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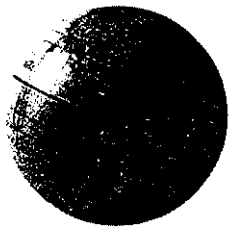

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A New and Uncertain Future for Managed Care Mergers

AN ANTITRUST ANALYSIS OF THE AETNA/PRUDENTIAL MERGER

Robert E. Bloch, Scott P. Perlman & Lawrence Wu

I
INTRODUCTION

In recent years, increasing pressure from employers to reduce health insurance costs has led to consolidation among managed care plans, including health maintenance organizations ("HMOs"), point-of-service ("POS") plans, and preferred provider organizations ("PPOs"). The desire of managed care plans to achieve efficiencies, to offer new products and new geographic areas of coverage, and to increase their bargaining power with health care providers have motivated many proposed mergers. Recent transactions include United HealthCare's acquisition of MetraHealth and United's aborted acquisition of Humana, the merger between PacifiCare and FHP, CIGNA's acquisition of HealthSource, and Aetna's acquisitions of U.S. Healthcare and NYLCare.

In the past, state regulators have expressed more concern about the trend towards consolidation among health insurers than either the Federal Trade Commission or the Antitrust Division of the Department of Justice. For instance, it was the Missouri Department of Insurance that required United HealthCare to divest its interest in MetLife in St. Louis as a condition to approving the MetraHealth acquisition in 1995. By contrast, the Antitrust Division and the FTC had not

ROBERT E. BLOCH is a partner in the Washington, D.C., office of Mayer, Brown & Platt, where he practices in the area of antitrust counseling and litigation. Prior to joining Mayer, Brown & Platt, he was Chief, Professions and Intellectual Property Section, Antitrust Division, U.S. Department of Justice. SCOTT P. PERLMAN is a partner in Mayer, Brown & Platt's Washington, D.C., office, where he practices in the areas of antitrust counseling and litigation, and Hart-Scott-Rodino compliance. Dr. LAWRENCE WU is a Vice President at National Economic Research Associates, Inc. (NERA) in White Plains, New York. Before joining NERA, he was a staff economist at the Federal Trade Commission. The authors represented Aetna, Inc. in its recent acquisition of Prudential Health Care, together with Mitchell Raup from Mayer, Brown & Platt and Thomas McCarthy and David Monk from NERA.

challenged a single managed care merger until this year. The federal antitrust agencies, however, were not ignoring these transactions; they were actively and closely reviewing proposed acquisitions. In its review of the PacifiCare/FHP merger, for example, the FTC was concerned about the impact of the transaction on competition among Medicare HMOs in Southern California and issued a request for additional information from the parties to examine the issue more closely, but eventually resolved its concerns.

All of this changed in June 1999, when the Antitrust Division and the State of Texas brought an enforcement action against Aetna and Prudential. The complaint in *United States v. Aetna, Inc*[1] is significant, not only because it represents the first federal antitrust challenge in this area, but also because of the novel positions that the Antitrust Division took on three particular issues:

- *Product market definition* — The Division and Texas alleged that the relevant product market was HMO and HMO-based POS ("HMO/POS") plans, and that the merger would have an anticompetitive effect in two local geographic markets, the Dallas and Houston Metropolitan Statistical Areas ("MSAs").
- *The effectiveness of entry and expansion* — The Division and Texas further claimed that, despite evidence of considerable new entry and the presence of numerous existing competitors in these markets, entry and expansion by new or existing competitors would not be sufficient to defeat a significant price increase by Aetna.
- *Monopsony power* — The Division and Texas also alleged that the merger would enable Aetna to exercise monopsony power against physicians, allowing Aetna to "depress physicians' reimbursement rates in Houston and Dallas, likely leading to a reduction in quantity or degradation in quality of physicians' services."[2]

The positions taken by the Antitrust Division have significant implications and represent a major shift in the approach that will be taken when conducting an antitrust analysis of managed care mergers. In particular, the narrower product market definition that was alleged by the Division, coupled with concerns over the increase in local market concentration, suggest that many future transactions will be subject to a significantly greater degree of scrutiny from federal antitrust enforcement authorities than previously had been the case.

In this new antitrust enforcement environment for managed care mergers, it is essential for counsel representing parties to such mergers to understand the legal and economic approaches that likely will be used by the agencies when they evaluate the competitive impact of these transactions. This article analyzes the positions taken by the Antitrust Division in *United States v. Aetna*, as well as the methodology used by

the Division in reaching its conclusions on these issues, including, in particular, some new econometric techniques.

II
ANTITRUST ENFORCEMENT PRIOR TO *UNITED STATES V. AETNA*

It is unclear why neither the Division nor the FTC had challenged a proposed managed care acquisition prior to *United States v. Aetna*. While the analysis of any given merger is very fact-specific, perhaps the common overriding factor has been that the agencies have defined the markets for managed care plans broadly and found them to be competitive even after the merger of two large HMOs. The absence of federal enforcement has been consistent with numerous court decisions defining the relevant antitrust product market to include HMOs, PPOs, POS plans, and the variety of alternatives that are available to help individuals pay for their health care. With one exception, courts rejected narrower markets based on a particular payment plan or health care delivery plan, such as HMOs.[3] Even the one exception eventually was overturned on appeal.[4]

The decisions prior to *United States v. Aetna* were based on facts that demonstrated that the relevant product market for analyzing managed care mergers was the market for all health care financing. In general, the different types of health plans, including HMOs, PPOs, POS plans, and indemnity plans, seem to perform the same function of insuring individuals against the risk of medical expenditures. In fact, over time, the different types of plans have come to resemble each other more closely.[5] For example, PPOs have adopted fixed co-payments (instead of co-insurance) and have dropped deductibles for many of their products. PPOs also have added "gatekeepers" (primary care physicians who must give their approval before a patient can see a specialist), which traditionally have been associated with HMOs. In addition, PPO plans have adopted utilization management and quality assurance features that mimic those of many HMOs. At the same time, HMOs have added POS and open access options that give their enrollees the freedom of choice that is typical of many PPO and indemnity plans. Further, the fact that many employers offer multiple health plans to their employees, including both HMO and non-HMO options, and offer an opportunity to switch plans during annual open enrollment periods, makes it relatively easy for employees to switch from one type of health plan to another.[6]

In addition, a product market defined this broadly meant that the geographic market was defined broadly as well. In particular, if indemnity plans were in the product market, it would follow logically that the geographic market should be national since an individual can be insured by a fee-for-service or an indemnity plan based anywhere in the country. At least a few courts have supported that view.[7] In

a broadly defined geographic market, it was unlikely any managed care merger would lead to competitive harm.

