DEPARTMENT OF JUSTICE

Antitrust Division

United States v. UnitedHealth Group Incorporated; Response to Public Comments on the Proposed Final Judgment

Pursuant to the Antitrust Procedures and Penalties Act, 15 U.S.C. 16(b)–(h), the United States hereby publishes the public comments received on the proposed Final Judgment in *United States* v. *UnitedHealth Group Incorporated,* Civil Action No. 1:08–cv–322, and the response to the comments. On February 25, 2008, the United States filed a Complaint alleging that the merger of UnitedHealth Group Incorporated (''United'') and Sierra Health Services, Inc. (''Sierra'') violated Section 7 of the Clayton Act, 15 U.S.C. 18. The proposed Final Judgment, filed on February 25, 2008, requires the combined company to divest United's individual Medicare Advantage line of business in the Las Vegas, Nevada area. Public comment was invited within the statutory 60-day comment period. Copies of the Complaint, proposed Final Judgment, Competitive Impact Statement, Public Comments, the United States' Response to the Comments, and other papers are currently available for inspection in Department of Justice, Antitrust Division, Antitrust Documents Group, 450 5th Street, NW., Suite 1010, Washington, DC 20530, telephone: (202) 514–2481 and the Office of the Clerk of the United States District Court for the District of Columbia, 333 Constitution Avenue, NW., Washington, DC 20001.

Copies of any of these materials may be obtained upon request and payment of a copying fee.

Patricia A. Brink,

Deputy Director of Operations, Antitrust Division.

In the matter of: United States District Court for the District of Columbia; United States of America, Plaintiff, v. UnitedHealth Group Incorporated and Sierra Health Services, Inc., Defendants.

[Case No. 1:08–cv–322–ESH]

Response of Plaintiff United States to Public Comments

Pursuant to the requirements of the Antitrust Procedures and Penalties Act (''APPA'' or ''Tunney Act''), 15 U.S.C. 16(b)–(h), the United States hereby files the four public comments that the United States received concerning the proposed Final Judgment in this case and the United States' response to those comments. The United States will move the Court for entry of the proposed Final Judgment after the comments and this Response have been published in the **Federal Register**, pursuant to 15 U.S.C. 16(d).

On February 25, 2008, the United States filed the Complaint in this matter alleging that the proposed merger of UnitedHealth Group Incorporated (''United'') and Sierra Health Services, Inc. (''Sierra'') would violate Section 7 of the Clayton Act, 15 U.S.C. 18. Simultaneously with the filing of the Complaint, the United States filed a proposed Final Judgment and a Hold Separate and Asset Preservation Stipulation and Order (''Stipulation'') signed by the United States and Defendants consenting to the entry of the proposed Final Judgment after compliance with the requirements of the Tunney Act.[1] Pursuant to those requirements, the United States filed a Competitive Impact Statement (''CIS'') in this Court on February 25, 2008; published the proposed Final Judgment and CIS in the **Federal Register** on March 10, 2008, see 73 FR 12762 (2008); and published summaries of the terms of the proposed Final Judgment and CIS, together with directions for the submission of written comments relating to the proposed Final Judgment, in the *Washington Post* for seven days beginning on March 16, 2008 and ending on March 22, 2008, and in the *Las Vegas Review-Journal* for seven days beginning on March 8, 2008 and ending on March 14, 2008. The 60-day period for public comments ended on May 15, 2008, and the United States received the four comments described below and attached hereto.

I. The United States' Investigation and the Proposed Final Judgment

On March 11, 2007, United and Sierra entered into an agreement, whereby United agreed to acquire all outstanding shares of Sierra. Over the next eleven months, the United States Department of Justice (the ''Department'') conducted an extensive, detailed investigation into the competitive effects of the proposed transaction. As part of this investigation, the Department obtained substantial documents and information from the merging parties and issued numerous Civil Investigative Demands to third parties. In response, the Department received and considered more than 2.5 million pages of material. The Department conducted approximately 150 interviews with customers, hospitals and physician groups, insurance companies, and other individuals with knowledge of the industry.

After conducting a detailed analysis of the acquisition, the Department concluded that the combination of United and Sierra likely would substantially lessen competition in the Las Vegas, Nevada area (consisting of Clark and Nye Counties, Nevada) in a product market no broader than the sale of Medicare Advantage health-insurance plans to senior citizens and other Medicare-eligible individuals. As defined by federal law, Medicare Advantage plans consist of Medicare Advantage health maintenance organization plans (''MA–HMO''), Medicare Advantage preferred provider organization plans (''MA–PPO''), and Medicare Advantage private fee-for-service plans (''MA–PFFS''). *See* 42 U.S.C. 1395w–21(a)(2). United and Sierra together would have accounted for approximately 94 percent of the total enrollment in Medicare Advantage plans in the Las Vegas area, which accounts for approximately $840 million in annual commerce. United markets and sells its Medicare Advantage products under the Secure Horizons and AARP brands. Sierra markets and sells its Medicare Advantage products under the Senior Dimensions, Sierra Spectrum, Sierra Nevada Spectrum, and Sierra Optima Select brands.

As more fully explained in the CIS, the Stipulation and proposed Final Judgment in this case are designed to preserve competition in the sale of Medicare Advantage health-insurance plans in the Las Vegas area by requiring United to divest its individual Medicare Advantage line of business in the Las Vegas area. The Stipulation and proposed Final Judgment also require United to take several steps to assist the acquirer in providing prompt and effective competition in the Medicare Advantage market, including assisting the acquirer to enter into agreements that will allow members of United's Medicare Advantage plans to have continued access to substantially all of United's provider network of physicians, hospitals, ancillary service providers, and other health care providers on terms no less favorable than United's existing agreements. United must also provide transition support services for medical-claims

[1] The merger closed on February 25, 2008. In keeping with the United States' standard practice, neither the Stipulation nor the proposed Final Judgment prohibited closing the merger. *See* ABA Section of Antitrust Law, *Antitrust Law Developments* 406 (6th ed. 2007) (noting that ''[t]he Federal Trade Commission (as well as the Department of Justice) generally will permit the underlying transaction to close during the notice and comment period''). Such a prohibition could interfere with many time-sensitive deals and prevent or delay the realization of substantial efficiencies.

processing, appeals and grievances, call-center support, enrollment and eligibility services, access to form templates, pharmacy services, disease management, Medicare risk-adjustment services, quality-assurance services, and such other services as are reasonably necessary for the acquirer to operate the Divestiture Assets.

On February 25, 2008, United and Humana Health Plan Inc. (''Humana'') signed an agreement providing for Humana to purchase United's Las Vegas Medicare Advantage line of business for approximately $185 million. After receiving approval from the Centers for Medicare and Medicaid Services (''CMS'') and the Nevada Division of Insurance, Humana completed the acquisition of United's Las Vegas Medicare Advantage line of business on May 1, 2008. In the Department's judgment, the divestiture of United's Las Vegas Medicare Advantage line of business to Humana, along with the other requirements contained in the Stipulation and proposed Final Judgment, are sufficient to eliminate the anticompetitive effects identified in the Complaint.

II. Standard of Judicial Review

Upon the publication of the Comment and this Response, the United States will have fully complied with the Tunney Act and will move for entry of the proposed Final Judgment as being ''in the public interest'' 15 U.S.C. 16(e)(l), as amended.

The Tunney Act states that, in making that determination, the Court shall consider:

> (A) the competitive impact of such judgment, including termination of alleged violations, provisions for enforcement and modification, duration of relief sought, anticipated effects of alternative remedies actually considered, whether its terms are ambiguous, and any other competitive considerations bearing upon the adequacy of such judgment that the court deems necessary to a determination of whether the consent judgment is in the public interest; and
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> (B) the impact of entry of such judgment upon competition in the relevant market or markets, upon the public generally and individuals alleging specific injury from the violations set forth in the complaint including consideration of the public benefit, if any, to be derived from a determination of the issues at trial.

15 U.S.C. 16(e)(1)(A)–(B); *see generally United States* v. *AT&T Inc.,* 541 F. Supp. 2d 2, 6 n.3 (D.D.C. 2008) (listing factors that the Court must consider when making the public-interest determination); *United States* v. *SBC Commc'ns, Inc.,* 489 F. Supp. 2d 1, 11 (D.D.C. 2007) (concluding that the 2004 amendments to the Tunney Act ''effected minimal changes'' to scope of review under the Tunney Act, leaving review ''sharply proscribed by precedent and the nature of Tunney Act proceedings'').[2]

As the United States Court of Appeals for the District of Columbia Circuit has held, under the APPA, a court considers, among other things, the relationship between the remedy secured and the specific allegations set forth in the government's complaint, whether the decree is sufficiently clear, whether enforcement mechanisms are sufficient, and whether the decree may positively harm third parties. *See United States* v. *Microsoft Corp.,* 56 F.3d 1448, 1458–62 (D.C. Cir. 1995). With respect to the adequacy of the relief secured by the decree, a court may not ''engage in an unrestricted evaluation of what relief would best serve the public.'' *United States* v. *BNS, Inc.,* 858 F.2d 456, 462 (9th Cir. 1988) (citing *United States* v. *Bechtel Corp.,* 648 F.2d 660, 666 (9th Cir. 1981)); *see also* Microsoft, 56 F.3d at 1460–62. Courts have held that:

> [t]he balancing of competing social and political interests affected by a proposed antitrust consent decree must be left, in the first instance, to the discretion of the Attorney General. The court's role in protecting the public interest is one of insuring that the government has not breached its duty to the public in consenting to the decree. The court is required to determine not whether a particular decree is the one that will best serve society, but whether the settlement is *''within the reaches of the public interest.''* More elaborate requirements might undermine the effectiveness of antitrust enforcement by consent decree.

Bechtel, 648 F.2d at 666 (emphasis added) (citations omitted). *Cf. BNS,* 858 F.2d at 464 (holding that the court's ''ultimate authority under the [APPA] is limited to approving or disapproving the consent decree''); *United States* v. *Gillette Co.,* 406 F. Supp. 713, 716 (D. Mass. 1975) (noting that, in this way, the court is constrained to ''look at the overall picture not hypercritically, nor with a microscope, but with an artist's reducing glass''). *See generally Microsoft,* 56 F.3d at 1461 (discussing whether ''the remedies [obtained in the decree are] so inconsonant with the allegations charged as to fall outside of the 'reaches of the public interest' '').

The government is entitled to broad discretion to settle with defendants within the reaches of the public interest. *AT&T Inc.,* 541 F. Supp. 2d at 6. In making its public-interest determination, a district court ''must accord deference to the government's predictions about the efficacy of its remedies, and may not require that the remedies perfectly match the alleged violations.'' *SBC Commc'ns, 489* F. Supp. 2d at 17; see also *Microsoft,* 56 F.3d at 1461 (noting the need for courts to be ''deferential to the government's predictions as to the effect of the proposed remedies''); *United States* v. *Archer-Daniels-Midland Co.,* 272 F. Supp. 2d 1, 6 (D.D.C. 2003) (noting that the court should grant due respect to the United States' prediction as to the effect of proposed remedies, its perception of the market structure, and its views of the nature of the case).

Court approval of a consent decree requires a standard more flexible and less strict than that appropriate to court adoption of a litigated decree following a finding of liability. ''[A] proposed decree must be approved even if it falls short of the remedy the court would impose on its own, as long as it falls within the range of acceptability or is 'within the reaches of public interest.' '' *United States* v. *Am. Tel. & Tel. Co.,* 552 F. Supp. 131, 151 (D.D.C. 1982) (citations omitted) (quoting *United States* v. *Gillette Co.,* 406 F. Supp. 713, 716 (D. Mass. 1975)), *aff'd sub nom. Maryland* v. *United States,* 460 U.S. 1001 (1983); *see also United States* v. *Alcan Aluminum Ltd.,* 605 F. Supp. 619, 622 (W.D. Ky. 1985) (approving the consent decree even though the court would have imposed a greater remedy). To meet this standard, the United States ''need only provide a factual basis for concluding that the settlements are reasonably adequate remedies for the alleged harms.'' *SBC Commc'ns,* 489 F. Supp. 2d at 17.

Moreover, the Court's role under the APPA is limited to reviewing the remedy in relationship to the violations that the United States has alleged in its complaint, rather than to ''construct [its] own hypothetical case and then evaluate the decree against that case.'' *Microsoft,* 56 F.3d at 1459. Because the ''court's authority to review the decree depends entirely on the government's exercising its prosecutorial discretion by bringing a case in the first place,'' it follows that ''the court is only authorized to review the decree itself,'' and not to ''effectively redraft the complaint'' to inquire into other matters that the United States did not pursue. *Id.* at 1459–60. As this Court recently confirmed in *SBC Communications,*

[2] The 2004 amendments substituted ''shall'' for ''may'' in directing relevant factors for courts to consider and amended the list of factors to focus on competitive considerations and to address potentially ambiguous judgment terms. *Compare* 15 U.S.C. § 16(e) (2004), *with* 15 U.S.C. § 16(e)(1) (2006).

courts ''cannot look beyond the complaint in making the public interest determination unless the complaint is drafted so narrowly as to make a mockery of judicial power.'' *SBC Commc'ns,* 489 F. Supp. 2d at 15.

In its 2004 amendments to the Tunney Act, Congress made clear its intent to preserve the practical benefits of utilizing consent decrees in antitrust enforcement, adding the unambiguous instruction that ''[n]othing in this section shall be construed to require the court to conduct an evidentiary hearing or to require the court to permit anyone to intervene.'' 15 U.S.C. 16(e)(2). The amendments codified what Congress intended when it passed the Tunney Act in 1974, as Senator Tunney then explained: ''[t]he court is nowhere compelled to go to trial or to engage in extended proceedings which might have the effect of vitiating the benefits of prompt and less costly settlement through the consent decree process.'' 119 Cong. Rec. 24,598 (1973) (statement of Senator Tunney). Rather, the procedure for the public-interest determination is left to the discretion of the court, with the recognition that the court's ''scope of review remains sharply proscribed by precedent and the nature of Tunney Act proceedings.'' *SBC Commc'ns,* 489 F. Supp. 2d at 11.[3]

III. Summary of Public Comments and the United States' Response

During the 60-day comment period, the United States received comments from the Service Employees International Union Local 1107 (the ''SEIU comment''), the American Medical Association, Nevada State Medical Association, and the Clark County Medical Society (collectively, the ''AMA comment''), the Honorable Nydia M. Velazquez, Chairwoman, United States House of Representatives Committee on Small Business (the ''Velazquez comment''), and the Honorable Chris Giunchigliani, Commissioner, Board of Commissioners—Clark County, Nevada (the ''Giunchigliani comment''). Those comments are attached to this Response.

After reviewing the comments, the United States has determined that the proposed Final Judgment remains in the public interest. The commenters raise two main concerns: (A) that the United States should have alleged and remedied harm to competition in additional product markets other than the Medicare Advantage market alleged in the United States' Complaint and (B) that the proposed Final Judgment does not adequately remedy the harms to competition alleged in the Complaint. The United States addresses these concerns below.

A. Comments That the United States Should Have Alleged and Remedied Additional Competitive Concerns

1. Summary of Comments

Each of the commenters argue that the United States should have alleged and remedied competitive concerns that are not addressed in the Complaint in this matter. They argue that the United States should have pursued a case of harm to competition in a commercial health-insurance market in Clark County, Nevada. (AMA comment at 12; SEIU comment at 4; Velazquez comment at 3; Giunchigliani comment at 1–2). The commenters also express concern that the United-Sierra merger will harm competition in the sale of various types of commercial health insurance, such as the provision of HMO policies, HMO and PPO policies, and the provision of commercial insurance to employers with 50 or fewer employees. (AMA comment at 12; SEIU comment at 4; Velazquez comment at 4; Giunchigliani comment at 1).

The AMA and Velazquez also argue that the United States should have alleged that the transaction would harm physicians and sought an appropriate remedy. They maintain that the merged company will control a sufficient share of the purchases for physicians services in Clark County such that the merged company will be able to reduce payments to physicians below competitive levels. (AMA comment at 5; Velazquez comment at 4). Similarly, the SEIU argues that the merged company will control a sufficient share of purchases of hospital services such that the merged company will be able unilaterally to reduce reimbursement rates to hospitals. (SEIU comment at 4). The SEIU argues that such lower reimbursement rates to hospitals will result in higher patient-to-nurse ratios and place patient safety and quality of care in jeopardy. (SEIU comment at 3–4).

2. The United States' Response

The comments that the United States should have alleged harm to competition for the sale of various types of health insurance or for the purchase of physician or hospital services, which are not addressed in the Complaint, are outside the scope of this APPA proceeding. The Department's decision to allege a harm in a specific market is based on a case-by-case analysis that varies depending on the particular circumstances of each product and geographic market The Department investigated the transaction's potential competitive effects on each of the types of health insurance identified by the commentators, and on the purchase of physician and hospital services, and concluded that it should not allege harm in these markets. As explained by this Court, in a Tunney Act proceeding, the district court should not second-guess the prosecutorial decisions of the Department regarding the nature of the claims brought in the first instance; ''rather, the court is to compare the complaint filed by the United States with the proposed consent decree and determine whether the proposed decree clearly and effectively addresses the [anticompetitive harms initially identified.'' *United States* v. *Thomson Corp.,* 949 F. Supp 907, 913 (D.D.C. 1996); *accord, Microsoft,* 56 F.3d at 1459 (in APPA proceeding, ''district court is not empowered to review the actions or behavior of the Department of Justice; the court is only authorized to review the decree itself''); *BNS,* 858 F.2d at 462–63 (''the APPA does not authorize a district court to base its public interest determination on antitrust concerns in markets other than those alleged in the government's complaint''). This court has held that ''a district court is not permitted to ''reach beyond the complaint to evaluate claims that the government did not make and to inquire as to why they were not made.' '' *SBC Commc'ns,* 489 F. Supp. 2d at 14 (quoting *Microsoft,* 56 F.3d at 1459) (emphasis in original). Nor does the fact that the State of Nevada obtained terms of settlement different from those obtained by the United States alter the ordinary Tunney Act standard of review.

The AMA's contention that the 2004 Amendments to the Tunney Act overruled precedent in this court and require a more extensive review of the United States' exercise of its prosecutorial judgment conflicts with this Court's holding in *SBC Communications, supra.* (AMA

[3] *See United States* v. *Enova Corp.,* 107 F. Supp. 2d 10, 17 (D.D.C. 2000) (noting that the ''Tunney Act expressly allows the court to make its public interest determination on the basis of the competitive impact statement and response to comments alone''); *United States* v. *Mid-Am. Dairymen, Inc.,* 1977–1 Trade Cas. (CCH) ¶ 61,508, at 71,980 (W.D. Mo. 1977) (''Absent a showing of corrupt failure of the government to discharge its duty, the Court, in making its public interest finding, should * * * carefully consider the explanations of the government in the competitive impact statement and its responses to comments in order to determine whether those explanations are reasonable under the circumstances.''); S. Rep. No. 93–298, 93d Cong., 1st Sess., at 6 (1973) (''Where the public interest can be meaningfully evaluated simply on the basis of briefs and oral arguments, that is the approach that should be utilized.'').

comment at 4). In *SBC Communications,* this Court held that ''a close reading of the law demonstrates that the 2004 amendments effected minimal changes, and that this Court's scope of review remains sharply proscribed by precedent and the nature of [APPA] proceedings.'' SBC *Commc'ns,* 489 F. Supp. 2d at 11. This Court continued that because ''review [under the 2004 amendments] is focused on the 'judgment,' it again appears that the Court cannot go beyond the scope of the complaint.'' Id. The 2004 amendments to the APPA, as interpreted and applied by this Court in *SBC Communications,* require the Court to evaluate the effect of the ''judgment upon competition'' in a Medicare Advantage market in the Las Vegas area. 15 U.S.C.16(e)(1)(b). Because the United States did not allege that the United's acquisition of Sierra would cause harm in additional markets, it is not appropriate for the Court to seek to determine whether the acquisition will cause anticompetitive harm in such markets.

B. Comment That the Proposed Final Judgment Does Not Adequately Address the Harms to Competition Alleged in the Complaint

1. Summary of Comment

The AMA states that the remedies in the proposed Final Judgment are inadequate to maintain competition in the sale of Medicare Advantage health-insurance plans in the Las Vegas area. (AMA comment at 13). The AMA argues in its comment that the proposed Final Judgment should include five additional remedies: (1) A permanent injunction on United's use of ''most-favored-nations'' clauses in healthcare-provider contracts; (2) a permanent injunction on United's use of ''all-products'' clauses in healthcare-provider contracts; (3) a divestiture of United's commercial health-insurance business in Clark County; (4) a requirement that United convey the use of certain trademarks to the acquirer of the Medicare Advantage line of business for at least five years; and (5) the immediate use of a monitoring trustee to ensure compliance with the proposed Final Judgment. (AMA comment at 13–15).

2. The United States' Response

The additional remedies proposed by the AMA are not necessary to ensure that competition will remain in the market alleged in the Complaint. Rather, the proposed Final Judgment is in the public interest because it is properly designed to eliminate the anticompetitive effects alleged in the Complaint. First, the proposed Final Judgment requires United to divest its entire individual Medicare Advantage line of business in the Las Vegas area to an acquirer approved by the United States and on terms acceptable to the United States. This line of business covers approximately 25,800 individual Medicare Advantage beneficiaries. As described in Section IV of the proposed Final Judgment, United is required to divest all tangible and intangible assets dedicated to the administration, operation, selling, and marketing of its Medicare Advantage plans to individuals in the Las Vegas area (''the Divestiture Assets''), including all of United's rights and obligations under the relevant United contracts with CMS. Thus, the acquirer will have the benefit of entering the Medicare Advantage market with United's entire individual Medicare Advantage line of business.

Second, the Stipulation and Sections IV(A) and (B) of the proposed Final Judgment required United to divest the Divestiture Assets within the shortest time period reasonable under the circumstances. A quick divestiture has the benefits of maintaining competition that would otherwise be lost in the acquisition and reducing the possibility of dissipation of the value of the assets while the sale is pending. Per these requirements, United divested the Divestiture Assets to Humana on May 1, 2008.

Third, the divestiture eliminates the anticompetitive effects of the merger by requiring United to divest the Divestiture Assets to an acquirer that can compete vigorously with the merged United-Sierra. The United States approved Humana as the acquirer of the Divestiture Assets because Humana is well positioned to be a strong competitor in the Medicare Advantage market in the Las Vegas area. Humana is an established health-insurance competitor with total annual revenue of $26 billion and a market capitalization of $8.3 billion. Humana is the second largest provider of Medicare Advantage plans in the nation after United. The company has 1.27 million Medicare Advantage enrollees nationwide. In the United States' judgment, Humana has the intent and capability (including the necessary managerial, operational, technical, and financial capability) to compete effectively in the sale of Medicare Advantage products, and the asset purchase agreements between United and Humana do not give United the ability to interfere with Humana's ability to compete effectively.

Fourth, the proposed Final Judgment requires Defendants to assist the acquirer in providing prompt and effective competition in the Medicare Advantage market and uninterrupted care to subscribers of United's Medicare Advantage plans by mandating that the Defendants adhere to the following requirements:

- Section IV(F) requires the Defendants to assist the acquirer to enter into an agreement with HealthCare Partners, LLC (''HealthCare Partners'') that will allow members of United's Medicare Advantage plans to have continued access to substantially all of United's provider network of physicians, hospitals, ancillary service providers, and other health care providers on terms no less favorable than United's pre-existing agreement with HealthCare Partners.
- Section IV(J) requires that, at the acquirer's option, and subject to approval by the United States, Defendants provide transition support services for medical claims processing, appeals and grievances, call-center support, enrollment and eligibility services, access to form templates, pharmacy services, disease management, Medicare risk-adjustment services, quality-assurance services, and such other transition services that are reasonably necessary for the acquirer to operate the Divestiture Assets.
- Section IV(G) of the proposed Final Judgment prohibits United, until March 31, 2010, from entering into agreements with healthcare providers who, prior to the transaction, participated in United's Medicare Advantage network, but did not participate in Sierra's.
- Sections IV(F) and (G) collectively ensure that Humana, but not the Defendants, will have access to these healthcare providers, which places Humana in the same competitive position with respect to the merged company as United was in with respect to Sierra prior to the merger of United and Sierra.
- Section IV(H) prohibits United from using the AARP brand for any of its individual Medicare Advantage plans in the Las Vegas area until March 31, 2009, and from using the SecureHorizons brands for any individual Medicare Advantage plans in the Las Vegas area until March 31, 2010. The Department has determined that Section IV(H) will give Humana sufficient time to establish its own brand in the Las Vegas area so that it can effectively compete for the provision of Medicare Advantage plans and reduce beneficiary confusion as to which company operates the Medicare Advantage plan in which the beneficiary is enrolled.

In short, the United States has determined that the remedies in the proposed Final Judgment are sufficient to allow Humana to be an effective

competitor and maintain competition in the Las Vegas Medicare Advantage market. As the United States now explains, the additional remedies that the AMA suggests are not needed to preserve the public interest.

a. Most-Favored-Nations Clauses

The AMA states that the proposed Final Judgment should permanently enjoin United from using ''most-favored-nations'' (''MFN'') clauses in its contracts with healthcare-providers. (AMA comment at 13). As explained in the affidavit of Professor David Dranove, submitted by the AMA, an MFN clause would require a healthcare provider to offer United rates no less favorable than those offered to other insurers. (AMA comment, Attachment A at 8.) MFNs may be anticompetitive or procompetitive, depending on the circumstances. Federal Trade Comm'n & U.S. Dept. of Justice, *Improving Health Care: A Dose of Competition* (Jul. 2004), ch. 6, p. 20, available at *http://www.usdoj.gov/atr/public/health_care/204694.htm.* MFN clauses may harm competition by, for example, discouraging healthcare providers from aggressively discounting to competing insurers who might be seeking to enter or expand in a market. *Id.*

It is not necessary to prohibit United from using MFN clauses to ensure that Humana can compete and maintain the premerger level of competition in Medicare Advantage plans. Pursuant to Section IV(F) of the proposed Final Judgment, on February 29, 2008, Humana entered into an agreement that gives Humana access to United's existing provider network of physicians, hospitals, ancillary service providers, and other healthcare providers on comparable terms to those enjoyed by United at the time of the acquisition. Accordingly, United could not use MFN clauses to attempt to prevent Humana from competing in the Medicare Advantage market. Of course, the United States remains free to challenge arty anticompetitive conduct of United, including MFN clauses, that the United States determines harm competition.

b. All-products Clauses

The AMA states that the proposed Final Judgment should permanently enjoin United's use of ''all-products'' clauses in healthcare-provider contracts. (AMA comment at 13.) An all products clause is a contractual provision that requires a physician or other healthcare provider to agree to participate in the networks for every one of a health-insurance company's products (e.g., commercial health insurance and Medicare Advantage) as a condition for participating in the network of any one of that health-insurance company's products.

The AMA does not make clear how a prohibition on United's use of all-products clauses would help maintain competition in a Medicare Advantage market. (AMA comment at 13.) The AMA comment refers to the affidavit of Professor David Dranove, submitted by the AMA, for an explanation of how all-products clauses can be anticompetitive. (AMA comment, Attachment A at 8.) Although Professor Dranove states in his affidavit that the proposed Final Judgment should prohibit all-products clauses to remedy harm in a market for the purchase of physician services, the Complaint did not allege or identify competitive harm in such a market. (Attachment A at 8.) To the extent that the AMA advocates a prohibition on all-products clauses to remedy harm in a market for the purchase of physician services, such remedies are outside the scope of this APPA proceeding as discussed in Section III.A. of this Response.

c. United's Commercial Health-insurance Business in Clark County

The AMA argues that the proposed Final Judgment should require United to divest its commercial health-insurance business in the Las Vegas area in addition to United's Medicare Advantage line of business because a Medicare Advantage business operating without a commercial component ''faces a significant risk of failure.'' (AMA comment at 13.) The AMA asserts that ''[t]here are significant economies of scope and scale that exist when both commercial and Medicare Advantage businesses are combined'' Id. The AMA, however, does not identify what these economies of scope and scale are nor why their absence creates a risk of failure.

The United States has considered this issue and concluded that Humana has the resources needed to effectively compete for the provision of Medicare Advantage plans in the Las Vegas area. Further, even assuming that there are benefits to providing both commercial and Medicare Advantage products, Section IV(F) of the proposed Final Judgment addresses this concern by ensuring that Humana has access to United's existing healthcare provider network on terms no less favorable than United's premerger terms. That provision and the other provisions of the proposed Final Judgment ensure that Humana will have a cost structure similar to United's premerger cost structure and be an effective competitor that maintains competition in the Las Vegas Medicare Advantage market.

d. Use of Certain Trademarks

The AMA argues that the acquirer of the Divestiture Assets should have use of certain United trademarks (AMA comment at 13–14). Section IV(H) of the proposed Final Judgment prohibits United from using the AARP brand for any of its individual Medicare Advantage plans in the Las Vegas area until March 31, 2009, and from using the SecureHorizons brands for any individual Medicare Advantage plans in the Las Vegas area until March 31, 2010. The AMA argues that the United States should extend these provisions to last at least five years because ''trademarks are of particular importance to continue to secure customer loyalty.'' (AMA comment at 13–14.)

The AMA, however, does not provide any facts to support its assertion that a longer prohibition period on United's use of the AARP and SecurdHorizons brands is necessary to allow Humana to be an effective competitor and maintain competition in the Las Vegas Medicare Advantage market. In the United States' judgment based on a review of the terms for the sale of the Divestiture Assets, its assessment of Humana's capabilities, and its investigation of the Las Vegas Medicare Advantage market, the brand prohibitions in the proposed Final Judgment are reasonable in light of their intended purpose—to give Humana time to establish its own brand in the Las Vegas area and reduce beneficiary confusion as to which company operates the plan in which the beneficiary is enrolled. *See SBC Commc'ns,* 489 F Supp. 2d at 17 (a district court ''must accord deference to the government's predictions about the efficacy of its remedies'').

e. Use of a Monitoring Trustee

The AMA argues that the proposed Final Judgment should require the immediate use of a monitoring trustee to ensure United's compliance with the proposed Final Judgment (AMA comment at 15). Section V of the proposed Final Judgment allows the United States, in its sole discretion and subject to approval by the Court, to appoint a monitoring trustee that would have the power to monitor Defendants' compliance with the terms of the proposed Final Judgment. Section V(H) of the proposed Final Judgment provides that, if a monitoring trustee is appointed, it shall serve until United has divested the Divestiture Assets and any agreements for transition support services have expired.

In the United States' judgment, the immediate use of a monitoring trustee is not necessary to ensure United's compliance with the proposed Final Judgment for at least three reasons. First, United has already complied with many of the provisions of the proposed Final Judgment. United has completed the divestiture of the Divestiture Assets and assisted Humana in entering into an agreement with HealthCare Partners that gives Humana access to healthcare providers on terms no less favorable than United's pre-existing agreement with HealthCare Partners. In addition, Humana and United have entered into a transition services agreement as contemplated by Section IV(J) of the Final Judgment. Second, the United States has reviewed the Humana-United transition services agreement and concluded that the agreement provides Humana with contractual rights such that a monitoring trustee is not currently necessary to ensure United's compliance with the terms of that agreement. Third, should United fail to comply with the terms of the transition support agreement, the United States remains free to appoint a monitoring trustee, subject to the Court's approval.

IV. Conclusion

The issues raised in the four public comments were among the many considered during the United States' extensive and thorough investigation. The United States has determined that the proposed Final Judgment as drafted provides an effective and appropriate remedy for the antitrust violations alleged in the Complaint, and is therefore in the public interest. The United States will move this Court to enter the proposed Final Judgment after the comments and this response are published in the **Federal Register**.

Dated: July 7, 2008.

Respectfully Submitted,

Peter J. Mucchetti (D.C. Bar # 463202),
Mitchell H. Glende,
Natalie A. Rosenfelt,

Trial Attorneys, Litigation I Section—Antitrust Division, United States Department of Justice; 1401 H Street NW, Suite 4000, Washington, DC 20530,(202) 353–4211, (202) 307–5802 (facsimile).

In the matter of: In the United States District Court for the District of Columbia; United States of America, Plaintiff, v. Unitedhealth Group Incorporated and Sierra Health Services, Inc., Defendants.

Judge: Ellen S. Huvelle.

Filed: 2/25/2008

[Civil No. I:08–cv–00322]

Tunney Act Comments of SEIU Local 1107 on the Proposed Remedy in United Health Group Inc.'s Acquisition of Sierra Health Services Inc.

The Service Employees International Union (''SEIU'') Local 1107 provides these comments on the proposed final judgment in United Health Group Inc.'s (''United Health'') acquisition of Sierra Health Services Inc. (''Sierra''). As described herein the SEIU believes the proposed remedy in this matter is inadequate and unlikely to prevent the substantial anticompetitive effects raised by the merger. As we explain below, the proposed merger is likely to reduce competition substantially in numerous markets, including the delivery of healthcare at hospitals. By creating a dominant health insurer in Clark County. Nevada, the merger will enable UnitedHealthcare to substantially lower reimbursements to hospitals. which, as demonstrated below, will ultimately harm patient care. We believe this provided a substantial basis for the Antitrust Division, Department of Justice (''DOJ'') to challenge the merger under Section 7 of the Clayton Act, and contend that DOJ's decision to enter into the consent decree was in error. We respectfully request that the proposed consent decree is rejected and the Department of Justice sue to enjoin the merger.

The SEIU is an organization of more than 1.9 million members united by the belief in the dignity and worth of workers and the services they provide. SEIU is the nation's largest union of health care workers representing over 900,000 caregivers and hospital employees, including 110,000 nurses and 40,000 doctors in public, private, and non-profit medical institutions. SEIU is dedicated to improving the lives of all workers and their families. In Nevada, SEIU Local 1107 represents more than 17,000 registered nurses, health care workers and public employees dedicated to improving the lives of workers, their families and their communities. Our members have chosen to dedicate their lives to serving the public, and provide the first line of health care service to thousands of patients in hospitals in Nevada. In that role we experience first hand how health insurance consolidation can harm consumers by restricting the ability of all health care providers to provide high quality health care. Ultimately, when health insurers acquire and exploit their power patients and health care workers suffer.

The SEIU submits these comments on the Proposed Final Judgment (''PFJ'') pursuant to the Antitrust Procedures and Penalties Act. 15 U.S.C. 16(b–e) (known as the ''Tunney Act''). The Tunney Act requires that ''[b]efore entering any consent judgment proposed by the United States * * *, the court shall determine that the entry of such judgment is in the public interest., 16 U.S.C. 15(e)(1). In applying this ''public interest'' standard the burden is on the government to ''provide a factual basis for concluding that the settlements are reasonably adequate remedies for the alleged harms.'' *United States* v. *SBC,* 489 F.Supp.2d 1, 16 (D.D.C. 2007), citing *United States* v. *Microsoft Corp.,* 56 F.3rd 1448, 1460–61 D.C.Cir, 1995).

The Court plays a vital role in determining the proposed decree fulfills the public interest. As Judge Greene observed in approving the AT&T settlement:

> [i]t does not follow * * * that courts must unquestionably accept a proffered decree as long as it somehow, and however inadequately, deals with the antitrust and other public policy problems implicated in the lawsuit. To do so would be to revert to the ''rubber stamp'' role which was at the crux of the congressional concerns when the Tunney Act became law.

U.S. v *American Telephone and Telegraph,* 552 F.Supp. 131, 151 (D.D.C. 1982), aff'd *sub nom., Maryland* v. *U.S.*, 460 U.S. 1001 (1983).

As detailed below, SE1U believes that the PFJ fails to meet the public interest standard. This merger will lead to an unprecedented level of consolidation and will create a dominant health insurer in Clark County. which is the largest county in Nevada and where Las Vegas is located. Allowing one health insurance company this kind of market control will harm the quality of care patients will receive in hospitals and further weaken the fragile health care system in Clark County. In particular, the merger will

- jeopardize patient safety and quality of care by reducing payments to hospitals;
- jeopardize the health care safety net;
- have a particularly adverse effect on rural hospitals;
- and, increase the number of uninsured and harm the delivery of care to the elderly.

I. The Merger Will Result in Dangerously High Nurse to Patient Staffing Ratios, Placing Patient Safety and Quality of Care in Jeopardy

The impact of the acquisition of Sierra by UnitedHealth on the quality of care in hospitals will be severe. This merger will lead to an unprecedented level of concentration, In the Clark County HMO

market UnitedHealth's market share will increase from 14% to 94%. If PPOs are included, UnitedHealth's market share increases from 9% to 60%. Even with the divestiture of the United Medicare Advarnage business as included in the PFJ. UnitedHealth's market share is over 50%. With such a dominant position UnitedHealth will be able to reduce reimbursement rates to hospitals unilaterally. Simply, hospitals will be unable to reject a ''take it or leave it'' offer from UnitedHealth.

When hospitals are forced to reduce reimbursement rates, the delivery of health care suffers. Reduced reimbursement leads to cut backs in services, less investment in equipment, and lower staffing levels. While these Comments will focus on the impact on nurses and, in turn, the impacts on patient care, these concerns are illustrative of the type of competitive problems that will arise overall from the reduction of compensation of reimbursement to hospitals.

Reductions in reimbursement force hospitals to reduce their expenses. Staff is the largest expense for hospitals, and Registered Nurses (''RNs'') represent hospitals' single largest labor expense. In Southern Nevada in particular, salaries and benefits represent 48.0% of total operating expenses,[1] and RNs comprise 76.9% of the hospital workforce.[2] Therefore, if hospitals are forced to accept low reimbursement rates, they will look to recoup their losses by cutting costs in the most logical place—their RN staff.[3] The result can be dangerously high patient-to-nurse staffing ratios.

The detrimental impact of a high patient-to-nurse ratio on patient safety and quality of care has been amply demonstrated in several markets by a recent set of academic studies, A comprehensive study conducted in 2002 and published in the Journal of the American Medical Association found that the risk of death increases by 7% for every patient in a nurse's care above a 4:1 patient to nurse ration, and increases by 16% when that ratio increases to 6:1; the study also concluded, most significantly, that there is 31% greater risk of dying in hospitals that force a single nurse to care for eight or more patients.[4] Moreover, according to a report by the Joint Commission, *Health Care at the Crossroads: Strategies for Addressing the Evolving Nurse Crisis,* understaffing is a contributing factor in 24% of sentinel events (unexpected occurrences that result in death or serious injury).[5] Indeed, patients in hospitals with fewer intensive care unit (''ICU'') nurses are more likely to suffer from complications after surgery and to have a longer length of stay in the hospital than patients in hospitals with a greater number of ICU nurses. It is also worth noting that patients are not the only ones who suffer harm to their health as a result of short-staffing: nurses are two to three times more likely to have a needle-stick injury in hospitals with low nurse staffing levels.[6]

Studies have also demonstrated that there can be better health care outcomes with adequate staffing levels. A recent study estimated that 6,700 in-hospital patient deaths could he avoided by increasing nurse staffing levels. The study further concluded that simply increasing nurse staffing levels would result in approximately 70,000 fewer adverse outcomes, including decreases in urinary tract infections, pneumonia and shock or cardiac arrest.[7]

Nurses in Nevada are already forced to work with dangerously high nurse-to-patient ratios. In 2000. Nevada ranked last among the states in RNs per capita and in per capita health services employment.[8] In 2005 Nevada ranked 49th among the states in per capita registered nurses, with only 579 RNs for every 100,000 residents, which is far below the national average of 799 RNs per 100,000 residents.[9] The RN-to-population ratios are higher in the northern part of the state and lower in Clark County. Although the number of registered nurses in Nevada has grown steadily, it has not kept pace with the state's population growth.[10] The average number of newly-minted RNs over the last five years has only been 1,264.[11] However, over the last three years, Nevada's population increased by 11.4%.[12]

Academic studies have shown that, much like the rest of the country, the epidemic of nurse understaffing in Nevada is due *not* to a shortage of registered nurses, but rather a shortage of registered nurses willing to work under the current conditions in Nevada hospitals. In 2000, active licenses were held by 12,900 registered nurses in Nevada but only 10,400 were employed in nursing.[13] In 2004 and 2005, Valley Hospital in Las Vegas reported that 206 registered nurses left employment at the hospital (Valley Hospital has approximately only 540 RNs employed at any given time).[14] At Desert Springs Hospital in Las Vegas, 137 registered nurses left employment in 2004 and 2005 (Desert Springs employs approximately only 290 RNs at any given time).[15] A case study of RNs in Nevada found that the number one reason that RN graduates leave their first job is due to patient care concerns such as unsafe patient ratios, not having

[1] Hospital Quarterly Reports. Calendar Year 2006 Summary Financial Report. Table A07 ''Operating Expenses'' and Table A08 ''Other Operating Expenses.'' Utilization and Financial Reports. Center for Health Information Analysis. University of Nevada Las Vegas. *http://www.unlv.edu/Research_Centers/chia/NHQR/Financial/NHQR_Financial_OutputCY2006%200822.xls* (Retrieved on October 15. 2007).

[2] Hospital Quarterly Reports. Calendar Year 2006 Summary Utilization Reports. Table F02 ''FTE Hospital Hours'' Utilization and Financial Reports. Center for Health Information Analysis. University of Nevada Las Vegas. *http://www.unlv.edu/Research_Centers/chia/NHQR/Utilization/NHQR_Utilization_Output_CY2006%200702.xls* (Retrieved on October 15. 2007).

[3] Kosel, Keith and Tom Olivo. ''The Business Case for Work Force Stability.'' *VHA Research Series,* 2002.

[4] Aiken. Linda H.; Clarke, Sean P.; Sloane, Douglas M.; Sochalski, Julie; Silber, Jeffrey H. ''Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction.'' *Journal of the American Medical Association,* 10/23/2002, Vol. 288 Issue 16.

[5] Joint Commission on Accreditation of Health Care Organizations. ''Health Care at the Crossroads: Strategies for Addressing the Evolving Nurse Crisis.'' 2003. *http://www.jointcommission.org/NR/rdonlyres/5C138711-ED76-4D6F-909F-B06E0309F36D/0/health_care_at_the_crossroads.pdf* (Retrieved on 3/6/07.)

[6] *Id.*

[7] Needleman, Jack, Peter I. Buerhaus, Maureen Stewart, Katya Zelevinsky and Soeren Mattke. ''Nurse Stafling in Hospitals: Is there a Business Case for Quality?'' *Health Affairs,* Vol. 25. No. 1. January/February 2006.

[8] U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions. ''State Health Workforce Profiles Highlights: Nevada. *http://bhpr.hrsa.gov/healthworkforce/reports/statesummaries/nevada.htm* (Last viewed 12/7/07).

[9] Kaiser State Health Facts. Nevada. Providers & Service Users. ''Nevada: Total Registered Nurses as of May 2005.'' *http://www.statehealthfacts.org/profileind.jsp?ind=438&cat=8&rgn=30* (last viewed 12/7/07).

[10] Packham, John, Tabor Griswold, Jake Burkey, Chris Lake. 2005 Survey of Licensed Registered Nurses in Nevada. November 2005. *http://www.nvha.net/papers/nursesurvey.pdf* Last viewed on 12/8/07.

[11] Nevada State Board of Nursing Annual Reports for years ending June 30, 2001—June 30, 2005. Includes new licenses created by examination and by endorsement.

[12] U.S. Census Bureau. American Fact Finder. Population Finder. ''Population for all Counties in Nevada, 2000 to 2006.'' *http://factfinder.census.gov/servlet/GCTTable?_bm=y&-geo&_id=0400US32&-_box_head_nbr=GCT-T1&-ds_name-PEP_2006_EST&-_lang=en&-format=ST–2&-sse=on* (Last viewed 12/7/07).

[13] U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions. ''State Health Workforce Profiles Highlights: Nevada.'' *http://bhpr.hrsa.gov/healthworkforce/reports/statesummaries/nevada.htm* (Last viewed 12/7/07).

[14] Data provided pursuant to collective bargaining information request.

[15] Data provided pursuant to collective bargaining information request.

enough time to spend with patients, and working conditions that are not conducive to safe patient care.[16] Job dissatisfaction among hospital nurses is four times greater than the average for all U.S. workers. Forty percent of hospital nurses report burnout levels that exceed the norm for health care workers and 1 in 5 hospital nurses intend to leave their current jobs within a year. Job stress and dissatisfaction increase when nurses are taking care of more patients. Each additional patient over four per nurse is associated with a 23% chance of job burnout and a 15% chance increase in odds of job dissatisfaction.[17]

Nurses also bear the brunt of the predictable results of short-staffing: every time a nurse goes to work when there are too few nurses working that shift, she puts her nursing license in jeopardy. Pursuant to Nevada statute (NAG § 632.895), a registered nurse can be subject to disciplinary action from the Nevada State Nursing Board if a patient suffers harm as a consequence of an act or an omission that could have been reasonably foreseen, up to and including suspending or revoking a nurse's license.[18] We have already explained the link between low nurse staffing levels and adverse patient outcomes including an increased risk of mortality. Yet another comprehensive study has found that rates of ''failure to rescue'' deaths increased when registered nurses were responsible for too many patients. (''Failure to rescue,'' is the death of a patient from complications including pneumonia, shock or cardiac arrest, upper gastrointestinal bleeding, sepsis or deep venous thrombosis.) Given that early identification of medical problems can decrease the risk of death in ''failure to rescue'' mortalities, inadequate staffing levels further increases the risk of harm to patients, thereby increasing the risk of a registered nurse being held responsible and losing his or her professional license.[19] In the context of this crisis, further staffing cuts as a result of this merger will drive even more Nevada nurses out of the profession.

These problems will be even more severe in Southern Nevada, where 71.1% [20] of the hospital market is controlled by for-profit companies. This concentrated for profit environment is almost unique in the U.S. A comprehensive review of clinical data from more than 4,000 hospitals in the United States found that for-profit hospitals consistently have worse outcomes than non-profit hospitals on three common medical conditions: congestive heart failure, heart attack and pneumonia.[21] The difference in quality may be attributed to the difference in accountability, while publicly-owned and non-profit hospitals are accountable to the community. for-profit hospitals are only accountable to their shareholders and, as a result, focus on strategies that increase profitability rather than strategies to benefit the community.[22]

The result of this concentration of for-profit hospital ownership is a relatively poor level of healiheare quality in Clark County. A Medicare Quality Improvement Organization, dedicated to tracking quality measures in medical settings, routinely ranks Clark County hospitals in the bottom half of our nation's hospitals in a wide-range of quality measures. In fact. some Clark County hospitals scored as low as the 6th and 7th percentile of all U.S. hospitals.[23]

The PFJ approving the United/Sierra merger will exacerbate these problems and diminish the level of health care quality. The ability of patients and doctors to determine the appropriate level of care will be weakened. Nurses that are working with inadequately low staffing levels will be faced with an additional risk to staffing levels and safe, quality patient care will be needlessly jeopardized.

II. Sierra Health Services & HCA: A Case Study of Anticompetitive Impact on Qualily & Access in Nevada

History demonstrates how the dominance of one health insurer in this market can harm the health care of children and families in our community. In Las Vegas we have already experienced the impacts of a health insurance company using its market dominance to increase their profits. In January 2007, after a contentious and public contract fight between Sierra Health Services and HCA hospitals in Clark County, Sierra Health Services terminated its contract with HCA hospitals because HCA refused to agree to the low reimbursement rates Sierra was demanding. When the contract was terminated, Sierra's 620,000 members were no longer able to access services at the three HCA hospitals in Clark County.

Children have been harmed the most by Sierra's decision. Sunrise Hospital, which is owned by HCA, specializes in pediatric care. Children are no longer able to access pediatric neurologists or pediatric radiologists in Clark County and may have to travel as far as Los Angeles to receive this level of specialized care. Children with cancer are no longer eligible to participate in protocol treatments at Sunrise Hospital. Patients who come to the Emergency Room at Sunrise Hospital who are covered by Sierra Health Services' products have to be transferred to a different hospital as soon as they are stabilized, including women in labor. Patients are sometimes forced to move from hospital to hospital to access all the care they need. We know of one patient, for example, who had to go to Sunrise Hospital to have a pacemaker removed and was then transferred to another hospital to have a new one inserted due to insurance demands.

