but avoiding robbery, how do we do it?

Mr. MARSHALL. As I have talked with you in the past, I think we have to go to some more of a—and I use this word term advisedly, more of a single-payer system. And how it gets implemented, I am not sure.

Senator SPECTER. Are you talking about the Federal Government as a single-payer?

Mr. MARSHALL. Or some collective of a single-payer.

Senator SPECTER. Are you talking about the Clinton health care plan?

Mr. MARSHALL. No, I assure you, Senator, I am not talking about the Clinton health care plan. That dog will not hunt.

But to the point, if Pat is right and physicians collectively bargain and that drives up cost, well we all—including physicians. As Marty will tell you, he has an office. His costs go up. It is not just malpractice. It is the cost of employing his nurses, it is paying their health care, and it is everything else.

What we are doing is just shifting it across. And if you really want to look at the health care problem for the last 25 years in this country is we have all been shifting. And nobody sat back and said okay, here are the things that confront us. We have health care inflation way over 2 percent or 3 percent or whatever the rate is.

And as I said earlier in my testimony, we either are going to have to lessen the demand, which is a pretty tough thing because we all sit, Stu sits with an emergency room, I sit with an emergency room and a number of the hospitals here sit with emergency rooms. But do not get to choose. We do not get to say sorry, you cannot come in because you do not have dollars. We are obligated under Federal law. If somebody gets on our door, we have to take care of it.

Senator SPECTER. Mr. Marshall, in taking a look at what has happened to Medical College of Pennsylvania, to what extent if at all do you attribute that to the low reimbursements from Blue Cross Blue Shield?

Mr. MARSHALL. Senator, as you know, we have looked very hard at it. I do not know. I am not sure I even understand what their—I am not sure I am even familiar with what percentage. But I would have to say if they are like us, they have probably equally as much of a complaint with the Federal Government and the State government.

I have to tell you, Senator, my neurosurgeons will come in and tell you they get $26 a visit for a medical assistance payment. And I assure you, because I pay those costs—

Senator SPECTER. Does IBC reimbursement less than Medicare?

Mr. MARSHALL. I do not know. I think in some cases. I do not know. I do not know the answer to that question.

Senator SPECTER. Dr. Trichtinger, does IBC reimburse less than Medicare?

Dr. TRICHTINGER. Yes, for us it does. And what is interesting to me is the fact that the—

Senator SPECTER. I am sorry, I did not hear you. You say it does?

Dr. TRICHTINGER. Yes, in fact, it does pay us less than Medicare. We are one of the few areas where instead of Medicare being the sort of the floor for prices, Medicare happens to be our ceiling. We get about 35 percent less than Medicare.

And what was interesting to me was that the Medicare Payment Advisory Commission just indicated that the HMO products in this country get 7 percent higher or have 7 percent higher than the fee-for-service amount for Medicare. And yet, ironically we are paid 35 percent less.

So if we could go to an entire Medicare fee-for-service system, theoretically the Government could save 7 percent and actually pay us hopefully 35 percent more.

Senator SPECTER. There has been considerable criticism of the Medicare reimbursement rates. They were scheduled to be cut March 1, 2003 by 4.4 percent and that cut was eliminated. They were scheduled to be cut both in fiscal year 2004 and 2005 and that was changed by the Medicare Reform Bill.

Dr. Badolato, you testified about Aetna in the field as well as Independence Blue Cross. Does the presence of Aetna provide any realistic competition with IBC to move to lower the cost?

Dr. BADOLATO. With few differences, it appears that one is a mirror of the other. In fact, in my written testimony there are 11 slides. One of the slides shows the per member per month paid to our practice by US Healthcare, then Aetna for 10 years. The same slide shows the Keystone payments per member per month, although it does not track the 10 years. I believe they would mirror each other.

Basically the payments today are less than 10 years ago. So we see problems that are unique within each company in that in their formulas of payment but the end result is very similar and very damaging.

Dr. TRICHTINGER. Senator Specter, because you moved so quickly on it, I know you were not looking for a thank you. But I did want to point out to those on this panel that it was the senior Senator from Pennsylvania who helped lead the fight in the Senate to correct that Medicare correction that you had mentioned earlier.

As I said, I realize you were not looking for a thank you, but I wanted to give it anyway.

Senator SPECTER. No, I was looking for a thank you. I really set you up for that one with a little head and shoulder fake.

Mr. GILLESPIE. Is that what time of year it is?

Senator SPECTER. Mr. Gillespie, it is always that time of the year, just like your collective bargaining, it is always there.

That is a recurring problem. You are looking for a comprehensive solution that Chip Marshall is looking for, we are all looking for. There is a lot of searching.

I have been on the Subcommittee for Health and Human Services in my 24th year and I have chaired it most of the time since 1995. And these are problems that are virtually intractable.

There is quite an array of talent here at this table, let me tell you. I have been at a lot of hearings and I have not seen a hearing with more talent than we have here today.

Usually our hearings in Washington are interrupted by votes and interrupted by appearances in some other room to make a quorum. And there is a lot which is being brought to bear here.

And Dr. Trichtinger is correct that Senator Stevens and I—he chairs the full Committee but I brought the issue to his attention and we eliminated that cut on March 1st. it was a 4.4 percent cut which would have cost $58 billion. And when we moved forward on Medicare reform we eliminated the cuts in 2004 and 2005 and added a small addition.

Dr. Badolato, I did not quite hear your answer as to whether Aetna provided any competition for the dominant market share of the IBC? Do you think Aetna does?

Dr. BADOLATO. I believe they do not.

Senator SPECTER. Mr. Ballou, you have commented about concern about the rates going up if there was to be collective bargaining. Do you have a view on what would happen if another insurance company was able to enter into the field? There are some which are trying to come in and they are faced with this requirement that Independence Blue Cross requires 75 percent enrollment, and IBC justifies that. Mr. Udvarhelyi, correct me if I am wrong but you need to spread the risk.

But when IBC requires 75 percent enrollment, nobody else can come in. If somebody else could come in, do you think that might provide some competition to lower rates?

Mr. BALLOU. This is an open market in terms of the ability to come in. There are other competitors here. We bid our insurance on the year. We look at Independence Blue Cross. We look at Aetna. Frankly Aetna's rates were not as good as Independence Blue Cross for us.

Somebody would have to find a way to do something kind of unnatural to lower the rates much. If you look at it, with a company on the scale of Independence Blue Cross—I heard earlier someone cite 9 percent administrative cost load. When you look at the underwriting burden that they carry and when you hear the reserve ratios, the money is not sitting at Independence Blue Cross. It is being spent in the system.

And if Aetna could do better rates than Independence Blue Cross, I am sure they would do that today to gain market share they could afford to do it. It is clear that they cannot. And that means that their cost structure is higher or they are not getting as good of rates from the physicians and hospitals.

The issue here is the total cost of the system as I see it. And no one sitting at this table has the comprehensive solution in hand. But I do believe there are elements of it that would require tax reform. Certainly it would be useful to make more medical expenses deductible. I think the health savings accounts on the part of the Medicare reform were actually a very positive step in the right direction there.

We are looking very, very hard at redesigning our insurance program to take advantage of health savings accounts, to actually make the user of the service more frequently the payor, and have incentives to manage the use of the care better.

I think that there are things that could be done with medical malpractice reform that would drive costs out of the system. I think that would be useful as well.

So as I see this, this is an issue of finding a way to contain and manage the cost of providing medical care as opposed to is there another insurer who could come in and do a better job? The costs are still the costs.

Senator SPECTER. Dr. Foreman, you mentioned the Sherman Act. Do you think there may be a Sherman Act issue of violation potentially in IBC's dominance in the market here?

Mr. FOREMAN. We have been to the FTC and Justice and asked them to look at a number of items of conduct that we thought should be put on the table for investigation, without making a direct conclusion of violation at all but as a subject for investigation.

To begin with, for example, we think that all four major Pennsylvania Blue Cross firms could be competing in this market quite actively and make the market improve. They do not, we understand, because of a division of markets agreement. We would like to see that agreement looked at, perhaps done away with.

Senator SPECTER. What are the provisions or terms of that agreement generally?

Mr. FOREMAN. We have not seen the agreement in words. We have heard people talk about it and we have seen the effect in that the four Blue Cross insurance firms in Pennsylvania have specific territories and they do not compete outside them generally. So even the basics of the agreement itself are not public.

Senator SPECTER. This is a territorial division?

Mr. FOREMAN. Yes, sir.

Senator SPECTER. And IBC has the five counties?

Mr. FOREMAN. Yes, sir.

Senator SPECTER. How many other counties are controlled by whom?

Mr. FOREMAN. By and large, Northeast Blue provides health insurance in Northeast Pennsylvania. I cannot exactly give you the number of counties. High Mark provides the insurance in 29 counties in Western Pennsylvania. And Capital Blue Cross, which does compete with High Mark, provides health insurance in 21 counties in central Pennsylvania.

Senator SPECTER. We had hearings with the FTC last week on OPEC, which is gouging us with a clear cut conspiracy and restraint of trade without any active state defense or any sovereign immunity.

I do not propose to ask this panel questions on that subject, but because the FTC has not acted does not mean a whole lot. They have got a pretty consistent record for inaction. They are experts in the field. They even compete with Congress for inaction. That is how good they are on that particular subject.

Mr. FOREMAN. I would just like to emphasize, it is possible there is not an active antitrust violation here, but that should not end the inquiry. The question then ought to be whether the antitrust

laws themselves ought to be strengthened to deal with this situation.

Senator SPECTER. Well, that is one of the things we are considering, whether there ought to be ability to combine. That would be a change in the antitrust laws.

Dr. Burns, you commented that IBC, the word you used was exploited. Would you amplify on what you meant by the term exploit?

Mr. BURNS. What I was referring to, Senator, was during the 1990s there is evidence suggesting that because of their large share of the market, being a very concentrated market, IBC could deny payments to providers, slow down payments to providers, downgrade payments to providers and hurting the cash flow of hospital in particular.

Senator SPECTER. Dr. Burns, I would like you to respond to issues raised by the Chester County Hospital, which filed a complaint in the United States District Court for the Eastern District of Pennsylvania on May 5th, 2002 stating that "in 1999 IBC effectively forced the hospital to enter into a contract that was 20 percent below cost. For fiscal year 2001 the hospital received approximately $34 million in revenue from the IBC Group and nevertheless sustained operating losses on IBC group patients exceeding $8.5 million and forcing the hospital into a negative operating position. For fiscal year 2002 the hospital is experiencing similar losses."

Before asking you to comment on that, Dr. Burns, Dr. Udvarhelyi, is that an accurate statement of that Chester County complaint?

Mr. UDVARHELYI. Senator, I cannot confirm the details of that complaint. I have not briefed that complaint specifically prior to this hearing.

Senator SPECTER. Could counsel confirm that?

Mr. TUFANO. Senator, I do not know word for word but yes, essentially that was one of the complaints in their lawsuit was with regard to the level of reimbursement.

Senator SPECTER. There is a confidentiality agreement which precludes the Chester County people from testifying?

Mr. TUFANO. And it would preclude me, Your Honor, as well from answering questions. We are in the process of finalizing the settlement agreement we have reached with them two months ago.

Senator SPECTER. I am not sure that is correct. The confidentiality runs to the benefit of IBC. Would that preclude you?

Mr. TUFANO. It is for both parties. It is a mutual confidentiality agreement. Both parties agreed to the confidentiality agreement, Senator.

Senator SPECTER. Would that be subordinate to an inquiry by the Senate Judiciary Committee?

Mr. TUFANO. I am not sure. I would like to confer with our outside counsel here.

Senator SPECTER. You are counsel.

Mr. TUFANO. I have our Chester County counsel from that lawsuit with us here. To the extent we needed to—

Senator SPECTER. Fine, I would like to hear his view on the subject.

Mr. TUFANO. To the extent we wanted to talk about things that were covered by the confidentiality agreement, I guess Senator, we would like to at least explore with you if there are ways that we could provide that information to you in a nonpublic forum, to the extent we get into things that might be directly covered by the confidentiality agreement and/or that our proprietary. Information like rates and things like that.

Senator SPECTER. The Chester County counsel is here.

Mr. TUFANO. Yes, he is.

Senator SPECTER. Could you step forward please? Would you identify yourself for the record, please?

Mr. KRESS. My name is Jim Kress. I am an attorney with Howrey Simon Arnold and White in Washington, D.C.

Senator SPECTER. Mr. Kress, I am not going to ask you to testify because well, a subpoena was authorized for you. You stated you did not want to testify because the matter was being finalized and we respect that.

So I will just offer an observation myself. If the confidentiality agreement runs to the benefit of IBC, I do not think there is anything that the Chester County Hospital would have reluctance to have disclosed. And I do think that a Judiciary Committee inquiry would take precedence.

Mr. Fine, following the advice of counsel, offered no testimony but responded to questions and he is under subpoena. And whatever he testifies hereto is immune from any action.

That is one of the benefits of having a Senate inquiry. What was testified to is absolutely privileged. But thank you for stepping forward.

Mr. KRESS. I may want to correct one statement. I was counsel to—

Senator SPECTER. You may be opening the door, but go ahead.

Mr. KRESS. I actually was counsel to Independence Blue Cross in its proceeding with Chester County Hospital and not to the hospital itself.

Senator SPECTER. I see. Okay, I am glad you corrected that.

Dr. Burns, what do you think about the Chester County complaint? Does that fit into your category of exploitation?

Mr. BURNS. It is consistent with other stories I have heard in the marketplace about hospitals talking about their negotiations with Blue Cross. But it is also consistent with what is happening to the payment rates for acute care hospitals in Southeastern Pennsylvania over time.

The American Hospital Association calculates a statistic. It is called the payment-to-cost ratio. If you look at what it costs the hospital for a patient for day, and if you look at what they get paid for that day, it is a ratio. And the higher that ratio, the better. That means the hospital is getting paid a decent rate to cover its costs and to earn a little surplus.

That payment-to-cost ratio in the private insurance market which Blue Cross dominates has dropped over the last seven years in Southeast Pennsylvania and it is now basically near the Medicare level.

I remember one of the gentlemen say that in his own particular situation they pay less than Medicare. But across all of Southeast

Pennsylvania, at least for hospitals, what the private sector insurers are paying the hospitals is basically similar to what Medicare pays.

The problem with that is they are paying at roughly 100 percent of cost. Hospitals are not making much of a margin on either Medicare or on Independence Blue Cross or other private insurers.

Senator SPECTER. Well, really not only much of a cost. At least according to the Chester County complaint they are getting less.

Mr. BURNS. Well, in some cases when you have less bargaining power, that is an average across all hospitals. Some may be slightly higher. Some may be lower. And the hospitals that have succeeded in getting rates slightly better from Independence Blue Cross and Aetna US Healthcare.

Senator SPECTER. So a little more bargaining power would help?

Mr. BURNS. That is what they have tried to do there.

Senator SPECTER. Maybe joining together with an antitrust exemption.

Mr. BURNS. We are talking about hospitals now?

Senator SPECTER. So am I.

Mr. BURNS. The hospitals now join together.

Senator SPECTER. The hospitals could join together.

Mr. BURNS. Sure, they can, and they have.

Senator SPECTER. I mean, they could if they had an exemption. They cannot under the current law.

Mr. BURNS. Hospitals can join together as long as their market share does not exceed 35 percent.

Senator SPECTER. They can join together in negotiating with IBC?

Mr. BURNS. Yes, they can.

Senator SPECTER. But doctors cannot?

Mr. BURNS. Doctors cannot. Not if the doctors are self-employed private practitioners.

Senator SPECTER. Is that correct; Mr. Marshall?

Mr. Fine, I see you reaching for the microphone. I do not want to miss this opportunity.

Mr. FINE. If I am understanding Dr. Burns' point correctly, I believe that hospitals can merge. Hospitals can, through corporate affiliations, come together under certain circumstances and within certain parameters negotiate with Blue Cross as a group.

Senator SPECTER. After they are merged they are one. That is called a marriage is it not, sort of?

Mr. FINE. Yes, sir, where hospitals such as my own that remain independent community hospitals cannot align with other independent community hospitals strictly for the purpose of negotiating third-party contracts.

Senator SPECTER. Dr. Trichtinger, what do you think of the situation at Chester County Hospital if their statements are accurate?

Dr. TRICHTINGER. As Dr. Burns had already stated, it fits with the circumstances that I am familiar with up in my area, though I do not know the particulars. The Chester County reports in the paper ought not to have surprised anyone on the northern side of the suburbs.

Mr. GILLESPIE. Senator, Pat Gillespie.

On the Chester County Hospital issue, I think we have to be cautious using that as some kind of template or some kind of example because when Chester County completed their initial negotiations with IBC for their rates, a five-year deal, they went out and announced to the marketplace what a wonderful deal that they had.

I do not know what circumstances changed in the deal, but certainly they were paid on time. And I do not think—I think it is being—I think accuracy is important in these issues.

It is not a story, as Dr. Burns said. It was fact. They actually went out, Chester County Hospital actually went out to the marketplace and used the negotiated settlement that they had with Independence Blue Cross as a way of how well they are doing business.

Senator SPECTER. Thank you for that information. I had not heard that. That is something we will pursue with Chester County if, as and when we are able to have their participation in this inquiry.

There was a complaint filed by Children's Hospital of Philadelphia in November of 1999 alleging that Independence Blue Cross improperly used CHOP's name in advertising after expiration of a contract between the two companies. In its complaint CHOP said that under its contract with IBC "CHOP agreed to provide pediatric hospital services to IBC enrollees and IBC agreed to pay CHOP for services covered under the relevant IBC product in an amount that was less than CHOP charges as defined in its usual and customary reimbursement rate."

Dr. Udvarhelyi, are you familiar with the situation with the CHOP complaint?

Mr. UDVARHELYI. I have some knowledge of it, Senator.

Senator SPECTER. Were they accurate about that?

Mr. UDVARHELYI. I cannot validate that particular point.

Senator SPECTER. Would you take a look to see if you can validate that?

Mr. UDVARHELYI. We will get back to you.

Senator SPECTER. Yes or no.

Dr. Foreman, what do you think about the allegations of the CHOP complaint if, in fact, they turned out to be validated by IBC?

Mr. FOREMAN. I suspect that just from the little I know about it, and I do not know a lot, from reading the newspapers and talking with some people in the industry, that this was part of the negotiating process that once more ended up at or near litigation.

Senator SPECTER. Counsel stood and wants to make a comment. Thank you, Paul.

Mr. TUFANO. Senator, the Children's Hospital lawsuit from 1999, one of the allegations that you referred to was a Lanham Act allegation. And as I recall the timing was such that one of the issues that was in dispute was whether or not the contract had terminated. And I believe as part of the lawsuit that they had filed they alleged that because the contract, in their opinion, had terminated at that point, our continuing to list them on our provider directory which we publish once or twice a year was a Lanham Act violation. That once the contract was expired that we did not have the ability legally to continue to include them in the provider directory.

