

ANTITRUST ISSUES BETWEEN PAYERS AND PROVIDERS

Thomas R. McCarthy*
Scott J. Thomas
National Economic Research Associates, Inc.
Los Angeles, CA

I. INTRODUCTION

A. Purpose of This Paper

1. The purpose of this paper is to review the possible antitrust concerns that could affect the managed care negotiations between payers and providers, merger reviews of health plans, or litigation pitting payers against providers. We will also provide general guidance about how to tell if these types of concerns reach anticompetitive levels or, in the case of managed care contracting and related litigation, are just the product of the normal give and take of commercial negotiations between parties of varying levels of bargaining strength.

B. The Managed Care Negotiation

1. Contract negotiations between payers and providers capture the price setting process in health care markets that is so often the focus of antitrust analysis. The typical health plan negotiation with a hospital or large medical group often involves the insurer and the provider submitting a number of proposals and counterproposals in an attempt to reach an agreement.¹
2. The proposals and counterproposals generally define obligations for covering a wide variety of services to be provided to a given population, reimbursements for those services, and the risk sharing provisions that apportion the financial responsibilities for managing the utilization of those services. There are a wide variety of contracts

* The authors are Senior Vice President and Vice President, respectively, of NERA. Questions, comments or other inquiries should be directed to either author at 213-346-3000.

¹ The typical negotiation involving an individual physician or medical specialist usually does not involve multiple proposals. Instead, the solo provider is frequently offered a single proposal that he or she can either accept or reject. This distinction may affect the analysis of potential monopsony contracting for physician services because a large portion of the market might or might not be contracted at a single price, a precondition of textbook monopsony (i.e., no price discrimination in the buying of physician services).

between insurers and providers, reflecting the many ways that health care markets try to finance and arrange for the delivery of care.

3. Historically, in exchange for lower rates, the insurer often promises to steer a significant proportion of its enrollees to the provider offering the most reasonable rates (or to the provider that is willing to bear risk). This is often thought of as volume discounting given by the provider to reflect lower transactions costs and greater budgetary certainty, but the discounts received can also be affected by the relative bargaining strength of the parties.
4. Similarly, in exchange for somewhat higher reimbursement rates, the provider may agree to include a most favored nations (“MFN”) clause, an exclusivity clause, or some other restrictive provision in the final agreement.
5. The outcome of this negotiation depends, in part, on the relative bargaining strength of the parties. A wide range of prices and risk sharing provisions in these managed care contracts is possible, given differences in negotiating skills, the mix of goals by each party, the financial status of the parties, and the supply and demand conditions in the relevant market. Bargaining strength is NOT the same thing as market power, though certainly, if one side possesses market power while the other doesn’t, that side will have a potentially commanding advantage in the bargaining, assuming bargaining takes place at all. If so, antitrust concerns and complaints may be well-founded.
6. Consolidation through mergers or joint ventures is sometimes pursued as a means for increasing bargaining “leverage” in these negotiations. The enforcement agencies must determine when consolidation or joint activity moves an insurer or a provider from a position of good bargaining leverage to a position of market power. Often, the transaction simply restructures the market toward greater efficiency and more realistic, long-term levels of capacity.
7. The Department of Justice (DOJ) has been showing increasing interest in monopsony power when reviewing recent health plan mergers. This interest began with the DOJ’s investigation and ultimate complaint relating to Aetna’s acquisition of Prudential’s managed care business in 1999, a complaint that contained a monopsony cause of action in seeking a curative divestiture in parts of Texas.²
8. Ironically, bargaining strength in many areas of the country has been shifting toward providers, not health plans. This has occurred for several reasons:

² *United States, et al. v. Aetna, Inc., et al.*, Civ. No. 3-99CV1398-H (N.D. TX, June 21, 1999).

- Increased consumer demand for more choice and greater access to a wide range of providers, in part, triggered by the so-called managed care “backlash”
- The demonstrated inability of many providers to bear risk and manage utilization effectively
- A general trend toward provider consolidation, especially given the recent history of unsuccessful antitrust challenges of provider consolidations.

C. Potential Allegations of the Parties in Negotiations, Mergers and Litigation Matters

1. The primary market that is being impacted by the negotiation between the payer and the provider (or related litigation) is the “input” market for provider services, where the providers are the sellers of the services and the payers are the buyers of the services.
2. By definition, since the providers are the sellers in this market, the main monopoly concern has to do with whether the providers can either unilaterally or collusively increase the reimbursement rates they are paid to supra-competitive levels. Similarly, since the payers are the buyers in this market, the main monopsony concern has to do with whether the payers can either unilaterally or collusively lower reimbursements rates (and the amount of provider services) below competitive levels.
3. A secondary market that may be impacted by the negotiation is the “output” market, in this case, the market for health care insurance, where the payers are the sellers of the insurance and consumers and employers are the buyers of the insurance coverage.
4. The insurer may argue that it is being forced to pay excessive rates (i.e., monopoly rates) to the provider since there are no adequate alternative providers that it can turn to in the area in question. This, of course, is the basic analysis that the antitrust agencies will explore when hospitals or physician groups merge. Private suits, such as the *Marshfield Clinic* case³, the *Dominican Santa Cruz* case⁴, and most staff privileges cases are born out of a primary accusation that a hospital or physician

³ *Blue Cross & Blue Shield United of Wisconsin, et al. v. Marshfield Clinic, et al.*, No. 94-C-0137-S (W.D. WI, January 6, 1995).

⁴ *Santa Cruz Medical Clinic, et al. v. Dominican Santa Cruz Hospital*, No. C93 20613 RMW (N.D. CA, August 13, 1993).

group has market power. While insurers have usually not sued providers in private actions, these types of cases could become relatively more frequent given recent shifts in bargaining strength toward providers. Such suits normally seek access and/or reasonable rates. In some instances (e.g., the *Marshfield Clinic* case and *U.S. Healthcare* case⁵), one insurer will sue another seeking to block the exclusive dealing arrangement that a particular insurer has with a provider that is considered by the plaintiff to be an essential facility.

5. The provider, in turn, may argue that it is being forced to accept below market rates (i.e., monopsony rates) from the insurer since the insurer covers a very large share of the patients in the area in question. This complaint is increasingly echoed by physicians in areas where health plan mergers are occurring, particularly in light of the 1999 *Aetna* complaint. That complaint included a claim that the acquisition of Prudential in Texas would create monopsony power for Aetna in the Dallas and Houston areas.
6. Claims of monopsony power on the part of payers are usually closely tied with concerns about the same payer also having monopoly power in the output market; that is, the market for health insurance (or some subset of that market, such as [fully-funded] HMO and point-of-service (POS) products, as the DOJ pled in the *Aetna-Prudential* transaction⁶). For the antitrust agencies in such cases, the remedy for both the monopsony problem and the monopoly problem is usually the same: challenge any part of the proposed health plan merger that may create monopoly power in the health insurance market, and that will simultaneously reduce monopsony power in the input markets for physician and hospital services. This was the nature of the settlement of the complaint issued by DOJ and the Texas Attorney General in the *Aetna* challenge, which ended in the divestiture of some of Aetna's health plan assets in Dallas and Houston, where both monopoly and monopsony would have allegedly resulted from the transaction.
7. Variations on these two themes include: the insurer arguing that it is being forced to accept more services or more provider locations than it wants to; the provider arguing that it is being forced to treat more types of patients or more insurance

⁵ *U.S. Healthcare, Inc. v. Healthsource, Inc.*, 986 F.2nd 589 (1st Cir. 1993).

⁶ Though it is not clear in the DOJ's complaint in the *Aetna* case, the product market on the health insurance (output market) side was restricted to *fully-funded* HMO and POS products. Even if we ignore the larger question of whether PPO products should have been included in the product market, a substantial amount of insurance capacity and provider network capacity for handling self-insured HMO and POS business is ignored with a product market definition restricted to fully-funded HMO/POS coverage. For a fuller discussion of this point and other insurance market issues in the *Aetna* case, see Robert E. Bloch, Scott P. Perlman, and Lawrence Wu, "A New and Uncertain Future for Managed Care Mergers: An Antitrust Analysis of the Aetna/Prudential Merger," *Antitrust Report* (October 1999), pp. 37-61.

product coverages than it wants to; one provider or insurer complaining that a vertically integrated hospital and insurer have foreclosed access to either the insurer's members or the hospital's facilities; and, the insurer or provider arguing that they are being forced to accept an MFN clause or other restrictive clause when they otherwise would not.

8. The remainder of the paper is organized as follows. Section II provides a few general observations about market power from the economist's point of view. Section III describes the monopoly concern and the economic criteria that can be used to examine whether market power from the selling side exists. Examples of these issues are provided. We then discuss in Section IV the monopsony concern and the criteria that can be used to examine whether market power from the buying side exists. We use the *Aetna* case and DOJ speeches and writings to analyze this new competitive concern by the DOJ when reviewing health plan mergers. Section V provides some brief comments on the related concerns of vertical restraints and tying. As we explain, those concerns are primarily offshoots of the monopoly and monopsony concerns and many of the same criteria can be used for examining their competitive effects. Thus, our paper concentrates on the more general monopsony and monopoly discussions. Finally, Section VI provides some concluding remarks.

