HEALTH INSURANCE INDUSTRY ENFORCEMENT ACT OF 2009

HEARING

BEFORE THE

SUBCOMMITTEE ON COURTS AND COMPETITION POLICY

OF THE

COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

FIRST SESSION

ON

H.R. 3596

OCTOBER 8, 2009

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OCTOBER 8, 2009

HEALTH INSURANCE INDUSTRY ENFORCEMENT ACT OF 2009

THURSDAY, OCTOBER 8, 2009

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON COURTS AND
COMPETITION POLICY
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Subcommittee met, pursuant to notice, at 12:23 p.m., in room 2237, Rayburn House Office Building, the Honorable Henry C. "Hank" Johnson, Jr. (Chairman of the Subcommittee) presiding.

Present: Representatives Johnson, Quigley, and Coble.

Also present: Representative DeGette.

Staff present: (Majority) Christal Sheppard, Subcommittee Chief Counsel; Anant Raut, Counsel; Elisabeth Stein, Counsel; Rosalind Jackson, Professional Staff Member; and Stewart Jeffries, Minority Counsel.

Mr. JOHNSON. This is the hearing of the Committee on the Judiciary, the Subcommittee on Courts and Competition Policy. It will now come to order.

Without objection, the Chair is authorized to declare a recess. Today, I begin the first in a series of hearings I call "An Antitrust System for the 21st Century."

Five years ago, the Judiciary Committee created a bipartisan Committee, the Antitrust Modernization Commission, to evaluate the Nation's antitrust laws and offer recommendations for updating and improving them.

One of their recommendations was to repeal the McCarran-Ferguson Act. McCarran-Ferguson was passed by Congress in 1945 and largely exempts insurance companies from the Federal antitrust laws.

You know, it is funny how for-profit insurance companies work. They want their premiums as high as possible, and they want to pay out as little of it as possible. It is in their shareholders' interest to cover the healthiest people and dump the sickest.

The insurance companies will tell us that they need this antitrust exemption because it really make the industry more competitive. Oh, really? Insurance profits have grown nearly sixfold in the past decade, while more than 40 million Americans go without insurance—and this is their idea of a competitive market.

The only thing these companies are competing for are the people who need them the least. Premiums have increased 87 percent in

the past 6 years. Where is this vigorous competition in the industry?

Last month I, Chairman Conyers and Representative DeGette joined our colleagues in the Senate to introduce the legislation before you, H.R. 3596. The bill says that McCarran-Ferguson can no longer be used by health and medical malpractice insurers as a shield for price fixing, bid rigging or market allocation.

With more and more people having to choose between having health insurance or having food on the table, I am very curious to hear what, if any, justifications can be offered for why the insurance industry continues to need protection from the antitrust laws.

[The bill, H.R. 3596, follows:]

I

111TH CONGRESS
1ST SESSION

H. R. 3596

To ensure that health insurance issuers and medical malpractice insurance issuers cannot engage in price fixing, bid rigging, or market allocations to the detriment of competition and consumers.

IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 17, 2009

Mr. CONYERS (for himself, Mr. JOHNSON of Georgia, and Ms. DEGETTE) introduced the following bill; which was referred to the Committee on the Judiciary

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A BILL

To ensure that health insurance issuers and medical malpractice insurance issuers cannot engage in price fixing, bid rigging, or market allocations to the detriment of competition and consumers.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Health Insurance Industry Antitrust Enforcement Act of 2009".

SEC. 2. PURPOSE.

It is the purpose of this Act to ensure that health insurance issuers and medical malpractice insurance

issuers cannot engage in price fixing, bid rigging, or market allocations to the detriment of competition and consumers.

SEC. 3. PROHIBITION OF ANTI-COMPETITIVE ACTIVITIES.

Notwithstanding any other provision of law, nothing in the Act of March 9, 1945 (15 U.S.C. 1011 et seq., commonly known as the ''McCarran-Ferguson Act''), shall be construed to permit health insurance issuers (as defined in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91) or issuers of medical malpractice insurance to engage in any form of price fixing, bid rigging, or market allocations in connection with the conduct of the business of providing health insurance coverage (as defined in such section) or coverage for medical malpractice claims or actions.

SEC. 4. APPLICATION TO ACTIVITIES OF STATE COMMISSIONS OF INSURANCE AND OTHER STATE INSURANCE REGULATORY BODIES.

Nothing in this Act shall apply to the information gathering and rate setting activities of any State commission of insurance, or any other State regulatory entity with authority to set insurance rates.

○

Mr. JOHNSON. I now recognize my colleague, Howard Coble, the distinguished Ranking Member of the Subcommittee, for his opening remarks.

Mr. COBLE. Thank you, Mr. Chairman.

And I will apologize to you and to the audience for my raspy throat. I have come down with my annual autumn cold, so it doesn't sound good, but I will—we will work through it.

Thank you, Mr. Chairman, for calling this hearing on the Courts and Competition Policy Subcommittee. I appreciate your willingness to involve the House Judiciary Committee in the health care debate that has been actively involved on—in Washington for the past few months.

These are important issues for the American people, and I have not ruled out, Mr. Chairman, insurance reform as an answer to America's health care problems, and I am having a little difficulty in embracing the bill before us, and I look forward to seeing what is—what sort of illumination is forthcoming for me.

The McCarran-Ferguson, as you pointed out, Mr. Chairman, was Congress' response to a 1944 Supreme Court decision holding that the business of insurance was interstate commerce. McCarran-Ferguson Act—Congress decided to keep regulation of insurance at the state level.

As part of that legislation, Congress gave a limited exemption to the Federal antitrust laws for insurance companies on the grounds that their activities would be regulated by state entities.

The states have, in fact, continued to rigorously regulate the insurance industry. Those regulators can and do guarantee that insurers do not collude to set price, rig bids or divide territories.

In addition to the state insurance commissioners, many state attorneys general have the authority to bring antitrust suits against insurers under state antitrust laws. To my mind, these state regulators have done a good job of protecting the consumers in their respective states.

Mr. Chairman, I know that the bill is targeted only at the health care and medical malpractice insurance markets. However, I am concerned, as are many of my friends, that it may mean the beginning of a broad scale to repeal McCarran-Ferguson for all insurance providers. I am not sure that the record supports such a broad-scale repeal.

Further, I am concerned that many key terms in the legislation, including issuers of medical malpractice insurance, price fixing, bid rigging and market allocation are undefined. While the latter three phrases are used in—as terms of art in antitrust litigation, there may be significant litigation to define what they mean as part of this legislation.

Mr. Chairman, this legislation raises a lot of questions, and I am glad that we have such a distinguished panel of experts before us to help us understand them all.

And with that, Mr. Chairman, I yield back the balance of my time. And without objection, I would like to submit for the record a statement from Lamar Smith, the distinguished Ranking Member of the full Committee; the testimony of the Property Casualty Insurers Association; the Insurers of Physicians Association; the

American Insurance Association; and the Americans Health Insurance Plans, if I may introduce those for the record.

Mr. JOHNSON. Without objection, it is so ordered.

[The information referred to follows:]

Statement of Judiciary Committee Ranking Member Lamar Smith
Subcommittee on Courts and Competition Policy
Hearing on H.R. 3596, the "Health Insurance Industry Antitrust Enforcement Act of 2009"
October 8, 2009

The bill under consideration, H.R. 3596, the "Health Insurance Industry Antitrust Enforcement Act of 2009," provides that, for the purposes of the McCarran-Ferguson Act, health insurers and medical malpractice insurers cannot fix prices, rig bids, or allocate markets. On its face, this is unobjectionable.

The purpose of the McCarran-Ferguson Act's federal antitrust exemption is to allow small insurers to aggregate information for underwriting purposes so they can compete effectively against larger national companies. In other words, McCarran-Ferguson should promote competition by making small underwriters viable.

McCarran-Ferguson is NOT intended to reduce competition through price fixing, bid rigging, or market allocation.

Another aspect of McCarran-Ferguson is that it makes clear that insurance continue to be regulated at the state level. These state regulators ensure that firms do not engage in these *per* se antitrust violations, either through regulation or through the states' own antitrust laws.

So what does this bill really do? It merely prohibits conduct that is already outlawed through state regulation, state antitrust law, or existing jurisprudential exemptions to the McCarran-Ferguson Act.

If this bill does nothing more than echo what the states have already outlawed, it begs the question, "what is this bill *intended* to do?"

For example, why are health and medical malpractice insurers singled out for McCarran-Ferguson repeal when neither type of insurance relies heavily on the historical data collection that is prevalent for other underwriters?

Is the bill intended to chill otherwise lawful, procompetitive behavior? Why are the terms price fixing, bid rigging, and market allocations not defined in this legislation? Why is health insurance defined, but medical malpractice insurance is not?

Are all insurers who are authorized to write medical malpractice insurance covered by this bill, even if they don't actually write any such insurance? Is this the beginning of a broader attempt to repeal McCarran-Ferguson for all insurance underwriters?

Doctors have complained about consolidation among health insurers and the complexities of antitrust law as it is applied to the practice of medicine, yet this bill does nothing to address those concerns.

Antitrust exemptions should be granted rarely and in as limited a way as necessary to meet a compelling goal. That said, when repealing an existing antitrust exemption, we must be very careful of the unintended consequences of our actions. It's doubtful that this legislation will do anything beneficial for the end customer.

Meanwhile, the growth of frivolous lawsuits against medical personnel creates real problems that should be addressed. According to a study by the Harvard School of Public Health, 40 percent of medical malpractice suits filed in the U.S. are "without merit."

So every doctor must purchase malpractice insurance at great expense to protect against frivolous lawsuits. A Department of Health and Human Services (HHS) study found that unlimited excessive damages add $70 billion to $126 billion annually to health care costs.

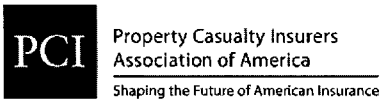
Doctors are so concerned about frivolous lawsuits that they order unnecessary — and expensive — tests and procedures that are of no benefit to the patient. HHS estimates the national cost of defensive medicine is more than $60 billion.

The costs of litigation and defensive medicine are then passed off to the patient in the price of health care.

That's why some states—including my home state of Texas—enacted tort reform to limit the amount of excessive damages awarded in frivolous suits. The result? Insurance premiums have fallen 30-40% and the availability of medical care has expanded. That means Texans pay less to have more options and better health care.

Rather than fiddling with legislative proposals that serve no purpose, Congress should take up tort reform—a proven and effective way to reduce health care costs. That is the type of health care reform that Congress should be considering.

I yield back the balance of my time.



Testimony
Property Casualty Insurers Association of America (PCI)

H.R. 3596, the "Health Insurance Industry Antitrust Enforcement Act of 2009"

Subcommittee on Courts and Competition Policy
Committee on the Judiciary
United States House of Representatives
October 8, 2009

The Property Casualty Insurers Association of America (PCI) is pleased to offer testimony on the impact of H.R. 3596, the Health Insurance Industry Antitrust Enforcement Act of 2009, which would amend the McCarran-Ferguson Act as it applies to health and medical malpractice insurers. PCI is the leading property-casualty trade association representing more than 1,000 insurers, the broadest cross-section of insurers of any national trade association. Our members are leading providers of home, auto and business insurance, including providing protection for doctors, hospitals and other medical providers against lawsuits for professional liability. Our testimony briefly highlights some of the unintended consequences that H.R. 3596 would have in reducing competition for consumers in the medical malpractice insurance market.

H.R. 3596 would expressly outlaw price fixing, bid rigging, and market allocations for health and medical malpractice insurers. However, the National Association of Insurance Commissioners (NAIC) opined on an earlier version of the bill several years ago that "no state insurance regulator has seen evidence that suggests medical malpractice insurers have engaged or are engaging in price fixing, bid rigging, or market allocation." We are not aware of any credible contrary evidence that would justify the amendments proposed in H.R. 3596.

H.R. 3596 is a solution in search of a problem and in fact would reduce competition by increasing trial lawyer suits and making it more difficult for insurers to enter into new markets or new insurers to be created.

Background on McCarran-Ferguson

The McCarran-Ferguson antitrust exemption was enacted by Congress in 1945 in response to a Supreme Court decision that preempted state control and governance of insurance. McCarran provides that:

> "No Act of Congress shall be construed to invalidate, impair or supersede any law enacted by any State for the purpose of regulating the business of insurance" (15 U.S.C. 1012(b), 1013(b) (1976)).

McCarran does not give insurers a blanket exemption from antitrust laws. In fact, every state has laws governing insurer information sharing and rates to foster a stable and competitive marketplace. Rather, Congress passed McCarran recognizing that insurance is a local issue with very different regional risks and tort laws, and that the states are better equipped to respond to local competitive needs than the federal government. In addition to state antitrust and insurance law, federal antitrust law will apply unless:

(1) The activity is the business of insurance,

(2) The activity is regulated by state law, and

(3) The activity does not involve boycott, coercion or intimidation.

Insurance is relatively unique in that it is one of the few industries that must price its product before it knows the costs of providing the products, which are known as "loss costs." Therefore, insurers must have a reliable way of projecting those loss costs in order to price their products in a sound manner. McCarran-Ferguson and the delegation of antitrust supervision of insurers to the states was enacted to facilitate the pooling of historical loss cost data necessary for sound underwriting, residual market mechanisms, risk pools, assessment allocation, forms uniformity, and a number of other areas that Congress and the

states have agreed promote competition. Many larger medical malpractice insurers, including many PCI members, do not rely heavily on industry-wide prospective loss costs to support their ongoing medical liability products because they write enough business to have a statistically significant base of information without need to use industry-wide data. However, start-ups and many medium and smaller insurers need such information on an ongoing basis. Even large insurers of any size seeking to enter new states, markets, classes of business, or product lines depend upon industry wide data that is available to them only because of the McCarran antitrust exemption. Repealing the McCarran antitrust delegation would affect the marketplace only by imposing a massive barrier to entry for new competition and smaller insurers, raising costs and further reducing choices for consumers.

Pooling of Loss Information Is Critical for Small Insurers to Compete

Many small and medium-sized "Main Street" insurers rely heavily on organizations such as the Insurance Services Office (ISO), which collect industry-wide data and develop prospective loss costs. This pooling of loss information enables these insurers to be able to more accurately predict their own projected costs, compete on coverage underwriting with an actuarially based price, and determine their necessary surplus to set aside for solvency. Without state governed loss pooling, insurers who do not dominate a particular market would have too little data to develop actuarially reliable rates, would have to charge consumers an extra risk premium, and would be more prone to insolvency. Research by the Wharton School of the University of Pennsylvania confirmed that repeal of McCarran Ferguson would likely reduce competition, increase the cost of insurance and reduce availability for some high-risk coverages, because the threat of antitrust litigation would make insurers unwilling to engage in efficiency-enhancing cooperative activities. [1]

[1] Patricia M. Danzon, the Wharton School of the University of Pennsylvania, *The McCarran Ferguson Act Anticompetitive or Procompetitive?*, Regulation - The Cato Review of Business and Government, 1991.

ISO also helps standardize coverage language to reduce legal uncertainty and enable consumers to compare policies and shop for rates. ISO and related statistical organizations do not publish joint rates – only prospective loss costs that are so critical for many insurers. Prospective loss costs are only one component of the final premium an insurer will charge – others include expenses, risk considerations, underwriting standards and the target rate of return. The Department of Justice has previously determined that ISO's activities fall within the McCarran-Ferguson exemption because it is part of the business of insurance regulated by state law.

Price fixing, bid rigging, and market allocations are generally illegal under state antitrust laws, but in any event, insurers do not use the McCarran-Ferguson antitrust exemption to engage in those anti-competitive practices. Insurers, including medical malpractice insurers, do use the exemption for the *pro-competitive* purpose for which the Congress adopted it in 1945, *i.e.*, to collect and use industry-wide prospective loss cost data that will assist them *not in price-fixing, but in making their own, independent actuarially sound decisions about pricing their products*. Abuses are not permitted under state insurance law. All states have laws governing rates and insurance conduct, generally prohibiting any rates that are excessive, inadequate, or unfairly discriminatory.

The McCarran antitrust exemption was particularly useful in helping to resolve the availability and affordability "crisis" that existed in the medical liability insurance market in the 1980s. In response to that, a number of doctor-owned mutual insurance companies were formed to provide medical liability coverage to the doctors who owned the companies. This helped fill the gap that had developed in the medical liability insurance market. But without aggregate loss information, many of the doctor-owned medical malpractice insurers would not have been able to enter the business when they were so sorely needed. And the absence of that aggregate data today would be a barrier to market entry for all new start-up insurers in the medical malpractice market. Over time, it could

threaten the small company franchise, prevent new entrants into the insurance industry, and have a chilling effect on the ability of existing insurers *of all sizes* to expand into new markets, classes of business, or new product lines.

Background on Medical Malpractice Insurance

According to the Congressional Research Service (CRS), most malpractice insurers are currently provider-owned companies.[2] In fact, the American Hospital Association has indicated that 40% of its member hospitals are self-insured. For physicians who cannot find coverage, many states have established joint underwriting residual markets, underwriting associations, and excess liability funds. CRS reports that 30 years ago, medical malpractice was largely provided by large diversified insurers. However, these providers were unable to obtain an adequate rate of return on capital and exited the marketplace. The remaining smaller insurers, and even geographically concentrated medium-sized insurers seeking to expand into additional markets, are now more reliant than ever on pooled loss information to increase competition.

Costs are Driven by Trial Lawyer Lawsuits

CRS listed as the top cause of increasing medical malpractice costs the "Tort System: 'Frivolous' Lawsuits and High Damage Awards", noting that insurance premiums have increased as a matter of course with claims from settlements and awards skyrocketing. CRS noted that a Joint Economic Committee study in 2003 reached the same conclusion that the tort system is the root of the problem, and that the Congressional Budget Office in 2004 cited "increased payments of claims as a major factor in driving medical malpractice insurance costs" (with other market forces also contributing).[3] A comprehensive Government Accountability Office (GAO) study found that "Increased losses on

[2] Congressional Research Service, *Medical Malpractice: An Overview*, RL 33358, May 5, 2006 (CRS).
[3] CRS, pp.11-12

claims are the primary contributor to higher medical malpractice premium rates."[4] GAO found that return on net worth for medical malpractice insurers declined precipitously from 1990 to 2001, generating significant and increasing net losses over time. GAO concluded that

> This declining profitability has caused some large insurers either to stop selling medical malpractice policies altogether or reduce the number they sell... [additional funds could be obtained] through capital markets, but even then, convincing investors to invest funds in medical malpractice insurance when profits are falling can be difficult.[5]

Since state laws reining in tort costs vary widely, GAO noted that medical malpractice loss experiences vary dramatically across their sampled states, with wide variations in premium rates, but that states are passing laws to reduce pressure on malpractice costs, mostly by "limiting the number of claims filed, the size of awards and settlements, and the time and costs associated with resolving claims."[6]

Conclusion

Because medical malpractice insurers do not engage in price fixing, bid rigging, or market allocations, adding an express prohibition on those practices to the existing McCarran exemption would have no benefit, but would pose a serious danger. Courts are likely to assume that the Congress passed the bill for a reason and might infer that the Congress intended to prohibit activities the exemption now protects – and the only things it protects now are the pro-competitive activities described above. Thus, by passing H.R. 3596, the Congress would jeopardize those pro-competitive activities, the absence of which could bar new entrants into the market and complicate the efforts of some existing medical malpractice insurers to price their products responsibly.

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[4] U.S. General Accounting Office, *Medical Malpractice Insurance, Multiple Factors Have Contributed to Increased Premium Rates*, p. 15 and 43, GAO-03-702, June 2003 (GAO).
[5] GAO, p.31
[6] GAO, Highlights and p.41.

Moreover, Section 3 of the bill would appear to single insurers out by denying to them standard antitrust defenses that are available to others, including the defense that actions undertaken pursuant to a state mandate are exempt from federal antitrust laws (state action doctrine).

The Congress is justifiably concerned about the rising cost of health care, and we share that concern. We are encouraged that President Obama recognized the role that medical malpractice costs play in increasing health care costs when he suggested a willingness to support tort reforms as part of the health insurance reform package now being considered in the Congress. He recognizes that our extraordinarily litigious society is contributing to spiraling health care costs and he has correctly identified the key elements – the practice of defensive medicine (increasing health care costs) and numerous malpractice suits and excessive awards (increasing insurance premiums, and thus health care costs). Reducing abusive litigation will help bring down insurance costs and will help ameliorate the impact those costs have on overall health care costs. Amending McCarran-Ferguson in a way that will jeopardize the pro-competitive activities that permit small and medium "Main Street" insurers to compete in the medical malpractice market and all insurers to enter new markets will have exactly the opposite effect on costs and consumer choice.

We appreciate the opportunity to offer our thoughts on the negative impact this bill could have on the medical malpractice insurance market, and we would be pleased to provide any further assistance the Subcommittee may require.

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PIAA Statement On Consumer Groups' Analysis of McCarran-Ferguson Repeal

Rockville, MD – October 30, 2009 – In response to recent claims by several consumer groups that the Health Insurance Industry Antitrust Enforcement Act (H.R. 3596) would result in, among other things, a 20 percent savings for doctors, Lawrence E. Smarr, president of the Physician Insurers Association of America (PIAA), issued the following statement:

"A recent analysis of the Health Insurance Industry Antitrust Enforcement Act of 2009 (H.R. 3596 and, by extension, its companion bill, S. 1681) by the Congressional Budget Office (CBO) has revealed that this legislation is in essence a politically motivated attempt to appease personal injury lawyers via a spurious bill.

Advocates for repealing the McCarran-Ferguson Act antitrust exemption for medical professional liability (MPL) insurers have made unsubstantiated claims of "price gouging" by the MPL insurance industry (ignoring the fact that the majority of doctors in the U.S. are insured by companies they own and/or operate—thus if they were "price gouging" they would be gouging themselves). McCarran-Ferguson opponents hail S. 1681/H.R. 3596 as the "silver bullet" for rising MPL premiums. If the government was able to prosecute allegations of "price fixing, bid rigging, or market allocations" within the MPL insurance industry, as the bill would allow, they claim premiums would fall 20 percent.

The CBO, however, views this legislation very differently. It noted, accurately, that MPL insurers are not engaged in any noncompetitive behaviors, and if they were they could already be prosecuted for such conduct, because, "states already bar the activities that would be prohibited under federal law if this bill was enacted." The CBO report went on to say that, in fact, "enacting the legislation would have no significant effect on the premiums that private insurers charge."

The CBO report hinges on one very important detail—a cogent definition of the prohibited activities. If normal definitions of "price fixing, bid rigging, or market allocations," are used, reason would dictate that such practices should be prosecuted (which is why states already prohibit such activities). If, however, regulators are given leeway to use makeshift definitions of the aforementioned terms (currently, the terms are completely undefined in the bill), that could lead to a proliferation of litigation against MPL insurers that are merely using legitimate data and methodologies for pricing their product. Thus, the lack of definition within the bills means there could be a major increase in legal expenses for MPL insurers, unforeseen by the CBO, which would eventually result in increased premiums for doctors, hospitals, and other healthcare providers—costs that would, in the end, get passed on to patients.

If the bill will have no effect on insurance industry practices, and could even lead to an increase in premiums for healthcare providers, why is Congress considering it? It may well be that this bill is essentially payback to the trial lawyers who have made large contributions to the campaigns of Congressional leaders and who have been alarmed to find that President Obama and others have suggested that medical liability reform should be included in the healthcare reform bill. They hope to scare insurers into abandoning efforts to reform a tort system that has allowed personal injury lawyers to reap large profits, while their clients take home a fraction of the settlements and awards they receive.

The CBO, on which Congressional leaders rely for unbiased analysis, has clearly stated that S. 1681 and H.R. 3596 will accomplish nothing. Congress should use that analysis to reject this legislation."

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The Physician Insurers Association of America (PIAA) is a leading insurer trade association, representing 70 domestic and international medical professional liability insurance companies owned and/or operated by physicians, hospitals, dentists, and other healthcare providers. PIAA domestic member companies include large national insurance companies, mid-size regional writers, single-state insurers, and specialty companies that serve specific healthcare-provider niche markets. Collectively, these companies provide insurance protection to more than 60% of America's private practice physicians, and write approximately 46% or $5.2 billion of the total industry premium. PIAA international members provide indemnification and other services to more than 400,000 healthcare professionals around the world and operate in eight countries. For more information, visit www.piaa.us.

American Insurance Association
Council of Insurance Agents and Brokers
The Financial Services Roundtable
Independent Agents & Brokers of America
National Association of Mutual Insurance Companies
National Association of Professional Insurance Agents
Physician Insurers Association of America
Property Casualty Insurers Association of America
Reinsurance Association of America

October 7, 2009

The Honorable John Conyers
Chairman
Committee on the Judiciary
U.S. House of Representatives
Washington, DC 20515

The Honorable Lamar Smith
Ranking Member
Committee on the Judiciary
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman and Congressman Smith:

The undersigned organizations represent all the segments of the property/casualty insurance industry, from primary insurers to agents, brokers, and reinsurers. We are writing to express our strong opposition to H.R. 3596 and S. 1681, identical bills introduced as the "Health Insurance Industry Antitrust Enforcement Act of 2009." These recently introduced bills would repeal long-standing provisions of the McCarran-Ferguson Act with respect to health and medical malpractice insurance (more appropriately called medical professional liability insurance) issuers. There is no demonstrated need to expand the scope of the healthcare reform debate in this fashion for the reasons below.

The McCarran-Ferguson Act, approved by Congress in 1945, entrusts states with the authority and responsibility for the regulation of the business of insurance. The McCarran-Ferguson Act creates a limited exemption from federal antitrust laws to the extent that the business of insurance – not the business of insurance companies – is regulated by the states; it does not grant insurers blanket immunity from federal antitrust laws, as some have erroneously suggested, and it does not shield insurers from laws that prohibit them from engaging in boycotts, intimidation, or coercion. Courts consistently have narrowly construed McCarran's limited antitrust exemption.

Under the regulatory regime that arose from the McCarran-Ferguson Act, more than 5,000 property/casualty insurers across the country are subject to a comprehensive and pervasive regimen of state-based regulation and antitrust enforcement, including health and medical professional liability insurance covered by H.R. 3596 and S. 1681. States regulate virtually every aspect of insurance, including licensing, market conduct, financial solvency, policy language and underwriting standards. Thus, federal action to repeal or amend the McCarran-Ferguson Act for these or any line of insurance is unnecessary to pursue any allegations of anti-competitive behavior.

Beyond the general disruption to the state regulatory system that these bills propose, the bills appear to have a much broader, but undisclosed agenda. For example:

Section 3 appears to expand the boundaries of antitrust violations in order to encourage attacks on insurers for marketplace behavior that would not otherwise be a violation of federal antitrust laws irrespective of McCarran-Ferguson.

Section 4 would have the effect of preempting or repealing state laws establishing mechanisms for insurers to gather information and develop actuarially-based rates through organizations that have been (i) created precisely for those purposes, (ii) are licensed and regulated by the states; and (iii) whose availability is critical to the states in carrying out their regulatory responsibilities. Thus, Section 4 would leave the states with only two options for health and medical malpractice insurance: they would either be required to set the prices themselves for health and medical malpractice insurance or be denied the right to have any mechanism for reviewing and regulating the prices established in the marketplace.

The bill appears designed to deny the affected insurers of standard antitrust defenses, such as the state action doctrine.

In short, the bill is an attempt to radically rewrite the antitrust laws for a certain segment of the insurance business.

We, therefore, urge you to oppose these current bills, as they would bring no consumer benefit while causing enormous marketplace disruption that might have the perverse effect of discouraging new marketplace entrants. It would be ironic indeed if the primary purpose of the federal antitrust laws – promoting competition – was undercut through enactment of either bill.

Sincerely,

Leigh Ann Pusey
President and CEO
American Insurance Association
(AIA)

Ken A. Crerar
President
The Council of Insurance Agents and Brokers
(CIAB)

Bob Rusbuldt
President and CEO
Independent Agents & Brokers
of America
(IIABA)

Steve Bartlett
President and CEO
The Financial Services Roundtable
(FSR)

Charles M. Chamness
President and CEO
National Association of Mutual
Insurance Companies
(NAMIC)

Dr. David A. Sampson
CEO
Property Casualty Insurers
Association of America
(PCIAA)

Len Brevik
Executive Vice President & CEO
National Association of
Professional Insurance Agents
(PIA)

Franklin W. Nutter
President
Reinsurance Association of
America
(RAA)

Lawrence E. Smarr
President
Physician Insurers Association
of America
(PIAA)

cc: Members of the House Judiciary Committee

America's Health
Insurance Plans

Karen Ignagni
President &
Chief Executive Officer

October 8, 2009

HAND DELIVERED

The Honorable Patrick Leahy
Chairman
Committee on the Judiciary
United States Senate
224 Dirksen Senate Office Building
Washington, DC 20510

The Honorable John Conyers
Chairman
Committee on the Judiciary
United States House of Representatives
2138 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Leahy and Chairman Conyers:

On behalf of America's Health Insurance Plans ("AHIP") and its member companies, we are writing regarding S. 1681 and H.R. 3596, both of which propose to repeal portions of the McCarran-Ferguson Act as they apply to health insurance plans and medical malpractice insurers.

In our view, the two bills under consideration may be based on a misperception of the scope and impact of the McCarran-Ferguson Act on health insurers. The Act does not preclude regulation of insurers but, instead, recognizes that the states play a central role in conducting oversight of health and other insurers. Indeed, the Congressional Research Service (CRS) recently noted that "[t]he McCarran-Ferguson Act prohibits the application of the antitrust laws and similar provisions of the FTC Act to the 'business of insurance' to the extent that it is regulated by state law."[1] In fact, health insurance is one of the most significantly regulated areas of the economy.

CRS also noted that "[t]he scope of the term 'business of insurance' has been narrowly construed by the Supreme Court to include only those activities involving the underwriting and spreading of insurance risk and the insurance companies' relationships with their policy holders." Given this narrow scope, it is inaccurate to describe the exemption as permitting anticompetitive conduct or mergers. CRS noted that "[t]he federal antitrust laws and FTC Act probably still

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apply to all other activities of insurance companies, including their attempts to merge and some of their negotiated agreements because the McCarran-Ferguson exemption is for the 'business of insurance,' not the 'business of insurers.'"

More generally, AHIP and our members stand on the side both of competition and of meaningful reform. We believe that the federal antitrust enforcement agencies can and do play a meaningful role in making health care markets more competitive, and we encourage initiatives to make them more effective in their missions. Similarly, we have endorsed comprehensive reform proposals for expanding coverage, improving quality, and slowing the growth rate of health care costs.

Thank you for your consideration of our thoughts on this issue. We would be happy to continue to discuss this and other issues with you.

Sincerely,

Karen Ignagni
President and CEO

Cc: The Honorable Jeff Sessions, Ranking Member, Committee on the Judiciary, United States Senate
The Honorable Lamar Smith, Ranking Member, Committee on the Judiciary, United States House of Representatives

[i] Congressional Research Service, Health Care Reform: Selected Antitrust Considerations (Aug. 31, 2009)

Mr. COBLE. And I yield back.

Mr. JOHNSON. I thank the gentleman for his statement.

And other Members' opening statements will be included in the record.

I am now pleased to introduce the witnesses for today's hearing. As you know, the health insurance trade association, or AHIP, has been invited to come before Congress and explain why health insurance companies need immunity from the antitrust laws. Although they declined to provide a witness, they have submitted a statement which will be introduced into the record.

I don't want to ruin the suspense for anyone, but they end up saying that they don't like our bill.

Our first witness is Mr. Jim Hurley on behalf of the American Association of Actuaries. Mr. Hurley has over 30 years of industry experience, with 25 of them in medical malpractice. Mr. Hurley is the former chairperson of AAA's subcommittee on medical professional liability.

Welcome, Mr. Hurley.

Our next witness will be Dr. Peter Mandell, former president of the California Orthopaedic Association. Dr. Mandell has practiced orthopedic surgery in the Bay Area for almost 30 years.

Welcome, Dr. Mandell.

Dr. MANDELL. Thank you, Mr. Chairman.

Mr. JOHNSON. Next, we have Ilene Knable Gotts, Chair of the American Bar Association's section of antitrust law. Ms. Gotts worked formerly as a staff attorney in the Federal Trade Commission's Bureau of Competition. She is currently working as a partner with the law firm of Wachtell Lipton Rosen & Katz.

Welcome, Ms. Gotts.

And finally, we have David Balto, Senior Fellow with the Center for American Progress. He has over 25 years of experience as an antitrust attorney in the private sector, the Antitrust Division of the Department of Justice and the Federal Trade Commission.

Welcome, Mr. Balto.

Thank you all for your willingness to participate in today's hearing. Without objection, your written statement will be placed into the record, and we would ask that you limit your oral remarks to 5 minutes.

You will note that we have a lighting system that starts with a green light. At 4 minutes, it turns to yellow, then red at 5 minutes. After each witness has presented his or her testimony, Subcommittee Members will be permitted to ask questions subject to the 5-minute limit.

And, Mr. Hurley, would you begin your testimony?

TESTIMONY OF JAMES D. HURLEY, MEMBER, MEDICAL PROFESSIONAL LIABILITY SUBCOMMITTEE, AMERICAN ACADEMY OF ACTUARIES, WASHINGTON, DC

Mr. HURLEY. Thank you, Mr. Chairman.

Chairman Johnson, Ranking Member Coble and distinguished Members of the Subcommittee, thank you for inviting me to testify today. My name is Jim Hurley. I am a consulting actuary with the firm Towers Perrin. I am an associate of the Casualty Actuarial Society and a member of the American Academy of Actuaries.

My work is primarily in the medical professional liability area as an actuary, and my comments will be from that perspective rather than from the health insurance perspective.

Before providing my comments, it is important to recognize the unique characteristics of medical professional liability coverage.

In comparison to other lines of insurance, medical professional liability is a low-frequency, high-severity, long-tailed coverage, meaning, on average, there is an extended period of time between the occurrence of an event, the report of a claim related to the event, and the ultimate resolution of the claim.

From a statistical standpoint, this makes the estimation of losses and premium rates is more uncertain than for other lines of insurance, such as most types of health insurance.

In the time allowed, I would like to comment on the bill's language and interpretations of it. More extensive comments are available in my submitted testimony.

The explicitly stated impact of the legislation would seem a nonevent on its face. The proposal states, in part, that nothing in the McCarran-Ferguson Act shall be construed to permit issuers of medical malpractice insurance to engage in any form of price fixing, bid rigging or market allocations.

My understanding is that engaging in these acts in the context of the proposed legislation is illegal pursuant to state laws enacted after implementation of the McCarran-Ferguson Act. And as such, in my experience, companies do not engage in collusive price fixing, bid rigging, or market allocation.

However, possible interpretations of the words "in any form" raise potential issues and consequences. In particular, it is possible that the words "in any form" as contained in the proposal could preclude the collection, aggregation and analysis of data across companies.

Currently, such analyses are permitted in accordance with the provisions of McCarran-Ferguson and with the oversight of state regulators.

Results of these analyses can be provided to companies that participate in the data collection or, perhaps, to other entities that may be given the opportunity to purchase that information.

Analyses of aggregated data serve several purposes, which align with the original intent of the McCarran-Ferguson Act and assist state regulators charged with overseeing the pricing of insurance coverage.

A few of these purposes are, one, these analyses provide more credible data upon which to base loss estimates and premium rates.

In the absence of this information, companies or self-insured entities would be forced to rely on their own more limited data to make loss or rate determinations. Reduced access to data could increase the volatility of these determinations from year to year.

Two, these analyses also serve to enhance competition. Without access to industry information, existing companies may be less willing to provide products in new markets or to cover different types of exposure because of the greater uncertainty associated with determining loss estimates and premium rates.

As further supports competition, industry information is of particular importance to newly formed companies or self-insurers looking to begin covering medical professional liability exposure.

Absent the use of information from the industry, they may be reluctant to assume or retain this exposure. Their decision not to provide coverage reduces competitive alternatives in the marketplace.

