AMA
AMERICAN
MEDICAL
ASSOCIATION

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

June 20, 2008

The Honorable William E. Kovacic
Chairman
U.S. Federal Trade Commission
600 Pennsylvania Avenue, NW
Washington, DC 20850

Re: Physician Network Integration and Joint Contracting

Dear Chairman Kovacic:

On behalf of the physician and student members of the American Medical Association (AMA), I would like to extend our appreciation for the opportunity to submit our comments to the Federal Trade Commission on the topic of physician network integration and joint contracting. Health care antitrust issues and improvement of the antitrust environment for physicians remain a top priority for the AMA. We are extremely concerned with what we see as the significant regulatory barriers that restrict physicians' ability to collaborate in ways crucial to improving quality and containing costs. To that end, we submit our comments discussing changes in the health care market that we believe warrant a shift in the Agencies' health care antitrust regulatory approach.

The Agencies current course was charted at a time when payers did relatively little to manage the cost or volume of services provided. Today the landscape is far different. Governmental and private payers take a much more active role in regulating the price and volume of physician services. Further, consolidation among private payers has resulted in more powerful health payers and a substantial reduction in physician autonomy. These forces reduce both the practical and the economic risks of joint activity among physicians.

Equally important, professional, market, and regulatory developments are encouraging physicians to collaborate in new ways. In particular, the federal government is encouraging physicians and other providers to invest in health information technology (HIT) to facilitate the collection and sharing of clinical data. HIT has the potential to significantly increase the efficiency of the health sector and to improve the quality of care. However, the adoption of HIT requires a level of physician investment and network integration that pose significant

barriers to implementation. At the same time, the emergence of new reimbursement mechanisms such as "pay for performance"—i.e., paying physicians in part based on their ability to meet or exceed quality or other performance benchmarks—place a premium on physicians' ability to collect data and utilize HIT. For physicians, who still practice predominantly in small groups, network arrangements provide one way of achieving the economies of scale necessary to participate in these initiatives.

Despite these developments, enforcement policy—embodied today in the *Statements of Enforcement Policy in Health Care* developed jointly by the FTC and the Department of Justice during the 1990s—still casts a suspicious eye on physician collaboration through network arrangements. The AMA submits that the *Statements of Enforcement Policy* go too far in deterring the formation and operation of legitimate physician networks. Joint contracting arrangements that are ancillary to the implementation of HIT or to the participation in innovative payment arrangements among other physician collaborations on quality improvement, ordinarily create plausible efficiencies and should not face summary condemnation. Accordingly, the AMA proposes a modification of the existing standards to reflect changes in the health care market and to provide greater flexibility for physicians to engage in pro-competitive joint arrangements.

The AMA proposal is discussed in much greater detail in the attached white paper entitled, "Physician Networks and Antitrust: A Call for More Flexible Enforcement Policy." We have appreciated the dialogue with the FTC on these matters to date and look forward to further discussions on the issues raised in the attached document.

Thank you in advance for your consideration. If you have any questions, please contact Carol Vargo, Assistant Director, Federal Affairs, at 202-789-7492 or carol.vargo@ama-assn.org.

Sincerely,

Michael D. Maves, MD, MBA

Attachment

PHYSICIAN NETWORKS AND ANTITRUST:

A CALL FOR A MORE FLEXIBLE ENFORCEMENT POLICY

AMERICAN MEDICAL ASSOCIATION WITH SIDLEY AUSTIN LLP

June 2008

EXECUTIVE SUMMARY

I. INTRODUCTION

Over the last thirty years, antitrust enforcement in health care has been a major priority of federal antitrust authorities. Both antitrust Agencies – the Federal Trade Commission (FTC) and the Department of Justice (DOJ) – have devoted considerable resources to actions involving health care services. Within health care, no group has received greater attention from the Agencies than physicians.

We believe that changes in health care markets warrant a shift in focus. When the Agencies charted their current course, payers did relatively little to manage the cost or volume of services provided. Today the landscape is far different. Governmental and private payers take a much more active role in regulating the price and volume of physician services. Further, consolidation among private payers has resulted in more powerful health payors and a substantial reduction in physician autonomy. These forces reduce both the practical and the economic risks of joint activity among physicians.

Equally important, professional, market and regulatory developments are encouraging physicians to collaborate in new ways. In particular, the federal government is encouraging physicians and other providers to invest in health information technology ("HIT") to facilitate the collection and sharing of clinical data. HIT "has the potential to significantly increase the efficiency of the health sector" and to "improve the quality of care."[1] However, the adoption of HIT requires a level of physician investment and network integration that pose significant barriers to implementation. At the same time, the emergence of new reimbursement mechanisms such as "pay for performance" -- *i.e.,* paying physicians in part based on their ability to meet or exceed quality or other performance benchmarks -- place a premium on physicians' ability to collect data and utilize HIT. For physicians, who still practice predominantly in small groups, network arrangements provide one way of achieving the economies of scale necessary to participate in these initiatives.

Despite these developments, enforcement policy – embodied today in the *Statements of Enforcement Policy in Health Care* developed jointly by the FTC and the DOJ during the 1990s – still casts a suspicious eye on physician collaboration through network arrangements. The AMA submits that the *Statements of Enforcement Policy* go too far in deterring the formation and operation of legitimate physician networks. Joint contracting arrangements that are ancillary to the implementation of HIT or to the

participation in innovative payment arrangements among other physician collaborations on quality improvement, ordinarily create plausible efficiencies and should not face summary condemnation. Accordingly, the AMA proposes a modification of the existing standards to reflect changes in the health care market and to provide greater flexibility for physicians to engage in procompetitive joint arrangements.

The AMA proposes the following specific modifications of the *Statements*:

1. Physician networks supported by plausible efficiencies should not face summary condemnation under the *per se* rule or the "inherently suspect" standard. The Agencies should explicitly recognize that joint contracting is ordinarily reasonably necessary to the attainment of the plausible efficiencies associated with implementing HIT or participating in P4P, among other physician collaborations on quality improvement.

2. Non-exclusive physician networks – those in which the physicians are genuinely available to contract with payers separately from the network – should almost always be found lawful under the rule of reason.

3. Exclusive physician networks should be evaluated under the rule of reason. Absent proof of market power or actual anticompetitive effects, such networks should be found lawful. If an exclusive network is shown to have market power or to result in anticompetitive effects, the network should be viewed under a full rule of reason analysis that balances the anticompetitive effects against efficiencies created by the exclusive network. Among the expected benefits of exclusivity that the Agencies should explicitly recognize are the elimination of free riding and the removal of obstacles to the acquisition and implementation of HIT.

[1] Congressional Budget Office, "Evidence on the Costs and Benefits of Health Information Technology," (May 2008) (hereinafter "*CBO Report")*, at 1.

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However, the adoption of HIT requires a level of physician investment and

network integration that pose significant barriers to implementation. At the same time, the emergence of new reimbursement mechanisms such as “pay for performance” -- i.e., paying physicians in part based on their ability to meet or exceed quality or other performance benchmarks -- place a premium on physicians’ ability to collect and utilize HIT. For physicians, who still practice predominantly in small groups, network arrangements provide one way of achieving the economies of scale necessary to participate in these initiatives.

Despite these developments, enforcement policy – embodied today in the *Statements of Enforcement Policy in Health Care* developed jointly by the FTC and the DOJ during the 1990s – still casts a suspicious eye on physician collaboration through network arrangements. The AMA submits that the *Statements of Enforcement Policy* go too far in deterring the formation and operation of legitimate physician networks. Joint contracting arrangements that are ancillary to the implementation of HIT or to the participation in innovative payment arrangements among other physician collaborations on quality improvement, ordinarily create plausible efficiencies and should not face summary condemnation. Accordingly, the AMA proposes a modification of the existing standards to reflect changes in the health care market and to provide greater flexibility for physicians to engage in procompetitive joint arrangements.

This paper begins by describing changes in the health care market since the Agencies adopted their current enforcement policy relating to physician networks. It then describes the *Statements* and considers whether antitrust law leaves room for a change in policy. Finally, the paper describes a more flexible approach based on the rule of reason.