Moreover, even if the federal agencies were to view the product and/or geographic markets more narrowly, there still was reason to believe that a managed care merger resulting in a relatively concentrated market was unlikely to result in anticompetitive effects. The main reason was that any attempt by the merged plan (whether acting alone or in concert with other plans) to exercise market power (i.e., increase prices above competitive levels) was likely to be defeated by new entry or expansion by existing competitors. This was reflected in the fact that there has been a great deal of HMO growth all over the country. For example, between 1991 and 1997, the number of Americans enrolled in HMOs more than doubled, from approximately 38 million to 78 million.[8] Moreover, between 1994 and 1997, the number of HMOs in the United States (not including those that serve only Medicaid recipients) increased approximately 17 percent, from 519 to 608.[9]

Despite the court decisions and the highly competitive dynamics of the industry, there was growing political pressure from the medical community for antitrust enforcement to slow HMO consolidation. This pressure was exacerbated generally by the public debate over managed care plan coverage and all of the issues associated with whether there should be a "patient bill of rights." In short, managed care and everything associated with it were receiving close scrutiny from all quarters. Consolidation continued, but several managed care mergers were subject to state regulatory restrictions. Even though the justification for some of this antitrust enforcement was questionable, state enforcement authorities were able to demand and obtain relief before approving certain transactions.[10]

There also were indications that the federal agencies were taking a closer look at health plan transactions. For example, the FTC issued a request for additional information to investigate the potential impact of PacifiCare's proposed acquisition of FHP in several "Medicare HMO markets" in Southern California. Even though the FTC ultimately approved the transaction, the California Department of Corporations imposed a number of restrictions on the merging plans.[11] Concerns about consolidation in the industry also were expressed in a speech given by the FTC Chairman Robert Pitofsky in 1997, in which he stated:

> [A]s we review consolidations of managed care plans, we consider whether the transaction is likely to injure competition through the creation of buyer, as well as seller, power. Where there is evidence that such power will distort a competitive market and thereby harm consumers, enforcement action may be appropriate.[12]

In *United States v. Aetna*, the Antitrust Division concluded, among other things, that it had found such a case.

III
UNITED STATES V. AETNA: OVERVIEW

A. The merger

Aetna and Prudential entered into an agreement on December 9, 1998, under which Aetna was to acquire substantially all of the assets relating to Prudential's health insurance business for approximately $1 billion. At the time of the transaction, Aetna, through its subsidiary, Aetna U.S. Healthcare, was the largest health insurance company in the United States, with 15.8 million enrollees in all fifty states and the District of Columbia. Aetna offered a full array of health insurance products, including indemnity plans, PPOs, POS plans, and HMOs. Prudential was the nation's ninth-largest health insurance company, with 4.9 million enrollees in twenty-eight states and the District of Columbia. Like Aetna, Prudential provided indemnity, PPO, POS, and HMO health insurance coverage.[13]

Aetna viewed the transaction as an opportunity to expand its provider networks, to strengthen the geographic scope and depth of the data base it had created to provide disease management services, and to achieve cost savings and synergies of approximately $130–$150 million within a few years.[14] Aetna also was acquiring a large number of additional covered lives at an extremely attractive price of approximately $200 a life; in the U.S. Healthcare merger, for instance, Aetna had paid more than $3,000 per life.[15]

B. The Antitrust Division's investigation

The Antitrust Division's investigation of the merger took seven months. During this period, the Division reviewed close to one million documents from the parties. The Division also reviewed documents from third parties and interviewed customers and competitors. In addition, the Division requested extensive data from the parties relating to premiums, provider reimbursements, and claims. The Division performed an econometric analysis using these data as well as additional data it obtained from third parties. The analysis and data were used to estimate elasticities of demand for the purpose of defining the relevant product market.

Initially, the Division focused on more than forty MSAs in which Aetna and Prudential had overlapping HMO and HMO-based POS plans. In the end, it concluded that the transaction raised competitive concerns in only two MSAs, Houston and Dallas, Texas.[16]

C. The complaint

On June 21, 1999, the Division filed a complaint in the U.S. District Court for the Northern District of Texas alleging that the merger would violate Section 7 of the Clayton Act in the markets for HMO and HMO/POS plans in the Houston and Dallas MSAs. The State of Texas, represented by the Texas Attorney General, was a co-plaintiff.

1. Allegations regarding the sale of HMO and HMO/POS plans

Relevant product market. Despite the convergence of product features between HMOs and PPOs as well as the considerable legal precedent holding that no separate market existed for HMOs, the Division alleged that the relevant product market was comprised of fully insured, commercial HMO and HMO/POS products only.[17] The Division provided three justifications to support its alleged product market. First, features of HMO and HMO/POS plans differ considerably from those of other types of health plans. HMOs provide superior preventive care benefits but place limits on treatment options and require their enrollees to see a primary care gatekeeper before they can have access to specialists. In contrast, PPO plans do not emphasize preventive care, do not require their enrollees to see a gatekeeper, and allow access to providers outside of the PPO network, as do indemnity plans. According to the Division, HMOs generally are the least expensive health insurance option and PPO and indemnity plans the most expensive options.[18]

The Division also claimed that HMO and HMO/POS plans are perceived as distinct products by purchasers. For instance, PPO plans are not viewed as adequate substitutes for HMO and HMO/POS plans by employers, employees, or brokers, but rather are viewed as different products addressing different needs. Enrollees leaving one HMO generally select another HMO, not a PPO, as a replacement.[19]

Finally, the Division alleged that the analysis of the data it had obtained was consistent with the information it had received in interviews in defining a separate market for HMO and HMO/POS plans. According to the Division, these analyses demonstrated that the elasticity of demand for HMO and HMO/POS plans is low, which meant that a small but significant price increase for HMO and HMO/POS plans would not cause consumers to shift to other types of plans in sufficient numbers to make the price increase unprofitable.[20] As a result, the Division and Texas alleged that HMO and HMO/POS plans were the relevant product market for purposes of analyzing the merger.

Relevant geographic market. Having defined the product market as HMO and HMO/POS plans, which were delivered through local provider networks, the Division alleged a local geographic market (i.e., the Metropolitan Statistical Area or

MSA) based on the area in which enrollees had access to these contracted providers. The Division alleged it was unlikely that, in response to a price increase for HMO or HMO/POS plans, a sufficient number of enrollees would switch to health plans outside the local MSA in which their plan was located to defeat a price increase. According to the Complaint, the transaction raised competitive concerns in two geographic markets—Houston and Dallas.[21]

Competitive effects in the sale of HMO and HMO/POS plans. Within these relevant markets, the Division and Texas alleged that after the merger, Aetna would have an HMO and HMO/POS market share for fully-insured, commercial members in Houston of 63 percent, and a 42 percent share in Dallas. In addition, the Division alleged that Aetna and Prudential were among each other's principal competitors and that employers viewed Aetna and Prudential as close substitutes based on product design and quality.[22]

The Division and Texas further alleged that neither *de novo* entry nor expansion by existing competitors would be sufficient to offset the potential anticompetitive effects of the merger in the Houston and Dallas markets. New entry sufficient to defeat an anticompetitive price increase was unlikely because it would take two to three years at a cost of approximately $50 million. Expansion by existing PPO and indemnity plans into HMO or HMO/POS products was alleged to be unlikely based on interviews with managed care providers who apparently stated that such a shift "would be difficult, expensive, time consuming, and that they would not enter the HMO or HMO-POS markets even if Aetna were to raise its prices a 'small but significant amount.'"[23]

Finally, the Division and Texas claimed that existing HMO and HMO/POS plans in Houston and Dallas would be unlikely to expand sufficiently to defeat an anticompetitive price increase by Aetna because they would face some of the same costs and difficulties that faced a new entrant. The Complaint alleged that many of these existing HMOs would not have the ability to overcome "Aetna's advantages in national reputation, quality accreditation, product array, and provider network."[24]

For all these reasons, the Division concluded that the merger would allow Aetna to raise prices and lower quality unilaterally for HMO and HMO/POS plans in the Houston and Dallas MSAs in violation of Section 7.[25] There was no allegation that the transaction would result in coordinated pricing behavior by the remaining carriers.