Such industry analyses serve as guidance for companies, self-insurers and regulators in reducing the likelihood of insolvencies, both a long-term and recent concern.

Through the review of the industry data, these entities are better able to evaluate if too little is being charged or not enough is being set aside in reserves for a given exposure situation.

These data aggregations serve the purposes outlined, particularly for medical professional liability, which has characteristics that make it a statistically challenging exposure for companies and self-insurers.

A couple of examples may help illustrate some of the challenges. One example is industry analyses can provide guidance to companies and self-insurers regarding reasonable charges for higher limits of coverage.

For instance, the experience of an individual company or self-insurer is probably not sufficient to estimate losses at $10 million or $20 million limits of coverage.

Additionally, a single entity's data would rarely be sufficient to determine the appropriate differentials among types of exposure. For example, what would be an equitable loss cost differential among a family practice physician, a general surgeon or an obstetrician?

There are a number of possible consequences of not having credible information to assist in making loss cost determinations. Insurance companies and self-insurers, in the interest of preserving their viability, would be more cautious, if not unwilling, to assume exposure given the risk of the coverage.

Thus, at the end of the—the end result relating to medical professional liability insurance companies is likely to be reduced availability with fewer willing insurers, less vigorous competition among those who do write the coverage, and higher costs to the consumer.

Self-insurers are likely to be less willing to retain exposure, reducing their risk financing options and possibly increasing their costs as well.

It is my understanding that one stated purpose of the proposed legislation is to reduce medical professional liability premiums. In my opinion, this change will not accomplish that purpose. In fact, it is more likely to have the opposite effect for the reasons I have outlined.

Additionally, medical professional liability losses and rates have been flat or declining in the last 2 to 3 years without the influence of this proposed change.

Attached to the written version of my testimony is an exhibit displaying rate change activity for the last 3 years, showing approximately 30 percent of the observations reflect rate reductions.

These trends occurred following the implementation of, and debate about, tort reforms in many states, as well as the growing impact of risk management and patient safety initiatives.

I thank you for this time and this opportunity to comment on the proposed legislation. I will be happy to answer any questions you have about these comments. Thank you.

[The prepared statement of Mr. Hurley follows:]

PREPARED STATEMENT OF JAMES D. HURLEY

AMERICAN ACADEMY *of* ACTUARIES

Subcommittee on Courts and Competition Policy
United States House of Representatives

Hearing on
H.R. 3596, the "Health Insurance Industry Antitrust Enforcement Act of 2009"

Statement of James D. Hurley, ACAS, MAAA
Medical Professional Liability Subcommittee
American Academy of Actuaries

October 8, 2009

The American Academy of Actuaries ("Academy") is a 16,000-member professional association whose mission is to serve the public on behalf of the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

Chairman Conyers, Ranking Member Smith, and members of the Subcommittee.

Thank you for inviting me to testify regarding H.R. 3596, the proposed Health Insurance Industry Antitrust Enforcement Act. My name is Jim Hurley. I am a consulting actuary with the firm Towers Perrin, working in the firm's Atlanta, GA office. I have worked for the Firm for approximately 25 years and am an Associate of the Casualty Actuarial Society and a Member of the American Academy of Actuaries. My work is primarily in the medical professional liability area and my comments will be from that perspective rather than from the health insurance perspective. Additionally, my comments will be from the perspective of someone who is frequently looking to estimate medical professional liability loss costs and, often, ultimately rates to be charged by insurance companies to insure such losses or for physicians and entities self-insuring their own medical professional liability exposure. In other words, my perspective is that of an actuarial practitioner actively working on medical professional liability problems daily.

Before providing my comments, it is important to recognize the unique characteristics of medical professional liability coverage. In comparison to other lines of insurance, medical professional liability is a low-frequency, high-severity, long-tailed coverage (meaning, on average, there is an extended period of time between the occurrence of an event, the report of a claim related to the event, and the ultimate resolution of the claim). From a statistical standpoint, this makes the estimation of losses and premium rates more uncertain than for other lines of insurance, such as most types of health insurance. The low-frequency, high-severity, long-tailed nature of medical professional liability coverage contributes to the volatility in its coverage rates. This uncertainty is one of the reasons the coverage is often written on a claims-made basis rather than occurrence basis like most other property/casualty coverages.

In the time allowed, I would like to comment on:

1. Concerns regarding the bill's language and possible misinterpretations;
2. Issues relating to data collection, aggregation and analysis of medical professional liability data; and
3. Some of the potential purposes and consequences of the proposed legislation.

From a practitioner's perspective, the explicitly stated impact of the legislation would seem a non-event on its face. The proposal states, in part, that nothing in the McCarran-Ferguson Act (the 'Act') shall be construed to permit….issuers of medical malpractice insurance to engage in any form of price fixing, bid rigging or market allocations. My understanding is that engaging in these acts in the context of the proposed legislation is illegal pursuant to state laws enacted after implementation of the McCarran-Ferguson Act. In my experience, companies do not engage in collusive price-fixing, bid-rigging, or market allocation. However, possible interpretations of the words 'in any form' raise potential issues and consequences.

In particular, it is possible that the words 'in any form' as contained in the proposal, could preclude the collection, aggregation, and analysis of data across companies.

Currently, such analyses are permitted in accordance with the provisions of the McCarran-Ferguson Act and with the oversight of state regulators. Results of these analyses can be provided to companies that participate in the data collection or, perhaps, to other entities that may be given the opportunity to purchase the information.

By way of background, in general, property/casualty insurance companies are required as a condition to being licensed to designate an entity to which they will report data. Probably the most well-known of these entities is Insurance Services Office (ISO). ISO is approved by the states to operate in this capacity as well as to analyze data and make results available to participants and others, subject to state regulations establishing the rules as to what types of analyses are permitted.

These analyses of aggregated data, or data aggregation serve several purposes, which align with the original intent of the Act and assist state regulators charged with overseeing the pricing of insurance coverage. A few of these purposes are:

1. These analyses provide more credible data upon which to base loss estimates and premium rates. In the absence of this information, companies or self-insured entities would be forced to rely on their own, more limited data to make loss or rate determinations. Reduced access to data could increase the volatility of these determinations from year to year as companies are forced to establish rates using less credible data.
2. These analyses also serve to enhance competition. Without access to industry information, existing companies may be less willing to provide products in new markets or to different types of exposure because of the greater uncertainty associated with determining loss estimates and premium rates.
3. As further support to competition, industry information is of particular importance to newly formed companies or self-insurers looking to begin covering medical professional liability exposure. Absent the use of industry information, they may be reluctant to assume or retain this exposure. Their decision not to provide coverage reduces competitive alternatives in the marketplace.
4. Such industry analyses serve as guidance for companies, self-insurers, and regulators in reducing the likelihood of insolvencies, a long-term and recent concern. Through the review of industry data, companies, self-insurers, and regulators are better able to evaluate if too little is being charged or not enough is being set aside in reserves for a given exposure situation.

These data aggregations serve the purposes outlined above, particularly for medical professional liability which, as suggested earlier, has characteristics that make it a statistically challenging exposure for companies and self-insurers. A few examples may help illustrate some of the challenges. For this coverage, any single company's own data, even for relatively large companies, is often not sufficiently credible to determine basic loss costs in multiple markets. Thus, a company writing a small amount of business in a given market may not have sufficiently credible data to estimate a stable and reliable loss cost for that jurisdiction. In another example, industry analyses can also provide guidance to companies and self-insurers regarding reasonable charges for higher limits of

coverage. For instance, the experience of an individual company or self-insurer is probably not sufficient to estimate losses at $10 million or $20 million limits of coverage. Additionally, a single entity's data would rarely be sufficient to determine the appropriate differentials among types of exposure. For example, what would be an equitable loss cost differential among a family practice physician, a general surgeon, and an obstetrician?

There are a number of possible consequences of not having credible information to assist in making loss cost determinations. Such entities, in the interest of preserving their viability, would be more cautious, if not unwilling, to assume exposure given the risk of the coverage. Remember, these industry analyses facilitate having such information available for new small companies, self-insurers, and large established entities looking to cover this exposure in new states.

Thus, the end result relating to medical professional liability insurance companies is likely to be reduced availability with fewer willing insurers, less vigorous competition among those that do write the coverage, and higher costs to the consumer. Self-insurers are likely to be less willing to retain exposure, reducing their risk financing options and possibly increasing their costs as well.

It is my understanding that one stated purpose of the proposed legislation is to reduce medical professional liability premiums. In my opinion, this change will not accomplish that purpose. In fact, it is more likely to have the opposite effect for the reasons I have outlined above.

Additionally, medical professional liability losses and rates have been flat or declining in the last two to three years without the influence of this proposed change. Attached to the written version of this testimony is an exhibit containing a graph obtained from the *Medical Liability Monitor*, which summarizes the results of their annual survey for the last three years. The graph shows the distribution of the percentage change in filed rates implemented by physician insurers and that, in the last three years, approximately 30% of the observations reflect rate reductions. These trends occurred following the implementation of, and debate about, tort reforms in many states as well as the growing impact of risk management and patient safety initiatives.

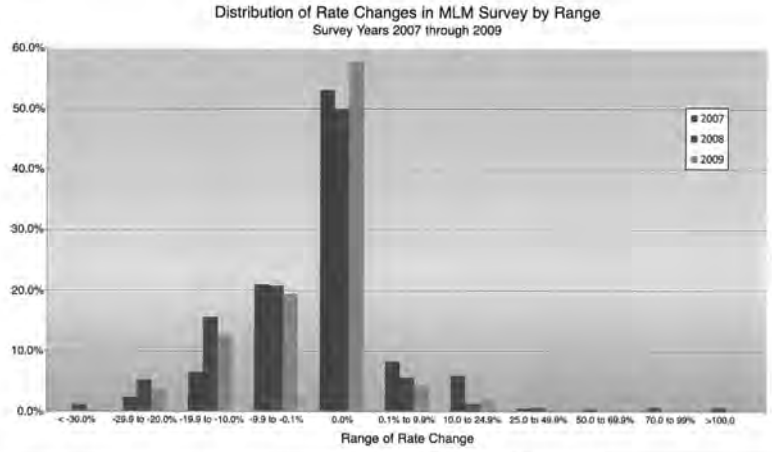
In summary, I note the following –

1. the broad intent of the proposal is already being effectuated at the state level;
2. clarification of other implications (e.g., data collection and analysis) of the bill would help affected parties better understand the impact of the change;
3. collection, aggregation, and analyses of data is an important element of the current environment; it supports better decisions, promotes competition, and aids in protecting solvency; particularly for new and/or smaller competitors;
4. consumers benefit from a more competitive marketplace given the above;
5. implementation of this proposal will not assure lower medical professional liability premiums; it may, in fact, increase them; and

6. medical professional liability rates have been declining without this change, coincidental with the timing of tort reforms, and the growing impact of risk management and patient safety initiatives.

Again, thank you for this opportunity to comment on the proposed legislation, and I will be happy to answer any questions you might have related to these comments.

Exhibit 1



METHODOLOGY

In this issue of the MEDICAL LIABILITY MONITOR, we bring you our 19th Annual Rate Survey. This survey provides a continuing overview of changing rates for physicians' liability insurance. It is a snapshot in time, reporting rates effective July 1, 2009.

It is a picture we paint state by state because where physicians practice largely determines the premiums they pay. This is because insurers base their rates on the aggregate claims experience in a particular geographic area.

Because state insurance departments may regulate rates, state tort reforms can affect the cost and patient compensation funds may influence the total premium, it is impossible to project a common national picture.

Each year we survey major writers of liability insurance for physicians. We ask for manual rates for specific mature claims-made specialties with limits of $1 million/$3 million, by far the most common limits. These are the rates reported unless otherwise noted.

We report on three specialties to reflect the wide range of rates charged: internal medicine, general surgery and obstetrics/gynecology.

With the exception of Medical Protective, all rates shown were volunteered by their respective companies. Medical Protective has historically opted not to participate in the Rate Survey; the company's rates published herein were obtained through independent research and believed to be accurate.

The rates reported should not be interpreted as the actual prelums an individual physician pays for coverage. They do not reflect credits, debits, dividends or other factors that may reduce or increase premiums. Rates reported also do not include other underwriting factors that can increase premiums.

States without compensation funds, by far the largest group, are reported first. Patient compensation fund states are grouped at the end of the survey.

In patient compensation fund states, physicians pay surcharges ranging from a modest percentage to more than the base premium. Also, limits of coverage can differ in these states, which is noted.

When we contact survey participants, we ask them to provide data on all the states in which they actively market to physicians. We only report rates for companies that maintain filed and approved rates for each state in which they sell physicians malpractice insurance. We try to capture the leading, active writers in each state, but every writer may not be included.

In comparing this year's report with previous reports, it will be evident that the market is always changing. Many companies, formerly included, no longer sell physicians' malpractice insurance in certain states, do not currently entertain new business, have withdrawn from this line of insurance or no longer exist. The companies shown were available for business July 1, 2009.

We estimate that this survey represents companies that comprise 65 to 75 percent of the market, and as such, is the most comprehensive report on medical liability rates anywhere.

The expanded rate report could not have been completed without the cooperation of the many people who work in the companies surveyed. Their cooperation is invaluable in providing this information to all who have an interest in this field.

Source: Medical Liability Monitor, October 2009 Vol 34, No 10

Mr. JOHNSON. Thank you, Mr. Hurley.
Dr. Mandell, please begin.

TESTIMONY OF PETER J. MANDELL, FORMER PRESIDENT, CALIFORNIA ORTHOPAEDIC ASSOCIATION, BURLINGAME, CA

Dr. MANDELL. Thank you, Mr. Chairman and Ranking Member Coble and the distinguished Members of the Committee.

The California Orthopaedic Association appreciates this opportunity to submit testimony to the Committee about H.R. 3596. We appreciate and support the Subcommittee's interest in this issue.

However, respectfully, we do raise some concerns about H.R. 3596, and I will briefly outline those for you. The handouts will go into greater detail.

We have consulted our antitrust experts and have failed to find any cases where commercial health insurers have been charged with price fixing, collusion or market allocation.

In fact, we believe the commercial health insurers moved past that business model many years ago and have little need to fix prices or allocate markets because they have done things in other ways, like consolidated to gain a larger share of the insurance market.

As you know, in the last decade, there have been over 400 health care mergers—health insurance mergers. The Payor market has become more concentrated, less divers. And payors have enjoyed substantial negotiating leverage over patients and providers in most markets.

The most recent data indicates that the two largest insurance companies actually control about 36 percent of the market and 67 million lives. And control is pretty much the right word for that in terms of their health care.

Instead of price fixing, we believe the larger problem is the virtual monopolies that commercial health insurers have. In many areas of the country, there may be only one or two carriers. There is no effective competition.

Physicians are told to take it or leave it with the contracts they are offered, and there is no—and accept below-market reimbursement. Patient coverages are also rescinded when they become ill. These inappropriate activities and decisions have been well documented in the media and also in these halls of Congress.

The power garnered by health insurers through rapid, large-scale consolidation has not been used to the advantage of patients. Premiums have soared, and many employers have stopped providing coverage, substantially limited or reduced the scope of benefits, or asked employees to pay higher shares of the premiums.

As far as we can see, the Federal Trade Commission and the Department of Justice have shown little interest in restricting additional mergers and no interest in addressing complaints of monopolization by dominant health insurers.

We would urge that the Subcommittee consider some real enforcement of merger laws and even break up the commercial insurers who have this virtual monopoly.

In addition, repeal of the antitrust protections afforded to commercial insurers under McCarran-Ferguson could have some negative impact on health care cooperatives such as those being discussed now in this Congress as a way of developing more care—delivering more care to individuals.

New companies would likely benefit from the antitrust protections under the act. Repealing the carriers' protections will make it more difficult for these small companies to gain market share and easier for the large companies to gobble them up once they are formed.

And finally, we ask the Subcommittee to reconsider the inclusion of medical liability carriers in this bill. In California, many of the medical liability carriers we currently have were created in the mid 1970's when we had our medical liability crisis. Many of them were doctor-formed.

In our opinion, they achieved the goals of availability, affordability and stability. We see no evidence that the medical liability carriers in our state share data or drop physicians from coverage. We would urge the medical liability carriers be excluded from this bill.

We thank you for this opportunity to talk to the Subcommittee today, and we appreciate your consideration of our comments and hope that we will be able to work with you and your staff further as this important effort continues.

[The prepared statement of Dr. Mandell follows:]

PREPARED STATEMENT OF PETER J. MANDELL

"Keeping You Active"

California
Orthopaedic
Association

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Statement

Of the

California Orthopaedic Association

to the

Judiciary Committee Subcommittee on Courts and Competition Policy
United States House of Representatives

RE: H.R. 3596

Health Insurance Industry Antitrust Enforcement Act of 2009

Presented by: Peter J. Mandell, M.D.

October 8, 2009

Statement
of the
California Orthopaedic Association

to the
Judiciary Subcommittee on Courts and Competition Policy
United States House of Representatives

RE: H.R. 3596 – "Health Insurance Industry Antitrust Enforcement Act of 2009

Presented by: Peter J. Mandell, M.D.
October 9, 2009

The California Orthopaedic Association (COA) represents over 75% of orthopaedic surgeons practicing in the state. Orthopaedic surgeons are integral to the health care delivery system treating patients with all types of musculoskeletal problems – hips, knees, shoulders, back, hands and wrists, and feet and ankles. As our population ages and as more individuals live longer active lifestyles, orthopaedic surgeons will become even more important in the management of musculoskeletal injuries and diseases through techniques such as joint replacement and ligament repair.

COA appreciates the opportunity to submit testimony before Chairman Johnson and other members of the Subcommittee on H.R. 3596, a bill which would remove anti-trust protections of health insurance issuers and medical liability carriers under the McCarran-Ferguson Act.

We appreciate and support the Subcommittee's interest in this issue; however, we respectfully would like to raise some concerns with H.R. 3596 as it is currently drafted.

We have consulted anti-trust experts and have failed to find any cases where the commercial health insurers have been charged with price-fixing or collusion in sharing price information. In fact, we believe the commercial health insurers moved past that business model many years ago and have little need to collude on pricing as they have consolidated and been able to control a larger part of the health insurance market.

In fact, during the last 10 years, there have been over 400 health insurer mergers. As a result, the payor market has become more concentrated, less diverse, and payors have enjoyed substantial negotiating leverage over patients and providers in most markets. For the last six years, the American Medical Association (AMA) has tracked and published a report entitled, "*Competition in Health Insurance: A Comprehensive Study of U.S. Markets.*" These reports have shown that the country's largest health insurers have continued to pursue aggressive acquisition strategies. The largest insurer, WellPoint, Inc. (formed from the merger of Anthem Inc. and WellPoint Health networks) has acquired 11 health insurers since 2000. The second-largest health insurer, UnitedHealth Group (United) has also acquired 11 health insurers since 2000.

To put this into perspective, in 2000, the two largest health insurers, Aetna and United, had a total membership of 32 million lives. As a result of mergers and acquisitions since 2000, the top two insurers in 2007, WellPoint and United, each have memberships, respectively, of 34 million and 33 million, totaling more than 67 million covered lives.

Together, WellPoint and United control 36 percent of the national market for commercial health insurers. *(AMA 2007, Competition in Health Insurance) (AMA Letter to the U.S. Assistant Attorney General for Antitrust, July, 2009)* In 2004 and 2005, 28 mergers valued at a total of $53.8 billion were completed or announced, which exceeded the value of all the deals completed in the previous eight years. (*Corporate Research Group, The Managed Care M&A Explosion, 2005).*

Instead of price fixing, we believe the larger problem is the virtual monopolies that the commercial health insurers have been able to form. In many areas of the country, there may be only one or two carriers in a particular region. There is no effective competition. Physicians are told to take-or-leave contracts and accept below market reimbursement rates. Patients' coverages are rescinded when they become ill and in most need of their insurance. These inappropriate activities and rescissions have been well documented in the media:

> "**Poizner: Blue Shield Canceled Policies – State Insurance Chief plans to pursue a $12.6 million fine for dropping patients**...Poizner accused a Blue Shield of California unit of committing more than 1,200 violations that resulted in some 200 people losing their medical insurance...Blue Shield was cancelling insurance after the fact...Blue Shield is the latest giant health plan caught in a state crackdown over policy cancellation practices. In recent years, consumer groups and regulators have contended that insurers wrongly revoked hundreds of policies after patients filed claims for costly medical care. Blue Cross of California, Health Net, Cigna, and Aetna have come under scrutiny." Sacramento Bee 12/2007
>
> "**Calif. Blue Cross Stops Asking Doctors About Patients' Omissions** .... Blue Cross of California said it would stop sending letters to doctors asking them to help find patients who had failed to report pre-existing medical conditions to the insurance company...Schwarzenegger said the practice is akin to telling doctors to "rat out the patients .....so they have a reason to cancel the policy"." Wall Street Journal, 2/2008
>
> **"Health Insurance Rescission Three Times More Likely Than Losing Russian Roulette**...every patient can be assured that, upon filing a major claim for chemotherapy or neurosurgery or the like, the insurance company will scour their medical records and application to find any excuse to deny coverage. The outrageous part is that **half** of these investigations of expensive claims result in rescission. Litigation and Trial, 8/2009
>
> In 2004 in California, Blue Cross and the State Compensation Insurance Fund (SCIF) joined together to control, at the time, over 50% of the Workers' Compensation market in the state and a large part of group health coverage. **SCIF demanded that physicians contract with Blue Cross in order to be part of their Workers' Compensation medical provider network and Blue Cross required that physicians accept all of their products or they were completely dropped from the Blue Cross network as well as the network of all their affiliates.** Blue Cross has over 300 affiliates. This joining of markets has allowed Blue Cross in California to demand below cost reimbursements that have little basis in the actual costs of rendering the care, but rather are designed to utilize their market control to artificially drive down reimbursement rates.

Even when Members of Congress demand that the carriers cease and desist their inappropriate rescission activities, commercial health insurers such as UnitedHealth, Assurant Health, and Wellpoint Blue Cross, say they will not.

> **"Insurers Not Committing to End Rescission**" A Congressional investigation into UnitedHealth, Assurant Health and Wellpoint Blue Cross found that they cancelled the coverage of more than 20,000 people in a five-year period, allowing the companies to avoid paying $300 million in claims. In spite of these findings, executives from these companies said that they would <u>not</u> pledge to limiting the practice of dropping coverage

to [only] cases of policy holders who lied or committed fraud to get policies. Wall Street Journal, 6/2009.

The power garnered by health insurers through rapid, large-scale consolidation has not been used to the advantage of consumers or providers. Patient premiums have soared in this increasingly consolidated market and physician reimbursement has decreased. As premiums have risen, many employers have stopped providing coverage, substantially limited or reduced the scope of benefits provided, and/or asked employees to pay a higher share of the overall premium.

Nor have physicians benefited from these premium increases. To the contrary, powerful insurers have depressed physician revenues. This reduction in physician income has not benefited patients, and indeed may have harmed them.

Health plan executives and shareholders, on the other hand, have reaped enormous monopoly profits. The bottom lines of the major national health firms experienced double-digit growth between 2001 and 2008. United and WellPoint, specifically, had 7 years of consecutive double-digit growth that ranged from 20% to 70% year after year through 2003. *(Health Affairs, Consolidation and the Transformation of Competition in Health Insurance)*

The Federal Trade Commission and the Department of Justice have shown little interest in restricting additional mergers and no interest in addressing complaints of monopolization by dominant health insurers.

To have a meaningful impact on the anti-competitive activities of commercial health insurers, we would urge members of the Subcommittee to relax the anti-trust restrictions on health care providers instead of removing the anti-trust protection on carriers. This would allow providers to collectively share electronic medical records to improve patient care, to monitor data relating to utilization and medical outcomes, to form accountable care organizations that add value to health care delivery, and to come together to work with commercial health insurers in their communities to ensure that patients receive appropriate medical care.

We would also urge the Subcommittee to consider some real enforcement of the merger laws and a break-up of the commercial health insurers who have these virtual monopolies.

We believe these activities, relaxing the anti-trust restrictions on providers and a break-up of the commercial health insurers' monopolies, would have a more meaningful impact on reining in the problems felt by patients and physicians in the commercial health care market.

In addition, a repeal of the anti-trust protections afforded to commercial insurance carriers under the McCarran-Ferguson Act, could have a negative impact on health care cooperatives that may be formed under the health care reforms being considered by Congress. New companies would likely benefit from anti-trust protections under the Act. Repealing the carriers' protections will make it more difficult for these small companies to gain market share. Passage of H.R. 3596 in its current form, could potentially protect even more the monopolies enjoyed by the existing commercial health insurers allowing them to continue their anti-competitive activities, which could be an unintended consequence of this legislation.

Finally, we oppose the inclusion of the medical liability carriers in this bill. In California, many of the medical liability carriers were created in the mid-1970s to bring stability, availability, and affordability to the medical malpractice market. In our opinion, they have achieved those goals without engaging in anti-competitive activities and price fixing. We see no evidence that medical liability carriers share data or drop physicians from coverage should malpractice claims be filed against them. We would urge that the medical liability carriers be excluded from the bill

Thank you for the opportunity to present these views to the Subcommittee.

We appreciate your consideration of our comments and we look forward to working with you and your staff in this important effort. If you have any questions or would like any additional information, please do not hesitate to contact Diane Przepiorski, Executive Director, California Orthopaedic Association, (916) 454-9884 or e-mail her at: coa1@pacbell.net.

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ADDENDUM 1

AMA
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Competition in health insurance

A comprehensive study of U.S. markets | **2007 update**

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AMA
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Competition in health insurance

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I. Overview

A. Introduction

This is the sixth edition (2007–2009) of the American Medical Association (AMA) publication "Competition in health insurance: A comprehensive study of U.S. markets." This year, the study includes metropolitan statistical area (MSA) information for 313 MSAs located in 44 states.[1]

The goal of the study is to identify problem markets where competition is diminished and to prompt discussion about the long-term impact of consolidated health insurance markets on the health care system and find solutions. As the AMA's summary of findings shows, in the majority of MSAs, a single health insurer dominates the market. Competition is undermined in hundreds of markets across the country.

The findings of this study need to be viewed in the context of recent health insurance market dynamics. Over the five years since the AMA's first study, the country's largest health insurers have continued to pursue aggressive acquisition strategies. The largest insurer, WellPoint Inc. (formed from the merger of Anthem Inc. and WellPoint Health Networks), has acquired 11 health insurers since 2000. The second-largest health insurer, UnitedHealth Group (United) has also acquired 11 health insurers since 2000.

To put this in perspective, in 2000, the two largest health insurers, Aetna and United, had a total membership of 32 million lives. As a result of mergers and acquisitions since 2000, the top two insurers today, WellPoint and United, each have memberships, respectively, of 34 million and 33 million, totaling more than 67 million covered lives. Together, WellPoint and United control 36 percent of the national market for commercial health insurance. In 2004 and 2005, 28 mergers valued at a total of $53.8 billion were completed or announced, which exceeded the value of all the deals completed in the previous eight years. (Corporate Research Group, The Managed Care M&A Explosion, 2005).

Observers predict that large health insurers will continue to acquire their smaller competitors. WellPoint's new chief executive officer stated in February that mergers will be one of the key drivers of WellPoint's future growth. Further, in March, United announced its proposed acquisition of Sierra Health Services, the largest health plan in Nevada. The AMA has asked the U.S. Department of Justice (DOJ) to block the merger, because if the merger is approved United will control 56 percent of the Nevada marketplace (compared with its current 11 percent market share).

While large health insurers have posted very healthy profits since 2000, premiums for consumers have increased without a corresponding increase in benefits. In fact, during the same time period, consumers have faced increased deductibles, co-payments and co-insurance. This has effectively reduced the scope of their health benefits coverage.

It is clear that patients—the ultimate consumers of health care—are not benefiting from these mergers. The AMA is concerned that the United States is heading toward a system dominated by a few publicly traded companies that operate in the interest of shareholders and not primarily in the interest of patients. It is time for lawmakers and regulators to take a serious look at the long-term negative impact of consolidated health insurance markets on the nation's health care system.

The impact of consolidated health insurance markets
The AMA has long been concerned about the impact of consolidated markets on patient care. The physician's role as patient advocate has never been more important. Physicians have a legal and ethical obligation to their patients. Health insurers' primary obligation is to their shareholders. The physician's role is being systematically undermined as dominant insurers are able to impose take-it-or-leave-it contracts that directly affect the provision of patient care and the patient-physician relationship. Physicians are the least-consolidated component in the health care industry. Most are in practices with four or fewer physicians[2] and simply have no negotiating power with health insurance behemoths.

The DOJ has recognized that monopsony power—which is the health insurer's power over purchase of physician services—is an important consideration in evaluating the competitiveness of health insurance markets. In the past 12 years, out of more than 400 mergers, the DOJ has challenged only two. Both of these challenges were based in large part on the health insurer's potential to exercise monopsony power over physicians to the detriment of patients. The DOJ's concern is whether a health insurer could use its market power to depress reimbursement rates in a manner that would "lead to a reduction in the quantity and quality of physician services provided to patients."[3]

In conducting its analyses of monopsony power, the DOJ focused on whether the physicians in the market could

terminate or threaten to terminate a health insurer contract without losing so much business that it would threaten the financial viability of their practices. The DOJ recognized that a physician practice is different from other businesses in terms of its ability to terminate contracts because a physician cannot replace lost business quickly. The DOJ noted that physicians are limited in their ability to encourage "patient switching" because the patient may not be able to switch to another employer-sponsored health plan in which the physician participates, or the option may not be available for many months.

In its 2005 challenge to the United/PacifiCare merger, the DOJ recognized that where a health plan accounts for more than 30 percent of a physician's practice revenue, the health insurer can have monopsony power to the detriment of patients. The DOJ also found that these percentages "can understate the importance to physicians of payments from commercial health insurance to compensate for the lower revenue earned from Medicare and Medicaid business."[4] Those physicians whose practices depend most heavily on patients covered by a particular health insurer are most vulnerable to unreasonable contracting terms and anti-competitive reimbursement rates.

This study shows unequivocally that many physicians in markets across the country do not have bargaining power with dominant health insurers and that many health insurers are in a position to exert monopsony power. In 299 of the 313 markets the AMA surveyed, one health plan accounts for at least 30 percent of the combined health maintenance organization (HMO)/preferred provider organization (PPO) market.[5]

Barriers to entry
The findings of the AMA market study also need to be viewed in light of the very substantial barriers to entering health insurance markets. Evaluating barriers to entry is critical to antitrust analysis. If entry is easy, even a high market share may not necessarily translate into market power. If entry is difficult or takes a number of years, then a health plan with a strong market position is more likely to be able to charge high prices without the threat of competition.

Entry into health insurance markets is difficult. Significant barriers to entry include state regulatory requirements, the cost of developing a health care provider network and the development of sufficient business to permit the spreading of risk. If entry into health insurance markets were easy, one would expect to see significant entry in response to the significant profits many health insurers have posted in the past five years. However, the opposite has occurred. There have been minimal new entrants into health insurance markets in the past five years. That large health insurers like WellPoint and United are acquiring existing health insurers in a market, as opposed to developing or expanding their own networks and products, is further evidence of substantial barriers to entry.

Conclusion
The AMA believes it is time to re-examine the legal landscape that has resulted in unfettered consolidation of health insurance markets. If not corrected, the imbalances in the marketplace will have serious negative long-term consequences for the health care system.

B. Geographic and product market definitions

To determine market shares, it is necessary to begin by defining the relevant market in each of two dimensions: the product market and the geographic market. A "product market" is defined to include all products that purchasers view as reasonable substitutes for the product in question. There is little evidence regarding substitutability of various forms of health insurance and no consensus about whether some products are substitutable for others. Therefore, the AMA looked at HMOs and PPOs as separate product markets and then at a combined HMO/PPO product.

After determination of the relevant product market, the second element in market definition is a determination of the geographic area where the market participants operate. The "geographic market" is the area to which consumers can practically turn for alternative products if a competitor increases price.

The realities of the delivery of health care, as well as the marketing and other business practices of health insurers, lead to a conclusion that health insurance markets are local. From the standpoint of the market for health insurance, most sellers (insurers) market locally, for the obvious reason that purchasers (employers) are interested in purchasing health insurance products that will service their employees in proximity to where they work and live. The goal of this study was to present data at the local level. The data allow the AMA to present market share and market concentration information for 313 MSAs (as defined by the U.S. Census Bureau) in 44 states.

C. Data sources

This edition reports the separate HMO and PPO product markets and the combined HMO/PPO product market. Calculations of commercial health insurer HMO and PPO market shares are based on enrollment information reported by health insurers. All of the data presented are based on

actual reported lives. All of the geographic markets are MSAs as defined by the U.S. Census Bureau.

1. HMO data

The HMO enrollment information used for this study was obtained from InterStudy's Managed Market MSA Surveyor and Managed Market State Surveyor. The InterStudy databases provide Jan. 1, 2005, HMO enrollment data for all 50 states, Washington, D.C., and each MSA in the country. InterStudy sends a written survey to health insurance plans requesting their HMO enrollment at the state and county levels. Since MSAs are defined by the U.S. Census Bureau as aggregates of counties, InterStudy adds HMO survey results from county-level data to obtain MSA figures. To the extent that HMOs fail to report their enrollment, InterStudy supplements the survey with public information.

2. PPO data

The PPO enrollment information used in this study was obtained from InterStudy and HealthLeaders. InterStudy's Managed Market MSA Surveyor and Managed Market State Surveyor provides Jan. 1, 2005, PPO enrollment for all 50 states, Washington, D.C., and each MSA in the country. InterStudy sends a written survey to health insurers requesting their PPO enrollment at the state and county levels. Since MSAs are defined by the U.S. Census Bureau as aggregates of counties, InterStudy adds PPO survey results from county-level data to obtain MSA figures.

HealthLeaders provides PPO enrollment information in its Jan. 1, 2005, database for 19 states and more than 50 MSAs. HealthLeaders also uses a written survey to obtain health insurance plan enrollment at the state and county levels. To the extent that health insurers failed to report their PPO information to InterStudy, the HealthLeaders' data were incorporated into the study.

With both HMO and PPO data, in some MSAs there were inconsistencies in the data that prevented inclusion of those MSAs in the study. For example, a single plan may have reported covered lives in excess of the total available commercial lives in the area. The AMA worked with state medical associations to identify these markets.

D. Methodology

Definition of market share
"Market share" identifies the shares of specific firms within a market. This study measures market shares of health insurers by enrollment. The combined HMO/PPO market share of an insurer is the sum of that insurer's HMO and PPO enrollment, divided by the total HMO and PPO enrollment in the market, multiplied by 100. HMO market share is that HMO's enrollment, divided by total HMO enrollment in the market, multiplied by 100. Similarly, a PPO's market share is that PPO's enrollment, divided by total PPO enrollment in the market, multiplied by 100.

Definition of HHI
The Herfindahl-Hirschman Index (HHI) of competition is a measure of the competitiveness of a market overall. It is not a measure specific to any one insurer, though it is a function of each insurer's market share. The DOJ uses the HHI when evaluating the impact of a merger or acquisition on the competitiveness of a market. The HHI is the most appropriate measure of market concentration.

The HHI is the sum of the squared market shares of each firm in the market. The more competitive the market, the lower the HHI. The less competitive the market, the higher the HHI. The largest value the HHI can take is 10,000 when there is a single insurer in the market. If a market has four firms, each with a 25 percent share, the HHI for that market would be:

$$25^2 + 25^2 + 25^2 + 25^2 = 2{,}500$$

If the number of firms in a market increased, but they all had an equal market share, the HHI would decrease. For instance, if a fifth firm were added in the above example, so that each firm had a 20 percent market share, the HHI would fall from 2,500 to 2,000. Alternatively, if the number of firms falls to three, each with a third of the market, the HHI would increase to 3,333.

This report presents HHIs for a combined HMO/PPO product market and separate HMO and PPO product markets.

