AMA AMERICAN MEDICAL ASSOCIATION

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July 8, 2009

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

Re: Competition in Health Insurance: A Comprehensive Study of U.S. Markets (2008 update)

Dear Ms. Varney:

The American Medical Association (AMA) appreciates the opportunity to meet with you to discuss competition in health insurance and other antitrust matters of importance to physicians. In advance of our meeting, we are providing you with a copy of the AMA's latest study entitled, "Competition in Health Insurance: A Comprehensive Study of U.S. Markets (2008 update)."

The AMA commends the Obama administration for recognizing the threats that health insurer consolidations pose to the delivery of health care across the country. As then Senator Obama stated during his Presidential election campaign:

> There have been over 400 health care mergers in the last 10 years. The American Medical Association reports that 95 percent of insurance markets in the United States are now highly concentrated and the number of insurers has fallen by just under 20 percent since 2000. …As president, I will direct my administration to reinvigorate antitrust enforcement. It will step up review of merger activity and take effective action to stop or restructure those mergers that are likely to harm consumer welfare, while quickly clearing those that do not.[1]

The AMA would like to assist the Department of Justice (DOJ) as you move forward in this important effort, and we look forward to working with you and your staff. The following discussion provides more detail on these issues from the physician perspective.

[1]Barack Obama, "Statement of Senator Barack Obama for the American Antitrust Institute" at *http://www.antitrustinstitute.org/archives/files/aai-%20Presidential%20campaign%20-%20Obama%209-07_092720071759.pdf*

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I. Health Insurer Market Shares and Market Concentration

Every year for the past eight years, the AMA has conducted the most in-depth study of commercial health insurance markets in the country. The AMA's most recently published study, "Competition in Health Insurance: A Comprehensive Study of U.S. Markets (2008 update)" (the study), is intended to help researchers, policy makers, and federal and state regulators identify areas of the country where consolidation among health insurers may have harmful effects on consumers, on providers of care and on the economy. The study reports health insurer shares and Herfindahl-Hirschman Indices (HHIs) for combined HMO and PPO markets and separate HMO and PPO markets in 42 states and 314 smaller geographic areas across the United States (metropolitan statistical areas, or MSAs).[2,3] Based on the DOJ/Federal Trade Commission Horizontal Merger Guidelines, key findings in this study are as follows. Considering combined HMO and PPO product markets:

- 94 percent (295) of the MSAs examined are highly concentrated.
- In nearly 90 percent (279) of MSAs, one or more insurers had a market share of 30 percent or greater.
- In more than 40 percent (138) of the MSAs, at least one insurer had a market share of 50 percent or greater.
- In 16 percent (49) of the MSAs, at least one insurer had a market share of 70 percent or greater.

Independent academic researchers, examining different data, have reached similar conclusions. For example, Dafny, Duggan and Ramanarayanan (2009) estimate that the fraction of local markets falling into the "highly concentrated" category (per the DOJ's Horizontal Merger Guidelines) increased from 68 to 99 percent between 1998 and 2006.[4]

II. Health Insurer Market Power

The existence of health insurer market power may be inferred in most of the health insurance markets examined in the AMA's study. *United States v. Grinell Corp*., 384 U.S. 563, 571 (1966)(the existence of market power "ordinarily may be inferred from the predominant share of the market"). The AMA is aware that the influential Seventh Circuit opinion (*Ball Memorial Hospital v. Mutual Hospital Insurance, Inc.*, 784 F.2d 1325, 1325 (7th Cir. 1986)), authored 20 years ago by Judge Easterbrook, concluded that the health insurer defendant's high market share did not establish market power because entry barriers in health insurance were low. All that was required, reasoned the court, was a license and money, "which may be supplied on a moment's notice," and "no firm has captive customers." *Id.*, at 1335-36.

The intervening 20 years have demonstrated that the Seventh Circuit in *Ball Memorial* did not consider the significant barriers that we now know exist, and the assumptions on which the court relied have proven false. It is now well understood that many barriers to entry exist, including: state regulatory requirements; brand name acceptance of established insurers; developing sufficient

[2] The product market excludes Medicare and Medicaid because a significant number of consumers are not eligible for these programs. Thus, Medicare and Medicaid are not substitutes for commercial insurance. The localized geographic market is supported by the observation that most health insurers market locally because employers, employees and other individuals purchase health insurance products that will serve them in proximity to where they work and live.

[3] The smaller geographic areas include MSAs and metropolitan divisions as defined by the U.S. Office of Management and Budget. The vast majority of these are MSAs, while a few of them are metropolitan divisions, which are subcomponents of very large MSAs (e.g., New York, Chicago). For convenience, both of these smaller areas are referred to as MSAs throughout the report.

