Chapter 2

Field of Dreams: Dominant Health Plans and the Search for a "Level Playing Field"

by Robert W. McCann, Esq.

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§ 2:1 Introduction

The classic model of monopsony is agriculture—markets in which there are many small sellers (family farmers) and only one or a few buyers for the crops in any given market. Given that crops are perishable and small farmers lack the wherewithal to defer income, they are compelled to take whatever prices are offered by the buyers. So, with legislative blessing, farmers long ago formed cooperatives to obtain better prices.

Health care providers, particularly physicians, feel they are in the same boat when it comes to health plan contracting, but without the same ability to form "cooperatives." Providers have long argued that IPAs, PHOs, hospital mergers, and other forms of provider collaboration receive disproportionate scrutiny from antitrust regulators when compared to the continuing consolidation in the health insurance industry. Organized medicine in particular has pointed to what it perceives as an increasingly unlevel playing field that forces doctors into take-it-or-leave-it managed care contracts. A study by the American Medical Association (AMA) suggests that six of every ten major metropolitan areas is dominated by a single health insurer, and providers argue that dominant payors have continued to drive down reimbursements while raising premium costs and making record profits. However, antitrust regulators have been reluctant to make organized medicine's complaint a priority—stating that the available evidence is not consistent with the exercise of "monopsony" power by health plans. The reluctance of antitrust regulators to address insurance markets also may reflect the fact that the causative link between "monopsony" power and consumer injury is difficult both to comprehend and to quantify.

Nonetheless, the skepticism attendant to any aggregation of market power seems no less justified when health insur-

ance markets are involved. Indeed, the market effects of a dominant health plan are in some ways of greater concern than those of, for example, allegedly monopsonistic big-box retailers such as Wal-Mart. This is because some (perhaps many) health insurers exercise market power over both provider "inputs" and health insurance "output" within the same market and—regardless of the effects on provider incomes—that situation can deter effective health plan competition and reduce consumer welfare.

This chapter explores the extent of consolidation in the health insurance industry, and discusses the implications of that consolidation in terms of market power. The discussion then turns to the ability of health plans to exert any such market power as "monopsony" buyers of health care services, and the implications of monopsony for health services consumers. The chapter concludes with a discussion of how the antitrust laws treat monopsony and whether there are effective legal remedies for perceived abuses of market power by dominant health plans.

§ 2:2 Health plan consolidation and market concentration—Recent studies

The occurrence of consolidation in the health insurance sector is well recognized, particularly given recent high-profile transactions, such as the Wellpoint-Anthem consolidation and United Healthcare's acquisitions of major regional health plans, such as Oxford Health Plan, MAMSI, Pacificare, and John Deere Health Plan. The extent to which consolidation is changing the competitive landscape may not be as well appreciated. As one example, in 1986, there were 134 independent Blue Cross and Blue Shield plans in the United States; today there are fewer than 40 as a result of plan mergers and, in particular, the acquisition of Blue plans by Wellpoint/Anthem. Since the high tide of managed care in the 1980's small, local HMOs and health plans have largely disappeared from the scene in favor of national and mid-market companies, and the mid-market companies have now become acquisition targets as well. The AMA reports 400

health plan mergers and acquisitions between 1995 and 2005.[1]

Evidence suggests that consolidation within the health insurance and managed care industry has been accompanied by increased dominance of many "markets" by one or a few large plans. Although the AMA has been in the media forefront of this issue, other studies report similar conclusions.

§ 2:3 Health plan consolidation and market concentration—Recent studies—Robinson

Economist James Robinson, using mostly 2003 data, examined insurance market shares, generally on a state-wide basis, and found that in thirty-eight states, the largest commercial health insurance firm controlled one-third or more of the market, and that in sixteen states, the largest firm controlled more than half of the market.[1] In all states but three, the largest commercial insurer was a Blue Cross plan. Assuming a state-wide market, Robinson found that market concentration, as measured by the HHI,[2] was "high" (HHI > 1800) under the standards of the federal *Merger Guidelines*, in thirty-four states and "low" (HHI < 1000) in only two.[3] Robinson separately examined the market shares of the four largest U.S. health plans, and found that Blue

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[Section 2:2]

[1] American Medical Assn., Competition in Health Insurance: A Comprehensive Study of U.S. Market, 2005 Updates, Ref. No. OP427106 (2005). This report is available at http://www.ama.org.

[Section 2:3]

[1] Robinson, "Consolidation and the Transformation of Competition in Health Insurance," 23 Health Affairs 11 (Nov./Dec. 2004).

[2] The HHI, a statistical measure of market concentration, is calculated simply by summing the squares of the percentage market shares of all competitors in the relevant market. It has a theoretical range of values from 1 to 10,000. Competitors under common ownership are counted as a single firm in the calculation.

[3] U.S. Department of Justice and Federal Trade Commission, Horizontal Merger Guidelines (1997). The *Merger Guidelines* define markets with an HHI in excess of 1,000 as "concentrated," and in excess of 1,800 as "highly concentrated." A market would require a minimum of six competitor firms (more if the market shares of those firms are significantly unequal) to have an HHI below 1,800, and a minimum of 11 firms to have an HHI below 1,000.

Cross[4] and the three largest non-Blues carriers (United, Aetna, and Cigna) collectively control more than 60 percent of the market in thirty-four states and more than 70 percent of the market in twenty-three states.[5] These findings predated, *e.g.*, United's acquisitions of Pacificare and John Deere Health Plan, and Wellpoint's acquisition of the New York Blue Cross plan, Wellchoice.

Robinson reported these findings in conjunction with an examination of health plan costs, prices, and profits in the period 2000-2003. His analysis concludes that, despite increasing medical cost inflation (*i.e.*, increasing medical loss ratios), insurers were consistently able during this period not only to raise premiums but also to increase their operating margins. In other words, growth in premium revenues exceeded cost increases. In fact, Wellpoint and United increased their operating margins by more than 50 percent in this period, while Aetna and Cigna had increases in excess of 100 percent. Returns on invested capital averaged 19.9 percent annually for publicly-traded health plans in the same period, and large plans outperformed the S&P 500 Index for appreciation in stock prices. Blue Cross plans enjoyed similar results. Between 2002 and 2003, nonprofit Blues plans increased operating earnings by 111 percent and net income by 87 percent.[6] Robinson posits that the data point to the likelihood of further consolidation and an increase in barriers to entry in the short term.

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[4]Robinson treats Blue Cross plans collectively as a single insurer for purposes of this analysis, noting that, under the aegis of the Blue Cross Blue Shield Association, the plans do not compete against each other but act as a cooperative to write and service national accounts and to cover each other's out-of-area subscribers.

[5]The disparity between the four largest companies and the rest of the industry is substantial. For example, there were 12 health insurance and managed care companies listed in the most recent *Fortune* 1000. The four largest of those companies (in order, United, Wellpoint, Aetna, and Cigna) had approximately $9 billion of combined profit on combined revenues of approximately $129 billion. The remaining eight of those companies (Humana, Health Net, Coventry, Amerigroup, Wellcare (since acquired by Wellpoint), Medical Mutual of Ohio, Molina, and Centene) had combined profits of approximately $1.3 billion on approximately $41 billion of combined revenue. *Fortune* (Apr. 17, 2006), reprinted at http:/money.cnn.com/magazines/fortune/fortune 500.

[6]Further to this point, in 2004, the constituent plans of the Blue Cross and Blue Shield Association earned $3.7 billion in profits, a 32 percent increase over 2003. Notwithstanding these record profits, the As-

A critique of Robinson's analysis by attorney William Kopit posits that the results do not establish a correlation between consolidation (*i.e.*, mergers and acquisitions) and the exercise of market power (*i.e.*, higher premiums), arguing that statewide markets generally are not relevant for antitrust purposes, and that Robinson's analysis does not compare premiums in more- and less-concentrated markets.[7] A separate critique by William Kovacic and David Hyman, respectively the general counsel of and special counsel to the Federal Trade Commission, also criticizes Robinson's approach to market definition, and notes that high concentration alone is not evidence of unlawful behavior and that there is no reason to believe that the high profits reported by Robinson are supra-competitive.[8] Their response also takes the opportunity to suggest that critics of the state of the health insurance market are mostly self-interested providers, a recurrent theme for the FTC. This statement undoubtedly is a reference to the efforts of the AMA in particular.

§ 2:4 Health plan consolidation and market concentration—Recent studies—American Medical Association

Annually since 2001, the AMA has issued a report on competition in health insurance. The most recent of those reports, for 2005-2006, examines market concentration in approximately 300 Metropolitan Statistical Areas (MSAs), and thus takes the analysis to a level more closely approaching antirust-relevant markets.[1] The report examines market concentration for HMO products, PPO products, and a

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sociation in 2004 also released a study blaming hospitals for rising health care costs. Benko, "Passing the Buck," Modern Healthcare, at 8 (Dec. 13, 2004).

[7]Kopit, "Is There Evidence That Recent Consolidation in the Health Insurance Industry Has Adversely Affected Premiums?" 23 Health Affairs 29 (Nov./Dec. 2004).

[8]Hyman and Kovacic, "Monopoly, Monopsony, and Market Definition: An Antitrust Perspective on Market Concentration Among Health Insurers," 23 Health Affairs 25 (Nov./Dec. 2004).

[Section 2:4]

[1]American Medical Assn., Competition in Health Insurance: A Comprehensive Study of U.S. Market, 2005 Updates, Ref. No. OP427106 (2005). This report is available online at http://www.ama.org.

combined market of HMO and PPO products. With respect to the combined product market, the study concludes:

- In 95 percent of the MSAs examined, market concentration was high (HHI > 1800).
- At least one insurer had a market share of at least 30 percent in 95 percent of the cases, at least 50 percent in 56 percent of the cases.
- A single insurer had at least a 70 percent share in 19 percent of the MSAs.
- In four percent of the MSAs, a single insurer held at least a 90 percent market share.

§ 2:5 Health plan consolidation and market concentration—Recent studies—The FTC/DOJ competition report

As the Hyman and Kovacic article would suggest, a different perspective emerges from the federal agencies charged with enforcement of the antitrust laws. In 2004, the Federal Trade Commission and the Antitrust Division of the Department of Justice (the "Agencies") published *Improving Health Care: A Dose of Competition* (the "*Competition Report*")[1] a much anticipated report on competition policy in health care. The 360-page document assesses a wide range of provider and payor behavior and contains recommendations and observations intended to guide policymakers and enforcement activities. One chapter of the Report is devoted to competition in health insurance.

The *Competition Report* was premised, in part, on testimony presented at a series of public hearings on health care competition. Testimony on behalf of providers predictably stressed the implications of the increasing concentration in health insurance markets. For example, the AMA argued that physician actions are scrutinized far more closely by the antitrust enforcement agencies than third party payors, noting that over fifty actions had been brought against physician organizations in recent years; none against health

[Section 2:5]

[1] Federal Trade Commission and U.S. Department of Justice, Improving Health Care: A Dose of Competition (July 2004).

insurers.[2] The AMA urged the Commission to devote more attention to issues of monopsony power, payor joint ventures, coordinated conduct among insurers, and abusive contracting practices.

In a more analytical vein, the Pennsylvania Medical Society presented an extensive analysis of market conduct by insurers in that state.[3] That analysis showed that the dominant health plan in each of four regions within that state is a Blue Cross plan. The data presented showed that Independence Blue Cross (Southeast Pennsylvania) had a 72 percent share of the market, Highmark (Western Pennsylvania) had a 74 percent share, Northeast Blue (Northeast Pennsylvania) had a 63 percent share, and Capital Blue Cross (Central Pennsylvania) had a 53 percent share. All of these plans were able to maintain higher rates of increase in premiums and were substantially more profitable than their commercial competitors over a 10-year period. In 2001, the Pennsylvania Blues plans had pre-tax net income in excess of $500 million; all private commercial plans together had pre-tax net income of less than $68 million for the same period. The analysis also concluded that the market power imbalance had resulted in lower-than-expected rates of payment to physicians, and had resulted in a substantial rate of increase in unpaid claims. Finally, the study noted the prevalence in participation agreements of “most favored nation” provisions, “gag clauses” and other terms unfavorable to providers, which also were attributed to payor market power.

