U.S. Department of Justice

Antitrust Division

Office of the Assistant Attorney General

Washington, D.C. 20530

September 7, 1993

The Honorable Cynthia M. Maleski
Insurance Commissioner
Commonwealth of Pennsylvania
Insurance Department
13th Floor, Strawberry Square
Harrisburg, Pennsylvania 17120

Dear Commissioner Maleski:

The Antitrust Division submits these comments for consideration by the Pennsylvania Insurance Department in connection with its review of the Fair Payment Rate Limitation (FPRL) clause proposed by Blue Cross of Western Pennsylvania (BCWP). The FPRL, if approved, would entitle BCWP to the lowest price a hospital has negotiated with its private health plan payers.

The mission of the Antitrust Division is the promotion and maintenance of competition in the United States economy. In carrying out that mission, the Division has had a great deal of experience in conducting economic analysis of hospital and health plan markets, which has enabled us to develop considerable expertise relevant to an evaluation of the FPRL.

The Division recommends that the Insurance Department disapprove the FPRL. Based on our review, we conclude that implementation of the FPRL likely would result in higher hospital prices to BCWP's competitors. The cost to hospitals of making price concessions to BCWP's competitors would increase because the same price concessions would have to be granted to BCWP[1]. It is unlikely that any savings to BCWP from the FPRL would benefit western Pennsylvania health plan purchasers. The increase in BCWP's competitors' costs likely would cause their health plan prices to rise, which would enable BCWP to increase its health plan prices. Finally, there are other means available to accomplish such cost savings, used by Blue Cross plans elsewhere in the country, that would not impede competition.

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[1]The cost to hospitals of price concessions would be particularly large because BCWP has 63 percent of private insureds in western Pennsylvania and its largest rival has 7.5 percent. Statistics from Exhibit A of Letter to Daniel Clearfield, Office of Attorney General, from Stephen Ban, July 19, 1993.

I urge you to reject the FPRL to preserve the competitive functioning of both hospital and health plan markets. Competition, not the contractual restraint of the FPRL, is the best means to accomplish lower prices and reduced costs for western Pennsylvania health care services.

ANALYSIS OF THE BCWP FPRL

BCWP's traditional health insurance plan offers free choice of providers to its enrollees.[2] Although traditional insurance plans have the attractive "free choice" feature, they have been steadily losing ground to managed care plans (MCPs). A major factor in this trend has been MCPs' use of selective contracting with hospitals as an important tool to control costs.[3]

In some circumstances, provisions such as the FPRL, that guarantee a purchaser the best rate given to any other purchaser, are not anticompetitive. However, where sellers (hospitals) and buyers (health plans) negotiate price and a large buyer asks sellers for a guarantee of the best rate given to any other purchaser, anticompetitive results can occur.[4] With an FPRL or similar contract provision in place, the cost to a hospital of granting a price concession to a selectively contracting MCP increases dramatically because this same price must given to the large buyer (in this case, BCWP). This reduces the incentive of a hospital to grant price concessions to MCPs and thus helps the hospital negotiate a higher price with MCPs. For these reasons, MCPs would likely pay much higher hospital prices under the FPRL.

There are a number of reasons to believe that BCWP also will not obtain significantly lower hospital rates under the FPRL. First, because BCWP has such a large market share relative to its next largest competitor, price concessions to these competitors will be unusually costly for hospitals and hence, less likely. Second, one HMO (HealthAmerica) reports that five of its Pittsburgh area contracting hospitals plan to raise their prices to Blue Cross' current level in the event of an FPRL.[5] BCWP itself acknowledges the possibility of unchanged BCWP hospital prices:

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[2] BCWP also offers two managed-care plans. In these comments "BCWP" will refer only to the free-choice plan that contracts with each of the general hospitals in its area of operation.