II. GENERAL COMMENTS ON MARKET POWER

- A. To economists, and to many courts, seller "market power" of the type that rises to anticompetitive concerns is defined as the ability to raise prices *above* competitive levels and to exclude new entry or significant expansion by remaining rivals, such that the price increase can be profitably sustained.⁷ The "ability" to raise price and preclude entry may stem from anticompetitive conduct or from external forces, such as government regulation or other characteristics of the market. Seller market power in this context is synonymous with "monopoly power."
- B. When defined from the buying side, market power here is, similarly, the ability to lower prices for specialized inputs *below* competitive levels and to keep rival buyers of these inputs from entering to bid input prices back up to competitive levels. Buyer side market power in this context is synonymous with "monopsony power."
- C. Both monopoly and monopsony are long run concepts. That is, to test whether the market power is sustainable – i.e., whether monopoly prices will fall with the entry of new sellers or whether monopsony prices will rise with the entry of new buyers of the

⁷ Market power issues can also arise for anticompetitive reductions in quality as the mechanism by which price is, in effect, raised.

monopsonized inputs – we must consider whether, how, and when such entry will occur to correct the non-competitive market prices and whether that entry is sufficiently timely in the court’s eyes. As described below, identifying true market power means that the benchmarks that are used must be taken from clearly competitive markets that are in “long run equilibrium.” The economic concept of long run equilibrium means that resources have flowed into or out of the market to the point where both the efficient buyers and the efficient sellers of the inputs are making only normal levels of profitability – i.e., not so high that more sellers would want to come in if they could (or buyers exit), and not so low that sellers of inputs would want to exit if they could (or buyers enter).⁸

- D. In the merger context, the *Merger Guidelines*⁹ generally allow a two-year window for such adjustments. In effect, the “long run” is limited to two years. If the market’s predicted ability to adjust prices from worrisome levels to competitive pricing is not likely to occur within this span, the merger raises competitive concerns and will likely be challenged by the agencies.

- E. Because the *Guidelines* define worrisome price levels as any “small but significant non-transitory increase in price” (sometimes referred to as SSNIP), there can be a large difference between a worrisome price increase (or decrease, in the case of monopsony) that might result from a merger review and a true monopoly (or monopsony) price. For example, assume that a particular hospital merger allows the merged entity to raise price by 5-10% and that the price increase is not likely to be cured by new entry within two years. Therefore, the agencies would probably move to block the merger. But that price increase may result from moving an excess-capacity hospital market from a condition in which every hospital in the market is losing money to a position of, say, only breakeven (i.e., no profits, much less a normal level of profitability). While such a price increase may meet the SSNIP standard sufficient to raise concerns under the *Guidelines*, prices have not reached true monopoly levels.¹⁰ In fact, prosecutorial discretion might be warranted

⁸ There are some exceptions to this general observation that a competitive, long run equilibrium yields only normal profits for sellers; for example, a seller might have a legal and enforceable patent (or some other intellectual property barrier) that does not allow new sellers to come into the market in response to high profitability, even though they may want to do so. Such a patent may grant legal market power, though, of course, not all patents are good enough to create such market power for their holders. Similarly, one seller might have a unique cost advantage that the marginal, new seller cannot duplicate (say, access to a scarce input or a unique locational advantage). But, in competitive markets, entry at the margin will occur until the marginal, efficient firm is making only normal profitability. Because price and profit signals trigger the flows of resources in and out of alternative uses, economists look at whether these signals are functioning properly to reallocate resources to their highest value use.

⁹ U.S. Department of Justice and Federal Trade Commission, *1992 Horizontal Merger Guidelines* (1992).

¹⁰ The *Guidelines* assume, in general, that the starting price in the market prior to the merger is the competitive price, but not necessarily the competitive price in long-run equilibrium. Thus, the implicit benchmark could be well less or well more than the long-run competitive price. The *Guidelines* do allow the agencies to take significant disequilibrium effects into account in their antitrust analysis. Usually, however, the agencies would

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by the agencies in such a circumstance and the reviewing agency might well be persuaded to “pass” on challenging the transaction. But more importantly, any Sherman Act litigation brought against this merger should fail for lack of proof that monopoly pricing has resulted. Thus, price increases that may trigger merger concerns are not necessarily sufficient to trigger monopolization concerns. To an economist, the appropriate benchmark price for monopolization (or monopsonization) must be taken from a market that is in relative long-run equilibrium, not simply an apparent change in market power measured under the *Guidelines* as a predicted percentage increase (or decrease) in price. Put differently, while the economic reasoning embodied in the *Guidelines* is very well-considered and very helpful in implementing merger policy in the U.S., the *Guidelines*’ lessons are not always appropriate to Sherman Act cases.

- F. In summary, price levels can be an important measure of market power. But, analyzing prices in merger reviews can be very different from analyzing prices in monopoly or monopsony cases. Further, the appropriate price benchmarks for analyzing monopoly/monopsony problems are prices found in similar input markets that are in long-run competitive equilibrium.

III. MARKET POWER ON THE SELLER SIDE OF THE INPUT MARKET: THE MONOPOLY CONCERN

- A. Historically, monopolization has been the main focus of the antitrust authorities and of private litigation. But, in our experience, most monopolization cases against providers have been filed by other providers. The stereotypical case involves a physician’s loss of privileges or failure to be granted privileges at the hospital of his/her choice. Because many hospital markets have long been characterized by excess capacity, monopoly overcharge cases brought by insurers against hospitals have been relatively uncommon. That does not mean that insurers have not expressed concern about provider consolidations. Insurers and large employers have almost always been consulted by the agencies during a merger review for their views on whether hospital or physician group consolidation in the relevant market is likely to lead to higher prices. For the most part, however, insurers have shown little concern and have often supported hospital consolidation as a means for removing costs from the delivery system. There are, of course, notable exceptions that became court challenges of mergers.

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expect that very low prices benefit consumers, even if derived from severe excess capacity, and might not pass on a merger that could raise price unless the competition has gone so far as to create a failing firm for one of the competitors.

B. From the merger perspective, to the extent insurers have worried about provider consolidation, their economic concern has been that the providers will demand higher reimbursement rates in the input market and, thus, force insurers to charge higher premiums in the output market. The higher premiums, in turn, will result in a reduction in consumer welfare relative to the premiums that would be charged in a competitive insurance market had the provider inputs been purchased at competitive reimbursement rates. Moreover, if a given insurer has the least bargaining strength compared to other insurers in its market, that insurer may feel competitively disadvantaged in the insurance market. Examples of concerns about provider monopoly include:

1. In the merger arena, there are many hospital mergers that have been challenged by federal and state agencies. The most recent court challenge was brought by the California State Attorney General against the Sutter-Summit hospital merger in Oakland, California.¹¹ (For a review of this and other hospital merger challenges, see McCarthy and Thomas [forthcoming]¹², and Wu [1998]¹³.) In virtually all of the hospital merger cases, insurers testified by deposition and in court, some in support of the merger and some against it. Whatever their position, the principal issues addressed by the insurers were two: first and foremost, will the insurers have sufficient alternative providers to contract with if the merged entity does not offer reasonable pricing (i.e., can the insurers defeat an attempted price increase by moving their enrollees to alternative providers?); and, second, will the proposed merger produce efficiencies and, thus, lower costs? Though insurers' opinions usually count very heavily in the agencies' decisions on whether to bring a challenge, these concerns have not been sufficient in recent cases to convince the courts to block the merger being challenged. In the most recent FTC challenge, the *Poplar Bluffs* hospital merger case¹⁴, every insurance witness opposed the merger at trial. Only one employer testified that he supported the merger, and even his testimony was significantly undercut by his admission that he would not have much recourse but to use the merged hospital if prices were raised. The trial court moved to block the merger but, to the surprise of many observers, was reversed by the Eighth Circuit Court of Appeals.
2. The antitrust agencies have also investigated other complaints made by insurers against providers. One category of such investigations involves the conduct of physician

¹¹ *State of California v. Sutter Health System, et al.*, No. C99-03803 MMC (N.D. CA, 1999).

¹² Thomas R. McCarthy and Scott J. Thomas, "Geographic Market Issues in Hospital Mergers," in American Bar Association Monograph on Hospital Mergers, forthcoming

¹³ Lawrence Wu, "The Evidence Is In: A Review of the Market Definition Debate in Hospital Merger Cases," *Antitrust Report* (November 1998), pp. 23-41.

¹⁴ *FTC v. Tenet Healthcare Corporation, et al.*, No. 4:98CV709 CDP (E.D. MO, 1998).

networks and physician-hospital organizations (PHOs). Because physicians in both IPAs and PHOs contract jointly as a single network with insurers, the IPA or PHO must negotiate prices without going too far and facilitating price fixing among the physicians. These concerns are particularly strong when the IPA or PHO represents a large proportion of the area physicians, specialty-by-specialty. In at least three such cases, the antitrust agencies have scrutinized the joint behavior of just such extensive IPA/PHOs.¹⁵ In each case, the agency reached consent agreements with the IPAs, largely focused on devising less risky methods of implementing the messenger model on pricing and other economic provisions in the payer contracts. In the *Mesa County IPA* matter, the main change in conduct required by the consent involved not allowing the IPA's Contract Committee to review and advise members on the merits of the economic provisions of various contracts offered to individual member physicians (particularly contracts with new insurers trying to move into the Grand Junction, Colorado, area). In these cases, the insurers were concerned that the physician IPAs (1) fostered illegal collective bargaining by otherwise horizontal competitors, and (2) made entry and expansion very difficult for all but a few favored insurers.

3. Insurers have sometimes sued or threatened to sue providers over pricing or contracting behavior that the insurers felt represented abuses of market power by sellers in the input market. There have been relatively few of these types of cases, which may not be surprising given the excess capacity that has characterized many provider markets during the late 1980s and most of the 1990s. Examples include:
 - Blue Cross & Blue Shield United of Wisconsin's suit against the Marshfield Clinic and its exclusive HMO, the Security Health Plan of Wisconsin.¹⁶ The primary issue here was the Blues failed attempt to enter and offer an HMO plan in the central and northern Wisconsin area allegedly dominated by the highly-regarded Marshfield Clinic and its related physicians and hospitals. The fundamental issue was the Blues alleged lack of access to the Clinic physicians and those other physicians contracted with the Clinic's Security Health Plan. Though the Blues won the case at the trial level (in part, based on the trial court's agreement that HMO insurance represented a separate relevant product market), most of the trial court's findings were reversed by the Seventh Circuit, which found an "all health insurance" product market and that the physician services markets in the area – i.e., the barrier to entry allegedly erected by defendants to maintain its monopoly over HMO health plans in the area – had not been monopolized. Given the relatively rural location of the Marshfield Clinic and its strong reputation for quality

¹⁵ *United States v. Health Choice of Northwest Missouri, Inc.*, No. 95-6171-CV-SJ-6 (W.D. MO, September 1995); *United States v. HealthCare Partners Inc.*, No. 395-CV-01946-RNC (D. Conn, October 1995); and, *Mesa County Physicians Independent Practice Association, Inc.*, FTC Docket No. 9284 (1998).

