AMA
AMERICAN MEDICAL ASSOCIATION

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September 18, 2023

The Honorable Lina M. Khan
Chair
Federal Trade Commission
Room H-135 (Annex P)
600 Pennsylvania Avenue, NW
Washington, DC 20580

The Honorable Jonathan Kanter
Assistant Attorney General
U.S. Department of Justice
950 Pennsylvania Avenue, NW
Washington, DC 20530

Re: AMA Comments on Draft Merger Guidelines

Dear Chairperson Khan and Assistant Attorney General Kanter:

On behalf of the American Medical Association (AMA) and our physician and medical student members, I would like to extend our appreciation for the opportunity to submit the following comments on the Draft Merger Guidelines (the Guidelines). The AMA commends the Department of Justice (DOJ) and the Federal Trade Commission (the Agencies) for this opportunity to address what we consider to be top priority issues for our members, as well as their patients.

Why Merger Enforcement is an Important Issue to Physicians and Patients

The AMA has long understood that competition in health insurance and in health care markets generally, not consolidation, is the right prescription for these markets. Competition will lower premiums, force insurers to enhance customer service, pay bills accurately and on time, and develop and implement innovative ways to improve quality while lowering costs. Competition also allows physicians to bargain for contract terms that touch all aspects of patient care.

We evaluate the Guidelines from the perspective of their real-world consequences in solving competition problems in health care. Health insurance markets are highly concentrated. The AMA's 2022 update to *Competition in Health Insurance: A Comprehensive Study of U.S. Markets* (2022 Update)[1] presents 2021 data on the degree of competition in commercial health insurance markets. It is intended to help identify areas where consolidation involving health insurers may cause anticompetitive harm to consumers and providers of care.

Key findings from the 2022 Update on commercial health insurance markets include:

- Seventy-five percent of the metro service area (MSA)-level markets (287) were highly concentrated (Herfindahl-Hirschman Index (HHI)>2,500) in 2021, up from 71 percent in 2014.
- The average HHI across MSA-level markets was 3504 in 2021.

[1] See, Guardado, J. & Kane, C. *Competition in Health Insurance: A Comprehensive Study of U.S. Markets, 2022 Update.* Chicago, IL: American Medical Association; ("Competition in Health Insurance") available at https://www.ama-assn.org/system/files/competition-health-insurance-us-markets.pdf.

- Fifty-eight percent of markets experienced an increase in the HHI between 2014 and 2021. Among those markets, the average increase was 540 points.
- Of the markets that were not highly concentrated in 2014, 30 percent experienced an increase in the HHI large enough to place them in the highly concentrated category by 2021.
- In 91percent (349) of MSAs, at least one insurer held a commercial market share of 30 percent or greater, and in 48 percent (183) of MSAs, one insurer's share was at least 50 percent.

The Guidelines are Needed Given Health Insurer Monopsony Power

Health Insurer Monopsony Power in the Market for Physician Services is a Serious Concern

Where a health insurer has market power in their output market of health insurance, it is very likely it also has monopsony power in their input market of physician services. This is because geographically these markets roughly coincide.[2] Thus, mergers of market power health insurers tend to result in lower than competitive payments to health care providers, but there is no evidence the cost savings are passed through to consumers in the form of lower premiums.[3] This is supported by the fact that health insurer monopsonists typically are also monopolists. Facing little if any competition, they lack the incentive to pass along cost savings to consumers. "If past is prologue," notes Harvard University Professor Leemore S. Dafny, PhD, "insurance consolidation will tend to lead to lower payments to health care providers, but those lower payments will not be passed on to consumers. On the contrary, consumers can expect higher insurance premiums."[4]

In principle, the antitrust laws should prevent both monopsony and monopoly. This is explained well by Professors David Dranove, PhD and Lawton R. Burns, PhD, in their recent book entitled, *Megaproviders*

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[2] See e.g., Corry Capps, *Buyer Power in Health Plan Mergers*, J. Comp Law and Econ (2009).