[3] See, Melnick, G.A. et al., "The Effects of Market Structure and Bargaining Position on Hospital Prices," Journal of Health Economics, 11 (1992) 217-233; Dranove, D. et al., "Price and Concentration in Hospital Markets: The Switch from Patient-Driven to Payor-Driven Competition," Journal of Law and Economics, (1993) forthcoming; and Gruber, J., "The Effects of Price Shopping in Medical Markets: Hospital Responses to PPOs in California," October 1992, Working Paper No. 4190, National Bureau of Economic Research.

[4] Cooper, T.E., and T.L. Fries, "The Most-Favored-Nation Pricing Policy and Negotiated Prices," International Journal of Industrial Organization, 9 (1991) 209-203.

[5] Salop, S. et al, "Economic Analysis of the Effects on Competition and Consumers of Blue Cross of Western Pennsylvania's Proposed Most Favored Nation Clause," August 16, 1993.

> Blue Cross does not dispute that the Fair Payment Rate Limitation could, at some hospitals, result in not a reduction of price to Blue Cross, but rather some increase in the hospital's price to Health America.[6]

Third, despite the fact that BCWP made projections of net cost savings due to the FPRL, actual letters of agreement with hospitals show almost no success in obtaining lower prices from acute-care hospitals. Of the approximately 30 letters of agreement BCWP has reportedly negotiated so far, only 6 involve any price reductions. Four of the 6 hospitals offering price reductions are rehabilitation hospitals. Rehabilitation hospitals differ dramatically from acute-care general hospitals in their payment sources. In particular, private health plans are much less significant payers at these hospitals than they are at acute-care general hospitals. The favorable effect of the FPRL at two acute-care hospitals at which the FPRL reportedly has resulted in lower prices is limited to very specialized services[7] that likely account for a fairly small portion of these two hospitals' revenues. Even if BCWP's hospital costs fell by a small amount with the FPRL, it is, nonetheless, likely that health plan prices would rise. The increases in BCWP's competitors' hospital costs are likely to result in increases in their health plan prices. This in turn would allow BCWP to raise the prices for its health plan.

BCWP'S JUSTIFICATION FOR THE FPRL

BCWP offers three major justifications for the FPRL:

> (1) BCWP is the largest buyer of hospital services, so it should get the lowest prices.
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> (2) BCWP explicitly pays hospitals for uncompensated care, "shortfalls" from government payers, and other costs while MCPs do not. When MCPs receive discounts, these discounts must be made up by BCWP. The FPRL is a mechanism to stop this "cost shifting" and force MCPs to support their "fair share".
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> (3) BCWP provides many community services at the health plan level such as open enrollment (no person is denied coverage because of his medical history), reduced rates for non-group coverage, and low cost programs for the economically disadvantaged. BCWP needs the FPRL in order to continue to support these services.

We address these justifications in turn.

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[6] "Comments in Support of Filing No. 1-HA-93-WP and Filing No. 2-HA-93-WP in Response to HealthAmerica of Pennsylvania Comments," May 26, 1993, Blue Cross of Western Pennsylvania, 5.

[7] We have been told that one hospital is offering the lower prices for cardio-thoracic surgery and the other hospital is offering lower prices for kidney transplants.

In response to BCWP's first point, large buyers routinely find ways to purchase goods and services without resorting to purchasing methodologies that impose higher costs on their competitors. For example, in this instance, BCWP could obtain lower prices by engaging in selective contracting.

As for BCWP's second major point, the Division disagrees with BCWP's assumption that hospital costs are fixed, so that if one payer pays less, then the rest of the payers will be charged the difference. This assumption is based on BCWP's assertion that selective contracting does not induce hospitals to reduce overall costs or markups. This assertion has little basis in theory or fact. Zwanziger and Melnick (1988) find that selective contracting in California caused hospitals to reduce costs. Dranove et al. (1993) find that, as a group, California payers saved money under selective contracting. Gruber (1992) finds that California hospitals reduced their markups in response to selective contracting.[8] However, it is not necessarily the case that discounts obtained by one payer will lead only to increased efficiency by hospitals and/or reductions in hospital markups. Hospitals also may respond to discounts from payers by raising prices to other payers or reducing uncompensated care. Thus, the reality is that selective contracting results in some "cost-shifting," but it also leads to lower costs and prices for hospital services.

