
**THE CASE FOR REINVIGORATING ANTITRUST ENFORCEMENT
FOR HEALTH PLAN MERGERS AND
ANTICOMPETITIVE CONDUCT
TO PROTECT CONSUMERS AND PROVIDERS
AND SUPPORT MEANINGFUL REFORM¹**

**I. Antitrust Review of Market Power Concerns
in Health Insurance Mergers**

Since the mid-1990s, the Department of Justice Antitrust Division's (DOJ or Antitrust Division) merger review activities in health care have focused primarily on proposed mergers between health insurance plans² (health plans) that each hold substantial market share in the same general geographic area(s) or market.³ DOJ is the primary reviewer of health plan mergers at the federal level. This section provides an overview of the antitrust framework DOJ uses to determine the likely competitive effects of a proposed merger between health plans and a discussion of the most significant DOJ investigations of proposed mergers.⁴

The Merger Review Framework

The DOJ merger review process is generally guided by the principles of the Horizontal Merger Guidelines,⁵ which set out the conditions under which a merger could result in a substantial reduction in competition. The inquiry under the Guidelines focuses on whether a merger is likely to result in a greater ability to exercise market power than would have existed absent the merger. A merger is examined for whether it allows a greater exercise of market power either unilaterally by the merged firm or through sufficient consolidation that the few remaining firms effectively could coordinate their competitive activity. The exercise of market power is usually considered to be the ability to raise price or reduce quality of service, but it can also be a reduction in innovation or a change in terms of service or contractual provisions.

DOJ in some circumstances also focuses its analysis on the potential abuse of increased purchasing power by the merging parties. Abuse of purchasing power is described as the exercise of monopsony power or the ability to extract lower than competitive prices from

suppliers, with the potential adverse effects of reduced quality or innovation. DOJ focuses on whether merged firms will exercise market power in the purchase of goods and services, and has not developed a comprehensive analysis to identify when the exercise of monopsony power is anticompetitive.

Unlike the situation in many other fields and industries, mergers between health plans generate concerns about both the creation of or an increase in market **and** monopsony power. With regard to health plan mergers, these concepts typically apply in the following manner:

- Market power: whether the newly merged health plan could raise premiums to commercial customers (usually employers) and consumers and/or reduce the variety of plans or quality of services offered to those customers and consumers.
- Monopsony power: whether the newly merged health plan could lower hospital or other provider reimbursement below competitive levels or otherwise adversely impact the ability of hospitals to support innovation to enhance quality, efficiency or technological improvements.

The exercise of monopsony power against a hospital or physician could result in significant, secondary effects on patients if it negatively affects the quality, efficiency or availability of care, for example, by forcing postponement or elimination of needed investments in the adoption of technological improvements, such as electronic medical records. The acquisition of exercise of monopsony power through a health plan merger could skew, delay or eliminate hospitals' investment in initiatives intended to improve the quality and efficiency of care.

Recent DOJ health plan merger investigations involving monopsony power have typically focused on the likelihood that the merger could artificially depress reimbursement for physicians because the merged plans would control such a large share of their patients.⁶ DOJ filings and public statements on health plan mergers show comparatively less focus on reimbursement effects for hospitals. However, in its report

on the health care hearings conducted jointly with the Federal Trade Commission (FTC) in 2004, DOJ did signal some willingness to extend its analysis of monopsony power in health plan mergers as it affects hospitals.

Regarding *market power*, recent DOJ merger investigations have focused specifically on the possibility that a merger between two health plans could substantially increase premiums or the prices paid by employers and enrollees, including co-pays.

In analyzing whether a merger is likely to create or enhance market power, DOJ should consider whether there is sufficient competition from health plans other than those merging to keep the market competitive. To that end, DOJ examines current market competitors and potential new entrants. Specifically, DOJ asks: (1) What are the alternatives for employers and consumers to the merging plans' products and services; and (2) What are the alternative health plans and sources of revenue to which hospitals and physicians can turn?

To answer these questions, DOJ begins by determining the relevant product and geographic markets for the products/services offered by the merging health plans. A relevant product refers to a product or sets of products consumers could switch to, or threaten to switch to, that could discipline an exercise of market power, such as premium increases, by the merging plans. Similarly, geographic market definition involves the identification of the specific purchasers or suppliers of these products/services that are practical alternatives. Market definition is a useful part of the process for identifying whether the merged firm can lower and maintain reimbursement below competitive levels to some health care providers in a geographic area without the risk of losing so many providers from their networks that an anticompetitive price increase would be unprofitable. Essentially, it provides a means to consider the practical alternatives to which consumers, employers, physicians, or hospitals could turn for some or all of their business as a means to keep prices competitive.

Beyond identifying relevant markets, DOJ determines the likely competitive effects of a proposed merger by:

- Evaluating the shares of the merging parties and the levels of concentration in the relevant markets. This involves looking at the relative size of the merging parties as compared to other market participants, based on revenues or enrollees, and applying both general and specific thresholds for concentration. Under the Merger Guidelines, a merger that results in increased concentration, as determined by a conventional antitrust tool called the Herfindahl-Hirschman Index (HHI), by over 50 points in a highly concentrated market should be subject to close scrutiny; those with post-merger HHIs between 1,000 and 1,800 with a change in HHI of 100 points or more may also receive close scrutiny.⁷ While there is no absolute level of HHI-measured concentration that triggers close scrutiny, DOJ has investigated proposed health plan mergers where the ultimate market share was as little as 33 percent.⁸
- Assessing competitive factors. This takes into consideration whether there are factors that would make it easier or more difficult for any alleged anticompetitive activity to occur, such as the ability of those affected by the proposed merger to drop the health plans or develop other payors to replace some or all of their business and whether doing so would result in significant costs or losses in attempting to resist the merged plans' pricing increases or reimbursement reductions.
- Assessing factors that would discipline the exercise of market power by the merging parties, such as the prospects for timely, likely, and sufficient entry by other competitors and expansion by smaller competitors already in the market. If, for example, DOJ found that timely entry by competitors offering Health Maintenance Organization (HMO) products or expansion by a smaller health plan was likely, it might view those possibilities as sufficient to limit the exercise of market power by the merging health plans.
- Assessing expected efficiencies that will occur because of the merger. Where there is a concern that the merger may result in increased prices, DOJ examines whether the benefits that are specific to the merger are substantial and that they would, on balance, result in benefits, or at least a lack of harm, to consumers.

No individual or even a combination of concerns or negative responses to the issues listed above will determine for certain whether DOJ investigates or challenges a proposed health plan merger. However, a combination of concerns and negative responses make it much more likely that the merger will receive serious prolonged scrutiny.

Antitrust Issues Raised by Health Plan Mergers

Between 1995 and 2006, consolidation in the health insurance industry was rampant. While consolidation has slowed somewhat since then, it still continues at an alarming pace with two particularly large and problematic consolidations coming under DOJ review in 2008. Health plan mergers of particular concern included the combination of Aetna and Prudential; United and PacifiCare; Anthem and WellPoint; United and Oxford; United and MetraHealth; and HIP and GHI. These mergers share some basic similarities in that each involved competing health plans with at least some geographic overlap. In most cases, DOJ investigated the merger, albeit comparatively few were challenged. In a few cases, state agencies challenged a merger that DOJ had cleared. None of these investigations reveals any substantial focus on whether the merger would further entrench an already dominant health plan or a significant concern with the impact of health plan consolidation on hospitals.

