



The Next Chapter in Antitrust and Health Care: Health Insurance Mergers An ABA Program Summary

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As health insurance companies prepare for implementation of the Patient Protection and the Affordable Care Act (“ACA”), they are considering many issues, including whether the scale and efficiencies achieved through mergers is necessary to continue to grow and thrive. The Antitrust Section’s Health Care & Pharmaceuticals and Insurance & Finance Services Committees recently co-sponsored a panel on health care insurance mergers that covered this topic and how the review of health plan mergers may change under the ACA.

Although the ACA is groundbreaking legislation, by the end of the presentation it appeared that the panelists do not expect the law to significantly impact health plan merger review. Rather, the ACA is more likely to cause changes in health insurance market characteristics which in turn could impact affecting the identification of the relevant product market. The panel was moderated by Lauren Rackow, Associate at Cahill Gordon & Rendel LLP. The panelists were: Arthur Lerner, Partner at Crowell & Morning LLP; Joshua Soven, Partner at Gibson, Dunn & Crutcher LLP; Brian Armstrong, Senior Deputy Attorney General, State of Nevada, Office of the Attorney General; and Peter Mucchetti, Chief of Litigation I Section at the Department of Justice (“DOJ”).

Background on the ACA

Under the ACA, managed care providers are accountable for how much they charge, and how much they spend, per member. Rate increases over 10 percent require a public notice justifying the increase. Premiums must accurately reflect the amount of claims and allowable quality improvement activities spent on members. If a health insurer’s costs do not account for a certain percentage of the premiums charged, then the insurer must pay their members a rebate. This percentage is referred to as the Minimum Medical Loss Ratio. In addition, health plans are facing other changes under the ACA. The obligation to accept all members, regardless of preexisting conditions, will increase the risk population. At the same time, health plans anticipate they may face additional competition from new health insurance exchanges, which are anticipated to be increasingly transparent and easy to compare on elements of cost, pricing, and plan offerings. As a result, health insurers recognize the need to generate efficiencies to cut costs and maintain positive revenue streams.

Merger Review Under the ACA

Because of these pricing and efficiency-generating pressures associated with the ACA, moderator Lauren Rackow asked the panelists whether they believe health insurance companies are further incentivized to merge in



this environment. Mr. Lerner stated that managed care companies are more likely to consider merging under the ACA, but it is uncertain whether more mergers will actually result. In his opinion, many companies will assess whether larger scale is necessary to reduce business costs. Along those same lines, Mr. Soven added that Medicare Advantage subsidies will be reduced, so smaller Medicare Advantage companies may need to increase their scale.

Prior to the ACA, managed care providers that offered Medicare Advantage were, in some instances, able to offer zero-dollar copay plans because of federal funding. Under the ACA, federal funding may decrease. When Ms. Rackow asked the panelists whether a decrease in congressional funding to Medicare Advantage plans will result in higher copays, panelists were in agreement that copays could increase. Moreover, if Congress does not continue to fund Medicare Advantage as it has in the past, then the plans may no longer be as competitive against their government-sponsored counterparts and therefore may become closer substitutes for traditional Medicare. This shift could result in a change in how the Antitrust Division defines product markets, leading it to include Medicare Advantage and traditional Medicare in the same market.

Mr. Mucchetti summarized this point when he said, “the space between the product markets will shrink” if the value of these plans is no longer beyond what original Medicare can offer. In prior cases, such as UnitedHealth Group Inc.’s (“United”) acquisition of Sierra Health Services (“Sierra”) and Humana Inc.’s (“Humana”) acquisition of Arcadian Management Services, Inc., the DOJ alleged that the relevant market was no broader than

Medicare Advantage.¹ As the Medicare Advantage product adapts to the changing health care environment, Medicare Advantage may no longer be an applicable product market on its own.