After Sierra Health Services dropped HCA, Sierra Health Services required their enrollees to be directed to other hospitals in Clark County. Our nurses who work at the other hospitals saw first hand the impact of having 620,000 consumers suddenly redirected to their hospitals. A nurse at Valley Hospital reported that their Intensive Care Units, Emergency Room and Operating Room became overwhelmed with heart patients and other critically ill patients. Universal Health Services, the for-profit corporation that owns Valley Hospital, is already known for short staffing its Registered Nurses, so when Sierra's decision took effect, Operating Room and Recovery Room RNs and techs were on call at the hospital for 16–20 hours

[16] Bowles, Cheryl and Lori Candela. ''First Job Experiences of Recent R.N. Graduates.'' *Journal of Nursing Administration.* 2005.

[17] Aiken, Linda H., Sean P. Clarke, Douglas M. Stone, Julie Sochalski and Jeffrey H. Silber. ''Hospital Nurse Staffing and Patient Mortality, Nurse Burnout and Job Dissatisfaction.'' *Journal of the American Medical Association,* Vol. 288. No. 16, 10/23/2002.

[18] Nevada Administrative Code. Chapter 632. *http://www.leg.state.nv.us/NAC/NAC-632.html.*

[19] Needleman, Jack and Peter Buerhaus, Soeren Mattke, Maureen Stewart and Katya Zelevinsky, ''Nurse Staffing Levels and the Quality of Care in Hospitals.'' *New England Journal of Medicine,* Vol. 346, No. 22. 5/30/2002.

[20] Quality Care Nevada. ''Hospitals and Health Systems.'' *http://www.qualitycarenevada.org/index.asp?Type=B_BASIC&SEC={7707D6CB–3079–4EF0-A9D6-B81FB8D31E7F}.*

[21] Landon, Bruce E.. Sharon-Lise T. Normand, Adam Lessler, A. James O'Malley, Stephen Schmaltz, Jerod M. Loeb and Barbara McNeil. ''Quality of Care for the Treatment of Acute Medical Conditions in U.S. Hospitals.'' *Arch Intern Med,* Vol. 166, Dec 11/25, 2006.

[22] Physicians for a National Healthcare Program. ''New England Journal of Medicine Article Says Evidence Against For-Profit Hospitals Now Conclusive.'' August 1999. *http://www.pnhp.org/news/1999/august/new_england_journal_.php* (Last viewed on 12/7/07).

[23] Health Insight. *http://www.healthinsight.org* (Last viewed on 10/31/07).

every day. Emergency Room RNs had to take 4 to 8 patients each, and patients were forced to stay in the Emergency Room for 2–3 days before they were able to he transferred to a bed in Intensive Care.

Sixteen months have passed since the contract between Sierra Health Services and HCA hospitals in Clark County was severed, and patients are still not able to access care at these hospitals. At Sunrise Hospital, the census and case load continue to be low and patients continue to be refused treatment. Nurses who work at HCA hospitals have seen their hours cut and face the threat of layoffs. Many registered nurses have had to find work at other facilities or have used up all of their vacation time because there is not enough work for them. Registered Nurses have had to quit working at Sunrise Hospital because there have not been enough hours for them to work and they have been unable to pay their mortgage.

SEIU Local 1107 believes that the HCA example demonstrates the likely anticompetitive effects from the UnitedHealthcare/Sierra merger. When an insurance company is in a dominant position, it can demand dramatically lower reimbursement rates from hospitals. Most hospitals have few alternatives but to accept a take-it-or-leave-it offer from dominant health insurer. But even if they reject such an offer, it is important to recognize that the harm to consumers will not be limited simply to UnitedHealthcare/Sierra consumers. For those consumers, there is one less hospital outlet available for them to access care. But for all consumers the termination of a hospital from an insurer network imposes significant costs. Ultimately, the increased costs of serving Sierra patients at other hospitals are spread to all consumers who use those alternative hospitals as the level of care diminishes.

III. The Merger Will Create a Crisis for the Clark County's Safety Net Services by Placing Additional Strain on Nevada's Only Public Hospital

The United/Sierra merger will also harm Clark County's health care safety net by creating a crisis for Nevada's sole public hospital, University Medical Center (UMC), located in Las Vegas.

University Medical Center has served Southern Nevada for 75 years. It operates Nevada's only Level 1 Trauma Center, Nevada's only burn care facility and the only HIV inpatient unit in Southern Nevada. It also serves as the primary clinical campus for University of Nevada School of Medicine, Its Primary and Quick Care network provides primary and urgent care access to more than 300,000 patients each year.[24]

UMC treats the vast majority of the uninsured in Clark County and serves as the community's safety net hospital in Las Vegas. UMC cares for 44% of all of Clark County's Medicaid patients and 48% of Clark County's self-pay patients and has provided $280 million in charity care in the last 5 years. At the same time, UMC cares for less than 11% of the market for each of the better paying Medicare and commercial insurance.

UMC's ability to provide essential services is continuously threatened by its poor payer mix and the financial instability that that brings. UMC operates near capacity, with an occupancy rate of 84.5%, but its average operating margin for the last four years has been −3.9% because of its poor payer mix. UMC's expenses have been increasing at a higher rate than revenue since 2001, and with the rate of uninsured predicted to increase by 24% by 2021 in Clark County, this deficit is expected to continue.[25] In fiscal year 2006 UMC incurred an operating deficit of approximately $34.3 million and the operating deficit is projected to reach $60 million in fiscal year 2007.[26] Given UMC's precarious circumstances, if one insurance company were permitted to obtain market dominance, any actions that increase the number of uninsured or underinsured will severely undermine the ability of UMC to meet its obligations in providing a community safety net for Nevadans. For example, if as a result of the merger, United-Sierra dramatically raises premiums and increases the numbers of uninsured and underinsured individuals (which we discuss further below), this will only increase the demand on UMC's already over-taxed services.

Yet another way UMC will be harmed if only one insurance company insures a large percentage of the patients at a single hospital is in the area of claims resolution. Any difficulties in resolving outstanding claims will have a significant impact on the ability of the public hospital to meet its public service obligations. In fact, UMC has already had precisely this kind of trouble with UnitedHealth. Modern Healthcare reported that since UnitedHealth took over PacifiCare in 2005, UMC has had trouble with UnitedHealth's claims payment process and has had difficulty getting claims resolved.[27] If this merger is approved and these problems persist, the effects will be on a much bigger scale and it will put essential medical services at risk. UMC cannot afford the financial and operational havoc that unpaid or unresolved claims could have on their ability to provide services.

IV. The Merger Will Exacerbate the Condition of Nevada's Most Vulnerable Populations: the Uninsured and Underinsured, and the Elderly

The acquisition of Sierra Health Services by UnitedHealth will result in UnitedHealth dominating a faction of the market and possessing the power to unilaterally set the price for health insurance premiums. If individuals and/or employers are unable to afford the premiums, they will have no other health insurance options available to them and we will see an increased number of uninsured in Las Vegas.

Approximately 18% of Nevadans live without insurance, which is higher than the national average of 16%. Seventeen percent of children in Nevada live without health insurance, higher than the national average of 12%.[28] The uninsured rate in Clark County grew 31% from 2000–2006 and is expected to grow at least another 24% in the next 15 years.[29]

When patients do not have insurance they are more likely to delay seeking treatment and they are more likely to obtain their care in the emergency room. When we see them in the hospital they are much sicker than they would have been otherwise. They are more likely to have a longer length of stay. If their insurance will not cover their care they need while they are in the hospital they are more likely to have a delayed recovery and make repeat visits to the hospital.

Living without insurance can have dire consequences. In rural Nevada, there are a high number of uninsured pregnant women. When laboring moms come to the hospital with no medical records because they were unable to afford prenatal visits, a danger is posed to the mother and the child.

This merger will increase the number of underinsured in Clark County. If UnitedHealth decides that they will no

[24] Lewin Group. Clark County Final Summary Presentation,'' February 20, 2007, Slide 54.

[25] Lewin Group. Clark County Final Summary Presentation,'' February 20, 2007, slide 5, 7 & 63.

[26] University Medical Center Public Outreach Summary Report.'' Presented to the Clark County Board of County Commissioners on 9/4/2007.

[27] Benko, Laura B. ''All Bets are Off: Bigger, Yes, But Better?'' *Modern Healthcare.* 3/19/2007.

[28] Kaiser Family Foundation. State Health Facts. ''Health Coverage & Uninsured.'' *http://www.statehelathfacts.org/profilecat.jsp?rgn=30&cat=3* (Last viewed on 10/30/07).

[29] Lewin Group. ''Clark County Final Summary Presentation.'' February 20, 2007, slide 37 & 38.

longer provide coverage for certain kinds of care than that decision will leave more than 808,000 people in Nevada.[30] approximately 32.4% of the population,[31] with a choice of either going without necessary care or paying for that care out of their own pocket. SEIU Local 1107 members represent a large number of UnitedHealth's potential consumers; approximately 74.0% of SEIU Local 1107 members currently have Health Plan of Nevada (Sierra's HMO product) as their only HMO option.

Increasing the number of uninsured and underinsured will lengthen emergency room wait times and impact the quality of the care we provide at our hospitals. Hospitals are mandated by law to provide care to anyone who asks for medical treatment and, because of this, people use the ER for everyday medical problems. We are inundated with non-emergent patients that have no other place to go to receive health care. The burden takes nurses and doctors away from treating truly emergent, life-threatening patients and creates emergency room wait times that can last 6 to 8 hours. If ones insurer provides coverage to a large percentage of people in the community and that insurer decides to raise premiums, the number of uninsured or underinsured residents will increase, and all of the problems associated with that will increase as well.

Clark County is already in a perilous position of being unable to provide the appropriate level of care to elderly and disabled residents. Clark County hospitals are short staffed and do not have enough nurses to provide necessary care, The County is also suffers from a shortage of doctors, dentists and almost every other health care professional.[32] A Veterans Administration official stated that these shortages will eventually lead to premature deaths, intense strain on families and missed diagnosis that will cause patients to suffer.[33]

* * *

We believe that the PFJ thus to address the substantial competitive concerns raised by UnitedHealth's acquisition of Sierra and should he rejected by the Court.

[30] Robison, Jennifer. ''Mergers and Acquisitions: Official OKs Sierra Health buyout.'' *Las Vegas Review Journal.* 8/28/2007.

U.S. Census Bureau. Population Finder. Nevada. Population estimates in 2006: 2,495, 529. *http://factfinder.census.gov/servlet/SAFFPopulation?_event=Search&_name=&_state=04000US32&_country=&_cityTown=&_zip=&_sse=on&_lang=en&pctxt=fph* (Last viewed on 10/30/07)

[32] Hidalgo, Jason, 6/17/2007.

[33] Hidalgo, Jason, 6/17/2007.

Respectfully submitted,

Jane McAlevey, Executive Director, *Service Employees International Union, Local 1107.*

Chris Giunchigliani, Commissioner, Board of County Commissioners, Clark County Government Center, 500 S Grand Central Pky, Box 551601 Las Vegas, NV 89155–1601, (702) 455–3500 Fax: (702) 383–6041

May 14, 2008.

Joshua H. Soven, Chief, Litigation I Section, U.S. Department of Justice, Antitrust Division, 1401 H Street, NW, Ste. 400, Washington, DC 20530

RE: Tunney Act Comments, *United States* v. *UnitedHealth Group*, Civil Case No. 08–0322

Dear Mr. Soven:

As an individual Commissioner of Clark County, I am submitting these comments to express my serious concerns with the proposed final judgment entered into by the U.S. Department of Justice (''DOJ'') with UnitedHealth Group, Inc. and Sierra Health Services, Inc. over the UnitedHealth/Sierra acquisition. I believe that this proposed final judgment is inadequate to resolve the very serious competitive concerns raised by this merger.

UnitedHealth's acquisition of Sierra will create a single health insurance company that will dominate the Clark County market. By combining these two companies, a single firm will have over a 50% share of the commercial health insurance market. This single firm will have substantial power to dictate the terms and conditions in which employers, particularly small employers, will be forced to purchase health insurance. Clark County is a significant distance from other major metropolitan markets arid the commercial health insurance market has traditionally been dominated by a small group of firms.

The DOJ's decree is inadequate because it fails to recognize the potential competitive harm from the merger on employers who purchase insurance, and uninsured and underinsured individuals in Clark County. Clark County is the largest county in Nevada with a population of 2 million individuals, over 300,000 of which are uninsured, over 17% of the Clark County population. This merger is of particular concern for the county, which because it operates the largest public hospital in Nevada, University Medical Center (''UMC''). UMC is the safety net healthcare facility for the county. Uninsured and underinsured individuals use UMC as their primary source of healthcare services.

This merger, by permitting the creation of a single dominant health insurer in Clark County will substantially increase the costs of numerous commercial health insurance products, ultimately harming the consumers in Clark County.

This, in turn, will increase the number of uninsured individuals. This impact will be particularly felt by relatively small employers in Clark County. As the cost of insurance increases substantially, small employers will be increasingly unable to provide health insurance to their employees, and in turn this will further substantially increase the number of uninsured individuals in the county. Those individuals must rely on UMC for most of their healthcare services. Thus, the merger will ultimately increase the cost of healthcare services in Clark County. Moreover, this merger will diminish the service and quality of health care that patients receive as more demand is placed on the services of UMC.

The Nevada State Attorney General filed a complaint and a final judgment simultaneous to the DOJ action. The Attorney General was able to secure some modest relief to address the concerns of UMC, including the payment of overdue claims for UMC. Although these remedies aim to solve some ongoing problems between UnitedHealth and UMC, they do not provide any long-term relief to protect the interests of UMC, the uninsured, or Clark County. Now that the merger is consummated. Clark County is left dealing with an incredibly powerful health insurance company that can unilaterally reduce reimbursement, which in turn will significantly diminish the ability of the county to deliver adequate services to both insured and uninsured individuals.

I believe that the DOJ's proposed enforcement action should be rejected, and the Department should re-open its investigation to secure adequate relief to protect the uninsured individuals in Clark County and the concerns of the County itself.

Sincerely,

Chris Giunchigliani, *Commissioner.*

Congress of the United States

U.S. House of Representatives

Committee of Small Business

2561 Rayburn House Office Building

Washington, DC 20515–0315

May 15, 2008.

VIA E-MAIL

The Honorable Thomas O. Barnett, Assistant Attorney General for Antitrust, c/o Joshua H. Soven, Chief, Litigation I Section, U.S. Department of Justice, Antitrust Division, 1401 H Street, N.W., Suite 4000, Washington, DC 20530

RE: Tunney Act Comments, *United States* v. *UnitedHealth Group Incorporated*, Civil Case No. 08–0322

Dear Assistant Attorney General Barnett:

These comments are submitted pursuant to the Tunney Act [1] regarding the Proposed Final Judgment (PFJ) filed by the U.S. Department of Justice (DOJ) with the U.S. District Court for the District of Columbia in *United States* v. *UnitedHealth Group Incorporated*, Civil Case No. 08–0322.

The Tunney Act requires the Court to determine whether the PFJ is in the public interest.[2] In making this determination, the Court must carefully consider the fact that entry of the PFJ will profoundly reduce competition in the health care markets of Clark County and the State of Nevada, and pose significant risks to consumers, physicians and small businesses. The public

[1] 15 U.S.C. §§ 16(b)–(h).

[2] 15 U.S.C. § 16(e).

benefit arising from entry of the PFJ is not readily apparent.

While the Department of Justice (DOJ) took steps to protect senior citizens by requiring the divestiture of Medicare Advantage related assets, I am concerned the PFJ does not adequately protect the rest of the public, including small businesses, healthcare providers and patients.

On October 25, 2007, the Committee on Small Business held a hearing entitled *Health Insurer Consolidation—The Impact on Small Business.* The Committee heard from witnesses representing small businesses, the medical community and consumers who expressed concern regarding the growing trend of consolidation in the health insurance industiy.

Witnesses made the following comments at the hearing:

''* * * consolidation has left physicians with little leverage against unfair contract terms that deal with patient care and little control over their own employees rising health insurance premiums.'' [3]

''The lack of competition among health insurers absolutely affects my insurance cost, as well as the quality and scope of coverage. Our state's [Illinois] non-competitive health care insurance environment, due to the monopoly of one or two carriers, places all the leverage in the hands of the insurers. I can't vote with my feet and dollars if I have no alternatives from which to select.'' [4]

''Consolidation of health insurance plans have [sic] created a profound imbalance that hurts the ability of family physicians to negotiate contracts. This is harmful to our practices. but also means that many of our patients cannot find the primary care physicians who accept their insurance.'' [5]

''Health insurance consolidation has in part created a take it or leave it market for small businesses. Reduced competition through consolidations both of insurance carriers and health insurance carrier provider networks has led to increased pricing (and) fewer choices for small businesses and their employees.'' [6]

The hearing record is included as part of this comment.

Access to health insurance is an area of key concern to small businesses. The rising cost of health care is regularly cited by small firms as one of their biggest worries. Small businesses need to have choices in the health insurance marketplace. In addition, mergers should not be permitted that enable a health insurer to reduce compensation to physicians below competitive rates. If the playing field for health care providers is not level, quality of care declines and patients ultimately suffer.

The health insurance marketplace has become increasingly consolidated in recent years. Consolidation has left small businesses with fewer choices and physicians with diminished leverage to negotiate with plans. Econometric evidence shows that in the managed care field, an increase in the number of competitors is associated with lower health plan costs and premiums; conversely, a decrease in the number of competitors is associated with higher health plan costs and premiums.[7] In the majority of metropolitan areas, a single insurer now dominates the marketplace. If individuals and small businesses cannot get coverage through the dominant insurer in these areas, they may not be able to find alternatives.

Because mergers of health insurers affect access to health care and influence the quality of medical services to consumers, they command great scrutiny.

To maintain competition in the marketplace, the proposed acquisition of Sierra Health Services, Inc. (''Sierra'') by UnitedHealth Group Incorporated (''United'') requires the divestiture of more assets than merely those related to United's Medicare Advantage business in the Las Vegas area. Sierra is United's largest rival in the state of Nevada. The level of concentration posed by this merger is tremendous. A combined United-Sierra would have a nearly 80 percent share of the commercial HMO market in Nevada and almost a 94 percent share of the commercial HMO market in Clark County.

DOJ notes that ''United and Sierra together account for approximately 94 percent of the total enrollment in Medicare Advantage plans in the Las Vegas area,'' and that the ''acquisition is likely to reduce competition substantially in the sale of Medicare Advantage plans in the Las Vegas area in violation of Section 7 of the Clayton Act.'' [8] Similar effects on competition will likely arise both in the commercial HMO market, which will see virtually the same levels of concentration as the Medicare Advantage market, and the market for the purchase of physician services. The PFJ fails to address this diminishment of competition in these markets in Las Vegas and the State of Nevada.

It is critical that the Court consider the following factors in evaluating the PFJ:

The PFJ Could Enhance United's Market Power and Hurt Small Businesses

United will go from having a 12 percent share of the HMO market in the state of Nevada to an 80 percent share. In Clark County, the market share will surge from 14 percent to 94 percent. By allowing the two largest competitors in the state to merge, small businesses will face severely diminished options in health insurance plans. The insurance marketplace in Nevada and Clark County is already highly concentrated—which necessitates an even higher level of scrutiny. With such a dominant market position, a combined United-Sierra could attain market power to raise prices to small businesses above competitive levels. Small businesses will have few alternatives to a combined United-Sierra and as a consequence, will be stuck with higher premium costs. If costs rise above competitive levels more small firms will stop providing coverage to employees, increasing the number of Nevada's uninsured.

Additionally, it is important to contemplate that existing barriers to entry in the HMO market are extremely high. It is unlikely that a combined United-Sierra will face any new competitors in Nevada in the near future.

The PFJ Could Enhance United's Monopsony Power and Hurt Physicians and Patients

With such an overwhelming market share, the combined United-Sierra could reduce compensation for providers to the point where it is below competitive levels. Lower service, poorer quality and reduced access to health care could result. Physicians and other providers may not have sufficient alternatives to allow them to circumvent the compensation decreases of a combined United-Sierra. The costs for physicians to switch to other health care insurers are substantial as physician time is valuable and it can be difficult for a physician to quickly replace lost patients. With such a dominant market share and high switching costs, physicians may find that, when faced with lower reimbursement, they are unable to switch from a combined United-Sierra to another insurer. If this is the case, a combined United-Sierra could exercise market power against health care providers.

I appreciate consideration of the above mentioned issues. I am concerned that the PFJ does not adequately preserve competition in the health insurance marketplace for small businesses, physicians and consumers.

Sincerely,

Nydia M. Velázquez,
Chairwoman.

Full Commi1tee Hearing on Health Insurer Consolidation—The Impact on Small Business

Committee on Small Business

United States House of Representatives

One Hundred Tenth Congress

First Session

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[3] Statement of Dr. William G. Plested, III, Immediate Past President. American Medical Assn.

[4] Statement of Robert Hughes. President of the National Association for the Self-Employed (quoting a member).

[5] Statement of Dr. James D. King, President, American Academy of Physicians.

[6] Statement of James R. Office, General Counsel, Victory Wholesale Grocers.

[7] *Examining Health Care Mergers in Pennsylvania:* Hearing Before the Senate Judiciary Committee, 110th Congress (April 9, 2007) Statement of Lawton Burns, Professor, Wharton School of Business.

[8] 73 **Federal Register** 12763 (March 10, 2008).

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Full Committee Hearing on Health Insurer Consolidation—The Impact on Small Business

Thursday, October 25, 2007.
U.S. House of Representatives,
Committee on Small Business,
Washington, DC.

The Committee met, pursuant to call, at 9:30 a.m., in Room 2360 Rayburn House Office Building, Hon. Nydia Velázquez [Chairwoman of the Committee] presiding.

Present: Representatives Velázquez, Gonzalez, Cuellar, Altmire, Clarke, Ellsworth, Sestak, Higgins, Chabot, Bartlett, and Fallin.

Opening Statement of Chairwoman Velázquez

Chairwoman Velázquez. Good morning. I call this hearing to order to address Health Insurer Consolidation—The Impact on Small Business.

Access to health insurance is an area of concern to small businesses. The rising costs of health care are regularly cited by small firms as one of their biggest worries. Small businesses need to have choices in the health insurance marketplace. It is imperative that the marketplace is diverse and competition flourishes.

It is also critical that small medical providers are able to continue offering services. Physicians and other providers must be able to operate on a level playing field with health insurers and be reimbursed at fair rates. If not, quality of care will decline, and it is the patient who ultimately will suffer.

Consolidation in the health insurance industry is one area of special concern that has a direct impact on these issues. Because these mergers affect access to care and influence the quality of medical services, they command careful scrutiny by regulators. Unfortunately, the health insurance industry, like a number of other industries, has seen a general lack of enforcement of antitrust laws.

Earlier this year, The Wall Street Journal reported that the Federal Government has nearly stepped out of the antitrust enforcement business. While some mergers benefit consumers and increase the competitiveness of U.S. companies, others pose substantial risks to competition and innovation.

The health insurance marketplace has become increasingly concentrated in recent years. Consolidation has left small businesses with fewer choices, and physicians with diminished leverage to negotiate. In the majority of metropolitan areas, a single insurer now dominates the marketplace. If individuals and small businesses cannot get health coverage through the dominant insurer, they may not be able to find alternatives.

Recent mergers in the health insurance industry have tended to not generate efficiencies that have lower costs for small businesses or improved coverage. Premiums for small businesses have continued to increase without a corresponding increase in benefits. Consumers are facing increased deductibles, co-payments, and co-insurance, which have reduced the scope of their coverage.

When operating in highly concentrated markets, physicians often find they are stuck with take it or leave it contracts. The Department of Justice has recognized that physicians face special difficulties in dealing with health insurers—namely, it is very costly for them to switch from one insurer to another.

Replacing lost business for a physician by attracting new patients from other sources is very difficult in our current health care system. Physicians face barriers in attracting potential new HMO patients, since they are filtered through an HMO plan. Physicians struggle to maintain the quality of care in the

face of reduced reimbursement—a large administrative burden.

When physicians are forced to spend less time on each appointment, ultimately it is the patients that suffer. It is essential that competition remains vibrant in the health insurance marketplace. Not surprisingly, studies have found that when competition declines premium costs generally go up. The rising costs of health care are leading to greater numbers of uninsured, and less small businesses and individuals can afford to pay premiums.

Small businesses continue to be burdened by the high cost of health care. These rising costs of health insurance is one of the primary reasons the ranks of the 46 million uninsured Americans continue to grow. Tragically, 18,000 Americans lose their lives each year because of a lack of health insurance. We need to ensure that providers are on a level playing field, and small businesses and individuals have choices when it comes to health care.

I yield now to Ranking Member Chabot for his opening statement.

Opening Statement of Mr. Chabot

Mr. Chabot. Thank you very much, Madam Chairwoman. I want to apologize for being a couple of minutes late. It was one of those mornings where just too many things were scheduled and I just couldn't make it to everything on time. So I apologize.

And I want to thank the Chairwoman for holding this important hearing on the impact of mergers and increasing concentration in the health insurance market. This hearing continues this Committee's examination of the cost of health care on small businesses, both as purchasers of health care and as providers.

The Supreme Court has stated that ''The unrestrained interaction of competitive forces will yield the best allocation of our economic resources, the lowest prices, the highest quality, and the greatest material progress.'' In short, competitive markets represent the cornerstone of American progress and the success of our democracy. Antitrust laws were established to protect these precious values. By providing a mechanism to ensure that competition is not unreasonably hindered, the antitrust laws can be seen as further bracing the competition foundation of this country.

When mergers occur, that may reduce competition. It behooves the Justice Department or the Federal Trade Commission to closely assess the value of these mergers. That is particularly crucial in the context of health care. When the members of this Committee travel back to their districts, they are put face to face with constituents and small business owners that struggle every day to cope with the rising costs of obtaining or providing health care.

If the number of companies that supply health insurance continues to decrease, basic economics suggest that costs of obtaining health care coverage will increase. It then becomes vital to assess the impact of industry consolidation on small business owners who already have significant difficulty in obtaining health insurance coverage.

Today, we have witnesses that represent small business purchasers of health care who will inform the Committee of the increasing difficulty that they have in obtaining health care coverage at reasonable costs that are not made any easier as concentration in the industry increases. In addition to the obvious effects on purchasers of health care coverage, it is important to remember that many providers of health care are small businesses.

If concentration increases in the health insurance industry, then the multitude of providers are faced with the market power of a very large single purchaser that will be able to dictate prices and the service rendered. And if the prices do not cover the physician's costs, physicians will stop seeing patients, thus reducing choice even more. Of course, in addition to the bulwark of antitrust laws to protect competition, another avenue is to increase competition in the provision of health insurers.

This Committee, under the former Chairman, Mr. Talent, took the lead in promoting competition in the health insurance market by creating association health plans. The House, on a number of occasions—I believe six times in a five-year period—passed association health plan legislation that unfortunately died in the Senate.

The Chairwoman, Chairwoman Velázquez, should be commended for her courageous votes in support of association health plans. Given their potential to reduce costs and increase competition, I think the Committee seriously needs to investigate the resuscitation of that concept.

I look forward to a thoughtful discussion from the panel of witnesses, a very distinguished panel I might add that we have here today, and their ideas on how to protect and improve competition in the health insurance markets. And, again, I want to thank the Chairwoman for holding this important hearing, and I yield back my time.

Chairwoman Velázquez. Thank you, Mr. Chabot.

And we are going to start with our first witnesses, and let me just take this opportunity to thank all of you for being here today. We are going to have a timer in front of you. Green means you go, and then the red one means five minutes are up. Each one of you will have five minutes to make your presentation.

Dr. Plested, Dr. William Plested, is our first witness. He served as the President of the American Medical Association from June 2006 to June 2007. Dr. Plested is a cardiovascular surgeon and has been in private practice in Santa Monica, California, for more than 35 years. The American Medical Association is the nation's largest physician group and advocates on issues vital to the nation's health.

Thank you, and welcome.

Statement of Dr. William G. Plested, III, Immediate Past President, American Medical Association, Brentwood, California

Dr. Plested. Thank you, Madam Chair. My name is Bill Plested. I am a past president of the American Medical Association and a cardiac surgeon from Santa Monica, California. I want to thank you very kindly for inviting me to testify today and for holding a hearing on this exceedingly important issue—health insurance consolidation.

Consolidation in the health insurance market is critical to the AMA, because physicians are both patient advocates and small business owners. Physicians have primary responsibility for advocating for their patients, and they also are small business that want to provide health care insurance for their employees.

Physicians' ability to perform either of these vital functions, however, has been severely compromised by growing consolidation in the for-profit health insurance market. This consolidation has left physicians with little leverage against unfair contract terms that deal with patient care and little control over their own employees' rising health insurance premiums.

As you all know, our market performs optimally when consumers have a choice of competing products and services. Increasingly, however, choice in the health insurance market has been severely restricted as health plans have pursued aggressive acquisition strategies to assume dominant positions.

In the past decade, there have been over 400 mergers. Contrary to claims of greater efficiency and lower cost, these mergers in fact have led to higher premiums and decreased patient access to care. If the current trend continues, we fear it will lead to a health care system dominated by a few companies that, unlike physicians, have an obligation to shareholders, not to patients.

Our worst fears may be realized in Nevada where we have urged the Department of Justice to block the merger of the United Health Group and Sierra Health Systems. This merger would have a devastating impact on Nevada's patients and physicians and would reverberate throughout the health care system as a harbinger of unrestricted consolidation, would drastically reduce competition, and severely limit health insurance choice for employers and individuals in Nevada.

The United-Sierra merger would give United a 94 percent HMO market—share of the HMO market in Clark County and an 80 percent share of the HMO market in the entire State of Nevada. Nevada is in need of more competition, not less. The State currently ranks 47th in the country for access to care and 45th in access to physicians. This merger would push Nevada even further down these lists by exacerbating physician shortages.

Competition is essential to the delivery of high quality health care services, and this merger would serve only to further disadvantage an already challenged Nevada health care system. Consolidation is not benefiting patients. Health insurers are recording record high profits while patient health insurance premiums continue to rise. In fact, United and Wellpoint have had seven—seven years of consecutive double-digit profit growth that has ranged to 20 to 70 percent year after year.

In addition to compelling results of the AMA's annual competition study, many areas across the country exhibit characteristics typical of uncompetitive markets and growing monopolistic behavior.

These include significant barriers to entry for new health insurers, the ability of large entrenched insurers to raise premiums without losing market share, and the power of dominant insurers to coerce physicians into accepting unreasonable and unjust contracts.

The AMA believes that the Federal Government must take steps to address the serious public policy issues raised by unfettered health insurer consolidation. The current situation in Nevada is emblematic of the total absence of boundaries and enforcement currently applied to health plan mergers.

Therefore, we respectfully encourage this Committee to urge the DOJ to enjoin the merger of United and Sierra. By so doing, the Committee would be taking a meaningful step on behalf of America's patients towards correcting the existing inequities in the health care market.

Thank you.

[The prepared statement of Dr. Plested may be found in the Appendix on page 27.]

ChairwomanVelázquez. Thank you, Dr. Plested.

Our next witness is Mr. Robert Hughes. He is the President of the National Association for the Self-Employed. Mr. Hughes has managed his own accounting practice, Hall & Hughes, in Dallas/Fort Worth, for the past 20 years. NASE represents hundreds of thousands of entrepreneurs and microbusinesses and is the largest non-profit, non-partisan association of its kind in the United States.

Welcome.

Statement of Robert Hughes, President, National Association for the Self-Employed

Mr. Hughes. Thank you very much. It is our pleasure to be here this morning, and thank you, Ms. Chairwoman, for the invitation. As a representative of over 250,000 microbusinesses across the country, the NASE is committed to addressing the issue of affordable health coverage. I am here to tell you that health care costs and coverage premiums are adversely affecting microbusiness and impairing their ability to grow, compete, and succeed.

In addition to the high cost of health coverage, it has a serious personal impact on business owners and their employees. Oftentimes, the small business will sacrifice saving for retirement, putting money aside for their children's education, and addressing other personal needs to redirect funds to health coverage in order to stay insured. Of course, the worst result of mounting premiums is dropping coverage all together, which puts their business, their employees, their family, and themselves at risk when they face even a minor medical event.

In a 2005 survey, the NASE found that the majority of microbusiness owners, those businesses with 10 or less employees, do not have for themselves, nor do they offer, health insurance to their employees. Most alarming is the rate at which premiums for microbusinesses have been increasing. In a similar health study conducted in 2002, microbusinesses indicated the median premium increase for the year before was a little over 11 percent.

In 2005, microbusiness owners were experiencing a median premium increase of over 17 percent. Premium costs are the single most important factor that determines whether a business owner will insure himself and provide coverage for employees. Thus, the key question here today is if the increasing number of mergers among health insurers is playing a role in premium increases.

The self-employed and microbusinesses purchase health insurance in either the small group market or the individual market. The small group market is much more restrictive and regulated, which reduces, in our opinion, competition and availability. The NASE believes that minimization of insurance carriers due to consolidation, compounded with a concern of high risk in the small group segment, and excessive state regulation leave small business with minimal options to set up small group health plan, and is a factor contributing to high premiums in insurance markets.

A 2005 GAO report highlighted that the median market share of the largest carrier in the small group market was 43 percent, up 10 percent from just three years earlier. The five largest carriers in the small group market, when combined, represented three-quarters or more of the market in 26 of the 34 states that participated in the GAO study. The dominance of a few carriers in the small group market was also supported by studies from the AMA and leading health insurance experts.

How, then, is this lack of competition affecting insurance premiums? Well, let me give you a quote from one of our members, a freelance writer from Geneva, Illinois. ''The lack of competition among health insurers absolutely affects my insurance cost, as well as the quality and scope of coverage I can barely afford. Our state's non-competitive health care insurance environment, due to the monopoly of one or two carriers, places all of the leverage in the hands of the insurers. I can't vote with my feet and dollars if I have no alternatives from which to select.''

David, along with other microbusiness owners, will tell you that competition plays a central role in improving quality, spurring innovation, and keeping prices down. Research has indicated that health plans have increased premiums consistently above the rate of growth in costs. Cumulative, the premium increases for the last six years have exceeded 87 percent, which is more than three times the overall increase and medical inflation of 28 percent.

Why have insurance companies increased rates at these paces? I guess the simple answer is: they can. I believe that the current state regulatory climate plays an even more critical role in keeping costs high and impairing competition. State mandates are an issue. Some believe that state mandates increase insurance premiums by as much as 20 percent or even more.

Microbusiness owners have long been a proponent of market-based solutions for dealing with our health care system. However, competition without competitors will not deliver the desired incentive for health care improvement. The NASE urges Congress to address the disparities in individual and group markets. There are over 20 million non-employer firms in America. Certainly, they have access to, and choice of, health care coverage at a very limited basis, and that issue should be addressed.

Increasing insurer competition for the strong economic market segment, addressing state insurance regulation and mandates, and creating equitable federal tax treatment for these non-employer firms, are key to increasing access to affordable health coverage.

[The prepared statement of Mr. Hughes may be found in the Appendix on page 39.]

Chairwoman Velázquez. Thank you, Mr. Hughes.

Our next witness is Dr. James D. King. He is the President of the American Academy of Family Physicians. Dr. King is in private practice in the rural community of Selmer, Tennessee. He serves as the Medical Director of Chester County Health Care Services. The American Academy of Family Physicians is one of the largest national medical organizations with more than 94,000 members in 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, and Guam.

Welcome.

Statement of Dr. James D. King, President, American Academy of Family Physicians, Selmer, Tennessee

Dr. King. Thank you. On behalf of the Academy, I appreciate the concern about the effect of consolidated health plans on family physicians. We are members of the small business community, and also are professionals concerned about the effective delivery of health care to our patients.

Consolidation of health insurance plans have created a profound imbalance that hurts the ability of family physicians to negotiate contracts. This is harmful to our practices, but also means that many of our patients cannot find the primary care physicians who accept their insurance.

According to the industry analysis, between 1992 and 2006 the number of health insurance companies dropped from 95 to 7. The American Medical Association reports that 280 U.S. markets, at least one-third of the covered lives, are members of a single largest insurer in that market. In the U.S., only two insurance companies cover one-third of all insured Americans.

This market concentration gives health plans huge power to determine the coverage and payment terms. Let me give you a snapshot of how this affects the individual member. Nearly two-thirds of the patients of a solo family physician in Colorado are insured by one commercial payer. This situation occurred because of a merger. When this doctor made the case for a payment increase to keep pace with inflation, he was told by the insurance company, ''As a solo physician, you are the weakest economic unit and must take what we decide to give.''

That single statement bluntly and accurately describes our problem. As the economic heavyweights, health plans have no incentive to agree to physician requests. When a doctor doesn't agree to the terms of the contract, the plan just removes the

practice from the network. This means that patients essentially are denied access to their physicians.

In most cases, family doctors stick to their patients and sign untenable contracts. These contracts can affect many aspects of the practice. They dictate treatment decisions, require the use of special labs, require peer-to-peer requests for prior authorizations, demand completion of multiple-page forms, and delay payment while requiring responses to endless questions.

Many insurance contracts even allow the health plan to change the terms at any time without notifying the physician simply by posting new information on their web site. These business practices may increase the profit—may increase the profits of the insurance company, but they create enormous burdens for our small and solo practices and may hurt patient care.

As a result, more primary care physicians are driven to work in other settings, such as emergency rooms, in cash only practices. Some leave medical practice all together. Worst of all, payment rates and other contract terms are unrelated to quality of care.

Let me give you another quick story. A family physician who had been honored several times as the best physician in Arizona, who had more than 100 physicians as his patients, and who received the highest possible rating from his health plans for quality and efficiency, is taking more than $100,000 out of his savings each year just to keep his practice afloat. Despite his good work, he has been unable to negotiate higher payment rates with insurers.

Speaking more broadly, insurance plans consolidate threaten—consolidation threatens the potential for quality improvement in U.S. health care. For example, family medicine and other primary care specialties are advocating for the patient-centered medical home for all Americans. This medical home would be a practice that has been transformed to offer comprehensive, continuous, and coordinated care to our patients.

Experience with health systems based on primary care in other industrialized nations have demonstrated the exceptional value of a medical home in terms of quality and cost effectiveness. However, the success of the medical home depends on a long-term relationship between the physician and the patient. This relationship can be threatened, even destroyed, if insurance companies dictate the terms of the medical practice and limit our patients' freedom of choice.

The AAFP recommends changing antitrust laws so that physicians can be true market participants. The current statutes were established years ago during a very different competitive environment. Under these outmoded laws, physicians are barred from discussing the financial aspects of their practice with any entity unrelated to their practice. In contrast, insurance companies use market share and shared economic strength to carry out near monopolistic behavior.

AAFP commends the Committee for highlighting the significant problems resulting from health insurance consolidation. Family physicians, many of whom provide health care in small and solo practices in rural and other under served areas, feel the effect of the insurance consolidation as they attempt to negotiate in an environment that is stacked against them.

Again, I want to thank you for this opportunity to provide this testimony, and I look forward to answering your questions.

[The prepared statement of Dr. King may be found in the Appendix on page 44.]

Chairwoman Velázquez. Thank you, Dr. King.

And now the Chair recognizes Dr. Chabot for the purpose of introducing our next witness.

Mr. Chabot. Thank you very much, Madam Chair. I would like to introduce Mr. Office. He is the Vice President and General Counsel for Victory Wholesale Group, which is headquartered in Springfield, Ohio. Mr. Office is currently sponsorship chair and a board member of the Southwest Ohio Chapter of Association of Corporate Counsel.

Victory is a national wholesale distributor of grocery, health and beauty, and pharmaceutical products, and we are very pleased to have a fellow buckeye here this morning. And we welcome you and are looking forward to hearing from you, Mr. Office.

Thank you.

Statement of James R. Office, General Counsel, Victory Wholesale Grocers, Springboro, Ohio

Mr. Office. Thank you, Madam Chairwoman, Representative Chabot, and members of this Committee, for inviting us to discuss this important issue.

Victory Wholesale Group appreciates the opportunity to submit these comments to the Committee. The rising and out-of-control increases in health costs is a very important subject to us and every other small business across America. Health insurance consolidations are a large contributor to the increased health costs. One of Victory's largest expenses is for the health care coverage that it provides its employees.

Let me first tell you a little something about Victory. Some of you may know something about Victory through our involvement in and grants over the many years to the Congressional Hunger Foundation. Victory is a group of family-owned separate companies. The first was established in 1979. Our businesses include a wholesale grocery distributor, a food marketing company, a public warehouse business, a contract packaging business, a pharmaceutical wholesale distributor, a promotional items distributor.

Victory has a small number of employees and businesses in over 22 states, including Ohio, New York, Florida, California, Nevada, and the Commonwealth of Puerto Rico. Health insurance is the cornerstone of benefits that Victory provides its employees. Victory has tried different health care plan models, including fully insured, self-insured, PPOs, and HMOs, with the objective to reduce our health insurance care costs, or to control their increases.

Victory, having employees around the country, has not been able to find a single affordable health care plan that covers our separate businesses and employees on a national basis with health care provider networks that can compete with the regional health care providers.

In Victory's experience, insurance consolidation has led to the decreased competition and higher prices in the market. Let me elaborate. First, we have found that controlling health care costs is nearly impossible. The health care industry is both fragmented and concentrated. It is loaded with administrative costs, it is inefficient, it is not measured. Accounting for quality and for value just simply doesn't exist.

Next, we have found that the deepest discounts and best coverage networks are offered on a regional basis. We have found that the markets where we have employees are dominated by a few large insurance carriers. Carriers with a smaller market share in these regions generally have weak hospital and doctor networks, or smaller discounts. Plans with fewer hospitals and doctors to choose from are simply not very popular with employees, and, therefore, employers.

We have found that many of the markets where we have employees have several dominant affiliate health care provider networks or groups. These are groups of one or more hospitals and physicians that have combined into an affiliation or network, and they rent these networks to insurance companies and employers.

A few dominant health care provider networks in a region can and do use their enhanced market clout to resist negotiating discounts with insurance carriers and employers. We have found that the dominant insurance carriers in the region generally price health care plans for small businesses through what I would describe as experience rating, i.e. healthy groups get fairly high prices, and unhealthy groups get very high prices.

Insurance carriers have an uncanny way of learning the health of a group, even if they don't insure your group. We have found that a single serious or major health event within a group will virtually eliminate competitive bids and result in much higher than average cost increases as well as dictated structural changes in your benefits to the group's plan at renewal.

We have found that faced with the increasing health care costs, employers and employees are faced with very few choices. I would call it a menu of the lesser of evils. These options include: 1) increasing the amount of premium that each employee pays each month; 2) increasing the co-payments or deductibles; 3) imposing changes on unhealthy lifestyles, like charging smokers or obese people more premiums; 4) incorporating higher deductibles and lower benefits into the plan design, and sometimes using like a health savings account or health reimbursement accounts, which in the end is just a cut in benefits, reducing or modifying or eliminating benefits, and providing financial incentives or disincentives to use the modified benefits.

And lastly, an option that I find is becoming a lot more common today, which is small businesses are just eliminating offering employer-provided health insurance. Historically, small businesses make up the

backbone of our nation's employers. Collectively, small businesses employ the largest number of people in the United States. Yet because each company is small, we have almost no market clout to help bring changes to our health care system.

Health insurance consolidation has in part created a take it or leave it market for small businesses. Reduced competition through consolidations both of insurance carriers and health insurance carrier provider networks has led to increased pricing, fewer choices for small businesses and their employees.

[The prepared statement of Mr. Office may be found in the Appendix on page 49.]

Chairwoman Velázquez. Mr. Office, your time is up, and they just called for a vote. So I would like to move to the next witness. And for that purpose, I recognize Mr. Bartlett.

Mr. Bartlett. Thank you very much. Mr. Scandlen wasn't in his chair when the Committee began, I suspect for the same reason I wasn't in my chair. I think we both probably came down 270 this morning. I left two hours and 15 minutes before the Committee, because I really wanted to be here on time. But, unfortunately, this was my second longest commute in 15 years of commuting that 50 miles from Frederick, Maryland, down to the Hill. So thank you very much for braving the traffic and being here this morning.

Greg Scandlen is from Hagerstown, Maryland. He is the founder of Consumers for Health Care Choices, a non-partisan, non-profit membership organization aimed at empowering consumers in the health care system. He is considered one of the nation's experts on health care financing, insurance regulation, and employee benefits.

He testifies frequently before Congress and appears on such television shows as The O'Reilly Factor, NBC Nightly News, and CNN. He has published many papers on topics such as health care costs, insurance reform, employee benefits, individual insurance programs, HSAs, HRAs, and every aspect of consumer-driven health care. Mr. Scandlen was the president of the Health Benefits Group and the founder and executive director of the Council for Affordable Health Insurance. He also spent 12 years in the Blue Cross/Blue Shield system, most recently as the director of state research at the national association.

Thank you very much for joining us today.

Statement of Greg Scandlen, President, Consumers for Health Care Choices

Mr. Scandlen. Thank you, Mr. Congressman. Thank you, Madam Chairman, and members of the Committee. I was going to ask you, Mr. Bartlett, for a note excusing my tardiness, but you have made that unnecessary. Thank you very much. I do apologize for being late, though.

I know you have a vote pending, so I will be very quick. I just want to share a couple of thoughts with you. One is that concentration of—in this market is not an accident, and it is not an inherent part of the small group market. When I was with the Blue Cross/Blue Shield Association, I was—one of my responsibilities was working with the National Association of Insurance Commissioners on their small group reform proposals back in the late 1980s.

And I can tell you, at the time the Commissioners and their staff made it very clear that these reforms would do nothing to lower cost, nothing to increase access. Their purpose was to stabilize the market, and that was their language.

And what they meant by that was they thought there was too much competition in the small group market. It was confusing for employers, and they would prefer it if there were only three or four competitors in every market. That would be easier to understand, and, frankly, probably easier for the regulators to regulate, with a smaller number of companies.

So I think the situation we have today is the direct consequence of regulatory interference with the market. Many of those regulations were well intentioned, but I think they all add to cost and complexity in this market, and many, many smaller companies decided they simply could not afford to comply with the various state and changing from year to year regulations that they had to follow. So they simply got out of the business.

Many of them were life insurance companies, and they sold off their health books to larger carriers that were—that are better able to afford the compliance costs associated with all of these regulations. And what we have today, and as the other witnesses have mentioned, we have coverage that is overpriced, inefficient, unaccountable, inconvenient, and incomprehensible to the consumer.

We need—these are, I believe, the characteristics of a non-competitive market. There is insufficient competition. If you don't like what—if you don't like what one company offers, it really doesn't matter because everybody else is offering the exact same thing at the exact same price.

This market is sorely needing innovation and efficiency. The insurance industry is notoriously inefficient. And back in the 19th century when it comes to technology and computer support, larger is not better, larger results in monopolization and a lack of innovation. And there have been some proposals that have come before the Congress that I think would help here.

One is the interstate purchase of coverage. So if I am living in Maryland, and there is a better product available in Pennsylvania, I would like to be able to purchase that product, and I don't see why I can't. Another possibility would be an alternative federal charter, so insurance companies could become like banks. They could decide whether they would like to be regulated by the states or by the Federal Government.

And if they choose the states, they are confined to doing business in the state that is regulating them. If they choose a federal charter, they can operate nationally, and Mr. Office and other multistate's smaller employers would be able to purchase the same product for all of their employees.

So I think solutions are there, but I think decisive action is needed, because this market is collapsing.

Thank you very much.

[The prepared statement of Mr. Scandlen may be found in the Appendix on page 56.1

Chairwoman Velázquez. Thank you very much.

The Committee stands in recess and will resume right after the vote.

[Recess.]

Chairwoman Velázquez. Gentlemen, the Committee is called back to order. I know the Ranking Member is on his way here.