Following is a chart depicting all the major health plan mergers DOJ has publicly investigated since 1993:

Date	Major Health Plan Mergers
1993	Anthem -- Blue Cross/Blue Shield of Kentucky
1995	Anthem -- Community Mutual (a Blue Cross/Blue Shield plan in Ohio) United -- MetraHealth United -- PHP of Missouri
1996	WellPoint -- Group Life and Health (Subsidiary of Mass Mutual Life) United -- PHP of North Carolina Aetna -- US Healthcare
1997	Anthem -- Blue Cross/Blue Shield of Connecticut
1998	United -- Humana (abandoned for financial reasons) United -- PHP of Texas Blue Cross Illinois -- Blue Cross Texas (formed HCSC) Aetna -- NYL Care
1999	Anthem -- Blue Cross/Blue Shield of New Hampshire Anthem -- Blue Cross/ Blue Shield of Colorado and Nevada Aetna -- Prudential Yellowstone Community Health Plan -- BCBS of Montana
2000	Anthem -- Blue Cross/Blue Shield of Maine WellPoint -- Rush Prudential Health Plans of Illinois
2001	HCSC -- Blue Cross New Mexico WellPoint -- Cerulean Companies Inc. (Blue Cross/Blue Shield of Georgia)
2002	Anthem -- Trigon (Blue Cross/Blue Shield of Virginia) WellPoint -- RightCHOICE (Blue Cross/Blue Shield of Missouri and HealthLink) WellPoint -- Methodist Care (Texas HMO)
2003	WellPoint -- Cobalt (Blue Cross/Blue Shield of Wisconsin)
2004	Anthem -- WellPoint Health Networks Inc. United -- Oxford United -- MAMSI
2005	WellPoint -- Lumenos United -- PacifiCare HCSC -- Blue Cross HIP -- GHI
2006	United -- John Deere
2007-08	United -- Sierra Independence Blue Cross -- Highmark (abandoned 2009)

In examining these mergers, DOJ has focused to a far greater degree on the direct price impact on the commercial customers of health plans and less often on the impact on the providers and provision of health care services.

- ***Product and Geographic Market Definition***

A key issue that DOJ has struggled with in health plan mergers is how to define the relevant product market and whether this market should be broadly defined and include any and all types of insurance products, or more narrowly defined to include only specific products, such as HMOs. Health insurers typically offer a variety of plans: HMO, point of service (POS), preferred provider organization (PPO), ASO, indemnity, and other plans that constitute commercial insurance. A threshold issue is whether consumers would switch between and among these types of plans based on relatively small changes in premiums. A similar, though less developed, issue is whether physicians and hospitals could obtain sufficient patients and revenues by shifting to other plans.

Geographic markets are typically defined as local areas, such as metropolitan areas, because that is where consumers and employers seek health care. Similarly, for physicians and hospitals seeking alternative sources of revenues to the merging plans, the health plans to which they can turn are those that cover patients in the local areas from which most of their patients are drawn.

The chart below depicts the relevant geographic and product markets where DOJ identified competitive concerns in mergers of major health plans:

Merging Health Plans	Geographic Area	Product(s)
United-MetraHealth	St. Louis, MO	HMO
Aetna-Prudential	Houston, TX	HMO & HMO/POS
Aetna-Prudential	Dallas, TX	HMO & HMO/POS
United-PacifiCare	Tucson, AZ	Health insurance for small-group employers
United-PacifiCare	Boulder, CO	Physician services
United-PacifiCare	Metropolitan areas in CA	Commercial health insurance & physicians and hospital services
HIP-GHI	New York metropolitan area	Various plans to public sector employees
Anthem-WellPoint	Areas in 9 states: CO, CT, IN, KY, ME, NV, NH, OH, VA	Physician and hospital services
United-Oxford	CT, NY, NJ	Fully insured health insurance products, HMO, PPO, POS
United-Sierra	Las Vegas, NV area	Medicare Advantage plans sold to senior citizens

As is evident, DOJ review of health plan mergers between 1995 and the present show some consistency, but no uniformity, in the definition of the relevant product market. As mentioned previously, many of these cases have focused very specifically on the effect of the merger on commercial customers of the plans. In many of the cases, such as the Aetna-Prudential merger, DOJ concluded that the market was limited to HMO or POS plans, thereby excluding PPO and other plans. In the United-PacifiCare merger, DOJ defined the relevant market as the provision of “commercial health insurance to small-group employers.” In the United-Sierra merger, discussed more fully later in this section, DOJ defined another product market focused on the provision of Medicare Advantage plans.

DOJ has addressed to some degree the potential impact health plan mergers have had on hospitals and physicians, but information is more limited on how it reached its conclusions. For example, DOJ defined a second relevant market in the United-PacifiCare merger as the market for physician services. It concluded that the merger would substantially reduce competition for physician services in both Tucson, Arizona, and Boulder, Colorado. DOJ provided little analysis, however, of the market in which health plans competed for physician services and how they competed.

The record is even less developed with regard to competition among health plans for hospital services. In the United-PacifiCare merger review, DOJ did not expressly mention hospital services. In closing its investigation of the Anthem-WellPoint merger, DOJ did indicate that it investigated and developed market share estimates in the nine states in which the merging health plans overlapped for *both* physician and hospital services, but did not further elaborate. DOJ's closing statement in the UnitedHealth-Oxford Health Plan merger addressed the potential implications for hospitals. It indicates that DOJ evaluated the competitive effects of the transaction in metropolitan statistical areas as well as larger geographic areas where hospitals could contract on a system-wide basis. It provides little or no discussion, however, of plan shares and roles in that market.

▪ *Competitive Effects and Entry*

As noted in preceding sections, merger analysis has focused on the ability of the merged plans to raise prices or reduce reimbursements and adversely affect output and quality. In some instances, DOJ has expressed particular concern that one of the merging parties was particularly competitively aggressive with regard to pricing, such that the merger would be likely to eliminate an especially important competitor. Almost uniformly, the concern has been about the ability of the merged plan to raise prices without risking sufficient diversion to other plans, which would make such increases unprofitable; this is called *unilateral effects*. Other factors considered are the ability of other health plans to enter and expand in the market, the cost and timing of such entry and expansion, and regulatory barriers. In many cases, DOJ has concluded that the prospects for timely entry

by would-be competing health plans were insufficient to serve as a check on the merging plans' market power.

With regard to providers, DOJ has focused on whether the combined membership of the merged company would represent a substantial proportion of provider revenues and whether the providers would readily be able to obtain sufficient revenues from other plans. The competitive concerns DOJ raised included harm to both physicians and their patients: "Lower prices paid to physicians by Aetna would likely have caused some physicians to drop out of the market, to curtail their hours, or to spend less time with each Aetna HMO patient; in any such case, the quantity or quality of medical care would have suffered."⁹ In *United-PacifiCare*, DOJ was apparently able to demonstrate that there was a sufficient number of physicians who were heavily dependent on the merging health plans and that the plans would acquire a market share sufficient to create monopsony power, albeit the actual reported market share was only 33 percent.

In discussing why it took no action on the *United-Oxford* transaction, DOJ considered whether the merged health plan would account for such a substantial share of a single hospital's or system's revenues that the hospital would have difficulty shifting away from and replacing the plans' patients with those of other plans. In evaluating the alternative sources of revenue and the share of revenue attributable to the merging plans, it appears that DOJ took into account all provider revenues, including those from government payors, in determining how much of a hospital's or system's total revenues the merged health plan would comprise. It concluded that the hospitals would have sufficient alternatives and that the share of hospital revenues comprised by the merged plans would be low. DOJ also identified factors that it concluded would limit insurer market power and keep the merged health plan from lowering prices or imposing new, adverse conditions. These included the prevalence of PPO products that provided out-of-network reimbursement. DOJ reasoned that even if a hospital were to leave or be dropped from the merged plan's network, it would still receive revenues as out-of-network reimbursement. DOJ also concluded that the ability of hospitals to negotiate on a system-

wide basis as well as consumer preferences for broad networks would give hospitals sufficient bargaining power with insurers.

