AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

August 21, 2008

The Honorable John Dingell
Chairman
Energy and Commerce Committee
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

On behalf of the nearly 95,000 members of the American Academy of Family Physicians (AAFP), I am writing to encourage the United States Congress to pass legislation to ease Federal Trade Commission (FTC) restrictions on primary care physicians' contract negotiations with third party payors.

Current FTC policies on health care antitrust enforcement which prevent physicians from negotiating with health plans are particularly onerous for primary care physicians. Rising costs combine with static or reduced payments to challenge the economic viability of primary care practices. Yet physicians are being forced to accept or reject entirely the contract terms of insurance companies.

The number of practicing primary care physicians nationwide is shrinking in the face of inadequate third party payor payments. Physicians remain at a critical disadvantage when negotiating for better pricing and payments without risking sanctions under current federal antitrust enforcement policies.

The AAFP testified at a hearing held by the House Small Business Committee on the impact of health insurance consolidation on small business. As detailed in the enclosed testimony, FTC regulatory barriers to physician collaboration combine with insurance market consolidation and "take-it-or-leave-it" contract offers to hamper the delivery of quality primary care.

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Thank you for your thoughtful consideration of our request that physicians be allowed to participate fully and freely in the health care market place.

Sincerely,

Rick Kellerman, MD, FAAFP
Board Chair

Enclosure

Similar letters sent to Energy and Commerce Committee Ranking Republican Joe Barton and Senate Commerce, Science and Transportation Committee Chairman Daniel Inouye; and Ranking Republican Kay Bailey Hutchison.

AMERICAN ACADEMY OF FAMILY PHYSICIANS

Testimony of

Jim King, MD, FAAFP
President

To the Committee on Small Business
U. S. House of Representatives
Washington, DC

October 25, 2007

Thank you, Chairwoman Velazquez and Rep. Chabot, and the members of the Small Business Committee for the opportunity to participate in this hearing today. On behalf of the 93,800 members of the American Academy of Family Physicians, we applaud your deep concern for how the consolidation of health insurance plans affects family physicians both as members of the small business community and as professionals concerned about the effective delivery of health care.

As described by the American Medical Association, the merging and consolidation of health insurance plans has created a massive imbalance in the ability of physicians to negotiate contracts with insurers to the detriment of physician practices. This, in turn, has led to the inability of many of our patients to locate a primary care physician who can accept their insurance and still maintain financial viability.

The trend toward consolidation is persistent. The industry analysts of investment bank Shattuck Hammond reported that between 1992 and 2006, the number of competitor consolidations resulted in 95 different payers shrinking to merely seven. According to the AMA's 2005 report on Competition in Health Insurance, in 280 U.S. markets, 30 percent or more of HMO and PPO lives are covered by the single largest insurer in that market. Looking at the US as a whole, only two insurers cover a third of all commercially insured lives. This market concentration gives these health plans excessive power in determining the conditions of coverage, payment and practice.

Effects on Family Physicians

How does this consolidation affect family physicians? Let me give you just two examples. In the Dallas/Fort Worth area, a 3-physician group practice has a payer mix consisting of principally three payers: 30 percent United Healthcare, 28 percent Blue Cross and 18 percent Aetna. A solo physician practice in Colorado has 60 percent of his practice insured by one commercial payer, a situation that occurred as a result of a merger.

As a result of similar concentrations of payers, many family physicians in small or solo practices have little leverage in their negotiations with the health plans. As the physician in Colorado noted when he attempted to make the case for a payment that at least would cover inflation, he was told by the representative of a large insurance company, "As a solo physician, you are the weakest economic unit and must take what we decide to give." Another family physician noted that because small and solo practices cannot compare financial data before they sign a contract, they find out afterwards that their payment rates are substantially less than those of larger groups that can negotiate better terms.

Further, plans have no incentive to accede to any of a physician's requests when the plan has the ability to remove the physician from the network for not agreeing to the terms of the contract and effectively denying that physician's

patients access to the practice. Physicians in this situation have little choice but to sign whatever contract is offered by the health plans. Many practices find it financially impossible to sacrifice a significant part of their patient base to take a stand against untenable contract provisions.

Declining Payment Rates and Terms of Agreement

The health plans use this negotiating power created by this pattern of consolidation to dictate smaller payments and onerous terms. In California, the mergers of PacifiCare Health Systems with United Healthcare and WellPoint Health Networks/Blue Cross of California with Anthem, Inc. have produced fee cuts of as much as 20 to 30 percent. According to a California Medical Association survey of 500 state medical practices, 20 percent of 1,500 affiliated physicians had terminated a Blue Cross contract or planned to do so. By forcing practices to accept these cuts or lose their patients, health plans are making it more difficult for patients to secure the health care they need.

It is not only payment rates that cannot be negotiated, but the terms of the agreement cannot be challenged. Health plans affect every segment of the practice of medicine and compel treatment decisions; for example, by requiring practices to use specific labs; by determining which tests may be performed in the office; and by demanding the completion of multiple-page forms that reduce the amount of time a physician has available for treating patients.