That is what, I think, that allegation was about.

Senator SPECTER. Okay, thank you for your addition.

Mr. TUFANO. Could I also add to that, we had just last week announced a new four-year agreement with Children's Hospital last week.

Senator SPECTER. Anybody else like to add anything to the preceding? Dr. Trichtinger?

Dr. TRICHTINGER. I just wish that IBC was spending less money on lawyers and reimbursing the physicians with some of that money.

Senator SPECTER. Any of the lawyers want to respond to that?

Mr. GILLESPIE. Lawyers should not respond.

Senator Pat Gillespie, as a board member of Independence Blue Cross. It was mentioned that a number of the hospitals had merged and became one. And they now do enjoy negotiating power and they are negotiating. And yet, it still does not seem to be enough.

The point is that there is health care dollar out there that if it is not adequate, then I think these forces should come up and say listen, it is not adequate. We have to spend more than $15,000 a year to indemnify ourselves for health care. It has to be $30,000. That is where we have to go here.

We have this tremendous entity of health care, and by the way of full disclosure, I really should not even say this, but my kid is a doctor over at Children's Hospital. So I know a little bit about the dilemma that they are having, especially with the debt.

But the problem is that society has to come forward and say look, we have to spend more money than this. Or maybe we will come up with some other resolution to the problem.

But just going around in circles here and finding someone to scapegoat, I heard Dr. Burns mention a couple of times about untimely payments. That is one of the things that Independence Blue Cross prides themselves on. They get their payments out on time, significantly under what normal business practices are.

Thank you.

Senator SPECTER. Dr. Badolato?

Dr. BADOLATO. Senator, thank you.

I would love the opportunity for some summary comments and I also offer a solution.

First of all, Dr. Udvarhelyi referred to two major points he wanted to address at the beginning. One is misinformation.

If we look at our practice as an example, and again top 1 percent in performance quality measurements and so on, 15,000 patients, eight physicians, et cetera.

Our effective per member per month reimbursement in 2004 is less than what we got in 1994. We are getting 80 percent of Medicare except for a non-physician visit code. Our physicians' hourly compensation is equivalent to Mr. Gillespie's people, which I calculated between $32 and $33. That is what our physicians, after 11 years of training and 15 years of experience, are getting.

We believe that we have 10 years of data which can show, which can demonstrate, in fact it is on page two of my presentation, that quality costs less.

We have invited by at least two of my statements if not three for a collaborative opportunity to look at quality practices, to look at leadership practices and then use Mr. Ballou's recommendations of

economics 101 which I adhere to and say what does it cost? And therefore worked the reimbursements based on that.

I believe we are one of the few practices in the country, if not the only, that has generated a slide as is our slide number one, showing number of visits, phone calls, et cetera, that is required to take care of such a population of 15,000.

And on October 1st, 2002, I sent what I believe to be a wonderfully collegial collaborative invitation to Dr. Udvarhelyi. That invitation was passed down to other medical directors and eventually my request for a collaborative working relationship to solution find was refused.

And that is a correction of some misinformation.

Senator SPECTER. Thank you very much, Dr. Badolato.

A couple of other issues on litigation, Dr. Udvarhelyi. In 2002, the Pennsylvania Orthopedic Society sued IBC for failing to properly reimburse, and alleged that IBC never disclosed its reimbursement schedule to the doctors and that it engaged in a practice of improperly denying reimbursements.

And in a 2003 settlement IBC agreed to provide the following to the plaintiff class: fuller disclosure of its payment policies, and increased payments up to $40 million over the following two years.

Dr. Udvarhelyi, do you know if that is accurate?

Mr. UDVARHELYI. That is generally correct, Senator.

Senator SPECTER. You say it is?

Mr. UDVARHELYI. Yes, sir.

Senator SPECTER. And on the issue of retaliation, where counsel said that he would make an inquiry, there was a suit filed by Centennial School District in 1993 and then IBC filed a counterclaim alleging defamatory statements which were attributed to a Mr. Bradley Hearse, a school board member. Quoting Mr. Hearse as saying that IBC "wanted all those enrolled in a rival HMO to be turned over to Keystone, an IBC subsidiary, for the same benefits at a higher price. And that Blue Cross actions were predatory."

That is reportedly an opinion filed by Federal Judge John Padova on July 11th, 1994 to grant in part and deny in part a motion to dismiss a counterclaim. Dr. Udvarhelyi, are you familiar with that?

Mr. UDVARHELYI. No, Senator, I am not.

Senator SPECTER. Counsel, are you?

Mr. TUFANO. Senator, that is about six years before I joined the company. I am vaguely familiar with the Centennial case but not enough to give you a thorough response to that.

Senator SPECTER. If you would take a look at that, we would appreciate it.

Mr. TUFANO. I will.

Senator SPECTER. Anything else, gentlemen?

Mr. UDVARHELYI. Senator, if I could just clarify a couple of points.

With regard to payment for both physicians and hospitals, we pay claims we receive in approximately eight days from the time we receive it. We have done, for example hospitals, we know that from the time a patient is discharged to the time we receive the bill is approximately 36 days. So that full time elapsed, most of that time is time from patient discharged until we send a check is actually the bill has not yet come to us from the hospital. And then

there is additional time at the hospital to when that money gets posted.

So when we hear about the long time for payment, at least from the time we have received it for both physicians and hospitals, about eight days. So we do not believe that there is a slow pay issue.

And the Insurance Department, when they reviewed us, found that we paid claims according to State regulations almost at 100 percent.

The other clarification on market share that I would like to make is that I do not know how everyone sometimes calculate these numbers. We believe the right way to look at it is for people who actually live in the five counties who carry a part of one of our products is a sort of accurate way to do that.

And if you calculate it that way, our market share is just over 50 percent, not at the 80-some percent that was quoted earlier. We do insure, as in the case of Mr. Ballou's company, employers who are based in Pennsylvania but who may have employees in other States. We do not believe that it is right to take those employees that are living in other States and put them over a denominator that is just the people living in Philadelphia.

So I think that if we were going to include the people that live in California, Chicago, et cetera, we would have to include the residents that live there as well. So again, we think the number is slightly lower.

And lastly, Senator, I would like to offer a comment as to the intended effects of increasing rates to physicians and hospitals. I think the math is pretty simple, and that is that the cost of health care is really a function of two things. Well, three actually.

It is the number of services that are used, the mix of those services, and the price per service. Whether Independence Blue Cross is providing coverage or whether Aetna or some new entrant, if you assume that the physicians are ordering the services the patients need and the hospitals are doing the same thing—I would contend by the way, as I mentioned in my testimony, that the rate of services is not only going up but the mix is going up. So when we look at somebody's lungs with a radiology study, we are not looking at a plain x-ray anymore. We are doing a spiral CT scan. We are exchanging a test that costs maybe $50 to one that costs hundreds of dollars.

So when we look at now the total cost of care, that mix can have a big impact. But if all we do is assume that the doctors and the hospitals are going to order the same services for patients they do today, but a new entrant comes in and whether it is collective bargaining or anything else, the prices go up. I do not understand how the new entrant is going to offer their insurance product at a lower rate for that same defined population if they are paying 20 percent more than the current rates.

There is no way the costs go out of the system in that model.

So the solution, I think, is that we have to work together to eliminate the waste, the redundancy, the defensive medicine. I will tell you that I have talked to physicians and talked to the medical society. Doctors order tests that are not needed because they are afraid they are going to be sued. They order tests that some other

doctors ordered because they do not know that they have been ordered.

And so there is redundancy, there is waste in the system. I think collectively that we can try to trim that down. And as you can see in my written testimony, the sad truth is that—these are researchers at Dartmouth, Elliot Fisher and David Wennberg have shown that high cost areas in the United States, and Philadelphia is one of them, unfortunately we do not necessarily have better outcomes. What their research has shown is that for use of known effective preventive services, the high cost areas like Philadelphia have actually lower rates of those services. And even things like death rates from hip fracture, heart attacks and colon cancer are higher in high cost areas of the country.

Senator SPECTER. Dr. Udvarhelyi, there is no doubt that the scope of this issue is very broad and we have not touched on a fraction of it in the focus narrowly here.

We are working, as Mr. Ballou commented about the so-called lottery verdicts, trying to find a formula for caps. It has been before the Senate three times now and far short of cloture, 49 votes.

We changed the Balanced Budget Act of 1997 substantially. I have taken the lead on graduate medical education, disproportionate share, moving in many, many directions with CMS to try to tackle a wide range of medical issues.

So that in your closing statement you started to talk on some of them which are vast beyond any question. And we are tackling them at many levels.

State Senator Greenleaf and I held a hearing in Norristown a week ago Friday to try to acquaint seniors with the new Medicare prescription drug issue, but also the possibility of small business going together.

But this is under very active consideration. We had Dr. Thompson, Secretary of HHS, testify extensively within the past month. And Dr. Zerhouni, head of NIH. It is a vast subject. And a good part of the cost turns on new procedures and new technology.

I was the beneficiary of an MRI which we did not have not too long ago. And we are fortunately enabling people to live longer. And the question as to how we provide their services.

And the new Act wants to give everybody a medical examination, the seniors, and then have pharmaceutical available to them for preventative medicine. It is a giant issue and we will work on it on many, many levels.

I thought today's hearing was very informative, although we did not cover everything but a little attempt at investigation. You have heard at least one Senator's views of confidentiality agreements and retaliatory lawsuits. I used to be that line of work. I do not do that anymore. In fact, I do not think I had any retaliatory lawsuits but I used to bring a fair number of prosecutions when I had a different hat.

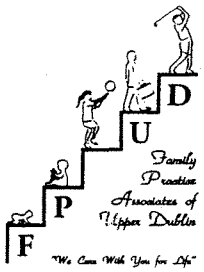
But to repeat, this is very informative and we thank you all.

That includes our hearing.

[Whereupon, at 11:02 a.m., the Subcommittee was adjourned.]

[Submissions for the record follow.]

SUBMISSIONS FOR THE RECORD



Family Practice Associates of Upper Dublin

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Testimony to US Senate Judiciary Committee, Subcommittee on Antitrust April 12, 2004

I appreciate the opportunity to present to you, Senator Specter, to the other panelists and to all others present today.

I come to you as the senior physician of a Family Practice in Fort Washington, Pennsylvania, where 8 physicians and 26 staff care for 15,000 patients who mostly reside in Eastern Montgomery County. I am in my 26th year of practice and I love the service I perform. In our practice we have a passion for excellence and are committed to quality and safety in the medical care for our patients. Our practice has been recognized for leadership in quality by the 2 major insurance companies of Southeastern Pennsylvania, and in almost every measurement from both companies we rank in the top 1 percent.

Our patients receive optimum care through the continuum of their medical experiences including inpatient and outpatient care. Our excellent outcomes demonstrate our commitment to what we do.

Unfortunately, the financial condition of our practice continues to deteriorate, and our ability to continue to practice is imminently threatened. We are in serious financial debt as a result of extreme reductions in reimbursements imposed by the 2 dominant health insurance companies of Pennsylvania.

We have 10 years of data pertaining to our quality and the decreasing reimbursements. We welcome an in depth analysis by appropriate professionals of the microeconomics within our practice. We believe that such a study will reveal the truth and define the equitable reimbursements required to support and sustain 99th percentile performing practices who have achieved quality and safety outcomes for their patients. Our 10 years of data can help to define what is Quality and how should it be sustained.

We believe that if the current path of severely reduced reimbursements continues, it will further destroy the infrastructure of quality Primary Care practices. The performance of Family Practice of Upper Dublin is in concert with the Institute of Medicine, Quality Chasm Report of March 1, 2001.

I am prepared to address any questions regarding the insurance company formulas used to calculate per member/per month reimbursements and the level of reductions in fee-for-service reimbursements compared to Medicare.

Board Certified by the American Board of Family Practice

David J. Badolato, M.D. Ira Z. Gerstman, M.D. [redacted]
Adam T. Turk, M.D. Margaret M. Mulligan, M.D. Louise H. Kuklinski, M.D.
Sam C. Masarachia, M.D. Gregory T. Soltner, D.O. Colleen A. Devinney, D.O.

I am further prepared to address insurance company statements such as:

1. "We pay for quality."
2. "The Co-pays have gone up."
3. "The bill aboves are greater."(Fee-for-service items)

The financial facts behind such phrases are:

1. "Paying for quality": we have a practice whose health and disease management measurements are constantly in the top 1 percent. However, since January of 2003, IBC's payments to us have been reduced by $3,000 per month (for 2,560 patients) based on our patients receiving generic medicines 38% of the time. Best Practices guidelines for diseases such as asthma, diabetes, elevated cholesterol, osteoporosis, and more, require the use of medications for which there are no generics. In addition, a recent prescribing summary (produced by Medco for IBC patients) shows that, compared to our peers, pharmacy costs and the imposed generic penalty, yields a financial benefit to the insurance company of $473,395 per year. The pharmacy costs for our patients are $14.21 less PMPM than our peers. The generic penalty prevents us from receiving an additional $1.20 PMPM ([14.21 PMPM + $1.20 PMPM] x 2,560 = $473,395).

2. The impact of the increased copays per member per month is $1.04.

3. $0.53 PMPM is the amount received in the past year for bill aboves. The current PMPM reimbursement with IBC's Keystone product is $12.13 for commercial patients. The current medicare PMPM is $30.09. The 1994 US Healthcare commercial PMPM was $12.41 and the Medicare PMPM was $40.87. I have requested PMPM data from IBC pertaining to the past 10 years and that request has been refused.

4. If we close the practice to new enrollment of Keystone patients, the IBC PMPM falls from $12.13 to $8.58 for a decrease of 29 percent for commercial patients, and the Medicare PMPM falls from $30.09 to $23.29 for a decrease of 23 percent. Aetna imposes a similar penalty. This is one of the prime examples of what appears to be a market dominant, "take it or leave it" contracting; or one could say, take the contract or leave the state.

5. Our practice cost centers such as healthcare insurance, malpractice insurance, worker comp insurance, rent, personnel costs, and insurance company demands for more information technology hardware and software, have experienced increases during the past 10 years of between 100% and 300%. With only a 2.5% annual cost of living adjustment, the $12.41 PMPM of 1994 would be $16.00 PMPM in 2004. The costs of maintaining a 99th percentile performing Practice exceed $16 PMPM. Our reimbursements are nowhere near the equitable levels required to sustain quality or medical care.

It appears that the 2 dominant health insurance companies of Southeastern PA have been able to proceed with reimbursement reductions unchecked by any outside entity during the past 10 years. They have been able to reduce fee-for-service reimbursements to 20% below Medicare levels, except for the non-physician visit code of 99211.

In addition, the last 10 years have seen a dramatic increase in the insurance company requirement for administrative resources required at the practice level. The administrative resource consumption and the barriers (such as preauthorization/precertification mechanisms) have placed road blocks even in the delivery of gold standard diagnostic tests and treatments.

In March 2003 I presented a lecture on the microeconomics of Quality Healthcare at the AAFP Research Convocation. I have also presented my comprehensive PowerPoint presentation covering all of these issues to selected audiences in Pennsylvania, as well as to the leadership of the two major insurance companies of Southeastern PA. I have requested a collaborative partnership with the two major insurance companies and have been refused.

The impact of reduced reimbursements compounded by the Malpractice Premium issue has led to a serious reduction of entry into Family Practice by United States medical school graduates. These graduates are leaving medical school with a $200,000+ debt load, and cannot afford to enter the specialty of Family Practice. Therefore, Family Practice residency entry has an overall 25% vacancy rate over the past few years. 58% of those entering Family Practice residencies are graduates from foreign medical schools. This is how our infrastructure is being impacted, during a time in which the population of patients age 65 and older is increasing. We need our best and our brightest to support the foundation of Quality, especially in Family Practice.

I request the opportunity to work in collaborative synergy with others who accept the responsibility to be guardians and stewards of an essential social good called Quality Healthcare.

I hope that all who are present today feel compelled to commit to appropriate collaborative actions.

Equitable reimbursements for quality performance is essential. Unnecessary administrative barriers are not cost-effective and interfere with Best Practices.

Centers of Excellence must be used to identify quality delivery systems and appropriate reimbursement systems.

I, and the physicians, staff, and patients of Family Practice of Upper Dublin, invite you to the practice for collaborative analysis of Quality and the reimbursements that are required to sustain it. We welcome the government, Corporate America, medical academic institutions and business leadership to a collaborative platform with us. Together we can define a financially feasible quality healthcare system as it pertains to a foundation specialty, such as Family Practice.

I urge you to stop the increasing damage to the medical infrastructure. If we continue on this path, it may take an entire generation to rebuild the quality components, which will have been destroyed due to our neglecting to act responsibly as guardians and stewards of the essential social good of Quality Healthcare.

I thank you for your attention and consideration, and I expect your responsible actions.

Sincerely,
David J. Badolato, MD
(enclosure: 11 slides)

Family Practice of Upper Dublin (FPUD) Profile

Measured Service Units Per Year (2000)

- 27,000 physician visits
  - 3,700 per FTE
  - Burden of Care Issues
- 5,000 non-physician visits
- 81,120 incoming calls
  - No automated attendant
  - Other dedicated lines not included
- 26,000 calls on Referral line
- 2,600 calls on Billing line
- 21,840 calls by physicians
- 28,340 calls by staff
- 15,000 referrals generated
  - For 5,000 AUSHC patients
- Precerts per year under study

FPUD Profile (Continued)

- "Managing" care for 15,000 community patients
  - 5500+ capitated patient payor arrangement (2004)
    - 2900 Insurer #1 Commercial Members
      - 37 Medicare
    - 2050 Insurer #2 Commercial Members
      - 555 Medicare

Care delivered by 7.25 FTE physicians and 28.5 FTE staff

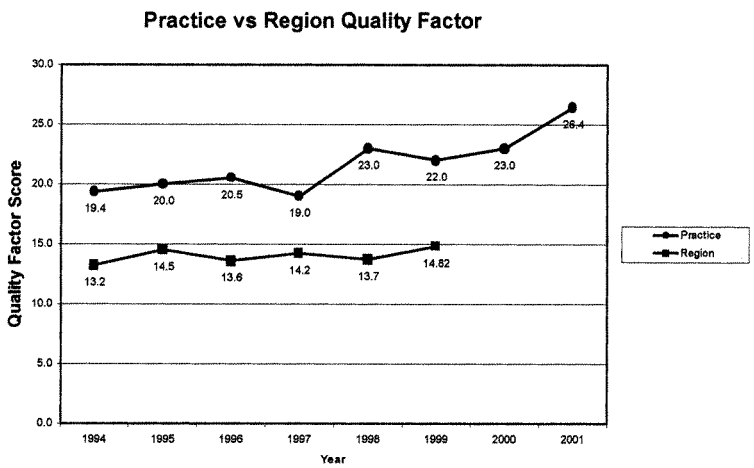
Major Insurer Measurements of FPUD Quality

99th Percentile in Quality Measurements

- Highest Quality Factor Rating
  - 26.4 vs 14.82 SEPA* 50th percentile
- Lowest Transfer Factor
  - 1.9 vs 9.8 SEPA* 50th percentile
- Chart reviews for NCQA Health and Disease Management focus areas consistently in 99th percentile

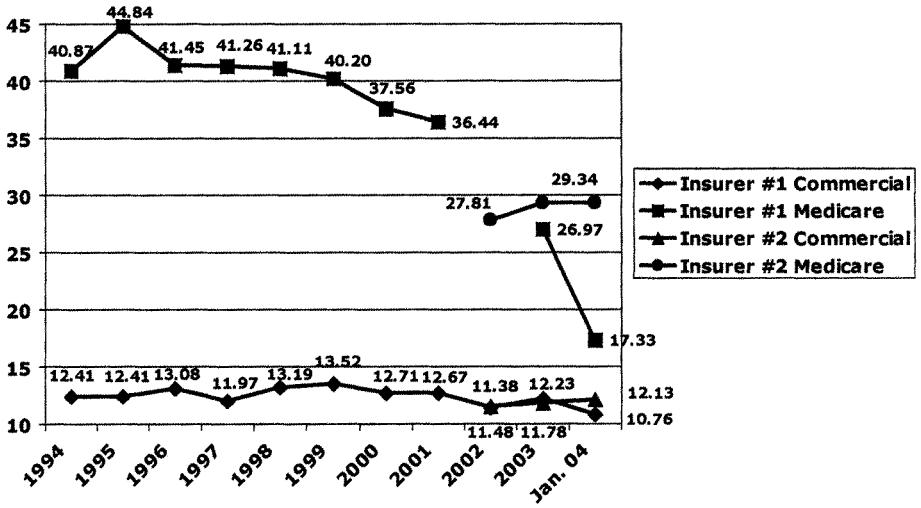
* Southeastern Pennsylvania

Major Insurer Measurements of Quality Factors in Primary Care



*Quality Factor as measured and reported by major insurer, predominantly for outpatient care of their members in family medicine, pediatric and internal medicine practices. Region data not available for 2000 and 2001.