- ***Remedies for Anticompetitive Mergers***

Each of the major cases challenged by DOJ has been remedied by some often relatively modest divestitures, given the size and scope of the overall merger. Generally, DOJ requires the merging plans to sell some portion of their book of business and any relevant assets to another health plan with a demonstrated commitment to be an effective competitor in the affected markets. Such competitors have included smaller plans or plans already doing business in other parts of the state. For example, to address competitive concerns in the United-PacifiCare transaction, DOJ required the divestiture of commercial insurance contracts in Tucson and a contract in Boulder, and further required United to modify or, if necessary, terminate its contract with Blue Shield in California. The divestitures were required to preserve competition available to small-group employers and eliminate monopsony effects on physicians. Contract modifications were required to prevent adverse effects on consumers in California. More recently, in the United-Sierra transaction, DOJ required divestiture of most of United's assets related to its Medicare Advantage business and even pre-approved an acquirer. To facilitate the divestiture, DOJ's final judgment had several provisions that would require United to assist the new acquirer with the transition into the market, and to ensure that beneficiaries affected by the switch maintained the same levels of access to United's provider network. These provisions were included, presumably, to ensure that the acquiring entity had a chance of becoming a real competitive presence in the market.

Recent Health Plan Mergers

Recently, in addition to the United-Sierra merger, DOJ considered the merger of Highmark and Independence Blue Cross (IBC), two of the largest insurers in Pennsylvania. These mergers are similar to the ones reviewed within the past few years because they involve health plans that sell commercial insurance products to employers and enrollees and do business in the same geographic areas. DOJ allowed UnitedHealth and Sierra to move forward with their proposed merger, but only after a formal

investigation and divestiture order. DOJ cleared the proposed Highmark and IBC merger with a minimum of investigation.

- *United's Acquisition of Sierra*

In 2008, United and Sierra consummated their merger following an investigation by DOJ, the Nevada State Attorney General, and the Nevada Division of Insurance that resulted in some divestitures and other conditions to mitigate potential competition problems.

Before DOJ and the State Attorney General took action, the Nevada Division of Insurance scrutinized the merger and found that it would create a high market share for Medicare Advantage plans that would pose a risk of anticompetitive unilateral effects on consumers of those products and substantial increase in market concentration. However, it found no similar risk for providers in the state from consolidation of these plans or other commercial products.

The Nevada Division of Insurance allowed the merger to proceed only after extracting certain concessions. One of those concessions prevented the merged insurance plan from passing on the costs of the merger to consumers or decreasing provider reimbursement as a result of those costs. In other words, United and Sierra could not structure premiums or reimbursement rates in a way that would pass on the costs of the acquisition to enrollees and providers. These provisions, however, would not prevent the newly merged plan from exercising any monopsony power gained from the transaction in negotiating new contracts with providers.

The only other provider-specific concession was a prohibition against United implementing its “laboratory protocol,” whereby it charges physicians a \$50 penalty for “excessive” referrals to out-of-network laboratories. The merged plans also agreed that Sierra would continue to offer substantially the same Medicare products and benefit design after the acquisition, maintain staffing levels in the local home office, and “continue in its historic role in serving the Nevada marketplace.”

DOJ found that the merger would “substantially increase concentration in an already highly concentrated market that is no broader than Medicare Advantage health insurance plans sold to senior citizens” within the Las Vegas area. DOJ acknowledged that Medicare Advantage was created by Congress to serve as a private market alternative to “traditional” Medicare with the belief that competition within the private market would prove beneficial to seniors. Prior to the merger, DOJ found that United and Sierra had competed to attract Medicare beneficiaries by offering plans with zero premiums, reduced co-payments, no deductibles, improved drug coverage, desirable fitness benefits, and more attractive provider networks.

DOJ concluded that market forces were unlikely to serve as a counterbalance against the potential anticompetitive effects of the merger for Medicare Advantage. Low out-of-pocket costs and richer benefits made it unlikely that seniors would switch away from Medicare Advantage to traditional Medicare in sufficient numbers to make anticompetitive price increases or reductions in quality unprofitable. Beneficiaries in the Las Vegas area could enroll only in Medicare Advantage plans that Centers for Medicare & Medicaid Services (CMS) approves for the county in which they live and therefore could not turn to plans in other parts of the state or country. DOJ noted that the entry of new competitors into the market was unlikely due to substantial cost, reputation, and distribution disadvantages.

DOJ did, however, allow the merger to proceed under certain conditions. United was required to divest itself of most of its assets related to its Medicare Advantage business. DOJ approved Humana as a buyer, subject to approval by CMS and the Nevada Division of Insurance. United was also required to assist the new acquirer with the transition into the market and, in particular, assist it in negotiating agreements with existing provider networks. This was intended to allow all plan participants affected by the switch to have the same access to United’s entire provider network on terms “no less favorable” than they currently had.

DOJ did not, however, include any conditions designed to protect hospitals or other health care providers from unilateral anticompetitive conduct by the merged plan. The potential harm to providers and their patients was not even mentioned.

The Nevada Attorney General also sought concessions to allow the merger to proceed, which included:

- Prohibiting all products clauses or most favored nation's (MFN) clauses for two years;
- Prohibiting exclusive contracts with medical service providers for two years;
- Prohibiting any requirement that health care providers disclose rates charged to other third-party payors;
- Requiring a \$15 million charitable contribution, including a \$7 million contribution to the University Medical Center;
- Providing small group employers at least 60 days' notice of any intent to raise rates;
- Establishing a "Physicians Council" to serve as a forum to discuss issues of concern to physicians and establish goals and benchmarks for the physician-payor relationship; and
- Paying \$875,000 in attorneys' fees.

Although the State's complaint was virtually identical to that filed by the DOJ, the remedies contemplated in the State's proposed final judgment clearly go well beyond the DOJ judgment. Several of these provisions directly affect providers. For instance, the merged entity is prohibited from forcing providers to disclose rates, except in the normal course of operation (e.g., coordination of benefits in connection with specific claims). In the event that rates are shared, either through the providers themselves or through information from a self-insured employer, United and Sierra are prohibited from using that information to negotiate rates with those providers and must take measures to keep the information confidential.

Additionally, the Attorney General has required commitments to Nevada's University Medical Center (UMC), the only public hospital and provider of last resort in Southern Nevada. For instance, United and Sierra agreed to operate in accordance with the terms and conditions of the existing hospital participation agreements for at least two years, and agreed not to unilaterally terminate the participation agreements for two years. The parties also agreed to resolve existing billing disputes with the hospital and develop a mutually acceptable billing and claims dispute resolution process. As for existing billing disputes, United and Sierra made a cash advance of more than \$2 million toward old claims. Additionally, United and Sierra agreed not to steer a disproportionate share of low-income, high-cost individuals to UMC, nor take away members for services for which UMC is contracted to provide.

A final provision worth noting is the term that prohibits United and Sierra from using the "Ingenix" database to establish reasonable and customary charges for reimbursement of out-of-network physicians in Nevada for medical services to enrollees of United's Health Plan of Nevada (HPN) or Sierra's Health and Life Insurance Company. United and Sierra cannot use this database for two years, and for uses declared unlawful, they may not use the database for 10 years.

