

Mergers: Antitrust Issues for Hospitals and Health Plans

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I. Introduction¹

Antitrust and competition-based enforcement activity involving mergers and acquisitions by health care payors has increased, paralleling an apparent upswing in deal activity. This follows an earlier period, leading up to the current decade, of acquisitions and investigations. This time, even more than last, health plan acquisitions have been the focus of heightened public attention, spurred in part by rising health care and health insurance costs and active opposition by some health care provider and consumer organizations claiming that health insurance markets are heavily concentrated.² The topic has been the focus of joint Federal Trade Commission - Department of Justice hearing sessions and congressional inquiry, with the American Medical Association (“AMA”) expressing concern that “consolidation in the market for health insurance has led to decreased competition .

¹ The valuable assistance of Shawn Johnson and Lauren Kim for this presentation is acknowledged and appreciated.

² See, e.g., “Competition in Health Insurance: A Comprehensive Study of US Markets,” American Medical Association, 2007.

. . . and increased problems for patients and physicians.”³ At the same time, health care plans and insurers face a challenging marketplace in which government and private sector customers are seeking a broader array of product choices, more sophisticated health care cost and quality management tools, and moderation of accelerating cost trends, while health care providers are becoming increasingly sophisticated in the strategies they employ to resist downward pricing pressure from health plans.

The Department of Justice has recently challenged two transactions, while state attorneys general and state departments of insurance are also active in reviewing health plan mergers and can seek or impose their own remedies to address competition concerns. The current level of activity picks up on an enforcement focus that was already under way in the mid- and late 1990s. Whereas the “managed care backlash” was well under way then, and may now have dissipated to some extent, there appears to now be heightened sensitivity to market concentration worries about the industry. Issues of relevant market definition, barriers to entry, and theories of potential competitive harm and viable relief have provided fertile grounds for contention.

Enforcement officials are focusing on the possibility of narrower product markets, focusing on particular customer segments as well as product variations.

³ See Jacqueline M. Darrah, M.A., J.D., Prepared Statement of the American Medical Association to the Federal Trade Commission and Department of Justice Hearing on Health Care Competition Law and Policy Concerning Perspectives on Competition Policy and the Health Care Marketplace, February 27, 2003; Edward L. Langston, M.D., Prepared Statement of the American Medical Association to the Senate Committee on the Judiciary Concerning Perspectives on Competition Policy and the Health Care Marketplace, September 6, 2006.

They are also seeking to apply more sophisticated econometric analyses to these merger issues. This presentation provides an overview of various facets of this “terra sorta incognita.”

II. The Antitrust Enforcers

Federal antitrust enforcement is entrusted to two separate government agencies, the Antitrust Division of the U.S. Department of Justice and the Federal Trade Commission. Both agencies enforce Section 7 of the Clayton Act, which prohibits mergers and acquisitions which may substantially lessen competition or tend to create a monopoly.⁴ The DOJ and FTC may also investigate transactions under the standards of the Sherman Act⁵ and the Federal Trade Commission Act,⁶ respectively. While both agencies share the burden of enforcing the federal antitrust laws, the Department of Justice, via an informal division of labor with the FTC, takes the lead in reviewing mergers and acquisitions within the health insurance field.

State attorneys general may also investigate M&A activity in the health insurance industry. These investigations may be conducted either under state antitrust laws⁷ or through *parens patriae* actions pursuant to the Clayton Act,⁸ and

⁴ See 15 U.S.C. § 18.

⁵ See 15 U.S.C. §§ 1, 2 (prohibiting contracts, combinations, or conspiracies in restraint of trade as well as activities, which can include mergers, that monopolize or attempt to monopolize a particular market).

⁶ See 15 U.S.C. § 45 (prohibiting unfair methods of competition).

⁷ Some state antitrust laws exempt activities expressly approved by a state regulatory body, so that insurance department approval of an insurer or health plan merger may block application of state

may be conducted either in conjunction with the federal authorities or on a stand-alone basis. The state attorneys general are not bound by the prosecutorial decisions of their federal counterparts, either regarding case selection or choice of remedy.

State insurance departments also must review and approve proposed insurer and health maintenance organization mergers and acquisitions under state insurance holding company laws. Private plaintiffs, including providers, individual employers, employer coalitions, unions, and consumer groups have taken a more active role in this arena as well, and could also bring private litigation.

A table of merger enforcement actions in the health plan/insurance industry is presented in Appendix A, including federal enforcement actions, “no action” statements, and state insurance department and attorney general actions in which some remedial measure was sought or imposed, dating back to the 1990s.

III. Merger Antitrust Enforcement

When the antitrust laws are enforced by the federal agencies, mergers and acquisitions are typically analyzed under the Horizontal Merger Guidelines (the “Guidelines”) issued jointly by the FTC and the DOJ.⁹ The Guidelines provide a structured analytical framework for assessing whether a merger is likely to

antitrust law to the transaction. The Nevada Attorney General’s complaint in the United – Sierra matter, discussed below, pleads only a violation of the federal antitrust laws.

⁸ See, e.g., *Burch v. Goodyear Tire & Rubber Co.*, 554 F.2d 633 (4th Cir. 1977). Note, though, that state law authority may limit or prevent exercise of this authority provided by federal law.

⁹ See U.S. Dep’t of Justice & Federal Trade Comm’n, Horizontal Merger Guidelines (1992, amended 1997) (“*Merger Guidelines*”), available at <http://www.usdoj.gov/atr/public/guidelines/hmg.htm>.

substantially lessen competition taking into account the relevant product and geographic markets, and such factors as market shares, ease of entry and expansion in the relevant market, the dynamics of competition, the ability of the firms to exploit particular customers without losing business from others, and efficiencies to be achieved through the merger. Based upon the premise that a transaction is unlikely to create or enhance market power or facilitate its exercise unless as a threshold matter it significantly increases concentration within a relevant market, the Guidelines begin with the issue of market definition.

A. Relevant Product Markets

In many cases, the definition of the relevant product market is the single most important factor in assessing a transaction's potential competitive impact. The basis for market shares and market concentration calculations, the Guidelines define the relevant product market as that product or group of products such that a hypothetical monopolist that was the only present and future seller of those products likely would impose a small but significant non-transitory increase in price (a "SSNIP"). "Price" in this context has a meaning that could encompass changes in service, quality of product or level of benefits. Thus, a reduction in service, quality or benefit levels is equivalent to a price increase. Practically speaking, the relevant product market consists of those products that are reasonable substitutes for one another.

1. Defining the Relevant Product Market

The relevant product market definition raises a number of interesting questions in the context of health plan mergers. In what product market(s) do managed care firms compete? What products are substitutes or complements for one another? What is the level of demand elasticity between different forms of health care coverage, etc.? What choices do particular types of consumers have? Can consumers with few choices be targeted for price increases or reductions in services or benefits without substantial loss of business from other types of customers?

Health plan products and the firms that provide them vary in a number of ways. At the most basic level, some firms provide health coverage while others do not. A fully insured product consists of a wide range of specialized services, each of which constitutes only a single component of the overall product. These components include insurance-risk assessment, claims processing, utilization management and quality assurance, just to name a few. Each of these components can be purchased separately, or all can be purchased together. Alternatively, an employer may elect to provide any one or all of those components on its own.

Those firms that provide coverage are also different from one another. For example, some firms provide traditional highly-managed closed panel HMO products while others provide point-of-service, preferred provider, fee-for-service, managed indemnity or traditional indemnity plans. Others may provide all of these. Companies are increasingly offering a range of products, often blending

features commonly associated with other types of products. Such features include use of primary care gatekeepers, use of prior authorization requirements, financial risk arrangements with providers, coverage for out-of-network providers' services, and in some cases establishment of three (or even more) levels of benefits depending on choice of provider and whether a primary care physician referral was given. A few plans employ or operate their own health care provider facilities and clinics. More commonly, many firms provide access to their own proprietary physician networks, while others offer networks they may "rent" from provider network organizations, or even from a competitor. Virtually every health plan provider offers its own distinct and proprietary products and product combinations. These differences do not in themselves make out different product markets, but provide fuel for debate on the issue.

The diverse nature of the health plan industry also raises critical questions regarding the appropriate measure of market share and potential competitive effects. Should market share calculations be based on covered lives, managed lives, or revenues, lives for whom a company provides the contracted provider network, or by some other measure altogether? How does one assess an employers' ability to switch health plan providers and employees' ability to switch among health plans? Is there a separate market for small employers to whom product offerings are typically more-heavily regulated and who arguably cannot self-insure? How easy is it for health plans to switch from segment to segment -- from commercial plans to Medicaid or Medicare or from large group to small group?

2. Relevant Product Markets in Recent Cases

A relatively “early” case to address the question of health insurance product markets, albeit not in a merger context, *Blue Cross & Blue Shield of Wisconsin v. Marshfield Clinic*, provides strong support for a broad “health care financing” or similarly defined market, and its ruling parallels the results in a string of other cases.¹⁰ In the *Marshfield Clinic* case, which focused on alleged price-fixing and other Sherman Act violations, the Seventh Circuit rejected the jury’s determination that a separate relevant market existed for HMO products, reasoning that HMOs compete not only with one another but also with various types of fee-for-service products.¹¹ The logic behind this broad market definition is that the more intensely “managed” the product, the lower the price, in dollar terms, at which it can typically be offered. According to the court’s analysis, if a hypothetical HMO monopolist attempted to impose an anticompetitive price increase, customers would defeat that

¹⁰ 65 F.3d 1406, 1410 (7th Cir. 1995). *See also* U.S. Healthcare, Inc. v. Healthsource, Inc., 986 F.2d 589 (1st Cir. 1993); Ball Memorial Hosp., Inc. v. Mutual Hosp. Ins., Inc., 784 F.2d 1325, 1331 (1st Cir. 1986); Kartell v. Blue Shield of Massachusetts, Inc., 749 F.2d 922, 934 (1st Cir. 1984), cert. denied, 471 U.S. 1029 (1985); Reazin v. Blue Cross & Blue Shield of Kansas, Inc., 663 F. Supp. 1360, 1478-80 (D. Kan. 1987), aff’d in relevant part, 899 F.2d 951 (10th Cir.), cert. denied, 497 U.S. 1005 (1990) (rejecting notion that HMOs constituted a distinct submarket and finding that HMOs are “in direct competition with other methods of private health care financing”); Pennsylvania Dental Ass’n v. Medical Serv. Ass’n, 574 F. Supp. 457, 469-71 (M.D. Pa. 1983), aff’d, 745 F.2d 248 (3d Cir. 1984), cert. denied, 471 U.S. 1016 (1985) (finding that a single market encompassed both prepaid service benefit dental programs and dental insurance programs); Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of Rhode Island, 692 F. Supp. 52 (D.R.I. 1988), aff’d, 883 F.2d 1101 (1st Cir. 1989), cert. denied, 494 U.S. 1027 (1990) (finding parties stipulated the relevant market as the “market for health care insurance in Rhode Island”); Hassan v. Independent Practice Ass’n, P.C., 698 F. Supp. 679 (E.D. Mich. 1988) (rejecting contention that HMOs constituted a separate market and held the relevant market to be the “market for health care financing”).

