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 "Tunney 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]

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 a 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

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[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. 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).

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 Antitrust Improvements 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).

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[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.

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 divestiture in order to resolve concerns in these markets. If DOJ has changed its 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

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[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* Fed. Reg. Vol. 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) [hereinafter United/PacifiCare Complaint], *available at* www.usdoj.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.

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 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.

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[11] *See* Section IX herein.
[12] Aetna Complaint at paragraph 22.
[13] *Id.*
[14] United/PacifiCare Complaint at 27.
[15] *Id.* at paragraph 41.

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

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[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 DOJ 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.

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

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[19] *Id.* at 4.

[20] *Id.* at 6.

[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.

> 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.
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> 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…
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> 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. [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 prices for suppliers, and may well result in higher prices charged to final consumers.[26]

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[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.

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.
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> [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]

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[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).

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 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

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[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.gov/atr/public/guidelines/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), a*vailable at* http://www.usdoj.gov/atr/public/press_release/2004/204674.htm.

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.

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[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 beyond the current range of two to five weeks). This problem is far worse in Nevada.

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 does 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

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[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_13731e.pdf.

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

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 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 anticompetitive 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

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[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).

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, included United, have used corrupted data

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[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.

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.

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 PFJ 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 PFJ, we strongly urge it to treat the PFJ as an interim remedy and expressly leave open

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[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.

the possibility of supplementing the PFJ with additional remedies to address these competitive concerns.[44]

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[44] See remarks of former Federal Trade Commission Chariman 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.