▪ ***Highmark and IBC Proposed Merger***

The Highmark and Independence Blue Cross (IBC) plans, located in Pennsylvania, announced a planned consolidation in 2007. The proposed merger drew substantial public scrutiny and expressions of concern from a number of directions, with the notable exception of the Antitrust Division. Provider groups and even other health plans raised concerns that the transaction was anticompetitive. The Pennsylvania legislature undertook work on bills in response to it, and the U.S. Senate held an investigatory hearing. The Pennsylvania Insurance Department's review and public concern over the merger recently led the parties to abandon it.

In late April or early May 2008, the plans reportedly filed notice of their transaction with the federal antitrust agencies, and in late May 2008 filed a second time. This was not the first time DOJ had reason to look at whether these plans had or were exercising

monopsony power. In 2002, it apparently initiated an inquiry into the imposition of an MFN clause by Highmark in its provider contracts. Highmark withdrew the clause in the face of that concern, just as it had done nearly a decade before when DOJ warned against its earlier attempt to exercise monopsony power in that manner. In fact, DOJ has alluded to a similar investigation of Independence in 2002.¹⁰ Despite DOJ's history of concern over the preexisting monopsony power of these plans and the immediate concerns of other government actors with their proposed merger, DOJ granted early termination of the waiting period twice under the Hart-Scott-Rodino Act. DOJ apparently made no significant inquiry and offered no public explanation for its lack of concern.

The proposed merger was abandoned in early 2009. The Pennsylvania Insurance Commissioner was reportedly prepared to issue an order disapproving the merger on the grounds that it would have lessened competition and disadvantaged providers, resulting in fewer choices for consumers who depend on those networks for access to quality health care. The Insurance Commissioner raised concerns about the merged plans gaining undue leverage over providers, to the detriment of the consumers: “[T]here is a careful balance to be struck between insurer power and provider power. Concentrated power in the hands of hospitals and doctor networks and concentrated power in the hands of insurers are both bad for consumers. The best market is a competitive one in which multiple insurers compete with multiple providers and no single entity on either side has the power to dictate contract terms.”¹¹

Summary

In the last 12 years, there have been a number of major health plan mergers; many have received antitrust scrutiny by DOJ and, in many cases, by state and local agencies. The principle focus of these inquiries has been on the impact on the commercial customers of the health plans. The definition of the relevant market used in these inquiries has evolved from narrower markets that excluded PPOs to markets that now appear to include “fully insured health insurance products” such as PPOs but not self-insurance plans. This evolution appears to have addressed some criticisms that the DOJ analysis had not kept pace with changes in the marketplace with the introduction of POS and the broadening of

other HMO products. With the United-Sierra merger, DOJ entered new territory, defining a more narrow product market *i.e.*, a Medicare Advantage market, and developing a case based on what it sees as likely anticompetitive effects in that market despite the regulatory role CMS plays in that area.

By contrast, an examination of the impact of health plan mergers on providers appears to have occurred sporadically, with little public focus on the specific effects on hospitals and with somewhat more attention given to physicians. After its review of the two most recent health plan mergers, DOJ did not address in action or through explanation the potential harm to hospitals and physicians.

DOJ's work has shown little or no consideration of whether health plans singly or collectively are already exercising monopsony power over hospitals and other providers. In other contexts, DOJ has recognized that health plans, even without mergers, can possess monopoly or monopsony power at relatively low levels of market share. An example is the case brought by DOJ against Medical Mutual of Ohio, which alleged that an insurer with more than 35 percent of the commercially insured population in Cleveland had unlawfully deterred hospitals from contracting with smaller and more innovative plans through imposition of an MFN clause.¹² The Antitrust Division's view that health plans can have pre-existing substantial monopsony or monopoly power is reported in a number of public statements and well supported by market data.

The Antitrust Division has not publicly provided the results of any examination or inquiry it might have made on the effectiveness of remedies it has obtained, despite the fact that it seems firmly of the view that entry by new, or expansion by existing, health plans is unlikely and thus any anticompetitive effects from a merger are unlikely to be short term or transitory. On the other hand, the Antitrust Division has not publicly given significant weight to any claims of efficiencies from health plan mergers, and has never cited any type of efficiency that might benefit the market in contracting for hospital and physician services.

II. Trends in the Health Plan Industry: Increasing Concentration and Profitability

“With health insurance premiums rising this decade at four times the rate of inflation and draining a growing share of personal income, middle-class support for an [health insurance] overhaul would seem to be reaching a critical mass.”

New York Times, December 14, 2008.

This section provides a brief overview of recent developments in the health insurance industry, including trends in consolidation at the local and national levels and trends in pricing and profitability.

Assessment of Health Plan Consolidation

The health insurance industry has experienced substantial consolidation in recent years, with numerous acquisitions by the largest insurers. For example, in 2004 and 2005, 28 mergers involved health insurers with a total value of approximately \$54 billion. Several of the acquisitions involved the largest insurers, including WellPoint and United; these two insurers account for more than one-third of the covered lives in the United States. United, in particular, continues to grow through consolidation rather than competition, for example, acquiring its largest rival in Nevada in 2008.

▪ *Market Share and Concentration Measures*

Health plan growth can occur either through competition between or among plans for an increasing number of customers based on price, service, and quality or by acquisition of other plans' customers through consolidation. Most of the recent growth of the largest health plans appears to have occurred as a result of consolidation rather than competition.

There are a limited number of studies that examine concentration in the health plan industry. Among the timeliest are the American Medical Association's (AMA) frequent studies on *Competition in Health Insurance*. In 2008, AMA's study examined market share data in 43 states and in 314 metropolitan statistical areas (MSAs) and division. The study reports market structure measures including HHI and market share of the leading

firms, and breaks the data down for HMOs and PPOs separately, as well as for HMOs and PPOs combined. The AMA report focuses on market share in the sale of health plan products, not a market share in the contracting for hospital or physician services.

The key findings of the 2008 study are:

- The vast majority of MSAs are highly concentrated, whether measured as HMO, PPO, or HMO/PPO combined.
- 89 percent of MSAs have a single health plan with a market share greater than 30 percent. In 44 percent of the MSAs, one health plan has a share greater than 30 percent. In two-thirds of those, one health plan has more than 50 percent share, and in just under one-fourth, one health plan has a share of greater than 70 percent. While this point may be examined in different ways, typical examples of highly concentrated MSAs include:
 - Burlington, VT: two health plans with 76 percent share
 - Cedar Rapids, IA: two health plans with 91 percent share
 - Columbia, MO: two health plans with 88 percent share

The health plans with shares in excess of 30 percent to 70 percent tend to be the largest ones in the country, although there are some local or regional competitors with high shares. And, the highest shares for individual plans tend to be held by Blue Cross/Blue Shield organizations in various areas; in Alabama MSAs, the share is as high as 97 percent. Of the 314 MSAs for which data are reported, the largest national health plans are positioned as either first or second in the market.

James Robinson, in a 2004 study of consolidation in the health plan sector, made consistent findings. That study found that in a majority of states, the top five insurers, which are Wellpoint/Anthem, Blue Cross/Blue Shield, United, Aetna, and Cigna, account for more than 50 percent of enrollees, and in many instances account for more than 65 percent.¹³

Trends in HMO and PPO Enrollment

Data and information on HMO and PPO plans show that larger plans have grown both in numbers of enrollees as well as in geography, by offering plans in many states and gaining share within the states. Older plans tend to grow relative to newer and smaller plans. In general, the data indicate substantial expansion by a relatively small number of plans without substantial new entry of plans or major changes in share due to organic growth in local areas.