II. CHANGES IN THE HEALTH CARE MARKETPLACE

Since the *Statements of Enforcement Policy* were last revised in 1996, health care market conditions have changed in significant ways. The principal changes include (a) increasing health insurer consolidation and market power; (b) a retreat from financial risk-sharing between health insurers and physicians; and (c) the emergence of HIT and new payment methodologies.

A. Health Insurer Monopsony Power

The Agencies adopted the *Statements of Enforcement Policy* shortly before a tidal wave of mergers swept through the health insurance industry. In the last decade, dozens of major health insurer mergers have resulted in an increasingly consolidated payer market. Premiums have steadily increased, even as patient co-pays and deductibles have expanded, effectively shrinking the scope of coverage. As a result of these mergers, health insurance markets throughout the country are at levels of concentration associated with monopsony power.

The AMA's most recent study of the health insurance industry shows that 96% (or 299 of 313) of the metropolitan statistical areas ('"MSAs") analyzed by the AMA, are controlled by a single insurer with a combined HMO/PPO market share of 30% or more.[2] The report further shows that 64% (or 200 of 313) of the MSAs were controlled by a single insurer with a combined HMO/PPO market share of 50% or greater.[3] In addition, 96% of the MSAs studied by the AMA are considered highly concentrated (with a Herfindahl-Hirschman Index above 1,800) under the Agencies' Horizontal Merger Guidelines.[4] The AMA's "study shows unequivocally that physicians across the country have virtually no bargaining power with dominant health insurers and that those health insurers are in a position to exert monopsony power."[5] Put another way, if physicians were to refuse the terms of the dominant health insurer, they would likely suffer an irrecoverable loss of revenue. Consequently, physicians can be forced

to accept inadequate reimbursement rates likely to lead to a reduction in the supply of physician services – despite the demand for such services by patients. Indeed, recent projections by the Health Resources and Services Administration suggest a looming shortage of physicians in the United States.[6]

It is a mistake to assume that, when insurers push down the cost of physician services, their interests are perfectly aligned with those of consumers.[7] Health insurers who exercise monopsony power by driving physician fees below the competitive level may cause patients to receive an inadequate level of service and quality.[8] Also, because health insurer monopsonists typically are also monopolists, lower input prices (for physician services) do not lead to lower consumer output prices (for health care premiums).[9] Indeed, the evidence from mergers throughout the U.S. strongly suggests that the creation of buyer power from health insurance consolidation has not benefited competition or consumers.[10] Although compensation to physicians has been reduced, health insurance premiums have continued to increase rapidly.

In this environment, one of the key concerns historically animating antitrust enforcement policy in health care – preventing physicians' collective resistance to the entry of managed care – has only marginal relevance. Between the statutorily-fixed prices of Medicare and Medicaid in the governmental sector, and the negotiating leverage of private health plans that dominate commercial markets, there is only a narrow slice of the market left that is even theoretically vulnerable to a physician-orchestrated conspiracy.

B. Retreat from Risk-Sharing

In 1996, when the *Statements of Antitrust Enforcement Policy* were adopted, managed care was in its ascendancy. Many in health care expected to see continued growth in HMOs and other forms of risk sharing. Today, by contrast, employers and other purchasers of health care coverage have largely rejected payer-

provider risk-sharing arrangements.[11] Many IPAs that previously attempted to share financial risk experienced significant financial losses and ceased offering the model.[12] Consumers also resisted arrangements that placed physicians at financial risk. Contrary to early predictions, in most areas of the country physician capitation proved to be an unpopular and highly controversial payment methodology. Employers wanted broad networks that allowed patients a significant choice among physicians, but without any perceived incentives to ration care.

C. The Emergence of HIT and New Payment Methodologies

One of the more significant and promising developments in the health care market since the promulgation of the *Statements* in the mid-90s is the emergence of HIT. HIT has the potential, if adopted widely and used effectively, to save the health care sector about $80 billion annually (in 2005 dollars).[13] At the same time, by making it possible for physicians to collect and analyze vast numbers of patient encounters, HIT promises to drive advancements in medical science and clinical practice.

Notwithstanding the tremendous promise of HIT, its adoption has lagged.[14] To date, only 14% of physicians have minimally functional EMR systems.[15] Solo or single partner practices, accounting for about half of all doctors, had the lowest level of comprehensive EMR use – 7.1% of solo practitioners, 9.7% of those with a partner.[16] The Congressional Budget Office (CBO) attributes this disappointing response to challenges in implementing HIT systems and to physician inability to achieve financial returns from HIT sufficient to offset its daunting implementation costs.[17] Most of the benefits of HIT – such as less duplication of diagnostic tests or increased availability of patient data – accrue to health insurance companies or patients rather than to the physicians who incur the costs of implementation. This lack of symmetry leads the CBO to conclude that "[h]ow well HIT lives up to its potential

depends in part on how effectively financial incentives can be realigned to encourage the optimal use of the technology's capabilities."[18] Network arrangements provide one way for physicians in small practices both to spread the costs of HIT implementation and to internalize the potential gains from enhanced efficiency.

Closely linked to the adoption of HIT is the emergence of a new payment methodology known as "pay for performance" ("P4P"). The core purpose of P4P is to provide financial incentives for physicians to meet pre-established performance benchmarks. While P4P is in its infancy and has raised a host of methodological concerns – including errors in data used, over-reliance on cost measures, and lack of transparency and physician input in performance metrics – it is "now routinely used by both private and public payers in the U.S. health care system."[19] A majority of commercial HMOs use P4P, and the Center for Medicare and Medicaid Services has been directed by Congress to adopt value-based purchasing.[20] P4P depends upon accurate and medically appropriate performance measurement, which in turn depends upon HIT. If the adoption of P4P spreads and its use expands, physicians in small practices will face yet another force driving them into "integrated care networks that [will] allow the physicians to more seamlessly coordinate care."[21]

III. CURRENT ENFORCEMENT POLICY

A. The Statements of Enforcement Policy in Health Care

The initial version of the Statements was released in September, 1993. Issued in response to calls from the American Medical Association, the American Hospital Association, and other leading health care organizations, the Statements reflected a significant effort to provide heightened clarity to medical professionals and companies. The Statements articulated in a clear, accessible format policies that had emerged previously only in advisory letters, speeches, and consent decrees.

1. Financial Integration

As originally issued, the Statements contained eight separate policy statements. Statement 8, entitled "Physician Network Joint Ventures," identified two features of particular importance to the antitrust analysis of physician networks: (1) the size of the network, in terms of participating physicians, as a measure of potential market power; and (2) whether the physicians had integrated their practices by sharing "substantial financial risk." The AMA's focus is on the latter requirement.

As set forth in the initial version of the Statements, physicians in a contracting network could share "substantial financial risk" in either of two ways: (1) by accepting "capitated" or "per-member per-month" payments; or (2) by incentivizing physicians to contain costs through the use of a substantial withhold from payments. With capitation or substantial withholds in place, the network would be deemed to have sufficient financial incentive to enhance efficiencies. Otherwise, without such financial integration, a physician network that engaged in joint price negotiations with health insurers would be summarily condemned as a *per se* illegal price-fixing agreement.

The concept of integration as an antitrust guidepost did not originate in the Statements. Rather, antitrust law has long sought to distinguish between mere cartels and legitimate joint ventures. "Integration" is used as shorthand to describe attributes that make a joint arrangement sufficiently likely to generate efficiency that application of the rule of reason is appropriate. What was distinctive in the Agencies' approach was the suggestion that, in the specific context of physician contracting networks, only the sharing of "substantial financial risk" would suffice to allow the network to escape application of the *per se* rule. Other forms of integration – structural, functional, or transactional – would not carry the day.

With the rapid decline of risk sharing arrangements since the Statements'

inception, the requirement of financial risk-sharing as the defining feature of a legitimate physician network proved unduly restrictive.

2. Clinical Integration

In the 1996 version of the Statements, the Agencies recognized a second type of integration that could qualify a physician network for rule of reason treatment. "Clinical integration," as defined in the Statements, is evidenced "by the network implementing an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and to create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality."[22] Clinical integration as so defined represented a sort of "as if" standard: A physician network that acted "as if" its members shared financial risk – by instituting the types of cost containment techniques that would necessarily be in place for a capitated group – might qualify for rule of reason treatment despite the absence of "substantial financial risk."

