Comments on the Draft Vertical Merger Guidelines with Special Consideration to Health Care

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We appreciate the opportunity to be able to comment on these new guidelines. The purpose of our comments is threefold. First, we offer broad comments about the Draft Vertical Merger Guidelines (VMG). Second, given our expertise, we do a deeper dive into what VMG mean for health care. Third, we finish wish some final points that the agencies might want to consider with respect to VMG.

We begin with discussing the important issue of presumption of harm. There was great enthusiasm and support that the Draft VMG did not presume either a lack of efficiencies or a lack of anticompetitive harm from vertical mergers. But we believe adding the five rebuttable presumptions listed below would strengthen the VMG.

Presumption of Harm

- The VMG should be less neutral and adopt the following five rebuttable presumptions of anticompetitive effects when at least one of the two markets (upstream or downstream) is concentrated and certain conditions are met.[1]
    1. Input Foreclosure Presumption
        - If the upstream merging firm in a concentrated market is a substantial supplier of a critical input to the competitors of the downstream-merging firm and a hypothetical decision by the merged entity to stop dealing with its downstream competitors would lead to a substantial diversion of business to the merged firm.
    2. Customer Foreclosure Presumption
        - If the downstream merging firm is a substantial purchaser of the input and a decision to stop dealing with the competitors of the upstream merging firms would lead to the exit, marginalization, or significantly higher variable costs of one or more of those competitors by diverting a substantial amount of business away from them.
    3. Elimination of Potential Entry Presumption
        - If either (or both) of the merging firms has a substantial probability of entering into the other firm's concentrated market absent the merger.
    4. Dominant Platform Presumption
        - If a dominant platform acquires a firm with a substantial probability of entering in competition with it absent the merger, or if that dominant platform company acquires a competitor in an adjacent market.
    5. Two-tiered Entry Presumption

[1] See Baker, Jonathan B., Nancy L. Rose, Steven C. Salop, Fiona Scott Morton. "Five Principles for Vertical Merger Enforcement Policy." *Antitrust* 33, no. 3 (2019): 12-19. Available from: https://scholarship.law.georgetown.edu/facpub/2148/ for more details.

- Post-merger a new entrant would have to enter both input and output markets if a substantial fraction of both input or output market is vertically integrated.
- VMG guidelines should provide threshold for defining substantial fraction in this context.
- VMG might consider different thresholds for defining substantial fraction based on the following criteria:
    - The substantial fraction threshold should be lower in more concentrated input or output markets.
    - The substantial fraction threshold should be lower in markets with significant barriers to entry in both the input and output market.

We suggest the VMG outline how competitive harm can occur. That is, here are the X number of ways harm can occur. The Draft VMG do not discuss (or only discuss in passing) the following topics related to potential competitive harm.

- Dominant platforms
- Customer foreclosure
- Two-tier foreclosure
- Entry barriers enhanced by having to enter two markets
- Mavericks
- Bargaining leverage[2]
- Merging parties could be the most likely entrants to each other in both markets
- Information advantages

[2] Dafny, Leemore, Kate Ho, and Robin S. Lee. "The price effects of cross-market mergers: theory and evidence from the hospital industry." *The RAND Journal of Economics* 50, no. 2 (2019): 286-325.

We now do a deep dive into health care starting with a few points as to why the possibility of anticompetitive harm from vertical mergers may be particularly strong for health care as opposed to other sectors of the economy. Next, we discuss why non-price effects need to be examined in health care markets and outline our concern about the 20% market share threshold potentially acting as a safe harbor for health care companies that intend to pursue vertical mergers in the future.