¹⁶ Cited above as the *Marshfield Clinic* case.

in the area, this is exactly the type of monopolization case that might be filed no matter what the trend in health care markets more broadly.

- Santa Cruz Medical Clinic's suit against Dominican Santa Cruz Hospital filed in 1993.¹⁷ The main allegation of this suit was monopoly pricing for inpatient services following an allegedly illegal merger with AMI-Community, which, at the time, was the only other acute care hospital in Santa Cruz, California. Santa Cruz is somewhat geographically isolated by the Pacific Ocean to the south and west and a mountain range to the north and east between Santa Cruz and San Jose, which again gives rise to the claim of abuse by an isolated provider. While this suit was filed by physician clinic plaintiffs only, the original dispute also involved two HMO insurers (TakeCare and HealthNet). The clinic plaintiffs arranged to take assignment for the insurers' overcharge damages. Moreover, the physician clinic claimed standing to challenge the alleged monopoly prices based on the risk-sharing provisions in the insurance contracts that obligated the clinic to bear 75 percent of the excess costs of inpatient hospital services. Thus, in effect, the Santa Cruz Medical Clinic was suing in its capacity as an insurer. Though the case settled shortly before trial, substantial analysis was performed on identifying what constitutes a monopoly price and a competitive benchmark price for hospital services in a monopolization claim.¹⁸ This aspect of the case is discussed further below.
- More recently, more monopolization claims against providers have been threatened. For example, Blue Cross of California and its related company, Wellpoint, recently engaged in a very public dispute with the Sutter hospital system over access at good prices to the Sutter hospitals and physician clinics.¹⁹ Though not argued in these terms, but in antitrust terms, Blue Cross apparently claimed that Sutter was engaged in tying and full-line forcing by requiring contracting with all Sutter hospitals if Blue Cross wanted contracts with any of them. Because Sutter owns a few relatively isolated hospitals, it was argued that Sutter had market power in some locations that it was using as the tying product for better contracts with hospitals at more competitive locations. Sutter claimed that Blue Cross had paid too little for years and had cream-skimmed only the hospitals it wanted, market to market. The dispute was resolved without legal

¹⁷ Cited above as the Dominican Santa Cruz case.

¹⁸ A recent paper by an FTC economist has been written about this case, but that paper deals with geographic market issues in the merger context more than monopolization issues. See John Simpson, "Geographic Markets in Hospital Mergers: A Case Study," unpublished working paper (January 26, 2001).

¹⁹ Laura B. Benko and Deanna Bellandi, "The Rough and Tumble of It: Hospitals Flexing Their Muscles in Contract Disputes with Insurers," *Modern Healthcare* (March 19, 2001), pp. 53-56.

recourse when a large employer group in the San Francisco area intervened to mediate for the parties.

- C. As insurers move to build broad provider networks in the face of demands by consumers for greater choice and access, they will face greater pressure from providers to raise reimbursements substantially. Monopoly overcharge cases brought by insurers against hospitals will likely become more common.
- D. There are generally two ways that economists examine whether a provider has monopoly power. The first is the “market structure” approach, which involves identifying the relevant market that the provider competes in, then determining the provider’s share of that market, concentration and other market characteristics such as the ease of entry. This approach is inferential in that the analysis tries to identify whether the market conditions that might realistically lead to a competitive problem exist or not. The second is the firm performance or “competitive effects” approach, which involves comparing the provider’s performance (in terms of prices, output and profits) with the performance of “comparable” providers located in competitive markets. This approach examines whether there is any evidence that competition has been harmed based on a finding of supra-competitive prices and profits or output restrictions. Often, the two approaches are used together in a complementary fashion, borrowing elements of each where any information will provide insight as to the competitive conditions in the market at issue.²⁰

E. General Elements of the “Market Structure Approach”

1. In this approach, a *relevant market* must be identified. Determining market power first requires an understanding of the market that is in danger of being monopolized. All of the products and producers that can constrain the price of the good or service at issue must be considered as part of the relevant market. Thus, the relevant market has a product dimension and a geographic dimension.
2. For most hospital mergers or litigation issues, the *relevant product market* is usually defined as the cluster of services known as acute inpatient care, though this definition often provides only a first approximation of the market power issue that must be examined on a fact-specific basis. For example, because managed care insurers contract for a wide range of services with acute care hospitals, it is arguable that outpatient services are also part of the relevant product market. This is because rival outpatient providers may constrain the pricing of inpatient services, not simply by

²⁰ As a general matter, these same two categories of analysis apply to analyses of monopsony issues. That is, one can examine whether the input market at issue has the structural characteristics that are likely to produce monopsony results or one can look for competitive benchmarks in similar input markets to see directly whether there is evidence of monopsony pricing and output levels.

direct substitution but, rather, by the insurer being able to punish a hospital for high inpatient prices by diverting outpatients to, say, outpatient facilities not owned by the hospital. That is, the cluster of services at issue in the contract negotiation may be broader than just inpatient services. This indirect punishment can cause even isolated hospitals to moderate their inpatient pricing, and this bargaining approach is sometimes used in negotiations by payers. But relevant product markets can be more narrowly defined in some instances based on the nature of the claim. This might arise in connection with an alleged tying claim. For instance, the *Hyde v. Jefferson Parish* case²¹ involved the allegation that anesthesia services were tied to surgical services, not tied to all acute inpatient care services. Similarly, health plans may raise full-line forcing or tying claims if, say, the hospital required an exclusive contract on all inpatient care if the payer wants access to a service that might be deemed “essential” within a local area, say, high-level neonatal care. Thus, the relevant product market in hospital cases is a fact-intensive inquiry that must be consistent with the claim being made.

3. In mergers or litigation involving physicians, the relevant product market is usually defined on a specialty-by-specialty basis. One likely debate in such cases will be whether some specialties overlap competitively in the kinds of services performed (or could realistically overlap). For instance, do family practitioners (FPs) compete with pediatricians because they sometimes treat children? Do FPs compete with OB/Gyns because they sometimes deliver babies? Do podiatrists compete with orthopods because they both operate on bones in the ankles and feet? These questions again become fact-specific and can be informed by actually examining claims data to determine which physicians perform what kinds of services and, then, by determining whether the overlap is sufficient to constrain the pricing of one type of specialist by another type.
4. The *relevant geographic market* is a very significant issue in almost all hospital mergers or antitrust litigations. Most, though not all, merger challenges have been decided based on the court’s view of how big the relevant geographic market is. (See McCarthy and Thomas [forthcoming] for a complete review of geographic market issues in hospital mergers.) In general, hospital markets have been found to be very broad, usually covering multiple counties, partly because the margin of patients that must abandon the hospital to make a price increase unprofitable is often quite low, say around 10 percent to defeat a five percent price increase. The most recent issue debated in defining relevant geographic markets for hospitals has been whether patients can be steered to alternative facilities when, and if, the price goes up. Steering can be done in many ways: by capitation and budget incentives to primary

²¹ *Jefferson Parish Hospital District No. 2, et al. v. Edwin G. Hyde*, No. 82-1031 (E.D. LA, 1981).

care physicians (PCPs), by copayment provisions for insurers, by pre-certification processes, etc. To the extent that managed care has less power to steer in the face of consumer demands for greater access, it is possible that the size of the relevant geographic market may be somewhat smaller in future hospital merger analyses. The debate would then center on other competitive factors in disciplining hospital prices, such as the role of physicians and employers, incentives to collude, and, perhaps, the not-for-profit status of the hospital.

5. Once the relevant geographic and product markets are defined, the next step in the structural approach is to measure the share of the merging parties (or defendants in litigation) in the relevant product market. In general, low shares are dispositive in that it is extremely difficult for a provider with a small share of the market to exercise market power. While low shares may be dispositive in getting a case dismissed, high shares (say, over 50 percent) are not by themselves an indicator of market power. High shares are generally a necessary but never a sufficient condition for finding market power. Similar comments are appropriate to measures of market concentration, such as a four-firm concentration ratio or the Herfindahl-Hirshman Index (HHI). While the *Guidelines* indicate that a highly concentrated market is one with HHIs greater than 1800, this threshold is not closely observed by the agencies in hospital mergers, largely because the HHI is a measure of the likelihood that coordinated activities might produce a competitive problem. Such coordinated or collusive activities have not been given much credence in most health care cases since it is hard for hospitals or physicians to collude effectively.
6. Moreover, using market share and concentration data to analyze competitive conditions can be misleading unless at least two assumptions are reasonably approximated. First, the relevant market being used to calculate the shares must be reasonably correct. If the market is defined too narrowly or too broadly, the share measures simply reflect the weakness in defining the relevant market. For example, the market share of a health insurer can look much higher in a “[fully-funded] HMO/POS market in Dallas, Texas,” as was claimed by DOJ in the *Aetna* complaint, than it would if the relevant market had been defined as “all health insurance in Texas.” Second, the more product differentiation there is among the rivals being considered (i.e., the more the qualitative differences among the competitors), the less useful is share data. For instance, if the market includes a large urban tertiary hospital and a low-quality, low-acuity rural hospital just outside of the city, a share table listing both of these hospitals implicitly assumes that “a bed is a bed” – no matter where it is found. While often true (i.e., even the rural hospital probably handles a reasonable range of primary care services that can keep patients from going into the large urban hospital, thus stealing some margin of patients from the urban hospital), the more the differentiation, the less comparable the hospitals may be and the less suitable for inclusion in the same share table, particularly if some type of high-level care is the relevant product at issue.

7. High shares and high concentration signal that further investigation may be warranted, since these are almost always preconditions for identifying possible competitive problems (though again, not sufficient conditions for identifying such problems). The possible competitive concerns are two. First, high shares might indicate that a single hospital or physician group is truly “dominant.” This label does not simply mean that it is simply the biggest among many, as some provider’s marketing documents may sometimes trumpet. Rather, dominance in this context means that the firm can raise price profitably and earn excess profits on a relatively sustained basis, usually by (somehow) keeping their smaller rivals from expanding or new entrants from coming in. This potential problem is labeled a (negative) “unilateral competitive effect” because the dominant firm may be able to successfully raise price above competitive levels unilaterally. It needs no cooperation, coordination or collusion with its rival providers.