[3] Glenn A. Melnick et al., "The Increased Concentration of Health Plan Markets Can Benefit Consumers through Lower Hospital Prices," *Health Affairs,* 30, no. 9 (2011): 1728-1733, Asako S. Moriya, William B. Vogt, and Martin Gaynor, "Hospital Prices and Market Structure in the Hospital and Insurance Industries." *Health Economics, Policy and Law* 5.04 (2010): 459-479.; and Erin E. Trish, and Bradley J. Herring, "How do Health Insurer Market Concentration and Bargaining Power with Hospitals Affect Health Insurance Premiums?" *Journal of Health Economics,* 42 (2015):104-114; Leemore Dafny, Mark Duggan, and Subramaniam Ramanarayanan, "Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry," *American Economic Review,* 2012, 102(2): 1161-1185; Steven Sheingold et al., ASPE Issue Brief, "Competition and Choice in the Health Insurance Marketplaces, 2014-2015: Impact on Premiums," U.S. Dept. of Health and Human Services, July 27, 2015, *available at* http://aspe.hhs.gov/basic-report/competition-and-choice-health-insurance-marketplaces-2014-2015-impact-premiums; Zirui Song, Mary Beth Landrum, and Michael E. Chernew, "Competitive Bidding in Medicare: Who Benefits From Competition?" *The American Journal of Managed Care* 18.9 (2012): 546; Dickstein, Michael J, Mark Duggan, Joe Orsini and Pietro Tebaldi. the Affordable Care Act." American Economic Review, 105(5): 120-25; Eric T. Roberts, Michael E. Chernew and J. Michael McWilliams, "Market Share Matters: Evidence Of Insurer And Provider Bargaining Over Prices," *Health Affairs,* 2017, 36(1): 141-148, doi:10.1377/hlthaff.2016.0479; Kate Ho and Robin S. Lee, "Insurer Competition in Health Care Markets," *Econometrica,* forthcoming, *http://www.columbia.edu/~kh2214/papers/InsurerComp.Main.pdf*. 2015. "The Impact of Market Size and Composition on Health Insurance Premiums: Evidence from the First Year of the Affordable Care Act." American Economic Review, 105 (5):120-25.

[4] See Dafny, "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 Senate Committee on the Judiciary, September 22, 2015, at 10.

and the High Cost of Healthcare in America, University of Chicago Press (2021) (Dranove & Burns).[5] Monopolists diminish competition in the output market, at the expense of consumers, while monopsonists diminish competition in the input market, at the expense of suppliers.[6] Monopoly and monopsony pose the same challenge to the economy—mispricing of resources (material or human), resulting in their underemployment.[7] It is due to these concerns that the Clayton Act merger law was drafted to apply to anticompetitive mergers by both sellers and buyers.[8]

Notwithstanding the similar policy concerns, government antitrust enforcement to protect labor markets has been, until recently, absent—a condition that helps explain the paucity of private litigation.[9] It is the AMA's hope, therefore, that the adoption of the Guidelines will lead to vigorous consideration of monopsony concerns in physician markets when health insurers merge.

It is our strong contention that the Agencies must have merger guidelines that protect physicians against health insurer mergers that may substantially lessen competition for the purchase of physician services and that degrade physician working conditions. One ongoing example of that degradation of physician working conditions is occurring in the area of practice administrative requirements.[10] Physicians vigorously complain that they are spending more time than ever with paperwork, electronic health record (EHR) documentation, and bureaucratic "administrivia," such as obtaining health plan "prior approval" for patient care.[11] The authors of one study found that for every hour a primary care physician spends in direct patient care, they spend two hours engaged in administrative functions.[12] Moreover, a Brookings Competition Report and numerous studies observe that administrative requirements are believed to be major contributors to physician burnout and dissatisfaction.[13] These realities make it critical for private health plans in markets made more competitive

