American Medical Association

Physicians dedicated to the health of America

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Statement

to the

Federal Trade Commission and
  the Department of Justice
Hearings on Health Care Competition Law and Policy

RE: **The Impact of Monopsony on the
            Practice of Medicine: Market
            Definition, Competitive Effects and
            Countervailing Power Theory
            and Practice**

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April-May 2003

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The Impact of Monopsony on the Practice of Medicine: Market Definition, Competitive
Effects and Countervailing Power Theory and Practice

Stephen E. Foreman, PhD, JD, MPA
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The American Medical Association (AMA) appreciates this opportunity to offer comments to the Federal Trade Commission (FTC) and the Department of Justice (DOJ) on the third set of hearings on health care competition law and policy. The AMA is particularly pleased that the FTC and DOJ have chosen to focus on an area that has been largely ignored by courts and regulators: that of monopoly and monopsony power of health insurers. These issues are extremely important to the AMA because they directly impact the practice of medicine and the ability of America's physicians to continue to provide the best medical care in the world. These issues also are central to patients' ability to access high quality medical care.

I. OVERVIEW

The AMA believes that our patients – the true consumers of health care – will only receive effective, efficient, high-quality medical care if health care markets are fully-functional and competitive. The AMA also believes that growing consolidation and concentration in health insurer markets and in the market for the purchase of medical care imperils the competitive process.

Many health insurance markets across the country are highly concentrated and are not competitive. This is well-documented and should concern all parties in the health care system. Large health insurers are not guardians of the competitive process or the welfare of patients. That task is essential to the mission of FTC and the DOJ. The AMA believes that if this trend away from competitive markets continues, consumers will be harmed as both quality and access to care decline.

Therefore, it is necessary to establish competition in many health care markets, or at the very least, to permit an appropriate market response to deal with the imperfections that have already been produced. The AMA strongly urges the FTC and the DOJ to take firm action to deal with the issue of growing concentration in health insurance markets. Competition preserves patient choice in a way that fosters cost-efficient, high quality medical care. The AMA appreciates the opportunity to offer its comments about some of the factors that are contributing to the breakdown of health care markets and what it might take to make these markets "workable," if not perfectly, competitive.

During earlier workshops and hearings the AMA and several state medical societies have already expressed a number of concerns about the competitive process in the markets for health insurance. These concerns include:

- Apprehension about uneven and unfair enforcement of the antitrust laws;
- Problems with growing market concentration and market breakdown, market power imbalances, problem conduct by some market participants, excessive health insurer profits and reserves, lack of negotiating power for most physicians; and
- Rapidly rising health care premiums as further evidence of market breakdown.

The AMA was encouraged by the renewed commitment of the DOJ (announced in September 2002) to devote additional resources to scrutinizing health insurer mergers. The AMA would like to see the agencies go a step further, however. As a result of these hearings, we urge the FTC and DOJ engage in a comprehensive assessment and restatement of their policies regarding concentration in the market for health insurance. This restatement should make clear the position of the FTC and DOJ on the acquisition and use of market power by health insurers. Restated public policy should include the regulatory response to proposed mergers but should also outline procedures for dealing with existing levels of market concentration by health insurers. Any revised policy should also provide for a more level playing field between health insurers and physicians.

Moreover, to the extent that the FTC and DOJ determine that it is not feasible to establish competition in all health insurance markets and eliminate health plan abuses of market power, they should affirmatively permit the exercise of countervailing power and should define a range of prohibited conduct for health insurers with market power. Full and open competition in health insurance markets should be our goal. Until then, appropriate limitations on the exercise of market power and some countervailing power for physicians and other health care providers will be necessary for appropriate access to high quality health care for all.

A. FACTUAL BACKGROUND

A. Many health insurance markets are not competitive

There is ample evidence of an underlying industry trend toward the evolution of large, dominant, sellers of health insurance that are also large, dominant buyers of medical care. These firms are price makers in the market for health insurance and price makers in the market

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for medical care. They use their market power to generate substantial levels of profit and to maintain substantial surplus reserves.

Consider this fact: Over half of all commercially insured Americans are covered by the ten largest health insurers.[1] Many U.S. health insurance markets and the corresponding markets for the purchase of medical care are not competitive. During these hearings and in public reports various health insurance industry advocates have argued strenuously that the industry is competitive (or that most health insurance markets are contestable). The figures in Table 1 undercut those arguments. So do the facts reported in the AMA's *Competition in Health Insurance: A Comprehensive Study of US Markets* (2002).[2] While the study was discussed in detail at the February 2003 hearings, a few facts bear repeating:

- All of the PPO product markets in the 70 metropolitan areas in the AMA study are highly concentrated, 90% of the HMO markets are highly concentrated, and 87% of the combined HMO and PPO product markets are highly concentrated.

- In almost all of the highly concentrated markets there is at least one insurer with a market share in excess of 30%. In four out of ten markets, a single insurer has a market share in excess of 50%.

Health insurance industry advocates use a number of approaches to argue that there is competition where none exists. They first count the total number of firms licensed to sell health insurance products in a market as if all firms are equally competitive.[3] They claim that more firms indicate greater levels of competition. However, the particular facts of a given market are much more relevant.

For example, in Market A there are fifteen firms, each with a six percent share. Market A is competitive. In contrast, in Market B there are also fifteen firms but one has a 75% share and fourteen others have less than a two percent share each. Market B is not competitive. In fact, in a health insurance market with one or two dominant firms (one in excess of 50% or two that each have 30% or more market share) more firms indicate less – not more – competition because the market relegates each of the added firms to "fringe" status. The AMA *Competition* study indicates that most of the urban health insurance markets in the U.S. are similar to Market B.

To illustrate this with an actual example, InterStudy's Competitive Edge data set lists 23 HMOs operating in Philadelphia during 2001. No metropolitan statistical area in the country had more. A review of the 23 firms, however, showed that Independence Blue Cross (IBC) had a

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[1] 2002 Securities Exchange Commission filings. Table 1 contains enrollment figures for the ten largest U.S. for-profit (publicly traded) health insurers and the ten largest not-for-profit (generally regional) firms.

[2] American Medical Association, COMPETITION IN HEALTH INSURANCE: A COMPREHENSIVE STUDY OF US MARKETS, American Medical Association, (2003).

[3] Testimony of Stepanie Kanwit, Federal Trade Commission and Department of Justice Hearings on Health Care and Competition Law and Policy, April 24, 2003. Parenthetically, Ms. Kanwit's testimony attacks the *Competition* study for failing to include point of service product enrollment. This is wrong. The *Competition* study includes POS enrollment as part of HMO enrollment figures (as maintained by InterStudy) to reflect the fact that these products are competitive with one another.

