American Hospital Association

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Sent via overnight mail

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The Honorable Martha Coakley
Attorney General
State of Massachusetts
One Ashburton Place
Boston, MA 02108

Dear Madam Attorney General:

On behalf of the American Hospital Association (AHA), we are offering comments on the Preliminary and Final Report on its Investigation of Health Care Cost Trends and Cost Drivers ("Reports") issued by your office on January 29, 2010 and March 16, 2010. We do so because of our concern that the Reports are being cited by the insurance industry as justification for price increases to consumers.[i]

The Reports analyze health care cost growth in the Commonwealth of Massachusetts and identify factors that drive up health insurance premiums. While the Attorney General's office is to be commended for its efforts to address an important issue, a number of unanswered questions and assumptions contained in the Reports are concerning. In part, it is difficult to evaluate the rigor and completeness of the analysis described in the Reports because of the absence, in some instances, of sufficient information to fully assess the findings and methodology. The information that is provided does raise some concerns about the conclusions and how they might be used outside the state to impact public policy.

Our comments address three areas of concern: missing information, methodology and concerning assumptions, and conclusions. This is not a comprehensive list; rather, the comments highlight a number of critical issues.

MISSING INFORMATION

There are a number of areas where the Reports omit information that is necessary to be able to fully evaluate its methodology and conclusions. Those areas are as follows.

Participants in the study: Although the Preliminary Report appropriately preserves the confidentiality of the providers and insurers that were selected for examination, it does not

explain how the selection was made, nor does it reveal what percent of Massachusetts providers, and what percent of insurers were included in the study. Important details such as geographic distribution and the types of providers and insurers could have been revealed without violating confidentiality protections.

The Final Report does identify some hospitals and health plans, but it is not clear which 15 hospitals were evaluated. Also, it does not explain how the hospitals were selected or provide any of the information referenced above. While the Final Report discusses payments to hospitals within particular regions, it does not identify those regions.

Methodology: The Preliminary Report does not explain, nor does it contain sufficient information with which to fully evaluate, its methodology. For example, the Preliminary Report does not reveal how the information was compiled from providers and insurers; it does not reveal how the various geographic areas examined were selected and defined (or what they were), and it does not reveal how the authors assessed "relative market position." Similarly, the Preliminary Report uses examples from a single health plan in a number of places, but does not reveal whether results from other health plans were the same or different. In particular, it does not reveal whether the results reported for one health plan were consistent across health plans for the same providers.

The Final Report provides more information to address the points noted above, but it is still insufficient to evaluate the methodology. It contains an appendix with more detail on methodology, but ultimately does not shed much additional light on the findings and conclusions.

Timing: The Preliminary Report does not address how much of the data were generated before Massachusetts health care reform went into effect and if the reforms had any effect on the results.

Some of the reported results in the Final Report appear to be from 2008, or post-reform, but it is not clear whether that applies to the entire Report or just those items that are dated.

Statistical analysis: The Preliminary Report makes broad statements about various types of payment, *e.g.*, that case rates are generally used by hospitals, but does not reveal how often case rates are not used, and what impact looking at other types of payment would have had on the results. The Preliminary Report also states that the authors examined some providers' internal cost analyses, but does not reveal how many or what percent of providers have such analyses or how the authors used the information.

The Final Report contains the same broad statements that continue to be troubling, particularly in light of several inconsistent descriptions of payments, such as "a startling level of variation" and "a wide number of payment methodologies."

The Reports fails to consider that payment and methodological variation could be an effort by providers to develop better reimbursement methodologies or simply a reflection of variations in procedures and treatments.

The omissions described above are just examples of where the Reports lack sufficient information for a full evaluation of the findings, conclusions and recommendations.

METHODOLOGY ISSUES

For a number of reasons, the methodology that is revealed in the Preliminary Report is concerning. For example, the Preliminary Report gathered information from only 15 health care providers, including both hospitals and physicians, and does not explain how that could possibly be a representative sample of the more than 100 hospitals and thousands of physicians in Massachusetts.

Similarly, the Preliminary Report relies on internal analyses from two health plans, but is silent about whether the results are consistent with information from other health plans and whether the results were checked against information from the providers to which the results pertain. The Final Report adds information from internal analyses of a third health plan, but remains silent about the other two studied. While the results appear to differ from plan to plan, it is not possible to tell whether those differences are statistically significant.