2. Monopsony allegations

The Division and Texas also alleged that the merger would have an anticompetitive effect in the markets for physicians' services in Houston and Dallas.

They claimed that the transaction would allow Aetna to exercise monopsony power with respect to the terms upon which it was willing to contract with physicians.

For purposes of analyzing this claim, the Division and Texas alleged that the relevant market was physician services sold to individuals or to commercial or government payors because there were no other purchasers to whom physicians could sell their services. A small but significant *decrease* in physician compensation would be unlikely to cause them to seek other purchasers or to shift into providing other services.[26] The Division alleged that the relevant geographic markets were the Houston and Dallas MSAs. It believed that patients' preferences as well as physicians' investments in time and money to establish their practice were such that too few physicians would relocate to another geographic area in response to a small but significant reduction in reimbursement levels.[27]

It also was alleged that within these relevant markets, physicians no longer would be able to reject adverse contractual terms if Aetna tried to impose them. That was because the contractual terms that a physician could obtain from a managed care plan depended on the physician's ability to terminate that plan. And, according to the Division and Texas, the ability of physicians to terminate a managed care plan was limited because it was difficult for a physician to replace a terminated plan's lost business and to do it in a timely manner.[28] This was predicated on the assumption that physicians have only limited influence in encouraging their patients to switch plans. For instance, depending upon which plans are offered by a patient's employer, the patient might not have the option of switching to a plan in which the patient's doctor participates. Further, the likelihood that a physician will retain the business of a patient may be low if the patient can see the physician only by going outside of his health plan's provider network and paying higher out-of-pocket costs.[29]

The alleged harm resulting from the consolidation of purchasing power over physician services was claimed to be problematic for two reasons. First, after the merger, Aetna would account for a large percentage of all physician payments in Houston and Dallas. Second, Aetna would account for a large percentage of the revenue of individual physicians for a substantial percentage of physicians in Houston and Dallas. The latter concern was allegedly exacerbated by Aetna's "all products clause," which required physicians who agreed to serve as a provider for any one Aetna plan (e.g., PPO) also to serve as a provider for its other plans (e.g., HMO and POS).[30]

Based on these factors, the Division and Texas concluded that, after the merger, Aetna would be in a position "to depress physician reimbursement rates in Houston and Dallas, likely leading to a reduction in the quantity or degradation in quality of physicians' services," thereby violating Section 7.[31]

D. The consent decree

On June 21, 1999, the same day that the Division and Texas filed the Complaint, a Final Judgment and Hold Separate Stipulation and Order were filed settling the case. Aetna agreed to divest its interests in the Houston operations of NYLCare-Gulf Coast and the Dallas operations of NYLCare-Southwest.[32] These two health plans had been acquired from NYLCare in 1998. Aetna agreed to divest these plans because of various legal and regulatory difficulties involved in divesting Prudential's business in these areas.[33]

IV
KEY ISSUES AND ANALYSIS

The Antitrust Division focused on three key issues: (1) product market definition; (2) the effectiveness of entry and expansion in disciplining the pricing of incumbent firms in a given MSA; and (3) the potential for monopsony power post-acquisition. These issues always have been relevant in the antitrust analysis of health plan mergers, but recent industry trends made them more difficult to resolve than before. The following sections highlight the controversies as well as the underlying legal and economic theories and facts.

A. Relevant market definition

In analyzing whether a proposed transaction is likely to result in market power, an important first step is to define the relevant market. The relevant market is the narrowest market that includes all of the rivals whose presence constrains the pricing power of the merged entity. A market that is broader than this would include non-competitors who have no constraining influence on the price charged by that firm. An overly narrow definition would exclude competitors who may limit the firm's pricing power.

In *United States v. Aetna*, the alleged product market—fully insured, commercial HMO products—was clearly a subset of a broader array of health plans. If the market was broader, the proposed transaction would not have resulted in competitive harm. Thus, in evaluating the evidence on this issue, the debate revolved around the questions of whether there was evidence that consumers were switching from HMO to non-HMO products; and whether it was sensible to define a market based on whether a health plan has an HMO license or an indemnity/PPO license.

1. Evidence of demand substitution

Often the first step in analyzing the product dimension of the relevant market is to examine the products that customers compare when making a purchase. Here,

the analysis involved identifying the types of health plans that are viewed as substitutes for each other. Implicit in this analysis is an evaluation of the willingness of employers and individuals to switch from one type of health plan to another. If employers and their employees view PPOs, POS plans, indemnity plans, and self-funded plans as close substitutes for HMO-type coverage, then the relevant market must include these products.

The analysis of product market definition, which involved the review of many types of evidence, was particularly difficult because of two recent trends in the marketplace. The first is that more and more consumers are choosing to enroll in PPOs and health plans that are not as restrictive as HMOs. The commonly held perception is that HMO-type plans restrict access to specialists while PPO-type plans do not. A recent survey conducted by Mercer/Foster Higgins found that the trend towards HMO and POS plans reversed during 1998.[34] The study found that Americans now favor health plans with more choice, such as PPOs. In fact, PPO membership increased from 35 percent to 40 percent of health plan enrollment during 1998, while HMO enrollment declined from 50 percent to 47 percent.[35] In other words, enrollment in PPO-based plans is rising, not enrollment in HMO-based plans. A recent study conducted on behalf of The Henry J. Kaiser Foundation reached similar conclusions.[36] Among employers with fewer than 200 employees, the percentage of all employees who were enrolled in an HMO fell from 29 percent to 17 percent between 1996 and 1998. During this period, the percentage of all employees of such employers who were enrolled in PPOs increased from 38 percent to 40 percent, and the percentage enrolled in POS plans increased from 7 percent to 30 percent. The same was true for large employers with 200 or more employees. Among large employers, the percentage of employees in HMOs fell from 33 percent to 30 percent, while the percentage in PPOs increased from 25 percent to 34 percent and the percentage enrolled in POS plans increased from 16 percent to 22 percent.

The second major trend is the proliferation of managed care products that blur the lines that used to separate HMOs from other types of health plans. There has been a great deal of convergence of product designs and benefit packages in the past five years. Innovation of this kind has led to a full range of health insurance products that are functionally indistinguishable. In other words, it is no longer always the case that PPOs offer more choice of providers and less stringent utilization management. PPO plans are combining features that traditionally have been characteristic of HMO plans, such as the use of gatekeeper primary care physicians, fixed dollar co-payments, case management techniques, utilization review, and preauthorization. A gatekeeper PPO, for instance, operates just like an HMO/POS plan in that it requires its subscribers to get a referral from a primary care physician in order to obtain access to a specialist.[37]

At the same time, HMO plans have started to offer many of the benefits commonly associated with PPOs. Some HMOs, for instance, allow enrollees to use non-participating or out-of-network providers. Other HMO plans provide more choice in other ways. For example, "open access" HMO plans allow enrollees to go directly to a specialist without the referral or approval of a primary care physician gatekeeper.[38] An open access HMO is licensed as an HMO, but in terms of its characteristics, it is identical to many PPOs.

