A NOVEL LOOK AT ANTITRUST ANALYSIS IN HEALTH INSURANCE MARKETS

BY BARAK D. RICHMAN & KEVIN A. SCHULMAN [1]


I. INTRODUCTION

Health care markets are in constant evolution. But the remarkable proposals for mergers of four of the five largest health insurance companies in the United States, Anthem with Cigna and Aetna with Humana, would have transformed the industry. The U.S. Department of Justice ("DoJ") filed to block the mergers due to concerns over market concentration in the large employer market (in the case of the *Anthem-Cigna* merger) and in the Medicare Advantage and the Affordable Care Act exchange markets (in the case of the *Aetna-Humana* merger).

In both cases, the DoJ did a thorough and skillful job of defining markets, measuring market share and finding hotspots where the mergers would create presumptively illegal market concentration. When the insurers claimed the mergers would generate certain efficiencies, the DoJ successfully rebutted their efforts and cast dispersion on the claims that savings would be achieved and transmitted to customers.

A less obvious but more revealing — and more alarming — narrative focuses on how the insurance industry arrived at a point where four of the "big five" were in a position to request these megamergers. By nature, the antitrust cases focused on narrow definitions of specific markets and the likely impact of these mergers. The cases omitted a broader discussion of the forces acting on the health care market that brought these proposals forward. This would have been an instructive exercise, both in evaluating these merger agreements and in preparing for further merger proposals that are sure to come.

In this paper, we examine the structure of health care markets, examine some specific questions about antitrust theory in this case, examine alternative theories of antitrust regulation addressing innovation and conclude with a new model to consider the market itself in developing theories of antitrust enforcement.

1 Barak D. Richman is the Edgar P. and Elizabeth C. Bartlett Professor of Law at the Duke University School of Law and a professor of business administration at Duke's Fuqua School of Business; and Kevin A. Schulman is a professor of medicine and an associate director of the Duke Clinical Research Institute at the Duke University School of Medicine.

II. BACKGROUND: HEALTH CARE MARKETS

To better understand the market, it is helpful to understand the role of health insurers today. Health insurers are an integral part of the system for financing health care services. They have two essential roles in the market. The first role is to develop a network of providers — hospitals and physicians — that are contracted to provide clinical services at negotiated prices. These networks are a powerful response to the extraordinary prices set for services in the absence of a contract, a system based on a concept called "charges."[2] The second role is to sell access to this network to customers, individuals, employers and government, either in the form of health insurance products that carry full insurance risk or as a concept called "administrative services" only for self-insured employers.

The key feature of this market is the negotiating leverage of the parties in developing the networks. We have seen a remarkable transformation of the provider market over the past two decades. In many markets, not-for-profit hospitals have developed extensive networks of acquired and managed hospitals, and they have acquired physician practices to cement their patient referral networks. This consolidation has proceeded rapidly, with economists suggesting that half of U.S. hospital markets are highly concentrated, one-third are moderately concentrated and the remaining markets unconcentrated. None are considered highly competitive.[3] Given this level of consolidation, the DoJ has successfully blocked several proposed provider mergers recently but has done little to address the significant consolidation already in existence.

Viewed from this perspective, health insurers are intermediaries, negotiating contracts for services with hospitals systems and physicians on behalf of the ultimate payers. A great deal of the value of the insurance network can be assessed by the size of the network (i.e. which hospitals and physicians are included in the network) and by the unit prices achieved in contract negotiations. Insurers proffer these attributes as a significant part of their value.

