UNITED STATES OF AMERICA v. UNITEDHEALTH GROUP INCORPORATED et al Doc. 11 Att. 4

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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 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.

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[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.

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

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

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 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

[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.

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

[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

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 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

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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 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 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 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.

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.

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[10] Health insurers play dual roles as sellers of insurance services and buyer's 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 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 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

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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).

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 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]

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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. 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).

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'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 worker's earnings. Average annual premium increases have ranged from 8.2% to 13.9 % since 2000.[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

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[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.

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 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 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]

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[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).

[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.

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 merger.[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 "gate keeper" 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]

[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*

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]

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 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

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[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.

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").

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

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

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 Country the combined United-Sierra markets 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.

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.

[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 Country.

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 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]

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[36] *See* 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* *h*ttp://www.usdoj.gov/atr/public/speeches/3924.wpd.

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]

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

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[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 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.

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 the 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]

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[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

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. Under staffed nursing departments require nurses to work over-time, 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]

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.

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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 .

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 significantly 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 entrant must develop a reputation and product recognition with purchasers to convince them to disrupt their current relationships with the dominant

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[48] *See* Thomas Greaney, Chicago's Procrustean Bed: Applying Antitrust Law in Health Care, 71 Antitrust L.J. 857 n1 (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.

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").

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[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.

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

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[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, 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.

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]

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[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).

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 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

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[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.

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 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 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(1), we urge the Commissioner to deny the merger application.