69% HMO market share, and Aetna had a 27% HMO market share. Nine of the HMOs listed had no members in the area. Seven of the HMOs were owned by Aetna or IBC, and two offered no commercial coverage.

The second health insurance industry tack is to claim that competition exists because there are numerous types of health insurance products – each of which provides competition for the others.[4] For example, they claim that because many large employers are self-insured, this makes health insurance markets competitive or contestable. However, these arguments fail to consider the extent to which dominant health insurers provide a substantial amount of the coverage or services for each of the products offered in a market – including administrative services only (ASO) for self-insured employers. If a dominant carrier provides a dominant share of HMO, PPO, POS, fee for service and ASO services for self-insured employers, the existence of multiple products does not increase competition in the market.[5]

In short, competition in the health insurance industry has been seriously undermined. The structure of health insurance markets and the way that large dominant health insurers operate should be a great concern to policy makers and regulators. Therefore, some type of review is warranted.

B.   Increased market concentration corresponds with increases in health insurance premiums and increased health insurer profits

Dominant health insurers use market power to increase premiums and generate higher levels of profit. In 2001, 2002, and 2003 the health insurance industry, dominated by large firms, was able to increase health insurance premiums at double-digit rates: 11% in 2001, 13% in 2002 and 15% in 2003. Cumulatively, the premium increases during the last three years have exceeded 45%, with no end in sight.[6] Administrative costs and profits rose even faster.[7]

As shown in Table 1, the 2002 pre-tax profits of the ten largest U.S. *for-profit* insurers was $4.9 billion. The for-profit carriers' profits grew by 50% in 2002 alone (compared with 2001). First quarter 2003 profits for these firms were $1.6 billion - an increase of 42% over the first quarter of 2002. At this rate, 2003 profits for these companies could come close to $7 billion. In addition, in 2001, the ten largest *not-for-profit insurers* earned another $1.5 billion, and those figures are expected to be even larger for 2002 when annual reports are released.

As the AMA noted in its February 2003 testimony, the premium hikes and the large profit increases should raise concerns about the use of market power by dominant health insurers. The AMA also believes that this potential monopoly power translates into potential monopsony

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[4] Testimony of Lawrence Wu, Federal Trade Commission and Department of Justice Hearings on Health Care and Competition Law and Policy, April 24, 2003.
[5] The proportion of the fee-for-service and ASO business maintained by a market's dominant health insurer is most telling here. Employers must have the provider discounts that monopsony power can bring in order to make self insured plans work. Accordingly, they must use the dominant carrier in the area for ASO services.
[6] For example, Independence Blue Cross filed for a 26% rate increase for its indemnity product effective October 1, 2003, and Blue Cross of Northeastern Pennsylvania filed for a 46% increase. 33 PA. BULL. 2331 (May 9, 2003).
[7] Kaiser/HRET Survey of Employer-Sponsored Health Benefits.

power as these dominant firms purchase physician services. The combination of monopoly and monopsony power enables the firms to generate large levels of profit, even in a slow economy.

C. Physician payments remain flat while premiums and profits escalate

The health insurance industry wrongly asserts that a major driver of premium increases between 1999 and 2003 was substantial increases in "provider payment."[8] Physicians, however, are the smallest and most fragmented of the participants in health care markets. As might be expected, physicians have received almost no part of the substantial added resources generated by the health insurers' premium increases. Indeed, self-employed physicians' (61.5% of physicians in 2001) practice revenues (in real terms) fell by 1.5% per year between 1998 and 2000 while health insurers increased premium levels by double-digit amounts. The median real income of all U.S. physicians remained flat during the 1990s, increasing an average of 0.2% per year from $130,000 in 1990 to $132,800 in 2000.[9] See Figure 1.

The Pennsylvania market provides a specific example of the disconnect between premium increases and physician payment. Pennsylvania's Blue Cross and Blue Shield firms divide the state into four regions. The market for health insurance in each region is dominated by one of the state's four Blue Cross and Blue Shield carriers.[10] Between 1991 and 2001, Pennsylvania health insurance premiums (collectively) increased by 10% or more each year. These increases exceed the rates of inflation in consumer goods or medical care. See Figure 2. However, in real terms, payment per physician visit by all Pennsylvania health insurance firms (for private commercial insurance enrollees) declined 20% from 1994 to 2000. See Figure 3.

In fact, the most telling indication of the health insurers' power is the role they play in determining physician fees. Large health insurers impose most physician fee schedules on a "take-it-or-leave-it" basis.[11] This process, coupled with the secrecy surrounding the content of the physician fee schedules, is consistent with profit maximizing monopsony price discrimination behavior and an unwillingness to disclose.

D. Insurance premium increases exacerbate the problem of the uninsured

More than 42 million Americans are currently without health insurance coverage, and this number is rising. There are a number of complex reasons for this, but it is surely exacerbated by market structure problems that allow dominant firms to raise premiums at the same time that they report significant increases in profit margins.

For example, according to annual reports filed with the Pennsylvania Department of Insurance approximately 204,000 Pennsylvania residents lost their health insurance coverage during 2001. This represented an increase in the percentage of uninsured residents from 7.5% in 2000

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[8] Testimony of Monica Noether, Federal Trade Commission and Department of Justice Hearings on Health Care and Competition Law and Policy, May 7, 2003.
[9] Carol Kane and Horst Loeblich, *Physician Incomes: the Decade in Review*, PHYSICIAN SOCIOECONOMIC STATISTICS, American Medical Association (2003).
[10] Each has a market share in excess of 50%.
[11] The exception is limited primarily to insurers who negotiate with large physician groups.

to 9.2% in 2001.[12] At the same time, Pennsylvania health insurers increased premiums 13% in 2001 while generating nearly $600 million in profits.

E.   The wave of mergers in the 1990s has created anticompetitive effects

The 1990s saw a wave of merger activity in health insurance markets. Between 1995 and 2000, there were over 350 mergers involving health insurers and managed care organizations. The number of HMOs operating nationally dropped from a high of 652 in 1997 to the current level of 490.

Mergers of health insurance competitors have the potential to produce a range of potentially anti-competitive effects. The most direct problem relates to the ability of the new firm to raise price (or diminish quality). After the merger-wave peaked beginning in 1999, the health insurance industry began imposing a series of double-digit annual premium increases. The impact of these mergers on price and quality is an area worth further exploration.

Mergers and acquisitions of competing health insurers also have the potential to diminish employer alternatives. As industry concentration proceeds, fewer "brand names" remain in the market. When brand names merge, it reduces the total number of brand names and enhances the recognition factor of those remaining. Accordingly, mergers may have the effect of increasing brand name loyalty even though there has been no change in quality.