¹¹ 65 F.3d at 1406.

increase by simply switching to lower cost, non-HMO-type programs, which do not impose the “cost” of managed care plan restrictions.

In some enforcement actions, the DOJ has similarly defined broad relevant markets for health plan products. It explains that it will assess market definition based on the basis of the specific market facts. For example, in connection with its investigation of UnitedHealth Group’s acquisition of Oxford Health Plans, the DOJ concluded that the appropriate relevant product market included all fully-insured health insurance products and no complaint was filed.¹² The exclusion of programs offered to serve self-insured employers may have reflected DOJ’s view that some customers are not able to self-insure and that health plans could effectively price discriminate against those customers. Even so, this broad market, including all fully-insured products, reflects the increasingly blurred lines between the various managed care, HMO, POS, PPO and managed indemnity products.

In other cases, both before and after, however, the DOJ has pursued narrow product market definitions focusing largely on the customer type, and in some regards on the type of product offered to that customer type. In the very recent UnitedHealth/Sierra Health transaction, for example, the DOJ and the Nevada Attorney General alleged a narrow relevant product market limited to Medicare

¹² See DOJ, Background to Closing of Investigation of UnitedHealth Group’s Acquisition of Oxford Health Plans (July 20, 2004) (*Oxford Health Closing Statement*) (stating that “the Division concluded that the appropriate product market was no broader than the market for fully-insured health insurance products sold to employers that are largely located in the tri-state area”), *available at* http://www.usdoj.gov/atr/public/press_releases/2004/204676.htm.

Advantage (“MA”) plans.¹³ The complaint therefore focuses both on a particular subset of health plan consumers – Medicare beneficiaries – and on a particular type of product offering for them. This was the first merger enforcement action in which the DOJ alleged that the MA program constitutes a separate relevant market from other Medicare benefit options, which include traditional fee for service Medicare, with or without Medicare Supplement coverage, and with or without the new prescription drug (or Part D) benefit plan alternative.¹⁴

In their complaints, the DOJ and the Nevada Attorney General alleged that an insufficient number of MA enrollees would be likely to switch from an MA plan to the fee for service program in response to a SSNIP to render such a price increase unprofitable.¹⁵ In less technical jargon, they alleged that the fee for service Medicare program (with or without supplemental coverage or Part D benefits in addition) was sufficiently distinct from the MA program in terms of cost to the beneficiary or available benefit options that it could not be viewed as a meaningful substitute for a significant number of MA program enrollees. Thus, according to the complaints, if the combined entity were to increase the price or reduce the benefits of its MA plans, many enrollees would have faced significant barriers to switching to a fee for service alternative, and would thus have had no real choice but to absorb

¹³ United States v. UnitedHealth Group, 1:08-cv-00322 (D.D.C. 2008) (complaint) (“*Sierra Health Complaint*”) and State of Nevada v. UnitedHealth Group Inc., 2:08-cv-00233 (D. Nev. 2008) (complaint). The speaker acted as counsel for Sierra Health Services in connection with the DOJ and Nevada Attorney General investigations and settlements, and represents Sierra and United in connection with the Tunney Act review of the proposed final judgment resulting from the DOJ settlement.

¹⁴ *Id.* ¶¶ 15-18.

those higher costs or benefit reductions. In order to eliminate these concerns, United and Sierra agreed to divest United MA plans in Clark County and Nye County, Nevada and to conditions intended to foster effective competition by the acquirer of the divested assets.¹⁶ The remedy contained in the Nevada Attorney General proposed consent judgment contains some further requirements,¹⁷ including:

- Not conditioning provider participation in any line of business on the provider's willingness to participate in other lines of business (sometimes referred to as an “all products clause”) for a period of two years.
- Refraining from new exclusive provider contracts in violation of state or federal antitrust laws, or new contracts with most favored nation clauses, for a period of two years.
- Notifying small employers 60 days in advance of intent by United to increase rates.
- Making \$15 million in donations to charitable programs specified by the Attorney General.
- Agreeing not to use the Ingenix Prevailing Healthcare Charges System Database to establish reasonable and customary fees to reimburse out-of-network providers that furnish services to enrollees of Health Plan of Nevada or Sierra Health and Life Insurance Company (the Sierra subsidiaries that issue HMO and PPO plans, respectively) for a period of two years.
- Providing the Nevada Attorney General advance notice of certain future acquisitions.
- Providing confidentiality protections for rate information it obtains on providers’ dealings with other plans (for instance, through coordination of benefits), and not using such fee information that it obtains from self-insured employer customers to negotiate fees with those providers.
- Setting up a physicians counsel
- Participating in a state government program intended to develop benchmarks for resolution of consumer issues with health plans
- Resolving outstanding billing disputes with the government operated University

¹⁵ *Id.* ¶ 18.

¹⁶ The definition of MA plans employed by DOJ and the State Attorney General includes Medicare Advantage “private fee-for-service plans,” even though they typically do not involve a contracted provider network.

¹⁷ *See State of Nevada v. UnitedHealth Group Inc.*, 2:08-cv-00233 (D. Nev. 2008) (proposed final judgment).

Medical Center.

Changes in the funding or other legislatively driven aspects of the MA program could change the government's product market analysis if the changes convinced the government that switching back to fee-for-service Medicare would be a more likely response to reduced benefits or higher out-of-pocket costs to Medicare Advantage enrollees.

The UnitedHealth/Sierra Health transaction was not the first in which the DOJ alleged that specific types of health coverage constitute distinct markets in the sale of health insurance products. In connection with Aetna's acquisition of Prudential, the DOJ and the Texas Attorney General defined a relevant product market limited to HMO and HMO-POS products.¹⁸ In that case, the DOJ and the Texas Attorney General alleged that other health insurance products, including PPO and indemnity products, were not reasonable substitutes due to differentials in their benefit design, pricing, and other unspecified factors.¹⁹ In conducting its analysis, the DOJ and the Texas Attorney General relied on the opinions of employers and employees, as well as evidence that enrollees who leave an HMO disproportionately select another HMO product, rather than transitioning to a PPO or another alternative product.²⁰ Rather than litigating the issue, the parties to the

¹⁸ United States v. Aetna, Inc., 1999-2 Trade Cas. (CCH) ¶ 72,730 (N.D. Tex. 1999) (complaint) (*"Aetna Complaint"*).

¹⁹ *Id.* ¶ 17.

²⁰ *Id.*

transaction agreed to divest Aetna's NYLCare HMO business in Houston and Dallas-Fort Worth, Texas.

Similar allegations regarding United and Sierra's alleged domination of the HMO or broader commercial health benefits coverage business in the Las Vegas for private sector lines of business, apart from Medicare Advantage, Medicare or other government benefit programs, have been made by a number of parties who have publicly opposed the United-Sierra acquisition. While DOJ has not publicly addressed the issue, its election not to alleged an "HMO" or "HMO + POS only" market may have reflected a judgment, like in the United-Oxford matter, that PPO products compete in the same market. As for the broader commercial market, its judgment would have entailed an assessment of competitive effects, presumably, rather than market definition concerns.

The DOJ defined a separate relevant market for the sale of health insurance to small-group employers in its complaint challenging aspects of UnitedHealth Group's acquisition of PacifiCare.²¹ Alleging that small group employers typically cannot or do not self-insure their employees' health benefits, and noting the distinct regulatory scheme for small group health insurance and the manner in which small group coverage is sold, the DOJ distinguished these groups from other purchasers of commercial health insurance plans.²² In its complaint, the DOJ alleged that the transaction would eliminate competition between the merging firms and enable

²¹ United States v. UnitedHealth Group, 1:05-cv-2436 (D.D.C. 2005) (complaint) ("*PacifiCare Complaint*").

²² *Id.* ¶ 16.

UnitedHealth Group to raise prices and/or reduce the quality of commercial health insurance plans sold to small group employers in the Tucson, Arizona area.²³ In order to remedy these potential effects, the parties agreed to divest a block of small group business in the Tucson, Arizona area.

Finally, the DOJ has also alleged relevant markets for the purchase of health care provider services. For example, the DOJ and the Texas Attorney General alleged that the purchase of physician services constituted a relevant market in which competition would be harmed, in connection with the Aetna/Prudential transaction.²⁴ Similarly, the closing statement issued by the DOJ in connection with the UnitedHealth Group/Oxford Health Plan transaction alleged that the purchase of provider services, including hospital services, also constituted a relevant product market.²⁵

As this brief overview of recent antitrust enforcement actions indicates, we are now seeing sharp and very granular focus in the analysis of health plan mergers on specific product segments and customer categories, and a confirmation of the need to consider both “selling” and “buying” markets in which health plans compete. Different judgments may be made by the enforcement agencies depending on facts that may vary from market to market. While not litigated cases, these negotiated consent decrees highlight the need to consider even what might appear to be very

²³ *Id.* ¶ 30.

²⁴ *Aetna Complaint* ¶ 27.

²⁵ *See Oxford Health Closing Statement* (noting that the Division “examined the possibility that this transaction would give the combined company buying-side market power over health care providers ... [including both] physician services and hospital services.”).

narrow product segments or customer categories as the potential focus of antitrust scrutiny.

