AMA
AMERICAN
MEDICAL
ASSOCIATION

Michael D. Maves, MD, MBA, Executive Vice President, CEO

June 3, 2010

The Honorable Jon Leibowitz
Chairman
Federal Trade Commission
Office of the Secretary
Room H-135 (Annex P)
600 Pennsylvania Avenue, NW
Washington, DC 20580

The Honorable Christine Varney
Assistant Attorney General for Antitrust
United States Department of Justice
950 Pennsylvania Avenue, NW
Washington, DC 20530-0001

Re: HMG Revision Project – Comment, Project No. P092900

Dear Chairman Leibowitz and Assistant Attorney General Varney:

On behalf of the physician and student members of the American Medical Association (AMA), I would like to extend our appreciation for the opportunity to submit the following comments on the proposed Horizontal Merger Guidelines (Guidelines), released on April 20, 2010. The AMA applauds the Federal Trade Commission (FTC) and the Department of Justice (DOJ) for undertaking a comprehensive review of the Guidelines. This effort is an opportunity to address important matters, including that of competition, in the health care industry.

Our previous comments on the Guidelines reflect our long-standing concern that federal antitrust enforcement policy has not prevented health insurer mergers that have contributed to the formation of highly concentrated health insurance markets leading to anticompetitive effects in consumer (output) and physician (input) markets. We are supportive of the approach taken in the proposed Guidelines, which presents a more flexible and comprehensive merger analysis that could allow for a more rigorous merger enforcement program against health insurers.

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The AMA supports the shift in the proposed Guidelines concerning market definition. The proposed Guidelines follow current economic thought on market definition that emphasizes the importance and use of evidence concerning adverse competitive effects when defining a relevant market. We agree that adverse competitive effects—not market definition—should be the focus of antitrust analysis. According to the revised Guidelines, market definition is neither an end in itself nor a necessary starting point of merger analysis. These revisions also address our concern that the market definition principles contained in the present Guidelines can result in improperly large markets. The proposed Guidelines correctly incorporate the market definition approach utilized by the FTC's enforcement action in, *In re Matter of Evanston Northwestern Healthcare Corporation*. More importantly, the proposed Guidelines present a more sophisticated approach for dealing with mergers between firms selling differentiated products. Further, the proposed Guidelines also recognize that the market definition process should not be used to justify mergers between firms that view each other as primary rivals simply because other firms also have some role in the market. The AMA believes that these principles have direct application to health insurance mergers. We are pleased that the latest, proposed Guidelines state "that evidence of competitive effects can inform market definition, just as market definition can be informative regarding competitive effects."

The AMA also supports the inclusion of a new section that addresses mergers of competing buyers (Section 12, Mergers of Competing Buyers). There are, however, two significant omissions. First, the analysis of monopsony power can have some important differences from the analysis of market power. For example, health insurers can exercise monopsony power in physician markets with market shares of less than thirty-five percent. The AMA believes that the proposed Guidelines should acknowledge, in a statement that would apply to all industries, that monopsony (buyer-side) power issues can emerge with lower market shares than those associated with market (seller-side) power. Second, when evaluating mergers, the proposed Guidelines identify two broad theories for identifying anticompetitive effects: (a) coordinated interaction; and (b) unilateral effects. Coordinated interaction is a greater risk in markets involving homogeneous products; unilateral effects are more likely in markets for differentiated products. Given the realities of health insurance markets, it is possible that the effect on consumers of a merger between health insurers requires an analysis under a unilateral effects theory, while the analysis of its impact on physician markets requires a coordinated interaction theory. The reason is that health insurance policies may arguably be differentiated, while the setting of physician reimbursement rates by insurers is highly susceptible to their coordinated interaction. This difference also provides some explanation why monopsony power can become a problem at lower levels of concentration than typically associated with market power. The possible need for a two-tier analysis should be addressed in the Guidelines.

We are encouraged by the monopsony discussion in the proposed Guidelines. We believe that this development and the very recent DOJ expression of monopsony concerns associated with the proposed health insurance merger in the Lansing, Michigan area, are encouraging signs of new vigorous and responsible antitrust enforcement protecting both consumers and physicians from anticompetitive health insurance mergers.