If mergers are more likely to occur as a result of the ACA and its impact on health plan business strategies, then Ms. Rackow questioned whether there would be any modifications to how the agencies review these transaction or to the arguments raised in defense. Panelists agreed that health plan merger reviews will continue to focus on the number of competitors offering the same product. Mr. Armstrong indicated that the analysis will depend on the relevant product market and whether there are more entrants in the marketplace as a result of the exchanges. Similarly, Mr. Mucchetti noted that the agencies consider the popularity of certain types of plans, the different plan designs, the ability of new competitors to enter the market, and potential competitive effects such as the existence of higher prices or tacit coordination through greater price transparency.

Ms. Rackow asked the panelists to explain the roles of the DOJ, the state attorneys general, and the state insurance commissioners when evaluating a health plan transaction and the level of coordination between these entities. Both Mr. Armstrong and Mr. Mucchetti explained how the DOJ and the state attorneys general often coordinate their review to efficiently utilize government resources. Mr. Mucchetti added that state attorneys general often have more expertise about the customers within the state and the competitive dynamics between the competitors in the state, which

¹ See Complaint, U.S. v. UnitedHealth Group Inc., No. 1:08-CV-00322 (D.D.C. Feb. 25, 2008); see also Complaint, U.S. v. Humana, Inc., No. 1:12-cv-00464 (D.D.C. Mar. 27, 2012).



makes the state attorney general an important ally during the review.

Mr. Armstrong was quick to note that merger analysis varies from state to state. He reminded listeners that the merging parties also need to address the concerns of the relevant state insurance commissions. While there may be coordination between the state attorney general and the state insurance commissioner, sometimes the investigations are treated separately. In particular, confidential information may not be mutually shared between the offices, requiring the state attorney general to issue a subpoena for the relevant information.

Ms. Rackow then directed the panel discussion to the issue of relevant product in the context of health plan mergers. Mr. Mucchetti noted that the DOJ has taken several different approaches. In prior matters, the DOJ has defined the product as Medicare Advantage plans,² Medicaid managed care plans,³ individual versus group plans,⁴ and HMO versus PPO plans.⁵ However, Mr. Mucchetti stated that there is nothing preventing the DOJ from viewing these markets differently in the future or looking at other markets such as self-insured

plans or fully insured plans. As noted in its statement regarding the closure of its investigation into United's acquisition of Oxford Health Plans Inc., the DOJ observed that the division between HMOs and PPOs were beginning "to blur" because HMO plans are no longer requiring members to stay in network to obtain reimbursement.⁶ Therefore, HMOs and PPOs may not be separate products in some instances.

Once the product market is defined, market shares are calculated. Ms. Rackow asked about the role of market shares in managed care merger analysis. All panelists stated that competitive effects are the most important part of the analysis; however, market shares are used to help assess these effects. Mr. Mucchetti stated the DOJ will continue to follow the Horizontal Merger Guidelines and assess the potential competitive effects that will result from the transaction.⁷ Mr. Armstrong agreed and emphasized that entry will play an important role in the analysis.

Mr. Lerner and Mr. Soven added that the role of market share data will also depend on the type of competitive effects alleged—whether the reviewing entities believe that there will be unilateral effects or coordinated effects—as a result of the merger. With the advent of health insurance exchanges, price transparency could increase the possibility of coordinated effects, so agencies may be more apt to investigate this potential theory of harm. Mr. Mucchetti concurred and warned that the DOJ will

² See Complaint, U.S. v. UnitedHealth Group, No. 1:08-CV-00322 (2008); see also Complaint, U.S. v. Humana, Inc., No. 1:12-cv-00464 (2012).

³ See Press Release, U.S. Dept. of Justice, Amerigroup Corp.'s Divestiture of Its Virginia Operations Addresses Department of Justice's Concerns with WellPoint Inc.'s Proposed Acquisition of Amerigroup: Divestiture Will Maintain Competition in Medicaid Managed Care Plan (Nov. 28, 2012), available at <http://www.justice.gov/opa/pr/2012/November/12-at-1416.html>.

⁴ U.S. v. Blue Cross Blue Shield Michigan, No. 2:10-cv-1515-DPH-MKM (D.D.C. filed Oct. 18, 2010).