For several years following the publication of the 1996 Statements, the Agencies gave no further guidance on the meaning of clinical integration. In 2002, however, the Commission issued a staff advisory letter to MedSouth, Inc., an IPA based in Denver, Colorado with over 400 physicians.[23] And in 2007, the Commission issued a staff advisory letter to the Greater Rochester Independent Practice Association, Inc. (GRIPA), a network based in Rochester, New York with over 600 physician members.[24] The MedSouth and GRIPA letters demonstrate how high the bar has been set for physician networks seeking to qualify for rule of reason treatment through clinical integration.

While the MedSouth and GRIPA arrangements are not identical, they bear significant similarities. Notably, both networks were originally built for capitation, but needed to be re-tooled in the face of market resistance. Thus, both MedSouth and

GRIPA were constructed "as if" the physicians would be sharing substantial financial risk. Only when risk contracting proved to be commercially infeasible did the networks seek Commission approval for their programs of clinical integration.

In addition, both MedSouth and GRIPA made significant investments in capital and resources, using a cadre of consultants and technology experts to assist in the effort. Both networks invested in electronic medical records and tracking technology to share information on their patients and to monitor data relating to utilization and medical outcomes. And both networks developed clinical practice guidelines and procedures for monitoring compliance with them. In both instances, the Commission advisory letters noted no apparent anticompetitive motivation for the physicians' efforts.

Despite these features, neither MedSouth nor GRIPA achieved agency approval easily or without significant caveats. Both letters reflected intensive Commission investigation of the networks' histories, purposes, contracting mechanisms, disciplinary methods for non-compliant physicians, and strategies for producing efficiencies. Each involved a searching examination of the so-called "ancillarity" of the networks' pricing mechanisms to their efficiency-enhancing potential. Each left the Commission plenty of room to bring a later enforcement action if the networks' operations could not later be shown to produce significant efficiencies.

Interestingly, however, both MedSouth and GRIPA included a structural feature which might have persuaded the Commission to forego such probing examination. Both networks were "non-exclusive" in the sense that members were permitted to, and did, participate in other contracting networks. The Statements make clear that whether a network is judged to be "non-exclusive" depends on the "physician participants' activities, and not simply by the terms of the contractual relationship."[25] In both MedSouth and GRIPA, the Commission was persuaded that the network was

designed to be truly non-exclusive. In practical terms, this meant that any payer that did not wish to support the physicians' experiment in clinical integration could simply walk away, without losing access to any desirable physicians who belonged to the network.

Without the ability to force any payer to accept its terms, it is difficult to see how either network could have an anticompetitive effect – even if it were not particularly adept at generating efficiency. Indeed, the Commission appeared to recognize as much when it stated in *GRIPA*:

> [I]t appears that, if GRIPA in fact operates as it has proposed, Rochester-area payers unwilling for whatever reason to negotiate and contract jointly with physicians through GRIPA nevertheless should be able to deal individually or through other networks in order to obtain the services of GRIPA's member physicians. Under these conditions, it appears unlikely that GRIPA's program would permit it or its physician members to exercise market power or have anticompetitive effects in the market for physician services in the Rochester area.[26]

If a non-exclusive network has no discernible mechanism by which to restrain trade, why require it to adopt all the bells and whistles of clinical integration in order to escape summary condemnation? Why not let it sink or swim in the market? One answer may be that the law simply does not leave room for such ventures. The AMA addresses that issue below.

B. Does Antitrust Law Leave Room For Greater Flexibility In The Concept Of Integration?

As their name attests, the Statements of Antitrust Enforcement Policy in Health Care represent enforcement policy rather than law. As such, the Statements do not necessarily stand at the outer boundaries of what antitrust law permits. Indeed, the AMA submits that the Statements impose restrictions tighter than required by either the law itself or by sound enforcement policy in the current market environment.

Outside the health care context, courts and the Agencies themselves apply a more flexible analysis than is found in the *Statements*. For example, in the Agencies' guidelines on competitor collaboration, the Agencies make no mention of financial or clinical integration. Instead, the *Competitor Collaboration Guidelines* ask more generally whether a joint venture involves "an efficiency-enhancing integration of economic activity" and whether any restraints are "reasonably related to the integration and reasonably necessary to achieve its procompetitive benefits."[27] The Supreme Court, too, in its joint venture cases has eschewed any fixed formulation of what may constitute integration sufficient to warrant rule of reason treatment.

The Agencies' approach to integration has its origins in the Supreme Court's decision in *Arizona v. Maricopa County Medical Society*.[28] *Maricopa* involved physician foundations in Phoenix and Tucson, Arizona. Both foundations included a large number of the physicians in the community; the Maricopa County foundation included over 70% of the county's physicians. And both foundations established maximum fee schedules that were voted on and approved by their memberships. In a 4-3 decision, the Supreme Court held that these maximum fee schedules represented *per se* unlawful price-fixing agreements.

In so holding, the Court distinguished the foundations from "partnerships or other joint arrangements in which persons who would otherwise be competitors pool their capital and share the risks of loss as well as the opportunities for profit."[29] The physicians in the foundations did not put up capital; they did not accept capitation, but instead billed on a fee-for-service basis. Nor did the Court observe any other indicia of integration among the physician practices that comprised the foundations. By contrast, Justice Powell and the two justices who joined his dissent reasoned that the foundations were comparable to the joint licensing arrangements held subject to the rule of reason rather than the *per se* rule in *Broadcast Music Inc. v. CBS.*[30]

Since *Maricopa* was decided, the Agencies have struggled to determine its proper scope. Read for all its worth, *Maricopa* might be said to prohibit any fee-for-service contracting by a physician-sponsored network. But the Agencies have not read the decision this broadly, and for good reasons. *Maricopa* was decided by a closely divided Court and is in significant tension with other Supreme Court cases holding joint arrangements to be subject to the rule of reason.[31] Indeed, the strictest reading of *Maricopa* might prohibit even the robust programs of clinical integration considered in *MedSouth* and *GRIPA*.

Further, the principal issue before the Court in *Maricopa* was whether maximum price-fixing should be treated differently under Section 1 of the Sherman Act from minimum price-fixing. In upholding the application of the *per se* rule to both forms, the Court had no need to – and did not – consider the potential efficiencies of joint contracting. Nor did the Court consider whether the foundations' fee schedules had any actual harmful effect on competition.

In addition, *Maricopa* was decided in 1982, at the dawn of health care antitrust enforcement – only a few years after the Supreme Court held in *Goldfarb v. Virginia State Bar* that professions were subject to the antitrust laws.[32] Nothing in the decision suggests that it was intended to provide the final word on whether and under what conditions physician networks might qualify for rule of reason treatment. If anything, the decision can be criticized as a rush to judgment on a relatively new business form with which the judiciary lacked the experience usually considered necessary before a practice is deemed *per se* unlawful.[33]

Finally, the Supreme Court has long recognized that "the boundaries of the doctrine of *per se* illegality should not be immovable."[34] This principle applies to the antitrust Agencies as well as courts. Indeed, it is the Agencies that have often led the

way toward judicial abrogation of *per se* rules when "the economic realities underlying earlier decisions have changed."[35] For all these reasons, *Maricopa* should not be viewed as posing an obstacle to a more accommodating enforcement policy for physician networks.[36]

IV. A RECONSIDERATION OF EXISTING POLICY

This section describes a more flexible approach to analyzing the activities of physician networks engaged in joint contracting. It begins by describing the potential efficiencies of joint contracting by a physician network. It then considers whether joint pricing is "reasonably necessary" to the attainment of these efficiencies. Finally, it applies the rule of reason to the network's activities.

A. Efficiencies in Physician Network Contracting

The Agencies have long been skeptical of the potential for efficiencies in joint contracting by a physician network. In *GRIPA,* the Commission compared the transactional efficiencies of network contracting to those offered by a mere cartel.[37] The AMA believes the Agencies have been too dismissive. While the efficiencies offered by joint contracting in a physician network may not always be sufficient to warrant a favorable outcome under the rule of reason, these efficiencies should almost invariably be enough to avoid application of the *per se* rule. In the current environment, this is particularly true of networks formed to facilitate joint investment in and use of HIT.