In summary, the AMA believes that the proposed Guidelines require further revisions that take into account our comments above, along with our previous recommendations (enclosed) on the market definition and the issue of monopsony power. The AMA looks forward to working with the FTC and DOJ on this important effort. If you have any questions or would like any additional information, please do not hesitate to contact Carol Vargo, Assistant Director, Federal Affairs, (202) 789-7492 or email her at carol.vargo@ama-assn.org.

Sincerely,

Michael D. Maves, MD, MBA

Enclosure

Re: HMG Review Project -- Comment, Project No. P092900

The American Medical Association ("AMA") submits the following comments on the Horizontal Merger Guidelines in connection with the public workshop addressing a possible update of those guidelines.

The AMA applauds the Federal Trade Commission (FTC) and the Department of Justice (DOJ) for undertaking a comprehensive review of the Horizontal Merger Guidelines and appreciates the opportunity to provide comment. This effort is an opportunity to address important matters facing the health care industry, including that of competition in the health insurance industry. In July, 2009, the AMA submitted a letter to Assistant Attorney General Christine Varney outlining the physician's perspective on health insurance consolidation. For your information, we have attached this letter to provide context to our following comments on the Horizontal Merger Guidelines.

The AMA believes that the Merger Guidelines should be revised to take into account developments in antitrust law since 1992. First, the market definition section of the Merger Guidelines should (a) more accurately reflect how market definition is actually performed, and (b) explain the relationship of market definition to the theories of anticompetitive harm identified by the DOJ and FTC (the "Agencies") in their "Commentary on the Horizontal Merger Guidelines." Second, the Merger Guidelines should address the issue of monopsony power and how it can injure competition.

A. Geographic Market Definition

The Merger Guidelines devote less than two pages to geographic market definition. As a result, the Merger Guidelines provide only the most superficial statement as to how geographic markets are defined, and supply inadequate guidance as to how the Agencies actually define geographic markets.

The Merger Guidelines' current approach is to start with the locations at which the two merging firms operate and ask what would happen if the new entity were to raise its prices by a small but significant and nontransitory amount. If "buyers would respond to a price increase on products produced within the tentatively identified region only by shifting to products produced at locations of production outside the region" the hypothetical market is too narrow. The question then becomes whether the price increase

would result in a large enough diversion of sales to the outside producers so as to make the price increase unprofitable. This entire approach is fundamentally asking whether firms outside the hypothetical market exert some form of competitive discipline on the merging firms.

The problem with the summary contained in the Merger Guidelines is that it ignores important differences between markets. Experience has shown that differences between markets require different types of analysis and the evaluation of different types of information. For example, significant differences exist between product markets and service markets, and mergers within these types of markets raise different analytical questions. The Merger Guidelines' having one method of analysis for product markets and service markets has caused confusion on the proper method of delineating geographic markets and has impaired the Agencies efforts to block certain anticompetitive mergers.

When two manufactures merge, the primary questions are whether consumers can turn to other products that are functionally similar and where consumers can find those products. If the merged entity's products are sold to consumers in retail locations, an initial step in the process is determining whether functionally similar products are sold in the same retail locations. This information helps identify realistic alternative products for consumers, as well as identifying the general contours of the geographic market. A second step involves determining if functionally similar products are sold in retail locations that are relatively close to the retail locations in which the merged entity's products are sold. The inquiry then turns to whether functionally similar products could easily enter the hypothetical geographic area, and, thus, become viable alternatives for consumers. [1]

When focusing on the scope of a product's geographic market (in a merger involving manufacturers), a critical issue is the way in which the relevant products are distributed and the ways in which these distribution arrangements will change in response to a small but significant and nontransitory increase in price. Attention is given to issues such as shipping methods and the cost of shipping the relevant products over varying distances. The focus is on the movement of the product and not the movement of the ultimate consumer.

Service markets have a dynamic that is very different from the competitive dynamic in markets for manufactured products. In service markets, consumers typically have to travel to a specific location to obtain the service. This is certainly true, for example, with respect to the provision of hospital services. The focus of a geographic market analysis is not the current distribution patterns for a product in the hypothetical market but the preferences and travel patterns of consumers. For various medical services, consumers will not travel long distances because of the nature of the service or

[1] Defining product markets and geographic markets is an interrelated process. Two products are in the same product market if consumers would switch to the different product in response to a small but significant and nontransitory increase in the price of the other product. That question cannot be answered without first having a hypothetical geographic market in which consumers can make that choice. The Merger Guidelines should address this interrelationship.

the repetitive nature of the service. For example, consumers typically cannot travel long distances for emergency services. Consumers will not travel long distances for services such as physical therapy or kidney dialysis. Under these conditions, the proximity of consumers to possible service locations is an important factor, as well as any impediments that may exist on their ability to travel to a facility. The road network, quality of the roads, and amount of traffic all become important questions.

