AMA
AMERICAN MEDICAL ASSOCIATION

Statement

of the

American Medical Association

to the

Committee on the Judiciary, Subcommittee on Antitrust, Competition Policy, and Consumer Rights United States Senate

RE: Consolidation in the Pennsylvania Health Insurance Industry: The Right Prescription?

Presented by: Henry S. Allen, Jr., Esq.

July 31, 2008

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I Opening Statement

The American Medical Association (AMA) appreciates the opportunity to present testimony to the Committee on the Judiciary on consolidation in the Pennsylvania health insurance industry. We commend Chairman Kohl, Ranking Member Hatch, Senator Specter and the other members of the Subcommittee on Antitrust, Competition Policy, and Consumer Rights for your leadership in recognizing the threats that health insurer consolidations pose to the delivery of health care in Pennsylvania and across the country.

The AMA believes that competition, not consolidation, is the right prescription for health insurer markets. Competition will lower premiums, force insurers to enhance customer service, pay bills accurately and on time, and develop and implement innovative ways to improve quality while lowering costs. Competition also allows physicians to bargain for contract terms that touch all aspects of patient care.

In Pennsylvania where health insurer entry from outside the state has been difficult and little incumbent competition exists, the potential competition that Highmark poses to Independence Blue Cross ("IBC" or "Independence") is the only market mechanism that protects patients from higher premiums. This potential competition also offers the prospect that physicians practicing in IBC's territories will have somewhere else (i.e., Highmark) to sell their services.[1] A merger would foreclose this alternative and provide the merged firm with the sort of monopsony power[2] that is depriving physicians of the ability to negotiate competitive health insurer contract terms in markets around the country. Accordingly, the AMA opposes the proposed merger of Highmark and IBC.

II. Merger to Monopoly

The market shares of Highmark and IBC are more than sufficient for the merger to be found presumptively illegal under both Section 7 of the Clayton Act (15 USC § 18) (Section 7) and the Pennsylvania Insurance Holding Companies Act("PAIHCA"). Monica Noether, PhD, a former Deputy Assistant Director of the Federal Trade Commission Bureau of Economics[3], has concluded that the merger would combine a Highmark market share of 42 percent with that of IBC's share of 30 percent, and would result in a combined entity with more than 70 percent of

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[1] See Lawrence A. Sullivan & Warren S. Grimes, The Law of Antitrust: An Integrated Handbook §11.3b-.3b1 (2000) (for a discussion of the consumer welfare benefits of potential competition).

[2] Text from: "Agenda for Joint FTC / DOJ Hearings on Health Care and Competition Law and Policy" (Washington D.C., Thursday, April 24, 2003) Available from: http://www.ftc.gov/ogc/healthcarehearings/030405hcagenda.shtm; Accessed 07/30/2008. This source defines monopsony as a "substantial market power being exercised by buyers over sellers. In the health insurance industry, health insurers are both sellers (of insurance to consumers) and buyers (of, for example, hospital and physician services).

[3] Monica G. Noether, PhD. "Testimony on Commonwealth of Pennsylvania Public Hearing Associated with the Form A Filings for Highmark, Inc. and Independence Blue Cross." (Pittsburgh, July 8, 2008). Text From: Competitive Analysis of the Proposed Consolidation Between Highmark, Inc., and Independence Blue Cross in the Commonwealth of Pennsylvania. Available from: www.ins.state.pa.us; Accessed 07/29/2008. (Noether Report).

the fully and self-insured commercial health insurance market in the Commonwealth.[4] The resulting post-merger level of market concentration, and the increase in that market concentration caused by the merger, triggers the presumption that the merger may substantially lessen competition or tend to create a monopoly under both Section 7 and the PAIHCA.[5] Moreover, under federal antitrust law, the resulting entity's possession of a 70 percent market share also establishes a prima facie case of monopoly power, a conclusion buttressed by the substantial barriers to market entry (also documented in Dr. Noether's report).[6] In short, this proposed merger is so anticompetitive that it amounts to a merger to a monopoly.

Highmark/IBC's statement addressing the PAIHCA's competitive standard omits any discussion of entry into the market – a factor, that under the Act, may be considered in determining whether a merger has anticompetitive effect.[7] The reason for this omission is obvious. In Pennsylvania health insurance markets there has been very little in the way of new entry[8]. Health insurers that have successfully competed in other parts of the nation including Aetna, United HealthCare, and Cigna, have barely any presence in Pennsylvania. This is

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[4] *Id.* at 7.