Joint contracting by physicians in a network can result in significant cost savings both for payers and for physicians. On the payer side, joint contracting can make it possible for a payer to obtain ready access to a panel of physicians offering broad geographic and specialty coverage.[38] Because physicians still practice predominantly in solo practice or in small groups, creating a physician panel can be a

very time-consuming and expensive task for a payer seeking to enter or expand its place in a market. In its complaint in *United States v. Aetna*, the Justice Department noted that "effective new entry for an HMO or HMO/POS plan in Houston or Dallas typically takes two to three years and costs approximately $50,000,000."[39] When the initial task of network formation is undertaken by the physicians themselves, the costs of entry and expansion for payers may be substantially reduced. Joint contracting thus has the potential both to reduce costs for payers and to increase competition in payer markets. These are cognizable efficiencies, with real potential to lower premiums and expand coverage for purchasers. Any doubt concerning the intrinsic efficiency of physician networks is eliminated by the thriving rental network business that has emerged to service the needs of self-insured employers and even national insurers with inadequate directly contracted networks.

Joint contracting can also make physician contracting more efficient and lead to better informed contract decisions. Most physician practices are simply too small to afford to hire businesspersons and lawyers to review their contracts with payers. Such practices do not have the resources to analyze complex contracts. Whereas payers have sophisticated actuarial and financial resources that enable them to structure and evaluate complex contract proposals, physicians are often in the dark when they consider a contract. By pooling their resources, physicians can spread the costs associated with the analysis of payer contracts, and develop appropriate counter-offers that can benefit physicians, payers, and patients. The effect is to enhance the efficiency of the physicians' practices and make them more responsive to the demands of competition.

Likewise, joint contracting makes it much more practical for physicians to create a network that will facilitate collaboration on information technology, data collection, and other programs designed to monitor patient care and improve quality.

Indeed, joint contracting is essential for those physicians in small or solo practices who wish to participate in performance-based payment initiatives. P4P initiatives are often specifically targeted at medical groups or networks rather than small practices. As a Commonwealth Fund study on P4P recently noted:

> Smaller groups generally have few incentives for care coordination, as they usually do not receive payment beyond the evaluation and management fees they are able to bill for acute visits. However, by banding together under the umbrella of organizations, and becoming eligible for performance payments through [the Medicare P4P Demonstration Project] or similar incentive programs, they have more motivation and support for care coordination.[40]

Under existing enforcement policy, however, physicians in small practices must either lose out on such programs or take the risk that their venture will fall short of the Agencies' notions of clinical or financial integration.

B. Is Joint Contracting "Reasonably Necessary" to the Attainment of Efficiencies?

For a joint venture to qualify for rule of reason treatment under the antitrust laws, it is not enough that the venture generate efficiencies. In addition, to the extent that the venture involves agreements on price, such agreements must be "reasonably related to the integration and reasonably necessary to achieve its procompetitive benefits."[41] This requirement that price restraints be "ancillary" to the procompetitive features of a joint venture is well established in the *Statements* and in case law.[42] We think that, in the context of a physician network engaged in the acquisition and deployment of HIT, this requirement is readily met.

The Commission gave the issue of so-called "ancillarity" extensive consideration in its advisory letters to *MedSouth* and *GRIPA.* In the end, the Commission found that joint negotiation of network contracts was ancillary to the networks' procompetitive purposes. For example, in *GRIPA*, the network asserted that

it could establish an effective program of care coordination among its members only if all physicians were contractually bound at the same time. Achieving this goal required that the physicians be represented jointly rather than individually in contract negotiations with payers. As the Commission stated:

> Identifying up front a set network of physicians, all of whom will participate in all aspects of the program of integration regarding all patients covered under all GRIPA contracts, on its face appears calculated to assure that those efforts will have maximum application and efficacy. And this can only be achieved if GRIPA jointly negotiates the contracts with payers on behalf of all of its physician members.[43]

In reaching this conclusion, the Commission considered the proposition that, because some programs promoting clinical coordination and quality improvement are initiated and administered *by payers*, a physician-sponsored program cannot "ever be 'reasonably necessary' to achieving the efficiencies of clinically integrated programs."[44] The Commission properly rejected this conclusion. The standard for "ancillarity," after all, is one of *reasonable* necessity, not absolute necessity. It does not mandate a "one-size-fits-all" solution. As the Commission recognized, "[d]ifferent types of programs may have different strengths and weaknesses, and the market should determine which programs are most desirable." Moreover, "the competitive restraints that may accompany integrated physician-initiated network programs must be evaluated for their reasonable necessity in the context in which they occur."[45]

The same reasoning should apply generally to physician networks that acquire and use HIT to collect medical data regarding the physicians' collective performance and use it to enhance quality. Joint contracting is reasonably necessary to the efficiencies created by an HIT-driven network for several reasons. First, as in *GRIPA,* the network may need an up-front commitment from its physicians to participate in all contracts negotiated by the network in order to ensure the integrity of the network's

program of data collection and analysis. Without such a commitment, the network cannot know in advance how many physicians will participate, and therefore cannot effectively determine the degree to which the efficiencies of its quality improvement program will be realized.

Second, joint contracting makes it much more practical for physicians to make investments in HIT to monitor patient care and improve quality. HIT systems require considerable investments in time and money. As noted in a recent Congressional Budget Office report, acquiring an office-based HIT system costs between $25,000 and $45,000 per physician, with an additional recurring cost of 12 to 20 percent of that amount in annual operating and maintenance expenses.[46] In addition to these out-of-pocket costs, physicians must also "devote considerable time to training, to personalizing the system, and to adapting their work processes to achieve the maximum benefits."[47]

Physicians cannot be expected to bear such costs without a reasonable prospect of making a return on investment.[48] Yet, as the CBO report notes, from the perspective of a small physician practice, most of the benefits of HIT accrue to payers and other third parties. For example, information technology systems may reduce the frequency of primary and specialty physicians ordering the same test. Although physicians are committed to increasing the quality of care and reducing unnecessary care, neither primary care physicians nor specialists reap an economic advantage by eliminating this duplication. Network formation provides a method for physicians to deal with this "externality" – i.e., to internalize the gains of HIT while spreading its costs, which in turn makes it more likely that physicians will invest in HIT. If in this process the network were to charge higher unit prices than individual members, there remains the potential for overall savings to consumers. As the Commission recognized in GRIPA:

> Higher unit prices may be of little concern to a customer if they occur within integrated programs that result in lower total costs (e.g., through elimination of unnecessary and inappropriate utilization of services) and higher quality (e.g., better medical outcomes).

GRIPA, at 27.

Third, joint contracting addresses a potential "hold out" problem faced by networks that develop HIT. As documented in the CBO report, HIT is characterized by network effects: Some of its benefits increase in value as more providers purchase and use interoperable systems. Accordingly, physicians may wish to postpone the commitment decision until more of their colleagues have purchased systems, allowing them to benefit from others' experience. More importantly, many physicians may decide it is better to wait and see if the organization succeeds than to join it up front. To solve this hold out problem, the HIT network needs the up-front commitment of its physicians to participate in network contracts. This commitment makes it more likely that the HIT network will achieve the necessary critical mass to achieve efficiencies. Potential hold outs who are not willing to make that commitment risk exclusion from the network's contracts.

Because network joint contracting is reasonably necessary to achieving the efficiencies associated with the adoption and implementation of HIT, networks involved in the use of HIT should generally be accorded rule of reason treatment. The required nexus between joint pricing and the potential for efficiency is even more evident when the adoption of HIT is linked to alternative payment mechanisms. For example, in the context of P4P initiatives, most solo or small physician practices lack the scale to participate. By teaming up with other practices in a network, small practices may gain the scale necessary both for care coordination and for the aggregation of data necessary to implementation of performance-based incentives. Accordingly, negotiation by a network of performance-based incentives tied to the achievement of specified

quality goals by the network's members should be treated as "ancillary" to the network's procompetitive purposes.

3. Application of the Rule of Reason

Once the efficiencies of joint contracting are recognized both as non-trivial and as "ancillary" to a network's procompetitive purposes, the rule of reason provides the appropriate analytical approach for balancing those efficiencies against the potential for harm to competition. In the case of a non-exclusive network – one that does not prohibit its members, in law or in fact, from contracting with payers apart from the network – the potential harm to competition is minimal. As explained above, without the ability to force a payer to do business with the network, the physicians have no mechanism for forcing up fees.[49] Non-exclusive networks therefore should generally be found lawful under the rule of reason, without the need for extensive analysis.