I would like to address my first question to Dr. Plested. We all agree that it is critical that physicians are in a position to be advocates for their patients. I understand that some physicians are concerned that important decisions relating to care of patients has been taken away from them by burdensome rules imposed by insurers.

My question is, Dr. Plested, have these rules gotten more onerous as the insurance industry has consolidated? And how do these policies affect the doctor-patient relationship? Is the quality of care impacted?

Dr. Plested. Thank you, Madam Chair, and the answer to the question is unequivocally yes, quality of care is affected. The basis for patient care throughout history has been based on what we call the patient-physician relationship. And both of those partners in that relationship have the same interest, and that is the health of the patient. Regardless of how you change that, if you put anyone in between that, whether that be an insurer or an employer, if anyone else gets in between those two parties in that relationship, their interest is different.

With an insurer, the CEO of every insurance company's primary interest is his shareholders, not the patient. So that it can just—it just follows by reason that any time we dilute that basic fundamental relationship it is not in the interest of patients. And when the insurer can bludgeon the physician with paperwork, with unnecessary rules and regulations and unilateral—contracts that can be unilaterally amended, all these things that you have heard in the testimony today, that directly affects the care that those patients can get.

Chairwoman Velázquez. Have you conducted any survey among doctors regarding that doctor-patient relationship as a result of consolidation?

Dr. Plested. Specifically related to consolidation, I don't know that we have, but we have all kinds of data about what has happened to the relationship, and consolidation is an integral part of that. And it has all been detrimental.

Chairwoman Velázquez. Thank you, Dr. Plested.

Dr. King, the difficulty physicians have faced with the insurance industry is in large part based upon the size of the companies and the market share they command. Some insurance companies have grown so large that physicians have found it difficult to negotiate a contract with favorable terms. What has been the experience of your members? Are they being forced to accept take it or leave it contracts?

Dr. King. The short answer is yes. I practice in a small town in Selmer, Tennessee, west Tennessee in a rural area. And so we only have one or two major industries to begin with, and when we only have one insurance product they have as much as 30, 40, 50 percent of the patient base for us to take care of.

And I have been taking care of these patients for 20 years, and all of a sudden I

am dealing with an insurance company that has offered a contract that I know is inappropriate, that is going to interfere with the quality of care that I need to provide. And it is tough for me even to consider making a living and supply jobs for my employees. I am a small business, too. I have got—we have seven physicians, we have 39 employees that we need to supply their health care, we need to provide them with pay.

So I am a small business, but I am also providing the health care. And if I choose to eliminate 20 percent of the patients I have been taking care of I don't think too many businesses can do that. And we are seeing that every day, that they are having to either accept a contract that is not acceptable, that we know we can't make it work, or give up 30 percent of the patients we have been caring for over years.

Chairwoman Velázquez. Thank you.

Mr. Hughes, the cost of the same health benefits are likely to be higher for a small firm than for a large firm. How does this make for an unleveled playing field for your members when it comes to negotiating health insurance plans? And with increased concentration in the industry, do you expect this disparity to grow?

Mr. Hughes. The micro-employer is in a very difficult position, because they are facing regulation that places them into the small group market. So even though we may have a very small employer group of only one or two people, they are thrown into the group market that is accordingly rated based on that group experience.

What we are seeing is a significant premium rate increases as a result of that. The small group simply doesn't have a chance to compete the way the larger group does in the marketplace.

Chairwoman Velázquez. What can be done to remedy this disparity?

Mr. Hughes. Well, one of the factors involves federal taxation. It is clear that taxes affect social behavior, and it is also clear that in the Tax Code today all businesses receive an exemption for the payment of income taxes and payroll taxes on premiums that they provide for their employees for health insurance coverage.

The exception to that rule is for the sole proprietor, the self-employed individual. That particular individual does not receive a payroll tax deduction for these health insurance premiums, and accordingly must pay then 15 percent of payroll taxes on those premiums. The effect is that if the tax law were amended to be equitable to all business owners, self-employed proprietors could then reduce their premium costs by 15 percent across the board.

Chairwoman Velázquez. Thank you, Mr. Hughes.

Mr. Office, you mentioned that insurance companies may entice employers by offering low coverage rates to new groups, and then dramatically increase premiums or change benefits on renewals. You mentioned that this behavior often chases competition out of the market, thus allowing the insurer to later increase prices. What have your experiences been with such enticement rates, and what can your business do to respond to dramatically increased renewal premiums when you only have one or two other insurers to choose from?

Mr. Office. If you have any suggestions, I am open.

[Laughter.]

That is the thousand-pound gorilla that we face. You will get an insurance carrier that will come into the market. And to buy market share they will offer discounts, and most small businesses look at price. That is a critical factor. And once they have done that, you are moving—your numbers stay the same.

In any community, you have a certain number of people that are insured, and you are just moving them from this bucket to this bucket, and so this area over here loses those people and they push out of the marketplace. Once that is done, then they do increase the premiums. Or if, structurally, they say, ''Well, we will keep your premium the same, but here is the policy you are going to have next year,'' it is going to have fourth-tier pharmaceutical or it is going to have higher co-pays and deductibles, or ''we are not going to cover, you know, these procedures,'' or whatever.

But as a small business, you react to what they present to you. You don't really—and you don't have a market to go look for to say, ''Well, what About an alternative?'' So any questions are welcome.

Chairwoman Velázquez. Sure. Mr. Scandlen—and I will recognize Mr. Bartlett—I heard when you spoke about the direct consequences of state regulations that it really encourages concentration. And I know how frustrating it is. You said that one of the avenues could be interstate purchase of health insurance or federal charter.

But even without going into that, what role or how do you assess the Department of Justice role, or lack of oversight, regarding antitrust laws when it comes to consolidation?

Mr. Scandlen. I think there is an important role for antitrust enforcement here. Clearly, when there are only two or three players, when they actually merge together, that is a concern. But I, quite frankly, think that is—that is something for the—it is not a universal solution, because if there is a company that would like to sell its business to another company, because the first company simply is not profitable, then antitrust enforcement there strikes me as inappropriate.

So I guess I am reluctantly embracing antitrust in selected cases. And, for instance, in the United-Sierra merger in Nevada, my organization was quite concerned about that and communicated with the Department of Justice encouraging them to reject that merger, because here were two very strong viable companies that consumers we couldn't see would derive any benefit from—from the merger. And if consumers are not benefiting from it, then I think it—and could actually be disadvantaged by it, then I think it is a problem. But I don't see it as the number one solution to this issue.

Chairwoman Velázquez. Thank you.

Now I recognize Mr. Chabot.

Mr. Chabot. Thank you, Madam Chair.

Dr. Plested, I will start with you if I can. You noted that investigating consolidation regulators have tended to focus on physicians rather than on health insurers. Could you expand upon that a little bit? Why do you think that is so, and what should be done about that?

Dr. Plested. Well, I certainly can't testify to the motivation of the DOJ, but I can testify to what has happened, and it would appear that the doctor—an individual doctor is much less able to withstand an assault from the DOJ. And it makes their rate of caring actions that they succeed on exceedingly high, because it—an individual physician just can't withstand this.

A huge insurer certainly can, and I think the point that the Chairman just raised is exceedingly important. What can we do, or what can this Committee do? And the answer to that is it is time to draw a line in the sand and say, ''This is going to stop.'' The answers are complex, as everybody has said, and they aren't going to be solved in this testimony or this action. But to put down a marker and say this Committee from—to the DOJ, we have got to make it crystal clear that this is going to stop, and get this merger enjoined, would be the necessary first step that could be made.

Mr. Chabot. Thank you, Doctor.

Mr. Hughes, if I could turn to you next. In your written testimony, you urged Congress to address the inequitable tax treatment of health insurance for individuals purchasing coverage on their own. I really couldn't agree more with you on that, and, in fact, today I am reintroducing a bill that I have introduced in previous Congresses. Unfortunately, we haven't gotten it passed into law yet, but we are going to continue working.

It is called the Health Insurance Affordability Act, and it is legislation that would provide a tax deduction for gross income—or, excuse me, from gross income for the health insurance costs of an individual taxpayer, the taxpayer's spouse, and dependents as well. In other words, you know, large corporations obviously can fully deduct the health care costs for their employees, but an individual basically pays for their premiums and doesn't get to claim those for the most part. And a lot of small businesses also aren't able to do so, at least to 100 percent.

Could you explain how a deduction like that would help individuals in small firms?

Mr. Hughes. Well, again, going out in the individual market, as you indicate, those health insurance premiums are paid with aftertax dollars, meaning that their purchasing power has been eroded significantly. And if there is a way, a mechanism that would allow for the deduction of health insurance premiums across the board, whether employee or business or small business owner, then my sense is that it is going to have the impact of bringing more people into the marketplace, creating a marketplace that has in effect lower ultimate cost of premiums, and theoretically that should increase competition, because more insurers should go after that market niche. So we wholeheartedly support that type of legislation.

Mr. Chabot. Thank you very much.

Dr. King, in your written testimony you state that ''As a result of concentration of

insurers, many family practice physicians in small or solo practices have little leverage in negotiations with health plans.'' Could you discuss that briefly, and what effect that ultimately has?

Dr. King. I will be glad to. In fact, I can give you an example of my own practice. As I stated earlier, I practice in a small town in west Tennessee. We have a large employer there, and they changed insurances for cost, as mentioned earlier. There was no physician in my county in the network that insurance product provided. And they not only didn't come at us with a contract we wouldn't accept, they didn't offer us one at all.

Under their arrangement, all they had to do was have a doctor within 45 miles of the plant that signed up. Then, they met all the requirements they felt like they needed to do. And they wouldn't even sit down and talk to us.

And my patients had a choice to make that year. They came and saw me and we tried to work out a way that they could pay me for their services and we didn't bill their insurance, or they drove 45 miles. So they were doing back and forth for an entire year until they finally changed that plan. They chose not to make any changes at all.

So not only do they come at us and we can't negotiate, and this was every physician in the county, that, you know, they have enough, but for—with our family physicians, most of us are solo practitioners or small groups, anywhere from one doctor to maybe four or five. We have absolutely no leverage.

Mr. Chabot. Thank you very much, Doctor.

Mr. Office, you mentioned that your companies maintain multiple health insurance plans to foster competition, and to help reduce costs. How much of an impact does this make on your overall health insurance costs?

Mr. Office. I would be happy to share some numbers with you, which I came prepared to. But we range—for example, single only coverage in one geographic location where I understand there is some competition, and I am not involved in the buying there, but they are paying $177 a month per employee. And in the area that I work in, we are paying $570 a month. So there is a $400 difference. For family coverage, the difference is $450 versus $1,400. So you can see that there could be significant differences.

Now, because of the regionalization I can't go to, say, New York or Puerto Rico where I might get a lower rate and buy a plan for, you know, south—you know, southern Ohio where we have most-you know, a large group of people, or Florida. We just can't get that, because we end up with networks. We are not going to buy a plan and pay a premium and then get a network where there is no doctors in that area. Our employees will—there will be a mutiny.

[Laughter.]

Mr. Chabot. Okay. Thank you.

Mr. Office. So, you know, if you are going to pay the premium, you have to have hospitals and doctors in that network. And you don't want to make people have to change those choices. So there can be a big difference.

Mr. Chabot. One of our colleagues, John Shadegg from Arizona, has introduced a plan over the years relative to health insurance that would allow people to go across state lines and would undo some of the difficulties there are with various states having different requirements and regulations and keeping companies out that aren't necessarily in a particular state. So it is something that we probably ought to look at.

Finally, Mr. Scandlen, in your written testimony you discuss the need for innovation in the types of health insurance coverage that are offered, such as health savings accounts, for example. Howwould small businesses benefit from greater innovation? And is there anything that you would suggest this Committee or Congress do in that area to be of assistance?

Mr. Scandlen. I am not sure how you could encourage innovation other than just encouraging competition. I mean, I think it is the same thing. And there are some very, very interesting things out there. One of the things I mentioned in the testimony was the special needs plans under Medicare, and that is sort of an experiment that—that I think so far is having very good results, very interesting results.

These are insurance companies that focus on the needs of the chronically ill, and one of the reasons they are able to do that is because they receive—Medicare pays out risk-based premiums, so they are receiving premiums that enable them to service that special population.

Mr. Chabot, if I could very quickly also, in terms of the—your tax deduction for individuals, I think that is a marvelous idea, and I think it is worth remembering that up until 1983 individuals could deduct their health insurance premiums as part of the medical expense deduction, as long as, in 1983, it didn't exceed three percent of their AGI.

That was raised to 5.5 percent, and then in '87 raised to 7.5 percent. and we have seen, as that has eroded, the individual market has just gone in the tank, because that tax advantage has been withheld from people that buy individual coverage.

Mr. Chabot. Thank you very much.

I yield back, Madam Chair.

ChairwomanVelázquez. Thank you.

Mr. Gonzalez.

Mr. Gonzalez. Thank you very much, Madam Chairwoman. The issue of availability and affordability—and it transcends big business, small business, every American situated one way or another. The interesting thing, I think the government has a tremendous stake in making sure there is robust competition, because the future does hold more government involvement in assisting individuals, small business, families, in acquiring health insurance.

So availability and affordability looms large, whether it is the President's tax proposal, whether it is what Mr. Chabot was talking about, associated health plans, subsidizing premiums and such. All that is for naught if we don't have a healthy insurance industry that will provide choice, which will drive down cost, obviously. At least that is what I have used as the big picture.

Some of the things that we have covered here, though, I am wondering if it really does in any way assist in achieving that final goal of availability and affordability. I will say that I think our first witness alluded to—I guess it is the United acquisition of Sierra. Is that right? And maybe that should be a marker. Maybe we ought to pay a lot of attention to that, and put everybody on notice. And I think that point is well taken.

One thing that Dr. King pointed out—and I am thinking all short of that—is, how do we get all of the different participants fully empowered?

Chairwoman Velázquez. Will the gentleman suspend? Mr. Gonzalez. Yes.

Chairwoman Velázquez. I just would like to ask unanimous consent, and the Ranking Member agreed with me, for every member to have the opportunity to ask one question. This is going to be quite—a very disruptive session today. Right now on the floor they are going to be calling procedural votes.

So in light of that, I will give the opportunity for everyone to ask one question, since I know that some of the members of the panel have flights to catch.

Mr. González. I will be real brief, then. I will just ask Dr. King, you pointed out that maybe empowering physicians to negotiate, where presently they are prohibited by law—that was my understanding of your testimony—if you could just kind of elaborate a little bit on that, and how you see that would be beneficial to the big question of availability and affordability.

Dr. King. Well, in allowing us to be able to negotiate, or at least talk to each other, you know, about the different insurance products, about the contracts that we are being offered to make sure that we can compare, we talk doctor talk, we don't talk lawyer talk. And we need to have the ability to share information and share problems and concerns as we look at the contracts, so that we can make decisions that is the best interest for our patients.

And then, if we can negotiate that, I can see how, you know—you know, I don't know about the—you know, the consolidation of all of the insurance companies and all, but I see how the health care of my patients can improve, and we can arrive at a better plan that we take away the barriers that I try to help take care of my patients with that, so that physicians won't desert. We don't have enough primary care physicians out there. They are going into different arrangements. They are going into ERs, they are going into urgent cars, which is not where we want our patients, and they are going into markets that don't include insurance.

So we have—just to get the physicians out in the rural areas and taking care of patients like we need to, they have got to be able to negotiate and make it work.

Mr. González. Thank you. I yield back.

Chairwoman Velázquez. Thank you. Mr. Bartlett.

Mr. Bartlett. Thank you very much. You know, we don't really have much of a health care system in our country. We have a really good sick care system. It is the best in the world, and I would hope that we might move a little more toward a health care system, so maybe we wouldn't need such a big sick care system.

One of the problems in rising health care costs is the fact that health care—I am using

that word euphemistically—health care is about the only thing that most people shop for in our country and never ask the price. So they are not a careful shopper.

And one of the things that I wanted to personally do, so that I could become a careful shopper—and these were in the days before health savings accounts, which really makes a person a careful shopper, and I am a big fan of those. But absent that, when I retired 20-couple years ago, I wanted to find a catastrophic policy with a $5,000 deductible. See, I think that these little nickel and dime things just wear you out and enormously increase the cost of health care.

I can pay the first $5,000. That might be a little painful, but what I can't pay is that second half million. And I think that many of the policies drop. You have a cap at about a half million. I couldn't find a catastrophic policy with a $5,000 deductible. That ought to be a pretty cheap policy, shouldn't it? And wouldn't it make people a really careful shopper? And why don't you—why doesn't the industry offer that kind of a policy?

Mr. Scandlen. I think they are available now. And if I am not mistaken, the AMA has offered a $10,000 deductible policy to its members for a long time. So I think if you were shopping today, Mr. Bartlett, you would be able to find that.

Mr. Bartlett. Madam Chair, I would like you to encourage our people here who provide our options for health care to include that as one of the options.

Chairwoman Velázquez. Definitely.

Mr. Bartlett. Thank you very much.

Chairwoman Velázquez. Ms. Clarke.

Ms. Clarke. I want to thank our Chairwoman and our Ranking Member. This is probably one of the most critical issues facing Americans today. As small businesses, as health care providers, as consumers, we are all in a quandary and involved in the same meltdown together.

There are so many questions that I would like to ask, but I want to get an understanding of some of what is happening out there to physicians' claims. I want to ask for anyone on the panel—I have heard that health insurers have employed coercive tactics, such as re-pricing of physician claims, which results in non-contracted physicians receiving less than contracted physicians for the same service. What is re-pricing exactly, and what other manipulative practices have health insurers used to undermine a physician's bargaining power? Dr. Plested?

Dr. Plested. Re-pricing is a very interesting phenomenon. It is complex, but there have been contracts let by entities that do not provide any care. They just round up a large number of contracted doctors who will accept a price, and there are literally hundreds of these contracted groups. There are now entities called re-pricers that take every physician and match that physician by computers with every contract that they have signed for every service that they provide.

And so that when you get a bill from your insurance company that has six things on it, that may be a sign by a re-pricer to six or seven different contracts, so that he gets the lowest one. It is complex, but it is a very Machiavellian type of system.

There are also the things that the insurers can do that have been mentioned that they can unilaterally amend a contract. They can change the amount that they agreed to pay you. They can unilaterally put in screens. They have computerized screens that will reduce the amount that they pay for things that it doesn't pay the physician to charge—to try to challenge each of these. There are a multitude of monopolistic behaviors that are allowed by this.

Chairwoman Velázquez. Thank you. And I want to take this opportunity to thank all the witnesses. And I am sorry we do not have more time to spend with you, but I am very, very happy that we really had an opportunity to have this dialogue on an issue that is so important, not only for small businesses and small practitioners, but also for consumers in America.

The Small Business Committee will call on federal antitrust regulators to play a more active role in ensuring that health insurance markets remain competitive, and, to that effect, I will ask the Ranking Member to join with me in sending a letter to the Department of Justice. I will also—I already discussed with Chairman Conyers on the House floor, when we went to vote, asking him to do a joint hearing between Judiciary and Small Business to examine specific mergers that may be pending.

I know, Mr. Scandlen, that you said that this is just one aspect of a bigger picture, but we have to make sure that there is proper oversight and examination before these mergers can proceed.

With that, I thank all the witnesses for your participation. I ask unanimous consent that members have five legislative days to enter statements and supporting materials into the record, and this Committee is adjourned.

[Whereupon, at 11:45 a.m., the Committee was adjourned.]

Statement of the Honorable Nydia M. Velázquez, Chairwoman,United States House of Representatives, Committee on Small BusinessFull Committee Hearing: ''Health Insurer Consolidation—The Impact on Small Business''

October 25, 2007.

I call this hearing to order to address ''Health Insurer Consolidation—The Impact on Small Business.''

Access to health insurance is an area of concern to small businesses. The rising costs of health care are regularly cited by small firms as one of their biggest worries. Small businesses need to have choices in the health insurance marketplace. It is imperative that the marketplace is diverse and competition flourishes.

It is also critical that small medical providers are able to continue offering services. Physicians and other providers must be able to operate on a level playing field with health insurers and be reimbursed at fair rates. If not, quality of care will decline and it is the patients who ultimately will suffer.

Consolidation in the health insurance industry is one area of special concern that has a direct impact on these issues. Because these mergers affect access to care and influence the quality of medical services, they command careful scrutiny by regulators.

Unfortunately, the health insurance industry, like a number of other industries, has seen a general lack of enforcement of antitrust laws. Earlier this year, the Wall Street Journal reported that ''the federal government has nearly stepped out of the antitrust enforcement business.''

While some mergers benefit consumers and increase the competitiveness of U.S. companies, others pose substantial risks to competition and innovation.

The health insurance marketplace has become increasingly concentrated in recent years. Consolidation has left small businesses with fewer choices and physicians with diminished leverage to negotiate with plans. In the majority of metropolitan areas, a single insurer now dominates the marketplace. If individuals and small businesses cannot get coverage through the dominant insurer, they may not be able to find alternatives.

Recent mergers in the health insurance industry have tended to not generate efficiencies that have lowered costs for small businesses or improved coverage. Premiums for small businesses have continued to increase without a corresponding increase in benefits. Consumers are facing increased deductibles, co-payments and co-insurance which have reduced the scope of their coverage.

When operating in highly concentrated markets, physicians often find they are stuck with take it or leave it contracts. The Department of Justice has recognized that physicians face special difficulties in dealing with health insurers—namely, it is very costly for them to switch from one insurer to another.

Replacing lost business for a physician by attracting new patients from other sources is very difficult in our current health care system. Physicians face barriers in attracting potential new HMO patients since they are filtered through an HMO plan.

Physicians struggle to maintain the quality of care in the face of reduced reimbursements and large administrative burdens. When physicians are forced to spend less time on each appointment, ultimately, it is patients that suffer.

It is essential that competition remains vibrant in the health insurance marketplace. Not surprisingly, studies have found that when competition declines, premium costs generally go up. The rising costs of healthcare are leading to greater numbers of uninsured as fewer small businesses and individuals can afford to pay premiums.

Small businesses continue to be burdened by the high costs of health care. The rising cost of health insurance is one of the primary reasons the ranks of the 46 million uninsured Americans continue to grow. Tragically 18,000 Americans lose their lives each year because of a lack of health insurance.

We need to ensure that providers are on a level playing field, and small businesses and individuals have choices when it comes to healthcare.

I yield to Ranking Member Chabot for his opening statement.

Opening Statement

Hearing Name: Health Insurer Consolidation—The Impact on Small Business

Committee: Full Committee

Date: 10/25/2007

Opening Statement of Ranking Member Chabot

''I would like to thank the Chairwoman for holding this important hearing on the impact of mergers and increasing concentration in the health insurance market. This hearing continues this Committee's examination of the cost of health care on small businesses—both as purchasers of health care and as providers.

''The Supreme Court has stated that 'that the unrestrained interaction of competitive forces will yield the best allocation of our economic resources, the lowest prices, the highest quality, and the greatest material progress* * *' In short, competitive markets represent the cornerstones of American progress and the success of our democracy.

''The antitrust laws were established to protect these precious values. By providing a mechanism to ensure that competition is not unreasonably hindered, the antitrust laws can be seen as further bracing the competitive foundation of this country.

''When mergers occur that may reduce competition, it behooves the Justice Department or the Federal Trade Commission to closely assess the value of those mergers. That is particularly crucial in the context of health care.

''When the members of this Committee travel back to their districts, they are put face-to-face with constituents and small business owners that struggle every day to cope with the rising costs of obtaining or providing health care. If the number of companies that supply health insurance continues to decrease, basic economics suggests that costs of obtaining health care coverage will increase. It then becomes vital to assess the impact of industry consolidation on small business owners who already have significant difficulty in obtaining health care coverage. Today, we have witnesses that represent small business purchasers of health care who will inform the Committee of the increasing difficulty that they have in obtaining health care coverage at reasonable costs that are not made any easier as concentration in the industry increases.

''In addition to the obvious effects on purchasers of health care coverage, it is important to remember that many providers of health care are small businesses. If concentration increases in the health insurance industry, then the multitude of providers are faced with the market power of a very large single purchaser that will be able to dictate prices and the service rendered. And if the prices do not cover, for example, costs associated with obtaining malpractice insurance, providers will opt of accepting coverage from consumers reducing choice even more.

''Of course, in addition to the bulwark of the antitrust laws to protect competition, another avenue is to increase competition in the provision of health insurance. This Committee under the former Chairman, Mr. Talent, took the lead in promoting competition in the health insurance market by creating association health plans. The House on a number of occasions passed association health plan legislation that then died in the Senate. The Chairwoman should be commended for her courageous votes in support of association health plans. Given their potential to reduce costs and increase competition, I think the Committee seriously needs to investigate the resuscitation of that concept.

''I look forward to a thoughtful discussion from the panel of witnesses and their ideas on how to protect and improve competition in the health insurance markets.

''With that, I yield back.''

Statement of the Honorable Jason Altmire House Committee on Small Business Hearing''Health Insurer Consolidation—The Impact on Small Business''

October 25, 2007.

Thank you, Chairwoman Velazquez, for calling today's hearing to examine the impact health insurer consolidation will have on small business. Consolidation of health insurers has been on the rise in recent years. leaving fewer health care provider choices for small businesses. This committee consistently hears that cost is the number one factor when determining if a small business will offer health care coverage. As more and more health care providers merge, they are able to exert more bargaining power, leaving small businesses with limited options.

In my home state of Pennsylvania, the state's two largest health insurers, Highmark Inc. and Independence Blue Cross, announced a plan to combine the two organizations. The state is currently going through the review process and while the US. Department of Justice reviewed the terms of the consolidation and determined that it raises no antitrust or other anti-competitive issues under federal law, I am concerned that this consolidation may limit competition and drive up health insurance prices for small businesses, If the merger goes through, it is estimated that the new organization will control at least 53 percent of the state's health insurance market,

If health insurer mergers continue to follow the trend of resulting in fewer options and higher costs, more small businesses will face barriers to health care. Now and in the future as mergers are considered, it is important to ensure that choices in the health insurance marketplace remain so access to health care is not compromised.

Madam Chair, thank you again for holding this important hearing today. I yield back the balance of my time.

Statement of the American Medical Association to the Committee on Small Business, United States House of Representatives

Re: Health Insurer Consolidation—The Impact on Small Business

Presented by William G. Plested III, MD

October 25, 2007.

Division of Legislative Counsel

202–789–7426

The American Medical Association (AMA) appreciates the opportunity to present testimony to the Committee on Small Business on health insurer consolidation and its impact on small business. We commend Chairwoman Velázquez, Ranking Member Chabot, and Members of the Committee for your leadership in recognizing that the dramatic and ongoing consolidation of the health plan industry has severely diminished, if not eliminated, competition among the insurance companies to the detriment of patients and their treating physicians.

Consolidation in the health insurance market is critical to the AMA because our members are both patient advocates and small business owners. In an environment where health insurers have increasing control over patient care and decreasing accountability, physicians have primary responsibility for advocating that their patients receive the appropriate medical care covered by their health insurance. Their ability to do so, however, has been severely compromised where dominant insurers force them to adhere to contracts that create significant obstacles to providing the best possible patient care. Physicians are also vulnerable to dominant health insurer practices as small business owners. The majority of physician practices are small businesses that are attempting to provide health insurance coverage to their employees in the face of substantial health insurance premiums. The growing consolidation in the health care market and the extreme imbalance that has resulted has meant that physicians have little leverage in either of their roles as health care advocates or purchasers of insurance.

A market performs optimally when consumers have a choice of competing products and services. Increasingly, however, choice in the health care market has been severely restricted due to rampant health insurer consolidation. Large health plans have pursued aggressive acquisition strategies to assume dominant positions in various markets across the country. In fact, a few health insurers now overshadow the majority of health care markets. In the past decade alone there have been over 400 mergers.[1] These mergers have led to higher premiums and increasing problems with patient access to care. If the current trend continues, it will inevitably lead to a health care system dominated by a few publicly traded companies that operate in the interest of shareholders rather than patients.

Our worst fears may be realized in Nevada where we have urged the U.S. Department of Justice (DOJ) to block the merger of UnitedHealth Group (United) and Sierra Health Systems (Sierra). Should this merger be consummated, it will have a devastating impact on Nevada's patients and physicians and will reverberate throughout the health care system as a harbinger of future unrestricted consolidation. The AMA's Competition Study, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets*, as well as the presence of several characteristics typical of uncompetitive markets, further supports the notion that competition has been and will continue to be severely undermined in Nevada and nationwide.

We believe that the federal government must take steps to correct the current

[1] Irving Levin Associates, *The Healthcare Acquisition Report,* 2001–2006 Editions.

imbalance in the market and address the deceptive, noncompetitive conduct of large, dominant health insurers. The boundaries of acceptable consolidation in the health insurance market must be reexamined and enforced so that current threats to the health care system are blocked and future harmful consolidation is deterred. Thus, we encourage the House Small Business Committee to urge the DOJ to take steps to enjoin the merger of United and Sierra in Nevada. By doing so, the Committee would be taking a meaningful step towards correcting the existing inequities in the health care market.

United-Sierra Merger

We believe that a vital component to assuring a competitive marketplace is antitrust enforcement against anticompetitive mergers and exclusionary conduct. Over the past several years, however, the DOJ has not brought any cases against anticompetitive conduct by health insurers and has challenged only two mergers since 1999, requiring onJy moderate restructuring.[2] Currently, the AMA is urging the DOJ to prevent the United-Sierra merger, which will create an exceptional level of concentration in Nevada, particularly in Clark County, resulting in higher prices, less service, and lower quality of care.

The United-Sierra merger will drastically reduce competition for the provision of health insurance to employers and individuals in Nevada. The market share for Sierra and United combined in Nevada is 48 percent, while in Clark County the combined United-Sierra market share is 60 percent.[3] For Health Maintenance Organization (HMO) based insurance, should the merger proceed, United will have an 80 percent market share of all HMOs in Nevada and a 94 percent market share of the HMO market in Clark County.[4] According to the Herfindahl-Hirschman Index (HHI), the typical measure of market concentration, the Nevada and Clark County markets would be significantly above the threshold for being considered ''highly concentrated.'' [5] Indeed, the level of concentration would be unprecedented. Where, as here, a merger produces an entity that is so disproportionately larger than any of its competitors, there is a considerably increased likelihood that the entity will be able to raise prices, decrease compensation, and reduce quality without fear of meaningful competitive market responses.

Nevada is in need of more competition, not less. It cannot afford a merger that will further restrict patient access to care. Nevada currently ranks 47th in the country for access to care, 51st in quality of care, last for immunization coverage for children under 3, 49th in access to nurses, 44th for women's mortality rates, and 45th in access to physicians—approximately 25 percent below the nationwide median, with one of the lowest physician-to-population ratios in the country.[6] The United-Sierra merger would push Nevada even further down the access to quality medical care list by exacerbating physician and staffing shortages through decreased compensation and increased use of unreasonable contracts. Competition is essential to the delivery of high quality health care services. Its absence in the face of this merger will serve only to further disadvantage the already challenged Nevada health system.[7]

Competition in the Health Insurance Market

As noted above, the competitive health care market has been steadily eroding. Health insurers have become significantly more concentrated and have used their power to the disadvantage of patients and physicians. As mentioned above, over the past 10 years there have been over 400 mergers involving health insurers and managed care organizations.[8] In 2000, the two largest health insurers, Aetna and UnitedHealth Group (United), had a total combined membership of 32 million people. Due to aggressive merger activity since 2000, including United's acquisition of California-based PacifiCare Health Systems, Inc., and John Deere Health Plan in 2005, United's membership alone has grown to 33 million. Similarly, WellPoint, Inc. (Wellpoint), the company born of the merger of Anthem, Inc. (originally Blue Cross Blue Shield of Indiana), and WellPoint Health Networks, Inc. (originally Blue Cross of California), now owns Blue Cross plans in 14 states. In 2005, WellPoint acquired the last remaining Blue Cross Blue Shield plan, the New York-based WellChoice. Consequently, WellPoint now covers approximately 34 million Americans.[9] Together, WellPoint and United control 36 percent of the U.S. commercial health insurance market.

AMA Competition Study

The effects of consolidation are particularly striking at the local and regional levels, illustrated by the AMA's Competition Study, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets.*[10] Every year for the past six years, the AMA has conducted the most in-depth study of commercial health insurance markets in the country. The study analyzes the most current and credible data available on health insurer market share for 313 Metropolitan Statistical Areas (MSA5) and 44 states.[11]

In addition to its exhaustive geographic reach, the study analyzed the product market in three ways—considering only HMO products; considering only Preferred Provider Organization (PPO) products; and considering HMO and PPO products combined. For each, the study calculated the HHI,[12] which measures the competitiveness of a market overall,[13] and, applying the 1997 Federal Trade Commission/Department of Justice Horizontal Merger Guidelines (Merger Guidelines), classified them as ''not concentrated,'' ''concentrated,'' or ''highly concentrated.''[14] The results form the most extensive and accurate portrayal of the health insurance market to date. And they confirm that in the majority of health care markets competition has been severely undermined.

With regard to market concentration (HHI), the study found the following:

- In the combined HMO/PPO product market, 96 percent (299) of the MSAs are highly concentrated.
- In the HMO product market, 99 percent (309) of the MSAs are highly concentrated.
- In the PPO product market, 100 percent (313) of the MSAs are highly concentrated.

With regard to market share,[15] the study found the following for each product market:

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[2] *See United States* v. *UnitedHealth Group Inc.,* Case No. 1:05CV02436 (D.D.C. Dec. 20, 2005), available at *http://www.usdoj.gov/atr/cases/f213800/213815.htm; United States* v. *Aetna,* Revised Competitive Impact Statement, Civil Action 3–99CV1398–H (N.D.Tex, 1999), available at *http://www.usdoj.gov/atr/cases/f2600/2648.htm.*

[3] Nevada State Health Division

[4] *Id.*

[5] Merger Guidelines S. 1.51.

[6] *Nevada Strategic Health Care Plan,* Report of the Legislative Committee on Health Care, Nevada Revised Statute 439B.200, February 2007; *http://system.nevada.edu/Chancellor/University/index.htm*; *http://www.commonwealthfund.org/statescorecard/statescorecard_show.htm?doc_id=495871; http://hrc.nwlc.org/.*

[7] United claims that efficiencies produced by the merger will outweigh anticompetitive harms. As a general matter, however, efficiencies from health insurance mergers have not been passed on to patients. This is evidenced by the United PacifiCare merger, which has not resulted in lower premiums or better services for subscribers.

[8] Irving Lewvin Associates, *supra.*

[9] WellPoint Health Networks and Anthem, Inc., merged in 2004 The merged entity, WellPoint, Inc., is nearly double the size of either entity.

[10] The AMA focused on state and MSA markets because health care delivery is local, and health insurers focus their business and marketing practices on local markets.

[11] Significantly, state-level data is often misleading because in many states health insurers do not compete on a state-wide basis.

[12] The HHl is the sum of the squared market shares of each firm in the market. The more competitive the health insurance market, the lower the HHI, The less competitive the health insurance market, the higher the HHI. The largest value the HHI can take is 10,000 when there is a single insurer in the market. As the number of firms in the market increases, however, the HHI decreases. For instance, if a market has four firms, each with a 25 percent share, the HHI would be 10,000 divided by 4, which equals 2500. The HHI would continue to decrease with additional firms in the market.

[13] The HHI is not a measure specific to any one firm, although it is a function of each firm's market share, The DOJ uses the HHI when evaluating the impact of a merger or acquisition on the competitiveness of a market.

[14] Markets with an HHI of less than 1000 are classified as ''not concentrated.'' The DOJ and FTC will generally not restrict merger activities in these markets. Markets with an HHI between 1000 and 1800 are classified as ''concentrated.'' Under the Merger Guidelines, a merger in one of these markets that raises the HHI by more than 100 points may raise significant competitive concerns. Markets with an HHI above 1800 are classified as ''highly concentrated.'' A merger in a ''highly concentrated'' market that raises the HHI by more than 50 points may raise significant competitive concerns, and a merger that raises the HHI more than 100 points is presumed to be anti-competitive.

[15] The AMA measures market share of health insurers by enrollment. The combined HMO/PPO market share of an insurer is the sum of that insurer's HMO and PPO enrollment, divided by the total HMO and PPO enrollment in the market, multiplied by 100. HMO market share is that HMO's enrollment, divided by total HMO enrollment in the market, multiplied by 100. Similarly, a PPPO's market share is that PPO's enrollment, divided by total PPO enrollment in the market, multiplied by 100.

For the combined HMO/PPO product market:

- In 96 percent (299) of the MSAs, at least one health insurer has a market share of 30 percent or greater.
- In 64 percent (200) of the MSAs, at least one health insurer has a market share of 50 percent or greater.
- In 24 percent (74) of the MSAs, at least one health insurer has a market share of 70 percent or greater.
- In 5 percent (15) of the MSAs, at least one health insurer has a market share of 90 percent or greater.

For the HMO product market:

- In 98 percent (306) of the MSAs, at least one health insurer has a market share of 30 percent or greater.
- In 64 percent (201) of the MSAs, at least one health insurer has a market share of 50 percent or greater.
- In 37 percent (117) of the MSAs, at least one health insurer has market share of 70 percent or greater.
- In 16 percent (49) of the MSAs, at least one health insurer has a market share of 90 percent or greater.

For the PPO product market:

- In 97 percent (304) of the MSAs, at least one health insurer has a market share of 30 percent or greater.
- In 76 percent (238) of the MSAs, at least one health insurer has a market share of 50 percent or greater.
- In 36 percent (112) of the MSAs, at least one health insurer has a market share of 70 percent or greater.
- In 9 percent (28) of the MSAs, at least one health insurer has a market share of 90 percent or greater.

This study establishes, unequivocally, that competition has been undermined in hundreds of markets across the country. Sadly, the ultimate consumers of health care—patients—are not the ones benefiting from the consolidation. To the contrary, patient premiums have risen dramatically without any expansion of benefits, while many health insurers have posted record profits.

Market Characteristics Indicating Absence of Meaningful Competition

In addition to high market share and market concentration, many health care systems across the country exhibit characteristics typical of uncompetitive markets and growing monopoly and monopsony power. There are significant barriers to entry for new health insurers in these markets. Large, entrenched health insurers are able to raise premiums without losing market share. And dominant health insurers are able to coerce physicians into accepting unreasonable contracts.

Barriers to Entry Into the Market

Barriers to entry are relevant when determining whether a high market share threatens competition in a specific market. Where entry is easy, even a high market share may not necessarily translate into market power, as attempts to increase price will likely be countered by entry of a new competitor. On the other hand, where entry is difficult, a dominant player is able to sustain profitability amid significant price increases without fear of competition.

Most markets across the country currently display substantial barriers to entry. Start-up health insurers must meet costly state statutory and regulatory requirements, including strict and substantial capitalization requirements. To do this, they must have sufficient business to permit the spreading of risk, which is difficult, if not impossible, in markets with dominant health insurers. Indeed, it would take several years and millions of dollars for a new entrant to develop name and product recognition with purchasers to convince them to disrupt their current relationships with the dominant health insurers. The DOJ underscored the significant obstacles associated with entering certain health insurance markets in *United States* v. *Aetna,* when it noted, ''[n]ew entry for an HMO or HMO/POS plan in Houston or Dallas typically takes two to three years, and costs approximately $50,000,000.[16] Such market conditions represent insurmountable barriers for new entrants.

Premium Increases

The ability of dominant health insurers to raise premiums and remain profitable is another sign of excessive market power. This practice harms small businesses, exacerbates access to care problems, and contributes to the alarming numbers of uninsured. When premiums rise, many employers stop providing coverage, reduce the scope of benefits provided, and/or ask employees to pay a higher share of the overall premium. In some cases, small businesses must choose between growth and the provision of health insurance. Even when employers continue to offer health plans, increases in premiums, deductibles, and co-payments lead many workers to forego their employer-sponsored health insurance. In fact, according to a survey by the Agency for Healthcare Research and Quality, employee health plan participation at large companies declined from 87.7 percent to 81 percent between 1996 and 2004.[17] This declining coverage puts an enormous strain on the health care system and leads to otherwise avoidable expenditures for emergency care and other medical services.

The past several years have been marked by increasing health plan premiums and profits. In 2007, premiums for family coverage increased by 6.1 percent.[18] In 2006, premiums increased by 7.7 percent and in 2005 premiums rose by 9.2 percent [19]—in all years outpacing overall inflation by 3.5 to a full 5.7 percent.[20] Cumulatively, the premium increases during the last six years have exceeded 87 percent, with no end in sight. This is more than three times the overall increase in medical inflation (28 percent) and more than five times the increase in overall inflation (17 percent) during the same period.[21] This has directly led to an increase in the number of uninsured, which currently exceeds 47 million, or one in seven Americans. Notably, these increased premiums have not led to corresponding increases in medical benefits.

Health insurers seek to deflect attention from their huge profits by falsely asserting that physician payments are driving recent premium increases. Such claims are baseless. While premium levels have risen by double-digit amounts, physician revenues have fallen. The median real income of all U.S. physicians remained flat during the 1990s and has since decreased.[22] The average net income for primary care physicians, after adjusting for inflation, declined 10 percent from 1995 to 2003, and the net income for medical specialists slipped two percent.[23] In contrast, recent reports on health insurer profits show that the profit margins of the major national firms have experienced double-digit growth since 2001. In fact, United and WellPoint have had seven years of consecutive double-digit profit growth that has ranged from 20 to 70 percent year-over-year. Thus, it is shareholders and health insurance executives, not physicians, who are profiting within an anticompetitive market at patients' expense.

Physician Bargaining Power

Growing market domination of health insurers is undermining the patient-physician relationship and eviscerating the physician's role as patient advocate. Physicians have little-to-no bargaining power when negotiating with dominant health insurers over contracts that touch on virtually every aspect of the patient-physician relationship. This is particularly troublesome given physicians' critical role as patient advocates in an environment where health insurers have increasing control and limited accountability regarding decisions that affect patient treatment and care.

Many health insurer contracts are essentially ''contracts of adhesion.'' Contracts of adhesion are standardized contracts that are submitted to the weaker party on a take-it or leave-it basis and do not provide for negotiation. Many contracts of adhesion contain onerous or unfair terms. In the health insurer context, these terms may include provisions that define ''medically necessary care'' in a manner that allows the health plan to overrule the physician's medical judgment and require the lowest cost care, which may not be the most optimal for the patient. They also frequently require compliance with undefined ''utilization management'' or ''quality assurance'' programs that often are

[16] *United States* v. *Aetna.* Revised Competitive Impact Statement, Civil Action 3–99CV1398–H (N.D.Tex, 1999), available at *http://www.usdoj.gov/atr/cases/f2600/2648.htm.*

[17] Fuhrmans, Wall Street Journal, 8–25–06.

[18] *Employer Health Benefits, 2007 Annual Survey,* The Kaiser Family Foundation and Health Research and Education Trust.

[19] Strunk, et al, ''Tracking Health Care Costs,'' *Health Affairs* (Sept. 26, 2001), W45.

[20] Jon Gabel, et al, ''Job-Based Health Insurance in 2001: Inflation Hits Double Digits, Managed Care Retreats,'' *Health Affairs* (Sept/Oct. 2001), at 180.

[21] Kaiser/HRET: Employer Health Benefits Survey, 2005 Annual Survey.

[22] Physician Income: A Decade of Change, Carol K. Kane, PhD, Horst Loeblich, *Physician Socioeconomic Statistics* (2003 Edition), American Medical Association.

[23] Losing Ground: Physician Income, 1995–2005, Ha T. Tu, Paul B. Ginsburg, *Center for Studying Health Systems Change Tracking Report No. 15* (June 2006).

nothing more than thinly disguised cost-cutting programs that penalize physicians for providing care that they deem necessary.

In addition to interfering with the treatment of America's patients, many health insurer contracts make material terms, including payment, wholly illusory. They often refer to a ''fee schedule'' that can be revised unilaterally by the health insurer and is not provided with the contract. In fact, many contracts allow the health insurer to change any term of the contract unilaterally. In addition, these contracts frequently contain such unreasonable provisions as ''most favored payer'' clauses and ''all products'' clauses.

''Most favored payer'' clauses require physicians to bill the dominant health insurer at a level equal to the lowest amount the physician charges any other health insurer in the region. This permits the dominant health insurer to guarantee that it will have the lowest input costs in the market, while creating yet another barrier to entry. ''All products clauses'' require physicians to participate in all products offered by a health insurer as a condition of participation in any one product. This often includes the health insurer reserving the right to introduce new plans and designate a physician's participation in those plans. Given the rapid development of new products and plans, the inability of physicians to select which products and plans they want to participate in makes it difficult for physicians to manage their practices effectively.

Despite the improper restrictions and potential dangers these terms pose, physicians typically have no choice but to accept them. Any alleged ''choice'' is illusive given that choosing to leave the network often means terminating patient relationships and drastically reducing or losing one's practice. Physicians simply cannot walk away from contracts that constitute a high percentage of their patient base because they cannot readily replace that lost business. [24] In addition, physicians are limited in their ability to encourage patients to switch plans, as patients can only switch employer-sponsored plans once a year during open enrollment, and even then they have limited options and could incur considerable out-of-pocket costs.[25]

Health insurers have even employed tactics to coerce non-contracted physicians who have managed to preserve some level of bargaining power, into signing contracts. For example, a number of large health insurers are refusing to honor valid assignments of benefits executed by a patient who receives care from a non-contracted physician. This means that health insurers, rather than pay the non-contracted physician directly, pay the patient for the services provided. Similarly, many health insurers engage in the practice of ''repricing'' of physician claims (including proprietary claims edits and the use of rental network PPOs [26]), which results in non-contracted physicians receiving less than contracted physicians for the same service.[27] These and other manipulative practices are clearly designed to undermine any residual bargaining power a physician practice might have, and further depress physician payments.

Monopsony Power

In a substantial number of markets across the country, dominant health insurers have the potential to exercise monopsony power over physicians to the detriment of consumers. Monopsony power is the ability of a small number of buyers to lower the price paid for a good or service below the price that would prevail in a competitive market. When buyers exercise monopsony power in the labor market, they exploit workers in the sense of decreasing fees below their true market value. Monopsony power also has an adverse impact on the economic well being of consumers as it results in a reduced quantity of the firms' products available for purchase.

In the health insurance industry, health insurers are both sellers (of insurance to consumers) and buyers (of, for example, hospital and physician services). As buyers of physician services, health insurers are acting as monopsonists—lowering the prices they pay to a point at which physicians are forced to forego investments in new technology, reduce staff and services, and even leave the market, all of which inevitably lead to increased waiting times and reduced access to care. Moreover, because health plans have posted considerable profits without decreasing premiums, the benefits of their ability, as a buyer of services, to lower the prices they pay suppliers (physicians), have not been passed on to consumers.

In fact, the DOJ has recognized that a health plan's power over physicians to depress reimbursement rates can be harmful to patients—the ultimate consumers of health care. Such was the basis for the DOJ's decision in 2005, requiring United to direst some of its business in Boulder, CO as a condition of approving its merger with PacifiCarc.[28] Specifically, the DOJ noted that because physicians cannot replace ''lost business'' quickly, the point at which physicians are locked-into a managed care contract is significantly lower than for other businesses.[29] In the United-PacifiCare merger, the DOJ found that where the merged company would control 30 percent of physician revenues, the plan could exercise monopsony power over physicians in a manner that would lead to a ''reduction in the quantity or quality of physician services provided to patients.'' [30]

Health insurers with monopsony power can use the economic benefits of reduced reimbursement in medical care to protect and extend their monopoly position and increase barriers to entry into the market. Thus, rather than producing ''efficiencies,'' increasing monopsony power in health care markets across the country causes a number of distortions in the market that harms patients by reducing access to care.