One of the greatest concerns regarding health insurance firm mergers should be the impact of the merger on potential competition. This is another area that has not been fully explored and also warrants further study.

II.   BARRIERS TO ENTRY IN HEALTH INSURANCE MARKETS

Consideration of barriers to entry to is essential to assessing the level of competition in a market. If entry is easy, even a high market share will not necessarily translate to market power. Any attempt to increase price, even by a monopolist, will be defeated by the entry of a new competitor. If entry is difficult, or is likely to be extended over a long period because of regulatory barriers or other market circumstances, then a competitor with a strong market position is more likely to be able to profitably sustain a significant price increase.

There are substantial barriers to entry in health insurance markets. The lack of entry into health insurance markets in the past three years (as health insurers post healthy profits), provides strong evidence of this.[13] Some of those barriers to entry include:

- Costs of regulatory approval, including capitalization requirements;

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[12] D. Koken, Unpublished Pennsylvania Department of Insurance Fact Sheet (April 16, 2003).
[13] At the FTC/DOJ Hearings on Health Care and Competition Law and Policy, Lawrence Wu of NERA testified that entry to insurance markets was relatively easy by using the examples of Houston and Atlantic City between 1994 and 1998. The data is not current and is not applicable to later years or other markets. Both Houston and Atlantic City have become more concentrated since 1998, and the share of the dominant insurer in each market has grown. In fact, between 1998 and 2001, the average number of firms serving the average metropolitan statistical area fell from 5.8 to 3.3. See Table 2.

- Developing credibility with employer-purchasers;
- Developing an effective broker network;
- Developing a provider network;
- Underpricing of premiums by incumbent firms.

There may well exist a "tipping point" in health insurance markets, where an incumbent's market share is so large that new entry is impossible.

A.   High costs of regulatory approval and capitalization requirements

Start-up health insurers must meet the statutory and regulatory requirements of the states in which they plan to operate. These include, strict, and substantial capitalization requirements. It is common for a state to require an HMO or any form of insurance to demonstrate a significant net worth, to deposit cash and securities in the treasury and to require the entity to put-up additional sums to cover its anticipated losses in its initial years of operations.

In its 1999 challenge to the Aetna/Prudential merger, the DOJ noted these significant barriers to entry, finding 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." Moreover, in order to be financially viable, health insurers need to develop sufficient business to permit the spreading of risk.

B.   Developing credibility with employer-purchasers

Employers purchase the bulk of private commercial health insurance and often sign multiyear contracts. Changing health insurers is disruptive, expensive, and can create employee morale issues. Many insurers spend millions of dollars a year in local ads targeted to employer "open enrollment" season. Therefore, a new entrant in a market with a dominant insurer faces an uphill battle in trying to establish name and product recognition. This is even more difficult where there is a history of exit by other health insurers.

Also, some health insurers use a "75%" rule when contracting with medium and smaller firms. The health insurer will not sign with a firm unless 75% of their employees enroll with the insurer. The rule has the effect of an additional barrier to entry. Some employers might be willing to offer a new health plan as an additional choice for their employees, however, they are not willing to force all of their employees into a new plan.

C.   Building an effective broker network

Most medium and small employers use brokers to obtain health insurance. Health insurers trying to enter a new market must be able to appeal not only to employers and employees, but also to the health insurance brokers. In some markets, dominant health insurers use a system of exclusive brokers. To change health insurers, an employer must also change brokers. This adds an additional and potentially insurmountable barrier to developing business with that important market segment.

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D.   Developing a provider network

A new entrant must gain access to a sufficient number of physicians and hospitals to develop a network attractive to employers. As the DOJ recognized in the Aetna/Prudential matter, these are very substantial costs. For example, credentialing is costly for an existing firm, and for a firm that needs to build a new network, costs are even greater.

The problem can be exacerbated by contract term provisions that make it difficult for physicians to limit the number of an existing health insurer's patients (all products clauses, practice closure provisions) or limit the providers' ability to contract with new entrants (most favored nations provisions).

E.   Under-pricing of premiums by incumbent firms

Incumbent dominant health insurers usually have a substantial level of "surplus reserves" or other easy access to capital. They can use this capital to under-price health insurance premiums to ward off new entrants. While predatory pricing is almost impossible to establish factually, it is a real possibility in some markets.
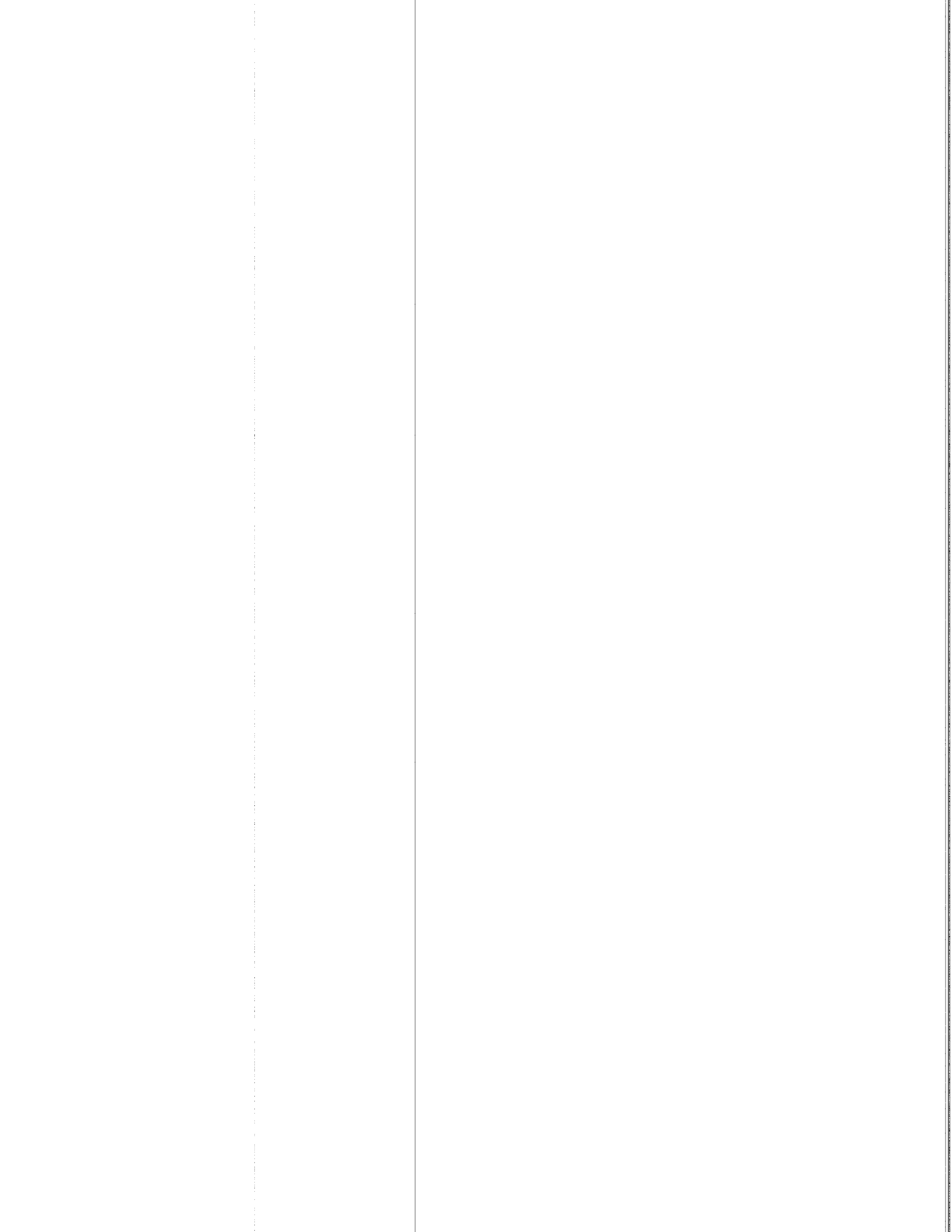
IV.   MONOPSONY POWER: MARKET DEFINITIONS

