

providing advice to parties considering a merger. Thus, the Agencies concluded that a revamping of the Guidelines is neither needed nor widely desired at this time. Rather, the Guidelines' analytic framework has proved both robust and sufficiently flexible to allow the Agencies properly to account for the particular facts presented in each merger investigation.

Even after losing six consecutive hospital merger cases between them and being informed by the economic research on the price effects of hospital mergers, the agencies did not recommend or adopt unique standards, analytic frameworks, or special presumptions for assessing hospital mergers. Instead, as the "Guidelines Commentary" makes clear, the agencies apply the standard framework in a fact-specific fashion that is tied to the evolving structure of the hospital industry.¹³¹ This approach is equally appropriate and sufficient for antitrust analysis of health plan mergers.¹³²

In summary, the American Hospital Association's various requests for reinvigorated antitrust enforcement of health plan mergers are unwarranted and are not supported by the arguments in the AHA white paper. Despite the claims in that white paper, DOJ enforcement of health plan mergers is consistent, robust, and vigorous, and appropriately follows the time-tested analytic framework prescribed by the FTC and DOJ *Horizontal Merger Guidelines*.

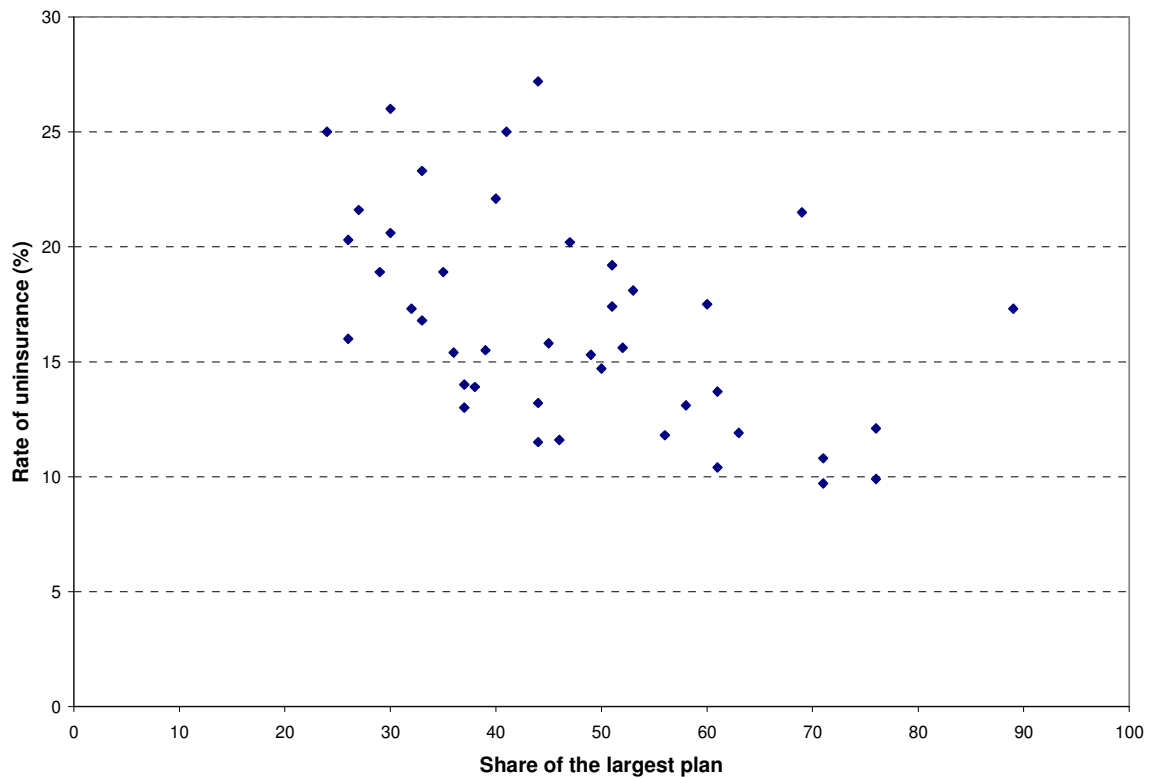
¹³¹ "The Agencies have used bargaining theory to analyze the effects of hospital mergers on the prices they charge managed care organizations" ("Guidelines Commentary," 34). The "Commentary" goes on to describe one hospital case, a joint venture, that the FTC did not oppose and one hospital merger case that the FTC did oppose.