8. The second concern raised by high shares/high concentration is the “coordinated effects” issue. That is, if there are only a few firms each with high shares, they may recognize their economic interdependence to a degree where they “coordinate” their pricing, quality or output so as to attain higher prices and profits jointly. This coordination may be implicit (as in a signaling or price leadership model) or explicit (as in a cartel model). In health care, whether involving hospitals, insurers or even physicians, we are aware of very few examples of antitrust concerns that derive from concerns about collusive behavior. Staff privileges cases often assert a claim of a conspiracy between the hospital and the physicians who would benefit by keeping the excluded physician out. But these claims usually end up being only due process claims and, usually, make little economic sense because hospitals have no incentive to help their physician staff members attain monopoly status.²² Also, in health care, it is very difficult to reach a collusive understanding, monitor whether it is being followed (especially given the private negotiations that go on between payers and providers), or to punish any members of the cartel that have violated the collusive agreement. Generally, coordinated activities have not been prominent among the antitrust concerns arising in health care markets.

9. The next, and often final, step in the mechanics of the “market structure approach” is to examine the conditions of entry or expansion by rivals. In merger analysis, the entry and expansion must be timely, likely, and sufficient. That is, entry and expansion must be seen to occur in a reasonable time with an ability to constrain the possible price increases of the merged firm. Generally, this is at most a two-year window under the *Guidelines*. In antitrust litigation, the effect of entry on pricing often seems to be

²² See, e.g., the trial court and Ninth Circuit’s decision in *The County of Tuolumne, et al. v. Sonora Community Hospital, et al.*, No. CV-F-96-5380 REC DLB (E.D. CA, 1998).

expressed more as a belief, based on the evidence, as to whether new entry and the subsequent competitive process can be counted on to discipline the monopolist.

10. All of the market structure characteristics are then brought together into an expert opinion about whether the market is susceptible to monopolization. This analysis also introduces case-specific information in reaching an expert opinion. For instance, what is the role, if any, of sophisticated buyers? Is the market one in which competitive bidding takes place regularly? Is there a history of collusive behavior and was it successful? Is there sufficient excess capacity to absorb the amount of business that the merged entity or defendant must lose to defeat a price increase? All of these characteristics (and others) shape the final opinion about whether negative competitive effects are likely.

F. General Elements of the “Competitive Effects Approach”

1. The competitive effects approach is an attempt to measure directly whether competition has been harmed, or is likely to be harmed, as a result of the alleged anticompetitive conduct. In many ways, it is a superior approach to the market structure approach because it attempts to rely on direct evidence of competitive harm in a market. While this direct approach usually serves best in the litigation context because there is more likely to be an historical record to examine, this approach is also appropriate to merger analysis in some circumstances. In particular, there may already exist examples of markets with similar characteristics to the post-merger structure of the market being examined. If the comparables are valid, examining these benchmark markets may provide insight into the likely competitive effects of the merger in a different market.²³ Similarly, in both the litigation and merger contexts, survey research can sometimes provide data to test hypotheses about how buyers might react to price increases or other changes in market conditions. In almost all cases, the analysis is very quantitative. Below, we present a brief example from an antitrust litigation for which historical data were available, the *Dominican Santa Cruz* case mentioned above. From this example, the direct analysis of competitive effects can be demonstrated. While these economic arguments were never tested in court due to a late settlement in the case, they are instructive as to the types of economic analyses that will be needed in monopoly cases, which may increase in frequency given the shift away from selective and exclusive contracting.

²³ A good example of applying this technique in the merger context is found in the *Staples-Office Depot* challenge brought by the FTC. See *Federal Trade Commission v. Staples, Inc., et al.*, No. 1:97CV00701 (D.D.C., 1997). In that case, a statistical analysis was done to determine how pricing changed when there were one, two, three or more “office superstores” in a given area. If done well, which remained a dispute among the litigants, the results can indicate whether prices are significantly higher where only two superstores are present (as would be true post-merger in many areas) when compared to where three are present, as with the pre-merger market structure in many areas.

2. **Economic Evidence in the Dominican Santa Cruz Case.** The suit contained both a Clayton Act Section 7 claim of an illegal merger and a Sherman Act Section 2 claim for monopolization. The accusations, as described above, were that Dominican Santa Cruz was charging monopoly prices and was able to do so because of an allegedly illegal merger that occurred in 1990 – i.e., the acquisition of AMI-Community Hospital, which, at the time, was the only other hospital in the city of Santa Cruz. The accusations present an interesting mix of evidentiary demands. On the merger claim, if the merger was illegal, as claimed, almost any significant price rise of five percent or more might indicate that the merger created an anticompetitive effect under the *Guidelines*.²⁴ Even if true, Dominican argued forcefully that AMI Community was a failing firm at the time of its acquisition by Dominican. The hospital had been “shopped” and its financial condition was very weak and had not improved with previous attempts by AMI to correct the problems, including adding an open-heart program and contracting at very deep discounts with managed care to get more volume. Moreover, AMI Community was due for very significant earthquake code upgrades following the 1989 Loma Prieta earthquake, whose epicenter was nearby. Because there was little prospect of current or future profits and a clear need for substantial capital investment, AMI felt it had no choice but to put the hospital up for sale. Dominican bought the facility and converted it into a long-term care and ambulatory care facility, which required considerably less upgrading and remodeling.

3. While the legality of the merger under the Clayton Section 7 claim was never adjudicated, there was a very reasonable defense to that claim that had been developed: the failing firm defense. There is also an open question as to whether prices had risen significantly compared to similarly situated hospitals. Still, if the court had accepted plaintiffs’ claim that this was an illegal merger, the standard for determining an anticompetitive effect would probably have been an examination as to whether the merger had allowed a “small but significant, non-transitory increase in price” (again, SSNIP, which is often arbitrarily set at five percent as an initial benchmark). At the time, Dominican’s operations were generating a slightly negative margin and AMI Community was losing significant amounts of money. Thus, even a five percent price increase would not necessarily restore Dominican to the levels of operating margin enjoyed by healthy, stable hospitals in competitive markets. (The merger did not.) Thus, the resulting price increases could not possibly have reached monopoly levels. The price increases largely resulted from excess capacity being

²⁴ This is the conclusion found in Simpson [2001], cited above. It is a conclusion that is debated by those who were part of Dominican’s management at the time of the litigation. Our analysis at the time showed a small price increase but less than five percent and one that was not out of line in any way relative to other hospitals in California or in nearby San Jose during the same period.

removed in the Santa Cruz area and bringing the market closer to long run equilibrium.²⁵

4. The Sherman Act claims that a monopolization had occurred were analyzed separately from the Section 7 standards. Thus, an extensive analysis of Dominican's pricing and profits was undertaken. This included examining Dominican's managed care contracts, their overall average prices per day and per episode, their efficiency, and their profitability over the four (and sometimes five) years that had passed since the acquisition in 1990. But what is the economic principle that organizes that investigation? By definition, monopoly power allows sustained high pricing and profitability. Conceptually, then, to determine whether Dominican's pricing and profits were at monopoly levels, one must measure Dominican's pricing and profits against some benchmark of competitive pricing and profitability.²⁶ The proper standard is to look at pricing and profits by efficient, similarly situated hospitals in markets that are stable in terms of no strong incentives for new hospitals to move in or existing hospitals to exit; that is, markets at or near long run equilibrium. If the Dominican pricing and profitability had been out of line with these benchmark measures, a monopoly pricing problem may exist. If Dominican looked substantially like the benchmarks, then there would be no evidence that a monopolization had occurred.

5. In the mid-1990s in California, few markets met even this standard of relative equilibrium, as there has generally been a long-term problem of excess capacity in California, and in many hospital markets across the country during this time. We examined a sample of over 50 acute care hospitals with greater than 100 beds that were in business in California for the entire period of the study. We looked at many different measures of pricing levels for these hospitals during the pre- and post-acquisition period. These measures included, for example, prices per inpatient day, per episode, for non-government payers only, severity and casemix adjusted, cost of living adjusted, etc. We also looked at rates of increases in these prices over a five-

²⁵ Even if one ignores the possible competitive effects of hospitals in nearby San Jose, it is interesting to note that, in the mid-1990s, Sutter built a new small acute care hospital in Santa Cruz that focused on short stays and inpatient care for women, especially maternity care. This hospital has struggled financially from the beginning.

²⁶ There is a well-known problem in economics relating to the use of accounting measures of profits (e.g., operating margins, return on investment, return on equity) as evidence of market power. Accounting profits are not the same as economic profits. Because economic profitability is hard to measure in a way that meets the exact meaning for economists, accounting profits as a measure of market power, when analyzed at all, must be used very cautiously. To the extent that any information is given by these measures, it is important to look at multiple measures of profits (e.g., EBITDA, not just operating income or margins) over long periods of time, when possible. Accounting profits can be misleading, partly because of the way fixed costs and capital investments are financed and depreciated. Thus, short-term capital decisions can greatly affect the "snapshot" given by one year of accounting data. While these data must be used with great caution, they can provide some insight, particularly in identifying differences among hospitals over time.

year period. In addition, we looked at a variety of profit measures, and their averages and rates of increase over time. In no case was there evidence that Dominican was out-of-the mainstream of California hospitals. In the vast majority of measures, Dominican was below the statewide median for the measure. For some of the rate-of-increase measures in prices or profits, Dominican sometimes was just above the median, indicating that short-run prices had gone up very modestly. But the level of pricing and profits *post-acquisition* was still generally at or below the statewide median, indicating that no evidence of monopolization was present.