Exclusive physician networks may require a more searching examination under the rule of reason. A critical consideration at the outset is the percentage of physicians in the geographic market who participate in the venture. If a large percentage of the available physicians participate in an exclusive network, the network may have the potential to exercise market power.[50] In that event, it then becomes appropriate to look at the competitive effects. Among the potential procompetitive effects, exclusivity may reflect the physicians' enhanced commitment to working together in the network to achieve efficiencies. Without exclusivity, physicians might not invest in a joint venture by coordinating their work, purchase expensive technologies like HIT, pool knowledge by educating each other on best practices, or engage in forms of practice supervision to advance patient care. Concerns about externalities – that are acute in the context of HIT – may make it impossible for the network to have initial success. In addition, exclusivity may help address physician concerns that some

members will "free ride" on the network's efforts by using the jointly-developed HIT to strike their own separate deals with payers. It is well-recognized that exclusive dealing arrangements are a common method of preventing free riding.[51]

In the analysis of an exclusive physician network possessing high market shares and engaged in the acquisition and use of HIT, additional considerations under the rule of reason may include:

- How much capital and time have the physicians invested in the acquisition, operation, and maintenance of HIT?
- How effectively is the network using HIT to collect and analyze medical data?
- To what extent is the network able to document cost savings and improvements in quality resulting from the use of HIT?
- To what extent has the use of HIT enabled the network to participate in performance-based payment or other alternative forms of reimbursement?

As is always the case under the rule of reason, these considerations should be carefully examined to determine whether the network's procompetitive benefits outweigh its anticompetitive effects. The fundamental point, however, is that competitive harm should not merely be presumed, but should be determined based upon a full consideration of the record.

V. CONCLUSION

Price-fixing is, and of course should continue to be, treated as the most serious form of antitrust offense. However, the Statements overestimate the anticompetitive potential that networks lacking market power have on the ability to restrain trade. Arrangements that create plausible efficiencies while posing little risk of anticompetitive injury should not face summary condemnation.

Also, antitrust enforcement policy must adjust to market developments. Presently, however, the Statements impede the ability of physician networks to achieve

plausible efficiencies through joint contracting on a basis that would allow for the implementation of HIT and the participation in P4P and other quality initiatives.

Accordingly, the AMA proposes the following modifications of the existing Statements to reflect changes in the health care market and antitrust law and to provide greater flexibility for physicians to engage in procompetitive joint arrangements.

1. Physician networks supported by plausible efficiencies should not face summary condemnation under the *per se* rule or the "inherently suspect" standard. The Agencies should explicitly recognize that joint contracting is ordinarily reasonably necessary to the attainment of the plausible efficiencies associated with implementing HIT or participating in P4P, among other physician collaborations on quality improvement.

2. Non-exclusive physician networks – those in which the physicians are genuinely available to contract with payers separately from the network – should almost always be found lawful under the rule of reason.

3. Exclusive physician networks should be evaluated under the rule of reason. Absent proof of market power or actual anticompetitive effects, such networks should be found lawful. If an exclusive network is shown to have market power or to result in anticompetitive effects, the network should be viewed under a full rule of reason analysis that balances the anticompetitive effects against efficiencies created by the exclusive network. Among the expected benefits of exclusivity that the Agencies should explicitly recognize are the elimination of free riding and the removal of obstacles to the acquisition and implementation of HIT.

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[1] Congressional Budget Office, "Evidence on the Costs and Benefits of Health Information Technology," (May 2008) (hereinafter "*CBO Report")*, at 1.

[2] American Medical Association, Competition in Health Insurance: A Comprehensive Study of U.S. Markets (2007) at 5, available at http:www.ama-assn.org/ama/pub/category/9573.html.

[3] *Id.*

[4] *Id.*

[5] *Id.* at 2.

[6] *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 week).

[7] Affidavit of Professor David Dranove at 6-7 (May 13, 2008) submitted in United States v. UnitedHealth Group Inc. and Sierra Health Service Civil No1:08-CV-00322.

[8] Mark V. Pauly, "Competition in Health Insurance Markets," 51 Law & Contemp. Probs. 237 (1998).

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

[10] See Testimony from "Examining Competition in Group Health Care," Hearing before the Senate Judiciary Committee, 109th Cong. (Sept. 6, 2006), and "Health Insurer Consolidation – The Impact on Small Business," Hearing before the House Small Business Committee, 110th Cong. (Oct. 25, 2007).

[11] *In the Matter of North Texas Specialty Physicians*, FTC Docket No. 9312, slip op. at 46.

[12] *See* FTC Staff Advisory Opinion to MedSouth, Inc. (Feb. 19, 2002), at http://www.ftc.gov/bc/adops/medsourth.htm [hereinafter "MedSouth"] (acknowledging that many financially integrated IPAs have "experience significant financial difficulties under [capitated] contracts, and a number of the organizations [have] declared bankruptcy. In the wake of this experience, payers and most physician groups,…terminated their capitated contracts").

[13] *CBO Report,* at 18.

[14] *Id.* at 19.

[15] Office of National Coordinator for Health Informational Technology (July 2007).

[16] *Id.*

[17] *CBO Report*, at 19-20.

[18] *Id.* at 7.

[19] M. Rosenthal, B. Landon, et al., "Climbing Up the Pay-For-Performance Learning Curve: Where Are the Early Adopters Now?," 26 Health Aff. 1674 (2007).

[20] M. Rosenthal, R. Dudley, "Pay-for-Performance: Will the Latest Payment Trend Improve Care?," 297 J.A.M.A. 740 (2007).

[21] Pham & Ginsburg, *supra*, at 1596; *see id.* at 1590 ("One obstacle to performance measurement and incentive programs' have an impact remains the fragmented nature of U.S. care delivery systems.").

[22] U.S. Department of Justice & Federal Trade Commission, *Statements of Antitrust Enforcement Policy in Health Care* (Aug. 1996) (hereinafter "*Health Care Statements"* or "*Statements"*), at 72-73.

[23] Letter from Jeffrey W. Brennan, Asst. Director, Bureau of Competition, to John J. Miles (Feb. 19, 2002) ("*MedSouth").* When the FTC took a second look at MedSouth five years later, the network had decreased in size to 280 physicians. *See* Letter from Markus H. Meier to John J. Miles (June 18, 2007).

[24] Letter from Markus H. Meier to Christi J. Braun & John J. Miles (Sept. 17, 2007) ("*GRIPA"*).

[25] *Health Care Statements,* at 66.

[26] *GRIPA,* at 26.

[27] *Antitrust Guidelines for Collaborations Among Competitors* (April 2000) (*"Competitor Collaboration Guidelines")* at § 3.2.

[28] *Arizona v. Maricopa County Medical Society,* 457 U.S. 332 (1982).

[29] *Id.* at 356.

[30] *Broadcast Music, Inc. v. Columbia Broadcasting System,* 441 U.S. 1 (1979) ("*BMI*").

[31] *See, e.g., BMI,* 441 U.S. 1; *National Collegiate Athletic Association v. Board of Regents,* 468 U.S. 85 (1984) ("*NCAA*").

[32] 421 U.S. 773 (1975).

[33] *See* 457 U.S. at 367 (Powell, J., dissenting).

[34] *Leegin Creative Leather Prods., Inc. v. PSKS, Inc.,* 127 S. Ct. 2705, 2721 (2007) (overruling *per se* rule against vertical price restraints).

[35] *State Oil v. Khan*, 522 U.S. 3, 21 (1997) (overruling *per se* rule against maximum vertical price-fixing).

[36] The Fifth Circuit's recent decision in *North Texas Specialty Physicians* is not to the contrary. ___ F.3d ___ (5th Cir. 2008). Indeed, rather than finding a *per se* violation by the physician network in that case, the court viewed the network's activities under the rule of reason.

[37] *GRIPA,* at 23 ("Any joint marketing arrangement, and indeed any cartel, provides transaction costs efficiencies when compared to engaging in individual sales transactions in markets with numerous participants.")

[38] *See* F. Easterbrook, "Maximum Price Fixing," 48 U. Chi. L. Rev. 886, 898-99 (1981) (noting transactional efficiencies of joint contracting by physician network).

[39] *United States v. Aetna,* No. 3-99CV1398-H (N.D. Tex.) (complaint filed June 21, 1999).