B. Relevant Geographic Markets

Relevant geographic market issues have not typically been as contentious in recent health plan merger enforcement matters. Pursuant to the Guidelines, the DOJ will delineate the relevant geographic market to be that region in which a hypothetical monopolist could profitably impose a price increase. Thinking about it in another way, the relevant geographic market is that geographic region in which buyers would seek to purchase alternative products in the event that the merged entity attempted to increase price.

1. Defining the Relevant Geographic Market

The scope of the relevant geographic market is largely dependent upon the product being sold. For example, while the relevant geographic market for health care financing in general may be national,²⁶ the relevant market for the sale and provision of specific commercial insurance products is typically alleged to be more local or regional in nature.²⁷ This reflects that fact that managed care products include arrangements for the delivery of health care services through a contracted network, which it is claimed limits the relevant geographic market to that local area

²⁶ See, e.g., *Ball Memorial Hosp. v. Mutual Hosp. Insurance*, 784 F.2d 1325, 1336 (7th Cir. 1986) (affirming district court holding that the relevant market was “regional, if not national”).

²⁷ See, e.g., *Sierra Health Complaint* ¶ 19.

in which consumers will seek alternative providers or within which employers will select group health plan coverage. This has the effect of limiting the participants in the relevant market to those firms that already have access to a viable provider network in that area or could rapidly secure one. In this way, the relevant geographic market analysis is heavily dependent upon the definition of the relevant product. In some ways, though, the market definition itself is less important than judgments about who is able to compete within the relevant area, since if a firm already operating elsewhere is easily able to access the necessary provider network and marketing support to compete, then it can be viewed as a source of competition to constrain an exercise of market power in a “local” geographic market, even though it may not yet have significant local presence.

2. Relevant Geographic Markets in Recent Cases

Health plan mergers have typically been assessed at the local market level. As the DOJ and the Texas Attorney General noted in *Aetna/Prudential*, “[p]atients seeking medical care generally prefer to receive treatment close to where they work or live, and many employers require managed care companies to offer a network that contains a certain number of health care providers within a specified distance of each employee’s home.”²⁸ Based upon these facts, the DOJ and the Texas Attorney General alleged that the “relevant geographic market in which HMO and HMO-POS health plans compete are thus no larger than the local areas within

²⁸ *Aetna Complaint* ¶ 19.

which managed care companies market their respective HMO and HMO-POS plans.”²⁹ The DOJ made similar arguments in connection with its investigations of UnitedHealth Group’s acquisitions of both PacifiCare and Sierra Health.³⁰

C. Potential Anticompetitive Effects

Through the history of merger activity within this industry, a variety of theories of potential competitive harm have been explored. Some of those theories are traditional and quite basic in their framing, e.g., the combined firm may exert sufficient market power to increase prices, or the resulting concentration would foster tacit collusion among the remaining firms. The key harm challenge is to identify the method by which this harm can be effected, and not be defeated by market forces, and the market, customer or product characteristics that make this likely. Key themes are whether the merging parties are more direct head-to-head competitors in the market than most other firms, so that their customers would be less likely to switch away in the event of a price increase, or whether the merging firms have control or influence over necessary inputs (providers? brokers?) through, for example, exclusivity agreements or “most favored nation clauses,” or a lower cost structure that cannot be readily replicated by other firms. For example, if two plans’ provider networks were closely matched, a merger between those companies might be more suspect, all other things being equal, than a merger of firms with very different provider networks.

²⁹ *Id.*

Pursuant to the Guidelines, the DOJ’s analysis of potential competitive effects typically begins with the identification of market participants and the calculation of market shares.³¹ Beyond these initial measures of market concentration, the DOJ and other enforcers focus on the likelihood of coordinated or unilateral effects.³² Recent enforcement actions indicate that both of these issues remain a significant concern in the health plan industry, though the “action” has largely been the latter front. A third issue, potential monopsony power, is also a focus of inquiry.

1. Unilateral Exercise of Market Power

The unilateral effects theory of competitive harm posits that a merger or acquisition may harm competition because the merged firm may find it profitable to unilaterally increase its price, reduce its output, or decrease the quality of its product.³³ This was the focus of the DOJ’s challenges to UnitedHealth’s acquisitions of both PacifiCare and Sierra Health Services. In the PacifiCare transaction, DOJ alleged that the parties were the second and third largest providers of commercial health insurance to small group employers in Tucson, Arizona, and were close competitors.³⁴ The DOJ also alleged that there were few

³⁰ See *PacifiCare Complaint* ¶ 25; *Sierra Health Complaint* ¶ 19.

³¹ See *Merger Guidelines* § 1.0.

³² See *id.* § 2.0.

³³ See *Merger Guidelines* § 2.2.

³⁴ *PacifiCare Complaint* ¶¶ 26-27.

other meaningful competitors, and that PacifiCare was the low cost provider.³⁵

Based upon these facts, the DOJ concluded that with few alternatives and the loss of the low cost competition, the transaction would likely “permit United to increase price and reduce quality of commercial health insurance plans to small-group employers in Tucson.”³⁶

The DOJ came to a similar conclusion, in a different product market context, in its challenge to the Sierra Health Services transaction. The DOJ alleged that the combination of United’s and Sierra’s Medicare Advantage businesses would “substantially increase concentration in an already highly concentrated market.”³⁷ According to the Complaint, the parties’ combined share of MA enrollment was approximately ninety-four percent.³⁸ Based on their overwhelming share, and the fact that an insufficient number of existing enrollees would switch plans in response to increase in price, DOJ alleged that the combination would have likely led to a unilateral increase in price and/or a reduction in the quality and breadth of benefits available to MA enrollees in Clark and Nye County, Nevada.³⁹ Obviously, if the DOJ had concluded that traditional Medicare coverage, with or without Medicare supplement benefits or Medicare Part D drug plan coverage, was in the same

³⁵ *Id.* ¶¶ 26, 29.

³⁶ *Id.* ¶ 30.

³⁷ *Sierra Health Complaint* ¶ 1.

³⁸ *Id.*

³⁹ *Id.* ¶ 24. While DOJ recognized the role that the Centers for Medicare and Medicaid Services plays in approving proposed Medicare Advantage benefit designs and premiums, the DOJ did not believe that CMS’ regulatory oversight would prevent competitive harm resulting from the transaction.

market, the shares for the merging parties would have been much smaller and the result perhaps different. Similarly, the market shares alone would not have led to a complaint if DOJ believed that expansion of smaller plans or new entry by competitors such as Wellpoint and Aetna would have prevented anticompetitive harm.

Unlike the conclusions reached by the DOJ in the acquisitions of PacifiCare and Sierra Health Services, in the merger involving Anthem, Inc. and WellPoint Health Networks, Inc., the DOJ concluded that the combination of these two companies would not result in increased market power, specifically noting that the two were not close competitors. In closing its investigation, the DOJ issued the following statement:

The facts did not support a conclusion that this merger will give a combined Anthem/WellPoint market or monopsony power in any market in which they compete. WellPoint's share in the markets in which they overlap is very small, and these companies are not particularly close competitors. Although this particular transaction should not threaten to harm competition or consumers, we will continue to be vigilant in our enforcement of the antitrust laws in this area.

2. Coordinated Interaction

A transaction may also diminish competition by increasing the likelihood that the remaining market participants will engage in coordinated interaction. Through this type of activity, which includes consciously parallel market activity on the one hand, and outright collusion on the other, a group of firms may profit at the expense of consumers by acting jointly to increase prices or otherwise reduce consumer

benefits.⁴⁰ Such coordinated activity can harm consumers by allowing competitors to charge supra-competitive prices or to reduce the quality of their products.

This type of “coordinated effect” was addressed in the DOJ’s analysis of the United/PacifiCare transaction. In that case, United had previously entered into an agreement to rent access to the CareTrust provider network from Blue Shield, one of PacifiCare’s key competitors in California.⁴¹ Pursuant to their rental agreement, United and Blue Shield regularly exchanged certain competitively sensitive information, including information relating to provider contract negotiations and terminations, network and new product development, and the discounts CareTrust negotiated with physicians and hospitals throughout California.⁴² Because the acquisition of PacifiCare would make United and Blue Shield key competitors in California, DOJ alleged that the merger would have created significant opportunities and incentives for United and Blue Shield to coordinate their competitive activities and reduce competition in violation of Section 7.⁴³ United agreed to modify and, after one year, terminate its network access agreement with Blue Shield.

⁴⁰ *See Merger Guidelines* § 2.1.

⁴¹ *PacifiCare Complaint* ¶ 46.

⁴² *Id.* ¶¶ 46-47.

⁴³ *Id.* ¶ 53.

3. Monopsony Power

The third primary competitive concern related to mergers and acquisitions in the health plan industry is the potential acquisition of monopsony power.

Monopsony concerns arise from the accumulation of market power in the acquisition or purchasing of a relevant product, and the possibility that such a dominant firm may profitably reduce prices it pays below their competitive level.⁴⁴ The exercise of such monopsony power has the potential to harm consumers by reducing the quantity or quality of the relevant product available.⁴⁵

The terms a physician, hospital or other provider can obtain from a health plan depend to a significant extent upon the provider's ability to terminate (or credibly to threaten to terminate) his or her existing provider contract in response to a proposed price decrease.⁴⁶ If a merger results in the accumulation of market power in the acquisition or purchasing of physician and hospital services, physicians and others could have little means of recourse in light of their limited ability in that circumstance to encourage patient shifting or to replace lost patients in a timely manner.⁴⁷ It is important to stress, though, that product market distinctions which may be made with respect to the sale of health benefit products to customers – small group vs. large group; Medicare Advantage vs. traditional

⁴⁴ See U.S. Dep't of Justice & Federal Trade Comm'n, Report: Improving Health Care: A Dose of Competition (2004), *available at* <http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf>.

⁴⁵ See *id.*

⁴⁶ *Aetna Complaint* ¶ 30.