- *HMOs*

Data on HMOs show that established HMOs gained share over newer HMOs in recent years, and as of 2005 accounted for 71.1 percent of HMO enrollees in the United States. In general, enrollment in HMOs has declined while enrollment in PPOs has increased.

As a result of consolidation as well as expansion, a substantial proportion of HMO enrollment (as well as PPO enrollment) is in networks that span multiple states and, in some cases, the nation. Nearly three-fourths of HMO enrollees are in larger HMO networks. There were almost 60 million enrollees (out of a total of 77 million) in these large HMO networks. In the aggregate, in 2005 the six largest HMO insurers had a total of 209 plans in various locations throughout the country. The largest three of these are: Blue Cross/Blue Shield with 63 HMOs and 19.9 million enrollees, United with 48 HMOs and 9.9 million enrollees, and Cigna with 35 HMOs, and 2.5 million enrollees.

- *PPOs*

Approximately 93 million enrollees are in PPO plans operated by the major corporate PPO networks (these networks account for about 85 percent of all PPO-eligible employees). The three largest HMOs just identified account for more than 60 percent of the nationwide PPO enrollment: Blue Cross/Blue Shield with 27.8 million enrollees, United with 20 million enrollees, and Cigna with 1.5 million enrollees.

Control Over Provider Reimbursement

Increased concentration results in greater provider dependency on fewer health plans. Currently, approximately 56 percent of hospitals' revenues come from health plans. With

revenue controlled by a shrinking cohort of health plans, hospitals and other providers have few, if any, alternatives when faced with reimbursement below competitive levels from health plans. Medicare and Medicaid patients, which account for approximately 39 percent of those revenues, are not an adequate replacement because government reimbursement does not generally cover the cost of providing care to these patients and continues to decline relative to hospital costs. In addition, pervasive regulatory requirements attached to those government programs eliminate or severely circumscribe hospitals' ability to substitute Medicare and/or Medicaid patients for those with private coverage.

Some health plan executives admitted that a goal of consolidation is to drive down hospital and other provider reimbursements. For example, in connection with Aetna's 1996 acquisition of U.S. Health, U.S. Health's CEO declared that he did the deal "to get the mass we needed, the power to negotiate with the physicians, hospitals, the drug companies and force down their charges."¹⁴ IBC and Highmark apparently defended their recent failed merger with the claim that competition among health plans led to the harmful result of reducing monopsony power.¹⁵

Pricing and Profitability

During this period of increased concentration, health plan prices have increased well above the rate of inflation:

Exhibit 1.2
Average Percentage Increase in Health Insurance Premiums Compared with Other Indicators, 1988-2007

	Overall Inflation	Workers' Earnings	Premium Increase
1988	3.9%	3.1%	12.0%
1989	5.1	4.2	18.0
1990	4.7	3.9	14.0
1993	3.2	2.5	8.5
1999	2.3	3.6	5.3*
2000	3.1	4.9	8.2*
2001	3.3	4.0	10.9*
2002	1.6	2.6	12.9*
2003	2.2	3.0	13.9*
2004	2.3	2.1	11.2*
2005	3.5	2.7	9.2*
2006	3.5	3.8	7.7*
2007	2.6	3.7	6.1*

*Estimate is statistically different from estimate for the previous year shown. No tests are done for overall inflation of workers' earnings, or for health insurance premium increases prior to 1999.

Note: Data on premium increases reflect the cost of health insurance premiums for a family of four. The average premium increase is weighted by covered workers.

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2007; KPMG Survey of Employer-Sponsored Health Benefits, 1993, 1996; The Health Insurance Association of America (HIAA) 1988, 1989, 1990; Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation; All Urban Consumers (April to April), 1988-2007; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1988-2007 (April to April).

A study by the Kaiser Family Foundation and the Health Resource and Education Trust (HRET) found pronounced premium growth across all regions of the country, as indicated below:

Health Insurance Premium Growth by Region, 1999-2007

	1999	2000	2001	2002	2003	2004	2005	2006	2007
Northeast	5.1%	8.8%	10.9%	12.8%	13.7%	11.3%	9.3%	8.8%	6.2%
Midwest	5.1%	9.2%	11.8%	13.5%	13.8%	12.5%	9.1%	7.1%	6.0%
South	5.1%	7.6%	10.5%	12.4%	12.9%	9.9%	10.1%	7.7%	6.3%
West	6.4%	7.3%	10.4%	13.1%	16.3%	12.1%	7.9%	7.2%	5.6%

Source: Kaiser/HRET Survey of Employer Sponsored Health Benefits, 1999-2007

As shown below, it also found premium growth for all types of health plans and for all sectors of the economy. Information on HMO premiums from Verispan shows premiums increasing by about 60 percent for individuals and by 52 percent for families from 2000 to 2005.

Average Percentage Increase in Health Insurance Premiums by Plan Type 1999-2007

	1999	2000	2001	2002	2003	2004	2005	2006	2007
Conventional	6.0%	9.5%	11.3%	13.8%	14.3%	11.1%	5.0%	8.4%	7.3%
HMO	5.6	7.6*	10.4	13.5*	15.2	12.0*	9.4*	8.6	8.3
PPO	5.4	8.5*	11.6	12.7*	13.7	10.9*	9.4*	7.3*	5.3*
HDHP/SO	^	^	^	^	^	^	^	4.8	6.3
ALL PLANS	5.3%*	8.2%*	10.9%*	12.9%*	13.9%	11.2%*	9.2%*	7.7%*	6.1%*

*Estimate is statistically different by plan type from estimate for the previous year shown.

^Information was not obtained for HDHP/SO plans prior to 2006.

Note: Data on premium increases reflect the cost of health insurance premiums for a family of four. The average premium increase is weighted by covered workers

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2007.

As shown below, the largest health plans' profit margins remained strong or increased substantially from 2003 to 2006. During the same period shown above, health premiums were also increasing, albeit at a somewhat lower rate than during the 2001-2003 time period.

Pre-Tax Profit Margins, 2003-2006

Company	2003	2004	2005	2006
WellPoint	8.1%	8.6%	9.1%	9.3%
Aetna	8.6	10.1	11.9	10.9
Cigna	4.8	13.1	10.7	10.5
United	10.2	11.0	11.8	9.8

Note: Profit Margin = (Non-Interest Income – Non-Interest Expense)/Non-Interest Expense

Source: finapp.forbes.com

Summary

The trends in health plans that have collided over the past decade involve increased concentration, increased profitability, and increased premiums. While an in-depth review of insurer profitability is beyond the scope of this paper, such an examination would almost certainly be called for to determine whether consolidation has yielded health plan profits above what could be achieved in a competitive marketplace. Already, the vast majority of areas or markets within the United States are dominated by one or two large national health plans, leaving little opportunity for meaningful competition given the barriers to entry, particularly in the current economic climate.

III. Recommendations for Improved Antitrust Analysis of Health Plan Mergers

As the previous two sections of this paper have demonstrated, DOJ has neither conducted nor disclosed any significant study of health plan mergers, and, in particular, has provided little information or insight into its examination, if any, of the impact of these mergers on hospitals and other providers. For example, the extensive report the federal

antitrust agencies issued in July 2004 broadly discusses competition in the health care industry and delves extensively into hospital merger analysis and ways to improve its track record for those mergers.¹⁶ The report's discussion of health plan mergers stands in stark contrast to that on hospital mergers; it simply reviews past cases and attempts to identify relevant issues. However, it offers no analytical insights or new strategies for reviewing or challenging future health plan mergers.