The *Competition Report*, however, reflects a different conclusion. The Agencies concluded that, contrary to the assertions and testimony of the medical associations, the available evidence does not indicate that there is a “monopsony” power problem (*i.e.*, a monopolistic health plan) in most markets. The Agencies commented that, even if there were such a problem in a market, permitting providers to create

[2]Statement of Donald Palmisano, M.D., President-Elect, American Medical Association, before the Federal Trade Commission Workshop on Health Care Competition Law and Policy (Sept. 9, 2002).

[3]Written Comments of the Pennsylvania Medical Society before the Federal Trade Commission Workshop on Health Care Competition Law and Policy (Sept. 30, 2002). The comments were authored by Stephen Foreman, Ph.D., Director, Pennsylvania Medical Society Health Services Research Institute and Dennis Olmstead, MPA, Vice President and Chief Economist of the Pennsylvania Medical Society.

countervailing market power "should not be considered an effective response to disparities in bargaining power between payors and providers." Instead, the Agencies stated that they will remain vigilant in monitoring the third party payor market for conduct evidencing monopsony power. The Agencies also stated that they will continue to monitor the use of so-called "most favored nation" clauses in contracts between third party payors and providers, and will challenge such clauses when there are anticompetitive effects.[4] However, they also indicated their view that there may be economic justification for use of the clauses in some cases.

For many in the provider community, the *Competition Report* was an affirmation of the Agencies' historical "hands-off" approach to health plan consolidation. To this point, an official of the Antitrust Division later commented on the question of monopsony power in light of the Report:

> Although the report does reflect a significant reservation over whether health plans have monopsony power as broadly as some provider groups have contended, the report does not reject the proposition that some health plans have or may exercise monopsony power. . . . Though high market shares, properly measured, can be an important signal about the presence of market or monopsony power, the agencies apply a full and more careful analysis. The presence of strong competitors or the likelihood an ability of new entrants, as well as other factors may make a high market share an inadequate indication, standing alone, of monopsony power.[5]

The points made are basically correct—the fact that a health plan has a dominant market share may or may not indicate the existence of monopoly or monopsony power, and the existence of market power is a separate question from its

[4]However, antitrust challenges to abuses of *unilateral* monopsony power (as opposed to collusive monopsonies among purchasers) are difficult to maintain because of the difficulty of proving harm to consumers with any certainty (a subject discussed further in § 4 of this article). Hence, such challenges are historically almost non-existent. Thus the Agencies' promise of vigilance sounds better than it is. For a good introduction to the antitrust economics of monopsony, *see* Blair and Harrison, *Antitrust Policy and Monopsony*, 76 Cornell L. Rev. 297 (1991). *See also* McCann, "Blue Cross—What Happened?" Health Law Handbook (Gosfield, ed. 2003).

[5]Guadagnino, "Government Addresses Health Care Competition," Physician's News Digest (Jan. 2005) (interview with Mark J. Botti, Esq., Chief, Litigation I Section, Antitrust Division, U.S. Department of Justice).

exercise.[6] But these points simply beg the question of whether, and to what extent, health insurance markets ordinarily exhibit attributes consistent with the existence and/or exercise of market or monopsony power.

§ 2:6 Health plan consolidation and market concentration—Are there consumer benefits from health plan consolidation?

To the extent parties to health plan mergers and acquisitions have been tasked to explain the benefits of their transactions to consumers, the dominant rationale has been the prospect of achieving increased efficiency, and thereby becoming more cost-effective.[1] Certainly, achieving economies of scale (the ability to produce the same output at lower unit cost) and/or economies of scope (the ability to achieve the critical mass necessary to expand output) are sound objectives in any business combination. However, the validity of this argument as it relates to health plan combinations has

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[6]Botti's characterization, in the health plan context, of high market shares as an "important signal" with respect to market power could be viewed in contrast with the Agencies' more usual view (prevalent in the provider context) that high market concentration creates a *presumption* that competitive concerns exist. For example, in the FTC's recent challenge to a consummated hospital merger, In re Evanston Northwestern Healthcare Corporation, No. 9315 (Initial Decision Oct. 20, 2005), the Commission alleged in its complaint that an increase in market concentration without cognizable efficiencies from the challenged merger sufficed to establish a violation of the Clayton Act—without need of showing actual anticompetitive effects. The FTC made a similar argument (albeit unsuccessfully) regarding the standard for a preliminary injunctive relief against a hospital merger in F.T.C. v. University Health, Inc., 938 F.2d 1206 (11th Cir. 1991). Indeed, the federal *Merger Guidelines* are built on the proposition that high levels of market concentration are, absent efficiencies or low barriers to entry, dispositive of the competitive question.

[Section 2:6]

[1]For example, Anthem predicted that its 2002 acquisition of Trigon (the Virginia Blue Cross plan) would generate $40 million of "operating synergies" in its first year, increasing to $75 million in 2004. These results were expected to be generated principally by (1) cross-selling specialty products; (2) eliminating duplicative information technology; (3) reducing investment management costs; and (4) general administrative savings. Anthem, "Trigon Predict They'll Save $40 Million in 2003 Through Merger," The AIS Report on Blue Cross and Blue Shield Plans, at 1 (May 2002).

been questioned, notably in the context of recent Blue Cross transactions.

One of the most comprehensive examinations of this argument is a 2001 study of Blue Cross plan performance authored by health care economist Carl Schramm. The study was undertaken in regard to the State of Maryland's review of the proposed for-profit conversion, and subsequent acquisition by Wellpoint, of CareFirst Blue Cross and Blue Shield (the plan serving Maryland, Delaware, the District of Columbia, and Northern Virginia),[2] a transaction that (for a variety of reasons) ultimately failed to gain regulatory approval. Schramm's study concluded, *inter alia*, (1) that independent nonprofit Blue Cross plans had lower overhead costs than either consolidated nonprofit Blue Cross plans or investor-owned Blue Cross plans; (2) Blue Cross plan size did not correlate to profitability; and (3) larger plans created through acquisition were not necessarily more efficient than smaller plans, due to the difficulty of integrating different sales and marketing strategies, underwriting policies, information systems, and provider and regulatory relationships. Schramm also concluded that consolidated plans operating in dispersed multiple geographic markets had approximately half the average earnings (in the period 1997 to 2000) of companies operating in single or contiguous states. Each of these findings calls into question the argument that there are efficiencies inherent in health plan combinations.[3]

One might think, nonetheless, that the trend toward consolidation in the insurance industry itself is evidence of likely efficiencies. But—at one time—Aetna (then Aetna U.S. Healthcare) was the most active acquirer of health insur-

[2]Schramm, Blue Cross Conversion: Policy Considerations Arising From A Sale of the Maryland Plan (The Abell Found. Nov. 2001). Dr. Schramm also submitted a report covering similar issues in regard to the proposed acquisition of the Kansas BCBS plan by Anthem. Schramm, Implications for Health Care Providers Resulting From the Sale of Kansas Blue Cross Blue Shield (Dec. 2001). These studies are available, respectively, from the Maryland and Kansas insurance departments.

[3]More anecdotally, a Maryland Health Care Commission report found that small, local health plans "far outperformed" large national health plans in a survey of HMO quality and consumer satisfaction. However, the Maryland BCBS plan (CareFirst), which was to be acquired by Wellpoint, had the most below-average scores among the 12 HMOs surveyed. American Health Line (Oct. 2, 2001).

ance businesses, and the largest health insurer, in the United States. Nonetheless, by 2001, Aetna faced significantly declining financial results, which led the company to announce that it would reduce its enrollment by 20 percent (3.9 million, mostly high-risk, covered lives) and lay off 11,000 employees in an effort to improve profitability (which was in fact successful).[4] The Aetna experience suggests, first, that the company was not able to realize significant scale economies as it grew, and, in turn, that consumers do not obviously benefit from the aggregation of health plans under a common umbrella. Rather, it tends to confirm that health insurance markets, like health care services markets, are localized, and that success depends at least in part on the ability to respond to the idiosyncrasies of the local market.

The foregoing also points back to the question of whether the lower medical loss ratios and higher profits of consolidated health plans are indeed a function of market power.

§ 2:7 Examining health plan market power

The antitrust laws are most frequently applied to the seller side of the market. Within that context, the term "market power" refers to the ability that a seller may have to raise prices or reduce output without fear that the competitive responses of other firms in the market (or prepared to enter the market) will make those decisions unprofitable. The extreme case of seller market power is "monopoly power." In most circumstances, a firm will not be presumed to have monopoly power absent a market share in excess of 65-70 percent.[1] Further, most courts have held that an attempted monopolization claim (which requires market power suf-

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[4]Robinson, "Consolidation and the Transformation of Competition in Health Insurance," 23 Health Affairs 11 (Nov./Dec. 2004), reports that, from 2001 to 2003, Aetna's medical cost ratio improved from 89.8 percent to 78.3 percent, its return on equity grew from -2.7 percent to 11.1 percent, and its stock price growth went from 19.7 percent to 64.4 percent.

[Section 2:7]

[1]Eastman Kodak Co. v. Image Technical Services, Inc., 504 U.S. 451, 112 S. Ct. 2072, 119 L. Ed. 2d 265 (1992) (80 percent market share sufficient to survive summary judgment on monopolization claim); Houser v. Fox Theatres Management Corp., 845 F.2d 1225 (3d Cir. 1988) (monopoly power may be inferred from share between 66 percent and 71 percent); Fineman v. Armstrong World Industries, Inc., 980 F.2d 171, 24 Fed. R. Serv. 3d 162 (3d Cir. 1992) (55 percent insufficient).

ficient to suggest a "dangerous probability" of successful monopolization[2]) cannot be maintained unless the defendant has at least a 50 percent share of the relevant market or, alternatively, a smaller share (but not less than 35 percent) combined with factors indicating that market entry is difficult or that there are other structural impediments to competition.[3]

Assuming that those standards would appropriately be applied to the buyer side of the market, and given that virtually all of MSAs examined by the AMA contained at least one firm with a 30 percent or greater share of the market, the question then becomes whether one typically would expect to find additional facts indicating that there are structural or other barriers to competition. That is, a competitive market in theory will discipline an erstwhile monopolist because the high profits earned by the monopolist will attract additional competitors to the market, and the ensuing competition will drive prices and profits down to competitive levels. The theory fails, however, if structural or regulatory requirements, or anticompetitive behavior, prevent new firms from entering the market.

Barriers to competition may exist in many forms, but it is useful to think of them in two categories: those imposed on firms in the market, and those created by firms in the market. In the former category, high capital investment requirements, significant resource acquisition costs, government regulation of entry (*e.g.*, in the form of licensure or, as in health care, certificates of need), government regulation of operations (*e.g.*, price controls or, as in health care, the government itself being a significant regulator *qua* purchaser), and low rates of return on investment may be deterrents to competition. In the latter category are efforts by firms to raise the costs of potential competitors through their dealings with suppliers and customers (which may raise

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[2]Spectrum Sports, Inc. v. McQuillan, 506 U.S. 447, 113 S. Ct. 884, 122 L. Ed. 2d 247 (1993); Armstrong Surgical Center, Inc. v. Armstrong County Memorial Hosp., 185 F.3d 154 (3d Cir. 1999).