Medicare or commercial plans – are presumptively of no direct bearing on the existence of monopsony power. This is because, absent persuasive evidence to the contrary, a hypothetical HMO monopolist could not impose a price squeeze on physicians where as a purchaser it faces strong competition from non-HMO types of payors, including government programs such as Medicare. Some observers have questioned whether government programs should be “excluded from the denominator” in this analysis, due to alleged disparities in pricing between commercial and government programs and the allegedly fixed volume of services that could be provided to government program beneficiaries. This conclusion and the accuracy and/or sufficiency of its premises appear at a minimum contestable.

Monopsony power was a significant focus of the DOJ complaint issued in the Aetna/Prudential transaction. In that case, DOJ and the Texas Attorney General alleged that the merged firm would represent “a large share of all payments to physicians in the Houston and Dallas areas, and a particularly large share of revenue of individual physicians for a substantial number of physicians in the area.”⁴⁸ DOJ and the Texas Attorney General alleged that “the proposed acquisition will give Aetna the ability to depress physicians’ reimbursement rates ...likely leading to a reduction in quantity or degradation in quality of physician services.”⁴⁹

⁴⁷ *Id.*

⁴⁸ *Id.* ¶ 33.

⁴⁹ *Id.*

It was also a focus in the United/PacifiCare transaction. The merger of United and Pacificare would have accounted for a large share of total payments to all physicians in the Boulder, Colorado and Tucson, Arizona areas. The DOJ alleged that “United's acquisition of PacifiCare will give it control over both a large share of revenue of a substantial number of physicians in Tucson and Boulder and a large share of all patients in those areas. which would enable United to reduce the rates paid for those services.”⁵⁰ The DOJ was concerned that the acquisition would give United the ability to “unduly depress physician reimbursement rates in Tucson and Boulder, likely leading to a reduction in quantity or degradation in the quality of physician services.”⁵¹ In order to address this concern, United agreed not to require physicians practicing in Tucson to participate in United’s network for any Medicare health insurance product, as a condition for participating in any of United's networks for its commercial health insurance products and vice versa. Divestiture of some blocks of business also reduced the share that would be held by the merged firm.

IV. Affirmative Defenses

Two potentially relevant affirmative defenses are the “state action” doctrine and the McCarran – Ferguson Act’s partial exemption of the “business of insurance” from the federal antitrust laws.

⁵⁰ United States v. UnitedHealth Group, 1:05-cv-2436 (D.D.C. 2005) (competitive impact statement).

⁵¹ *Id.*

A. State Action

The state action doctrine precludes federal antitrust scrutiny of certain actions taken by states and state-sanctioned entities. In order for private parties to qualify for this defense, the challenged action must have been undertaken “pursuant to a clearly articulated and affirmatively expressed state policy” to replace competition with regulation.⁵² The state must also “actively supervise” the applicable regulatory mechanisms in order to ensure they further that articulated state policy.⁵³ The courts therefore analyze whether the state has exercised sufficient independent judgment and control such that the challenged activity is “a product of deliberate state intervention.”⁵⁴ Mere approval by the state is not enough. That an action was encouraged by the state is not enough. Both elements – fulfillment of a purpose expressed by the state as sovereign and active supervision – are required.

States expressly permit mergers of health plans and insurers typically via the approval process conducted through state insurance departments. These reviews apply a number of criteria, including a requirement that the transaction not lessen competition. Insurers and health plans are also subject to ongoing regulation of their product offerings, marketing, and with variation from state to state, their premium setting for at least some products. It is questionable, though, whether in the most common situations a merger of health plans or insurers would qualify for

⁵² *Hoover v. Ronwin*, 466 U.S. 558, 569 (1984).

⁵³ *See California Retail Liquor Dealers Ass’n. v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105-06 (1980).

the state action defense. Even though a state law that merely permits, rather than compels, anticompetitive behavior, can be enough to satisfy the first prong of the state action criteria,⁵⁵ it is not evident that the insurance holding company act laws are properly viewed as laws intended to replace competition with regulation. Indeed, they expressly include a review process intended to ensure that mergers are not anticompetitive.

In addition, there is case law indicating that in the merger context, the “active supervision” requirement would require not only supervision of the merger, but ongoing state supervision of marketplace conduct of the merging parties, including regulation of prices and products. While such supervision was found to be present in one case involving the merger of public utilities,⁵⁶ there is no case law addressing whether the typical level of HMO or health insurance regulation by states would satisfy this requirement.⁵⁷

B. McCarran-Ferguson Act

The McCarran-Ferguson Act exempts the “business of insurance” from the federal antitrust laws, including the FTC Act, where the activity is regulated by the

⁵⁴ See *FTC v. Ticor Title Ins. Co.*, 504 U.S. 621, 633-635 (1992).

⁵⁵ See *Southern Motor Carriers Rate Conference v. U.S.* 471 U.S. 48, 60-62 (1985) (“when other evidence conclusively shows that a State intends to adopt a permissive policy, the absence of compulsion should not prove fatal to a claim of [state action] immunity”).

⁵⁶ See *FTC v. Equitable Resources, Inc.*, 2007-1 Trade Cas. ¶ 75,502 (W.D. Pa. 2007).

⁵⁷ See *North Carolina ex rel. Edmisten v. P.I.A. Asheville, Inc.*, 740 F.2d 274, 279 (4th Cir. 1984), *cert. denied*, 471 U.S. 1003 (1985).

state, and so long as the activity does not constitute boycott, coercion or intimidation or an agreement to commit such.⁵⁸ Not all activities of insurance companies are considered to be the “business of insurance.” The FTC held back in the 1970s that a merger of two insurers was not the “business of insurance,” and therefore was not protected by the McCarran-Ferguson Act, even though the merger had been subject to regulation and approved by two states.⁵⁹ The Commission relied on a Supreme Court ruling addressing, under another provision of the McCarran-Ferguson Act, the applicability of federal securities law to an insurance company merger approved by the State of Arizona Insurance Director. There, the federal law would not apply due to the McCarran-Ferguson Act if it “impaired” a state law regulating the “business of insurance.”⁶⁰ The Supreme Court explained:

Statutes aimed at protecting or regulating th[e] relationship [between insurers and policyholders], directly or indirectly, are laws regulating the ‘business of insurance . . . The crucial point is that here the State has focused its attention on stockholder protection; it is not attempting to secure the interests of those purchasing insurance policies.’⁶¹

That is the portion of the opinion relied upon by the FTC. In contrast to that portion of its opinion, though, the Supreme Court also said, a separate state law provision that required the State Director of Insurance to find that the proposed

⁵⁸ See 15 U.S.C. 1013 et seq.

⁵⁹ See *American General Insurance Co.*, 81 F.T.C. 1052 (1972).

⁶⁰ See *Securities and Exchange Commission v. National Securities, Inc.*, 393 U.S. 453 (1969).

⁶¹ *Id.* at 460.

merger would not "substantially reduce the security of and service to be rendered to policyholders" before he gives his approval "clearly" did relate to "the business of insurance."⁶²

This results in the possibility that a merger of insurers is or is not the "business of insurance" for purposes of the McCarran-Ferguson Act exemption depending on the objectives of the state law under which a state has approved or regulated the conduct. Where it is policyholders whose interests are being protected by the state law, then the merger could, by this reasoning, be considered the "business of insurance." This could certainly be the case with regard to the competition-based approval provisions of state insurance holding company acts. If this reasoning prevails, then McCarran-Ferguson Act immunity could apply to a merger of health insurers. No court has yet decided whether an insurer merger, approved under a state insurance holding company act after a competition review, should be considered the business of insurance, and within the immunity provisions of the McCarran-Ferguson Act.

The FTC has also ruled that where the anticompetitive effects of a merger would be felt in all 50 states, the state regulation criterion for McCarran-Ferguson Act applicability should not be considered satisfied, so no immunity applies.⁶³ This consideration would not apply where the alleged relevant geographic market is local and the anticompetitive effects will allegedly occur in a single state.

⁶² *Id.* at 462.

VI. State Insurance Department Reviews

Apart from state attorney general antitrust enforcement, state insurance departments must typically approve mergers and acquisitions involving health insurers and HMOs, pursuant to each state's insurance holding company system law's competitive impact standards. The National Association of Insurance Commissioners Model Insurance Holding Company System Regulatory Act ("the "Model Act"), adopted with some variation by the states across the country, establishes pre-acquisition notification and approval requirements for acquisitions of non-domestic and domestic insurers and, in many cases, HMOs. Market share thresholds codified in these laws are in most cases remarkably low, compared to the evolving antitrust standards reflected in the FTC-DOJ Merger Guidelines.

A. Non-Domestic Insurer

State insurance holding company laws following the Model Act usually require pre-acquisition notification of a change in control of an insurer authorized to do business in the state. The insurers also must comply with a 30-day waiting period prior to closing the transaction. An exception to these requirements is available if as an immediate result of the acquisition 1) in no market would the combined market share of the insurers exceed five percent of the total market; 2) there would no increase in any market share; or 3) in no market would the

⁶³ See *American General Insurance Co.*, 81 F.T.C. 1052 (1972).

combined market share of the insurers exceed 12 percent of the total market and the market share increase by more than two percent of the total market. A market for purposes of the prior notice exception means direct written insurance premium in the state for a line of business as contained in the annual statement required to be filed by insurers licensed to do business in the state.

A state may enter an order to enjoin the acquisition where the proposed acquisition would substantially lessen competition or tend to create a monopoly in the market. The market is usually assumed to be the direct written insurance premium for a line of business unless proven otherwise. Under the Model Act, there is a rebuttable presumption of a violation of this standard where the insurers have the following respective market shares in a highly concentrated market (combined share of the four largest insurers is 75 percent or more):

<u>Insurer A</u>	<u>Insurer B</u>
4 percent	4 percent or more
10 percent	2 percent or more
15 percent	1 percent or more

If the market is not highly concentrated, the following market shares apply:

5 percent	5 percent or more
10 percent	4 percent or more
15 percent	3 percent or more
19 percent	1 percent or more

Take note: in a non-concentrated market, a merger is presumptively to be disallowed if the combined share of the merged firm will be as little as 10%.

A rebuttable presumption of a violation may also exist if there is a "significant trend toward increased concentration" in the market and one insurer market share is two percent or more and the other's share is within the group used to determine a significant trend toward increased concentration. There is a significant trend toward increased concentration when the aggregate market share of any grouping of the largest insurers in the market, from the two largest to the eight largest, has increased by seven percent or more over a ten year period.

