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HEALTH INDUSTRY ALERT

UNANSWERED QUESTIONS FROM THE ANTITRUST CHALLENGE TO THE UNITEDHEALTH/SIERRA MERGER: HOW DID THE ANTITRUST DIVISION VIEW THE POTENTIAL IMPACT ON PROVIDERS?

On February 25, 2008, UnitedHealth Group (United) and Sierra Health Services, Inc. (Sierra) announced that they would proceed with a merger whereby United will acquire all outstanding shares of Sierra in a transaction valued at $2.6 billion. Their statement came shortly after the United States Department of Justice (DOJ) and Nevada state attorney general conditionally approved the merger, subject to a divestiture by United and certain other conditions.

The DOJ action provides substantial guidance to the healthcare industry regarding the antitrust issues arising from health plan mergers. For example, it is noteworthy for what it does address, namely, the DOJ Antitrust Division's view that health plan mergers can be anticompetitive because of the impact they have on the Medicare Advantage program. This is a theory of harm on which the Division has not relied previously. At the same time, the action is noteworthy for what it does not address, namely, how the Division evaluated the claim that the merger would have an impact on healthcare providers. The Division has addressed the possible impact from health plan mergers on physicians and hospitals several times in the past, and has specifically recognized the possibility of mergers creating buyer-side market power, or monopsony power, in contractual relationships with physicians or hospitals. For instance, the Division challenged the United/PacifiCare merger based in part on its potential impact on physicians. In the Anthem/WellPoint merger, the Division discussed in its closing statement the possibility that the merger might have an anticompetitive impact on hospitals. By contrast, the Division was completely silent on that potential impact here, despite indication during the investigation of the merger that this was a concern. Several entities, including the American Medical Association (AMA), the Nevada State Medical Association and the Clark County Medical Society, have accordingly made filings with the DOJ and the U.S. District Court for the District of Columbia, where the case is pending, urging the court to reject the DOJ's proposed final judgment.

In joint comments filed pursuant to the Tunney Act, 15 U.S.C. § 16, the provider groups argued that the DOJ's enforcement action was inadequate for (1) its failure to secure relief in the market for the purchase of physician services, (2) its failure to secure relief in the commercial insurance market and (3) its failure to construct a remedy to fully restore competition in the Medicare Advantage Market. They also argue that the DOJ departed significantly from past enforcement

actions and the DOJ's own Merger Remedy Guidelines, and they demand an explanation from the DOJ as to the reason behind the change in policy. Also filing Tunney Act comments were the U.S. House of Representatives Committee on Small Business, the Service Employees International Union (SEIU), and the Commissioner of Clark County, NV.

The enforcement action is indeed limited in scope, with both federal and state actions focusing almost solely on the effects on competition for Medicare Advantage enrollees. As stated above, both actions are, for the most part, silent on the potential impact the merger will have on the interests of providers. The few provider-specific measures that are addressed, appearing primarily in the Nevada state attorney general's action, are limited, and the rationale for these provider-focused remedies does not appear based on competition concerns. Furthermore, none of the enforcement agencies sought to block the transaction in its entirety. Instead, as mentioned, they permitted it to proceed with limited divestitures and other conditions. Opponents of the merger argue that the divestiture remedy does not fit well within the antitrust paradigm for divestitures. The case is worth watching because the Division's response to the Tunney Act comments or the federal district court's decision on whether to enter the decree may provide greater guidance on how the antitrust laws apply to the potential impact on healthcare providers from health plan mergers.

BACKGROUND

United, a Minnesota corporation, is the largest health insurer in the United States. In the Las Vegas area, the relevant market for purposes of this action, United offers Medicare Advantage products sold under the brands Secure Horizons and AARP. United provides health insurance to approximately 27,800 Medicare Advantage enrollees, accounting for 34 percent of the Medicare Advantage market. United also offers commercial insurance products to consumers in the Las Vegas area.

Sierra is a Nevada corporation and is the largest insurer in the state. It sells Medicare Advantage plans under the brand Sierra Optima Select and its 49,500 enrollees account for 60 percent of the Medicare Advantage market in the Las Vegas area. It, too, offers commercial insurance products.

Unlike traditional Medicare coverage, Medicare Advantage coverage is offered by private insurance companies, and, when the program works as intended, provides enrollees with richer benefits at lower costs. The program is structured so that insurers have an interest in lowering their projected costs so that they will be able to offer richer benefits to their enrollees, and thus be able to compete with other insurers.

