James L. Madara, MD
CEO, EXECUTIVE VICE PRESIDENT
james.madara@ama-assn.org

April 21, 2022

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

The Honorable Jonathan Kanter
Assistant Attorney General
United States Department of Justice
950 Pennsylvania Avenue, NW
Washington, DC 20530-0001

Re: Modernizing Enforcement of the Antitrust Laws Regarding Mergers

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 how the agencies can modernize enforcement of the antitrust laws regarding mergers. The AMA commends the Department of Justice and the Federal Trade Commission ("the Agencies") for this opportunity to address important matters.

Why AMA cares about merger enforcement.

The AMA has long understood that competition in health insurance, not consolidation, is the right prescription for health insurer 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.

Need for Guidance on Monopsony Effects of Health Insurer Mergers.

We are especially grateful for the invitation to consider monopsony power and "labor market effects of mergers."[1] Mergers of competing buyers in labor markets, such as the markets in which physicians sell services to health insurers, receive short shrift in the existing Merger Guidelines.[2] *See* Horizontal Merger MGs at 12. Merely one page is devoted to monopsony, and there is no discussion of monopsony issues in labor markets.[3]

Guideline inattention to monopsony concerns in labor markets may explain why the government has *never* blocked a merger based on its labor market, including physician market, effects**.**[4] The closest the government has come to successfully litigating monopsony concerns is in *United States v. Anthem, Inc.*,

[1] Request for information on merger enforcement ("RFI") ¶9.
[2] As used herein, the term "Merger Guidelines" refers both to the 2010 Horizontal Merger Guidelines and the 2020 Vertical Merger Guidelines.
[3] As used herein, the term "labor markets" refers to the markets in which physicians sell services to health insurers.
[4] Iona Marinescu & Herbert Hovenkamp, "Anticompetitive mergers in Labor Markets" Washington Center for Equitable Growth Working Paper,(2018) (*Marinescu & Hovenkamp*) at 1373.

855 F.3d 345 (DC Cir. 2017) (Kavanaugh, J dissenting) where the AMA urged, and the DOJ decided, to make a monopsony claim that the merger of Anthem and Cigna would harm physician markets. While *Anthem* was ultimately decided based on the merger's effects in the markets for the sale of health insurance, monopsony concerns in physician labor markets were heavily litigated. Lessons from that singular experience should make their way into the Guidelines and other statements of federal antitrust merger policy, as will be discussed below.

The importance, unique features, and changing realities of health care markets call for focused guidance on monopsony concerns in physician markets when health insurers merge. Such industry-focused guidance could be incorporated into a new edition of *The Statements of Antirust Policy in Health Care* (1996), as urged by leading economists and legal scholars on antitrust in health care. *See,* David Dranove & Lawton R Burns, *Megaproviders and the High Cost of Healthcare in America*, University of Chicago Press (2021) ("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).

Health Insurers Typically Have Monopsony Power in the Market for Physician Services.

Health Insurance Markets are Localized and Mostly Highly Concentrated

The local nature of health care delivery and the marketing and other business practices of health insurers strongly suggest that health insurance markets are local.[5] Consumers buy coverage that serves them close to where they work and live.[6] The AMA's most recent study, published last year, finds that 73 percent of metropolitan statistical area health insurance markets are "highly concentrated," based on the criteria of the Merger Guidelines.

Health Insurer Monopsony Power

Where a health insurer has market power in their output market (i.e., monopoly power), it is very likely they also have monopsony power in their input market (in the purchasing of physician services). This is because geographically these markets roughly coincide.[7] 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.[8]

---

[5] See, Guardado J.& Kane C. *Competition in Health Insurance: A Comprehensive Study of U.S. Markets, 2021 Update*. Chicago, IL: American Medical Association; 2021. ("Competition in Health Insurance") available at https://www.ama-assn.org/system/files/competition-health-insurance-us-markets.pdf

[6] *See Competition in Health Insurance at 2.*

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

[8] 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,

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."[9]

Monopsony issues are important and antitrust enforcement has been missing.

