

Vertical Merger Guidelines Overlook Health Care Co. Issues

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With the vertical merger guidelines released on June 30, the U.S. Department of Justice and Federal Trade Commission offer expanded guidance on an important and wide-ranging set of business combinations.[1]

In particular, the guidelines illustrate how competitive harm and pro-competitive benefits may occur from mergers between firms at different stages of the same supply chain, at different stages of competing supply chains, or that produce complementary products.

Though comprehensive in scope, the guidelines lack specificity that would be helpful in analyzing many nonhorizontal mergers. For instance, the guidelines do not consider how information asymmetries, distorted incentives, a reliance on platforms and other intermediaries, and prices set through bargaining affect antitrust analysis.

Moreover, the guidelines' generality differs from real-world practices: The agencies use complex economic models when necessary, such as in the AT&T Inc./Time Warner Cable Inc. merger,[2] which provides valuable guidance on how they assess complex competitive interactions.[3]

The health care sector, which has been the subject of much antitrust scrutiny, has many such complex interactions. Antitrust analysis of health care markets can be challenging, as experts must take into account several defining features, such as:

- **Moral hazard:** Patients with health insurance do not typically bear the full marginal cost of health care, which may lead them to consume low-value services.
- **Information asymmetry:** Patients have limited information on the price and value of care and may rely heavily on guidance from medical professionals.
- **Two-stage competition:** Competition among health care providers takes place in two stages: First, providers compete for inclusion in insurer networks; and second,



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providers compete for patients. Insurers operate as a platform or intermediary, connecting patients to a provider network and setting the conditions under which health care services are transacted, e.g., price and coverage.

- Price negotiation: Providers and insurers typically negotiate prices and contracting terms in the first stage of competition. The bargaining context requires different models of post-merger pricing.

Health Care Markets

The defining features of health care markets complicate the assessment of competitive effects and foreclosure or raising rivals' costs. In addition, although the guidelines discuss elimination of double marginalization as one price-reducing mechanism, the bargaining context provides a different mechanism through which the combination of complements can lead to lower prices.

Foreclosure and Raising Rivals' Costs

The guidelines follow a two-pronged framework to assess foreclosure:

- Does the merged firm have the ability to foreclose rivals?
- Does the merged firm have the incentive to foreclose rivals?

When consumers rely on expert advice and gatekeeping, as they do for health care services, the gatekeeper role can offer the ability to foreclose rivals in ways that the guidelines do not address. This foreclosure can occur via physician referrals and formation of provider networks, which at the same time can be tools to address informational asymmetries and moral hazard.

For example, physicians influence patient flow through referrals to other physicians and medical facilities. Patients may lack the knowledge to independently identify the best provider and have limited incentives to choose lower-cost providers because insurance shields them from the full cost of care. Through control over referrals, integrated providers could deny patient volume to rivals or refer the most profitable cases to providers within their own health system, leaving less profitable cases for other systems.

Economists have long raised the concern that physician groups that own ambulatory surgery centers, specialty hospitals or other facilities may raise rivals' costs by selectively referring the most profitable patients to their affiliates.[4] In some circumstances, however, control over referrals will be limited if patients have strong preferences for certain providers or clinical considerations clearly favor referral to a specific provider.

Merger of Health Care Providers

Foreclosure through control over referrals arose as a concern in two transactions from 2012-2013. In Saltzer Medical Group's attempted 2012 acquisition of St. Luke's Health, the plaintiffs challenged the transaction in part by claiming that the merged entity would be able to redirect patients to St. Luke's hospitals, foreclosing other hospitals.[5]

The Massachusetts Health Policy Commission raised similar concerns in Partners HealthCare's

attempted 2013 acquisition of South Shore Hospital and Harbor Medical Associates, fearing that the combined entity would steer patients to the allegedly high-priced Partners and South Shore facilities.[6]

Merger of Insurers and Health Care Providers

The merger of an insurer and provider could also raise foreclosure concerns if, in the first stage of bargaining, the insurer were to deny competing providers network access. These concerns arose in two recent mergers of health insurers with pharmacy benefit managers: Cigna Corp./Express Scripts Holding Co. in 2018 and CVS Health Corp./Aetna Inc. in 2019.