Courts and regulators have generally ignored the issue of monopsony power in markets. Underlying this is a belief that a monopsonist increases consumer welfare by lowering the prices it pays to suppliers. In health care markets, however, the exercise of monopsony power by a dominant insurer appears to be causing a number of distortions that will harm consumers and markets in the long run by reducing access to care.

The AMA urges the FTC and DOJ (as well as courts and regulators) to look more closely and broadly at monopsony issues. For example, what is the downstream impact of monopsony power? Do the reduced prices a health insurer obtains from physicians actually flow downstream to the patient in the form of lower health insurance premiums? In the current market place, where health plans are posting healthy profits while premiums are increasing at double-digit rates, this is certainly not the case.

Our discussion of monopsony power focuses first on issues of market definition, including a discussion of market share and elasticities of supply and demand, then focuses more closely on the harm caused by monopsonists in health insurance markets.

A.   Monopsony market definition

The threshold question posed by the FTC and DOJ is "whether and how to reverse the standard seller-side formula that asks about that the extent to which at-risk consumers can and will shift to other sellers in response to a post-merger small but significant and non-transitory increase in price." In essence, can we establish monopsony power through the ability of the monopsony health insurer to impose a "small but significant non-transitory reduction in physician fees?"

B.   A Buying Power Index

While questions of market definition are complex for determining monopoly power, they are even more complex in the context of monopsony. To begin, the buyer (health insurer) must have market power, and the seller (physician) must not have market power. Blair & Harrison have developed a formula which is an important starting point in monopsony analysis. The Buying Power Index (BPI) is:

$$BPI = S/(e + ?(1-S))$$

Under the BPI, buying power comes about when:

- A dominant insurer (buyer) makes a large share of the total purchases in the market ("Share" or "S");
- Physicians (sellers) are relatively unable to switch their sales to other buyers ("Switching" – supply elasticity or "e"); and
- Smaller insurers (fringe buyers) are unable to expand their operations to buy more of the physicians' and hospitals' services ("External Demand" or "?")

C.   The influence of market share

As the dominant health insurer's market share increases, its market power increases. At some point a dominant insurer's share can become so large that the conduct of other ("fringe") health insurers becomes irrelevant. How much market share is enough to infer monopsony power in the health insurance industry? There are some possible benchmarks. Blair and Harrison note that the 1992 Merger Guidelines use 35% market share as a "critical value." Areeda and Turner have suggested a 25% threshold.

While market share alone does not determine buying power, market share nonetheless is likely the most important factor when considering monopsony power. As will be discussed, price elasticity of physician supply is low in situations with a dominant payor, and "switching costs" for physicians are high. Price elasticity of demand for physician services is also low because most physicians have very little market power. Therefore, the health insurer's market share will be the determining factor under the BPI.

D.   Price elasticity of physician supply is low, switching costs are high.

Price elasticity of supply is the ability of the seller (physician) to switch to other buyers of the product. Sellers that produce "perishable" commodities have a perfectly inelastic supply curve because they cannot store what they produce for sale to other buyers if prices do not clear the market. As Blair and Harrison note, "labor is an extremely perishable commodity." After years of extensive and specialized training, physicians are no different from other highly trained and skilled professionals. They are trained for one occupation -- to practice medicine. It is certainly inappropriate to suggest that physicians should withhold services or change occupations in response to fee reductions by health insurers.

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For most physicians, their "price elasticity of supply" is close to zero. When physicians are presented with "take-it-or-leave-it" contracts from dominant health insurers, the decision often boils down to whether to continue practicing medicine or to retire. The option to refuse to contract with a health insurer is not available to physicians if that particular health insurer represents a substantial portion of their practice. It is simply not economically feasible.

Insurance industry advocates' suggestion that physicians may, somehow, be able to substitute other outlets for their services is simply insupportable. The DOJ has recognized the substantial switching costs that physicians face when dealing with a dominant insurer. In its 1999 challenge of the Aetna/Prudential merger based on Aetna's potential monopsony power over physicians in Dallas and Houston, the DOJ recognized that there are substantial barriers to physicians expeditiously replacing lost revenue as a result of switching health plans. It also noted that this imposes a permanent loss of revenue. The DOJ focused on two key barriers. First, physicians are limited in their ability to encourage "patient switching" because the patient may not be able to switch to another employer-sponsored plan in which the physician participates (or that option may not be available for many months). Second, the patient may not be in a position to absorb the substantial out-of-pocket costs associated with going "out of network."

Some health insurance industry supporters claim that physicians can drop enrollees of large dominant commercial carriers and replace them with Medicare and Medicaid patients. These are price-controlled government programs, and it is common knowledge that in most markets, Medicare pays substantially less than commercial payers. Medicaid pays even less than Medicare, and most physicians accept Medicaid patients as a public service.[14] Therefore, Medicare and Medicaid do not represent any type of equivalent revenue source and should not be considered as part of a switching analysis.

E.   Price elasticity of demand is not substantial

In the monopsony context, the determination of price elasticity of demand depends on the ability of physicians to sell their services to "fringe buyers." The underpinning of the concept is that faced with an unacceptable, "take-it-or-leave it" contract from a dominant insurer (Insurer A), the physician can walk away and provide all of his or her services to an a alternative, "fringe" carrier (Insurer B). If enough physicians are in a position to walk away, Insurer A will not be able to maintain a physician network if it engages in monopsony pricing. If there is significant price elasticity of demand, the market can deal with abuses of power by Insurer A, and no regulatory response is necessary.