[4] Dafny, L., Duggan, M., and Ramanarayanan, S., 2009. "Paying a Premium on Your Premium? Consolidation in the U.S. Health Insurance Industry," unpublished working paper.

business to permit the spreading of risk; contending with established insurance companies that have built long-term relationships with employers and other consumers; and the cost of developing a health care provider network. *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).

The presence of significant entry barriers in health insurance markets was demonstrated in the recent hearings before the Pennsylvania Insurance Department on the competition ramifications of the proposed merger between Highmark Inc. and Independence Blue Cross. The AMA testified at these hearings in opposition to the proposed merger and our submission to the Insurance Department is included for your review. Significant evidence was introduced in those hearings, showing that replicating the Blues' extensive provider networks constituted a major barrier to entry.[5] The evidence further demonstrated that there has been very little in the way of new entry that might compete with the dominant Blues Plans in the Pennsylvania health insurance markets.[6] In a report commissioned by the Department, LECG concluded that it was unlikely that any competitor would be able to step into the market after a Highmark/IBC merger:

> [B]ased on our interviews of market participants and other evidence, there are a number of barriers to entry—including the provider cost advantage enjoyed by the dominant firms in those areas and the strength of the Blue brand in those areas.... On balance, the evidence suggests that to the extent the proposed consolidation reduces competition, it is unlikely that other health insurance firms will be able to step in and replace the loss in competition.[7]

LECG's conclusion is consistent with the federal antitrust enforcement agencies' observation that national insurers have been unsuccessful in entering some of the Blue Cross-dominant markets in recent years.[8] For instance, Rob McCann reports that Blue Cross Blue Shield of Michigan has had "market dominance for decades." Robert W. McCann, *Field of Dreams: Dominant Health Plans and the Search for a "Level Playing Field,"* Health Law Handbook, p.42 (Thomson West 2007).

Some market barriers are created by contracting practices used by dominant health insurers. These include most favored nations clauses whereby physicians must agree to give the dominant payor at least as favorable a rate as they give to any other insurer. Other problematic contracting practices

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[5] The Department held three public hearings, in which 101 interested parties offered comments, and compiled a Web site that hosted nearly 50,000 pages of commentary. The proposed merger was also the subject of two United States Senate Judiciary Committee hearings. The extensive record included the analysis of financial and economic experts such as LECG, Monica Noether of CRA International, the Blackstone Grays and others. See *http://www.ins.state.pa.us/ins/lib/ins/whats_new/Excerpts_from_PA_Insurance_Dept_Expert_Reports.pdf* for background information, including excerpts from the experts' reports.

[6] Dr. Monica G. Noether. "Testimony on Commonwealth of Pennsylvania Public Hearing Associated with the Form A Filing for Highmark, Inc. and Independence Blue Cross." (Pittsburgh, July 8, 2008). Test From: Competitive Analysis of the Proposed Consolidation Between Highmark, Inc., and Independence Blue Cross in the Commonwealth of Pennsylvania. Available at *www.ins.state.pa.us*; Accessed 07/29/2008. (Noether Report, pp. 8-11).

[7] LECG Inc., "Economic Analyses of The Competitive Impacts From The Proposed Consolidation of Highmark and IBC." September 10 2008, Page 9.

[8] "Improving Health Care: A Dose of Competition, Federal Trade Commission and Department of Justice" (July 2004) at pp. 8-11.

include all products clauses, anti-assignment provisions and minimum enrollment assurances. *See Id*., at pp.46-49.[9] The Highmark/IBC hearings also highlighted how market division arrangements prevent entry and allow entrenched firms to maintain market power.

There is a consensus among health economists that most health insurance markets are not perfectly competitive, and as a result, large insurers can exercise market power. A new research study by Northwestern University Professor Leemore Dafny, PhD, to be published by the prestigious *American Economic Review*, finds evidence that health insurers exercise at least some market power in an increasing number of geographic markets.[10] Enclosed is a copy of Dr. Dafny's study for your review. Dr. Dafny concludes that it takes at least six insurers in a market before market power is eliminated. A study by Dranove *et al*. published in the *Journal of Industrial Economics* reaches similar conclusions.[11]

III. Health Insurers Possess and Exercise Monopsony Power

Concentration data reported in the AMA's study can be used to study health insurer monopsony power. One reason is that the geographic market in which an insurer sells its services to consumers coincides with the geographic market from which it secures services from physicians and other health care providers. Supporting this conclusion is the observation that patients will travel for hospital and physician services only within narrow geographic limits. Therefore, employers want health insurance coverage for their employees in each of the locales where the employees reside or work. Responding to this preference, health insurers must obtain physician coverage in each locale. Moreover, physicians invest and develop their practices locally. Physicians are not mobile and must sell their services to health insurers controlling any significant portion of their practices.