[3]Barr Laboratories, Inc. v. Abbott Laboratories, 978 F.2d 98, 24 Fed. R. Serv. 3d 117 (3d Cir. 1992) (50 percent market share insufficient given low entry barriers); Yeager's Fuel, Inc. v. Pennsylvania Power & Light Co., 953 F. Supp. 617 (E.D. Pa. 1997) (31 percent market share presented jury issue in combination with entry barriers).

antitrust concerns), or by petitioning the government for protection (which generally does not raise such concerns).

As discussed in the following sections, there is reason to believe that both categories of competitive barriers may be present to some degree in health insurance markets.

§ 2:8 Examining health plan market power—Structural barriers to health plan competition

The prevailing antitrust wisdom is that entry barriers in the insurance industry are low. In the oft-cited *Ball Memorial Hospital v. Mutual Hospital Insurance, Inc.*,[1] the Seventh Circuit found that the only major requirement to be in the insurance business is monetary capital, which is assumed to be readily available. However, it bears noting that the assumptions and structure of the health insurance industry at the time of that decision (twenty years ago) was markedly different from today, and the assumption of low entry barriers may simply be too facile.[2]

Perhaps the best evidence of whether entry barriers exist in fact is whether new competitors enter markets in which one or a small number of plans are dominant. At least anecdotally, it appears they do not. For example, Blue Cross Blue Shield of Michigan (BCBSM) is the largest nonprofit, non-mutual health plan in the United States. It covers approximately 75 percent of the non-Medicare, non-Medicaid population in the state and enjoys a long-standing and close relationship with the United Auto Workers, the single largest group benefit provider in the state. BCBSM's market dominance has existed for decades. Meaningful competition

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[Section 2:8]

[1]Ball Memorial Hosp., Inc. v. Mutual Hosp. Ins., Inc., 784 F.2d 1325 (7th Cir. 1986).

[2]*Ball Memorial* was precipitated by the decision of the Indiana Blue Cross plan to implement a new-fangled concept called a "preferred provider organization" and to contract with physicians on a selective, discounted basis. From an economic standpoint, one can appreciate the change in perspective from the mid-1980's to the present by reading economist Mark Pauly's contemporaneous analysis of health insurance monopsony issues ("Monopsony Power in Health Insurance: Thinking Straight While Standing on Your Head," 6 J. of Health Economics 73 (1987)), in which many of the questions he asks about the directions of the health insurance market are now self-evident.

from major national insurance companies such as Aetna and Cigna, all of which have significant cash and access to capital, is virtually non-existent.[3]

Similarly, a former Missouri insurance commissioner testified at the *Competition Report* hearings that no new entry has occurred in the St. Louis HMO market since the mid-1990's.[4] Robinson suggests that these results are not unusual.[5] As he states, start-ups of new plans are rare because there have been no major innovations in technology, product design, or structure that would allow new plans to offset the economic scale advantages of entrenched health plans. Large firms also demonstrate caution in entering new markets, and if they do so, almost always undertake such expansion through the acquisition of a large local health plan.[6] Thus, for example, United Healthcare was largely unsuccessful in establishing a presence in Western Illinois and Eastern Iowa until it acquired John Deere Health Plan. Such acquisitions, in and of themselves, do not reduce the concentration of the market.

In its 1999 challenge to Aetna's acquisition of Prudential's national health insurance lines, the Department of Justice in fact alleged that high entry barriers existed in the affected markets (which were defined as just two metropolitan areas in Texas).[7] The DOJ asserted that a new entrant to either of those markets would require three years and an

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[3]United Healthcare has obtained a foothold through the acquisition of a provider-sponsored HMO. Meanwhile, in 2006, BCBSM announced its intention to acquire M-Care, a large regional HMO that could be viewed as its closest HMO competitor in Southeast Michigan. Inasmuch as BCBSM is already established in the HMO product market, this acquisition appears to be a blocking strategy to prevent M-Care's acquisition by a national competitor.

[4]Competition Report, Ch. 6 p. 10.

[5]Robinson, "Consolidation and the Transformation of Competition in Health Insurance," 23 Health Affairs 11, 20 (Nov./Dec. 2004).

[6]Indeed, one could reasonably posit that, if entry into most markets were a simple matter of money, national insurers with large cash reserves would find it cheaper and more efficient to enter markets *de novo*, rather than to do so by acquiring existing firms.

[7]U.S. v. Aetna Inc., No. 3-99CV 1398-H, ¶¶ 17-18 (June 21, 1999) (complaint), available at http://www.usdoj.gov/atr/cases/f2500/2501.pdf; *see also* U.S. v. Aetna Inc., No. 3-99 CV1398-H, at 5-6 (Aug. 3, 1999) (revised competitive impact statement), available at http://www.usdoj.gov/atr/cases/f2600/2648.pdf.

investment of at least $50 million to reach a minimum viable scale. There have been no significant federal challenges to health plan acquisitions subsequent to Aetna-Prudential, and so the current thinking of the Agencies on this point is not clear. The more recent *Competition Report* takes no firm position, which tends to be consistent with the *Report*'s more general skepticism as to whether health insurers exercise monopsony power.

If barriers to entry exist in concentrated health insurance markets, there may be many sources of those barriers. For example, it is thought that Blue Cross plans have long benefited from their extensive (*i.e.*, hard to replicate) provider networks, brand name acceptance,[8] and public-oriented image (as well as restrictive customer and provider contracting practices, discussed in §§ 2:11 to 2:14), and the existence of these benefits may raise the costs of prospective competitors.

§ 2:9 Examining health plan market power—Structural barriers to health plan competition—Provider networks as entry barriers

There is disagreement on the question of whether it is difficult or costly for a health plan to acquire a competitive (*i.e.*, marketable) provider network, such that the need to do so would deter competitive entry into a market. The *Competition Report* summarized conflicting testimony on this point.[1] Some testimony noted that new entrants in a concentrated market face the dilemma of needing a large provider network to attract customers, but at the same time needing a large customer base to obtain provider discounts sufficient to make the new plan entrant competitive with the incumbent. This

[8]To this point, a Bear Stearns research report (Nov. 1, 2001) on Anthem, Inc. was subtitled "The Power of Blue" and discussed (among other factors) the benefits of the Blue Cross and Blue Shield name and trademarks to the investment value of the company. In 2002, the Blue Cross and Blue Shield Association threatened to revoke the trademark license of the North Carolina plan in an effort to leverage concessions from state regulators in the pending review of that plan's conversion to a for-profit company.

[Section 2:9]

[1]Competition Report, Ch. 6, p. 9.

dilemma requires new entrants to subsidize higher provider rates and/or lower customer premiums for some period of time until the two conditions can be satisfied. However, other witnesses stated that the need to create a provider panel is usually not a significant barrier because existing, commercially-attractive networks can be rented.[2] But it is far from clear that this option is realistic for a health plan that wishes to mount a serious competitive challenge.[3] Overall, the testimony appears to favor the view that the interrelated needs to create a provider network and to reach a minimum scale can act as barriers to entry.[4]

§ 2:10 Examining health plan market power—Structural barriers to health plan competition—Customer switching costs as entry barriers

There is also debate as to whether brand recognition and customer loyalty operate as an entry barrier. Pauly notes, for example, that insurance agents typically receive higher commissions for new accounts than for renewal of existing accounts, and infers that it is harder to sell a new account than an existing account, which would certainly suggest that brand loyalty is a factor in competition.[1] He also notes that Blue Cross has zealously defended its trademarks and brand name over time, and that economic theory (if not the law) recognizes that product differentiation by initial sellers confers market power on an incumbent relative to a new

[2]This point is cited by Kopit in his response to Robinson. Kopit, "Is There Evidence That Recent Consolidation in the Health Insurance Industry Has Adversely Affected Premiums?" 23 Health Affairs 29, 30 (Nov./Dec. 2004).

[3]Experience suggests that readily-available provider networks typically would be obtained from non-insurer PPO organizations that succeed in obtaining broad provider participation mainly by not insisting on deep discounts. Those networks thus are an expensive solution for a health plan that desires to challenge a dominant incumbent. United Healthcare, for example, has entered a number of markets by renting networks from MultiPlan, but those arrangements arguably have not always proven viable for United.

[4]Competition Report, Chapter 6, pp. 8-13.

[Section 2:10]

[1]Pauly, "Monopsony Power in Health Insurance: Thinking Straight While Standing on Your Head," 6 J. of Health Economics 73, 80 (1987).

entrant. Perhaps more to the point is Robinson's conclusion that purchasers of health insurance have been ineffective in restraining premium increases (and profits) in markets where consolidation has reduced the number of competing health plans.[2] This suggests not only that purchasers of health insurance do not constrain the exercise of market power, but also that potential new entrants to the market in fact must overcome some level of brand loyalty or perceived switching costs in attempting to recruit these purchasers as new customers.

§ 2:11 Examining health plan market power—Contracting practices as entry barriers

Once established in the market, a health plan may be able to create entry barriers through restrictive provider and customer contracting terms. These practices tend to be more effective as the entrenched plan's market share increases.

§ 2:12 Examining health plan market power—Contracting practices as entry barriers—Barriers created through provider contracts

The use of "all products" and "most favored nation" clauses are common examples of terms that raise a competing insurer's costs of acquiring a competitive provider network and thus deter entry into the market. "All products" or "universal" agreements require a provider to participate in all (or, at least, many) of the insurer's products as a condition of participating in any of them. For example, an insurer may require providers to sign an agreement to participate in its HMO product and/or its Medicare Advantage product in order to participate in its PPO product, which typically has a larger enrollment, higher reimbursement rates, and fewer restrictions on the provision of services, and therefore is more significant economically to the provider. In some markets, health plans recently have employed the same strategy to obtain provider participation in so-called "high deductible" health savings account (HSA) plans.

This tactic can have several effects. If, as is often the case, the insurer has a lesser degree of market power (*i.e.*, faces

[2] Robinson, "Consolidation and the Transformation of Competition in Health Insurance," 23 Health Affairs 11, 21 (Nov./Dec. 2004).

more competition) in the HMO market than in the PPO market, the insurer can command a higher level of participation in the HMO product and at lower rates of payment than would otherwise be the case, and thereby disadvantage existing or potential competitors. More insidiously, the practice can deter innovation in the market. HSA plans, for example, represent one of the few innovations in health plan design in recent years, which, as noted by Robinson, is a condition that would be expected to stimulate competition. If an insurer can force providers into its HSA network through an all-products clause, it has a presumptive advantage that new entrants cannot easily replicate, regardless of whether they offer a "better" HSA product (from the customer's standpoint) than the entrenched, dominant insurer.

In a similar vein, "most favored nation" provisions require a provider to give the contracting plan the benefit of any better rate that the provider gives to any other plan. Since plans with market power are, by definition, economically significant to the provider, the cost of giving better rates to a potential competitor of the plan are prohibitively high. For example, a physician who gives an incremental five percent discount to a small health plan representing two percent of the physician's revenue is giving up (through the incremental discount) a mere one-tenth of one percent of total revenue. If, by operation of an MFN, the physician must also give the same incremental five percent discount to a plan representing fifty percent of revenues, the amount of revenue lost suddenly increases by an additional two and one-half percent, thus making the original decision to give the small plan an extra discount more costly (and more unlikely).

The expected effect of an MFN provision, therefore, is to entrench the dominant plan's market position.[1] Nonetheless, the Agencies have maintained in the past (and as recently

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[Section 2:12]

[1]Because health services and, to a large degree, health insurance are sold in localized markets, a health insurer is not really concerned with getting the provider's "best" price in some absolute sense as long the insurer can be assured that its competitors are not getting a better price. Stated differently, a health insurer with an MFN will have lower costs than any equally efficient competitor (and higher profits than any comparably priced competitor). For a more extensive discussion of MFNs, *see* McCann, "Ocean State Redux: Dominant Health Plans, Antitrust, and Health Reform," Health Law Handbook (Gosfield, ed. 1994).

as the *Competition Report*) that MFNs can be beneficial to consumers. MFN clauses have been challenged infrequently by the Department of Justice, mostly in the context of dental and other specialty plans where the economic significance of the plan to a provider's income has been manifest.[2] In light of these cases, however, some plans abandoned the use of MFNs; others replaced their contractual MFNs with requirements for extra-contractual assurances that they are receiving the provider's best rate, or with contractual statements of intent that the provider will guarantee the insurer a "competitive" rate.