POS plans are the ultimate hybrid. POS plans combine HMO-type benefits with a degree of provider choice that used to be characteristic of indemnity or PPO plans. In a POS plan, members do not have to choose how services will be financed until those services are needed.[39] The names that have been used to describe POS plans plainly reveal their hybrid nature—POS plans sometimes are called "HMO swingout plans" or "primary care PPOs."[40] With respect to its underlying license, a POS plan can be underwritten on either an HMO license or a PPO license.[41]

There also has been a convergence in the premiums charged by HMOs and PPOs. The price differential between HMO-type plans and PPO-type plans is narrowing and the price difference is expected to continue to narrow over time. In fact, now there is virtually no price difference between HMOs and PPOs in the Midwest, which is where PPOs have increased their share the most.[42] Thus, while the perception by some may be that HMOs have lower premiums and lower out-of-pocket costs, the reality has been changing.

These industry trends provided the context for the product market analysis of the proposed transaction. It was clear that the convergence of HMO-based plans and PPO-based plans in terms of benefits and price greatly enhanced the likelihood that the two types of products were in the same market. If alternative products (e.g., PPOs) had similar attributes to HMOs, then it was more likely that there would be substitution among these alternatives. With this starting point, the issue of consumer switching focused on whether consumers *would* turn (or had turned in the past) to non-HMO products in response to a change in relative prices.

To assess the degree to which substitution would occur in response to changes in price, both the Division and the parties conducted an analysis focused on a variety of evidence. For example, information that insurance brokers use to help their clients compare health plans showed that HMO and non-HMO plans were being compared option-by-option and feature-by-feature, from premiums and out-of-pocket premiums to breadth of coverage. Won and lost account history also was instructive in showing that PPO-based plans routinely took business away from HMO-based plans on the basis of price. There also were interviews of Aetna and Prudential customers that the Division claimed supported its allegations of a separate product

market for HMO and POS plans (though the parties had many customer statements to the contrary).

There was statistical evidence as well. As in the analysis of other mergers, estimates of the elasticity of demand often are helpful in assessing the degree to which consumers are willing to switch from one product to another in the face of a price increase. If the demand for HMOs is inelastic, that is, if demand is relatively insensitive to price, then there is a greater likelihood that the market may be defined narrowly to include HMOs only.

The Antitrust Division did not reveal the results of its econometric analysis. The Complaint and Competitive Impact Statement ("CIS") suggest, however, that the Division found relatively low elasticities of demand, a result that may have been significant in concluding that a narrowly defined HMO market existed.[43]

In the end, the most important components that went into the product market analysis were company documents, won and lost accounts, company and industry data, and interviews with employers and their brokers and consultants about their preferences and selection criteria. Direct statistical evidence on the substitution for HMO and non-HMO plans was clearly an important element of the analysis as well, and econometric analyses of this kind undoubtedly will be used in future transactions.

2. The relevance of HMO licenses

The product market alleged in the Complaint included commercial plans that were underwritten on an HMO license, but excluded health plans like PPOs written on an indemnity license. In light of recent industry trends, from the point of view of employers and employees, it should be irrelevant whether the health plan is licensed as an HMO or PPO. Indeed, as discussed above, many non-HMO products have features and characteristics similar to HMO-based products. Ultimately, what matters is price, access to care, and quality. Here, price means premiums and out-of-pocket payments. Access to care means the breadth of the provider network as well as restrictions on referrals and utilization management. With respect to these features, PPOs and HMOs can be indistinguishable, and these are the things that consumers care about. Despite the convergence of features and benefits, the Antitrust Division concluded that PPOs were not in the relevant market it defined. If PPOs had been included, there would have been no alleged violation.

B. Entry and expansion

Even if the relevant market is defined narrowly as HMOs that serve a particular MSA, proper analysis of an HMO merger requires consideration of the competitive influence of firms that do not currently market a competing health plan in that

metropolitan area or that currently have only a small presence in the market. In particular, it is important to evaluate carefully the prospect of entry and the ability of incumbent firms other than the merging plans to expand their customer base. In this case, because the alleged product market was so narrowly defined, a great deal of emphasis was placed on an evaluation of entry and expansion post-acquisition.

The issue is crucial because if entry and expansion are in fact easy, then an analysis of market shares should demonstrate—taking this fact into account—that there is no adverse competitive impact from the transaction.[44] Market shares, which are often used as a measure of a firm's competitive importance in the marketplace, are not useful indicators of a firm's ability to compete for business when expansion is accomplished easily.[45] Market share is a measure of a firm's historical success, rather than the ease with which it could expand in response to an attempt to exercise market power by the merged entity. This is particularly true for a smaller insurer, whose enrollment easily could double or triple if it wins one or two large accounts. In this way, an insurer's enrollment can change dramatically from year to year. In other words, market share can understate a smaller firm's ability to compete just as easily as it can overstate a larger firm's ability to compete.

1. The analysis of entry and expansion

The analysis of entry and expansion involves an evaluation of several factors. Entry must be timely, likely, and sufficient.[46] In *United States v. Aetna*, there was a general consensus that a significant number of new competitors had entered most of the MSAs the Division examined, including Houston and Dallas. Moreover, there were good reasons to believe that incumbent health plans, small and large, could expand their enrollment readily in a short period of time. For incumbent insurers, expansion could be accomplished with little incremental cost because it primarily involved signing contracts with additional providers and hiring more administrative staff, if needed. The incremental cost would be low because an incumbent carrier already would have its provider network in place. There was no suggestion by the Division that providers and administrative staff were in short supply, and no capacity constraint ever was identified that would have made expansion for a health plan more costly. Notwithstanding these facts, the principal area of contention was whether expansion by new entrants and existing competitors would be sufficient to defeat a significant price increase by Aetna after the merger.

2. The relevance of switching costs

The Division's concern regarding the ability of new entrants and small incumbent firms to obtain or increase their membership was based largely on the notion that employers would be unwilling to give their employees the option of

selecting a new entrant or smaller incumbent, and that employees would be unwilling to select such health plans even if given the option. More specifically, individual consumers might have been concerned that changing health plans would require them to change physicians, and employers might have been concerned about the administrative costs associated with adding or changing their health benefits plan, as well as the possibility that employee morale might fall following such a change.

Whether entry or expansion is made more difficult by the presence of high switching costs is largely an empirical matter. In an effort to quantify the extent to which individuals would have to change physicians if employers in the area were to switch from Aetna to a competing carrier, evidence was presented showing that Aetna's rivals had broad, overlapping provider networks. The broader the network of competing plans, the less likely a subscriber would have to switch doctors. Aetna also contended that the cost of switching health plans was not great because many employers offered more than one health plan option (e.g., the vast majority of Dallas employees were offered multi-option plans by their employers).

Moreover, the data showed that employers and employees regularly changed to new health plans. The "voluntary disenrollment" rate, which captured switching by employers from one insurer to another, and employees who could have enrolled in Aetna, for example, but did not, was relatively high.