Under these conditions, the Merger Guidelines' focus on the locations of the service centers (like in a manufacturing case) is misplaced. It is more appropriate to focus on the locations of the consumers that actually purchase the relevant services.

The locations and travel patters of consumers in health care markets, however, is only part of the analysis. With respect to medical and hospital services, a geographic market analysis has to consider how these services are actually purchased. Focusing on how these services are consumed leaves out a critical dimension of the competitive process and results in poorly delineated geographic markets.

Most health services are purchased by health insurance companies that sign participation agreements with the providers and facilities their policyholders desire. A health insurance plan needs to offer its policyholders health care providers that fall within the area in which its policyholders want to go for health care services. A plan, for example, that does not include a hospital used by a large number of its policyholders will face substantial difficulties marketing its plan to those consumers. A reduced premium is economically how a plan would typically have to address the reduced quality of the plan to consumers by its not having the necessary hospital. A plan's reducing its premiums, however, is almost certainly an unrealistic response. If a health insurance plan cannot price discriminate, it would almost certainly lose significantly more in reduced premiums than the revenue it would lose if it were forced to swallow entirely a price increase caused by a merger.

The FTC's enforcement action in *In re Matter of Evanston Northwestern Healthcare Corporation* shows that the Merger Guidelines market definition approach as presently stated is not useable in many health care markets. The analysis in *Evanston Northwestern* showed that a direct focus on patient travel patterns and defining the geographic scope of the market through the iteration process contained in the Merger Guidelines would have indicated an overly large geographic market that would significantly understate the merged entities' market power.

More importantly, in *Evanston Northwestern* the market definition process was fundamentally connected to the analysis of competitive harm. Trying to sequentially identify a geographic market and then evaluate competitive harm would have probably caused a different conclusion in *Evanston Northwestern*. This is not a trivial issue. The FTC's record challenging hospital mergers in the 1990s probably has much to do with the separation of market definition from competitive effects analysis.

The same principles and problems apply to mergers of health insurance companies. For similar reasons, the market definition principles in the Merger Guidelines do not provide adequate guidance for health insurance company mergers. Health insurance companies provide consumers with coverage options and a network of providers. Extensive coverage options lose significant value to consumers if the health insurance plan does not have a suitable network of health care providers. Accordingly, plans offering the same coverage options may have dramatically different value to consumers in a particular area because of differences in their provider networks. Framing the issue as what would happen in response to a small but significant and nontransitory increase in the price of a health insurance premium could create improperly large health insurance markets.

B. Monopsony

The Merger Guidelines devote one paragraph to the problem of monospony power in the section of the Merger Guidelines entitled "Purpose and Underlying Policy Assumptions of the Guidelines." Section 0.1. Specifically, the Merger Guidelines recognize that the "exercise of market power by buyers ('monopsony power') has adverse effects on competition comparable to those associated with the exercise of market power by sellers." The Merger Guidelines then state that the "Agencies will apply an analytical framework analogous to the framework of these Guidelines."

The Merger Guidelines do not contain an adequate discussion of how a merger that raises monopsony problems should be analyzed. More importantly, the Merger Guidelines fail to address the issue of monopsony power, even though the Agencies recognize that the analytical frameworks for monopsony power and seller power are not identical; they are only "analogous." Analyzing monopsony power and its creation or enhancement through a merger requires the adaptation of merger analysis, currently geared toward the selling side of the market, to the buying side.

Since the Merger Guidelines were last revised, monopsony power created by health insurance company mergers has become a serious problem. Today, in 279 metropolitan statistical areas analyzed by the AMA, one or more insurers has a market share of 30 percent or greater. In 138 metropolitan statistical areas analyzed by the AMA, at least one health insurer has a market share of 50 percent or greater. Much of this concentration has occurred as result of mergers of health insurance companies over the last 15 years. As a result of these mergers and the resulting concentration of health insurance markets, most physicians face take it or leave it negotiations when health insurance companies offer reimbursement rates.