Health Care

- Virtually every sector of health care delivery and payment is characterized by high concentration.[3] Therefore the potential of anticompetitive effects …
    - Over 90% of inpatient acute care hospital markets are concentrated.[4]
    - The four largest commercial insurers have over 80% of the nation's commercial insurance business, with half of all markets comprised of two insurers controlling over 70% of the market.[5]
    - 65% of all MSAs have highly concentrated physician specialty markets and approximately 40% of local primary care markets are concentrated.[6]
    - The three largest pharmacy benefit management companies control over 70% of the business and two pharmacy chains control 50-75% of the market in the nation's largest markets.[7]
- Given the high level of concentration in health care markets, we suggest careful attention be paid to the following five points.
    1. The need for vigilance over vertical consolidation in health care is particularly acute based on long experience demonstrating that market dominance achieved by mergers can give rise to anticompetitive conduct.[8]
    2. The potential of cumulative anticompetitive effects arising from sequential vertical mergers is particularly acute in health care given that physician practice consolidation has been driven by small acquisitions that make it difficult for agencies to intervene.[9]
    3. While there are undeniably potentially significant benefits resulting from vertical integration among health care providers, there is less evidence that such benefits

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[3] Greaney, Thomas L., Statement Before the U.S. Senate Committee on the Judiciary Subcommittee on Antitrust, Competition Policy, and Consumer Rights (June 12, 2019), available at https://www.judiciary.senate.gov/imo/media/doc/Greaney%20Testimony.pdf ; Greaney, Thomas L. Navigating the Backwater: Vertical Mergers in Healthcare, CPI Antitrust Chronicle 1 (May 2019).

[4] Fulton, Brent D. "Health care market concentration trends in the United States: evidence and policy responses." *Health Affairs* 36, no. 9 (2017): 1530-1538.

[5] Dafny, Leemore, "Health Insurance Industry Consolidation: What Do We Know From the Past, Is It Relevant in Light of the ACA, and What Should We Ask?" Testimony Before the Subcomm. on Antitrust, Competition Policy, and Consumer Rights of the S. Comm. on the Judiciary, 114 Cong. 5 (2015) available at http://www.judiciary.senate.gov/imo/media/doc/09-22-15%20Dafny%20Testimony%20Updated.pdf

[6] Fulton, *supra* note 6.

[7] Dafny, *supra* note 8.

[8] Thomas L. Greaney and Barak D. Richman, "Consolidation in Provider and Insurer Markets: Enforcement Issues and Priorities." Part I of the American Antitrust Institute White Paper Series on Competition in Payment and Delivery of Health Care Services (June, 2018), available at http://www.antitrustinstitute.org/content/aai-issues-part-i-new-white-paperseries-competition-delivery-and-payment-healthcare;

[9] Capps, Cory, David Dranove, and Christopher Ody. "Physician practice consolidation driven by small acquisitions, so antitrust agencies have few tools to intervene." *Health Affairs* 36, no. 9 (2017): 1556-1563.

flow from integration of payers and providers. The most recent evidence shows that economic integration in health care has failed to generate clinical integration that produces either better quality or cost savings.[10] A just published paper analyzing 29 quality measures found vertical integration had a limited effect on a small subset of quality measures while market concentration was strongly associated with reduced quality across all 10 patient satisfaction measures.[11]

4. Ultimately, health care consists of a collection of conditions precedent for concern: high entry barriers, concentration at every level, regulation that inhibits competition and encourages consolidation, market dominance that gives rise to anticompetitive conduct, and a history of vertical integration that has often not yielded benefits.[12]
5. Since the VMGs are not industry-specific, the DOJ/FTC should consider promulgating policy statements akin to the 1994 Health Care Policy Statements with have provided some guidance to practitioners and courts.[13]

We are very concerned that the Draft VMG lack a discussion of the potential non-price anticompetitive effects of vertical mergers. The VMG should discuss how the following four non-price effects could manifest.

- Quality
- Customer choice (e.g. Physicians directing patients to vertically integrated hospitals)
- Entry
- Innovation

The Draft VMG is particularly problematic for markets where prices are regulated. A number of health care markets are regulated by the government (e.g. Medicare, Medicaid). Hence, health care markets may be particularly susceptible to non-price anticompetitive effects of vertical mergers.