ERISA plans
Many employers provide health insurance coverage to employees through self-insured Employee Retirement Income Security Act (ERISA) plans, and many of them retain an insurance firm to administer these plans. If the administrator of a self-insured plan is a health insurer surveyed by InterStudy, then its covered lives are included in this study. If the self-insured ERISA plans are self-administered by the employer, they are not reflected in these data sets.

Double-counting PPO covered lives
A number of entities, typically referred to as "rental network PPOs," have entered into contractual relationships with in-

surers either for PPO plan administration (actuarial services and claims administration) or for use of provider networks. These entities do not provide insurance coverage. Sometimes these entities report PPO "covered lives" to InterStudy. This results in those lives being reported twice. To avoid potential "double counting" of PPO lives, the AMA identified these entities and removed those that it determined did not provide health insurance coverage in the specific geographic markets.

2005 health insurer mergers
Although the enrollment information reported by insurers to InterStudy and HealthLeaders are dated Jan. 1, 2005, there were several significant health insurer mergers or acquisitions completed in 2005. Market data has been adjusted to reflect UnitedHealth Group Inc.'s acquisitions of PacifiCare Health Systems and John Deere Health Plan Inc.

HHI analysis
The 1997 Federal Trade Commission (FTC)/DOJ Horizontal Merger Guidelines (1997 Merger Guidelines) define market concentration as measured by the HHI as follows:

- Markets with an HHI less than 1,000 are "not concentrated." The DOJ and FTC will generally not restrict merger activity in markets where the post-merger HHI is less than 1,000.
- Markets with an HHI between 1,000 and 1,800 are "concentrated." Under the 1997 Merger Guidelines, a merger in these markets that raises the HHI by more than 100 points may raise significant competitive concerns.
- Markets with an HHI above 1,800 are "highly concentrated." Under the 1997 Merger Guidelines, a merger in these markets that raises the HHI by more than 50 points may raise significant competitive concerns, and mergers that raise the HHI more than 100 points are presumed to be anti-competitive.

Under the 1997 Merger Guidelines, barriers to market entry and other qualitative factors are also considered to determine whether it is likely that a merger will result in market power for the merged entity.

II. Summary of findings

Tables 1–3 illustrate the market concentration (HHI) and the market shares of the two largest insurers for 313 MSAs and 44 states by product market. Table 4 provides a summary of HHIs by product by state and MSA.

A. Metropolitan areas

This edition of the study analyzed 313 MSAs. This compares with 292 metropolitan areas in the 2005 study, 84 in the 2003 study, 70 in the 2002 study, and 40 in the 2001 study.

In terms of market concentration (HHI), the study found the following:

- In the combined HMO/PPO product market, 96 percent (299) of the MSAs are highly concentrated (HHI>1,800), applying the 1997 Merger Guidelines.
- In the HMO product market, 99 percent (309) of the MSAs are highly concentrated (HHI>1,800), applying the 1997 Merger Gutdelines.
- In the PPO product market, 100 percent (313) of the MSAs are highly concentrated (HHI>1,800), applying the 1997 Merger Guidelines.

B. Market share

In terms of market share of individual insurers, the study found the following for each product market:

HMO/PPO product market

- In 96 percent (299) of the MSAs, at least one insurer has a combined HMO/PPO market share of 30 percent or greater.
- In 64 percent (200) of the MSAs, at least one insurer has a combined HMO/PPO market share of 50 percent or greater.
- In 24 percent (74) of the MSAs, at least one insurer has a combined HMO/PPO market share of 70 percent or greater.
- In 5 percent (15) of the MSAs, at least one insurer has a combined HMO/PPO market share of 90 percent or greater

HMO product market

- In 98 percent (306) of the MSAs, at least one insurer has a HMO market share of 30 percent or greater.
- In 64 percent (201) of the MSAs, at least one insurer has a HMO market share of 50 percent or greater.
- In 37 percent (117) of the MSAs, at least one insurer has a HMO market share of 70 percent or greater.
- In 16 percent (49) of the MSAs, at least one insurer has a HMO market share of 90 percent or greater.

PPO product market

- In 97 percent (304) of the MSAs, at least one insurer has a PPO market share of 30 percent or greater.
- In 76 percent (238) of the MSAs, at least one insurer has a PPO market share of 50 percent or greater.
- In 36 percent (112) of the MSAs, at least one insurer has a PPO market share of 70 percent or greater.
- In 9 percent (28) of the MSAs, at least one insurer has a PPO market share of 90 percent or greater.

III. State and MSA tables

Table 1. Combined HMO/PPO product markets HHI market concentration and dominant insurers

State and MSAs	HMO/PPO HHI	Insurer 1	Share	Insurer 2	Share
Alabama	6,881	BCBS AL	83	Health Choice	5
Anniston–Oxford, AL	8,809	BCBS AL	94	NAMCI	2
Auburn–Opelika, AL	9,071	BCBS AL	95	CIGNA	1
Birmingham–Hoover, AL	5,373	BCBS AL	72	Health Choice	13
Decatur, AL	8,139	BCBS AL	90	Health Choice	4
Dothan, AL	9,080	BCBS AL	95	NAMCI	2
Florence, AL	8,849	BCBS AL	94	UnitedHlthcare	2
Gadsden, AL	9,065	BCBS AL	95	NAMCI	2
Huntsville, AL	8,879	BCBS AL	94	UnitedHlthcare	2
Mobile, AL	5,897	BCBS AL	76	Gulf Hlth Plan	10
Montgomery, AL	7,978	BCBS AL	89	UnitedHlthcare	4
Tuscaloosa, AL	5,293	BCBS AL	67	Aetna	29
Alaska	4,907	Premera BC	60	Aetna	35
Anchorage, AK	4,660	Premera BC	54	Aetna	42
Fairbanks, AK	9,202	Premera BC	96	Mutual of Omaha	3
Arizona	2,679	BCBS AZ	43	UnitedHlthcare	22
Flagstaff, AZ	2,162	Health Net	30	CIGNA	28
Phoenix–Mesa–Scottsdale, AZ	2,929	BCBS AZ	47	UnitedHlthcare	22
Prescott, AZ	2,809	Aetna	41	CIGNA	30
Tucson, AZ	2,676	BCBS AZ	38	UnitedHlthcare	28
Yuma, AZ	3,464	CIGNA	48	Aetna	31
Arkansas	5,765	BCBS AR	75	UnitedHlthcare	6
Fayetteville–Springdale–Rogers, AR–MO	6,877	BCBS AR	83	Aetna	6
Fort Smith, AR–OK	5,090	BCBS AR	68	UnitedHlthcare	19
Hot Springs, AR	4,515	BCBS AR	63	UnitedHlthcare	22
Jonesboro, AR	7,893	BCBS AR	89	CIGNA	5
Little Rock–North Little Rock, AR	6,021	BCBS AR	77	UnitedHlthcare	9
Pine Bluff, AR	6,561	BCBS AR	80	UnitedHlthcare	7
Texarkana, TX–Texarkana, AR	9,400	BCBS AR	97	WellPoint Inc.	2
California	1,524	Kaiser	24	WellPoint Inc.	20
Bakersfield, CA	4,496	UnitedHlthcare	65	WellPoint Inc.	11
Chico, CA	2,615	BS of CA	39	WellPoint Inc.	25
El Centro, CA	2,277	BS of CA	35	CA Foundation for Medical Care	24
Fresno, CA	1,850	WellPoint Inc.	31	BS of CA	19
Hanford–Corcoran, CA	4,238	Aetna	62	WellPoint Inc.	15
Los Angeles–Long Beach–Glendale, CA	1,778	WellPoint Inc.	27	Kaiser	24
Madera, CA	2,398	Aetna	38	BS of CA	21
Merced, CA	2,027	Aetna	30	WellPoint Inc.	25
Modesto, CA	1,473	WellPoint Inc.	23	BS of CA	17
Napa, CA	2,998	Kaiser	47	BS of CA	22
Oakland–Fremont–Hayward, CA	2,671	Kaiser	46	BS of CA	15
Oxnard–Thousand Oaks–Ventura, CA	1,790	WellPoint Inc.	30	BS of CA	23
Redding, CA	2,414	BS of CA	31	WellPoint Inc.	28
Riverside–San Bernardino–Ontario, CA	1,514	Kaiser	24	WellPoint Inc.	17
Sacramento–Arden-Arcade–Roseville, CA	2,059	Kaiser	36	BS of CA	21
Salinas, CA	2,701	WellPoint Inc.	40	CA Foundation for Medical Care	25
San Diego–Carlsbad–San Marcos, CA	1,393	Kaiser	24	WellPoint Inc.	14

Table 1. (continued) **Combined HMO/PPO product markets HHI market concentration and dominant insurers**

State and MSAs	HMO/PPO HHI	Insurer 1	Share	Insurer 2	Share
San Francisco–San Mateo–Redwood City, CA	1,944	Kaiser	34	BS of CA	21
San Jose–Sunnyvale–Santa Clara, CA	1,574	Kaiser	26	Aetna	19
San Luis Obispo–Paso Robles, CA	2,325	WellPoint Inc.	34	BS of CA	22
Santa Ana–Anaheim–Irvine, CA	1,650	WellPoint Inc.	27	BS of CA	21
Santa Barbara–Santa Maria, CA	2,024	WellPoint Inc.	30	BS of CA	26
Santa Cruz–Watsonville, CA	1,738	WellPoint Inc.	25	BS of CA	24
Stockton, CA	1,560	Kaiser	25	BS of CA	20
Vallejo–Fairfield, CA	4,295	Kaiser	63	BS of CA	13
Visalia–Porterville, CA	2,002	WellPoint Inc.	30	Aetna	23
Yuba City–Marysville, CA	3,030	Aetna	47	WellPoint Inc.	23
Colorado	1,828	WellPoint Inc.	29	UnitedHlthcare	24
Boulder, CO	1,937	UnitedHlthcare	33	Kaiser	17
Colorado Springs, CO	1,706	UnitedHlthcare	25	WellPoint Inc.	24
Denver–Aurora, CO	2,033	WellPoint Inc.	30	UnitedHlthcare	24
Fort Collins–Loveland, CO	2,157	UnitedHlthcare	32	WellPoint Inc.	27
Grand Junction, CO	4,014	Rocky Mountain	60	WellPoint Inc.	17
Pueblo, CO	5,870	WellPoint Inc.	76	CIGNA	5
Connecticut	3,398	WellPoint Inc.	55	Health Net	11
Bridgeport–Stamford–Norwalk, CT	3,256	WellPoint Inc.	51	Health Net	17
Danbury, CT	2,983	WellPoint Inc.	48	Health Net	16
Hartford–West Hartford–East Hartford, CT	4,316	WellPoint Inc.	63	UnitedHlthcare	14
Delaware	2,789	CareFirst BCBS	42	Coventry	23
Dover, DE	3,787	BCBS DE	55	Coventry	25
Wilmington, DE–MD–NJ	2,252	Aetna	31	BCBS DE	28
Florida	1,522	BCBS FL	30	Aetna	15
Cape Coral–Fort Myers, FL	2,690	BCBS FL	43	Aetna	27
Deltona–Daytona Beach–Ormond Beach, FL	2,130	BCBS FL	34	Florida Hlth Care Plans	26
Fort Walton Beach–Crestview–Destin, FL	4,688	BCBS FL	66	All Florida PPO	16
Gainesville, FL	3,890	BCBS FL	60	AvMed Hlth Plan	12
Jacksonville, FL	2,972	BCBS FL	48	Aetna	24
Lakeland–Winter Haven, FL	2,422	BCBS FL	45	Aetna	12
Miami–Miami Beach–Kendall, FL	1,568	UnitedHlthcare	27	Dimension Health Inc.	20
Naples–Marco Island, FL	4,778	BCBS FL	67	All Florida PPO	16
Ocala, FL	3,998	BCBS FL	61	All Florida PPO	14
Orlando–Kissimmee, FL	1,621	BCBS FL	29	UnitedHlthcare	16
Palm Bay–Melbourne–Titusville, FL	2,103	BCBS FL	32	Health First Hlth	24
Panama City–Lynn Haven, FL	4,528	BCBS FL	65	All Florida PPO	16
Pensacola–Ferry Pass–Brent, FL	5,192	BCBS FL	71	All Florida PPO	12
Port St. Lucie–Fort Pierce, FL	3,693	BCBS FL	53	Humana	28
Punta Gorda, FL	4,570	BCBS FL	66	All Florida PPO	11
Sarasota–Bradenton–Venice, FL	4,216	BCBS FL	63	Aetna	10
Vero Beach, FL	3,834	BCBS FL	59	All Florida PPO	15
West Palm Beach–Boca Raton–Boynton Beach, FL	1,851	UnitedHlthcare	27	BCBS FL	23
Georgia	3,874	WellPoint Inc.	61	UnitedHlthcare	8
Albany, GA	6,083	Phoebe Hlth Partners	77	HealthOne	5
Athens–Clarke County, GA	5,962	WellPoint Inc.	76	Athens Hlth Plan	9
Atlanta–Sandy Springs–Marietta, GA	3,483	WellPoint Inc.	56	Aetna	10

State and MSAs	HMO/PPO HHI	Insurer 1	Share	Insurer 2	Share
Augusta–Richmond County, GA–SC	4,736	WellPoint Inc.	65	BCBS SC	22
Columbus, GA–AL	2,582	WellPoint Inc.	41	BCBS AL	21
Gainesville, GA	4,522	WellPoint Inc.	66	Aetna	11
Hinesville–Fort Stewart, GA	5,151	WellPoint Inc.	70	CIGNA	11
Macon, GA	6,671	WellPoint Inc.	81	Secure Hlth Plan	5
Rome, GA	3,484	WellPoint Inc.	52	UnitedHlthcare	26
Savannah, GA	7,964	WellPoint Inc.	89	CIGNA	4
Warner Robins, GA	6,009	WellPoint Inc.	77	UnitedHlthcare	7
Hawaii	6,454	BCBS HI	78	Kaiser	20
Honolulu, HI	6,665	BCBS HI	79	Kaiser	19
Idaho	3,186	BC of ID	46	Regence BS	29
Boise City–Nampa, ID	3,887	BC of ID	58	Primary Hlth	18
Coeur d'Alene, ID	3,942	BC of ID	59	Primary Hlth	16
Idaho Falls, ID	4,595	BC of ID	63	Primary Hlth	22
Lewiston, ID–WA	3,101	BC of ID	40	Regence BS	36
Pocatello, ID	4,571	BC of ID	63	Primary Hlth	22
Illinois	2,837	HCSC (BCBS)	47	WellPoint Inc.	22
Bloomington–Normal, IL	5,900	HCSC (BCBS)	75	WellPoint Inc.	12
Champaign-Urbana, IL	3,651	HCSC (BCBS)	50	Coventry	33
Chicago–Naperville–Joliet, IL	3,013	HCSC (BCBS)	51	WellPoint Inc.	12
Danville, IL	3,930	HCSC (BCBS)	57	CIGNA	19
Decatur, IL	3,618	HCSC (BCBS)	55	Coventry	20
Kankakee–Bradley, IL	2,447	HCSC (BCBS)	40	UnitedHlthcare	19
Lake County–Kenosha County, IL–WI	3,258	HCSC (BCBS)	53	UnitedHlthcare	14
Peoria, IL	3,459	HCSC (BCBS)	55	John Deere (UnitedHlthCare)	15
Rockford, IL	4,214	HCSC (BCBS)	60	CIGNA	22
Springfield, IL	3,912	HCSC (BCBS)	58	Coventry	17
Indiana	3,910	WellPoint Inc.	60	M*Plan (HlthCare Grp)	15
Anderson, IN	5,448	WellPoint Inc.	72	UnitedHlthcare	15
Bloomington, IN	3,847	Aetna	55	WellPoint Inc.	27
Columbus, IN	3,943	WellPoint Inc.	54	Aetna	31
Elkhart–Goshen, IN	4,893	WellPoint Inc.	68	CIGNA	12
Evansville, IN–KY	5,387	HCSC (BCBS)	71	WellPoint Inc.	15
Fort Wayne, IN	3,475	WellPoint Inc.	52	Lutheran Preferred	23
Gary, IN	5,251	HCSC (BCBS)	68	WellPoint Inc.	24
Indianapolis, IN	4,827	WellPoint Inc.	68	UnitedHlthcare	9
Lafayette, IN	2,544	PhyCor	34	WellPoint Inc.	33
South Bend–Mishawaka, IN–MI	4,086	HCSC (BCBS)	57	WellPoint Inc.	26
Iowa	5,170	Wellmark	71	John Deere (UnitedHlthCare)	9
Ames, IA	6,173	Wellmark	77	John Deere (UnitedHlthCare)	17
Cedar Rapids, IA	6,171	Wellmark	78	John Deere (UnitedHlthCare)	7
Davenport–Moline–Rock Island, IA–IL	3,407	HCSC (BCBS)	52	John Deere (UnitedHlthCare)	22
Des Moines, IA	4,554	Wellmark	64	Coventry	16
Iowa City, IA	6,359	Wellmark	79	John Deere (UnitedHlthCare)	7
Sioux City, IA–NE–SD	6,089	Wellmark	77	UnitedHlthcare	13
Waterloo–Cedar Falls, IA	4,569	Wellmark	64	John Deere (UnitedHlthCare)	21

Table 1. (continued) **Combined HMO/PPO product markets HHI market concentration and dominant insurers**

State and MSAs	HMO/PPO HHI	Insurer 1	Share	Insurer 2	Share
Kentucky	3,772	WellPoint Inc.	59	Health Partners	10
Bowling Green, KY	6,495	WellPoint Inc.	79	Center Care Hlth Benefit Programs	17
Elizabethtown, KY	4,941	WellPoint Inc.	66	Aetna	24
Lexington–Fayette, KY	2,683	UnitedHlthcare	40	Center Care Hlth Benefit Programs	28
Louisville, KY–IN	3,197	WellPoint Inc.	51	Aetna	14
Owensboro, KY	5,914	HCSC (BCBS)	73	WellPoint Inc.	26
Louisiana	3,984	BCBS LA	61	UnitedHlthcare	13
Alexandria, LA	5,424	BCBS LA	71	Humana	14
Baton Rouge, LA	4,861	BCBS LA	67	UnitedHlthcare	15
Houma–Bayou Cane–Thibodaux, LA	3,853	BCBS LA	57	Aetna	18
Lafayette, LA	7,223	BCBS LA	85	Humana	8
Lake Charles, LA	5,034	BCBS LA	68	UnitedHlthcare	15
Monroe, LA	3,993	BCBS LA	59	Vantage Hlth	15
New Orleans–Metairie–Kenner, LA	3,013	BCBS LA	49	Aetna	15
Shreveport–Bossier City, LA	2,515	BCBS LA	35	UnitedHlthcare	24
Maine	6,219	WellPoint Inc.	78	Aetna	10
Bangor, ME	6,809	WellPoint Inc.	82	Aetna	8
Lewiston–Auburn, ME	6,719	WellPoint Inc.	74	Aetna	14
Portland–South Portland, ME	6,216	WellPoint Inc.	78	CIGNA	9
Maryland	3,302	CareFirst BCBS	52	UnitedHlthcare	19
Baltimore–Towson, MD	4,595	CareFirst BCBS	66	UnitedHlthcare	12
Bethesda–Gaithersburg–Frederick, MD	2,160	UnitedHlthcare	34	CareFirst BCBS	22
Cumberland, MD–WV	3,385	CareFirst BCBS	43	UnitedHlthcare	38
Hagerstown–Martinsburg, MD–WV	3,043	CareFirst BCBS	46	UnitedHlthcare	26
Salisbury, MD	4,727	CareFirst BCBS	65	UnitedHlthcare	20
Massachusetts	3,128	BCBS MA	50	Tufts	17
Barnstable Town, MA	4,474	BCBS MA	53	Harvard Pilgrim	21
Boston–Cambridge–Quincy, MA–NH	3,012	BCBS MA	46	Harvard Pilgrim	20
Brockton–Bridgewater–Easton, MA	3,799	BCBS MA	57	Harvard Pilgrim	20
Framingham, MA	2,931	BCBS MA	47	Tufts	20
Haverhill–North Andover–Amesbury, MA–NH	2,079	BCBS MA	33	Tufts	23
Lawrence–Methuen–Salem, MA–NH	2,552	BCBS MA	40	Tufts	26
Leominster–Fitchburg–Gardner, MA	2,853	BCBS MA	47	Fallon Hlthcare	19
Lowell–Billerica–Chelmsford, MA–NH	2,958	BCBS MA	46	Tufts	22
Lynn–Peabody–Salem, MA	3,172	BCBS MA	47	Tufts	28
New Bedford, MA	3,392	BCBS MA	53	Harvard Pilgrim	17
Pittsfield, MA	3,892	BCBS MA	57	Tufts	20
Springfield, MA–CT	2,850	BCBS MA	48	Hlth New England	16
Taunton–Norton–Raynham, MA	3,407	BCBS MA	54	Harvard Pilgrim	17
Worcester, MA–CT	2,654	BCBS MA	45	Fallon Hlthcare	19
Michigan	4,428	BCBS MI	65	Ford Hlth Sys	8
Ann Arbor, MI	2,642	BCBS MI	37	Trinity Hlth (Care Choice)	26
Battle Creek, MI	8,892	BCBS MI	94	Humana	2
Bay City, MI	6,148	BCBS MI	76	HealthPlus Michigan	19
Detroit–Livonia–Dearborn, MI	3,607	BCBS MI	55	Ford Hlth Sys	21
Flint, MI	4,508	BCBS MI	61	HealthPlus Michigan	28

State and MSAs	HMO/PPO HHI	Insurer 1	Share	Insurer 2	Share
Grand Rapids–Wyoming, MI	4,169	BCBS MI	46	Priority Hlth	46
Jackson, MI	4,055	BCBS MI	51	UnitedHlthcare	37
Kalamazoo–Portage, MI	7,972	BCBS MI	89	Humana	3
Lansing–East Lansing, MI	6,156	BCBS MI	76	UnitedHlthcare	19
Monroe, MI	3,643	BCBS MI	57	Ford Hlth Sys	15
Muskegon–Norton Shores, MI	4,179	Priority Hlth	49	BCBS MI	42
Niles–Benton Harbor, MI	8,116	BCBS MI	90	CIGNA	3
Saginaw–Saginaw Township North, MI	5,499	BCBS MI	70	HealthPlus Michigan	25
Warren–Farmington Hills–Troy, MI	4,789	BCBS MI	67	Ford Hlth Sys	13
Minnesota	3,461	BCBS MN	50	Medica	26
Missouri	4,894	WellPoint Inc.	68	UnitedHlthcare	11
Columbia, MO	7,238	WellPoint Inc.	85	UnitedHlthcare	9
Jefferson City, MO	6,239	WellPoint Inc.	77	UnitedHlthcare	15
Joplin, MO	8,853	WellPoint Inc.	94	Humana	2
Kansas City, MO–KS	3,072	BCBS KS City	41	Coventry	36
Springfield, MO	5,156	WellPoint Inc.	68	Cox Health	21
St. Joseph, MO–KS	4,792	BCBS KS City	55	Heartland (Community Hlth Plan)	42
St. Louis, MO–IL	4,794	WellPoint Inc.	67	UnitedHlthcare	11
Montana	5,794	BCBS MT	75	New West Hlth	10
Billings, MT	5,690	BCBS MT	74	New West Hlth	10
Great Falls, MT	9,045	BCBS MT	95	Great West (One Hlth)	3
Missoula, MT	8,078	BCBS MT	90	New West Hlth	7
Nebraska	2,922	BCBS NE	44	UnitedHlthcare	25
Lincoln, NE	4,372	BCBS NE	60	UnitedHlthcare	28
Omaha–Council Bluffs, NE–IA	2,482	BCBS NE	34	UnitedHlthcare	28
Nevada	2,059	Sierra Hlth	29	WellPoint Inc.	28
Carson City, NV	6,089	Washoe Hlth System	77	WellPoint Inc.	13
Las Vegas–Paradise, NV	2,666	Sierra Hlth	38	WellPoint Inc.	28
Reno–Sparks, NV	3,324	Washoe Hlth System	47	WellPoint Inc.	30
New Hampshire	3,391	WellPoint Inc.	51	CIGNA	24
Manchester, NH	3,057	WellPoint Inc.	46	Harvard Pilgrim	26
Nashua, NH–MA	2,451	WellPoint Inc.	40	Harvard Pilgrim	23
Portsmouth, NH–ME	3,339	WellPoint Inc.	52	CIGNA	19
Rochester–Dover, NH–ME	4,727	WellPoint Inc.	62	CIGNA	29
New Jersey	2,154	Horizon BCBS	34	Aetna	25
Atlantic City, NJ	3,564	Horizon BCBS	56	AmeriHealth	13
Camden, NJ	2,696	Aetna	41	Horizon BCBS	22
Edison, NJ	2,323	Horizon BCBS	35	QualCare	23
Newark–Union, NJ–PA	2,205	Horizon BCBS	38	Aetna	20
Ocean City, NJ	3,802	Horizon BCBS	58	Aetna	16
Trenton–Ewing, NJ	2,889	Aetna	35	UnitedHlthcare	31
Vineland–Millville–Bridgeton, NJ	3,403	Aetna	47	Horizon BCBS	32
New Mexico	2,494	HCSC (BCBS)	35	Presbyterian Hlth	30
New York	1,557	GHI	26	Empire BCBS	21
Albany–Schenectady–Troy, NY	3,164	Capital District Phy. Hlth.	41	GHI	33
Binghamton, NY	3,419	Empire BCBS	48	Excellus	27
Buffalo–Cheektowaga–Tonawanda, NY	4,513	Health Now (BCBS)	61	GHI	26

Table 1. Combined HMO/PPO product markets
(continued) **HHI market concentration and dominant insurers**

State and MSAs	HMO/PPO HHI	Insurer 1	Share	Insurer 2	Share
Ithaca, NY	6,065	Empire BCBS	76	Excellus	15
New York–White Plains–Wayne, NY–NJ	1,535	GHI	21	UnitedHlthcare	20
Poughkeepsie–Newburgh–Middletown, NY	2,659	GHI	39	Aetna	30
Rochester, NY	4,613	Excellus	57	Preferred Care	37
Suffolk County–Nassau County, NY	2,122	GHI	33	Empire BCBS	22
Syracuse, NY	3,482	Excellus	42	Empire BCBS	40
North Carolina	3,459	BCBS NC	53	UnitedHlthcare	20
Asheville, NC	4,059	UnitedHlthcare	50	BCBS NC	39
Burlington, NC	3,636	BCBS NC	53	UnitedHlthcare	25
Charlotte–Gastonia–Concord, NC–SC	2,544	BCBS NC	43	CIGNA	20
Durham, NC	3,662	BCBS NC	55	CIGNA	18
Fayetteville, NC	3,377	UnitedHlthcare	40	BCBS NC	39
Goldsboro, NC	5,776	BCBS NC	72	CIGNA	23
Greensboro–High Point, NC	4,196	BCBS NC	49	UnitedHlthcare	42
Hickory–Morganton–Lenoir, NC	5,532	BCBS NC	72	UnitedHlthcare	16
Jacksonville, NC	4,623	BCBS NC	64	CIGNA	21
Rocky Mount, NC	4,683	BCBS NC	64	UnitedHlthcare	18
Wilmington, NC	4,099	UnitedHlthcare	46	BCBS NC	44
Winston–Salem, NC	6,277	BCBS NC	77	UnitedHlthcare	17
Ohio	2,282	WellPoint Inc.	41	Medical Mutual	17
Akron, OH	1,569	Medical Mutual	27	WellPoint Inc.	19
Canton–Massillon, OH	3,848	WellPoint Inc.	60	AultCare	9
Cincinnati–Middletown, OH–KY–IN	5,864	WellPoint Inc.	76	Humana	8
Cleveland–Elyria–Mentor, OH	2,065	Medical Mutual	33	UnitedHlthcare	26
Columbus, OH	2,463	WellPoint Inc.	32	Aetna	30
Dayton, OH	4,924	WellPoint Inc.	66	UnitedHlthcare	23
Lima, OH	3,921	WellPoint Inc.	60	Medical Mutual	11
Mansfield, OH	2,353	Medical Mutual	40	CIGNA	20
Sandusky, OH	3,064	Medical Mutual	51	CIGNA	15
Springfield, OH	4,581	WellPoint Inc.	64	UnitedHlthcare	19
Toledo, OH	4,065	Medical Mutual	61	Health Choice	13
Youngstown–Warren–Boardman, OH–PA	5,601	WellPoint Inc.	74	Medical Mutual	6
Oklahoma	3,014	BCBS OK	45	CommunityCare	26
Lawton, OK	3,584	BCBS OK	50	Aetna	29
Oklahoma City, OK	3,705	BCBS OK	52	UnitedHlthcare	27
Oregon	1,643	Providence Hlth	25	Regence BCBS	23
Bend, OR	3,215	Providence Hlth	52	Pacific Source Hlth Plans	13
Corvallis, OR	2,525	Providence Hlth	38	Regence BCBS	26
Eugene–Springfield, OR	4,397	Providence Hlth	63	Pacific Source Hlth Plans	18
Medford, OR	3,188	Providence Hlth	43	Regence BCBS	35
Portland–Vancouver–Beaverton, OR–WA	2,649	Providence Hlth	46	Kaiser	18
Salem, OR	2,684	Providence Hlth	44	Regence BCBS	21
Rhode Island	6,431	BCBS RI	79	UnitedHlthcare	16
Norwich–New London, RI	2,706	WellPoint Inc.	45	Health Net	18
Providence–Fall River–Warwick, RI–MA	4,503	BCBS RI	65	UnitedHlthcare	14

State and MSAs	HMO/PPO HHI	Insurer 1	Share	Insurer 2	Share
South Carolina	4,599	BCBS SC	66	CIGNA	9
Anderson, SC	4,530	BCBS SC	64	Aetna	17
Charleston–North Charleston, SC	5,886	BCBS SC	76	CIGNA	10
Columbia, SC	4,266	BCBS SC	62	Carolina Care Plan	17
Florence, SC	5,983	BCBS SC	76	Premier Hlth Systems	8
Greenville, SC	4,174	BCBS SC	62	Aetna	15
Myrtle Beach–Conway–North Myrtle Beach, SC	5,548	BCBS SC	73	Premier Hlth Systems	9
Spartanburg, SC	4,345	BCBS SC	63	Aetna	15
Sumter, SC	5,807	BCBS SC	75	Premier Hlth Systems	8
Tennessee	2,866	BCBS TN	50	Total Choice	12
Chattanooga, TN–GA	3,245	BCBS TN	54	Total Choice	13
Clarksville, TN–KY	2,410	WellPoint Inc.	35	BCBS TN	31
Cleveland, TN	4,476	BCBS TN	65	Total Choice	10
Jackson, TN	4,390	BCBS TN	64	Total Choice	13
Johnson City, TN	3,981	BCBS TN	61	Total Choice	12
Kingsport–Bristol, TN–VA	3,544	BCBS TN	56	John Deere (UnitedHlthCare)	16
Knoxville, TN	2,888	BCBS TN	49	Total Choice	16
Memphis, TN–MS–AR	2,858	BCBS TN	49	CIGNA	14
Morristown, TN	3,635	BCBS TN	57	John Deere (UnitedHlthCare)	15
Nashville-Davidson–Murfreesboro, TN	2,404	BCBS TN	42	CIGNA	16
Texas	2,293	HCSC (BCBS)	39	Aetna	20
Abilene, TX	4,464	HCSC (BCBS)	60	Covenant Hlth	29
Amarillo, TX	5,125	HCSC (BCBS)	68	Covenant Hlth	21
Austin–Round Rock, TX	3,839	HCSC (BCBS)	59	Aetna	15
Beaumont–Port Arthur, TX	4,047	HCSC (BCBS)	58	Aetna	24
Brownsville–Harlingen, TX	3,489	HCSC (BCBS)	52	Mutual of Omaha	23
College Station–Bryan, TX	3,868	HCSC (BCBS)	46	Scott & White Hlth	41
Corpus Christi, TX	2,997	HCSC (BCBS)	45	Humana	26
Dallas–Plano–Irving, TX	3,249	HCSC (BCBS)	50	Aetna	20
Fort Worth–Arlington, TX	3,599	UnitedHlthcare	54	Aetna	21
Houston–Sugar Land–Baytown, TX	3,032	HCSC (BCBS)	44	Aetna	31
Killeen–Temple–Fort Hood, TX	4,178	Scott & White Hlth	57	HCSC (BCBS)	30
Lubbock, TX	4,325	HCSC (BCBS)	68	Covenant Hlth	15
McAllen–Edinburg–Mission, TX	5,724	HCSC (BCBS)	74	CIGNA	10
Midland, TX	6,393	HCSC (BCBS)	83	CIGNA	9
San Angelo, TX	4,174	HCSC (BCBS)	55	WellPoint Inc.	32
San Antonio, TX	2,846	HCSC (BCBS)	46	Aetna	23
Sherman–Denison, TX	4,334	CIGNA	63	HCSC (BCBS)	16
Tyler, TX	7,238	HCSC (BCBS)	84	CIGNA	11
Wichita Falls, TX	5,913	HCSC (BCBS)	76	CIGNA	10
Utah	3,014	Regence BCBS	47	Intermountain Hlth	21
Logan, UT–ID	2,412	Intermountain Hlth	34	Regence BCBS	32
Ogden–Clearfield, UT	2,779	Regence BS	42	Coventry	25
Provo–Orem, UT	2,643	Regence BS	34	Intermountain Hlth	34
Salt Lake City, UT	3,637	Regence BS	56	Intermountain Hlth	16
St. George, UT	3,949	Intermountain Hlth	53	Regence BCBS	32

Table 1. (continued) **Combined HMO/PPO product markets HHI market concentration and dominant insurers**

State and MSAs	HMO/PPO HHI	Insurer 1	Share	Insurer 2	Share
Vermont	6,110	BCBS VT	77	CIGNA	13
Burlington–South Burlington, VT	5,273	BCBS VT	69	Aetna	20
Virginia	2,941	WellPoint Inc.	50	Aetna	11
Charlottesville, VA	4,201	WellPoint Inc.	52	Aetna	39
Harrisonburg, VA	7,515	WellPoint Inc.	86	OPTIMA Hlth (Sentara)	7
Lynchburg, VA	6,717	WellPoint Inc.	80	Piedmont (Centra)	17
Richmond, VA	4,398	WellPoint Inc.	62	Aetna	23
Roanoke, VA	8,965	WellPoint Inc.	95	Coventry	2
Winchester, VA–WV	5,574	CareFirst BCBS	73	UnitedHlthcare	14
Washington	2,270	Premera BC	38	Regence BS	23
Bellingham, WA	4,036	Premera BC	58	GHI	20
Bremerton–Silverdale, WA	2,780	Premera BC	36	KPS Hlth Plans	31
Kennewick–Richland–Pasco, WA	5,051	Premera BC	69	UnitedHlthcare	12
Longview–Kelso, WA	4,224	Kaiser	53	Premera BC	38
Mount Vernon–Anacortes, WA	4,596	Premera BC	65	GHI	15
Olympia, WA	2,372	GHI	32	Premera BC	32
Seattle–Bellevue–Everett, WA	2,669	Regence BCBS	42	Premera BC	26
Spokane, WA	4,900	Premera BC	64	GHI	29
Tacoma, WA	2,131	Premera BC	36	GHI	18
Wenatchee, WA	7,502	Premera BC	86	CIGNA	6
Yakima, WA	7,143	Premera BC	84	GHI	7
Wisconsin	2,961	WellPoint Inc.	52	UnitedHlthcare	10
Appleton, WI	4,040	Humana	52	CIGNA	35
Eau Claire, WI	7,169	WellPoint Inc.	84	Physician's Service Insurance	6
Fond du Lac, WI	6,024	WellPoint Inc.	77	Humana	9
Green Bay, WI	4,158	WellPoint Inc.	61	Humana	16
Madison, WI	3,069	WellPoint Inc.	49	Dean Hlth	19
Milwaukee–Waukesha–West Allis, WI	2,773	WellPoint Inc.	46	UnitedHlthcare	17
Oshkosh–Neenah, WI	4,283	WellPoint Inc.	61	Humana	20
Racine, WI	4,047	HCSC (BCBS)	61	UnitedHlthcare	14
Sheboygan, WI	3,618	WellPoint Inc.	47	Aetna	36
Wausau, WI	4,280	Marshfield Clinic	57	WellPoint Inc.	32
Wyoming	5,205	BCBS WY	70	UnitedHlthcare	15

Sources of HMO and PPO data: Based on enrollment information from InterStudy Managed Market MSA and State Surveyor (Jan. 1, 2005), HealthLeaders (Jan. 1, 2005), and available public sources.