Antitrust Law and Policy Restrictions on Physicians

Ironically, rather than focus on the health insurance industry, which, as noted above, has boasted record profits and increased premiums corresponding to recent waves of consolidation, regulators have focused on physicians, the least consolidated segment of the health insurance industry. This is confounding given the current health insurer environment. Since April 2002, the FTC has brought at least 25 cases against physician groups based upon contracting arrangements with health insurers.[31] All but one of the groups chose to settle with the FTC rather than engage in a protracted, financially devastating legal battle.[32] These actions have had a chilling effect on physician practices,

Due to the significant burdens and responsibilities associated with ''financial integration,'' the only other option currently available to physicians is so-called ''clinical integration,'' as described by the DOJ/FTC in their 1996 *Statements of Antitrust Enforcement Policy in the health Care Area.* The agencies, however, have provided little guidance on what exactly constitutes clinical integration, other than to make clear that meeting the standard requires several years of development and millions of dollars of infrastructure investment; an option that is simply not feasible for the vast majority of physicians who are not part of a large group

[24] The DOJ, in its 1999 challenge of the Aetna/Prudential merger recognized that there are substantial barriers to physicians expeditiously replacing lost revenue by changing health plans. It also noted that this imposes a permanent loss of revenue. *United States* v. *Aetna*, Revised Competitive Impact Statement, Civil Action 3–99CV1398–H (N.D. Tex, 1999), available at: *http://www.usdog.gov/atr/cases/f2600/2648.htm.* The DOJ reiterated this position in its challenge to the UnitedHealth Group/PacifiCare merger. See *United States* v. *UnitedHealth Group Inc.*, Case No. 1:05CV02436 (D.D.C. Dec. 20, 2005), available at *http://www.usdoj.gov/atr/cases/f213800/213815.htm.*

[25] *See id.*

[26] A ''rental network PPO'' exists to market a physician's contractually discounted rate primarily to third-party payers, such as insurance brokers, third-party administrators, local or regional PPOs, or self-insured employers. Rental network PPOs may also rent their networks and associated discounts to entities such as ''network brokers'' or ''repricers'' whose sole purpose is finding and applying the lowest discounted rates, often without physician authorization.

[27] ''Repricing'' practices and rental networks also deprive contracting physicians of the benefits of their contracts when they result in payment below the contracted fee schedule, These tactics make it difficult for physicians to administer their practices and undercuts efforts to make the health care system more transparent.

[28] *See United States* v *UnitedHealth Group Inc.,* Case No. I :05CV02436 (D.D.C. Dec. 20, 2005), *available at http://www.usdoi.gov/atr/cases/f213800/213815.htm.*

[29] *See id.*

[30] *Ibid.*

[31] *See* FTC website at *http://www.ftc.gov/os/actions.shtm.*

[32] At the same time, the FTC has been extremely restrictive regarding the ability of physicians to jointly negotiate with insurers, approving only three arrangements. *See http://www.brownandtotand.com/publish/en/about/news_room/ftc_ information-Par-0005-DownloadFile.tmp/4.5FTCNotice.pdf(Brown* and Toland); *http://www.ftc.gov/bc/adops/070618medsouth.pdf* (MedSouth); *http://www.ftc.gov/os/closings/staff/070921finalgripamcd.pdf* (Greater Rochester Independent Practice Association).

practice, hi fact, the few endeavors that have been approved have been limited to large practices consisting of hundreds of physicians.

Given the increasing power and size of health insurers and the corresponding decrease in physician bargaining power, the policy landscape that has resulted in aggressive antitrust enforcement actions against physicians should be reexamined. Physician joint contracting can make it possible to obtain ready access to a panel of physicians offering broad geographic and specialty coverage. In addition, non-exclusive physician networks pose no threat to competition. Physicians can independently consider contracts presented from outside the network. Likewise, health insurers that cannot reach a ''package deal'' with a physician network can contract directly with its physicians or approach a competing network. Rather than restraining trade, the physicians will have created an additional option for purchasers—a pro-competitive result. Thus, the AMA believes that less restrictive approaches to physician joint contracting will have pro-competitive benefits such as greater flexibility, more innovation, and ultimately a better health care system.

Conclusion

It is time for the federal government to address the serious public policy issues raised by the unfettered consolidation of health insurance markets. The current situation in Nevada is emblematic of the total absence of boundaries and enforcement applied to health plan mergers. The AMA's Competition Study and the presence of market characteristics that typify dominant market power, further prove that competition has already been undermined in markets across the country. This has real, lasting negative consequences for the delivery of health care in this country. Thus, we strongly urge the House Small Business Committee to lay the groundwork for reversing this dangerous trend toward a marketplace controlled by a few health insurance behemoths by encouraging the DOJ to enjoin the United-Sierra merger.

Testimony of Robert Hughes, President, The National Association for the Self-EmployedHouse Committee on Small Business ''Health Insurer Consolidation—The Impact on Small Business''

October 25, 2007.

As the representative of over 250,000 micro-businesses across the country, the National Association for the Self-Employed (NASE) is committed to addressing the issue of affordable health coverage, which is the number one concern of our members and all small businesses in our nation. I am hear to tell you that rising health care costs are significantly hurting micro-business and impairing their ability to grow. compete and succeed. in addition, the high Cost of health coverage has serious personal consequences on business owners and employees. Often times our members will sacrifice saving for retirement, putting money aside for their children's education, and addressing other personal needs to redirect funds to health care Costs in order to stay insured. Of course, the worst result of mounting premiums is dropping coverage all together which puts their business, their family and themselves at risk should they face a medical crisis.

The number of Americans living without health coverage rose in 2006 to 47 million, an increase of almost 16 percent over the previous year. in a 2005 survey, the National Association for the Self-Employed (NASE) found that a majority of micro-business owners, those businesses with ten or less employees, do not have for themselves nor offer a health insurance plan to their employees. The smallest companies are most impacted, with only 14% of companies that grossed less than $50,000 annually having health insurance compared to 70% among those grossing more than $500,000 yearly. Most alarming is the rate at which premiums for micro-businesses have been increasing. In a similar health survey conducted by the NASE in 2002, micro-businesses indicated the median premium increase from the year before was a little over 11%. However, in 2005 micro-business owners were experiencing a median premium increase of over 17%, a substantial escalation.

Premium costs are the single most important factor that determines whether a business owner will insure himself and provide coverage for his/her employees. Most importantly, if a micro-business owner cannot afford insurance for himself and family, he/she will not likely provide health benefits to employees. The issue of choice or lack there of in earner options plays a role in terms of it's affect on price. Thus, the key question here today is if increasing consolidation amongst health insurers are playing a role in premium increases.

First, I would like to highlight that the self-employed and micro-businesses purchase health insurance in two markets: the small group market and the individual market. The definition of a small group is determined by each state, though most define it as one with 50 or fewer employees. Firms in this size range looking to offer access to health insurance for their employees will look to the small group market for insurance options. However, of those currently insured, the majority of self-employed and micro-businesses have purchased individual health coverage. While micro-businesses surveyed by the NASE indicate that they believe it is an employer's responsibility to assist their employees with health coverage, the high cost to both the business and the employee in terms of cost sharing are the most significant barriers impeding business owners from providing employees with coverage. Micro-businesses may assist their employees with their health care costs by setting up a Health Reimbursement Arrangement (HRA), contributing to an HSA or increasing their take home salary to help employees pay for individual insurance but a large percentage are not setting up an employer-based small group health plan.

The health insurance options and number of carriers differ in the individual and small group market. Most states have a suitable number of insurance carriers with an array of coverage options within the individual market. The small group market is much more restrictive in terms of competition and availability. The NASE believes that minimization of insurance carriers due to consolidation compounded with the concern of high risk in this small group segment and excessive state regulation leaves small businesses with minimal options to setup a small group health plan and is a factor contributing to high premiums in insurance markets.

A 2005 GAO report highlighted that the median market share of the largest carrier in the small group market was 43%, up 10% from 2002. The five largest carriers in the small group market, when combined represented three-quarters or more of the market in 26 of co the 34 states that participated in the GAO study compared to only 19 of 34 states in 2002. Blue Cross and Blue Shield is by far the giant in this sector, growing to 44% market share in all participating states. To support the GAO findings, we see similar depictions of lack of competition from a 2006 AMA study on the nation's health insurance markets which found that 95 percent of markets had a single insurer with a market share of 30 percent or greater and 56% of markets had a single insurer with a market share of 50 percent or greater.

From the data we see a notable dominance of a few carriers in the small group market. Thus, the next question that begs an answer is how this lack of competition is affecting premiums. Any micro-business owner will tell you that competition plays a central role in improving quality, spurring innovation and keeping prices down, Thus, the NASE feels the lack of competition may be a vital element in high premium costs in the small group sector. James C. Robinson, PhD, a professor of health economics at the University of California, Berkeley, School of Public Health, in an article for Health Affairs revealed that between 2000 and 2003 health plans raised premiums consistently above the rate of growth in costs. For investors in private insurance companies, returns were tremendous and Robinson states, ''the non-profit Blue Cross and Blue Shield plans enjoyed financial results equal to or better than those of their for-profit counterparts.'' (Health Affairs, Volume 23, Number 6) According to previous AMA testimony, in 2005 premiums for employment-based insurance policies increased by 9.2 percent—outpacing overall inflation by a full 5.7 percent. Cumulatively, the premium increases during the last six years have exceeded 87 percent, which is more than three times the overall increase in medical inflation (28 percent) and more than five times the increase in overall inflation (17 percent) during the same period. (AMA Testimony to Senate Judiciary Committee, 2006) Hence, we see that premiums have consistently increased in the face of minimal competition.

However, the NASE feels that the state regulatory climate plays an even more critical role in keeping costs high and impairing competition. State mandates on coverage in all markets increase the cost of basic health coverage between from a little less than 20% to more than 50% depending on the state. The Council for Affordable Health Insurance

has identified that there are currently over 1,600 mandates in our health care system. While mandates can make health insurance more comprehensive, they also make it more expensive by requiring insurers to pay for certain health services that consumers previously funded out of their own pockets. It is likely that insurers will push that added mandate cost into premium rates. The cost that excessive mandates add to health coverage can mean the difference between a micro-business owner just purchasing coverage for himself or also providing it to his employees. Additionally, the regulatory and statutory conditions in states have created barriers that make it difficult for new carriers and new products to expand into markets. Without new carriers or competing insurance products, price will remain high when one insurance carrier dominates a market.

Micro-business owners have long been a proponent of market-based solutions for dealing with our health care system. However, ''competition without competitors will not deliver the desired incentives for health care improvement.'' (Health Affairs, Volume 23, Number 6) We must increase competition in the small group market to encourage lower premium costs which will spur micro-businesses to seek to expand coverage to their employees. We must address excessive state mandates and restrictive climates hurting innovation. Additionally the NASE urges Congress to address the disparities in the individual market since the majority of self-employed business owners are purchasing individual health insurance. Currently there are over 20 million non employer firms, in which the owner must seek health coverage on the individual market. Thus, addressing the inequitable tax treatment of health insurance for those purchasing coverage on their own will also be a key step forward to increasing access to health coverage.

The self-employed and micro-business community continues to be the backbone of our nation's economy, therefore the NASE urges you to take immediate action to alleviate the massive health cost burden laid at their feet in order to ensure their survival and that of our nation's economy.

Statement of the American Academy of Family Physicians

Submitted to the Committee on Small Business Concerning the Impact of Health Insurance Consolidation on Small Business
Presented By James D. King, MD, FAAFP, President
October 25, 2007.

Thank you, Chairwoman Velazguez and Rep. Chabot. and the members of the Small Business Committee for the opportunity to participate in this hearing today. On behalf of the 93,800 members of the American Academy of Family Physicians, we applaud your deep concern for how the consolidation of health insurance plans affects family physicians as members of the small business community, as professionals and as small employers concerned about the effective delivery of health care.

As described by the American Medical Association, the merging and consolidation of health insurance plans has created a profound imbalance adversely affecting the ability of physicians to negotiate contracts with insurers to the detriment of physician practices. This, in turn, has led to the inability of many of our patients to locate a primary care physician who can accept their insurance and still maintain financial viability.

The trend toward consolidation is persistent. The industry analysts of investment bank Shattuck Hammond reported that between 1992 and 2006, the number of competitor consolidations resulted In 95 different payers shrinking to merely seven. According to the AMAs 2005 report on Competition in Health Insurance, in 280 U.S. markets, 30 percent or more of HMO and PPO lives are covered by the single largest insurer in that market. Looking at the U.S. as a whole, only two insurers cover a third of all commercially insured lives. This market concentration gives these health plans excessive power in determining the conditions of coverage, payment and practice.

Effects on Family Physicians

How does this consolidation affect family physicians? Let me give you just two examples. In the Dallas/Fort Worth area, a 3-physician group practice has a payer mix consisting of principally three payers: 30 percent United Healthcare, 28 percent Blue Cross and 18 percent Aetna. A solo physician practice in Colorado has 60 percent of the patients his practice insured by one commercial payer, a situation that occurred as a result of a merger.

As a result of similar concentrations of payers, many family physicians in small or solo practices have little leverage in their negotiations with the health plans. As the physician in Colorado noted when he attempted to make the case for a payment increase that at least would cover inflation, he was told by the representative of a large insurance company, As a solo physician, you are the weakest economic unit and must take what we decide to give.'' Another family physician noted that because small and solo practices cannot compare financial data before they sign a contract, they find out afterwards that their payment rates are substantially less than those of larger groups that can negotiate better terms.

Further, health plans have no incentive to accede to any of a physician's requests when the plan has the unilateral ability to remove the physician from the network for not agreeing to the terms of the contract and effectively denying that physician's patients access to the practice. Physicians in this situation have little choice but to sign whatever contract is offered by the health plans. Many practices find it financially impossible to sacrifice a significant part of their patient base to take a stand against untenable contract provisions.

Declining Payment Rates and Terms of Agreement

The health plans use this negotiating power created by this pattern of consolidation to dictate smaller payments and onerous terms. In California, the mergers of PacitiCare Health Systems with United Healthcare and WellPoint Health Networks/ Blue Cross of California with Anthem, Inc. have produced fee cuts of as much as 20 to 30 percent. According to a California Medical Association survey of 500 state medical practices, 20 percent of 1,500 affiliated physicians had terminated a Blue Cross contract or planned to do so. By forcing practices to accept these cuts or lose their patients, health plans are making it more difficult for patients to secure the health care they need.

It is not only payment rates that cannot be negotiated, but the terms of the agreement cannot be challenged. Health plans affect every segment of the practice of medicine and compel treatment decisions; for example, by requiring practices to use specific labs; by determining which tests may be performed in the office; by demanding the completion of multiple-page forms that reduce the amount of time a physician has available for treating patients; and by delaying payments by requiring responses to seemingly endless trails of questions.

These requirements may enhance the profits of the insurer but they create significant burdens for practices and patients. For example, a family physician in practice outside a metropolitan area in Ohio contracts with a health insurer who changed its national laboratory arrangement that originally included two companies down to a single, exclusive laboratory arrangement. This change caused the insurer's enrollees to drive to the local hospital for lab services rather than walk across the hail from the physician's office to a duly qualified reference lab. If the physician had referred the patients to the non-participating lab across the halt, he or she could have faced fines by the payer.

Increased Un-Reimbursed Administrative Responsibilities

The insurance plans that have a large segment of the patient population also pass back to the physician practice many of their administrative responsibilities. According to a family medicine office manager, each radiology notification and authorization request now takes an average of up to ten minutes to perform with a physician peer-to-peer request adding another 10 minutes. Another physician in Arizona reported that these authorizations can often take at least 40 minutes per procedure to receive approval from the insurance plan. These administrative activities are not reimbursed by the health plan and so they have no incentive to become more efficient. The physician, in turn, is required to comply with time-consuming health plan requirements that riot only are unpaid but are increasing in a period of declining overall reimbursement.

Unilateral Contract Changes

Many contracts allow the health plan to unilaterally change the contract terms at any time, without notifying the physician, simply by posting the amended terms on the insurer's web site. Some contracts specifically forbid the physician from disclosing information about the fees that the

insurer pays to the physician, making it impossible for these physicians to inform patients about their out-of-pocket responsibility for deductible amounts under their policy. Few contracts provide physicians with payment terms spelling out how the fee schedule Will be calculated The result is more primary care physicians are driven into other care settings, such as Emergency Rooms or cash-only practices, or they leave health care altogether due to these negative contract conditions, excessive administrative requirements and downward pressure on their already slim margins.

Effect on Students and Residents

These contract imbalances concern not just the physician in practice now who is struggling to keep her business open but also the student who is looking at career options and deciding whether primary care offers a stable future. The number of medical students choosing family medicine and primary care has been declining for several years. Medical student debt averages over $200,000 upon graduation and the potential earnings has a strong effect on the student's choice of specialty. Patients' access to primary care will ultimately be reduced as more medical students choose nonprimary care residencies because of the financial uncertainty and instability of the current situation.

Effect on Small Business Community

It is important to note that the result of health plan mergers and consolidation is not the achievement of economies of scale that might be expected. Such economies would produce lower consumer premiums, which would make it possible for more small businesses, including small medical practices, to afford to offer health insurance to their employees. Instead, consolidation produces larger insurance companies wielding the kind of power and influence that leaves physicians helpless and frustrated. As a result, small businesses are not offered more affordable prices for their employees' health plans but rather fewer choices of physicians who will accept the plans that are offered.

Effect on Patients

The payment rates that the health plans dictate are unrelated to the quality of care that the physician provides to their patients. A family physician in Arizona notes that he has been honored several times as the best physician in the state and has over 100 other physicians among his patients. He receives the highest rating possible from his health plans for both quality and efficiency. Nevertheless, he is taking more than $100,000 out of his savings each year to stay in practice because he is unable to negotiate higher payment rates with the insurance companies. This situation is not only unfortunate, but it is also clearly unsustainable, If he is forced to close his practice, his patients will have lost that long-standing source of high-quality treatment, care coordination and preventive services in which they have place their faith and trust and upon which they have retied and depended. This is a sad statement of how we as a nation have allowed our health care priorities to be contaminated

Effect on Quality

Finally, the most serious effect of this rapid consolidation is to undermine the great potential for efficiency and quality improvement offered by what we are calling the patient-centered medical home. As proposed by family medicine, internal medicine, pediatrics and the osteopathic primary care physicians, the medical home is the practice that has been transformed to offer comprehensive, continuous, coordinated care. Experience with health systems based on primary care that exist in other industrialized nations amply demonstrates the value of a medical home. These practices provide guidance, assistance and responsiveness to patients navigating an increasingly complex health care system. But the patient-centered medical home depends on a long-term relationship between the physician and the patient, which is threatened and possibly destroyed if an insurance company dictates the terms of practice of medicine and preempts the patient's freedom of choice.

Conclusion

The AAFP recommends changes in existing anti-trust laws that will provide physicians with tools thai allow them to be true market participants. The current anti-trust laws were established during a very different competitive environment. Under these outmoded laws, physicians are barred from discussing the financial aspects of their practice with any entity unrelated to their practice, yet it is ciear that insurance companies ''price to the mean'' which is how the natural competitive forces are supposed to work and is what creates a dynamic market. Small and solo practice primary care physicians are excluded from that very basic business condition while market share and shear economic strength foster these near monopolistic insurer behaviors.

Again, AAFP commends the committee for highlighting the issues resulting from health insurance consolidation. Family physicians, many of whom provide health care in small and solo practices in rural and other underserved areas, feel the effects of insurance consotidation by trying to negotiate in a very disadvantageous environment. The Academy would like to work with all stakeholders to ensure a path to an improved health care system that puts the patient first and supports the sustainability of a practice that delivers high quality primary care; toward a system that places an emphasis on personalized, coordinated, primary care and that enables such patient-centered practices to fairly compete. One step in this direction would be to enact common sense changes that would modernize anti-trust laws to better support small business medical practices and to enable them to negotiate contracts with insurers from a position of equality.

Thank you for the opportunity to provide this testimony and I look forward to answering your questions.

Statement of James R. Office, Vice President and General CounselVictory Wholesale Group Springboro, OH

On Health Insurance Consolidation—The Impact on Small Business

Before the Committee on Small Business, U.S. House of Representatives, United States Congress

October 25, 2007.

Victory Wholesale Group (''Victory'') appreciates the opportunity to submit these comments. The rising and out-of-control increase in health costs, which are largely due to consolidations in the health care industry, is a very important subject to us and every other small business across America. One of Victory's largest expenses is for the health care coverage it provides to all its employees, who are called associates.

About Victory Wholesale Group

Victory is a group of family owned, separate companies; the first established in 1979. Our businesses include: a wholesale distributor of dry grocery, health and beauty care and general merchandise, with 83 employees in Ohio, 24 in Florida, 6 in Nevada, 10 in California and 17 people in 13 other states; a food marketing company with 6 people in Connecticut and 24 employees in 12 other states; a public warehousing business with 104 employees in two Ohio locations; a contract packaging business with 17 Ohio employees; an interstate trucking company with 4 Florida, 27 Ohio and 9 employees in 5 other states; a pharmaceutical wholesale distributor with 100 employees in Puerto Rico; a fundraising gift distributor with 16 New York employees and a promotional item distributor with 5 Ohio employees.

Victory's Health Insurance Benefits

Health insurance is the largest and most costly benefit that each of Victory's companies provides its associates. Insurance type's range from self-insured health plans, governed under ERISA, to fully insured health plans provided by large regional health insurers. Our companies maintain multiple health care programs, to help reduce costs and foster competition among providers, because of the widely dispersed locations of our business operations and the regional nature of health insurance providers and their support networks.

Why Victory Maintains Different Health Plans and Victory's Experience

Because Victory has employees and operations across the country, we've been unable to find a single, affordable health care plan that will cover all our separate businesses and associates. Over the years Victory has tried different types of health plans including: self-insured and fully-insured, including PPO's and HMO's. Our objective is to provide a valuable and quality health benefit that allows associates as much free choice in selecting health care providers as reasonably possible while also controlling costs for everyone.

It has been Victory's experience, that if a health plan has one, or more, participants with a serious or major health condition its competitive choices and alternatives disappear, and its premiums are increased.

Also we have found that the deepest and best discounts are offered through regional providers and networks of preferred providers that have hospitals, doctors and other health care service providers, that combine into a single entity to provide health plans with agreed pricing or discounts in exchange for the health plan steering its employees to the network. Networks are either regional with large numbers of local doctors and hospitals as members, or national with more limited numbers of doctors and hospitals, or that offer smaller discounts.

We find that controlling health care costs is nearly impossible; that the health care industry is both fragmented, yet concentrated. It's loaded with administrative costs, it's inefficient, it's not measured or accountable for quality or value. In the present system the best way to control costs is to have only young, healthy employees.

Consolidation and affiliation of hospital and physician groups standardizes patient medical information and makes it available and easily accessible to all affiliated providers that may treat the patient; but on the negative side, it creates a concentrated front to impose increases on health insurers or to resist providing discounts.

We find that insurance carriers' quotes end up largely ''experience rating'' our group's claims experience. That means they take our actual costs, add the insurance company's overhead and their desired profit and that is the premium we are quoted. We can't find plans that cover all our locations with any meaningful provider's networks or discounts. Thus we are forced to shop on a local basis from a limited number of carriers for separate groups with small numbers of employees.

Further, we found that in most of the regions in which we sought quotes there were only one or two dominant insurers that essentially controlled each local market. And to make matters worse, those regions also were dominated by one or two major hospital and physicians affiliated groups.

Additionally, we found that some carriers, through pricing, force small businesses to take a pre-set benefit or networks. We have found that changing networks can be very disruptive to employees and their families (and company administration). Changing a network might require a participant to find new doctors and go to hospitals that they are unfamiliar with. In designing our benefits we try to the extent possible to minimize disruptions to our associates' choice of providers.

We were faced with increasing cost, less choice, multiple plans and a whole bunch of administrative problems managing the programs. Today's health care system is largely a pass though of all costs to employers and individual participants/insureds.

We have learned that sometimes an insurance carrier will ''buy market share'' by offering low prices to new groups and then dramatically increase premiums or change the benefits on renewals. When an insurer ''buys a market'' through price discounts, it often chases competition out of the market thus allowing the insurer to later increase prices without opposition.

As most small businesses can attest, in a year following any significant claim(s), it becomes virtually impossible to switch providers or to receive competitive quotes at renewal. Even with competition, in the regions where we have operations, we find they are dominated by only two large carriers; thus limiting our choices because both carriers were expensive, only one was more so.

Consolidation in Southwest Ohio

We have a large number of associates in Southwest Ohio (Cincinnati and Dayton, areas). Once there were a number of independent physician practices and independent hospitals. Over the past 15 years, through several consolidations, we found that Dayton's five primary hospitals became essentially two through affiliations (excluding Children's Medical Center).

For more than a year recently, one major hospital in Dayton (and the physicians who maintained privileges only at that hospital) refused to accept the pricing the larger of only two regional health insurers was demanding. So, the two entities parted ways. Our associates living in the neighborhoods surrounding that hospital were forced to find new doctors and use new hospitals on the other side of town. Our choices and those of other small businesses during that year were further reduced because the other big regional health insurer did not cover a major portion of the geographic region in which our employees lived. As employers, we faced the additional disruption that employees go through when they were forced to use new doctors and hospitals outside their own neighborhoods.

In Cincinnati a similar thing happened. 13 Hospitals became 3 through affiliations (excluding Children's). In both regions physician practices were purchased, consolidated and affiliated with one of the large hospital affiliated groups and now they are large enough to stand up to the insurers in the area and resist pricing pressures.

Throughout Southwest Ohio, the few large hospital and affiliated physician groups have been successful at increasing their prices by threatening to again ''kick out'' one or both of the only two very large regional health insurance companies that wanted discounts or reduced increases. This was at the expense of the employees of small businesses in the entire area that have been forced to pay the higher rates. Small businesses lack the necessary clout to use against either the medical providers or insurers.

The message remains the same, small businesses' choices are reduced and prices are increased without any meaningful competition. The market today for small business health insurance is essentially ''take it or leave it.''

Don't Underestimate the Impact of Discriminatory Underwriting in the Small Business Market

Another phenomenon that we now face is that our insurance carriers engage in *discriminatory* pricing and/or coverages. In years when our associates and their families were generally healthy our premiums rose consistent with reported national average increases. However, in recent years we've had some associates with serious health problems. In the case of our fully insured plans, our premiums have increased well beyond the national averages and we have been unable to get competitive insurers to quote the group. (Examples of serious health problems include: organ transplants, heart problems, cancer, stroke, aneurysms, premature childbirth and conditions that can be treated with very expensive drugs such as MS (Victory has seen pharmaceuticals costing as much as $20,000 per month).

In our self-insured health plans, our excess insurers would simply delete the ill participant from our group (it's called ''lasering out'' a patient or condition). For example, the premium for our excess insurance would still increase. In addition, the carrier would tell Victory that we would have to cover the first $50,000 or $75,000 of a particular individual's health costs. Again, while we might get quotes from excess carriers, we found that they all generally behave the same as it relates to individuals facing serious health problems. I would describe this concept as insurance companies only wanting to insure healthy groups.

One of Victory's smaller businesses has a number of older associates with many of the ailments that go along with age and they are paying a higher premium than any of our other groups. This particular business employs fewer than 20 associates and it is stuck with our incumbent regional carrier. Whenever we can get quotes from carriers willing to quote this group, they are always higher, or exclude afflicted associates or they adjust the benefits to include unreasonable limitations on benefits—such as a 40% co-payment on non-formulary brand name drugs without any cap. If an associate has MS and their medications costs $5,000 month, 40% would be $2,000 a month. That cost is simply not affordable so the treatment is discontinued or less effective treatments are used.

We have found that even former associates electing coverage under COBRA can and do have an impact on health insurance costs if the individual has a serious health condition. Former associates who have existing medical problems often find they have no choice but to continue with coverage under COBRA because they are unable to obtain affordable health insurance elsewhere. Consolidation in the industry has compounded the problem, by reducing the number of available insurers to whom an individual can even apply for coverage.

Another unexplained phenomenon is that if a group is turned down or priced by one carrier at a premium, it seems like every other carrier in the region somehow learns of this which makes it more difficult to find alternatives.

Victory has also seen a number of conflicts in the industry that are generally hidden from its insureds. For example one of our PPO networks receives undisclosed payments from the doctors and hospitals that are subscribers. When we inquired as to why they received these payments, and whether these payments were passed though to Victory by way of discounts, we were unable to get an answer. It was strongly suggested by

our broker not to push the issue. Are these payments made to keep the network from demanding deeper discounts? What about hospital and treatment centers that are owned by physicians. Why are these arrangements hidden? In the end they can stifle competition, cost and choice.

Victory's experience is that the health insurance industry covertly or otherwise discriminates against small business and individuals that have significant health problems. Small businesses have no market power or advocate for the wrongful conduct, so large and powerful regional health insurance and hospital/physician affiliates stand to lose nothing by engaging in this conduct.

How do small businesses control health care costs today?

Unfortunately this proves to be an exercise of the lesser of a number of evils, few that the small business can control. Each year at our annual health insurance renewals, we get a quote from our broker that first shows the price of keeping the same health benefits for the upcoming year. From an employer standpoint this is the least disruptive to the employees and their families (and business administration). Unfortunately, in our experience, this usually includes a cost increase. So our broker then offers a series of options to either keep the cost the same as the previous year or reduce the increase in cost for the upcoming year. These options include:

- Increasing the amount of premium that each associate pays;
- Increasing co-payments and/or deductibles;
- Impose charges on unhealthy lifestyles, such as smoking or obesity premiums;
- Reduce and/or eliminate benefits;
- Modifying benefits and provide financial incentives (or disincentives as the case may be) to use modified benefits [1];
- Be very selective in hiring employees—*i.e.* hire only healthy employees [2];
- Incorporate a Health Savings Account or Health Reimbursement Account into the plan design (higher deductible and lower benefits); and/or
- Eliminate offering employer provided health insurance.

Conclusion

Historically small businesses make up the backbone of our nation's employers. Collectively small businesses employ the largest number of people in the U.S. Yet, because each company is small, we have almost no market clout to help bring changes into the health care system. For improvements we must depend on you in the Congress.

Reduced competition in health care at the insurer level or the provider level has increased the costs of health care to Victory and its employee-associates as well as those of other small businesses. Solutions must include some meaningful competition. Pooling and sharing of risks without selective health screening, will advance competitive pricing. Keeping a multiple payer and provider system gives greater flexibility to experiment and discover ways to improve our health care system, A single payor or socialized plan will put all of our nation's eggs in one basket, which certainly disfavors innovation and experimentation. On paper our present system should work, but because of inefficiencies and gaming, it doesn't.

Victory appreciates the Committee on Small Business review of this important issue and the opportunity to present its views on the topic. We thank you for the invitation to present our views. We hope that the Committee and U.S. Congress will take our comments along with the comments from fellow panel members and others, seriously and not make this just another political battle without substantive change. Small business and the tens of millions of their employees, and your constituents will suffer.

The problems are complex and involve a large number of interested parties; political pressure will be exerted by the well-funded. Let's work toward a solution and show the world that we can not only put humans on the moon, but we have the intelligence and creativity to fix a broken, expensive and complex system of delivering health care.

Testimony of Greg Scandlen, President, Consumers for Health Care Choices

''Health Insurer Consolidation: The Impact on Small Business''
Committee on Small Business, United States House of Representatives
October 25, 2007.

Madam Chairman, and Members of the Committee,

Thank you for the opportunity to share some thoughts with you today about the problems created by excess concentration in the health insurance market.

I am Greg Scandlen. I am the founder and president of Consumers for Health Care Choices, a national, non-profit and non-partisan membership organization with members in 44 states. I have been in health policy since 1979 when I was hired by Blue Cross Blue Shield of Maine to rewrite their contracts in plain language. I spent 12 years in the Blue Cross Blue Shield system, including 8 years with the national association where I was responsible for state government relations, including being liaison with the National Association of Insurance Commissioners, National Governors' Association, National Conference of State Legislatures, and other organizations of state officials.

I left the Blues in 1991 to organize a trade association of smaller insurance companies, the Council for Affordable Health Insurance. I ran that organization for five years and left to become a consultant and a researcher for several national think tanks.

I applaud this committee for its long-standing interest in the health insurance market, especially for small employers. For many years surveys have shown there is no greater issue weighing on the minds of small business owners, but now we are seeing that the issue has gone from being a worry of business owners to a crisis in health policy as fewer employers are able to offer coverage at all. The latest Kaiser Family Foundation survey (available at *http://www.kff.org/insurance/7672/index.cfm*) found that the percentage of the smallest employers (with 3–9 employees) offering any coverage has dropped from 57% in 2000 to 45% today.

This fall-off of enrollment is usually attributed simply to rising costs, but I think it is deeper than that. I think both employers and employees look at the health insurance market and find products and services that are over-priced, inefficient, unaccountable, inconvenient, and incomprehensible. They simply do not find value here and they don't see many available alternatives.

This indifference to customer needs and preferences is characteristic of non-competitive markets. Vendors see little need to innovate, cut costs, improve services, or simplify processes because everyone else is offering the exact same product at the exact same price. Customers are stuck.

The Consequences of Excessive Regulation

This non-competitive market is not an accident of history and it is not inherent in health insurance. I was closely involved in the small group reform efforts of the NationalAssociation of Insurance Commissioners (NAIC) in the late 1980s. I knew the commissioners and the staff of the committees that developed the NAIC's model laws and regulations quite well, and they were very explicit about their intentions. They said at the time the reforms they were proposing would do nothing to lower costs or increase access. All they wanted to do was ''stabilize the market.'' In their view, the small group market was suffering from an excess of competition that was confusing to purchasers. They thought it would be better if there were only three or four competing companies in each state.

They have been wildly successful. In my state of Maryland there are now just two companies controlling 90% of the small group market. Options are few and prices are high. Individual coverage is a far better deal in Maryland, and in most other states, than small group coverage. That is part of the reason small employers are dropping group coverage—they and their employees can get a better deal with individual insurance.

The regulations imposed on the small group market included some that were later made industry-wide by Congress when it enacted HIPAA. but also a host of other regulations that discouraged participation in this market—rating restrictions, underwriting restrictions, minimum participation and employer contribution requirements, bans on list billing, standardized benefit designs, requirements on provider participation,

[1] For example, last week in our annual health insurance renewal, our broker suggested that we encourage our associates to have elective surgical procedures performed overseas. We were advised that even paying for travel for two, treatment and recovery at what was described as Four Seasons like heath care facilities that cater to westerners; we would save tens of thousands on elective surgical procedures. We were informed, for example, that a single knee replacement that costs approximately $30,000 in the Midwest would cost under $5,000 inclusive of travel for two in Singapore. Victory is not ready to mandate its associates travel thousands of miles and away from their families and loved ones to obtain health care, however it is difficult not to seriously consider the potential savings.

[2] Victory doesn't engage in, support or condone this practice; however, we understand that the practice is not uncommon.

claims approval and claims review requirements, capitalization and reserve requirements, investment restrictions, minimum loss-ratio standards, market conduct requirements, and of course, state-mandated benefits.

All of these regulations, however well-intentioned, add to the cost of coverage. Moreover, many carriers found it expensive and difficult to comply with all the varying requirements of many different states, especially as the requirements changed from year to year. As a consequence, many carriers decided to get out of the health business and sold off their blocks of business to larger carriers who could afford the compliance costs. This is the primary cause of concentration in this market.

Is Concentration a Good Thing?

Now, some people will argue that this concentration is a good thing, but these arguments are based on a poor understanding of insurance markets. Let me explain.

Risk Pooling

People often argue that the purpose of insurance is to pool risks, so the bigger the carrier, the better. Too much competition, they say. ''segments the market'' and loses the benefit of the pooling mechanism.

Risk pooling is indeed an essential function of insurance, but all of the benefits of pooling are achieved with a relatively small number of people. The optimal size of a risk pool is frequently debated among actuaries and depends on a host of factors (See, for instance, *www.sonoma-county.org/health/ph/mmc/pdf/models.pdf*), but most of the beneficial effects of pooling can be achieved with as few as 25,000 covered lives. It is simply not the case that bigger pools are better.

Economies of Scale

Similarly, people argue that bigger is better to achieve economies of scale. Fixed costs can be spread across a larger population, lowering the cost to each individual.

Again, the argument is valid—as far as it goes. But at a certain point there will also be dis-economies of scale and managerial inefficiency. Where that point is, is open to debate. The graphic below is taken from *Risk Pooling in Health Care Financing: The Implications for Health System Performance*, by Peter C. Smith and Sophie N. Witter, both of the Centre for Health Economics at the University of York, York, UK, and published by the World Bank in 2004 (available at *http://extsearch.worldbank.org/servlet/SiteSearchServlet?q=risk%20pooling*).

It illustrates two things:

1. The advantage of risk pooling levels off at a certain number of covered lives;

2. There are substantial dis-economies of scale beyond a certain number.

QuickTime™ and a TIFF (LZW) decompressor are needed to see this picture.

Adverse Selection

Finally, people will argue that having a wide selection of health coverage choices invites ''adverse selection,'' that is, people of like-risks will segment themselves into different health plans, with the healthiest going into one with minimal benefits and the sickest going into the one with the richest benefits. They say it would be fairer to allow only rich benefits so that the healthy will subsidize the preferences of the ill.

Certainly selection happens but it can be manageable, as we have seen with FEHBP. Plus, the flip side of adverse selection is moral hazard. If it is true that high-risk people will select the richest benefit programs, it is also true that low-risk people who are placed into rich benefits programs will use more health care services than they otherwise would, raising the costs of coverage for all. In either case, the presence of insurance distorts normal consumer behavior. ''Fairness'' is not served by forcing people to purchase benefits they have no use for, and that is one of the reasons so many small employers are not buying coverage at all.

Innovation Needed

These criticisms all assume that there is a single type of health insurance coverage that is most suitable for all people, but as Clark Havighurst and his colleagues at the Duke Law School have found, the type of comprehensive coverage that is most common today is aimed at the well-educated elite and is in fact subsidized by lower-income working people who derive little value from the coverage. In a recent special edition of *Law and Contemporary Problems*, (available at *http://www. law.duke.edu/journals/journaltoc?journal=lcp&toc=lcptoc69autumn2006.htm).* Mr. Havighurst says, ''lower-income insureds get less out of their employer's health plans than their higher-income coworkers despite paying the same premiums.'' He argues that over-regulation prohibits the offering of more modest benefit packages that would have greater appeal to the same lower-income workers who have little ability to influence the regulators. He adds that the current system ''greatly amplifies price-gouging opportunities for health care firms with monopoly power.''

One exception to this situation has been the introduction of Health Savings Accounts (1–ISAs), a very modest innovation that appeals to some segments of the market that did not find value in comprehensive coverage. By some measures, between 30 percent and 40 percent of the non-group and small group purchasers of HSAs were previously uninsured (see, for example, *HSAs and Account-Based Plans: An Overview of Preliminary Research*, 6/28/2006, available at *http://www.ahipresearch.org/*), suggesting that they did not find value in the comprehensive plans that used to be the only option.

But HSAs are only one small example of the potential for innovation in the benefits market. Another can be found within the Medicare program. Medicare's Special Needs Plans (SPNs) have had very promising success in designing benefits specifically for subsets of beneficiaries, such as people with chronic conditions. (See, for example, *Managed Healthcare Executive*, ''Medicare Advantage Plans establish SNPs to provide care to dual eligibles, high-risk patients,'' *http://mhe.adv100.com/mhe/article/articleDetail.jsp?id=322943*). This is a major departure from conventional practice where health plans typically try to avoid high-risk people with costly conditions. These Special Needs Plans welcome them and design benefits for them that will lower the cost of their care.

Another potential innovation was designed by a recently deceased member of my organization, James Pendleton, MD. The ''Pendleton Plan'' (available at *http://www.chcchoices.org/articles.html*) is aimed at costly hospital inpatient care. It is like a Schedule of Allowances benefit structure based on average hospital costs in an area, but it also includes graduated co-payments or rebates if the patient chooses a facility that is more or less expensive than the average. This plan has not yet been brought to market, but several insurers are interested in it and may try it out on a demonstration basis.

I am familiar with several other entrepreneurs who are working on unique benefit designs and trying to raise the capital to turn these ideas into reality. But they are discovering very significant barriers to entry in the small group market imposed by the regulatory system. They are likely to focus instead on the large group market that has relatively few regulatory barriers at this time.

Creating a More Competitive Market for Small Group Coverage

There is a lot that has to be done to restore competition in health insurance. Anti-trust enforcement is one aspect, and my organization was concerned enough about the recent United/Sierra merger in Nevada to ask the Department of Justice to reject the merger. In our letter to the Attorney General (March 26, 2007) we wrote:

We have no opinion about the companies themselves. Whether they are good or bad or something in between is irrelevant to us. The question to us is solely whether this merger increases or decreases competition and consumer choice. This is the same standard we would apply to any other merger proposal, between hospitals, between pharmaceutical manufacturers, or any other aspect of the health care system.

Consumers need more choices, not fewer. There is already far too much concentration in the hands of a few giant players in health care. Greater concentration means less competition and that is bad for consumers.

Indeed, concentration is rife throughout the health care system with mergers of not only insurers, but hospitals and pharmaceutical companies as well.

The health plans will argue they need to become more concentrated to deal with the rising concentration of these other actors. But hospitals argue they need to merge to deal with the rising concentration of the carriers. It is a spiral that is quickly leading to near-monopolization throughout health care, to the detriment of individual consumers.

Anti-trust action can forestall the most egregious of these mergers, but anti-trust does not create new competitors or encourage innovation if the artificial barriers to entry are high and the regulatory environment unfavorable, Indeed, anti-trust cannot prevent a company from going out of business in an unprofitable climate.

We also do not expect many states to relax their regulatory burdens. Some have, but it is

unusual for legislatures to admit errors and repeal laws. Plus, most of these regulations have constituencies that will tight to retain them. These constituents often include the remaining health plans that enjoy their near-monopoly position and do not want to encourage new competitors.

That leaves only two courses of action for Congress.

1. Allow the interstate purchase of health insurance. States would continue to regulate their domestic carriers, but buyers would be able to purchase coverage from any licensed carrier in the United States. Congressman John Shadegg sponsored legislation (H.R. 2355) in the last Congress to do just this. Small business owners would be able to purchase coverage according to, not only the reputation and integrity of the insurance company, but also the set of regulations that apply to it.

2. Create an alternative federal charter that carriers could choose to operate within. This would be like the current banking system where banks can choose to be state chartered or federally chartered. A state chartered insurance company would be confined to operating within that state, but a federally chartered company could operate anywhere within the United States.

In either case, Congress would restore the intent of the interstate Commerce Clause of the Constitution, which vested the regulation of interstate commerce solely in Congress. Congress ceded its authonty to the states in 1946 when it enacted the McCarran-Ferguson Act, but there is no reason Congress cannot reclaim some or all of that authority, as it did when it enacted ERISA in 1974.

Conclusion

The small group market for health insurance has become dysfunctional over the past twenty years. Excessive regulations, though well-intentioned, have resulted in oligopoly conditions that have led to higher prices, poorer services, and very few choices.

Consumer choice is meaningful only when there is a wide variety of products, services, and vendors from which to choose. We desperately need vigorous competition throughout the health care system to restore market discipline and encourage innovation.

Congressional remedies are limited, but are needed because the states have failed to get the job done.

Statement of Consumer Federation of America, Consumers Union, and US PIRG

To the Committee on Small Business, United States House of Representatives, Regarding Health Insurer Consolidation
October 25, 2007.

Consumer Federation of America, Consumers Union, and US PIRG (''consumer groups'') appreciate the opportunity to present our views to the Committee on Small Business on health insurer consolidation. We commend the Committee for holding this hearing and for its efforts in identifying ongoing conduct that may harm the competitive marketplace. This hearing puts a spotlight on issues critical to consumers and small businesses throughout the United States. An unabated flood of health insurance mergers has led to highly concentrated markets, higher premiums, and lower reimbursement. Skyrocketing premiums have put insurance out of reach for millions of consumers and the number of uninsured Americans has increased to critical levels: over 89 million or one out of three Americans under age 65.[1] As consumers have suffered from egregious deceptive and anticompetitive conduct by insurance companies, those companies have recorded record profits. The problems presented could not be more stark or have a more severe impact on consumers.

In the past decade there have been over 400 health insurer mergers and in only two cases has the Department of Justice brought any enforcement action. The Justice Department has not brought any cases challenging anticompetitive conduct by health insurers, even though numerous private plaintiffs and State Attorneys Generals have challenged this type of conduct. In effect, the insurance companies have gained a newly found ''antitrust immunity.''

The consequences of lax enforcement for consumers are clear. The American Medical Association reports that 95% of insurance markets in the United States are now highly concentrated and the number of insurers has fallen by just under 20% since 2000. These mergers have not led to benefits for consumers: instead premiums have skyrocketed, increasing over 87 percent over the past six years. Patient care has been compromised by the over-aggressive efforts of supposed managed care, and the number of uninsured Americans has reached record levels.

A vital component to assuring the competitive marketplace is protecting the ability of consumers to choose between alternatives. Antitrust enforcement against anticompetitive mergers and exclusionary conduct is essential to a competitive marketplace. This unprecedented level of concentration and the lack of antitrust enforcement pose serious policy and health care concerns. As Vermont Senator Patrick Leahy observed in Hearings before the Senate Judiciary Committee last year on health insurance consolidation:

> a concentrated market does reduce competition and puts control in the hands of only a few powerful players. Consumers—in this case patients—are ultimately the ones who suffer from this concentration. As consumers of health care services, we suffer in the form of higher prices and fewer choices.[2]

Congress is currently grappling with the severe problems of the uninsured. The number who have been uninsured for some period in any two year period has increased by over 17 million since 2001 and now amounts to over 89 million Americans. The reason is simple: the cost of health insurance has outstripped the pocketbooks of both consumers and small businesses.[3] Premiums for both job-based and individual health insurance have risen rapidly over the past seven years and have increased by double-digit amounts annually since 2001. Moreover, these rising premiums have far outstripped increases in worker earnings. Between 2000 and 2006, premiums for job-based health insurance increased by 73.8 percent, while median worker earnings rose by only 11.6 percent.

There is a direct relationship between the insurance consolidation and the anticompetitive conduct engaged in by health insurers, and the increasing problem of the uninsured in the United States. Increased concentration and a lack of enforcement has led to skyrocketing premiums, higher deductibles and higher co-pays. The most severe problems occur simply when employers or employees can no longer afford insurance. Increasingly employers have been forced to scale down insurance or drop insurance altogether. Thus, the number of uninsured individuals has hit a record level. The lack of enforcement has created an environment where the insurance companies act as if they are immune from antitrust scrutiny. This must be reversed.

As a first step, some of us have recommended that the Antitrust Division of the Department of Justice carefully scrutinize United Healthcare's acquisition of Sierra Health, which, if approved, will lead to a virtual monopoly in various health insurance markets in Las Vegas. We have attached a statement of the Consumer Federation of America before the Nevada Commissioner of Insurance on the United Healthcare/Sierra Health merger, which articulates the types of problems posed by increasing consolidation in the health insurance industry.

Again, we welcome the attention of the Committee to this important issue.

Testimony of David Balto, on Behalf of the American Antitrust Institute and Consumer Federation of America

Before the Nevada Commissioner of Insurance on the United Health Group Proposed Acquisition of Sierra Health Services[1]
(July 27, 2007)

I. Introduction

The American Antitrust Institute (''AAI'') and Consumer Federation of America, (''consumer groups'') appreciate this opportunity to testify before the Commissioner of Insurance on United Health Group's (''United'') proposed acquisition of Sierra Health Services, Inc. (''Sierra'').[2] As

[1] See *Wrong Direction: One out of Three Americans are Uninsured* (Families USA 2007).

[2] Statement of Senator Patrick Leahy, Hearing on ''Examining Competition in Group Health Care'' U.S. Senate Committee on the Judiciary (Sept. 6, 2006).

[3] Families USA study at fn 1.

[1] I have practiced antitrust law for over 20 years, primarily in the federal antitrust enforcement agencies: the Antitrust Division of the Department of Justice and the Federal Trade Commission. At the FTC, I was attorney advisor to Chairman Robert Pitofsky and directed the Policy shop of the Bureau of Competition. Maria Patente, Washington College of Law (Class of 2008), provided extensive assistance in the preparation and research of the testimony.