¹³² The FTC and DOJ explicitly considered whether the *Guidelines* were effective in analyzing both monopoly and monopsony harm: "The Agencies, therefore, consider the possibility that a merger would produce a significant anticompetitive effect by eliminating competition between the merging firms in a relevant market in which they compete for an input. By eliminating an important alternative for input suppliers, a merger can lessen competition for an input significantly." "Guidelines Commentary," 36.

Appendix A. Sensitivity analysis of the negative relationship between uninsurance rates and AMA-reported health plan concentration

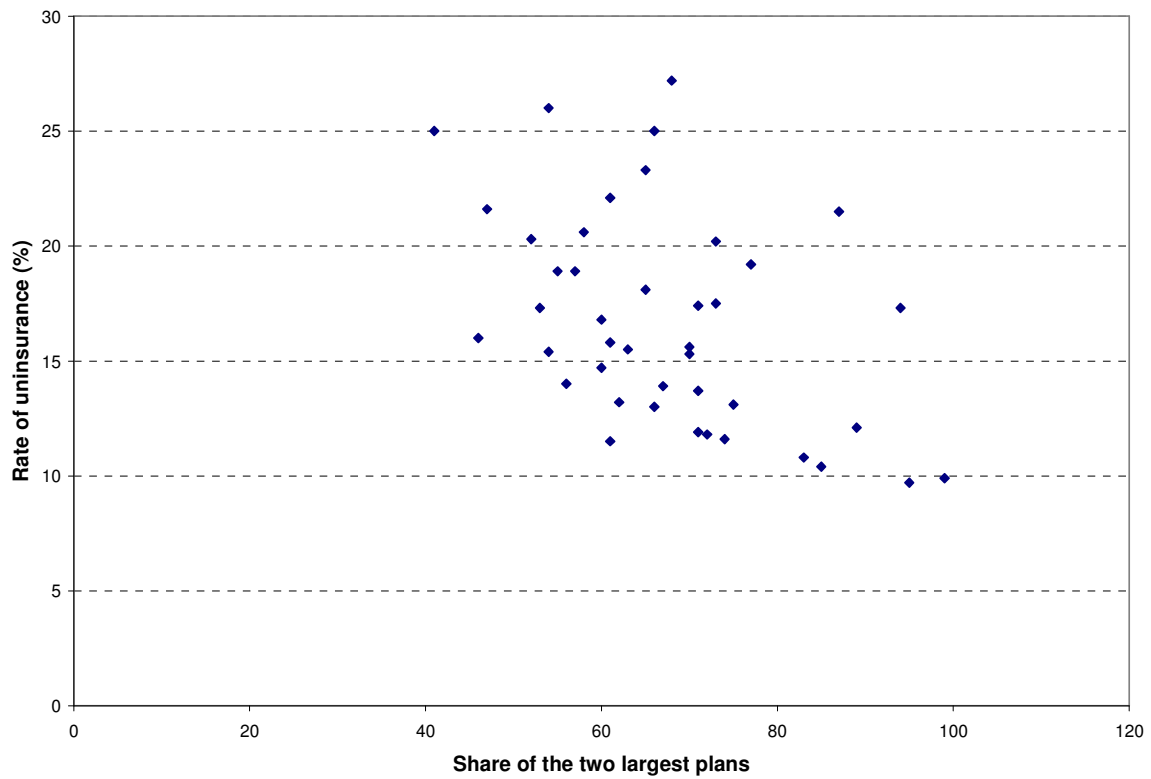
The absence of a positive relationship between concentration and rates of uninsurance is robust across time, concentration measures, and data sources. For example, the AMA also reports statewide market shares for the largest and second largest insurer in each state. As shown in Figure 12 and Figure 13, markets with higher AMA-reported “largest insurer” and “largest two insurers” shares also generally have lower rates of uninsurance, not higher.

Figure 12. State-level uninsurance rates and the AMA-reported share of the largest plan, 2006



Source: AMA, *Competition in Health Insurance, 2008 update* (containing data for 2006); 2006 Current Population Survey (CPS), Table HIA-6.