[5] The PAIHCA at 40 P.S. § 991.1403(d)(2)(i) provides that a highly concentrated market is one in which the share of the four largest insurers is 75 percent or more of the market. In a concentrated market when an insurer with a 4 percent market share acquires one with a 4 percent share, that would constitute a prima facie violation of the act's competitive standards. *Id.* The Noether Report at Exhibit 2 documents that in a statewide Pennsylvania market, the four largest insurers possess a total market share of 86 percent. Moreover, the shares of merging firms dramatically surpasses the 4 percent. *See also* Horizontal Merger Guidelines, US Department of Justice and Federal Trade Commission at *http://www.usdoj.gov/atr/public/guidelines/horiz_book/hmg1.html.*
In *United States v. Philadelphia National Bank*, 374 U.S. 321 (1963), the U.S. Supreme Court announced a rule of presumptive illegality in the context of heavily concentrated markets. In that case, the acquiring firm held a 30 percent market share, while the acquired firm's market share was only 3 percent.

[6] *See e.g. United States v. Grinnell Corp,* 384 US 563, 571 (1966) (The existence of monopoly power may be inferred from a predominant share of the market).

[7] *See* 40 P.S. § 991.1403(d)(2)(iv).

[8] Monica G. Noether, PhD. "Testimony on Commonwealth of Pennsylvania Public Hearing Associated with the Form A Filings for Highmark, Inc. and Independence Blue Cross." (Pittsburgh, July 8, 2008). Text From: Competitive Analysis of the Proposed Consolidation Between Highmark, Inc., and Independence Blue Cross in the Commonwealth of Pennsylvania. Available from: www.ins.state.pa.us; Accessed 07/29/2008. (Noether Report, 8-11).

consistent with the federal antitrust enforcement agencies' observation that national plans have been unsuccessful entering some of the Blue Cross dominant markets in recent years.[9]

Entry is difficult.[10] As the Federal Trade Commission has reported, there are significant barriers to entry in health insurance markets. These barriers include the problems of: (i) developing a health care provider network; (ii) developing sufficient business to permit the spreading of risk; and (iii) contending with established insurance companies that have built long term relationships with employers and other consumers. Because there has been little to no entry in either of Highmark's orIBC's dominant market areas, this merger would permanently eliminate their biggest potential rival.[11]

III. Highmark and IBC are Best Characterized as "Competitors"

In a failed effort to avoid a prima facie violation, Highmark/IBC assert in their "Statement Regarding Compliance with the Competitive Standard of 40 P.S. Section 991.1403(d)" that they do not compete in the same market that they operate in different regional markets.[12] Consequently, their economist Barry Harris, PhD claims, "[t]he consolidation does not result in any anticompetitive effects."[13] The insurance market in Pennsylvania, however, *is* regional, and thus, the merger will substantially reduce competition. IBC and Highmark are dominant in each of the alleged regionalized markets. In the absence of a merger, Highmark's

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[9] "Improving Health Care. A Dose of Competition, Federal Trade Commission and Department of Justice" (July 2004) at 8-11.
[10] *Id.*
[11] *See* Affidavit of Professor Dranove, Exhibit 1.
[12] "Statement Regarding Compliance with the Competitive Standard of 40 P.S. Section 991.1403(d)", at 1-2.
[13] Comments by Barry C. Harris, PhD, in the Pennsylvania Insurance Department Public Informational Hearings July, 2008.

entry as a competitor would result in a substantial deconcentration of IBC's regionalized market.[14]

Highmark has the means other than through merger to enter IBC's regional territory. As an established Blues insurer in Pennsylvania, Highmark does not face the barriers to entry confronted by other insurers. In the past, Highmark would have marketed its Blue Shield plan in IBC's territory of southeastern Pennsylvania, but for Highmark's 1996 purchase agreement with IBC. Pursuant to that agreement, Highmark exited southeastern Pennsylvania by selling interests in two plans to IBC and promising not to re-enter IBC's territories under the Blue Shield service mark for ten years.[15] That market division agreement expired around the time this consolidation was proposed. Presently, in the absence of this agreed-upon territorial restraint, Highmark is free, capable, and desirous of offering its services in the southeastern Pennsylvania territory where IBC presently sells. In fact, Highmark has previously successfully marketed its products in southeastern Pennsylvania.[16] It could easily offer products there again, using the network of physicians it already has under contract in that region. Highmark only needs to add a relatively small number of hospitals to that network. Expanding state-wide is also made easier by the presence of companies that rent networks in Pennsylvania.[17] With the strong appeal of the Blue Shield Trademark, Highmark could accomplish its CEO's stated goal of gaining state-wide