Provider consolidation has had a significant impact on the cost of health care services. In one study in California, patients who see physicians who own their own practice cost their health plan $3066, whereas patients who see physicians whose practice is owned by a multihospital system cost their health plan $4776.[4] Across multiple studies, hospital consolidation in concentrated markets results in price increases of at least 20 percent.[5] Overall, the total cost of employer-sponsored health insurance in 2016 was $6435 for an individual and $18,142 for family coverage. These costs represent a 58 percent increase from 2006.[6]

Thus, coming into the insurance merger cases, we have a market in which hospitals are highly concentrated with significant pricing leverage driving up costs. Whether consolidation of the private health insurance market could have had a significant impact on this dynamic was a question at trial, and the court showed significant skepticism on this issue in the end. In the *Anthem* case, the merger of the second and third largest health insurers in the U.S., Anthem outlined the anticipated economic savings from the merger. Anthem argued that it could rebrand Cigna plans as Anthem to gain access to Anthem's lower rates, could use its "affiliates" clause to extend its current discounts to Cigna health plans and could renegotiate lower rates with providers. The court rejected this efficiencies defense. Beyond the concept that extending the Anthem discount was not merger-specific, the court expressed skepticism about extending the affiliates clause, "because the providers were unlikely to accept lower rates and provide more services without getting anything in return." On the concept of market leverage, the district court found that:

2 Richman, Kitzman, Milstein & Schulman, *Battling the Chargemaster: A Simple Remedy to Balance Billing for Unavoidable Out-of-Network Care*, Am J Manag Care. 2017;23(4):e100-e105.

3 Cutler & Morton, *Hospitals, Market Share, and Consolidation*, JAMA. 2013;310(18):1964-1970.

4 Robinson & Miller, *Total Expenditures per Patient in Hospital-Owned and Physician-Owned Medical Groups in California*, JAMA. 2014;312(16):1663-1669.

5 Gaynor & Town, *The Impact of Hospital Consolidation-Update*, Robert Wood Johnson Foundation. June 2012. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261.

6 The Kaiser Family Foundation and the Health Research and Educational Trust. Employer Health Benefits 2016 Annual Survey. http://files.kff.org/attachment/Report-Employer-Health-Benefits-2016-Annual-Survey.

attempts to achieve the claimed savings through renegotiation of provider contracts would run into similar problems. It found that any savings would take time to be realized, and that Anthem's expert failed to account for utilization, i.e., the amount of medical services that would be consumed by a given customer. In sum, it found the claimed savings were aspirational inasmuch as every proffered strategy either floundered in the face of business reality or was achievable without the merger, or both.[7]

III. ADDITIONAL DEFENSES

Economic theory teaches that concentrated markets generate higher prices, and this has been shown to be true in insurance markets. When fewer insurance companies compete, prices for insurance are higher.[8,9] This is reason enough for many to oppose the mergers.

There are many reasons, however, why these mergers might not have translated into a sharp increase in prices. First, health insurance rates are highly regulated, both by state insurance commissioners and also by the Affordable Care Act's "medical loss ratio" ("MLR") requirements. (The MLR is the proportion of the health insurance premium used for medical expenses.) Both federal and state regulations could limit how much an insurer with market power can increase prices.

Second, to the degree that market power exists in health insurance markets — and, indeed, many regional markets are dominated by insurers with monopoly power — such market power is often enjoyed by Blue Cross–licensed insurance plans (Anthem is the for-profit Blue's licensee in 14 states). In markets where more competition among health insurers may be sorely needed, the mergers would bestow little additional market power to the merging parties compared to these dominant plans. Furthermore, the merged Anthem-Cigna entity would face entry restrictions on expanding into additional states based on Anthem's licensing agreement with the Blue Cross Association. However, there might be reason to think that the Aetna-Humana merged entities could have mounted a more meaningful challenge in these Blue-dominant markets.

Third, the markets in which some of these merging health insurers dominate offer limited prospects for supra-competitive pricing. A combined Aetna and Humana, for example, could control the Medicare Advantage market, but those products are heavily regulated — on both price and quality — by the Centers for Medicare & Medicaid Services. Some fear that reducing the number of national health insurers will concentrate the availability of multistate plans, but that void can be filled by coalitions of independent Blues, third-party administrators, or private health insurance exchanges that incorporate regional health plans.

These concepts were or could have been part of the argument at trial to support these mergers.