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[5] Dranove & Burns at 193.
[6] *Id.*
[7] Id.; Ioana Marinescu & Eric Posner, *Why Has Antitrust Failed Workers*, Cornell Law Review, Vol. 105:1343, 1346 (2019) ("Marinescu & Posner") (Noting also that the Supreme Court has observed "the kinship between monopoly and monopsony and suggesting that similar legal standards should apply to claims of monopolization and to claims of monopsonization.")
[8] Ioana Marinescu & Herbert Hovenkamp, *Anticompetitive Mergers in Labor Markets*, Washington Center for Equitable Growth Working Paper (2018) ("Marinescu & Hovenkamp").
[9] Marinescu & Posner at 1379.
[10] *See* Gaynor, Mostashari and Ginsberg, "*Making Healthcare Markets Work: Competition Policy for Health Care*", Carnegie Mellon University/Center for Health Policy, Brookings/USC Schaeffer Center for Health Policy and Economics (April, 2017) at 12-15, https://www.brookings.edu/research/making-health-care-markets-work-competition-policy-for-health-care/?utm_campaign=Economic%20Studies&utm_source=hs_email&utm_medium=email&utm_content=50778822 (Brookings Competition Report).
[11] *Id.*
[12] Sinsky, C., Colligan, L., Li, L., Prgomet, M., Reynolds, S., Goeders, L., Westbrook, J., Tutty, M., & Blick. G. (2016). Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties. *Annals of Internal Medicine*. 165, 753-760. doi: 10.7326/M16-0961.
[13] Brookings Competition Report at 12-16, citing Rao, S. K., Kimball, A.B., Lehrhoff, S.R., Hidrue, M.K., Colton, D.G., Ferris, T.G., & Torchiana, D.F. (2017). *The Impact of Administrative Burden on Academic Physicians: Results of a Hospital-Wide Physician Survey*. *Academic Medicine*. 92(2), 237-243; Peckham, C. (2015). *Physician Burnout: It Just Keeps Getting Worse.* Medscape Family Medicine. http://www.medscape.com/viewarticle/838437_3 and Jackson Healthcare. (2015). *Physicians Continue to Leave Private Practice for Employment*. *http://www.jacksonhealthcare.com/physician-trends/other-articles/physicians-*

by antitrust merger enforcement to take more seriously the burden of these administrative requirements, which have been characterized as "individually reasonable, and collectively insane."[14]

The AMA Welcomes the Focused Guidance on Monopsony Effects of Mergers

Unfortunately, mergers of competing buyers in labor markets, such as the markets in which physicians sell services to health insurers, have received short shrift in the existing merger guidelines. Specifically, merely one page is actually devoted to monopsony, and there is no discussion of monopsony issues in labor markets. *See* Horizontal Merger Guidelines at 12. Guideline inattention to monopsony concerns in labor markets may explain why it has taken until last year for the government to block a merger based on its labor market effects. See, *United States v. Bertelsmann SE & Co., et al.*, No.1:21-cv–02886, 2022 LEXIS 202847 (D.D.C. Oct. 31, 2022) (Pan, J., sitting by designation) (*Bertelsmann*).

<u>Caselaw Developments on Mergers Raising Monopsony Concerns in Labor Markets</u>

United States v. Bertelsmann SE & Co., et al.

Last year, the U.S. government won its first monopsony merger decision when a court blocked Penguin Random House's planned $2.18 billion purchase of Simon & Schuster. *United States v. Bertelsmann SE & Co., et al.*, No.1:21-cv–02886, 2022 LEXIS 202847 (D.D.C. Oct. 31, 2022) (Pan, J., sitting by designation) (*Bertelsmann*). The court found the proposed merger to be in a highly concentrated publishing industry such that the combined company would have had too much leverage over authors in negotiations for book rights. The court enjoined the merger to protect the author/workers.

From an antitrust perspective, physicians negotiating with health insurers are like the *Bertelsmann* authors negotiating with publishing houses. Just as antitrust protects the authors from negotiating leverage gained through publishing house mergers in concentrated publishing markets, so too antitrust should protect physicians from health insurance mergers in highly concentrated health insurance markets.

Given the dearth of caselaw on monopsony and the lucidity of Judge Pan's opinion in *Bertelsmann*, the case deserves a citation within Guideline 11 on monopsony.

United States v. Anthem, Inc.

In 2016, Anthem announced a horizontal merger with Cigna that reflected the apparent health insurance industry-held belief that by joining together, insurers can gain added negotiating leverage over physicians and hospitals. The AMA opposed this merger in Congressional hearings, before the DOJ, state health insurance departments, and attorney general offices, and ultimately, in 2017, in an amicus brief filed in the United States Court of Appeals in *United States v. Anthem, Inc*, 855 F.3d 345 (D.C. Cir 2017) (*Anthem*).