These requirements may be cost-effective for the insurer but create significant burdens for practices and patients. For example, a family physician in practice outside a metropolitan area in Ohio contracts with a health insurer who changed its national laboratory arrangement that originally included two companies down to a single, exclusive laboratory arrangement. This change caused the insurer's enrollees to drive to the local hospital for lab services rather than walk across the hall from the physician's office to a competitor's reference lab. If the physician had referred the patients to the non-participating lab across the hall, he or she could have faced fines by the payer.

Increased Un-reimbursed Administrative Responsibilities

The insurance plans that have a large segment of the patient population also pass back to the physician practice many of their administrative responsibilities. According to a family medicine office manager, each radiology notification and authorization request now takes an average of up to ten minutes to perform with a physician peer-to-peer request adding another 10 minutes. Another physician in Arizona reported that these authorizations can often take at least 40 minutes per procedure to receive approval from the insurance plan. These administrative activities are not reimbursed by the health plan and so they have no incentive to become more efficient. The physician, in turn, is required to comply with time-consuming health plan requirements that not only are unpaid but are increasing in a period of declining overall reimbursement.

Unilateral Contract Changes
Many contracts allow the health plan to unilaterally change the contract terms, whenever they choose, without notifying the physician, simply by posting the amended terms on the insurer's web site. Some contracts specifically forbid the physician from disclosing information about the fees that the insurer pays to the physician, making it impossible for these physicians to inform patients about their out-of-pocket responsibility for deductible amounts under their policy. Few contracts provide physicians with payment terms spelling out how the fee schedule will be calculated. The result is more primary care physicians are driven into other care settings, such as Emergency Rooms or cash-only practices, or they leave health care altogether due to these negative contract conditions, excessive administrative requirements and downward pressure on fees.

Effect on Students and Residents
These contract imbalances concern not just the physician in practice now who is struggling to keep her business open but also the student who is looking at career options and deciding whether primary care offers a stable future. The number of medical students choosing family medicine and primary care has been declining for several years. Medical student debt averages over $200,000 upon graduation and the potential earnings has a strong effect on the student's choice of specialty. Patients' access to primary care will ultimately be reduced as more medical students choose non-primary care residencies because of the instability of the current situation.

Effect on Small Business Community
It is important to note that the result of health plan mergers and consolidation is not the achievement of economies of scale that might be expected. Such economies would produce lower consumer premiums, which would make it possible for more small businesses to afford to offer health insurance to their employees. Instead, consolidation produces larger insurance companies wielding the kind of power and influence that leaves physicians helpless and frustrated. As a result, small businesses are not offered more affordable prices for their employees' health plans but rather fewer choices of physicians who will accept the plans that are offered.

Effect on Patients
The payment rates that the health plans offer are unrelated to the quality of care that the physician provides to their patients. A family physician in Arizona notes that he has been honored several times as the best physician in the state and has over 100 other physicians among his patients. He receives the highest rating possible from his health plans for both quality and efficiency. Nevertheless, he is taking more than $100,000 out of his savings each year to stay in practice because he cannot negotiate higher payment rates. This situation is clearly not sustainable. If he is forced to close his practice, his

patients will have lost that long-standing source of care coordination and preventive services on which they have depended.

Effect on Quality

Finally, the most serious effect of this rapid consolidation is to undermine the great potential for efficiency and quality improvement offered by what we are calling the patient-centered medical home. As proposed by family medicine, internal medicine, pediatrics and the osteopathic primary care physicians, the medical home is the practice that has been transformed to offer comprehensive coordinated care. Experience with health systems based on primary care that exist in other industrialized nations shows the value of a medical home. It is a practice that provides guidance, assistance and responsiveness to patients navigating an increasingly complex health care system. But the patient centered medical home depends on a long-term relationship between the physician and the patient, which is impossible if an insurance company dictates the terms of practice of medicine and prevents the patient's freedom of choice.

Conclusion

The AAFP recommends changes in existing anti-trust laws that will provide physicians with tools that encourage them to be true market participants. The current anti-trust laws were established during a very different competitive environment. Under these outmoded laws, physicians are barred from discussing the financial aspects of their practice with any entity unrelated to their practice, yet it is clear that insurance companies "price to the mean" which is how the natural competitive forces are supposed to work and is what creates a dynamic market. Small and solo practice primary care physicians are excluded from that very basic business condition.

Again, AAFP commends the committee for highlighting the issues resulting from health insurance consolidation. Family physicians, many of whom provide health care in small and solo practices in rural and other underserved areas, feel the effects of this trend to consolidation by trying to negotiate on a very uneven playing field. Let us work together to ensure a path to an improved health care system that puts the patient first and supports the sustainability of a practice that delivers high quality primary care. One step in this direction would be to engage the medical community on how the anti-trust laws could be changed to better support the small businesses that are medical practices, so that they can negotiate contracts with insurers from a position of equality.

Thank you for the opportunity to provide this testimony and I look forward to answering your questions.