The AMA's study indicates that numerous insurers possess the sort of monopsony power in physician markets that the DOJ claimed to exist in its challenges of UnitedHealthcare's acquisition of PacifiCare[12] and Aetna's acquisition of Prudential's national health insurance lines.[13] In those cases, the DOJ embraced the notion of a localized market in which health insurers purchase physician services.[14]

The nature of the health care industry facilitates the potential for a health insurer possessing any significant market share to exercise monopsony power over physicians selling health care services within the health insurer's market. If physicians were to refuse the terms of the dominant buyer, they would likely suffer an irretrievable loss of revenue. Medical services can neither be stored nor exported, and it is difficult to convince consumers (which in many cases are employers) to switch to

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[9] Available at *http://www.drinkerbiddle.com/People/detail.aspx?id=996&MainAuthors=996*.
[10] Dafny L. "Competition in Health Insurance Markets" (attached) (May 2009), forthcoming in the *American Economic Review*.
[11] Dranove, D., Gron, A. and M. Mazzeo, 2003, "Differentiation and Competition in HMO Markets" *Journal of Industrial Economics.*
[12] Complaint *U.S. v. UnitedHealthcare Group, Inc.*, No. 1:05CV02436 (U.S.D.C. December 20, 2005) [hereinafter United-PacifiCare Complaint].
[13] *U.S. v. Aetna Inc.*, No. 3-99CV 1398-H, ¶¶ 17-18 (June 21, 1999) (complaint), available at *http://www.usdoj.gov/atr/cases/f2500/2501.pdf*; *see also U.S. v. Aetna, Inc.*, No. 3-99 CV 1398-H, at 5-6 (Aug. 3, 1999) (revised competitive impact statement), available at *http://www.usdoj.gov/atr/case/s/f2600/2648.pdf*.
[14] See e.g. Aetna Complaint ¶ 20 (alleging that the relevant geographic markets were the MSAs in and around Houston and Dallas, Texas)

different health insurers.[15] Consequently, a physician's ability to consider realistically terminating a relationship with a health insurer because of low reimbursement rates depends on that physician's ability to make up lost business by immediately switching to an alternative health insurer. Where those alternatives are lacking, a health insurer will have the ability to reimburse physicians at rates that are below a true competitive level. Health economist Cory Capps, PhD has concluded that this monopsony injury can occur at a health insurer market share of less than 35 percent.[16] Given that in nearly 90 percent of MSAs one or more insurers possess a market share of 30 percent or greater (see summary of study findings at page 2 *supra*),[17] it is critical for antitrust enforcers to maintain a competitive market in which physicians have adequate competitive alternatives.

IV. Consumer Injury

In an era of spiraling costs, it is tempting to conclude that anything that drives down medical fees, such as monopsony, is a good thing for consumers. But it is a mistake to assume that when insurers push down the cost of physician services, insurers' interests are perfectly aligned with those of consumers.

Health insurer monopsonists typically are also monopolists. Therefore, their lower input prices (for physician services) do not necessarily lead to lower consumer output prices (for health insurance premiums).[18] As a general proposition, monopsonists drive down their buying price by purchasing fewer products. Because there is less product purchased, there is, in turn, less product sold, which leads to higher output prices. That lower physician fees paid by monopsonist insurers may result in higher premiums to patients was emphasized by R. Hewitt Pate, a former Assistant Attorney General of the Antitrust Division, in a 2003 statement before the Senate Judiciary Committee:

> A casual observer might believe that if a merger lowers the price the merged firm pays for its inputs, consumers will necessarily benefit. The logic seems to be that because the input purchaser is paying less, the input purchaser's customers should expect to pay less also. But that is not necessarily the case. Input prices can fall for two entirely different reasons, one of which arises from a true economic efficiency that will tend to result

[15] 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. Complaint at paragraph 37.

[16] Capps, C. (2009)"Economic Analysis of Buyer Power in Health Plan Mergers," Working Paper, Bates White, Washington, D.C.