Notably, these practices are themselves indicia of market power over the purchase of provider services. That is, they are terms that a plan can insist upon because of its position as an economically significant or monopsonistic purchaser of provider services.[3]

§ 2:13 Examining health plan market power—Contracting practices as entry barriers—Barriers created through customer contracts

In addition, group insurance and individual subscriber agreements also may contain terms that deter entry into the market and protect the health plan from competition on the merits. For example, "anti-assignment" provisions prevent a health plan member from assigning the plan's payment to a non-participating provider. This practice has the effect (and arguably the principal purpose) of deterring providers from leaving the plan's network. That is, providers who departicipate are forced to obtain payment from the member,

[2] U.S. v. Medical Mutual of Ohio, 1999-1 Trade Cas. (CCH) ¶ 72,465 (N.D. Ohio Jan. 29, 1999); U.S. v. Delta Dental of R.I., 1997-2 Trade Cas. (CCH) ¶ 71,860 (D. R.I. July 2, 1997); U.S. v. Vision Service Plan, 1996-1 Trade Cas. (CCH) ¶ 71,404 (D. D.C. Apr. 12, 1996); U.S. v. Oregon Dental Service, 1995-2 Trade Cas. (CCH) ¶ 71,062 (N.D. Cal. July 14, 1995); U.S. v. Delta Dental Plan of Arizona, Inc., 1995-1 Trade Cas. (CCH) ¶ 71,048 (May 19, 1995).

[3] Other provider contract terms that are indicative of health plan market power include risk-shifting provisions, such as requirements for provider indemnification of the plan for the plan's misuse of confidential patient information, provisions that allow unilateral amendment of the contract by the plan, provisions that permit the plan to adopt payment-related rules (*e.g.*, bundling and unbundling protocols) without the provider's consent, and undisclosed fee schedules.

and are placed in the undesirable position of dunning the patient, a situation that is made worse in the event payment by the health plan is delayed or denied.

Some large health plans (particularly Blue Cross plans) also have required customers to give minimum enrollment assurances. For example, a Blue Cross plan may require an employer who wishes to offer a non-Blue Cross option to its workforce to guarantee that at least 75 percent of the eligible employees will elect the Blue Cross product. If the minimum enrollment guarantee is not met, the employer's premium for the Blue Cross products is increased. This practice, quite obviously, deters employers and other group sponsors from offering competing plans to their employees, and increases the cost to a competing plan that wishes to enter the market.

Again, these practices are dependent on market power. A plan with market power can insist on compliance with reasonable confidence that the customer will not seek other alternatives; a plan without market power cannot. Note that there is a significant interrelationship between market power over providers and market power over customers—a plan that can "lock in" a large provider network at a significant discount is economically significant to any insured individual or group, and a plan that insures or manages a large number of covered lives is economically significant to any provider. This is a significant observation (even if it seems obvious) in the analysis of health plan monopsony power, as discussed further beginning at § 2:15.

§ 2:14 Examining health plan market power—Contracting practices as entry barriers—Collusive barriers

Health plans may collude to create competitive barriers, and an interesting example is found in the rules of the Blue Cross and Blue Shield Association (BCBSA). Blue Cross Blue Shield Plans are independent licensees of the BCBSA. The BCBSA, in turn, is a trade association of the licensed plans. It is not a governmental or quasi-governmental agency. Its rules and regulations are created and approved by the member plans for their mutual benefit.

As licensees, the plans are governed by the BCBSA rules and regulations and by the terms and conditions of the BCBSA licensing agreement. Licensed plans are permitted

to use the Blue Cross and Blue Shield names and service marks, and to participate in a reciprocal arrangement that permits accounts and subscribers enrolled by one plan to receive services on an "in-network" (prepayment) basis through other Plans. This arrangement accommodates not only traveling subscribers, but also national accounts with employees in multiple locations.

Licensed Blue plans consequently are granted exclusive geographic territories. In general, the licensing scheme prohibits any plan from competing for customers in another plan's territory under the Blue Cross or Blue Shield name. As part of this arrangement, plans also are prohibited (with only limited exceptions) from contracting with *providers* in another plan's territory (the "Contracting Restriction"). Presumably, the Contracting Restriction is intended to limit inter-plan competition by maintaining the integrity of each plan's provider network, effectively preserving each plan's exclusive territory.

More significantly, the Contracting Restriction creates significant economic leverage against providers. That is, providers *must* contract with their "home" plan if they wish to participate in *any* Blue Cross/Blue Shield business, regardless of the origin of that business.[1] For example, Michigan hospitals reportedly receive as much as 20 percent of their Blue Cross revenues from plans other than Blue Cross Blue Shield of Michigan (BCBSM), primarily because of business attributable to national accounts written by Blue Cross plans in other states. Ordinarily, a Michigan hospital's relationship with the non-BCBSM Plans would be maintained through its contract with BCBSM, *i.e.*, as a matter of reciprocity between the plans. But if a hospital's BCBSM contract were to terminate, the hospital would have no abil-

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[Section 2:14]

[1]Several federal appellate decisions have struck down territorial restraints imposed by associations on quite similar facts. *See*, *e.g.*, General Leaseways, Inc. v. National Truck Leasing Ass'n, 744 F.2d 588 (7th Cir. 1984) (upholding preliminary injunction granted to restrain defendant's enforcement of association rule limiting geographic competition among members); Los Angeles Memorial Coliseum Com'n v. National Football League, 726 F.2d 1381 (9th Cir. 1984) (holding unlawful under the Rule of Reason an NFL league rule requiring that the transfer of any franchise to a location within the "home" territory of another franchise be approved by a 3/4 majority of the teams).

ity to contract directly with other Blue Cross plans to preserve the national account business. In such a case, consumers effectively are denied the potential benefits of competition from other health plans that may be well positioned to compete against BCBSM.

§ 2:15 Monopsony and health plans

Based on the foregoing discussion, there is at least a reasonable basis to believe that competitive barriers exist in health insurance markets, and therefore that health plans with large market shares have presumptive market power. With regard to the expressed concerns of providers, the question is then whether this power can be exercised as monopsony power and, if so, under what circumstances should the exercise of that power raise antitrust concerns.

§ 2:16 Monopsony and health plans—Does monopsony follow monopoly?

Some studies, the AMA's report in particular, have tended to automatically equate insurer market power (or monopoly) over the sale of output (*i.e.*, health insurance coverage) with market power (or monopsony) over the purchase of inputs (*i.e.*, provider services). Although perhaps intuitive, this is not a necessary correlation. From an economic standpoint, the concepts are distinct, and a brief discussion will help focus the issues appropriately.

First, at a theoretical level, a monopsonistic buyer of inputs may not have market power as a seller of outputs. This scenario is easy to picture—in a traditional "company town" situation, the company would be a monopsonistic buyer of human labor within the town, but would sell the output of that labor in regional or national markets where competition existed. Obviously, these circumstances do not describe a typical health care services market. A health plan that is (hypothetically) the only buyer of professional health services in a local market cannot package those services and sell them in other markets (except perhaps for some specialized services for which patients have a greater willingness to travel).

Conversely, a monopolistic seller may not have market power as a buyer of inputs. From an economic perspective, this would occur if the supply of the relevant input were

highly "elastic," *i.e.*, if suppliers can respond easily to a change in demand for the input. Generally, in the case of a decrease in demand (which would be the assumed outcome of a monopsony, as discussed further below) supply would be elastic if producers can profitably stockpile excess inventory for sale when market conditions improve, and/or can easily switch their productive capacity to other purposes. Generally, neither condition exists for health care services. The "productive capacity" of a physician or a hospital is dedicated to producing health services and cannot be re-tooled in the short run to produce, *e.g.*, educational services or widgets. Moreover, unsold health services cannot be stockpiled and sold at a later date. If a physician can see 10 patients a day, but only sees six, the income from the four unsold visits on that day is lost forever. In other words, if the price and/or demand for health care services falls, health care providers cannot easily replace the lost income.[1]

Thus, in fact, a health plan with a significant market share is likely to have some degree of market power—perhaps a significant degree—over the purchase of provider services. The health plan is able to exercise that market power because it controls a meaningful portion of a provider's income. Most providers, particularly physicians, have no countervailing leverage. The loss of a single physician from a plan network is usually of little consequence to the plan because other physicians are numerous, and the antitrust laws prevent independent providers from taking a collective negotiation stance. A provider's only basis for negotiation in many markets is the ability to bring a unique specialty, facility, or reputation to the network.

§ 2:17 Monopsony and health plans—Implications of bilateral monopoly

At least with respect to hospitals, health plans have

[Section 2:16]

[1]Hypothetically, of course, a physician with declining income could take a second job in another field, but a physician who has invested extensive time and resources in medical training typically lacks the credentials or experience to obtain a job within a short time that would provide a comparable return on investment. Hospitals, which are capital intensive, are in the same boat—there is no economically significant alternative use for a hospital.

argued that their ability to exercise any negotiating leverage is overstated in many or most markets because mergers and consolidations have vested hospitals with market power of their own. This situation is sometimes referred to as a "bilateral monopoly" (or, in a less extreme case, bilateral oligopoly), and an extensive body of game theory has developed to predict the consequences of bilateral monopoly.[1] Bilateral monopoly (or something close to it) exists in some labor markets, a good example being the markets for the services of professional athletes.[2] NFL players, for example, are represented by the National Football League Players Association, which negotiates with a single buyer—the National Football League to determine the structure for salary negotiations, and to agree upon uniform benefits. Similar structures exist in professional basketball and professional baseball.

Economists are unanimous in concluding that bilateral monopoly is less desirable—from a consumer welfare standpoint—than multi-firm competition. However, there is not agreement as to whether bilateral market power produces a better result for consumers than unilateral market power (*i.e.*, buyer monopsony or seller monopoly, but not both).[3] This is because there is no single model to predict the likely outcome in a bilateral monopoly negotiation. Due to the possibility of stalemate, neither the buyer nor the seller is able to fully exercise its market power, and the result—as

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[Section 2:17]

[1]*See, e.g.*, Bowley, "Bilateral Monopoly," 25 Economic Journal 651 (1928); Scherer and Ross, Industrial Market Structure and Economic Performance (3d ed. 1990).

[2]Indeed, the labor union movement in the United States has significant roots in efforts to displace a monopsony model of purchasing human services (particularly in the company towns that were prevalent in the late 1800's and early 1900's) with a bilateral monopoly model of negotiation.

[3]To confuse matters further, a paper by three Tufts University economists concludes that, contrary to popular thinking, providers and insurers do not earn maximum net revenue when they are monopolies or monopsonies, but rather at an intermediate level of market power. Eggleston, Norman, and Pepall, "Pricing Coordination Failures and Health Care Provider Integration," 3 Contributions to Economic Analysis & Policy, Iss. 1, Art. 20 (2004). This would tend to suggest that a bilateral monopoly would enhance consumer welfare.

one would intuitively expect—depends on the relative negotiating skills of each side, and the possible presence of buyer or seller objectives other than profit-maximization. Historical studies of labor markets suggest, however, that in classic "company town" situations, the formation of labor unions (*i.e.*, the restoration of some degree of bargaining balance) resulted in wages that approached those of a competitive market.[4] In other words, the argument that bilateral monopoly may be beneficial for consumers is based on the concept that, if market distortion on one side of the buyer-seller equation is a given, adding a countervailing distortion on the other side of the equation may improve welfare.[5]

But economists also argue that consumers are not automatically better off in every case of bilateral monopoly, and the outcome depends in part on the efficiency of the countervailing power, as well as the relative elasticities of supply and demand in the affected market. In other words, is the monopoly level of output predicted to be greater or less than that of the buyer monopsony, and which side of the table can exercise its power more effectively?[6] At a more pragmatic (and easier to comprehend) level, it has been suggested that, if the monopolist and monopsonist each recognize the other's market power, they can negotiate an agreement to share the monopoly profits, in which case consumers may see no improvement over the case of pure monopsony or pure monopoly.[7]

Thus, without getting too mired in the economics, it appears that whether bilateral monopoly is perceived as a better (albeit sub-optimal) result in health insurance bargaining depends on the assumptions regarding the strategies and objectives of the parties on each side of the bargaining table. In this context, for example, it probably makes a dif-

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[4]"Bilateral Monopoly," AmosWEB Encyclonomic WEB*pedia, http://www.AmosWEB.com, AmosWEB, LLC, 2000-2007.