The DOJ correctly argued that an Anthem/Cigna merger would harm physicians and hospitals when the newly merged entity used its merger-enhanced monopsony purchasing power in price negotiations.

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continue-to-leave-private-practice-for-employment/: 64 American Academy of Family Physicians. (2017). *AAFP's Agenda for Regulatory and Administrative Reforms*. http://www.aafp.org/dam/AAFP/documents/advocacy/campaigns/ST-Reg-Admin-Reform-013117.pdf.

[14] Brookings Competition Report at 13; See *also* HHS /FTC Competition Report at 92.

Anthem agreed that provider fees would fall but characterized this result as a consumer savings—an efficiency that justified the merger because Anthem would pass most of the savings to enrollees.

Ultimately, the DC Circuit Court of Appeals in *Anthem* stopped short of deciding the monopsony merger violation issue. Notably, there was a dissenting opinion from Judge Kavanaugh expressing the view largely championed by the AMA, that assuming certain facts, the government could "block this merger based on the merger's effects on hospitals and doctors."[15] The court, however, concluded by blocking the Anthem/Cigna merger on the alternative ground that it would have anticompetitive effects in certain markets for the sale of health insurance.[16]

Specific Provisions of the Guidelines

Guideline 1: Mergers should not Significantly Increase Concentration in Highly Concentrated Markets

Ramifications in Health Insurance Markets

Likely, one of the least controversial Guidelines is the first one that reads, "Mergers should not significantly increase concentration in highly concentrated markets." The real challenge is deciding how concentration levels should be measured and judged.

Under the existing Guidelines and using 2021 data, the AMA finds that 75 percent of MSA-level health insurance markets were highly concentrated (HHI >2500). *See* Footnote 1, supra.[17] As you are aware, a merger in any of those highly concentrated markets that increased the HHI by more than 200 would be presumed likely to enhance market power.

The Guidelines, if adopted, would substantially limit the merger approval opportunities for health insurers. Mergers would be subject to a structural presumption of unlawfulness if the post-merger HHI is greater than 1800 and the change in HHI is greater than 100, ***or*** the market share is greater than 30 percent and the change in HHI is greater than 100.

The new thresholds for structural presumption would be felt in health insurance markets. According to the 2022 Update, 96 percent of MSA-level markets would have an HHI greater than 1800. Also, in 91 percent of the markets, at least one insurer had a market share of at least 30 percent. These competitive conditions are concerning and might have been avoided had the 1800 concentration threshold, first introduced into the merger guidelines in 1982 as a screening measure, *not* been revised upwards to 2,500 in the 2010 guidelines.

The Guidelines on Monopsony and Ramifications in Physician Markets

Presently, and as noted above, merely one page of the merger guidelines is devoted to monopsony, and there is no discussion of monopsony issues in labor markets.[18] Past guideline inattention to monopsony concerns in labor markets may explain why the government has only very recently, and for the first time

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[15] Id at 373 and 377-379.
[16] *United States v. Anthem*, Inc ,855 F.3d 345, 371 (D, C. Cir 2017).
[17] See Footnote 1, supra.
[18] As used herein, the term "labor markets" includes the markets in which physicians sell services to health insurers.

in *Bertelsmann,* blocked a merger based on its monopsony effects on workers.[19] **The AMA is pleased, therefore, that the monopsony problem in labor markets is acknowledged and addressed in the Guidelines.**[20] The AMA believes that the Guidelines, as proposed, should help prevent mergers that lessen competition for workers, including physicians.