Dranove & Burns explain that "[i]n principle, the antitrust laws should prevent both monopsony and monopoly."[10] 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.[11] Monopoly and monopsony pose the same challenge to the economy—mispricing of resources (material or human), resulting in their underemployment.[12] Thus, Clayton Act merger law was drafted to apply to anticompetitive mergers by both sellers and buyers.[13]

Notwithstanding the similar policy concerns, government antitrust enforcement to protect labor markets has been absent, a condition that helps explain the scarcity of private litigation.[14] Hopefully with this request for information, the Agencies are now engaged in a process that will lead to vigorous consideration of monopsony concerns in physician markets when health insurers merge.

AMA experience addressing the issue of monopsony power in Anthem/Cigna.

No doubt the market concentration information contained in AMA's annual report on competition in health insurance has discouraged some further market consolidation. But health insurers have continued to do merger deals that have triggered intense AMA opposition. For example, in 2016, Anthem announced a horizontal merger with Cigna that reflected the apparent 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 Department of Justice ("DOJ"), state health insurance

---

"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.

[9] 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.

[10] Dranove & Burns at 193.

[11] Id.

[12] 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.")

[13] Ioana Marinescu & Herbert Hovenkamp, *Anticompetitive Mergers in Labor Markets*, Washington Center for Equitable Growth Working Paper (2018)("Marinescu & Hovenkamp").

[14] Marinescu & Posner at 1379.

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*").

AMA responses to the RFI Questions posed by the Agencies.

The Agencies ask: **For those mergers that appear to yield lower input purchasing prices, how can cost savings due to monopsony power be distinguished from other forms of savings?**[15]

This was an issue presented in *Anthem.* There, the DOJ argued that an Anthem/Cigna merger would harm physicians and hospitals when the new merged entity used its merger-enhanced monopsony purchasing power in price negotiations. 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, although there was a dissenting opinion from Judge Kavanaugh expressing the view largely championed by AMA, that assuming certain facts, the government could "block this merger based on the merger's effects on hospitals and doctors."[16] The court blocked the merger on the alternative ground that it would have anticompetitive effects in certain markets for the sale of health insurance.[17]

The court did, however, reject the notion that Anthem/Cigna's obtaining deep discounts from physicians short of monopsony would represent a consumer benefiting efficiency that could justify an otherwise anticompetitive merger in markets for the sale of health insurance. Instead, the court's majority agreed with prominent amici health economists that in highly concentrated health insurance markets, large insurers are less constrained by competition and thus find it more profitable to capture medical savings and increase premiums.[18]

So how should antitrust tribunals determine the difference between mergers that promote cost efficient bargaining from those that create monopsonistic reductions in labor supply? One good approach is suggested by Marinescu & Posner and is similar to that conventionally followed in output markets: First determine whether the firms operate in concentrated labor markets and, if so, whether their merger would significantly increase concentration in those labor markets.[19] This requires calculating the Herfindahl-Hirschman Index (HHI) of the labor market in which the firms operate and the increase in HHI post-merger.[20] Marinescu & Posner conclude that "if HHI and the HHI increase are sufficiently high, then the merger should be presumptively blocked."[21]

This solution for screening cost savings due to monopsony power from other forms of savings that appear to yield lower input purchasing prices is also described by Professors Marinescu and Hovenkamp: "If the labor supply market is concentrated and the merging firms account for a high proportion of it, that at least

[15] RFI at ¶14e.
[16] Id at 373 and 377-379.
[17] *United States v. Anthem*, Inc ,855 F.3d 345, 371 (D, C. Cir 2017) See also Merger Guidelines that refuse to recognize as an efficiency "anticompetitive reductions in output or service" HMG at Section 10.
[18] Id 363.
[19] Marinescu & Posner at 1373.
[20] Marinescu & Posner at 1355-56 and 1391-1392.
[21] Id at 1391.