[40] M. Trisolini, G. Pope, et al., "Medicare Physician Group Practices: Innovations in Quality and Efficiency," The Commonwealth Fund (2006), available at www.commonwealthfund.org/usr_doc/971_Trisolini_Medicare_physician_group_practices_i.pdf.

[41] *Competitor Collaboration Guidelines* at § 3.2.

[42] *See, e.g., NCAA v. Board of Regents of the Univ. of Oklahoma,* 468 U.S. 85 (1984).

[43] *GRIPA,* at 19.

[44] *Id.* at 17.

[45] *Id.*

[46] *CBO Report,* at 17 (and studies cited therein).

[47] *Id.* at 19.

[48] *Id.* (noting that "many providers cannot generate the additional income necessary to justify the significant investment in time and money that the adoption of such a system would require").

[49] *See* H. Hovenkamp, *Federal Antitrust Policy: The Law of Competition and Its Practice* § 5.6 (1994) (a non-exclusive physician network is "absolutely inconsistent with the economics of cartelization: no cartel could restrict its output and raise price if it permitted its members freely to come and go, or to make unlimited 'non-cartel' sales.").

[50] The effect of high physician market shares on consumer welfare depends on the pre-existing concentration of health plan purchasing power. *See* Roger Blair & Jill Herndon, *Physician Cooperative Bargaining Ventures: An Economic Analysis,* 71 Antitrust L.J. 989 (2004); Tom Campbell, *Bilateral Monopoly in Mergers,* 74 Antitrust L.J. 521 (2007).

[51] *See e.g., Continental T.V. , Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36 (1977).

ATTACHMENT

A

UNITED STATES OF AMERICA,

Plaintiff,

v.

UNITEDHEALTH GROUP INCORPORATED and SIERRA HEALTH SERVICES, INC.,

Defendants.

Civil No. 1:08-cv-00322

Judge: Ellen S. Huvelle

Filed: 2/25/2008

Affidavit of Professor David Dranove

I. Qualifications

I am the Walter McNerney Distinguished Professor of Health Industry Management at the Kellogg School of Management, as well as the Director of the Center for Health Industry Market Economics and the Director of *Health at Kellogg*. I have studied health care competition for over 20 years and have published numerous books and peer reviewed papers on the topic. My vita is attached.

I have also studied the Nevada health care market place, paying particular attention to physician markets in Clark County. This includes examining secondary data and supervising a physician survey. I am submitting this affidavit because I am concerned about the potential anticompetitive impact of the merger of UnitedHealth Group and Sierra Health Services, particularly the impact on the market for physician services.

II. Background[1]

The proposed merger between UnitedHealth Group and Sierra Health Services would create the largest private health insurer in Nevada. The Antitrust Division of the US Department of Justice (DoJ) has reviewed this merger and filed a Complaint, Competitive Impact Statement, and Proposed Consent Order that narrowly focus on conduct and a remedy in the output market for Medicare Managed Care insurance. Specifically, UnitedHealth will be required to divest its Medicare Managed Care offerings as a condition for DoJ approval.

I have extensively researched health care competition, including competition among insurers. I have also studied the Nevada healthcare marketplace, including conducting interviews and a

[1] The American Medical Association paid for the time I spent researching the Nevada market and preparing this affidavit.

survey of Nevada physicians that I describe below. In my opinion, the DoJ focus on the Medicare Managed Care market is too narrow. In particular, the proposed remedy is inadequate because it fails to address the potential for the United/Sierra merger to create monopsony power in the market for the purchase of physician services.[2] It also does not address the potential for a dominant insurer to limit competition by such arrangements such as most favored nation contracts and bundling of contracts.

In the remainder of this affidavit, I explain why I believe the United/Sierra merger raises concerns about monopsony power in the market for purchasing physician services and also why it poses a substantial threat of anticompetitive behavior in output markets. With regards to the issue of monopsony in particular, I am concerned that the DoJ did not apply the proper economic analysis. I discuss monopsony in detail in sections III-VI of this affidavit. Section VII presents a shorter discussion of other issues. My main conclusion is that the United/Sierra merger may pose a substantial risk of harm in the market for the purchase of physician services that would adversely affect both healthcare providers and consumers, and that this risk was apparently underestimated by the DoJ.

III. Theory of Monopsony Power

Market Definition

In order to determine whether a merger poses a risk of the exercise of market power, or in this case, monopsony power, it is essential to first define the market in which competition takes place. Markets are defined in both product and geographic dimensions. Competition between United and Sierra takes place in both input and output markets; I am focusing on input markets.

Market definition requires defining both a product market and geographic market. I will first consider the product market. Insurers purchase many inputs, including physician services. There are no adequate substitutes for physician services, due both to training and licensing laws. Moreover physicians are confined to supplying services within their training and licensures and cannot do something else in response to a decrease in compensation. Thus, the purchase of physician services represents a relevant product market.[3]

I believe that a relevant geographic market consists of an area no larger than the Las Vegas metropolitan area, which can be approximated by Clark County. This is a relevant geographic market from an input market perspective because physicians have limited alternatives in responding to a decrease in compensation. Physicians could not, for example travel to Los Angeles for additional business.[4] At the same time, insurers offering provider networks to Las Vegas area employers and employees could not expect to do business if their networks excluded Clark County providers. Thus, I believe it is indisputable that physician services in Clark County comprise a relevant market for antitrust analysis.

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[2] Merger analysis focuses on the potential exercise of market power. "Monopsony power" is the power to decrease prices paid to producers or service providers who have little opportunity to sell other than to the monopsonist.

[3] There may well be even smaller markets within the physician services market, such as markets for specific specialties.

[4] Moreover, from the output market perspective the market is limited to Clark County. Insurers must market their provider networks to employers, who in turn make the network available to their employees. Most firms draw their workers from local areas, such as metropolitan areas. For example, it would be impractical for a Las Vegas casino to offer its employees a physician network that relied on physicians outside of Clark County.

It Is Appropriate to Exclude Medicare and Medicaid

Competitive concerns arise whenever a firm, through merger, eliminates an important rival and gains the ability to influence prices. This is why market share calculations are so important to assessing mergers.

A critical issue in determining the likely effect of a medical insurer merger on the market for physician services may be whether to center the analysis on the commercial market share affected by the merger and to exclude Medicare and Medicaid, which are typically two of the largest purchasers in any medical market. The DoJ does not discuss potential monopsony power in the input market that I have defined, perhaps because it included Medicare and Medicaid beneficiaries in its calculation of buyer side market shares, and as a result the market shares of United and Sierra were not large enough to rise to the level of monopsony. But careful consideration suggests that the market for measuring monopsony power does not include Medicare and Medicaid.

A useful place to start thinking about this problem is to consider the more familiar problem of defining output markets. Suppose there are four firms – A, B, C, and D – equally dividing an output market. Suppose that firm A raises price by, say, $2 per unit. In the absence of collusive behavior, this effort is likely to fail, because consumers who are unhappy about the price increase will purchase the product from B, C, or D. This helps explain why antitrust analysts are rarely concerned about the potential exploitation of market power when there are many sellers in a market.

Now consider the same market with the same four sellers, only this time B, C, and D are capacity constrained. If A raises its prices, its consumers would either accept the increase or do without the product. They would not be able to take their business elsewhere. This gives seller A effective monopoly power over its customers. Thus, it is the ability of consumers to *redirect their business away from a high price seller*, and not the number of sellers *per se*, that limits a seller's ability to increase its prices.

The same intuition applies to monopsony. Suppose there are four purchasers of an input, again labeled A, B, C, and D. If purchaser A attempts to reduce the wage it pays for the input by $2 per unit, suppliers of the input would offer their services to purchasers B, C, and D. Thus, A's effort will fail. But if purchasers B, C, and D are constrained in the amount of labor inputs they can use in production, then sellers *will not be able to redirect their output* to these purchasers.[5] This gives purchaser A effective monopsony power over its suppliers.

With this intuition in hand, consider the market for physician services. Physicians who agree to participate in the network of insurer A accept a discounted fee from A in exchange for an expectation of higher volume. Physicians who do not agree to participate may still treat insurer A's enrollees as "out of network" patients, often requiring those patients to pay higher fees.

[5] Workers might offer their services to B, C, and D, but if these firms accept, they would have to lay off other workers, who in turn would face the same tradeoff as the new hires—work for A or stop working.