However, in reality the ability of the fringe buyer (Insurer B) to increase its market share in response to physicians' willingness to provide service to more of their enrollees is limited. The primary limiting factor is the fringe buyer's ability to market health insurance to employers. As noted, employers are often locked into annual or biannual contracts with dominant providers and are reluctant to sever those relationships to contract with a fringe firm. In short, in markets with a dominant insurer, fringe buyers' elasticity of demand would not be substantial.

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[14] Testimony of H.E. Frech III, Federal Trade Commission and Department of Justice Hearings on Health Care and Competition Law and Policy, April 24, 2003.

F. Geographic and product market definitions

In order to define market share, the analysis of geographic and product market definition becomes as important in the monopsony setting as for monopoly. As with any antitrust analysis, market geographic and product market definitions depend on the facts and circumstances of each case. In the monopsony setting it is the physician's (i.e., the seller's) perspective that is crucial.

As described by Blair and Harrison, "the product market (for monopsony analysis) is composed of competing uses for the seller's output." In the case of physician services, particularly for physician specialists, the number of possible alternative uses is very limited. This compels a narrow product market definition. For example, in the market for physician services the appropriate product would be an equivalent or "substitute" specialty.[15]

In determining the geographic market for physician services, the question is, what is the logical area where physicians can sell their services to buyers? The relevant geographic market for physician services is substantially smaller than the entire service area of a health insurer. It might logically be a county or even part of a county. In large urban areas, it may be a certain area of the city. As Judge Richard Posner noted in the *Marshfield Clinic* case, "for primary care services, at least, the market is a local one." For some referral specialists, the geographic area may be somewhat larger, and in some rare circumstances it might constitute a multi-county area.[16]

The geographic markets for purchase of health insurance and for purchase of physician services are separate, but related. While the market for the purchase of health insurance generally will be broader, if a health insurer has a dominant market share at the regional level (50% for example), there must exist local areas within the region where it will, by definition, represent the same or a greater portion (50%) of physicians' patients. Monopsony power in the market for health insurance in the region infers the existence of monopsony power at a local level.

V. MONOPSONY AND CONSUMER HARM - HEALTH INSURANCE MARKETS

A. Overview of monopsony theory

The classic view of monopsony is that it creates substantial long-run (not necessarily short-run) problems precisely because the monopsonist holds down the prices it pays to suppliers. In the long run, this causes a number of distortions that can harm and even unwind a market.

A profit maximizing monopsonist (in this case, the health insurer) fixes quantity at the level that maximizes profits in the downstream markets where it sells goods or services (the health insurance markets). This is the point where the monopsonist's putative demand curve intersects its marginal factor cost curve. The monopsonist health insurer is a price maker in the

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[15] *All Care Nursing Service, Inc. v. High-Tech Staffing*, 135 F.3d 740 (11th Cir. 1998).

[16] *Robinson v. McGovern, supra.* The market for open-heart surgeons is a 16-county area of Western Pennsylvania and West Virginia.

market for input factors (services provided by physicians). This means setting prices where the input suppliers' revenue (the fees and payments physicians received from the health insurer) just equal their marginal cost of production. However, the monopsonist health insurer does not fully understand the supplier's (physician's) marginal costs. In addition, other factors can intervene that push prices (physician fees) below the physician's marginal cost of supplying services. In the long-run, supply is reduced and social welfare suffers. Figure 4 illustrates the concept.

Figure 4 depicts a simple, long run industry level supply and demand curve where physician suppliers provide (quantities of) medical care services as shown by the curve labeled "supply."[17] For each price level there is a level of service that physicians (in the aggregate) are willing to provide. The demand for physician services (mediated by health insurers) in a competitive market is shown by the curve labeled "demand" in Figure 4. If the market were competitive, the quantity of physician services supplied[18] (Q*) would match the quantity demanded (point c in Figure 4) such that price would be set by the market at P*. This provides optimal social welfare. Social welfare is the sum of benefit to the producer (the physician) or producer surplus and the benefit to the consumer (the patient) or consumer surplus. The triangle acP* in Figure 4 shows patient benefit and the triangle P*C*e shows physician benefit.

Now we interject a monopsonist health insurer. The health insurer fixes the amount it purchases at the level where the "marginal factor cost" (the cost of buying the next unit of physician service) equals the value of the "marginal product" (what the insurer gains by adding one enrollee who wants the one unit of physician service). This is the point where the marginal factor cost curve meets the demand curve, point b in Figure 4. At this level of "demand" the monopsonist could fix price anywhere in the range between point b and point d. The monopsonist thus wants to drive the price as low as possible and selects C^M. Thus, the monopsony equilibrium is price C^M and quantity Q^M. Price is lower and quantity supplied is lower as well. Consequently, the monopsonist's suppressed price limits patient access. Consumer surplus rises (by C^MP*fd -bcf). Producer surplus declines (by C^MP*fd -bcf). Overall, there is a loss of surplus equal to the triangle bcd. This inefficiency loss to society (welfare loss) is called "deadweight loss."

B.   Monopsony market distortions lead to consumer harm

On the surface, the monopsony health insurer's ability to pay suppliers less than those in a competitive market appears to be beneficial because it potentially reduces price to the consumer (the purchasers of health insurance, ultimately the patient). This is the conceptual underpinning to health insurers' claims that they perform a public service by holding down the price of medical care services. However, this approach overlooks a number of distortions.

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[17] Discussion adapted from Roger D. Blair and Jeffrey L Harrison, MONOPSONY: ANTITRUST LAW AND ECONOMICS, Princeton, NJ: Princeton University Press (1993).

[18] In accordance with basic monopsony theory, most of the discussion here relates to price and quantity. In actuality, consumers (patients) demand price-quality bundles (quality at a price). How insurers and employers represent this demand introduces another distortion into the structure of the market. It can be modeled as an agency problem.

Individually and collectively these distortions cause much more harm than the benefits they actually produce.

First, the argument requires the monopsonist to pass along the benefits of the reduced input price to consumers. The large premium increases, increased profits, and increased number of uninsured persons is at odds with this.

Second, the health insurer monopsonist does not want to force physician suppliers from the market, at least to the extent that insufficient supply diminishes the quantity of medical care that is available and increases input price. But because the monopsonist may not know the physician supplier's cost structure it can miscalculate, driving physicians out of the market. Having forced the physician to his or her marginal cost production level, any unanticipated cost increases will result in a price below his or her marginal cost of production. If the health insurer refuses to increase price to cover the physician's unanticipated cost increases, physicians may leave the market, particularly if there are better alternatives available elsewhere.[19]

A third distortion produced by the monopsony setting relates to investments in new technology and innovation. If the physician has been forced to produce at his or her marginal cost of production there will be no incentive to invest in new technology. Over time, medical care will not advance.