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[14] For a discussion of these factors in a merger context, *see United States v. Marine Bancorporation, Inc.*, 418 U.S. 602 (1974).
[15] December 6, 1996 Purchase Agreement between IBC and Pennsylvania Blue Shield, Section 7.2, at 10.
[16] Monica G. Noether, PhD. "Testimony on Commonwealth of Pennsylvania Public Hearing Associated with the Form A Filings for Highmark, Inc. and Independence Blue Cross." (Pittsburgh, July 8, 2008). Text From: Competitive Analysis of the Proposed Consolidation Between Highmark, Inc., and Independence Blue Cross in the Commonwealth of Pennsylvania. Available from: www.ins.state.pa.us; Accessed 07/29/2008. (Noether Report, 12)
[17] For a list of these companies see Noether Report at 7.

presence[18] – a goal that is consistent with serving employers whose employees reside state-wide.[19]

Highmark's and IBC's ability to compete with each other is not altered by the status of the parties as Blue Cross/Blue Shield licensees. The Blue Cross and Blue Shield Association (BCBSA) explained in its correspondence to acting Insurance Commissioner Ario that, "Nothing in the license agreements prevents a licensee of the Blue Cross brand from using that brand to compete against a licensee of the Blue Shield brand, and visa versa within its license service area...[M]oreover, BCBSA licensed companies may compete anywhere with nonBlue branded business, and many do."[20] Accordingly, Highmark as a Blue Shield licensee can compete in IBC's territories notwithstanding IBC's status as a Blue Cross licensee. In addition, IBC would be free to compete against Highmark in western Pennsylvania using, for example, "Amerihealth HMO" as its product.

Although Highmark and IBC have engaged in an agreement to divide the market, there are reasons of principle and policy for characterizing their proposed merger as one that lessens competition or tends to create a monopoly. First, there is no meaningful difference between actual and potential competition.[21] As Areeda & Hovenkamp observe in the leading treatise on antitrust law, once a firm like Highmark is recognized as a factor "in future predictions about the market, that firm must be counted as a competitor even though that firm has not yet won its first bid or indeed has not made any bid at all."[22] Thus, the foreclosure of this future market role serves "to lessen competition." Second, a restrictive reading understates the competitive

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[18] "Talking with Ken Milani," Harrisburg, Patriot News, July 22, 2007.
[19] Dranove Affidavit, Exhibit 1.
[20] Dec. 21, 2007 correspondence from Roger G. Wilson, Senior Vice President and General Council, Blue Cross Blue Shield Association to Joel Ario, Acting Insurance Commissioner.
[21] IV Areeda & Hovenkamp, *Antitrust Law*: An *Analysis of Antitrust Principles and their Application* ¶907 (2007) (Exhibit 2) (which explains that there are good reasons for not reading the Clayton Act requirements narrowly).
[22] *Id.*

significance of mergers that, like here, occur in highly concentrated non-competitive markets.[23] Indeed, where the merger results in a market share of monopoly proportions, the merger should constitute a Section 2 offense of monopolization because it eliminates either actual or potential competition.[24]

In sum, Highmark and IBC cannot escape the anticompetitive implications of their combined market share by arguing that they are not rivals in each other's markets. IBC and Highmark are actual competitors, as best evidenced by their agreement not to compete, which was required to control the natural rivalry between them.

IV. Anticompetitive Effects of Merger in the Insurance Market Where Physicians Sell Their Services

The merger would result in a dominant health insurance company with monopsony power in insurance markets where physicians sell their services. Consequently, physicians could be forced to accept inadequate reimbursement, which would likely to lead to a reduction in the supply of physician services - in spite of the demand for such services by patients. This is particularly significant given that recent projections by the U. S. Health Resources and Services Administration already suggest an impending shortage of physicians.[25]

It is a mistake to assume that when insurers push down the cost of physician services, insurers' interests are perfectly aligned with those of consumers.[26] Because health insurer monopsonists typically are also monopolists in the output market for healthcare insurance, lower

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[23] *Id.*
[24] *Id* at ¶912(Exhibit 3).
[25] See Health Resources and Services Administration, *Physician Supply and Demand: Projections to 2020* (Oct 2006) (which projecting a shortfall of approximately 55,000 physicians in 2020); *see also* Merritt, Hawkins, et al., *Will the Last Physician in America Please Turn Off The Lights? A Look at America's Looming Doctor Shortage* (2004). (which predicts 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).
[26] Mark V. Pauly, "Competition in Health Insurance Markets," 51 Law & Contemp. Probs. 237 (1998).