THE DEPARTMENT OF JUSTICE ACTION

On February 25, 2008, the DOJ filed a civil action to permanently enjoin the acquisition on the grounds that it would "substantially increase concentration in an already highly concentrated market that is no broader than Medicare Advantage health insurance plans sold to senior citizens" within the Las Vegas area. The acquisition, according to the DOJ, has the potential to substantially decrease competition in the sale of Medicare Advantage plans in violation of Section 7 of the Clayton Act.

The complaint recognized the fact that Medicare Advantage was created by Congress to serve as a private market alternative to "traditional" Medicare provided by the government with the belief that competition within the private market would prove beneficial to seniors. Indeed, at least in the Las Vegas area, the competition between the two major Medicare Advantage offerors —United and Sierra — did produce real benefits for seniors, saving enrollees thousands of dollars in health care costs annually. For instance, the two entities compete to attract members by offering plans with zero premiums, reducing co-payments, eliminating deductibles, improving drug coverage, offering desirable fitness

benefits and attempting to make their provider networks more attractive to potential members. The model, according to the DOJ, was working as Congress intended, with competitive forces creating real, measurable savings for seniors.

According to the DOJ's competitive impact statement, the combination of the two main competitors threatened to reduce or eliminate those benefits that seniors have come to enjoy as a result of the competition between United and Sierra. It further found that market forces were unlikely to serve as a counterbalance against potential anticompetitive effects. First, because of low out-of-pocket costs and richer benefits associated with the Medicare Advantage plans, seniors would not likely switch away from Medicare Advantage to traditional Medicare in sufficient numbers to make anticompetitive price increases or reductions in quality unprofitable. Second, beneficiaries in the Las Vegas area may only enroll in Medicare Advantage plans that the Centers for Medicare & Medicaid Services (CMS) approves for the county in which they live — therefore they cannot turn to Medicare Advantage plans in other parts of the state or country. Finally, the DOJ noted that the entry of new competitors into the market is unlikely due to substantial cost, reputation and distribution disadvantages.

Along with the complaint, the DOJ filed a proposed final judgment that would, in effect, resolve the lawsuit and alleviate the DOJ's competitive concerns. Under the terms of the final judgment, the parties are allowed to proceed with the transaction, provided that United divest itself of most of its assets related to its Medicare Advantage business, namely, the assets dedicated to plans it offers under five separate CMS contracts — those it markets under the names Secure Horizons and AARP — within 45 days of the date the complaint was filed.

According to the final judgment, United must divest its assets to an acceptable acquirer "in such a manner as will allow the Acquirer to be a viable, ongoing business engaged in the sale of Medicare Advantage Plans in the Las Vegas area." The DOJ tentatively approved Humana as a buyer, subject to approval by CMS and the Nevada Division of Insurance. Humana is one of the biggest sellers of Medicare Advantage plans in the country and, while it does have operations in Nevada, according to state officials, it does not operate any Medicare Advantage plans in the state.

The final judgment has several provisions that would require United to assist the new acquirer with the transition into the market and, in particular, assist it in negotiating agreements with existing provider networks. This is intended to allow all plan participants affected by the switch to have the same access to substantially all of United's provider network on terms "no less favorable" than they currently have.

THE NEVADA STATE ATTORNEY GENERAL ACTION

On the same day the DOJ filed its complaint and proposed final judgment, the Nevada attorney general also filed a complaint seeking to block the merger. The state's proposed final judgment, which would allow the merger to go forward, imposes a list of terms on the merging entities, including the following items —

- no "all products clauses" or "most favored nations" provisions for two years
- no exclusive contracts with medical service providers for two years
- parties must not require a health care provider to disclose rates charged to other third-party payers
- parties must provide small group employers at least 60 days' notice of any intent to raise rates
- parties must establish a "physicians council" to serve as a forum to discuss issues of concern to Nevada physicians and establish goals and benchmarks for the physician-payer relationship

- parties may not increase premiums for beneficiaries nor decrease providers' fees as a result of costs associated with the transaction.

Although the state's complaint was virtually identical to that filed by the DOJ, the remedies contemplated in the state's proposed final judgment clearly go well beyond the DOJ judgment.