Essentially Guideline 11 (containing the monopsony provisions) rightly recognizes that (1) "a merger between competing sellers may harm buyers" and (2) that "labor markets are important buyer markets."[21]

Reflecting these concerns, Guideline 11, also provides, "when a merger involves competing buyers, the Agencies examine whether it may substantially lessen competition for workers or other sellers." The accompanying commentary rightly recognizes that Section 7 prevents monopsony or "buyer power" by protecting competition among buyers (including employers) for workers. Thus, as discussed above, Section 7 prohibits mergers that may substantially lessen competition in *any* relevant market, including in "labor markets where employers are the buyers of labor and workers are the sellers."[22]

Guideline 11 rightly observes that "the level of concentration at which competitive concerns arise may be lower in buyer markets than in seller markets, *given the unique features of certain buyer markets.*" (emphasis added)[23] In agreement with the Agencies, **the AMA believes that the market structure thresholds, such as the market shares associated with health insurer monopsony power, should be lower in the case of a monopsony analysis than in an analysis of monopoly power.**[24] Moreover, the AMA asserts that in markets where the merged health insurers might lack market power to raise premiums for patients, the merged insurers would likely still have the power to force down physician compensation to anticompetitive levels. This is because physicians cannot readily replace lost business by refusing the insurer's contract and dealing with other payers without suffering irretrievable lost income.[25] It is difficult to convince consumers (which in many cases are employers) to switch to different health insurers.[26] Also, switching health insurers is a very difficult decision for physicians because it impacts their patients and disrupts their practices. **The patient-physician relationship is a very important aspect of the delivery of high-quality health care.** It is a very serious decision both personally and professionally for physicians to disrupt this relationship by dropping a health insurer. Thus, in the UnitedHealth Group Inc./PacifiCare merger, the DOJ required a divestiture based on monopsony

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[19] See discussion of past guideline inattention to monopsony concerns in Iona Marinescu & Herbert Hovenkamp, "Anticompetitive mergers in Labor Markets" Washington Center for Equitable Growth Working Paper, (2018) (*Marinescu & Hovenkamp*) at 1373.
[20] Guideline 11 at 25-27.
[21] Guideline 11 at 25.
[22] Guideline 11 at 26.
[23] Id.
[24] Stucke, Maurice E., "Looking at the Monopsony in the Mirror" (2013). College of Law Faculty Scholarship. https://trace.tennessee.edu/utk_lawpubl/59 (The reasoning is that more than the monopsonist's market share is relevant, specifically the elasticity of alternative buyers' demand.)
[25] See Capps, Cory S., Buyer Power in Health Plan Mergers (June 2010). Journal of Competition Law and Economics, Vol. 6, Issue 2, pp. 375-391.
[26] See e.g., U.S. v. UnitedHealth Group and Pacificare Health Systems., Complaint, No. 1:05CV02436, ¶ 37 (December 20, 2005), available at http://www.justice.gov/file/514011/download. (As alleged in the United/PacifiCare complaint, physicians encouraging patients to change plans "is particularly difficult for patients employed by companies that sponsor only one plan because the patient would need to persuade the employer to sponsor an additional plan with the desired physician in the plan's network" or the patient would have to use the physician on an out-of-network basis at a higher cost).

concerns in Boulder, Colorado, even though the merged entity would not necessarily have had market power in the sale of health insurance. The reason was straightforward: **the reduction in compensation would lead to diminished service and quality of care, which harms patients (consumers) even though, given the lack of market power on the sell side, the direct premiums paid by subscribers do not increase.**[27]

Some have argued that physicians who are unhappy with the fees they receive from a powerful insurer could turn away from that insurer and instead treat more Medicare and Medicaid patients. In truth, however, physicians cannot increase their revenue from Medicare and Medicaid in response to a decrease in commercial health insurer payments. Enrollment in these programs is limited to special populations, and these populations only have a fixed number of patients. Physicians switching to Medicare and Medicaid plans would have to incur substantial marketing costs to pull existing Medicare and Medicaid patients from their existing physicians. Moreover, public programs' reimbursements to providers—especially Medicaid—underpay physicians. Thus, even if a physician dropping a commercial health insurer could attract more Medicare and Medicaid patients, this strategy would be a losing proposition if one is to compete in the market, especially at a time when value-based payment models require practice investments.