IV. THE DOJ'S BEDFELLOWS

Extremely telling in the analysis of these mergers were the identification of the parties most vocally against the mergers. The leading opponents were not consumers or employers (who remained strikingly silent) but the American Hospital Association ("AHA") and the American Medical Association ("AMA"). These associations have argued that the enlarged insurers will squeeze reimbursements to providers and threaten the quality and availability of care.

There is a painful irony in the arguments proffered by the AHA and AMA. Yes, dominant insurers will have more negotiating power against providers, but insurers have long decried continued consolidation of providers. As already discussed, most local hospital markets are now highly concentrated — and insurers have complained that dominant providers enjoy

7 United States Court of Appeals for District of Columbia Circuit, No. 17-5024. Argued March 24, 2017. Decided April 28, 2017.

8 Dafny, Duggan & Ramanarayanan, *Paying a Premium on Your Premium? Consolidation in the U.S. Health Insurance Industry*, Am Econ Review. 2012;102(2):1161-1185.

9 Dafny, Gruber & Ody, *More Insurers Lower Premiums: Evidence from Initial Pricing in the Health Insurance Marketplaces*, Am J Health Econ. 2015;1(1):53-81.

excessive power in contract negotiations.[10]

There are plausible reasons to buy the insurers' argument that dominant providers justify dominant insurers. Health care costs have increased 58 percent over the past decade, largely as a result of increases in the prices charged by providers. It is possible that an insurer with negotiation power could counteract provider monopoly power and can secure more favorable health care prices. Since the Affordable Care Act requires a minimum MLR of 80 percent or 85 percent depending on the market, insurers are somewhat limited in how their market power could drive up additional costs to consumers. If they saved more than the expected MLR they used to calculate the premium under this statute, they would have to pass any savings along to consumers.

However, there are two grave dangers in this posturing. The first is that in several markets in which there are both dominant insurers and dominant providers, such as in Michigan and Boston, the twin giants used their collective leverage not to extract concessions from each other, but rather, to coordinate efforts to secure their collective leadership.[11] Whereas haggling between insurers and hospital systems are often described as a giant Gordian knot with payers and providers arm-wrestling over payments of epic proportions, recent evidence suggests that the giants are at least as likely to quietly collude and support each other, while excluding potential competitors.[12]

The other danger is that battles between providers and insurers are described as a fight over a fixed pie. The true test of a merger, however, is not the impact on other parties but its impact on consumers in the short and medium terms. In America's health care markets, primary attention ought to focus on how these mergers affect innovations in how we currently pay for and deliver health care. Evaluating the impact of these mergers should not exclusively use current U.S. prices and quality as a baseline, but should also consider possibilities to move towards an ideal reference price based on health care unit prices widely available in Europe (50 percent of U.S. costs), or even India (10 percent of U.S. costs).

V. INNOVATION AND CONSOLIDATION

Beyond the specific considerations at issue in the case, the health insurance market, and the structure of the health care market more broadly, became an issue in the arguments when looking at ways to achieve better value for consumers. This narrative was revealed in the *Anthem-Cigna* trial in a remark made by DoJ expert witness David Dranove when he was asked to assess the merger's impact on innovation. Dranove's central remark was that Cigna has been innovative only because of its relatively smaller position in the marketplace. He was concerned that, once Cigna became part of the larger Anthem, it would stop innovating. (During summation, the DoJ's lead attorney, Jon Jacobs, emphasized this argument, stating, "This merger will eliminate Cigna's incentive to innovate.") But Dranove made a broader observation about the industry, not just about Cigna and Anthem, when he decried the lack of industry-wide innovation among health insurers. He concluded, "My evaluation left me quite sober…. I was very concerned about the path this industry has been going on."[13]

Antitrust law considers the concept of innovation in evaluating consumer surplus. One of us recently evaluated antitrust actions against IBM's many tying arrangements and found:

> first, that the DOJ was successful in forcing IBM to unbundle several of its significant bundling strategies—i.e., but for the DOJ's scrutiny, IBM would have proceeded bundling several of its products and services; and second, when IBM acceded to the DOJ's demands and ended the targeted bundling arrangements, it proceeded to open new markets and unleash significant economic surplus. In short, this case study offers at least one instance in

10 Capps & Dranove, *Market Concentration of Hospitals*, (Bates White Economic Consulting Analysis, June 2011). www.ahipcoverage.com/wp-content/uploads/2011/10/ACOs-Cory-Capps-Hospital-Market-ConsolidationFinal.pdf.