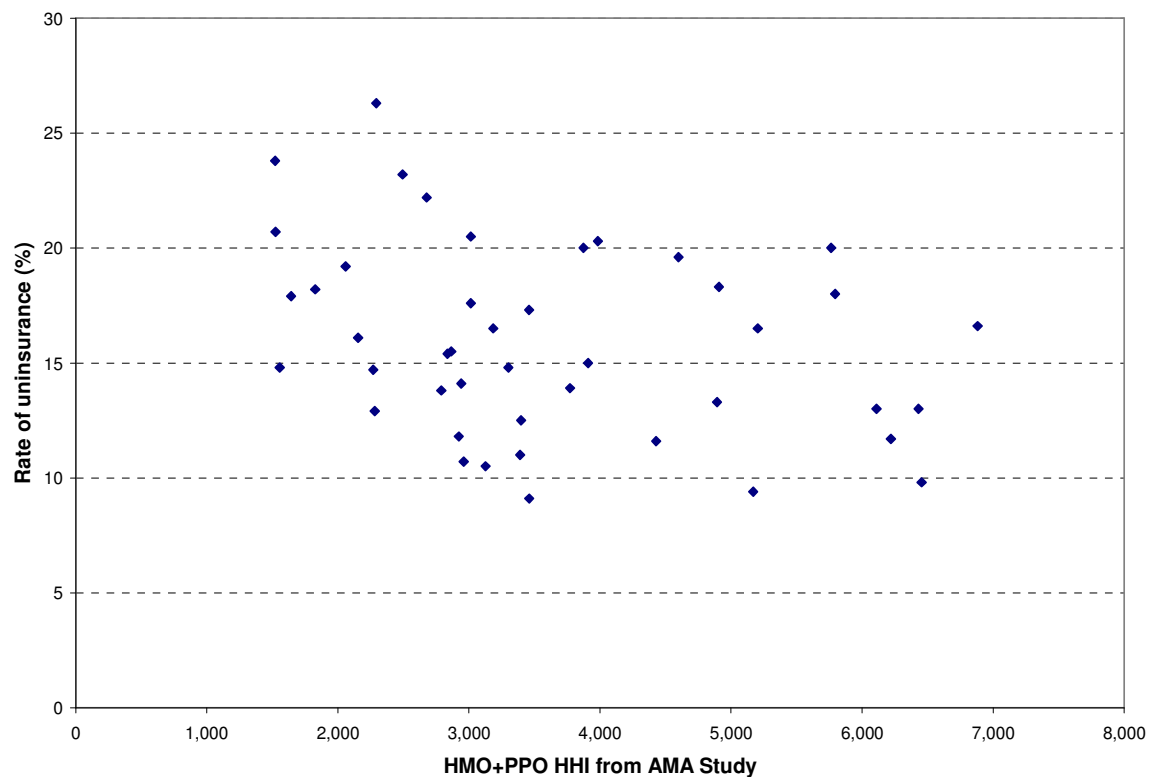
Figure 13. State-level uninsurance rates and the AMA-reported combined share of the two largest plans, 2006



Source: AMA, *Competition in Health Insurance, 2008 update* (containing data for 2006); 2006 Current Population Survey (CPS), Table HIA-6.

As shown in Figure 14, the negative relationship between the AMA-reported HMO+PPO HHI and uninsurance rates also held in 2005.¹³³

¹³³ The 2008 AMA report is based on HLIS data for 2006, and the 2007 AMA report is based on HLIS data for 2005.

Figure 14. State-level uninsurance rates and the AMA-reported HMO+PPO HHI, 2005

Source: AMA, *Competition in Health Insurance, 2007 update* (containing data for 2005); 2006 Current Population Survey (CPS), Table HIA-6.

Other factors, such as economic conditions, could cause some states to have both high levels of uninsurance and fewer health plans. As the regression in Figure 15 shows, controlling for income and the unemployment rate does not change the basic, negative relationship between the rate of uninsurance and the HHI measure reported by the AMA (i.e., the negative and statistically significant coefficient on “HMO/PPO HHI” indicates that, on average, rates of uninsurance are lower in states where AMA-reported concentration is higher).¹³⁴

¹³⁴ The relationship between the AMA’s HHI measure and uninsurance is statistically insignificant when state fixed effects are included. This indicates that *changes in the AMA’s HHI* are not statistically correlated with *changes in the rate of uninsurance*.