HHI: The Herfindahl–Hirschman Index of Competition (HHI) is used by the U.S. Department of Justice (DOJ) to evaluate competition. The DOJ considers markets with an HHI greater than 1,000 to be concentrated and those with an HHI greater than 1,800 to be highly concentrated.

Table 2. HMO product markets
HHI market concentration and dominant health insurer

State and MSAs	HMO HHI	Insurer 1	Share	Insurer 2	Share
Alabama	5,405	VIVA Hlth	69	HealthSpring	24
Anniston–Oxford, AL	9,874	VIVA Hlth	99	Aetna	1
Auburn–Opelika, AL	10,000	Aetna	100	————	—
Birmingham–Hoover, AL	5,374	VIVA Hlth	64	HealthSpring	36
Decatur, AL	10,000	Aetna	100	————	—
Dothan, AL	10,000	UnitedHlthcare	100	————	—
Florence, AL	10,000	Aetna	100	————	—
Gadsden, AL	10,000	Aetna	100	————	—
Huntsville, AL	9,603	VIVA Hlth	98	Aetna	2
Mobile, AL	7,569	VIVA Hlth	86	HealthSpring	14
Montgomery, AL	8,093	VIVA Hlth	90	UnitedHlthcare	6
Tuscaloosa, AL	7,174	VIVA Hlth	83	UnitedHlthcare	15
Alaska	NA	Premera BC		Aetna	
Anchorage, AK	NA	————	—	————	—
Fairbanks, AK	NA	————	—	————	—
Arizona	2,916	CIGNA	45	UnitedHlthcare	24
Flagstaff, AZ	4,517	Health Net	59	CIGNA	31
Phoenix–Mesa–Scottsdale, AZ	2,549	CIGNA	38	UnitedHlthcare	24
Prescott, AZ	4,283	CIGNA	56	Aetna	33
Tucson, AZ	3,477	CIGNA	47	UnitedHlthcare	33
Yuma, AZ	9,002	CIGNA	95	Aetna	4
Arkansas	2,988	BCBS AR	40	QCA Hlth	33
Fayetteville–Springdale–Rogers, AR–MO	2,705	BCBS AR	42	QCA Hlth	25
Fort Smith, AR–OK	3,099	BCBS AR	44	UnitedHlthcare	27
Hot Springs, AR	3,129	QCA Hlth	43	UnitedHlthcare	27
Jonesboro, AR	3,483	BCBS AR	51	QCA Hlth	22
Little Rock–North Little Rock, AR	3,682	BCBS AR	43	QCA Hlth	42
Pine Bluff, AR	3,871	BCBS AR	53	QCA Hlth	31
Texarkana, TX–Texarkana, AR	3,613	BCBS AR	46	CIGNA	36
California	2,377	Kaiser	42	WellPoint Inc.	18
Bakersfield, CA	2,545	Kaiser	42	WellPoint Inc.	21
Chico, CA	6,650	BS of CA	79	WellPoint Inc.	19
El Centro, CA	5,270	BS of CA	64	UnitedHlthcare	34
Fresno, CA	2,486	WellPoint Inc.	33	Kaiser	30
Hanford–Corcoran, CA	2,650	BS of CA	42	WellPoint Inc.	20
Los Angeles–Long Beach–Glendale, CA	2,201	Kaiser	36	WellPoint Inc.	22
Madera, CA	3,219	Kaiser	48	BS of CA	26
Merced, CA	2,622	WellPoint Inc.	35	BS of CA	31
Modesto, CA	2,204	Kaiser	30	WellPoint Inc.	25
Napa, CA	6,628	Kaiser	80	Health Net	10
Oakland–Fremont–Hayward, CA	4,114	Kaiser	62	Health Net	9
Oxnard–Thousand Oaks–Ventura, CA	2,014	WellPoint Inc.	33	Kaiser	20
Redding, CA	4,945	CIGNA	64	Aetna	29
Riverside–San Bernardino–Ontario, CA	2,181	Kaiser	37	WellPoint Inc.	17
Sacramento–Arden-Arcade–Roseville, CA	2,909	Kaiser	49	BS of CA	14
Salinas, CA	6,290	WellPoint Inc.	78	BS of CA	15
San Diego–Carlsbad–San Marcos, CA	2,101	Kaiser	37	UnitedHlthcare	19

Table 2. **HMO product markets**
(continued) **HHI market concentration and dominant health insurer**

State and MSAs	HMO HHI	Insurer 1	Share	Insurer 2	Share
San Francisco–San Mateo–Redwood City, CA	3,141	Kaiser	52	WellPoint Inc.	12
San Jose–Sunnyvale–Santa Clara, CA	2,736	Kaiser	47	Aetna	19
San Luis Obispo–Paso Robles, CA	3,728	WellPoint Inc.	44	BS of CA	41
Santa Ana–Anaheim–Irvine, CA	2,028	WellPoint Inc.	31	Kaiser	25
Santa Barbara–Santa Maria, CA	2,592	WellPoint Inc.	36	BS of CA	24
Santa Cruz–Watsonville, CA	2,301	UnitedHithcare	27	BS of CA	25
Stockton, CA	2,372	Kaiser	40	UnitedHithcare	15
Vallejo–Fairfield, CA	5,348	Kaiser	72	Health Net	9
Visalia–Porterville, CA	2,920	WellPoint Inc.	43	Health Net	27
Yuba City–Marysville, CA	6,249	Kaiser	77	BS of CA	17
Colorado	2,562	Kaiser	41	UnitedHithcare	23
Boulder, CO	4,214	Kaiser	62	CIGNA	17
Colorado Springs, CO	2,434	Kaiser	38	UnitedHithcare	23
Denver–Aurora, CO	3,116	Kaiser	48	UnitedHithcare	22
Fort Collins–Loveland, CO	3,887	UnitedHithcare	55	CIGNA	28
Grand Junction, CO	8,664	Rocky Mountain	93	Aetna	5
Pueblo, CO	5,313	WellPoint Inc.	71	Rocky Mountain	13
Connecticut	2,344	WellPoint Inc.	36	Health Net	21
Bridgeport–Stamford–Norwalk, CT	2,846	WellPoint Inc.	36	Health Net	35
Danbury, CT	2,733	WellPoint Inc.	36	Health Net	33
Hartford–West Hartford–East Hartford, CT	2,886	WellPoint Inc.	45	CIGNA	18
Delaware	3,531	Coventry	54	UnitedHithcare	20
Dover, DE	4,850	Coventry	66	UnitedHithcare	20
Wilmington, DE–MD–NJ	2,467	Coventry	33	Aetna	31
Florida	1,343	BCBS FL	19	CIGNA	19
Cape Coral–Fort Myers, FL	3,469	Aetna	48	BCBS FL	33
Deltona–Daytona Beach–Ormond Beach, FL	4,238	Florida Hlth Care Plans	61	UnitedHithcare	21
Fort Walton Beach–Crestview–Destin, FL	8,670	BCBS FL	93	UnitedHithcare	3
Gainesville, FL	4,204	BCBS FL	47	AvMed Hlth Plan	44
Jacksonville, FL	3,032	Aetna	39	BCBS FL	37
Lakeland–Winter Haven, FL	2,115	Aetna	27	BCBS FL	25
Miami–Miami Beach–Kendall, FL	1,487	Neighborhood Hlth Partnership	27	UnitedHithcare	16
Naples–Marco Island, FL	2,820	WellCare	35	BCBS FL	30
Ocala, FL	2,564	BCBS FL	43	Aetna	16
Orlando–Kissimmee, FL	1,814	UnitedHithcare	25	Aetna	23
Palm Bay–Melbourne–Titusville, FL	2,991	Health First Hlth	44	Aetna	30
Panama City–Lynn Haven, FL	6,417	Humana	77	BCBS FL	22
Pensacola–Ferry Pass–Brent, FL	6,628	BCBS FL	80	Humana	11
Port St. Lucie–Fort Pierce, FL	4,893	Humana	62	BCBS FL	33
Punta Gorda, FL	6,189	BCBS FL	77	Aetna	18
Sarasota–Bradenton–Venice, FL	5,136	BCBS FL	70	Aetna	15
Vero Beach, FL	3,995	Humana	56	Health First Hlth	27
West Palm Beach–Boca Raton–Boynton Beach, FL	2,341	CIGNA	35	UnitedHithcare	27
Georgia	3,486	WellPoint Inc.	55	Kaiser	17
Albany, GA	6,313	Aetna	63	UnitedHithcare	38
Athens–Clarke County, GA	4,812	WellPoint Inc.	58	Athens Hlth Plan	37

State and MSAs	HMO HHI	Insurer 1	Share	Insurer 2	Share
Atlanta–Sandy Springs–Marietta, GA	3,159	WellPoint Inc.	50	Kaiser	20
Augusta–Richmond County, GA–SC	9,465	WellPoint Inc.	97	CIGNA	1
Columbus, GA–AL	5,144	WellPoint Inc.	60	Evergreen Hlth Plan	40
Gainesville, GA	7,192	WellPoint Inc.	84	Kaiser	8
Hinesville–Fort Stewart, GA	6,980	WellPoint Inc.	82	CIGNA	18
Macon, GA	9,271	WellPoint Inc.	96	UnitedHlthcare	4
Rome, GA	4,154	WellPoint Inc.	53	CIGNA	35
Savannah, GA	8,282	WellPoint Inc.	91	CIGNA	8
Warner Robins, GA	8,374	WellPoint Inc.	91	UnitedHlthcare	9
Hawaii	4,959	BCBS HI	55	Kaiser	44
Honolulu, HI	5,053	BCBS HI	57	Kaiser	42
Idaho	3,853	Regence BS	55	BC of ID	24
Boise City–Nampa, ID	5,304	BC of ID	65	Primary Hlth	33
Coeur d'Alene, ID	6,018	GHI	75	BC of ID	21
Idaho Falls, ID	9,579	BC of ID	98	Aetna	2
Lewiston, ID–WA	6,787	Regence BS	81	CIGNA	11
Pocatello, ID	10,000	BC of ID	100	———	—
Illinois	3,073	HCSC (BCBS)	52	WellPoint, Inc.	12
Bloomington–Normal, IL	8,596	John Deere (UnitedHlthCare)	92	HCSC (BCBS)	7
Champaign-Urbana, IL	9,939	Coventry	100	HCSC (BCBS)	0
Chicago–Naperville–Joliet, IL	3,648	HCSC (BCBS)	57	WellPoint Inc	14
Danville, IL	9,892	Coventry	100	John Deere (UnitedHlthCare)	0
Decatur, IL	4,090	HCSC (BCBS)	45	Coventry	45
Kankakee–Bradley, IL	4,259	Coventry	61	HCSC (BCBS)	21
Lake County–Kenosha County, IL–WI	2,981	HCSC (BCBS)	49	Humana	20
Peoria, IL	6,334	OSF Hlthcare	78	John Deere (UnitedHlthCare)	16
Rockford, IL	4,998	HCSC (BCBS)	61	Rockford Hlth	36
Springfield, IL	5,104	Coventry	57	HCSC (BCBS)	43
Indiana	3,942	WellPoint Inc.	60	M*Plan (HlthCare Grp)	15
Anderson, IN	6,853	WellPoint Inc.	81	CIGNA	17
Bloomington, IN	8,336	WellPoint Inc.	91	ADVANTAGE Hlth Plan	6
Columbus, IN	6,670	WellPoint Inc.	79	SE IN Hlth Org	20
Elkhart–Goshen, IN	6,105	WellPoint Inc.	76	ADVANTAGE Hlth Plan	19
Evansville, IN–KY	8,008	Welborn Hlth	89	WellPoint Inc	10
Fort Wayne, IN	5,025	Physicians Hlth Plan	66	WellPoint Inc	26
Gary, IN	3,724	WellPoint Inc.	50	CIGNA	32
Indianapolis, IN	4,830	WellPoint Inc.	66	M*Plan	20
Lafayette, IN	6,745	PhyCor	81	WellPoint Inc.	11
South Bend–Mishawaka, IN–MI	4,900	ADVANTAGE Hlth Plan	57	WellPoint Inc.	40
Iowa	3,394	Wellmark	49	John Deere (UnitedHlthCare)	26
Ames, IA	4,683	Wellmark	62	John Deere (UnitedHlthCare)	26
Cedar Rapids, IA	7,238	Wellmark	84	John Deere (UnitedHlthCare)	17
Davenport–Moline–Rock Island, IA–IL	4,450	John Deere (UnitedHlthCare)	59	Wellmark	29
Des Moines, IA	3,765	Wellmark	46	Coventry	36
Iowa City, IA	7,171	Wellmark	84	John Deere (UnitedHlthCare)	12
Sioux City, IA–NE–SD	4,321	Wellmark	60	DAKOTACARE (State Med. Assn)	24
Waterloo–Cedar Falls, IA	5,160	Wellmark	59	John Deere (UnitedHlthCare)	41

Table 2. (continued) **HMO product markets**
HHI market concentration and dominant health insurer

State and MSAs	HMO HHI	Insurer 1	Share	Insurer 2	Share
Kentucky	2,731	Health Partners	44	WellPoint Inc.	18
Bowling Green, KY	9,646	CIGNA	98	Aetna	2
Elizabethtown, KY	7,348	CIGNA	84	Aetna	16
Lexington-Fayette, KY	3,501	UnitedHlthcare	49	Humana	32
Louisville, KY-IN	3,811	WellPoint Inc.	53	Humana	30
Owensboro, KY	10,000	CIGNA	100	HCSC (BCBS)	
Louisiana	2,195	Humana	33	BCBS LA	25
Alexandria, LA	6,964	Humana	82	CIGNA	14
Baton Rouge, LA	2,786	BCBS LA	36	Humana	31
Houma-Bayou Cane-Thibodaux, LA	6,770	Humana	81	CIGNA	12
Lafayette, LA	6,714	Humana	81	CIGNA	15
Lake Charles, LA	6,927	Humana	82	CIGNA	13
Monroe, LA	4,318	Vantage Hlth	53	Humana	38
New Orleans-Metairie-Kenner, LA	2,799	BCBS LA	36	Coventry	31
Shreveport-Bossier City, LA	3,691	Healthcare OK	48	Humana	36
Maine	4,665	WellPoint Inc.	63	CIGNA	21
Bangor, ME	5,640	WellPoint Inc.	73	CIGNA	15
Lewiston-Auburn, ME	4,354	WellPoint Inc.	60	Aetna	20
Portland-South Portland, ME	4,841	WellPoint Inc.	66	CIGNA	20
Maryland	2,685	UnitedHlthcare	42	Kaiser	19
Baltimore-Towson, MD	2,449	UnitedHlthcare	35	CareFirst BCBS	28
Bethesda-Gaithersburg-Frederick, MD	4,072	UnitedHlthcare	58	Kaiser	25
Cumberland, MD-WV	7,819	UnitedHlthcare	88	CareFirst BCBS	10
Hagerstown-Martinsburg, MD-WV	5,792	UnitedHlthcare	74	Aetna	14
Salisbury, MD	5,740	UnitedHlthcare	71	CareFirst BCBS	26
Massachusetts	2,606	BCBS MA	41	Tufts	21
Barnstable Town, MA	3,509	BCBS MA	46	Harvard Pilgrim	35
Boston-Cambridge-Quincy, MA-NH	2,766	BCBS MA	36	Tufts	27
Brockton-Bridgewater-Easton, MA	3,193	BCBS MA	45	Harvard Pilgrim	30
Framingham, MA	2,572	BCBS MA	38	Tufts	24
Haverhill-North Andover-Amesbury, MA-NH	2,189	BCBS MA	30	Tufts	27
Lawrence-Methuen-Salem, MA-NH	2,594	BCBS MA	36	Tufts	30
Leominster-Fitchburg-Gardner, MA	2,686	BCBS MA	35	Fallon Hlthcare	33
Lowell-Billerica-Chelmsford, MA-NH	2,776	BCBS MA	37	Tufts	28
Lynn-Peabody-Salem, MA	3,120	BCBS MA	42	Tufts	33
New Bedford, MA	2,713	BCBS MA	43	Harvard Pilgrim	22
Pittsfield, MA	3,576	BCBS MA	52	Tufts	21
Springfield, MA-CT	2,354	BCBS MA	36	Hlth New England	26
Taunton-Norton-Raynham, MA	2,724	BCBS MA	43	Harvard Pilgrim	22
Worcester, MA-CT	2,563	BCBS MA	34	Fallon Hlthcare	33
Michigan	1,891	BCBS MI	26	Ford Hlth Sys	25
Ann Arbor, MI	3,464	M-CARE (U of M)	47	Trinity Hlth (Care Choice)	33
Battle Creek, MI	9,637	BCBS MI	98	UnitedHlthcare	2
Bay City, MI	5,813	HealthPlus Michigan	70	BCBS MI	30
Detroit-Livonia-Dearborn, MI	3,623	Ford Hlth Sys	51	BCBS MI	29
Flint, MI	4,515	HealthPlus Michigan	61	BCBS MI	26
Grand Rapids-Wyoming, MI	6,917	Priority Hlth	82	BCBS MI	11

State and MSAs	HMO HHI	Insurer 1	Share	Insurer 2	Share
Jackson, MI	5,134	UnitedHlthcare	69	BCBS MI	17
Kalamazoo–Portage, MI	8,235	BCBS MI	90	UnitedHlthcare	10
Lansing–East Lansing, MI	5,060	UnitedHlthcare	60	BCBS MI	38
Monroe, MI	3,098	Ford Hlth Sys	46	BCBS MI	25
Muskegon–Norton Shores, MI	7,225	Priority Hlth	83	BCBS MI	17
Niles–Benton Harbor, MI	5,058	BCBS MI	67	Aetna	19
Saginaw–Saginaw Township North, MI	6,165	HealthPlus Michigan	74	BCBS MI	26
Warren–Farmington Hills–Troy, MI	3,475	Ford Hlth Sys	47	BCBS MI	33
Minnesota	3,719	Medica	48	HealthPartners	36
Missouri	2,037	Coventry	34	BCBS KS City	17
Columbia, MO	3,566	WellPoint Inc.	54	Coventry	16
Jefferson City, MO	3,330	Coventry	37	UnitedHlthcare	33
Joplin, MO	7,676	WellPoint Inc.	87	UnitedHlthcare	7
Kansas City, MO–KS	3,864	Coventry	53	BCBS KS City	32
Springfield, MO	4,080	WellPoint Inc.	57	Humana	25
St. Joseph, MO–KS	6,112	Heartland (Community Hlth Plan)	75	BCBS KS City	21
St. Louis, MO–IL	2,529	Coventry	34	CIGNA	24
Montana	6,515	BCBS MT	78	New West Hlth	19
Billings, MT	6,446	BCBS MT	78	New West Hlth	20
Great Falls, MT	10,000	BCBS MT	100		
Missoula, MT	5,852	BCBS MT	72	New West Hlth	25
Nebraska	5,533	Coventry	72	Mutual of Omaha	19
Lincoln, NE	4,442	UnitedHlthcare	60	Mutual of Omaha	27
Omaha–Council Bluffs, NE–IA	6,631	Coventry	79	Mutual of Omaha	20
Nevada	4,814	Sierra Hlth	68	UnitedHlthcare	11
Carson City, NV	4,670	Washoe Hlth System	63	WellPoint Inc.	20
Las Vegas–Paradise, NV	6,817	Sierra Hlth	81	UnitedHlthcare	13
Reno–Sparks, NV	3,821	Saint Mary's HlthFirst	53	Washoe Hlth System	30
New Hampshire	3,400	CIGNA	42	WellPoint Inc.	36
Manchester, NH	3,020	WellPoint Inc.	34	Harvard Pilgrim	33
Nashua, NH–MA	2,541	Harvard Pilgrim	30	WellPoint Inc.	29
Portsmouth, NH–ME	3,131	WellPoint Inc.	38	CIGNA	37
Rochester–Dover, NH–ME	4,465	CIGNA	50	WellPoint Inc.	44
New Jersey	2,629	Aetna	45	CIGNA	14
Atlantic City, NJ	2,962	AmeriHealth	39	Horizon BCBS	28
Camden, NJ	4,478	Aetna	62	AmeriHealth	25
Edison, NJ	2,844	Aetna	47	Health Net	16
Newark–Union, NJ–PA	2,391	Aetna	38	CIGNA	22
Ocean City, NJ	3,082	Aetna	39	AmeriHealth	35
Trenton–Ewing, NJ	4,413	Aetna	64	UnitedHlthcare	11
Vineland–Millville–Bridgeton, NJ	6,427	Aetna	79	AmeriHealth	15
New Mexico	3,688	Ardent Hlth Srvs	45	Presbyterian Hlth	36
New York	1,344	HIP	26	Excellus	15
Albany–Schenectady–Troy, NY	6,489	Capital District Phy. Hlth.	79	Health Now (BCBS)	14
Binghamton, NY	6,670	Excellus	80	Capital District Phy. Hlth.	15
Buffalo–Cheektowaga–Tonawanda, NY	7,946	Health Now (BCBS)	88	Excellus	12

Table 2. (continued) **HMO product markets**
HHI market concentration and dominant health insurer

State and MSAs	HMO HHI	Insurer 1	Share	Insurer 2	Share
Ithaca, NY	9,915	Excellus	100	Preferred Care	0
New York–White Plains–Wayne, NY–NJ	2,193	HIP	38	Aetna	17
Poughkeepsie–Newburgh–Middletown, NY	2,320	Aetna	43	GHI	14
Rochester, NY	5,072	Preferred Care	62	Excellus	35
Suffolk County–Nassau County, NY	2,331	HIP	41	Empire BCBS	18
Syracuse, NY	9,353	Excellus	97	Aetna	2
North Carolina	2,760	CIGNA	32	UnitedHithcare	29
Asheville, NC	5,244	UnitedHithcare	69	BCBS NC	20
Burlington, NC	2,710	UnitedHithcare	33	BCBS NC	30
Charlotte–Gastonia–Concord, NC–SC	2,797	CIGNA	43	BCBS NC	21
Durham, NC	2,562	CIGNA	38	BCBS NC	22
Fayetteville, NC	3,688	UnitedHithcare	52	BCBS NC	25
Goldsboro, NC	5,030	CIGNA	63	BCBS NC	33
Greensboro–High Point, NC	4,831	UnitedHithcare	63	BCBS NC	29
Hickory–Morganton–Lenoir, NC	4,196	BCBS NC	57	UnitedHithcare	28
Jacksonville, NC	3,392	UnitedHithcare	39	BCBS NC	35
Rocky Mount, NC	4,009	CIGNA	49	UnitedHithcare	40
Wilmington, NC	5,087	UnitedHithcare	67	BCBS NC	23
Winston–Salem, NC	5,674	BCBS NC	71	UnitedHithcare	25
Ohio	1,391	WellPoint, Inc.	21	UnitedHithcare	20
Akron, OH	1,948	Hlth Plan Upper Ohio	29	Kaiser	25
Canton–Massillon, OH	2,661	AultCare	38	Hlth Plan Upper Ohio	30
Cincinnati–Middletown, OH–KY–IN	3,074	Humana	42	WellPoint, Inc.	33
Cleveland–Elyria–Mentor, OH	2,661	Kaiser	46	UnitedHithcare	15
Columbus, OH	2,706	UnitedHithcare	34	Aetna	30
Dayton, OH	4,256	UnitedHithcare	49	WellPoint Inc.	43
Lima, OH	4,090	CIGNA	50	WellPoint Inc.	38
Mansfield, OH	7,122	CIGNA	84	Aetna	11
Sandusky, OH	4,316	WellPoint Inc.	51	CIGNA	40
Springfield, OH	3,492	UnitedHithcare	45	WellPoint Inc.	35
Toledo, OH	3,609	WellPoint Inc.	41	CIGNA	39
Youngstown–Warren–Boardman, OH–PA	1,680	CIGNA	30	UPMC Hlth	16
Oklahoma	2,921	CommunityCare	46	Aetna	20
Lawton, OK	6,534	CIGNA	79	BCBS OK	18
Oklahoma City, OK	3,126	UnitedHithcare	39	Aetna	36
Oregon	5,293	Kaiser	71	UnitedHithcare	11
Bend, OR	4,282	Regence BCBS	59	Health Net	23
Corvallis, OR	6,780	UnitedHithcare	82	Regence BCBS	9
Eugene–Springfield, OR	6,556	UnitedHithcare	80	Providence Hlth	11
Medford, OR	9,569	Health Net	98	UnitedHithcare	1
Portland–Vancouver–Beaverton, OR–WA	5,373	Kaiser	79	UnitedHithcare	7
Salem, OR	5,140	Kaiser	69	Regence BCBS	17
Rhode Island	4,984	UnitedHithcare	65	BCBS RI	26
Norwich–New London–RI	3,436	Health Net	45	WellPoint Inc.	35
Providence–Fall River–Warwick, RI–MA	2,600	UnitedHithcare	43	BCBS RI	19

State and MSAs	HMO HHI	Insurer 1	Share	Insurer 2	Share
South Carolina	3,119	CIGNA	36	BCBS SC	32
Anderson, SC	4,940	CIGNA	63	BCBS SC	32
Charleston–North Charleston, SC	3,708	BCBS SC	42	CIGNA	40
Columbia, SC	4,342	Carolina Care Plan	53	BCBS SC	38
Florence, SC	3,853	BCBS SC	51	Carolina Care Plan	31
Greenville, SC	3,407	CIGNA	42	BCBS SC	30
Myrtle Beach–Conway–North Myrtle Beach, SC	3,654	Carolina Care Plan	48	CIGNA	29
Spartanburg, SC	4,292	CIGNA	59	BCBS SC	25
Sumter, SC	3,532	BCBS SC	41	Carolina Care Plan	37
Tennessee	4,929	CIGNA	68	John Deere (UnitedHithCare)	12
Chattanooga, TN–GA	8,646	John Deere (UnitedHithCare)	93	UnitedHithcare	7
Clarksville, TN–KY	7,833	CIGNA	88	HealthSpring	5
Cleveland, TN	8,585	John Deere (UnitedHithCare)	92	UnitedHithcare	8
Jackson, TN	4,269	UnitedHithcare	58	Aetna	25
Johnson City, TN	10,000	John Deere (UnitedHithCare)	100	BCBS TN	
Kingsport–Bristol, TN–VA	9,200	John Deere (UnitedHithCare)	96	WellPoint Inc.	3
Knoxville, TN	8,927	John Deere (UnitedHithCare)	94	UnitedHithcare	6
Memphis, TN–MS–AR	5,606	CIGNA	70	Aetna	28
Morristown, TN	9,884	John Deere (UnitedHithCare)	99	UnitedHithcare	1
Nashville-Davidson–Murfreesboro, TN	5,727	CIGNA	74	HealthSpring	14
Texas	1,519	CIGNA	23	Aetna	22
Abilene, TX	9,987	Covenant Hlth	100	Aetna	0
Amarillo, TX	9,998	Covenant Hlth	100	UnitedHithcare	0
Austin–Round Rock, TX	2,828	Humana	42	Aetna	28
Beaumont–Port Arthur, TX	5,048	Aetna	67	WellPoint Inc.	17
Brownsville–Harlingen, TX	9,899	Valley Baptist Hlth Plan	100	UnitedHithcare	0
College Station–Bryan, TX	9,459	Scott & White Hlth	97	Covenant Hlth	3
Corpus Christi, TX	8,586	Humana	93	Aetna	6
Dallas–Plano–Irving, TX	3,061	CIGNA	46	HCSC (BCBS)	27
Fort Worth–Arlington, TX	2,744	HCSC (BCBS)	38	CIGNA	28
Houston–Sugar Land–Baytown, TX	3,425	Aetna	54	WellPoint Inc.	19
Killeen–Temple–Fort Hood, TX	8,398	Scott & White Hlth	91	Covenant Hlth	9
Lubbock, TX	5,001	Covenant Hlth	53	Centene Corporation	47
McAllen–Edinburg–Mission, TX	6,845	UnitedHithcare	80	Aetna	20
Midland, TX	9,629	Covenant Hlth	98	Aetna	2
San Angelo, TX	9,951	HCSC (BCBS)	100	Aetna	0
San Antonio, TX	2,682	Humana	38	Aetna	23
Sherman–Denison, TX	5,193	CIGNA	67	HCSC (BCBS)	25
Tyler, TX	7,924	Aetna	88	UnitedHithcare	12
Wichita Falls, TX	10,000	Aetna	100	HCSC (BCBS)	
Utah	3,802	Intermountain Hlth	52	Coventry	32
Logan, UT–ID	8,367	Intermountain Hlth	91	Molina Hlthcare	4
Ogden–Clearfield, UT	3,821	Coventry	45	Intermountain Hlth	42
Provo–Orem, UT	5,711	Intermountain Hlth	73	Coventry	21
Salt Lake City, UT	3,336	Intermountain Hlth	47	Coventry	30
St. George, UT	6,783	Intermountain Hlth	80	Molina Hlthcare	30

Table 2. **HMO product markets**
(continued) **HHI market concentration and dominant health insurer**

State and MSAs	HMO HHI	Insurer 1	Share	Insurer 2	Share
Vermont	9,557	BCBS VT	98	CIGNA	2
Burlington–South Burlington, VT	9,984	BCBS VT	100	Harvard Pilgrim	0
Virginia	1,451	WellPoint Inc.	23	UnitedHlthcare	19
Charlottesville, VA	3,423	Coventry	51	OPTIMA Hlth (Sentara)	23
Harrisonburg, VA	4,224	Coventry	51	OPTIMA Hlth (Sentara)	40
Lynchburg, VA	6,198	Piedmont (Centra)	77	WellPoint Inc.	11
Richmond, VA	3,245	WellPoint Inc.	52	Coventry	16
Roanoke, VA	4,992	WellPoint Inc.	68	Coventry	14
Winchester, VA–WV	4,778	CareFirst BCBS	65	UnitedHlthcare	19
Washington	4,106	Grp Hlth Cooperative	61	Kaiser	15
Bellingham, WA	6,436	GHI	79	CIGNA	12
Bremerton–Silverdale, WA	8,132	GHI	90	CIGNA	8
Kennewick–Richland–Pasco, WA	6,208	GHI	76	CIGNA	23
Longview–Kelso, WA	8,845	Kaiser	94	CIGNA	5
Mount Vernon–Anacortes, WA	6,886	GHI	81	CIGNA	18
Olympia, WA	6,726	GHI	81	UnitedHlthcare	11
Seattle–Bellevue–Everett, WA	5,240	GHI	70	CIGNA	14
Spokane, WA	7,682	GHI	87	CIGNA	10
Tacoma, WA	6,184	GHI	78	CIGNA	11
Wenatchee, WA	5,267	CIGNA	65	Molina Hlthcare	33
Yakima, WA	4,065	GHI	52	CIGNA	34
Wisconsin	1,362	WellPoint Inc.	24	Dean Hlth	19
Appleton, WI	3,023	Humana	41	UnitedHlthcare	30
Eau Claire, WI	2,853	WellPoint Inc.	39	GHI	29
Fond du Lac, WI	2,877	Dean Hlth	42	Humana	25
Green Bay, WI	4,930	UnitedHlthcare	64	Humana	27
Madison, WI	2,669	Dean Hlth	36	WellPoint Inc.	24
Milwaukee–Waukesha–West Allis, WI	3,371	WellPoint Inc.	41	UnitedHlthcare	35
Oshkosh–Neenah, WI	5,466	MercyCare	69	Physicians Plus	25
Racine, WI	3,138	UnitedHlthcare	39	Humana	31
Sheboygan, WI	4,095	WellPoint Inc.	57	UnitedHlthcare	24
Wausau, WI	8,507	Marshfield Clinic	92	WellPoint Inc.	8
Wyoming	8,722	WIN Hlth	93	Aetna	7

Sources of HMO and PPO data: Based on enrollment information from InterStudy Managed Market MSA and State Surveyor (Jan. 1, 2005), HealthLeaders (Jan. 1, 2005), and available public sources.

HHI: The Herfindahl–Hirschman Index of Competition (HHI) is used by the U.S. Department of Justice (DOJ) to evaluate competition. The DOJ considers markets
with an HHI greater than 1,000 to be concentrated and those with an HHI greater than 1,800 to be highly concentrated.