[2] The American Antitrust Institute is an independent Washington-based non-profit education, research, and advocacy organization. Its mission is to increase the role of competition, assure that competition works in the interests of consumers, and challenge abuses of concentrated

Continued

detailed in our testimony based on our preliminary review we strongly believe that this acquisition will harm all Nevada health insurance consumers, particularly those in Clark County, through higher prices, less service, and lower quality of care. The level of concentration posed by this merger is simply unprecedented: it is far greater than in any merger approved by the Antitrust Division of the U.S. Department of Justice (''DOJ'') and would give United clear monopoly power in Clark County.

In evaluating this merger under NRS 692C.210(1) the Commissioner of Insurance must consider several factors including: (1) whether ''the effect of the acquisition would be substantially to lessen competition in insurance in Nevada or tend to create a monopoly'' and (2) whether if approved the ''[a]cquisition would likely be harmful or prejudicial to the members of the public who purchase insurance.'' As we explain below, both of these factors counsel for denial of the application. The merger creates a dominant insurer, particularly in Clark County, with the ability to raise premiums, reduce service and quality and reduce compensation to providers. It will clearly harm purchasers of insurance who will pay more for service that provides lower quality care.

This unprecedented level of concentration raises important policy and health care concerns relevant to the factors evaluated in these Hearings. As Vermont Senator Patrick Leahy observed in Hearings before the Senate Judiciary Committee last year on health insurance consolidation:

a concentrated market does reduce competition and puts control in the hands of only a few powerful players. Consumers—in this case patients—are ultimately the ones who suffer from this concentration. As consumers of health care services, we suffer in the form of higher prices and fewer choices.[3]

Creating a dominant insurance provider should be a profound concern in Nevada, a state plagued with shortages of nurses, doctors and other health care professionals.

This testimony, which is based solely on public information, provides our preliminary views that this merger would ''substantially lessen competition in insurance in Nevada or tend to create monopoly'' and ''would likely be harmful or prejudicial to the members of the public who purchase insurance.'' This paper also addresses the United-Sierra merger in the context of the numerous competitive imperfections and market failures unique to the HMO and health insurance industry and with respect to the specific challenges facing Nevada's health care due to a serious shortage of doctors and nurses.

II. Summary

The consumer groups urge the Commissioner to focus on the following issues:

• ***Will the United-Sierra merger reduce competition for the provision of health insurance to employers and individuals seeking health coverage in Nevada?*** Yes. Sierra is the largest HMO provider in Nevada and United is the only significant rival. The United-Sierra merger in Nevada would give United an 80% market share of all HMOs in Nevada and a 94% market share of the HMO market in Clark County. Although its market share is smaller than Sierra's, United has the potential for significant growth in Nevada since its acquisition of PacifiCare in 2005. Moreover, the next largest HMO rival in Clark County has only a 2% market share. The merger would adversely affect a wide range of buyers including small employers, governmental and union purchasers.

• ***Will the United-Sierra merger reduce competition for the provision of services in the Medicare Advantage program?*** Yes. Medicare is increasingly turning to a managed care model. Increasingly Medicare beneficiaries are signing up for the Medicare Advantage program which provides health care services to beneficiaries in a managed care model. The only current bidders for Medicare advantage in Nevada are United and Sierra. United is the largest Medicare Advantage program in the U.S. The merger would create a monopoly in the provision of services for Medicare Advantage program resulting in a lower level of care and higher prices.[4]

• ***Could the United-Sierra merger increase the threat of monopsony power and reduce access to medical care and the quality of medical care in Nevada?*** Yes. There is currently a significant and chronic shortage of health care providers including physicians and nurses in Nevada, an understaffed region where health professionals are forced to work overtime, double-shifts, weekends, and holidays. This merger will exacerbate those problems for health care providers dependent upon the merged firm. A combined United-Sierra can reduce compensation resulting in a diminution of service and quality of care. In the past the DOJ has brought enforcement actions because of concerns over monopsony power where the market share exceeded 30%, a level clearly exceeded by this acquisition. This merger may lead to a significant reduction in reimbursement for health care providers, leading to lower service and quality of care.

• ***Will other insurance companies readily enter the market (or expand) and fully restore the competition lost from the merger?*** No. In some cases it may be unnecessary to challenge a merger if other firms can readily enter a market to a sufficient degree to avert the anticompetitive effects of the merger. That is clearly not the case for this market. As the DOJ has recognized in other cases, barriers to entry in the HMO market are extremely high due to the extensive physician networks, technology networks, and specialized medical infrastructure that are essential to the industry. Moreover, Nevada already faces a serious shortage of both doctors and nurses, and attracting a sufficient number of personnel would pose a high barrier for a new entity interested in providing HMO plans in Nevada. There has been little historical entry into the Nevada HMO market, in spite of the growth of population. Moreover, with a dominant United-Sierra, it is highly unlikely a new entrant would undertake the risk of new entry.

• ***Do the efficiencies from the United-Sierra merger outweigh the anticompetitive harms?*** No. The parties have not proposed significant efficiencies from this consolidation. If there were any efficiencies they probably could be achieved through internal growth, considering the rapid population growth in Nevada. Moreover, efficiencies should only be included in the competition calculus if they will result in lower prices or better service to consumers. As a general matter, efficiencies from health insurance mergers have not been passed on to consumers. Health insurance mergers have generally led to increased subscriber premiums without expansion of medical benefits. There is little evidence if any that any efficiencies achieved in the United-PacifiCare merger have resulted in lower premiums or better service for United or former PacifiCare subscribers. Since the combined United-Sierra would have a dominant market share post-merger it is highly unlikely any savings would be passed on to consumers.

• ***Would a divestiture or other structural relief be sufficient to alleviate the competitive problems raised by the merger?*** No. The parties have not suggested that they would be willing to divest assets to solve the competitive concerns raised by the merger. Even if they did the Commissioner should be extremely skeptical of any proposed relief. In the past the DOJ has attempted to resolve competitive concerns over some mergers by requiring the divestiture of a certain number of contractual arrangements in order to spur new entry. These divestitures have been insufficient to cure the competitive problems posed by those mergers. A divestiture is even less likely to resolve the competitive concerns in this merger where the merged firm will clearly be the dominant insurer in the market.

• ***Would consumers be better off if the Commissioner rejected the merger?*** Yes. The ultimate antitrust question in evaluating

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economic power in the American and world economy. For more information, please see *www.antitrustinstitute.org.* This testimony has been approved by the AAI Board of Directors. A list of contributors of $1,000 or more is available on request. The Consumer Federation of America (''CFA'') is the nation's largest consumer-advocacy group, composed of over 280 state and local affiliates representing consumer, senior citizen, low income, labor, farm, public power and cooperative organizations, with more than 50 million individual members. CFA represents consumer interests before federal and state regulatory and legislative agencies and participates in court proceedings. CFA has been particularly active on antitrust issues affecting health care.

[3] Statement of Senator Patrick Leahy, Hearing on ''Examining Competition in Group Health Care,'' U.S. Senate Committee on the Judiciary (Sept. 6, 2006).

[4] A large number of the consumer complaints filed with the Commissioner about this merger raise concerns over the loss of competition in the Medicare Advantage market. Many of these complaints are from elderly beneficiaries who are particularly vulnerable to anticompetitive conduct. Over 30% of Nevada Medicare beneficiaries subscribe to Medicare Advantage, one of the highest enrollments of any state.

any merger is what would happen ''but for'' this merger? What would happen to the merging parties, consumers, and providers? The answer in this case seems rather transparent. United and Sierra are both successful, financially sound, capable companies that would continue to grow and thrive. Through its acquisition of PacifiCare, United established an important beachhead in Nevada. But for this merger, United would continue to expand in Nevada and challenge Sierra's strong position in the market. That competition between United and Sierra would lead to lower premiums, greater innovation and better service. There is simply no reason why United can not achieve most of the benefits of this acquisition through internal growth.

The remainder of the testimony is set forward as follows. First, we make some observations about special considerations for health insurer mergers and suggest why regulators and enforcers can not rely on the theoretical assumptions of a competitive market. Then we focus on past enforcement actions and the principles of antitrust enforcement. We then explain how the merger will reduce competition in both the provision of certain health insurance products (impact on buyers) and health care providers (impact on sellers). Finally, we explain why other factors such as ease of entry or efficiencies will not prevent the anticompetitive effects of the merger.

III. Antitrust Merger Standards and Past Antitrust Enforcement Actions

The U.S. antitrust laws, like the Nevada insurance statute, provide that a merger may be illegal if it may ''tend substantially to lessen competition or to tend to create a monopoly.'' [5] The concern under the merger laws is that a merger may tend to reduce competition and lead to higher prices, lower service, less quality, or less innovation. Concerns over a reduction in quality, central to the delivery of health care services, is an important element of competition.[6] As the Supreme Court has observed, competition protects ''all elements of a bargain—quality, service, safety, and durability—and not just the immediate cost.'' [7]

In order to determine the likely competitive effects of a merger the case law and the Merger Guidelines established by the Department of Justice and the Federal Trade Commission set forth a multi-step process.[8] The process begins by defining the ''line of commerce'' or relevant product market and the ''section of the country'' or relevant geographic market. A relevant market can include any group of products or services. Once a relevant market is defined, the level of concentration and market share is calculated to determine the likely competitive effects of the merger. In cases where there is an undue level of concentration in the relevant market (generally a market share over 30%) there is a prima facie case of illegality and a presumption of unlawfulness.[9] If there is a presumption of unlawfulness then the burden shifts to the defendants to rebut the prima facie case and demonstrate that other market characteristics make the presumption of anticompetitive effects implausible. Two types of evidence are prominent in merger cases—if the defendants can offer evidence that entry is relatively easy, that may dispel the notion that the merger will lead to significant anticompetitive effects. Finally, if a merger will lead to substantial efficiencies, these may counteract those anticompetilive effects.

The two most instructive antitrust cases involving health insurance mergers are the DOJ's challenges to Aetna's 1999 acquisition of Prudential and United's 2006 acquisition of PacifiCare. Both of these mergers were resolved with divestitures to facilitate the entry of a new competitor to remedy the competitive concerns. Each case focused both on the harm to purchasers of HMO and other insurance services from the exercise of monopoly power and the harm to healthcare providers from the exercise of monopsony power.[10] In both the United-PacifiCare and the Aetna-Prudential mergers, the DOJ identified highly concentrated markets that were substantially likely to suffer harm to competition as a result of these mergers.

In 1999, the DOJ and the State of Texas settled charges that the merger between Aetna and Prudential in the State of Texas would harm competition. The DOJ focused on relevant markets of HMO products and physician services. Aetna and Prudential were head to head competitors in the HMO markets in Houston and Dallas. The proposed merger would have increased Aetna's market share from 44% to 63% in Houston and 26% to 42% in Dallas.[11]

Moreover, the merger raised monopsony concerns by giving the merged firm the potential to unduly suppress physician reimbursement rates in Houston and Dallas, resulting in a reduction of quantity or degradation of quality of medical services in the areas.[12] The operative question from DOJ's perspective was could health care providers defeat an effort by the merged firm to reduce provider compensation by a significant amount, *e.g.*, 5%. The question was answered in the negative for several reasons: physicians have limited ability to encourage patients to switch health plans, and physicians' time (unlike other commodities) cannot be stored, which means that physicians incur irrecoverable losses when patients are lost but not replaced. To exacerbate matters, contracts with physicians were negotiated on an individual basis, and were therefore susceptible to price discrimination by powerful buyers. Thus, DOJ concluded that Aetna had sufficient power to impose adverse contract terms on physicians, especially decreased physician reimbursement rates, which would ''likely lead to a reduction in quantity or degradation in the quality of physicians' services.'' [13]

To resolve these competitive concerns the DOJ ordered Aetna to divest its entire interest in NYLCare-Gulf Coast and NYLCare-Southwest, its Houston and Dallas commercial HMO business. This consisted of 260,000 covered lives in Houston and 167,000 covered lives in Dallas.

[5] Clayton Act. 15 U.S.C. § 18. There is no case law evaluating the competitive legality of mergers under NRS 692C.210(l), however the language of the statute is identical to the Clayton Act. Thus, it is appropriate to apply the standards of federal antitrust law. The Nevada antitrust statute is similar to the Clayton Act. It prohibits mergers that will ''result in the monopolization of trade or commerce * * * or would further any attempt to monopolize trade or commerce'' or ''substantially lessen competition or be in restraint of trade'' NRS 598A.060(l(f).

[6] Section 7 prohibits anticompetitive reductions in quality because it equivalent to an increase in price—consumers pay the same (or greater) price for less. *Community Publishers. Inc.* v. *Donrey Corp.*, 892 F. Supp. 1146, 1153 n.8 (W.D. Ark. 1995), *aff'd sub nom. Community Publishers, Inc.* v. *DR Partners*, 139 F.3d 1180 (8th Cir. 1998); *Merger Guidelines*, § 0.1 (''Sellers with market power also may lessen competition on dimensions other than price, such as product quality, service, or innovation.''); id. § 1.11.

[7] *Nat'l Soc'y of Prof Eng'rs* v. *United States*, 435 U.S. 679,695 (1978).

[8] U.S. Dept of Justice and Federal Trade Comm'n, *Horizontal Merger Guidelines* (1997) (hereinafter ''*Merger Guidelines*''), The Nevada statute provides that in determining whether to approve a merger the Commissioner of Insurance ''shall consider the standards set forth in the Horizontal Merger Guidelines * * * NRS 692C.256(2).

[9] Concentration in merger cases is expressed in terms of market shares and a measure known as the Herfindahl Hirschman Index (''HHI''). The HHI is calculated by adding together the squares of the market share of individual competitors in the market. In a market with a single seller, the HHI is 10,000. The FTC/DOJ Merger Guidelines provide that an HHI below 1000 corresponds to an ''unconcentrated'' market; an HHI between 1000 and 1800 corresponds to a ''moderately concentrated'' market, and a HHI above 1800 corresponds to a ''highly concentrated'' market. The HHI is a screening tool used to assess whether a proposed merger will lead to anticompetitive consequences. Under the Guidelines different presumptions apply, depending on the extent of post-merger market concentration and the increase in HHI that will result from the merger. The greatest competitive concerns are raised where the post-merger HHI exceeds 1800. In such as case, it s ''presumed that mergers producing an increase in the HHI of more than 100 points are likely to create or enhance market power or facilitate its exercise,'' *Merger Guidelines*, § 1.51.

[10] Health insurers play dual roles as sellers of insurance services and buyers of health care services. In its first role, the health insurer's ''output'' consists of health benefit packages, and the output prices are paid for by customers in the form of subscriber premiums. In the role as the seller of health benefits, a dominant health insurer in a concentrated market could potentially act as a ''monopolist'' charging an above market price for health benefits. In its second role, the health insurer acts as a buyer, and the inputs consist of physician and other medical services. The insurer's input prices are the compensation it pays in the form of physician fees and fees for medical services. In this role, the health insurer may act as a ''monopsonist,'' reducing the level of services or quality of care by reducing compensation to providers. Health insurers are both buyers of medical services and sellers of insurance (to consumers), so insurance mergers can raise both monopsony and monopoly concerns.

[11] These market shares are substantially smaller than the market shares which would result from the United-Sierra merger in the HMO markets of Nevada and Clark County (80% in Nevada and 94% in Clark County).

[12] *United States* v. *Aetna*, Revised Competitive Impact Statement, Civil Action 3–99CV1398–H.

[13] *Id.*

In 2006, the DOJ investigated the merger between United and PacifiCare and focused on potential competitive concerns in relevant markets for commercial health insurance for small group employers in Tucson, Arizona and physician services in both Tucson and Boulder, Colorado.[14] Small group employers are employers with 2–50 employees. The merger would have combined the second and third largest providers of commercial health insurance in Tucson and increased United's market share from 16% to 33%.

The merger also raised concerns over the potential harm to competition in the purchase of physician services in both Tucson and Boulder. The DOJ explained that by combining United and PacifiCare ''the acquisition will 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.'' [15] In other words the DOJ found that a health plan's power over physicians to depress reimbursement rates can be harmful to patients—the ultimate consumers of health care. The market shares involved were relatively modest: in excess of 35% in Tucson and in excess of 30% in Boulder ''for a substantial number of physicians in those areas.''

In response to the potential harm to competition, the DOJ required United to divest contracts covering at least 54,517 members residing in Tucson, Arizona to yield a post-merger market share equal to its pre-merger market share. Furthermore, the DOJ required United to divest 6,066 members covered under its contract with the University of Colorado. This divesture constituted nearly half of PacifiCare's total commercial membership in Boulder.

The antitrust laws protect not only consumers but any group of buyers, potentially including a governmental buyer. Buyers of health insurance services have varying needs and ability to secure competitive rates. An example of this is a case filed by the City of New York challenging the merger between Group Health Incorporated (''GHI'') and the Health Insurance Plan of Greater New York (''HIP'') in the fall of 2006.[16] There are numerous health insurance competitors, including HMOs and PPOs in the New York City market, but for the low cost product required by the City and affiliated entities the only rivals were GHI and HIP. The case alleged that the merger of GHI and HIP would create a monopoly in the New York metropolitan area market for low cost health insurance purchased by the City of New York and its employee unions together with the city's employees and retirees as well as 35 other employers with ties to the city and their employees and retirees such as the Housing Authority, the Metropolitan Museum of Art and universities (all of which participate in the New York City health benefits program). The case alleges that city employees and retirees and those individuals who participate in the health benefits program would be faced with increased costs for insurance and reduced service if the merger were consummated. Litigation in the case is ongoing, but it suggests the broad range of markets that can be adversely affected by a merger.

IV. Special Information Concerns for Health Insurance Mergers

In determining the competitive effect of a merger the crucial issue is the impact on the consumer, the ultimate beneficiary of the insurance system. The questions to be examined include will consumers have to pay more for insurance in higher premiums or deductibles, will they suffer from poorer service such as longer waiting times or deterred services, and will they suffer from lower quality of care? Since consumers can not vote on a merger,[17] how does the Commissioner, antitrust enforcer, or the courts evaluate the impact of a merger on consumers? Insurance companies, employers, unions and buyers of insurance (''plan sponsors''), and health care providers will all have views of the impact of the merger on consumers. The views of the insurance companies can not be determinative, since they have an obligation to their stockholders to maximize profits.

The views of plan sponsors are relevant, but their failure to object to a merger may not be of significant evidentiary value. Plan sponsors represent the interests of their subscribers and thus may be concerned with the exercise of monopoly power leading to higher premiums. However, as antitrust authorities have recognized in many merger investigations, buyers of services may be very reluctant to complain about a merger for a variety of factors. They may simply pass on higher post-merger prices to the ultimate customer. In the health insurance area, although plan sponsors may be concerned about the cost of health insurance they may be less sensitive to the reduction in quality or service that may result from a merger. Finally, a customer may fear retribution postmerger.[18] This may particularly be the case in Nevada where the acquired firm will remain as the largest insurer even if the merger is denied. Thus, the fact that plan sponsors do not complain, or actually support a merger, should not be determinative of a merger's likely competitive effect.[19]

On the other hand healthcare providers may be a far more superior representative of the consumer interest and their concerns deserve careful attention. Physicians and other healthcare providers directly experience the diminution of service and quality when so-called cost containment efforts go too far. Physicians serve as advocates for the patient, especially in the often adversarial setting of managed care. Since health care providers experience first hand the impact of reductions in service they are more sensitive to the potential exercise of market power by health insurance. It is important to recognize in evaluating the concerns raised by providers that they are not just complaining about decreased compensation. Rather the issues raised by health care providers are central to concerns over quality of care: reduced services, greater waiting times, unacceptably short hospital stays, postponed or unperformed medical treatments, suboptimal alternative medical treatments, laboratory tests not performed, and other output restrictions on health services.

IV. Competitive Analysis of the United-Sierra Merger

Health Insurer Concentration: Harm To Buyers

The concentration of the health insurance industry has increased nationally due to a tremendous number of mergers and acquisitions and numerous smaller insurers exiting the industry.[20] Over the past 10 years there have been over 400 health insurer mergers. United has acquired several firms including California-based PacifiCare Health Systems, Inc., Oxford Health Plans, and John Deere Health Plan, increasing its membership to 32 million. Similarly, WellPoint, Inc. now owns Blue Cross plans in 14 states. Together, WellPoint and United control over 33 percent of the U.S. commercial health insurance market.

This increase in concentration has not benefited consumers. Studies indicate that health insurance premiums have increased at a rate more than twice the rate of inflation or the rate of increases in worker's earnings. Average annual premium increases have ranged from 8.2% to 13.9% since 2000,[21]

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[14] *United States* v. *UnitedHealth Group Inc.*, Case No. 1:05CV02436 (D.D.C. Dec. 20, 2005), available at *http://www.usdoj.gov/atr/cases/f213800/213815.htm.*

[15] *United States* v. *UnitedHealth Group*, Competition Impact Statement at 8, available at *http://www.usdoj.gov/atr/cases/f215000/215034.htm.*

[16] *City of New York* v. *Group Health Inc., et al.,* (S.D.N.Y. 2006).

[17] Fortunately, the Commissioner has decided to hold an extensive series of hearings on the merger and provided a significant opportunity for public comment. The majority of the public comments filed by consumers to date oppose the merger.

[18] There are a wide variety of reasons why customer support of a merger may not be particularly probative. *See* Ken Heyer, Predicting the Competitive Effects of Merger by Listening to Buyers, 74 Antitrust L.L. 87 (2007); Joseph Farrell, Listening to Interested Parties in Antitrust Investigations: Competitors, Customers, Complementors, and Relativity, Antitrust, Spring 2004 at 64 (explaining why customers may support an otherwise anticompetitive merger).

[19] In several cases courts have enjoined mergers even where customers testified in support of the merger. *See FTC* v. *H.J. Heinz Co.*, 246 F.3d 708 (D.C. Cir. 2001) (customers strongly supported merger); *United States* v. *United Tote*, 768 F. Supp. 1064, 1084–85 (D.Del. 1991) (enjoining merger despite testimony of ''numerous buyers'' that the merger would be procompetitive in creating a stronger rival to a dominant firm); *United States* v. *Ivaco*, 704 F. Supp. 1409, 1428 (W.D. Mich. 1989) (all testifying customers supported merger); *FTC* v. *Imo Indus.*, 1992–2 Trade Cas. (CCH) § 69,943, at 68,559 (D.D.C. 1989).

[20] Victoria Colliver, ''Insurer's Mergers Limiting Options: Health Care Choices Are Narrowing Says Study by AMA,'' San Francisco Chronicle, April 18, 2006 (last viewed 7/8/07) *http://sfgate.com/cgi-bin.article.cgi?file=/chronicle/archive/2006/04/18/BUGUQIAH161.DTL&type=business*

[21] Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2006 Summary of Findings,* 2006 (last viewed 7/8/

Moreover, since 2000, the number of employers offering health coverage benefits has decreased by nearly 10%. Studies indicated that medical benefits have not expanded despite premium increases. In contrast, health insurer profits have increased by 246% in the aggregate over the past decade.[22]

Consumers in highly concentrated health insurance markets are most vulnerable to insurance premium increases without comparable benefit increases, mirroring data of escalating health costs on the national level. One study found that more than 95% of Metropolitan Statistical Areas (MSAs) had at least one insurer in the combined HMO/PPO market with a market share greater than 30% and more than 56% of MSAs had at east one insurer with market share greater than 50%.[23] In concentrated MSAs such as these, there is a much greater likelihood that one firm, or a small group of firms, could successfully exercise market power and profitably increase prices or decrease compensation leading to less quality or service. As one prominent health care professor has observed in testimony before the U.S. Senate Judiciary Committee:

What is so important about the sheer number of competitors? Econometric evidence shows that in the managed care field, an increase in the number of competitors is associated with lower health plan costs and premiums; conversely, a decrease in the number of competitors is associated with increases in plan costs and premiums. The evidence also shows that the sheer number of competitors exerts a stronger influence on these outcomes than does the penetration level achieved by plans in the market.[24]

As we discuss below, the health insurance markets in the state of Nevada, especially Clark County are highly concentrated, and the merger of Sierra with United is likely to substantially harm competition and consumers.

Harm to Competition in Nevada From the United-Sierra Merger

Correctly defining an economically meaningful market is essential for ensuring that consumers of that market do not become subject to market power due to increases in market concentration and decreases in competition as a result of a merger. The key question in this merger as in other mergers is the definition of the relevant product market. The courts have held that a relevant product market ''must be drawn narrowly to exclude any other product to which, within reasonable variation and price, only a limited number of buyers will turn.'' *Times-Picayune Pub. Co.* v. *United States,* 345 U.S. 594, 612 n.31 (1953). Market definition focuses on demand substitution facts, and whether or not consumers would or could turn to a different product or geographic location in response to a ''small but significant non-transitory increase in price.'' [25] Typically, the antitrust agencies and the courts have implemented this test by seeking to identify the smallest group of products over which prices could be profitably increased by a ''small but significant'' amount (normally 5 percent) for a substantial period of time (normally one year).[26]

In health insurance mergers the DOJ has reached different, although not inconsistent. conclusions as to the relevant product market, For example, in the Aetna-Prudential merger DOJ concluded that the relevant product markets were the sale of health maintenance organization (''HMO'') and HMO-based point of service (''HMO-POS'') health plans. The DOJ noted that HMO and HMO-POS products differ from PPO or other indemnity products in term of benefit design cost and other factors. HMOs provide superior preventative care benefits, place limits on treatment options and generally require the use of a primary care physician ''gatekeeper.'' PPO plans are not structured in that fashion and do not emphasize preventative care. HMOs were perceived as being better devices to control costs and configure benefits. In addition, both the insurers and buyers of insurance services perceived PPOs and HMOs as being separate products. Thus, the DOJ concluded that the elasticity of demand for HMO's and HMO-POS plans are sufficiently low that a small but significant price increase for these plans would be profitable because consumers would not shift to PPO and other indemnity plans to make the increase unprofitable.

In United/PacifiCare, the DOJ defined a relevant product market as the sale of commercial health insurance to small group employers. This market consisted of employers with 2–50 employees. These employers were particularly susceptible to potential anticompetitive conduct because they lacked a sufficient employee population to self-insure and they lacked the multiple locations necessary to reduce risk through geographic diversity. In addition the manner in which commercial health insurance was sold also distinguished the small and large group markets. Large employers were more likely than smaller employers to be able to successfully engage extensive negotiations with United and PacifiCare.

We believe that both an HMO and small employer market may be adversely affected by the United-Sierra merger.[27] Surveys demonstrate that consumer do not perceive HMOs and PPOs as substitute products and consumers believe that they differ in terms of benefit design, cost, and general approaches to treatment.[28] PPOs tend to provide more flexibility in selection of physicians and specialists and tend to be more expensive. In contrast, HMOs focus more on preventative medicine but limit treatment options and require referrals from a ''gate keeper'' for many procedures. Consumers with special health needs and those relying more on strong relationships with their physicians would generally not he satisfied if forced to subscribe to an HMO with restrictions on personal choices. ''A small but significant price increase in the premiums for HMOs and HMO-POS plans would not cause a sufficient number of customers to shift to other health insurance products to make such a price increase unprofitable.'' [29]

Moreover, small employers are less likely to have significant alternatives in response to a price increase by the merged firm. Small employers are unable to self-insure and have little power to negotiate better rates.

The relevant geographic market seems to be a fairly straightforward matter since health care services are primarily local. From the perspective of the buyers of insurance services, employers want insurance where the employees work and live. Thus in Aetna/Prudential, the DOJ concluded ''the relevant geographic market in which HMO and HMO–POS plans compete are thus generally no larger than the local areas within which HMO * * * enrollees demand access to providers. * * * As a result, commercial and government health insurers—the primary purchasers of physician services—seek to have their provider network's physicians whose offices are convenient to where their enrollees work or live.''

In this merger the likely geographic markets are Clark County, Nevada, and the larger geographic market of the State of Nevada. Consumers faced with an increase in prices for HMOs are unlikely to travel a long distance away from homes or places of business to in order to escape price increases and purchase HMO services at a lower price. Generally, consumers are reluctant to travel lengthy distances when they are sick. Moreover, virtually all managed care companies provide networks in localities where employees live and work, and they compete with the other local networks.[30] Thus, we believe the proper relevant markets are the provision of HMO services in Clark County and Nevada.[31]

2007) *http://www.kff.org/insurance/7527/upload/7528.pdf*

[22] Laura Benko, ''Monopoly Concerns: AMA asks Antitrust Regulators to Restore Balance,'' Modern Physician, June 1, 2006.

[23] Edward Langston, ''Statement of the American Medical Association to the Senate Committee on the Judiciary United States Senate: Examining Competition in Group Health Care,'' Sept. 6, 2006 (last viewed 7/8/07) *http://www.ama-assn.org/amal/pub/upload/mm/399/antitrust090606.pdf.*

[24] Testimony of Professor Lawton R. Burns re the Highmark/Independence Blue Cross Merger, before the Senate Judiciary Committee (April 7, 2007).

[25] According to the Merger Guidelines,''[a] market is defined as a product or group of products and a geographic area in which it is produced or sold such that a hypothetical profit-maximizing firm, not subject to price regulation, that was the only present and future seller of those products in that area would likely impose at least a 'small but significant nontransitory' increase in price, assuming the terms of sale of all other products are held constant.'' *Merger Guidelines* § 1.0.

[26] *FTC* v. *Staples,* 970 F. Supp. at 1076 n.8; *Merger Guidelines* § 1.11, at 5–6.

[27] Defining the market in terms of a single product is appropriate since the Nevada statute provides that the Commissioner can deny a merger application if she ''determines that an acquisition may substantially lessen competition *in any line of insurance* in this state or tends to create a monopoly.'' NRS 692.258(1).

[28] *See United States* v. *Aetna,* Revised Complaint Impact Statement, Civil Action 3–99CV1398–H (N.D. Tex, 1999).

[29] *Id.*

[30] *Id.*

[31] As to the market for the sale of health insurance products to small employers we have no reason to

Continued

Concentration and Competitive Effects

Once the market is defined antitrust authorities and the courts calculate market shares and concentration levels (using the Herfindahl-Hirschman index (HHI)). This merger will lead to an unprecedented level of concentration. In the Clark County HMO market United's market share will increase from 14 to 94%. If PPOs are included, United's market share increases from 9% to 60%. Regardless of how the product market is defined United is clearly a dominant firm, far larger than the post merger market shares of the combined Aetna/Prudential or United/PacifiCare in those markets where DOJ brought enforcement actions. Even in a Nevada HM0 market, the market share increases from 12% to 80% and in a Nevada HMO–PPO market United's market share increases from 7% to 48%. Simply put, post-merger United will be a dominant firm no matter how the market is defined.

Measuring concentration using the HHI leads to similar results. The Merger Guidelines define a market with an HHI over 1800 as ''highly concentrated'' and an increase over 100 is ''likely to create or enhance market power or facilitate its exercise.'' The post-merger HHI for HMOs in the state of Nevada is 4,871 and the post-merger increase in HHI is 1,625. The HM0 market in Clark County is even more concentrated, with a post-merger HHI of 8,884 and a post-merger increase in HHI of 2,235. These exorbitantly high HHIs support the presumption that a merger between the two largest HMOs in the highly concentrated Nevada HMO market would likely create or enhance market power or facilitate its exercise. The market share data obtained form the Nevada State Health Division is provided below, (Figure 1).

Figure 1. Market Share Data for the HMO Market in Nevada and Clark County.[32]

Nevada			Clark County		
HMO	# patients	Market Share	HMO	Members	Market Share
Sierra Health Plan	279,679	68%	Sierra Health Plan	267,274	80%
United PacifiCare	48,196	12%	United PacifiCare	47,242	14%
Aetna	9,108	2%	Aetna	8,296	2%
WellPoint	11,365	2.70%	Nevada Care	10,639	3%
Hometown Health	23,281	6%	WellPoint	1,297	0.05%
Saint Mary's Healthfirst	27,411	7%	Total	334,748	99%
NevadaCare	10,827	2.60%			
Total	409,867	100%			

The Nevada and Clark County markets are highly concentrated, no matter how defined. The parties may suggest that this is of little import because the increase in concentration is not substantial because United currently has a relatively modest market share. Such an argument is inconsistent with the facts and the law. United is the largest health insurer in the United States and the second largest rival in the market, with the ability and incentive to expand competition. As to the law as the Supreme Court has acknowledged, ''if concentration is already great, the importance of preventing even slight increases in concentration is correspondingly great.'' [33]

As important, the combined United-Sierra will be substantially larger than its next closest rival. In the Nevada HMO market it will be over 10 times larger (80% to 7% for the second largest firm) and in the Clark County market it will be over 30 times larger (94% to 3%). The courts have recognized that smaller rivals are far less likely to constrain the conduct of a dominant firm post-merger, and have enjoined mergers with far smaller disparities in market share. *United States* v. *Phillipsburg Nat'l Bank,* 399 U.S. 350, 367 (1970) (merged firm three times the size of next largest rival): *FTC* v. *PPG,* 798 F.2d 1500, 1502–03 (D.C. Cir. 1986) (two and one-half times as large). Where a merger produces a firm that is significantly larger than its closest competitors, it increases the likelihood that the firm will be able to raise prices, decrease compensation, and reduce quality without fear that the small sellers will be able to take away enough business to defeat the price increase. *See United States* v. *Rockford Mem. Corp.,* 898 F.2d 1278. 1283–84 (7th Cir.) (Posner, J.), cert. denied, 498 U.S. 920 (1990); H. Hovenkamp, *Federal Antitrust Policy* § 12.4c (1993) (''markets may often have small niches or pockets where new firms can carve out a tiny position for themselves without having much of an effect on competitive conditions in the market as a whole'').

Combined PPO and HMO Markets

Using a definition of the health insurance product market as the combination of HMOs and PPOs, the health insurance market in Nevada is highly concentrated, and the United-Sierra merger would substantially increase the likelihood of competitive harm.

The market share for Sierra and United combined in Nevada is 48%, while in Clark County the combined United-Sierra market share is 60%. The post-merger HHI for the Nevada and Clark County markets are 3372 and 5244. respectively. The increase in the HHI market resulting from the United-Sierra merger is 555 for the state of Nevada and 921 for Clark County. Data of market shares from the Nevada State Health Division for the HMO and PPO markets is provided in Figure 2.

believe the concentration measures differ significantly from the HMO market.

[32] Data provided from the Nevada State Health Division.

[33] *United States* v. *General Dynamics Corp.,* 415 U.S. 486, 497 (1974).

[34] Data from the Nevada State Health Division.

[35] The market share for WellPoint in Clark County is overstated because in the absence of data by territory, all WellPoint customers were allocated to Clark County.

Figure 2. Market Share Data for the HMO/PPO Market in Nevada and Clark County.[34]

Nevada			Clark County [35]		
Insurance Firm	Members	% Market Share	Insurance Firm	Members	Market Share
Aetna Health Inc.,	9,108	1.18%	Sierra	297,825	51.35%
Sierra Health	312,702	40.67%	WellPoint	231,971	39.99%
WellPoint	231,971	30.17%	United	50,210	8.66%
Hometown Health	99,189	12.90%	Total	580,006	100.00%
NevadaCare	20,331	2.64%			
United Pacific Care	52,456	6.82%			
Saint Mary's Health First	43,141	5.61%			
Total	768,898	100.00%			

Conclusion on the Impact of the United-Sierra Merger on Consumers

As the U.S. Supreme Court has held where a merger results in a significant increase in concentration and produces a firm that controls an undue percentage of the market, the combination is so inherently likely to lessen competition substantially that it ''must be enjoined in the absence of evidence clearly showing that the merger is not likely to have such anticompetitive effects.'' *United States* v. *Philadelphia Nat'l Bank,* 374 U.S. 321, 363 (1963). The United-Sierra merger clearly raises extraordinary and unprecedented levels of concentration which raise serious concerns about this merger. Nevada is in need of greater competition, not less. Further consolidation among the limited health plan providers in Nevada poses a substantial threat of harming customers, increasing the costs of health care, and decreasing access to quality health care and the quality of health. This merger clearly ''would likely be harmful or prejudicial to the members of the public who purchase insurance'' and thus should be denied.

V. Health Insurance Concentration: Harm to Health Care Professionals and Quality of Care

The nature of the health care industry facilitates the potential for a dominant health coverage or insurance firm to exercise market power (or monopsony) over individuals selling health care services within a geographic region. Because medical services can be neither stored nor exported. health care professionals generally must sell their services to buyers (insurance firms and their customers) in a relatively small geographic market. Refusing the terms of the dominant buyer, physicians may suffer an irrevocable loss of revenue. Consequently, a physician's ability to terminate a relationship with an insurance coverage plan depends on her ability to make up lost business by switching to an alternative insurance coverage plan. Where those alternatives are lacking a physician may be forced to reduce the level of service in response to a decrease in compensation.

Not all insurance providers are equal from the perspective of a health care provider. A smaller insurance company with fewer covered lives may not be an attractive alternative. Health care providers who depend on an insurance program for all or most of their income are at a substantial disadvantage when there are not competing programs available; when they switch programs, they tend to lose the patients who have that particular coverage. It makes little sense for a provider to switch to an insurer who has a substantially smaller market share because there won't be enough patients to sustain the practice. Thus, it is critical for insurance regulators to maintain a competitive market in which health care providers have significant competitive alternatives.

In the Aetna/Prudential and United/PacifiCare mergers, the DOJ raised monopsony concerns in markets for purchasing physicians services where the market shares were far less substantial than they are in Clark County. For example, in United/PacifiCare the DOJ alleged that the combined firm would account for an excess of 35% in Tucson and over 30% in Boulder.

In addition, it is important to recognize that it may be appropriate to prevent a firm from securing monopsony power even if it faces a competitive downstream market. In other words there may be antitrust concerns if a health insurer can lower compensation to providers even if it can not raise prices to consumers. For example, in United/PacifiCare the Division required a divestiture based on monopsony concerns in Boulder even though United/PacifiCare would not necessarily have had market power in the sale of health insurance. The reason is straightforward—the reduction in compensation would lead to diminished service and quality of care, which harms consumers even though the direct prices paid by subscribers do not increase.[36]

Underlying the monopsony analysis in these cases is the premise that physicians who have a large share of reimbursements from the merged firm lack alternatives in response to a reduction in compensation. As alleged in Aetna, they cannot retain or timely replace a sufficient portion of those payments if the physicians stop participating in the plans. Moreover, it is difficult to convince patients to switch to different plans.[37]

Consequently. according to the Division these physicians would not be in a position to reject a ''take it or leave it'' contract offer and could be forced to accept low reimbursement rates from a merged entity, likely leading to a reduction in quantity or degradation in quality of physician services.

The merging parties may suggest that there is some safe harbor for mergers leading to a market share below 35%. As the DOJ enforcement action in Boulder demonstrates, that is not the case. The unique nature of health care provider services explains why monopsony concerns are raised at lower levels of concentration than may be appropriate in other industries. If a health care provider's output is suppressed by a reduction in compensation, then it is a lost sale that cannot be recovered later. Physician services can not be stored for later sale. As the DOJ observed in United/PacifiCare: ''A physician's ability to terminate a relationship with a commercial health insurer depends on his or her ability to replace the amount of business lost from the termination, and the time it would take to do so. Failing to replace lost business expeditiously is costly.'' [38] The DOJ observed that there are limited outlets for physician services: ''There are no purchasers to whom physicians can sell their services other than individual patients or the commercial and governmental health insurers that purchase physician services on behalf of their patients.'' [39] As a former DOJ official observed ''these factors explain why the Department concluded that shares below 35 percent, in the particular markets at issue, sufficed to allege competitive harm.'' [40]

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[36] See Marius Schwartz, Buyer Power Concerns and *Aetna-Prudential Merger,* Address Before the Annual Health Care Antitrust Forum at Northwestern University School of Law 4–6 (October 20. 1999) (noting that anticompetitive effects can occur even if the conduct does not adversely affect the ultimate consumers who purchase the end-product), available at *http/www.usdoj.gov/atr/public/speeches/3924.wpd.*

[37] As alleged in the *United* complaint, physicians encouraging patients to change plans ''is particularly difficult for patients employed by companies that sponsor only one plan because the patient would need to persuade the employer to sponsor an additional plan with the desired physician in the plans's network'' or the patient would have to use the physician on an out-of-network basis at a higher cost. Complaint at paragraph 37.

[38] Complaint at paragraph 36.

[39] Complaint at paragraph 33.

[40] Mark Botti, Remarks before the ABA Antitrust Section, ''Observations on and from the Antitrust Division's Buyer-Side Cases: How Can ''Lower'' Prices Violate the Antitrust Laws.'' He also noted that: ''Physicians have a limited ability to maintain the business of patients enrolled in a health plan once the physician terminates. Physicians could retain patients by encouraging them to switch to another health plan in which the physician participates. This is particularly difficult for patients employed by companies that sponsor only

Continued

Again the proponents of health insurance mergers may suggest that regulators should take a benign view about the creation of monopsony power because health insurers are ''buyers'' acting in the interest of reducing prices. As we suggested earlier, this view is mistaken. Health insurers are not true fiduciaries for insurance subscribers. Plan sponsors may have a limited concern over the product based on the cost of the insurance, and not the quality of care. Furthermore, health coverage plans operate in the interest of a group, not in the best interest of individual patients. Consequently, insurance firms can increase profits by reducing the level of service and denying medical procedures that physicians would normally perform based on professional judgment. In the absence of competition among insurers, patients are more likely to pay for these procedures out-of pocket or forego them entirely. Ultimately, the creation of monopsony power from a merger can adversely impact both the quantity and quality of health care.

Finally, the evidence from mergers throughout the U.S. strongly suggests that the creation of buyer power from health insurance consolidation has not benefited competition or consumers. Although compensation to providers has been reduced, health insurance premiums have continued to increase rapidly. Moreover, evidence from other mergers suggests that insurers do not pass savings on from these mergers on to consumers. Rather, insurance premiums increase along with insurance company profits.

Monopsony in the Health Care Markets of Nevada

United's acquisition of Sierra would give it unique control over the physicians serving the HMO and HMO–PPO markets in Clark County and the State of Nevada. The merger will combine the two largest HMOs with an 84% market share in Nevada and a 90% market share in Clark County, dramatically higher than the concentration in any merger approved by the DOJ. In light of these high market shares, a physician faced with unfair contract terms could not credibly threaten to leave the combined United-Sierra health plan, except by departing Clark County.

The parties have suggested the markets for physician reimbursement are far less concentrated. At the earlier hearing they suggested the merged firm would account for only 17% of physician reimbursement in the state and 21% in Clark County. We do not know the basis for the claimed reimbursement percentages. One should take United's estimates of market shares with a large grain of salt. In United/PacifiCare their lawyers suggested the parties' total share of physicians' reimbursements likely were substantially below the 35% threshold, but those estimates were rejected by DOJ. As one of their advocates said ''indeed the parties' calculated their total shares of physician reimbursements in the Tucson and Boulder MSAs were substantially lower than the shares asserted in the complaint.'' [41] The estimates of the proponents in the Aetna/Prudential merger were also rejected by the DOJ.[42]

Monopsony power exercised by HMOs and health insurance plans, like high medical malpractice insurance premiums, has the potential to drive health care professionals out of geographic regions and even into other professions. The Nevada health care market currently faces one of the largest shortages of doctors and nurses in the country.[43] It ranks 49th of the 50 states in physician coverage. Shortages of health care professionals can become a vicious cycle admonishing others against entering the profession. Doctor shortages increase with shortages of nurses and increases in insurance costs.'' [44] Nationally, it has become less attractive to become a physician because of the enormous cost associated with medical education, long years of schooling and residencies, and increased difficulty in earning a living.[45] Recently, Nevada has implemented programs to attract doctors from Mexico and train doctors in Mexico at the Universidad Autonoma de Guadelajara.[46]

Similar problems exist in nursing. Understaffed nursing departments require nurses to work overtime, work more holiday shifts, and undertake more responsibilities. These conditions exacerbate protracted work-related stress and decrease the attractiveness of working as a nurse in Nevada. Moreover, reduced flexibility for time-off and patient dissatisfaction resulting from overworked nurses is generally associated with lower levels of job satisfaction and higher turnover rates.[47]

Conclusion on the Impact on Health Care Professionals and Quality of Care

The United-Sierra merger poses a substantial threat to competition leading to reduced compensation for health care professionals who may be forced to reduce service and quality of care. This reduced quality of care ''would likely be harmful or prejudicial to the members of the public who purchase insurance.'' Further consolidation in the HMO and health coverage markets in Nevada may have detrimental short-term and long-term effects by exacerbating the crisis of the health professional shortage. Competition is essential to the delivery of high quality health care services. The United-Sierra merger will further distort the already concentrated and inefficient Nevada health care market.

Barriers to Entry Are High

As noted earlier, entry can be a factor in the analysis of a merger that may reverse the presumption of anticompetitive effects. The courts have required that ''entry into the market will likely avert the anticompetitive effects from the acquisition.'' *FTC* v. *Staples,* 970 F. Supp. 1066, 1086 (D.D.C. 1997). Entry must be ''timely, likely insufficient in its magnitude. character and scope to deter or counteract the competitive effects'' of a proposed acquisition. Merger Guidelines § 3.0.

The barriers to entry in the HMO and health insurance markets in Nevada and Clark County are very high. There has been relatively little recent entry into either Clark County or Nevada. The fact that United, the largest health insurer in the U.S., chose to enter into Nevada through two acquisitions—PacifiCare and Sierra—suggests the significant difficulty of de novo entry in these markets.

Generally, entry into health insurance markets is difficult. The health care industry does not fit the traditional model of perfect competition as expounded by the Chicago School.[48] For example, there is a high degree of ''lock-in'' because plan sponsors cannot disrupt the medical treatment of countless employee/patients. New entrants are vulnerable to the high switching costs that characterize the health insurance industry. Many consumers have no choice for health coverage plans and must accept the plan provided by an employer. Other consumers can only switch during an ''open enrollment'' season. Doctors cannot easily switch their patients to a different health plan and, in the

one plan because the patient would need to persuade the employer to sponsor an additional plan with the desired physician in the plan's network. Alternatively, the patient may remain in the plan, visiting the physician on an out-of-network basis. The patient would be faced with the prospect of higher out-of-pocket costs, either in the form of increased co-payments for use of an out-of-network physician, or by absorbing the full cost of the physician care.'' Complaint at paragraph 37.

[41] Fiona Schaeffer et al., ''Diagnosing Monopsony and other issues in Health Care Mergers: An overview of the United/PacifiCare Investigation,'' Antitrust Health Care Chronicle (2006).

[42] The estimates of the level of physician reimbursement by the proponents of the Aetna/Prudential merger were also rejected by the DOJ, The proponents suggested that the total amount of physician revenues affected by the merger were far less than thirty percent according to public available data. According to the proponents, the merged firm would have accounted for about 20% of total physician revenues in Houston and about 25% of total physician revenues in the Dallas Fort Worth area after the transaction. In addition, there were 14 HMOs in the Houston area and 12 HMOs in Dallas. *See* Robert E. Bloch et al. ''A New and Uncertain Future for Managed Care Mergers: An Antitrust Analysis of the Aetna/Prudential Merger.'' Yet the DOJ required an enforcement action to address monopsony concerns in spite of these alleged low shares of reimbursement.

[43] *See* Lawrence Mower, ''Help Sought South of the Border,'' Las Vegas Review Journal, Jan. 22, 2007; *see also* Lenita Powers, ''Big Day at Lawlor,'' Reno Gazette, Dec. 9, 2006 (expressing that nurses in Nevada are in a desperately short supply, especially OR nurses).

[44] *See* Lawrence Mower, ''Help Sought South of the Border,'' Las Vegas Review Journal, Jan. 22, 2007.

[45] Lawrence Mower, ''Help Sought South of the Border,'' Las Vegas Review Journal, Jan. 22, 2007.