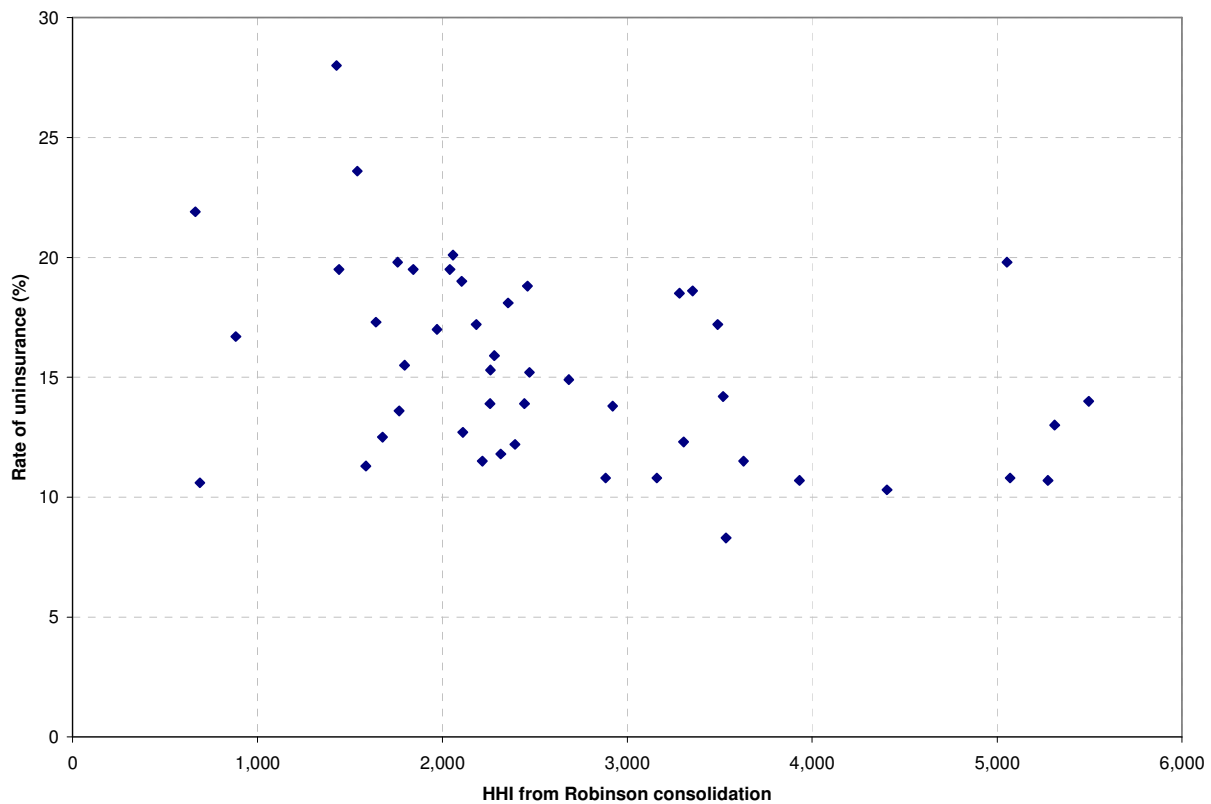
Figure 15. Regression of state-level uninsurance rates on AMA-reported HHI and control variables, 2005 and 2006

Variable	Coefficient	Std. Error	t-Statistic	Prob.
HMO/PPO HHI	-0.00133	0.00027	-4.86000	0.00000
Income	-0.00029	0.00006	-5.14000	0.00000
Unemployment Rate	-0.36707	0.42780	-0.86000	0.39300
2006 Dummy	0.42511	0.81114	0.52000	0.60200
Constant	36.19234	4.21225	8.59000	0.00000
Adjusted R-squared	0.3303			
Number of observations	86			

Source: AMA, *Competition in Health Insurance, 2007 Update and 2008 Update*; 2006 Current Population Survey (CPS), Table HIA-6; U.S. Census Bureau: 2005 Median Household Income by State; and U.S. Bureau of Labor Statistics: 2005 Unemployment rate data.