11 Herzlinger, Richman & Schulman, *Market-Based Solutions to Antitrust Threats—The Rejection of the Partners Settlement*, N Engl J Med. 2015;372(14):1287-1289.

12 Havighurst & Richman, *The Provider-Monopoly Problem in Health Care*, Oregon Law Review. 2011;89:3.

13 Hoover, *Economist Says Anthem-Cigna Deal Will Stifle Innovation*, https://www.law360.com/health/articles/866453/economist-says-anthem-cigna-deal-will-stifle-innovation.

which prosecuting illegal ties yielded significant social benefits.[14]

Another classic case of innovation and antitrust law concerns AT&T. The DoJ filed suit in 1974, alleging that "AT&T had illegally manipulated its dominant position in three sets of telecommunications markets—equipment, local exchange, and long-distance—in order to monopolize the entire domestic telecommunications industry…. The Justice Department also alleged antitrust violations by AT&T in its use of the regulatory process."[15] Upon the settlement that broke up the company, the telecommunications industry underwent dramatic change. Evaluation of these changes suggests that:

> innovations have been more rapidly deployed in telecommunications networks the more competitive have been the markets in which those networks operated. This positive correlation between competition and adoption of new technology suggests that regulators and enforcement officials should be wary of claims that, by adhering to policies designed to preserve competition, they will impede firms from deploying innovations or bringing new services to consumers.[16]

Both the IBM and AT&T cases suggest a need to understand the market more broadly in evaluating potential mergers in health care.

VI. PATHWAYS TO INNOVATION

Dranove's lament begs for a new framework for assessing future consolidation in the health care markets, at either the health plan level or the provider level. Rather than a static assessment of a proposed merger in a single market, we can consider the potential dynamic impact of a proposed merger on a market taking into consideration the overall "market architecture." We define this concept as the interaction of the entire value chain within a market, including actions of incumbents and patterns of firm entry or exit from the market. In health care, we have described a market with concerns about market concentration of providers (hospitals and physicians), and consolidation among insurers (even without the mergers). The result is an architecture characterized by extremely high prices, lack of market entry and significant questions of value. The dynamic question to consider is how any proposed merger would change this equation and improve value for consumers.

The merger trials revealed that the prevailing business model among U.S. health insurers is to seek scale: size offers insurers efficiencies in managing financial risk and offers negotiation leverage against health care providers. The business model predicated on scale has insurers focusing only on prices paid for medical services and claims made by beneficiaries, with little analysis of value creation for consumers. There is little evidence that insurers become more innovative as they grow in size; there also is little reason to suspect valuable innovations will emerge from the current market structure. But this lack of empirical direction only reaffirms the need for policy makers to consider creative policy interventions to promote innovation, and the proposed mergers might have offered a unique opportunity to do so.

Insurers were represented as little more than large-scale purchasers and check writers. In many ways, the business model drives a market not dissimilar to early computer or telecommunications markets in which a key attribute of the market architecture was the lack of market entry.

In the management literature, there are two separate but related concepts about innovation, organizational innovation and disruptive innovation.[17] Organizational innovation can drive performance of an existing business model through business process improvement or business restructuring, typical efficiencies defenses claimed as benefits in mergers. Disruptive

14 Richman, Usselman & Elhauge, *On Tying: Vindicated by History*, Tulsa L. Rev. 2014;49(3):689-711.

15 MacAvoy & Robinson, *Winning by Losing: The AT&T Settlement and Its Impact on Telecommunications*, Yale Journal on Regulation. 1983;1(2):1-42. http://digitalcommons.law.yale.edu/yjreg/vol1/iss1/2.