[46] *Id.*

[47] *See* Jennifer Kettle, *Factors Affecting Job Satisfaction in the Registered Nurse,* Journal of Undergraduate Nursing Scholarship, Fall 2002 (last viewed July 9, 2007) *http://www.juns.nursing.arizona.edu/articles/Fall%202002/Kettle.htm.*

[48] *See* Thomas Greaney, *Chicago's Procrustean Bed: Applying Antitrust Law in Health Care,* 71 Antitrust L.J. 857 n. 1 (2004) (''Perfectly competitive markets demonstrate the following four characteristics: (1) Perfect product homogeneity (2) large numbers of buyers and sellers (3) perfect knowledge of market conditions by all market participants and (4) complete mobility of all product resources.'')

absence of a large number of patients enrolled in a plan, a doctor may find that additional claim processing costs exceed the benefits of carrying an additional health coverage provider. Similarly, doctors may be reluctant to switch plans because earnings lost in pursuit of new patients and alternate third-party payers may lead to exorbitant losses.[49]

Developing an HMO from scratch requires extensive expenditure on recruiting and maintaining health professionals, developing computer information systems and data banks, and high expenditures on overhead and clinical facilities. De novo entry is very challenging since new entrants must develop a reputation and product recognition with purchasers to convince them to disrupt their current relationships with the dominant health insurers.[50] As a recent DOJ/FTC report on health care competition reported, there has been relatively little de novo entry by national health insurers.[51]

Not surprisingly the DOJ has recognized the substantial barriers to entry and expansion in health insurance markets. In the Aetna/Prudential merger, the DOJ found substantial entry barriers. Certainly Dallas and Houston were attractive markets for health insurers. Both markets had a substantial number of alternative health insurers capable of expansion. And there were numerous competitors in other Texas markets that were capable of entering into these markets. Yet the DOJ found substantial entry barriers and that entry could take two to three years and cost up to $50 million.[52] In particular it found that it was ''unlikely that a company that currently provides PPO or indemnity health insurance in either Dallas or Houston would shift its resources to provide an HMO or HMO–POS plan'' in either market.[53]

Entry barriers are even more substantial in Nevada and Clark County. The shortage of health care professionals in Nevada increases barriers to entry because new entrants are unlikely to be able to contract with an adequate number of health professionals to attract new plan sponsors and enrollees. Moreover, when a dominant HMO maintains a high market share, other health providers may perceive or experience higher rates of adverse selection, moral hazard, and general vulnerability to tactics by a dominant HMO to raise rival's costs.[54] Experience indicates that new HMOs have not historically entered highly concentrated markets after a merger occurs.

The parties may also suggest that some of the smaller HMOs and health insurance providers in Nevada may be able to expand post-merger to prevent any anticompetitive effects. This is extremely unlikely because the fringe firms are currently so extremely small and far smaller than a combined United-Sierra. In cases with an even far smaller size disparity between the merged and fringe firms courts have declined to find that small players might suddenly expand to constrain a price increase by leading firms. *United States* v. *Philadelphia Nat'l Bank,* 374 U.S. 321, 367 (1963); *United States* v. *Rockford Mem. Corp.,* 898 F.2d 1278, 1283–84 (7th Cir. 1990) (''three firms having 90 percent of the market can raise prices with relatively little fear that the fringe of competitors will be able to defeat the attempt by expanding their own output to serve customers of the three large firms'').

The small firm expansion claim was rejected by the DOJ in Aetna/Prudential, a case with far smaller post-merger market shares and a far greater number of fringe firms:

> Due not only to these costs and difficulties, but also to advantages that Aetna and Prudential hold over their existing competitors—including nationally recognized quality accreditation, product array, provider network and national scope and reputation—existing HMO and HMO–POS competitors in Dallas or Houston are unlikely to be able to expand or reposition themselves sufficiently to restrain anticompetitive conduct by Aetna in either of these geographic markets.[55]

History demonstrates that one can not rely on new entry in Clark County. Few competitors from the rest of Nevada have been able to successfully enter Clark County. Attempting to enter into a market dominated by a single firm is a daunting task. There may be several obstacles to expansion including cost disadvantages, efficiencies of scale and scope and reputational barriers. In other mergers, the courts have found these types of impediments to be significant barriers to entry and expansion. For example, in the FTC's successful challenge to mergers of drug wholesalers the court noted: ''[t]he sheer economies of scale and scale and strength of reputation that the Defendants already have over these wholesalers serve as barriers to competitors as they attempt to grow in size.'' [56] We believe similar obstacles exist for potential entrants in these markets.

Relying on promises of entry and expansion may be a risky path for competition and consumers. In recent FTC/DOJ health care hearings, a former Missouri Commissioner of Insurance discussed several HMO mergers that his office approved based on the parties' arguments that entry was easy, that there were no capacity constraints on existing competitors (there were at least ten HMO competitors), and that any of the 320 insurers in the state could easily enter the HMO market. Unfortunately, those predictions were mistaken and there has been no entry in the St. Louis HMO market since the mid-1990s.[57] This experience, should make any regulator cautious about relying on predictions of new entry.

Efficiencies of the United-Sierra Merger Are Minimal

The parties have not suggested that there are significant efficiencies that may result from the merger. Under the Nevada statute, the Commissioner can consider efficiencies that either ''create[] substantial economies of scale or economies in the use of resources that may not be created in any other manner'' or ''substantially increase[] the availability of insurance.'' [58] In either case, the public benefit of either of these efficiencies must exceed the loss of competition. This standard simply can not be met in this case where the merger creates a dominant firm.

As a matter of U.S. merger law, efficiencies can justify an otherwise anticompetitive merger in very limited circumstances. Those efficiencies which are considered under the antitrust laws are solely those efficiencies which lead to improvements for consumers in terms of lower prices, greater innovation or greater service and quality. Moreover, an efficiency must be merger specific—that is it can not be achieved in any less anticompetitive fashion. When a cost savings does not result in those benefits to consumers it is not properly considered.

The record on recent health insurance mergers does not suggest that these mergers have led to substantial benefits to consumers in lower prices, better quality of care or service. Despite the occurrence of hundreds of health insurance mergers that have occurred in the past decade, subscriber premiums have continued to rise at twice the rate of inflation and physician fees.[59] Health benefits have not expanded with subscriber premiums.[60] Consequently, the efficiencies

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[49] Moreover, most employee/patients are limited to the physicians within the plan sponsors contract.

[50] At the FTC/DOJ Health Care hearings, a former Missouri Commissioner of Insurance suggested that new entrants ''face a Catch 22—they need a large provider network to attract customers, but they also need a large number of customers to obtain sufficient price discounts from providers to be competitive with the incumbents.'' In addition, he observed that there is a first mover, or early mover, advantage in the HMO industry, possibly resulting in later entrants having a worse risk pool from which to recruit members. He also observed reputation may inhibit entry. *See Improving Health Care: A Dose of Competition,* A Report by the Federal Trade Commission and the Department of Justice, Chapter 6 at 10 (July 2004), *available at http://www.usdoj.gov/atr/public/health_care/204694/chapter6.htm#3.*

[51] *Id.* at 11 (citing testimony that the only successful entry of national plans has been by purchasing hospital-owned local health plans).

[52] In light of the health professional shortage in Nevada, these values could be understated.

[53] Complaint at paragraph 23.

[54] *See* Roger Noll, *Buyer Power and Antitrust: ''Buyer Power'' and Economic Policy,* 72 Antitrust L.J. 589, 2005.

[55] Complaint at paragraph 24. In Aetna, the post-merger market shares were 44% and 62% and there were between 10–12 smaller competitors capable of expansion. In this case, the post-merger market share is greater than 90% and there are a handful of smaller competitors.

[56] *FTC* v. *Cardinal Health, Inc.,* 12 F. Supp. 34, 57 (D.D.C. 1998); *see United States* v. *Rockford Memorial Hosp.,* 898 F.2d 1278. l283–84 (7th Cir. 1990) (''the fact [that fringe firms] are so small suggests that they would incur sharply rising costs in trying almost to double their output . . . it is this prospect which keeps them small'').

[57] Testimony of Jay Angoff, former Missouri Commissioner of Insurance, before the FTC/DOJ Healthcare Hearings, April 23, 2003 at 40–45, discussed at *Improving Health Care: A Dose of Competition,* A Report by the Federal Trade Commission and the Department of Justice, Chapter 6 at 10 (July 2004), available at *http://www.usdoj.gov/atr/public/health_care/204694/chapter6.htm#3.*

[58] NRS 692C.256(3).

[59] Laura Benko, ''Monopoly Concerns: AMA Asks Antitrust Regulators to Restore Balance,'' Modern Physician, June 1, 2006.

[60] Best Wire, ''Study Says Competition in Health Markets Waning,'' Best Wire Apr. 19, 2006.

in health insurance mergers deserve careful scrutiny and a heavy dose of skepticism.[61]

The actual record on efficiencies from health insurance mergers is spotty at best. As Professor Lawton Burns has observed in Congressional testimony:

[T]he recent historical experience with mergers of managed care plans and other types of enterprises does not reveal any long-term efficiencies.

[E]ven in the presence of [efforts to achieve cost-savings] and defined post-integration strategies, scale economies and merger efficiencies are difficult to achieve. The econometric literature shows that scale economies in HMO health plans are reached at roughly 100,000 enrollees. * * * Moreover, the provision of health insurance (e.g., front-office and back-office functions) is a labor-intensive rather than capital-intensive industry. As a result, there are minimal economies to reap as scale increases. * * * Finally, there is little econometric evidence for economies of scope in these health plans—e.g,. serving both the commercial and Medicare populations. Serving these different patient populations requires different types of infrastructure. Hence, few efficiencies may be reaped from serving large and diverse client populations. Indeed, really large firms may suffer from diseconomies of scale.[62]

United's actual record in achieving efficiencies is a mixed one at best. Bigger is not necessarily better and a national platform is not better than a local one. To provide just one example, United completely disrupted efficient working relationships between University Medical Center and PacifiCare by replacing the local insurer's claims processing with a more bureaucratic national one.[63] This disruption in working operations increased the number of unpaid claims and created other problems with provider services. One need look no further than United's track record for inadequate claims processing over the past five years.

• The Nebraska Department of Insurance, which imposed a fine of $650,000, the largest ever, on United Health for inadequately handling complaints, grievance, and appeals.

• In March 2006, the Arizona Department of Insurance fined United $364,750 for violating State law by denying services and claims, delaying payment to providers and failing to keep proper records.

• In December 2005, the Texas Department of Insurance fined United $4 million for failing to pay promptly, lacking accurate claim data reports and not maintaining adequate complaint logs. They also had to pay restitution to physicians.[64]

State imposed fines are an inadequate remedy for poor services to patients and doctors. First, the actual payer of these fines is the consumer, because United can pass these fines on to consumers in the form of higher premiums and co-payments. Second, fines pose no solace to patients that may suffer the persistent hounding from creditors as a result of unpaid insurance claims. Further consolidation will only enhance the likelihood of shoddy claims service since consumers will have few rivals to turn to in response to poor quality of service.

United may suggest the merger is procompetitive because it will lead to improved cost containment initiatives. Of course, Sierra may adopt those measures without a merger. In addition, although efforts to contain costs are rooted in legitimate needs, the actual implementation of cost containment efforts can produce negative consequences for the quality of health care provided to consumers. However, most cost containment efforts center on decreasing utilization. Moreover, in concentrated markets, the likelihood of administered pricing and agreements not to reimburse for a procedure is more likely. Ultimately, the insurer's gross margin increases by reducing access to care and the quality of care for consumers.

The burden should be on the merging parties to demonstrate that the efficiencies they put forward are not speculative, that they exceed the likely anticompetitive effects on consumers and suppliers of services, and that the benefits will be passed on in the form of lower premiums and better quality, rather than larger profits for shareholders. It is highly unlikely that burden can be met in this case.

Recommendations

The United-Sierra merger poses a serious threat to competition in the provision of insurance and health care services in Nevada, especially Clark County. This merger requires heightened scrutiny given the currently high concentration of the health coverage providers in the Nevada market and the current shortage of health care professionals in the State. The merger should be denied because it ''would * * * substantially * * * lessen competition in insurance in Nevada or tend to create and monopoly,'' through the creation of a dominant health insurance provider particularly in Clark County. Moreover, it will lead to a reduction in the level and quahty of service thus harming and prejudicing ''the members of the public who purchase insurance.'' Enhancement of Nevada's health care requires increased levels of competitton and greater market efficiency, which cannot be achieved through a merger between two of the States largest health insurance providers. The likelihood of competitive harms from the United-Sierra merger is substantial, and the procompetitive benefits *de minimus*. Pursuant to NRS 692C.258(l), we urge the Commissioner to deny the merger application.

In the matter of: In the United States District Court for the District of Columbia, United States of America, Plaintiff, v. UnitedHealth Group Incorporated and Sierra Health Services, Inc.; Defendants.

[Civil No. 1:08–cv–00322] Judge: Ellen S. Huvelle. Filed: 2/25/2008.

Comments of the American Medical Association, Nevada State Medical Association and The Clark County Medical Society on the Proposed Consent Order

On February 25, 2008 the Antitrust Division of the Department of Justice filed a complaint and proposed final judgment (''PFJ'') with this Court regarding the acquisition of Sierra Health Services by UnitedHealth Group. Although this acquisition creates a dominant health insurer and permanently transforms the health insurance market for Clark County, Nevada, the DOJ identified a very limited set of competitive concerns in the Medicare Advantage market and proposed a remedy limited to that market.

The American Medical Association, Nevada State Medical Association and the Clark County Medical Society file these comments pursuant to the Antitrust Procedures and Penalties Act, 15 U.S.C. 16(b–e) (known as the ''Tunny Act'') because the DOJ's complaint and PFJ are seriously inadequate to remedy the competitive concerns arising from this transaction. This merger results in United dominating the commercial health insurance market with over a 56% market share. In spite of the substantial level of concentration resulting from this merger, the DOJ chose to challenge the impact of the merger on a single duplicative product, Medicare Advantage. The Justice Department's enforcement action is inadequate in several respects.

• It fails to secure relief in the market for the purchase of physician services;

• It fails to secure relief in the commercial insurance market; and

• It fails to prevent United from using contractual provisions such as most favored nations and all products clauses that may diminish the likelihood that the remedy will fully restore competition. The relief is also inadequate to fully restore competition in the Medicare Advantage market.

Finally, we explain why United's history of regulatory violations should raise significant concerns about relying on its promises to comply with the PFJ.

The DOJ decision not to challenge this acquisition is inconsistent with critical healthcare concerns. As documented in recent Congressional hearings before the Senate Judiciary Committee and the House Small Business Committee there is a tremendous trend of health insurance consolidation, which has led to higher premiums and a greater number of uninsured.[1] The proposed merger faced almost unprecedented opposition from community groups, public interest groups, healthcare alliances, physicians, nurses. employers. and state legislators.[2]

[61] See Laura Benko, ''Bigger Yes, But Better?'' Modern Health Care, March 19, 2007.

[62] Testimony of Professor Lawton R. Burns re. the Highmark/Independence Blue Cross Merger, before the Senate Judiciary Committee (April 7, 2007).

[63] *See* Laura Benko, ''Bigger Yes, But Better?'' Modern Health Care, March 19, 2007.

[64] Marshall Allen, ''Insurer Comes Here With a Trail of Fines From Other States,'' Las Vegas Sun, June 20, 2007.

[1] See testimony from: *Examining Competition in Group Health Care,* Hearing before the Senate Judiciary Committee, 109th Cong. (Sept. 6, 2006), and *Health Insurer Consolidation—The impact on Small Business,* Hearing before the House Small Business Committee, 110th Cong. (Oct. 25, 2007).

[2] For example, see Jennifer Robison, *MERGERS AND ACQUISITIONS:* Buyout sessions conclude. Las Vegas Rev. J. (July 28, 2007). Twenty-four organizations and individuals ranging from doctors and nurses to business owners, spoke out in opposition to the merger at the Nevada Dept. of Ins.

As described herein. the DOJ enforcement action is insufficient to address the critical healthcare and competitive concerns in the market highlighted by the widespread opposition. In spite of the particularly fragile Nevada health care delivery system, DOJ applied an even more lax standard than used in previous mergers and permitted an unprecedented level of concentration clearly in violation of the law and the Merger Guidelines. Ultimately, the Nevada Attorney General had to step in and file a separate case in federal court with 61-page consent order to address some, but not all, of the concerns ignored by the DOJ.[3] The PFJ should be rejected and this matter should be reopened to fully address the competitive concerns raised by this merger.

I. The Interests of the Parties

These comments are submitted on behalf of the American Medical Association, a non-profit professional association of approximately 240,000 physicians, residents, and medical students; the Nevada State Medical Association, and the Clark County Medical Society. The Medical Associations represent the interests of 1,458 doctors in the State of Nevada, and in particular 846 doctors in Clark County. These physicians will be competitively injured from the merger. The merger will result in a dominant health insurance company with the unilateral ability to reduce the level of compensation to physicians and in turn reduce the level of service and quality of treatment that those physicians can provide to patients. In addition, those physicians purchase insurance for themselves and their employees and will have to pay more for insurance because of this merger.

II. Procedural Background

In March 2007 United announced its proposed purchase of Sierra for $2.6 billion. In May, the DOJ issued a ''second request'' under the federal Hart-Scott-Rodino AntitrustImprovements Act of 1976, seeking more information. The state of Nevada conducted a simultaneous investigation.[4]

On February 25, 2008, after an 11-month investigation. the DOJ and Nevada Attorney General's office filed simultaneous, but separate enforcement actions. The DOJ action claimed that the merger would pose significant competitive problems in the Medicare Advantage health insurance market in Las Vegas, Nevada because the merged firm would control 94% of the market. The DOJ alleged this would result in higher prices, fewer choices, and a reduction in the quality of plans purchased by seniors in this area. These concerns were partially addressed within the PFJ which merely requires the divestiture of United's Medicare Advantage business.

Simultaneously, the state of Nevada filed a complaint and decree in federal court in Las Vegas, Nevada. The 61-page Nevada consent order also compelled the divestiture of United's Medicare Advantage business; but went far beyond the DOJ action and addressed competitive concerns involving physicians, Clark County, the University Medical Center and the delivery of healthcare to underserved populations. For example, on physician-related concerns, the Nevada decree enjoins the merging parties from enforcing all products and most favored nations clauses in their contracts for a period of two years, prohibits the merging parties from entering into exclusive contracts with physicians for a period of two years, and creates a Physicians Council for the purpose of addressing the relations between United and physicians, among other relief.

III. The Tunney Act Standards

The Tunney Act requires that ''[b]efore entering any consent judgment proposed by the United States * * *, the court shall determine that the entry of such judgment is in the public interest.'', 16 U.S.C. § 15(e)(1). In applying this ''public interest'' standard the burden is on the government to ''provide a factual basis for concluding that the settlements are reasonably adequate remedies for the alleged harms.'' *United States* v. *SBC,* 489 F.Supp. 2d 1, 16, (D.D.C. 2007), citing *United States* v. *Microsoft Corp.,* 56 F.3d 1448, 1460–61 (D.C. Cir. 1995).

The 2004 Congressional amendments to this Act specifically overruled District of Columbia Circuit Court of Appeals and District Court precedent that was deemed overly deferential to Antitrust Division consent decrees.[5] In response to those decisions, Congress reemphasized its intention that courts reviewing consent decrees ''make an independent, objective, and active determination without deference to the DOJ.''[6] Courts are to provide an ''independent safeguard'' against ''inadequate settlements''.[7] Specifically, the Act was amended to *compel* reviewing courts to consider both ''ambiguity'' in the terms of the proposed remedy, as well as the ''impact'' of the proposed settlements on ''competitors in the relevant market or markets.''[8] Moreover, the 2004 amendments were adopted to highlight that Congress expected an independent judiciary to oversee proposed settlements to ensure that the needs of the consumer were met.

We submit the DOJ has an extra burden to justify the limited relief in this case for two important reasons. First, the DOJ decision not to bring an enforcement action challenging the anticompetitive effects of the merger in the physician services or commercial insurance markets described herein is inconsistent with past enforcement actions such as United/PacifiCare[9] and Aetna/Prudential,[10] in which it required a enforcement policy on health insurance mergers it bears an obligation to disclose the reasons for those changes, so that the court can determine whether entry of the PFJ is in the public interest.

Second, the action taken by the DOJ is inconsistent with the State of Nevada's separate suit challenging the merger in federal court in Nevada. In that action, the Nevada Attorney General secured relief to address some of the substantial concerns raised by the medical associations, consumer groups, Clark County, and public interest groups. The Department's failure to address these concerns in its enforcement action requires heightened scrutiny by this court.

As described herein, the Department's apparent abandonment of its prior enforcement policies and failure to address the concerns recognized by the State of Nevada is especially unfortunate given the national shortage of physicians and the medical market distress that is particularly acute in Nevada.[11] All of these concerns demand the attention of this court.

IV. No Relief in the Market for the Purchase of Physician Services

The DOJ erred in failing to secure relief in the market for the purchase of physician services, even though the merger will significantly increase the level of concentration in that market. The merger will increase United's overall market share in the sale of commercial insurance products to

hearings held July 2007. In addition, there was strong opposition to the merger by consumer groups including Consumers Federation of American and the American Antitrust Institute. See testimony of David A. Balto before the Nevada Commissioner of Insurance on the UnitedHealth Group proposed acquisition of Sierra Health Services, Inc. (July 27, 2007) (appended herein as Attachment C).

[3] *State of Nevada* v. *UnitedHealth Group Inc. and Sierra Health Services, Inc.,* Case No. 2:08–cv–00233 (D. NV 2008).

[4] The Nevada Division of Insurance conducted hearings and approved the merger in August 2007 based on an agreement that United would maintain staffing levels in its local home office, would not pass on acquisition costs to subscribers, and other provisions.

[5] In this matter, the DOJ may claim that the court's review is limited to reviewing the remedy in relationship to the violations that the United States has alleged in its complaint, and does not authorize the court to go beyond the scope of the complaint. See FR 73, No. 47, at 12774 (March 10, 2008). We believe that view is inconsistent with the legislative history of the 2004 Amendments to the Tunney Act. Congress amended the Tunney Act in 2004 to overrule District of Columbia Circuit Court of Appeals and District Court precedent that was overly deferential to Antitrust Division consent decrees. The amendments to the Tunney Act *compel* the reviewing court to consider, *inter alia,* the ''impact'' of the entry of judgment on ''competition in the relevant market.'' See Pub. L. 108–327, § 221(b)(2) rewriting 15 U.S.C. § 16(e).

No suggestion is made in the statute or legislative history that the courts should defer to either the Government's identification of injury or the Government's proposed remedy to that injury. On the contrary, as one of the authors of the legislation noted, the reviewing court is to achieve an ''independent, objective, and active determination without deference to the DOJ.'' *See* 150 Cong. Rec., S. 3617 (April 2, 2004) (Statement of Sen. Kohl).

For criticism of the overly deferential standard see Darren Bush and John J. Flynn, *The Misuse and Abuse of the Tunney Act: The Adverse Consequences of the ''Microsoft Fallacies'',* 34 Loy. U. Chi. L.J. 749 (2002–2003).

[6] *See* 150 Cong. Rec., S 3617 (April 2,2004) (Statement of Sen. Kohl).

[7] *Id.*

[8] *Id.*

[9] *United States* v. *UnitedHealth Group, Inc.,* Case No. 1:05CV02436 (D.D.C. Dec. 20, 2005) (complaint) [hereafter United/PacifiCare Complaint], available at *www.usdoij.gov/atr/cases/f213800/213815.htm.*

[10] *United States* v. *Aetna, Inc.,* Case No. 3:99CV1398–H (N.D. Tex. June 21, 1999) (complaint) [hereinafter Aetna Complaint], available at *www.usdoj.gov/atr/cases/f2500/2501.pdf.*

[11] *See* Section IX herein.

56%. By combining two of the three largest buyers of physician services in Clark County, the merger poses a significant threat of reducing physicians' compensation and leading to an overall decrease of the level of service provided to patients.

The DOJ has brought enforcement actions on potential concerns over the decrease in competition in the past at market share levels similar or less significant than in this matter. In Aetna/Prudential it required a divestiture where the commercial insurance market shares would increase from 44% to 63% in Houston [12] and 26% to 42% in Dallas [13]. In United/Pacificare it required a divestiture where the commercial insurance market shares increased from 16% to 33% in Tucson [14] and to over 30% in Boulder, Colorado.[15] These enforcement actions were brought even though the defendants alleged much lower market shares in the purchase of physician services markets.

The nature of the health care industry facilitates the potential for a dominant health insurer to exercise monopsony power over physicians selling health care services within a geographic region. Because medical services can be neither stored nor exported, health care professionals have limited options for selling their services to buyers (insurance firms and their customers). If the physicians were to refuse the terms of the dominant buyer, they would likely suffer an irrevocable loss of revenue. Consequently, a physician's ability to terminate a relationship with an insurance coverage plan depends on that physician's ability to make up lost business by switching to an alternative insurance coverage plan. Where, as in the instant case, those alternatives are lacking, a physician may be forced to reduce the level of service in response to a decrease in compensation. Moreover, it is difficult to convince patients to switch to different plans.[16] Consequently, according to the DOJ in past enforcement actions, these physicians would not be in a position to reject a ''take it or leave it'' contract offer and could be forced to accept low reimbursement rates from a merged entity, likely leading to a reduction in quantity or degradation in quality of physician services.

Moreover, the size of the insurer impacts the ability of a physician to leave or credibly threaten to leave a plan. Not all health insurers are equal from the perspective of a physician. To terminate participation in a health insurer, a physician must make up the lost revenue. Smaller plans will offer fewer prospective patients. It makes little sense for a physician to switch to a plan which has a substantially smaller market share because there will not be enough patients to sustain the physician practice. Thus, it is critical for antitrust enforcers to maintain a competitive market in which physicians have adequate competitive alternatives.[17]

These concerns are documented by the affidavit of Professor David Dranove, the Walter McNerney Distinguished Professor of Health Industry Management at the Kellogg School of Management at Northwestern University.[18] Professor Dranove investigated the impact of the United/Sierra merger on the purchase of physician services. Based on the physician survey, consisting of supervising interviews with physicians and his knowledge of healthcare markets, he concludes there is a relevant market for the purchase of physician services in Clark County, Nevada. He further concludes that the merger will pose a substantial risk of harm in that market, and will adversely affect both physicians and consumers.

Professor Dranove posits that perhaps one reason that the DOJ did not seek to remedy potential anticompetitive effects in the market for the purchase of physician services is that the DOJ mistakenly underestimated the monopsony power created by the merger by including Medicare and Medicaid in the relevant market. Physicians can not increase their revenue from Medicare and Medicaid in response to a decrease in commercial medical insurer compensation. Enrollment in these programs is limited to the elderly and disabled and there are only a fixed number of these patients. Moreover, Medicaid pays physicians significantly less than commercial insurance payers. Professor Dranove concludes: ''Medicare and Medicaid do not represent viable alternatives for physicians who face lower fees from a monopsonist insurer. Because Medicare and Medicaid are large purchasers of physician services, excluding them from market share calculations will profoundly change inferences about market shares and monopsony power.[19] Medicare and Medicaid should therefore be excluded when computing shares in the market for the purchase of physician services.

Although the market share information in the market for the purchase of physician services is not publicly available there are proxies that can be used. The shares of the commercial market present a useful proxy of the share in the physician market. Professor Dranove has determined that the market shares in Sierra and United in the Las Vegas metropolitan area (which closely approximates Clark County) were 38% and 18% respectively. The combined market share is 56%. Professor Dranove concludes that this combined share, as well as the increase in share, raises substantial concerns about monopsony power that the DOJ does not appear to have addressed.[20] United/Sierra's combined market share in the commercial market suggests they have a substantial market share in the physician payment market. These market shares are clearly sufficient to raise concerns over the exercise of monopsony power.[21]

Professor Dranove's affidavit and the results of the physician survey demonstrate the potential anticompetitive effects of the merger on the delivery of physician services. As he observes, some physicians would have to cut back on the level of service. Other physicians would consider moving from the market. Other physicians might be forced to see fewer patients. Professor Dranove summarizes the potential harm to consumers:

> Part and parcel with a reduction in the compensation of physicians will be a reduction in the number of physicians who participate in the monopsonist's network. (This is the natural consequence of a monopsonist moving down its upward sloping supply curve.)[22] The patients who previously utilized the services of physicians who are no longer in the network must now either (a) select another, less preferred physician within the network, or (b) see their prior physician out-of-network and consequently pay higher out-of-network fees. Either way, these patients are worse off than before the exercise of monopsony power.

Even the patients of physicians who remain in the United/Sierra network may be

[12] Aetna Complaint at paragraph 22.

[13] *Id.*

[14] United/PacifiCare Complaint at 27.

[15] *Id.* at paragraph 41.

[16] As alleged in the *United/PacifiCare* complaint, physicians encouraging patients to change plans ''is particularly difficult for patients employed by companies that sponsor only one plan because the patient would need to persuade the employer to sponsor an additional plan with the desired physician in the plan's network'' or the patient would have to use the physician on an out-of-network basis at a higher cost. Complaint at paragraph 37.

[17] In most cases, like this one, a firm with monopsony power will also have market power in the downstream market—the sale of commercial insurance so that lower input prices do not lead to lower consumer output prices. See Peter J. Hammer and William M. Sage, *Monopsony as an Agency and Regulatory Problem in Health Care*, 71 Antitrust L.J. 949, 967 (2004). But even if that was not the case, there may be antitrust concerns if a health insurer can lower compensation to physicians even if it can not raise prices to patients. For example, in *United/PacifiCare* the DOI required a divestiture based on monopsony concerns in Boulder even though United/PacifiCare would not necessarily have had market power in the sale of health insurance. The reason is straightforward—the reduction in compensation would lead to diminished service and quality of care, which harms consumers even though the direct prices paid by subscribers do not increase. *See* Gregory J. Werden, *Monopsony and the Sherman Act: Consumer Welfare in a New Light*. 74 Antitrust L.J. 707 (2007) (explaining reasons to challenge monopsony power even where there is no immediate impact on consumers). Marius Schwartz, *Buyer Power Concerns and the Aetna-Prudential Merger*, Address Before the 5th Annual Health Care Antitrust Forum at Northwestern University School of Law 4–6 (October 20, 1999) (noting that anticompetitive effects can occur even if the conduct does not adversely affect the ultimate consumers who purchase the end-product), *available at http://www.usdoj.gov/atr/public/speeches/3924.wpd*.

[18] *See* Dranove Aff. (May 13, 2008), appended herein as Attachment A.

[19] *Id.* at 4.

[20] *Id.* at 4.

[21] For example, in United/PacifiCare the DOJ alleged that the combined firm would account for an excess of 35% of physician reimbursement in Tucson and over 30% in Boulder. Yet in both of these actions DOJ required a divestiture in order to resolve concerns about the potential exercise of monopsony power. In addition, as a former DOJ official explains, the unique nature of health care physician services explains why monopsony concerns are raised at lower levels of concentration than may be appropriate in other industries. Mark Botti, Remarks before the ABA Antitrust Section, ''Observations on and from the Antitrust Division's Buyer-Side Cases: How Can ''Lower'' Prices Violate the Antitrust Laws,'' (April 18, 2007).

[22] When supply is upward sloping, a seller with monopsony power profits by reducing the wages it pays, relative to the competitive wage. By doing so, fewer suppliers offer their goods and services, so that the monopsonist ends up reducing the quantity of output it produces.

worse off, because the reduction in the fees paid to these physicians may cause them to reduce the quantity and/or quality of services they provide* * *

If physicians reduce their office hours, this is likely to affect access for all of their patients. (Physicians who contract with a monopsonist could not normally limit their availability to the monopsonist's patients only.) Similarly, if a physician cuts back on staff and/or equipment, or invests less in continuing education, all patients would surfer. Of course if the physician exits the market altogether, all patients suffer.[23]

The DOJ's failure to oppose the merger suggests that it takes a benign view about the creation of monopsony power. Perhaps the DOJ, like proponents of health insurer mergers, is now taking the view that health insurers are ''buyers'' acting in the interest of reducing prices. As we suggested earlier, this view fails to come to grips with the monopsony issue in any meaningful way and fails to address the reality that patients are the ultimate consumers.[24] As a general proposition, monopsony power does decrease economic welfare. Monopsonists drive down their buying price by purchasing fewer products. Because there is less product purchased, there is, in turn, less product sold.[25] Thus, the reduced input costs of monopsonist medical insurers will not necessarily result in lower premiums to patients and hence elevated levels of consumer welfare. This fact was emphasized by R. Hewitt Pate, the Assistant Attorney General of the Antitrust Division, in a 2003 statement before the Senate Judiciary Committee:

A casual observer might believe that if a merger lowers the price the merged firm pays for its inputs, consumers will necessarily benefit. The logic seems to be that because the input purchaser is paying less, the input purchaser's customers should expect to pay less also. But that is not necessarily the case. Input prices can fall for two entirely different reasons, one of which arises from a true economic efficiency that will tend to result in lower prices for final consumers. The other, in contrast, represents an efficiency-reducing exercise of market power that will reduce economic welfare, lower price for suppliers, and may well result in higher prices charged to final consumers.[26]

Moreover, University of Pennsylvania Health Economics Professor Mark Pauly has demonstrated that health insurers with monopsony power may profit from pushing provider prices ''too low'' so that consumers do not receive an adequate level of service and quality.[27] Also, because health insurer monopsonists typically are also monopolists, lower input prices do not lead to lower consumer output prices.[28]

In any event, health insurers are not true fiduciaries for insurance subscribers. Plan sponsors may have a limited concern over the product based on the cost of the insurance, and not the quality of care. Furthermore, health coverage plans operate in the interest of a group, not in the best interest of individual patients. Consequently, health insurers can increase profits by reducing the level of service and denying medical procedures that physicians would normally perform based on professional judgment. In the absence of competition among insurers, patients are more likely to pay for these procedures out-of-pocket or forego them entirely. Ultimately, the creation of monopsony power from a merger can adversely impact both the quantity and quality of health care.

Finally, the evidence from mergers throughout the U.S. strongly suggests that the creation of buyer power from health insurance consolidation has not benefited competition or consumers.[29] Although compensation to providers has been reduced, health insurance premiums have continued to increase rapidly. Moreover, evidence from other mergers suggests that insurers do not pass savings on from these mergers on to consumers. Rather, insurance premiums increase along with insurance company profits. As Professor Lawton Burns has observed in Congressional testimony:

[T]he recent historical experience with mergers of managed care plans and other types of enterprises does not reveal any long-term efficiencies.

[E]ven in the presence of [efforts to achieve cost-savings] and defined post-integration strategies, scale economies and merger efficiencies are difficult to achieve. The econometric literature shows that scale economies in HMO health plans are reached at roughly 100,000 enrollees. * * * Moreover, the provision of health insurance (e.g., front-office and back-office functions) is a labor-intensive rather than capital-intensive industry. As a result, there are minimal economies to reap as scale increases. * * * Finally, there is little econometric evidence for economies of scope in these health plans—e.g., serving both the commercial and Medicare populations. Serving these different patient populations require different types of infrastructure. Hence, few efficiencies may be reaped from serving large and diverse client populations. Indeed, really large firms may suffer from diseconomies of scale.[30]

Concerns about the merger's impact in the physician market were recognized by the Nevada Attorney General in the companion enforcement action brought in federal court in Nevada. The Nevada Attorney General, although filing a similar complaint, secured some relief to address physician reimbursement issues. The Department's failure to address these concerns demonstrates the inadequacy of its enforcement action.

In sum, the merger poses significant risks of harm in the market for the purchase of physician services and will lead to a diminution of the quality of healthcare in Clark County's underserved healthcare market. The DOJ should have secured relief that would have prevented this harm in the physician services market. In any case, the DOJ should provide an extensive statement on its reasons not to bring an enforcement action in this market, including whether the relevant market includes governmental payors.[31]

V. The DOJ Has Arbitrarily Departed From its Past Antitrust Enforcement Policies

As discussed earlier, the DOJ has brought enforcement actions against insurance mergers which threatened harm to the market for the purchase of physician services. In these cases, the DOJ adopted the position that antitrust should be concerned with monopsony

[23] Dranove Aff. at 6–7

[24] Francis H. Miller, Vertical Restraints and Powerful Health Insurers: Exclusionary Conduct Masquerading as Managed Care?, 51 Law & Contemp. Probs. 195, 222 (1998).

[25] 2A Phillip E. Areeda & Herbert Hovenkamp, Antitrust Law § 575, at 363–64 (2002).

[26] R. Hewitt Pate, Asst. Att'y Gen., Antitrust Div., U.S. Dept. of Justice, Statement Before the Senate Committee on the Judiciary Concerning Antitrust Enforcement in the Agricultural Marketplace, at 4 (Oct. 20, 2003), available at *http://www.usdoj.gov/atr/public/testimony/201430.pdf*.

[27] Mark V. Pauly, Competition in Health Insurance Markets, 51 Law & Contemp. Probs. 237 (1998).

[28] Peter J. Hammer and William M. Sage, Monopsony as an Agency and Regulatory Problem in Health Care, 71 antitrust L.J. 949 (2004).

[29] See testimony from: Examining Competition in Group Health Care, Hearing before the Senate Judiciary Committee, 109th Cong. (Sept. 6, 2006), and Health Insurer Consolidation—The Impact on Small Business, Hearing before the House Small Business Committee, 110th Cong. (Oct. 25, 2007).

[30] Testimony of Professor Lawton R. Burns re. the Highmark/Independence Blue Cross Merger, before the Senate Judiciary Committee (April 7, 2007).

[31] Providing clarity on the reasons not to bring an enforcement action in these markets is consistent with the Division's policy on ''Issuance of Public Statements Upon Closing of Investigations,'' available at*http://www.usdoj.goviatripublicimidelines/201888.htm* (factors that will lead to the issuance of a closing statement include ''whether the matter has received substantial publicity [and] the value to the public in receiving information regarding the reasons for non-enforcement (including public trust in the Department's enforcement, and the value of the analysis for other enforcers, businesses and consumers)''). DOJ has issued closing statements in other health insurance mergers. See DOJ Press Release No. 04–497 (statement closing investigation of UnitedHealth's acquisition of Oxford Health Plans), available at *http://www.usdoj.gov/atr/public/press_ release/2004/204674.htm.*

mergers harming suppliers without the necessity for evidence of harm to downstream consumers.

Accordingly in challenging Aetna's 1999 acquisition of Prudential and United's 2006 acquisition of PacifiCare, the DOJ addressed the harm to health care providers from the exercise of monopsony power. Both of these mergers were resolved with divestitures to facilitate the entry of new competitors to remedy the competitive concerns. In the Aetna/Prudential matter, the proposed merger would have increased Aetna's market share from 26% to 42% in Dallas, giving the merged entity a smaller share than would result from the merger here. Nevertheless, the DOJ concluded that the merger raised monopsony concerns by giving the merged firm the potential to unduly suppress physician reimbursement rates, resulting in a reduction of quantity or degradation of quality of medical services. The operative question from DOJ's perspective was could health care providers defeat an effort by the merged firm to reduce provider compensation by a significant amount, e.g. 5%. The question was answered in the negative for the same reasons explained by Professor Dranove in the instant case: physicians have limited ability to encourage patients to switch health plans, and physicians' time (unlike other commodities) cannot be stored, which means that physicians incur irrecoverable losses when patients are lost but not replaced. To exacerbate matters, contracts with physicians were negotiated on an individual basis, and were therefore susceptible to price discrimination by powerful buyers. Thus, DOJ concluded that Aetna had sufficient power to impose adverse contract terms on physicians, especially decreased physician reimbursement rates, which would ''likely lead to reduction in quantity or degradation in the quality of physicians' services.[32] As a remedy, the DOJ ordered Aetna to divest the business that would have given the merged entity monopsony power.

VI. The DOJ's Reversal in Its Enforcement Stance Comes Under Particularly Adverse Circumstances in Nevada

Merger analysis always focuses on the unique circumstances in every market. The Nevada healthcare market is particularly vulnerable, because of longstanding shortages of healthcare providers. Here are the simple facts:

- Nevada ranks 47th for access to care (based on the number of adults that should have visited a doctor but did not because of costs, and the number of uninsured);
- Nevada ranks 45th in access to physicians—approximately 25 percent below the nationwide median and has one of the lowest physician to population ratios;[33]
- Nevada ranks 51st in the country in quality of care (based on the number of adults receiving recommended screenings, diabetics receiving preventive care, Medicare patients that get enough time with a doctor);
- Nevada is last for immunization coverage for children under age 3—a fundamental role of primary care;
- Not surprisingly, based on the foregoing data, Nevada is 41st for mortality rates.

Assuming that Clark County's performance measures are similar to the rest of the state, allowing this merger into monopsony will for the reasons explained earlier, lead to a further reduction in quantity and degradation of quality of physician services. Thus, DOJ's refusal to adhere to its previous enforcement stance in cases of health insurer mergers into monopsony demand the attention of this court.

Turning to the market for the sale of commercial insurance where the parties control over 50% of the market in Clark County, Nevada, the record of health insurance coverage has been deplorable. Nevada has nearly half a million residents without health care coverage, almost 25 percent of the State. A high uninsured population not only presents health problems for those without coverage. When the uninsured do receive medical care, the costs are often shifted to the insured population; 2005 estimates indicate that health care treatment for uninsured persons in Nevada cost $397 million, $314 million of which was covered by higher premiums for those with insurance.[34] These factors too strongly suggest that the Court should be particularly judicious in evaluating the adequacy of the PFJ.

VII. No Relief in the Market for the Sale of Commercial Insurance

We believe that the DOJ also erred by not securing relief in the market for the sale of commercial insurance. Sierra and United were respectively the first and third largest sellers of commercial insurance products (including both .HMO and PPO products). The merger led to a combined share in the commercial insurance market of 56%. If the market was limited to HMO products, where United and Sierra were the two largest rivals the combined market share was 90%. In similar cases, the DOJ has required divestiture to resolve competitive concerns.

For example in United/PacifiCare, the DOJ defined a relevant product market as the sale of commercial health insurance to small group employers. This market consisted of employers with 2–50 employees. These employers were particularly susceptible to potential anticompetitive conduct because they lacked a sufficient employee population to self-insure and they lacked the multiple locations necessary to reduce risk through geographic diversity. In addition, the manner in which commercial health insurance was sold also distinguished the small and large group markets. Large employers were more likely than smaller employers to be able to successfully engage in extensive negotiations with United and PacifiCare.

We believe that both an HMO and small employer market may be adversely affected by the United-Sierra merger. Surveys demonstrate that consumers do not perceive HMOs and PPOs as substitute products, and consumers believe that they differ in terms of benefit, design, cost, and general approaches to treatment.[35] PPOs tend to provide more flexibility in selection of physicians and specialists and tend to be more expensive. In contrast, HMOs focus more on preventative medicine but limit treatment options and require referrals from a ''gatekeeper'' for many procedures. Moreover, small employers are less likely to have significant alternatives in response to a price increase by the merged firm. Small employers are unable to self-insure and have little power to negotiate better rates.

Again, as in the physician services market, the PFJ should be reopened to

[32] Aetna Complaint at paragraph 33.

[33] Nationally, there is a substantial and increasing shortage of physicians. *See e.g.* Health Resources and Services Administration (HRSA) *Physician Supply and Demand: Projections to 2020.* (Oct 2006) Projecting a shortfall of approximately 55,000 physicians in 2020) Merritt, J., J. Hawkins, et al. *Will the Last Physician in America Please Turn Off The Lights? A Look at America's Looming Doctor Shortage.* Irving, TX. Practice Support Resources, Inc. (2004) (Predicting a shortage of 90,000 to 200,000 physicians and that average wait times for medical specialties is likely to increase dramatically behond the current range of two to five weeks. This problem is far worse in Nevada.

[34] Paying a Premium: The Added Cost of Care for the Uninsured. Families USA (June 2005). Available at *http://www.familiesusa.org/assets/pdfs/Paying_a_Premium_rev_July_1373le.pdf.*

[35] *See United States* v. *Aetna,* Civil Action 3–99CV1398–H (N.D.Tex, 1999) (Revised Complaint Impact Statement).

secure relief in the commercial insurance market. In the alternative, the DOJ should issue a comprehensive statement of its reasons not to seek enforcement in this market.

VIII. Inadequacy of Remedies

Finally, the proposed remedies in the PFJ are inadequate in several respects. First, the restrictions that a dominant firm can impose on physicians are often critical to the acquirer of divested assets to effectively compete in the market. In this case, there are a variety of provisions that United can use that will deter the ability of the acquirer of the divested Medicare Advantage business to restore competition. For example, if Humana (the acquirer of United's Medicare Advantage business) were to attempt to attract greater physician coverage through attractive reimbursement rates, United could impose ''most favored nations'' provisions, which would prevent doctors from giving a more attractive rate to Humana. Similarly, United could utilize ''all products clauses'' which would require physicians to participate in United's Medicare Advantage program as a condition for participating in United's commercial program.[36] Professor Dranove explains how both of these provisions can be used in anti-competitive fashion.[37] The PFJ should have prevented the use of these provisions.[38]

Second, the DOJ requires solely the divestiture of the Medicare Advantage business rather than all of United's health insurance business in Clark County. This piecemeal approach faces a significant risk of failure. There is no evidence that a Medicare Advantage business can operate solely on its own without a commercial component. There are significant economies of scope and scale that exist when both commercial and Medicare Advantage businesses are combined. Moreover, the failure to divest an entire ongoing business is inconsistent with the DOJ's Merger Remedy Guidelines.[39]

The remedy is inadequate in several other respects. First, the DOJ recognizes the critical aspect of trademarks in being able to secure and keep an ongoing business. To elderly consumers the names ''United'' or ''Sierra'' are nowhere near as important or prominent as ''Secure Horizons,'' ''AARP'' or ''Senior Dimensions.'' In situations like this where trademarks are of particular importance to continue to secure customer loyalty, the antitrust agencies often prevent the merged party from using the trademark for a period of time. However, in this case the Justice Department imposed that obligation for only an extremely short period of time. Essentially within one to two years United can again reuse the Senior Dimensions (after March 31, 2010) or AARP (after March 31, 2009) trademark and lure customers to United's product.

We believe the remedy should be strengthened in the following fashion. First, the PFJ should require the divestiture of all of United's business and not just the Medicare Advantage business. Second, if the divestiture is limited to the Medicare Advantage business, the trademarks should be conveyed for at least five years. Third, United's use of all products clauses and most favored nations provisions should be permanently enjoined.

IX. United's Prior Acts of Broken Promises

In evaluating whether the remedies in the PFJ are adequate, it is critical to recognize United's past record of continual disregard of its regulatory obligations. No other health insurance company has been the subject of as many serious enforcement actions involving the violation of consumer protection and insurance regulations. This record of continual regulatory abuse raises a serious likelihood that United will fail to comply with any regulatory order. United has a long track record of disregarding its regulatory obligations and patient protection laws.[40]

In February 2008, California regulators imposed a potential penalty of $1.3 billion in fines against United for violating the law more than 130,000 times [41] after acquiring PacifiCare. Upon reviewing 1.1 million claims, the investigation found that after United acquired PacifiCare in 2005, United failed to pay claims in a timely manner and had over a 10% overall error rate in processing claims. United wrongfully denied claims for covered medical care, with regulators finding that 30% of reviewed HMO claims were denied incorrectly and 55% of certain claims were incorrectly denied as duplicate submissions when they were not in fact duplicate submissions. Regulators found that 29% of reviewed provider disputes were handled incorrectly, and that documents including medical records, had been lost by United. In addition, United lacked sufficient staffing to process claims in a timely manner and had failed to provide accurate lists of in-network providers to consumers. Finally, regulators in California found that United lacked efficient procedures to handle provider disputes.

Earlier this year, the New York Attorney General announced an investigation of United and other insurance companies for possible fraud. The New York Attorney General believes the insurance companies, including United, have used corrupted data from United-owned firm Ingenix to set unfair and unjustifiably low reimbursement rates for out of network physicians, resulting in higher out-of-pocket costs for consumers.[42]

In a landmark enforcement action in September 2007, Insurance Commissioners in 36 states assessed a $20 million fine against United Health for ongoing failures in processing claims and responding to consumer complaints.[43] This settlement establishes numerous claims processing payment requirements and makes provisions for substantial regulatory relief and additional fines during its term which does not expire until December 31, 2010.