[5]*See* discussion in Gaynor and Vogt, "Antitrust and Competition in Health Care Markets," Handbook of Health Economics, Vol. 1B (Culyer and Newhouse, eds. 2000).

[6]Gaynor and Vogt, "Antitrust and Competition in Health Care Markets," Handbook of Health Economics, Volume 1B (Culyer and Newhouse, eds. 2000). The authors note that there has been very little empirical examination of the effects of relative bargaining power in the context of health plans and providers.

[7]Hovenkamp, *Mergers and Buyers*, 77 Va. L. Rev. 1369 (1991).

ference whether the other party's objective is to maximize profit,[8] to achieve a minimum rate of return, to maintain or grow market share, or some intermediate combination—all of which go to the question of how willing each side is to share the surplus that otherwise would accrue to it if it could exercise all of its market power.[9]

It is far more likely that the bilateral monopoly model will apply to hospital negotiations than to physician negotiations in any given market. There have been some well-publicized instances of confrontational negotiations between a dominant plan and a large hospital provider. While it would be risky to generalize from anecdotal evidence, there is a sense that health plans and providers pursue different objectives in such negotiations.

Two cases of "brinkmanship" from 2002 provide background. The first involved negotiations between Blue Cross of Michigan and Sparrow Hospital in Lansing. At the time, Sparrow represented about two-thirds of the hospital capacity in that community, and its scope of services was more extensive than its competitors—many of the hospitals proximate to Lansing are small, semi-rural facilities. Upon the breakdown of contract renewal negotiations, BCBSM issued a press statement branding the hospital as at risk for becoming "the only acute care hospital in Michigan that does not participate with the Blues," and indicating it would

[8] Although it may be the case that most insurers are profit-maximizers, some health plans may function as a "buyers cooperative" in which their objective would be merely to break even in the long run and to maximize total services delivered—which would be more in line with the behavior of a competitive firm. *See* Pauly, "Managed care, market power, and monopsony: Examining the Role of Regulation in an Evolving Healthcare Marketplace," 33 Health Services Research 1439, 1443 (Dec. 1998). At one time, Blue Cross plans probably fit this model. It is doubtful whether that is still predictably true. *See* McCann, "Blue Cross—What Happened?", Health Law Handbook (Gosfield, ed. 2003).

[9] It is also relevant that predictions of "consumer welfare" are more complicated in health care because a health plan is not a "pure" agent for consumers (*i.e.*, it acts with mixed motives based on its own objectives to, *e.g.*, maximize profits or market share), and insured consumers (with respect to covered services) do not completely determine the demand for those services, nor pay real prices for the services they consume.

direct patients to other facilities in cities as far as 75 miles from Lansing rather than accept the hospital's terms.[10]

Similarly, in 2002, the Blue Cross plan of the Washington, D.C. area (CareFirst) announced that contract talks had terminated with Children's National Medical Center based on (according to the plan) "excessive" rate demands by the hospital.[11] Children's is a highly regarded specialty facility and generally is considered a "must-have" provider for health plans in the metropolitan Washington area. Nonetheless, CareFirst indicated that it would encourage physicians who use Children's to obtain admitting privileges at other facilities. Children's, asserting that CareFirst was offering the facility rates below its costs despite continually increasing premiums, urged concerned families to change health plans.[12]

In both instances, the hospital ultimately agreed to terms with the plan, and did not permit its Blue Cross participation to terminate. Although experience suggests the result is not unusual, it is interesting because one could think that providers might have more leverage than insurers in a Mexican stand-off, because (arguably) a consumer would rather switch health plans than to consign himself or herself to using a more distant or possibly lower-quality hospital. But in reality providers and insurers are responding to different customers. Most health insurance is sold on a group basis—*e.g.*, to employers and labor organizations. The decision to switch health plans belongs to the plan sponsor, not the individual member, and the member is required to bear the cost of using an out-of network provider, or the disruption of changing providers, until and unless the sponsor determines that switching health plans is in its economic interest. In other words, consumers (members) can have high "switching costs" in these cases. Providers generally place a high value on the goodwill of the patient community

[10] "Sparrow Hospital Contract with Blue Cross Blue Shield of Michigan Ends on Dec. 31" Blue Cross Blue Shield of Michigan Press Release (Dec. 3, 2002).

[11] "Excessive Rate Increase Request Ends CareFirst-Children's Hospital Talks," CareFirst Blue Cross Blue Shield Press Release (Nov. 1, 2002).

[12] Statements published in 2002 at http://www.cnmc.org/parents/par3e_mn.htm.

(and their physicians), which is assuredly at risk in this type of situation. Moreover, health plans historically have been effective in framing these conflicts in terms of efforts to protect consumers by holding down the high costs of health care, while providers generally are ineffective in explaining their rationale for seeking higher payment rates.

Physicians typically (although not invariably) lack the market power of hospitals in the same community. Thus, physicians are more likely to experience the effects of monopsony if their community is dominated by a single health plan. But regardless of the type of providers finding themselves in an unequal bargaining position, the persistent question is whether the antitrust laws provide a source of relief.

§ 2:18 Legal analysis of monopsony conduct—Antitrust challenges to monopsonies

To appreciate the judicial view of monopsony, it is necessary to distinguish between distinct categories of cases. First, courts have had little difficulty condemning *collusive* monopsonies as *per se* unlawful conspiracies—*e.g.*, bid-rigging and other situations where buyers come together to exert market power over sellers.[1] For example, in *American Tobacco*, the Supreme Court upheld the liability of the three largest tobacco companies with respect to a price stabilization arrangement implemented through an elaborate code of behavior for tobacco auctions. The objective of the purchasing cartel was, in essence, to prevent an outbreak of input price competition that might impair retail profitability. The three tobacco companies represented between 50 and 80

[Section 2:18]

[1]*E.g.*, Bray v. Safeway Stores, Inc., 392 F. Supp. 851 (N.D. Cal. 1975); Mandeville Island Farms v. American Crystal Sugar Co., 334 U.S. 219, 68 S. Ct. 996, 92 L. Ed. 1328 (1948); American Tobacco Co. v. U.S., 328 U.S. 781, 66 S. Ct. 1125, 90 L. Ed. 1575 (1946). Bray concerned an alleged conspiracy (implemented through the National Association of Food Chains) to fix the price of beef at the wholesale level. The three named defendants controlled about 15 percent of the retail beef market, and the smallest of the three was twice as large as the next biggest chain buyer of beef. *Mandeville Farms* concerned an agreement among three California sugar refiners to pay uniform prices for California sugar beets. The defendants constituted, on a practical basis, the entire market for California sugar beet producers.

percent of annual domestic tobacco purchases at the time of the alleged conduct, and represented about 70 percent of total retail tobacco product sales. Their ability to constrain the overall market (both input and output) was therefore substantial.

Likewise, courts have found the exercise of monopsony power to be illegal where the challenged conduct impaired other potential *buyers* of the same input. Illustrative is *Klor's v. Broadway-Hale Stores*,[2] in which the Broadway-Hale department store chain was found to have engaged in an unlawful group boycott by using its monopsonistic buying power to convince certain manufacturers and distributors to stop selling to its competitors, or to sell to them only at a discriminatory price.

With respect to the monopsonistic implications of mergers, it is difficult to draw conclusions from the few cases purporting to address the issue. For example, the court in *U.S. v. Pennzoil*[3] recognized the potential competitive effect of a concentrated purchaser market in granting a preliminary injunction to block Pennzoil's acquisition of Kendall Refining Company. Pennzoil and Kendall were, respectively, the second and third largest purchasers of Pennsylvania Grade crude oil, collectively accounting for 34 percent of the total market. The court noted that the market for Pennsylvania Grade crude oil was highly concentrated—there were only six purchasers to which the 2,000 or so independent producers could sell, and only three (including Pennzoil and Kendall) were economically significant. Clearly, this is a situation that could describe many local health plan markets.

However, the difficulty in extracting a general rule from *Pennzoil* is that both Pennzoil and Kendall also held large market shares in the relevant output markets—production and refining. That is, Pennzoil produced Pennsylvania Grade crude oil from its own wells, purchased oil from independent producers, and refined the oil into lubricants. The court did

[2]Klor's, Inc. v. Broadway-Hale Stores, Inc., 359 U.S. 207, 79 S. Ct. 705, 3 L. Ed. 2d 741 (1959). *See also* U.S. v. Griffith, 334 U.S. 100, 68 S. Ct. 941, 92 L. Ed. 1236 (1948) (disapproved of by, Copperweld Corp. v. Independence Tube Corp., 467 U.S. 752, 104 S. Ct. 2731, 81 L. Ed. 2d 628 (1984)) (concerning the use of monopsony power to obtain exclusive supplier relationships that impair competitors of the buyer).

[3]U.S. v. Pennzoil Co., 252 F. Supp. 962 (W.D. Pa. 1965).

not articulate a clear theory of consumer injury from those facts, but it seems likely that the court's overriding concern was that Pennzoil, with a 56 percent post-acquisition share of the refining market, would be able to control output and raise prices in the lubricant market. That is, potential harm from concentration in the refining (output) market arguably condemned the acquisition independently of any concentration in the purchasing (input) market.

However, with respect to "pure" monopsony issues—where the question is the lawfulness of exercising unilateral market power *vis-à-vis* sellers—the courts are reluctant to find a violation of the antitrust laws.[4] As Pauly suggests, this result probably reflects two related circumstances.[5] First, because current antitrust policy holds that a firm with lawfully obtained monopoly power may lawfully set a monopoly price (*i.e.*, "big" is no longer *per se* "bad"), the courts by analogy are inclined to treat monopsonists similarly, without inquiry into the consumer welfare consequences. That is, the courts do not perceive that the exercise of monopsony power lawfully acquired is within the purview of the antitrust laws. Second, even if the welfare effects of monopsony are considered, those effects tend to be manifested in the first instance (as discussed below) in a loss of "producers' surplus" (*i.e.*, reduced profits for providers), and any adverse effects on consumers are not obvious.

Indeed, the decided cases reflect a willingness to presume that the effects of market power on the purchasing side—that is, the ability to drive input costs down—are beneficial to consumers (*i.e.*, in the form of lower output prices). For example, in a relatively recent decision, the Sixth Circuit held—curiously—that an agreement by film exhibitors not to bid competitively against each other for movie exhibition

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[4]Although § 1 of the Sherman Act plainly can be read to encompass collusive monopsonies (and in passing the Supreme Court said as much in U.S. v. Socony-Vacuum Oil Co., 310 U.S. 150, 223, 60 S. Ct. 811, 84 L. Ed. 1129 (1940)), § 2 of the Sherman Act speaks only and expressly to "monopolies"—a term that ordinarily is understood to refer to monopolistic sellers. The extension of § 2 to unilateral monopsony conduct is a matter of inference.