6. We also looked at Dominican's managed care contracts, especially those with the insurers that were implicated in the filing, TakeCare and HealthNet. We compared the Dominican contracts with the same companies' contracts at hospitals in nearby San Jose, an admittedly competitive area. Managed care contracts are very complex, so the comparison was done by "pricing out" the patient workload performed by Dominican under a given company's contract and then determining whether the same company's contract at a San Jose hospital would have cost more or less than getting that workload taken care of at Dominican. If Dominican were a monopolist, and if San Jose is in a separate market and forced to contract at competitive rates with managed care, then the cost of handling Dominican's workload in a San Jose facility should have been lower, especially after considering cost of living differences. In the majority of cases, the workload performed at Dominican was done at a lower total cost. There was no basis for saying that Dominican's contracts were more generous or at higher rates than the contracts at the San Jose facilities. Thus, there was again no evidence of a monopolization.
7. Finally, we also examined several measures of the productive efficiency of Dominican. Since Dominican is a not-for-profit facility, it might be argued that it had only reasonable levels of profits only because it let its costs rise due to inefficiency, thus masking high prices with the appearance of low profitability. (This claim is, of course, inconsistent with the concomitant finding of reasonable pricing by Dominican.) Alternatively, though there was no hint of quality problems at Dominican (in fact, the opposite was true; Dominican had won quality awards), perhaps Dominican was reducing quality as its means of taking out higher monopoly profits that were then used wastefully somehow by the not-for-profit firm. Neither hypothesis found any support in the data. As with the other measures, there was no indication that Dominican's production costs and patient care staffing were in any way out of line with other California hospitals.
8. The *Dominican Santa Cruz* case presents one example of measuring directly the economic effects of an alleged monopolization. We anticipate the need for more of this type of analysis in the future, given increasing payer complaints against providers' asking for significant price increases.

IV. MARKET POWER ON THE BUYER SIDE OF THE INPUT MARKET: THE MONOPSONY CONCERN

- A.** In the last five years, monopsony issues have clearly grown as an issue for public policy, for the antitrust regulators and, in a few instances, for the labor courts. The current heightened interest is reflected in at least two loosely related trends. *First*, the physician unionization and collective bargaining movement reflects physicians' reactions to the frustrations of dealing with managed care organizations. This movement has manifested itself in several important ways, including (1) attempts by otherwise independent physicians to be designated as appropriate groups for collective bargaining under the nation's labor laws (cases that have generally failed); (2) the introduction of legislation in some states to allow independent physicians to collectively bargain, including the passage of one relatively weak version of such a law in Texas; (3) the introduction of federal legislation under then-Representative Tom Campbell (R-CA) allowing physicians to collectively bargain with managed care; and (4) the class action lawsuits being filed by physicians and physician groups against managed care organizations for allegedly unduly influencing the way physicians deliver care under managed care contracts (i.e., the so-called "provider track" cases).
- B.** *Second*, beginning with the Aetna-Prudential complaint and consent agreement by the DOJ and the state of Texas, the antitrust authorities have started to turn their attention to the issue of monopsony. This concern has arisen in succeeding reviews of health plan mergers, though no new public complaint has resulted, to our knowledge. We expect this interest by DOJ to continue. Also, the Texas statute allows large groups of physicians to bargain collectively with a managed care insurer over price *only when it has been demonstrated that the insurer has monopsony power*, which is undefined in the statute. So there will certainly be future interest in identifying monopsony if Texas physicians want to bargain on price. Oddly, the interest comes at a time when the bargaining strength of managed care plans is generally falling, not rising. Still, pockets of potential monopsony problems remain, though, we would argue, they probably are few and shrinking.
- C.** The concern in these matters is that the actions of the insurer will lead to lower reimbursements in the input market. However, the antitrust authorities have not focused as much attention on this issue as on the monopoly issue since conventional wisdom suggests that the lower reimbursements in the input market could result in lower premiums in the output market which, by definition, would make consumers better off and not worse off. The antitrust laws, and their enforcement by state and federal agencies, have often favored consumer welfare over more general measures of social welfare and economic efficiency. In its recent *Cargill* and *Aetna* complaints,²⁷ the DOJ has moved to protect input

²⁷ *United States v. Cargill Inc.*, No. 99-1875 (D.D.C. filed July 8, 1999) and *United States, et al. v. Aetna, Inc., et al.*, Civ. No. 3-99CV1398-H (N.D. TX, June 21, 1999).

suppliers even where there is no evidence of harm to the competitive process or harm to consumers. This is explicit in the *Cargill* case, where, as the result of the proposed merger, many grain suppliers might get lower prices for their grain but there would be no significant effect on world grain prices or the prices of grain products to consumers.²⁸

- D.** In the *Aetna* case, the argument is subtler, but is also a central focus of the monopsony concern expressed by DOJ. There, the concern was particularly evident for protecting a subset of physicians that was heavily dependent upon Aetna and Prudential patients for a large share of their practices. There was never a showing of likely harm to competition in the input market for physician services generally and certainly no showing of harm to consumers overall. In fact, the DOJ *Complaint* and the accompanying *Competitive Impact Statement* (CIS) offer no data on Aetna's post-merger share of the buying and no data on whether physicians were getting low or high reimbursements relative to what physicians earned anywhere else, regardless of Aetna's (or any other insurer's) share in those areas.²⁹ For example, there was no demonstration that Aetna reimbursements were even low relative to other contracts that physicians signed voluntarily.
- E.** The monopsony claim in the complaint is based solely on argument that appears to be unsupported by data. Aetna, it is argued in the *Complaint*, would be able to "depress physician reimbursement rates." This power would then lead to a reduction in quantity or quality of physician services. As to the source of this power to reduce rates, there is only

²⁸ In the text of an October 1999 speech, the DOJ's chief antitrust economist at the time, Professor Marius Schwartz, stated, "Should antitrust be concerned with monopsony mergers which reduce welfare [for suppliers] but do not harm consumers?...[I]f a merger increases market power and thereby harms the firm's trading partners – consumers *or* suppliers – by more than it benefits the firm, antitrust concern is warranted. Insisting on consumer harm is overly narrow." [p. 8] To be clear, Professor Schwartz is not contradicting the normal tenets of his profession; he is stating the DOJ's public policy position. Earlier in the text of the speech, he points out that economists normally evaluate public policy interventions using an overall welfare (or social welfare) standard, not supplier or even consumer welfare alone. But he also clearly states that DOJ is entitled to weigh harm to different groups differently. That provides, perhaps, one reason that DOJ did not feel a need to work out the overall welfare effects of its monopsony complaints. Even with that acknowledgment of DOJ's weighing of preferences, it is a public policy fraught with dangerous distributional choices, particularly in a case like *Aetna* where it is the incomes of highly paid physicians being protected in the name of supplier welfare.

²⁹ From hospital merger work we have done in Texas, it has been reported to us in interviews that physicians in Dallas are very well reimbursed, in general, with commercial contracts that usually pay 130+ percent of Medicare reimbursements. In our experience, physicians in other areas usually get considerably less out of their commercial contracts, more like 110 percent of Medicare for HMO contracts. [Note: these figures are only reported in interviews and should not be relied upon as litigation-quality survey data. We point these figures out merely to show their importance to the discussion.] A proper analysis requires that a reimbursement level survey be done. Still, the antitrust agency might simply claim to be concerned about any falling reimbursements that might result from a merger, whether those reimbursements start their fall from the high end of typical reimbursement levels or from the low end where a monopsony concern might realistically arise. No such survey was done in the *Aetna* case, though we are aware of DOJ gathering reimbursement level data in other health plan mergers they have been reviewed since *Aetna*.

an assertion of a “*large share* of all the payments to physicians in the Houston and Dallas areas, and a particularly *large share* of the revenue of individual physicians for a substantial number of physicians in those areas [emphasis added].” This is in sharp contrast to the investigation made by DOJ on the supply side allegation against Aetna in the output market, which received considerable documentary, interview and statistical analysis by DOJ economists and lawyers. As discussed below, Aetna’s post-merger share of buying physicians’ services in Dallas and Houston would have been only 22-26 percent, as presented to DOJ by defendants – figures never mentioned in the CIS or calculated independently by DOJ. The only purpose of the monopsony claim and settlement appears to be to protect the subset of physicians suppliers that DOJ and the state of Texas apparently felt would be vulnerable in post-merger negotiations with Aetna. There was nothing more than a presumption of likely harm to the market and to a subset of suppliers.

F. The Economic Theory of Monopsony

1. Economic theory predicts that a monopsony is more likely to result in a *consumer* welfare loss in the output market only if several conditions are met: (a) the geographic extent of the input and output markets approximately overlap, (b) the seller side of the input market is competitive, (c) the buyer in the input market buys a very large proportion of the inputs – virtually a single buyer – and faces an upward-sloping supply curve for the input, (d) the buyer in the input market cannot effectively price discriminate in that market in the way that it “buys” inputs (i.e., the buyer pays a single price to each and every unit of input), and (e) the monopsony buyer also has market power in the output market. On the other hand, if these conditions are not met, then a monopsony in the input market will either increase or have no effect on consumer welfare in the output market.³⁰ The many conditions necessary for a consumer welfare loss from monopsony suggest why monopsony has been viewed by many courts as being relatively harmless as an antitrust issue.³¹ In many cases, but not all, consumers can be made better off by lower input prices. Even though fewer inputs may be purchased by the monopsonist – leading to lower output being produced – the

³⁰ In particular, if (e) is not met, then the input market can be “monopsonized” with possible harm to input suppliers, but many consumers may in fact benefit from lower prices in the output market. See, e.g., Mark V. Pauly, “Managed Care, Market Power, and Monopsony,” *Health Services Research* 33 (December 1998), pp. 1439-1460; and, Jonathon M. Jacobson and Gary J. Dorman, “Joint Purchasing, Monopsony and Antitrust,” *Antitrust Bulletin* 36 (Spring 1991), pp. 1-79.