Finally, there may be downstream effects of monopsony in the market for the purchase of insurance. As Herndon notes, monopsony health insurers can use the economic benefits of reduced prices in medical care services markets to protect and extend their monopoly position in the downstream market for health insurance.[20] The monopsony health insurer also can impose a number of contract terms on physicians that not only serve to enhance the monopsonist's economic benefits but also serve to increase barriers to entry into the market for health insurance.

C.   Monopsonists' price-making behavior is not welfare neutral

Some observers contend that because in the short term, physicians are not reducing the quantity of services and are not exiting markets in large numbers, monopsony price-making behavior is welfare neutral. Blair & Harrison[21] and Herndon[22] attempt to explain this seemingly inconsistent response of physicians using what they call an "all-or-nothing supply curve." Their explanation is that the physician's basic decision is whether to provide his or her services at the same quantity or withhold them altogether. Blair & Harrison and Herndon argue that in medical care (at least in the short run) the effect of lower prices imposed by monopsony health

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[19] There are certainly examples of this stemming from the current professional liability insurance (PLI) crisis. In some markets, including Pennsylvania, health insurer payments are not sufficient to physician costs in light of skyrocketing PLI costs. Physicians are leaving markets in these situations.

[20] Jill Boylston Herndon, *Health insurer monosony power: the all-or-none model,* JOURNAL OF HEALTH ECONOMICS, Vol. 21 (2002), pp. 197-206.

[21] Blair & Harrison, *supra.*

[22] Herndon, *supra.*

insurers is to "push" physicians onto an all-or-nothing supply curve that lies below the normal supply curve and has a greater elasticity of supply.

However, the all-or-nothing theory suggests that physicians agree to lower prices because they are "locked in" to their situations. This would indicate that the all-or-nothing supply curve (if it exists at all) should be above, not below, a normal supply curve.

Blair & Harrison and Herndon theorize that the implications of the monopsonist's short run decisions are not welfare reducing, because there is no reduction in quantity supplied. Consequently, the price reduction has no short run negative impact on social welfare. Since it transfers assets from physicians to health insurers its effects are "merely distributional" in nature.

However, these distributional effects are important and have consequences. Assuming that maintaining a high quality health care system is an important goal, physicians need to receive a fair share of system resources. This is in the best interest of America's patients. In this sense the distribution of resources between health insurers and physicians matters very much.

We agree with Blair & Harrison and Herndon that the long-run implications of the monopsonist's price reducing decision are welfare reducing because, over time, physicians will leave markets.

D.   Price discrimination is evidence of the exercise of monopsony power

To the extent that health insurers engage in buyer price discrimination (paying different physicians different prices), this is consistent with the existence and use of monopsony power. In fact, health insurer monopsonists use price discrimination to perfect their monopsony pricing. Cost minimizing monopsony health insurers pay physicians as low a rate as the physician or physician group will accept. The way to do this is to dictate fee schedules to as many physicians as possible (which is common) and to negotiate different rates with the rest that are still as low as possible.

In order to maintain pricing and bargaining leverage, the monopsonist must keep the payment terms confidential. For this reason monopsony price discrimination is generally accompanied by a secrecy agreement, forbidding the physician from disclosing the terms of any fee schedule. In short, the existence of payment differentials including the imposition of some contracts and negotiated terms for others, coupled with nondisclosure provisions in contrasts, provides good evidence of the existence and use of monopsony power.

E.   A health insurer without monopoly power may exercise monopsony power

A health insurer without monopoly power in the market for the sale of health insurance, could nonetheless exercise monopsony power. Suppose that Insurer A holds a 100% market share (in the market for the purchase of physician services) in the one county where Insurer B's market share is zero but in the entire region (a five-county area) Insurer B has a 76% share of the market for health insurance while Insurer A has 24%. Insurer A could be a monopsonist in the

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market for physician services at the county level without having downstream regional monopoly power in the market for health insurance.

F. Conclusion: Monopsony power

In a substantial number of markets across the country, dominant health insurers have the potential to exercise monopsony power to the detriment of consumers. In these markets, one or two large health insurers (buyers) have large market shares (30% or higher), physicians (sellers) in general have little or no negotiating power or ability to "switch" to other sellers, and the opportunity for fringe buyers to increase their market share is very limited.

Health insurers also are engaging in other problem conduct. This includes the use of substantial levels of excess health insurer reserves to undercut competitors and fend off new entry, and a range of problem conduct in business relations with physicians. This problem conduct in physician contracting includes "tying arrangements," like all-products clauses, and contracts that contain fee schedules that are not disclosed to the physician and that can be altered unilaterally by the insurer.

In addition, many health insurers forbid physicians to release or publish the fee schedules that they impose unilaterally (or that they present in a take-it-or-leave-it fashion – if they provide physicians with any fee schedule at all). We believe that the purpose for these restrictions is to enforce price discrimination. Certainly, to the extent the fee schedules are imposed and not negotiated, their mere publication should not be construed as any type of pricing collusion. Regulators might well consider whether state or federal regulation should require publication of any fee schedule unilaterally imposed on a physician as well as any fee schedule between a physician and a health insurer with a significant market share.

Moreover, allowing health insurers to act as market price, quantity and quality regulators is not good public policy. The regulation of markets requires regulators to be accountable to the public through executive and legislative oversight. Private firms simply do not provide the public an equivalent level of accountability.

VI. COUNTERVEILING MARKET POWER

The optimal solution to the breakdown of health insurance markets and the exercise of market power by dominant insurers is reestablishing competition. If regulators and the courts are unwilling to disturb the market power of dominant health insurers, however, it is essential that physicians be permitted to exercise counterveiling market power.

Where a dominant health insurer exercises monopoly power and does not pass all of the benefits of lower input costs along to employers (or the government), granting countervailing power to physicians to "level the playing field" can redistribute a *share* of the health insurer's monopoly and monopsony rents depending on the size and power of the counterbalancing physician group. Giving countervailing power to employers by permitting purchasing cooperatives can improve social welfare – as well as improving distributional consequences. In the long run, a level playing field can help preserve the health insurance industry and the

medical care infrastructure and will help maintain quality. While a perfectly competitive solution would be preferable, countervailing power is at least a better alternative than unilateral market power held and exercised by a health insurer with market power.

Reforming the antitrust laws to provide physicians some ability to jointly negotiate with health insurers remains a top priority of the AMA. The AMA has already testified on this subject, including the various ways in which consumers would benefit from physicians' ability to negotiate patient care contracts with health insurers instead of receiving "take-it-or-leave-it" contracts. We look forward to exploring this issue in more detail at the September hearings on physician issues.