PMPM Analysis: Major Insurers' Reimbursements to FPUD



Economic Impact of Declining PMPM on FPUD

- Using annual inflation factor of 2.5%, $12.00 PMPM reimbursement in 1994 should have increased to $15.36 in 2004
  - This assumes healthcare inflation mirrored the overall economy when, in fact, some costs have risen 100 – 300%
  - PMPM should have gone up ≥ 50%, but they have dropped 12.5% for Insurer #1
  - Impact of the co-pay differential for 2003 vs. 1994 increased the 2003 PMPM by $1.04
- FPUD HMO capitated total has been stable at 6,000 members
  - Reimbursement deficit ≥ $6.00 PMPM
  - $36,000 per month = $432,000 for 2003/2004
- Disconnect between reimbursements and quality care in quality leader family practice in S.E. Pennsylvania

Insurer #1 Financial Disclosure

- Premiums increase 16.5% in 2003
- Significant insurer profit increases continue and reserves rise
  - Evidenced by total reserves for Pennsylvania of $4 Billion; $900,000,000 in SEPA (well above requirements) -Insurer #2
- This while 1994 – 2004 PMPM reimbursements decrease

1. Systemic Threats and Challenges to Family Practice (Continued)

- Insufficient physician income
  - Avg. $100,000 annual salary @ 60+ hours per week = $32 per hour
    - Insufficient to repay $200,000+ debt from educational loans
  - FPUD compensation package for 1999 to Present is below 1994
    - Total 10-year pension/profit sharing contribution for highest paid physician = $24,000
- Decreased U.S. medical student interest in the specialty
    - 25% vacancy in Family Practice Residencies in 2003
    - 58% filled by graduates from foreign medical schools in 2003
- Physicians leaving family practice in unprecedented numbers; difficult to recruit/retain physicians and staff
- Skyrocketing malpractice premiums compound the problem
- Increased administrative load to meet payer requirements

2. Define "Quality" in Family Practice

Institute of Medicine (IOM) *Quality Chasm*

Definition -- Care should be:

- **Safe** = Patients should not be harmed
- **Effective** = Best practices
- **Patient-centered** = Responsive
- **Timely** = Remove unnecessary barriers
- **Efficient** = Optimal use of resources
- **Equitable** = Assure access to consistent quality care

Barriers to Access to Quality Care

- Incomplete disclosure of plan specifications / benefits
  - Pharmacy plan
  - DME
  - Chiropractic care
- Inconsistent and inappropriate implementation of "benefits"
  - Pharmacy precerts
  - Denials
  - Downgrading
- Catastrophic / high morbidity case migration to where they are not considered "Adverse Selection"
  - IDS
  - Lower Quality Factor practices
  - Boston / California

5. Reward Quality Outcomes Achieved in a Cost-Responsible Manner

Future models for reimbursement should:

- Compensate for achievement of quality of care and quality of service targets
- Understand and incent leading indicators of quality outcomes
- Reward quality outcomes achieved in a cost-responsible manner

U.S. Senate

Hearings on Health Insurance Markets in Southeast Pennsylvania

Sen. Arlen Specter

Testimony of Lawton R. Burns, Ph.D., MBA
The James Joo-Jin Kim Professor
Professor of Health Care Systems and Management
The Wharton School
University of Pennsylvania
April 12, 2004

Testimony of Lawton R. Burns regarding the Market Structure for Health Insurance in Southeast Pennsylvania

1. Introduction

Good morning. My name is Lawton Robert Burns. I am the James Joo-Jin Kim Professor, Professor of Health Care Systems and Management, and Director of the Wharton Center for Health Management and Economics - - all at the Wharton School at the University of Pennsylvania. I appreciate the opportunity to present testimony about the market structure for health insurance in Southeast Pennsylvania and some of its observed effects.

My remarks are drawn from research I am now conducting on the history of the Southeast Pennsylvania insurer and hospital markets during the 1980s and 1990s. They are also based on past research of some of my colleagues at the University of Minnesota on the effects of managed care market structure nationally, and a current research project we are jointly conducting on the relationship between insurer market structure and hospital market structure.

I should point out that my remarks on Southeast Pennsylvania are based on several years of research, data analysis, and interviews with major stakeholders in this market. However, I have not had as much access to the executives of Independence Blue Cross as I would have liked. Thus, my remarks do not fully reflect their side of the story. With Blue Cross' assistance, I would like to correct this in the future.

The Southeast Pennsylvania market, for the purposes of my remarks today, includes Philadelphia County and the four suburban counties in Pennsylvania: Bucks, Montgomery, Delaware, and Chester. Also for purposes of definition, I define "market structure" in terms of the number of competitors and their relative share of the market. These two components are often summarized as the Herfindahl-Hirschman Index (HHI). This index measures how much market share is concentrated in one or a few large firms.[1] The higher the HHI, the more concentrated the market, and the more powerful are one or a few firms. According to the Department of Justice's Horizontal Merger Guidelines, markets with HHI greater than 1,800 are highly concentrated.

2. The Southeast Pennsylvania Market

.The five-county area in Southeast Pennsylvania exhibits a big contrast in insurer and hospital market structures. During the 1990s, the hospital market featured lots of competition between lots of hospitals. The HHI for hospital services in Southeast Pennsylvania ranged from 185 – 654, depending on the year of measurement and whether one assessed market share in terms of beds or inpatient days. Regardless of which

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[11] The HHI is measured as the sum of the squared shares of each firm in the market. Thus, a market with three firms whose shares are 25%, 25% , and 50% would be equal to: $25^2 + 25^2 + 50^2 = 3{,}850$.

measure one used, this was a very competitive hospital market with low concentration. Philadelphia consistently ranked among the five (5) most competitive hospital markets (i.e., low HHI) in the U.S. with a million or more population. All of the hospital system formations during the 1990s barely raised the hospital HHI in Southeast Pennsylvania.

On the other hand, the health insurance market in Southeast Pennsylvania is quite concentrated. Data from both InterStudy and health insurers' Annual Reports filed with the Pennsylvania Department of Insurance. Data from InterStudy indicates that the HHI for health maintenance organizations (HMOs) operating in the Philadelphia market was 4,134 in 1999 and 4,209 in 2000.[2] Data from the Pennsylvania Department of Insurance indicates that the HHI for HMOs in Philadelphia has risen steadily since 1994 (HHI = 3,577) until 2000 (HHI = 4,603).[3] Depending on which data source you use, this places Southeast Pennsylvania in the top five percent (5%) most concentrated insurer markets in the U.S. with a million or more population.

To be sure, HMOs are only one part of the insurer market. One also needs to consider preferred provider organization (PPO) and point-of-service (POS) plans. A recent report that analyzes the market structure of large U.S. metropolitan areas with a million or more population found that Philadelphia had the fifth (5th) most concentrated market for PPO enrollment, and the highest (#1) concentrated market for combined HMO and PPO enrollment (HHI = 3,643).[4]

For both HMO and PPO products, Independence Blue Cross (IBC) is the market leader in Southeast Pennsylvania. In 1997, for example, IBC had captured 41.1% share of the HMO market through its Keystone Health Plan East subsidiary, and 68.5% share of the PPO market.

In sum, Southeast Pennsylvania features two contrasts with other large cities: a very competitive hospital market (low HHI) and a very concentrated insurer market (high HHI). This type of situation may lead to high levels of insurer market power over hospitals (and consumers of health insurance). I consider some of the evidence for this below.

3. Possible Exercise of Market Power by Independence Blue Cross

My research on the history of the Philadelphia market did not concentrate on IBC or its use of its potential market power. However, several studies conducted during the 1990s by the Delaware Valley Hospital Council suggest that IBC utilized its market power in ways detrimental to the cash flow of hospitals. For example, among commercial insurers

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[2] HMO enrollment data are based on the following products: traditional HMO, open-ended HMO, Medicare, Medicaid (where the plan also sees non-Medicaid patients), and self-insured.

[3] HMO enrollment data include all products according to the insurers' Annual Reports.

[4] American Medical Association (2001). *Competition in Health Insurance: A Comprehensive Study of U.S. Markets* (Chicago, IL: AMA).

during the mid-1990s, IBC exhibited the highest denial rate for hospital inpatient services - - both in terms of the percentage of patients denied and the % of inpatient days denied. Similarly, IBC and its HMO subsidiary (Keystone Health Plan East) exhibited the highest median payment denial rate for emergency room services. Finally, IBC exhibited the lowest access to acute rehabilitation services for its Medicare managed care enrollees.

Other data collected by the Pennsylvania Medical Society and the American Hospital Association provide additional evidence for the exercise of market power by IBC. During the mid to late 1990s, IBC featured the largest number of unpaid claims to Philadelphia providers in terms of dollar volume among all insurers. Hospital payment to cost ratios for privately-insured patients also began to fall by the mid-1990s through the end of the decade. These decreases were more pronounced in Southeast Pennsylvania than in other metropolitan areas. As noted above, IBC dominated this market.

4. A Look at the National Evidence

Nationally, there is also evidence that HMOs that have attained market power have exercised it over both consumers and providers. For example, my colleagues at the University of Minnesota have documented that HMOs that enjoy high HHIs sell their managed care products at higher premium levels to employers and other buyers. Similarly, they have found that HMOs that account for a larger share of all inpatient days in market can force down hospital prices per day paid.).[5] The researchers have not investigated whether HMOs attempt to exercise market power simultaneously both upstream (with employers/buyers) and downstream (with hospital suppliers).

The typical US metropolitan area has a concentrated HMO market. Across all metropolitan areas with one million or more population, the median HHI for HMO insurance is 2291 (1999-2000 data). Although this value is higher than the cutoff point used by the Department of Justice (HHI = 1,800) to define a highly concentrated market, it does not include competition from other types of insurance. It is thus unclear whether the effects described are widely found in other parts of the country. Philadelphia, however, appears to be an outlier compared to the rest of the country.

5. Conclusion

The data suggest that Philadelphia is a unique market when one considers both the insurer market and the hospital market. There seems to be a huge imbalance of bargaining power between insurers and hospitals due to the high concentration (HHI) in the former and the

[5] D. Wholey, R. Feldman, and J. Christianson (1995), "The Effect of Market Structure on HMO Premiums." *Journal of Health Economics* 14(1): 81-105. R. Feldman and D. Wholey (2001), "Do HMOs Have Monopsony Power?" *International Journal of Health Care Finance and Economics* 1: 7-22. The authors do find that while HMOs use their power to extract lower prices from hospitals, they then tend to purchase more days (thus leading to a net welfare gain and no net change in how much money they spend on hospital services).

low concentration (HHI) in the latter. Evidence also seems to suggest that IBC has exploited this differential market power. Moreover, at least nationally, there has been a tendency to allow insurers to amass more market power than providers in order to allow them to extract lower prices for inpatient and outpatient care, with the hope of lowering the rate of increase in healthcare spending.

I am not aware of rate of increase in healthcare spending in Southeast Pennsylvania, and thus cannot comment on what overall effects may have been exerted or achieved by IBC's dominance in the market. The available evidence suggests the welfare of hospitals may have been hurt - - as reflected in past statistics on denial rates, slow payment of claims, and low payment-to-cost ratios.

Statement

of the

Pennsylvania Medical Society

to the

Subcommittee on Antitrust, Competition Policy and Consumer Rights
Committee on the Judiciary
U.S. Senate

RE: The Healthcare Crisis in Southeastern Pennsylvania:
The Role of the Health Insurance Industry

Presented by: Stephen Foreman, Ph.D., J.D., M.P.A.
Vice President, Research, Pennsylvania Medical Society and
Director, Pennsylvania Medical Society Health Services Research Institute

April 12, 2004

Pennsylvania
MEDICAL SOCIETY®
Doctors and Patients. Preserve the Relationship.®

Testimony of the Pennsylvania Medical Society regarding Southeast Pennsylvania Health Insurance Markets

1. Introduction

Good morning. I am Stephen Foreman, Vice President for Research of the Pennsylvania Medical Society and Director of the Medical Society's Health Services Research Institute. The Medical Society appreciates this opportunity to present testimony about Pennsylvania's health insurance markets and their impact on the practice of medicine. We view this as an important hearing to enhance interaction between patients and their doctors. Our goal is to ensure a strong patient-physician relationship.

Today's remarks concentrate on markets in the five counties of Southeastern Pennsylvania. However, there are problems in other regions of the state and nationally. We believe that it would be a public service to conduct additional hearings into the operation of other regional health insurance markets.

My testimony will briefly describe the Southeast Pennsylvania health insurance market and how it evolved into its present form. Specific information will focus on market shares, participant conduct, economies of scale, barriers to entry, and expected reactions by participants.

I would like to make it clear that our testimony is not intended as a corporate or personal attack on any of the market participants and the people who work for them. Each of them is doing what they think is best. However, each is "doing what comes naturally" in a failed market. This, we believe, is the fundamental cause of a host of problems and calls for extensive public policy analysis and response.

2. The Southeast Pennsylvania market

Clearly, Independence Blue Cross has a dominant share of the Southeast Pennsylvania health insurance market. We define the product market as private commercial health insurance and the geographic market as Philadelphia, Montgomery, Delaware, Chester and Bucks counties. In 2002, according to its Annual Report, Independence had about 2.5 million private commercial enrollees in this market. Aetna's filing with the Pennsylvania Department of Health shows approximately 400,000 enrollees in these five counties. No other firm lists any significant enrollment. Accordingly, in 2002 Independence had an 86% share and Aetna 13.5%. Please refer to Figure 1.

Health insurers collect premiums from employers (and private individuals) to cover medical expenses. They pay hospitals and physicians for medical services rendered to enrollees. Accordingly, we look at how the market has responded by considering employers, hospitals, and physicians.

Basically, employers, hospitals, and physicians in this market are fragmented. Most employers in the Philadelphia market have fewer than 250 employees. To our knowledge there is no effective employer purchasing coalition. Certainly, employers hold nowhere near the market power maintained by Independence. Despite a wave of defensive consolidations that has put most hospitals in Southeast Pennsylvania into a system, the market for hospital services in Southeast Pennsylvania is not very concentrated either - with the largest system holding a 23.5% share. Figure 2 shows hospital concentration. About half of the physicians in the market are employed. Of those who are not employed it is rare to have a physician group that is larger than ten members. Physicians are fragmented as well.

What does such a market produce? Annual double-digit health insurance premium increases going back to the early 1990s. Please see Figure 3. Unilateral decisions about hospital payment with a number of hospitals having trouble making ends meet. Physician fee schedules that are unilaterally imposed and have provided stagnant or declining compensation (even after a 20% increase over the past several years) leaving most private commercial physician fee levels substantially below Medicare levels. Financially, health insurers have generated substantial profit levels – with returns as high or higher than other national or regional health insurers.

How did this market evolve? Not by "skill, foresight and industry." Independence's overhead costs are good - but not remarkably better than other firms in the industry. Contributing factors to market concentration include a division of markets agreement among Pennsylvania's Blue Cross firms, IBC's acquisition of full control of Keystone East in 1997, Personal Choice's expansion by pricing PPO products below competitors' HMO prices, use of an exclusive broker system, low payments to physicians and hospitals, use of all products and most favored payer contract terms, and imposition of a 75% rule for employers.

There is no evidence that larger health insurers are more efficient. To the contrary, published studies show that health insurers exhaust their economies of scale at 100,000 to 150,000 enrollees. Our own work confirms this conclusion, albeit at a slightly higher number. Insurers with one million, two million, four million or five million enrollees are not any more efficient and may, in fact, be more inefficient than smaller ones.

America's Health Insurance Plans, the insurance industry's trade association, contends that health insurance competition is robust and that entry into health insurance markets is easy. This is certainly not the case in Southeast Pennsylvania. Effective competition in the form of new entry requires employer credibility that an entrant will make a long-term commitment to the market. Given market exit by most smaller Southeast Pennsylvania plans, this credibility is lacking. Nor does employer self insurance provide effective competition in an area where dominant insurers demand and receive lower provider prices than self insured plans could ever receive on their own.

Market entry barriers are high – and are rising higher. In order to compete effectively new entrants would have to bring (and be willing to spend) capital matching the surpluses maintained by Independence – more than $840 million. In addition, duplicating the networks and knowledge that have been built by existing health insurers provides a substantial entry barrier. Most favored payer contract clauses and all products requirements taken in tandem (enforced by

conduct after contract terms were dropped) ensure that new entrants will gain no pricing advantages. Indeed, the best evidence that there are substantial barriers to entry in this market is that despite existing firm profit levels exceeding $200 million annually there has been no substantial new entry in this market during the past ten years.

3. Antitrust

So why isn't the Southeast Pennsylvania market the subject of an antitrust investigation? The Sherman Act has two provisions that would appear to apply – prohibitions of (1) monopolization and (2) contracts, combinations and conspiracies in restraint of trade.