Under the Model Act, the insurers may rebut the presumptive violation based on evidence on such factors as the number of competitors, market concentration, trend of market concentration, and ease of market entry and exit. Typically, state laws provide that the state may not enter an order to enjoin the acquisition if the acquisition will yield substantial economies of scale or economies in resource utilization that cannot be feasibly achieved in any other way and that are greater than the public benefits arising from not lessening competition.

Most states have adopted provisions similar to the Model Act.⁶⁴ Nevada law, in contrast, departs from the benchmarks in the Model Act, instead instructing the Insurance Commissioner to consider the standards set forth in the FTC-DOJ Merger Guidelines in determining whether a proposed merger will substantially

⁶⁴ See, e.g., Ariz. Rev. Stat. Ann. § 20-481.25; Ga. Code Ann. § 33-13-3.1; Ill. Rev. Stat. § 5/131.12; Mo. Rev. Stat. § 382.095; N.J. Rev. Stat. § 17:27A-4.1; 40 Pa. Stat. § 991.1403.

lessen competition or tend to create a monopoly.⁶⁵ In some states, acquisitions of HMOs or non-profit health services corporations (e.g., certain Blue Cross and Blue Shield plans) may not be subject to the same review requirements.⁶⁶

B. Domestic Insurer

State insurance holding company laws following the NAIC Model Insurance Holding Company Act generally provide that no person may enter into an agreement to merge with or to acquire control of a domestic insurer without the prior approval of the state insurance commissioner. Where insurers must obtain approval under this provision, the pre-acquisition notification and waiting period provisions in regard to non-domestic insurers usually do not apply, because the acquisition cannot occur without state insurance commissioner approval in any event. States typically apply the same competitive standard and presumptions for acquisition of a non-domestic insurer to a domestic insurer.⁶⁷

In the recent United-Sierra transaction, the Nevada Insurance Commissioner approved the acquisition, subject to a number of restrictions, in a ruling addressing

⁶⁵ See Nevada Rev. Stat. 692C.256(2).

⁶⁶ Cf. *Capital Blue Cross v. Pennsylvania Insurance Department*, 937 A. 2d 552 (Comm. Ct. Pa. 2007) (insurance holding company act requirements held not applicable to consolidation of two “Blue” plans).

⁶⁷ See, e.g., Ariz. Rev. Stat. §§ 20-481.06 -.07, 20-481.25; Colo. Rev. Stat. §§ 10-3-803, -803.5; 40 Pa. Stat. § 991.1402.

issues of product and geographic market, market shares and competitive effects.⁶⁸

The Commissioner effectively deferred to the Department of Justice on Medicare Advantage-related product market issues, in light of the federal character of and regulatory authority over the program.

Other state insurance department orders in health plan merger proceedings are included in the table contained in Appendix A.

⁶⁸ See In the Matter of Acquisition of Health Plan of Nevada, Inc. by UnitedHealth Group, Inc., State of Nevada Department of Business and Industry, Division of Insurance, Cause No. 07.188 (Findings of Fact, Conclusions of Law and Order Aug. 27, 2007).

Appendix A

Health Plan Merger Enforcement Actions

DEPARTMENT OF JUSTICE REVIEW		
Parties	Allegations of Competitive Harm	Conclusion
<p>Highmark, Inc. & Independence Blue Cross</p> <p>Highmark, Inc. (“Highmark”) is a leading health insurer in the 49 counties of western and central Pennsylvania while Independence Blue Cross (“IBC”) is a leading health insurer in southeastern Pennsylvania.</p>	<p>The American Hospital Association (“AHA”) is concerned that the merger will result in a large accumulation of market power, considering that IBC and its subsidiaries and affiliates are Philadelphia region’s largest health insurer and that Highmark controls 60 percent of the insured population in western Pennsylvania counties.</p> <p>The AHA believes that merger would result in (1) inadequate reimbursement to providers, (2) the ability to dictate arrangements with hospitals, (3) increases to the price of health insurance coverage and (4) limits of choice and types of plans available to consumers.</p>	<p>The DOJ did not take any action when Highmark and IBC made their initial HSR filings. However, because the consolidation was not consummated within the specified time period, Highmark and IBC must re-file and did so on May 6, 2008. In light of this re-filing, the AHA has requested that the DOJ investigate the proposed merger.</p>
<p>UnitedHealth Group, Inc. & Sierra Health Services, Inc.</p> <p>UnitedHealth Group, Inc. (“United”) is the largest health insurer in the United States and provides health insurance to its MA-HMO enrollees in the Las Vegas area through a managed-care network. Sierra Health Services, Inc. (“Sierra”) was the largest health insurer in Nevada. Both United and Sierra sold Medicare Advantage plans in Las Vegas. Together, they accounted for 94 percent of Medicare Advantage insurance enrollment in the Las Vegas area.</p> <p><i>United States v. UnitedHealth Group, Inc., C.A. No. 1:08CV00322 (D.D.C. February 25, 2008)</i></p>	<p>The United States Department of Justice (“DOJ”) alleged that the merger would result in a substantial lessening of competition in the sale of Medicare Advantage health plans. According to the DOJ, the effects of such a lessening of competition would be decreased competition among MA plans in Las Vegas, increased prices and decreased levels of benefits and services for Medicare Advantage insurance.</p> <p>Provider organizations, a labor union, and a Congressional committee have publicized concerns that the merger would harm competition in the sale of HMO products and would result in monopsony power in the purchase of health care provider services, resulting in a reduction of quality of care to Nevada residents. The complaint filed by DOJ did not make allegations on these issues. The concerned organizations are seeking to press these issues in the Tunney Act federal court review of the DOJ consent judgment.</p>	<p>Under the consent decree, United agreed to divest its Medicare Advantage business in the Las Vegas area. The divestiture included additional requirements, most notably the following:</p> <ul style="list-style-type: none"> • Restricting the use of the AARP and Secure Horizons brand by United and Sierra in Las Vegas, for a defined period of time. • Trying to assure that the party acquiring the divested assets will have access to substantially the same provider network that the United enrollees had access to under its MA plans, as well as restricting agreements between United and certain provider groups for a period of time. • Facilitating a relationship between United’s top MA brokers and the acquiring party. • Trying first to sell to a particular potential buyer, indicating that the DOJ has imposed a “fix it first” type of relief, whereby the consent judgment was only executed after the divesting party had already identified and brought to DOJ an identified prospective purchaser.

This table lists health plan merger enforcement actions, including consent judgments, Department of Justice “no action” statements, and state insurance department orders imposing conditions on proposed mergers. The list may not be complete. The speaker would appreciate any additions.

Appendix A

Health Plan Merger Enforcement Actions

<p>UnitedHealth Group, Inc. & PacifiCare Health Systems, Inc.</p> <p>United and PacifiCare were the second and third largest sellers of commercial health insurance in Tucson and competed against one another in this market. Additionally, they both purchased health care services from physicians and other providers for their employer members and competed in this regard in both Tucson, Arizona and Boulder, Colorado. PacifiCare competed with Blue Shield of California both for the purchase of health care provider services and for the sale of commercial health insurance in California. Although United did not contract directly with health care providers in California, it rented provider networks of a Blue Shield of California subsidiary – CareTrust Networks.</p> <p><i>United States v. UnitedHealth Group Inc.</i>, C.A. No. 1:05CV02436 (D.D.C. December 20, 2005)</p>	<p>According to the DOJ, as the second and third largest sellers of commercial health insurance to small-group employers in Tucson, the merger of United and PacifiCare would have eliminated direct competition between them and could have permitted United to increase prices and reduce the quality of commercial health insurance plans to small-group employers in Tucson. Additionally, if merged, United would have accounted for a large share of total payments to all physicians in the Boulder and Tucson areas. As a result, the DOJ alleged that the merger could have enabled United to pay lower rates for physician services in Tucson and Boulder, which would likely have lead to a reduction in quantity or degradation in quality of physician services provided to patients in these areas. Finally, under its network access agreement with CareTrust Networks, United and Blue Shield were required to exchange information about provider network product developments. As a result of this merger, United would have competed directly with Blue Shield and the DOJ alleged that the continuation of the network access agreement could have substantially reduced competition for the purchase of health care provider services and for the sale of commercial health insurance in California.</p>	<p>United and PacifiCare entered into a consent decree with the DOJ that required them to divest portions of PacifiCare’s commercial health insurance business in Tucson, including its small group business, to a viable competitor as well as its HMO contract in Boulder with the Regents of the University of Colorado. United was also required to modify its network access agreement with CareTrust networks to prohibit United from continuing to exchange certain information with Blue Shield and then to terminate its network access agreement with CareTrust Networks within one year.</p>
<p>UnitedHealth Group, Inc. & Oxford Health Plans, Inc.</p> <p>UnitedHealth Group provided health insurance to people nationwide while Oxford Health offered health plans primarily in New York, New Jersey and Connecticut in addition to providing Medicare plans and third-party administration of employer-funded benefits plans.</p> <p>DOJ Closing Statement (July 20, 2004), avail. at http://www.usdoj.gov/atr/public/press_releases/2004/204676.htm</p>	<p>Whether acquisition would lessen competition in sale of health plans, or purchase of provider services, in overlap markets in New York, New Jersey or Connecticut.</p>	<p>The DOJ closed the investigation and provided the following reasons for its conclusion. Regarding the sale of health insurance products:</p> <ul style="list-style-type: none"> • Harm from coordinated interaction was unlikely due to the wide variety of health insurance products offered, the differentiation among product lines, the diversity of health insurance customers, and the different methodologies for pricing to customers. • Harm from unilateral effects was unlikely. • The combined entity would have several competitors after the merger.

This table lists health plan merger enforcement actions, including consent judgments, Department of Justice “no action” statements, and state insurance department orders imposing conditions on proposed mergers. The list may not be complete. The speaker would appreciate any additions.