Table 3. PPO product markets
HHI market concentration and dominant insurers

State and MSAs	PPO	Insurer 1	Share	Insurer 2	Share
Alabama	7,176	BCBS AL	84	Health Choice	5
Anniston–Oxford, AL	8,951	BCBS AL	95	NAMCI	2
Auburn–Opelika, AL	9,072	BCBS AL	95	CIGNA	1
Birmingham–Hoover, AL	5,843	BCBS AL	75	Health Choice	13
Decatur, AL	8,139	BCBS AL	90	Health Choice	4
Dothan, AL	9,093	BCBS AL	95	NAMCI	2
Florence, AL	8,850	BCBS AL	94	UnitedHlthcare	2
Gadsden, AL	9,066	BCBS AL	95	NAMCI	2
Huntsville, AL	8,917	BCBS AL	94	UnitedHlthcare	2
Mobile, AL	6,464	BCBS AL	80	Gulf Hlth Plan	10
Montgomery, AL	8,389	BCBS AL	92	UnitedHlthcare	4
Tuscaloosa, AL	5,318	BCBS AL	67	Aetna	29
Alaska	4,907	Premera BC	60	Aetna	35
Anchorage, AK	4,660	Premera BC	54	Aetna	42
Fairbanks, AK	9,202	Premera BC	96	Mutual of Omaha	3
Arizona	3,900	BCBS AZ	58	UnitedHlthcare	22
Flagstaff, AZ	1,953	CIGNA	26	Aetna	23
Phoenix–Mesa–Scottsdale, AZ	4,066	BCBS AZ	59	UnitedHlthcare	22
Prescott, AZ	2,768	Aetna	43	CIGNA	23
Tucson, AZ	4,359	BCBS AZ	61	UnitedHlthcare	24
Yuma, AZ	3,010	Aetna	43	CIGNA	28
Arkansas	6,372	BCBS AR	79	UnitedHlthcare	6
Fayetteville–Springdale–Rogers, AR–MO	7,135	BCBS AR	84	Aetna	6
Fort Smith, AR–OK	5,421	BCBS AR	71	UnitedHlthcare	18
Hot Springs, AR	6,196	BCBS AR	69	UnitedHlthcare	21
Jonesboro, AR	8,279	BCBS AR	91	CIGNA	5
Little Rock–North Little Rock, AR	6,913	BCBS AR	82	UnitedHlthcare	9
Pine Bluff, AR	7,020	BCBS AR	83	UnitedHlthcare	7
Texarkana, TX–Texarkana, AR	9,513	BCBS AR	98	WellPoint Inc.	2
California	1,844	BS of CA	25	WellPoint Inc.	24
Bakersfield, CA	6,343	UnitedHlthcare	79	WellPoint Inc.	8
Chico, CA	2,367	BS of CA	33	WellPoint Inc.	26
El Centro, CA	2,325	BS of CA	29	CA Foundation for Medical Care	28
Fresno, CA	2,258	WellPoint Inc.	30	BS of CA	24
Hanford–Corcoran, CA	5,317	Aetna	71	WellPoint Inc.	15
Los Angeles–Long Beach–Glendale, CA	2,627	WellPoint Inc.	38	CA Foundation for Medical Care	25
Madera, CA	3,406	Aetna	51	WellPoint Inc.	20
Merced, CA	2,237	Aetna	35	WellPoint Inc.	23
Modesto, CA	1,939	Aetna	23	BS of CA	22
Napa, CA	3,283	BS of CA	39	WellPoint Inc.	36
Oakland–Fremont–Hayward, CA	2,500	BS of CA	40	WellPoint Inc.	26
Oxnard–Thousand Oaks–Ventura, CA	2,401	BS of CA	32	WellPoint Inc.	27
Redding, CA	2,490	BS of CA	32	WellPoint Inc.	29
Riverside–San Bernardino–Ontario, CA	2,230	CA Foundation for Medical Care	32	BS of CA	26
Sacramento–Arden-Arcade–Roseville, CA	2,544	BS of CA	40	WellPoint Inc.	22
Salinas, CA	2,676	WellPoint Inc.	39	CA Foundation for Medical Care	25

Table 3. PPO product markets
(continued) **HHI market concentration and dominant insurers**

State and MSAs	PPO	Insurer 1	Share	Insurer 2	Share
San Diego–Carlsbad–San Marcos, CA	2,353	CA Foundation for Medical Care	38	BS of CA	25
San Francisco–San Mateo–Redwood City, CA	2,597	BS of CA	41	WellPoint Inc.	21
San Jose–Sunnyvale–Santa Clara, CA	1,827	BS of CA	26	CA Foundation for Medical Care	22
San Luis Obispo–Paso Robles, CA	2,326	WellPoint Inc.	31	CA Foundation for Medical Care	27
Santa Ana–Anaheim–Irvine, CA	2,287	BS of CA	30	CA Foundation for Medical Care	29
Santa Barbara–Santa Maria, CA	2,249	WellPoint Inc.	27	BS of CA	26
Santa Cruz–Watsonville, CA	2,098	WellPoint Inc.	27	CA Foundation for Medical Care	24
Stockton, CA	1,959	BS of CA	30	WellPoint Inc.	22
Vallejo–Fairfield, CA	5,002	BS of CA	61	WellPoint Inc.	35
Visalia–Porterville, CA	2,290	Aetna	32	WellPoint Inc.	26
Yuba City–Marysville, CA	3,443	Aetna	51	WellPoint Inc.	25
Colorado	2,543	WellPoint Inc.	41	UnitedHithcare	24
Boulder, CO	2,626	UnitedHithcare	43	WellPoint Inc.	22
Colorado Springs, CO	2,109	WellPoint Inc.	30	UnitedHithcare	26
Denver–Aurora, CO	3,030	WellPoint Inc.	47	UnitedHithcare	26
Fort Collins–Loveland, CO	2,166	WellPoint Inc.	32	UnitedHithcare	27
Grand Junction, CO	2,277	Rocky Mountain	36	WellPoint Inc.	27
Pueblo, CO	5,011	WellPoint Inc.	77	Aetna	4
Connecticut	4,871	WellPoint Inc.	68	Aetna	13
Bridgeport–Stamford–Norwalk, CT	4,196	WellPoint Inc.	61	Aetna	18
Danbury, CT	3,705	WellPoint Inc.	56	Aetna	19
Hartford–West Hartford–East Hartford, CT	5,508	WellPoint Inc.	72	UnitedHithcare	14
Delaware	3,616	CareFirst BCBS	53	Aetna	24
Dover, DE	4,830	BCBS DE	66	Coventry	16
Wilmington, DE–MD–NJ	2,642	BCBS DE	37	Aetna	31
Florida	2,039	BCBS FL	38	Aetna	13
Cape Coral–Fort Myers, FL	2,832	BCBS FL	49	Aetna	15
Deltona–Daytona Beach–Ormond Beach, FL	3,445	BCBS FL	56	All Florida PPO	14
Fort Walton Beach–Crestview–Destin, FL	4,629	BCBS FL	66	All Florida PPO	16
Gainesville, FL	4,435	BCBS FL	64	All Florida PPO	16
Jacksonville, FL	3,406	BCBS FL	55	Aetna	14
Lakeland–Winter Haven, FL	3,137	BCBS FL	52	All Florida PPO	13
Miami–Miami Beach–Kendall, FL	3,572	Dimension Health Inc.	43	UnitedHithcare	40
Naples–Marco Island, FL	5,015	BCBS FL	68	All Florida PPO	17
Ocala, FL	4,342	BCBS FL	63	All Florida PPO	16
Orlando–Kissimmee, FL	2,598	BCBS FL	46	All Florida PPO	11
Palm Bay–Melbourne–Titusville, FL	2,902	BCBS FL	50	All Florida PPO	12
Panama City–Lynn Haven, FL	4,641	BCBS FL	66	All Florida PPO	16
Pensacola–Ferry Pass–Brent, FL	4,856	BCBS FL	67	All Florida PPO	16
Port St. Lucie–Fort Pierce, FL	4,722	BCBS FL	66	All Florida PPO	16
Punta Gorda, FL	4,234	BCBS FL	63	All Florida PPO	15
Sarasota–Bradenton–Venice, FL	3,763	BCBS FL	59	All Florida PPO	13
Vero Beach, FL	4,547	BCBS FL	65	All Florida PPO	16
West Palm Beach–Boca Raton–Boynton Beach, FL	2,209	UnitedHithcare	28	Dimension Health Inc.	27

State and MSAs	PPO	Insurer 1	Share	Insurer 2	Share
Georgia	4,156	WellPoint Inc.	63	UnitedHlthcare	9
Albany, GA	6,087	Phoebe Hlth Partners	78	HealthOne	5
Athens-Clarke County, GA	6,647	WellPoint Inc.	81	Aetna	8
Atlanta-Sandy Springs-Marietta, GA	3,876	WellPoint Inc.	59	UnitedHlthcare	13
Augusta-Richmond County, GA-SC	3,888	WellPoint Inc.	55	BCBS SC	28
Columbus, GA-AL	2,627	WellPoint Inc.	37	BCBS AL	26
Gainesville, GA	3,464	WellPoint Inc.	55	Aetna	15
Hinesville-Fort Stewart, GA	4,821	WellPoint Inc.	67	HealthOne	13
Macon, GA	6,334	WellPoint Inc.	79	Secure Hlth Plan	6
Rome, GA	3,617	WellPoint Inc.	51	UnitedHlthcare	30
Savannah, GA	7,920	WellPoint Inc.	89	HealthOne	3
Warner Robins, GA	5,827	WellPoint Inc.	76	UnitedHlthcare	7
Hawaii	9,406	BCBS HI	97	Aetna	2
Honolulu, HI	9,624	BCBS HI	98	Aetna	1
Idaho	3,243	BC of ID	48	Regence BS	27
Boise City-Nampa, ID	3,842	BC of ID	58	Primary Hlth	17
Coeur d'Alene, ID	4,846	BC of ID	66	Primary Hlth	20
Idaho Falls, ID	4,585	BC of ID	63	Primary Hlth	22
Lewiston, ID-WA	3,311	BC of ID	48	Regence BS	27
Pocatello, ID	4,436	BC of ID	62	Primary Hlth	23
Illinois	2,844	HCSC (BCBS)	46	WellPoint Inc.	24
Bloomington-Normal, IL	6,048	HCSC (BCBS)	77	WellPoint Inc.	13
Champaign-Urbana, IL	4,414	HCSC (BCBS)	64	Coventry	14
Chicago-Naperville-Joliet, IL	2,849	HCSC (BCBS)	48	UnitedHlthcare	15
Danville, IL	4,817	HCSC (BCBS)	65	CIGNA	22
Decatur, IL	3,620	HCSC (BCBS)	55	Coventry	19
Kankakee-Bradley, IL	2,597	HCSC (BCBS)	43	UnitedHlthcare	20
Lake County-Kenosha County, IL-WI	3,400	HCSC (BCBS)	54	UnitedHlthcare	16
Peoria, IL	4,168	HCSC (BCBS)	61	John Deere (UnitedHlthCare)	14
Rockford, IL	4,322	HCSC (BCBS)	60	CIGNA	24
Springfield, IL	4,476	HCSC (BCBS)	63	CIGNA	21
Indiana	3,941	WellPoint Inc.	60	M*Plan (HlthCare Grp)	14
Anderson, IN	5,236	WellPoint Inc.	69	UnitedHlthcare	18
Bloomington, IN	3,962	Aetna	57	WellPoint Inc.	24
Columbus, IN	3,895	WellPoint Inc.	52	Aetna	34
Elkhart-Goshen, IN	4,868	WellPoint Inc.	68	CIGNA	13
Evansville, IN-KY	6,605	HCSC (BCBS)	80	WellPoint Inc.	16
Fort Wayne, IN	4,282	WellPoint Inc.	58	Lutheran Preferred	29
Gary, IN	5,673	HCSC (BCBS)	72	WellPoint Inc.	23
Indianapolis, IN	5,009	WellPoint Inc.	69	UnitedHlthcare	12
Lafayette, IN	2,997	WellPoint Inc.	47	Aetna	23
South Bend-Mishawaka, IN-MI	4,497	HCSC (BCBS)	61	WellPoint Inc.	25
Iowa	6,133	Wellmark	78	UnitedHlthcare	8
Ames, IA	6,661	Wellmark	80	John Deere (UnitedHlthCare)	15
Cedar Rapids, IA	5,841	Wellmark	75	UnitedHlthcare	9
Davenport-Moline-Rock Island, IA-IL	3,878	HCSC (BCBS)	58	John Deere (UnitedHlthCare)	18
Des Moines, IA	6,327	Wellmark	78	UnitedHlthcare	14

Table 3. (continued) **PPO product markets HHI market concentration and dominant insurers**

State and MSAs	PPO	Insurer 1	Share	Insurer 2	Share
Iowa City, IA	5,903	Wellmark	76	UnitedHlthcare	9
Sioux City, IA–NE–SD	6,398	Wellmark	79	UnitedHlthcare	14
Waterloo–Cedar Falls, IA	4,681	Wellmark	66	UnitedHlthcare	12
Kentucky	4,528	WellPoint Inc.	66	Aetna	8
Bowling Green, KY	6,596	WellPoint Inc.	79	Center Care Hlth Benefit Programs	17
Elizabethtown, KY	4,993	WellPoint Inc.	66	Aetna	24
Lexington–Fayette, KY	2,963	Center Care Hlth Benefit Programs	37	UnitedHlthcare	37
Louisville, KY–IN	3,260	WellPoint Inc.	51	Preferred Hlth Plan	17
Owensboro, KY	5,955	HCSC (BCBS)	73	WellPoint Inc.	26
Louisiana	5,310	BCBS LA	71	UnitedHlthcare	16
Alexandria, LA	7,224	BCBS LA	84	UnitedHlthcare	12
Baton Rouge, LA	6,340	BCBS LA	78	UnitedHlthcare	18
Houma–Bayou Cane–Thibodaux, LA	4,740	BCBS LA	65	Aetna	20
Lafayette, LA	8,538	BCBS LA	92	UnitedHlthcare	5
Lake Charles, LA	6,549	BCBS LA	79	UnitedHlthcare	16
Monroe, LA	6,995	BCBS LA	83	UnitedHlthcare	13
New Orleans–Metairie–Kenner, LA	3,827	BCBS LA	54	Aetna	21
Shreveport–Bossier City, LA	3,661	BCBS LA	49	UnitedHlthcare	34
Maine	7,682	WellPoint Inc.	87	Aetna	7
Bangor, ME	7,634	WellPoint Inc.	87	Aetna	6
Lewiston–Auburn, ME	7,186	WellPoint Inc.	84	Aetna	10
Portland–South Portland, ME	7,586	WellPoint Inc.	87	Aetna	7
Maryland	5,057	CareFirst BCBS	70	Aetna	10
Baltimore–Towson, MD	6,108	CareFirst BCBS	77	Aetna	8
Bethesda–Gaithersburg–Frederick, MD	2,541	CareFirst BCBS	42	Aetna	18
Cumberland, MD–WV	3,691	CareFirst BCBS	56	UnitedHlthcare	18
Hagerstown–Martinsburg, MD–WV	4,628	CareFirst BCBS	66	Aetna	12
Salisbury, MD	6,273	CareFirst BCBS	78	CIGNA	9
Massachusetts	3,824	BCBS MA	59	Tufts	13
Barnstable Town, MA	5,524	BCBS MA	73	Harvard Pilgrim	13
Boston–Cambridge–Quincy, MA–NH	3,489	BCBS MA	54	Harvard Pilgrim	16
Brockton–Bridgewater–Easton, MA	4,562	BCBS MA	65	Harvard Pilgrim	13
Framingham, MA	3,490	BCBS MA	54	Tufts	16
Haverhill–North Andover–Amesbury, MA–NH	2,192	BCBS MA	36	Tufts	19
Lawrence–Methuen–Salem, MA–NH	2,671	BCBS MA	44	Tufts	21
Leominster–Fitchburg–Gardner, MA	3,983	BCBS MA	61	Harvard Pilgrim	12
Lowell–Billerica–Chelmsford, MA–NH	3,305	BCBS MA	52	Tufts	17
Lynn–Peabody–Salem, MA	3,380	BCBS MA	52	Tufts	23
New Bedford, MA	4,348	BCBS MA	64	Harvard Pilgrim	13
Pittsfield, MA	4,558	BCBS MA	64	Tufts	18
Springfield, MA–CT	3,670	BCBS MA	58	WellPoint Inc.	14
Taunton–Norton–Raynham, MA	4,357	BCBS MA	64	Harvard Pilgrim	13
Worcester, MA–CT	3,640	BCBS MA	58	Harvard Pilgrim	11

State and MSAs	PPO	Insurer 1	Share	Insurer 2	Share
Michigan	6,768	BCBS MI	82	Aetna	6
Ann Arbor, MI	4,256	BCBS MI	61	Trinity Hlth (Care Choice)	20
Battle Creek, MI	8,795	BCBS MI	94	Humana	2
Bay City, MI	8,149	BCBS MI	90	HealthPlus Michigan	3
Detroit–Livonia–Dearborn, MI	5,243	BCBS MI	71	Aetna	14
Flint, MI	6,999	BCBS MI	83	HealthPlus Michigan	6
Grand Rapids–Wyoming, MI	6,292	BCBS MI	78	Priority Hlth	11
Jackson, MI	8,467	BCBS MI	92	Humana	3
Kalamazoo–Portage, MI	7,948	BCBS MI	89	Humana	3
Lansing–East Lansing, MI	8,785	BCBS MI	94	McLaren Hlth	3
Monroe, MI	5,266	BCBS MI	70	Aetna	15
Muskegon–Norton Shores, MI	5,524	BCBS MI	73	Trinity Hlth (Care Choice)	11
Niles–Benton Harbor, MI	8,216	BCBS MI	91	CIGNA	3
Saginaw–Saginaw Township North, MI	7,820	BCBS MI	88	HealthPlus Michigan	5
Warren–Farmington Hills–Troy, MI	6,200	BCBS MI	78	Aetna	10
Minnesota	4,438	BCBS MN	63	Medica	18
Missouri	5,878	WellPoint Inc.	76	UnitedHlthcare	11
Columbia, MO	7,871	WellPoint Inc.	88	UnitedHlthcare	9
Jefferson City, MO	7,177	WellPoint Inc.	84	UnitedHlthcare	13
Joplin, MO	9,072	WellPoint Inc.	95	Humana	2
Kansas City, MO–KS	3,069	BCBS KS City	49	Coventry	21
Springfield, MO	5,433	WellPoint Inc.	70	Cox Health	22
St. Joseph, MO–KS	6,069	BCBS KS City	75	Heartland (Community Hlth Plan)	23
St. Louis, MO–IL	5,317	WellPoint Inc.	71	HCSC (BCBS)	11
Montana	5,562	BCBS MT	73	UnitedHlthcare	9
Billings, MT	5,497	BCBS MT	72	Aetna	11
Great Falls, MT	8,498	BCBS MT	92	Great West (One Hlth)	5
Missoula, MT	8,686	BCBS MT	93	New West Hlth	4
Nebraska	3,417	BCBS NE	49	UnitedHlthcare	27
Lincoln, NE	4,663	BCBS NE	63	UnitedHlthcare	26
Omaha–Council Bluffs, NE–IA	2,990	BCBS NE	40	UnitedHlthcare	32
Nevada	2,584	WellPoint Inc.	44	UnitedHlthcare	15
Carson City, NV	7,100	Washoe Hlth System	84	WellPoint Inc.	10
Las Vegas–Paradise, NV	3,028	WellPoint Inc.	48	UnitedHlthcare	21
Reno–Sparks, NV	4,214	Washoe Hlth System	53	WellPoint Inc.	37
New Hampshire	4,704	WellPoint Inc.	67	Harvard Pilgrim	12
Manchester, NH	3,826	WellPoint Inc.	57	Harvard Pilgrim	19
Nashua, NH–MA	2,995	WellPoint Inc.	49	Harvard Pilgrim	17
Portsmouth, NH–ME	4,497	WellPoint Inc.	65	UnitedHlthcare	11
Rochester–Dover, NH–ME	6,874	WellPoint Inc.	83	CIGNA	5
New Jersey	2,616	Horizon BCBS	43	Aetna	18
Atlantic City, NJ	4,338	Horizon BCBS	64	UnitedHlthcare	12
Camden, NJ	2,713	Aetna	32	Horizon BCBS	30
Edison, NJ	2,925	Horizon BCBS	42	QualCare	29
Newark–Union, NJ–PA	2,803	Horizon BCBS	47	QualCare	19
Ocean City, NJ	5,128	Horizon BCBS	70	Aetna	9
Trenton–Ewing, NJ	3,109	UnitedHlthcare	39	Horizon BCBS	32
Vineland–Millville–Bridgeton, NJ	3,338	Horizon BCBS	44	Aetna	34

Table 3. PPO product markets
(continued) **HHI market concentration and dominant insurers**

State and MSAs	PPO	Insurer 1	Share	Insurer 2	Share
New Mexico	2,835	HCSC (BCBS)	44	Presbyterian Hlth	26
New York	2,207	GHI	34	Empire BCBS	26
Albany–Schenectady–Troy, NY	4,303	GHI	60	Health Now (BCBS)	25
Binghamton, NY	4,427	Empire BCBS	61	GHI	23
Buffalo–Cheektowaga–Tonawanda, NY	3,993	GHI	53	Health Now (BCBS)	32
Ithaca, NY	7,127	Empire BCBS	84	GHI	11
New York–White Plains–Wayne, NY–NJ	1,925	GHI	27	UnitedHlthcare	23
Poughkeepsie–Newburgh–Middletown, NY	3,185	GHI	48	Aetna	26
Rochester, NY	5,114	Excellus	66	Preferred Care	26
Suffolk County–Nassau County, NY	2,802	GHI	43	Empire BCBS	23
Syracuse, NY	3,564	Empire BCBS	52	Excellus	25
North Carolina	4,273	BCBS NC	62	UnitedHlthcare	17
Asheville, NC	3,991	BCBS NC	47	UnitedHlthcare	42
Burlington, NC	4,252	BCBS NC	60	UnitedHlthcare	22
Charlotte–Gastonia–Concord, NC–SC	3,239	BCBS NC	53	BCBS SC	15
Durham, NC	5,038	BCBS NC	69	UnitedHlthcare	13
Fayetteville, NC	3,463	BCBS NC	45	UnitedHlthcare	35
Goldsboro, NC	7,261	BCBS NC	85	CIGNA	11
Greensboro–High Point, NC	4,373	BCBS NC	56	UnitedHlthcare	35
Hickory–Morganton–Lenoir, NC	6,088	BCBS NC	77	UnitedHlthcare	13
Jacksonville, NC	5,185	BCBS NC	69	CIGNA	21
Rocky Mount, NC	6,390	BCBS NC	79	UnitedHlthcare	13
Wilmington, NC	4,193	BCBS NC	52	UnitedHlthcare	38
Winston–Salem, NC	6,584	BCBS NC	80	UnitedHlthcare	14
Ohio	2,624	WellPoint Inc.	45	Medical Mutual	20
Akron, OH	2,000	Medical Mutual	33	WellPoint Inc.	22
Canton–Massillon, OH	5,531	WellPoint Inc.	74	Medical Mutual	9
Cincinnati–Middletown, OH–KY–IN	7,312	WellPoint Inc.	85	Health Choice	4
Cleveland–Elyria–Mentor, OH	2,531	Medical Mutual	38	UnitedHlthcare	28
Columbus, OH	2,585	WellPoint Inc.	33	Aetna	30
Dayton, OH	5,776	WellPoint Inc.	75	UnitedHlthcare	13
Lima, OH	4,059	WellPoint Inc.	62	Medical Mutual	12
Mansfield, OH	2,483	Medical Mutual	43	Health Choice	17
Sandusky, OH	3,678	Medical Mutual	57	Health Choice	14
Springfield, OH	5,506	WellPoint Inc.	73	UnitedHlthcare	11
Toledo, OH	5,108	Medical Mutual	69	Health Choice	15
Youngstown–Warren–Boardman, OH–PA	6,025	WellPoint Inc.	77	Medical Mutual	6
Oklahoma	3,423	BCBS OK	52	CommunityCare	23
Lawton, OK	3,764	BCBS OK	52	Aetna	30
Oklahoma City, OK	4,008	BCBS OK	56	UnitedHlthcare	26
Oregon	2,046	Providence Hlth	32	Regence BCBS	26
Bend, OR	3,258	Providence Hlth	53	Pacific Source Hlth Plans	13
Corvallis, OR	2,808	Providence Hlth	43	Regence BCBS	28
Eugene–Springfield, OR	4,689	Providence Hlth	65	Pacific Source Hlth Plans	19
Medford, OR	3,224	Providence Hlth	43	Regence BCBS	35
Portland–Vancouver–Beaverton, OR–WA	3,744	Providence Hlth	59	Regence BCBS	10
Salem, OR	3,620	Providence Hlth	55	Regence BCBS	22

State and MSAs	PPO	Insurer 1	Share	Insurer 2	Share
Rhode Island	8,050	BCBS RI	90	UnitedHlthcare	5
Norwich–New London–RI	3,088	WellPoint Inc.	49	UnitedHlthcare	17
Providence–Fall River–Warwick, RI–MA	6,313	BCBS RI	79	BCBS MA	7
South Carolina	5,171	BCBS SC	71	Premier Hlth Systems	8
Anderson, SC	4,880	BCBS SC	67	Aetna	18
Charleston–North Charleston, SC	6,606	BCBS SC	81	Premier Hlth Systems	9
Columbia, SC	4,699	BCBS SC	66	UnitedHlthcare	11
Florence, SC	6,476	BCBS SC	80	Premier Hlth Systems	9
Greenville, SC	4,610	BCBS SC	65	Aetna	17
Myrtle Beach–Conway–North Myrtle Beach, SC	6,130	BCBS SC	77	Premier Hlth Systems	10
Spartanburg, SC	4,850	BCBS SC	67	Aetna	16
Sumter, SC	6,271	BCBS SC	78	Premier Hlth Systems	9
Tennessee	3,423	BCBS TN	56	Total Choice	13
Chattanooga, TN–GA	3,399	BCBS TN	55	Total Choice	14
Clarksville, TN–KY	2,771	WellPoint Inc.	38	BCBS TN	34
Cleveland, TN	4,834	BCBS TN	68	Total Choice	10
Jackson, TN	4,402	BCBS TN	64	Total Choice	13
Johnson City, TN	4,013	BCBS TN	61	Total Choice	12
Kingsport–Bristol, TN–VA	3,555	BCBS TN	56	John Deere (UnitedHlthCare)	15
Knoxville, TN	3,042	BCBS TN	50	Total Choice	17
Memphis, TN–MS–AR	3,645	BCBS TN	58	Total Choice	15
Morristown, TN	4,060	BCBS TN	61	Total Choice	13
Nashville-Davidson—Murfreesboro, TN	3,034	BCBS TN	50	UnitedHlthcare	17
Texas	2,681	HCSC (BCBS)	43	UnitedHlthcare	20
Abilene, TX	6,221	HCSC (BCBS)	78	CIGNA	9
Amarillo, TX	6,812	HCSC (BCBS)	82	CIGNA	7
Austin–Round Rock, TX	4,819	HCSC (BCBS)	68	Aetna	13
Beaumont–Port Arthur, TX	4,715	HCSC (BCBS)	65	Aetna	19
Brownsville–Harlingen, TX	4,444	HCSC (BCBS)	60	Mutual of Omaha	27
College Station–Bryan, TX	5,685	HCSC (BCBS)	74	CIGNA	12
Corpus Christi, TX	4,314	HCSC (BCBS)	62	Aetna	20
Dallas–Plano–Irving, TX	4,113	HCSC (BCBS)	59	Aetna	25
Fort Worth–Arlington, TX	4,776	UnitedHlthcare	65	Aetna	22
Houston–Sugar Land–Baytown, TX	3,324	HCSC (BCBS)	49	Aetna	28
Killeen–Temple–Fort Hood, TX	4,870	HCSC (BCBS)	67	Scott & White Hlth	14
Lubbock, TX	5,902	HCSC (BCBS)	76	CIGNA	9
McAllen–Edinburg–Mission, TX	5,733	HCSC (BCBS)	74	CIGNA	10
Midland, TX	7,130	HCSC (BCBS)	84	CIGNA	10
San Angelo, TX	5,741	WellPoint, Inc.	72	Mutual of Omaha	24
San Antonio, TX	3,850	HCSC (BCBS)	57	Aetna	25
Sherman–Denison, TX	3,977	CIGNA	54	WellPoint Inc.	31
Tyler, TX	7,242	HCSC (BCBS)	84	CIGNA	11
Wichita Falls, TX	5,915	HCSC (BCBS)	76	CIGNA	10
Utah	4,693	Regence BCBS	67	Coventry	10
Logan, UT–ID	2,586	Regence BCBS	45	Aetna	16
Ogden–Clearfield, UT	3,951	Regence BS	59	Coventry	15
Provo–Orem, UT	3,873	Regence BS	59	Aetna	12

Table 3. PPO product markets
(continued) **HHI market concentration and dominant insurers**

State and MSAs	PPO	Insurer 1	Share	Insurer 2	Share
Salt Lake City, UT	5,666	Regence BS	74	UnitedHlthcare	10
St. George, UT	3,893	Intermountain Hlth	45	Regence BCBS	42
Vermont	5,066	BCBS VT	68	CIGNA	17
Burlington–South Burlington, VT	4,176	BCBS VT	56	Aetna	28
Virginia	4,235	WellPoint Inc.	62	Aetna	13
Charlottesville, VA	4,792	WellPoint Inc.	55	Aetna	42
Harrisonburg, VA	9,093	WellPoint Inc.	95	OPTIMA Hlth (Sentara)	4
Lynchburg, VA	9,803	WellPoint Inc.	99	Great West (One Hlth)	1
Richmond, VA	4,938	WellPoint Inc.	64	Aetna	28
Roanoke, VA	9,812	WellPoint Inc.	99	Coventry	0
Winchester, VA–WV	6,245	CareFirst BCBS	78	UnitedHlthcare	11
Washington	3,246	Premera BC	47	Regence BS	29
Bellingham, WA	6,469	Premera BC	78	Aetna	18
Bremerton–Silverdale, WA	3,929	Premera BC	47	KPS Hlth Plans	40
Kennewick–Richland–Pasco, WA	6,878	Premera BC	82	UnitedHlthcare	15
Longview–Kelso, WA	7,466	Premera BC	86	Aetna	10
Mount Vernon–Anacortes, WA	6,482	Premera BC	79	Aetna	16
Olympia, WA	3,291	Premera BC	52	UnitedHlthcare	17
Seattle–Bellevue–Everett, WA	3,481	Regence BCBS	49	Premera BC	30
Spokane, WA	9,007	Premera BC	95	UnitedHlthcare	2
Tacoma, WA	2,956	Premera BC	46	Regence BCBS	22
Wenatchee, WA	8,559	Premera BC	92	Mutual of Omaha	2
Yakima, WA	9,252	Premera BC	96	CIGNA	2
Wisconsin	4,606	WellPoint Inc.	66	Physician's Service Insurance	11
Appleton, WI	4,092	Humana	53	CIGNA	36
Eau Claire, WI	8,291	WellPoint Inc.	91	Physician's Service Insurance	7
Fond du Lac, WI	7,276	WellPoint Inc.	85	Humana	7
Green Bay, WI	4,180	WellPoint Inc.	61	Humana	16
Madison, WI	5,594	WellPoint Inc.	73	Physician's Service Insurance	18
Milwaukee–Waukesha–West Allis, WI	2,914	WellPoint Inc.	47	HCSC (BCBS)	20
Oshkosh–Neenah, WI	4,852	WellPoint Inc.	66	Humana	21
Racine, WI	5,054	HCSC (BCBS)	69	Aetna	12
Sheboygan, WI	3,759	WellPoint Inc.	46	Aetna	39
Wausau, WI	4,843	WellPoint Inc.	68	Humana	14
Wyoming	6,003	BCBS WY	76	UnitedHlthcare	17

Sources of HMO and PPO data: Based on enrollment information from InterStudy Managed Market MSA and State Surveyor (Jan. 1, 2005), HealthLeaders (Jan. 1, 2005), and available public sources.

HHI: The Herfindahl–Hirschman Index of Competition (HHI) is used by the U.S. Department of Justice (DOJ) to evaluate competition. The DOJ considers markets with an HHI greater than 1,000 to be concentrated and those with an HHI greater than 1,800 to be highly concentrated.

IV. Summary table

Table 4. HHI by product for state and MSAs

State and MSAs	HMO/PPO HHI	HMO HHI	PPO HHI
Alabama	6,881	5,405	7,176
Anniston–Oxford, AL	8,809	9,874	8,951
Auburn–Opelika, AL	9,071	10,000	9,072
Birmingham–Hoover, AL	5,373	5,374	5,843
Decatur, AL	8,139	10,000	8,139
Dothan, AL	9,080	10,000	9,093
Florence, AL	8,849	10,000	8,850
Gadsden, AL	9,065	10,000	9,066
Huntsville, AL	8,879	9,603	8,917
Mobile, AL	5,897	7,569	6,464
Montgomery, AL	7,978	8,093	8,389
Tuscaloosa, AL	5,293	7,174	5,318
Alaska	4,907	———	4,907
Anchorage, AK	4,660	———	4,660
Fairbanks, AK	9,202	———	9,202
Arizona	2,679	2,916	3,900
Flagstaff, AZ	2,162	4,517	1,953
Phoenix–Mesa–Scottsdale, AZ	2,929	2,549	4,066
Prescott, AZ	2,809	4,283	2,768
Tucson, AZ	2,676	3,477	4,359
Yuma, AZ	3,464	9,002	3,010
Arkansas	5,765	2,988	6,372
Fayetteville–Springdale–Rogers, AR–MO	6,877	2,705	7,135
Fort Smith, AR–OK	5,090	3,099	5,421
Hot Springs, AR	4,615	3,129	5,196
Jonesboro, AR	7,893	3,483	8,279
Little Rock–North Little Rock, AR	6,021	3,682	6,913
Pine Bluff, AR	6,561	3,871	7,020
Texarkana, TX–Texarkana, AR	9,400	3,613	9,513
California	1,524	2,377	1,844
Bakersfield, CA	4,496	2,545	6,343
Chico, CA	2,615	6,650	2,367
El Centro, CA	2,277	5,270	2,325
Fresno, CA	1,850	2,486	2,258
Hanford–Corcoran, CA	4,238	2,650	5,317
Los Angeles–Long Beach–Glendale, CA	1,778	2,201	2,627
Madera, CA	2,398	3,219	3,406
Merced, CA	2,027	2,622	2,237
Modesto, CA	1,473	2,204	1,939
Napa, CA	2,998	6,628	3,283
Oakland–Fremont–Hayward, CA	2,671	4,114	2,500
Oxnard–Thousand Oaks–Ventura, CA	1,790	2,014	2,401
Redding, CA	2,414	4,945	2,490
Riverside–San Bernardino–Ontario, CA	1,514	2,181	2,230
Sacramento–Arden-Arcade–Roseville, CA	2,059	2,909	2,544
Salinas, CA	2,701	6,290	2,676
San Diego–Carlsbad–San Marcos, CA	1,393	2,101	2,353

State and MSAs	HMO/PPO HHI	HMO HHI	PPO HHI
San Francisco–San Mateo–Redwood City, CA	1,944	3,141	2,597
San Jose–Sunnyvale–Santa Clara, CA	1,574	2,736	1,827
San Luis Obispo–Paso Robles, CA	2,325	3,728	2,326
Santa Ana–Anaheim–Irvine, CA	1,650	2,028	2,287
Santa Barbara–Santa Maria, CA	2,024	2,592	2,249
Santa Cruz–Watsonville, CA	1,738	2,301	2,098
Stockton, CA	1,560	2,372	1,959
Vallejo–Fairfield, CA	4,295	5,348	5,002
Visalia–Porterville, CA	2,002	2,920	2,290
Yuba City–Marysville, CA	3,030	6,249	3,443
Colorado	1,828	2,562	2,543
Boulder, CO	1,937	4,214	2,626
Colorado Springs, CO	1,706	2,434	2,109
Denver–Aurora, CO	2,033	3,116	3,030
Fort Collins–Loveland, CO	2,157	3,887	2,166
Grand Junction, CO	4,014	8,664	2,277
Pueblo, CO	5,870	5,313	6,011
Connecticut	3,398	2,344	4,871
Bridgeport–Stamford–Norwalk, CT	3,256	2,846	4,196
Danbury, CT	2,983	2,733	3,705
Hartford–West Hartford–East Hartford, CT	4,316	2,886	5,508
Delaware	2,789	3,531	3,616
Dover, DE	3,787	4,850	4,830
Wilmington, DE–MD–NJ	2,252	2,467	2,642
Florida	1,522	1,343	2,039
Cape Coral–Fort Myers, FL	2,690	3,469	2,832
Deltona–Daytona Beach–Ormond Beach, FL	2,130	4,238	3,445
Fort Walton Beach–Crestview–Destin, FL	4,688	8,670	4,629
Gainesville, FL	3,890	4,204	4,435
Jacksonville, FL	2,972	3,032	3,406
Lakeland–Winter Haven, FL	2,422	2,115	3,137
Miami–Miami Beach–Kendall, FL	1,568	1,487	3,572
Naples–Marco Island, FL	4,778	2,820	5,015
Ocala, FL	3,998	2,564	4,342
Orlando–Kissimmee, FL	1,621	1,814	2,598
Palm Bay–Melbourne–Titusville, FL	2,103	2,991	2,902
Panama City–Lynn Haven, FL	4,528	6,417	4,641
Pensacola–Ferry Pass–Brent, FL	5,192	6,628	4,856
Port St. Lucie–Fort Pierce, FL	3,693	4,893	4,722
Punta Gorda, FL	4,570	6,189	4,234
Sarasota–Bradenton–Venice, FL	4,216	5,136	3,763
Vero Beach, FL	3,834	3,995	4,547
West Palm Beach–Boca Raton–Boynton Beach, FL	1,851	2,341	2,209
Georgia	3,874	3,486	4,156
Albany, GA	6,083	5,313	6,087
Athens–Clarke County, GA	5,962	4,812	6,647
Atlanta–Sandy Springs–Marietta, GA	3,483	3,159	3,876

Table 4. HHI by product for state and MSAs
(continued)