³¹ See, e.g., *Kartell v. Blue Shield of Massachusetts, Inc.*, 749 F.2d 922 (1st Cir. 1984). For a more complete review of how the courts have treated monopsony issues, see Stuart I. Silverman, “Monopsony Power and Aetna’s Acquisition of Prudential’s Managed Care Plans,” *Antitrust Review* 4 (Spring 2001), pp. 1-8.

lower price to consumers in the output market will have value to those consumers still buying the output.³²

2. While consumers may be better off or at least not hurt by monopsony in many cases, that does not mean that monopsony, when really present, does not cause harm. Competitive input suppliers and overall economic efficiency are harmed in the presence of true monopsony, though the harm may be very small and very isolated to the monopsonized input market. This “harm” is largely because too few inputs are purchased by the monopsonist and society would prefer that more inputs were purchased under prevailing supply conditions. If the monopsonist is willing to buy fewer inputs than would be purchased under competitive conditions, then it can negotiate a lower price for the units it does “hire.” To understand why this may occur is a relatively simple theoretical proposition, but the problem occurs only under a set of conditions that are rarely observed in most input markets, and these conditions are even less likely in physician provider markets where the DOJ and Texas found a problem. While monopsony power is still possible in health care markets, such as input markets for nursing employment by isolated hospitals in rural areas, even there, it is likely to be rare.
3. In explaining the DOJ’s concern over monopsony problems in the *Aetna* case, the DOJ’s lead economist at the time, Professor Marius Schwartz, discussed the problem in terms of the “textbook case of monopsony.”³³ This starting premise is the source of most of the conclusions reached by DOJ in its finding of monopsony power in Texas. Unless it is first determined that the “textbook case of monopsony” fits the situation in Texas, then simply presuming that it does gets the analysis off on the wrong theoretical foot.
4. What is a textbook case of monopsony? First, a typical example might be coal miners in an isolated company town, where there is, in effect, only one purchaser of labor. Another example is the hiring of sugar cane cutters on an isolated island plantation. In Dallas and Houston, there were many other insurers that purchased physician services for their enrollees – as many as 15 or so HMOs in each city, not to mention countless PPOs and indemnity carriers, Medicare, Medicaid, county indigent services, Champus, the VA, and other health care contractors for physician services. Post-acquisition, Aetna would have only about one quarter of the physician services purchasing activity in these cities. That is a far cry from being “mono” or the only employer of physician services.

³² For an example of how this can occur when the monopsonist does not have market power in the output market, see Pauly [1998].

³³ Schwartz [1999], p. 3.

5. Second, the examples given suggest another key to “textbook monopsony”; that is, the laborers are not mobile and have no other local employment opportunities. The only employer is the coal mining company or the sugar cane plantation. For cultural or economic reasons, the laborers will not leave the area. Another way to think of this, more generally, is that the laborers are highly specialized. In their current location, they can only be hired to do the specific job they are doing. There are no other employers who are interested in paying them even the low monopsony wage. To a large extent, physicians are specialized, but they are not immobile and they do have alternative buyers of their services in most local markets. In fact, as one major example in Dallas, the majority of the physicians in the Genesis IPA, made up of some about 750 physicians, dropped *all* Aetna products prior to the merger rather than abide by Aetna’s “all products rule.” Moreover, the Aetna provider contracts did NOT contain any exclusivity clause binding physicians to work only for Aetna.

6. Third, in the textbook monopsony case – very much unlike the case for physician services anywhere – the quality of the product in the output market does not depend on how much you pay the labor inputs or how happy the coal miners or sugar cane workers are. Sugar made from the sugar cane cut under monopsony conditions is still just sugar to the consumer. Coal is coal. In medicine, the “labor input” – the doctor, in this case – interacts intimately and daily with the insurers’ prized commodity, its covered members. Unhappy physicians would not be Aetna’s best advertisement. This point is important because DOJ felt that Aetna would take monopsonistic advantage of the physicians who had a high proportion of Aetna enrollees on their patient rolls. That is, Aetna “could target physicians which [sic] it deemed more vulnerable post merger, and seek to impose worse terms selectively on them.”³⁴ This observation is important for two reasons: first, it indicates that Aetna was willing to turn its most important doctors into its angriest doctors, which few would consider good business strategy. Other companies, like PacifiCare, spend extra time training and assisting the physician groups that handle large blocks of their enrollees, and have even rushed in with financial aid when the physician group got into trouble trying to manage risk. Second, as discussed below, the ability to price discriminate in buying labor inputs undercuts the whole theoretical basis for monopsony problems arising in the first place.

7. Fourth, the basic result in a monopsony labor market is that the monopsonist buys less of the input in total. With less input used, the total output in the output market could fall if the output market is roughly of the same geographic scope as the input market, which is what DOJ argued in the *Aetna* case and has continued to use as the basis for

³⁴ Schwartz [1999], p. 6.

later inquiries about monopsony power. That is, the relevant geographic market for HMO/POS insurance is roughly the same size as a physician services market – the size of a city. In *Aetna*, there was no investigation of total market output, only the assertion that quantity and quality might fall and that Aetna patients might get less service, suggesting that not only will Aetna willingly anger its most important doctors but also its enrollees by allowing its physician panel to give the Aetna enrollees low quality care. “Lower prices paid to physicians by Aetna would likely have caused some physicians to drop out of the market, to curtail their hours, or to spend less time with each Aetna HMO patient.”³⁵ In addition, there was no discussion of why these responses were thought to be likely. It is nothing more than a theoretical prediction that output must somehow be affected if you believe a monopsony condition prevails. Moreover, without a sense of what an economically appropriate level of physician care is in Dallas or an appropriate level of income, there is no way to distinguish this worry from a simple movement down a supply curve. That is, if the market price for physician services falls, some physicians may choose to exit the market, as in any other profession. It has happened throughout the period during which managed care has grown, as demand for specialists, in particular, has fallen. To demonstrate that this exit of physicians is a result of monopsony requires proof that the post-merger reimbursement rates to physicians are actually lower than that found in competitive markets where physicians are earning a reasonable return on their educational investment. Even in these markets, some physicians may leave.

8. Perhaps the single biggest question to answer before ascribing monopsony behavior to an insurer that is negotiating with physicians for lower reimbursements is, “Is the labor market for physician services in a relatively stable long-run equilibrium to start with?” Consider three possibilities.
 - **The Input Monopoly Situation.** In this situation, the seller or sellers in the input market have market power and the buyer of these inputs does not. Assume that one buyer merges with another buyer of the inputs in the market to form a monopsony buyer. What is the effect of the new monopsony? In the example of

³⁵ Schwartz [1999], p. 5. This quote also reflects a point already mentioned – unlike “textbook monopsony,” the quality of the service to the enrollee under an Aetna health plan is directly affected; that is, the quality of care in the output market is lower. In this case, the Aetna enrollee is bearing the brunt of the monopsony underpayment through lower quality. Put differently, if the consumer’s sugar were not as sweet when it comes from the monopsonized plantation, would he/she continue to buy that type of sugar when it costs the same as other sugar? Later in his speech, the DOJ economist explains why it may be hard for a physician to retain an Aetna patient by getting him/her to switch to another plan. In this case, a modest contradiction arises; some patients are assumed to remain happy with Aetna and, thus, reluctant to switch with the physician who is abandoning Aetna. “[S]o while loyalty to a physician is important, it may not always be enough to outweigh the other attributes of a plan that the enrollee finds attractive and induce the enrollee to switch to a non-Aetna plan.” [p. 7] Apparently, the sugar is sweet enough to keep the consumer buying from Aetna, despite the monopsony induced drop in output that DOJ worries will be borne directly by Aetna patients.

physicians, the physician groups would be earning excess profitability, perhaps as monopolists or perhaps just because of a relatively short-term excess demand for their services. It is well understood in the economics literature that a monopsony buyer of inputs can obtain better prices from an input monopolist and output in both the input and output markets will likely rise. Everyone, except the input monopolist, will be better off.³⁶ This situation is often called a “bilateral monopoly,” i.e., a monopsony on the buying side of the input market and a monopoly on the selling side of the input market.

- If physicians are merely in an excess demand position, as some might argue has been going on in Dallas given its strong population growth, then the changes that DOJ expected to be caused by monopsony (e.g., physician exit and fewer hours spent with patients) are unlikely to happen in any significant degree, assuming the textbook structure of bilateral monopoly. In fact, in-migration of new physicians is more likely at the current reimbursement levels. The fact that a large insurer might be able to obtain better rates is fully consistent with one rationale heard all the time for health plan mergers – the insurer wants to get “more negotiating leverage with providers.” There would be no monopsony problem in this case, as a bilateral monopoly situation usually improves things. If this situation exists, one would expect to see high physician reimbursements pre-merger, unwillingness of physicians to take risk or to cooperate with other managed care contract provisions as physicians might be expected to do in other areas, and then, falling reimbursements and expansion of output in the input and output markets following the merger. The fact that output rises with the introduction of monopsony is the key to improving economic efficiency in this input market.³⁷
- **The Monopsony Situation.** If a true monopsonist is created by a health plan merger and if the monopsonist in that market faces an *upward sloping supply curve* for contracting with many independent physicians, then a monopsony problem may occur.³⁸ The upward sloping supply curve is an important predicate

³⁶ See, e.g., Pauly [1998].

³⁷ See Pauley [1998], pp. 1444-45.

³⁸ Professor Schwartz asserts that monopsony is a completely parallel situation on the buying side to monopoly on the selling side. (Schwartz [1999], p. 4.) While the statement is true for the “textbook case of monopsony” that Professor Schwartz discusses, it is not true for all monopsony cases. (See, e.g., Jacobsen and Dorman [1991], p. 5.) Any input buyer that faces a constant cost long-run supply curve for the input, or a downward sloping cost curve, will not have any incentive to behave like a monopsonist by reducing the amount of input purchased. Labor markets for specialized labor are more likely to have upward sloping supply curves with varying degrees of supply elasticity, suggesting that the monopsony concern may arise more appropriately for physician services than, say, for hospital services or other “bricks and mortar” inputs, unless the hospital is operating at high levels of capacity. But even labor market supply curves may have substantial elasticity of supply (i.e., be relatively close to a constant cost situation) if labor is in an excess supply condition, or if labor is
(continued...)

for the existence of monopsony. Simply put, “upward sloping” (if it exists) means that, if the insurer wants to contract for more and more physician services, the insurer must pay a higher and higher reimbursement level to get the added physician inputs. The monopsony problem arises simply because the insurer recognizes that, as the only buyer, every increase in the purchase of inputs means that the monopsonist is raising the price of *all* units of the input that it buys. It is as if the monopsonist is causing its input price for all the inputs it is buying to rise with every expansion. Thus, the monopsonist realizes that the real cost of buying more of the input is not just the higher price it must pay those added physician services, but the higher price it must pay every previous physician contractor already on its panel. Because the real price to the insurer is rising faster than just the cost of the next contracting physician, the monopsonist insurer realizes it will make higher profits if it contracts with fewer total physicians.