Amicus groups argued that these transactions would result in anti-competitive vertical issues.[7] The American Medical Association contended that CVS/Aetna could foreclose retail pharmacy competition by requiring that enrollees use CVS pharmacies. Despite the AMA's concern, however, CVS/Aetna may lack the incentive to exclude competitors, as that could lead enrollees to switch to other insurers.

Observers also expressed concerns that CVS/Aetna could undermine pharmacy benefit manager services provided to other insurers by omitting important drugs from their formulary.[8] This incentive would depend on the gains in profits from new Aetna enrollees outweighing losses from insurers directing patients away from CVS's pharmacy benefit manager services. Analyzing this incentive would involve addressing the pharmacy benefit manager's role as a multisided platform, balancing the interests of insurers, manufacturers and consumers.

Changes in Post-Merger Prices When Prices Are Negotiated

The guidelines recognize that vertical mergers and mergers of complements can lead to price reductions through the elimination of double marginalization, as they would take into account the "impact of lower prices for one [good] on demand for the other." In industries like health care, where prices are negotiated, this price decline is also expected from mergers of complementary providers.[9]

Mergers of complements in an insurer network generate price declines because the merged entity cannot take advantage of the impact of network inclusion of each party on the value of including the other in negotiating prices. Imagine, for example, negotiations between an insurer, the local pediatric hospital, and the local skilled nursing facility.

Each provider, when negotiating separately, has a high marginal value-add to the insurer's network if the other provider is already in-network: They are strong complements. Since a combined entity can only threaten to not contract with the insurer once, its leverage is smaller than the sum of the leverage of the two providers negotiating separately — the merger eliminates a double threat rather than a double margin per se.[10]

All else being equal, the greater the complementarities — that is, the more the sum of each individual product's value exceeds the combined product's value to the network — the greater the potential decline in the negotiated price.

Complementarity was a key issue in the 2016 merger of Cabell and St. Mary's hospitals in Huntington, West Virginia. The FTC challenged the merger because the hospitals were close substitutes for many patients.[11]

However, because each hospital specialized in a different set of services — Cabell in neonatal and obstetrical care; St. Mary's in complex cardiac care — state regulatory agencies found that the parties were both needed and complementary within insurer networks. A merger could thus reduce the combined entity's bargaining leverage and prices.[12]

Other nonhorizontal mergers, particularly in industries where purchases are mediated through a platform, could result in higher prices even if they operate in different markets. In health care, this could occur when providers are substitutes to insurers when forming networks or when providers' bargaining weights increase with system size, even if patients would not view them as substitutes.[13]

Thus, the effect of a merger on prices depends on the bargaining context, substitutability or complementarity within the insurer network, and the countervailing payer bargaining power, among other factors.

Health Care Markets' Distinct Sources of Efficiencies for Mergers of Complements

The guidelines recognize that vertical mergers frequently allow for pro-competitive efficiencies, such as the ability to "streamline production, inventory management, or distribution" through coordination and "create innovative products in ways that would not likely be achieved through arm's length contracts." This discussion is brief, however, especially when considering industries where the value of coordination is large.

In health care, coordination can allow providers to better combine the many treatments needed to support patient health and can overcome an individual patient's inability and lack of incentive to select an efficient course of care.

In fact, government policy recognizes the room for efficiency-enhancing coordination by encouraging integration through accountable care organizations and through CMS's move toward bundled reimbursement for all provider services within an episode of care.[14] Integrated providers and delivery systems can enact quality-enhancing, cost-saving measures that independent providers might not.

Despite this, efficiencies stemming from mergers of complements in health care may be challenging to measure objectively. Efficiencies addressing moral hazard might lead to reduced output — typically a sign of declining quality in other industries — but also improve patients' health and satisfaction. Conversely, efficiencies may increase output if they make facilities more attractive to patients. Changes in price and quantity thus provide incomplete evidence on competitive effects and efficiencies.

As an example, researchers have found that insurers offering integrated medical and pharmaceutical plans — like the ones the CVS/Aetna and Cigna/Express Scripts mergers facilitated — provided more generous coverage of expenditure-reducing drug therapies than stand-alone pharmaceutical plans, leading to higher drug utilization but likely lower medical costs.[15]

Moreover, medical/pharmaceutical integration that increases information sharing could improve formularies and create stronger incentives for patient compliance.