There are some concerns in the Preliminary Report's analysis of prices. First, it does not appear that any of the price comparisons were adjusted based on geographic location; although the heading on page 7 refers to providers in the same geographic area, the discussion seems to relate to Massachusetts hospitals in general. If the results were adjusted for geography, that is not explained. If the results were not adjusted, then the Reports failed to consider how different operating costs, taxes, wages and the like would legitimately affect prices.

Second, the Preliminary Report does not appear to have looked at components of price. For example, if the cost of pharmaceuticals is examined separately, that may affect the analysis and would demonstrate that a substantial portion of prices are unrelated to costs within hospitals' control. Third, the Preliminary Report concludes that larger hospitals have higher prices, but "larger" hospitals are defined in terms of revenue. Defining large hospitals by revenue, and then saying they have higher prices, is circular logic – higher prices may result in higher revenue, rather than the other way around. Larger hospitals also are defined by the number of patients who are HMO members, but limiting the analysis to HMO members leaves out a lot of patients.

The Final Report's appendix states that some of the pricing information submitted by the health plans in written filings in connection with this proceeding was different from the information provided earlier to the Attorney General. This difference is unexplained and concerning. Also, the pricing analysis appears to be based on uncritical acceptance of the health plans' characterization of relative prices of hospitals. The data does not appear to have been directly examined to independently verify the conclusions. Further, the Final Report adds an analysis of "unit costs" for providers, but only for "a number of hospitals" and "some providers." It does not specify how many were studied and, again, seems to be based on unverified information provided by health plans.

Probably the most troublesome aspect of the methodological flaws is the Preliminary Report's use of terms such as "market position" and "leverage" in ways unrelated to the true meaning of

those terms. The Preliminary Report assesses "relative market position" without regard to market share. Similarly, the Preliminary Report lists a number of factors that lead to providers having "leverage," but market share is not among them; the concerning conclusions the Reports draws about "leverage" are described below. Although the Preliminary Report neglected to discuss the effects of market position and concentration of health plans in the context of "leverage" the Final Report contains a *brief* discussion of insurer leverage with respect to payments to providers within particular regions.

CONCERNING ASSUMPTIONS AND CONCLUSIONS

The Preliminary Report reaches a number of conclusions and makes a number of assumptions about hospital prices that are not well supported. For example:

- The Preliminary Report draws apparently definitive conclusions about the relationship between prices and cost, but acknowledges that the authors have not finished analyzing the cost data – how is it possible to reach those conclusions then? The Final Report adds to this confusion by acknowledging that it is difficult to rely on and/or meaningfully understand cost data.

- The Preliminary Report states that "higher price and payment rates are reflected in higher cost structures, but are not *caused* by them," but does not explain what that means. It also states that providers manage costs to budgets based on revenue (presumably as opposed to seeking revenue that covers their costs). But that is no different from the way many companies set their budgets, and is not, in and of itself, an indication of a systemic problem. This is especially true for not-for-profit hospitals, which are mostly interested in generating a sufficient return to have enough capital to keep their facilities in good shape, to provide high quality services, and to meet the needs of their missions.

- The Preliminary Report also seems to criticize "highly paid" providers for being able to fund depreciation at a higher level than industry standards. All this means is that with higher revenue more capital investments are possible; hospitals will have the financial ability to provide better facilities and more modern equipment, both of which confer significant benefits on their patients. The Final Report seems to acknowledge these important points.

- The Preliminary Report discusses what it calls "parity." "Parity," as used in the Preliminary Report, is really another term for "most favored nations" clauses in contracts, in which providers agree that the prices they are charging the health plan with which they are contracting will not be less favorable (or will be more favorable) than the prices charged to other health plans. The discussion of the implications of these clauses is relatively accurate, but it leaves out any mention of health plan market power as an important factor. The Final Report does not remedy this omission.

- The Preliminary Report assumes that complexity and quality of care are the only reasons prices should differ among providers. But there are any number of reasons that prices may vary, including higher payments to reward innovation, to recognize consumer preference and

the like. So-called "high-priced" hospitals may simply be those that physicians and consumers prefer.