Although the empirical analysis contradicted the assertion that switching costs could not be overcome with proper marketing, discounted pricing, broad provider networks, product design, and reliable service, the Antitrust Division reached a different conclusion, namely, that entry or expansion would have been unlikely after the acquisition. As stated in the Complaint, the Division argued that the most likely category of new entrants consisted of niche players, who lacked the interest and-or ability to expand.[47]

3. Sufficiency of entry

As to the future, it is unclear how much entry will be enough to convince the Division that a competitive problem does not exist in a similarly defined product and geographic market. For example, notwithstanding the Division's allegations that sufficient entry or expansion would be unlikely to defeat a significant price increase, the empirical fact is that substantial entry has taken place in Texas, just as it has in other parts of the country. All told, there were twenty-nine new HMOs started in Texas since 1994; in Houston, new entrants since 1994 accounted for 23 percent of all HMO enrollment in the area in 1998.[48]

C. Monopsony

Concern about post-acquisition monopsony power was present from the beginning. From the day the merger was announced, the AMA opposed the transaction, claiming that it was not in the interests of patients. According to the AMA, the merger would lead to poorer service and give managed care plans greater negotiating power over physicians and other providers. More specifically, the AMA asserted that the acquisition would affect the quality of medical care and give Aetna the ability to impose "onerous" contractual terms (such as the "all products clause") on physicians after the acquisition. However, an AMA analysis criticizing the transaction focused largely on Aetna's reimbursement policies for physician services.[49] Clearly, the AMA was most concerned about what physicians were being paid and might be paid in the future.

The AMA also mobilized state medical societies into action. The Texas Medical Association was the most vocal. Not only did the societies oppose the transaction, but they also strongly opposed the growth of managed care. In Texas, opposition to the growth of managed care was perhaps the driving force behind the Texas Medical Association's effort to lobby the Texas legislature to introduce a bill that would allow doctors to negotiate collectively with managed care plans that had substantial market power. The legislation, which was signed into law by Governor George W. Bush in June 1999, is the first of its kind in the country.[50]

At the same time, a similar bill sponsored by Representative Tom Campbell (R-Calif.) was being hotly debated on Capitol Hill.[51] That bill, which had more than 100 sponsors and bipartisan support, would allow all independent, competing health care providers, including doctors, to negotiate collectively with managed care plans as if they were a collective bargaining unit with a labor exemption from the antitrust laws. The Antitrust Division and the FTC opposed the bill, and Assistant Attorney General Joel Klein and Chairman Robert Pitofsky testified at a hearing on the day after the Complaint in the case was filed.[52] It was against this backdrop that the transaction, and particularly the issue of monopsony power, was reviewed.

1. The theory behind the allegations

The allegations of monopsony power—the first charge of this kind in a managed care merger—focused on whether Aetna would have the ability to depress physician reimbursement rates, and whether the transaction would likely lead to a reduction in the quantity of physician services or a degradation in the quality of services provided. The Division and the State of Texas alleged that these effects were likely because the transaction would make it more difficult for physicians to reject the terms of Aetna's contracts, which they assumed would be better if Aetna and

Prudential remained independent. The theory underlying the allegations therefore focused on describing why physicians and patients would not have the ability to defeat an attempt by Aetna to lower reimbursement rates or to reduce the quantity or quality of physician services.

The theory of monopsony power described in the Complaint had several elements. First and foremost, the theory requires Aetna to have a post-acquisition share of physician revenues that is high enough to give it undue negotiating leverage over providers. That is because the ability and willingness of providers to credibly turn to other health plans depends upon whether these alternatives have enough market presence to be a significant source of revenue. If other health plans have a significant market presence, Aetna would not be able to force physicians to accept less-than-competitive contractual terms.

Second, the theory assumes that Aetna's subscribers are unwilling or unlikely to switch to other health plans, even if Aetna's physicians were to reduce the quantity or the quality of the care they provide because of the alleged underpayment. In other words, for monopsony power to have a competitive impact on individual consumers, Aetna's subscribers must be unwilling to switch to other health plans or unwilling to switch to physicians who are affiliated with other managed care plans to obtain better care or service.

A third element of the theory is that when a physician has a significant percentage of his or her practice dependent upon Aetna, that doctor will find it more difficult to switch to another plan. For the doctor, the cost of terminating her contract with Aetna and switching health plans is high because she would be risking a large part of her patient base and income. For instance, her patients may decide to stay with Aetna. Put differently, if Aetna pushes reimbursement rates too low, Aetna's physicians must believe that it would not be economically sensible for them to contract with alternative plans.

A fourth, but related, assumption is that physicians are limited in their ability to encourage patients to switch health plans, even if they themselves switch their affiliations to other plans. If, contrary to the allegations, physicians do influence the health plan decisions of their patients or if patients are more loyal to their doctor than they are to their health plan, then it is unlikely that a physician would find it overly risky economically to switch health plans.

Fifth, the theory requires Aetna's physicians to be unwilling to move their practices to new geographic areas (e.g., areas outside of Houston or Dallas). For example, physicians may have invested significant time and resources into developing their practices. Aetna would not have significant bargaining leverage unless it was costly and difficult for physicians to move to new areas.

Finally, the theory assumes that a significant decrease in Aetna's reimbursement rates would not induce physicians to relocate their practices to new areas.

The theory of post-acquisition monopsony power therefore hinges on the validity of these assumptions. However, the Complaint and the CIS did not refer to any specific evidence that supported these assumptions. Other than to assert that Aetna would have a large share of all payments to physicians in Houston and Dallas, there was no specific evidence cited that described or defined the market shares that gave rise to these allegations. There was no proof offered that the quantity or quality of physician services would decline, and no proof that reimbursement rates to physicians either had declined or would decline in the future. In fact, as described below, the available data suggested that many of the conditions that must be met for there to be monopsony power were not present.

2. The likelihood of monopsony power after the acquisition

The competitive effects of monopsony power typically appear in two ways. Monopsony power may be evident in a reduction of output of physician services or a reduction in the quality of those services. Monopsony power also may lead to provider reimbursement rates that fall below competitive levels. In this case, there was concern about a third possible effect—that some physicians, particularly those who have many patients insured through Aetna, would be "locked in" to Aetna and unable or unwilling to contract with alternative health plans due to their financial dependence upon Aetna. The evidence, though, suggested that competitive harm from the exercise of monopsony power was unlikely.

First, the publicly available data on physician revenues in the Houston and Dallas areas indicated that Aetna would not have monopsony power after the acquisition and that the transaction fell into the safe harbor described in the Statements of Antitrust Enforcement Policy in Health Care issued by the Antitrust Division and the FTC ("Health Care Policy Statements").[53] In discussing joint purchasing arrangements among health care providers, the Health Care Policy Statements adopt an antitrust safety zone for joint purchasing arrangements where the services purchased account for less than 35 percent of the total sales of the purchased product or service in the relevant market. The Policy Statements assume that it is unlikely that a buying group or a monopsonist would be able to reduce the purchase price of the services involved below competitive levels if it accounts for a relatively small share of all purchases in the marketplace.[54]

Based on publicly available data, Aetna would have accounted for about 20 percent of total physician revenues in Houston and about 25 percent of total physician revenues in the Dallas-Fort Worth area after the transaction, shares well within the Health Care Policy Statements safety zone.[55] Shares of this magnitude

were too low for Aetna to have "buyer power" over physicians and demonstrate that physicians in Dallas and Houston would have continued to have a variety of other third-party payors and patients to whom they could turn for reimbursement after the merger. Indeed, in 1998, there were fourteen HMOs in the Houston area and twelve HMOs in Dallas. There also were many PPOs, traditional indemnity plans, and government payment sources, such as Medicare and Medicaid.