Finally, the AMA also cites insurer market share and HHI data from a study by Robinson (2004).¹³⁵ The same negative relationship between uninsurance and the measured HHI holds based on data from that study. See Figure 16.

¹³⁵ “AHA White Paper,” 19, citing James C. Robinson, “Consolidation and the Transformation of Competition in Health Insurance,” *Health Affairs* 23, no. 6 (2004): 11–24.

Figure 16. State-level uninsurance rates and the HHI reported in Robinson (2004)

Source: Robinson (2004); 2006 Current Population Survey (CPS), Table HIA-6.

Appendix B. There is no relationship between private health care spending and the AMA-reported measure of concentration

The AHA claims that the high health plan enrollment shares alleged by the AMA imply that health plans also have monopsony power in markets for the purchase of provider services.¹³⁶ This claim is unsupported for two reasons. First, the predicate that the AMA-reported HHIs constitute evidence of health plan market power (in markets for the sale of health insurance) is inconsistent with the analysis showing that rates of uninsurance are generally *lower*, not higher, in states with higher AMA-reported HHIs.¹³⁷ Second, available data on state-level private

¹³⁶ “AHA White Paper,” 27.

¹³⁷ If higher AMA-reported HHIs indicate that health plans have and exercise market power in many states, the price of commercial insurance should be higher—and insurance coverage rates lower—in more concentrated states. The data clearly reject this hypothesis. See section 3.5.

healthcare spending are also inconsistent with the AHA's premise that "most health insurers have preexisting monopsony power."¹³⁸

In particular, a monopsonist will purchase a lower quantity of the monopsonized inputs in order to reduce the price of those inputs.¹³⁹ Because a monopsonist purchases *fewer* inputs at *lower* prices, total expenditures on inputs should be lower in a monopsonized market than in a competitive market.¹⁴⁰ Therefore, if the AMA measures of concentration, which the AHA relies upon, are valid indicators of the presence and exercise of monopsony power then private healthcare spending should be lower in those states that the AMA report alleges are most concentrated.

As shown in Figure 17, however, there is in fact no meaningful relationship between private healthcare spending and the AMA's measure of concentration. The vertical axis in Figure 17 contains 2004 state-level private healthcare spending per person under-65, and the horizontal axis contains the 2005 HMO+PPO HHI reported in the 2007 AMA study.¹⁴¹ Contrary to the hypothesis of monopsony power, per capita private healthcare expenditures are not systematically lower in states with higher AMA-reported HHIs. In fact, there is a visually apparent modestly positive (not negative) relationship between private healthcare spending and the AMA-reported HHI, though that relationship is statistically insignificant ($t = 0.69$).¹⁴²

