

October 22, 2018

The Honorable Charles E. Grassley
Chairman
Committee on the Judiciary
United States Senate
Washington, DC 20510

Dear Chairman Grassley:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) writes to provide you some additional perspective on an article that appeared in the *Wall Street Journal* suggesting hospitals were at the root of contract terms that could disadvantage consumers. Your recent inquiry to the Federal Trade Commission (FTC) provides us the opportunity to share with you and the FTC some of our views on why that article misconstrued the dynamics between hospitals and commercial health insurers as it pertains to contract negotiations.

The overwhelming majority of hospitals and health systems are not the drivers in contract negotiations with commercial health insurers. In addition, the contract provisions hospitals and health systems are able to secure in negotiations typically have procompetitive and pro-consumer purposes, such as enabling the hospital or health system to successfully offer value-based care alternatives or protecting the hospital and its patients from unwarranted denials.

Moreover, the article's suggestion that the rise in the cost of health care is attributable to these contract negotiations is not borne out by the fact that hospital prices are currently at historically low growth rates and spending for hospital services overall is declining as a percentage of national health expenditures.



THE MARKET FOR COMMERCIAL HEALTH INSURANCE IS HIGHLY CONCENTRATED

When evaluating the relative bargaining power between commercial health insurers and hospitals and hospital systems, it is highly relevant that these insurers typically operate in markets where they have high market shares and face little competition.¹

That is why the United States Department of Justice (DOJ) successfully sued to stop anticompetitive mergers between four of the five largest commercial health insurers several years ago. DOJ said:

[C]ompetition is now at risk. Today, the industry is dominated by five large insurers commonly referred to as “the big five”... In a scramble to become even bigger, four of the big five now propose to merge ... These mergers would reshape the industry, eliminating two innovative competitors ... at a time when the industry is experimenting with new ways to lower healthcare costs. Other insurers lack the scope and scale to fill this competitive void. After the mergers, the big five would become the big three, each of which would have almost twice the revenue of the next largest insurer.²

The residual impact of this concentration was highlighted in a recent study in *Health Affairs* that reported it is concentrations of commercial health insurers, not hospitals, which are responsible for premium price increases; premiums are 50 percent higher in areas with monopoly insurers.³ It further concluded that “hospital market structure had relatively weak association with premiums across markets.”⁴ This is consistent with a recent study by Charles River and Associates that found revenues declined following contemporary hospitals mergers; a finding that also is inconsistent with the suggestion that hospital systems have the market power to raise prices, much less insist on contract terms that have the same effect on commercial health insurers or consumers.⁵

HOSPITAL COST GROWTH IS AT HISTORICALLY LOW LEVELS

The article’s suggestion that certain hospital contract negotiations could contribute to increased prices for consumers is belied by data showing historically low growth rates in hospital prices. From 2008 to 2017, hospital prices had an average annual growth rate

¹[B]ased on the market concentration methodology in the DOJ/FTC Horizontal Merger Guidelines, 69 percent of the 389 MSAs studied were highly concentrated....” Competition in Health Insurance A comprehensive study of U.S. markets, American Medical Association, 2017 Update.

² United States v. Aetna and Humana, July 21, 2016 <https://www.justice.gov/atr/case/us-and-plaintiff-states-v-aetna-inc-and-humana-inc>

³ ACA Marketplace Premiums Grew More Rapidly in Areas with Monopoly Insurers Than in Areas with More Competition, August 2018, *Health Affairs*, p. 1243 (Marketplace Premiums).

⁴ Marketplace Premiums.

⁵ Hospital Merger Benefits: Views from Hospital Leaders and Econometric Analysis, Monica Noether, Ph.D. and Sean May, Ph.D. January 2017, <https://www.crai.com/sites/default/files/publications/Hospital-Merger-Full-Report-FINAL-1.pdf>.

of 2 percent. In comparison, the overall price of medical care had an average annual growth rate of 3 percent, employee health insurance premiums increased by 5.5 percent,⁶ and drug prices had an average annual growth rate of 5.6 percent for that same period.⁷ Likewise, hospitals' share of total health expenditures has gradually decreased over time as a percentage of total national health expenditures – declining from 42.7 percent in 1980 to 34 percent in 2016. By comparison, during the same period, retail prescription drug spending, which does not include drugs administered in institutional settings, doubled as a share of total national health expenditures.⁸

COMMERCIAL INSURERS USE THEIR MARKET POWER DURING NEGOTIATIONS AND AFTERWARDS

The article neglected to reference another lawsuit brought by DOJ or a recent instance in which a large commercial health insurer sought to institute new contract provisions that disadvantaged patients and providers following concluded contract negotiations. These examples illustrate actual and more typical dynamics between hospitals and commercial health insurers in contract negotiations.