[5]Pauly, "Managed care, market power, and monopsony: Examining the Role of Regulation in an Evolving Healthcare Marketplace," 33 Health Services Research 1439, 1457-68 (Dec. 1998), *citing* Blair and Harrison, Monopsony (1993).

rights "may simply lower prices paid by exhibitors to distributors" and consequently "may lower prices to moviegoers at the box office and may serve rather than undermine consumer welfare."[6] Earlier decisions involving challenges to monopsonistic health plan practices, all of which were decided in favor of the payors, reflect similar thinking.[7] Indeed, the idea that health plans are merely disinterested agents of their members is persistent in the case law.

Curiously, however, in its brief in the "baby food" merger case, the Federal Trade Commission argued that "where the power buyer is an intermediate purchaser, they may not necessarily act to protect the market, but may simply pass on . . . price increase[s]" to consumers.[8] In that case, the argument supported the FTC's view that the potential increase in market power resulting from the challenged merger would not be offset by the countervailing market power of large wholesale buyers. The FTC has been less inclined to such a view when it comes to health plans as intermediate purchasers (*i.e.*, buyers' agents), *e.g.*, in the *Competition Report*.

§ 2:19 Legal analysis of monopsony conduct—Monopsony power as a defense

The flip-side argument—that the antitrust laws should countenance an aggregation of market power by sellers (or buyers) where necessary to offset the market power of buyers (or sellers) in the market—has been embraced by the courts only rarely, and there are perhaps no general rules to

[6]Balmoral Cinema, Inc. v. Allied Artists Pictures Corp., 885 F.2d 313, 316-17 (6th Cir. 1989).

[7]Kartell v. Blue Shield of Massachusetts, Inc., 749 F.2d 922 (1st Cir. 1984); Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Connecticut, Inc., 675 F.2d 502 (2d Cir. 1982); Travelers Ins. Co. v. Blue Cross of Western Pa., 481 F.2d 80 (3d Cir. 1973); Pennsylvania Dental Ass'n v. Medical Service Ass'n of Pennsylvania, 574 F. Supp. 457 (M.D. Pa. 1983), judgment aff'd, 722 F.2d 731 (3d Cir. 1983) and judgment aff'd, 722 F.2d 733 (3d Cir. 1983) and judgment aff'd, 722 F.2d 733 (3d Cir. 1983) and judgment aff'd, 722 F.2d 733 (3d Cir. 1983) and judgment aff'd, 722 F.2d 734 (3d Cir. 1983) and judgment aff'd, 745 F.2d 248, 16 Fed. R. Evid. Serv. 1263 (3d Cir. 1984).

[8]Reply Memorandum In Support Of Plaintiff's Motion for Preliminary Injunction, [*FTC v. H.J. Heinz Co.*, 116 F. Supp. 2d 243 (D.D.C. 2000)] (Aug. 28, 2000), at 19.

be drawn from the cases. In *U.S. v. Baker Hughes Co.*,[1] the court rejected a federal challenge to a merger vesting the defendants with a 75 percent market share. The court observed, among other things, that the likelihood of competitive harm was mitigated by the fact that the affected purchasers were generally large and highly sophisticated firms. However, the court also found that barriers to entry in the affected market were low, which in context would seem to be equally or more important to the result. Somewhat similarly, in *U.S. v. Country Lake Foods*,[2] the court declined to enjoin a merger of the second and third largest sellers in the market, based in part on a finding that the market was dominated by a large buyer that could, if necessary, solicit new entrants into the market. But this conclusion was predicated on evidence that there were, in fact, firms in contiguous markets that were in a position to enter the market (which also could be construed as evidence that the market was too narrowly defined in the first instance).

In a different context, the Ninth Circuit rejected a § 2 monopolization claim against an owner of movie theaters where the evidence showed that large movie distributors were successful in defeating any exercise of monopsony power by the defendant.[3] Of particular note, however, the Supreme Court has cautioned that a few "power buyers" cannot be expected to protect *other* (*i.e.*, smaller) buyers in the market from the effects of a monopolistic seller.[4] That is, the fact that *some* buyers may be large did not, in the Court's view, immunize from challenge a merger that affects both large, sophisticated buyers and small, less sophisticated ones. In fact, some cases hold that a merger may properly be enjoined even if the product has only *one* customer.[5] Presum-

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[Section 2:19]

[1]U.S. v. Baker Hughes Inc., 908 F.2d 981 (D.C. Cir. 1990).

[2]U.S. v. Country Lake Foods, Inc., 754 F. Supp. 669 (D. Minn. 1990).

[3]U.S. v. Syufy Enterprises, 903 F.2d 659 (9th Cir. 1990).

[4]Eastman Kodak Co. v. Image Technical Services, Inc., 504 U.S. 451, 475-76, 112 S. Ct. 2072, 119 L. Ed. 2d 265 (1992).

[5]*E.g.,* F.T.C. v. PPG Industries, Inc., 798 F.2d 1500 (D.C. Cir. 1986); Grumman Corp. v. LTV Corp., 665 F.2d 10 (2d Cir. 1981); F.T.C. v. Alliant Techsystems, Inc., 808 F. Supp. 9 (D.D.C. 1992); F.T.C. v. Imo Industries, 1992-2 Trade Cas. ¶ 69,943 (D.D.C. 1989). All of these cases involved

ably, the converse situation (of a conglomerate "power seller" and a monopolistic buyer) would be treated similarly.

§ 2:20 Legal analysis of monopsony conduct—Adverse effects of monopsony

The judicial view of monopsony (particularly as an offensive cause of action, as opposed to a defense) reflects uncertainty as to the probable consumer welfare implications. Accepted economic theory (as opposed to legal theory) holds that monopsonies can be inimical to consumer welfare, and suggests that the welfare loss may be particularly large in health care markets.[1] If antitrust policy is to re-think its approach to health plan monopsonies, an understanding of these effects is critical.

Welfare loss occurs in monopsony because a firm with the power to drive down the market price of an input will maximize its profit not simply by reducing its total costs, but by reducing the quantity of the input purchased (and thus reducing the buyer's output as well).[2] This will transfer some of the economic surplus from the producers (*i.e.*, the providers) to the intermediate purchaser (*i.e.*, the health plan). Consumers will be affected if this reallocation affects the price, quality, or quantity of the health insurance and medical care available to them.

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defense industry products that were purchased solely by the United States, so query whether national interest considerations alone were sufficient to influence the courts' decisions.

[Section 2:20]

[1]For a very good explanation of the economic issues and the interplay of economic theory and antitrust law, *see* Blair and Harrison, *Antitrust Policy and Monopsony*, 76 Cornell L. Rev. 297 (1991). The discussion here draws heavily on this article.

[2]This may seem counter-intuitive, but may be explained as follows: If a firm buys inputs in a competitive market, it will (following basic economic theory) purchase at a price determined by the point where demand equals supply on a market-wide basis. A monopsonist by definition is not constrained to a market-determined price and therefore will purchase at a price (and corresponding quantity) that maximizes its surplus (profit). This will occur at the price point where demand equals "marginal factor cost," which is the increase in the firm's total costs resulting from the purchase of one additional unit of input. This occurs at a lower quantity of input purchases than the competitive equilibrium quantity. Assuming an upward sloping (*i.e.*, normal) supply curve, fewer units of the input will be supplied at the lower, profit-maximizing purchase price.

§ 2:21 Legal analysis of monopsony conduct—Adverse effects of monopsony—Price effects

Economic theory predicts that the prices paid by consumers for a monopsonist's output will not decrease even if the monopsonist's costs go down. This is a fairly straightforward proposition if the monopsonist faces a competitive output market. By definition, the price in a competitive market is determined independently of any one firm's costs or output. That is, the monopsonist takes the market price, and banks the reduced costs in the form of higher profits.

More importantly, however, a profit-maximizing firm that has *both* market power in the input market *and* market power in the output market—which, as discussed above, is the expected case for a monopsonistic health plan—will charge *higher* prices to consumers than a firm that has market power only in the output market, even though its costs are lower.[1] In other words, if and to the degree a health plan is a profit maximizer, the acquisition of negotiating leverage over provider prices is predicted by economic theory to result in increased premiums compared to a plan with comparable market share that does not have power over provider prices. This is highly significant in suggesting that courts have too easily assumed that the purchasing power of large health plans is exercised for the benefit of subscribers.

§ 2:22 Legal analysis of monopsony conduct—Adverse effects of monopsony—Output effects

The more significant and insidious effects of monopsony probably occur on the output side. There are two dimensions in which output effects may be manifested. The first potential effect concerns the ability for a monopsony purchaser to force a reduction in the number of suppliers (providers) in the

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[Section 2:21]

[1]Although a detailed discussion of the economic theory is beyond the scope of this paper, this occurs because a firm's price and output decisions are based (at least theoretically) on marginal costs, not total costs. Marginal costs actually are higher for a monopsonist than for a firm that lacks monopsony power because, as noted, the monopsonist will maximize its profits by purchasing fewer inputs (and producing less output) than a competitive market would require. That is, the marginal (not total) cost of production will rise, output in turn will be reduced, and (in a noncompetitive market) prices to consumers will increase as a consequence.

market. In general, as the price of a good or service falls (or is forced down), fewer units are produced. Therefore, a monopsonist that exerts its power over price will expect to be able to buy less of the particular input. In a typical non-health care market, the result would be that producers overall will produce less, and some of them will exit the market. But the monopsonist—if it had the ability—could increase its profits even more if it could somehow force the suppliers to sell more inputs at the lower price (*i.e.*, to move off the supply curve), and health plan monopsonists do, in fact, have this ability.

Health plans exercise monopsony power over providers in many markets; yet, the number of providers in those markets usually does not fall to any significant degree, at least in the short run. This is because large health plans can force providers onto what economists term an "all or nothing" supply curve. That is, as noted previously, providers cannot stockpile their unused services and sell them on a later date when prices go up again. Therefore, the alternative to contracting with a large health plan at the price demanded by the health plan could well be to sell nothing at all (or, at best, to sell a drastically reduced quantity of medical services as an out-of-network provider). An unsold medical service can never be sold and therefore, if the alternative is to sell little or nothing, the provider will in fact supply more services at the lower price than it would in a competitive market. The plans can impose this decision on providers because the antitrust laws prevent non-integrated providers from making an organized response.[1]

The economic effect of this situation is that, in a situation analogous to price discrimination, the entire producers' surplus of the providers is transferred to the health plan.

[Section 2:22]

[1]This, of course, was the reason for the prevalence a few years ago of federal and state legislative proposals to exempt certain types of collective provider negotiation from antitrust scrutiny. *See, e.g.*, "Governor Signs Bill Allowing Doctors to Negotiate Jointly With Health Plans," Antitrust & Trade Reg. Report (BNA), at 89 (Feb. 1, 2002); "FTC Warns Alaska of Proposal to Cause Substantial Harm," Antitrust & Trade Reg. Report (BNA), at 116 (Feb. 8, 2002); "Reps. Barr, Conyers Propose Bill Allowing Providers to Negotiate Jointly With Insurers," Health Plan & Provider Report (BNA), at 312 (Mar. 13, 2002). Legislative responses are discussed at § 2:25.

This may well have no effect on the supply of providers in the short run, but in the longer term may cause some providers to exit the market (*i.e.*, if price no longer covers their average total costs). These long-run effects are hard to predict, however.[2] Notably, however, this transfer of the producer surplus is invisible to consumers and, based on the case law to date, to the courts.

There is a second, related, and more direct way in which a health plan monopsonist may affect output. Recall that a monopsonist following expected economic behavior will reduce the quantity of inputs (provider services) that it buys. The principal way that a health plan would accomplish this would not be to contract with fewer providers, but rather to place greater limitations on covered services and/or to implement stricter underwriting policies (*i.e.*, reduce the number of enrollees).[3] Note that premiums (or premium increases) actually could be lower in this circumstance, but (at least for a profit-maximizing health plan) not lower than they would be in a competitive market. This result is more directly visited upon consumers than the effects of price-squeezing providers.