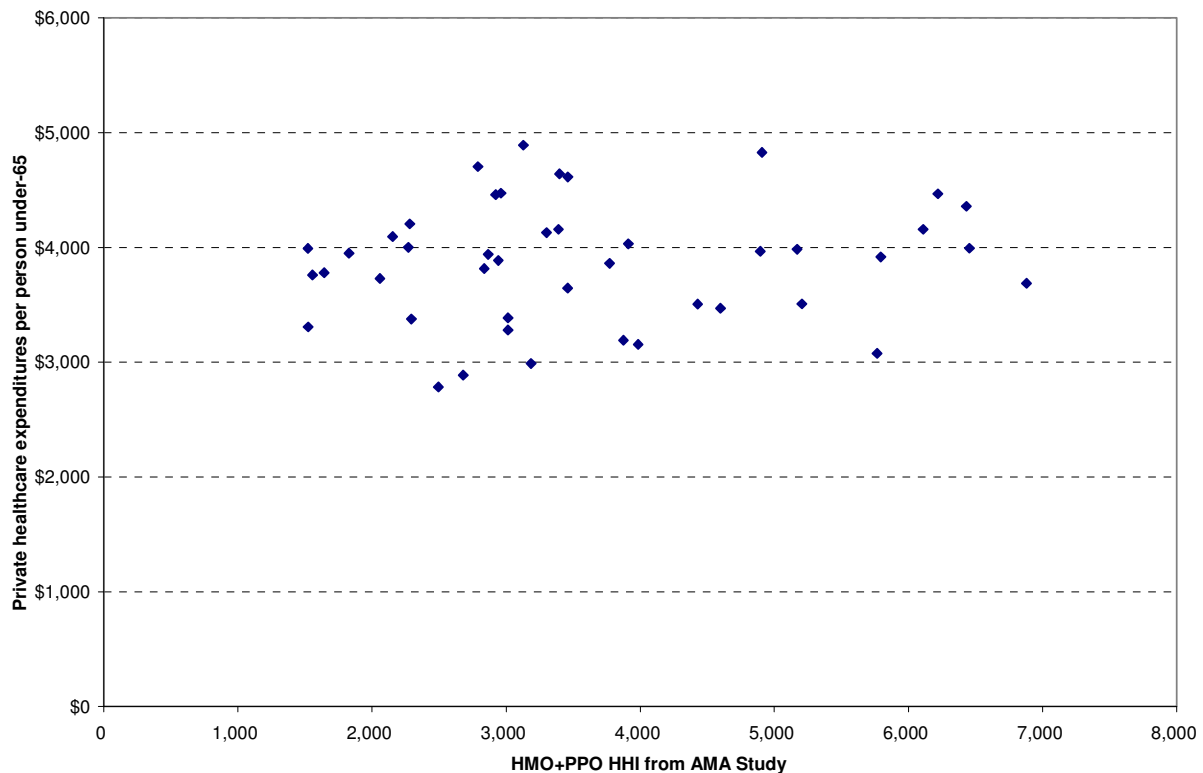
¹³⁸ "AHA White Paper," 27.

¹³⁹ This is simply the mirror image of monopoly: where a monopolist reduces its output in order to increase the sale price relative to the competitive level, a monopsonist reduces its purchases of inputs in order to reduce the purchase price relative to the competitive level. See also, *supra* note 41.

¹⁴⁰ Even though expenditures on inputs are reduced, genuine exercise of monopsony power is inefficient. As explained in the *Dose of Competition* report, "[w]hen a monopsonist reduces purchases of inputs to reduce input prices, society foregoes the production of output whose value to consumers exceeds the resource costs of associated inputs, thereby creating a welfare loss to society." *Dose of Competition*, ch. 6, section III.

¹⁴¹ State-level private healthcare expenditures are calculated from the most recent year of itemized state-level data, 2004 (CMS, "Health Expenditures by State of Provider, 1980-2004"). Private expenditures per capita are computed as [(Total personal healthcare expenditures – Medicare and Medicaid personal healthcare expenditures) / 2005 Under-65 population]. Personal healthcare expenditures, as defined by CMS, do not include the costs of private health insurance (i.e., administrative expenses and profit).

¹⁴² CMS notes that the state-level data, which are calculated on the basis of provider rather than patient states, may be biased by travel across borders. A regression based just on the 25 largest states, which likely have less cross-border travel, also shows an insignificant relationship ($t = -0.49$). The same is true for a regression that includes region fixed effects, which controls for the fact that cross-border travel is most likely an issue in the Northeast ($t = -0.35$).

Figure 17. State-level private healthcare expenditures are unrelated to the AHA-reported HHI

Source: AMA, *Competition in Health Insurance, 2007 update* (containing data for 2005); CMS, *Health Expenditures by State of Provider, 1980–2004*; U.S. Census Bureau, *Interim State Population Projections, 2005*.

Appendix C. Statistical basis for cost and premium calculations

CMS maintains the National Health Expenditures (NHE) data, which are “the official estimates of total health care spending in the United States.”¹⁴³ The most recent set of NHE tables contains highly detailed annual data for the period 1997–2007, as well as data for selected earlier years.¹⁴⁴ In particular, Table 12 in the NHE tables contains data on the total dollar value of Private Health Insurance (PHI) payments for personal health care (i.e., expenditures on benefits) and the total dollar value of insurance premiums. Table 13 in the NHE tables contains data on premiums collected by private health insurers on a per enrollee basis.

¹⁴³ http://www.cms.hhs.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp.

¹⁴⁴ <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf>.