Second, there was no specific evidence in the Complaint or CIS that Aetna's physicians were providing less service than they should be providing, nor was there any evidence that there had been or would be any decline in the quality of the services provided. All four of Aetna's HMO plans in Texas are accredited by the National Committee for Quality Assurance. HEDIS reports also provided no indication that Aetna's HMOs offered inferior service or quality. Moreover, it is unclear how such evidence should have been interpreted even if it did exist. It often is difficult to distinguish between an alleged reduction in quality and a reduction in unnecessary utilization of medical services. Indeed, it is the ability of HMOs to monitor utilization and to provide high quality, cost-effective care that attracted consumers to managed care plans in the first place.

Third, there was no evidence in the Complaint or CIS that Aetna's reimbursement rates to physicians were anything but competitive. If Aetna offered less-than-competitive rates, other carriers would have taken advantage of the opportunity by offering Aetna's physicians higher reimbursement rates that were closer to or at competitive levels. Moreover, in the eyes of consumers, one of the important characteristics of a health plan is the quality and breadth of the plan's provider network. Contracting with high-quality physicians (at market rates) who have a large or growing patient base is a natural part of a health plan's competitive and marketing strategy.

Apart from these market realities, managed care plans, as negotiators with physicians on behalf of employers and employees, are entitled to use the leverage that they have *lawfully* obtained to get the best possible price for their subscribers. Justice Breyer zeroed in on this issue in *Kartell v. Blue Shield of Massachusetts, Inc.*,[56] where an allegation of monopsony power was raised in connection with Blue Shield's ban of balance billing by physicians. Antitrust analysis, he said, should focus on keeping prices low for consumers, not on keeping fees high for physicians:

> [T]he prices at issue are low prices, not high prices . . . the Congress that enacted the Sherman Act saw it as a way of protecting consumers against prices that were too high, not too low . . . . And, the relevant economic considerations may be very different when low prices, rather than high prices are at issue. These facts suggest that courts at least should be

> cautious—reluctant to condemn too speedily—an arrangement that, on its face, appears to bring low price benefits to the consumer.

Fourth, there was no specific evidence cited in the Complaint or CIS that physicians would be "locked in" to Aetna after the acquisition. Aetna, like all successful plans, tries to offer a large, high-quality provider network to attract enrollees. Aetna did not have exclusivity or most-favored-nation clauses in its provider contracts. The absence of exclusives and the desire to develop a broad network of providers were driven by competitive market conditions.

The evidence available to the parties suggested that it would not be difficult for physicians to switch health plans, even in Houston and Dallas. One reason was that most doctors already had contractual relationships with health plans other than Aetna and Prudential. In fact, there was a substantial overlap in the provider networks of many of the plans that serve Houston and Dallas. There also was evidence showing that doctors can and do switch plans.

Finally, the available evidence suggested that physicians easily could begin serving the enrollees of alternative health plans with minimal, if any, financial risk. Not only were many physicians already affiliated with other plans, but a substantial percentage of many physicians' patients were not enrolled in an Aetna plan. In part, this was because most companies offered their employees more than one health plan and patients may have been able to switch plans without changing their doctor. For example, 74 percent of the employers in Dallas offered their employees more than one health plan, and Aetna and its rivals tended to have broad, overlapping networks. Consistent with this was the fact that subscribers voluntarily switched plans regularly, and that physicians, in fact, have a great deal of influence over their patients and their choice of health plans.[57]

It is difficult to know whether monopsony power will continue to be a focal point in future health plan mergers, or how the potential for monopsony power will be evaluated in future cases. The Complaint and CIS offer little guidance because no reference was made to any evidence that supported the allegations. For instance, the Complaint did not state how large Aetna's post-acquisition share of physician revenues would have been in Houston or Dallas. More importantly, even though the allegations articulate a concern about the ability of Aetna's doctors to reject Aetna's contractual terms, if those terms turned out to be less attractive after the acquisition, there was no evidence that Aetna's alleged purchasing power would have harmed consumers.

V
CONCLUSIONS

The Antitrust Division's and Texas's challenge to Aetna's acquisition of Prudential, albeit limited, has ushered in a new and dramatic change in the antitrust enforcement environment for managed care mergers. For the first time, the federal government formally defined the product market in a managed care merger narrowly as HMO-based products and a geographic market limited to MSAs. Also for the first time, the government alleged that a managed care merger would result in monopsony power. Further, the government has shown that in evaluating these mergers, it will use sophisticated economic analysis, including econometric modeling, particularly with respect to product market definition. The clear implication of the Division's challenge in *United States v. Aetna* is that managed care mergers will be subjected to far greater scrutiny, at a far greater cost to both the government and the merging parties, than has been the case in the past.

The challenge to the Aetna/Prudential transaction also raises a number of difficult questions regarding future antitrust enforcement of managed care mergers, including:

- How much weight will be given to the results of econometric analysis relative to more traditional antitrust evidence (e.g., similarity of product characteristics, actual evidence of switching, and customer interviews)?
- What are the standards by which sufficiency of entry will be evaluated in future transactions?
- What are the standards by which the monopsony power of a managed care plan will be judged, including whether the principles and market share thresholds described in the Health Care Policy Statements will be applied in these situations?

In summary, the antitrust enforcement environment for managed care mergers has changed. Parties contemplating such mergers should take great care in evaluating the competitive issues raised by these transactions to minimize the antitrust risks posed by such transactions, including the risk of a protracted and expensive investigation.