DOJ's analysis has almost certainly been hindered by the limited amount of study devoted to understanding health plan markets and the actual impacts of those mergers on consumers and providers. Unlike hospital mergers, which have been comprehensively studied by the FTC in a multi-year retrospective, no comparable efforts apparently have been undertaken to evaluate the short- or long-term impact of health plan mergers on consumers and providers. Indeed, while studies show that the price of health care insurance has increased for employers and consumers, no comprehensive study has been made on the impact on hospital and provider reimbursement during this period of increasing health plan concentration. DOJ's experience with health plan mergers seems to arise principally from the information it gathers in the necessarily rushed context of a merger investigation. While that information is important, a more comprehensive and focused effort is surely needed.

The information disclosed by DOJ in public documents surrounding its investigations of health plans reflects a degree of knowledge about the impact of those mergers on employers and consumers that vastly exceeds anything that has been disclosed about the impact on providers. For example, the Antitrust Division explored and adopted theories of competitive harm that distinguish among the types of health plans, considering whether HMOs, for example, compete in a separate product market from other forms of health care financing.¹⁷ Additionally, the Antitrust Division has relied on theories of price discrimination in finding that some consumers of health plans' services, such as small group employers or Medicare beneficiaries, might suffer harm from a merger, but other employers and consumers would not.¹⁸

DOJ should reexamine its approach to health plan mergers in a manner that allows it to better understand, and hence remedy when appropriate, the anticompetitive impact on hospitals and other health care providers. And, in doing so it should take in account the full range of products controlled by the health plan(s). The incontrovertible facts about the health plan industry and its relationship to hospitals and providers underscores the urgency of such a reexamination:

- Concentration in the health insurance industry is substantial and increasing, and has achieved levels that are suspect under the agencies' Horizontal Merger Guidelines.
- Many health insurers have merged with only a few, relatively minor challenges, and those challenges nearly always focus on the direct effect on employers and consumers.
- Employers and consumers have not realized expected savings from these mergers in the form of reduced or even stable health insurance premiums.
- Hospitals and providers have become more dependent on fewer health insurance plans.
- Health insurer profits have grown or remained stable, despite economic conditions that suggest profits should have declined.

In light of these facts, DOJ should consider more fully: the impact health plan mergers have had on hospitals and other healthcare providers (based on the entire range of products controlled by the plans, the residual impact on hospital-based technological innovation and/or the acquisition of technology, such as electronic medical records and hospital-directed quality improvement efforts), the need to reinvigorate the analytical framework to deal more comprehensively with the implications of further concentration in health plan markets that are already heavily concentrated, and the need to consider more fully the prospects of sufficient entry and expansion by smaller entities into markets facing consolidation. These considerations, which DOJ has not fully addressed nor discussed in past actions and announcements, could significantly change the approach to future transactions and the likely outcome of any investigation into their likely

competitive harm. Moreover, DOJ should consider greater openness about the analytical methods used for assessing and empirically testing market or monopsony power.

We therefore recommend that DOJ, alone or in conjunction with other agencies, state attorneys general and/or state insurance commissioners who have subpoena authority, undertake a retrospective study of health plan mergers, conduct in-depth hearings on the reasons and remedies for the lack of competition in health plan markets, the analytical tools and approaches that are best suited for testing market or monopsony power, and routinely report on its analysis of the likely impacts on hospitals and other providers when enforcement actions are taken. In particular, the agencies should address the following issues in one or more of these forums.

Nearly Any Health Plan Merger in a Highly Concentrated Market Raises Serious Competitive Concerns

Both DOJ's analyses and publicly available evidence strongly suggest that many health plan markets do not behave competitively and, in particular, do not behave competitively with regard to contracting for provider services. As previously discussed above, many markets are characterized by health plans with a substantial preexisting and remarkably stable share of the market for the sale of commercial health plans. While the information available does not describe health plan market shares based on reimbursements to hospitals or physicians, the market share levels for the sale of health insurance necessarily implies that health insurance plans have substantial control over a hospital's revenues, and thus such revenue market shares are likely to be similarly high. If so, DOJ would almost certainly conclude that most health insurers have preexisting monopsony power.

Some of DOJ's past activities appear to foreshadow such a conclusion. For example, in 1998, the Antitrust Division sued Medical Mutual of Ohio (Medical Mutual) for unlawfully exercising market power in the Cleveland area through imposition of a MFN clause on hospitals. The Antitrust Division relied on its finding that the health plan accounted for 25 to 30 percent of the commercial payments to Cleveland-area hospitals. In the United-PacifiCare merger, the Antitrust Division challenged the likely monopsony

effects on physicians based on its finding that the merged firm would have greater than 30 percent of *some* physicians' revenue stream. Market shares at these levels (25 to 30 percent) are likely to be found for the leading health plans in many, even most, relevant geographic areas, even when government payors are included in the market.

Market concentration on the purchasing side is likely to be high even when Medicare and Medicaid revenues are included. These federal programs provide roughly 45 percent of hospitals' reimbursement and, if these programs are treated as market participants, any market in which a health plan merger occurs would already be highly concentrated. Under the Horizontal Merger Guidelines, such levels would far exceed the highly concentrated threshold that signals a serious threat that a merger would be anticompetitive. In such highly concentrated markets, a health plan merger where one competitor had 10 percent of the market and another had as little as 3 percent would raise significant competitive concerns. A merger of a health plan with 10 percent of the market with another having 5 percent would be presumptively unlawful.

A More Consistent Approach to Including Government Reimbursement in Market Share Totals is Needed

Although inclusion of Medicare and Medicaid revenues still leaves markets highly concentrated, DOJ should examine whether including Medicare and Medicaid reimbursement in the analysis understates the likelihood of competitive harm. For example, even if hospitals could replace some of the merging plans' reimbursement with that of other payors, such as Medicare and Medicaid, DOJ should explore whether such diversion would be feasible or economical. Medicare and Medicaid pervasively underpay hospitals relative to costs, currently 91 cents and 88 cents on the dollar, respectively, based on 2007 reimbursement amounts. Merging health plans may have substantial room to cut reimbursement below competitive levels before reaching the point at which Medicare and Medicaid could ever become viable alternatives. DOJ acknowledged this point explicitly for the first time in its challenge to the United-PacifiCare merger, relying on allegations that physicians view Medicare and Medicaid reimbursement as less profitable. For certain hospitals, Medicare and Medicaid may be

an even less remunerative alternative to health plans for hospitals than they are for physicians.¹⁹

Moreover, DOJ needs to better understand the competitive significance of a potential shift of Medicare beneficiaries to Medicare Advantage plans. To the extent that trend continues, it will decrease the theoretical availability of Medicare as an alternative source of revenue and signal likely growth in the share of commercial health plans beyond their current market shares.

Finally, DOJ has not been consistent in its treatment of federal program revenue in its assessment of market power; in some instances it has suggested that Medicare and Medicaid reimbursement counts equally in determining market share and in others excludes that reimbursement entirely. When the Antitrust Division challenged Medical Mutual's MFN clause, for example, the complaint excluded Medicare and Medicaid when calculating the health plan's market share. Instead, it relied on Medical Mutual's market power where it had less than 30 percent of the commercial market payments to hospitals.