State and MSAs	HMO/PPO HHI	HMO HHI	PPO HHI
Augusta–Richmond County, GA–SC	4,736	9,465	3,888
Columbus, GA–AL	2,582	5,144	2,627
Gainesville, GA	4,522	7,192	3,464
Hinesville–Fort Stewart, GA	5,151	6,980	4,821
Macon, GA	6,671	9,271	6,334
Rome, GA	3,484	4,154	3,617
Savannah, GA	7,964	8,282	7,920
Warner Robins, GA	6,009	8,374	5,827
Hawaii	6,454	4,959	9,406
Honolulu, HI	6,665	5,053	9,624
Idaho	3,186	3,853	3,243
Boise City–Nampa, ID	3,887	5,304	3,842
Coeur d'Alene, ID	3,942	6,018	4,846
Idaho Falls, ID	4,595	9,579	4,585
Lewiston, ID–WA	3,101	6,787	3,311
Pocatello, ID	4,571	10,000	4,436
Illinois	2,837	3,073	2,844
Bloomington–Normal, IL	5,900	8,596	6,048
Champaign–Urbana, IL	3,651	9,939	4,414
Chicago–Naperville–Joliet, IL	3,013	3,648	2,849
Danville, IL	3,930	9,892	4,817
Decatur, IL	3,618	4,090	3,620
Kankakee–Bradley, IL	2,447	4,259	2,597
Lake County–Kenosha County, IL–WI	3,258	2,981	3,400
Peoria, IL	3,459	6,334	4,168
Rockford, IL	4,214	4,998	4,322
Springfield, IL	3,912	5,104	4,476
Indiana	3,910	3,942	3,941
Anderson, IN	5,448	6,853	5,236
Bloomington, IN	3,847	8,336	3,962
Columbus, IN	3,943	6,670	3,895
Elkhart–Goshen, IN	4,893	6,105	4,868
Evansville, IN–KY	5,387	8,008	6,605
Fort Wayne, IN	3,475	5,025	4,282
Gary, IN	5,251	3,724	5,673
Indianapolis, IN	4,827	4,830	5,009
Lafayette, IN	2,544	6,745	2,997
South Bend–Mishawaka, IN–MI	4,086	4,900	4,497
Iowa	5,170	3,394	6,133
Ames, IA	6,173	4,683	6,661
Cedar Rapids, IA	6,171	7,238	5,841
Davenport–Moline–Rock Island, IA–IL	3,407	4,450	3,878
Des Moines, IA	4,554	3,765	6,327
Iowa City, IA	6,359	7,171	5,903
Sioux City, IA–NE–SD	6,089	4,321	6,398
Waterloo–Cedar Falls, IA	4,569	5,160	4,681

State and MSAs	HMO/PPO HHI	HMO HHI	PPO HHI
Kentucky	3,772	2,731	4,528
Bowling Green, KY	6,495	9,646	6,596
Elizabethtown, KY	4,941	7,348	4,993
Lexington-Fayette, KY	2,683	3,501	2,963
Louisville, KY-IN	3,197	3,811	3,260
Owensboro, KY	5,914	10,000	5,955
Louisiana	3,984	2,195	5,310
Alexandria, LA	5,424	6,964	7,224
Baton Rouge, LA	4,861	2,786	6,340
Houma-Bayou Cane-Thibodaux, LA	3,853	6,770	4,740
Lafayette, LA	7,223	6,714	8,538
Lake Charles, LA	5,034	6,927	6,549
Monroe, LA	3,993	4,318	6,995
New Orleans-Metairie-Kenner, LA	3,013	2,799	3,827
Shreveport-Bossier City, LA	2,515	3,691	3,661
Maine	6,219	4,665	7,682
Bangor, ME	6,809	5,640	7,634
Lewiston-Auburn, ME	5,719	4,354	7,186
Portland-South Portland, ME	6,216	4,841	7,586
Maryland	3,302	2,685	5,057
Baltimore-Towson, MD	4,595	2,449	6,108
Bethesda-Gaithersburg-Frederick, MD	2,160	4,072	2,541
Cumberland, MD-WV	3,385	7,819	3,691
Hagerstown-Martinsburg, MD-WV	3,043	5,792	4,628
Salisbury, MD	4,727	5,740	6,273
Massachusetts	3,128	2,606	3,824
Barnstable Town, MA	4,474	3,509	5,524
Boston-Cambridge-Quincy, MA-NH	3,012	2,766	3,489
Brockton-Bridgewater-Easton, MA	3,799	3,193	4,562
Framingham, MA	2,931	2,572	3,490
Haverhill-North Andover-Amesbury, MA-NH	2,079	2,189	2,192
Lawrence-Methuen-Salem, MA-NH	2,552	2,594	2,671
Leominster-Fitchburg-Gardner, MA	2,853	2,686	3,983
Lowell-Billerica-Chelmsford, MA-NH	2,958	2,776	3,305
Lynn-Peabody-Salem, MA	3,172	3,120	3,380
New Bedford, MA	3,392	2,713	4,348
Pittsfield, MA	3,892	3,576	4,558
Springfield, MA-CT	2,850	2,354	3,670
Taunton-Norton-Raynham, MA	3,407	2,724	4,357
Worcester, MA-CT	2,654	2,563	3,640
Michigan	4,428	1,891	6,768
Ann Arbor, MI	2,642	3,464	4,256
Battle Creek, MI	8,892	9,637	8,795
Bay City, MI	6,148	5,813	8,149
Detroit-Livonia-Dearborn, MI	3,607	3,623	5,243
Flint, MI	4,508	4,515	6,999
Grand Rapids-Wyoming, MI	4,169	6,917	6,292

Table 4. HHI by product for state and MSAs
(continued)

State and MSAs	HMO/PPO HHI	HMO HHI	PPO HHI
Jackson, MI	4,055	5,134	8,467
Kalamazoo–Portage, MI	7,972	8,235	7,948
Lansing–East Lansing, MI	6,156	5,060	8,785
Monroe, MI	3,643	3,098	5,266
Muskegon–Norton Shores, MI	4,179	7,225	5,524
Niles–Benton Harbor, MI	8,116	5,058	8,216
Saginaw–Saginaw Township North, MI	5,499	6,165	7,820
Warren–Farmington Hills–Troy, MI	4,789	3,475	6,200
Minnesota	3,461	3,719	4,438
Missouri	4,894	2,037	5,878
Columbia, MO	7,238	3,566	7,871
Jefferson City, MO	6,239	3,330	7,177
Joplin, MO	8,853	7,676	9,072
Kansas City, MO–KS	3,072	3,864	3,069
Springfield, MO	5,156	4,080	5,433
St. Joseph, MO–KS	4,792	6,112	6,069
St. Louis, MO–IL	4,794	2,529	5,317
Montana	5,794	6,515	5,562
Billings, MT	5,690	6,446	5,497
Great Falls, MT	9,045	10,000	8,498
Missoula, MT	8,078	5,852	8,686
Nebraska	2,922	5,533	3,417
Lincoln, NE	4,372	4,442	4,663
Omaha–Council Bluffs, NE–IA	2,482	6,631	2,990
Nevada	2,059	4,814	2,584
Carson City, NV	6,089	4,670	7,100
Las Vegas–Paradise, NV	2,666	6,817	3,028
Reno–Sparks, NV	3,324	3,821	4,214
New Hampshire	3,391	3,400	4,704
Manchester, NH	3,057	3,020	3,826
Nashua, NH–MA	2,451	2,541	2,995
Portsmouth, NH–ME	3,339	3,131	4,497
Rochester–Dover, NH–ME	4,727	4,466	6,874
New Jersey	2,154	2,629	2,616
Atlantic City, NJ	3,564	2,962	4,338
Camden, NJ	2,696	4,478	2,713
Edison, NJ	2,323	2,844	2,925
Newark–Union, NJ–PA	2,205	2,391	2,803
Ocean City, NJ	3,802	3,082	5,128
Trenton–Ewing, NJ	2,889	4,413	3,109
Vineland–Millville–Bridgeton, NJ	3,403	6,427	3,338
New Mexico	2,494	3,688	2,835
New York	1,557	1,344	2,207
Albany–Schenectady–Troy, NY	3,164	6,489	4,303
Binghamton, NY	3,419	6,670	4,427
Buffalo–Cheektowaga–Tonawanda, NY	4,513	7,946	3,993
Ithaca, NY	6,065	9,915	7,127

State and MSAs	HMO/PPO HHI	HMO HHI	PPO HHI
New York–White Plains–Wayne, NY–NJ	1,535	2,193	1,925
Poughkeepsie–Newburgh–Middletown, NY	2,659	2,320	3,185
Rochester, NY	4,613	5,072	5,114
Suffolk County–Nassau County, NY	2,122	2,331	2,802
Syracuse, NY	3,482	9,353	3,564
North Carolina	3,459	2,760	4,273
Asheville, NC	4,059	5,244	3,991
Burlington, NC	3,636	2,710	4,252
Charlotte–Gastonia–Concord, NC–SC	2,544	2,797	3,239
Durham, NC	3,662	2,562	5,038
Fayetteville, NC	3,377	3,688	3,463
Goldsboro, NC	5,776	5,030	7,261
Greensboro–High Point, NC	4,196	4,831	4,373
Hickory–Morganton–Lenoir, NC	5,532	4,196	6,088
Jacksonville, NC	4,623	3,392	5,185
Rocky Mount, NC	4,683	4,009	6,390
Wilmington, NC	4,099	5,087	4,193
Winston–Salem, NC	6,277	5,674	6,584
Ohio	2,282	1,391	2,624
Akron, OH	1,559	1,948	2,000
Canton–Massillon, OH	3,848	2,661	5,631
Cincinnati–Middletown, OH–KY–IN	5,864	3,074	7,312
Cleveland–Elyria–Mentor, OH	2,065	2,661	2,531
Columbus, OH	2,463	2,706	2,585
Dayton, OH	4,924	4,256	5,776
Lima, OH	3,921	4,090	4,059
Mansfield, OH	2,353	7,122	2,483
Sandusky, OH	3,064	4,316	3,678
Springfield, OH	4,581	3,492	5,506
Toledo, OH	4,065	3,609	5,108
Youngstown–Warren–Boardman, OH–PA	5,601	1,680	6,025
Oklahoma	3,014	2,921	3,423
Lawton, OK	3,584	6,534	3,764
Oklahoma City, OK	3,705	3,126	4,008
Oregon	1,643	5,293	2,046
Bend, OR	3,215	4,282	3,258
Corvallis, OR	2,525	6,780	2,808
Eugene–Springfield, OR	4,397	6,556	4,689
Medford, OR	3,188	9,569	3,224
Portland–Vancouver–Beaverton, OR–WA	2,649	6,373	3,744
Salem, OR	2,684	5,140	3,620
Rhode Island	6,431	4,984	8,050
Norwich–New London, RI	2,706	3,436	3,088
Providence–Fall River–Warwick, RI–MA	4,503	2,600	6,313

Table 4. HHI by product for state and MSAs
(continued)

State and MSAs	HMO/PPO HHI	HMO HHI	PPO HHI
South Carolina	4,599	3,119	5,171
Anderson, SC	4,530	4,940	4,880
Charleston–North Charleston, SC	5,886	3,708	6,606
Columbia, SC	4,266	4,342	4,699
Florence, SC	5,983	3,853	6,476
Greenville, SC	4,174	3,407	4,610
Myrtle Beach–Conway–North Myrtle Beach, SC	5,548	3,654	6,130
Spartanburg, SC	4,345	4,292	4,850
Sumter, SC	5,807	3,532	6,271
Tennessee	2,866	4,929	3,423
Chattanooga, TN–GA	3,245	8,646	3,399
Clarksville, TN–KY	2,410	7,833	2,771
Cleveland, TN	4,476	8,585	4,834
Jackson, TN	4,390	4,269	4,402
Johnson City, TN	3,981	10,000	4,013
Kingsport–Bristol, TN–VA	3,544	9,200	3,555
Knoxville, TN	2,888	8,927	3,042
Memphis, TN–MS–AR	2,858	5,606	3,645
Morristown, TN	3,635	9,884	4,060
Nashville-Davidson–Murfreesboro, TN	2,404	5,727	3,034
Texas	2,293	1,519	2,681
Abilene, TX	4,464	9,987	6,221
Amarillo, TX	5,125	9,998	6,812
Austin–Round Rock, TX	3,839	2,828	4,819
Beaumont–Port Arthur, TX	4,047	5,048	4,715
Brownsville–Harlingen, TX	3,489	9,899	4,444
College Station–Bryan, TX	3,868	9,459	6,685
Corpus Christi, TX	2,997	8,586	4,314
Dallas–Plano–Irving, TX	3,249	3,061	4,113
Fort Worth–Arlington, TX	3,599	2,744	4,776
Houston–Sugar Land–Baytown, TX	3,032	3,425	3,324
Killeen–Temple–Fort Hood, TX	4,178	8,398	4,870
Lubbock, TX	4,325	5,001	5,902
McAllen–Edinburg–Mission, TX	5,724	6,845	5,733
Midland, TX	6,993	9,629	7,130
San Angelo, TX	4,174	9,951	5,741
San Antonio, TX	2,846	2,682	3,850
Sherman–Denison, TX	4,334	5,193	3,977
Tyler, TX	7,238	7,924	7,242
Wichita Falls, TX	5,913	10,000	5,915
Utah	3,014	3,802	4,693
Logan, UT–ID	2,412	8,367	2,586
Ogden–Clearfield, UT	2,779	3,821	3,951
Provo–Orem, UT	2,643	5,711	3,873
Salt Lake City, UT	3,637	3,336	5,666
St. George, UT	3,949	6,783	3,893

State and MSAs	HMO/PPO HHI	HMO HHI	PPO HHI
Vermont	6,110	9,557	5,066
Burlington–South Burlington, VT	5,273	9,984	4,176
Virginia	2,941	1,451	4,235
Charlottesville, VA	4,201	3,423	4,792
Harrisonburg, VA	7,515	4,224	9,093
Lynchburg, VA	6,717	6,198	9,803
Richmond, VA	4,398	3,245	4,938
Roanoke, VA	8,965	4,992	9,812
Winchester, VA–WV	5,574	4,778	6,245
Washington	2,270	4,106	3,246
Bellingham, WA	4,035	6,436	6,469
Bremerton–Silverdale, WA	2,780	8,132	3,929
Kennewick–Richland–Pasco, WA	5,051	6,208	6,878
Longview–Kelso, WA	4,224	8,845	7,466
Mount Vernon–Anacortes, WA	4,596	6,886	6,482
Olympia, WA	2,372	6,725	3,291
Seattle–Bellevue–Everett, WA	2,669	5,240	3,481
Spokane, WA	4,900	7,682	9,007
Tacoma, WA	2,131	6,184	2,956
Wenatchee, WA	7,502	5,267	8,559
Yakima, WA	7,143	4,065	9,252
Wisconsin	2,961	1,362	4,606
Appleton, WI	4,040	3,023	4,092
Eau Claire, WI	7,169	2,853	8,291
Fond du Lac, WI	6,024	2,877	7,276
Green Bay, WI	4,158	4,930	4,180
Madison, WI	3,069	2,669	5,594
Milwaukee–Waukesha–West Allis, WI	2,773	3,371	2,914
Oshkosh–Neenah, WI	4,283	5,466	4,852
Racine, WI	4,047	3,138	5,054
Sheboygan, WI	3,618	4,095	3,759
Wausau, WI	4,280	8,507	4,843
Wyoming	5,205	8,722	6,003

Sources of HMO and PPO data: Based on enrollment information from InterStudy Managed Market MSA and State Surveyor (Jan. 1, 2005), HealthLeaders (Jan. 1, 2005), and available public sources.

HHI: The Herfindahl–Hirschman Index of Competition (HHI) is used by the U.S. Department of Justice (DOJ) to evaluate competition. The DOJ considers markets with an HHI greater than 1,000 to be concentrated and those with an HHI greater than 1,800 to be highly concentrated.

ADDENDUM 2

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SYMPOSIUM: ABJS CARL T. BRIGHTON WORKSHOP ON HEALTH POLICY ISSUES IN ORTHOPAEDIC SURGERY

Physician Collective Bargaining

Anthony Hunter Schiff JD, MPH

Abstract Current antitrust enforcement policy unduly restricts physician collaboration, especially among small physician practices. Among other matters, current enforcement policy has hindered the ability of physicians to implement efficient healthcare delivery innovations, such as the acquisition and implementation of health information technology (HIT). Furthermore, the Federal Trade Commission and Department of Justice have unevenly enforced the antitrust laws, thereby fostering an increasingly severe imbalance in the healthcare market in which dominant health insurers enjoy the benefit of largely unfettered consolidation at the cost of both consumers and providers. This article traces the history of antitrust enforcement in healthcare, describe the current marketplace, and suggest the problems that must be addressed to restore balance to the healthcare market and help to ensure an innovative and efficient healthcare system capable of meeting the demands of the 21st century. Specifically, the writer explains how innovative physician collaborations have been improperly stifled by the policies of the federal antitrust enforcement agencies, and recommend that these policies be relaxed to permit physicians more latitude to bargain collectively with health insurers in conjunction with procompetitive clinical integration efforts. The article also explains how the unbridled consolidation of the health insurance industry has resulted in higher premiums to consumers and lower compensation to physicians, and recommends that further consolidation be prohibited. Finally, the writer discusses how health insurers with market power are improperly undermining the physician-patient relationship, and recommend federal antitrust enforcement agencies take appropriate steps to protect patients and their physicians from this anticompetitive conduct. The article also suggests such steps will require changes in three areas: (1) health insurers must be prohibited from engaging in anticompetitive activity; (2) the continuing improper consolidation of the health insurance industry must be curtailed; and (3) the physician community must be permitted to undertake the collaborative activity necessary for the establishment of a transparent, coordinated, and efficient delivery system.

Each author certifies that he or she has no commercial associations (e.g., consultancies, stock ownership, equity interest, patent/licensing arrangements, etc) that might pose a conflict of interest in connection with the submitted article.

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Introduction

The antitrust laws are "a consumer welfare prescription" [1]. They ensure competition and prohibit restraints on trade that lead to higher prices, reduced quality, or injury to market efficiencies for inputs such as hospital and physician services [2, 3].

Several antitrust statutes have application in the healthcare area. A key federal statute for physicians is Section 1 of the Sherman Act (15 U.S.C. §1), which provides:

> "Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or

commerce among the several states, or with foreign nations, is declared to be illegal."

Large health insurers must also be required to comply with the statutes involving mergers and monopolization. Section 7 of the Clayton Act (15 U.S.C. §18) prohibits mergers that may "substantially...lessen competition, or...tend to create a monopoly." Section 2 of the Sherman Act makes it unlawful for a company to "monopolize, or attempt to monopolize" trade or commerce.

Because of the important economic underpinnings reflected in the antitrust laws, penalties for violating them are severe. Criminal violations of the Sherman Act are felonies punishable by imprisonment for up to 3 years and/or fines of up to $350,000 for individuals and $10 million for corporations per violation (15 U.S.C. §1). A criminal conviction virtually assures civil liability. Judgments for civil violations often run in the millions of dollars, particularly because a private party can recover three times the amount of damages actually sustained, as well as other costs and attorneys' fees incurred in prosecuting the action—fees which often exceed $1 million.

This article traces the history of antitrust enforcement in health care, which has often harmed physicians while at the same time greatly benefited health insurers. The discussion then turns to the health care marketplace in 2009, and documents four major factors that compel a need to revisit antitrust enforcement policy: (1) uncontrolled health insurer consolidation and market power; (2) healthcare workforce shortages; (3) the rising disparity between increasing physician practice costs and flat or declining reimbursements; and (4) the demand for investments in health information technology. Finally, the discussion turns to potential remedies for the imbalance in the marketplace between health insurers and physicians, including changes in antitrust enforcement policy to curtail continued health insurer consolidation and prohibit anticompetitive conduct by health insurers with market power on the one hand, while relaxing the rules applicable to physicians to permit procompetitive collaborations necessary for the optimal implementation of health information technology and other innovations necessary to an efficient health care delivery system.

Physicians and the Antitrust Laws

For many years, the general consensus was that the professions were immune from the antitrust laws. However, in 1975 the landscape changed dramatically when the U.S. Supreme Court issued its opinion in the case of Goldfarb v. Va. State Bar [4], in which the high court concluded that the antitrust laws applied to attorneys, and every other profession, stating that the "nature of an occupation, standing alone, does not provide sanctuary from the Sherman Act... nor is the public-service aspect of professional practice controlling in determining whether §1 includes professions." Any doubt as to whether physicians were covered by the Goldfarb decision was eliminated in Arizona v. Maricopa County Medical Society [5], where the U.S. Supreme Court found that an agreement among physicians to set maximum prices charged by those who participated in a PPO network constituted a per se violation of the Sherman Act. Under the per se rule, the practice is deemed so manifestly anticompetitive in nature that it is deemed illegal, without regard to its actual market impact. Under the "rule of reason," the standard more commonly applied to an antitrust challenge, the anticompetitive consequences of a challenged practice are weighed against its purpose and procompetitive effect.

Unfortunately, the Maricopa decision went much farther than just to confirm that physicians were subject to the antitrust laws. It applied the per se rule to outlaw a joint contracting activity—the agreement to a maximum fee-schedule—that was arguably necessary to the maintenance of a physician network. Yet, as the proliferation of the rental network PPO market has demonstrated, physician rental networks clearly have a place in the healthcare delivery system. Indeed, the Maricopa case came to the Supreme Court in response to a request by the State of Arizona for an early legal ruling that an agreement between competitors to set maximum prices was illegal per se, just as an agreement between competitors to set minimum prices had long been declared to be flatly illegal. The parties to the case *had engaged in only limited discovery* by the time of this request, so there was no factual record before the U.S. Supreme Court on the potential efficiencies of physician joint contracting. Thus, it should not be surprising that the decision is in tension with other U.S. Supreme Court cases holding similar joint arrangements in other industries to be subject to the so-called rule of reason [6], or that Maricopa was a 4-3 decision.

The application of the antitrust laws to physicians has continued to be the subject of concern since the overly broad Maricopa decision. Responding to concerns that the antitrust laws were unduly stifling healthcare innovation, the Federal Trade Commission (FTC) and Department of Justice (DOJ) jointly issued Statements of Enforcement Policy in Health Care (the "Statements") during the 1990s in an effort to provide clearer guidance as to those activities the agencies would (or would not) find problematic. While these Statements are not binding on the courts, they are important reflections of FTC/DOJ enforcement priorities.

The initial version of the Statements was released in September 1993 and contained eight separate policy

statements, including Statement 8 on "Physician Network Joint Ventures" [7]. Reflecting the Maricopa decision, Statement 8 identified two features of particular importance: (1) the network's percentage or "share" of the physicians in each physician specialty practicing in the relevant geographic markets; and (2) whether the physicians had integrated their practices by sharing "substantial financial risk." Only the sharing of "substantial financial risk" was sufficient to allow a network to be evaluated under a reasonableness standard. Other forms of integration—structural, functional, or transactional—were not considered adequate to avoid per se condemnation.

According to the Statements, sharing "substantial financial risk" could be accomplished in one of two ways: (1) by accepting "capitated" or "per-member per-month" payments; or (2) by incentivizing physicians to contain costs through the use of a substantial withhold from payments. The existence of either type of substantial financial risk meant that the physician collaboration, if challenged, would be evaluated under the rule of reason standard. The absence of any evidence of substantial financial risk would result in summary condemnation of the collaboration as per se illegal price fixing [7]. As noted above, per se illegality conclusively presumes the challenged practices unreasonable. In other words, when a per se offense, like price fixing among competitors, is charged, all that must be established is that the defendant has, in fact, engaged in the proscribed practice.

With the rapid expansion of managed care in the 1990s, the requirement of financial risk-sharing as the defining feature of a legitimate physician network proved to be unduly restrictive. In many regions of the country, physician capitation proved to be an unpopular and highly controversial payment methodology. Employers wanted broad networks that allowed patients a broad choice among physicians, without perceived incentives to withhold or ration care. Yet, the definition of "substantial financial risk" adopted by the agencies creates a significant barrier to the participation of physician-led contracting networks.

In the 1996 version of the Statements, the agencies recognized a second type of integration that could qualify a physician network for rule of reason treatment—"Clinical Integration." Clinical integration, as defined in the Statements, is evidenced "by the network implementing an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality" [8]. Clinical integration as so defined represented a sort of "as if" standard, i.e., a physician network that acted "as if" its members shared financial risk—by instituting the types of efficiencies associated with financial risk sharing—might qualify for rule of reason treatment despite the absence of "substantial financial risk." For several years following the publication of the 1996 Statements, the agencies gave no further guidance on the meaning of clinical integration.

In 2002, however, the FTC issued a staff advisory letter addressing the clinical integration proposal of MedSouth, Inc., an independent practice association based in Denver, CO, with over 400 physicians [9]. And in 2007, the FTC issued a similar staff advisory letter to the Greater Rochester Independent Practice Association, Inc. (GRIPA), a network based in Rochester, NY, with over 600 physician members [10]. The MedSouth and GRIPA letters demonstrate how high the bar has been set for physician networks seeking to integrate clinically. While the MedSouth and GRIPA proposals are not identical, they bear substantial similarities. Both networks were originally built for capitation, but needed to adapt in the face of market resistance. Thus, both MedSouth and GRIPA were constructed "as if" the physicians were sharing substantial financial risk. Only when risk contracting proved to be commercially infeasible did the networks seek FTC approval for their clinical integration programs. Both MedSouth and GRIPA made major investments, using myriad consultants, lawyers, and technology experts to assist in the effort. Both networks invested in electronic medical records and tracking technology to permit their network physicians to share information on their patients and to monitor data relating to utilization and medical outcomes. Both networks developed clinical practice guidelines and procedures for monitoring compliance, and both networks were "nonexclusive," meaning that payors choosing not to support the clinically integrated program would not lose access to any desirable physicians who were participating in the network. Importantly, the FTC found no anticompetitive motivation for either network.

Despite the substantial investment of resources, neither MedSouth nor GRIPA achieved FTC approval easily or without significant ongoing conditions and caveats. Both FTC advisory letters reflected extensive agency investigation of the networks' history, purposes, contracting mechanisms, disciplinary methods for noncompliant physicians, and strategies for producing efficiencies. Each investigation involved a searching examination of the so-called "ancillarity" [11] of the networks' pricing mechanisms to its efficiency-enhancing potential. Ancillarity refers to whether a pricing mechanism is "reasonably related to the integration and reasonably necessary to achieve its pro-competitive benefits." Each letter also left the FTC plenty of room to bring a later enforcement action if the networks' operations could not later be shown to produce substantial efficiencies.

The MedSouth and GRIPA advisory letters reflect the extremely high level of clinical integration required for

FTC approval. As a practical matter, absent vast resources, such as those available to MedSouth and GRIPA, most physicians are effectively barred from forming physician networks. Unfortunately, unless they are employed in an integrated medical group, physicians cannot work collaboratively on costly and complex healthcare quality initiatives nor participate in balanced negotiations with health insurers without such networks.

Outside the healthcare context, courts and the federal agencies themselves appear to apply a more flexible analysis than that found in the Statements. For example, in the Joint FTC/DOJ Guidelines on Competitor Collaboration, there is no mention of financial or clinical integration. Instead, the Competitor Collaboration Guidelines ask more generally whether a joint venture involves "an efficiency-enhancing integration of economic activity" and whether any restraints are "reasonably related to the integration and reasonably necessary to achieve its pro-competitive benefits" [12]. The Supreme Court, too, in its joint venture cases has rejected any fixed formulation of what may constitute integration sufficient to warrant rule of reason treatment [6].

Health Insurers and the Antitrust Laws

Health insurers, like physicians, were originally thought to be immune from the antitrust laws. This changed in 1944 when the U.S. Supreme Court ruled in United States v. South-Eastern Underwriters Association [13] that Congress had the power to regulate insurance companies, despite the then prevailing view that "insurance is not commerce." However, unlike physicians, insurers were successful in reinstating much of their prior immunity the next year when Congress enacted the McCarran-Ferguson Act. Under that Act, the federal antitrust laws do not apply to the "business of insurance" as long as the state regulates in that area, except in cases of boycott, coercion, and intimidation.

While the precise scope of the McCarran-Ferguson Act immunity remains unclear, it is not absolute, particularly when it comes to merger challenges. Because health insurers are both sellers of insurance to consumers and buyers of medical services, mergers and other conduct involving health insurers potentially can raise issues related to both monopoly (only one seller) power and monopsony (only one buyer) power. As discussed below, health insurers have entered into consent decrees with respect to certain mergers.

The 1992 Horizontal Merger Guidelines ("Merger Guidelines") specify that "mergers should not be permitted to create or enhance market power or to facilitate its exercise" [14]. As with the FTC/DOJ Statements, these Merger Guidelines do not bind courts, but they do describe the Agencies' enforcement priorities. Market power "is the ability profitably to maintain prices above competitive levels for a significant period of time" [14 at n.9]. A merger also may "lessen competition on dimensions other than price, such as product quality, service, or innovation" [14 at n.6].

To identify mergers that are likely to cause competitive problems, the Merger Guidelines provide for the examination of several issues, including: whether the merger, in light of market concentration and other factors that characterize the market, would be likely to have adverse competitive effects; whether entry would be timely, likely, and sufficient either to deter or to counteract the competitive effects of concern; whether there are efficiency gains from the merger that meet the Agencies' criteria for examination; and whether, but for the merger, either party to the transaction would be likely to fail, causing its assets to exit the market [14 at §0.2].

As discussed below, the health insurance market in the United States is now highly concentrated. While the new administration may institute change, to date the FTC and DOJ have shown little interest in restricting additional mergers, and no interest in addressing complaints of monopolization by dominant health insurers.

The Current Healthcare Market

Over the past several years, healthcare market conditions have changed in major ways that suggest a need to revisit the antitrust landscape. Health insurers have consolidated to the point that the ability of physicians to advocate on behalf of their patients and themselves has been severely compromised. At the same time, and exacerbated by this imbalance, shortages of healthcare providers are becoming increasingly acute, as discussed in detail below. Simultaneously, the aging population is creating a greater demand for healthcare services. Finally, market and regulatory developments are increasingly placing a premium on the use of HIT and the measurement and improvement of medical care.

While beyond the scope of this paper, the writer notes that community hospitals have also been impacted by predatory contracting tactics employed by the insurance industry. Required by state law to maintain licensed services, including skilled nursing, and burdened by technology cost outlays, community nonprofit hospitals have been very vulnerable to predatory contracting tactics. And like physicians, hospitals are prohibited from engaging in collective bargaining. As a result, these hospitals have in many instances downsized or gone out of business, leaving the public more vulnerable to pandemics and other natural disasters and emergencies.

Uncontrolled Health Insurer Market Power and Consolidation

The health insurer market has changed substantially due to a wave of mergers over the past decade, steadily eroding the competitive payor market [15]. In fact, during the last decade, there have been over 400 health insurer mergers. Tellingly, only three mergers have been challenged by the DOJ. As a result, the payor market has consolidated and payors enjoy substantial negotiating leverage over providers in most markets. The AMA has just completed the 2008 edition of its publication tracking the consolidation of the health insurance industry entitled "Competition in health insurance: A comprehensive study of U.S. markets" [16]. In this most recent study, the AMA found that 94% of the Metropolitan Statistical Areas (MSAs) it examined are highly concentrated using standards relied on by the federal antitrust enforcement agencies. Further, in 89% of those MSAs, a single health insurer holds at least 30% of the market for commercial health insurance [16].

To put this in perspective, in 2000, the two largest health insurers, Aetna and UnitedHealth Group ("United"), had a total combined membership of 32 million people. Due to aggressive merger activity since 2000, including United's acquisition of California-based PacifiCare Health Systems, Inc., and John Deere Health Plan in 2005, United's membership alone has grown to 33 million. Similarly, WellPoint, Inc. ("Wellpoint"), the company born of the merger of Anthem, Inc. (originally Blue Cross Blue Shield of Indiana), and WellPoint Health Networks, Inc. (originally Blue Cross of California), now owns Blue Cross plans in 14 states, covering approximately 34 million Americans [17]. Most recently, United acquired Sierra Health Systems in Nevada, allowing United to acquire over 50 percent of the Nevada market, including a 90 percent share of the health maintenance organization ("HMO") market.

The power garnered by health insurers through rapid, large-scale consolidation has not been used to the advantage of consumers or providers. Patient premiums have soared in this increasingly consolidated market and physician reimbursement has decreased. As premiums have risen, many employers have stopped providing coverage; particularly those firms with three to nine employees [18], substantially limited or reduced the scope of benefits provided, and/or asked employees to pay a higher share of the overall premium, thus effectively shrinking the scope of coverage. The 2008 Kaiser Family Foundation survey found that large firms (classified as having 200 or more workers) provide 99% of their full time employees with health insurance, as opposed to 40% in firms with 3-9 employees. This figure was 56% for small firms in 1999. As of 2006, premiums for employer-based health insurance rose more than twice as fast as overall inflation and wages for the seventh straight year [19]. Since 2000, the amount that workers pay toward family healthcare coverage has skyrocketed 84% [19] and 5 million fewer workers were receiving job-based coverage in 2006 than in 2000 [19]. During the same period, average wages increased only 20% [19]. These soaring costs have directly contributed to an increase in the number of uninsured. Research shows that a 1% increase in premiums results in a net increase in the uninsured of 164,000 individuals [20].

Nor have physicians benefited from these premium increases. To the contrary, powerful insurers have depressed physician revenues [21]. *The median real income of all U.S. physicians remained flat during the 1990s and has since decreased* [22]. The average net income for primary care physicians, after adjusting for inflation, declined 10% from 1995 to 2005, and the net income for medical specialists declined 2% [22].

This reduction in physician income has not benefited patients, and indeed may have harmed them. The phenomenon of lower physician fees paid by insurers potentially resulting in higher prices to patients was emphasized by R. Hewitt Pate, a former Assistant Attorney General of the Antitrust Division, in a statement before the Senate Judiciary Committee:

> "A casual observer might believe that if a merger lowers the price the merged firm pays for its inputs, consumers will necessarily benefit. The logic seems to be that because the input purchaser is paying less, the input purchaser's customers should expect to pay less also. But that is not necessarily the case. Input prices can fall for two entirely different reasons, one of which arises from true economic efficiency that will tend to result in lower prices for final consumers. The other, in contrast, represents an efficiency-reducing exercise of market power that will reduce economic welfare, lower prices for suppliers, and may well result in higher prices charged to final consumers."

Health plan executives and shareholders, on the other hand, have reaped enormous monopoly profits [23]. The profit margins of the major national firms experienced double-digit growth between 2001 and 2008 [23 at pp. 19–20]. United and WellPoint, specifically, had 7 years of consecutive double-digit growth that has ranged from 20% to 70% year after year (through 2003) [23 at pp. 19–20].

In addition to affecting costs, payments, and profits, this consolidation has created an extreme imbalance in health insurer-physician contracting that threatens all aspects of patient care. Health insurers are able to dictate important aspects of patient care and material contract terms to

physicians that intrude into medical care decisions [18 at p.5]. Physicians have little to no ability to influence insurer contracts that touch on virtually every aspect of the patient-physician relationship. Many contracts are essentially "contracts of adhesion"—standardized contracts that are submitted to a weaker party on a take-it or leave-it basis and do not provide for negotiation. This means that physicians must agree to contracts that often include provisions that make it difficult, if not impossible, for them to promote what they deem to be the optimal patient care. For example, many contracts define "medically necessary care" in a manner that allows the health insurer to overrule the physician's medical judgment and require the lowest cost, but not necessarily optimal, care for the patient. Others require compliance with undefined "utilization management" or "quality assurance" programs that often are nothing more than thinly disguised cost-cutting programs that penalize physicians for providing care they deem necessary. Some have gone so far as to require the physician to suffer a significant financial penalty if the physician fails to use a designated setting for services, even when the use of that setting would jeopardize the patient's health or impose a substantial hardship.

These contracts also often dictate key financial terms in ways that no supplier of services in any other industry sector would tolerate. For example, these contracts may refer to "fee schedules" that are never provided and can be revised unilaterally by the health insurer. Many contracts allow the health insurer to change any term of the contract unilaterally. These contracts also frequently contain such unreasonable provisions as "most favored payor" clauses—clauses requiring physicians to bill the dominant health insurer at a level equal to the lowest amount the physician charges any other health insurer in the region. This permits the dominant health insurer to guarantee that it will have the lowest input costs in the market, making it that much more difficult for new payors to enter the market. They also contain "all products" clauses—clauses requiring physicians to participate in all products offered by a health insurer as a condition of participation in any one product. This often includes the health insurer reserving the right to introduce new plans and designate a physician's participation in those future plans. Given the rapid development of new products and plans, the inability of physicians to select which products and plans they want to participate in makes it difficult for physicians to manage their practices effectively.