- If no monopsony existed, each time the many competing insurers went out to contract for more physician services, they would simply observe (more or less) a going market rate. The insurers would not perceive any effect on reimbursement rates when they decide to buy more inputs. Because monopsonists hire fewer units of input than would be hired in the competitive condition, some of the inputs go unemployed or under-employed. This is economically inefficient. If, rather than being quickly upward sloping, the supply curve of labor for physician services is very elastic (i.e., very little or no upward slope), the monopsonist does not perceive that it bids against itself in the labor market by driving up price for all previous units of input. It can get all the inputs it needs at roughly the same price. This is clearly the condition facing most insurers in most physician services markets because even large insurers are nowhere near the size needed to perceive the effect they have on input prices. More importantly, the whole monopsony problem assumes that the monopsonist is paying only a single price for all units of physician services. That is simply not true, especially in well-developed managed care markets. For large physician groups and large IPAs capable of sharing risk, individual contracts are negotiated. Negotiation allows for contracting at different rates, rates that do not need to be passed on to all previously contracted physicians on the panel. Thus, a fundamental condition for the existence of monopsony – the monopsonist’s perceived rapidly upward sloping supply curve

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mobile and can readily move in and out of the physician services market in a particular geography. This is likely to be less true for those physician specialties that rely on established referral networks (since they are less likely to move quickly). This means that new physician entry will be more important in bringing those types of labor markets into equilibrium. Other specialties are likely to be more elastic in supply, like hospital-based anesthesiologists or radiologists, who do not rely on referrals and who are relatively interchangeable in performing their specialty.

of labor – is regularly breached in physician services markets. Consequently, monopsony is unlikely to arise very often.

- **The Excess Supply of Inputs Situation.** This situation has likely characterized many physician services markets in the U.S. for at least a decade, though it is rapidly changing. In this case, the physician markets have too many physicians, particularly specialists. The primary effect of managed care growth in the late 1980s and throughout the 1990s has generally been a reduction in demand for health care providers. Managing care means that insurers have tried to contract selectively with those providers that best control unnecessary care and excess utilization. This was often implemented by relying on primary care physicians (PCPs) as “gatekeepers” to determine when hospitalization was warranted or when care was needed from a specialist. The demand for both appears to have fallen as a result of PCP oversight and other utilization controls. In such a situation, hospitals and specialists came into a position of relative excess supply in many areas. That is, generally, there has been pressure in input markets to reduce reimbursements to hospitals and specialists. This transition has occurred in varying degrees at varying speeds in most medical input markets. To insurers, large or small, physician services have become available at reasonable reimbursements. Even large buyers of physician services do not face an upward sloping supply curve. There are plenty of physicians to contract with at prevailing market prices. Moreover, the relative excess supply would be expected to push prices down further. In such a case, the physician services market would be moving to a new competitive equilibrium, with lower reimbursements and lower physician incomes, especially for specialists.
- What do such markets look like? Essentially, they mimic the conditions predicted by the advent of monopsony. Reimbursements to providers fall and fewer inputs are used. Some economists have proposed that these two indicia (falling reimbursements and falling levels of input use) are evidence that distinguishes monopsony from the bilateral monopoly situation (where reimbursements fall, but the level of inputs used *rises*).³⁹ One way to distinguish this situation from a

³⁹ See Pauley [1998]. This third condition of excess supply appears to be contemplated, but not fully laid out in a later section of the Pauley paper on “Monopsony and Moral Hazard,” p. 1451-1452. Similarly, Professor Schwartz notes in his speech that there are only two reasons for understanding why input prices might drop in an input market after a merger: efficiencies or monopsony. If the merger makes it cheaper to contract by, perhaps, allowing the large insurer to perform certain services for the providers more efficiently, then reimbursements might fall for that reason. The other reason that input prices might fall after a merger is the implementation of monopsony power by the new, larger insurer. Schwartz does not really consider the case where falling input prices result from a larger buyer negotiating more effectively with a monopoly provider group or under a condition of (temporary) excess demand for provider services, nor does he consider the case of excess supply, which could cause lower input prices with or without a merger.

monopsony situation following a merger is to examine whether such trends are occurring elsewhere in clearly competitive input markets with similar mixes of managed care, but no single large monopsonist. If physician reimbursements are falling based on the introduction of more managed care and more risk sharing with physicians, even in the absence of one large buyer, then falling prices and falling use of specialty physicians does not reflect monopsony. Rather, it more likely reflects a market in transition to a lower-price equilibrium.

9. Without properly diagnosing which of these situations best describes the prevailing input market condition, one cannot determine the proper action to take as a matter of antitrust policy. In two of the three situations, the input and output markets will improve or stay the same with the lowering of reimbursements in the market. In one case, monopsony may injure economic efficiency in the input market, but even then, only in the presence of an upward sloping supply curve for labor. *What will be true in all three cases is that physicians will not like it, and will complain.* But in at least two cases, the agency should ignore the complaints. In the third, a careful study should follow. In *Aetna*, our best estimate is that the Dallas market, at least, was in an excess demand situation with relatively generous reimbursements for physicians. The real fight was over whether physicians would be encouraged through the all products rule to sign contracts that required them to bear risk. Many Dallas physicians wanted only Aetna's PPO contracts, but did not want to get involved in risk sharing under the HMO products. One purpose of the all products rule was to give physicians an incentive to sign risk-bearing contracts. Dallas physicians may not have been hungry enough to try risk bearing, as physicians in many areas felt was necessary to do to maintain their livelihoods.

G. The General Indicia of Monopsony

1. Like monopoly, monopsony can be analyzed using both the market structure approach and the competitive effects approach. While direct measures of competitive harm are usually preferred, data from comparable markets are usually not available. So, in the few instances in which monopsony has been examined, a market structure approach is more likely. In *Aetna*, the DOJ used a market structure approach, though we would argue that their analysis was very incomplete in that case. This may have been because the remedy was the same as for the insurance market power case that the DOJ had more carefully built. Perhaps it was felt that a lot of extra analysis would have just led to the same conclusion – divest some of the Aetna health plan assets in Houston and Dallas. Still, the DOJ raised only two monopsony issues by its analysis, neither of which was documented in the Complaint or in the CIS. First, Aetna would have a large share of the purchase of physician services and particularly high shares with many individual physicians, post merger. “Large share” was not defined. Our analysis, which was never accepted or rejected by the DOJ, indicated that all Aetna products, post-merger, would have accounted for about one quarter of

physician reimbursements. Second, DOJ found that Aetna's "all products rule" made it hard for physicians to drop one type of Aetna plan without being dropped by Aetna from its more desirable sister plan, the Aetna PPO, which physicians were happy to serve. This made it hard for physicians to switch out of Aetna, the DOJ claimed, because the physicians would need to replace the large amount of lost Aetna patients from their practice. Being "stuck" with Aetna, these physicians would have likely been targeted for reimbursement decreases. In the end, the DOJ and state of Texas claim was more the combination of worries expressed by physicians and a reasonable theory about switching costs than it was the product of analyzing the broader indicia of monopsony. DOJ instead appears to have used a cursory version of the market structure approach – i.e., the market conditions seemed likely to foster monopsony after the merger.

2. What else could DOJ have considered as indicia of monopsony? While it is hard to know all that was reviewed, it is clear that a complete analysis of the following indicia was not done. It is also clear that, since *Aetna*, the DOJ is looking at more of these factors when reviewing health plan mergers for monopsony concerns.
 - **Reduced Contracting or Lower Employment Market Wide.** The hallmark of monopsony is reduced numbers of inputs being hired, in this case, fewer physicians under contract, and the resulting cut in output in the output market. While the alleged monopsony was only in its incipiency because the merger was never fully approved, it is very unlikely that fewer physicians would have been contracted with Aetna in an effort to impose a lower price. Health insurers rely on broad networks to provide their health plan delivery. In particular, PPO networks offer bigger panels and broader provider choice than HMO networks, yet Aetna was asking all PPO providers to accept HMO provider agreements with Aetna too. Fewer HMO contracts with Dallas and Houston physicians would mean a more restrictive PPO network. Even if one accepts that HMOs are in a separate market, such a move by Aetna would cause Aetna to lose enrollment in its PPO products to other PPOs, a market segment that was not considered threatened by the merger. This is contrary to Aetna's need for broad networks. As evidence, DOJ might have examined contracting changes in areas where Aetna or other HMOs had a very high share to see if less contracting occurred with growth in share. Moreover, beyond the normal grumbling of physicians under managed care, we are aware of no significant threats by Texas physicians to leave medicine in any greater numbers than among any group of physicians in any city that does not like managed care generally, but still has no dominant buyer.
 - **Aetna's Share of Physician Services Reimbursements.** It is very unlikely that the DOJ made any independent estimates of the share of payments Aetna represented to physicians, since none were contained in the Complaint or the related CIS. Defendants submitted estimates that Aetna would be responsible for

about one-quarter of all payments to physicians after its proposed merger with Prudential. These data were never rejected or contradicted.