Finally, other states have brought similar enforcement actions against United. In December 2006, the Nebraska Department of Insurance imposed its largest fine ever when it fined United $650,000 for failing to handle complaints, grievances and appeals in a timely fashion. In March 2006, the Arizona Department of Insurance fined United $364,750 (the largest fine in its history) for violating state law by denying services and claims, delaying payment to providers, and failing to keep proper records. In December 2005, the Texas Department of Insurance fined United $4 million for failing to pay claims promptly, lacking accurate claim data reports and not maintaining adequate complaint logs.

[36] All products clauses were prohibited in the consent order in United/Pacificare. *See United States* v. *UnitedHealth Group Inc.,* Case No. 05CV0436 (D.D.C. 2005) (Competitive Impact Statement at sec. III).

[37] Dranove Aff. at 8.

[38] There may be a suggestion that the relief in the Nevada consent decree may be sufficient to address these concerns. We do not agree with that view. The Nevada decree only prohibits these provisions for a short time—2 years. That period is inconsistent with the DOJ remedy in United/PacifiCare, which banned these provisions for the life of the Judgment.

[39] *See Antitrust Division Policy Guide to Merger Remedies,* U.S. Dept. of Justice, Antitrust Division at sec. III, C., (Oct. 2004).

[40] See American Medical Association letter to Nevada Commissioner of Insurance, Alice A. Molasky-Arman (June 5, 2007) concerning the history of United in failing to comply with state regulations (appended herein as Attachment B).

[41] Girion, Lisa, *Health Plan Faces Fines of $1.33 Billion*, Los Angeles Times, January 29, 2008.

[42] *Cuomo expands probe of health insurers.* Modern Healthcare Daily Dose. March 6, 2008.

[43] Allen, Marshal. *36 States Join to Fine UnitedHealth, Las Vegas Sun*, September 13, 2007.

We believe that these violations raise serious concerns about United's likely compliance with the provisions of the PFJ and highlight the need to strengthen the PFJ provisions. We suggest that the PFJ be modified to immediately impose the use of a monitor trustee to ensure compliance with the order.

X. Conclusion

After an 11-month investigation of a merger posing an unprecedented level of concentration in perhaps the most vulnerable healthcare market in the United States, the DOJ chose a modest remedy on a single line of business. That remedy is inadequate to resolve the concerns in the Medicare Advantage market and is inconsistent with the DOJ's Merger Remedy Guidelines. But more important, the FJ fails to address the significant loss of competition in both the purchase of physician services and sale of commercial insurance markets. Although the State of Nevada attempted to supplement the modest DOJ action, both actions permit a merger that poses a significant threat of causing substantial harm to consumers.

Thus, we believe the PFJ should be rejected. If the court, however, accepts the FJ, we strongly urge it to treat the PFJ as an interim remedy and expressly leave open the possibility of supplementing the PFJ with additional remedies to address these competitive concerns.[44]

Dated: May 15 2008.

Respectfully Submitted,
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Attachment A

In the matter of: United States of America, Plaintiff v. UnitedHealth Group Incorporated and Sierra Health Services, Inc.; Defendants.

[Civil No. 1:08-cv-00322]

Judge: Ellen S. Huvelle.

Filed: 2/25/2008.

Affidavit of Professor David Dranove

I. Qualifications

I am the Walter McNerney Distinguished Professor of Health Industry Management at the Kellogg School of Management, as well as the Director of the Center for Health Industry Market Economics and the Director of *Health at Kellogg.* I have studied health care competition for over 20 years and have published numerous books and peer reviewed papers on the topic. My vita is attached.

I have also studied the Nevada health care market place, paying particular attention to physician markets in Clark County. This includes examining secondary data and supervising a physician survey. I am submitting this affidavit because I am concerned about the potential anticompetitive impact of the merger of UnitedHealth Group and Sierra Health Services, particularly the impact on the market for physician services.

II. Background [1]

The proposed merger between UnitedHealth Group and Sierra Health Services would create the largest private health insurer in Nevada. The Antitrust Division of the U.S. Department of Justice (DOJ) has reviewed this merger and filed a Complaint, Competitive Impact Statement, and Proposed Consent Order that narrowly focus on conduct and a remedy in the output market for Medicare Managed Care insurance. Specifically, UnitedHealth will be required to divest its Medicare Managed Care offerings as a condition for DoJ approval.

I have extensively researched health care competition, including competition among insurers. I have also studied the Nevada healthcare marketplace, including conducting interviews and a survey of Nevada physicians that I describe below. In my opinion, the DoJ focus on the Medicare Managed Care market is too narrow. In particular, the proposed remedy is inadequate because it fails to address the potential for the United/Sierra merger to create monopsony power in the market for the purchase of physician services.[2] It also does not address the potential for a dominant insurer to limit competition by such arrangements such as most favored nation contracts and bundling of contracts.

In the remainder of this affidavit, I explain why I believe the United/Sierra merger raises concerns about monopsony power in the market for purchasing physician services and also why it poses a substantial threat of anticompetitive behavior in output markets. With regards to the issue of monopsony in particular, I am concerned that the DOJ did not apply the proper economic analysis. I discuss monopsony in detail in sections III-VI of this affidavit. Section VII presents a shorter discussion of other issues. My main conclusion is that the United/Sierra merger may pose a substantial risk of harm in the market for the purchase of physician services that would adversely affect both healthcare providers and consumers, and that this risk was apparently underestimated by the DOJ.

III. Theory of Monopsony Power

Market Definition

In order to determine whether a merger poses a risk of the exercise of market power, or in this case, monopsony power it is essential to first define the market in which competition takes place. Markets are defined in both product and geographic dimensions. Competition between United and Sierra takes place in both input and output markets; I am focusing on input markets.

Market definition requires defining both a product market and geographic market. I will first consider the product market. Insurers purchase many inputs, including physician services. There are no adequate substitutes for physician services, due both to training and licensing laws. Moreover physicians are confined to supplying services within their training and licensures and cannot do something else in response to a decrease in compensation. Thus, the purchase of physician services represents a relevant product market.[3]

I believe that a relevant geographic market consists of an area no larger than the Las Vegas metropolitan area, which can be approximated by Clark County. This is a relevant geographic market from an input market perspective because physicians have limited alternatives in responding to a decrease in compensation. Physicians could not, for example travel to Los Angeles for additional business.[4] At the same time, insurers offering provider networks to Las Vegas area employers and employees could not expect to do

[44] See remarks of former Federal Trade Commission Chairman Robert Pitofsky, *A Slightly Different Approach to Antitrust Enforcement* before the Antitrust Section of the American Bar Association, Chicago Illinois (Aug. 7, 1995). Available at *http://www.ftc.gov/speeches/pitofsky/pitaba.shtm.*

[1] The American Medical Association paid for the time I spent researching the Nevada market and preparing this affidavit.

[2] Merger analysis focuses on the potential exercise of market power. ''Monopsony power'' is the power to decrease prices paid to producers or service providers who have little opportunity to sell other than to the monopsonist.

[3] There may well be even smaller markets within the physician services market, such as markets for specific specialties.

[4] Moreover, from the output market perspective the market is limited to Clark County. Insurers must market their provider networks to employers, who in turn make the network available to their employees. Most firms draw their workers from local areas, such as metropolitan areas. For example, it would be impractical for a Las Vegas casino to offer its employees a physician network that relied on physicians outside of Clark County.

business if their networks excluded Clark County providers. Thus, I believe it is indisputable that physician services in Clark County comprise a relevant market for antitrust analysis.

It Is Appropriate To Exclude Medicare and Medicaid

Competitive concerns arise whenever a firm, through merger, eliminates an important rival and gains the ability to influence prices. This is why market share calculations are so important to assessing mergers.

A critical issue in determining the likely effect of a medical insurer merger on the market for physician services may be whether to center the analysis on the commercial market share affected by the merger and to exclude Medicare and Medicaid, which are typically two of the largest purchasers in any medical market. The DoJ does not discuss potential monopsony power in the input market that I have defined, perhaps because it included Medicare and Medicaid beneficiaries in its calculation of buyer side market shares, and as a result the market shares of United and Sierra were not large enough to rise to the level of monopsony. But careful consideration suggests that the market for measuring monopsony power does not include Medicare and Medicaid.

A useful place to start thinking about this problem is to consider the more familiar problem of defining output markets. Suppose there are four firms—A, B, C, and D—equally dividing an output market. Suppose that firm A raises price by, say, $2 per unit. In the absence of collusive behavior, this effort is likely to fail, because consumers who are unhappy about the price increase will purchase the product from B, C, or D. This helps explain why antitrust analysts are rarely concerned about the potential exploitation of market power when there are many sellers in a market.

Now consider the same market with the same four sellers, only this time B, C, and D are capacity constrained. If A raises its prices, its consumers would either accept the increase or do without the product. They would not be able to take their business elsewhere. This gives seller A effective monopoly power over its customers. Thus, it is the ability of consumers to *redirect their business away from a high price seller,* and not the number of sellers *per se,* that limits a seller's ability to increase its prices.

The same intuition applies to monopsony. Suppose there are four purchasers of an input, again labeled A, B, C, and D. If purchaser A attempts to reduce the wage it pays for the input by $2 per unit, suppliers of the input would offer their services to purchasers B, C, and D. Thus, A's effort will fail. But if purchasers B, C, and D are constrained in the amount of labor inputs they can use in production, then sellers *will not be able to redirect their output* to these purchasers.[5] This gives purchaser A effective monopsony power over its suppliers.

With this intuition in hand, consider the market for physician services. Physicians who agree to participate in the network of insurer A accept a discounted fee from A in exchange for an expectation of higher volume. Physicians who do not agree to participate may still treat insurer A's enrollees as ''out of network'' patients, often requiring those patients to pay higher fees.

Suppose A reduces physician fees. As noted by the DoJ in their complaint against the merger between United and PacifiCare,[6] the ability of A to sustain this fee reduction ''depends on the physician's ability to terminate (or credibly threaten to terminate) the relationship. A physician's ability to terminate a relationship with a commercial health insurer depends on his or her *ability to replace the amount of business lost from the termination* (emphasis added), and the time it would take to do so. Failing to replace lost business expeditiously is costly.'' [7]

In determining the potential exercise of monopsony power, I assume the DoJ considered the options available to physicians. Physicians might refuse to contract with A. Insurer A's patients would then have to go out-of-network or seek a different insurer who has kept a broad network. (This is analogous to the case where the would-be monopsonist lowers its wages, and suppliers offer their services elsewhere.) Physicians might be proactive, joining rival networks and encouraging patients (and their employers) to switch plans. As a result, insurer A might end up with fewer enrollees. In this way, the presence of rival purchasers is essential if physicians are to have a ''credible'' ability to terminate their relationship with insurer A.

Physicians cannot increase volume or revenue by persuading their patients to sign up for Medicare, however, because enrollment in these programs is limited to the elderly and disabled.[8] Nor can physicians collectively treat more Medicare patients, because there are a limited number of patients and there is no means to increase the volume of patients. Thus, insurer A cannot lose physician business to Medicare; Medicare's business is fixed. Thus, from the perspective of physicians, the Medicare population is fixed. An analogous argument applies to Medicaid.

Even if physicians could collectively increase their Medicare and Medicaid workloads, this would not be an attractive alternative because Medicare, and, especially Medicaid, typically pay significantly lower rates than do private insurers. Medicaid rates are so much lower than most private insurer rates that few physicians would consider dropping insurer A in favor of Medicaid business even if insurer A lowered its rates appreciably.

The above argument demonstrates that when defining a relevant market for contracting for physician services, and computing market shares in that market, it is appropriate to exclude Medicare and Medicaid. Medicare and Medicaid do not represent viable alternatives for physicians who face lower fees from a monopsonist insurer. Because Medicare and Medicaid are large purchasers of physician services, excluding them from market share calculations will profoundly change inferences about market shares and monopsony power.

IV. Evidence on Monopsony Power

Physician Survey and Interviews

In my investigation I conducted physician telephone interviews in which I asked them about the competitive environment and how they might respond to the United/Sierra merger. Based on these interviews, I developed and oversaw a survey of physicians in Clark County. We sent surveys via e-mail, fax, and mail to the administrators of all 122 medical group practices identified in Clark County using the Universe File of the Medical Group Practice Association and to a random sample of 333 office-based physicians in the County, drawn from the American Medical Association Masterfile and oversampling primary care physicians and obstetrician-gynecologists. Twenty-four medical group administrators responded (for a response rate of 22.9% after adjustment for invalid and duplicate records). Seventy-three physicians responded (for an adjusted response rate of 27.5%). Additional details of the survey are

[5] Workers might offer their services to B. C, and D, but if these firms accept, they would have to lay off other workers, who in turn would face the same tradeoff as the new hires—work for A or stop working.

[6] *United States* v. *UnitedHealth Group Inc.,* Case No. 1:05CV02436 (D.D.C. Dec. 20, 2005), available at *http://www.usdoj.gov/atr/cases/f213800/213815.htm.*

[7] Complaint at Paragraph 36.

[8] The exception is Medicare managed care, as recognized by the DoJ consent order.

included as an appendix to this affidavit.[9]

Survey Findings Pertaining to Monopsony Power

A purchaser has monopsony power if it faces ''upward sloping supply.'' That is, the firm is able to reduce the price it pays for inputs without driving all of its input suppliers to other purchasers. One way to assess the potential presence of monopsony power is to determine whether suppliers have viable alternatives in the event they could not sell to the potential monopsonist. If a purchaser had monopsony power, then suppliers would respond in a variety of ways; some would sell to other purchasers, some would do nothing different, and some might even shut down operations. It is this range of responses—the varying degrees of leverage that a purchaser possesses over its suppliers—that characterizes upward sloping supply.

During my telephone interviews, I asked physicians how they would respond to the Sierra/United merger and a potential reduction in payments. Physicians offered a range of responses including closing their practice to doing nothing. To assess this issue more systematically, the survey included the following question: ''*What, if anything, would your practice do if United and Sierra merged and you did not continue to have a contract with the merged health plan?*''

Here are excerpts from a sampling of responses:

I'll go to California
Close practice
Leave town
I would consider relocating to another state or join the VA
This would hurt the practice tremendously. Actually I don't know what I'll do.
Nothing at present
Get on other contracts that will pay higher rates
Continue to service other health plans
Make do with remaining plans
We would be out-of-network provider and try to increase the other plans available
'Discourage patients from getting United/Sierra health insurance

The range of responses confirms what my telephone interviews had suggested, namely that some physicians have a viable alternative to United/Sierra but that many others would be harmed by losing the United/Sierra contract. This suggests that United/Sierra would have varying degrees of leverage over physicians, which is consistent with the ability to exercise monopsony power.

These data suggest that the United/Sierra merger may be creating substantial monopsony power within Clark County. It was incumbent upon the DoJ to explore this issue more thoroughly. Their complaint and the proposed order suggest that they failed to do so.

Market Concentration

In determining the competitive effects of any acquisition, it is often important to measure the level of concentration in the market. Unfortunately there is no significant public information available to compute market shares in the market for the purchase of physician services by commercial health insurers. One useful proxy would be the output shares of commercial health insurers. While the Bureau of Health Planning and Statistics of the Nevada State Health Division Department of Health and Human Services (henceforth, the ''Bureau'') collects data on HMO enrollments by plan and county, its data on PPO enrollments is incomplete.

The consulting firm Interstudy offers an alternative source of information about HMO and PPO market shares through their Managed Market MSA Surveyor and Managed Market State Surveyor databases. The American Medical Association has used these data to produce a report entitled ''*Competition in Health Insurance: A Comprehensive Study of U.S. Markets.*'' Based on the 2007 update of this report, I determined that the market shares for Sierra and United in the Las Vegas metropolitan area (which closely approximates Clark County) were 38% and 18% respectively. The combined market share is 56%. This combined share, as well as the increase in share, raise substantial concerns about monopsony power that the DoJ does not appear to have addressed.

V. Monopsony Power Can Harm Healthcare Consumers

Monopsony power can harm healthcare consumers in several ways. Part and parcel with a reduction in the compensation of physicians will be a reduction in the number of physicians who participate in the monopsonist's network. (This is the natural consequence of a monopsonist moving down its upward sloping supply curve.)[10] The patients who previously utilized the services of physicians who are no longer in the network must now either (a) select another, less preferred physician within the network, or (b) see their prior physician out-of-network and consequently pay higher out-of-network fees. Either way, these patients are worse off than before the exercise of monopsony power.

Even the patients of physicians who remain in the United/Sierra network may be worse off, because the reduction in the fees paid to these physicians may cause them to reduce the quantity and/or quality of services they provide. Physicians who receive lower fees will be forced to do more with less. This may result in longer waiting times as physicians are forced to reduce staffing. Economics teaches that physicians are to be expected to reduce their output; again, this is a standard prediction associated with upward sloping supply. Another standard result from economic theory is that sellers who experience lower price-cost margins will have less incentive to maintain quality.[11] There is substantial evidence that this occurs in medicine.[12]

Responses to the aforementioned survey question ''*What, if anything, would your practice do if United and Sierra merged and you did not continue to have a contract with the merged health plan?*'' confirm these concerns about patient welfare. As mentioned previously, some physicians might close their practices. Here are some additional responses:

Downsize practice
See a lot less patients
All patients would have to be self-pay under merged health plan
Lay off staff and reduce number of physicians on staff
I would consider having a cash only office

Several telephone interviews offered similar responses. All of these responses would have harmful repercussions for patients.

VI. Why Competition in the Output Market Would Not Discipline United/Sierra

A firm might not exercise its monopsony power if doing so harms its consumers who, as a result, turn to

[9] The survey had several limitations. Due to the desire to maximize responses, the survey was kept deliberately short. This limited our ability to tailor survey questions to address specific economic issues. Despite the brevity of the survey, the response rate was too low to reach definitive conclusions. Even so, the findings were sufficiently suggestive that, in my opinion, the DoJ. should have investigated these issues more thoroughly.

[10] When supply is upward sloping, a seller with monopsony power profits by reducing the wages it pays, relative to the competitive wage. By doing so, fewer suppliers offer their goods and services, so that the monopsonist ends up reducing the quantity of output it produces.

[11] See Spence, M. ''Monopoly, Quality, and Regulation'' *Bell Journal of Economics* 6(2), 1975 and Dranove, D. and M. Satterthwaite, ''Monopolistic Competition When Price and Quality Are Imperfectly Observable'' *RAND Journal of Economics,* 23(4), 1992.'

[12] Dranove, D. *The Economic Evolution of American Healthcare* Princeton University Press, 2000, reviews this evidence.

alternatives in the output market. In other words, output market competition might discipline the would-be monopsonist. The nature of the provision of medical services works against such market discipline. Suppose that physicians in the United/Sierra network are forced to cut back services in response to fee cutbacks. One might think that this would devalue the United/Sierra products, leaving it at a disadvantage relative to the competition. In other words, if physician services are ''public goods,'' whose quality applies to all of their patients, then the harmful effects of reduced monopsonist fees are felt by all patients and the monopsonist suffers no competitive harm.

There is a public good element in many physician decisions. If physicians reduce their office hours, this is likely to affect access for all of their patients. (Physicians who contract with a monopsonist could not normally limit their availability to the monopsonist's patients only.) Similarly, if a physician cuts back on staff and/or equipment, or invests less in continuing education, all patients would suffer. Of course, if the physician exits the market altogether, all patients suffer. If quality is a public good, as I conjecture, then the monopsonist can internalize all the benefits of fee reductions while the harm is felt by patients enrolled by all insurers. Thus, market forces do not necessarily discipline the monopsonist whose aggressive pricing causes quality to suffer.

Concluding Comments About Quality

Unfortunately, the DoJ complaint and consent order are silent on the issue of quality. In both the qualitative interviews and the survey conducted under my supervision, I learned about some of the ways that fee cutbacks could harm quality. Some of the alternatives physicians mentioned included exiting the market, curtailing their hours, spending less time with patients, and cutting back on staffing. In light of these responses, there should have been greater analysis of the potential impact of the United/Sierra merger on the quality of physician.

VII. Contractual Provisions That Raise Competitive Concerns

The purpose of merger enforcement is to prevent the creation of market power or its exercise. In some cases, in order to prevent competitive harm from a proposed merger the antitrust agencies and the courts may impose some type of injunctive relief. In this case, I believe the DoJ should have sought to prohibit two types of arrangements: most favored nation provisions and all products clauses.

Most Favored Nation Provisions

In my experience, many large insurers exploit their size by demanding and receiving most favored nation status from providers. A most favored nation provision requires the provider to offer the dominant insurer the most favorable rate it offers to any other insurer. Both theory and empirical evidence suggest that most favored nation status harms consumers by discouraging providers from aggressively discounting to other insurers.[13] Most favored nation provisions may prevent other insurers from entering or expanding in the market through these favorable discounting arrangements. The DoJ complaint and the proposed consent order are silent on this issue. The DoJ should have required the combined United/Sierra to foreswear MFN as a condition for approving the deal.

Bundling and All Products Clauses

It is also my experience that large insurers often require providers to abide by ''all products clauses'' whereby a provider who wishes to be a preferred provider for one of the insurer's products must agree to contract for all of that insurer's products. I am particularly concerned about the ability of a large insurer to bundle products in different markets. In particular, I believe that the combined United/Sierra will have monopsony power in the market for securing physician services for privately insured patients. It may now use that market power to bundle together contracting in the Medicare Advantage and private insurance markets. Such bundling would not offer any obvious promise of efficiencies and should be viewed with skepticism by anyone promoting market efficiency.

It is not obvious from the DoJ complaint and consent order whether these issues were investigated or how they were resolved. The DoJ should have explored these issues and if they believed there was potential for such bundling, the combined United/Sierra should have been required to allow physicians to contract separately for private insurance and the Medicare Advantage program.

May 13, 2008.

David Dranove,

Walter McNerney Distinguished Professor of Health Industry Management,
Northwest University.

[13] For example, see Scott Morton, F. ''The Strategic Response by Pharmaceutical Firms to the Medicaid Most-Favored-Customer Rules'' RAND Journal of Economics, 28(2), 1997 for an exposition of the theory and evidence from pharmaceutical pricing. The theory is broadly applicable to other markets including physician services.

Appendix: Survey Methods

Setup Procedures

All documents were verified by project client. Documents included the cover letter and survey instrument with a version each for the medical group sample and one for the physician practice sample.

All materials included the logos and respective signatures from: AMA, the county medical society, and the state medical society of Nevada.

The project client provided the sample database of medical groups and physician practices, including the name and phone number of a contact.

PRS provide the fax number and address for mailings in the phone calls, as appropriate.

Mailing Procedures Medical Group Sample

On February 12, 2008 Population Research Systems (PRS) mailed the survey to the medical groups, with a cover letter and business-reply envelope, to the 122 medical group administrators in the Clark County, NV medical group file. The outgoing envelope was addressed to the name of the person or the administrator, when available, otherwise the term ''Practice Administrator'' was included, for example: Ms. Jean Smith or Practice Administrator, Desert Medical Group, 1234 Pine Hill Drive, Las Vegas, 11111.

About 9–10 days after the initial mailing, PRS faxed another survey and cover letter, to all non-respondents from among the 122 group administrators.

Another 5 days later, the sample with non-responders, invalid or missing fax numbers was returned to the project client, who conducted a round of reminder phone calls and updated all invalid fax numbers. Contacted medical groups who requested another fax received one from PRS within 24 hours of that information being provided by the project client. PRS also sent another fax to all invalid and missing fax numbers.

About 6 days after the reminder call, PRS sent another round of faxes to all non-responders.

Another 10 days later, PRS initiated another round of faxes to all non-responders, followed immediately by a second round of reminder calls conducted by the telephone staff of PRS. PRS attempted every record until a respondent or answering machine was reached, and PRS telephone interviewers left scripted messages on answering machines (see below).

Telephone Reminder Script

Hi, my name is ___, and I am calling on behalf of the AMA. Yesterday, we sent you a fax with a very brief survey about the United/Sierra merger in Clark County, and we are very interested in your opinion. Please take a few minutes to complete the survey and fax it back to the number shown on the cover letter. We will keep your responses confidential.

If Not Received Fax:

Can you confirm your fax number for me so we can send you another fax?

We appreciate your participation. Thank you.

Response Rate

This effort resulted in a total of 24 completed surveys, out of a sample of 102 records. Of those 102 records, 7 records were invalid (group did not exist, was closed, wrong address/name) and 101 records were duplicates within the sample, resulting in 86 valid records. Out of those 86 valid records, 24 completes constitute a corrected response rate of 28.2%.

Count of IDs	
Status	Total
Complete	24
Invalid record	7
No response	61
Duplicate record	10
Grand Total	1021

Mailing Procedures Individual Physician Sample

On February 12, 2008 PRS e-mailed the cover letter and survey embedded in the body of the e-mail message to 353 physicians identified by the project client. PRS inserted the medical society logos into the email itself, as well as the signatures, similar to the Medical Group survey.

About 3 days after the initial e-mail, PRS faxed a reminder survey to all physicians who had not responded at that point. The cover letter for the fax was slightly different from the e-mail cover letter to reflect the change of modus.

Approximately 8 days later, the sample with non-responders, invalid or missing fax numbers was returned to the project client, who conducted a round of reminder phone calls and updated all invalid fax numbers. Contacted medical groups who requested another fax received one from PRS within 24 hours of that information being provided by the project client. PRS also sent another fax to all invalid and missing fax numbers.

About 7 days after the reminder call, PRS sent another round of faxes to all non-responders.

Another 6 days later, PRS initiated another round of faxes to all non-responders, followed immediately by a second round of reminder calls conducted by the telephone staff of PRS. PRS attempted every record until a respondent or answering machine was reached, and PRS telephone interviewers left scripted messages on answering machines (see script above).

During this process, PRS noted that 13 records of the original sample were duplicates (duplicate e-mail, address and fax number, and those records were replaced with another 13 records, resulting in a final total of 353 records.

Response Rate

This effort resulted in a total of 73 completed surveys, out of a sample of 353 records. Of those 353 records, 55 records were invalid (group did not exist, was closed, wrong address/name) and 13 records were duplicates within the sample, resulting in 285 valid records. Out of those 285 valid records, 73 completes constitute a corrected response rate of 25.6%.

Count of IDs	
Status	Total
Complete	73
Invalid record	55
(blank)	212
Duplicate record	13
Grand Total	353

Attachment B

June 5, 2007.

Honorable Alice A. Molasky-Arman
Nevada Commissioner of Insurance
Division of Insurance-Legal Section
788 Fairview Drive, Suite 300
Carson City, NV 89701–5491

Re: UnitedHealth Group Acquisition of Sierra Health Systems

Dear Commissioner Molasky-Arman:

The AMA is writing to express its strong opposition to the proposed acquisition of Sierra Health Systems (Sierra) by UnitedHealth Group (United). The AMA has urged the United States Department of Justice to block the merger because of the impact in Nevada. The impact in the state of Nevada is unlike the impact in any market of any previous health insurer merger. Our testimony will focus on the anti-competitive effect this merger will have on Nevada insurance markets, a negative effect that will be compounded by questionable business practices engaged in by United in other markets. We also strongly support the position of the Nevada State Medical Association.

It is clear that United's goal in pursuing this merger is to dominate the Nevada insurance market, in particular Las Vegas. The numbers are truly staggering, as shown in the attached chart. For the past five years, the AMA has conducted the most in-depth study of commercial health insurance markets (by actual reported enrollment) in the country. This study, *Competition in Health Insurance: A Comprehensive Study of U.S. Markets,* is based on the most current and credible data available and includes both HMO and PPO products. The AMA is in the process of finalizing our most recent edition, based on 2004 data. The findings for Nevada strongly suggest that this merger undermines competition in Nevada and in Las Vegas especially.

The AMA analysis of InterStudy and HealthLeaders data shows the following:

- At the state level, in the combined HMO/PPO market, United would have a market share of 43% after the merger, compared to its current market share of 14%. In the HMO market, United would have a 78% market share after the merger, compared to its current 11 % market share.

In the Las Vegas-Paradise metropolitan statistical area (MSA), in the combined HMO/PPO market, United would have a market share of 56% after the merger, compared to its current market share of 18%. United would have a market share of 95% after the merger, compared to its current market share of 13% in the HMO market.

These market shares should be considered in the context of the financial aspects of United's operations. At a time when premiums continue to escalate, United is posting high profit margins. Since 2002, United has posted year-end earning increases of between 27% and 53%. For 2006 its net earnings increased 27%. United has also awarded its senior executives mind-boggling compensation packages over this same time period. United is currently in the midst of several ongoing investigations and shareholder lawsuits over illegally backdating senior executives' stock options to increase their already extravagant compensation.

The Threat of Market Dominance

The AMA has long been concerned that ongoing consolidation of health insurance markets will ultimately lead to a market dominated by one or two health insurers that places profits over patients. The ascendancy of a dominant health insurer jeopardizes patient care in two important ways. First, without competition to help ensure that patient and employer choice counterbalance profit motives, the for-profit health

insurer's drive to maximize profits will inevitably compel it to place profits over patients.

Second, physicians have a professional, legal, and ethical responsibility to advocate on their patient's behalf. In the presence of health plan dominance the physician's role as patient advocate becomes even more critical. However, that role is being systematically undermined as dominate insurers are able to impose take-it or leave-it contracts that include provision that directly impact patient care, such the determination of what is ''medically necessary care.'' A physician who engages in aggressive patient advocacy risks exclusion from the dominant health plan's network and faces the realistic possibility that his/her practice will no longer be financially viable. In the presence of these dynamics, only state oversight and intervention can prevent deterioration of the patient-physician relationship, foster physician advocacy, and make patient choice a reality.

United's Failure to Comply With State Regulations

United's conduct shows a dismissive attitude towards its state regulatory obligations. It has been fined by a number of states for failing to comply with state law since 2001. Moreover, in some of those states, United has been fined more than once for the same conduct. United has the unenviable position of having had the largest fines ever levied against a health insurer in several states.

Specific examples include:

Arizona: In March 2006, the Arizona DOI fined United for the second time for violations of a number of state laws. These include state prompt payment laws, and state laws on member's rights to appeal denials of care. United was fined $364,750, the largest fine in Arizona's history. This was the second fine levied against United for similar violations. The first was in 2003. In the 2006 case, the director of the Arizona DOI stated that, ''I will not tolerate knowing violations of consent orders.''

- *Nebraska:* In December 2006, the Nebraska DOI filed a complaint which stated that United violated 18 state laws over 800 times. United delayed decisions, made incorrect decisions about coverage, and had an inadequate network of emergency services in rural areas. A settlement was reached in May 2007. It includes a $650,000 fine, the largest ever levied by the Nebraska DOI. The settlement also requires United to meet customer service standards and to give United's Nebraska staff the final decision on claims and grievances. This was the second time United has been fined for similar state law violations. The 2005 investigation resulted in United paying a $72,500 fine.
- *New York:* In 2006, the New York State Health Department took the unusual step of banning United from enrolling any new customers in its HMO plan because United continued to repeatedly defy state regulations. These include wrongly denying payment to providers and filing incomplete and inaccurate reports with the state. A state official noted that, ''we've had several years of findings, United doing corrective action plans, but then we go out again, and we have the same findings.''
- *Rhode Island:* In April 2007, UnitedHealthcare of New England was fined $67,500 for violating a state law intended to protect health-insurance coverage for small-business employees. United failed to provide documentation showing that it had complied with the law. In addition, according to documents released by the Health Insurance Commissioner's office, United overcharged members who were in poor health.
- *Texas:* Between 2001 and 2005, the Texas Department of insurance (TDI) has fined United three times for violating Texas prompt pay laws. The most recent fine, issued in December 2005, included a finding that United failed to report accurate and complete provider claims data for over 2 years. The 2005 fine totaled $4 million and United also agreed to pay restitution to physicians.
- *Missouri:* In *Schoedingerg* vs. *United,* a Missouri physician sued United for failing to comply with the state prompt payment law. In its finding of facts, the court found that the plaintiff had proven that United did not pay his claims within the time period set by Missouri law. Specifically, the 2006 opinion found that ''United's claims processing system was flawed in many ways, including denying, reducing and improperly processing claims on a regular basis. And despite innumerable requests, United was unwilling to remedy the underlying errors in its systems. United was consistently delinquent in paying claims.''

Ongoing State Investigations of United's Business Conduct

In the past several months, two states have announced investigations into United's business practices and whether they comply with state law. These investigations are specified below.

- *California:* The California Department of Insurance and the California Department of Managed Health Care (CDMHC) have announced an investigation into a range of United business practices. According to the California Medical Association (CMA), there is a liaison process between CMA and United. While United is generally responsive to the individual physician complaints, it is not responsive to fixing the underlying issues. This causes the objectionable practices to continue which must be battled one physician and one claim at a time. The regulators indicated that their objective is to bring United into compliance with state laws for the benefit of California patients.
  - *Note:* in May 2007, the CDMIIC found that United subsidiary PacifiCare engaged in ''dishonest and unfair'' conduct when it failed to disclose its planned termination of a provider network during open enrollment. The CDMHC ordered PacifiCare to continue to authorize and allow access to the network through November 2007.
- *New Jersey:* In April 2007, the New Jersey Department of Banking and Insurance ordered United to justify a lab referral protocol that has outraged physicians across the country. This policy, which was the outgrowth of a 10-year exclusive contract with Lab Corp, provides that if physicians refer to an out-of-network lab, they can be fined or dropped from the network. This is the first instance of a health plan threatening financial penalties for out-of-network referrals. The DOBI ordered United to ''appear and show cause why it should not be required to pay restitution or take other remedial measures.'' This is in regards to the effects of its proposed sanctions on physicians.

The AMA believes that United's conduct reflects a philosophy that it is more cost-effective to violate state law and possibly pay a fine than to assure compliance with laws designed to protect both patients and physicians. The AMA's first concern is that this unprecedented merger will create monopoly conditions in Nevada to the detriment of Nevada citizens. That being said, given the magnitude of this merger in Nevada and United's track record in other states, if this merger is allowed to go forward, it is incumbent on the Nevada Department of insurance to assure that United is held accountable for compliance with state laws.

If the AMA can be of further assistance, please do not hesitate to contact me. The AMA appreciates the opportunity to comment on this matter.

Sincerely,

Michael D. Maves, MD, MBA.
Attachment
cc: Larry Matheis, Executive Director, Nevada State Medical Association.

Attachment C

Testimony of David Balto On Behalf of the American Antitrust Institute and Consumer Federation of America Before the Nevada Commissioner of Insurance on the United Health Group Proposed Acquisition of Sierra Health Services [1] (July 27, 2007)

I. Introduction

The American Antitrust Institute (''AAI'') and Consumer Federation of America, (''consumer groups'') appreciate this opportunity to testify before the Commissioner of Insurance on United Health Group's (''United'') proposed acquisition of Sierra HealthServices, Inc. (''Sierra'').[2] As detailed in our testimony based on our preliminary review, we strongly believe that this acquisition will harm all Nevada health insurance consumers, particularly those in Clark County, through higher prices, less service, and lower quality. The level of concentration posed by this merger is simply unprecedented: it is greater than in any merger approved by the Antitrust Division of the U.S. Department of Justice (''DOJ'') and would give United clear monopoly power in Clark County.

In evaluating this merger under NRS 692C.210(1) the Commissioner of Insurance must consider several factors including: (1) whether ''the effect of the acquisition would be substantially to lessen competition in insurance in Nevada or tend to create a monopoly'' and (2) whether if approved the ''[a]cquisition would likely be harmful or prejudicial to the members of the public who purchase insurance.'' As we explain below, both of these factors counsel for denial of the application because the merger creates a dominant insurer, particularly in Clark County, with the ability to raise premiums, reduce service and quality and reduce compensation to providers. It will clearly harm purchasers of insurance who will pay more for service that provides lower quality care.

This unprecedented level of concentration raises important policy and health care concerns relevant to the factors evaluated in these Hearings. As Vermont Senator Patrick Leahy observed in Hearings before the Senate Judiciary Committee last year on health insurance consolidation:

> a concentrated market does reduce competition and puts control in the hands of only a few powerful players. Consumers—in this case patients—are ultimately the ones who suffer from this concentration. As consumers of health care services, we suffer in the form of higher prices and fewer choices.[3]

Creating a dominant insurance provider should be a profound concern in Nevada, a state plagued with shortages of nurses, doctors and other health care professionals.

This testimony, which is based solely on public information, provides our preliminary views that this merger would ''substantially to lessen competition in insurance in Nevada or tend to create and monopoly'' and ''would likely be harmful or prejudicial to the members of the public who purchase insurance.'' This paper also addresses the United-Sierra merger in the context of the numerous competitive imperfections and market failures unique to the HMO and health insurance industry and with respect to the specific challenges facing Nevada's health care due to a serious shortage of doctors and nurses.

II. Summary

The consumer groups urge the Commissioner to focus on the following issues:

- *Will the United-Sierra merger reduce competition for the provision of health insurance to employers and individuals seeking health coverage in Nevada?* Yes, Sierra is the largest HMO provider in Nevada and United is the only significant rival. The United-Sierra merger in Nevada would give United a 80% market share of all HMOs in Nevada and a 94% market share of the HMO market in Clark County. Although its market share is smaller than Sierra's, United has the potential for significant growth in Nevada since its acquisition of PacifiCare in 2005. Moreover, the next largest HMO rival in Clark County has only a 2% market share. The merger would adversely affect a wide range of buyers including small employers, governmental and union purchasers.
- *Will the United-Sierra merger reduce competition for the provision of services in the Medicare Advantage program?* Yes. Medicare is increasingly turning to a managed care model. Increasingly Medicare beneficiaries are signing up for the Medicare Advantage program which provides health care services to beneficiaries in a managed care model. The only current bidders for Medicare advantage in Nevada are United and Sierra. United is the largest Medicare Advantage program in the U.S. The merger would create a monopoly in the provision of services for Medicare Advantage program resulting in a lower level of care and prices.[4]
- *Could the United-Sierra merger increase the threat of monopsony power and reduce access to medical care and the quality of medical care in Nevada?* Yes, there is currently a significant and chronic shortage of health care providers including physicians and nurses in Nevada, an understaffed region where health professionals are forced to work overtime, double-shifts, weekends, and holidays. This merger will exacerbate those problems for health care providers dependent upon the merged firm. A combined United-Sierra can reduce compensation resulting in a diminution of service and quality of care. In the past the DOJ has brought enforcement actions because of concerns over monopsony power where the market share exceeded 30%, a level clearly exceeded by this acquisition. This merger may lead to a significant reduction in reimbursement for health care providers, leaning to lower service and quality of care.
- *Will other insurance companies readily enter the market (or expand) and fully restore the competition lost*

[1] I have practiced antitrust law for over 20 years, primarily in the federal antitrust enforcement agencies: the Antitrust Division of the Department of Justice and the Federal Trade Commission. At the FTC, I was attorney advisor to Chairman Robert Pitofsky and directed the Policy shop of the Bureau of Competition. Maria Patente, Washington College of Law (Class of 2008), provided extensive assistance in the preparation and research of the testimony.

[2] The American Antitrust Institute is an independent Washington-based non-profit education, research, and advocacy organization. Its mission is to increase the role of competition, assure that competition works in the interests of consumers, and challenge abuses of concentrated economic power in the American and world economy. For more information, please see *www.antitrustinstitute.org.* This working paper has been approved by the AAI Board of Directors. A list of contributors of $1,000 or more is available on request. The Consumer Federation of America (''CFA'') is the nation's largest consumer-advocacy group, composed of over 280 state and local affiliates representing consumer, senior citizen, low income, labor, farm, public power and cooperative organizations, with more than 50 million individual members. CFA represents consumer interests before federal and state regulatory and legislative agencies and participates in court proceedings. CFA has been particularly active on antitrust issues affecting health care.

[3] Statement of Senator Patrick Leahy, Hearing on ''Examining Competition in Group Health Care'' U.S. Senate Committee on the Judiciary (Sept. 6, 2006).

[4] A large number of the consumer complaints filed with the Commissioner about this merger raise concerns over the loss of competition in the Medicare Advantage market. Many of these complaints are from elderly beneficiaries who are particularly vulnerable to anticompetitive conduct. Over 30% of Nevada Medicare beneficiaries subscribe to Medicare Advantage, one of the highest enrollments of any state.

from the merger? No. In some cases it may be unnecessary to challenge a merger if other firms can readily enter a market to a sufficient degree to avert the anticompetitive effects of the merger. That is clearly not the case for this market. As the DOJ has recognized in other cases, barriers to entry in the HMO market are extremely high due to the extensive physician networks, technology networks, and specialized medical infrastructure that are essential to the industry. Moreover, Nevada already faces a serious shortage of both doctors and nurses, and attracting a sufficient number of personnel would pose a high barrier for a new entity interested in providing HMO plans in Nevada. There has been little historical entry into the Nevada HMO market, in spite of the growth of population. Moreover, with a dominant United-Sierra, it is highly unlikely a new entrant would undertake the risk of new entry.

• *Do the efficiencies from the United-Sierra outweigh the anticompetitive harms?* No. The parties have not proposed significant efficiencies from this consolidation. If there were any efficiencies they probably could be achieved through internal growth, considering the rapid population growth in Nevada. Moreover, efficiencies should only be included in the competition calculus if they will result in lower prices or better service to consumers. As a general matter, efficiencies from health coverage mergers have not been passed on to consumers. Health insurance mergers have generally led to increased subscriber premiums without expansion of medical benefits. There is little evidence if any that any efficiencies achieved in the United-PacifiCare merger have resulted in lower premiums or better service for United or former PacifiCare subscribers. Since the combined United-Sierra would have a dominant market share post-merger it is highly unlikely any savings would be passed on to consumers.

• *Would a divestiture or other structural relief be sufficient to alleviate the competitive problems raised by the merger?* No. The parties have not suggested that they would be willing to divest assets to solve the competitive concerns raised by the merger. Even if they did the Commissioner should be extremely skeptical of any proposed relief. In the past the DOJ has attempted to resolve competitive concerns over some mergers by requiring the divestiture of a certain number of contractual arrangements in order to spur new entry. These divestitures have been insufficient to cure the competitive problems posed by those mergers. A divestiture is even less likely to resolve the competitive concerns in this merger where the merged firm will clearly be the dominant insurer in the market.

• *Would consumers be better off if the Commissioner rejected the merger?* Yes. The antitrust question in evaluating any merger is what would happen ''but for'' this merger? What would happen to the merging parties, consumers, and providers? The answer in this case seems rather transparent. United and Sierra are both successful, financially sound, capable companies that would continue to grow and thrive. Through its acquisition of PacifiCare, United established an important beachhead in Nevada. But for this merger, United would continue to expand in Nevada and challenge Sierra's strong position in the market. That competition between United and Sierra would lead to lower premiums, greater innovation and better service. There is simply no reason why United can not achieve most of the benefits of this acquisition through internal growth.

The remainder of the testimony is set forward as follows. First, we make some observations about special considerations for health insurer mergers and suggest why regulators and enforcers can not rely on the theoretical assumptions of a competitive market. Then we focus on past enforcement actions and the principles of antitrust enforcement. We then explain how the merger will reduce competition in both the provision of certain health insurance products (impact on buyers) and health care providers (impact on sellers). Finally, we explain why other factors such as ease of entry or efficiencies will not prevent the anticompetitive effects of the merger.

III. Antitrust Merger Standards and Past Antitrust Enforcement Actions

The U.S. antitrust laws, like the Nevada insurance statute, provide that a merger may be illegal if it may ''tend substantially to lessen competition or to tend to create a monopoly.'' [5] The concern under the merger laws is that a merger may tend to reduce competition and lead to higher prices, lower service, less quality, or less innovation. Concerns over a reduction in quality, central to the delivery of health care services, is an important element of competition.[6] As the Supreme Court has observed, competition protects ''all elements of a bargain—quality, service, safety, and durability—and not just the immediate cost.'' [7]

In order to determine the likely competitive effects of a merger the case law and the Merger Guidelines established by the Department of Justice and the Federal Trade Commission set forth a multi-step process.[8] The process begins by defining the ''line of commerce'' or relevant product market and the ''section of the country'' or relevant geographic market. A relevant market can include any group of products or services. Once a relevant market is defined, the level of concentration and market share is calculated to determine the likely competitive effects of the merger. In cases where there is an undue level of concentration in the relevant market (generally a market share over 30%) there is a prima facie case of illegality and a presumption of unlawfulness.[9] If there is a presumption of unlawfulness then the burden shifts to the defendants to rebut the prima facie case and

[5] Clayton Act, 15 U.S.C. § 18. There is no case law evaluating the competitive legality of mergers under NRS 692C.210(1), however the language of the statute is identical to the Clayton Act. Thus, it is appropriate to apply the standards of federal antitrust law. The Nevada antitrust statute is similar to the Clayton Act. It prohibits mergers that will ''result in the monopolization of trade or commerce * * * or would further any attempt to monopolize trade or commerce'' or ''substantially lessen competition or be in restraint of trade.'' NRS 598A.060(1)(f).

[6] Section 7 prohibits anticompetitive reductions in quality because it is equivalent to an increase in price—consumers pay the same (or greater) price for less. *Community Publishers, Inc.* v. *Donrey Corp.,* 892 F. Supp. 1146, 1153 n.8 (W.D. Ark. 1995), *aff'd sub nom. Community Publishers, Inc.* v. *DR Partners,* 139 F.3d 1180 (8th Cir. 1998); *Merger Guidelines,* § 0.1 (''Sellers with market power also may lessen competition on dimensions other than price, such as product quality, service, or innovation.''); *id.* § 1.11.

[7] *Nat'l Soc'y of Prof. Eng'rs* v. *United States,* 435 U.S. 679, 695 (1978).

[8] U.S. Dep't of Justice and Federal Trade Comm'n, *Horizontal Merger Guidelines* (1997) (hereinafter *''Merger Guidelines''*). The Nevada statute provides that in determining whether to approve a merger the Commissioner of Insurance ''shall consider the standards set forth in the Horizontal Merger Guidelines * * *'' NRS 692C.256(2).

[9] Concentration in merger cases is expressed in terms of market shares and a measure known as the Herfindahl Hirschman Index (''HHI''). The HHI is calculated by adding together the squares of the market share of individual competitors in the market. In a market with a single seller, the HHI is 10,000. The FTC/DOJ Merger Guidelines provide that an HHI below 1000 corresponds to an ''unconcentrated'' market; an HHI between 1000 and 1800 corresponds to a ''moderately concentrated'' market, and an HHI above 1800 corresponds to a ''highly concentrated'' market. The HHI is a screening tool used to assess whether a proposed merger will lead to anticompetitive consequences. Under the Guidelines different presumptions apply, depending on the extent of post-merger market concentration and the increase in HHI that will result from the merger. The greatest competitive concerns are raised where the post-merger HHI exceeds 1800. In such cases, it is ''presumed that mergers producing an increase in the HHI of more than 100 points are likely to create or enhance market power or facilitate its exercise.'' *Merger Guidelines,* § 1.51.

demonstrate that other market characteristics make the presumption of anticompetitive effects implausible. Two types of evidence are prominent in merger cases—if the defendants can offer evidence that entry is relatively easy, that may dispel the notion that the merger will lead to significant anticompetitive effects. Finally, if a merger will lead to substantial efficiencies, these may counteract those anticompetitive effects.

The two most instructive antitrust cases involving health insurance mergers are the DOJ's challenges to Aetna's 1999 acquisition of Prudential and United's 2006 acquisition of PacifiCare. Both of these mergers were resolved with divestitures to facilitate the entry of a new competitor to remedy the competitive concerns. Each case focused both on the harm to purchasers of HMO and other insurance services from the exercise of monopoly power and the harm to healthcare providers from the exercise of monopsony power.[10] In both the United-PacifiCare and the Aetna-Prudential mergers, the DOJ identified highly concentrated markets that were substantially likely to suffer harm to competition as a result of these mergers.