Suppose A reduces physician fees. As noted by the DoJ in their complaint against the merger between United and PacifiCare,[6] the ability of A to sustain this fee reduction "depends on the physician's ability to terminate (or credibly threaten to terminate) the relationship. A physician's ability to terminate a relationship with a commercial health insurer depends on his or her *ability to replace the amount of business lost from the termination* (emphasis added), and the time it would take to do so. Failing to replace lost business expeditiously is costly."[7]

In determining the potential exercise of monopsony power I assume the DoJ considered the options available to physicians. Physicians might refuse to contract with A. Insurer A's patients would then have to go out-of-network or seek a different insurer who has kept a broad network. (This is analogous to the case where the would-be monopsonist lowers its wages and suppliers offer their services elsewhere.) Physicians might be proactive, joining rival networks and encouraging patients (and their employers) to switch plans. As a result, insurer A might end up with fewer enrollees. In this way, the presence of rival purchasers is essential if physicians are to have a "credible" ability to terminate their relationship with insurer A.

Physicians cannot increase volume or revenue by persuading their patients to sign up for Medicare, however, because enrollment in these programs is limited to the elderly and disabled.[8] Nor can physicians collectively treat more Medicare patients, because there are a limited number of patients and there is no means to increase the volume of patients. Thus, insurer A cannot lose physician business to Medicare; Medicare's business is fixed. Thus, from the perspective of physicians, the Medicare population is fixed. An analogous argument applies to Medicaid.

Even if physicians could collectively increase their Medicare and Medicaid workloads, this would not be an attractive alternative because Medicare, and, especially Medicaid, typically pay significantly lower rates than do private insurers. Medicaid rates are so much lower than most private insurer rates that few physicians would consider dropping insurer A in favor of Medicaid business even if insurer A lowered its rates appreciably.

The above argument demonstrates that when defining a relevant market for contracting for physician services, and computing market shares in that market, it is appropriate to exclude Medicare and Medicaid. 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.

IV. Evidence on Monopsony Power

Physician Survey and Interviews

In my investigation I conducted physician telephone interviews in which I asked them about the competitive environment and how they might respond to the United/Sierra merger. Based on these interviews I developed and oversaw a survey of physicians in Clark County. We sent

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[6] *United States v. UnitedHealth Group Inc.,* Case No. 1:05CV02436 (D.D.C. Dec. 20, 2005), *available at* http://www.usdoj.gov/atr/cases/f213800/213815.htm

[7] Complaint at Paragraph 36.

[8] The exception is Medicare managed care, as recognized by the DoJ consent order.

surveys via e-mail, fax, and mail to the administrators of all 122 medical group practices identified in Clark County using the Universe File of the Medical Group Practice Association and to a random sample of 333 office-based physicians in the County, drawn from the American Medical Association Masterfile and oversampling primary care physicians and obstetrician-gynecologists. Twenty-four medical group administrators responded (for a response rate of 22.9% after adjustment for invalid and duplicate records). Seventy-three physicians responded (for an adjusted response rate of 27.5%). Additional details of the survey are included as an appendix to this affidavit.[9]

Survey Findings Pertaining to Monopsony Power

A purchaser has monopsony power if it faces "upward sloping supply." That is, the firm is able to reduce the price it pays for inputs without driving all of its input suppliers to other purchasers. One way to assess the potential presence of monopsony power is to determine whether suppliers have viable alternatives in the event they could not sell to the potential monopsonist. If a purchaser had monopsony power, then suppliers would respond in a variety of ways; some would sell to other purchasers, some would do nothing different, and some might even shut down operations. It is this range of responses – the varying degrees of leverage that a purchaser possesses over its suppliers – that characterizes upward sloping supply.

During my telephone interviews, I asked physicians how they would respond to the Sierra/United merger and a potential reduction in payments. Physicians offered a range of responses including closing their practice to doing nothing. To assess this issue more systematically, the survey included the following question: *"What, if anything, would your practice do if United and Sierra merged and you did not continue to have a contract with the merged health plan?"*

Here are excerpts from a sampling of responses:

> I'll go to California
> Close practice
> Leave town
> I would consider relocating to another state or join the VA
> This would hurt the practice tremendously. Actually I don't know what I'll do.
> Nothing at present
> Get on other contracts that will pay higher rates
> Continue to service other health plans
> Make do with remaining plans
> We would be out of network provider and try to increase the other plans available
> Discourage patients from getting United/Sierra health insurance

The range of responses confirms what my telephone interviews had suggested, namely that some physicians have a viable alternative to United/Sierra but that many others would be harmed by losing the United/Sierra contract. This suggests that United/Sierra would have varying degrees of leverage over physicians, which is consistent with the ability to exercise monopsony power.

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[9] The survey had several limitations. Due to the desire to maximize responses, the survey was kept deliberately short. This limited our ability to tailor survey questions to address specific economic issues. Despite the brevity of the survey, the response rate was too low to reach definitive conclusions. Even so, the findings were sufficiently suggestive that, in my opinion, the DoJ should have investigated these issues more thoroughly.

These data suggest that the United/Sierra merger may be creating substantial monopsony power within Clark County. It was incumbent upon the DoJ to explore this issue more thoroughly. Their complaint and the proposed order suggest that they failed to do so.

Market Concentration

In determining the competitive effects of any acquisition it is often important to measure the level of concentration in the market. Unfortunately there is no significant public information available to compute market shares in the market for the purchase of physician services by commercial health insurers. One useful proxy would be the output shares of commercial health insurers. While the Bureau of Health Planning and Statistics of the Nevada State Health Division Department of Health and Human Services (henceforth, the "Bureau") collects data on HMO enrollments by plan and county, its data on PPO enrollments is incomplete.

The consulting firm Interstudy offers an alternative source of information about HMO and PPO market shares through their Managed Market MSA Surveyor and Managed Market State Surveyor data bases. The American Medical Association has used these data to produce a report entitled "*Competition in Health Insurance: A Comprehensive Study of U.S Markets*". Based on the 2007 update of this report, I determined that the market shares for Sierra and United in the Las Vegas metropolitan area (which closely approximates Clark County) were 38% and 18% respectively. The combined market share is 56%. This combined share, as well as the increase in share, raise substantial concerns about monopsony power that the DoJ does not appear to have addressed.

V. Monopsony Power Can Harm Healthcare Consumers

Monopsony power can harm healthcare consumers in several ways. Part and parcel with a reduction in the compensation of physicians will be a reduction in the number of physicians who participate in the monopsonist's network. (This is the natural consequence of a monopsonist moving down its upward sloping supply curve.)[10] The patients who previously utilized the services of physicians who are no longer in the network must now either (a) select another, less preferred physician within the network, or (b) see their prior physician out-of-network and consequently pay higher out-of-network fees. Either way, these patients are worse off than before the exercise of monopsony power.

Even the patients of physicians who remain in the United/Sierra network may be worse off, because the reduction in the fees paid to these physicians may cause them to reduce the quantity and/or quality of services they provide. Physicians who receive lower fees will be forced to do more with less. This may result in longer waiting times as physicians are forced to reduce staffing. Economics teaches that physicians are to be expected to reduce their output; again, this is a standard prediction associated with upward sloping supply. Another standard result from

[10] When supply is upward sloping, a seller with monopsony power profits by reducing the wages it pays, relative to the competitive wage. By doing so, fewer suppliers offer their goods and services, so that the monopsonist ends up reducing the quantity of output it produces.

economic theory is that sellers who experience lower price-cost margins will have less incentive to maintain quality.[11] There is substantial evidence that this occurs in medicine.[12]

Responses to the aforementioned survey question *"What, if anything, would your practice do if United and Sierra merged and you did not continue to have a contract with the merged health plan?"* confirm these concerns about patient welfare. As mentioned previously, some physicians might close their practices. Here are some additional responses:

> Downsize practice
> See a lot less patients
> All patients would have to be self-pay under merged health plan
> Layoff staff and reduce number of physicians on staff
> I would consider having a cash only office

Several telephone interviews offered similar responses. All of these responses would have harmful repercussions for patients.