Appendix A

Health Plan Merger Enforcement Actions

		<ul style="list-style-type: none"> • United and Oxford were not considered close substitutes for one another for many customers. The parties had differences in the breadth and quality of their networks, their customer types, their relative strengths in particular locations and their ability to provide additional network features. <p>Regarding the purchase of health care provider services</p> <ul style="list-style-type: none"> • The combined entity would not account for a substantial percentage of provider revenues
<p>Anthem, Inc. & WellPoint Health Networks, Inc.</p> <p>Anthem, Inc. (“Anthem”) and WellPoint Health Networks, Inc. (“WellPoint”) were large health insurance companies and were the two largest licensees of the Blue Cross Blue Shield Association. At the time of the proposed acquisition (2004), the combined entity would have become the largest managed care insurance company in the U.S.</p> <p>DOJ Closing Statement (Mar. 9, 2004), avail. at http://www.usdoj.gov/atr/public/press_releases/2004/202738.htm</p>	<p>Investigation focused on whether the combined Anthem/WellPoint would have market or monopsony power in the health care benefit product and health care provider purchasing markets in which they competed.</p>	<p>The DOJ closed the investigation, stating that “[t]he facts did not support a conclusion that this merger will give a combined Anthem/WellPoint market or monopsony power in any market in which they compete. WellPoint's share in the markets in which they overlap is very small, and these companies are not particularly close competitors. Although this particular transaction should not threaten to harm competition or consumers, we will continue to be vigilant in our enforcement of the antitrust laws in this area.”</p> <p>The DOJ provided the following reasons for its conclusion:</p> <ul style="list-style-type: none"> • Anthem and WellPoint did not compete for the sale of health insurance products based upon the fact that Blue Cross assigned specific geographic territories to each licensee. This prohibited both Anthem and WellPoint from using the Blues Marks outside their respective territories. Although Anthem did compete with two WellPoint subsidiaries in each of the nine states in which Anthem was a Blues licensee, the DOJ concluded that WellPoint’s market share in those states was small and neither of the subsidiaries was a close competitor to Anthem in those states. • The merger would not have resulted in the combined entity having buyer-side market power over health care providers because the DOJ

This table lists health plan merger enforcement actions, including consent judgments, Department of Justice “no action” statements, and state insurance department orders imposing conditions on proposed mergers. The list may not be complete. The speaker would appreciate any additions.

Appendix A

Health Plan Merger Enforcement Actions

		<p>concluded that WellPoint’s market share in the overlap states was very low. As a result, Anthem’s share of revenue earned by providers would only have increased by a very small amount.</p> <ul style="list-style-type: none"> • There was no indication that as a result of the merger, it was more likely that the combined entity would impose contractual clauses that might raise competitive concerns in their contracts with hospitals. • There was concern about the possibility that competition for the acquisition of Blues plans might be reduced, thereby possibly decreasing the purchase prices of other selling plans. The DOJ determined that it could not predict that this competitive harm would result in the foreseeable future and therefore concluded that such a possibility did not support a challenge to the merger.
<p>Aetna, Inc. & The Prudential Insurance Company of America</p> <p>At the time of the review, Aetna, Inc. (“Aetna”) was one of the largest health insurance companies in the United States and Prudential Insurance Company of America (“Prudential”) was a smaller yet relatively large health insurance company. Both companies offered managed health insurance plans and were principal competitor’s in alleged HMO and HMO-based POS products markets in Houston and Dallas, Texas. Additionally, both Aetna and Prudential contracted with physicians for services for their health plan members.</p> <p><i>United States v. Aetna, Inc.</i>, C.A. No 3-99CV 1398-H (N.D. Tex. December 7, 1999).</p>	<p>The DOJ’s complaint alleged that the merger would have eliminated the direct competition between Aetna and Prudential and would have given Aetna the ability to increase its prices or lower its quality of services to HMO members in Houston and Dallas. In addition, the DOJ alleged that Aetna would possess increased market power in the purchase of physician’s services, which would have allowed Aetna to depress physicians’ reimbursement rates in Houston and Dallas. According to the DOJ, this, in turn, would likely have lead to a reduction in the quantity or a degradation in the quality of physician services.</p>	<p>The consent decree required Aetna to divest its commercial HMO business in Houston and Dallas. This business was part of Aetna’s 1998 acquisition of NYLCare Health. Aetna was also required to take all steps necessary to ensure that NYLCare-Gulf Coast and NYLCare-Southwest were maintained and operated as independent, on-going, economically viable, and active competitors until completion of the divestitures ordered by the Revised Final Judgment.</p>

FEDERAL TRADE COMMISSION REVIEW		
Parties	Allegations of Competitive Harm	Conclusion
Yellowstone Community Health Plan/Blue Cross Blue Shield of Montana		The FTC indicated that the merger raised significant antitrust concerns but nevertheless closed its

This table lists health plan merger enforcement actions, including consent judgments, Department of Justice “no action” statements, and state insurance department orders imposing conditions on proposed mergers. The list may not be complete. The speaker would appreciate any additions.

Appendix A Health Plan Merger Enforcement Actions

<p>Yellowstone Community Health Plan and Blue Cross Blue Shield of Montana were two of the largest health insurers in Montana.</p> <p>FTC No. 991-0028 (closing letter sent July 14, 1999).</p>		<p>investigation in light of conditions placed on the merger by the Montana Insurance Commissioner. These conditions included the requirement that the merged entity not prohibit or discourage providers from serving as or contracting with any other health plans, insurers, or HMOs.</p>
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STATE ATTORNEY GENERAL REVIEW		
Parties	Allegations of Competitive Harm	Conclusion
<p>UnitedHealth Group, Inc. & Sierra Health Services, Inc.</p> <p>UnitedHealth Group, Inc. (“United”) is the largest health insurer in the United and provides health insurance to its MA-HMO enrollees in the Las Vegas area through its well-established managed-care network. Sierra Health Services, Inc. (“Sierra”) was the largest health insurer in Nevada. Both United and Sierra sold Medicare Advantage plans in Las Vegas. Together, they accounted for 94 percent of the Medicare Advantage insurance market in Las Vegas.</p> <p><i>Nevada v. UnitedHealth Group, Inc.</i>, C.A. No. 2:08-cv-00233-JCM-RJJ (D. Nev., complaint filed February 25, 2008)</p>	<p>See Department of Justice table above.</p>	<p>With regard to divestiture, the remedial provisions under the proposed Stipulated Final Judgment with the Nevada Attorney General mirror the Department’s requirements. The Nevada Stipulated Final Judgment contains additional commitments on the part of United and/or Sierra, including the following:</p> <ul style="list-style-type: none"> • Not conditioning provider participation in any line of business on the provider's willingness to participate in other lines of business (sometimes referred to as an “all products clause”) for a period of two years. • Refraining from new exclusive provider contracts in violation of state or federal antitrust laws, or contracts with most favored nations clauses, for a period of two years. • Notifying small employers 60 days in advance of intent by United to increase rates. • Making \$15 million in charitable donations to charitable activities specified by the Attorney General. • Agreeing not to use the Ingenix Prevailing Healthcare Charges System Database to establish reasonable and customary fees to reimburse out-of-network providers that furnish services to enrollees of Health Plan of Nevada or

This table lists health plan merger enforcement actions, including consent judgments, Department of Justice “no action” statements, and state insurance department orders imposing conditions on proposed mergers. The list may not be complete. The speaker would appreciate any additions.

Appendix A

Health Plan Merger Enforcement Actions

		<p>Sierra Health and Life Insurance Company (the Sierra subsidiaries that issue HMO and PPO plans, respectively) for a period of two years.</p> <ul style="list-style-type: none"> • Providing the Nevada Attorney General advance notice of certain future acquisitions. • Providing specific confidentiality protections for certain provider rate information it obtains with respect to provider dealings with other health plans (for instance, through coordination of benefits), and specifically, must refrain from using such fee information that it obtains on specific providers to negotiate fees with those providers.
<p>Aetna, Inc. & The Prudential Insurance Company of America</p> <p>At the time of the review, Aetna, Inc. (“Aetna”) was one of the largest health insurance companies in the United States and Prudential Insurance Company of America (“Prudential”) was a smaller yet still relatively large health insurance company. Both companies offered managed health insurance plans and were principal competitor’s in the HMO and HMO-based POS markets in Houston and Dallas, Texas. Additionally, both Aetna and Prudential contracted with physicians for services for their health plan members.</p> <p><i>United States v. Aetna, Inc.</i>, C.A. No 3-99CV 1398-H (N.D. Tex. December 7, 1999).</p>	<p>See Department of Justice table above.</p>	<p>The Texas Attorney General consent decree required Aetna to divest its commercial HMO business in Houston and Dallas. This business was part of Aetna’s 1998 acquisition of NYLCare Health. Aetna was also required to take all steps necessary to ensure that NYLCare-Gulf Coast and NYLCare-Southwest were maintained and operated as independent, on-going, economically viable, and active competitors until completion of the divestitures ordered by the Revised Final Judgment.</p>

Appendix A

Health Plan Merger Enforcement Actions

<p>Harvard Community Health Plan, Inc. & Pilgrim Health Care, Inc.</p> <p>Pilgrim Health Care, Inc. (“Pilgrim”) was a rapidly growing IPA model HMO with close ties to provider community and high levels of consumer satisfaction. Harvard Community Health Plan (“Harvard”) was a larger HMO, with staff and network model features, with flatter growth in recent years. Neither plan was known for exclusive contracts with providers, other than Harvard's own staff model capacity.</p> <p>No. 95-0331E (Mass. Sup'r Ct. Jan. 18, 1995) (assurance of discontinuance).</p>	<p>The Massachusetts Attorney General was apparently concerned that the affiliation would be anticompetitive in an HMO market for eastern Massachusetts.</p>	<p>The Massachusetts Attorney General (“AG”) did not challenge the combination of the Harvard and Pilgrim, but imposed the following conduct and community benefit remedies.</p> <ul style="list-style-type: none"> • Prior notice and approval by AG for any acquisition of a Massachusetts licensed HMO, unless there were no members in eastern Massachusetts and fewer than 20,000 in the remainder of state. • Prior notice and approval by AG for any contract with a hospital prohibiting a hospital from affiliation with all other managed care payors, not counting hospitals controlled by Harvard/Pilgrim. The provision did not limit Harvard/Pilgrim's right to determine not to contract with any hospital. • Prior notice and approval by AG for any contract with a physician precluding the physician from contracting with all other managed care payors, where contract would result in exclusive contracts with over 25% of physicians in the same specialty in a county where the group was located. • Ban on contracts requiring a provider to charge Harvard/Pilgrim the lowest fee charged or offered to any other plan. The provision did not limit Harvard/Pilgrim's ability to negotiate with a provider based on fee schedule of any other plan. • For two years, prior notice to AG before acquiring more than 50% interest in any physician group in a county, if as a result, Harvard/Pilgrim would have a controlling interest in more than 25% of physicians in the same specialty in that county. • Harvard/Pilgrim could not increase filed rates for non-group and small group traditional HMO products in 1995 in any quarter over filed rates for such products for same quarter of 1994.
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This table lists health plan merger enforcement actions, including consent judgments, Department of Justice “no action” statements, and state insurance department orders imposing conditions on proposed mergers. The list may not be complete. The speaker would appreciate any additions.