raises the inference that their ability to obtain lower rates results from a reduction in competition for the purchase of labor rather than any bargaining efficiencies."[22]

The Agencies ask**: How, if at all, should the thresholds for applicable market structure presumptions differ [in analysis of monopsony power] from those used in the analysis of monopoly power?[23]**

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] 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 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 insurer. Thus, in the UnitedHealth Group Inc./PacifiCare merger, the DOJ required a divestiture based on monopsony 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 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. However, physicians cannot increase their revenue from Medicare and Medicaid in response to a decrease in commercial health insurer payment. 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

---

[22] Marinescu & Hovenkamp at 37-38.
[23] RFI at ¶9a.
[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)..
[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.

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.

The Agencies ask**: What changes in standards or approaches would appropriately strengthen enforcement against mergers that eliminate a potential competitor?**[28]

Federal merger enforcement policy should acknowledge that in health insurance markets, a merger that eliminates a potential competitor would likely result in a permanent loss of competition because barriers to entry prevent new entrants from restoring competitive pricing.

The greatest obstacle is perhaps the so-called chicken and egg problem of health insurer market entry. Health insurer entrants need to attract customers with competitive premiums that can only be achieved by obtaining discounts from providers. However, providers usually offer the best discounts to incumbent insurers with significant business—volume discounting that reflects a reduction in transaction costs and greater budget certainty. Hence, incumbent insurers have a durable cost advantage.

Other barriers include the need for sufficient business to permit the spreading of risk and contending with established insurance companies that have built long-term relationships with employers and other consumers.[29] In addition, a DOJ study of entry and expansion in the health insurance industry found that "brokers typically are reluctant to sell new health insurance plans, even if those plans have substantially reduced premiums, unless the plan has strong brand recognition or a good reputation in the geographic area where the broker operates."[30]

Thus, the evidence suggests that to the extent a health insurer merger would eliminate a potential competitor, the lost competition would be permanent, given high market entry and switching barriers.[31] Consequently, a proposed health insurer acquisition of a potential competitor in a typically highly concentrated health insurance market should be met with extreme skepticism by antitrust enforcers. One good expression of this skepticism would be new merger guidelines making the burden of health insurer procompetitive rebuttal of lost competition very high.[32]

---

[28] RFI at ¶7a.

[29] See Robert W. McCann, Field of Dreams: Dominant Health Plans and the Search for a "Level Playing Field," Health Law Handbook (Thomson West 2007); Mark V. Pauly, Competition in Health Insurance Markets, 51 Law & Contemp. Probs. 237 (1988); Federal Trade Commission and U.S. Department of Justice, Improving Health Care: A Dose of Competition (July,2004); Vertical Restraints and Powerful Health Insurers: Exclusionary Conduct Masquerading as Managed Care?, 51 Law & Contemp. Probs. 195 (1988).

[30] Sharis A. Pozen, Acting Assistant Att'y Gen., Dep't of Justice Antitrust Div., Competition and Health Care: A Prescription for High-Quality, Affordable Care 7 (Mar. 19, 2012) [hereinafter Pozen, Competition and Health Care]

[31] LECG Inc., "Economic Analyses of the Competitive Impacts From The Proposed Consolidation of Highmark and IBC." (September 10, 2008) at 9.

[32] Cf. Merger Guidelines impose higher standard for an efficiencies defense as the market share / power increases.

The Agencies ask: **In addition to wages salaries, and other financial compensation, what aspects of worker's terms and conditions of employment should be considered for analyzing mergers that may lessen competition in labor markets and thereby harms workers?**[33]

When Anthem and Cigna proposed to merge, the California Medical Association (CMA), with the assistance of the AMA, identified physician survey questions aimed at determining the aspects of physician services that should be considered in analyzing likely monopsony effects in physician markets. 989 physicians completed the survey.