Perhaps most significantly, the Guidelines recognize that **a merger's harm to competition among buyers is *not* saved by benefits to competition among sellers in a separate downstream product market**. In a nutshell, the Guidelines explain that "a merger can substantially lessen competition in one or more buyer markets, seller markets or both and the Clayton Act protects competition in any one of them."[28]

The Guidelines explicitly embrace the principle that a merger that generates health insurer monopsony power in, for example, physician markets, should be unlawful regardless of whether the merger also creates consumer benefits in the output product market of health insurance. One reason is that Section 7 of the Clayton Act prohibits a loss of competition "in any line of commerce." Also, there is substantial case law rejecting out-of-market benefits as a merger justification.[29] Moreover, the idea that merger harm in input markets (such as physician services) can be offset by benefits in output markets (such as for health insurance) has drawn substantial authoritative criticism from leading antitrust scholars. For example, Professors Iona Marinescu, PhD and Herbert J. Hovenkamp, PhD, observe that if a merger is anticompetitive in a labor market but the merger leads to reduced costs in the product market in which they sell, a court should not be asked to tolerate an anticompetitive outcome in one market, labor, for the benefit of a different group who purchase in the product market.[30] Drs. Marinescu and Hovenkamp conclude, "Existing law would not countenance such an approach, nor as a general matter should it"[31] and

[27] See Gregory J. Werden, Monopsony, and the Sherman Act: Consumer Welfare in a New Light, 74 ANTITRUST L.J. 707 (2007) (explaining reasons to challenge monopsony power even where there is no immediate impact on consumers); Marius Schwartz, Buyer Power Concerns and the Aetna-Prudential Merger, Address before the 5th Annual Health Care Antitrust Forum at Northwestern University School of Law 4-6 (October 20, 1999) (noting that anticompetitive effects can occur even if the conduct does not adversely affect the ultimate consumers who purchase the end-product), available at: http://www.usdoj.gov/atr/public/spceches/3924.wpd.
[28] Guidelines at 26-27.
[29] *See*, *United States v. Philadelphia Natl. Bank,* 374 U. S. 321, 370-371 (1963).
[30] Marinescu & Hovenkamp at 38.
[31] *Id.*

further observe that making quantitative assessments of benefits in one market and of harms in another would "place heroic demands on the courts."[32]

Health Care Focused Guidance on Monopsony Concerns in Physician Labor Markets could be Incorporated into a New Edition of *The Statements of Antitrust Policy in Health Care (1996)*

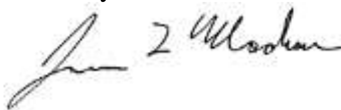
Notwithstanding the adoption of the Guidelines that would protect buyer competition for the purchase of worker services, the importance, unique features, and changing realities of health care markets also call for focused guidance on monopsony concerns in physician markets. Such industry-focused guidance could be incorporated into a new edition of *The Statements of Antitrust Policy in Health Care* (1996) that would replace the statements recently rescinded. The issuance of new statements has most notably been urged by leading scholars on antitrust in health care including David Dranove, PhD, Lawton R. Burns, PhD., and Thomas L. Greaney, JD. *See,* Dranove & Burns at 248-249; Thomas L. Greaney & *Richard* M Scheffler, *The Proposed Vertical Guidelines and Health Care: Little Guidance and Dubious Economics*, Health Affairs Blog (April 17, 2020)

Conclusion

The AMA commends the Agencies on their proposed draft Guidelines and looks forward to working with the Agencies on this critical effort. The AMA has a long history of studying health insurance market concentration and advocating for policies that promote competition to ensure a competitive health care marketplace.

If you have any questions or would like any additional information, please do not hesitate to contact Margaret Garikes, Vice President, Federal Affairs, at margaret.garikes@ama-assn.org and/or Henry Allen, Senior Attorney, Advocacy Resource Center, at henry.allen@ama-assn.org.

Sincerely,



James L. Madara, MD

[32] *See also* C. Scott Hempphill & Nancy L. Ross, *Mergers that Harm Sellers*, 127 Yale Law Journal 2078 (2018), reasoning that harm to sellers in an input market is sufficient to support antitrust liability, and that harm to final consumers is not an essential element of an antitrust claim. *See also*, dissenting opinion from Judge Kavanaugh in the D.C. Circuit case of *United States v. Anthem, Inc.*, 855 F.3d 345 (DC Cir. 2017) (Kavanaugh, J dissenting and expressing the view championed by AMA, that assuming certain facts, the government could "block this merger based on the merger's effects on hospitals and doctors" notwithstanding the expected cost savings for the health insurers.)