From 1999–2007, the growth rate in total expenditures by private insurers on personal healthcare (i.e., payments by private insurers on behalf of enrollees) grew at an average rate of 7.9%. This is almost identical to the 8.0% growth rate in per enrollee premiums over the same period. If the difference between the figures 7.9% and 8.0% is meaningful, rather than the result of rounding, this indicates that 98.75% of the increase in per enrollee premiums since 1999 is explained purely by increased payments to healthcare providers, pharmaceutical companies, and medical equipment manufacturers.¹⁴⁵

Figure 18. Private health insurance: expenditures on benefits and premiums

Year	Personal Health Care expenditures (“Benefits”), by type of provider (\$ billion) ^[1]				Premiums		
	Hospitals	Physicians and clinics	Other	Total	Kaiser / HRET ^[2]		NHE ^[3]
					Individual	Family	Per enrollee premiums
1998	\$121.9	\$122.1	\$100.4	\$344.4			\$2,012
1999	\$131.4	\$127.6	\$112.0	\$371.0	\$2,196	\$5,791	\$2,136
2000	\$144.0	\$136.7	\$122.1	\$402.8	\$2,471	\$6,438	\$2,306
2001	\$157.1	\$148.9	\$135.0	\$441.0	\$2,689	\$7,061	\$2,537
2002	\$172.1	\$163.1	\$147.1	\$482.3	\$3,083	\$8,003	\$2,821
2003	\$188.0	\$177.7	\$155.8	\$521.5	\$3,383	\$9,068	\$3,106
2004	\$202.8	\$191.1	\$166.7	\$560.6	\$3,695	\$9,950	\$3,306
2005	\$215.4	\$207.1	\$176.4	\$598.9	\$4,024	\$10,880	\$3,527
2006	\$236.1	\$221.5	\$180.3	\$637.9	\$4,242	\$11,480	\$3,729
2007	\$256.9	\$236.5	\$186.9	\$680.3	\$4,479	\$12,106	\$3,946
CAGR (1999 – 2007)	8.7%	8.0%	6.6%	7.9%	9.3%	9.7%	8.0%

Notes:

[1] 2007 National Health Expenditures Web Tables, Table 12.

[2] Kaiser/HRET 2008 Survey, Ex. 1.9.

[3] 2007 National Health Expenditures Web Tables, Table 13.

The data on premiums from the Kaiser/HRET survey show an average increase in individual and family premiums that is approximately 19% larger than the increase implied by the per enrollee figures from the NHE. There are at least two explanations for this difference, and both suggest that the NHE data are the more reliable basis for assessing increases in premiums. First, Census estimates indicate that from 2000 to 2007, average family size increased from 3.14 to 3.19.¹⁴⁶

¹⁴⁵ The NHE tables itemize personal health care expenditures into 10 distinct categories: Physician and Clinical Services, Other Professional Services, Dental Services, Other Personal Health Care, Home Health Care, Nursing Home Care, Prescription Drugs, Other Non-durable Medical Products, and Durable Medical Equipment.

¹⁴⁶ U.S. Census Bureau, Fact Sheet, 2000, <http://factfinder.census.gov/servlet/SAFFFacts>; U.S. Census Bureau, Fact Sheet, 2005–2007, <http://factfinder.census.gov/servlet/ACSSAFFFacts>.

While this difference may appear trivial, it implies one additional insured person for every 20 families with family coverage.¹⁴⁷ To the extent that increases in family premiums simply reflect increases in family size, the increase in family premiums will overstate the per enrollee increase in premium expenditures. An increase in premiums stemming from an increase in family size would reflect the costs of covering additional persons and would not constitute an actual price increase. Second, the NHE figures are constructed by combining the results of three data sources: (1) insurance industry data from A.M. Best and other sources, (2) provider and household survey data, and (3) surveys of employers and individuals. CMS also cross-checks its results against alternative sources, which include but are not limited to Kaiser/HRET.¹⁴⁸ Because the NHE data are more extensively sourced, researched, and cross-checked, they are likely to be more accurate.

¹⁴⁷ More than one-third of those who purchase insurance through their employers select family coverage. Kaiser/HRET 2008 Survey, Ex. 3.9.

¹⁴⁸ CMS, “National Health Expenditures Accounts: Definitions, Sources, and Methods, 2007,” 14–15, <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/dsm-07.pdf>.