Seventy-one percent of physician respondents to the AMA/CMA survey felt they had to contract with Anthem in order to have a financially viable practice; and 47 percent felt that way with respect to Cigna.[34]

The extent of the merged entity's monopsony power and how it ultimately would injure physician productivity was also revealed in physician responses to the question of would there be any consequences in not continuing to contract with the merged firm:

- 31 percent would cut investments in practice infrastructure;
- 40 percent would cut or reduce staff salaries;
- 43 percent would have to spend less time with patients; and
- 27 percent would cut quality initiatives or patient services.

These reductions in service levels and quality of care would represent immediate harm to the labor market for physician services. In the long run, the survey also revealed an appreciable risk that monopsony power enhanced in the merger would drive physicians from the market. According to the CMA survey, if Anthem/Cigna were to merge and the physicians did not continue to have a contract with the merged health plan, significant numbers of physicians would be driven from the market:

- 13 percent would retire from active practice;
- 15 percent would need to close their practices; and
- 8 percent would move their practice to a more competitive reimbursement market.

These astonishing physician survey results illustrate some of the myriad ways in which health insurer mergers can be evaluated for their possible monopsony harm in physician markets.[35] Where evidence, like that obtained in the survey responses above, indicates a merged insurer would reach "must have" status, monopsony power should be presumed, or at least it should take extra strong procompetitive rebuttal to overcome.

---

[33] RFI at ¶9g.

[34] See records from the California Department of Insurance at http://www.insurance.ca.gov/01-consumers/110-health/60-resources/upload/Anthem-Cigna-Merger-Decision-Letter-to-US-DOJ.pdf http://www.insurance.ca.gov/01-consumers/110-health/60-resources/upload/AMA-CMA-statement-March-29-2016.pdf.

[35] Further discussions of the CMA survey can be found at http://www.insurance.ca.gov/01-consumers/110-health/60-resources/upload/Anthem-Cigna-Merger-Decision-Letter-to-US-DOJ.pdf; http://www.insurance.ca.gov/01-consumers/110-health/60-resources/upload/AMA-CMA-statement-March-29-2016.pdf.

The Agencies ask**: Do the guidelines set forth a sufficient framework to analyze mergers that may lessen competition in labor markets and thereby harm workers?**[36]

The guidelines do not set forth a sufficient framework for analyzing mergers that may lessen competition in labor markets and harm workers. In fact, the guidelines do not even address the problem of labor market monopsony. This may partly explain why antitrust enforcement in the monopsony area has been missing despite the compelling importance of monopsony issues.[37]

The AMA would welcome the DOJ addressing, in the merger Guidelines, the problem of health insurer monopsony in physician markets. This effort should help close the litigation gap—the gap between the largeness of the labor monopsony problem and the smallness of the legal response.[38]

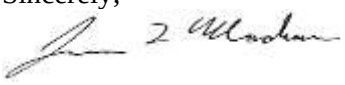
The Agencies ask: **How should the guidelines treat a merger that may generate monopsony power but does not substantially lessen competition in an output market?[39]**

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.[40] 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, Marinescu & Hovenkamp 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.[41] The authors conclude: "Existing law would not countenance such an approach, nor as a general matter should it."[42] The authors further observe that making quantitative assessments of benefits in one market and harms in another would "place heroic demands on the courts." *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.

The AMA looks forward to working with the Agencies on this important effort. 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.

Sincerely,



James L. Madara, MD

---

[36] RFI at ¶9d.
[37] *See* discussion *supra* at page 3.
[38] See Marinescu & Posner at 1373.
[39] Why has Antitrust Law Failed Workers?, Ioana Marinescu & Eric Posner, 105 Cornell Law Review 1343, 1373.
[40] *See, United States v. Philadelphia Natl. Bank*, 374 U. S. 321, 370-371 (1963).
[41] Marinescu & Hovenkamp at 38.
[42] Id.