Despite the improper restrictions and potential dangers of these contracts, the current imbalance in the market dictates that physicians typically have no choice but to accept them. Any alleged "choice" is illusory given that choosing to leave the network often means terminating patient relationships and drastically reducing or losing one's medical practice. In my experience, the strong personal relationships physicians form with their patients often influence them to accept contract terms that they would not accept but for those personal bonds. In addition, because medical services cannot be stored or exported, physicians have limited options for selling their services. If physicians were to refuse the terms of a major health insurer, they would likely suffer a significant loss. Consequently, a physician's ability to terminate a relationship with a health insurer depends on that physician's ability to make up for the loss by switching to an alternative insurer, or other purchasers of the physician's services.

Where alternative purchasers are lacking, physicians are forced to accept unfair contracts. The DOJ, in its 1999 challenge of the Aetna/Prudential merger recognized that there are substantial barriers to physicians expeditiously replacing lost revenue by changing health plans. It also noted that this imposes a permanent loss of revenue [24]. The DOJ reiterated this position in its challenge to the UnitedHealth Group/PacifiCare merger [25]. Furthermore, even where there are other insurers, physicians are limited in their ability to encourage patients to switch plans, as patients can typically switch employer-sponsored plans only during the once a year open enrollment period, and even then, patients have limited options and may incur considerable out-of-pocket costs should they wish to change insurers to follow their physicians [25].

In this environment, the antitrust enforcement agencies need to do far more to protect competition in health insurer markets. The continued enforcement focus on physician collaboration efforts is inappropriate given the scant likelihood in most payor-dominated markets that physician networks would be able to exercise market power in their negotiations with insurers. The brutal fact is that health insurers are aware that given the cost of office overhead, the vast majority of physicians must contract with all major payors if they are to remain viable, no matter how unreasonable the contract terms.

Healthcare Workforce Shortages

The problems described above have exacerbated the physician workforce shortage. The Association of American Medical Colleges (AAMC) publication "The Complexities of Physician Supply and Demand: Projections Through 2025" released in October 2008 highlights that the United States faces an increasing physician workforce shortage [26]. Numerous factors such as an aging population which requires more health resources and a growing population create added future demand on the US health system. On the supply side, key factors, including that (1) one-third of the active physicians (250,000) are over age 55 years and

likely to retire by 2020; and (2) the newest generation of physicians may be unwilling to work the extraordinarily long hours that prior generations of physicians routinely worked, will add additional strains to this expected physician supply dilemma [27].

A brief discussion of the current and projected demand for physician services is illustrative of the problem. The U.S. Census Bureau projected the 2006 U.S. population would be approximately 300 million. Medical care was provided to this population by 256,500 FTE general primary care physicians (general and family practice, general internal medicine, and general pediatrics); 90,900 FTE medical specialty physicians (cardiovascular disease, gastroenterology, internal medicine subspecialties, nephrology, pulmonology, and other medical specialties); 142,400 FTE surgeons (general surgery, obstetrics and gynecology, ophthalmology, orthopedic surgery, otolaryngology, thoracic surgery, urology, and other surgical specialties); and 190,800 FTE physicians classified as other patient care (anesthesiology, emergency medicine, neurology, pathology, psychiatry, radiology, and other specialties) [26]. In 2025, the U.S. population is projected to be 350 million. This population will receive medical care from an estimated 272,700 FTE general primary care physicians, 117,600 FTE medical specialty physicians, 138,800 FTE surgeons and 205,700 FTE physicians classified as other patient care [26]. The AAMC predicts these modest increases in physician supply will be inadequate to meet the needs (Fig. 1).

Recognizing that the expansion of U.S. medical school capacity will require 10 or more years, the AAMC has recommended a 30% increase in U.S. medical school enrollment and an expansion of Graduate Medical Education (GME) positions to accommodate this growth [28]. Nonetheless, with the baby boom generation entering retirement, and the extensive academic and clinical time required to produce physicians, simply educating and training more physicians will not be enough to address these shortages. Additional and complex changes to improve efficiencies, to reconfigure health service delivery, and to better use of the nation's physicians will also be needed. But change of this magnitude requires flexibility and resources.

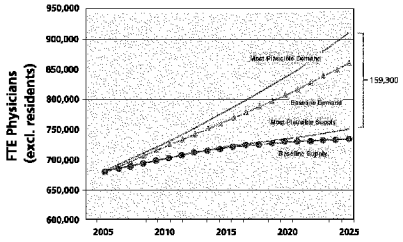

Fig. 1 A projection of numbers of FTE physicians 2006–2025 suggests the number will be inadequate. (© 2008 Association of American Medical Colleges. All rights reserved. Reproduced with permission.)

Increasing Disparity between Practice Costs and Reimbursements

Further compounding the problem is the accelerating disparity between the increases in physician practice costs and the flat or declining payments physicians are receiving for their services. This problem is most acute with respect to the Medicare fee schedule, as currently impacted by the misnamed "Sustainable Growth Rate" (SGR) (Fig. 2).

Indeed, the chart below depicts a conservative picture of the problem, as the physician cost data graphed on this chart is from the government's Medicare Economic Index. The physician practice cost surveys conducted by the Medical Group Management Association suggest that the inflation rate in physician practice expenses is far greater (Fig. 3).

Consumerism and Health Information Technology (HIT)

Another ongoing and major change in the healthcare market is the shift towards consumerism and the concomitant demand for more accessible health information. There

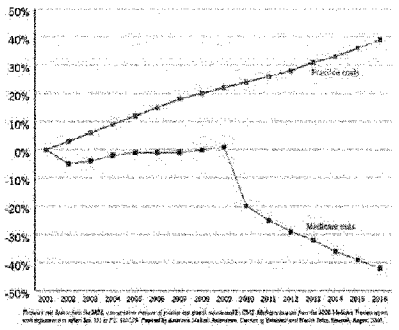

Fig. 2 Physician costs and Medicare reimbursement (abscissa) over time; there is a projected increase in the gap. (Prepared by the American Medical Association, Division of Economic and Health Policy Research.) (© 2008 American Medical Association. All rights reserved. Reproduced with permission.)

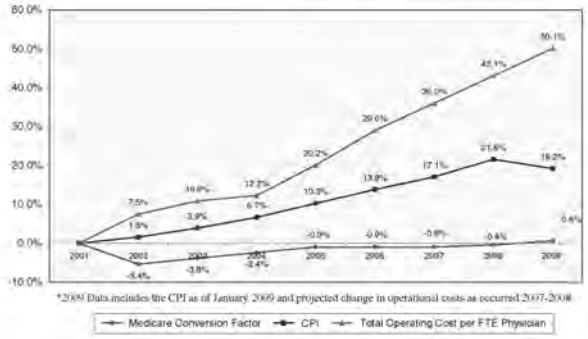

Fig. 3 Cumulative percent change since 2001 for the Medicare conversion factor, multispecialty group operating cost and the consumer price index medical group management association 2008. (© 2008 Medical Group Management Association. Reprinted with permission.)

are increasingly focused efforts on developing methods of promoting and measuring quality. At the same time, the federal government is seeking to encourage physicians and other providers to invest in HIT to facilitate the collection and sharing of clinical data. On the payor side, employers are favoring health plans that put increasing responsibility on patients to participate actively in choosing (and paying for) care. For physicians, who still practice predominantly in small groups, network arrangements provide a viable way of achieving the economies of scale necessary to participate in these initiatives, where optimal use of the integrative potential of the technology requires substantial capital and coordinated decision-making [29].

The shift towards performance-based reimbursement provides a good example of the strong incentives for physicians to collaborate with one another to collect and analyze quality data. "Pay-for-performance" (P4P) reimbursement is "now routinely used by both private and public payors in the U.S. healthcare system" [30]. A majority of commercial HMOs use P4P and recent legislation requires Medicare to adopt performance-based incentives [31]. As the adoption of P4P spreads and its use expands, physicians in small practices will be increasingly motivated to align with networks in order to have the capability to participate in these programs. However, and despite the potential for such arrangements to enhance efficiency, networking among physicians will not proliferate in the absence of a change in current antitrust enforcement policies.

Potential Remedies to the Current Malaise

As the preceding discussion illustrates, the profound imbalance in the marketplace between the health insurers who collect premiums to pay for medical care and the physicians who provide medical care, has resulted in an increasingly unfair and inefficient healthcare delivery system. The playing field between health insurers and physicians must be leveled to remedy the situation and restore the true competition and creativity that are sorely needed to ensure all Americans have access to affordable, quality medical care. This will require changes in three areas: (1) health insurers must be prohibited from engaging in anticompetitive activity; (2) the continuing improper consolidation of the health insurance industry must be curtailed; and (3) the physician community must be freed to undertake the collaborative activity necessary for the establishment of a transparent, coordinated, and efficient delivery system.

Prohibit Health Insurers from Engaging in Anticompetitive Activity

Health insurers throughout the country have amassed substantial market power and must be prohibited from exercising that power in ways that are anticompetitive. It is not clear that new laws are required to accomplish this; there are already many laws at both the federal and state levels that could be deployed for this purpose. *Rather, it appears that the principle change required is a reevaluation of the premise apparently shared by most antitrust enforcers that health insurers consistently act as surrogates for consumers.* As the prior discussion indicates consumers as well as physicians have suffered as ever more powerful health insurers have increased both premiums and profits. Predatory conduct by health insurers is at least as bad for consumer welfare as predatory conduct which occurs in other industries. If anything, prosecutorial

discretion should be exercised more aggressively in this market, particularly given the lack of accountability that this sector has enjoyed.

Curtail the Continuing Consolidation of the Health Insurance Industry

For the reasons discussed above, it is also critical that the health insurance industry not be allowed to become further consolidated. Again, there appear to be laws at both the federal and state levels to preclude further consolidation in any circumstance where the effect of the consolidation will be to lessen competition. The principal problem appears to be a failure of enforcement. However, given their focus on and expertise with health insurance, it does appear that state insurance commissioners could play a more important role in this area.

Permit Physicians to Participate in Procompetitive Collaborations

Finally, antitrust enforcement policies directed at physicians must be reevaluated. Joint contracting by physicians in a network can result in extensive collaboration to improve and measure care and to provide cost savings for both payors and physicians. On the payor side, joint contracting can make it possible for a payor to obtain ready access to a panel of physicians offering broad geographic and specialty coverage [32]. Since physicians still practice predominantly in solo or small group practices, creating a physician panel can be a very time-consuming and expensive task, and can be a barrier to entry or expansion for new or less significant insurers. In its complaint in United States v. Aetna, the DOJ noted that "effective new entry for an HMO or HMO/POS plan in Houston or Dallas typically takes 2 to 3 years and costs approximately $50,000,000" [24]. When the physicians themselves undertake the initial task of network formation, payors may substantially reduce the costs of the payors' entry and expansion. Indeed, any doubt concerning the intrinsic efficiency of physician networks should be eliminated by the thriving rental PPO network business that has emerged to supplement inadequate networks. Joint contracting thus has the potential both to reduce costs for payors and to increase competition in payor markets. These are cognizable benefits, with real potential to create efficiencies, lower premiums and expand coverage for patients.

Joint contracting can also make physician contracting more efficient and lead to better-informed contracting decisions. Most physician practices are simply too small to afford to hire business advisers and lawyers to review their contracts with payors. These physician practices do not have the in-house resources to analyze complex contracts. Whereas payors have sophisticated actuarial and financial resources that enable them to structure and evaluate complex contract proposals, physicians are often in the dark when they consider a contract. By pooling their resources, physicians can spread the costs associated with the analysis of payor contracts, and develop appropriate counteroffers that can benefit patient, physicians, and payors. The effect is to enhance the efficiency of the physicians' practices and make them more responsive to the demands of competition.

Likewise, joint contracting can provide the resources physicians need for creating networks that will facilitate collaboration on HIT. The benefits of HIT fall into two basic categories. First, the system may reduce the costs of running a medical practice. For example, it can eliminate the need to archive and store medical records. Medical records are rarely lost and communication between physicians is enhanced and preserved. Second, these systems can create cost savings by increasing the availability of patient data and, correspondingly, by eliminating the duplication of services to patients. For instance, HIT may reduce the frequency of primary and specialty physicians ordering the same test. Currently, however, physicians are unable to capture the financial returns or substantial benefits from HIT that are necessary to offset the high implementation costs. Today, those benefits and financial returns accrue mainly to health insurers, rather than physicians. Thus, it is unlikely, as noted by the Congressional Budget Office, that a solo practitioner or a small group practice will realize any real, internal cost savings from information technology systems [33].

This is a classic problem recognized in economics—the problem of externalities. An externality arises when an individual cannot recover the costs of investing in an asset because most of the benefits fall to an individual whom the investor has no way of charging for the benefit. Building roads is a good example of the problem of externalities, as is putting air filtration systems on factories. When the externality is large and the upfront costs for the investment are sizable in relation to the expected recoverable benefit, a market failure occurs. This market failure means the investment is not made and consumers are made worse off. In the healthcare context, the benefits of costly HIT systems [34] do not produce the necessary incentives for physicians to invest in them. Acquiring and implementing an Electronic Health Record (EHR) system, for example, entails a major financial investment. One study examining such acquisition costs for solo or small group practices estimated that "[i]nitial EHR costs were approximately $44,000 per full-time equivalent (FTE) provider per year, and ongoing costs were about $8,500 per FTE provider per year." For this reason, only 14% of physicians have

minimally functional HIT systems [35]. Solo or single-partner practices, accounting for about half of all doctors, had the lowest level of comprehensive HIT use—7.1% of solo practitioners and 9.7% of those with a partner [35].

While joint negotiation may increase the costs for physician services in the short term, it will reduce overall system costs in the long term. HIT systems will create efficiencies that will improve care and likely reduce costs. According to the CBO report, HIT has the potential, if adopted widely and used effectively, to save the healthcare sector about $80 billion annually (in 2005 dollars) [33]. Thus, gains in the form of market efficiencies, reduced utilization, and increased availability of patient data will offset higher costs for networks to implement HIT. The FTC recognized this in its GRIPA advisory letter:

> "Higher unit prices may be of little concern to a customer if they occur within integrated programs that result in lower total costs (e.g., through elimination of unnecessary and inappropriate utilization of services) and higher quality (e.g., better medical outcomes)" [11].

How well HIT lives up to its potential, however, depends in part on how effectively financial incentives are realigned to encourage the optimal use of the technology's capabilities [33]. In the current environment, health insurers, the entities most likely to benefit from cost savings, have demonstrated little interest in implementing these systems and are unlikely to make substantial investments in HIT in the future. Given the expense of HIT implementation and the inability of physicians, the group to which the burden of implementation has fallen, to capture the majority of benefits and returns, physicians should be permitted to negotiate jointly with payors to properly allocate cost savings. Without the ability to recoup some of the expense of these systems by joining a network and achieving increased contracting efficiencies, it will be difficult, if not impossible, for many physicians across the country to make the heavy investments in time and money that the adoption of such a system would require.

Joint contracting is also essential for those physicians in small or solo practices who wish to participate in performance-based payment initiatives. The data and coordination required for these programs is out of reach for the majority of physicians. The FTC in its GRIPA advisory letter recognized this when it noted that implementing a program in which different subsets of physicians are participating in different payor contracts "could interfere with the network's ability to effectively gather data and monitor and evaluate physician performance under the program." Currently, most performance-based payment initiatives are specifically targeted at medical groups or networks rather than small practices. As a Commonwealth Fund study on P4P recently noted:

> "Smaller groups generally have few incentives for care coordination, as they usually do not receive payment beyond the evaluation and management fees they are able to bill for acute visits. However, by banding together under the umbrella of organizations, and becoming eligible for performance payments through [the Medicare P4P Demonstration Project] or similar incentive programs, they have more motivation and support for care coordination" [36].

Physicians who predominantly still practice in small groups lack the economic scale. By teaming up in a network, small practices may gain the magnitude for the care coordination, aggregation of data, and purchasing power required for the implementation of these initiatives.

There are several potential strategies to achieve the goal of increased flexibility for physician collaboration. First, it is important that physicians are aware of "clinical integration" and other options the Federal antitrust enforcers have acknowledged as acceptable.

Second, major changes that have taken place in the market since the current FTC enforcement guidelines were drafted. In this regard, the AMA is actively working to have the guidelines revised. AMA has submitted a formal request to the FTC entitled: "Physician Networks and Antitrust: A Call for a More Flexible Enforcement Policy" [37].

Finally, legislation at the federal and/or state level is warranted to encourage physician collaboration. At the federal level, an option that deserves serious consideration is the countervailing market power approach which has been suggested by former Congressman Tom Campbell [38]. Under this proposal, physician groups would be allowed to bargain collectively without fear of violating the antitrust laws to the extent the group had no greater market power than that enjoyed by the health insurer with which it was bargaining. A state is also free to exempt itself from federal antitrust rules by enacting a law which both affirmatively expresses a decision to substitute regulation for a market competition as the best way of achieving a state policy objective, and creates a mechanism ensuring that the state "actively supervises" the resulting conduct to ensure that the state policy objective is indeed being promoted.

Discussion

In this paper, the writer has argued there is a profound imbalance in the marketplace between the health insurers who collect premiums to pay for medical care and the physicians who provide medical care. Such an imbalance has resulted in an increasingly unfair and inefficient healthcare delivery system. Further, FTC and DOJ

enforcement policies have led to aggressive antitrust actions primarily against physicians. This has had the counterproductive result of inhibiting the physician community from engaging in the innovative collaborations necessary to take optimal advantage of HIT. Unfortunately, these same agencies have adopted a largely "hands-off" policy towards the health insurers, resulting in the unfettered consolidation of the health insurance industry. The playing field between health insurers and physicians should be leveled to remedy the situation. This will require changes in three major areas: (1) health insurers should be prohibited from engaging in anticompetitive activity; (2) the continuing improper consolidation of the health insurance industry should be curtailed; and (3) the physician community should be freed to undertake the collaborative activity necessary to the establishment of a transparent, coordinated, and efficient delivery system.

Some economists have suggested that increased consolidation of health insurers will lead to increased efficiency and, concomitantly, that federal antitrust enforcement policy has properly prioritized the elimination of physician "cartels." These economists suggest that health insurers, as purchasers of health care services, act as surrogates for consumers, driving down physician reimbursement for the public good.

In this paper, the writer has argued that these economists are wrong.

The evidence suggests that health insurers, as a result of the consolidation of the market, are exercising both monopoly and monopsony power in many communities. These insurers are not sharing with consumers the bulk of the "savings" they have achieved by driving down provider reimbursement levels and in fact may be perversely increasing the cost of care by increasing physician workforce scarcity issues and slowing the adoption of HIT. Given that physician incomes are flat or declining, the continued focus on physician "cartels" seems unwarranted. Additional studies on the connection between health insurance premium increases and the relative consolidation of the health insurance would be helpful to develop a more robust understanding of the health insurance marketplace. Similarly, studies examining the impact of the plethora of FTC and DOJ enforcement actions against physicians would be helpful to understand whether these prosecutions have ultimately benefited the salient patient populations.

Importantly, the healthcare antitrust landscape has changed. This environment is very different from the early 1980s when the U.S. Supreme Court decided Maricopa. The lack of opportunities for physicians to collaborate on important initiatives must be reexamined and revised—either through judicial, administrative or legislative activity. As the increasingly inadequate supply of physicians demonstrates, the status quo is not sustainable. To achieve a truly efficient healthcare delivery system capable of meeting the challenges of the 21st century, including the demands of an increasing Medicare population, the physicians who provide the care must be allowed—and encouraged—to collaborate and innovate as critical participants in the healthcare marketplace.

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ADDENDUM 3

Michael D. Maves, MD, MBA, Executive Vice President, CEO

July 8, 2009

The Honorable Christine Varney
Assistant Attorney General for Antitrust
United States Department of Justice
950 Pennsylvania Avenue, NW
Washington, DC 20530-0001

Re: Competition in Health Insurance: A Comprehensive Study of U.S. Markets (2008 update)

Dear Ms. Varney:

The American Medical Association (AMA) appreciates the opportunity to meet with you to discuss competition in health insurance and other antitrust matters of importance to physicians. In advance of our meeting, we are providing you with a copy of the AMA's latest study entitled, "Competition in Health Insurance: A Comprehensive Study of U.S. Markets (2008 update)."

The AMA commends the Obama administration for recognizing the threats that health insurer consolidations pose to the delivery of health care across the country. As then Senator Obama stated during his Presidential election campaign:

> There have been over 400 health care mergers in the last 10 years. The American Medical Association reports that 95 percent of insurance markets in the United States are now highly concentrated and the number of insurers has fallen by just under 20 percent since 2000. ...As president, I will direct my administration to reinvigorate antitrust enforcement. It will step up review of merger activity and take effective action to stop or restructure those mergers that are likely to harm consumer welfare, while quickly clearing those that do not.[1]

The AMA would like to assist the Department of Justice (DOJ) as you move forward in this important effort, and we look forward to working with you and your staff. The following discussion provides more detail on these issues from the physician perspective.

[1]Barack Obama, "Statement of Senator Barack Obama for the American Antitrust Institute" at *http://www.antitrustinstitute.org/archives/files/aai-%20Presidential%20campaign%20-%20Obama%209-07_092720071759.pdf*

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I. Health Insurer Market Shares and Market Concentration

Every year for the past eight years, the AMA has conducted the most in-depth study of commercial health insurance markets in the country. The AMA's most recently published study, "Competition in Health Insurance: A Comprehensive Study of U.S. Markets (2008 update)" (the study), is intended to help researchers, policy makers, and federal and state regulators identify areas of the country where consolidation among health insurers may have harmful effects on consumers, on providers of care and on the economy. The study reports health insurer shares and Herfindahl-Hirschman Indices (HHIs) for combined HMO and PPO markets and separate HMO and PPO markets in 42 states and 314 smaller geographic areas across the United States (metropolitan statistical areas, or MSAs).[2,3] Based on the DOJ/Federal Trade Commission Horizontal Merger Guidelines, key findings in this study are as follows. Considering combined HMO and PPO product markets:

- 94 percent (295) of the MSAs examined are highly concentrated.
- In nearly 90 percent (279) of MSAs, one or more insurers had a market share of 30 percent or greater.
- In more than 40 percent (138) of the MSAs, at least one insurer had a market share of 50 percent or greater.
- In 16 percent (49) of the MSAs, at least one insurer had a market share of 70 percent or greater.

Independent academic researchers, examining different data, have reached similar conclusions. For example, Dafny, Duggan and Ramanarayanan (2009) estimate that the fraction of local markets falling into the "highly concentrated" category (per the DOJ's Horizontal Merger Guidelines) increased from 68 to 99 percent between 1998 and 2006.[4]

II. Health Insurer Market Power

The existence of health insurer market power may be inferred in most of the health insurance markets examined in the AMA's study. *United States v. Grinell Corp.*, 384 U.S. 563, 571 (1966)(the existence of market power "ordinarily may be inferred from the predominant share of the market"). The AMA is aware that the influential Seventh Circuit opinion (*Ball Memorial Hospital v. Mutual Hospital Insurance, Inc.*, 784 F.2d 1325, 1325 (7th Cir. 1986)), authored 20 years ago by Judge Easterbrook, concluded that the health insurer defendant's high market share did not establish market power because entry barriers in health insurance were low. All that was required, reasoned the court, was a license and money, "which may be supplied on a moment's notice," and "no firm has captive customers." *Id.*, at 1335-36.

The intervening 20 years have demonstrated that the Seventh Circuit in *Ball Memorial* did not consider the significant barriers that we now know exist, and the assumptions on which the court relied have proven false. It is now well understood that many barriers to entry exist, including: state regulatory requirements; brand name acceptance of established insurers; developing sufficient

[2] The product market excludes Medicare and Medicaid because a significant number of consumers are not eligible for these programs. Thus, Medicare and Medicaid are not substitutes for commercial insurance. The localized geographic market is supported by the observation that most health insurers market locally because employers, employees and other individuals purchase health insurance products that will serve them in proximity to where they work and live.

[3] The smaller geographic areas include MSAs and metropolitan divisions as defined by the U.S. Office of Management and Budget. The vast majority of these are MSAs, while a few of them are metropolitan divisions, which are subcomponents of very large MSAs (e.g., New York, Chicago). For convenience, both of these smaller areas are referred to as MSAs throughout the report.

[4] Dafny, L., Duggan, M., and Ramanarayanan, S., 2009. "Paying a Premium on Your Premium? Consolidation in the U.S. Health Insurance Industry," unpublished working paper.

business to permit the spreading of risk; contending with established insurance companies that have built long-term relationships with employers and other consumers; and the cost of developing a health care provider network. *See* Robert W. McCann, *Field of Dreams: Dominant Health Plans and the Search for a "Level Playing Field,"* Health Law Handbook (Thomson West 2007); Mark V. Pauly, *Competition in Health Insurance Markets*, 51 Law & Contemp. Probs. 237 (1988); Federal Trade Commission and U.S. Department of Justice, Improving Health Care: A Dose of Competition (July, 2004); *Vertical Restraints and Powerful Health Insurers: Exclusionary Conduct Masquerading as Managed Care?*, 51 Law & Contemp. Probs. 195 (1988).

The presence of significant entry barriers in health insurance markets was demonstrated in the recent hearings before the Pennsylvania Insurance Department on the competition ramifications of the proposed merger between Highmark Inc. and Independence Blue Cross. The AMA testified at these hearings in opposition to the proposed merger and our submission to the Insurance Department is included for your review. Significant evidence was introduced in those hearings, showing that replicating the Blues' extensive provider networks constituted a major barrier to entry.[5] The evidence further demonstrated that there has been very little in the way of new entry that might compete with the dominant Blues Plans in the Pennsylvania health insurance markets.[6] In a report commissioned by the Department, LECG concluded that it was unlikely that any competitor would be able to step into the market after a Highmark/IBC merger:

> [B]ased on our interviews of market participants and other evidence, there are a number of barriers to entry—including the provider cost advantage enjoyed by the dominant firms in those areas and the strength of the Blue brand in those areas.... On balance, the evidence suggests that to the extent the proposed consolidation reduces competition, it is unlikely that other health insurance firms will be able to step in and replace the loss in competition.[7]

LECG's conclusion is consistent with the federal antitrust enforcement agencies' observation that national insurers have been unsuccessful in entering some of the Blue Cross-dominant markets in recent years.[8] For instance, Rob McCann reports that Blue Cross Blue Shield of Michigan has had "market dominance for decades." Robert W. McCann, *Field of Dreams: Dominant Health Plans and the Search for a "Level Playing Field,"* Health Law Handbook, p.42 (Thomson West 2007).

Some market barriers are created by contracting practices used by dominant health insurers. These include most favored nations clauses whereby physicians must agree to give the dominant payor at least as favorable a rate as they give to any other insurer. Other problematic contracting practices

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[5] The Department held three public hearings, in which 101 interested parties offered comments, and compiled a Web site that hosted nearly 50,000 pages of commentary. The proposed merger was also the subject of two United States Senate Judiciary Committee hearings. The extensive record included the analysis of financial and economic experts such as LECG, Monica Noether of CRA International, the Blackstone Grays and others. See *http://www.ins.state.pa.us/ins/lib/ins/whats_new/Excerpts_from_PA_Insurance_Dept_Expert_Reports.pdf* for background information, including excerpts from the experts' reports.

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

[7] LECG Inc., "Economic Analyses of The Competitive Impacts From The Proposed Consolidation of Highmark and IBC." September 10 2008, Page 9.

[8] "Improving Health Care: A Dose of Competition, Federal Trade Commission and Department of Justice" (July 2004) at pp. 8-11.

include all products clauses, anti-assignment provisions and minimum enrollment assurances. *See Id.*, at pp.46-49.[9] The Highmark/IBC hearings also highlighted how market division arrangements prevent entry and allow entrenched firms to maintain market power.

There is a consensus among health economists that most health insurance markets are not perfectly competitive, and as a result, large insurers can exercise market power. A new research study by Northwestern University Professor Leemore Dafny, PhD, to be published by the prestigious *American Economic Review*, finds evidence that health insurers exercise at least some market power in an increasing number of geographic markets.[10] Enclosed is a copy of Dr. Dafny's study for your review. Dr. Dafny concludes that it takes at least six insurers in a market before market power is eliminated. A study by Dranove *et al.* published in the *Journal of Industrial Economics* reaches similar conclusions.[11]

III. Health Insurers Possess and Exercise Monopsony Power

Concentration data reported in the AMA's study can be used to study health insurer monopsony power. One reason is that the geographic market in which an insurer sells its services to consumers coincides with the geographic market from which it secures services from physicians and other health care providers. Supporting this conclusion is the observation that patients will travel for hospital and physician services only within narrow geographic limits. Therefore, employers want health insurance coverage for their employees in each of the locales where the employees reside or work. Responding to this preference, health insurers must obtain physician coverage in each locale. Moreover, physicians invest and develop their practices locally. Physicians are not mobile and must sell their services to health insurers controlling any significant portion of their practices.

The AMA's study indicates that numerous insurers possess the sort of monopsony power in physician markets that the DOJ claimed to exist in its challenges of UnitedHealthcare's acquisition of PacifiCare[12] and Aetna's acquisition of Prudential's national health insurance lines.[13] In those cases, the DOJ embraced the notion of a localized market in which health insurers purchase physician services.[14]

The nature of the health care industry facilitates the potential for a health insurer possessing any significant market share to exercise monopsony power over physicians selling health care services within the health insurer's market. If physicians were to refuse the terms of the dominant buyer, they would likely suffer an irretrievable loss of revenue. Medical services can neither be stored nor exported, and it is difficult to convince consumers (which in many cases are employers) to switch to

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[9] Available at *http://www.drinkerbiddle.com/People/detail.aspx?id=996&MainAuthors=996.*
[10] Dafny L. "Competition in Health Insurance Markets" (attached) (May 2009), forthcoming in the *American Economic Review*.
[11] Dranove, D., Gron, A. and M. Mazzeo, 2003, "Differentiation and Competition in HMO Markets" *Journal of Industrial Economics.*
[12] Complaint *U.S. v. UnitedHealthcare Group, Inc.*, No. 1:05CV02436 (U.S.D.C. December 20, 2005) [hereinafter United-PacifiCare Complaint].
[13] *U.S. v. Aetna Inc.*, No. 3-99CV 1398-H, ¶¶ 17-18 (June 21, 1999) (complaint), available at *http://www.usdoj.gov/atr/cases/f2500/2501.pdf; see also U.S. v. Aetna, Inc.*, No. 3-99 CV 1398-H, at 5-6 (Aug. 3, 1999) (revised competitive impact statement), available at *http://www.usdoj.gov/atr/case/s/f2600/2648.pdf.*
[14] See e.g. Aetna Complaint ¶ 20 (alleging that the relevant geographic markets were the MSAs in and around Houston and Dallas, Texas)

different health insurers.[15] Consequently, a physician's ability to consider realistically terminating a relationship with a health insurer because of low reimbursement rates depends on that physician's ability to make up lost business by immediately switching to an alternative health insurer. Where those alternatives are lacking, a health insurer will have the ability to reimburse physicians at rates that are below a true competitive level. Health economist Cory Capps, PhD has concluded that this monopsony injury can occur at a health insurer market share of less than 35 percent.[16] Given that in nearly 90 percent of MSAs one or more insurers possess a market share of 30 percent or greater (see summary of study findings at page 2 *supra*),[17] it is critical for antitrust enforcers to maintain a competitive market in which physicians have adequate competitive alternatives.

IV. Consumer Injury

In an era of spiraling costs, it is tempting to conclude that anything that drives down medical fees, such as monopsony, is a good thing for consumers. But it is a mistake to assume that when insurers push down the cost of physician services, insurers' interests are perfectly aligned with those of consumers.

Health insurer monopsonists typically are also monopolists. Therefore, their lower input prices (for physician services) do not necessarily lead to lower consumer output prices (for health insurance premiums).[18] As a general proposition, monopsonists drive down their buying price by purchasing fewer products. Because there is less product purchased, there is, in turn, less product sold, which leads to higher output prices. That lower physician fees paid by monopsonist insurers may result in higher premiums to patients was emphasized by R. Hewitt Pate, a former Assistant Attorney General of the Antitrust Division, in a 2003 statement before the Senate Judiciary Committee:

> A casual observer might believe that if a merger lowers the price the merged firm pays for its inputs, consumers will necessarily benefit. The logic seems to be that because the input purchaser is paying less, the input purchaser's customers should expect to pay less also. But that is not necessarily the case. Input prices can fall for two entirely different reasons, one of which arises from a true economic efficiency that will tend to result

[15] As alleged in the *United/PacifiCare* complaint, physicians encouraging patients to change plans "is particularly difficult for patients employed by companies that sponsor only one plan because the patient would need to persuade the employer to sponsor an additional plan with the desired physician in the plan's network" or the patient would have to use the physician on an out-of-network basis at a higher cost. Complaint at paragraph 37.

[16] Capps, C. (2009)"Economic Analysis of Buyer Power in Health Plan Mergers," Working Paper, Bates White, Washington, D.C.

[17] Bearing in mind that the concentration data cited earlier only consider commercial insurance, some have argued that physicians who are unhappy with the fees they receive from a powerful insurer could turn away from that insurer and instead treat more Medicare and Medicaid patients. However, health economist, David Dranove, PhD, the Walter McNerney Distinguished Professor of Health Industry Management at Northwestern's Kellogg of Management, explains why Medicare and Medicaid do not make good alternatives for physicians dealing with a monopsonist insurer. (*See* affidavit of Professor David Dranove in *United States v. UnitedHealth Group, Inc., and Sierra Health Services, Inc.* (attached)). According to Professor Dranove, physicians cannot increase their revenue from Medicare and Medicaid in response to a decrease in commercial health insurer reimbursement. Enrollment in these programs is limited to special populations, and these populations only have a fixed number of patients. Moreover, Medicaid reimbursements to physicians are significantly less than those from commercial health insurers. Professor Dranove concludes: "Medicare and Medicaid do not represent viable alternatives for physicians who face lower fees from a monopsonist insurer. Because Medicare and Medicaid are large purchasers of physician services, excluding them from market share calculations will profoundly change inferences about market shares and monopsony power. Medicare and Medicaid should therefore be excluded when computing shares in the market for the purchase of physician services."

[18] Peter J. Hammer and William M. Sage, "Monopsony as an Agency and Regulatory Problem in Health Care," 71 Antitrust L.J. 949 (2004).

> in lower prices for final consumers. The other, in contrast, represents an efficiency-reducing exercise of market power that will reduce economic welfare, lower prices for suppliers, and may well result in higher prices charged to final consumers.

The Pennsylvania experience is consistent with economic theory. At the conclusion of the Highmark/IBC hearings, the Pennsylvania Insurance Department was prepared to find the proposed merger to be anticompetitive in large part because it would grant the merged health insurer undue leverage over physicians and other health care providers. The Department released the following statement:

> Our nationally renowned economic expert, LECG, rejected the idea that using market leverage to reduce provider reimbursements below competitive levels will translate into lower premiums, calling this an "economic fallacy" and noting that the clear weight of economic opinion is that consumers do best when there is a competitive market for purchasing provider services. LECG also found this theory to be borne out by the experience in central Pennsylvania, where competition between Highmark and Capital Blue Cross has been good for providers and good for consumers.