Another issue raised by the Preliminary Report is the effect of what the authors call "product participation" provisions. These types of provisions are often referred to as "anti-steering" provisions – they typically prevent health plans from technically including providers in their networks but then steering patients to alternative providers. The Preliminary Report assumes these types of provisions are problematic, but contains no discussion of the reasons providers seek these clauses in contracts, nor does it discuss the effects of steering on providers' cost structure and patient mix. For example, a hospital may have offered a better price to be included in a network, but it does not get any benefit in return for the lower price if health plan members go to other hospitals. Or if a health plan steers patients seeking more profitable services to other providers, a hospital's cost structure could be adversely affected. Finally, the Preliminary Report also states – with no support and no explanation – that such provisions discourage providers from participating in new products. This section is similar in the Final Report. While the Final Report adds the point that these types of clauses will discourage new products if health plan competitors can market the same products, it does not explain why that is the case or what these clauses have to do with that potential problem.

The Final Report adds a new section on supplemental payments by health plans to providers in addition to contracted prices. It criticizes such payments but without explaining why they are problematic. For example, one type of payment is for "infrastructure," which is something that could be beneficial for patients by funding improvements that a hospital could not fund on its own.

The Preliminary Report's conclusions about "leverage" are questionable. The Preliminary Report simply focuses on size, and states that larger providers have more "leverage" because employers are less interested in networks that do not have large providers included. Other factors listed that create "leverage" according to the Preliminary Report are geographic location, niche or specialty service. None of these factors reflects anything other than the simple reality that different providers will be attractive to consumers for different and entirely understandable reasons, and that consumer preference is a legitimate basis on which prices may differ. The Final Report compounds the problem by adding a provider's "brand name" as a source of leverage. The discussion of "leverage" here is even more consistent with consumer preference being a legitimate basis on which prices may differ. Consumer preference is not a factor conventionally viewed as conferring "leverage."

Moreover, the Preliminary Report does not define "leverage" in a consistent manner, and its use of total revenue as a proxy for leverage is an unsupported leap in logic. Similarly, the Preliminary Report's statement that it is "clear" that prices reflect "leverage" is unsupported and incorrect. Given that the authors did not measure anything but size – based on revenues – and did not evaluate market share or any other indication of lack of patient choice, there is no basis to conclude that prices reflect a conventional concept of "leverage." The Final Report admits that its analysis is different from how defining relevant markets would be approached under antitrust laws. That makes the use of the term "leverage" even more inappropriate. The Final Report also elaborates on the use of the number of a health plans' HMO members to measure "leverage," *i.e.*,

if a hospital treats a large number of a health plan's HMO members, greater disruption would occur if a hospital is not included in a health plan's network. Again, this is simply an indication of consumer preference not "leverage."

The recommendations at the end of the Reports are vague and, therefore, difficult to evaluate. One point encourages transparency without explaining what that means. If the authors are referring to requiring hospital-health plan contracts to be available to the public, that could make prices and other contract provisions even less competitive. As the Federal Trade Commission has found, such transparency requirements can lead to higher prices.[ii] For example, if the health plans know the rates their competitors are paying and the providers know the rates their competitors are charging, those rates would tend to reach a higher level than they might in a less transparent environment.

Any recommendation that is "designed to promote convergence of provider rates" is a recipe for higher prices and less consumer choice. Similarly, "standardization of units of payment" is likely to have the same effect. If consumer preferences are not reflected in the payment system, there will be less incentive to provide innovative services and other types of care that are important to the public.

While we welcome a discussion about the need to make health care more affordable for all Americans, we believe that all sectors of the health care community should be part of the conversation. Focusing on just one, or even just a few health care sectors, will likely result in incomplete and even skewed results that will be useful to neither policymakers nor the public. For more information, please feel free to contact me at (202) 626-2336 or mhatton@aha.org.

Sincerely,

Melinda Reid Hatton
Senior Vice President and General Counsel

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[i] Letter to Rich Umbdenstock, President and Chief Executive Officer, American Hospital Association, from Samuel R. Nussbaum, M.D., Executive Vice President, Clinical Health Policy and Chief Medical Officer, WellPoint, Inc., March 24, 2010 (available upon request).

[ii] *See, e.g.*, Letter to Hon. James L. Seward, New York State Senate, from Federal Trade Commission Office of Policy Planning (March 31, 2009).