For monopolization or monopsonization it is necessary to show that a firm has a dominant market share and has engaged in "prohibited conduct." The dominant share test is met here. The question is whether there is prohibited conduct. Conduct that might fall under this rubric includes monopoly rents, diseconomies of scale, predatory pricing, price discrimination, product tie-ins (all products clauses), various contract provisions (or conduct in lieu of contract terms) including the combination of all products and most favored payer terms, discriminatory pricing in the sale of health insurance and the 75 % rule for sales to employers.

Contracts, combinations and conspiracies in restraint of trade are evaluated under per se and rule of reason standards. There are four substantial Blue Cross firms that operate in Pennsylvania: Independence, Highmark, Capital and Northeast Blue. Despite the fact that all four could easily compete in the Southeast Pennsylvania market, only Independence offers products in the region.[1] We understand that this is due to a division of markets and non-competition agreement at the national level. If this is the case, the full ramifications of the agreement bear investigating.

There are, perhaps, reasonable arguments that the way Southeast Pennsylvania markets are organized and operating does not violate the antitrust laws. We respectfully suggest that such a conclusion should not end the inquiry. We ask whether as a matter of public policy – good medical care and sound economics – such organization and operation is a "public good." If the conclusion is that it is not, then changes in the antitrust laws that restore competitive balance are clearly warranted.

4. Public policy

America's Health Insurance Plans argue with some force that dominant health insurers provide a public service because they hold down health care costs. Persuaded by this logic – fearing large health care premium increases from enhanced physician and hospital negotiating power – business and labor often side with the health insurers' assertion that bigger is better because it allows them to police utilization, control input prices and monitor billing and collection practices. You will hear today that Independence needs its size and that physicians and hospitals must stay fragmented in order to hold down health care cost increases. Simply put, this is not true and it does not make for sound public policy.

[1] With the exception of a small amount of remaining Blue Shield indemnity business served by Highmark under a joint operating agreement with Independence and joint ownership in Inter-County Health Plan.

First, our nation is built on the rule of law. We cannot permit violations of the antitrust law to persist, even for the best of motives. To foster or allow monopolization when it is "good for the public" makes a mockery of the law. If the antitrust law is flawed – if we really think that private regulation of health care prices is sound public policy – then we ought to repeal the antitrust laws in the health care setting rather than "looking the other way" in the public interest.

Second, despite the strenuous assertions of well meaning health insurers, we do not believe that private monopoly and monopsony enforcement of medical care prices is in the public interest. The very reason for antitrust laws is that competition – when it is possible – provides the most efficient allocation of scarce resources. And we see no reason why competition in health insurance could not work in Southeast Pennsylvania. If – as some like Nobel Laureate Kenneth Arrow argue – markets cannot work well in the medical care arena due to information asymmetry, public not private regulation is required. In competitive settings the market itself corrects "mistakes" or imbalances. Where competitive markets cannot work, public regulation steps in. The political process corrects mistakes and imbalances. However, where mistakes and imbalances are dealt with by private regulators neither the market nor the political process can be brought to bear and mistakes and imbalances can persist.

Third, one of the most problematic issues with monopolists and monopsonists is that over time such entities become inefficient. A number of leading health economists have chronicled this for Blue Cross firms. Even if dominant health insurers give us health care cost containment in the short run, the long-run inefficiency loss can easily outweigh short-run cost containment gains.

Fourth, the health insurers' cost containment argument presumes that health insurers pass their input "cost savings" (from reduced hospital payments and physician fees) along to employers and the public through reduced health insurance premiums. However, employers' double-digit health insurance premium increases over the past ten years and the level of health insurer profits suggests that these "savings" are not being passed on.[2]

Finally, the notion that the whole problem of rising health care costs can be dealt with through a simple "cost reduction" by reducing hospital and physician prices is totally misplaced. Rising costs are a function of a complex host of factors including an aging population, ever-higher levels of technology, increased demand, medical care provider supply and productivity (particularly nurses and specialty physicians), service industry sensitivity to inflation, increasing costs of supplying medical care and defensive medicine reactions to liability fears. Indeed, we expect that you will hear today about medical care utilization problems in the Philadelphia area. Hospitals and physicians are more cognizant of and more concerned about rising health care costs more than anyone in the system. However, a simplistic private regulatory response that shifts all of the responsibility to control costs to hospitals and physicians is unfair, improper and does not deal with the real underlying causes of medical care cost inflation. More important, such a simplistic response will inevitably destroy hospitals and physicians financially and will

[2] Indeed, the health insurers' argument – that better market balance would increase hospital and physician payments and that these costs would have to be passed on to the employer presumes that health insurers are not now charging "what the market will bear" in terms of health insurance premium prices. There is no evidence that health insurers are pricing "under market." Indeed, such conduct, if it existed, would not be economically rational and would lead to inefficiently high levels of private commercial health insurance coverage.

radically drastically reduce patients' access to quality medical care. Some of the physician and hospital testimony that follows will provide specific examples. This is the most compelling reason why private regulatory enforcement of medical care prices is not good public policy.

5. Conclusion

So where does this leave us regarding the composition and operation of the markets for health insurance and medical care in Southeast Pennsylvania? First, this problem while acute, is not unique to the Philadelphia market. The second edition of the AMA's Concentration in Health Insurance Markets published in early 2003[3] described high levels of health insurer concentration in a number of markets across the country. High levels of concentration and substantial health insurer profits suggest the need to broaden the inquiry regarding organization and operation of health insurance markets.

More important, the evolution of the Southeast Pennsylvania health insurance market puts us squarely at a crossroad. Do we believe that a fully competitive private commercial health insurance market is the best way to allocate scarce medical care resources?

If we believe that competition is the answer, major steps need to be taken to restore competition to this market and others. Enforcement and / or amendment of the antitrust laws would be an important first step. In addition, we should consider policy interventions from a menu of options that include ways to reduce the size and dominance of existing insurers, limitations on dominant insurer conduct, development of effective countervailing power tools and mechanisms to encourage and nurture new entry into concentrated markets.

If we believe that health care can only work through regulatory enforcement of medical care use and costs, we should consider implementing a single payer system. The details of such a system have long been the subject of intense debate. However, past debate has not focused on the role of the private commercial health insurer in a single payer system. We should not be ready to conclude, as many are beginning to suggest, that private commercial health insurers are the best choice as administrators (and private regulators) of a single payer system. There may be better options.

In any event, Pennsylvania's physicians believe that the current situation for health insurers, hospitals, physicians, employers and the public is untenable and growing worse. They are integral participants in failed markets for health insurance and medical care.

As our elderly population increases rapidly in the upcoming decade, we will need to provide ever-increasing amounts of medical care. Pennsylvania physicians urge appropriate action to deal with problems in health insurance and the medical care delivery system so that they can continue to deliver the best possible medical care to each of their patients.

[3] The third edition will be available soon.

Figure 1

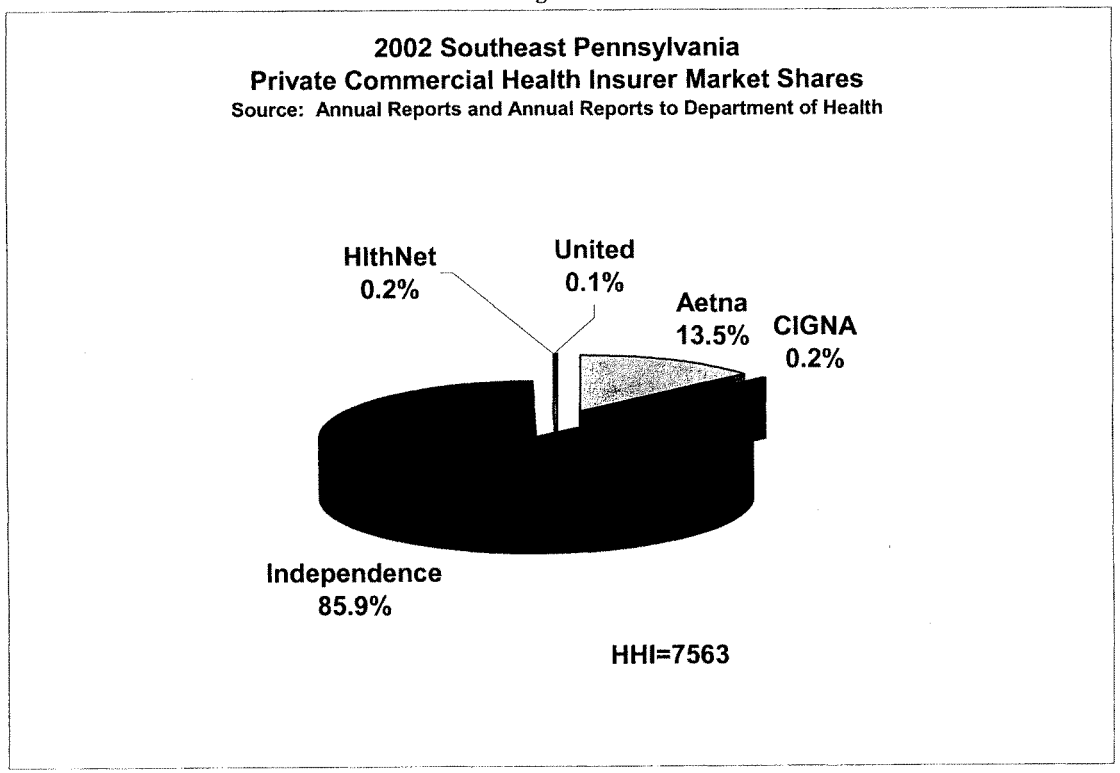

2002 Southeast Pennsylvania
Private Commercial Health Insurer Market Shares
Source: Annual Reports and Annual Reports to Department of Health
HlthNet
0.2%
United
0.1%
Aetna
13.5%
CIGNA
0.2%
Independence
85.9%
HHI=7563

Figure 2

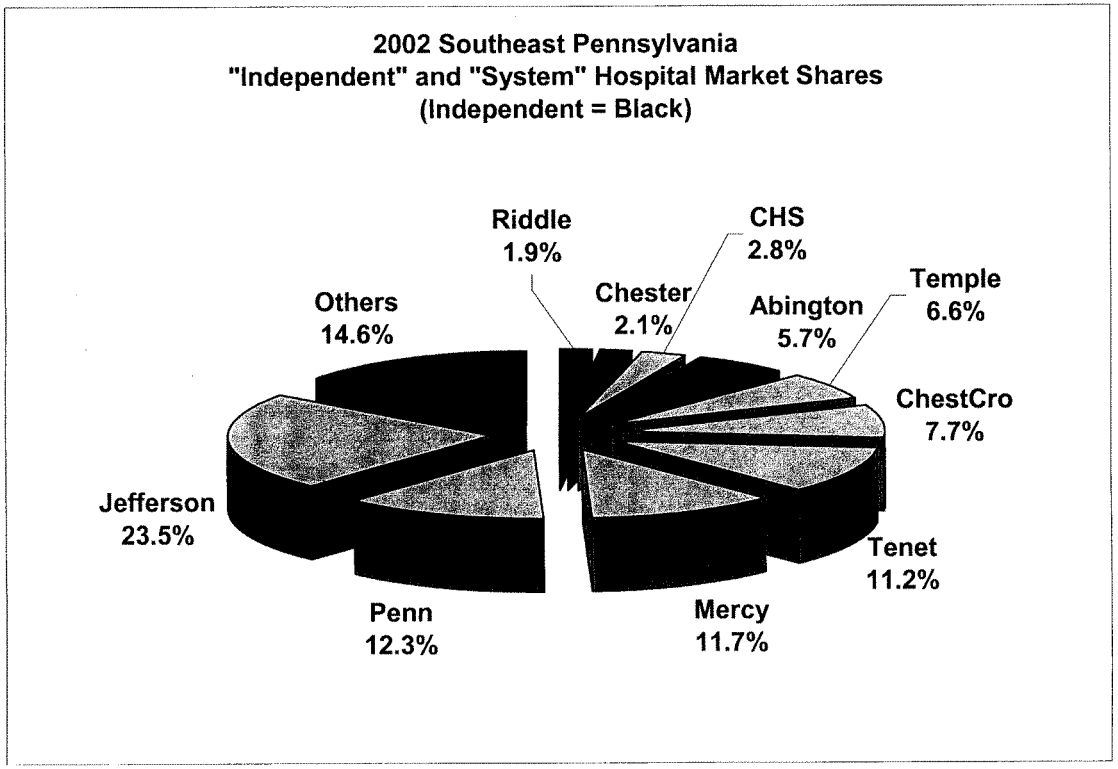
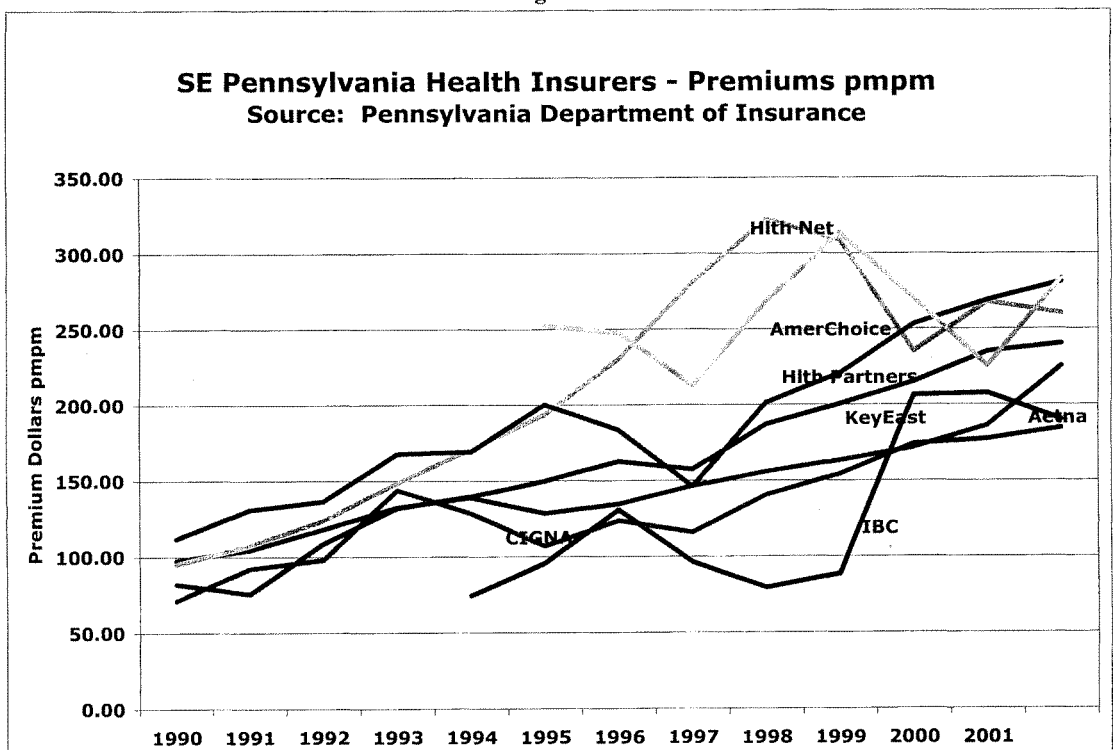

2002 Southeast Pennsylvania
"Independent" and "System" Hospital Market Shares
(Independent = Black)
Riddle
1.9%
CHS
2.8%
Temple
6.6%
Chester
2.1%
Abington
5.7%
Others
14.6%
ChestCro
7.7%
Jefferson
23.5%
Tenet
11.2%
Penn
12.3%
Mercy
11.7%

Figure 3


SE Pennsylvania Health Insurers - Premiums pmpm
Source: Pennsylvania Department of Insurance
Premium Dollars pmpm
350.00
300.00
250.00
200.00
150.00
100.00
50.00
0.00
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
Hlth Net
AmerChoice
Hlth Partners
KeyEast
Aetna
CIGNA
IBC

Statement of Joseph W. Marshall
Chairman and Chief Executive Officer
Temple University Health System

Appearing before the
Senate Subcommittee
on
Anti-trust, Competition Policy and Consumer Rights
of the
Senate Judiciary Committee

April 12, 2004

Good morning Senator Specter. I am Joseph W. "Chip" Marshall, III, Chairman and CEO of the Temple University Health System (TUHS). Thank you for the opportunity to testify today, and thank you for holding this hearing to consider whether anti-trust law should allow collective bargaining among physicians to enable them to negotiate with health insurers and to consider the role of large health insurers in the Southeast Pennsylvania healthcare market.

I last testified before you in March 2003 at another Senate hearing on Medicare Outlier Payments, and appreciate your leadership in helping healthcare providers receive fair and adequate reimbursement to ensure quality and accessible healthcare for all Pennsylvanians.

The Temple University Health System (TUHS) is comprised of a major academic teaching hospital, three community hospitals, one pediatric hospital, a ground transport team and network of more than 1,500 physicians, TUHS is a cornerstone of the health care delivery system in Philadelphia and the surrounding region.

On any given day, approximately 500 people utilize the services of TUHS emergency rooms and an additional 1,700 present for non-emergency ambulatory services. As one of the largest private employers in the City of Philadelphia, TUHS entities employ approximately 7,000 people, pay nearly $300 million annually in salaries, and an additional $73 million annually in benefits.

As CEO of this comprehensive health system, which is faced daily with numerous complex issues, I view the physician bargaining question from a unique vantage point. It would be a great relief if this were the only challenge before us. Every day, we struggle with rising pharmaceutical, medical supply and technology costs, workforce issues and escalating malpractice premiums. Compounding this, we are faced with a rising tide of patients without health

insurance. Last year alone, TUHS provided nearly $63 million in charity care to the communities we serve.

While we strive to mend a healthcare delivery system in urgent need of repair, we must take care not to focus on a quick fix. Rather, we must work collaboratively to promote improvements in the health care delivery system to benefit hospitals, physicians, insurers, employers, and above all, our patients.

I know that collective bargaining among physicians is offered as a solution to Pennsylvania's healthcare delivery problems. Some see this as a way to help balance competing interests of physicians and insurers, encourage physicians to practice in our region, and improve quality and continuity of healthcare. Others believe that insurers will simply pass along higher costs to employers and other consumers who continue to strive to meet rising insurance costs, ultimately causing an increase in the number of patients who present to hospitals without health insurance. Clearly, the question of collective bargaining is difficult, but is only one of many that must be answered in resolving the healthcare crisis in Southeast Pennsylvania.

There is no doubt that as the region's leading healthcare insurer, Independence Blue Cross (IBC) casts a giant shadow over healthcare providers in this region. In fact, a little over one year ago, TUHS locked horns with IBC during arduous contract negotiations.

Did IBC give us all that we asked? Certainly not. Did IBC take our concerns seriously? Yes. Did we negotiate a fair contract? Yes. Together, we issued a joint press release, and TUHS placed a full-page newspaper advertisement marking the successful completion of negotiations that marked the beginning of a new five-year agreement.