When evaluating mergers, the Merger Guidelines identify two broad theories for identifying anticompetitive effects: (a) coordinated interaction, and (b) unilateral effects. The Merger Guidelines and the Commentary on the Horizontal Merger Guidelines show that coordinated interaction is a greater risk in markets involving homogeneous products; unilateral effects are more likely in markets for differentiated products. Given the

realities of health insurance markets, it is possible that the effect of a merger between health insurers on consumers requires an analysis under a unilateral effects theory, while the analysis of its impact on physician markets requires a coordinated interaction theory. This two tier analysis should be addressed in the Merger Guidelines.

From the perspective of a consumer, health insurance policies look like differentiated products. They may cover different medical services, have different reimbursement rules, and have different provider networks. From a physician's perspective, although differences exist between health insurance companies, health insurance companies look more like homogeneous entities to physicians with respect to reimbursement. All health insurers provide access to a potentially large pool of patients. When physicians agree to provide their services at a discounted rate, they are essentially purchasing access to the health insurance company's patient pool. The access that health insurance companies are offering physicians is more akin to a homogeneous product than the health insurance policies sold to consumers. Therefore, while coordinated interaction may not occur on the policyholder (output) side of the market, it could take place on the physician (input) side of the market.

The setting of reimbursement rates is highly susceptible to coordinated interaction by health insurance companies. For example, the reimbursement rates offered to large numbers of physicians by a single health plan are fairly uniform. Health insurance companies also have a strong incentive to follow a price leader when it comes to reimbursement rates. When health insurance firms cannot coordinate on the output side of the market, they have a strong incentive to coordinate on the cost or input side of the market. Further, physicians cannot easily switch to different provider networks in response to the reduction of their reimbursement rate. This reality allows durable price coordination.

When faced with a reduction in reimbursement rates, a physician must make a business decision to determine whether he or she can seek more sustainable reimbursements at a rival health insurance company (assuming that the rival plan pays a higher reimbursement rate). If enough physicians drop out of the plan offering reduced reimbursement, that plan may become less competitive because it has a more limited provider panel than its rivals. A physician's dropping a plan, however, will cause the physician to incur significant switching costs. The physician will lose patients from the dropped plan, and will have to make up the lost revenue from the other plans in which the physician participates. The number of patients a physician will have to gain from another plan to break even will turn on the differential between the two reimbursement rates. This differential, however, has to be discounted by the risk a physician faces that he or she will not be able to replace patients lost by dropping the lower paying plan. Overall, in most cases, a physician will incur positive switching costs that the physician will not be able to offset with sufficient increased revenues.

Further, switching health plans is a very difficult decision for physicians that impacts their patients and disrupts their practice. The physician-patient relationship is a very important aspect to the delivery of high quality health care and it is a very serious

decision both personally and professionally for physicians to disrupt this relationship by dropping a health plan.

Under this analysis, cheating on a tacit reimbursement rate by a health insurance company is highly unlikely. First, a plan would have to significantly raise reimbursement rates in order to lure physicians away from a rival health network, and they will have to limit the number of physicians they add. Second, this type of cheating will be easily and quickly spotted by the rival plan. Health care plans will know, therefore, that the only probable outcome of cheating is to raise costs.

Unilateral effects theory may also show monopsony power. In the Commentary on the Horizontal Merger Guidelines, the Agencies discussed the DOJ's challenging the merger between Aetna and Prudential. The DOJ concluded that:

> the proposed merger would have allowed Aetna to reduce physician reimbursement rates because it would have significantly increased the number of patients enrolled in Aetna health plans and therefore also the number of patients a physician would have lost by terminating participation in Aetna health plans.

Commentary on the Horizontal Merger Guidelines, p. 36.

Mergers that give health insurance plans monopsony power hurt physicians and consumers. Physicians face the immediate loss of revenue in the form of reduced reimbursement rates. The reduced reimbursement rates, however, will, over time, reduce the quantity of physician services. While this may not result in increased premiums, it will reduce the quality of the health care services available to consumers.

By not addressing the monoposny issue in the Merger Guidelines, the Agencies send a message that this is not an important issue. The Agencies also make it impossible to determine how the agencies will evaluate health insurance mergers and the types of data the Agencies consider important.

Conclusion

Thank you again for the opportunity to comment. The AMA believes that the Horizontal Merger Guidelines should be revised to take into account the developments in antitrust law described above. The AMA looks forward to working with the FTC and DOJ on this important effort.