Mergers of complements could also facilitate efficiencies through reimbursement schemes that incentivize quality and cost savings, offsetting moral hazard that may lead patients to overconsume care. A health system that integrates hospitals, physicians, and other providers, for example, may foster closer collaboration, improving communication and coordination of care, and allowing for bundled or

capitated payments.[16] St. Luke's asserted this benefit in its attempted acquisition of Saltzer.[17]

Integrated health care systems may also provide higher-quality care with greater clinical effectiveness and lower utilization, seen in shorter stays, fewer medical errors and fewer office visits.[18] Integration across different facility types or physician specialties can lower costs and reduce duplicative testing.[19] Primary care physicians who concentrate their referrals within a smaller set of specialists achieve lower costs at similar quality.[20]

While some benefits may be possible without mergers, overcoming asymmetric information problems may require tighter coordination than contractual relationships allow.

Despite this potential, findings are mixed on the effect of hospital/provider integration on quality, patient expenditures and procedure rates.[21] In some cases, integration may increase low-value health care consumption if providers prescribe more of their affiliates' services.[22] The economics and health services literature has found inconclusive results on the effect of physician/hospital integration on utilization.[23]

Notably, federal regulations limit financial incentives to self-refer through the Stark Law and Anti-Kickback Statute. The guidelines do not discuss incorporating the effects of such regulatory limits. Though these regulations could curtail anti-competitive behavior and establish some mergers as net pro-competitive, the agencies might view such limits with the same skepticism they have historically applied to behavioral remedies.

Conclusion

The new vertical merger guidelines explain generally how the agencies will evaluate the competitive effects and the distinct sources of efficiencies in nonhorizontal mergers. They do not address how defining features of health care markets, such as moral hazard, information asymmetries and prices negotiations complicate merger assessments.

Similar features are prominent in other industries: Telecommunication markets include a first stage of competition, with negotiation of prices and a provider network; insurance markets generally include moral hazard; and financial services markets include informational asymmetries and reliance on experts. Health care is a useful lens to illustrate how these features interact with the new guidelines. In particular:

- When consumers rely on experts or prearranged expert networks for product choices, i.e., they lack the information or incentive to make optimal choices, merged entities have enhanced ability to foreclose rivals.
- Mergers when prices are negotiated may lead to post-merger price changes through mechanisms that differ from those of traditional models.
- The forces that allow merged entities to foreclose competitors may also lead to efficiencies through integration, by improving the allocation of health care resources.

These features require careful analysis to marry complex economic theory and empirics with the guidelines' general framework.

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[1] U.S. Department of Justice & The Federal Trade Commission, Vertical Merger Guidelines, June 30, 2020 (hereinafter "guidelines"), <https://www.justice.gov/atr/page/file/1290686/download>.

[2] Expert Report of Carl Shapiro, US v. AT&T Inc., DirectTV Group Holdings, LLC, and Time Warner Inc., February 2, 2018.

[3] Esther D'Amico & Victoria Turner, "US Vertical Merger Guidelines Reflect Existing Policy, Attorneys Say," Parr, March 7, 2020.

[4] Jason Barro et al., "The Effects of Cardiac Specialty Hospitals on the Cost and Quality of Medical Care," Journal of Health Economics, 25, 2006, pp. 702–721.

[5] The case was ultimately decided on horizontal grounds. Answering Brief of Saint Alphonsus Medical Center-Nampa et al., Saint Alphonsus Medical Center-Nampa, Inc. et al. and Idaho Statesman Publishing, LLC et al. v. St. Luke's Health System, Ltd. et al., July 16, 2014.

[6] Commonwealth of Massachusetts Health Policy Commission, "Review of Partners health care System's Proposed Acquisition of South Shore Hospital (HPC-CMIR-2013-1) and Harbor Medical Associates (HPC-CMIR-2013-2) Final Report," February 19, 2014.

[7] The American Antitrust Institute raised objections to both mergers in a letter to Assistant Attorney General Delrahim pursuant to the Tunney Act. See Letter from Diana L. Moss (American Antitrust Institute) to Peter Mucchetti (Department of Justice), "Re: United States v. CVS Health Corp., No. 1:18-cv-02340, Comments of the American Antitrust Institute," December 17, 2018. The American Medical Association also sent a Tunney Act comment to AAG Delrahim, focused mainly on the CVS/Aetna merger. See Letter from James L. Madara, MD (American Medical Association) to The Honorable Makan Delrahim (Department of Justice), "RE: The Acquisition of Aetna, Inc. by CVS Health Corporation," August 7, 2018.