⁵ U.S. v. Aetna Inc., No. 3-99 CV 398-H (D.D.C. filed Jun. 21, 1999).

⁶ Statement, U.S. Dept. of Justice, Background to Closing of Investigation of UnitedHealth Group's Acquisition of Oxford Health Plans (July 20, 2004), available at http://www.justice.gov/atr/public/press_releases/2004/204676.htm.

⁷ U.S. DEPT. OF JUSTICE & FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES (2010).



investigate potential coordinated effects from the exchanges' price transparency as necessary.

Ms. Rackow then questioned how the agencies will analyze the potential for price increases as a result of a health plan combination. Mr. Mucchetti stated that price increases can come in many shapes and sizes, taking the form of increased premiums or increased copays, for example.

On the other hand, competitive effects can also take the form of lower reimbursement rates to upstream providers. Theoretically, lower reimbursements to providers post-merger could result in a reduction in quality or supply of the provider services in an affected market. Mr. Soven discussed how a reduction in the quality and quantity of provider services in a given area may be a potential competitive effect that could result from a health plan merger. As a result, when analyzing a health plan merger, the agencies will consider the potential monopsony power from a transaction. However, panelists agreed that a monopsony case is a more challenging theory of competitive harm for enforcers to prove, especially because it is difficult to gather the necessary evidence. Even when there is evidence suggesting such power, an enforcer would need to allege and prove that declining reimbursement rates will harm consumers, which could be difficult in an environment where public policy favors efforts to stem rising health care costs.

To assess competitive effects, merger analysis requires an assessment of whether the merged entity will benefit from a small but significant non-transitory price increase, known as the SSNIP test, and whether there are any countervailing procompetitive benefits to the merger. In health plan mergers, assessing what "value [the combining managed care providers] contribute to the products or services used by

customers" may be difficult.⁸ Mr. Lerner and Mr. Mucchetti surmised "value" could potentially be measured as (1) the cost of the health plan, (2) the enhancements provided, or (3) the value associated with the plan's risk-bearing function. Again, the panelists emphasized that the overall concern with any merger is whether prices, in any form, will increase or the quality of the service will decrease.

The participants then turned their focus to vertical issues surrounding managed care mergers, such as exclusive contracts and most favored nation ("MFN") clauses, which may foreclose competitors from the market. In Mr. Mucchetti's opinion, MFN clauses and exclusive contracts have the ability to reduce entry; however, there are certain circumstances in which they are not anticompetitive. One such example can be when an insurer purchases a hospital. At the conclusion of the DOJ's investigation of Highmark's affiliation agreement with West Penn Allegheny Health System ("West Penn"), the DOJ found that the agreement was not anticompetitive although "[v]ertical agreements, such as the affiliation agreement, can reduce competition by limiting entry or expansion by third parties."⁹ Because Highmark, a managed care company, was not likely to sponsored entry of another hospital system, and West Penn previously failed to sponsor entry of another health insurer, the vertical agreement was not likely to inhibit new entry by another hospital or health insurer.

⁸ *Id.* at 10.

⁹ Statement, U.S. Dept. of Justice, Statement of the Department of Justice's Antitrust Division on its Decision to Close its Investigation of Highmark's Affiliation Agreement with West Penn Allegheny Health System (Apr. 10, 2012), available at http://www.justice.gov/atr/public/press_releases/2012/282076.htm.



Moreover, the DOJ found that West Penn's incentive to provide other health insurers competitive reimbursement rates was sufficiently strong because West Penn was attempting to increase its patient volume.

No merger analysis would be complete without consideration of the efficiencies generated from a merger. Nevertheless, when Ms. Rackow asked participants to discuss synergies likely to be generated from these transactions, Mr. Lerner stated that this topic is best answered by the businesspeople doing a deal. Mr. Lerner did note, however, that synergies likely to spawn from managed care mergers include the ability to generate new and diverse product designs and reducing overhead.