So does this really happen? In other words, does the value of services delivered per health plan member fall "more" than premiums per member as monopsony power increases. Pauly, reviewing studies as of 1998, finds the evidence inconclusive.[4] Robinson's evidence of increasing premiums and declining medical cost ratios in a period of medical cost inflation and health plan consolidation is suggestive of that conclusion, but is incomplete to the extent it does not rule out other explanations. Specifically, declining medical cost ratios over the study period (given higher premiums and profits) may mean that consumers received less insurance coverage and fewer services per dollar, and thus were worse

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[2] An additional possibility is that, over the long run, the quality of providers in the market will decline, even if the number of providers does not. In other words, over the long run, the "best and brightest" may seek careers other than medicine.

[3] Pauly, "Monopsony Power in Health Insurance: Thinking Straight While Standing on Your Head," 6 J. of Health Economics 73, 1450-51 (1987).

[4] Pauly, "Monopsony Power in Health Insurance: Thinking Straight While Standing on Your Head," 6 J. of Health Economics 73, 1453-55 (1987).

off, but alternatively could mean that the health plans simply were effective in eliminating unnecessary services (*i.e.*, services that do not add to consumer welfare) and/or increasing the efficiency of providers. The former outcome would be a concern within the purview of the antitrust laws; the latter would not.

§ 2:23 Are there remedies for monopsony?

If, as the evidence suggests, health plan consolidation and market power are increasing, and if there is at least a theoretical basis to believe that the exercise of monopsony power by health plans can be harmful to consumers (as well as to provider incomes), the question becomes whether there are meaningful ways to regulate the exercise of monopsony power under the antitrust laws or otherwise.

§ 2:24 Are there remedies for monopsony?—Antitrust remedies

As discussed, on the seller (monopoly) side of the equation, the antitrust laws do not provide a remedy for pure price and distributional effects. An otherwise-lawful monopolist is permitted to charge a monopoly price.[1] In part, this reflects judicial reluctance to engage in supervision of prices or restructuring of markets.[2] Supervision, instead, has been left to public policy and regulation (*e.g.*, public utility regulation). The antitrust laws are implicated only when the monopolist engages in abusive conduct—creating or extending the monopoly through coercion or predation. *Kartell* concluded that the reasons for not condemning pure mo-

[Section 2:24]

[1] *See, e.g.*, Berkey Photo, Inc. v. Eastman Kodak Co., 603 F.2d 263, 297, 53 A.L.R. Fed. 768 (2d Cir. 1979) (rejected by, Alaska Airlines, Inc. v. United Airlines, Inc., 948 F.2d 536 (9th Cir. 1991)) and (rejected by, General Cigar Holdings, Inc. v. Altadis, S.A., 205 F. Supp. 2d 1335 (S.D. Fla. 2002)).

[2] U.S. v. Trenton Potteries Co., 273 U.S. 392, 397-98, 47 S. Ct. 377, 71 L. Ed. 700, 50 A.L.R. 989 (1927). Indeed, the courts struggled with market restructuring, *e.g.*, in the cases of AT&T and Microsoft. Arguably, the former proved to be unsuccessful and the latter apparently proved to be inadvisable.

nopoly price effects under the antitrust laws extend to pure monopsony price effects as well.[3]

If current jurisprudence dictates that monopoly and monopsony are to be analyzed similarly under the antitrust laws, it comes as no surprise that provider litigation has focused more on instances of anticompetitive conduct made feasible by monopsony power than on the pure price effects of monopsony. For example, in 2002, a suburban Philadelphia hospital filed suit against Independence Blue Cross (IBC), alleging both monopoly and monopsony claims.[4] The complaint alleged that IBC held a 75 percent share of the covered lives in Southeastern Pennsylvania, and accounted for more than 60 percent of the hospital's commercial patient volume. The complaint cited the continued growth of IBC, the liquidation or exit of six competing health plans, and the reduced presence of IBC's largest competitor (Aetna) as evidence that the market was characterized by barriers to entry of new competitors. The hospital claimed that it had no meaningful or realistic choice as to the price or other terms of its contracts with IBC, and as a consequence lost in excess of $8.5 million on IBC business in the prior year, resulting in a negative operating margin.

The true focus of the lawsuit, however, was on specific conduct, including the use of both express and *de facto* "most favored nation" clauses, requirements to sign "all products" contracts with bundled rates, minimum participation requirements imposed on employers, and unlawful acquisitions and combinations with other health plans. In response, IBC asserted that the hospital's complaint was in reality a rate dispute that should be resolved by the state insurance commissioner and not the courts.[5] However, the case was never tried, and ultimately was resolved through a confidential out-of-court settlement.

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[3] Kartell v. Blue Shield of Massachusetts, Inc., 749 F.2d 922 (1st Cir. 1984).

[4] The Chester County Hospital v. Independence Blue Cross, et al., No. 02-2746 (E.D. Pa., complaint filed May 8, 2002).

[5] A common provider complaint is that state insurance departments are captive to the insurers they regulate, particularly large plans. This appears to have been an issue in Pennsylvania at the time. *See* DiStefano, "Insurers' Pet or Industry Watchdog?" The Philadelphia Inquirer (Dec. 8, 2002).

Legal challenges to health plan conduct also have been impeded by the persistent judicial presumption that health plans act as *bona fide* agents for their members, and therefore that plan and consumer interests are aligned. This can be true even in cases raising no antitrust questions. In 2001, for example, a New Jersey appellate court upheld the New Jersey Blue Cross plan's practice of refusing to recognize assignments of benefits to non-participating providers.[6] The provider plaintiffs argued that the plan's anti-assignment policy violated New Jersey common law and public policy, which rejects restrictions on the alienability of contract rights in favor of free assignability. The court agreed that the common law rule generally would apply, but concluded that the common law would not override the competing and superior public interests vested in the non-profit Blue Cross plan by its enabling law.[7] The court explained that the plan's ability to control costs and provide affordable health care coverage was directly related to the number of medical providers participating in its program, and went on to suggest that direct assignment of payment to non-participating providers would be a form of free-riding, in which the non-participating providers would get the benefits of participation without the burdens.

The court's opinion, delivered (ironically) just 10 days before the Blue Cross plan announced that it would begin

[6]Somerset Orthopedic Associates v. Horizon Blue Cross and Blue Shield of New Jersey, No. A-1562-00T2 (N.J. Super. Ct. App. Div. Dec, 4, 2001) (unpublished decision).

[7]As the Blue Cross movement took shape in the 1930's, states enacted enabling legislation under which Blue Cross plans could operate separate and apart from the commercial insurance industry. Although these laws were by no means uniform, three characteristics were virtually universal: (1) Blue Cross plans were organized on a nonprofit basis, operating as charitable corporations without owners for the benefit of the charitable hospital sponsors and the "subscribers" who bought coverage; (2) the plans were exempted from premium, income, and (frequently) property taxes, as well as other forms of traditional insurance regulation; and (3) in exchange, Blue Cross plans were charged with a public benefit obligation, generally understood to be a role as insurers of last resort for individuals who otherwise would have no option in the marketplace. The New Jersey court understood that state's enabling act as evidence of a broad legislative intent to protect the New Jersey plan.

formal exploration of a for-profit conversion,[8] did not consider the possibility that a dominant plan's interest in coercing broad provider participation in its network would evidence an intent to protect market share from competitive encroachment, not to control costs. Indeed, in a competitive market, a plan's commitment to maintain a broad provider network would increase its costs, not decrease them. Moreover, the free riding benefits to providers of non-participation typically are minimal, if they exist at all, as most plans pay lower net rates to non-participating providers, regardless of whether the claim is assigned. However, as the New Jersey court noted in its opinion, the validity of anti-assignment clauses in group health care contracts has been upheld almost uniformly in other states, and cited decisions from nine jurisdictions (of which seven upheld such an anti-assignment clause).[9]

In sum, it seems unlikely that the courts will provide a straightforward antitrust remedy for low provider rates imposed by a health plan that legitimately acquires market power over providers. At best, the antitrust laws as presently construed may be an effective avenue to block the acquisition of monopsony power (*i.e.*, a merger to monopsony) or to block abusive or predatory conduct that is made effective by the possession of monopsony power. Even in those cases, however, the burden will be significant to convince a court that the traditional presumption—that insurance monopsony is good for (or at least not antithetical to) consumers—does not hold in every case. The argument will require more research than currently exists into the behavior of dominant health plans and dominated markets.

§ 2:25 Are there remedies for monopsony?—Legislative remedies

If the antitrust laws are a difficult avenue of relief from a

[8]"Horizon Blue Cross Blue Shield of New Jersey Board Acts on Corporate Conversion," Horizon Blue Cross Blue Shield Press Release (Dec. 14, 2001).

[9]The court cites cases to this effect from Kansas, Colorado, Delaware, Nebraska, Pennsylvania, California, and the District of Columbia. The cited exceptions are American Medical International v. Arkansas Blue Cross & Blue Shield, 773 S.W.2d 831 (Ark. 1989) and Toranto v. Blue Cross and Blue Shield of Texas, Inc., 993 S.W.2d 648 (Tex. 1999).

health insurance monopsony, the logical alternative would lie in seeking legislative relief. Two quite different legislative avenues are open. The first, long favored by organized medicine, is to amend the antitrust laws to permit providers to act collectively in health plan negotiations. The second is to increase state regulatory oversight of health plan conduct that may create or enhance monopsony power.

§ 2:26 Are there remedies for monopsony?—Legislative remedies—Antitrust exemption for joint provider negotiations

The effort to enact federal legislation creating an antitrust exemption for joint physician negotiations with managed care plans reached its zenith in 2000, when a bill to that effect passed the U.S. House of Representatives by a 2-to-1 margin, but failed to find a sponsor in the Senate. Efforts to resurrect the legislation in 2001 and subsequent years failed, notwithstanding a continued push by the American Medical Association.

Similar efforts at the state level also have been largely fruitless. Three states, Texas, Vermont, and Washington enacted laws early on that were designed to give physicians more leverage in bargaining with health plans. The Vermont and Washington laws permitted physicians, with state supervision, to bargain collectively over a limited range of issues including payment methodologies, but not actual rates. The Texas law was more comprehensive, but required substantial oversight of negotiations by the state's Attorney General, which arguably made the law too burdensome to be effective.[1]

The Texas law had its first test in 2001 when the state attorney general gave final approval to a plan by eleven physicians in Henderson, Texas to conduct joint negotiations with the state's Blue Cross plan through the offices of the man-

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[Section 2:26]

[1]During 2001, similar legislation was approved by the City Council of the District of Columbia, but was vetoed by the District's financial control board, citing estimates that the law would have cost the District more than $3 million per year in higher health care costs by 2004. Romano, "At what cost? Price tag on possible antitrust exemptions for doctors remains mystery," Modern Healthcare, at 8 (July 9, 2001).

aged care director of the local hospital.[2] Henderson is an isolated rural community of about 12,000 population located 100 miles east of Dallas. The approval was based on a determination, as required by the state law, that the Texas Blue Cross plan had substantial market power, and that the terms and conditions of its contract threatened to adversely affect patient care in the Henderson, Texas, area by forcing physicians to cut back staff and services. The attorney general found that these conditions could lead to a general decline in the quality and availability of care and hamper recruitment of skilled physicians.

Blue Cross responded simply by refusing to negotiate with the Henderson physician group, stating that they were willing to contract with the doctors, but only on an individual basis.[3] The Texas law provided no means to compel Blue Cross' participation in the approved group negotiations, or even to mediate a deadlock. Therefore, assuming that Blue Cross in fact had the market power inherent in the attorney general's findings, the law actually provided no remedy for the inequality of bargaining power. Presumably, Blue Cross intended to rely on economic pressure to break the state-sanctioned cartel, as any additional collective actions by the physicians to force negotiations with Blue Cross would have been outside the scope of the attorney general's approval, and would have exposed them to antitrust claims.