NOTES

1. Complaint ¶ 33, United States v. Aetna, No. 3-99 CV 1398-H (N.D. Tex., filed June 21, 1999).

2. United States v. Aetna, Complaint ¶ 33.

3. *See e.g.*, Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic, 65 F.3d 1406, 1409-1411 (1995), *cert. denied*, 116 S. Ct. 1288 (1996) (reversing district court decision upholding a jury verdict based on an HMO-only product market on grounds HMOs compete with other types of health care financing); Doctors Hosp. of Jefferson, Inc. v. Southeast Med. Alliance, Inc., 123 F.3d 301, 308 n. 15 (5th Cir. 1997) (citing *Marshfield Clinic* in finding that PPOs compete with HMOs and other managed care and non-managed care plans, "all of which are substitutable"); U.S. Healthcare, Inc. v. Healthsource, Inc., 986 F.2d 589, 599 (1st Cir. 1993) (rejecting HMO-only market and recognizing market including all health insurance coverage; fact HMOs are less expensive than other forms of health care financing does not mean HMOs constitute a separate market, because the difference in cost may be offset "by the limits placed on the patient's choice of doctors"); Reazin v. Blue Cross & Blue Shield of Kansas, Inc., 663 F. Supp. 1360, 1478-80 (D. Kan. 1987), *aff'd in relevant part*, 899 F.2d 951 (10th Cir.), *cert. denied*, 497 U.S. 1005 (1990) (finding that HMOs are in direct competition with other types of private health care financing); Ball Mem'l Hosp., Inc. v. Mutual Hosp. Ins., Inc. 784 F.2d 1325, 1331-1332, 1337 (7th Cir.), *reh'g denied en banc*, 788 F.2d 1223 (1986) (upholding district court finding of a "health care financing" product market, which the district court had based on the fact that insurance companies, hospitals offering PPOs, HMOs, and self-insuring employers all are offering methods of health care financing, and employers and individuals easily can switch from one financing package to another); The Orthopedic Studio, Inc. v. Health Ins. Plan of Greater N. Y., Inc., No. CV-95-4338, 1996 U.S. Dist. LEXIS 10321 (E.D.N.Y. Feb. 9, 1996) (stating that an HMO, "which is 'basically a method of pricing medical services,' " competes with "medical insurers and other types of provider organizations in a market for 'medical-services contracting' " (quoting *Marshfield Clinic*, 65 F.3d at 1410)); Total Benefits Servs., Inc. v. Group Ins. Admin., Inc., 875 F. Supp. 1228, 1236-38 (E.D. La. 1995) (finding that indemnity plans, HMOs, and PPOs, including variations on these plans with respect to employer self-insurance and third-party claims administration, all are "reasonably interchangeable"); Hassan v. Independent Practice Assocs., P.C., 698 F. Supp. 679, 691 (E.D. Mich. 1988) (finding relevant product market was "health care financing," not "prepaid health services"); Pennsylvania Dental Ass'n v. Medical Serv. Ass'n, 574 F. Supp. 457, 469-71 (M.D. Pa. 1983) (finding single market encompassed both prepaid service benefit dental programs and dental insurance programs), *aff'd*, 745 F.2d 248 (3d Cir. 1984), *cert. denied*, 471 U.S. 1016 (1985); *see also* Capital Imaging Assocs., P.C. v. Mohawk Valley Med. Assocs., Inc., 996 F.2d 537, 547 (2nd Cir.) (analyzing HMOs market power in terms of both HMO covered lives and all insured lives in geographic market), *cert. denied*, 510 U.S. 947 (1993). *Compare* Continental Orthopedic Appliances, Inc. v. Health Insurance Plan of Greater New York, Inc., 40 F. Supp. 3d 109, 119 (E.D.N.Y. 1999) (stating that while it agreed with the holdings of the Seventh Circuit in *Marshfield Clinic* and the First Circuit in *U.S. Healthcare*, those cases did not "stand for the proposition that HMOs can never be a separate viable product market," and allowing discovery to proceed on HMO market alleged in complaint despite reservations that such a narrow market definition was proper in this case).

4. The district court in *Marshfield Clinic*, was overturned by the Seventh Circuit. *See, e.g.*, Blue Cross & Blue Shield of Wisconsin v. Marshfield Clinic, 65 F.3d at 1406 (reversing district court decision upholding jury verdict based on an HMO-only product market on the grounds HMOs compete with other types of health care financing).

5. *See, e.g.*, Gail A. Jensen et al., *The New Dominance of Manage Care: Insurance Trends in the 1990s*, Health Affairs, Jan./Feb. 1997, at 133; Larry Levitt, et al., The Kaiser Family Foundation,

Trends and Indicators in the Changing Health Care Marketplace: Chartbook, Aug. 1998, at 15.

6. *See Ball Mem'l Hosp.*, 784 F.2d at 1331-32 (upholding district court finding that employers and individuals easily can switch from one financing package to another).

7. *See Ball Mem'l Hosp.*, 784 F.2d at 1336 (affirming district court holding that relevant market is "regional, if not national" (citation omitted)); *Total Benefits Servs., Inc.*, 875 F. Supp. at 1237 (finding no credible evidence to support limiting geographic market to New Orleans; "the only evidence of geographic locations of suppliers solicited by customers indicated that customers looked to suppliers from all over the country" (footnote omitted)).

8. PriceWaterhouseCoopers Global Site, www.pwchealth.com/charts/chart25.html (Sept. 11, 1999) (citing Interstudy and American Association of Health Plans as sources).

9. *See* Roger D. Feldman et al., HMO Consolidations: How National Mergers Affect Local Markets, 18 Health Affairs No. 4 (July/Aug. 1999).

10. For example, in Harvard Community Health Plan's merger with Pilgrim Health Care, a merger of the two largest HMOs in northeastern Massachusetts, the Massachusetts Attorney General informally acknowledged that the product market was all health care financing. However, the Attorney General imposed a number of conditions, including a two-year cap on price increases, a prohibition on most favored nations clauses with providers, and a requirement that the parties donate almost $4 million for community benefit activities and funding for poor and elderly care.

In a transaction involving Pennsylvania Blue Shield and Blue Cross of Western Pennsylvania, the Pennsylvania Attorney General submitted comments to the Department of Insurance, which had responsibility for reviewing the merger. The Attorney General concluded that the relevant product market should be defined as all health care financing, citing the Seventh Circuit in *Marshfield Clinic*, but the Department of Insurance required the parties to agree to devote $65 million, or 1.25% of premium revenue, to charitable health care programs.

In United HealthCare's acquisition of GenCare Health Systems, which resulted in the merger of two of the three largest HMOs in St. Louis, the Missouri Department of Insurance concluded that the relevant market was HMOs, but that the merger would not be anticompetitive. Nevertheless, the Department imposed a two-year premium cap for small groups. And, in United HealthCare's acquisition of MetraHealth, the Missouri Department of Insurance approved the transaction subject to the requirement that United divest MetLife in St. Louis, which suggests that the Department again had defined a separate market for HMOs.

Additional detail on these transactions can be found in the following article by Thomas Sussman, *Market Analysis in HMO Mergers*, ABA Antitrust Healthcare Chronicle No. 2, Spring 1996, at 2.

11. These restrictions included prior approval of any changes to policies regarding quality assurance, utilization management, member services, member grievance processes, provider contracts or provider networks, as well as prohibitions on the use of exclusive contracts with providers and restrictions on the use of most favored nations clauses in the plan's Medicare HMO contracts.

12. Robert Pitofsky, *Thoughts on "Leveling the Playing Field" in Health Care Markets*, Feb. 13, 1997, at 12 (footnote omitted).

13. Revised Competitive Impact Statement at 4, United States v. Aetna No. 3-99 CV 1398-H [hereinafter CIS].

14. Aetna, Inc. Press Release (Dec. 10, 1998).

15. Wall St. J., Dec. 11, 1998, at A3, A6.

16. The Division indicated that it had not included any of the other MSAs it looked at in its complaint because the combined share of Aetna and Prudential in these areas did not raise competitive concerns. This was because either (a) Prudential was not a significant competitor to Aetna in the MSA prior to the merger; (b) Aetna was not a significant competitor to Prudential in the MSA prior to the merger; or (c) there would be significant re-

maining competitors after the merger to ensure competitive pricing. CIS at 8, n.3.

17. Complaint ¶¶ 13-17. While is not clear in the Complaint, only fully-insured HMO members were included in the market share calculations alleged.

18. Complaint ¶ 15.

19. Complaint ¶ 17.

20. Complaint ¶ 18; CIS at 7. *See also* U.S. Dep't of Justice & Federal Trade Comm'n, Horizontal Merger Guidelines § 1.11 (1992) (describing methodology for defining relevant product market) [hereinafter Merger Guidelines], *reprinted in* Antitrust Laws and Trade Regulation: Primary Source Pamphlet (Matthew Bender 1998).