The discussion of synergies led to a debate as to whether merging parties can effectively claim that some of their synergies are generated by securing lower reimbursement rates without alarming the antitrust regulators that the parties will have market power. Mr. Soven said that parties could plausibly raise this potential synergy if parties' combined market share in the downstream market was relatively low, for example, twenty-eight percent. Mr. Lerner was hesitant to find comfort in such figures because certain interested parties are more likely to raise market power concerns once the combined market share is around thirty-one percent or greater. Market share calculations can vary depending on how they are derived. Thus, when market shares are in the thirty percent range, merging parties need to be cautious about the implication of monopsony power from arguments they may put forward as to their ability to lower reimbursement rates paid to providers. With this in mind, Mr. Mucchetti offered two ways that parties often achieve synergies without exercising monopsony power: (1) the parties have a better contract negotiation system and (2) the parties are able to devise an

accounting system to pay providers more accurately and efficiently. Consequently, he believed that parties should not hesitate to claim reimbursement rate synergies when there are ways to achieve them without exercising market power as buyers.

Remedies To Address Competition Concerns

In the event that the reviewing agencies find a managed care merger potentially anticompetitive, Ms. Rackow asked how the DOJ or a state attorney general decides whether to require a divestiture or a behavioral remedy. Mr. Mucchetti said if concerns raised by the merger can be self-contained to a limited set of areas, then a divestiture is likely to remedy the potential harm. The divestiture affords the opportunity to maintain the same level of competition in an area by adding an additional competitor. Mr. Mucchetti cited United's recent acquisition of Sierra as an example. Mr. Mucchetti claimed that when the transaction closed in 2008, Humana acquired 26,000 lives in the Las Vegas, Nevada area pursuant to the settlement between United, Sierra, and the DOJ. These lives accounted for approximately 34 percent of the market. Currently, Humana now has 37,000 lives, approximating a 36 percent market share. These figures demonstrate how acquirers of divested assets can be successful and can maintain the appropriate level of competition. Since the time of the acquisition, Aetna and WellPoint entered this market and have gained *de minimis* share, proving the difficult nature of entry in this particular market and why there was a need for the divestiture.

Mr. Armstrong emphasized that when a divestiture is required, it is very important to have clear requirements regarding supporting assets and services to be transferred in order to adequately support the acquiring entity and to



create a smooth transition for the consumers. For example, usually there is some sort of transition services agreement to help facilitate early operations of the acquiring entity.

Alternatively, divestitures may not sufficiently address the potential competitive harm that may result from the transaction. Rather, behavioral remedies may be required. Mr. Armstrong discussed five types of behavioral remedies often used in health plan mergers. The first four pertain to restrictions in contracting: MFN restrictions, all-product clause restrictions, exclusive contract restrictions, and anti-tiering restrictions. These restrictions may be permanent, for a certain period of time, or are acceptable with appropriate notice and review by the issuing entity. Moreover, depending on the relationship between the parties (i.e., horizontal or vertical), the DOJ or the state attorney general may find it necessary to set up firewalls between the two organizations to prevent the merged party from using competitively sensitive information from a third party to reduce competition.

Mr. Lerner also made the point that remedies are designed to address the potential anticompetitive harm that is thought to result from the merger. Mr. Lerner emphasized that “a remedy is tied to the notion that, but for the remedy the merger would violate the antitrust laws.” In some instances, in his opinion, the remedies required by the DOJ or the state attorney general do not correlate to a harm alleged in the complaint.

Conclusion

Mergers between health insurers have always required a rigorous analysis of the relevant product market. It is anticipated that this analysis will become more complex as insurers participate in the exchanges and differences between the health plan products become less

clear. However, competitive effects analysis is unlikely to change, and the panelists do not anticipate that the introduction of exchanges or effects of the ACA will lead to a less burdensome antitrust clearance process for health plans seeking to merge. As Mr. Soven mentioned, health insurance merger review and remedies in problematic cases are not fashioned quickly, so counsel must adequately prepare their clients to anticipate a lengthy review process.