Make no mistake, however, neither TUHS nor any hospital in the region can say all is perfect in its payer relationships. We would love for IBC and other insurers to pay us more. Our costs are rising, but we cannot pass them on. We recognize, however, that there is no single cure for our region's healthcare problems, and finger pointing will not provide the solution.

Looking around this room, I see many stakeholders in the healthcare delivery system: labor leaders, business leaders, government leaders, physicians, healthcare administrators, and consumers. It is only by working collaboratively, that we can fix our region's healthcare system, to improve delivery, enhance quality, ensure affordability, and increase accessibility to all. TUHS is committed to working with all stakeholders to build a sturdy healthcare system to meet current needs and to assure a stable delivery system for the next generation.

Senator Specter, thank you for the opportunity to testify on this matter and for your leadership on this important issue.

Testimony of Martin D. Trichtinger, MD

Presented to

The Senate Committee on the Judiciary
Subcommittee on Antitrust, Competition Policy and Consumer Rights

April 12, 2004

Good morning Senator Specter and members of the committee. My name is Martin Trichtinger, MD. I am an internist practicing in Abington, Pennsylvania. I have been in practice since 1983. It is my pleasure to care for patients in the office, the hospital, and in nursing homes.

First, let me thank you for allowing me to speak with you this morning.

I would like to describe for you how difficult it is to provide the level of quality care to my patients, and your constituents, that I believe should be provided. The reason is because of the many wedges being driven into the patient-doctor relationship. Southeastern Pennsylvania has some of the highest practice costs in the nation, driven by the professional liability crisis and some of the worst reimbursement levels nationally for care delivered.

I'd like to begin by focusing on the contracting process. First, there are two giant insurers operating in this market—Independence Blue Cross, which I will refer to as IBC, and Aetna. Neither I nor the group of physicians in which I practice at Abington have the ability to negotiate or amend our contract with either of these two payers. Aetna and IBC insure over 95% of the private commercial patients regionally. For this reason, they dictate the terms of contracts including the level of reimbursement for the cost of patient care. It doesn't matter if the reimbursement is less than what it costs to deliver appropriate care. For example, it costs me more to provide immunizations than what I am paid not including my time to administer the immunization. I have no ability to change this dilemma. In fact, in 1998 IBC unilaterally decreased fees for many services. In some cases the decrease was more than 60 percent. Since that time, some fees have been increased, but many of the current fees remain below 1998 levels.

So, why would I accept a contract that provides unfavorable terms? Unfortunately, the answer is all too simple. I have no choice if I want to help patients.

In addition to the low levels of reimbursement, both fee-for-service and capitation, contracts also allow these insurers to play claims processing and other "insurance games," as well as impose administrative hassles on my staff and patients. This further tightens the vice grip of escalating office costs and unfair reimbursement. These games include bundling of separate services into a single payment. Insurance companies play another destructive game when they do not recognize various aspects of the Current Procedural Terminology, the nationally recognized procedure coding system known by the initials CPT®. CPT® was developed and is maintained by the American Medical Association.

In simple terms, there are a number of CPT® procedure code modifiers that are not recognized by these insurers or are not used as intended by CPT®. This failure contributes to the erosion of the financial stability of medical practices. The CPT® system must be fully utilized for the standardization of medicine and for the procedure code system to be valid. Having the ability to pick and choose what aspects of the coding

system favors the insurer, and electing not to adopt those coding provisions that favor patient care, is patently unfair.

Ultimately, the tight vice grip that squeezes physicians hurts patients, too. In some instances, because of this vice grip effect, patients may not have access to cutting-edge technology through a doctor's office due to financial restraints. Or, retention and recruitment of quality staff at doctor's offices are hurt because employment benefits might not be as attractive as they are in other locations without such a repressive insurer problem.

My practice at Abington admits patients to hospitals and cares for these patients while they are hospitalized. Hospital admissions can occur at any hour on any given day. Hospitalized patients often are quite ill and need their doctor. Care is often demanding, both clinically as well as emotionally.

Our group believes that it is in the patients' best interest to "be there" when patients are hospitalized. Our physicians play a vital role in advocacy, safety, quality, and teaching in the fulfillment of hospital obligations. These are values we think that IBC should cherish rather than discourage with the current reimbursement strategy.

Until August 2001, IBC paid an "episode of care" fee of $350 per admission to care for each Keystone 65 (that is, Medicare) patient I admitted to the hospital. This fee covered the admitting orders, daily visits to see the patient, ordering and reviewing diagnostic tests, discharge summary, and patient discharge instructions. In August 2001, IBC unilaterally terminated this fee. Compensation for this care was completely eliminated. Now, physicians admitting patients to the hospital receive no payment for the care they provide. Physicians who do not see patients in the hospital refer patients to hospitalists who are paid for this effort. When this dilemma was presented to IBC--why we couldn't be paid for our inpatient care even on referral from other primary care physicians, we were told we would be in violation of our contract with IBC. IBC has presented us and our patients with a "lose-lose" dilemma. Either we continue to treat our patients when they are admitted-for free-or in order to make up for the lost income we stop treating them when they are admitted. In either case patients and physicians both lose.

As an internist, hospital care was a major emphasis of my professional training. When this issue was brought to the attention of IBC, it was clear that IBC had no interest in changing its policy. It is this kind of "take-it-or-leave-it" approach that has changed the practice of medicine in a manner that's not good for patients.

It seems ironic, and possibly wasteful, that IBC will pay another physician to take care of my hospitalized patients. It makes little sense in terms of quality or continuity of care that IBC will not reimburse me to take care of my own hospitalized patients. No one knows my patients and their medical histories better than I do.

IBC's termination of this "episode of care" fee has had a substantial impact on our practice revenue. In a six-month period, approximately 5,572 hospital-level visits were

provided to IBC members by my group without compensation. This equates to hundreds of thousands of dollars in loss to our practice, and potentially millions of dollars in loss network wide since 2001. This is money that could be spent upgrading equipment, paying for escalating medical liability insurance costs, or improving benefits to retain quality staff or help with the recruitment of new physicians.

It should be noted that as a Medicare managed care contractor, IBC pays physicians below what Medicare pays physicians in its fee-for-service plan. But, because of their ability to completely control the market, IBC can set the payment bar at any level they desire.

Thank you for the opportunity to provide testimony today. I am hopeful that you will be able to have the appropriate federal regulatory agencies review the health delivery market dynamics in the Philadelphia area. We need to bring the best and brightest physicians to Philadelphia, and we need to keep them here so that patients benefit. We believe that now is the time to come to terms with this serious problem.

I'd be glad to answer any questions the subcommittee may have.

Testimony Before U.S. Senator Arlen Specter
Steven Udvarhelyi, MD
Senior Vice President and Chief Medical Officer
Independence Blue Cross

April 12, 2004

Senator Specter, thank you for the opportunity to participate in today's hearing. My name is Steven Udvarhelyi, and I am Senior Vice President and Chief Medical Officer for Independence Blue Cross. I am also a Board Certified Internist and a licensed physician in Pennsylvania, New Jersey and Delaware.

From my perspective, two critical health care issues are facing our region:

- One is a cost crisis that is making health care increasingly unaffordable;
- The other is the perpetuation of misinformation about what is causing this crisis.

The fact is, health care costs in this region are skyrocketing, and are higher than almost any other region in the country. And it's also a fact that when health care costs increase, so do health insurance premiums.

Here's the bottom line:

The most common Commercial policy we sell at Independence Blue Cross is our Personal Choice PPO family plan. Today it costs over $15,000 per year, including drug coverage. Four years ago, in 2000, the same coverage cost $8,000 per year. That is an increase of almost 90%.

$15,000 per year.

How are employers responding to these increased premiums?

- Most employers are sharing the cost with their workers.
- Many employers are buying fewer benefits.
- Some only pay for the worker's insurance, leaving the employee to pay for the rest of the family – out of pocket, after taxes. That cost, the difference between single and family coverage, is almost $9,000 per year.
- We should not wonder why so many workers cannot afford to cover spouse and children – who now become part of the growing ranks of the uninsured.
- And even more concerning, some employers are no longer providing any coverage at all.

This is a crisis, Senator Specter. And behind the increases in health insurance premiums are skyrocketing health care costs.

America's Health Insurance Plans (AHIP) calculates that for every 1% that health care costs go up, over 14,000 Pennsylvanians will lose their health insurance coverage over the next five years. (slide 1)

And the fact is, our medical costs are going through the roof. At IBC, our overall medical costs PER MEMBER, dating back the same four years, have also increased almost 90%. (slide 2) We're paying out **$660 million in claims each and every month** of the year. That's right – **almost $8 billion** in claims a year. In 1999, that number was only $5.3 billion.

There are several reasons for this increase in our costs:
First, Independence Blue Cross has increased its fees to hospitals and doctors.

- Over a 19-month period through March, 2003, we increased physician fees by more than 22% - worth over $300 million. (slides 3 and 4)
- We also have increased rates to hospitals – resulting in renegotiated agreements with every hospital in our network (25 systems representing over 55 hospitals) during the last four years.
- And payments to doctors and hospitals have increased due to an increase in the use of services and an increase in the use of more expensive services and technology.

Here are the numbers:

- In just five years, IBC's payments to hospitals have more than doubled – from $1.1 billion to $2.4 billion (slide 5)
- Per hospital, payments over that same period have risen 109% -- from $19 million to $39 million. (slide 6)
- Total Physician payments are up 92%. (slide 7)
- And our average annual payment to physicians has increased 69% -- from $85,400 to almost $145,000 a year. (slide 8)

And a major driver of these increases is this fact:

Almost no city in America uses medical services at the rate we do.

Consider these numbers:

- Philadelphia's overall medical costs per person are the 5th highest in the country for large metropolitan areas – higher than Boston, New York, Miami and many other places – and more than 40% higher per person than Chicago. (slide 9)
- Our rate of hospital inpatient care is 3rd highest in the nation. (slide 10)
- We also have 46% more hospital beds per capita than the national average – and 24% more than the Pennsylvania average. (slide 11)
- We make 38% more visits to physicians (per 1000 members) than the national average. (slide 12)
- We have higher rates of outpatient surgery than New York, Chicago, Houston Dallas, Boston and lots of other places. (slide 13)

- We are second in the nation for both radiology visits and cardiovascular visits. (slides 14 and 15)

The list goes on and on – for almost every type of medical service Philadelphia ranks higher than the rest of the country (slides 16-26).

Unfortunately, using more services isn't making us healthier. Research by Elliott Fisher and David Wennberg at Dartmouth Medical School indicates that regions like Philadelphia, which spend more on health care, actually had no better quality of care and, in some cases, worse outcomes – as measured by higher mortality rates for patients with hip fractures, heart attacks and colon cancer.

It is also worth noting what is not driving the higher costs and utilization. The increases are not due to increases in our membership. Since January 1, 2000, IBC's membership in Southeastern Pennsylvania has grown just 1.7%, and in fact, has been declining during the past two years. Our medical costs, however, have climbed higher and higher every year over that span – and show no sign of falling.

Now let's make no mistake: The hospitals and physicians of Southeastern Pennsylvania are facing extremely difficult financial issues, as are our customers and their employees. But IBC cannot solve the financial pressures facing hospitals and physicians: IBC represents only 26% of the average hospital's revenue. And the increases I shared a moment ago hardly support our critics' notion that IBC position in the marketplace forces hospitals and physicians to accept inadequate levels of reimbursement.

So while we don't question the right for physicians and hospitals to request increased reimbursements, here is our dilemma:

> **Every time we increase our payment rates to physicians, to hospitals, to pharmacies, and to any other entity that provides health care to our members, the people who buy our health insurance policies end up paying for it with higher premiums.**

The truth is, Senator, that the problems we are facing will not be solved by allowing hospitals or physicians to engage in collective bargaining. This will only increase costs at a faster rate and exacerbate the crisis.

This is not only our view. For years, the Federal Trade Commission has clearly taken a position against allowing physicians and hospitals to engage in collective bargaining. (See the attached letter from Michael G. Cowie, Esq., former Assistant Director and Senior Litigation Counsel for the Federal Trade Commission.) Moreover, as you can read in the attached letter from Dr. Anthony Coletta, physicians have been able to partner effectively with IBC without any changes in our anti-trust laws.

And this crisis also will not be solved by perpetuating myths about IBC. So let's bury those myths:

- IBC is not "tax-exempt;" we paid more than $170 million in federal, state and local non-payroll taxes in 2003 – more than any other health insurer in the Commonwealth.
- IBC has not decreased payments to hospitals and physicians; the data I have shared show a very different story.
- Finally, IBC's surplus is not the answer. It cannot begin to fund the host of ills that confront our health care system. What it can do is fund less than six weeks of claims in an emergency – and that, any expert will tell you, is absolutely not excessive.

Senator, it's time for people like those gathered here today to get serious about the real issue threatening our health care system:

Americans are losing access to their health care system because they cannot afford it.

And getting serious means focusing on how to reduce the system's cost:

- Like the cost of this state's decision to eliminate the Certificate of Need process, which has led to the construction of expensive – and often redundant – diagnostic facilities.
- Or the cost of bogus litigation, medical and prescription errors and the increasing practice of "defensive medicine" by doctors.
- Or the human cost of medical underwriting – a practice designed to make health insurance unaffordable for people who need it most. It needs to be outlawed and outlawed now.

How bad is this cost crisis, Senator?

So bad that the number of uninsured Pennsylvanians increased 36% between 1999 and 2002, to nearly 1.4 million people.

So bad that labor leaders like Pat Gillespie will tell you the number one issue in negotiations is no longer salary – it's health benefits.

So bad, Senator, that there is no light at the end of the tunnel.

We must keep our eye on the real issue, Senator:

$15,000 for one family's health insurance policy.

How much higher shall we go before we address the real issue – the increasingly unaffordable price of medical care?

Thank you again for the opportunity to share my views.

Projected Impact of a 1% Health Care Cost Increase in United States and PA from 2003-2007

Projected Impact of a 1% Health Care Cost Increase in United States and PA from 2003-2007	UNITED STATES OF AMERICA 2003 to 2007	STATE OF PENNSYLVANIA 2003 to 2007
Lost Jobs:	15,130	724
More Uninsured:	300,267	14,363
New Costs on Employers per Covered Employee:	$204	$204
Lost Wages:	$2,743,000,000	$131,000,000
Increase in Health Care Costs:	$27,615,000,000	$1,311,000,000

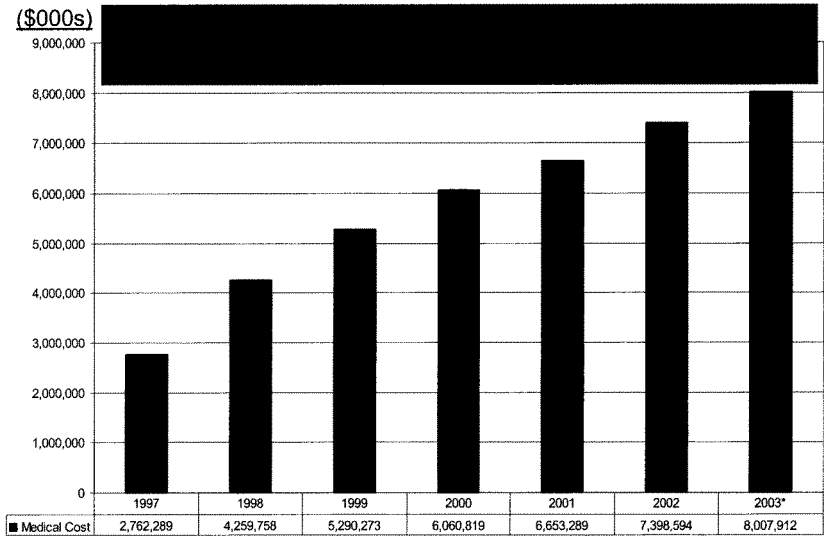
Source: 2003 American Association of Health Plans. Produced for AAHP by James Langenfeld and Richard Shin of LECG, LLC. User Interface Design by Pangeum Interactive, Inc. The full model estimates the total impact of a 1-15% per annum increase in health care costs on employers, families and employees, beyond inflation as projected by the Centers for Medicare and Medicaid Services (CMS).

IBC's Medical Costs Have Dramatically Increased

- IBC's total medical costs have dramatically increased--- in fact, using 1997 as a base, costs have increased more than 190% in 6 years --- from $2.8 billion to $8 billion
- Most of this is NOT due to membership growth: PMPY costs --- which neutralize impact of membership growth --- have increased 150% during same time frame

Independence Blue Cross
1997 - 2003 Medical Cost

IBC medical costs have almost tripled in six years



	1997	1998	1999	2000	2001	2002	2003*
Medical Cost	2,762,289	4,259,758	5,290,273	6,060,819	6,653,289	7,398,594	8,007,912

* - 2003 Medical Costs are DRAFT until audited.

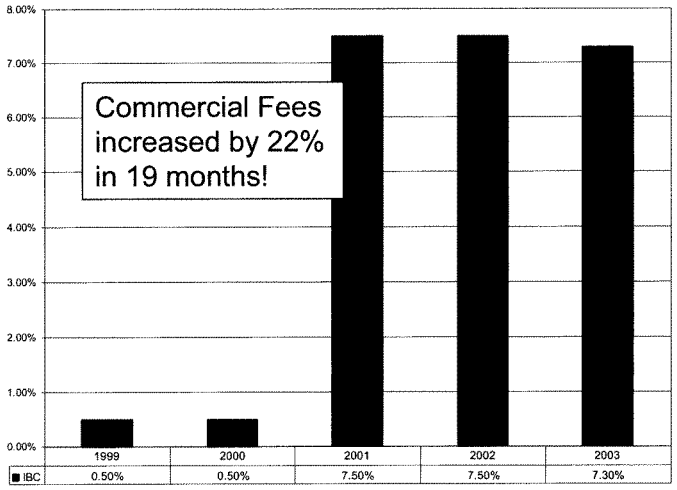
IBC's PMPY medical costs increased 150% over six years

Reviewed and Updated: 4/08/04 Source: IBCAudited GAAP Financial Stmts. / Consolidated financial statement/ 04-12-04: Page 2

IBC Specialist Fee Schedules Dramatically Increasing

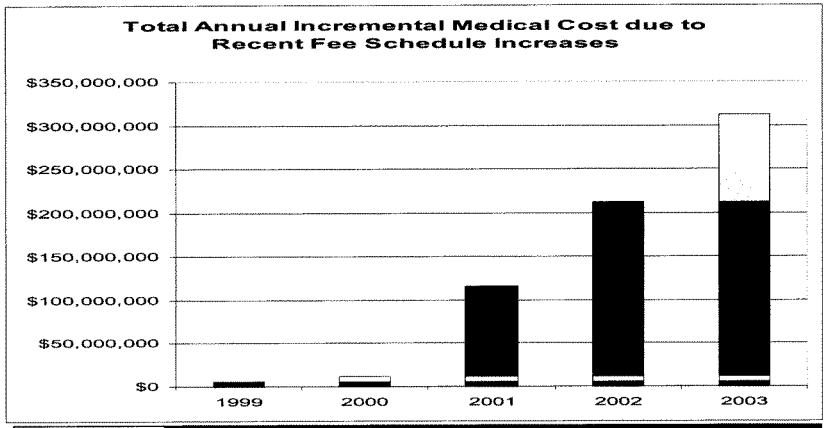
IBC Overall Commercial Fee Increases

- IBC's physician fee schedules are also dramatically increasing
- Two significant specialists rate increases have raised commercial fee schedules by 22% in a 19 month period between August 2001 through March 2003.