Appendix A Health Plan Merger Enforcement Actions

		<ul style="list-style-type: none"> • Increases in filed rates for any products for any quarter of 1996 could not exceed the higher of (a) average increase in filed rates for similar products of other HMOs or (b) 4.5%. • Increased funding by Harvard/Pilgrim to community-benefit activities by at least \$3.25 million over three years, with oversight by AG. • Requirement to continue selling the new Medicare risk product. If enrollment failed to hit specified targets, additional community benefit contributions was required. • Requirement to make non-group program available to enrollees who desired to use the Pilgrim network. • Funding COBRA continuation subsidies for below poverty line enrollees at \$250,000 per year for three years.
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STATE HEALTH INSURANCE COMMISSIONER REVIEW		
State	Parties	Conclusion
Pennsylvania	Highmark, Inc. & Independence Blue Cross	The Pennsylvania Insurance Department is currently reviewing the proposed consolidation of Independence Blue Cross and Highmark, Inc. On May 12, 2008, the Department announced that it has scheduled a series of public informational hearings in order to hear from consumers and other affected parties about how the proposed consolidation, plus related changes, will impact the healthcare marketplace.
Nevada	<p style="text-align: center;">UnitedHealth Group, Inc. & Sierra Health Services, Inc.</p> <p>UnitedHealth Group, Inc. (“United”) is the largest health insurer in the United and provides health insurance to its MA-HMO enrollees in the Las Vegas area through its well-established managed-care network. Sierra Health Services, Inc. (“Sierra”) was the largest health insurer in Nevada. The Commissioner’s review addresses product market and</p>	<p>The commissioner concluded that the acquisition was not likely to substantially lessen competition in the relevant commercial markets in Nevada or in any MSA in Nevada (including, but not limited to, the individual, small group and provider markets). However, it did conclude that there might be significant competitive issues with respect to the sale of Medicare products in Las Vegas but deferred to the DOJ with respect to this issue.</p> <p>The commissioner ultimately approved the acquisition, subject to the requirement that United and Sierra comply with the commitments made in a commitment letter to the commissioner. Among other things, the parties:</p> <ul style="list-style-type: none"> • Must not increase premiums nor decrease fees paid to providers as a result of the acquisition

This table lists health plan merger enforcement actions, including consent judgments, Department of Justice “no action” statements, and state insurance department orders imposing conditions on proposed mergers. The list may not be complete. The speaker would appreciate any additions.

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Health Plan Merger Enforcement Actions

	<p>competitive effects issues, in the sale of a range of health benefits products and regarding possible exercise of market power in the purchase of provider services.</p> <p><i>In the Matter of the Acquisition of Health Plan of Nevada, Inc. by UnitedHealth Group Incorporated, Finding of Fact, Conclusions of Law and Order, Cause No. 07.188 (August 27, 2007)</i></p>	<ul style="list-style-type: none"> • Must participate as voluntary individual reinsuring carriers or small employer reinsuring carriers in the Program of Reinsurance for Small Employers and Eligible Persons • Commit that Sierra will offer substantially the same Medicare products and benefit designs after the acquisition
California	<p>UnitedHealth Group, Inc. & PacifiCare Health Systems, Inc.</p> <p>United and PacifiCare were competitors in California and the acquisition was the focus of review by the California insurance commissioner.</p>	<p>The California insurance commissioner approved the acquisition but required the following conditions to be met:</p> <ul style="list-style-type: none"> • Earmark \$250 million for health care to underserved communities - \$200 million to be invested in clinics and hospitals that serve the poor and \$50 million in charitable donations including medical education and outreach to individuals eligible for public programs. • Not pass the costs of the deal on to their members. • Guarantee that customer service remains unaffected • Not fund any dividend with profits from PacifiCare’s health insurance operations in California for four years after the merger. • Pay \$13.7 million in incentives to doctors based on quality improvements.
California	<p>Anthem, Inc. & WellPoint Health Networks, Inc.</p> <p>Anthem, Inc. (“Anthem”) and WellPoint Health Networks, Inc. (“WellPoint”) were large health insurance companies and were the two largest licensees of the Blue Cross Blue Shield Association. At the time of the proposed acquisition (2004), the combined entity would have become the largest managed care insurance company in the U.S.</p>	<p>The California Insurance Commissioner initially disapproved the merger, which resulted in the filing of a suit against by Anthem in Los Angeles Superior Court. The Insurance Commissioner eventually approved the acquisition subject to specified conditions¹, including:</p> <ul style="list-style-type: none"> • Written commitment that Anthem would not increase premiums payable by WellPoint policyholders as a result of the merger. • Anthem’s agreement to invest in, and contribute to, low-income health programs totaling at least \$265 million over 20 years. This included a \$25 million donation to community clinics, \$15 million donation to the training of new nurses. \$15 million to the “Insuring Healthy Futures” initiative and a \$100 million donation to the Investment in a Healthy California Program. • Work with the Department’s staff to develop a new program for indemnity insurance programs and preferred provider organizations to increase coverage for prevention and early detection in specific measurable services included in the HEDIS index and agree to spend no less than \$25 million to reach measurable and specified improvements in objective indices in each of the categories. • Boost the percentage of premiums Anthem spends for medical care.

¹ These include some of the same commitments made to the Department of Managed Health Care.

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<p>Georgia</p>	<p>Anthem, Inc. & WellPoint Health Networks, Inc.</p> <p>Anthem, Inc. (“Anthem”) and WellPoint Health Networks, Inc. (“WellPoint”) were large health insurance companies and were the two largest licensees of the Blue Cross Blue Shield Association. At the time of the proposed acquisition (2004), the combined entity would have become the largest managed care insurance company in the U.S.</p>	<p>The Georgia Insurance Commissioner approved the acquisition subject to specified conditions, including,:</p> <ul style="list-style-type: none"> • Provide Georgia \$126.5 million over 20 years to improve health care in rural areas of the state. • Promise rates will not increase after the merger. • Guarantee that the insurance premiums for policyholders of Blue Cross and Blue Shield of Georgia (a WellPoint company) would not increase because of the merger or Anthem's financial commitment to the state. • Cover telemedicine procedures for Blue Cross policyholders and invest two percent of its investment portfolio each year for 20 years in bonds and other debt instruments issued by rural health care facilities for expansion, renovation, and equipment upgrades. <p>[Art – Information based on an article so I can’t determine whether the whether the ruling was pursuant to a competition issue.]</p>
<p>New York</p>	<p>Excelsus & Univera</p>	<p>In 2001, the Superintendent of Insurance approved the merger but required the parties to create a charitable foundation into which certain assets were contributed. The initial contributions would be used to fund charitable purposes to improve the health status of citizens in Univera’s service areas.</p>
<p>Kansas</p>	<p>Anthem Inc. & Blue Cross Blue Shield of Kansas, Inc.</p> <p><i>In the Matter of the Conversion and Acquisition of Blue Cross and Blue Shield of Kansas, Inc.</i>, Docket No. 3014-DM <i>Praeger v. Blue Cross and Blue Shield of Kansas, Inc.</i> et al, 75 P.3d 226, (Kan. 2003)</p>	<p>Anthem sought to acquire Blue Cross Blue Shield of Kansas (“BCBSKS”), the largest insurer in Kansas. The commissioner issued an order rejecting the merger, ruling that it would not benefit policyholders or the public. According to the commissioner, the record showed that Anthem would increase premium rates faster than BCBSKS because it would seek higher underwriting margins and that the merger would result in a 50 percent decrease in BCBSKS’ operating surplus. The Kansas Supreme Court upheld the Kansas Insurance Commissioner’s order. This ruling arose in the context of a conversion to for-profit status and is not principally based on competition grounds.</p>
<p>New Hampshire</p>	<p>Harvard Pilgrim Health Care and Matthew Thornton</p> <p>Harvard Pilgrim Health Care (“Harvard”) was the largest HMO in New England. Matthew Thornton (“Thornton”) was New Hampshire’s oldest HMO.</p> <p><i>In re Matthew Thornton Health Plan</i> (N.H. Ins. Dept. January 12, 1996)(approval, with conditions, of Harvard Pilgrim Health Care's acquisition of Matthew Thornton Health Care HMO).</p>	<p>The New Hampshire Insurance Department approved the acquisition of Matthew Thornton Health Plan by the Massachusetts-based Harvard Pilgrim Health Care, subject to the following conditions:</p> <ul style="list-style-type: none"> • Harvard-Thornton was barred from entering into an exclusive arrangement with the Hitchcock Clinic group practice in Concord, New Hampshire. • The parties were required to contribute \$15 million to state's health care transition fund for uninsured residents • The parties were required to spend \$20 million on activities designed to benefit the state's health care consumers. <p>The parties apparently found the conditions imposed by the Insurance Department for oversight of future changes in operation to be overly intrusive, and, the deal collapsed. <i>See Boston Globe</i>, Feb. 2, 1996 (at p. 27 Economy)</p>