[17] Bearing in mind that the concentration data cited earlier only consider commercial insurance, 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, health economist, David Dranove, PhD, the Walter McNerney Distinguished Professor of Health Industry Management at Northwestern's Kellogg of Management, explains why Medicare and Medicaid do not make good alternatives for physicians dealing with a monopsonist insurer. (*See* affidavit of Professor David Dranove in *United States v. UnitedHealth Group, Inc., and Sierra Health Services, Inc.* (attached)). According to Professor Dranove, physicians cannot increase their revenue from Medicare and Medicaid in response to a decrease in commercial health insurer reimbursement. Enrollment in these programs is limited to special populations, and these populations only have a fixed number of patients. Moreover, Medicaid reimbursements to physicians are significantly less than those from commercial health insurers. Professor Dranove concludes: "Medicare and Medicaid do not represent viable alternatives for physicians who face lower fees from a monopsonist insurer. Because Medicare and Medicaid are large purchasers of physician services, excluding them from market share calculations will profoundly change inferences about market shares and monopsony power. Medicare and Medicaid should therefore be excluded when computing shares in the market for the purchase of physician services."

[18] Peter J. Hammer and William M. Sage, "Monopsony as an Agency and Regulatory Problem in Health Care," 71 Antitrust L.J. 949 (2004).

> in lower prices for final consumers. The other, in contrast, represents an efficiency-reducing exercise of market power that will reduce economic welfare, lower prices for suppliers, and may well result in higher prices charged to final consumers.

The Pennsylvania experience is consistent with economic theory. At the conclusion of the Highmark/IBC hearings, the Pennsylvania Insurance Department was prepared to find the proposed merger to be anticompetitive in large part because it would grant the merged health insurer undue leverage over physicians and other health care providers. The Department released the following statement:

> Our nationally renowned economic expert, LECG, rejected the idea that using market leverage to reduce provider reimbursements below competitive levels will translate into lower premiums, calling this an "economic fallacy" and noting that the clear weight of economic opinion is that consumers do best when there is a competitive market for purchasing provider services. LECG also found this theory to be borne out by the experience in central Pennsylvania, where competition between Highmark and Capital Blue Cross has been good for providers and good for consumers.

There may be antitrust concerns if a health insurer can lower compensation to physicians even if it cannot raise prices to patients. For example, in the United/PacifiCare merger, the DOJ required a divestiture based on monopsony concerns in Boulder, Colorado, even though United/PacifiCare would not necessarily have had market power in the sale of health insurance. The reason is straightforward: the reduction in compensation would lead to diminished service and quality of care, which harms consumers even though the direct prices paid by subscribers do not increase. *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*.

Reductions in service levels and quality of care cause immediate harm to consumers. In the long run, we must also consider whether monopsony power will harm consumers by driving physicians from the market. Recent projections by the Health Resources and Services Administration suggest a looming shortage of physicians in the United States.[19] Moreover, a recent study by Merritt Hawkins and Associates tracked the viewpoints of physicians between the ages of 50 and 65 (which comprise 36 percent of the physicians in the United States, according to the AMA).[20] The survey found that more than 49 percent of physicians in this population are planning to make a change in their practices that will either eliminate or reduce the number of patients they treat due to frustrations with

[19] See Health Resources and Services Administration, Physician Supply and Demand: Projections to 2020 (Oct 2006) (projecting a shortfall of approximately 55,000 physicians in 2020); see also Merritt, Hawkins, et al., Will the Last Physician in America Please Turn Off the Lights? A Look at America's Looming Doctor Shortage (2004) (predicting a shortage of 90,000 to 200,000 physicians and that average wait times for medical specialties is likely to increase dramatically beyond the current range of two to five weeks).

[20] Merritt Hawkins and Associates, *2007 Survey of Physicians 50 to 65 Years Old*, available at *http://www.merritthawkins.com/pdf/mha2007olderocsurvey.pdf*.

inadequate reimbursement in the face of continually increasing overhead and administrative and regulatory burdens that detract from actual patient care. The continued exercise of monopsony power will exacerbate this looming shortage.

V. Conclusion and Recommendations for Additional Studies

The AMA hopes that you will find its "Competition in Health Insurance: A Comprehensive Study of U.S. Markets (2008 update)" helpful in fulfilling President Obama's promise of more rigorous antitrust enforcement in health insurance markets. Restoring competition in the marketplace for the purchase of physician services will improve the quality of care, redress the looming shortage of physicians and lower premiums. The AMA suggests a number of steps that the DOJ should consider in connection with this effort:

1) perform a retrospective study of health insurance mergers analogous to that performed by the Federal Trade Commission on hospital mergers;
2) commission new research to identify causes and consequences of health insurer market power;
3) create a framework for predicting the effects health insurer mergers will have on consumer and provider markets; and
4) gather information that would facilitate additional systematic studies.

The AMA looks forward to working with you and your staff in 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

Attachment