Smaller Insurers Are Unlikely to Preserve or Restore Competition in Mergers of Large Health Plans

The Antitrust Division should study further whether any "competitive fringe" of health insurance plans, which may collectively represent a moderate proportion of the marketplace but individually are small, are sufficient to keep reimbursement to providers at competitive levels. This is a standard aspect of merger analysis in other industries and should be applied to health plan mergers. Substantially more analysis and empirical evidence should be focused on whether providers credibly can switch to other, smaller health plans if reimbursement from the merged health plans falls below competitive levels. This can be examined both in markets with mergers and those without, where there are larger plans and smaller fringe players. Again, such a study will likely reveal that current merger analysis understates competitive concerns.

Hospitals Cannot Adequately Replace Lost Patient Revenues When Merged Plans Reduce Payments below Competitive Levels

To the extent that the Antitrust Division has focused on monopsony concerns, it has principally focused on harm to physicians. The view has been that physicians are vulnerable to abuse of health plan market power because their services are perishable from an economic perspective; if a doctor does not treat a patient on a given day, those lost hours cannot be replaced or inventoried. In addition, it views physicians as lacking the ability to switch their patient base rapidly to new sources, thus more of their potential business perishes during the interval it takes to replace a health plan that reduces reimbursement below competitive levels.

It is unclear why the antitrust agencies have not employed, at least not publicly, the same type of economic arguments in evaluating the potential harm from health plan mergers on hospitals. There is no reason to believe hospitals have sufficient alternative sources of revenue where physicians do not, or that hospitals are somehow less vulnerable to the exercise of monopsony power than physicians. Hospitals face a situation similar to that of physicians: They cannot replace or inventory lost patient stays, nor can they rapidly move to new sources of patients when a health plan contract is terminated.

In fact, regulatory constraints prevent or inhibit hospitals from switching to defeat an anticompetitive price decrease. DOJ should explore how hospitals can be expected to shift patient revenues in the face of an anticompetitive rate decrease following a merger. Hospitals face unique regulatory impediments to switching their revenue base away from the patients covered by the merging health plans. For example, federal anti-kickback laws broadly prohibit solicitation in return for referrals of Medicare and Medicaid patients. DOJ needs to work more closely with the Department of Health and Human Services to better understand the current regulatory framework and how it impedes hospitals from making the competitive responses that the Antitrust Division may be assuming they would attempt. Additionally, hospitals may be more vulnerable than physicians, because physicians may more directly influence or control where a patient receives care. A hospital's relationship with its physicians constrains its ability to reject

health plan demands because it means higher co-pays and deductibles or other payments for the patient.

Health Plans with Market Power Can Impose Anticompetitive Rates

The sparse public discussion by the Antitrust Division of the impact of health plan mergers on hospitals reflects little more than the view that some hospitals would refuse to contract with a merging health plan if it cut reimbursement below competitive levels. That is too limited an inquiry. Even if some hospitals are able to obtain alternative revenue sources and thus reject merging health plans' reimbursement cuts, DOJ should examine whether health plans would still increase profits from imposition of the rate cut. The critical loss for merger analysis must focus on the health plan's bottom line. Health plans can refuse to contract with some hospitals and still technically make those hospitals available to employers and consumers through out-of-network reimbursement or less preferred network reimbursement. Thus, health plans do not need to have a contract with every hospital in a geographic area in order to market their plans to consumers. That means that even if some hospitals can refuse the merged health plans' demand for below-market reimbursement, that plan may still impose that reimbursement to the extent that it can maintain its market share downstream among employers and reduce its costs through the imposition of the below-market rates on some hospitals.

DOJ should also consider the role that price discrimination plays in health plan contracting with hospitals. Other than a passing reference in one closing statement where the Antitrust Division did not challenge a health plan merger,²⁰ it has not publicly given any consideration to the role of price discrimination in contracting for hospital and physician services. In contrast, the Antitrust Division relied on price discrimination theory in finding small employer markets and a Medicare Advantage market when examining the sale of health plans in the United-Sierra merger. A price discrimination theory would examine whether a merged health plan increased its control over reimbursements to certain providers, such as smaller hospitals, to the extent that the plans could successfully reduce the rates paid to the hospitals below competitive levels. Smaller hospitals are less likely to deter a health plan from cutting rates by threatening to

fill beds from other sources and are less likely to threaten the marketability of the health plan if they reject rate cuts.

Recent data showing that health plans generally pay rates higher than government payors, such as Medicare and Medicaid, does not dispel concerns that health plans are already exercising monopsony power. That disparity does not show, and much less prove, that health plan rates are at or above competitive levels. Given the wide rift between hospitals' costs and government payments, it is likely that in highly concentrated health plan markets, rates paid to hospitals and physicians could still be below competitive levels.

Health Plans with Market Power Can Abuse It in Other Ways that Harm Hospitals

The exercise of monopsony power against hospitals by health plans can occur in ways other than through the imposition of lower reimbursement rates. For example, the development and/or execution of tailored hospital quality initiatives could be adversely impacted by the exercise of monopsony power. This is of particular concern to hospitals as they alone are currently subject to federal quality reporting mandates.

A recent AHA letter references concerns raised by hospitals in Kansas and numerous other states with regard to certain admission procedures imposed unilaterally by United that would have imposed new and onerous reporting requirements on hospitals and likely led to financial penalties for the hospitals. Additionally, in the United-Sierra merger, the state agencies obtained relief on particular contractual provisions. More recently the New York Attorney General succeeded in obtaining a health plan's agreement to stop using a physician-based reimbursement system that was suspected of intentionally skewing downward the determination of providers' usual and customary rates. Use of this same database was barred as part of the Nevada Attorney General's action against the United-Sierra merger. Health plans have also reportedly used their dominance to dissuade providers from obtaining information about the terms and conditions they offer and threatening litigation against providers that bring complaints to state and or federal authorities. Health plans would be unlikely to adopt such unfair practices if more local

markets were competitive. Moreover, these problems appear most prevalent among national health plans, raising the question of whether a national plan's acquisition of a local health plan, even one with preexisting monopsony power, changes the local plan's incentives toward such reimbursement practices.

Non-price terms and conditions should also be considered in merger analysis because they can result in substantial reductions in quality, innovation and/or reimbursement below competitive levels. Even if the antitrust agencies believe that hospitals' may have some ability to resist anticompetitive reductions in reimbursement, it may be that hospitals have less or no ability to resist the imposition of anticompetitive terms and conditions following a health plan merger that would adversely affect quality, efficiency or innovation.

The Impact on Incentives and Local Competition when Health Plans Without Overlapping Operations Threaten to Merge Needs to be Better Understood

In almost all instances, the Antitrust Division has focused its analysis solely on those areas where merging health plans compete head to head. The failed Highmark-Independence merger, and the Antitrust Division's apparent failure to investigate, brought starkly to public attention two facets of mergers among health plans whose core operations do not overlap that require greater scrutiny.

First, DOJ needs to better understand why major health plans do not enter each other's territory. The Antitrust Division's enforcement posture reflects the fact that entry is unlikely even in the face of an anticompetitive price increase. Mergers among major plans appear to remove some of the most likely entrants, which is a troubling observation given the already concentrated health plan markets. Moreover, in the case of Blue Cross/Blue Shield health plans, the Pennsylvania Insurance Department found that "Blue-on-Blue" competition can be of particular benefit to consumers and the market in general. Instead of moving toward competition with one another, however, Blues plans appear to be merging. Thirty three large health plan mergers from 1993 to 1997 were identified in section I of this paper. Sixteen of those mergers were "Blue-into-Blue" mergers.