DOJ sued a large commercial health insurer in the Midwest for abusing its market power by requiring hospitals with which it did business to accept most favored nations (MFNs) restrictions to stifle competition from other insurers.⁹ Tellingly, DOJ did not correspondingly sue the hospitals.

The complaint alleges that Blue Cross's MFNs have caused hospitals to increase prices to competing insurers. "The price increases caused by the MFNs have reduced competition in commercial health insurance markets by raising competitors' costs, which has likely increased premiums and directly increased costs to self-insured employers. Blue Cross intended that its MFNs increase its competitors' hospital prices."¹⁰

The case was resolved when the state of Michigan, which clearly recognized the harm to consumers from this practice, enacted laws banning the use of MFN clauses by insurers, health maintenance organizations and nonprofit health care corporations in contracts with providers.

⁶ Price increase for family policies, Kaiser Family Foundation Employer Health Benefits Survey, 2018; Kaiser/Health Research and Educational Trust Survey of Employer-Sponsored Health Benefits.

⁷ Statement of the American Hospital Association for the Committee on Health, Education, Labor and Pensions of the U.S. Senate, Hearing on How to Reduce Health Care Costs: Understanding the Cost of Health Care in America, June 27, 2018 (Senate Cost Hearings).

⁸ Senate Cost Hearings.

⁹ U.S. and State of Michigan vs. Blue Cross and Blue Shield of Michigan, <https://www.justice.gov/atr/case/us-and-state-michigan-v-blue-cross-blue-shield-michigan>. (US v. Blue Cross). MFNS are sometimes called "most favored pricing," "most favored discount," or "parity" clauses

¹⁰ U.S. v Blue Cross

Large commercial health insurers also have leveraged their market power following completed negotiations to change settled contract terms to their advantage. An example of this kind of conduct occurred last year when one of the nation's largest commercial health insurers abruptly announced new policies in about a dozen states denying payments for patients' use of certain emergency department (ED) services and CT scans and MRIs in hospital outpatient departments *unless it* determined the site of service was medically necessary. These new policies sought to preemptively alter existing contract terms with hospitals without any prior negotiation or consideration of the likely impact on the quality of alternative services or patients' access to comparable care.

For example, Sens. Roy Blunt, R-Mo., and Claire McCaskill D-Mo., have raised serious concerns that this abrupt policy shift would harm consumers by denying claims for needed ED services. Sen. Blunt stated categorically, "[p]atients in need of emergency medical treatment shouldn't have to weigh the financial risks before seeking care."¹¹

In terms of assessing bargaining leverage, just the indiscriminate manner in which these policies were instituted is indicative of the commercial insurer's superior market power in contract negotiations with hospitals and the need for providers to scrutinize and resist such provisions whenever they appear to ensure they do not adversely affect patient care.

EVEN SEEMINGLY RESTRICTIVE CONTRACT PROVISIONS CAN HAVE PROCOMPETITIVE BENEFITS FOR CONSUMERS

Many provisions that hospitals are able to secure in contract negotiations with commercial health insurers have procompetitive benefits for consumers, including some of the types referenced in the article. While not an exhaustive catalog of such provisions, the following examples suggest how such provisions benefit consumers.

Value-based Care. Contract negotiations between commercial health insurers and hospitals and hospital systems always should be viewed through the lens of an increasing drive toward value-based care. By definition, value-based care shifts some proportion of the financial risk for keeping patients healthy and caring for them when

¹¹ Missouri Oks law to combat Anthem's controversial ER policy. Will it help? Springfield News Leader, June 6, 2018, <https://www.news-leader.com/story/news/local/ozarks/2018/06/06/missouri-approves-law-combat-anthem-controversial-er-policy/674772002/>. See also, Coverage Denied: Anthem Blue Cross Blue Shield's Emergency Room Initiative, Office of U.S. Senator Claire McCaskill, July 19, 2018 "These findings indicate Anthem may have pursued an overly restrictive initial approach to reviewing ER claims and may have failed to equip employees with the proper training to apply company policies correctly. Because Anthem failed to provide more detailed and extensive information regarding denial and appeal rates, as well as assessments of reviewers and claims cases, it is difficult to assess whether changes made by the company have fully addressed these issues."
<https://www.mccaskill.senate.gov/imo/media/doc/07.17.18AnthemCoverageDenied.pdf>

they are sick or injured to the provider.¹² Consequently, hospitals closely monitor care and services to assure the best outcome for these patients. In 2016, 50 percent of community hospitals reported participating in an alternative payment arrangement premised on changing the paradigm from volume to value. Contract provisions that encourage patients to seek care outside the participating hospital are inimical to the ultimate success of value-based care. Therefore, you would expect that providers would resist them because commercial health insurers simply can't have it both ways: that is, enjoy additional savings from providers shouldering financial risk for safeguarding a patient's health while simultaneously encouraging those same patients to go elsewhere for care.