We see the inclusion of the 20% market share guidance in the Draft VMG as particularly problematic. In health care, hospital acquisitions of physician practices regularly fall under 20%, but research has shown that hospital acquisitions of physician practices often leads to higher prices without commensurate improvements in quality (see Post et al. (2018) for a review of the

[10] See, e.g. Beaulieu, Nancy D., Leemore S. Dafny, Bruce E. Landon, Jesse B. Dalton, Ifedayo Kuye, and J. Michael McWilliams. "Changes in Quality of Care after Hospital Mergers and Acquisitions." *New England Journal of Medicine* 382, no. 1 (2020): 51-59; Burns, Lawton. Testimony before the Investigatory Hearing on the Merger of Aetna into CVS Health Care Corporation, California Department of Insurance (June 19, 2018), available at http://www.insurance.ca.gov/01-consumers/110-health/60-resources/upload/Burns-Testimony-of-Lawton-R-Burns-in-Aetna-CVS-Merger-June-2018.pdf

[11] Short, Marah Noel and Vivian Ho. "Weighing the Effects of Vertical Integration Versus Market Concentration on Hospital Quality." *Medical Care Research and Review* (2019).

[12] Greaney, Thomas L. "The New Health Care Merger Wave: Does the 'Vertical, Good' Maxim Apply?" *Journal of Law, Medicine & Ethics* 46 (2018): 918-926.

[13] U.S. Department of Justice and Federal Trade Commission, Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust 4 Trade Reg. Rep. (CCH) 13152, 20769 (Sept. 30, 1994).

evidence).[14] In addition, there's the potential of cumulative anticompetitive effects arising from sequential vertical mergers.[15] For example, a hospital system that continually purchases small physician practices that fall into the under 20% market share safe harbor could eventually accumulate considerable market power. The safe harbor approach of the Draft VMG is also at odds with the current Horizontal Merger Guidelines. The Horizontal Merger Guidelines presume anticompetitive effects when a market is highly concentrated (HHI > 2,500) and HHI increases significantly (change in HHI > 200). The Draft VMG have the opposite presumption. Mergers between parties with less than 20% market share are presumed not to lead to anticompetitive effects.

We end our comments with a few final points that the agencies may wish to consider.

Final Points

- VMG should talk about the importance of evidence on relationship between market power/horizontal mergers and consumer harm in input or output market. Ultimately vertical mergers increase market power in input or output markets and thus the evidence from horizontal mergers is relevant.
- For efficiencies the following points should be noted:
    - Merger in required for efficiency.
    - Efficiency should be same market as market where competitive harm might occur. Efficiency in one market cannot offset competitive harm in other market.
    - Efficiency claims should have a high burden of proof and the responsibility should lie with the merging parties.
- We see the proposed guidelines as requiring efficiencies, including EDM, to be shown and interpret the adjective "cognizable" to mean "merger-specific." This could be made more explicit.
- On profitability and raising rivals' costs a question arises. Is the reference to profitability meant to only refer to incentives or was it meant to add an additional formal test, like the sacrifice-of-profits test, that plaintiffs would have to meet?
    - We interpret the statement as applying to the former but that the possibility of the latter is a real concern. The standard "raising rivals' costs" analysis does not entail a sacrifice of profits.
- Not clear Draft VMGs apply to complements as well as inputs. Same standards should apply generally.
- Attention to "stealth consolidation" should be encouraged. See FTC commissioners Wilson and Chopra statement Feb. 11, 2020: https://www.ftc.gov/system/files/documents/public_statements/1566385/statement_by_commissioners_wilson_and_chopra_re_hsr_6b.pdf
- Should be better coordinated with Horizontal Merger Guidelines and vertical restraints.

[14] Post, Brady, Tom Buchmueller, and Andrew M. Ryan. "Vertical integration of hospitals and physicians: Economic theory and empirical evidence on spending and quality." *Medical Care Research and Review* 75, no. 4 (2018): 399-433.

[15] Scheffler, Richard M., Daniel R. Arnold, and Christopher M. Whaley. "Consolidation trends in California's health care system: impacts on ACA premiums and outpatient visit prices." *Health Affairs* 37, no. 9 (2018): 1409-1416; Scheffler, Richard M., Daniel R. Arnold, and Brent D. Fulton. "The Sky's the Limit: Health Care Prices and Market Consolidation in California." California Health Care Foundation Report. October 3, 2019.