VII.   CONCLUSION

The AMA appreciates the opportunity to address these important issues before the FTC and DOJ and others. We sincerely hope that exploration of these issues leads to a comprehensive reevaluation of the agencies' policies on concentration in health insurance markets. We look forward to a continuing dialogue with both agencies as they work to ensure that health care markets are competitive.

Table 1
Major U.S. Health Insurers
2002 Year For Profit and 2001 Non-Profit
Year- End Enrollment and Before Tax Net Incomes (Profits)

For Profit	2002	2002	2001	1Q2003	Nonprofit	2001	2001
	Enroll	Profit	Profit	%change		Enroll	Profit
Aetna	13.7	$ 450	$266	387	Kaiser	8.1	$ 142
Wellpoint	13.2	703	415	37	Highmark	3.1	210
CIGNA	13.0	579	730	-25	Independence	4.0	203
Anthem	11.0	645	320	92	BC BS MI	4.8	-5.7
United	7.8	1,400	913	7	BlShield CA	2.6	79
Humana	6.6	209	183	333	CareFirst	3.2	113
Empire	4.6	131	133		Regence	3.2	80
PacifiCare	3.0	222	56	82	BC BS IL	3.0	423
Coventry	2.0	226	135	92	BC BS FL	6.0	162
Health Net	5.5	356	138	36	BC BS NC	2.7	132
	80.4	$4,921	$3,289	42		40.7	$1,538

*Source: For profit health insurer SEC filings from companies' Internet sites and nonprofit health insurers from A.M. Best & Co., Best's Insurance Guide (2003).
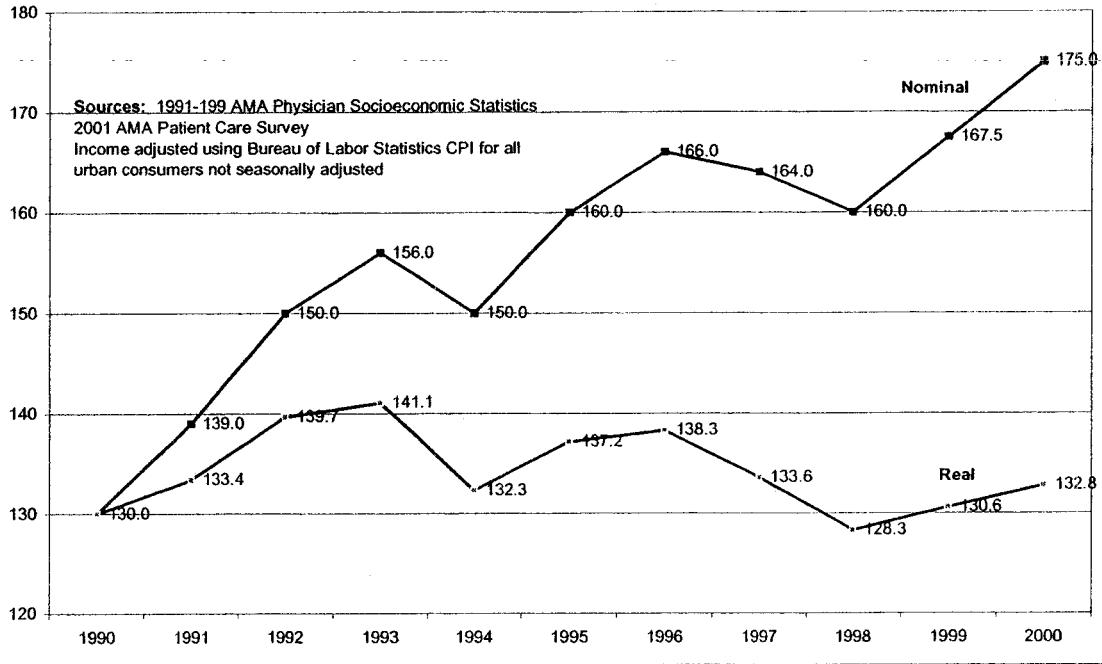**Enrollment and profit in millions. Profit is pre-tax.