At the federal level, the Agencies have consistently opposed any efforts to create or sanction joint negotiations by independent providers. The Department of Justice brought suit in 1998 against the Federation of Physicians and Dentists, a 7,500 member, AFSCME-affiliated labor union, alleging an unlawful group boycott and price-fixing by union orthopedic surgeons in Delaware.[4] The DOJ complaint alleged that the union represented virtually all orthopedic surgeons in Delaware and was designated by those physicians as their exclusive agent to bargain with Blue Cross

[2] Office of the Attorney General, State of Texas, "Cornyn Approves First-Ever Physician Joint Negotiation Program" (Press Release Aug. 30, 2001).

[3] *See* Romano, "Texas Physicians Get Antitrust Pass," Modern Healthcare, at 8 (Sept. 3, 2001).

[4] U.S. v. Federation of Physicians and Dentists, Inc., No. CA 98-475 (D. Del. Nov. 6, 2002) (Consent Judgment).

and Blue Shield of Delaware over a proposed 13 percent decrease in payments for indemnity patients. When negotiations with Blue Cross reached an impasse, the Federation, according to the complaint, undertook a variety of efforts to ensure that the physicians would not break ranks with the union. Eventually, almost all of the member orthopedists terminated their existing contracts with Blue Cross within days of each other.

The Federation maintained that its payor contracting activities, including its dealings with Delaware Blue Cross, were no more than a "messenger model" arrangement on behalf of its members. The Federation maintained that its members ultimately accepted or rejected payor contracts on an individual basis. DOJ maintained that a valid messenger arrangement could not involve any use of collective bargaining leverage, and alleged that the union's actions in Delaware crossed that line.

The case promised one of the first judicial examinations of the permissible scope of network messenger activities under the antitrust laws, as well as an examination of the scope of the labor exemption from the antitrust laws. Ultimately however, in 2001, the case settled by consent judgment. The settlement barred the Federation from participating in, encouraging, or facilitating any agreement or understanding between competing physicians or from negotiating, collectively or individually, any payor contract or contract term on behalf of competing physicians. It also prohibited the Federation from making recommendations to competing physicians about any payor contract or contract term, communicating—or expressing any opinion concerning—competitively sensitive information to competing physicians, discouraging physicians from making an independent business judgment whether to deal directly with payors, or encouraging physicians to deal exclusively with any payor through a third-party messenger. The Federation also was required to institute an antitrust compliance program.

However, the settlement permitted the Federation to continue serving as a collective bargaining agent for employed physicians in any manner permitted by the National Labor Relations Act, and to serve as a messenger for independent physicians, but only subject to specific conditions (which generally mirror the requirements set forth in

Statements Nos. 7 and 8 of the 1996 Statements of Antitrust Enforcement Policy in Health Care[5]).

Although both sides declared victory following the consent judgment,[6] it seems abundantly clear that the effect of the litigation was to severely limit the Federation's ability to serve in any kind of bargaining capacity on the competitive terms of managed care contracts. The Federation's efforts to encompass independent physicians within the protections of collective bargaining laws were unavailing, and its efforts to extend the "messenger" concept to encompass a loosely (or perhaps not so loosely) orchestrated boycott likewise fell short. In the end, only the parameters of the 1996 Enforcement Statements were affirmed, leaving the Federation in the same posture as any PHO in the country.

Unsurprisingly, the *Competition Report* affirmed the same long-held federal views, devoting eight pages to refuting the concept of physician collective bargaining.[7] The Agencies took the position that antitrust enforcement to prevent the unlawful acquisition or exercise of monopsony power by insurers is a better solution than allowing providers to exercise countervailing power. Of course, as discussed above, the antitrust laws historically have provided no effective basis to challenge the practices of a monopsonist health plan that neither unlawfully acquired nor unlawfully exercised that power. But the Agencies argue that authorizing physicians to engage in collusive conduct, even in that situation, would not serve the interests of consumers.

The Agencies also argue—without significant authority—that, because a health insurer with monopsony power is likely to impose quantity restrictions that will increase prices for consumers, allowing providers to acquire countervailing market power would likely result in further quantity restrictions—increasing the prices paid by consumers above those already imposed by the monopsonist. This conclusion conflicts with some models of bilateral monopoly, as discussed above.

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[5]U.S. Department of Justice and Federal Trade Commission, Statements of Antitrust Enforcement Policy in Health Care, 4 Trade Reg. Rep. (CCH) ¶ 13,153 (1996) (hereinafter referred to as the "1996 Statements").

[6]Taylor, "Labor Pains; Justice Department rejects collective-bargaining role for Florida group," Modern Healthcare, at 16 (Oct. 29, 2001).

[7]Competition Report, Ch. 2, pp. 18-25.

The *Competition Report* sets out a litany of harms that the Agencies believe would result from the creation of antitrust exemptions for physician collective bargaining, which basically can be summarized as higher prices and reduced insurance coverage. The Agencies cite their own past enforcement actions against providers as evidence for their view that collective bargaining is likely to result in substantial increases in the price of health care services. They also cite a 2000 Congressional Budget Office (CBO) report estimating that then-pending federal legislation to exempt physicians from antitrust scrutiny and allow collective bargaining would increase expenditures on private health insurance by 2.6 percent, increase direct federal spending on programs such as Medicaid by $11.3 billion over ten years, and decrease tax revenue by $10.9 billion over the same period.[8] With respect to any contrary viewpoints, the *Competition Report* notes in a single sentence—without discussion—that "Physician groups have argued that the actual cost of physician collective bargaining is likely to be modest."[9]

But are proponents of an antitrust exemption for provider negotiations really off-base? In at least some circumstances, allowing a bilateral monopoly model to be created could increase welfare. At the *Competition Report* hearings, James Langenfeld, a former Director for Antitrust in the Bureau of Economics of the FTC, testified that circumstances may exist in which permitting a bilateral monopsony would be beneficial to consumers. Those circumstances, according to Langenfeld, require four conditions with respect to the health plans in a given market: high concentration, substantial market power, significant inequality of market power compared to providers, and an inelastic supply of payors (*i.e.*, barriers to entry).[10] Those conditions certainly exist in some markets but, as Langenfeld testified, not all markets. Therefore, he concluded that an across-the-board legislative exemption would not be appropriate, but that the Agencies

[8] Cong. Budget Office, 106th Cong., H.R. 1304: Quality Health-Care Coalition Act of 1999, at 2 (Cost Estimate, Mar. 15, 2000).

[9] Competition Report, Ch. 2, p. 24.

[10] Langenfeld, Health Insurance/Providers Countervailing Market Power, presentation to FTC/DOJ Hearings on Health Care (May 7, 2003). Curiously, although the Agencies cite Langenfeld's testimony and writings on other topics in the *Competition Report*, they omit to discuss this particular testimony.

should be more permissive in permitting provider joint ventures or mergers in cases where health plans exercise significant and disproportionate market power.

Langenfeld's testimony points out the difficulty of crafting a legislative solution to the unequal playing field: to preserve the legitimate interests of the antitrust laws, any exemption must be limited by facts that would need to be defined and verified in each case—and those facts are capable of changing over time. Consequently, given the consistent opposition of the Agencies, legislative relief in the form of an exemption remains an unlikely scenario.

§ 2:27 Are there remedies for monopsony?—Legislative remedies—Legislative and regulatory relief directed to conduct

Although short of the empowerment that collective bargaining would give providers, it is perhaps more feasible to consider state legislative and regulatory approaches that would curtail practices that impede health plan competition and therefore permit dominant plans to maintain their market power. Although many of these practices are within the reach of the antitrust laws, regulatory enforcement at the state level has the potential to be a more efficient means of deterring and preventing abuses of market power.

As discussed above, the conduct most frequently associated with erecting barriers to new competition includes exclusivity, "all products" and "most favored nation" clauses in provider contracts, and anti-assignment and minimum enrollment clauses in subscriber contracts, and territorial allocations and contracting restrictions by Blue Cross plans. Defining such provisions as unfair insurance practices would not guarantee more competition, but could remove some impediments to innovation and increase the likelihood that plans would compete on the merits for both providers and customers.[1]

It also would be logical, in this context, to strengthen state standards for approval of health plan mergers and

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[1]To the extent plans may argue that some of these practices protect them from certain underwriting risks, it is conceivable that smaller plans (*i.e.*, those most vulnerable to underwriting risks) could be exempted.

acquisitions. In many states, the acquisition of a health plan involves little regulatory review beyond the financial solvency of the acquiring party. Consideration of the effects of the acquisition on health plan competition in some cases has been deemed irrelevant due to the state's (at least theoretical) ability to review and approve rates and contracts.[2] More stringent standards would not necessarily prevent large national insurers from acquiring local health plans, but could limit the ability of plans within a market to eliminate their competition or deter innovation.

In this regard, it is interesting to note that the two major national administrators of consumer-directed health plans—Lumenos and Definity—have each been acquired by one of the large national insurers (Wellpoint and United, respectively). As Robinson notes, innovations in technology and product design are one means by which new competitors may offset the economic scale advantages of entrenched health plans. If large firms pre-empt this innovation through acquisition, competitive market changes may be inhibited.

§ 2:28 Conclusion

Monopsony remains a more interesting economic theory

[2]For an illustration of this line of thinking, *see* Blue Cross and Blue Shield of Kansas, Inc. v. Sebelius, No. 02-C-340 (Kan. Dist. Ct. June 7, 2002), where, in regard to the de-mutualization and sale to Anthem of the Kansas Blue Cross plan, the court concluded that the two forms of conduct cited by the state insurance commissioner in disapproving the sale—raising premiums and reducing surplus—ordinarily would be permitted under Kansas law and could not form the basis of a decision to deny approval of the transaction. The court stated, "Although the Commissioner is granted power to supervise insurers and to enforce the Kansas Insurance Code, she is not authorized to add or change established legal requirements of take regulatory action based on anticipated rates or levels that would be either required by or consistent with the law under . . . statutory guidelines and case precedents." The court took particular exception to concerns expressed by the commissioner regarding the effects of the proposed transaction on rates charged to small group and individual policyholders, stating that if those lines were unprofitable, it would "indefensible" to deny the transaction so as to continue "unlawful" cross-subsidization of those groups by other policyholders. The court also held that commissioner's objections regarding the plan's reduced surplus must fail so long as the plan will continue to maintain the minimum surplus required under Kansas law. This decision was later reversed by the Kansas Supreme Court sub nom. Blue Cross and Blue Shield of Kansas, Inc. v. Praeger, 276 Kan. 232, 75 P.3d 226 (2003).

than a basis for antitrust enforcement. Yet, it seems clear that there is more to the concerns raised by organized medicine about the effects of dominant health plans than just declining reimbursements. There are also questions about the effects that health plan consolidation and market concentration may be having on the quality and quantity of both the insurance coverage and the medical services available to consumers. If there is to be a change in public policy (including the application of the antitrust laws to these situations), there will first need to be more specific evidence of outcomes in concentrated insurance markets, as well as some coalescence around definitions of quality and efficiency in the delivery of health care.[1]

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[1]In this regard, a dissertation published in late 2006 proposes a monopsony model of physician earnings and level of services for a monopolistic health insurer, and predicts that equilibrium wage and service levels are lower than those for a health insurer operating in competitive output and input markets. To test those predictions empirically, the author measures market concentration (HHI) of HMOs, along with a set of control variables, for 218 Metropolitan Statistical Areas (MSA). He concludes that the monopsony hypothesis cannot be rejected for the 70 largest MSAs. He finds evidence of negative effects on both primary care physician earnings and on the per capita number of PCPs. Seth, Effects of Health Insurer Monopsony (Boston College Nov. 16, 2006), available at http://www2.bc.edu/~sethpa/PallaviSaiSeth.pdf.