Whatever arrangement the Blues plans have that appears to confine each to a given territory, the Pennsylvania Insurance Department's findings make clear that when they break out and compete with each other, consumers benefit. Any arrangement that prevents such competition must be suspect under the antitrust laws and should be investigated.

Second, the merger of health of plans with different core areas results in the loss of local control and accountability because, in many cases, the merged plan becomes necessarily more focused on national programs of the parent plan and consequently less responsive to whatever local health plan competition exists. For example, New York Attorney General's recent agreement with United arose out of United's nationwide use of its data base to set usual and customary rates of reimbursement. DOJ alluded to this concern in its closing statement on the Anthem-WellPoint transaction but took no action.

DOJ needs to consider more carefully whether mergers among health plans, whose core current operations do not overlap, create anticompetitive concerns beyond the loss of local head-to-head competition, particularly with regard to entry.

Limited Divestitures Are Unlikely to be an Effective Remedy for Anticompetitive Health Plan Mergers

The Antitrust Division has prominently declared that once it has decided a merger is likely anticompetitive, restoring competition is the key to determining of the appropriate remedy. Conduct remedies, such as those obtained by the Nevada Attorney General apparently addressing monopsony concerns, are disfavored. Contrary to the limited divestitures obtained based on the monopsony concerns in the United PacifiCare merger, the Antitrust Division's policy states a preference for divestiture of an entire, preexisting business unit.

In studying health plan markets and health plan mergers, DOJ should carefully consider the implications of the risk of error inherent in requiring limited remedies or divestitures. For example, a price discrimination approach might well reveal that the hospitals most vulnerable to health plan market power are those that provide convenient local care to

their communities. It may well turn out to be the case that hospitals in economically disadvantaged areas are the ones that suffer most when reimbursement rates are reduced. Threats to the viability or range of services of these hospitals raise important issues regarding access to health care. Even for hospitals less critical to needy populations, an anticompetitive rate decrease threatens a reduction in the quality, volume, or types of health care services available.

DOJ should examine whether there are any significant efficiencies that would be lost from preventing further, anticompetitive concentration in health insurance plan markets. In fact, under the Guidelines, such efficiencies would have to be market specific before DOJ would credit them. That is, the health plan merger would have to improve the efficiency in the market for the purchase of the hospital or other provider services to justify an increase in monopsony power. If health plan mergers were delivering efficiencies to the relationship between plans and providers, the providers would certainly recognize that and support the transaction. Similarly, if the health plans were delivering efficiencies to employers and consumers, they too would recognize that and support such mergers. DOJ's enforcement record has not disclosed any such efficiencies. In connection with the Highmark-IBC merger, Pennsylvania insurance officials rejected just such claims by the merging health plans, concluding apparently that cutting provider reimbursement did not benefit consumers.

The risks of permitting further consolidation in the health plan industry are serious. However, it appears there would be little lost from preserving the level of competition that currently exists.

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¹ This paper benefited from the contributions of Meg Guerin-Calvert, especially on the principles and issues related to healthcare mergers.

² Throughout this paper, *health plans* is used to refer to health insurer companies such as Blue Cross/Blue Shield, United or PacifiCare. The term “product” refers to the specific plans or products offered such as HMO, PPO, or POS.

³ In addition to mergers of health insurance companies, DOJ activities since the 1990s also include business reviews related to the DOJ/FTC Health Policy Statements and some hospital merger review activities.

⁴ Information on the merger review provided in this section comes from two primary sources: (1) in cases that are challenged, DOJ files a complaint that sets out the allegations regarding the competitive effects of the transaction. Where DOJ settles the case with the merging parties, a consent decree or Final Judgment is filed that sets out the specifics of the divestitures or other conditions required. In turn, a Competitive Impact Statement is filed that identifies how DOJ believes that the proposed settlement addresses the specific competitive concerns in the complaint and, as noted above (2) if a merger is cleared, DOJ may issue a press release and a background statement, and there may additionally be speeches or discussion of the specific issues that were addressed in the merger review.

⁵ www.usdoj.gov/atr/public/guidelines/horiz_book/hmg1.html.

⁶ As is discussed in more detail below, only in the more recent mergers has the effect of a merger on reimbursement for hospitals specifically been addressed. The United-Sierra merger stands as an exception, as the interests of providers were largely ignored in any express statements.

⁷ The HHI is a measure of concentration that takes into account both market share and the size distribution of firms. It is derived by calculating each firm’s share of the market, squaring it, and then summing the square of the shares. As a result, markets with fewer firms or markets with more firms but a few with very high shares will each be highly concentrated. See www.usdoj.gov/atr/public/guidelines/horiz_book/hmg1.html.

⁸ *United States v. UnitedHealth Group, Inc. and PacifiCare Health Systems, Inc.*, No. 1:05 CV 2436 (D.D.C. filed Dec. 20, 2005).

⁹ Marius Schwartz, Economics Director of Enforcement, Antitrust Division, U.S. Department of Justice. “Buyer Power Concerns and the Aetna-Prudential Merger,” October 20, 1999, Text Released November 30, 1999.

¹⁰ Health Care and Competition Law and Policy Workshop, presentation of Deputy Assistant Attorney General Deborah Platt Majoras at 2-3, Washington D.C. (September 9, 2002).

¹¹ Statement of Pennsylvania Insurance Commissioner Joel Ario on Highmark and IBC Consolidation (Jan. 22, 2009), available at http://www.ins.state.pa.us/ins/lib/ins/whats_new/Statement_final.pdf.

¹² MFN clauses include contract provisions that require the supplier to offer the purchaser as favorable pricing as is provided to any other purchaser. Such clauses may be initiated by the supplier or by the purchaser, and may not raise competitive concerns. They have, however, been the subject of investigation and challenge.

¹³ Robinson, James C. “Consolidation and the Transformation of Competition in Health Insurance.” *Health Affairs*, Vol. 23: No. 6 (2004) at p. 16.

¹⁴ “A Merger of Health Insurers: The Industry; Managed Care Empires in the Making,” *The New York Times*, by Milt Freudenheim (Apr. 12, 1996).

¹⁵ See Excerpts from the Philadelphia Hearing *Blue-on-Blue Competition* (July 15, 2008) (exchange between Commissioner Ario, and IBC and Highmark executives), available at http://www.ins.state.pa.us/ins/lib/ins/whats_new/Excerpts_from_the_Philly_Hearing_Blue_on_Blue_Competition.pdf.

¹⁶ “Improving Health Care: A Dose of Competition,” A Report by the Federal Trade Commission and the United States Department of Justice (July 2004).

¹⁷ *United States v. Aetna, Inc. and Prudential Insurance Co.*, No. 3-99 CV 1398 (N.D. Tex. filed June 21, 1999).

¹⁸ See *United States v. UnitedHealth Group, Inc. and PacifiCare Health Systems, Inc.*, No. 1:05 CV 2436 (D.D.C. filed Dec. 20, 2005); *United States v. UnitedHealth Group, Inc. and Sierra Health Services*, No. 1:08-cv-0322 (D.D.C. filed Feb. 25, 2008).

¹⁹ “Hospital & Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Payers,” charts 3a, 3b, and 5 (Milliman, December 2008).

²⁰ Closing Statement, United States Department of Justice, Background to Closing of Investigation of UnitedHealth Group’s Acquisition of Oxford Health Plans (July 20, 2004), available at http://www.usdoj.gov/atr/public/press_releases/2004/204676.pdf.