Table 2
Number of HMOs by Major Urban Area
Stated and Corrected

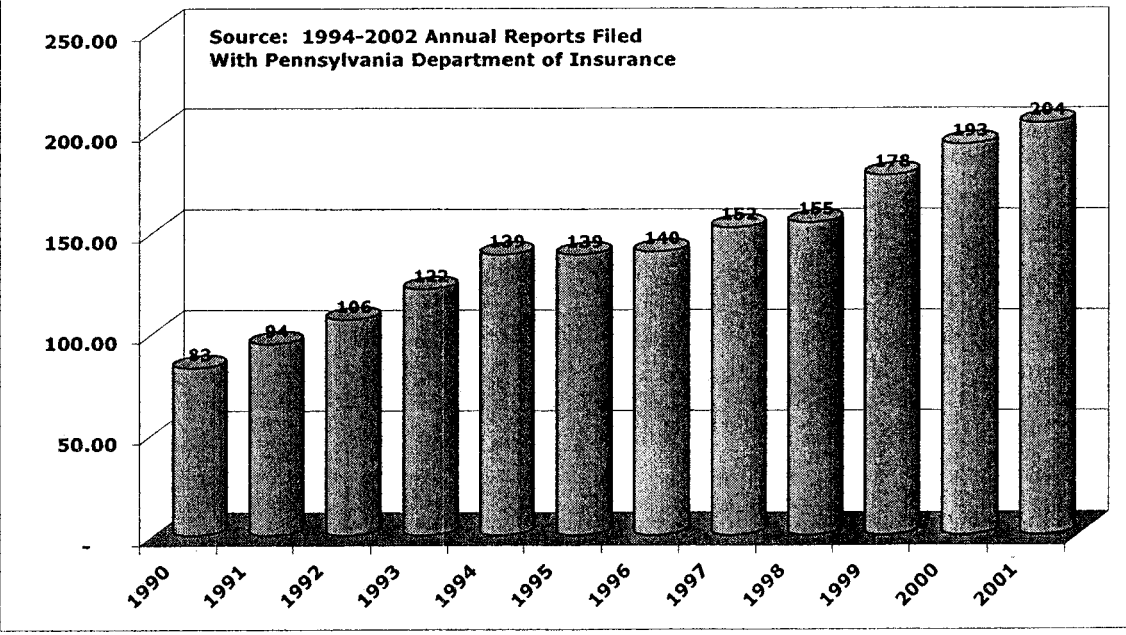| City	1994	1995	1996	1997	1998	1999	2000	2001	2002	Real	Pct
Atlanta	10	12	14	15	15	13	12	13	13	9	69%
Baltimore	17	16	16	12	13	14	14	14	13	7	54%
Boston	12	13	11	12	15	14	14	13	12	6	50%
Buffalo	3	4	7	5	7	6	6	4	3	3	100%
Charlotte	9	16	17	18	22	21	21	20	19	5	26%
Chicago	19	23	24	26	24	22	20	18	14	8	57%
Cincinnati	12	12	15	19	22	20	22	19	18	4	22%
Cleveland	14	14	16	17	18	19	21	21	20	7	35%
Dallas	13	14	18	18	23	22	21	18	17	8	47%
Denver	13	9	13	13	14	15	12	11	12	9	75%
Detroit	11	9	11	11	15	17	20	19	17	7	41%
Ft Lauder	6	11	14	14	16	16	18	21	21	10	48%
Ft Worth	8	11	14	17	20	19	18	16	15	6	40%
Houston	10	12	13	18	22	20	21	19	17	7	41%
Indianapolis	9	7	9	10	11	12	12	12	10	5	50%
Kansas City	12	15	19	21	20	19	18	18	18	8	44%
Los Angeles	21	22	23	20	20	21	21	19	17	12	71%
Miami	16	17	17	17	19	18	17	23	22	12	55%
Milwaukee	9	11	11	10	12	12	13	14	13	3	23%
Minneapolis	9	8	8	10	13	11	12	14	13	5	38%
New Orleans	10	13	11	12	12	11	11	9	8	6	75%
New York City	18	21	19	19	19	18	18	17	16	9	56%
Newark	11	14	16	15	14	13	12	13	12	6	50%
Oakland	11	12	15	13	15	16	15	13	12	9	75%
Orange Co	9	7	18	17	18	18	17	16	12	9	75%
Philadelphia	9	15	15	19	26	24	23	23	20	4	20%
Phoenix	8	10	10	11	12	11	11	11	11	9	82%
Pittsburgh	5	7	6	8	11	10	10	11	10	4	40%
Portland	10	11	9	10	8	8	7	6	6	5	83%
Providence	2	5	6	8	11	10	12	11	11	4	36%
Riverside	12	15	17	19	19	19	18	18	16	11	69%
Sacramento	11	12	14	13	14	14	15	14	13	7	54%
San Diego	11	12	14	12	16	15	14	13	12	9	75%
San Francisco	14	15	19	17	16	17	16	14	13	7	54%
San Jose	9	12	13	13	14	14	14	12	11	8	73%
Salt Lake City	8	8	8	8	8	8	7	8	8	3	38%
St. Louis	11	14	12	12	14	14	14	16	16	7	44%
Tampa	13	15	17	17	19	16	15	20	19	8	42%
Wash	17	17	19	16	21	22	22	21	18	8	44%
West Palm	8	12	13	14	16	17	16	19	18	6	33%
Total	**440**	**503**	**561**	**576**	**644**	**626**	**620**	**611**	**566**		**53%**

1994-2002 as stated by InterStudy. "Real" as corrected to eliminate firms with <10,000
enrollees, double counts and Medicaid only enrollment
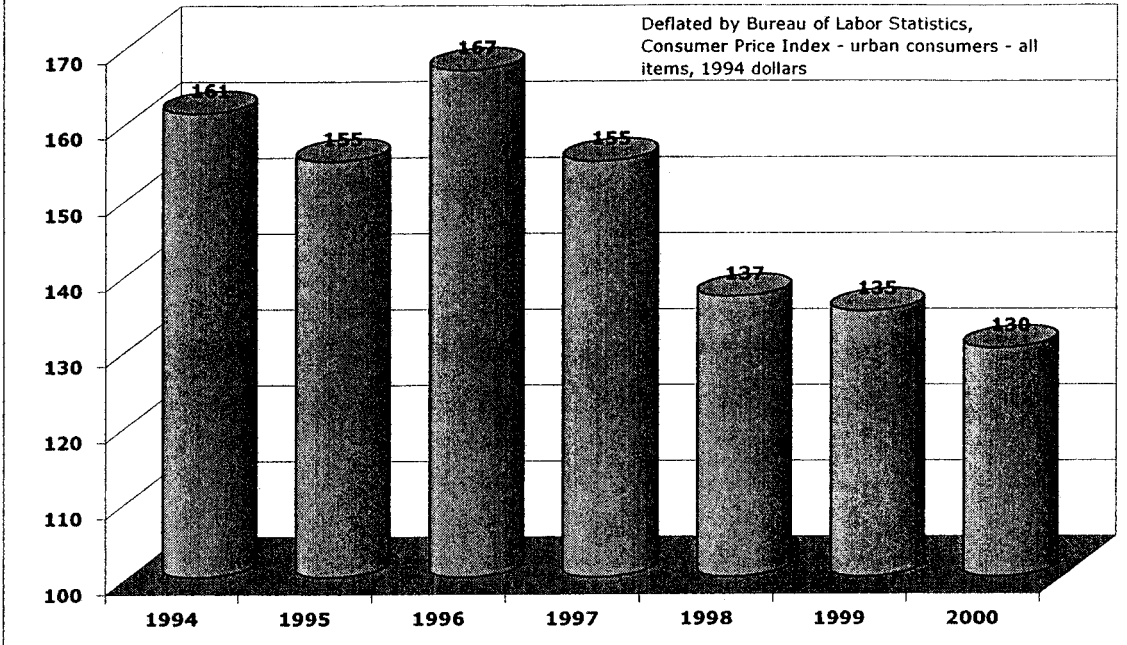Source: InterStudy, *Deluxe MSA Profiler*

Figure 1
Nominal and Real Median Net Income for Physicians
(Thousands of Dollars)

Sources: 1991-199 AMA Physician Socioeconomic Statistics
2001 AMA Patient Care Survey
Income adjusted using Bureau of Labor Statistics CPI for all
urban consumers not seasonally adjusted

Nominal

175.0
167.5
166.0
164.0
160.0
160.0
156.0
150.0
150.0
139.0

Real

141.1
139.7
138.3
137.2
133.6
133.4
132.3
130.6
132.8
130.0
128.3

Figure 2
Pennsylvania Health Insurance Premiums
Dollars per Member per Month

Source: 1994-2002 Annual Reports Filed
With Pennsylvania Department of Insurance

93
106
123
139
139
140
153
155
178
193
204

1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001

Figure 3
Pennsylvania Physician Payment per Visit 1994-2000
"Real" Dollars

Deflated by Bureau of Labor Statistics, Consumer Price Index - urban consumers - all items, 1994 dollars

Year	Payment
1994	161
1995	155
1996	167
1997	155
1998	137
1999	135
2000	130

Figure 4
Welfare Losses from Monopsony

Medical care cost

Marginal Factor Cost

Supply

a

b

f

P^M

c

C^1

d

Demand

e

O Q^M Q^* quantity