Reducing Care Denials. Some of the contract provisions championed by hospitals are designed to prevent commercial health insurers from denying claims that adversely affect both hospitals and their patients. One of the largest commercial health insurers, which was recently denied the opportunity to grow even larger by the courts, claimed that an efficiency resulting from the proposed deal would have been the ability to use the higher denial rates where those differed between the two insurers.¹³ The court appropriately noted "this analysis does not seem rooted in a search for a shared set of best-practices...."¹⁴ But the very claim that a benefit of the merger would be additional claim denials underscores the need for hospitals to be vigilant about contract provisions that could lead to excessive and unwarranted denials of payment for patient care.

A more recent example of why providers need to be vigilant about payment denials, is a report from the Department of Health and Human Services that found Medicare Advantage plans, where commercial health insurers dominate, were improperly denying claims for patients and providers citing "widespread and persistent problems related to denials of care and payment in Medicare Advantage."¹⁵ The report warned that "[b]ecause Medicare Advantage covers so many beneficiaries, even low rates of inappropriately denied services or payment can create significant problems for many Medicare beneficiaries and their providers."¹⁶

Assuring Consumers Get the Benefit of the Hospital/Insurer Bargain. Providers are aware that contract negotiations with a commercial insurer over provisions for a reliable network of providers and adequate medical services can be undermined if the commercial insurer is permitted to sell a lesser network or suite of service to its

¹² "The goal is straightforward but ambitious: Replace the nation's reliance on fragmented, fee-for-service care with comprehensive, coordinated care using payment models that hold organizations accountable for cost control and quality gains." <https://revcycleintelligence.com/features/what-is-value-based-care-what-it-means-for-providers>

¹³ United States vs. Aetna, U.S. Dct. Crt, January 23, 2017 found at <https://www.justice.gov/atr/case-document/file/930696/download>. (US v Aetna)

¹⁴ US v Aetna.

¹⁵ Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials, <https://oig.hhs.gov/oei/reports/oei-09-16-00410.asp>. (HHS Report on Payment Denials).

¹⁶ HHS Report on Payment Denials.

customers without further negotiations with providers. That selling technique results in consumers, who believe they are covered for certain services by certain providers at certain levels of reimbursement, discovering at the most inopportune time that the terms of coverage are different. The provider can be unaware of the problem and thus unable to even inform the consumer of the proper terms of coverage because the insurer has effectively changed the terms of its agreement with the provider by selling a different network or suite of services. Understandably, providers do their best to assure that the contracts they negotiate with commercial health insurers will provide consumers with the full suite of services and providers they expect.

Assuring Patients Get a More Complete Estimate of Total Costs. Patients want to know what the full cost of care will be when they enter the hospital. The article suggests that some hospitals and hospital systems withhold that information from commercial health insurers to confuse consumers. That is not the case. For example, one hospital mentioned strives to provide information to consumers directly (online or by telephone) in a more complete manner that attempts to avoid citing fees or rates piecemeal for a particular service and thus provide a more accurate estimate of the risk-adjusted total cost of care, including what the patient's insurer will cover and what the patient will pay under the policy.

FTC Concerns about Collusion. Even contract clauses that may at first appear ambiguous can have procompetitive benefits. For example, the article suggests that certain confidentiality clauses in provider contracts are intended to deprive consumers of information. However, such clauses are standard practice to protect proprietary information from competitors – not consumers – in order to prevent collusion. The FTC has expressed serious concerns when policymakers have suggested eliminating such provisions, noting their absence could facilitate collusion, raise prices and generally harm consumers.¹⁷

For example, in a letter on proposed legislation the FTC stated:

To the extent that the Bill mandates the disclosure of proprietary business information without effective protection, the Bill increases the likelihood of proprietary business information becoming public knowledge. If pharmaceutical manufacturers know the precise details of rebate arrangements offered by their competitors, then tacit collusion among them may be more feasible.¹⁸

As noted above, this letter is not an exhaustive discussion of the types of issues that arise in contract negotiations that are of concern to hospitals, health systems and consumers. However, we hope it provides greater perspective on the issue from the

¹⁷ Letter from FTC staff to the Hon. Nellie Pout (April 17, 2007)
https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-hon.nellie-pou-concerning-new-jersey.b.310-regulate-contractual-relationships-between-pharmacy-benefit-managers-and-health-benefit-plans/v060019.pdf (FTC Letter).

¹⁸ FTC Letter.

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providers' vantage point and illustrates the need for providers to be vigilant in resisting contract terms that could adversely impact patient care.

We would be pleased to discuss the issue in more detail with you and your staff, as well as with the federal antitrust agencies. If you have any questions, please feel free to contact me or have a member of your team contact Melinda Hatton, AHA general counsel, at (202) 626-2336 or mhatton@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President

cc: The Honorable Joseph Simons, Chair, Federal Trade Commission