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

February 24, 2020

Richard M. Scheffler
Professor of the Graduate School
School of Public Health and Goldman School of Public Policy
Director, Nicholas C. Petris Center on Health Care Markets and Consumer Welfare (petris.org)
University of California, Berkeley

Daniel R. Arnold
Research Director, Nicholas C. Petris Center on Health Care Markets and Consumer Welfare
School of Public Health
University of California, Berkeley

Timothy T. Brown
Associate Director for Research, Berkeley Center for Health Technology
Associate Adjunct Professor of Health Economics, School of Public Health
University of California, Berkeley

Richard G. Frank
Margaret T. Morris Professor of Health Economics
Department of Health Care Policy
Harvard Medical School

H. E. Frech III
Professor of Economics and Technology Management
Department of Economics, College of Letters and Science
Technology Management Program, College of Engineering
University of California, Santa Barbara

Brent D. Fulton
Associate Adjunct Professor of Health Economics and Policy
Associate Director, Nicholas C. Petris Center on Health Care Markets and Consumer Welfare
School of Public Health
University of California, Berkeley

Sherry A. Glied
Dean and Professor of Public Service
Robert F. Wagner Graduate School of Public Service
New York University
Thomas L. Greaney  
Visiting Professor of Law, UC Hastings College of Law  
Chester A. Myers Professor Emeritus, Saint Louis University School of Law  

Deborah Haas-Wilson  
Marilyn Carlson Nelson Professor of Economics  
Smith College  

Jaime S. King  
Bion M. Gregory Chair in Business Law and Professor of Law, UC Hastings College of the Law  
Associate Dean and UC Hastings Faculty Director, UCSF/UC Hastings Consortium on Law, Science, and Health Policy  
Co-Director, UCSF/UC Hastings Master of Science Program in Health Policy and Law  
Executive Editor, The Source on Healthcare Price and Competition  

Stephen M. Shortell  
Professor of the Graduate School  
Blue Cross of California Distinguished Professor of Health Policy and Management Emeritus  
Co-Director, Center for Healthcare Organizational and Innovation Research (CHOIR)  
Co-Director, Center for Lean Engagement and Research (CLEAR)  
Dean Emeritus, School of Public Health  
Professor of Organization Behavior, Emeritus, Haas School of Business  
University of California, Berkeley  

Neeraj Sood  
Professor of Health Policy and Vice Dean for Research  
Sol Price School of Public Policy  
University of Southern California
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**

---

• 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

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

---


7 Dafny, *supra* note 8.

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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{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

\textsuperscript{11} Short, Marah Noel and Vivian Ho. “Weighing the Effects of Vertical Integration Versus Market Concentration on Hospital Quality.” \textit{Medical Care Research and Review} (2019).
In addition, there’s the potential of cumulative anticompetitive effects arising from sequential vertical mergers. 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.
- Should be better coordinated with Horizontal Merger Guidelines and vertical restraints.

---