- **Aetna's Reimbursement Levels.** The Aetna contracts were not analyzed to determine whether Aetna paid high reimbursements or low reimbursements. Are Dallas and Houston currently areas where physicians are already poorly paid (and, thus, susceptible to monopsony problems) or are physicians well paid, with little or no evidence that monopsony would cause output reductions? Perhaps, these areas are characterized by markets in excess demand, not a relative equilibrium. One common standard for comparing the reimbursement levels in commercial contracts is to express them as a percentage of Medicare fee schedule payments under the RBRVS system. For instance, HMO contracts often come in at about 110 percent of RBRVS. As mentioned earlier in footnote 29, the Dallas area physicians apparently often contract in the 130+ percentage range. While this is based on interview information and may not prove to be accurate, such a survey would be important to judging the likely effect of Aetna's merger. If Aetna paid well to start with, there would be plenty of "room" to decrease price before anything like normal reimbursement levels were reached, even if it was felt that Aetna would lower rates after the merger. Such a drop might have been appropriate. Another possible study would be to establish whether there was any statistical relationship between Aetna's share in other markets and the level of reimbursements to physicians. While this study would require considerable data, attempting it would demonstrate just how many factors affect reimbursement levels.
- **Reimbursement Levels of Texas Physicians with Other Health Plans.** Another measure of the rates that Texas physicians might be willing to contract for would be to do a comparative study of the rates they receive in other health plan contracts, all expressed on a "percent of RBRVS" basis. Most contracts are evaluated on this basis anyway. If Aetna's contracts were in the upper part of the range, there would again be evidence that little harm would result, again, even if Aetna might have lowered reimbursements following the merger.
- **Dallas and Houston Physician Income Levels.** Similar to the price information, comparative statistics on income, by specialty, across MSAs might indicate whether Dallas and Houston physicians are paid poorly or paid well. This fact would help determine how vulnerable these physicians are to monopsony reimbursement levels.
- **The Presence of Price/Reimbursement Differentiation in Aetna Contracts and Other Health Plan Contracts.** One essential element of monopsony is that, for inefficiencies to result, the monopsonist must perceive that it pays higher and higher rates to *all* units of the input as more inputs are hired. If this is not true,

there is no incentive for a very large buyer to lower the amount of inputs hired to inefficient levels. If the alleged monopsonist can reimburse different physicians at different levels as a result of individual contract negotiations, then there is no perception that every time reimbursements go up for one physician group, they go up for all. Clearly, such individual rates are negotiated with large groups and IPAs, though there are many solo physicians who are offered single rate contracts because the transactions costs of negotiating are too high for individual negotiations. The usual response by solo physicians is to join IPAs to contract as a bigger group and get prices that are more acceptable to them.

- **Analysis of the Efficiencies and Business Justifications of the “All Products Rule.”** Since the all products rule underlies much of the monopsony leverage that the DOJ felt Aetna would be able to exercise after the merger, it would be helpful to understand the business justification for the rule as a possible efficiency offset to the alleged increase in buyer market power. To a large extent, the DOJ did ask about this aspect of Aetna’s policies. To start, it is important to recognize that Aetna introduced the all products rule almost everywhere, regardless of market share. This is because its purpose was not to consolidate buying power. Many employers and employees, and even some doctors, liked the rule because it assured them that they would have access to their physician if they switched from Aetna’s PPO product to its HMO product. This would minimize disruption when an employer or employee switched from one type of Aetna plan to another. Moreover, physicians have fewer contracts with Aetna since a separate contract is not needed for every health plan offered. What we believe was under-appreciated by DOJ in its analysis of the all products rule and the transaction in general was that the overall conclusion reached by the DOJ made no business sense for Aetna. First, on the insurance selling side, according to DOJ, Aetna would use its market power to raise premiums to employers and employees. This, of course, angers all the customers. Second, Aetna would use its monopsony power on the buying side for physician services to underpay its physicians, especially those that handle the largest proportions of Aetna’s enrollees. Third, these doctors would in turn, lower the quality of services to Aetna patients and many would begin refusing to see Aetna patients as they slowly disentangled from Aetna products. Summing up all these predicted effects leads to the conclusion that Aetna was intent on self-destruction. Angry employers, angry employees, angry physician providers and angry patients are not a reasonable formula for dominating health insurance markets in Texas.

V. RELATED CONCERNS: VERTICAL RESTRAINTS AND TYING

- A. Vertical Restraints.** This issue has been a focus of the antitrust authorities and of private litigation for a long period of time.⁴⁰ Two of the more prominent forms of vertical restraints that affect managed care negotiations have been exclusive dealing arrangements and most favored nations clauses.
- B.** The concern in these matters is that the vertical restraint (such as an exclusive dealing arrangement) can allow one of the parties to monopolize the market that it competes in by creating a barrier to entry for its rivals. However, one of the problems with these cases is that it is often implausible that an insurer would help a provider monopolize its market or vice versa.⁴¹ This is because if, for example, a provider were to obtain monopoly power as a result of signing an exclusive contract with an insurer, the provider would then likely turn around and charge the insurer higher rates. Given the insurer would be made worse off by paying the higher rates, it seems very unlikely that the insurer would have helped the provider monopolize its market in the first place.
- C.** Because in most instances a vertical restraint also has the potential to reduce costs, economic theory cannot predict ex ante what effect it will have on consumer welfare even if it is assumed that the vertical restraint will allow one of the parties to monopolize its market.⁴² Thus, the debate about the likely competitive effect of a vertical restraint usually involves weighing the potential anticompetitive effect of the vertical restraint against its potential procompetitive effect.
- D.** There are a number of criteria that economists use to examine whether a vertical restraint will make consumers worse off. First, regardless of whether the concern is on the provider side or the insurer side of the market, an examination of market concentration can be used to assess whether the vertical restraint is likely to reduce competition. For example, if the concern is on the provider side of the market and if the examination of market concentration shows that there are many other providers that the consumers and payers can turn to, then a vertical restraint (such as an exclusive contract with an insurer) is unlikely to make consumers worse off. Second, even if the market is concentrated, an examination of whether the vertical restraint is binding can be used to assess whether it is

⁴⁰ See, e.g., *Kartell v. Blue Shield of Massachusetts, Inc.*, 749 F.2d 922 (1st Cir. 1984); *Ocean State Physicians Health Plan v. Blue Cross and Blue Shield of Rhode Island*, 883 F.2d 1101 (1st Cir. 1989); and, *United States, et al. v. Aetna, Inc., et al.*, Civ. No. 3-99CV1398-H (N.D. TX, June 21, 1999).

⁴¹ Sometimes it is plausible as a result of either side payments (which are rare) or common ownership.

⁴² See, e.g., Dennis W. Carlton and Jeffrey M. Perloff, *Modern Industrial Organization* 2nd ed. (Chicago: HarperCollins, 1994), pp. 533-5360; also, Thomas R. McCarthy, Scott J. Thomas, and Lawrence Wu, "Efficiencies Analysis in Hospital Mergers," *Antitrust Health Care Chronicle*, Chicago: American Bar Association, Spring 1999.

likely to reduce competition.⁴³ For instance, in the case of the PacifiCare-FHP merger, an examination of the contracts that the IPAs had with their physicians revealed that those contracts were non-exclusive. Thus, even though PacifiCare's contracts with some of the IPAs had exclusivity incentives, they were not binding since the physicians could sign up with other insurers by joining other IPAs. Third, if the analysis is *ex post*, an examination of the historical market performance (reimbursement rates, premiums, and/or physician visits or hospital admissions) can be used to assess whether the vertical restraints have made consumers worse off.

- E. Tying and Bundling.** This issue has also been a focus of the antitrust agencies and of private litigation for a long time.⁴⁴ In recent times, two of the more prominent examples of tying that affect managed care negotiations have been the “all facilities rule” and the “all products rule.” In the former case, insurers have argued that the practice is evidence that the providers have monopoly power, while in the latter case providers have argued that the practice is evidence that the insurers have monopsony power.
- F.** The concern in these matters is that one of the parties is using its monopoly (or monopsony) power in one market to monopolize (or monopsonize) another, related market. That is, the concern is that one of the parties is trying to leverage its dominate position in the tying product (e.g., inpatient hospital services) to its competitive position in the tied product (e.g., outpatient hospital services). Of course, consumer welfare will likely be reduced in the monopoly case and could be reduced in the monopsony case.
- G.** Economists generally examine the tying concern using a three-step approach. First, they examine whether the alleged tying product and the alleged tied product are distinct relevant products. If the two products are not distinct, then, by definition, they cannot be tied. Second, economists examine whether the provider (or insurer) in question has monopoly (or monopsony) power in the tying service. If the provider (or insurer) does not have monopoly (or monopsony) power, then, by definition, he or she cannot be using it to force the other party to purchase (or sell) the tying services. To examine whether the provider (or insurer) has monopoly (or monopsony) power, economists generally use the same criteria as mentioned in Sections III and IV. Finally, economists examine whether there is any evidence that market performance in the tied service has been negatively impacted or has a dangerous probability of being so, or whether the alleged tying arrangement has resulted in efficiencies or other pro-competitive effects.

⁴³ In the case of exclusive dealing arrangements, these first two criteria are equivalent to examining the degree of potential foreclosure.

⁴⁴ See, e.g., *Jefferson Parish Hospital District No. 2, et al. v. Edwin G. Hyde*, No. 82-1031 (E.D. LA, 1981).

VI. CONCLUSION

- A.** Although there are a number of antitrust concerns that can affect or result from a managed care negotiation, in our experience, most of the concerns just represent hard-nosed bargaining and not evidence of monopoly or monopsony power. Moreover, there are usually sufficient criteria that can be used to examine if the antitrust concerns really exist. But the analysis must be thorough and consider all possible states of the market, excess supply, excess demand and equilibrium. The long run concepts of monopoly and monopsony require using long run competitive equilibrium as the appropriate benchmark for prices and profits. Merger issues often consider a different price benchmark, the predicted percentage price increase that may result from the merger (or in the case of monopsony, the predicted price decrease).
- B.** While the DOJ's recent interest in monopsony signals that this issue will be reviewed in almost all new health plan mergers, we believe that few plans will ultimately be challenged on this basis. One of the consequences of the managed care backlash has been to diminish the negotiating strength of the payers. As a result, the monopsony concerns seem to have decreased and are likely to continue in that direction in the near future. Also, the criteria used by DOJ in its monopsony review of Aetna were incomplete, though the DOJ will likely be consistent in reviewing the switching costs borne by physicians to leave the panel of large newly merged insurers.