In another setting (a hospital one-price policy that would be effective under an FPRL), BCWP contends that selective contracting will cause hospitals to become more efficient.[9] Although it is true that under a one-price policy hospitals have some incentive to become more efficient, this incentive is dulled significantly when a payor with a large share of the market, such as BCWP in this case, is willing to pay on the basis of costs. Cost reimbursement is widely viewed as a major culprit in the dramatic rise in health care costs in the 1970's and 1980's. In the days before selective contracting, hospitals were commonly reimbursed for their costs and their main strategy to attract new business was based on the provision of amenities (services offered, staffing levels, etc.). Such competition earned the nickname "medical arms races." Many studies have documented that, when cost reimbursement was prevalent,[10] hospitals engaged in this inefficient form of competition.[11]

Finally on this point, although the Division recognizes that BCWP does provide services such as support for uncompensated hospital care, this should not be an excuse for the use of contractual provisions that prevent competitors from negotiating lower prices and that ultimately will raise hospital costs to all consumers.

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[8] Zwanziger, J. and G. Melnick, "The Effects of Hospital Competition and the Medicare PPS Program on Hospital Cost Behavior in California," Journal of Health Economics, 7 (1988) 301-320; Dranove et al., op. cit.; and Gruber, op. cit.

[9] "Blue Cross of Western Pennsylvania's Response to Letter from Eric Brenner, Deputy Insurance Commissioner, Dated August 20, 1993."

[10] Cost reimbursement is rapidly disappearing, due to its widely acknowledged defects.

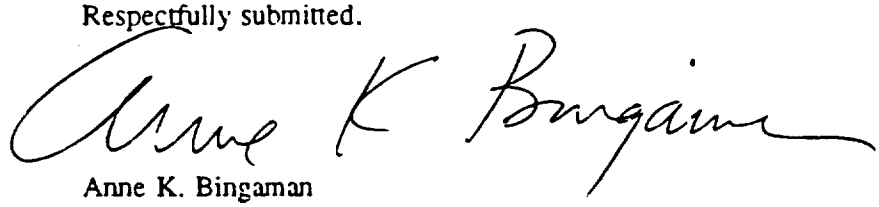
[11] See, for example, Luft, H. et al, "The Role of Specialized Clinical Services in Competition Among Hospitals," Inquiry 23 (1986) 83-94; and Robinson, J. and H. Luft, "Competition and the Cost of Hospital Care, 1972-1982," Journal of the American Medical Association 257 (1987) 3241-3245.

As for BCWP's third major justification for the FPRL, the Division acknowledges that BCWP provides many community services at the health plan level. However, when BCWP claims it needs the FPRL to continue supporting these services, it is in effect stating that it needs profits earned from the anticompetitive exercise of market power in order to support these services. The Division's position is that it cannot condone such an exercise of market power for any reason.

CONCLUSION

The FPRL raises two critical issues: (1) would western Pennsylvania private health plan purchasers benefit from the FPRL, and (2) could the FPRL reduce what BCWP terms "cost-shifting" and thus benefit BCWP's community service functions? As for the first question, the FPRL likely would raise hospital prices to BCWP's rivals by limiting their ability to contract selectively for hospital services at competitive prices. Furthermore, BCWP's large market share would make price concessions to BCWP unlikely under the FPRL. The actual contracting experience under the FPRL so far bears out this conclusion. Western Pennsylvania health plan purchasers likely will find themselves paying higher prices. As for the second question, the FPRL may reduce some "cost-shifting." Nonetheless, there are compelling reasons for rejecting the FPRL. "Cost shifting" is not a valid excuse for preventing competitors from negotiating lower prices. Moreover, disapproval of the FPRL could force BCWP to do what so many of its fellow Blue Cross plans have done--abandon the highly inefficient cost-based reimbursement system and adopt more efficient contracting systems. Finally and most important, disapproval of the FPRL will allow selective contracting to flourish, thereby promoting the competition so vital to providing affordable health care products to consumers.

Respectfully submitted,



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