16 Shelanski, *Competition and Deployment of New Technology in U.S. Telecommunications*, University of Chicago Legal Forum. 2000;2000(1):85-118. http://chicagounbound.uchicago.edu/uclf/vol2000/iss1/5.

17 Richman, Mitchell & Schulman, *Organizational Innovation in Health Care*, Health Management, Policy and Innovation. 2013;1(3):36-44.

innovation involves the introduction of a new business model, often accompanied by new technology, to drive markets to a new business paradigm. Disruptive innovation is the type of innovation that drove the tremendous value from unlocking the computer and telecommunications markets. Disruptive innovation can be an antidote to the adverse effects of market concentration by offering a truly competitive threat to current incumbents in a market. Even the threat of disruptive innovation can be an existential threat that can drive behavior of firms in a market.

We have seen the impact of disruption on many markets, with significant benefit to consumers.[18] In wide-ranging businesses from music (iTunes) to transportation (Lyft) to shopping (Amazon), consumers benefit from innovation, especially from innovation in business models enabled by technology. However, these types of innovation have appeared to be remarkably absent from the health care space (or, if they enter, the firms mostly struggle and fail to achieve significant impact on the market). The opportunity cost from the lack of disruptive innovation in health care is enormous.

Consumers have experienced enormous benefit from innovation in other markets. Productivity gains resulting from the digital transformation of telecommunications has led to one percent to eight percent annual improvements in performance.[19] Yet innovation has been painfully slow in health care markets, and one major reason has been the continued dominance of monopoly providers and monopsony purchasers. With both providers and purchasers in a dance of mutual reliance, there has been little incentive to introduce organizational innovations that will rewire care delivery, reform bloated financial transaction costs and drive down overall spending. There is especially little appetite for disruptive innovations that introduce uncertainty in financing or delivery. There is enormous incentive, meanwhile, to block new entrants who offer consumers potential improvements in cost, quality or access. Policy makers, in an effort to drive efficiencies in the provider market for the Medicare program, may actually have exacerbated the market power of providers and reduced the opportunity for significant disruption in the market.[20,21]

This discussion leads to a two-part test that can be considered for assessing future consolidation in the health care market: (1) the traditional direct assessment of likely consumer benefit from the proposed merger, and (2) the novel question of market architecture — what is the opportunity cost of the merger on the potential for entry of new organizations or new business models into the market? See Figure.

Market Architecture	Efficiency Defense	
	Synergy	Innovation
Value Producing	Allowed	Allowed
Value Consuming	Rejected	Required

There is no question that the current health care market is not delivering the value it could to consumers. This is an issue across the market and has reached into the policy arena in Washington. Novel approaches to address the underlying structure of the market are unfortunately scarce. For these reasons, health care competition policy should focus on possibilities to spur innovation and market changes. This perspective should shape how regulators view future proposed mergers. For example, regulators should inquire whether the merged entities will contract with specialty, low cost providers, or whether their plans will direct subscribers to enshrined dominant hospital systems. More aggressively, we could use proposed mergers as an opportunity to open existing insurance carrier provider networks to new entrants in a model akin to the market access programs in the phone industry. Not only would this approach bring greater transparency to the opaque metrics of healthcare

18 Christensen, *The Innovator's Dilemma: When New Technologies Cause Great Firms to Fail*, Boston, MA: Harvard Business School Press; 1997.

19 Hillestad, Bigelow & Bower, et al., *Can Electronic Medical Record Systems Transform Health Care? Potential Health Benefits, Savings, and Costs*, Health Aff (Millwood). 2005;24(5):1103-1117.

20 Richman & Schulman, *A Cautious Path Forward on Accountable Care Organizations*, JAMA. 2011;305(6):602-603.

21 Schulman & Richman, *Reassessing ACOs and Health Care Reform*, JAMA. 2016;316(7):707-708.

pricing and quality, it would also enable novel entrants to gain traction by offering consumers new sets of services that would be viable when linked to an existing carrier infrastructure. Developing an enforceable pathway to innovation in the market could offer opportunities to truly transform the role of the insurer in health care, and to transform the market to the benefit of consumers.