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		<p>The Insurance Department ruling followed an earlier determination by the state attorney general not to challenge the combination, on condition that the HMO not enter into exclusivity agreements with providers in Keene or Lebanon, New Hampshire or in medically underserved areas of the state, and that Hitchcock Clinic be free to contract with any managed care insurer for pediatric, obstetric or gynecological primary care in any area of the state. <i>See BNA Health Care Daily</i> (Jan. 23, 1996).</p>
Missouri	<p>United HealthCare Corporation & MetraHealth Companies, Inc.</p> <p>United HealthCare was one of the nation's largest and most experienced operators of various types of health care plans. MetraHealth was formed by the combination of the health care businesses of Metropolitan Life and the Travelers Insurance Companies. MetraHealth provided both traditional indemnity health insurance and managed health care plans.</p> <p><i>In re Proposed Acquisition of MetLife HealthCare Network, Inc.</i>, Case No. 95-07-13-0006 (Mo. Dept. of Ins. Sept. 28, 1995) (findings of fact, conclusions of law and consent)</p>	<p>To resolve concerns by the Missouri Department of Insurance that the acquisition of MetLife St. Louis HMO could lessen competition in a St. Louis metropolitan area geographic market for "insured managed care," in violation of the Missouri insurance holding company system law, United HealthCare ("UHC") agreed to a consent order requiring divestiture of MetLife St. Louis HMO. The HMO was being acquired as part of national acquisition of MetraHealth by UHC. The order provided that MetLife St. Louis group accounts would be given an opportunity, in a neutral and objective manner, to remain with it or to obtain coverage from other health plans of their choice, including the other UHC plans in the St. Louis area. The order did not require divestiture of MetraHealth's non-HMO programs in St. Louis.</p>
Missouri	<p>Blue Cross Blue Shield of Missouri & HealthLink</p> <p>HealthLink was the operator of a large PPO program for self-insured employers and for other insurers or payors who sought to "rent" a network. It owned a small start-up HMO.</p> <p><i>In re Proposed Acquisition of HealthLink Inc. and HealthLink HMO</i>, Case No. 95-06-13-0645 (Mo. Dept. Ins. Aug. 2, 1995) (findings of fact and conclusions of law, approval, consent and order).</p>	<p>The HMO portion of the acquisition of HealthLink by Blue Cross Blue Shield of Missouri was subject to state approval. The Missouri Department of Insurance approved the acquisition subject to the following conditions:</p> <ul style="list-style-type: none"> • From September 1, 1995 through August 31, 1996, the combined entities in St. Louis Metropolitan Statistical Area could not increase premium rate cells or rate formulas for HMO and PPO products offered to new group customers with 3- 99 employees on an average premium per member per month basis by more than 90% of the annual percentage increase in the medical services component of the CPI. Such new rates were to be guaranteed for 18 months. • For renewing groups from September 1, 1995 through August 31, 1996, the cumulative percentage change for small groups could not increase in the St. Louis area on an average per member per month basis over the year by more than 90% of the annual percentage increase in the medical services component of the CPI. • For renewing groups over the period from September 1995 through August 1997, the cumulative

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		<p>percentage change over the entire 2 year period in annual renewal premium rates for HMO and PPO products to small groups in the St. Louis area could not increase by more than 90% of the sum of the CPI increases for the two years.</p> <ul style="list-style-type: none"> • For two years, customer guaranteed access to the HealthLink provider network, at rates that only differentiate among classes of customers in a manner consistent with prior practice. • HealthLink’s guarantee that its employer fees for self-insured programs would not increase at rate in excess of the annual percentage increase in non-medical CPI. • For two years, the combined entities would not enter into any new contract with a hospital or hospital network in St. Louis area that contained any provision by which the hospital or hospital network agreed to lower rates to the new combined entities or HealthLink to a rate lower than those provided by the hospital or network to another insurer, managed care firm or other payer.
Missouri	<p>United HealthCare Corporation & GenCare Health Systems, Inc.</p> <p>United HealthCare (“United”) owned the 128,000-member Physicians Health Plan of Greater St. Louis. GenCare Health Systems, Inc. (“GenCare”) was St. Louis’ largest health plan.</p> <p><i>In re Proposed Acquisition of GenCare Health Systems, Inc.</i>, Case No. 94-10-03-0110 (Mo. Dept. of Ins. Dec. 1994)(findings of fact and conclusions of law, approval, consent and order)</p>	<p>The Missouri Department of Insurance approved United’s acquisition of GenCare Health System subject to the following conditions:</p> <ul style="list-style-type: none"> • United and GenCare would not increase premium rate cells or rate formulas for new group customers who have from 3 - 50 employees for a two year period through 1996. • For coverage renewals from March 1, 1995 through February 1997, United and GenCare would not increase annual renewal premium rate cells or rate formulas for small groups by more than 90% of increase in medical component of the Consumer Price Index. • For the same period, annual change in any one small group’s rates resulting from change in rate cells or rate formulas would not exceed 10%.

OTHER REVIEWS

State	Parties	Conclusion
New York	<p>Group Health Incorporated and HIP Foundation, Inc.</p> <p><i>The City of New York v. Group Health, Inc.</i>, 1:06-cv-13122-RJS-RLE (Filed November 13, 2006 in the S.D.N.Y. – Case Pending)</p>	<p>The City of New York (the “City”) filed an antitrust action seeking to prevent the planned merger of Group Health Incorporated (“GHI”) and the HIP Foundation, Inc. (“HIP”). The City alleged that the merger would create a monopoly in the New York metropolitan area market for low-cost health insurance. On November 14, 2006, the District Court of the Southern District of New York denied the City of New York’s bid for a temporary restraining order to block the merger between the two companies. The court has also ruled on other pre-trial motions, the most recent of which was an amended scheduling order.</p>

Mergers: Antitrust Issues for Hospitals and Health Plans

Health Plan Mergers

Arthur N. Lerner

June 30 – July 2, 2008

AHLA Annual Meeting

San Francisco, California

History of Health Plan Merger Enforcement

- Initial actions by state attorneys general and state insurance commissioners
- 1999 DOJ consent judgment in Aetna – Prudential merger addressed alleged harm to competition in
 - Local Texas markets for HMO and HMO-POS products
 - Purchase of physician services
- Next federal enforcement is United-PacifiCare (2005)
 - Pueblo, Colorado and Tucson, Arizona markets for purchase of physician services
 - Harm to competition for sale of “small group” products in Tucson
- Most recent – United-Sierra acquisition (2008)

Standard of Review under State Insurance Holding Company Acts

- Unlike federal antitrust laws, most state insurance holding company acts specify market shares that create rebuttable presumption of competitive harm
- Standards drawn from much earlier era of antitrust thinking
 - E.g., merger presumed anticompetitive if firm with 5% buys 5%, or 19% buys 1%
- Presumption can be overcome by evidence on dynamics of competition, continued strong competition
- In practice, state reviews have not given undue weight to presumption

McCarran-Ferguson Act

- Partial antitrust immunity for “business of insurance” where regulated by state
- FTC ruled merger of insurers is not “business of insurance” more than 30 years ago, so no exemption
 - Relied on Supreme Court ruling that federal securities legislation protecting stockholders of merging insurers is not a law regulating insurance business
 - No court has yet ruled whether federal antitrust law applies to merger where harm to competition is alleged in a single state where state insurance commissioner reviews competitive impact of merger on consumers/policyholders

Common Themes

- Geographic markets are local/metro-regional
- How should employer “self-insurance” be factored into product market assessment?
- Product market analysis may segment by customer class
 - Medicare Advantage?
 - “Small group”?
- Can different products available to same customers be in different product markets – e.g., HMO v. PPO
 - Watch out for share data for “non-market”
- Attention to both “sell” and “buy” side market power
- Main focus has been on likelihood of unilateral market power rather than facilitating coordinated interaction

Product Market

- Non-merger antitrust cases find HMO programs part of broader health care financing or health care benefits market
- In Aetna-Prudential, DOJ alleged separate “HMO and HMO-like POS product market”
- Later, in United – Oxford, DOJ closed investigation explaining that market was broader
- DOJ apparently reached same judgment in very recent United-Sierra matter.

Anticompetitive Effects?

- Market shares only a beginning
- Which competitors sell products that are “close substitutes”?
- How different are products that are less “close”
- Barriers to inter-product movement by customers and competitors?
- How does regulatory scheme affect competitive dynamic and likelihood that market power could be exercised
- Is potential expansion by a firm with a broad provider network, operating systems and an advertising budget enough to prevent exercise of market power by merged firm?
- Agency consideration of “diversion ratios” -- proportion of acquirer’s customers lost pre-merger to the acquired firm and vice versa

Some Monopsony Issues

- How measure buyer power? Shares of what?
 - Include government programs in “denominator”?
- Would decreased “quality” resulting from price squeeze be felt only by health plan’s members, or would it be spread to other health plans’ members?
- How does ability of providers and customers to switch plans affect analysis?
- How hard is it for providers to withdraw from participation?
 - “Pain” vs “Power” – “difficult to do without” vs “can’t do without”

United – Sierra

- Reviewed by Nevada Insurance Commissioner, Nevada Attorney General and DOJ Antitrust Division
- Insurance Commissioner approves
 - Finds broad product market in Las Vegas area
 - Market shares and other factors did not indicate likelihood of harm to competition, but defers to DOJ on Medicare products
 - Approval order imposes conditions

United – Sierra (cont'd)

- Antitrust Division alleges harm to Medicare Advantage market in Las Vegas area. DOJ says traditional Medicare not in market, even with Medicare Part D drug benefit.
- Settlement requires divestiture of MA individual product line and measures to help assure viability of acquirer. Transaction closed. Humana approved as acquirer.
- No harm to competition alleged in commercial product lines or in market for purchase of provider services
- Consent judgment now in Tunney Act review process. Comments object to relief and claim complaint should have addressed commercial product lines and alleged acquisition of power in purchase of provider services.

United – Sierra (cont'd)

- State Attorney General also issues complaint alleging federal antitrust violation. No state antitrust violation pled, presumably due to exemption for activity subject to state regulatory approval
- Complaint alleges harm only to competition in Medicare Advantage products
- Consent matches DOJ order on divestiture, but imposes additional requirements –
 - Restricts use of MFN and all products clauses, and other commercial practices
 - Requires \$15 million charitable commitment
 - Creation of physician council
 - Confidentiality for provider rates negotiated with other payors for whom United handles administrative tasks
- Settlement awaiting final order¹¹ issuance