[8] The American Antitrust Institute made this allegation in a Tunney Act comment on the DOJ's consent agreement with CVS/Aetna.

[9] Aviv Nevo, "Mergers that Increase Bargaining Leverage: Remarks Prepared for the Stanford Institute for Economic Policy Research and Cornerstone Research Conference on Antitrust in Highly Innovative Industries," January 22, 2014.

[10] Kathleen Easterbrook et al., "Accounting for Complementarities in Hospital Mergers: Is a Substitute Needed for Current Approaches?" *Antitrust Law Journal*, 82(2), 2019, pp. 497–531.

[11] Federal Trade Commission, "FTC Challenges Proposed Merger of Two West Virginia Hospitals," [FTC.gov](https://www.ftc.gov/news-events/press-releases/2015/11/ftc-challenges-proposed-merger-two-west-virginia-hospitals), November 6, 2015, <https://www.ftc.gov/news-events/press-releases/2015/11/ftc-challenges-proposed-merger-two-west-virginia-hospitals>.

[12] Decision, *In Re: Cabell Huntington Hospital, Inc.* Before the West Virginia Health Care Authority, June 22, 2016.

[13] Leemore Dafny et al., "The Price Effects of Cross-Market Mergers: Theory and Evidence from the Hospital Industry," *RAND Journal of Economics*, 50(2), 2019, pp. 286–325; Matthew Lewis & Kevin Pflum, "Hospital Systems and Bargaining Power: Evidence from Out-of-Market Acquisitions," *RAND Journal of Economics*, 48(3), pp. 579–610.

[14] Centers for Medicare & Medicaid Services (CMS), "CMS Announces Participants in New Value-Based Bundled Payment Model," [CMS.gov](https://www.cms.gov/newsroom/press-releases/cms-announces-participants-new-value-based-bundled-payment-model), October 9, 2018, <https://www.cms.gov/newsroom/press-releases/cms-announces-participants-new-value-based-bundled-payment-model>.

[15] Amanda Starc & Robert Town, "Externalities and Benefit Design in Health Insurance," NBER Working Paper, 21783, 2018.

[16] Jeffrey McCullough et al., "Health Information Technology and Patient Outcomes: The Role of Information and Labor Coordination," *RAND Journal of Economics*, 47(1), 2016, pp. 207–236.

[17] Answering Brief of Saint Alphonsus Medical Center-Nampa et al., *Saint Alphonsus Medical Center-Nampa, Inc. et al. and Idaho Statesman Publishing, LLC et al. v. St. Luke's Health System, Ltd. et al.*, July 16, 2014.

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[19] Laurence C. Baker et al., "The Effects of Multispecialty Group Practice on Health Care Spending and Use," NBER Working Paper, 25915, 2019; Joseph Bledsoe et al., "The Salutary Effect of an Integrated System on the Rate of Repeat CT Scanning in Transferred Trauma Patients: Improved Costs and Efficiencies," *American Journal of Surgery*, 214, 2017, pp. 198–200 at p. 198. See also Brad Brooks, "Creating an Integrated health care Ecosystem Through Mobile Communication Technology," *health care Financial Management*, August 1, 2018.

[20] Leila Agha et al., "Team Formation and Performance: Evidence from health care Referral Networks," NBER Working Paper, 24338, 2018.

[21] Alison Evans Cuellar & Paul J. Gertler, "Strategic Integration of Hospitals and Physicians," *Journal of Health Economics*, 25(1), 2006, pp. 1–28; Kristin Madison, "Hospital-Physician Affiliations and Patient Treatments, Expenditures, and Outcomes," *Health Services Research*, 39(2), 2004, pp. 257–278.

[22] Lawrence P. Casalino et al., "Physician Self-Referral and Physician-Owned Specialty Facilities," *Research Synthesis Report No. 15*, 2008.

[23] Thomas Koch et al., "How Vertical Integration Affects the Quantity and Cost of Care for Medicare Beneficiaries," *Journal of Health Economics*, 52, 2017, pp. 19–32; Laurence Baker et al., "Vertical Integration: Hospital Ownership of Physician Practices Is Associated with Higher Prices and Spending," *Health Affairs*, 33, 2014, pp. 756–763