21. Complaint ¶¶ 19-20. *See also* Merger Guidelines § 1.21 (methodology for determining relevant geographic market).

22. Complaint ¶ 21.

23. CIS at 8-9 (citation omitted).

24. CIS at 9 (citing Complaint ¶ 24).

25. CIS at 9; Complaint ¶ 25.

26. Complaint ¶ 27.

27. Complaint ¶¶ 28-29.

28. Complaint ¶ 30.

29. Complaint ¶ 31.

30. Complaint ¶¶ 32-33.

31. Complaint ¶ 33.

32. The decree provided Aetna with 120 days to enter into an agreement to sell the NYLCare plans to a purchaser acceptable to the Division, and file for all regulatory approvals. Aetna is required to consummate the sale within five days after the required approvals are obtained. The Division, in its sole discretion, can extend these periods another 60 days. Final Judgment ¶¶ IV(B)-(C). If the divestitures have not been accomplished within the required time periods, the Division can apply to the court to appoint a trustee to carry out the sale. Final Judgment ¶ V(A). Also, under the terms of the decree, Aetna was not permitted to consummate the Prudential acquisition until it satisfied the Division that the NYLCare entities had been "held separate" as independent and viable competitors and had satisfied other requirements of the decree. Final Judgment ¶ IV(H). The Division found that Aetna satisfied these requirements on July 27, 1999. After obtaining required approvals from state regulators, Aetna acquired Prudential on August 6, 1999.

33. CIS at 13, n.6. As of June 21, the NYLCare-Gulf Coast plan had 260,000 HMO and HMO/POS covered lives in the Houston area, compared to the 172,400 covered lives Prudential had in the area. The NYLCare-Southwest plan had 167,000 HMO and HMO/POS enrollees in the Dallas area, compared to 171,000 Prudential HMO and HMO/POS lives in that area. *Id.*

34. Mercer/Foster Higgins 1998 National Survey of Employer-Sponsored Health Plans [hereinafter Mercer Survey].

35. *Id.* at 6.

36. Jon Gabel et al., *Health Benefits of Small Employers in 1998*, Report prepared for The Henry J. Kaiser Family Foundation, Feb. 1999, at 21-23.

37. *See* Jensen, *supra* note 5, at 133. In Texas, for example, the regulations permit self-insured PPO plans to use gatekeepers.

38. These products become even closer substitutes when the wide range of coverage options are factored in (i.e., co-payment amounts, deductibles, co-insurance, or perhaps a drug benefits rider) that make one type of plan just as appealing as another.

39. For instance, the typical POS plan provides a difference in benefits (e.g., 100% coverage vs. 70% coverage) depending on whether the member chooses to use the plan's contracted providers and gatekeeper system or go to a non-participating provider.

40. *Glossary of Terms and Acronyms*, in The Managed Health Care Handbook 999-1000 (Peter R. Kongstuedt ed., 3d ed. 1996).

41. Peter D. Fox, *An Overview of Managed Care*, in The Managed Care Handbook 12 (Peter R. Kongstuedt ed., 3d ed. 1996).

42. Mercer Survey, *supra* note 34, at 11, 12.

43. *See* CIS at 7. The data requirements for such an analysis are very rigorous. Without complete data from the parties and all market participants, the methodology was likely to produce statistical results that indicated that demand was not price sensitive when in fact it could have been. Moreover, simulation analyses by the parties demonstrated that the lack of complete data generated a bias towards finding low elasticities of demand (and therefore a narrowly defined market) and that this bias could be quite large. For instance, an econometric analysis of the parties' data, but not the data of any other health plan, produced results that suggested that Aetna's HMO and Prudential's HMO were not in the same relevant market!

44. If the product market is defined too narrowly, an analysis of market share is inappropriate for another reason. The shares of the merging firms would be overstated. That is because market shares that are based on fully insured HMO enrollment would not account for the competitive role played by health plans that currently offer health insurance to employers who are self-insured, health plans that offer PPO-type plans, and health plans that serve Medicare and Medicaid. Assuming these plans could bring the capacity they have to the commercial HMO market segment if the opportunity were to arise, a properly defined market would result in much lower market shares for the merged entity.

45. Market share also may indicate relative efficiency or quality. That is, firms with high market share may be the more efficient, higher quality, and innovative firms in the marketplace that are being rewarded (e.g., they may be rewarded for having larger networks, better word-of-mouth support by current consumers, and more effective disease management programs).

46. Merger Guidelines § 3.0.

47. Complaint ¶ 23.

48. In Houston, Aetna and the NYLCare plan it acquired in 1998 together accounted for approximately two-thirds of the HMO covered lives in the MSA in 1994. By 1998, this figure had declined by 20 percentage points due to expansion by existing plans as well as new entry.

49. *American Medical Association Discussion Paper on Aetna/U.S. Healthcare Acquisition of Prudential Health Care* (Feb. 1999).

50. TX S.B. 1468 (signed June 20, 1999).

51. The Quality Health-Care Coalition Act of 1999, H.R. 1304 (1999).

52. *The Quality Health-Care Coalition Act of 1999: Hearing on H.R. 1304 before the House Judiciary Committee* (June 22, 1999) (statements of Joel I. Klein, Assistant Attorney General, Antitrust, Dep't of Justice, and FTC Chairman Robert Pitofsky).

53. U.S. Dep't of Justice & Federal Trade Comm'n, Statements of Antitrust Enforcement Policy in Health Care (1996), *reprinted in* Antitrust Laws and Trade Regulation: Primary Source Pamphlet (Matthew Bender 1998).

54. *Id.* Statement 7.

55. Aetna's post-acquisition share was much less than 35% even if it was calculated based on total physician expenditures, rather than revenues. Aetna's post-acquisition share of total physician expenditures would have been about 28% in Houston and 25% in Dallas-Fort Worth.

56. 749 F.2d 922 (1st Cir. 1984), *cert. denied*, 471 U.S. 1029 (1985).

57. The assertion that doctors have a limited ability to get patients to switch plans in which the doctors participate also is contrary to the Antitrust Division's and the FTC's position in many hospital merger cases. In the context of a hospital merger, an evaluation of the hospitals where physicians have privileges has been important because the evidence tended to show that physicians have a great deal of influence over where their patients receive hospital care. For example, in FTC v. Tenet Healthcare Corporation, No. 4:98CV709 CDP, 1998 U.S. Dist. LEXIS 11849 ¶ 14 (E.D. Mo. July 30, 1998), *rev'd*, 1999 U.S. App. LEXIS 16849, 1999-2 Trade Cas. (CCH) ¶ 72578 (8th Cir. 1999), the district court agreed with the government when it concluded that "[t]he evidence

also shows that patients are loyal to their primary physicians. . . ." The government made similar arguments regarding physician loyalty in United States v. Mercy Health Services, 902 F. Supp. 968 (N.D. Iowa 1995), *vacated*, 107 F.3d 632 (8th Cir. 1997). With the broad provider networks in Houston and Dallas, it seems implausible that Aetna's physicians would have sufficient influence over where patients receive their hospital care, but little influence with respect to their choice of health plan. The Complaint and the CIS provided no evidence to support this assertion. ❦