IBC's 3 Year Physician Reimbursement Increases Result in $300M Increase in Medical Costs

- This 22% increase produces an incremental annualized cost increase of over $300 million for all subsequent years- before counting large utilization increases



	1999	2000	2001	2002	2003
1999	$6,000,000	$6,000,000	$6,000,000	$6,000,000	$6,000,000
2000		$6,000,000	$6,000,000	$6,000,000	$6,000,000
2001			$104,000,000	$104,000,000	$104,000,000
2002				$96,000,000	$96,000,000
2003					$100,000,000
Cumulative	**$6,000,000**	**$12,000,000**	**$116,000,000**	**$212,000,000**	**$312,000,000**

Includes costs for funding the EOC programs, more billables for PCPs, tray fees for many in-office procedures and other charges

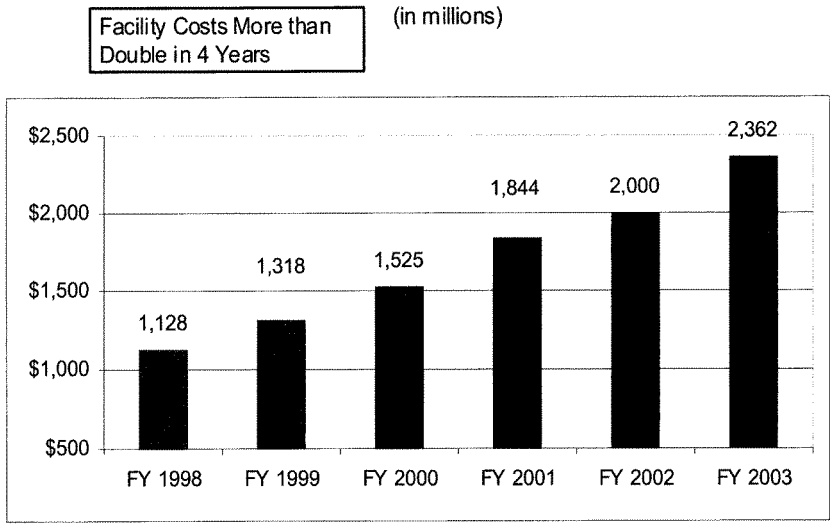
Reviewed : 09/03/03

Source: C&PN, IBC/

IBC Hospital Payments Dramatically Increasing

IBC Total Facility Costs - PA Facilities

- With increasing utilization across the board (inpatient / outpatient / ER) our total " facility " costs have more than doubled in the past four years from just over $1 billion dollars to $2.4 billion for 2002



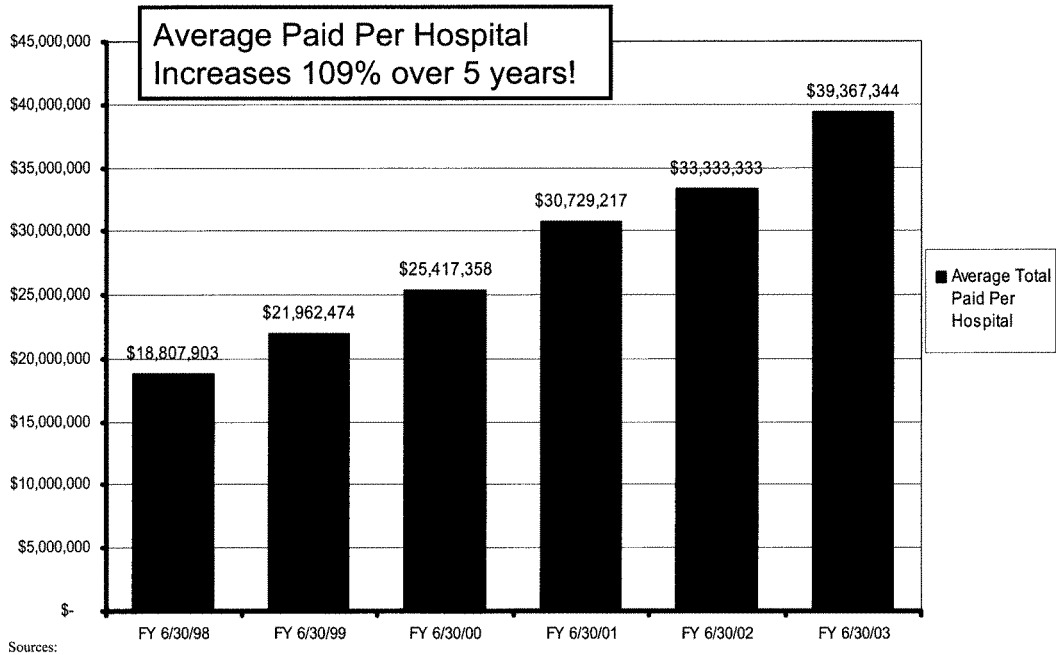
Includes Inpatient and Outpatient Facility Costs (including Rehab)

Updated: 03/25/04

Source: C&PN, IBC/

04-12-04: Page 5

Average Paid Per Hospital

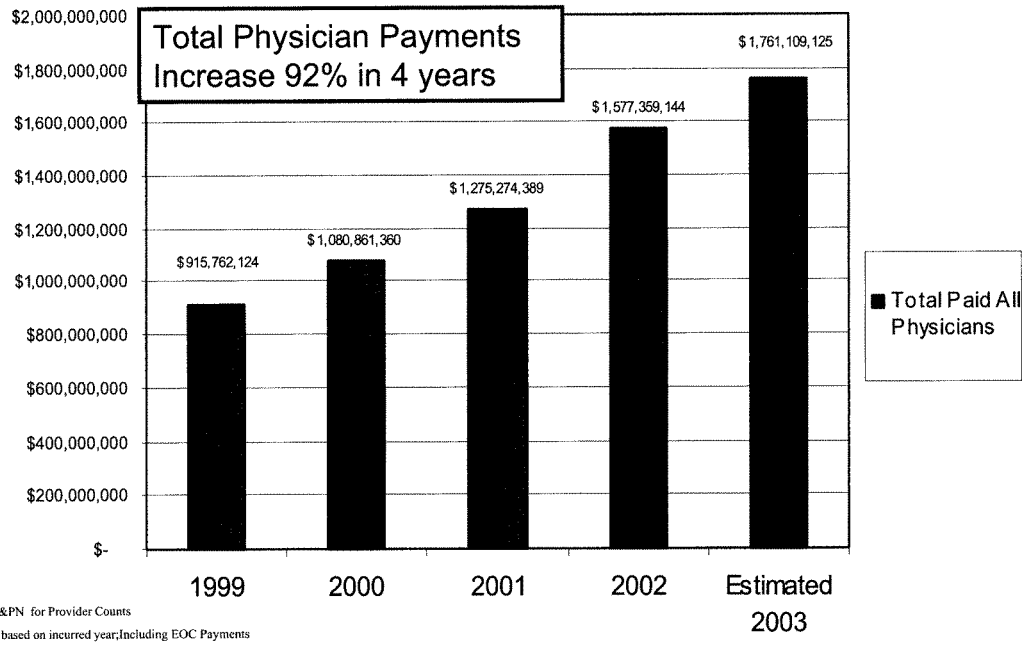


Sources:

Facility Costs: C&PN; Fiscal Year Data; Includes 60 Hospitals, Inpatient and Outpatient Facility Costs(including Rehab)

Updated: 03/25/04

Total Physician Payments



Sources: C&PN for Provider Counts

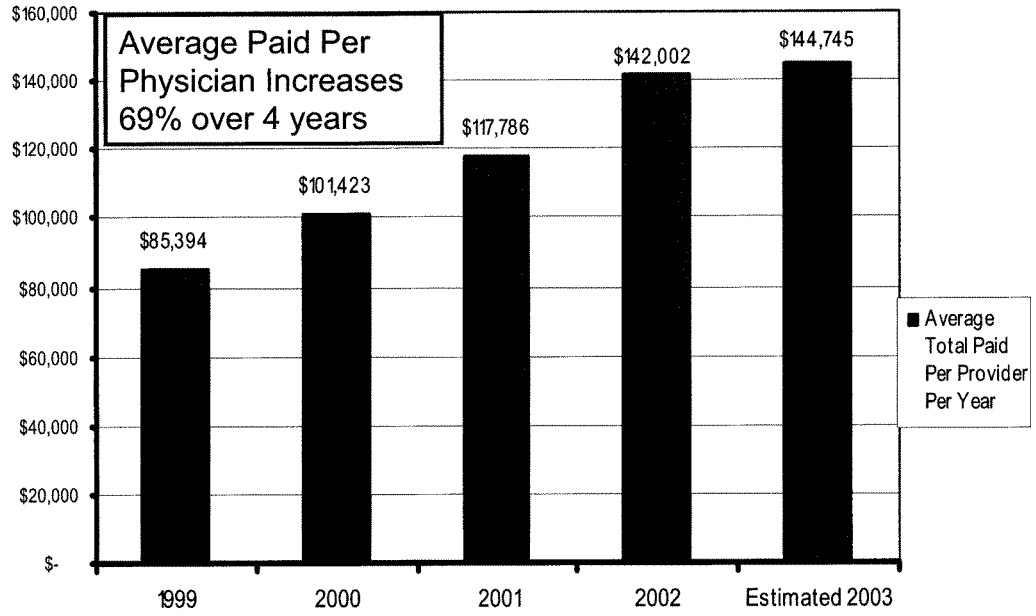
Claim data based on incurred year;Including EOC Payments

Membership: Flash Report; Products include: KHPE, KHPE6, PPO, PC65

Updated: 03/25/04

2003 Estimate is based on YTD September

Average Paid Per Physician Per Year



Sources: C&PN for Provider Counts

Claim data based on incurred year; Includes EOC Payments

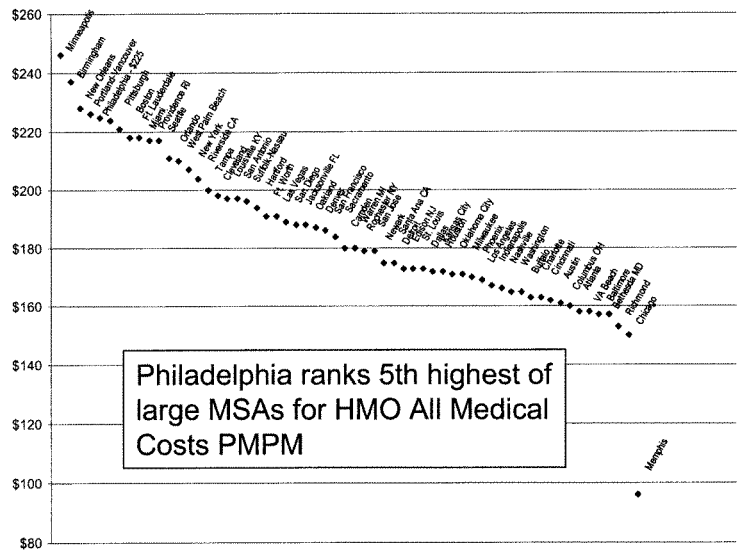
Membership: Flash Report; Products include: KHPE, KHPE6, PPO, PC65 ***2003 Estimate is based on YTD September***

Updated: 03/25/04

Philadelphia
HMO All Medical PMPM - 2002

MSAs with population >1M

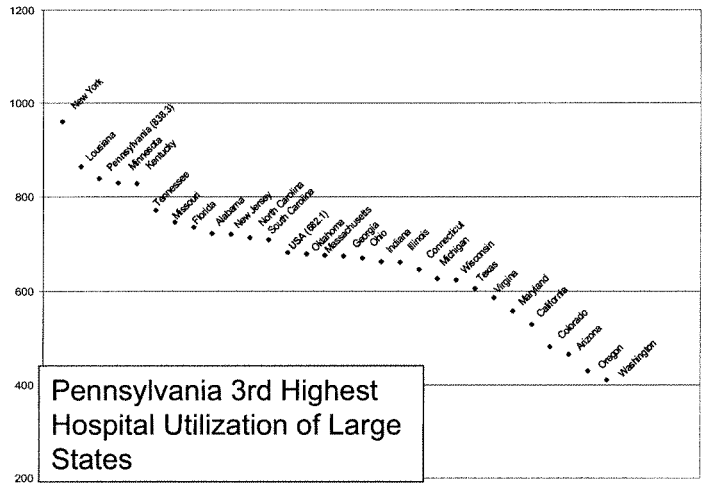
- Medical Costs in Philadelphia are high; Fueled, to a large degree, by abnormally high utilization...
- Philadelphia's HMO all medical related costs are the 5th highest in the entire US (major markets) ...costing $225 PMPM



Pennsylvania's Hospital Utilization Close to Highest in the Country

Inpatient Days/1000-States with Population >3M

- At just over 838 days per 1000 members, Pennsylvania ranks third highest in in-patient utilization in the entire country (major markets)



Source: AHA Hospital Statistics 2004 -2002 Data

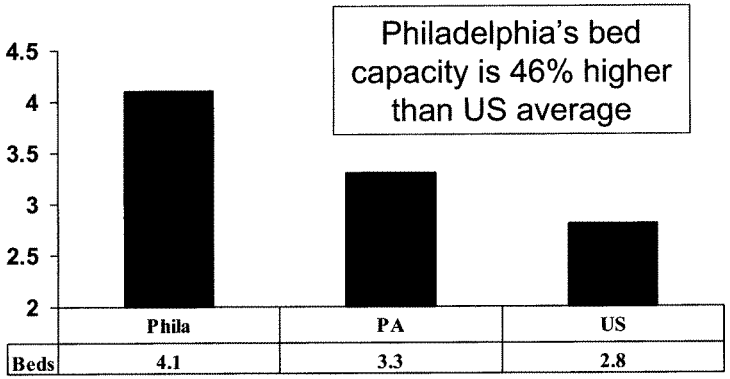
Extraordinarily High Hospital Bed Capacity

Hospital Capacity

Beds / 1000 population

Philadelphia's exceptionally high utilization is also fueled, in part, by…

- Extraordinarily high hospital bed capacity ---- 46% higher than the US average
- Bed capacity 24% higher than PA average

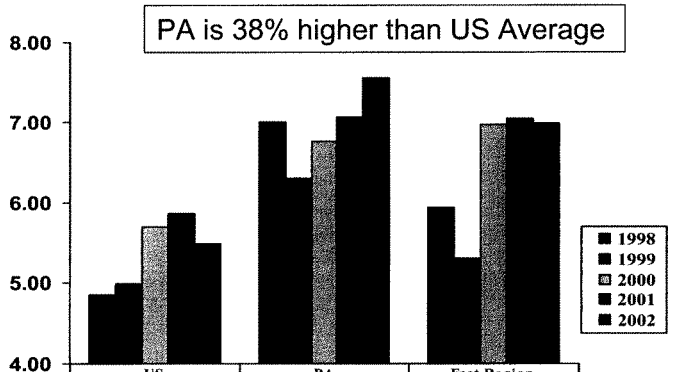


Source: Data are for FY 2001 as reported in InterStudy, 2003 (Philadelphia) and FY 2002 as reported in AHA, 2004 (PA and US)

PA Physician Utilization Higher than US Average

- PA physician visits are also higher than US average - - - by 38%
- Fueled, in part by:
  - → *enormous malpractice concerns (section 4)*
  - → *substantial increases in hospital utilization*
  - → *high # of specialists practicing in area*

Pennsylvania
Physician Visits Per Member Per Year



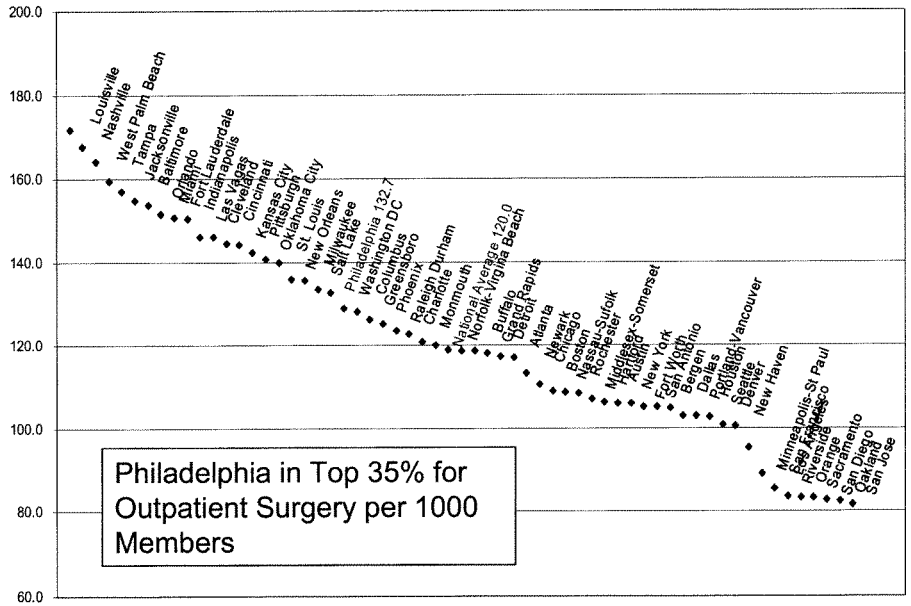
	US	PA	East Region
1998	4.85	6.99	5.94
1999	4.99	6.29	5.31
2000	5.7	6.75	6.96
2001	5.86	7.06	7.04
2002	5.48	7.55	6.98

Source: AM Best Health Center, 2002 Data

Outpatient Surgery

per 1000 Members

- Philadelphia outpatient surgery rates are 10.5% above the national average
- Our area rates are higher than those in New York, Boston or Detroit