VI. Why Competition in the Output Market Would not Discipline United/Sierra

A firm might not exercise its monopsony power if doing so harms its consumers who, as a result, turn to alternatives in the output market. In other words, output market competition might discipline the would-be monopsonist. The nature of the provision of medical services works against such market discipline. Suppose that physicians in the United/Sierra network are forced to cut back services in response to fee cutbacks. One might think that this would devalue the United/Sierra products, leaving it at a disadvantage relative to the competition. In other words, if physician services are "public goods," whose quality applies to all of their patients, then the harmful effects of reduced monopsonist fees are felt by all patients and the monopsonist suffers no competitive harm.

There is a public good element in many physician decisions. If physicians reduce their office hours, this is likely to affect access for all of their patients. (Physicians who contract with a monopsonist could not normally limit their availability to the monopsonist'sf patients only.) Similarly, if a physician cuts back on staff and/or equipment, or invests less in continuing education, all patients would suffer. Of course, if the physician exits the market altogether, all patients suffer. If quality is a public good, as I conjecture, then the monopsonist can internalize all the benefits of fee reductions while the harm is felt by patients enrolled by all insurers. Thus, market forces do not necessarily discipline the monopsonist whose aggressive pricing causes quality to suffer.

Concluding Comments about Quality

Unfortunately, the DoJ complaint and consent order are silent on the issue of quality. In both the qualitative interviews and the survey conducted under my supervision, I learned about some of

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[11] See Spence, M. "Monopoly, Quality, and Regulation" *Bell Journal of Economics* 6(2), 1975 and Dranove, D. and M. Satterthwaite, "Monopolistic Competition When Price and Quality are Imperfectly Observable" *RAND Journal of Economics*, 23(4), 1992

[12] Dranove, D. *The Economic Evolution of American Healthcare* Princeton University Press, 2000 reviews this evidence.

the ways that fee cutbacks could harm quality. Some of the alternatives physicians mentioned included exiting the market, curtailing their hours, spending less time with patients and cutting back on staffing. In light of these responses, there should have been greater analysis of the potential impact of the United/Sierra merger on the quality of physician.

VII. Contractual Provisions that raise Competitive Concerns

The purpose of merger enforcement is to prevent the creation of market power or its exercise. In some cases, in order to prevent competitive harm from a proposed merger the antitrust agencies and the courts may impose some type of injunctive relief. In this case, I believe the DoJ should have sought to prohibit two types of arrangements: most favored nation provisions and all products clauses.

Most Favored Nation Provisions

In my experience, many large insurers exploit their size by demanding and receiving most favored nation status from providers. A most favored nation provision requires the provider to offer the dominant insurer the most favorable rate it offers to any other insurer. Both theory and empirical evidence suggest that most favored nation status harms consumers by discouraging providers from aggressively discounting to other insurers.[13] Most favored nation provisions may prevent other insurers from entering or expanding in the market through these favorable discounting arrangements. The DoJ complaint and the proposed consent order are silent on this issue. The DoJ should have required the combined United/Sierra to foreswear MFN as a condition for approving the deal.

Bundling and All Products Clauses

It is also my experience that large insurers often require providers to abide by "all products clauses" whereby a provider who wishes to be a preferred provider for one of the insurer's products must agree to contract for all of that insurer's products. I am particularly concerned about the ability of a large insurer to bundle products in different markets. In particular, I believe that the combined United/Sierra will have monopsony power in the market for securing physician services for privately insured patients. It may now use that market power to bundle together contracting in the Medicare Advantage and private insurance markets. Such bundling would not offer any obvious promise of efficiencies and should be viewed with skepticism by anyone promoting market efficiency.

It is not obvious from the DoJ complaint and consent order whether these issues were investigated or how they were resolved. The DoJ should have explored these issues and if they believed there was potential for such bundling, the combined United/Sierra should have been required to allow physicians to contract separately for private insurance and the Medicare Advantage program.

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[13] For example, see Scott Morton, F. "The Strategic Response by Pharmaceutical Firms to the Medicaid Most-Favored-Customer Rules" *RAND Journal of Economics*, 28(2), 1997 for an exposition of the theory and evidence from pharmaceutical pricing. The theory is broadly applicable to other markets including physician services.

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Appendix: SURVEY METHODS

Setup Procedures:
All documents were verified by project client. Documents included the cover letter and survey instrument with a version each for the medical group sample and one for the physician practice sample.

All materials included the logos and respective signatures from: AMA, the county medical society, and the state medical society of Nevada.

The project client provided the sample database of medical groups and physician practices, including the name and phone number of a contact

PRS provide the fax number and address for mailings in the phone calls, as appropriate.

Mailing Procedures Medical Group Sample:

On February 12, 2008 Population Research Systems (PRS) mailed the survey to the medical groups, with a cover letter and business-reply envelope, to the 122 medical group administrators in the Clark County NV medical group file. The outgoing envelope was addressed to the name of the person or the administrator, when available, otherwise the term "Practice Administrator" was included, for example:

Ms. Jean Smith or Practice Administrator
Desert Medical Group
1234 Pine Hill Drive
Las Vegas, 11111.

About 9-10 days after the initial mailing, PRS faxed another survey and cover letter, to all non-respondents from among the 122 group administrators.

Another 5 days later, the sample with non-responders, invalid or missing fax numbers was returned to the project client, who conducted a round of reminder phone calls and updated all invalid fax numbers. Contacted medical groups who requested another fax received one from PRS within 24 hours of that information being provided by the project client. PRS also send another fax to all invalid and missing fax numbers.

About 6 days after the reminder call, PRS sent another round of faxes to all non-responders.

Another 10 days later, PRS initiated another round of faxes to all non-responders, followed immediately by a second round of reminder calls conducted the telephone staff of PRS. PRS attempted every record until a respondent or answering machine was reached, and PRS telephone interviewers left scripted messages on answering machines (see below).

Telephone reminder script
Hi, my name is____, and I am calling on behalf of the AMA. Yesterday, we sent you a fax with a very brief survey about the United / Sierra merger in Clark County, and we are very interested in your opinion. Please take a few minutes to complete the survey and fax it back to the number shown on the cover letter. We will keep your responses confidential.

IF NOT RECEIVED FAX:

Can you confirm your fax number for me so we can send you another fax? _____

We appreciate your participation. Thank you

Response Rate
This effort resulted in a total of 24 completed surveys, out of a sample of 102 records. Of those 102 records, 7 records were invalid (group did not exist, was closed, wrong address/name) and 101 records were duplicates within the sample, resulting in 86 valid records. Out of those 86 valid records, 24 completes constitute a corrected **response rate of 28.2%.**

Count of IDs	
Status	Total
Complete	24
Invalid record	7
No response	61
Duplicate record	10
Grand Total	1021

Mailing Procedures Individual Physician Sample:

On February 12, 2008 PRS email the cover letter and survey embedded in the body of the email message to 353 physicians identified by the project client. PRS inserted the medical society logos into the email itself, as well as the signatures, similar to the Medical Group survey.

About 3 days after the initial e-mail, PRS faxed a reminder survey to all physicians who had not responded at that point. The cover letter for the fax was slightly different from the email cover letter to reflect the change of modus.

Approximately 8 days later, the sample with non-responders, invalid or missing fax numbers was returned to the project client, who conducted a round of reminder phone calls and updated all invalid fax numbers. Contacted medical groups who requested another fax received one from PRS within 24 hours of that information being provided by the project client. PRS also send another fax to all invalid and missing fax numbers.

About 7 days after the reminder call, PRS sent another round of faxes to all non-responders.

Another 6 days later, PRS initiated another round of faxes to all non-responders, followed immediately by a second round of reminder calls conducted the telephone staff of PRS. PRS attempted every record until a respondent or answering machine was reached, and PRS telephone interviewers left scripted messages on answering machines (see script above).

During this process, PRS noted that 13 records of the original sample were duplicates (duplicate email, address and fax number, and those records were replaces with another 13 records, resulting in a final total of 353 records.

Response Rate

This effort resulted in a total of 73 completed surveys, out of a sample of 353 records. Of those 353 records, 55 records were invalid (group did not exist, was closed, wrong address/name) and 13 records were duplicates within the sample, resulting in 285 valid records. Out of those 285 valid records, 73 completes constitute a corrected **response rate of 25.6%.**

Count of IDs	
Status	Total
Complete	73
Invalid record	55
(blank)	212
Duplicate record	13
Grand Total	353