TUNNEY ACT FILINGS

In their May 15 filing, the provider groups criticized the DOJ's initial complaint and proposed final judgment as being "seriously inadequate to remedy the competitive concerns" presented by the proposed transaction, and the merger under the proposed terms as not being in the public's interest. Specifically, they challenged the decision to ignore the potential anticompetitive effects that the merger will have on the physician services and the commercial insurance markets, noting that this was highly inconsistent with its past enforcement actions in the United/PacifiCare and Aetna/Prudential mergers. According to the provider groups, "DOJ applied an even more lax standard than used in previous mergers and permitted an unprecedented level of concentration clearly in violation of the law and the Merger Guidelines." The comments also argued that even within the narrowly defined Medicare Advantage market, the DOJ's action is insufficient to restore competition.

According to an affidavit filed by Prof. David Dranove of the Kellogg School of Management, Sierra and United combined will hold 56 percent of the market share for commercial insurance in the Las Vegas area, which translates into an equally substantial market share in the physician services market. This degree of concentration, according to the provider groups, is sufficient to raise a concern over monopsony power. United and Sierra are not only sellers of Medicare Advantage plans, but they are also buyers of provider services. Therefore, the threat to competition lies in the ability of the merged entity to reduce physicians' compensation — the nature of a physician's services being such that buyers are not easily replaced and a physician may be forced to accept low reimbursement rates for fear of losing needed business. The provider groups argue that this, in turn, will lead to an overall decrease in the level of service provided to patients, both in quantity and quality. The negative effects of the reduced competition on the public interest are compounded by the state of the Nevada health care market, which, according to the comments, is particularly vulnerable because of a longstanding shortage of providers. For instance, Nevada ranks 47th in the nation for access to care, 45th in the nation for access to physicians and 51st in the nation for quality of care; nearly 25 percent of the state's residents are uninsured. Therefore, the provider groups posit that further reductions in the quantity of providers and the quality of their services will only worsen this vulnerable market.

The comments go on to point out that the DOJ's failure to adequately consider the monopsony issue was in stark contrast to its past enforcement actions. In the Aetna/Prudential merger in 1999, an increase in market share from 26 percent to 42 percent prompted the DOJ to address monopsony concerns such as the ones presented here. Similarly, in the United/PacifiCare merger, relatively low shares (30 percent in one market and 35 percent in another) supported a challenge. If Prof. Dranove's calculations are correct, the post-merger shares of United/Sierra exceed these numbers, and the provider groups invite the DOJ to address why it did not find a monopsony problem.

Turning to the impact on the commercial insurance market, the provider groups note again that the combined share of United and Sierra is 56 percent and, when limited to health maintenance organization (HMO) products, the combined share is 90 percent. Market shares reaching this level of concentration have spurred enforcement action in past mergers,

and the provider groups again ask that the proposed final judgment be revised to address the impact on this product market.

Finally, the comments list the ways in which the proposed remedies in the final judgment are inadequate to allow the acquirer of the divested Medicare Advantage business to compete effectively in the market. For instance, the DOJ failed to propose bans on "most favored nations" provisions, preventing providers from giving more attractive rates to competitors, or "all products clauses," requiring providers to participate in a Medicare Advantage program as a condition of participation in commercial programs. The comments also question the viability of a stand-alone Medicare Advantage business, stating "[t]here is no evidence that a Medicare Advantage business can operate solely on its own without a commercial component" and "there are significant economies of scope and scale that exist when both commercial and Medicare Advantage businesses are combined."

Indeed, the DOJ's own Merger Guidelines recognize that, in some industries, the divestiture of a single line of business may be insufficient to restore competition, and divestiture of more than a particular line of business may be required. This is particularly the case in industries where it is difficult to compete without offering a full line of products, or where one line of business is helpful or necessary to bolster a second line of business. In other words, even though only one subset of business implicates antitrust concerns, that subset may be so intertwined with the entire line of a firm's business that the subset could not compete on its own. The comments urge that that this merger presents exactly this type of situation, where the divestiture of the Medicare Advantage business, without the benefit of a commercial component, may be inadequate to ensure that the acquirer will be able to restore the competition lost as a result of the merger.

The United States attorney general is required to consider these comments and publish a response in the Federal Register. The United States District Court for the District of Columbia, the federal court where the DOJ filed its action, will determine whether or not the proposed final judgment submitted by the DOJ is in the public's interest as required by the Tunney Act. In making this determination, the court may consider the comments submitted by interested parties, including the AMA and other provider groups.

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