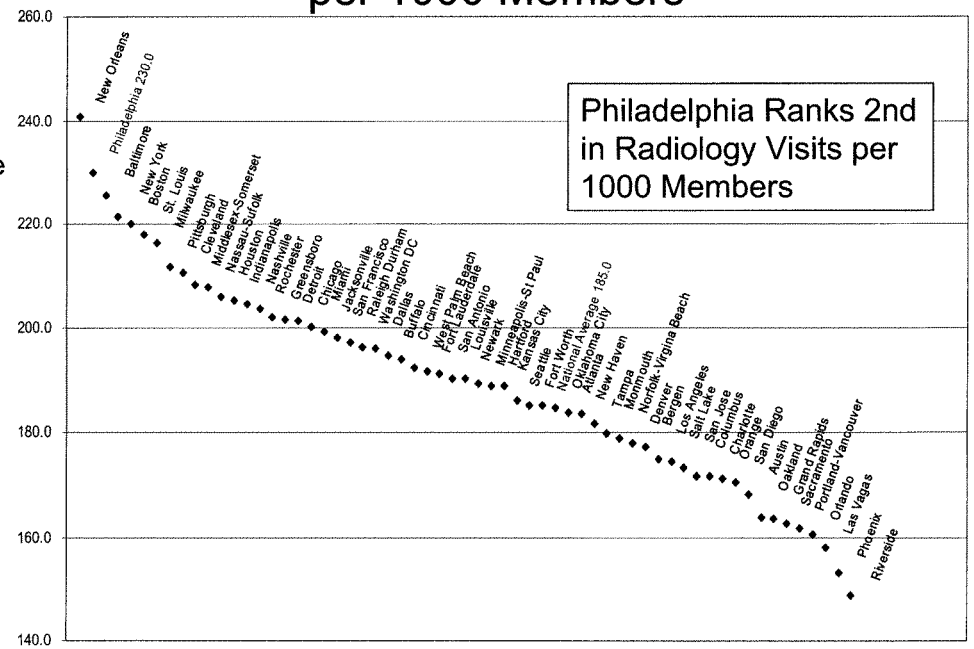


Source: Milliman U.S.A., Inc. 2003 - 2001 Data/ Health Cost Guidelines Commercial Area Factors - Includes hospital outpatient services for surgery in a hospital outpatient or free-standing surgical facility

Reviewed and Updated: 08/28/03

Radiology Visits
per 1000 Members

- Extensive use of outpatient services drives high physician radiology services

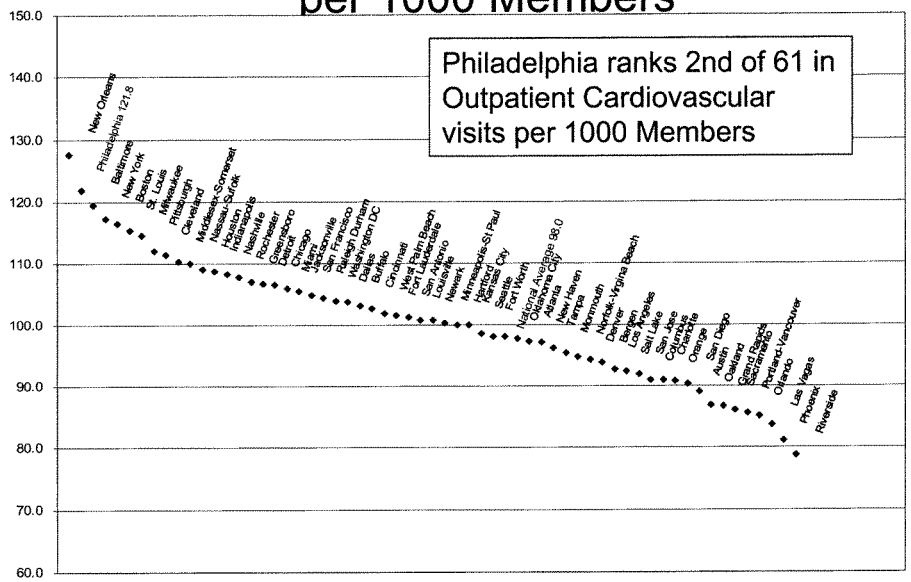


Philadelphia Ranks 2nd in Radiology Visits per 1000 Members

Source: Milliman U.S.A., Inc. 2003 - 2001 Data/ Health Cost Guidelines Commercial Area Factors - Includes the technical component of Radiology services performed by a hospital outpatient department or free-standing facility

Hospital Outpatient
Cardiovascular Visits
per 1000 Members

- Contributing to high outpatient use is the very high rate of cardiovascular related visits
- These visits are especially for diagnostic testing such as EKGs and stress tests



Source: Milliman U.S.A., Inc. 2003 - 2001 Data/ Health Cost Guidelines Commercial Area Factors -Includes cardiology services such as EKG tests & cardiac stress tests performed in a hospital outpatient department or free-standing facility

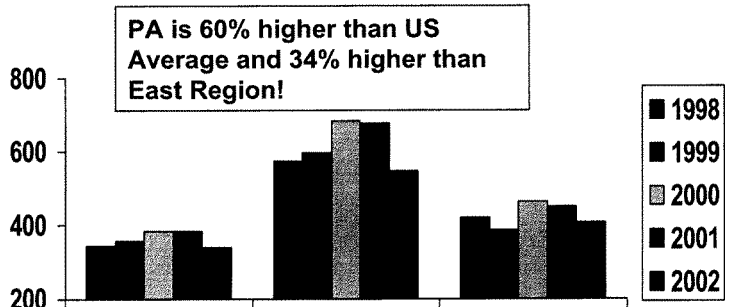
Reviewed and Updated : 08/28/03

HMO Utilization in PA Nearly Double the US Average

Pennsylvania

Total HMO Hospital Days /1000 Members

- Pennsylvania's exceptionally high utilization is fueled, in part, by…
- HMO utilization that is 60% higher than the US average



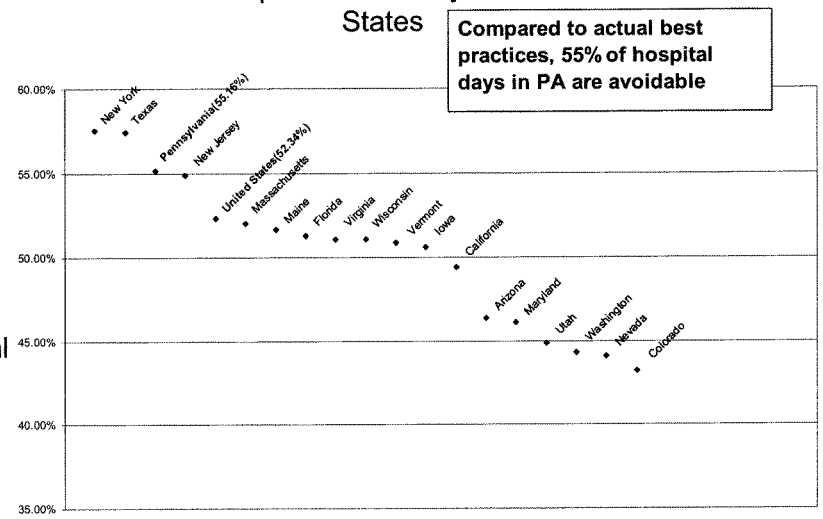
	US	PA	East Region
1998	345	574	419
1999	356	597	387
2000	385	682	463
2001	385	677	451
2002	340	546	406

Source: AM Best Health Center, 2002 Data

A Hospital "Inefficiency" Rating that ranks 3rd highest in US

- Pennsylvania's exceptionally high utilization is also fueled, in part, by…
- A hospital "Inefficiency" rating that ranks PA as the 3rd highest in the entire US
- Compared to actual "best practices" a Milliman study found that 55% of all PA hospital days are avoidable

Commercial Hospital Inefficiency Index[1] for Available States



[1]**Hospital Inefficiency Index** – Represent the ratio of the sum of the days avoidable due to longer than benchmark LOS plus potentially avoidable days due to avoidable admissions to the total number of days in a state or MSA.

Reviewed and Updated: 09/23/03

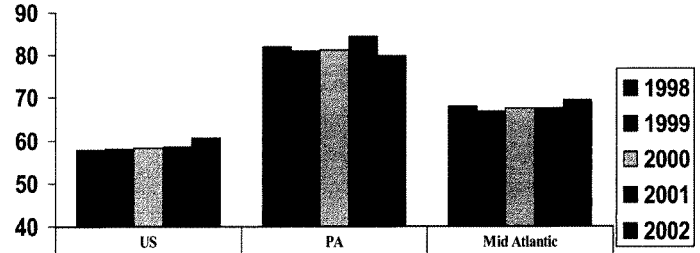
Source: Milliman U.S.A. Inc. 2003 - Hospital Efficiency Index, 2003, 2000 data

Ambulatory Surgery 32% higher than US

Pennsylvania Ambulatory Surgery / 1000 Members

- Pennsylvania's exceptionally high utilization is also evident in outpatient services
- Ambulatory surgery rates are 32% higher than the US average
- If PA outpatient surgeries/1000 continue to decrease at the current rate, they would still take over 30 years to reach the current US average outpatient surgery rate

PA is 32% higher than US average & 15% higher than Mid Atlantic in 2002



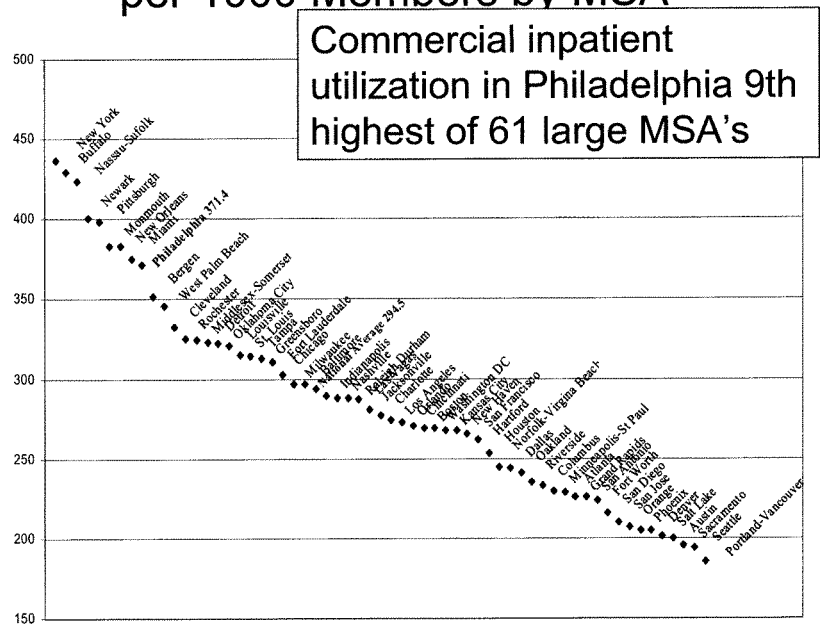
	US	PA	Mid Atlantic
1998	57.7	81.9	67.9
1999	58.1	80.9	66.8
2000	58.2	81.3	67.4
2001	58.6	84.2	67.6
2002	60.6	79.7	69.4

Source: AHA Survey 2004 - 1998 to 2002 Data

Annual Utilization

per 1000 Members by MSA

- Philadelphia is the 9th highest of 61 metropolitan statistical areas (MSAs) in hospital days/1000 for its commercial membership
- Philadelphia utilization is nearly twice as high as the lowest MSAs in the West



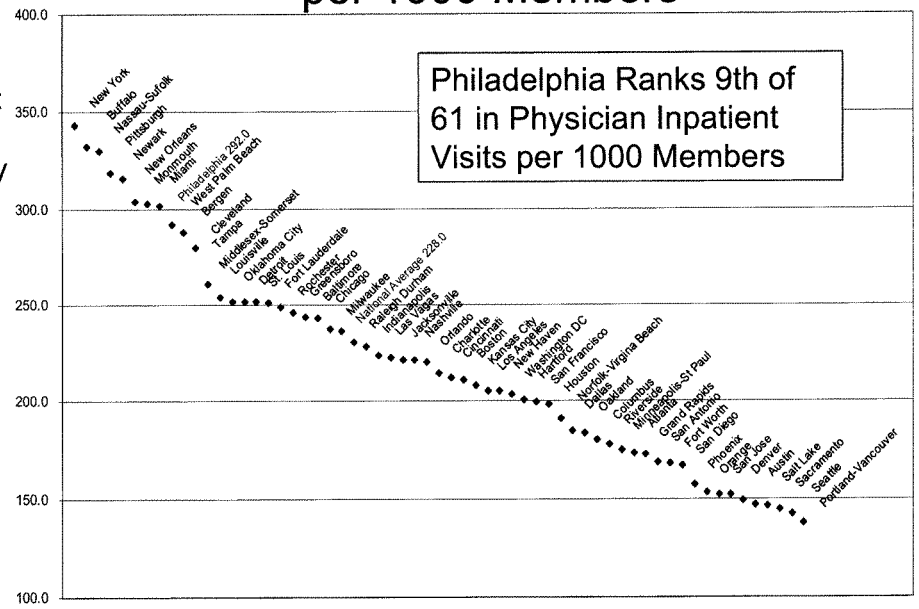
Reviewed and Updated: 08/28/03

Source: Milliman U.S.A. Inc. 2003 - 2001 Data / Health Cost Guidelines
Commercial Area Factors - includes all inpatient admissions

Physician Inpatient Visits

per 1000 Members

- High inpatient utilization rates also create very high rates of physician visits to hospitals



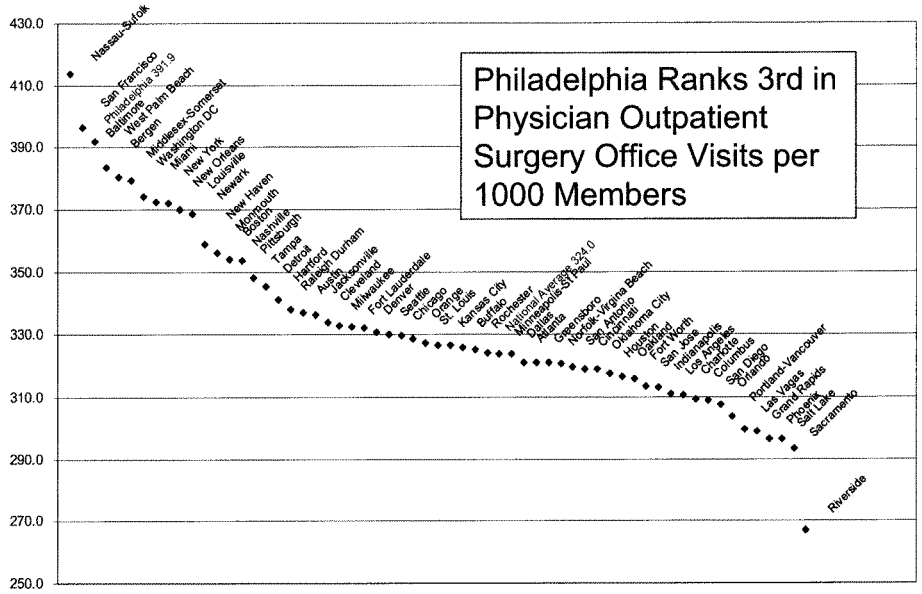
Reviewed and Updated: 08/28/03

Source: Milliman U.S.A., Inc. 2003 - 2002 Data/ Health Cost Guidelines Commercial Area Factors - Includes visits to a hospital or Skilled Nursing Facility by a physician

Physician Outpatient Surgery Office Visits

per 1000 Members

- High facility outpatient utilization rates also create high rates of related physician surgery

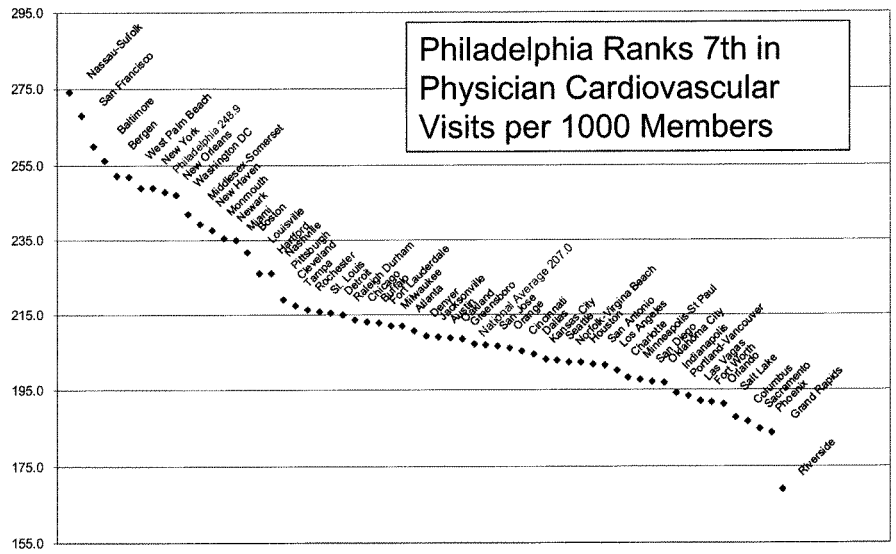


Philadelphia Ranks 3rd in Physician Outpatient Surgery Office Visits per 1000 Members

Source: Milliman U.S.A., Inc. 2003 - 2001 Data/ Health Cost Guidelines
Commercial Area Factors - Includes surgery by a physician in a physician's office

Physician Cardiovascular Visits per 1000 Members

- High rates of outpatient cardiovascular services are accompanied by high rates of related physician services

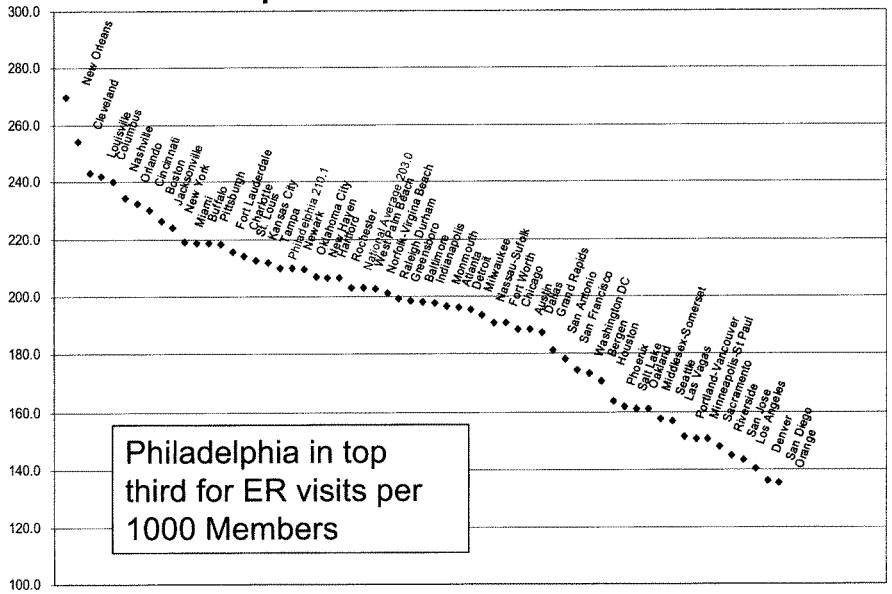


Source: Milliman U.S.A., Inc. 2003 - 2001 Data/ Health Cost Guidelines Commercial Area Factors - Includes therapeutic services such as cardiography, and other cardiovascular services performed by a physician