input prices (for physician services) do not lead to lower consumer output prices (for health care insurance premiums).[27] Indeed, 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 physicians has been reduced, health insurance premiums have continued to increase rapidly.[28]

Clearance of this merger by the U.S. Department of Justice(DOJ) greatly concerns the AMA.[29] The Department of Justice has challenged only three of more than 400 mergers involving health insurers and managed care organizations over the past 12 years.[30] As a result, markets for third-party payors, especially commercial insurance plans, have grown increasingly concentrated. In almost every state, one of three major insurance firms is the market leader. In most of these states, Blue Cross and Blue Shield is the dominant firm. For example, in 2002, Blue Cross and Blue Shield controlled 39 percent of the Maine market; by 2006, this had grown to 63 percent.[31] The Government Accountability Office (GAO) estimates that the largest insurer in each state of the United States typically has a 43 percent share of the market for small group coverage, a 10 percent increase in less than five years.[32] Other studies indicate that in 16 states, one insurer controls over half of the market.[33] This consolidation has developed mostly through mergers and acquisitions. Studies have shown unequivocally that in this market environment,

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[27] Peter J. Hammer and William Sage, "Monopsony as an Agency and Regulatory Problem in Health Care," 71 Antitrust L.J. 949 (2004). *See also Dranove Affidavit,* Exhibit I.
[28] 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, 100th Cong. (Oct. 25, 2007).
[29] See Highmarks Press Release of July 17, 2008.
[30] American Medical Association, *Competition in Health Insurance: A Comprehensive Study of US Markets* / 2007 Update, 1
[31] Robert Pear, "*Loss of Competition Is Seen in Health Insurance Industry*", New York Times, Apr. 30, 2006, at Section 1, 131.
[32] *Id.* at Section 1, 21.
[33] James C. Robinson, *Consolidation and the Transformation of Competition in Health Insurance*, 23 Health Affairs 11, 13-14 (2004).

physicians across the country have virtually no bargaining power with dominant health insurers that are monopsonists.[34]

V. Why Competition Is Good

Competition is essential to the health of the free market. Competition among insurers forces them to hold the line on premiums. With average premiums exceeding $12,000 for a family plan, even a few percentage points would make a significant difference for the typical family.

Examples of the benefits of competition among Blues plans can be found in the ongoing rivalry between Highmark and Capital BlueCross. Some of the benefits have been documented in the testimony of Anita Smith, President and Chief Executive Officer of Capital BlueCross.[35] She emphasizes that the competition between Capital BlueCross and Highmark has improved efficiency, innovation, quality, and price. Such benefits have also been discussed in the press. For example, The *Philadelphia Inquirer* carried an article on June 9, 2008, entitled "What can happen if Blues Compete; In a Swath of Pa., Capital and Highmark both offer health insurance."[36] The article contrasts the marketplace for insurance in southeast Pennsylvania, where IBC has no Blue rival, with the central area of the state, where Capital and Highmark are rivals. In central Pennsylvania, the article concludes, competition for the contract prevails, thus benefiting patients and providers. Patients and physicians should also reap the benefits of Highmark's and IBC's future competition. The firms should not be allowed to merge into a monopoly.

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[34] American Medical Association, *Competition in Health Insurance: A Comprehensive Study of US Markets* / 2007 Update, 2.
[35] Anita Smith. "Testimony before the Commonwealth of Pennsylvania Senate Banking and Insurance Committee Associated with the Form A Filings for Highmark, Inc. and Independence Blue Cross." (January 30, 2008). Available from: https://www.capbluecross.com/PressRoom/NewsReleases/testimony.htm ; Accessed 07/29/2008.
[36] Exhibit 4.

VI. Conclusion

The proposed merger will have anticompetitive effects in patient and physician service markets. IBC and Highmark have maintained dominant market positions for decades. There has been little to no entry by competitors into the territories they dominate. In essence, this merger represents a contractual extension of their explicit agreement not to compete. By clearing this proposed merger, the Department of Justice has demonstrated its lack of federal antitrust enforcement in health insurance markets. Accordingly, the AMA respectfully requests that this Committee urge the federal antitrust enforcement agencies to more rigorously enforce the antitrust laws with respect to future health insurer consolidations.