In 1999, the DOJ and the State of Texas settled charges that the merger between Aetna and Prudential in the State of Texas would harm competition. The DOJ focused on relevant markets of HMO products and physician services. Aetna and Prudential were head to head competitors in the HMO markets in Houston and Dallas. The proposed merger would have increased Aetna's market share from 44% to 63% in Houston and 26% to 42% in Dallas.[11]

Moreover, the merger raised monopsony concerns by giving the merged firm the potential to unduly suppress physician reimbursement rates in Houston and Dallas, resulting in a reduction of quantity or degradation of quality of medical services in the areas.[12] The operative question from DOJ's perspective was could health care providers defeat an effort by the merged firm to reduce provider compensation by a significant amount, e.g., 5%. The question was answered in the negative for several reasons: physicians have limited ability to encourage patients to switch health plans, and physicians' time (unlike other commodities) cannot be stored, which means that physicians incur irrecoverable losses when patients are lost but not replaced. To exacerbate matters, contracts with physicians were negotiated on an individual basis, and were therefore susceptible to price discrimination by powerful buyers. Thus, DOJ concluded that Aetna had sufficient power to impose adverse contract terms on physicians, especially decreased physician reimbursement rates, which would ''likely lead to a reduction in quantity or degradation in the quality of physicians' services.'' [13]

To resolve these competitive concerns the DOJ ordered Aetna to divest its entire interest in NYLCare-Gulf Coast and NYLCare-Southwest, its Houston and Dallas commercial HMO business. This consisted of 260,000 covered lives in Houston and 167,000 covered lives in Dallas.

In 2006, the DOJ investigated the merger between United and PacifiCare and focused on potential competitive concerns in relevant markets for commercial health insurance for small group employers in Tucson, Arizona and physician services in both Tucson and Boulder, Colorado.[14] Small group employers are employers with 2–50 employees. The merger would have combined the second and third largest providers of commercial health insurance in Tucson and increased United's market share from 16% to 33%.

The merger also raised concerns over the potential harm to competition in the purchase of physician services in both Tucson and Boulder. The DOJ explained that by combining United and PacifiCare ''the acquisition will 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.'' [15] In other words the DOJ found that a health plan's power over physicians to depress reimbursement rates can be harmful to patients—the ultimate consumers of health care. The market shares involved were relatively modest: in excess of 35% in Tucson and in excess of 30% in Boulder ''for a substantial number of physicians in those areas.''

In response to the potential harm to competition, the DOJ required United to divest contracts covering at least 54,517 members residing in Tucson, Arizona to yield a post-merger market share equal to its pre-merger market share. Furthermore, the DOJ required United to divest 6,066 members covered under its contract with the University of Colorado. This divesture constituted nearly half of PacifiCare's total commercial membership in Boulder.

The antitrust laws protect not only consumers but any group of buyers, potentially including a governmental buyer. Buyers of health insurance services have varying needs and ability to secure competitive rates. An example of this is a case filed by the City of New York challenging the merger between Group Health Incorporated (''GHI '') and the Health Insurance Plan of greater New York (''HIP'') in the fall of 2006.[16] There are numerous health insurance competitors, including HMOs and PPOs in the New York City market, but for the low cost product required by the City and affiliated entities the only rivals were GHI and HIP. The case alleged that the merger of GHI and HIP would create a monopoly in the New York metropolitan area market for low cost health insurance purchased by the City of New York and its employee unions together with the city's employees and retirees as well as 35 other employers with ties to the city and their employees and retirees such as the Housing Authority, the Metropolitan Museum of Art and universities (all of which participate in the New York City health benefits program). The case alleges that city employees and retirees and those individuals who participate in the health benefits program would be faced with increased costs for insurance and reduced service if the merger were consummated. Litigation in the case is ongoing, but it suggests the broad range of markets that can be adversely affected by a merger.

[10] Health insurers play dual roles as sellers of insurance services and buyers of health care services. In its first role, the health insurer's ''output'' consists of health benefit packages, and the output prices are paid for by customers in the form of subscriber premiums. In the role as the seller of health benefits, a dominant health insurer in a concentrated market could potentially act as a ''monopolist'' charging an above market price for health benefits. In its second role, the health insurer acts as a buyer, and the input consists of physician and other medical services. The insurer's input prices are the compensation it pays in the form of physician fees and fees for medical services. In this role, the health insurer may act as a ''monopsonist,'' reducing the level of services or quality of care by reducing compensation to providers. Health insurers are both buyers of medical services and sellers of insurance (to consumers), so insurance mergers can raise both monopsony and monopoly concerns.

[11] These market shares are substantially smaller than the market shareswhich would result from the United-Sierra merger in the HMO markets of Nevada and Clark County (80% in Nevada and 94% in Clark County).

[12] *United States* v. *Aetna,*, Revised Competitive Impact Statement, Civil Action 3–99CV1398–H.

[13] *Id.*

[14] *United States* v. *UnitedHealth Group Inc.,* Case No. 1:05CV02436 (D.C.C. Dec. 20, 2005), *available at* http://www.usdoj.gov/atr/cases/f213800/213815.htm.

[15] *United States* v. *UnitedHealth Group,* Competition Impact Statement at 8, available at http://www.usdoj.gov/atr/cases/f215000/215034.htm.

[16] *City of New York* v. *Group Health Inc., et al.,* (S.D.N.Y. 2006).

IV. Special Information Concerns for Health Insurance Mergers

In determining the competitive effect of a merger the crucial issue is the impact on the consumer, the ultimate beneficiary of the insurance system. The questions to be examined include will consumers have to pay more for insurance in higher premiums or deductibles, will they suffer from poorer service such as longer waiting times or deterred services, and will they suffer from lower quality of care? Since consumers can not vote on a merger,[17] how does the Commissioner, antitrust enforcer, or the courts evaluate the impact of a merger on consumers?

Insurance companies, employers, unions and buyers of insurance (''plan sponsors''), and health care providers will all have views of the impact of the merger on consumers. The views of the insurance companies can not be determinative, since they have an obligation to their stockholders to maximize profits.

The views of plan sponsors are relevant, but their failure to object to a merger may not be of significant evidentiary value. Plan sponsors represent the interests of their subscribers and thus may be concerned with the exercise of monopoly power leading to higher premiums. However, as antitrust authorities have recognized in many merger investigations, buyers of services may be very reluctant to complain about a merger for a variety of factors. They may simply pass on higher post-merger prices to the ultimate customer. In the health insurance area, although plan sponsors may be concerned about the cost of health insurance they may be less sensitive to the reduction in quality or service that may result from a merger. Finally, a customer may fear retribution post-merger.[18] This may particularly be the case in Nevada where the acquired firm will remain as the largest insurer even if the merger is denied. Thus, the fact that plan sponsors do not complain, or actually support a merger, should not be determinative of a merger's likely competitive effect.[19]

On the other hand healthcare providers may be a far more superior representative of the consumer interest and their concerns deserve careful attention. Physicians and other healthcare providers directly experience the diminution of service and quality when so-called cost containment efforts go too far. Physicians serve as advocates for the patient, especially in the often adversarial setting of managed care. Since healthcare providers experience first hand the impact of reductions in service they are more sensitive to the potential exercise of market power by health insurance. It is important to recognize in evaluating the concerns raised by providers that they are not just complaining about decreased compensation. Rather the issues raised by healthcare providers are central to concerns over quality of care: reduced services, greater waiting times, unacceptably short hospital stays, postponed or unperformed medical treatments, suboptimal alternative medical treatments, laboratory tests not performed, and other output restrictions on health services.

IV. Competitive Analysis of the United-Sierra Merger

Health Insurer Concentration: Harm to Buyers

The concentration of the health insurance industry has increased nationally due to a tremendous number of mergers and acquisitions and numerous smaller insurers exiting the industry.[20] Over the past 10 years there have been over 400 health insurer's mergers. United has acquired several firms including California-based PacifiCare Health Systems, Inc., Oxford Health Plans, and John Deere Health Plan, increasing its membership to 32 million. Similarly, WellPoint, Inc. now owns Blue Cross plans in 14 states. Together, WellPoint and United control over 33 percent of the U.S. commercial health insurance market.

This increase in concentration has not benefited consumers. Studies indicate that health insurance premiums have increased at a rate more than twice the rate of inflation or the rate of increases in workers' earnings. Average annual premium increases have ranged from 8.2% to 13.9% since 2001.[21] Moreover, since 2000, the number of employers offering health coverage benefits has decreased by nearly 10%. Studies indicated that medical benefits have not expanded despite premium increases. In contrast, health insurer profits have increased by 246% in the aggregate over the past decade.[22]

Consumers in highly concentrated health insurance markets are most vulnerable to insurance premium increases without comparable benefit increases, mirroring data of escalating health costs on the national level. One study found that more than 95% of Metropolitan Statistical Areas (MSAs) had at least one insurer in the combined HMO/PPO market with a market share greater than 30% and more than 56% of MSAs had at least one insurer with market share greater than 50%.[23] In concentrated MSAs such as these, there is a much greater likelihood that one firm, or a small group of firms, could successfully exercise market power and profitably increase prices or decrease compensation leading to less quality or service. As one prominent healthcare professor has observed in testimony before the U.S. Senate Judiciary Committee:

What is so important about the sheer number of competitors? Econometric evidence shows that in the managed care field, an increase in the number of competitors is associated with lower health plan costs and premiums; conversely, a decrease in the number of competitors is associated with increases in plan costs and premiums. The evidence also shows that the sheer number of competitors exerts a stronger influence on these outcomes than does the penetration level achieved by plans in the market.[24]

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[17] Fortunately, the Commissioner has decided to hold an extensive series of hearings on the merger and provided a significant opportunity for public comment. The majority of the public comments filed by consumers to date oppose the merger.

[18] There are a wide variety of reasons why customer support of a merger may not be particularly probative. *See* Ken Heyer, Predicting the Competitive Effects of Merger by Listening to Buyers, 74 Antitrust L.L. 87 (2007); Joseph Farrell, Listening to Interested Parties in Antitrust Investigations: Competitors, Customers, Complementors, and Relativity, Antitrust. Spring 2004 at 64 (explaining why customers may support an otherwise anticompetitive merger).

[19] *See FTC* v. *H.J. Heinz Co.,* 246 F.3d 708 (D.C. Cir. 2001) (customers strongly supported merger); *United States* v. *United Tote,* 768 F. Stupp. 1064, 1084–85 (D.Del. 1991) (enjoining merger despite testimony of ''numerous buyers'' that the merger would be procompetitive in creating a stronger rival to a dominant firm); *United States* v. *Ivaco,* 704 F. Supp. 1409, 1428 (W.D. Mich. 1989)(all testifying customers supported merger); *FTC* v. *Imo Indus.,* 1992–2 Trade Cas. (CCH) ¶ 69,943, at 68,559 (D.D.C. 1989).

[20] Victoria Colliver, ''Insurer's Mergers Limiting Options: Health Care Choices Are Narrowing Says Study by AMA,'' San Francisco Chronicle, April 18, 2006 (last viewed 7/8/07) *http://sfgate.com/cgi-bin/article.cgi?file=/chronicle/archive/2006/04/18/BUGUQIAH161.DTL&type=business.*

[21] Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits: 2006 Summary of Findings, 2006 (last viewed 7/8/2007) *http://www.kff.org/insurance/7527/upload/7528.pdf.*

[22] Laura Benko, ''Monopoly Concerns: AMA Asks Antitrust Regulators to Restore Balance,'' Modern Physician, June 1, 2006.

[23] Edward Langston, ''Statement of the American Medical Association to the Senate Committee on the Judiciary United States Senate: Examining Competition in Group Health Care,'' Sept. 6, 2006 (last viewed 7/8/07) *http://www.ama-assn.org/ama1/pub/upload/mm/399/antitrust090606.pdf.*

[24] Testimony of Professor Lawton R. Burns re. the Highmark/Independence Blue Cross Merger, before the Senate Judiciary Committee (April 7, 2007).

As we discuss below, the health insurance markets in the state of Nevada, especially Clark County, are highly concentrated, and the merger of Sierra with United is likely to substantially harm competition and consumers.

Harm to Competition in Nevada From the United-Sierra Merger

Correctly defining an economically meaningful market is essential for ensuring that consumers of that market do not become subject to market power due to increases in market concentration and decreases in competition as a result of a merger. The key question in this merger as in other mergers is the definition of the relevant product market. The courts have held that a relevant product market ''must be drawn narrowly to exclude any other product to which, within reasonable variations and price, only a limited number of buyers will turn.'' *Times-Picayune Pub. Co* v. *United States,* 345 U.S. 594, 612 n.31 (1953). Market definition focuses on demand substitution facts, and whether or not consumers would or could turn to a different product or geographic location in response to a ''small but significant non-transitory increase in price.'' [25] Typically, the antitrust agencies and the courts have implemented this test by seeking to identify the smallest group of products over which prices could be profitably increased by a ''small but significant'' amount (normally 5 percent) for a substantial period of time (normally one year).[26]

In health insurance mergers the DOJ has reached different, although not inconsistent, conclusions as to the relevant product market. For example, in the Aetna-Prudential merger DOJ concluded that the relevant product markets were the sale of health maintenance organization (''HMO'') and HMO-based point of service (''HMO–POS'') health plans. The DOJ noted that HMO and HMO–POS products differ from PPO or other indemnity products in term of benefit design cost and other factors. HMOs provide superior preventative care benefits, place limits on treatment options and generally require the use of a primary care physician ''gatekeeper.'' PPO plans are not structured in that fashion and do not emphasize preventative care. HMOs were perceived as being better devices to control costs and configure benefits. In addition, both the insurers and buyers of insurance services perceived PPOs and HMOs as being separate products. Thus. the DOJ concluded that the elasticity of demand for HMOs and HMO–POS plans are sufficiently low that a small but significant price increase for these plans would be profitable because consumers would not shift to PPO and other indemnity plans to make the increase unprofitable.

In United/PacifiCare, the DOJ defined a relevant product market as the sale of commercial health insurance to small group employers. This market consisted of employers with 2–50 employees. These employers were particularly susceptible to potential anticompetitive conduct because they lacked a sufficient employee population to self-insure and they lacked the multiple locations necessary to reduce risk through geographic diversity. In addition the manner in which commercial health insurance was sold also distinguished the small and large group markets. Large employers were more likely than smaller employers to be able to successfully engage extensive negotiations with United and PacifiCare.

We believe that both an HMO and small employer market may be adversely affected by the United-Sierra merge.[27] Surveys demonstrate that consumers do not perceive HMOs and PPOs as substitute products and consumers believe that they differ in terms of benefit design, cost, and general approaches to treatment.[28] PPOs tend to provide more flexibility in selection of physicians and specialists and tend to be more expensive. In contrast, HMOs focus more on preventative medicine but limit treatment options and require referrals from a ''gatekeeper'' for many procedures. Consumers with special health needs and those relying more on strong relationships with their physicians would generally not be satisfied if forced to subscribe to an HMO with restrictions on personal choices. ''A small but significant price increase in the premiums for HMOs and HMO–POS plans would not cause a sufficient number of customers to shift to other health insurance products to make such a price increase unprofitable.''[29]

Moreover, small employers are less likely to have significant alternatives in response to a price increase by the merged firm. Small employers are unable to self-insure and have little power to negotiate better rates.

The relevant geographic market seems to be a fairly straightforward matter since health care services are primarily local. From the perspective of the buyers of insurance services, employers want insurance where the employees work and live. Thus in Aetna/Prudential, the DOJ concluded ''the relevant geographic market in which HMO and HMO–POS plans compete are thus generally no larger than the local areas within which HMO * * * enrollees demand access to providers. * * * As a result, commercial and government health insurers—the primary purchasers of physician services—seek to have their provider network's physicians whose offices are convenient to where their enrollees work or live.''

In this merger the likely geographic markets are Clark County, Nevada and the larger geographic market of the State of Nevada. Consumers faced with an increase in prices for HMOs are unlikely to travel a long distance away from homes or places of business in order to escape price increases and purchase HMO services at a lower price. Generally, consumers are reluctant to travel lengthy distances when they are sick. Moreover, virtually all managed care companies provide networks in localities where employees live and work, and they compete with the other local networks.[30] Thus, we believe the proper relevant markets are the provision of HMO services in Clark County and Nevada.[31]

Concentration and Competitive Effects

Once the market is defined antitrust authorities and the courts calculate market shares and concentration levels (using the Herfindahl-Hirschman Index (HHI)). This merger will lead to an unprecedented level of concentration. In the Clark County HMO market United's market share will increase from 14 to 94%. If PPOs are included, United's market share increases from 9% to 60%. Regardless of how the product market is

[25] According to the Merger Guidelines, ''[a] market is defined as a product or group of products and a geographic area in which it is produced or sold such that a hypothetical profit-maximizing firm, not subject to price regulation, that was the only present and future seller of those products in that area would likely impose at least a 'small but significant nontransitory' increase in price, assuming the terms of sale of all other products are held constant.'' *Merger Guidelines* § 1.0.

[26] *FTC* v. *Staples,* 970 F. Supp. at 1076 n.8; *Merger Guidelines* § 1.11, at 5–6.

[27] Defining the market in terms of a single product is appropriate since the Nevada statute provides that the Commissioner can deny a merger application if she ''determines that an acquisition may substantially lessen competition *in any line of insurance* in this state or tends to create a monopoly.'' NRS 692.258(1).

[28] *See United States* v. *Aetna* Revised Complaint Impact Statement, Civil Action 3–99CV1398–H (N.D.Tex, 1999).

[29] *Id.*

[30] *Id.*

[31] As to the market for the sale of health insurance products to small employers we have no reason to believe the concentration measures differ significantly from the HMO market.

defined United is clearly a dominant firm, far larger than the post-merger market shares of the combined Aetna/Prudential or United/PacifiCare in those markets where DOJ brought enforcement actions. Even in a Nevada HMO market, the market share increases from 12% to 80% and in a Nevada HMO–PPO market United's market share increases from 7% to 48%. Simply put, post-merger United will be a dominant firm no matter how the market is defined.

Measuring concentration using the HHI leads to similar results. The Merger Guidelines define a market with an HHI over 1800 as ''highly concentrated'' and an increase over 100 is ''likely to create or enhance market power or facilitate its exercise.'' The post-merger HHI for HMOs in the state of Nevada is 4,871 and the post-merger increase in HHI is 1,625. The HMO market in Clark County is even more concentrated, with a post-merger HHI of 8,884 and a post-merger increase in HHI of 2,235. These exorbitantly high HHIs support the presumption that a merger between the two largest HMOs in the highly concentrated Nevada HMO market would likely create or enhance market power or facilitate its exercise. The market share data obtained form the Nevada State Health Division is provided below. (Figure 1).

Figure 1. Market Share Data for the HMO Market in Nevada and Clark County.[32]

Nevada			Clark County		
HMO	# patients	Market Share	HMO	Members	Market Share
Sierra Health Plan	279,679	68%	Sierra Health Plan	267,274	80%
United PacifiCare	48,196	12%	United PacifiCare	47,242	14%
Aetna	9,108	2%	Aetna	8,296	2%
WellPoint	11,365	2.70%	Nevada Care	10,639	3%
Hometown Health	23,281	6%	WellPoint	1,297	0.05%
Saint Mary's Healthfirst	27,411	7%	Total	334,748	99%
NevadaCare	10,827	2.60%			
Total	409,867	100%			

The Nevada and Clark County markets are highly concentrated, no matter how defined. The parties may suggest that this is of little import because the increase in concentration is not substantial because United currently has a relatively modest market share. Such an argument is inconsistent with the facts and the law. United is the largest health insurer in the United States and the second largest rival in the market, with the ability and incentive to expand competition. As to the law as the Supreme Court has acknowledged, ''if concentration is already great, the importance of preventing even slight increases in concentration is correspondingly great.'' [33]

As important, the combined United-Sierra will be substantially larger than its next closest rival, In the Nevada HMO market it will be over 10 times larger (80% to 7% for the second largest firm) and in the Clark County market it will be over 30 times larger (94% to 3%). The courts have recognized that smaller rivals are far less likely to constrain the conduct of a dominant firm post-merger, and have enjoined mergers with far smaller disparities in market share. *United States* v. *Phillipsburg Nat'l Bank,* 399 U.S. 350, 367 (1970) (merged firm three times the size of next largest rival); *FTC* v. *PPG,* 798 F.2d 1500, 1502–03 (D.C. Cir. 1986) (two and one-half times as large). Where a merger produces a firm that is significantly larger than its closest competitors, it increases the likelihood that the firm will be able to raise prices, decrease compensation, and reduce quality without fear that the small sellers will be able to take away enough business to defeat the price increase. *See United States* v. *Rockford Mem. Corp.,* 898 F.2d 1278, 1283–84 (7th Cir.) (Posner, J.), cert. denied, 498 U.S. 920 (1990); H. Hovenkamp, *Federal Antitrust Policy* § 12.4c (1993) (''markets may often have small niches or pockets where new firms can carve out a tiny position for themselves without having much of an effect on competitive conditions in the market as a whole'').

Combined PPO and HMO Markets

Using a definition of the health insurance product market as the combination of HMOs and PPOs, the health insurance market in Nevada is highly concentrated, and the United-Sierra merger would substantially increase the likelihood of competitive harm.

The market share for Sierra and United combined in Nevada is 48%, while in Clark County the combined United-Sierra market share is 60%. The post-merger HHI for the Nevada and Clark County markets are 3372 and 5244, respectively, The increase in the HHI market resulting from the United-Sierra merger is 555 for the State of Nevada and 921 for Clark County. Data of market shares from the Nevada State Health Division for the HMO and PPO markets is provided in Figure 2.

[32] Data provided from the Nevada State Health Division.

[33] *United States* v. *General Dynamics Corp.,* 415 U.S. 486, 497 (1974).

[34] Data from the Nevada State Health Division.

[35] The market share for WellPoint in Clark County is overstated because in the absence of data by territory, all WellPoint customers were allocated to Clark County.

Figure 2. Market Share Data for the HMO/PPO Market in Nevada and Clark County.[34]

Nevada			Clark County [35]		
Insurance Firm	Members	% Market Share	Insurance Firm	Members	Market Share
Aetna Health Inc.,	9,108	1.18%	Sierra	297,825	51.35%
Sierra Health	312,702	40.67%	WellPoint	231,971	39.99%
WellPoint	231,971	30.17%	United	50,210	8.66%
Hometown Health	99,189	12.90%	Total	580,006	100.00%
NevadaCare	20,331	2.64%			
United Pacific Care	52,456	6.82%			
Saint Mary's Health First	43,141	5.61%			
Total	768,898	100.00%			

Conclusion on the Impact of the United-Sierra Merger on Consumers

As the U.S. Supreme Court has held where a merger results in a significant increase in concentration and produces a firm that controls an undue percentage of the market, the combination is so inherently likely to lessen competition substantially that it ''must be enjoined in the absence of evidence clearly showing that the merger is not likely to have such anticompetitive effects.'' *United States* v. *Philadelphia Nat'l Bank,* 374 U.S. 321, 363 (1963), The United-Sierra merger clearly raises extraordinary and unprecedented levels of concentration which raise serious concerns about this merger. Nevada is in need of greater competition, not less. Further consolidation among the limited health plan providers in Nevada poses a substantial threat of harming customers, increasing the costs of health care, and decreasing access to quality health care and the quality of health. This merger clearly ''would likely be harmful or prejudicial to the members of the public who purchase insurance'' and thus should be denied.

V. Health Insurer Concentration: Harm to Sellers and Quality of Care

The nature of the health care industry facilitates the potential for a dominant health coverage or insurance firm to exercise market power (or monopsony) over individuals selling health care services within a geographic region. Because medical services can be neither stored nor exported, health care professionals generally must sell their services to buyers (insurance firms and their customers) in a relatively small geographic market. Refusing the terms of the dominant buyer, physicians may suffer an irrevocable loss of revenue, Consequently, a physician's ability to terminate a relationship with an insurance coverage plan depends on her ability to make up lost business by switching to an alternative insurance coverage plan. Where those alternatives are lacking a physician may be forced to reduce the level of service in response to a decrease in compensation.

Not all insurance providers are equal from the perspective of a health care provider. A smaller insurance company with fewer covered lives may not he an attractive alternative. Health care providers who depend on an insurance program for all or most of their income are at a substantial disadvantage when there are not competing programs available; when they switch programs, they tend to lose the patients who have that particular coverage, It makes little sense for a provider to switch to an insurer who has a substantially smaller market share because there won't be enough patients to sustain the practice. Thus, it is critical for insurance regulators to maintain a competitive market in which health care providers have significant competitive alternatives.

In the Aetna/Prudential and United/PacifiCare mergers, the DOJ raised monopsony concerns in markets for purchasing physicians' services where the market shares were far less substantial than they are in Clark County. For example, in United/PacifiCare the DOJ alleged that the combined firm would account for an excess of 35% in Tucson and over 30% in Boulder.

In addition, it is important to recognize that it may be appropriate to prevent a firm from securing monopsony power even if it faces a competitive downstream market. In other words there may be antitrust concerns if a health insurer can lower compensation to providers even if it can not raise prices to consumers. For example, in United/PacifiCare the Division required a divestiture based on monopsony concerns in Boulder even though United/PacifiCare would not necessarily have had market power in the sale of health insurance. The reason is straightforward—the reduction in compensation would lead to diminished service and quality of care, which harms consumers even though the direct prices paid by subscribers do not increase.[36]

Underlying the monopsony analysis in these cases is the premise that physicians who have a large share of reimbursements from the merged firm lack alternatives in response to a reduction in compensation. As alleged in Aetna, they cannot retain or timely replace a sufficient portion of those payments if the physicians stop participating in the plans. Moreover, it is difficult to convince patients to switch to different plans.[37] Consequently, according to the Division these physicians would not be in a position to reject a ''take it or leave it'' contract offer and could be forced to accept low reimbursement rates from a merged entity, likely leading to a reduction in quantity or degradation in quality of physician services.

The merging parties may suggest that there is some safe harbor for mergers leading to a market share below 35%. As the DOJ enforcement action in Boulder demonstrates that is not the case. The unique nature of health care provider services explains why monopsony concerns are raised at lower levels of concentration than may be appropriate in other industries. If a health care provider's output is suppressed by a reduction in compensation, then it is a lost sale that

[36] See Marius Schwartz, Buyer Power Concerns andthe *Aetna-Prudential Merger,* Address Before the 5thAnnual Health Care Antitrust Forum at Northwestern University School of Law 4–6 (October 20, 1999) (noting that anticompetitive effects can occur even if the conduct does not adversely affect the ultimate consumers who purchase the end-product), *available at http://www.usdoj.gov/atr/public/speeches/3924.wpd.*

[37] As alleged in the United complaint, physicians encouraging patients to change plans ''is particularly difficult for patients employed by companies that sponsor only one plan because the patient would need to persuade the employer to sponsor an additional plan with the desired physician in the plans's network'' or the patient would have to use the physician on an out-of-network basis at a higher cost. Complaint at paragraph 37.

cannot be recovered later. Physician services can not be stored for later sale. As the DOJ observed in United/PacifiCare: ''A physician's ability to terminate a relationship with a commercial health insurer depends on his or her ability to replace the amount of business lost from the termination, and the time it would take to do so. Failing to replace lost business expeditiously is costly.'' [38] The DOJ observed that there are limited outlets for physician services: ''There are no purchasers to whom physicians can sell their services other than individual patients or the commercial and governmental health insurers that purchase physician services on behalf of their patients.'' [39] As a former DOJ official observed ''these factors explain why the Department concluded that shares below 35 percent, in the particular markets at issue, sufficed to allege competitive harm.'' [40]

Again the proponents of health insurance mergers may suggest that regulators should take a benign view about the creation of monopsony power because health insurers are ''buyers'' acting in the interest of reducing prices. As we suggested earlier this view is mistaken. Health insurers are not true fiduciaries for insurance subscribers. Plan sponsors may have a limited concern over the product based on the cost of the insurance, and not the quality of care. Furthermore, health coverage plans operate in the interest of a group, not in the best interest of individual patients. Consequently, insurance firms can increase profits by reducing the level of service and denying medical procedures that physicians would normally perform based on professional judgment. In the absence of competition among insurers, patients are more likely to pay for these procedures out-of-pocket or forego them entirely. Ultimately, the creation of monopsony power from a merger can adversely impact both the quantity and quality of health care.

Finally, the evidence from mergers throughout the U.S. strongly suggests that the creation of buyer power from health insurance consolidation has not benefited competition or consumers. Although compensation to providers has been reduced health insurance premiums have continued to increase rapidly. Moreover, evidence from other mergers suggests that insurers dot not pass savings on from these mergers to consumers. Rather, insurance premiums increase along with insurance company profits.

Monopsony in the Health Care Markets of Nevada

United's acquisition of Sierra would give it unique control over the physicians serving the HMO and HMO-PPO markets in Clark County and the State of Nevada. The merger will combine the two largest HMOs with an 84% market share in Nevada and a 90% market share in Clark County, dramatically higher than the concentration in any merger approved by the DOJ. In light of these high market shares, a physician faced with unfair contract terms could not credibly threaten to leave the combined United-Sierra health plan, except by departing Clark County.

The parties have suggested the markets for physician reimbursement are far less concentrated. At the earlier hearing they suggested the merged firm would account for only 17% of physician reimbursement in the state and 21% in Clark County. We do not know the basis for the claimed reimbursement percentages. One should take United's estimates of market shares with a large grain of salt. In United/PacifiCare their lawyers suggested the parties' total share of physicians' reimbursement likely were substantially below the 35% threshold, but those estimates were rejected by DOJ. As one of their advocates said ''indeed the parties calculated their total shares of physician reimbursements in the Tucson and Boulder MSAs were substantially lower than the shares asserted in the complaint.'' [41] The estimates of the proponents in the Aetna/Prudential merger were also rejected by the DOJ.[42]

Monopsony power exercised by HMOs and health insurance plans, like high medical malpractice insurance premiums, has the potential to drive health care professionals out of geographic regions and even into other professions. The Nevada health care market currently faces one of the largest shortages of doctors and nurses in the country.[43] It ranks 49th of the 50 states in physician coverage. Shortages of health care professionals can become a vicious cycle admonishing others against entering the profession. Doctor shortages increase with shortages of nurses and increases in insurance costs.[44] Nationally, it has become less attractive to become a physician because of the enormous cost associated with medical education, long years of schooling and residencies, and increased difficulty in earning a living.[45] Recently, Nevada has implemented programs to attract doctors from Mexico and train doctors in Mexico at the Universidad Autonoma de Guadelajara.[46]

Similar problems exist in nursing. Understaffed nursing departments require nurses to work overtime, work more holiday shifts, and undertake more responsibilities. These conditions exacerbate protracted work-related stress and decrease the attractiveness of working as a nurse in Nevada. Moreover, reduced flexibility for time off and patient dissatisfaction resulting from overworked nurses is generally associated with lower levels of job satisfaction and higher turnover rates.[47]

[38] Complaint, at paragraph 36.

[39] Complaint, at paragraph 33.

[40] Mark Botti, Remarks before the ABA Antitrust Section, ''Observations on and from the Antitrust Division's Buyer-Side Cases: How Can ''Lower'' Prices Violate the Antitrust Laws.'' He also noted that: ''Physicians have a limited ability to maintain the business of patients enrolled in a health plan once the physician terminates. Physicians could retain patients by encouraging them to switch to another health plan in which the physician participates. This is particularly difficult for patients employed by companies that sponsor only one plan because the patient would need to persuade the employer to sponsor an additional plan with the desired physician in the plan's network. Alternatively, the patient may remain in the plan, visiting the physician on an out-of-network basis. The patient would be faced with the prospect of higher out-of-pocket costs, either in the form of increased co-payments for use of an out-of-network physician, or by absorbing the full cost of the physician care.'' Complaint at paragraph 37.

[41] Fiona Schaeffer *et al.*, ''Diagnosing Monopsony and other issues in Health Care Mergers: an overview of United/PacifiCare Investigation,'' Antitrust Health Care Chronicle (2006).

[42] The estimates of the level of physician reimbursement by the proponents of the Aetna/Prudential merger were also rejected by the DOJ. The proponents suggested that the total amount of physician revenues affected by the merger were far less than thirty percent according to public available data. According to the proponents the merged firm would have accounted for about 20% of total physician revenues in Houston and about 25% of total physician revenues in the Dallas-Fort Worth area after the transaction. In addition, there were 14 HMOs in the Houston area and 12 HMOs in Dallas. *See* Robert E. Bloch et al. ''A New and Uncertain Future for Managed Care Mergers: An Antitrust Analysis of the Aetna/Prudential Merger.'' Yet the DOJ required an enforcement action to address monopsony concerns in spite of these alleged low shares of reimbursement.

[43] *See* Lawrence Mower, ''Help Sought South of the Border,'' *Las Vegas Review Journal,* Jan. 22, 2007; *see also* Lenita Powers, ''Big Day at Lawlor,'' *Reno Gazette,* Dec. 9, 2006 (expressing that nurses in Nevadaare in a desperately short supply, especially OR nurses).

[44] *See* Lawrence Mower, ''Help Sought South of the Border,'' *Las Vegas Review Journal,* Jan. 22, 2007.

[45] Lawrence Mower, ''Help Sought South of the Border,'' *Las Vegas Review Journal,* Jan. 22, 2007.

[46] *Id.*

[47] *See* Jennifer Kettle, *Factors Affecting Job Satisfaction in the Registered Nurse, Journal of Undergraduate Nursing Scholarship,* Fall 2002 (last viewed July 9, 2007) *http://www.juns.nursing.arizona.edu/articles/Fall%202002/Kettle.htm.*

VI. Conclusion on the Impact of the United-Sierra Merger on Health Care Professionals and Quality of Care

The United-Sierra merger poses a substantial threat to competition leading to reduced compensation for health care professionals who may be forced to reduce service and quality of care. This reduced quality of care ''would likely be harmful or prejudicial to the members of the public who purchase insurance.'' Further consolidation in the HMO and health coverage markets in Nevada may have detrimental short-term and long-term effects by exacerbating the crisis of the health professional shortage. Competition is essential to the delivery of high quality health care services. The United-Sierra merger will further distort the already concentrated and inefficient Nevada health care market.

Barriers to Entry Are High

As noted earlier, entry can be a factor in the analysis of a merger that may reverse the presumption of anticompetitive effects. The courts have required that ''entry into the market will likely avert the anticompetitive effects from the acquisition.'' *FTC* v. *Staples,* 970 F. Supp. 1066, 1086 (D.D.C, 1997). Entry must be ''timely, likely insufficient in its magnitude, character and scope to deter or counteract the competitive effects'' of a proposed acquisition. Merger Guidelines § 3.0.

The barriers to entry in the HMO and health insurance markets in Nevada and Clark County are very high. There has been relatively little recent entry into either Clark County or Nevada. The fact that United, the largest health insurer in the U.S., chose to enter into Nevada through two acquisitions —PacifiCare and Sierra—suggests the significant difficulty of de novo entry in these markets.

Generally, entry into health insurance markets is difficult. The health care industry does not fit the traditional model of perfect competition as expounded by the Chicago School.[48] For example there is a high degree of ''lock-in'' because plan sponsors cannot disrupt the medical treatment of countless employee/patients. New entrants are vulnerable to the high switching costs that characterize the health insurance industry. Many consumers have no choice for health coverage plans and must accept the plan provided by an employer. Other consumers can only switch during an ''open enrollment'' season. Doctors cannot easily switch their patients to a different health plan and, in the absence of a large number of patients enrolled in a plan, a doctor may find that additional claim processing costs exceed the benefits of carrying an additional health coverage provider. Similarly, doctors may be reluctant to switch plans because earnings lost in pursuit of new patients and alternate third-party payers may lead to exorbitant losses.[49]

Developing an HMO from scratch requires extensive expenditure on recruiting and maintaining health professionals, developing computer information systems and data banks, and high expenditures on overhead and clinical facilities. De novo entry is very challenging since new entrants must develop a reputation and product recognition with purchasers to convince them to disrupt their current relationships with the dominant health insurers.[50] As a recent DOJ/FTC report on health care competition reported, there has been relatively little de novo entry by national health insurers.[51]

Not surprisingly the DOJ has recognized the substantial barriers to entry and expansion in health insurance markets. In the Aetna/Prudential merger, the DOJ found substantial entry barriers. Certainly Dallas and Houston were attractive markets for health insurers. Both markets had a substantial number of alternative health insurers capable of expansion. And there were numerous competitors in other Texas markets that were capable of entering into these markets. Yet the DOJ found substantial entry barriers and that entry could take two to three years and cost up to $50 million.[52] In particular it found that it was ''unlikely that a company that currently provides PPO or indemnity health insurance in either Dallas or Houston would shift its resources to provide an HMO or HMO-POS plan'' in either market.[53]

Entry barriers are even more substantial in Nevada and Clark County. The shortage of health care professionals in Nevada increases barriers to entry because new entrants are unlikely to be able to contract with an adequate number of health professionals to attract new plan sponsors and enrollees. Moreover, when a dominant HMO maintains a high market share, other health providers may perceive or experience higher rates of adverse selection, moral hazard, and general vulnerability to tactics by a dominant HMO to raise rival's cost.[54] Experience indicates that new HMOs have not historically entered highly concentrated markets after a merger occurs.

The parties may also suggest that some of the smaller HMOs and health insurance providers in Nevada may be able to expand post-merger to prevent any anticompetitive effects. This is extremely unlikely because the fringe firms are currently so extremely small and far smaller than a combined United-Sierra. In cases with an even far smaller size disparity between the merged and fringe firms courts have declined to find that small players might suddenly expand to constrain a price increase by leading firms. *United States* v. *Philadelphia Nat'l Bank,* 374 U.S., 321, 367 (1963); *United States* v. *Rockford Mem. Corp.,* 898F.2d. 1278, 1283–84 (7th Cir. 1990) (''three firms having 90 percent of the market can raise prices with relatively little fear that the fringe of competitors will be able to defeat the attempt by expanding their own output to serve customers of the three large firms'').

The small firm expansion claim was rejected by the DOJ in Aetna/Prudential, a case with far smaller post-merger market shares and a far greater number of fringe firms:

Due not only to these costs and difficulties, but also to advantages that Aetna and Prudential hold over their existing competitors—including nationally recognized quality accreditation, product array, provider network and national scope and reputation—existing HMO and HMO-POS competitors in Dallas or Houston are unlikely to be able to expand or reposition themselves sufficiently to

[48] *See* Thomas Greaney, *Chicago's Procrustean Bed; Applying Antitrust Law in Health Care,* 71 Antitrust L.J. 857 nl (2004) (''Perfectly competitive markets demonstrate the following four characteristics: (1) Perfect product homogeneity (2) large numbers of buyers and sellers (3) perfect knowledge of market conditions by all market participants and (4) complete mobility of all product resources.'')

[49] Moreover, most employee/patients are limited to the physicians within the plan sponsors contract.

[50] At the FTC/DOJ Health Care hearings, a former Missouri Commissioner of Insurance suggested that new entrants ''face a Catch 22—they need a large provider network to attract customers, but they also need a large number of customers to obtain sufficient price discounts from providers to be competitive with the incumbents.'' In addition, he observed that there is a first mover, or early mover, advantage in the HMO industry, possibly resulting in later entrants having a worse risk pool from which to recruit members. He also observed reputation may inhibit entry. *See Improving Health Care: A Dose of Competition,* A Report by the Federal Trade Commission and the Department of Justice, Chapter 6 at 10 (July 2004), *available at http://www.usdoj.gov/atr/public/health_care/204694/chapter6.htm#3.*

[51] *Id.* at 11 (citing testimony that the only successful entry of national plans has been by purchasing hospital-owned local health plans).

[52] In light of the health professional shortage in Nevada, these values could be understated.

[53] Complaint at paragraph 23.

[54] *See* Roger Noll, *Buyer Power and Antitrust: ''Buyer Power'' and Economic Policy,* 72 Antitrust L.J. 589, 2005.

restrain anticompetitive conduct by Aetna in either of these geographic markets.[55]

History demonstrates that one can not rely on new entry in Clark County. Few competitors from the rest of Nevada have been able to successfully enter Clark County. Attempting to enter into a market dominated by a single firm is a daunting task. There may be several obstacles to expansion including cost disadvantages, efficiencies of scale and scope and reputational barriers. In other mergers, the courts have found these types of impediments to be significant barriers to entry and expansion. For example, in the FTC's successful challenge to mergers of drug wholesalers the court noted: ''[t]he sheer economies of scale and scale and strength of reputation that the Defendants already have over these wholesalers serve as barriers to competitors as they attempt to grow in size.'' [56]We believe similar obstacles exist for potential entrants in these markets.

Relying on promises of entry and expansion may be a risky path for competition and consumers. In recent FTC/DOJ health care hearings, a former Missouri Commissioner of Insurance discussed several HMO mergers that his office approved based on the parties' arguments that entry was easy, that there were no capacity constraints on existing competitors (there were at least ten HMO competitors), and that any of the 320 insurers in the state could easily enter the HMO market. Unfortunately, those predictions were mistaken and there has been no entry in the St. Louis HMO market since the mid-1990s.[57] This experience should make any regulator cautious about relying on predictions of new entry.

Efficiencies of the United-Sierra Merger Are Minimal

The parties have not suggested that there are significant efficiencies that may result from the merger. Under the Nevada statute, the Commissioner can consider efficiencies that either ''create[ ] substantial economies of scale or economies in the use of resources that may not be created in any other manner'' or ''substantially increase[ ] the availability of insurance.'' [58] In either case, the public benefit of either of these efficiencies must exceed the loss of competition. This standard simply can not be met in this case where the merger creates a dominant firm.

As a matter of U.S. merger law, efficiencies can justify an otherwise anticompetitive merger in very limited circumstances. Those efficiencies which are considered under the antitrust laws are solely those efficiencies which lead to improvements for consumers in terms of lower prices, greater innovation or greater service and quality. Moreover, an efficiency must be merger specific—that is it can not be achieved in any less anticompetitive fashion. When a cost savings does not result in those benefits to consumers it is not properly considered.

The record on recent health insurance mergers does not suggest that these mergers have led to substantial benefits to consumers in lower prices, better quality of care or service. Despite the occurrence of hundreds of health insurance mergers that have occurred in the past decade, subscriber premiums have continued to rise at twice the rate of inflation and physician fees.[59] Health benefits have not expanded with subscriber premiums.[60] Consequently, the efficiencies in health insurance mergers deserve careful scrutiny and a heavy dose of skepticism.[61]

The actual record on efficiencies from health insurance mergers is spotty at best. As Professor Lawton Burns has observed in Congressional testimony:

[T]he recent historical experience with mergers of managed care plans and other types of enterprises does not reveal any long-term efficiencies.

[E]ven in the presence of [efforts to achieve cost-savings] and defined post-integration strategies, scale economies and merger efficiencies are difficult to achieve. The econometric literature shows that scale economies in HMO health plans are reached at roughly 100,000 enrollees. * * * Moreover, the provision of health insurance (e.g., front-office and back-office functions) is a labor-intensive rather than capital-intensive industry. As a result, there are minimal economies to reap as scale increases. * * * Finally, there is little econometric evidence for economies of scope in these health plans—e.g., serving both the commercial and Medicare populations. Serving these different patient populations requires different types of infrastructure. Hence, few efficiencies may be reaped from serving large and diverse client populations. Indeed, really large firms may suffer from diseconomies of scale.[62]

United's actual record in achieving efficiencies is a mixed one at best. Bigger is not necessarily better and a national platform is not better than a local one. To provide just one example, United completely disrupted efficient working relationships between University Medical Center and PacifiCare by replacing the local insurer's claims processing with a more bureaucratic national one.[63] This disruption in working operations increased the number of unpaid claims and created other problems with provider services. One need look no further than United's track record for inadequate claims processing over the past five years.

- The Nebraska Department of Insurance, which imposed a fine of $650,000, the largest ever, on United Health for inadequately handling complaints, grievance, and appeals.
- In March 2006, the Arizona Department of Insurance fined United $364,750 for violating state law by denying services and claims, delaying payment to providers and failing to keep proper records.
- In December 2005, the Texas Department of Insurance fined United $4 million for failing to pay promptly, lacking accurate claim data reports and not maintaining adequate complaint logs. The insurance giant also had to pay restitution to physicians.[64]

State imposed fines are an inadequate remedy for poor services to patients and doctors. First, the actual payer of these fines is the consumer, because United

[55] Complaint at paragraph 24. In Aetna, thepost-merger market shares were 44% and 62% and there were between 10-12 smaller competitors capable of expansion. In this case, the post-merger market share is greater than 90% and there are a handful of smaller competitors.

[56] *FTC* v. *Cardinal Health, Inc.,* 12 F. Supp. 34, 57 (D.D.C. 1998); see *United States* v. *Rockford Memorial Hosp.,* 898 F.2d 1278, 1283–84 (7th Cir. 1990) (''the fact [that fringe firms] are so small suggests that they would incur sharply rising costs in trying almost to double their output * * * it is this prospect which keeps them small'').

[57] Testimony of Jay Angoff, former Missouri Commissioner of Insurance, before the FTC/DOJ Healthcare Hearings, April 23, 2003 at 40–45, discussed at *Improving Health Care: A Dose of Competition.* A Report by the Federal Trade Commission and the Department of Justice, Chapter 6 at 10 (July 2004), available at *http://www.usdoj.gov/atr/public/health_care/204694/chapter6.htm#3.*

[58] NRS 692C.256(3).

[59] Laura Benko, ''Monopoly Concerns: AMA Asks Antitrust Regulators to Restore Balance,'' *Modern Physician,* June 1, 2006.

[60] Best Wire, ''Study Says Competition in Health Markets Waning,'' *Best Wire* Apr. 19, 2006.

[61] *See* Laura Benko, ''Bigger Yes, But Better?'' *Modern Health Care,* March 19, 2007.

[62] Testimony of Professor Lawton R. Burns re. the Highmark/Independence Blue Cross Merger, before the Senate Judiciary Committee (April 7, 2007).

[63] *See* Laura Benko, ''Bigger Yes, But Better?'' Modern Health Care, March 19, 2007.

[64] Marshall Allan, ''Insurer Comes Here With a Trail of Fines From Other States,'' Las Vegas Sun, June 20, 2007.

can pass these fines off to consumers in the form of higher premiums and co-payments. Second, fines pose no solace to patients that may suffer the persistent hounding from creditors as a result of unpaid insurance claims. Further consolidation will only enhance the likelihood of shoddy claims service since consumers will have few rivals to turn to in response to poor quality of service.

United may suggest the merger is procompetitive because it will lead to improved cost containment initiatives. Of course, Sierra may adopt those measures without a merger. In addition, although efforts to contain costs are rooted in legitimate needs, the actual implementation of cost containment efforts can produce negative consequences for the quality of health care provided to consumers. However, most cost containment efforts center on decreasing utilization. Moreover, in concentrated markets, the likelihood of administered pricing and agreements not to reimburse for a procedure is more likely. Ultimately, the insurer's gross margin increases by reducing access to care and the quality of care for consumers.

The burden should be on the merging parties to demonstrate that the efficiencies they put forward are not speculative, that they exceed the likely anticompetitive effects on consumers and suppliers of services, and that the benefits will be passed on in the form of lower premiums and better quality, rather than larger profits for shareholders. It is highly unlikely that burden can be met in this case.

Recommendations

The United-Sierra merger poses a serious threat to competition in the provision of insurance and health care services in Nevada, especially Clark County. This merger requires heightened scrutiny given the currently high concentration of the health coverage providers in the Nevada market and the current shortage of health care professionals in the State. The merger should be denied because it ''would * * * substantially lessen competition in insurance in Nevada or tend to create a monopoly,'' through the creation of a dominant health insurance provider particularly in Clark County. Moreover, it will lead to a reduction in the level and quality of service thus harming and prejudicing ''the members of the public who purchase insurance.'' Enhancement of Nevada's health care requires increased levels of competition and greater market efficiency, which cannot be achieved through a merger between two of the State's largest health insurance providers. The likelihood of competitive harms from the United-Sierra merger is substantial, and the procompetitive benefits *de minimus.* Pursuant to NRS 692C.258(1), we urge the Commissioner to deny the merger application.

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