Emergency Room Visits

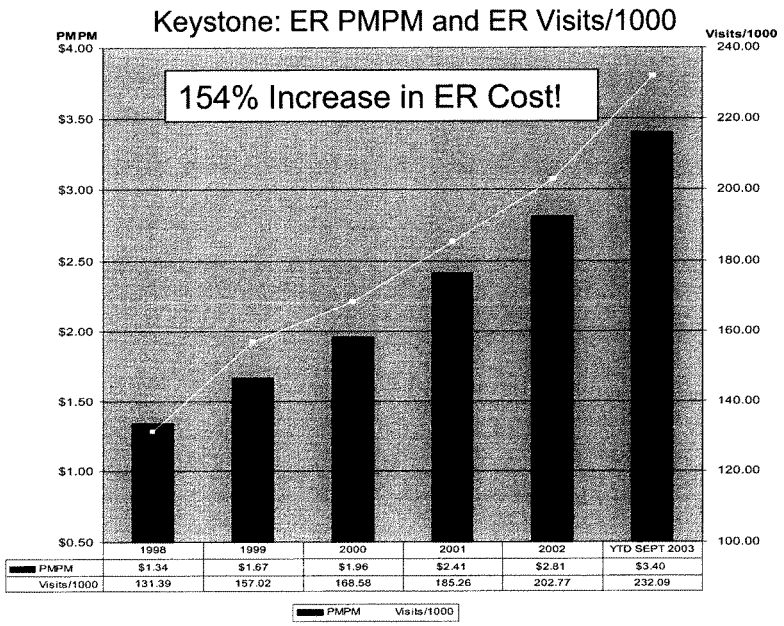
per 1000 Members

- Dramatic ER use rate increases have placed Philadelphia in the top third nationwide for ER visits



Legislative Mandates Exacerbated HMO Utilization

- Legislative mandates including Act 68, have exacerbated HMO utilization
- Keystone's ER Utilization has risen dramatically starting in 1999 with an even bigger up-tick in 2001 (Act 68 effective June 2001)
- Since 1998 Keystone's ER costs increased 154%



	1998	1999	2000	2001	2002	YTD SEPT 2003
PMPM	$1.34	$1.67	$1.96	$2.41	$2.81	$3.40
Visits/1000	131.39	157.02	168.58	185.26	202.77	232.09

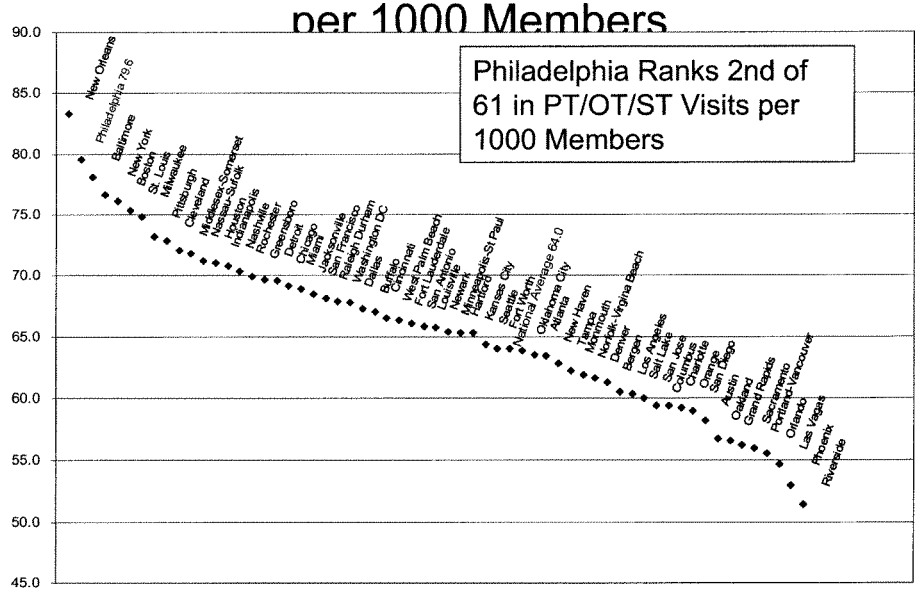
Source: IBC Internal / Medical Costs Report from Health Services

Hospital Outpatient PT/OT/ST

(Physical/Occupational/Speech Therapies)

per 1000 Members

- Philadelphia is also among the highest for physical, occupational and speech therapy services

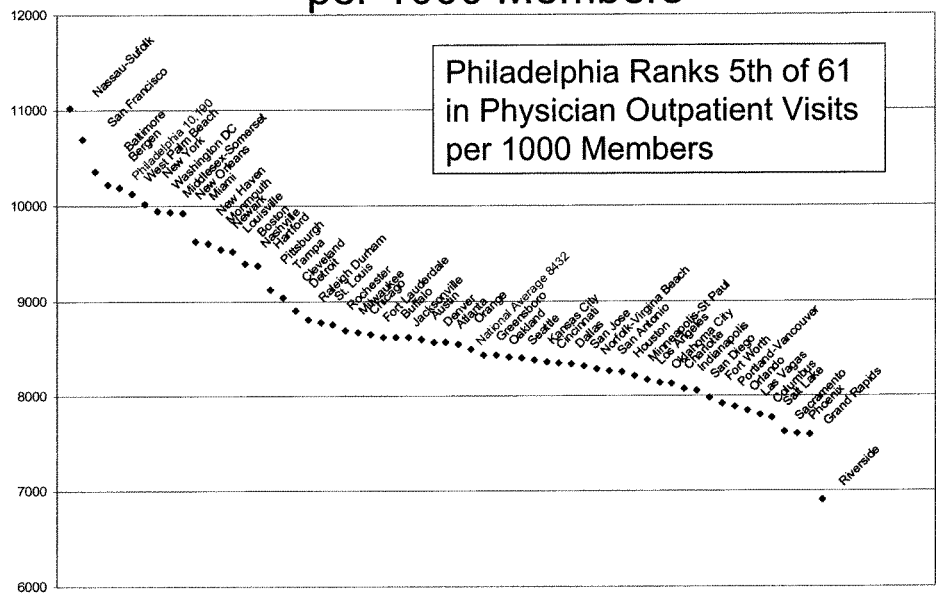


Source: Milliman U.S.A., Inc. 2003 - 2001 Data/ Health Cost Guidelines Commercial Area Factors - Includes PT,OT,ST services performed in a hospital outpatient department or free-standing facility

Physician Outpatient Visits

per 1000 Members

- High facility outpatient utilization rates also create high rates of related physician visits



Source: Milliman U.S.A., Inc. 2003 - 2001 Data/ Health Cost Guidelines Commercial Area Factors - Includes office visits, consultations, urgent care, physical therapy, cardiology, radiology & pathology

Reviewed and Updated: 08/28/03

04-12-04: Page 26

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Michael G. Cowie
Partner
202.383.7424
cowiem@howrey.com

April 8, 2004

The Honorable Arlen Specter
SH-711 Hart Senate Office Building
Washington, DC 20510-3802

Dear Senator Specter:

I am an attorney for Independence Blue Cross and formerly served as Assistant Director and Senior Litigation Counsel for the Federal Trade Commission. In 2002, Chairman Muris appointed me to lead a task force to investigate consummated hospital mergers that contributed to large price increases.[1] While at the FTC, I supervised antitrust investigations leading to enforcement actions against physician groups, hospitals systems, and other healthcare providers. I have also served as a representative of the FTC in the Healthcare Hearings conducted last year by the FTC and the Department of Justice.

The FTC has contributed substantial resources to ensure that the 15% of our nation's gross national product devoted to healthcare, amounting to about $1.3 trillion annual, is spent in competitive markets.[2] Aggressive competition in the healthcare industry promotes lower prices, higher quality, and enhanced access. Antitrust law plays an important function in ensuring that consumers, including employers and individuals, benefit from competition.

Physician Groups

The FTC has consistently opposed efforts by healthcare providers to exempt themselves from the antitrust laws that apply to all other sectors of the economy. In court cases going back several decades, the American Medical Association and state physician associations have been unsuccessful in claiming that they should be exempt from the antitrust laws designed to benefit consumers.[3] The tactic that they have recently taken is to try getting Congress and state legislatures to create for them a special exemption. This would allow them to engage in anticompetitive price fixing.

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[1] FTC Announces Formation of Merger Litigation Task Force, Aug. 28, 2002, www.ftc.gov/opa.

[2] Centers for Medicare & Medicare Services, U.S. Health Care System, www.cms.gov/charts/series.

[3] *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982); *FTC v. American Medical Association*, 94 F.T.C. 701 (1979); *FTC v. Michigan State Medical Society*, 101 F.T.C. 191 (1983).

Across administrations, the FTC has opposed antitrust exemptions for physician groups. Each FTC head from the past three administrations has adamantly opposed such exemptions:

- Since 2001, the FTC under the leadership of Chairman Timothy J. Muris has opposed legislation in three states.[4] An interview in Health Affairs recorded his views in this area: "Q: Doctors often claim that they need to negotiate fees collectively to counterbalance the leverage of managed care organizations. Can they do this and still not run afoul of the antitrust law? A: . . . Outside of the AMA, there's not a lot of support for letting the doctors get together to fix prices. In fact, there's universal condemnation. Doctors can do a lot of things collectively to improve quality . . . But when they are independent business people simply getting together to fix prices, we're going to be hostile. And we've been aggressive in that area."[5]

- Under Chairman Robert Pitofsky, the FTC opposed earlier attempts to exempt physician groups. In 1996, Chairman Pitofsky testified before the House Judiciary Committee in opposition to a bill backed by the American Hospital Association. In his testimony, Chairman Pitofsky stated: "In the past five years, the Commission, the Department of Justice, and state attorneys general have brought numerous enforcement actions challenging price fixing and boycotts by groups of physicians or other providers that have banded together to resist innovative efforts at cost-conscious purchasing. When this kind of egregiously anticompetitive conduct in uncovered, antitrust enforcers have been able to condemn it quickly."[6]

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[4] FTC Staff Opposes Ohio Bill to Allow Physician Collective Bargaining, Oct. 21, 2002, www.ftc.gov/opa; FTC Staff Opposes Washington State Proposal to Allow Physician Collective Bargaining, Feb. 14, 2002, www.ftc.gov/opa; FTC Staff Opposes Alaska Proposal to Allow Physician Collective Bargaining, Jan. 31, 2002, www.ftc.gov/opa.

[5] Protecting Competition and Consumers: A Conversation with Timothy J. Muris, Health Affairs, Vol. 22, No. 6, Nov./Dec. 2003.

[6] Prepared Statement of Robert Pitofsky, Chairman FTC, Committee on the Judiciary, U.S. House of Representatives, Feb. 27, 1996, www.ftc.gov/speeches/pitofsky (addressing H.R. 2925); *see also* FTC Chairman Tells House Judiciary Committee Doctor Collective Bargaining Bill Would Be Bad Medicine for Consumers, June 22, 1999, www.ftc.gov/opa; Prepared Statement of FTC Chairman Robert Pitofsky, Before the Committee of the Judiciary, U.S. House of Representatives, July 29, 1998, www.ftc.gov/os (opposing the Quality Healthcare Coalition Act of 1998); FTC Staff Letter to District of Columbia Office of Corporation Counsel, Oct. 29, 1999, www.ftc.gov/be (opposing exemption); FTC Staff Letter to Texas House of Representatives, May 13, 1999, www.ftc.gov/be (opposing exemption); FTC Staff Letter to Vermont Legislature, Oct. 20, 1994, www.ftc.gov/be (opposing exemption); FTC Staff Letter to North Dakota Assistant Attorney General, Mar. 8, 1993 (opposing exemption), www.ftc.gov/opa.

- As an FTC Commissioner Janet Steiger, appointed by former President George H. Bush to head the agency, also spoke publicly against antitrust exemptions for physician groups. Speaking in opposition to a bill introduced in Congress, she stated that "the record of antitrust enforcement in the health care field shows that competition is important to containing costs and ensuring quality, and that antitrust enforcement is able to prevent harmful conduct without interfering with joint conduct that is truly justified."[7]

The application of the antitrust laws to the physician sector does not prevent the formation of legitimate joint ventures or the growth of physician groups through mergers or acquisitions. The FTC regularly approves of physician joint ventures and other transactions that comport with the same antitrust laws that apply to other industries. What the FTC has challenged is naked price-fixing arrangements resulting in unwarranted cost increases.

Hospital Systems

Over $400 billion – about 32% of the $1.3 trillion Americans spend each year on healthcare – goes to inpatient hospital care. Efforts to exempt the hospital sector from the antitrust laws have been far less common. One effort to do so in the 1990s failed.[8]

The FTC would likely oppose any effort to relax antitrust enforcement for hospital systems, much less elimination of antitrust enforcement in this area by the creation of an exemption. The FTC has moved in the opposite direction – increasing resources directed to antitrust enforcement in the hospital sector.[9] Chairman Muris has highlighted the fact that "[h]ospital care just surpassed pharmaceuticals as the key driver of health care costs" and formed a task force to investigate hospital mergers resulting in large price increases.[10] This past

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[7] Prepared Remarks of Commissioner Janet D. Steiger, FTC, Before the Health Trustee Institute, Nov. 9, 1995, www.ftc.gov/speeches/steiger (addressing H.R. 2425).

[8] Prepared Statement of Robert Pitofsky, Chairman FTC, Committee on the Judiciary, U.S. House of Representatives, Feb. 27, 1996, www.ftc.gov/speeches/pitofsky (addressing H.R. 2925).

[8] Prepared Remarks of Commissioner Janet D. Steiger, FTC, Before the Health Trustee Institute, Nov. 9, 1995, www.ftc.gov/speeches/steiger ("We also saw this when there was a proposal for exemption of hospitals just a few years ago").

[9] Prepared Remarks of Timothy J. Muris at 19-20, Before the 7th Annual Competition in Health Care Forum, Chicago, Ill., Nov. 7, 2002, www.ftc.gov/speeches ("the Commission is in the midst of a retrospective study of consummated hospital mergers. The Bureau of Economics and Competition are evaluating the effects of hospital mergers in several cites").

[10] Prepared Remarks of Timothy J. Muris at 10, Before the 7th Annual Competition in Health Care Forum, Chicago, Ill., Nov. 7, 2002 (citing data from the Centers for Medicare & Medicare Servs., U.S. Health Care System, available

February, the FTC brought an enforcement action against a large hospital system that acquired a nearby rival. According to the FTC complaint, the acquisition enabled the hospital system to raise prices by over 40% to several health insurers that negotiate prices on behalf of employers and individuals.[11]

Antitrust enforcement is a valuable tool for keeping healthcare markets competitive. Creating special exemptions for physician groups and hospitals systems would risk higher prices and diminished access to care. This has been recognized by the FTC for many years and across party lines.

Respectfully submitted,

Mike Cowie

Michael G. Cowie

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at www.cms.gov/charts/series); FTC Announces Formation of Merger Litigation Task Force, Aug. 28, 2002, www.ftc.gov/opa.

[11] FTC Challenges Hospital Merger that Allegedly Led to Anticompetitive Price Increases, www.ftc.gov/opa; FTC's Evanston/Highland Park Complaint, www.ftc.gov/opa.

April 8, 2004

Honorable Arlen Specter
United States Senator
711 Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Specter:

Unfortunately, my schedule precludes me from being able to testify at the Hearings that you are presiding over in Philadelphia on April 12, 2004. Please allow me to present my views regarding the delivery of healthcare in Southeastern Pennsylvania in this letter.

As a matter of background, I am a general surgeon trained at Thomas Jefferson University Hospital in Philadelphia, and have actively practiced fulltime for 20 years at the Bryn Mawr Hospital. More than 10 years ago, seeing the emergence of managed care in our region, I took it upon myself to organize physicians on the Main Line into a contracting alliance (an Independent Practice Association), now known as the Renaissance Physician Organization. Over the years, more than 400 physicians have participated in this entity contracting successfully with managed care organizations largely through a "messenger model".

In the course of our development of this contracting model, the physician leaders involved have learned an incredible amount about both the finance and delivery of healthcare in our region. Although much of what we have learned is beyond the scope of this letter, there are several essential key points that I would like to emphasize:

1. The delivery of healthcare in our region, though supported with a superb underlying infrastructure of physicians and hospitals, is largely disjointed and enormously inefficient. Waste and redundancy is replete throughout the system. Best practice models, so highly regarded in most service industries are either non-existent or impractical and ignored. Physicians practice in "clinical silos" largely isolated from one specialty to the other with little or no sharing, capturing or measuring of information. This often results in redundant, un-monitored care. The opportunity for improvement is enormous.

2. Payments to physicians in the region are for the most part, egalitarian. Although there are programs in place in primary care specialties to provide increased reimbursement for higher quality care, those models are largely non-existent in surgical and medical specialties. Thus, payment is the same for these physicians regardless of practice patterns or outcomes. Such a lack of reward for experience or quality is unheard of in the business world.

3. Payors in the region have developed systems that can indeed capture clinical information and patterns in a manner that, when properly configured, could actually contribute to the enhancement of patient care both in treating disease and maintaining health. However, the "outside-in" nature of the insurer to physician relationship has largely precluded any meaningful benefit.

Renaissance Medical Management Company

487 Devon Park Drive, Suite 200 • Wayne, PA 19087 • Phone: 610.254.7662 • Fax: 610.687.8458 • www.rmmcdocs.com

Based upon these findings (as well as others), and after nearly seven years of a "collective bargaining" approach to payors in this market, our group made the fundamental decision to take a different approach. In essence, we sought to re-configure our physicians into an entity that could partner with one or more HMO's rather than just simply negotiate. Our premise was that a meaningful partnership, utilizing the powerful information generated by the insurer, re-configured into clinically meaningful information for physicians, and communicated to and by physicians through their own company (thereby eliminating the "outside – in" approach) could lead to not only higher quality care but also more efficient care. In the process, we committed to build a paradigm that ensured that physicians were reimbursed beyond current rates, in return, not for denying care, but for enhancing it.

Our company, the Renaissance Medical Management Company, utilizing a business plan financed and written by physicians, successfully met its goal of partnering with Independence Blue Cross (IBC). In conjunction with IBC we have created a joint venture, The Renaissance Health Alliance, owned equally by Renaissance and an IBC subsidiary, Keystone Healthplan East. Over the last three years, we have set about the task of maximizing the skills of both organizations with the entire focus being high quality, efficient care for our mutual patients. In a time when the cost of health care is spiraling nearly out of control, we are beginning to demonstrate that our model has the ability to not only reign in those costs, but identify and begin to change the patterns of behavior that result in so much waste and inefficiency. In the process, we are constructing financial models that are rewarding physicians for better care with higher reimbursement. This is as it should be.

As you can imagine, there are many additional details to this story. Suffice it to say that, rather take a confrontational approach to payors, we are a group of physicians who have chosen a collaborative, pro-active approach. We are beginning to demonstrate that such a collaborative approach can result in meaningful change, impacting on the very real problems that face effectively financing and delivering healthcare in Southeastern Pennsylvania both now and in the future.

If I can provide additional insight into these efforts, please do not hesitate to contact me. Thank you.

Sincerely,

Anthony V. Coletta MD, FACS
Chairman of the Board