There may be antitrust concerns if a health insurer can lower compensation to physicians even if it cannot raise prices to patients. For example, in the United/PacifiCare merger, the DOJ required a divestiture based on monopsony concerns in Boulder, Colorado, even though United/PacifiCare would not necessarily have had market power in the sale of health insurance. The reason is straightforward: the reduction in compensation would lead to diminished service and quality of care, which harms consumers even though the direct prices paid by subscribers do not increase. *See* Gregory J. Werden, *Monopsony and the Sherman Act: Consumer Welfare in a New Light.* 74 Antitrust L.J 707 (2007) (explaining reasons to challenge monopsony power even where there is no immediate impact on consumers). Marius Schwartz, *Buyer Power Concerns and the Aetna-Prudential Merger,* Address before the 5th Annual Health Care Antitrust Forum at Northwestern University School of Law 4-6 (October 20, 1999) (noting that anticompetitive effects can occur even if the conduct does not adversely affect the ultimate consumers who purchase the end-product), *available at http://www.usdoj.gov/atr/public/speeches/3924.wpd.*

Reductions in service levels and quality of care cause immediate harm to consumers. In the long run, we must also consider whether monopsony power will harm consumers by driving physicians from the market. Recent projections by the Health Resources and Services Administration suggest a looming shortage of physicians in the United States.[19] Moreover, a recent study by Merritt Hawkins and Associates tracked the viewpoints of physicians between the ages of 50 and 65 (which comprise 36 percent of the physicians in the United States, according to the AMA).[20] The survey found that more than 49 percent of physicians in this population are planning to make a change in their practices that will either eliminate or reduce the number of patients they treat due to frustrations with

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[19] See Health Resources and Services Administration, Physician Supply and Demand: Projections to 2020 (Oct 2006) (projecting a shortfall of approximately 55,000 physicians in 2020); see also Merritt, Hawkins, et al., Will the Last Physician in America Please Turn Off the Lights? A Look at America's Looming Doctor Shortage (2004) (predicting a shortage of 90,000 to 200,000 physicians and that average wait times for medical specialties is likely to increase dramatically beyond the current range of two to five weeks).

[20] Merritt Hawkins and Associates, *2007 Survey of Physicians 50 to 65 Years Old*, available at *http://www.merritthawkins.com/pdf/mha2007olderocsurvey.pdf.*

inadequate reimbursement in the face of continually increasing overhead and administrative and regulatory burdens that detract from actual patient care. The continued exercise of monopsony power will exacerbate this looming shortage.

V. Conclusion and Recommendations for Additional Studies

The AMA hopes that you will find its "Competition in Health Insurance: A Comprehensive Study of U.S. Markets (2008 update)" helpful in fulfilling President Obama's promise of more rigorous antitrust enforcement in health insurance markets. Restoring competition in the marketplace for the purchase of physician services will improve the quality of care, redress the looming shortage of physicians and lower premiums. The AMA suggests a number of steps that the DOJ should consider in connection with this effort:

1) perform a retrospective study of health insurance mergers analogous to that performed by the Federal Trade Commission on hospital mergers;
2) commission new research to identify causes and consequences of health insurer market power;
3) create a framework for predicting the effects health insurer mergers will have on consumer and provider markets; and
4) gather information that would facilitate additional systematic studies.

The AMA looks forward to working with you and your staff in this important effort. If you have any questions or would like any additional information, please do not hesitate to contact Carol Vargo, Assistant Director, Federal Affairs, (202) 789-7492 or email her at carol.vargo@ama-assn.org.

Sincerely,

Michael D. Maves, MD, MBA

Attachment

Mr. JOHNSON. Thank you, Dr. Mandell.
Next we will hear from Ms. Gotts.

TESTIMONY OF ILENE KNABLE GOTTS, CHAIR, SECTION OF ANTITRUST LAW, AMERICAN BAR ASSOCIATION, WASHINGTON, DC

Ms. GOTTS. Thank you, Mr. Chairman.
Mr. Chairman and Members of the Subcommittee, my name is Ilene Gotts and I am the chair of the section of antitrust law of the American Bar Association and a partner at the law firm of Wachtell Lipton Rosen & Katz.
I appreciate the opportunity to present the views of the American Bar Association on H.R. 3596. I am appearing on behalf of the American Bar Association today, and my testimony here reflects the position of the American Bar Association with respect to this legislation.
I would like to state from the outset that my testimony today is limited to this legislation. I am not addressing any of the larger health care issues and health care legislation currently before Congress, notwithstanding that this particular legislation is, to some extent, related to these broader issues.
The antitrust section of the ABA and the American Bar Association have repeatedly embraced the view that industry-specific exemptions from the antitrust laws are rarely justified.
McCarran-Ferguson dates back to another era of antitrust jurisprudence. It was enacted in 1945 to ensure that the regulation of the insurance industry remained principally the province of the states.
The Sherman Act has served this Nation well for nearly 120 years, because it is simple and very flexible. It states what the competition policy is and is interpreted by the courts based on the facts and circumstances presented in each particular case. This flexibility eliminates, in most cases, the need for industry-specific exemptions.
Moreover, the benefits of exemptions rarely outweigh the potential harm imposed on society by the loss of competition resulting from such exemptions and are often not necessary to limit the risk of deterring pro-competitive conduct.
In short, the objectives and goals of these exemptions frequently can be achieved in a manner consistent with established antitrust principles and enforcement policy, thus rendering exemptions unnecessary.
Consistent with these general principles, the American Bar Association, for over 20 years, has supported that McCarran-Ferguson reform occur for the entire industry and be instead replaced with a series of safe harbor protections for certain forms of collective insurer conduct that were unlikely to cause anticompetitive harm to consumers.
To the extent that H.R. 3596 constitutes a first step in this direction by repealing the antitrust exemption for these two types of insurance, the American Bar Association would support such legislation, but only if it were amended to provide safe harbors for certain pro-competitive conduct as set forth in the ABA policy that is attached to my written statement.

These safe harbors are not designed to alter the existing antitrust policy. Rather, they are to deter private litigation that might, post-exemption, challenge conduct that in the unique circumstances of the insurance industry may actually promote competition.

They have been included in several other McCarran repeal proposals over the years but are not contained in H.R. 3596, and the American Bar Association believes it is necessary to add these safe harbor provisions as clarifying amendments to the legislation.

Please note that in recommending that the insurance industry should not be subject to an antitrust exemption, the ABA is not suggesting that the industry be subject to a more rigorous antitrust standard than the rest of American industry.

We do not believe that it is the intention of the legislation, but the broad prohibitions on price fixing, bid rigging and market allocations could potentially be read to condemn activity that would otherwise be permissible under the antitrust laws.

The terms have very specific meanings in the existing case law interpreting the Sherman Act, and it should clearly not be the intent of this legislation to place a greater burden on the insurance industry than on other industries.

The safe harbors that we support help to ensure against this result, but further clarification on this point would also be beneficial.

Finally, I would like to thank you for the opportunity to appear here today to present the views of the American Bar Association. The American Bar Association believes strongly in—competition in the insurance industry can be enhanced, consistent with necessary joint activities, to benefit all segments of our society.

And I will be happy to answer any questions that you may have. Thank you.

[The prepared statement of Ms. Gotts follows:]

PREPARED STATEMENT OF ILENE KNABLE GOTTS

STATEMENT OF ILENE KNABLE GOTTS

Chair, ABA Section of Antitrust Law

On Behalf of the

AMERICAN BAR ASSOCIATION

Before the

Subcommittee on Courts and Competition Policy

Judiciary Committee

U.S. House of Representatives

CONCERNING H.R. 3596, "THE HEALTH INSURANCE INDUSTRY ANTITRUST ENFORCEMENT ACT OF 2009"

October 8, 2009

Mr. Chairman and Members of the Subcommittee:

My name is Ilene Gotts, and I am the Chair of the Section of Antitrust Law of the American Bar Association and a partner at the law firm of Wachtell, Lipton, Rosen & Katz. I appreciate the opportunity to present the views of the American Bar Association on H.R. 3596, "The Health Insurance Industry Antitrust Enforcement Act of 2009." I am appearing on behalf of the American Bar Association, and my testimony here today reflects the position of the American Bar Association on this legislation. At the outset, let me first make clear that my testimony today is limited to this legislation; I am not addressing any of the larger health care issues and health care legislation currently before Congress, notwithstanding that this particular legislation is, to some extent, related to these broader issues.

The American Bar Association has repeatedly embraced the view that industry-specific exemptions from the antitrust laws are rarely justified, and that evidence that the exemption results in consumer benefit should exist to justify any such exemptions.

The underlying rationale for the American Bar Association's position – sometimes expressed and sometimes implied – is that the Sherman Act has served the nation well for nearly 120 years because it is a simple and very flexible statement of competition policy that is interpreted by the courts based on the facts and circumstances of each particular case. This flexibility eliminates, in most cases, the need for industry-specific exemptions. Moreover, the benefits of these exemptions rarely outweigh the potential harm imposed on society by the loss of competition resulting from such exemptions, and often are not necessary to limit the risk of deterring procompetitive conduct. In short, the objectives and goals of these exemptions frequently can be achieved in a manner consistent with established antitrust principles and enforcement policy, thus rendering the exemptions unnecessary.

Consistent with these general principles, the American Bar Association has testified in support of McCarran-Ferguson reform in the past, most recently in June of 2006, in testimony before the Senate Judiciary Committee. Don Klawiter, the Chair of the Section of Antitrust Law of the ABA at that time, provided that testimony. At that time, the ABA expressed the view that the McCarran-Ferguson Act's antitrust exemption should be repealed for the entire insurance industry – not just with respect to the health insurance and medical malpractice insurance industries, as H.R. 3596 would do- and replaced with a series of "safe harbor" protections for certain forms of collective insurer conduct that were unlikely to cause anticompetitive harm to consumers. To the extent that H.R. 3596 constitutes a first step in this direction, by repealing the antitrust exemption for these two types of insurance, the American Bar Association would support legislation along the lines of H.R. 3596, but only if it were amended to provide safe harbors for certain procompetitive conduct as set forth in our attached ABA policy.

As I just indicated, the American Bar Association position on McCarran is not new; over the last twenty years the ABA has consistently maintained that the McCarran-Ferguson Act should be repealed and replaced with certain "safe harbor" protections that I will outline below. The American Bar Association's position – then and now – is that McCarran should be repealed and replaced by a series of safe harbor protections for certain insurance industry conduct. For all other conduct, the American Bar Association position is that the insurance industry should be subject to the same antitrust rules as other industries.

Before addressing some of the specifics of the proposed bill, I believe that a brief historical review of the origins of the McCarran-Ferguson Act is helpful.

Why do we have an antitrust exemption for the insurance industry? In the latter half of the 19th century, dramatic growth in the fire insurance industry led to increased interest by the

states in the regulation and taxation of insurance companies. In response, insurance companies, seeking to avoid such regulation, challenged the states' authority to regulate the insurance industry, contending that such regulation constituted a violation of the Commerce Clause. However, in Paul v. Virginia, 75 U.S. (8 Wall.) 168 (1868), the United States Supreme Court rejected the insurers' position, holding that the Commerce Clause did not preclude the states from regulating insurers.

In the wake of the *Paul* decision, state regulation of insurance increased significantly. Then, in 1944, the United States Supreme Court, in United States v. South-Eastern Underwriters Ass'n, 322 U.S. 533 (1944), effectively overruled *Paul*, holding that insurance was interstate commerce and therefore subject to federal regulation. In response, the very next year, Congress enacted the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.*, seeking to ensure that the regulation of the insurance industry remained principally the province of the states.

The Act provides the insurance industry generally –not just health insurers and medical malpractice insurers - with a limited exemption from the federal antitrust laws. Specifically, the McCarran-Ferguson Act exempts conduct if that conduct (1) constitutes "the business of insurance" (2) is "regulated by State Law" and (3) does not amount to an "agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation." All three prongs of the McCarran-Ferguson Act must be satisfied for the exemption to attach to an insurer's conduct.

In determining whether conduct qualifies as "the business of insurance" under the McCarran-Ferguson Act's first prong, the courts have considered (1) whether the activity has the effect of transferring or spreading a policyholder's risk; (2) whether the activity is an integral part of the policy relationship between insurer and insured; and (3) whether the activity is limited to entities within the insurance industry. See Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119

(1982); Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205 (1979). Notably, no single factor is determinative on this issue.

As to the second prong, courts have held that an activity is regulated by state law if the insurer is subject to general state regulatory standards. In addition, the quality of the regulatory scheme, or its enforcement, does not influence the availability of the exemption. Hartford Fire Ins. Co. v. California, 509 U.S. 794 (1993).

Finally, with respect to the third prong, the Supreme Court held in *Hartford Fire* that a boycott occurs, thus subjecting insurer conduct to the federal antitrust laws, when a refusal to deal is designed to pursue an objective "collateral" to the terms of the transaction in which the refusal to deal occurs.

With this as background, nearly twenty years ago the American Bar Association formed a commission to study, among other things, the important policy issues associated with the application of the U.S. antitrust laws to the business of insurance. Following two years of discussion and debate, the ABA adopted a resolution recommending the repeal of the McCarran-Ferguson exemption to the antitrust laws, to be replaced by a series of safe harbors defining certain categories of exempt conduct. The safe harbors are not intended to alter existing antitrust policy; rather, they are intended to serve the important objective of deterring private litigation that might, post-exemption, challenge conduct that, in the unique circumstances of the insurance industry, may actually promote competition. The ABA's recommendation, which is attached to this statement for your convenience, recognizes the benefits of safe harbors for the following conduct by insurance companies:

(1) Insurers should be authorized to cooperate in the collection and dissemination of past loss-experience data so long as those activities do not unreasonably restrain competition, but

insurers should not be authorized to cooperate in the construction of advisory rates or the projection of loss experience into the future in such a manner as to interfere with competitive pricing.

(2) Insurers should be authorized to cooperate to develop standardized policy forms to simplify consumer understanding, enhance price competition and support data collection efforts, but state regulators should be given authority to guard against the use of standardized forms to unreasonably limit choices available in the market.

(3) Insurers should be authorized to participate in voluntary joint-underwriting agreements and in connection with such agreements to cooperate with each other in making rates, policy forms, and other essential insurance functions, so long as these activities do not unreasonably restrain competition.

(4) Insurers participating in residual market mechanisms should be authorized in connection with such activity to cooperate in making rates, policy forms, and other essential insurance functions so long as the residual market mechanism is approved by and subject to the active supervision of a state regulatory agency.

(5) Insurers should be authorized to engage in any other collective activities that Congress specifically finds do not unreasonably restrain competition in insurance markets.

These safe harbors are intended to protect legitimate procompetitive joint activity by insurers while still subjecting the insurance industry to the antitrust rule of law. While much, if not all, of the safe harbor conduct would be permissible or even encouraged under current antitrust precedent, the idea of the safe harbors is to remove all doubt, and hence to discourage private suits challenging such procompetitive conduct.

Turning back now to H.R. 3596, the American Bar Association would support legislation along the lines of H.R. 3596, but only if it is amended to provide safe harbors that are procompetitive. The American Bar Association believes that the safe harbor provisions outlined above, that have been included in several other McCarran repeal proposals over the years but are not contained in H.R. 3596, are necessary amendments to the legislation.

In addition, while the American Bar Association's view is that the insurance industry should not be subject to an antitrust exemption, it should not be subject to a more rigorous antitrust standard than the rest of American industry either. While I do not believe that the bill's intention is to impose more demanding antitrust standards on the insurance industry than other industries, the bill's broad prohibition on "price fixing," "bid rigging" and "market allocations" could potentially be read to condemn activity that would be otherwise permissible under the antitrust laws. Specifically, some activities that might be characterized as "price fixing" or "market allocation" could have procompetitive justifications that would make them permissible under current antitrust doctrine. For example, the antitrust laws generally permit manufacturers to set exclusive territories for their downstream distributors, even though such conduct could be construed as a vertical "market allocation." These terms have very specific meanings in the existing case law interpreting the Sherman Act, and it should clearly not be the intent of this legislation to place a greater burden on the insurance industry than on other industries. The safe harbors that the American Bar Association supports help to ensure against this result, but further clarification on this point would also be beneficial.

Thank you for the opportunity to appear before you today to present the views of the American Bar Association on this legislation. The American Bar Association believes strongly

that competition in the insurance industry can be enhanced, consistent with necessary joint activities, to the benefit of all segments of our society.

I would be happy to answer any questions you may have.

Resolution Adopted By The
American Bar Association
House of Delegates
February 1989

BE IT RESOLVED, That the American Bar Association adopts the following recommendation:

1) The current McCarran-Ferguson exemption to the antitrust laws should be repealed and replaced with legislation containing the following features:

(1) Insurers should be made subject to general antitrust laws but provided with authorization to engage in specified cooperative activity that is shown to not unreasonably restrain competition in the industry.

(2) Insurers should be authorized to cooperate in the collection and dissemination of past loss experience data so long as those activities do not unreasonably restrain competition but should not be authorized to cooperate in the construction of advisory rates or the projection of loss experience into the future in such a manner as to interfere with competitive pricing.

(3) Insurers should be authorized to cooperate to develop standardized policy forms in order to simplify consumer understanding, enhance price competition and support data collection efforts, but state regulators should be given authority to guard against the use of standardized forms to unreasonably limit choices available in the market.

(4) Insurers should be authorized to participate in voluntary joint underwriting agreements and in connection with such agreements to cooperate with each other in making rates, policy forms, and other essential insurance functions so long as these activities do not unreasonably restrain competition.

(5) Insurers participating in residual market mechanisms should be authorized in connection with such activity to cooperate in making rates, policy forms, and other essential insurance functions so long as the residual market mechanism is approved by and subject to the active supervision of a state regulatory agency.

(6) Insurers should be authorized to engage in such other collective activities that Congress specifically finds do not unreasonably restrain competition in insurance markets.

(7) State regulation of insurance rates should not exempt insurers from the antitrust laws under the state action doctrine, except as specified in Recommendation B.1(1) to B.1(6). Other non – rate regulation by a state should not exempt insurers from the antitrust laws unless that regulation satisfies the requirements of the state action doctrine and the regulation is shown to not unreasonably restrain competition.

2) States should retain the authority to regulate the business of insurance. The federal government should defer to state regulation except in those unusual circumstances where the regulatory objective can only be effectively accomplished through federal involvement.

Mr. JOHNSON. Thank you, Ms. Gotts.
And now we turn to Mr. Balto for your testimony.

TESTIMONY OF DAVID BALTO, SENIOR FELLOW, CENTER FOR AMERICAN PROGRESS, WASHINGTON, DC

Mr. BALTO. Thank you, Chairman Johnson, Ranking Member Coble and the other distinguished Members of the Committee.

Thank you for the privilege of testifying before you today about health insurance markets and competition.

I know, from my experience as an antitrust enforcer and a representative of public interest groups on competition issues, there are three things for a market to function properly—transparency, choice and a lack of conflicts of interest. All of these elements are lacking in the health insurance markets.

Few markets are as concentrated, opaque and complex, and subject to rampant anticompetitive and deceptive practices. My simple message is as the health care debate continues, many may advocate for limited reform of the insurance system.

Their belief is that it is a fundamentally sound market; with a little dose of additional regulation, everything will be cured. They could not be more wrong.

My testimony, briefly summarized, is from both a competition and consumer protection perspective. Few markets are as dysfunctional as the health insurance market.

Profits are increasing rapidly. The number of uninsured are increasing significantly. It is not surprising Wall Street calls the tune for these health insurers. They have no choice but to try to increase profits as much as possible, and engaging in deceptive or fraudulent conduct doesn't stop them from doing that.

Unfortunately, as Dr. Mandell has pointed out, we have been in an 8-year period of regulatory neglect. You are talking about a statutory antitrust exemption.

But from the perspective of the Federal antitrust and consumer protection agencies, health insurance has enjoyed another antitrust exemption. They have brought zero cases against anticompetitive practices by health insurance. They have brought zero cases against consumer protection violations by health insurers.

Hundreds of mergers have been approved with only minor restructuring of two of them. Where have the enforcement dollars been spent? Going after doctors.

Now, there is no evidence in the world that doctors were a major source of escalating health care costs. The Bush administration brought over 30 cases against doctors and zero cases against insurance companies. Members of this Committee, that makes no sense.

The most effective means of addressing this problem is the establishment of the public plan, and the House deserves tremendous credit for the Committees enacting that.

What you need to restructure this market is to create an entity that doesn't play to the tune of Wall Street but plays to the public interest. The public plan will have the clout to go and bring competition to the markets.

The public plan will not engage in these practices because it has to serve the public interest. And in that fashion, other insurance companies will have to compete not by discriminating and cutting service but by improving service.

In any case, this record of regulatory neglect must be reversed. There must be significant regulatory reforms to attempt to begin to grapple with the broken health insurance markets.

What do I suggest? First, Congress has been doing it right. Your oversight function is tremendously important, and the work of various Committees in Congress to look at the anticompetitive and egregious practices of the health insurance industry must continue.

You should adopt 3596, but you should go further. There is uncertainty created by the McCarran-Ferguson Act about whether the FTC can go after anticompetitive or deceptive conduct by health insurers. Let's clarify that so that we can use the FTC to go after these practices.

Third, the Obama administration should marshal its enforcement resources to go after the egregious conduct by health insurers, not the conduct of small-town doctors.

Fourth, the FTC should create a separate division for health insurance consumer production enforcement.

Fifth, both agencies should look at anticompetitive practices by health insurers.

Sixth, the FTC and DOJ should do a retrospective on some of the mergers that Dr. Mandell has complained about. And if those mergers are anticompetitive, let's unwind them and break them up.

Finally, Congress should require the transparency of all health insurer intermediaries—not only insurers, but PBMs and group purchasing organizations. There is tremendous mischief going on in—with both of those intermediaries. Fortunately, H.R. 3200 addresses that partially for PBMs. It should also go on and address it for group purchasing organizations.

We face a daunting task here in trying to bring competition back to a market that is severely broken. We need a tremendous effort in terms of not only the public plan but, really, a realignment of enforcement efforts so that we can start to bring these industries—this industry in line so that consumers don't suffer from these egregious and deceptive practices.

I welcome your questions.

[The prepared statement of Mr. Balto follows:]

PREPARED STATEMENT OF DAVID BALTO

Statement of David Balto, Senior Fellow
Center for American Progress Action Fund

Before the House Judiciary Committee, Subcommittee on Courts and Competition Policy on "H.R. 3596, the "Health Insurance Industry Antitrust Enforcement Act of 2009"

October 8, 2009

Chairman Johnson, Ranking Member Coble and other members of the Subcommittee, I appreciate the opportunity to come before you today and testify about health insurance competition and consumer protection enforcement. As a former antitrust enforcement official I strongly believe the mission of the Federal Trade Commission and Antitrust Division of the Department of Justice is vital to protecting consumers and competition. However in the past administration the priorities of those enforcement agencies were not effectively aligned with the critical priorities in the health care market, with the result that there is substantial anticompetitive and fraudulent activity in the health insurance market that raises prices and costs for consumers and the American taxpayer.

Today's hearing is on "H.R. 3596, the "Health Insurance Industry Antitrust Enforcement Act of 2009" which will amend the McCarran-Ferguson Act to provide that certain anticompetitive conduct by health insurers and medical malpractice insurers is not immune under the act. That is a good first step to reforming health insurance markets. But the ability for health care reform to succeed depends upon all aspects of health care markets to function effectively, and by any measure, the health insurance market is broken – with supracompetitive profits, escalating numbers of uninsured, an epidemic of deceptive and fraudulent conduct, and rapidly escalating costs. Today, 47 million Americans are uninsured, while those who are insured have seen their premiums rise over 120% in the past decade.[1] Meanwhile, ten of the largest health insurers saw their profits balloon from $2.4 billion in 2000 to $13 billion in 2007.[2] There have been dozens of state enforcement actions securing potentially over $1 billion dollars in fines and penalties. As I describe in my testimony, for health care reform to work we need greater Congressional oversight and investigation of health insurers, comprehensive regulatory reform, and a realignment of priorities at the DOJ and FTC.

Former Justice Brandeis said that sunlight is the best disinfectant and Congress deserves substantial credit for the attention it has given to the competitive and consumer protection problems in health insurance markets. Members on either side of the aisle may disagree about the scope of health care reform, but I would hope there is little dispute that recent Congressional hearings have uncovered a disturbing pattern of egregious, deceptive, fraudulent and anticompetitive conduct in health insurance markets. That conduct must be stopped.

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[1] The Kaiser Family Foundation. kff.org

[2] Health Care for America Now, "Premiums Soaring in Consolidated Health Insurance Market: Lack of Competition Hurts Rural States. Small Businesses." May 2009. Accessed at http://hcfan.3cdn.net/dadd15782c627c5b75_g9m6isltl.pdf.

Last month, the Domestic Policy Subcommittee of the House Oversight and Government Reform Committee held an important hearing titled "Between You and Your Doctor: The Private Health Insurance Bureaucracy." In this hearing, consumers came forward and courageously told their stories about the egregious practices health insurers regularly engage in to avoid paying for health care and to ensure excessively high profits.

- Mark Gendernalik of West Hills, California, described how his health insurer created obstacles to his efforts to get his three-month-old daughter proper treatment for infantile spasms: "Consumers should not have to endure this kind of life-and-health threatening hassle. I hope Congress will find better ways to ensure that insurers deliver on the care they promise. The stress of constantly having to hold the HMO and their agents to their agreed upon obligations has relegated me to the role of my daughter's care manager, and all too often robbed me of my role as Sidney's loving daddy."[3]

- Errin C. Ackley of Red Lodge, Montana described her battle against Blue Cross Blue Shield of Montana to secure care for her father who was dying of Chronic Lymphocytic Leukemia. BCBSMT claimed that a transplant was still "investigational," and it took four months of letter writing, phone calls, and presentations of scientific data on the efficacy of the procedure, and legal work to convince the insurer to cover the procedure. After four months' delay, her father received the transplant but passed away just a few months later. Erinn testified, "Would there have been a different end to my dad's story if he had been given approval for the first transplant request in April 2006? ...We don't know. What we do know is that his chance for survival most assuredly did not increase because . . . Blue Cross Blue Shield of Montana built the bureaucratic roadblocks that changed the course of my father's treatment and made him wait four months for his potentially life-saving bone marrow transplant."[4]

- Wendell Potter, a former insurance executive, revealed the most basic motivation for these practices, one that will not necessarily disappear with the regulations of health care reform. Potter testified, "To win the favor of powerful [investment] analysts, for-profit insurers must prove that... the portion of the premium going to medical costs is falling... To help meet Wall Street's relentless profit expectations, insurers routinely dump policyholders who are less profitable or who get sick."[5] This practice, known as "purging," allows insurers to avoid paying for health care for those who need it most, and instead collect premiums with the explicit intention of avoiding paying for care.

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[3] Mark Gendernalik. Statement before the Domestic Policy Subcommittee, House Committee on Oversight and Government Reform. September 16, 2009. Accessed at http://groc.edgeboss.net/download/groc/domesticpolicy/prepared.testimony.of.mr.mark.gendernalik.pdf.

[4] Erinn C. Ackley. Statement before the Domestic Policy Subcommittee, House Committee on Oversight and Government Reform. September 16, 2009. Accessed at http://groc.edgeboss.net/download/groc/domesticpolicy/preparedtestimonyofms.erinnackley.pdf.

[5] Wendell Potter. Testimony before the Domestic Policy Subcommittee, House Committee on Oversight and Government Reform. September 16, 2009. Accessed at http://groc.edgeboss.net/download/groc/domesticpolicy/preparedtestimonyofmr.wendellpotter.pdf.

Health insurance companies mounted every obstacle possible to Mark's daughter's treatment and to Erinn's father's bone marrow transplant. As Wendell Potter documented their incentives are to satisfy Wall Street, to deny care, and to maximize profits. Even Judge Richard Posner has observed that the "incentive [of some insurers] is to keep you healthy if it can but if you get very sick, and are unlikely to recover to a healthy state involving few medical expenses, to let you die as quickly and cheaply as possible."

I know from my experience as a government antitrust enforcer that there are three elements for a market to effectively function: transparency, choice and a lack of conflicts of interest. All of these elements are lacking in health insurance markets. **Few markets are as concentrated, opaque and complex, and subject to rampant anticompetitive and deceptive conduct**. A recent report by the Congressional Research Service states it plainly: "The health insurance market has many features that can hinder markets, lead to concentrated markets, and produce inefficient outcomes."[6] As the health care debate progresses, many advocate for limited reform of the health insurance system. Their belief is that it is a fundamentally sound market and with a little dose of additional regulatory oversight, all the ills of the market will be cured. They could not be more mistaken.

Here are the essential points of my testimony:

- **From both a competition and consumer protection perspective health insurance markets are severely dysfunctional. Few markets are as concentrated, opaque, and a fertile ground for deceptive and anticompetitive conduct. Relying on these markets as currently structured in health care reform would be a serious error and weaken the chance for any successful reform.**
- **These competitive and cousumer protection problems are exacerbated by regulatory neglect by federal antitrust and consumer protection enforcers (the Justice Department and Federal Trade Commission). During the Bush Administration there were no actions against anticompetitive or deceptive conduct by health insurers. Hundreds of mergers were approved with only the minor restructuring of two mergers.**
- **The most effective means of addressing the broken market structure is the creation of a public plan, as envisioned in the House legislation.**
- **In any case, the record of regulatory neglect must be reversed. There must be significant regulatory reform to begin to attempt to grapple with the broken health insurance markets.**

My recommendations include:

- **Congress should enact H.R. 3596. But it should go further. It should amend the statute to eliminate potential obstacles to FTC enforcement against anticompetitive and deceptive conduct.**

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[6] D. Andrew Austin and Thomas L. Hungerford. Congressional Research Service. "The Market Structure of the Health Insurance Industry." September 28, 2009.

- **Congress should increase its vigilance of health insurance markets and increase its own scrutiny of anticompetitive and deceptive practices.**
- **The Obama Administration must marshal its competition and consumer protection enforcement resources to focus on anticompetitive, egregious and deceptive conduct by insurers.**
- **The FTC should significantly increase health insurance consumer protection enforcement and create a separate division for health insurance consumer protection enforcement.**
- **The DOJ and FTC should reinvigorate enforcement against anticompetitive conduct by health insurers. The FTC should use its full powers under Section 5 of the FTC Act to prosecute anticompetitive conduct that may not violate the Sherman or Clayton Act.**
- **The FTC and DOJ should establish much stronger standards for health insurance merger enforcement under their Merger Guidelines. The FTC should conduct a retrospective study of health insurer mergers to identify those which have harmed consumers.**
- **Congress should require transparency of all health care intermediaries, including health insurers, Pharmacy Benefit Managers ("PBMs") and Group Purchasing Organizations ("GPOs"), as a part of health care reform.**

I. Rampant Competitive and Consumer Protection Problems in Health Insurance

Let me begin with my earlier observation – the importance of choice and transparency to assure a competitive marketplace. Why are choice and transparency important? It should seem obvious. Consumers need meaningful alternatives to force competitors to vie for their loyalty by offering lower prices and better services. Transparency is necessary for consumers to evaluate products carefully, to make informed choices, and to secure the full range of services they desire. Only where these two elements are present can we expect free market forces to lead to the best products, with the greatest services at the lowest cost. Where these factors are absent, consumers suffer from higher prices, less service, and less choice. As the Health Care for America Now report observed "Without competition among insurers, insurers have no reason to drive down costs, and without additional choices in the marketplace, consumers have no choice but to pay inflated prices."[7]

As I describe below there has been no meaningful federal antitrust or consumer protection enforcement against health insurers. None. The result of the lack of health insurance enforcement is profound. **The number of uninsured has skyrocketed: more than 47 million Americans are uninsured, and according to Consumer Reports, as many as 70 million more have insurance that doesn't really protect them. In the past six years alone, health insurance premiums have increased by more than 87 percent, rising four times faster than**

[7] Health Care for America Now, "Premiums Soaring in Consolidated Health Insurance Market: Lack of Competition Hurts Rural States, Small Businesses." May 2009. Accessed at http://hcfan.3cdn.net/dadd15782e627e5b75_g9m6isltl.pdf.

the average American's wages. Health care costs are a substantial cause of three of five personal bankruptcies. At the same time from 2000 to 2007, the 10 largest publicly-traded health insurance companies increased their annual profits 428 percent, from $2.4 billion to $12.9 billion.

A. A Tsunami of Mergers Has Created a Competitively Unhealthy Market Structure

Any reasonable assessment would conclude that adequate choice and transparency are clearly lacking from today's health insurance markets. Study after study has found that health insurance markets are overly consolidated: in a recent report by Health Care for America Now, in 39 states two firms control at least 50% of the market and in nine states a single firm that controls at least 75% of the market.[8] A 2007 AMA study found almost 95% of all markets are highly concentrated.[9] Industry advocates claim that many markets have several competitors. But the reality is these small players are not a competitive constraint on the dominant firms, but just follow the lead of the price increases of the larger firms.

During the past Administration there was massive consolidation of health insurance markets. As then Presidential candidate Obama observed,

> There have been over 400 health care mergers in the last 10 years. The American Medical Association reports that 95% of insurance markets in the United States are now highly concentrated and the number of insurers has fallen by just under 20% since 2000. These changes were supposed to make the industry more efficient, but instead premiums have skyrocketed, increasing over 87 percent over the past six years.[10]

There is little evidence that this wave of consolidation led to significant efficiencies, or lower costs, or other benefits. In fact, the fact that insurance premiums continued to rapidly increase suggests that any efficiencies were simply pocketed by the companies, rather than resulting in lower premiums or other consumer benefits.

As Vermont Senator Patrick Leahy observed in hearings before the Senate Judiciary Committee in 2006 on health insurance consolidation:

> A concentrated market does reduce competition and puts control in the hands of only a few powerful players. Consumers—in this case patients—are ultimately the ones who suffer from this concentration. As consumers of health care services,

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[8] Health Care for America Now, "Premiums Soaring in Consolidated Health Insurance Market: Lack of Competition Hurts Rural States, Small Businesses." May 2009. Accessed at http://hcfan.3cdn.net/dadd15782e627e5b75_g9m6isltl.pdf.

[9] American Medical Association, "Competition in Health Insurance: A Comprehensive Study of U.S. Markets, 2007 Update."

[10] Statement of Senator Barack Obama for the American Antitrust Institute, September 27, 2007. Accessed at http://www.antitrustinstitute.org/archives/files/aai-%20Presidential%20campaign%20-%20Obama%209-07_092720071759.pdf.

we suffer in the form of higher prices and fewer choices.[11]

Competition matters: in a recent study Professor Leemore Dafny of the Kellogg School of Management documents the high cost of the recent increases in concentration. She estimates that the rise in the concentration of health insurers from 1998 to 2006 led to an overall increase in premiums of 2.1%, or $17 billion in extra profits, in essence over $2 billion a year. She also concludes that, in a concentrated market, insurers may enjoy monopsonistic power over health care providers, and as a result, physicians in that area earn less than they otherwise would.[12] A more general study noted that insurance premiums are 12 percent lower in those markets in which there is comparatively a lower level of concentration than in more concentrated markets.[13] Together, these facts confirm that antitrust concerns are certainly present in the health insurance industry, and the strength of federal enforcement and oversight should reflect this.

One cannot expect competition to break out in any of these markets in spite of the significant profit margins of the incumbent insurers. Recent history has demonstrated that it is practically impossible for new firms to enter metropolitan markets dominated by large insurers. There are numerous barriers to entry including the reputation and brand name of the incumbent insurers (especially when it is a Blue Cross plan), developing sufficient business to permit the spreading of risk, most favored nations provisions and all products clauses that tie up providers and the cost of developing a health care provider network. The failure of large financially successful firms such as United to enter major metropolitan markets speaks volumes about the substantial entry barriers.

In evaluating the competitive health of a market, antitrust enforcers typically look at three factors: concentration, entry barriers, and profits. Health insurance markets, by any measure, are highly concentrated. Substantial barriers to entry assure that concentration will not dissipate based on natural market forces. The lack of competition results in supracompetitive profits. Health insurance is clearly a structural broken market.

B. Anticompetitive Practices go Unchallenged

Similar to the history of regulatory neglect in mergers, the Bush administration did not bring a single case challenging anticompetitive conduct by insurance companies. Certainly there are various types of conduct by dominant insurers that deserve very careful scrutiny because they reinforce dominance and prevent rivals from entering and expanding.

Practices such as most favored nations provisions, all products clauses, and silent networks, which limit the ability of providers to enter into arrangements with rival insurers,

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[11] Senator Patrick Leahy. Statement before the Senate Judiciary Committee. "Examining Competition in Group Health Care." September 6, 2006. Accessed at http://judiciary.senate.gov/hearings/testimony.cfm?id=2046&wit_id=2629.

[4] Leemore Dafny, Mark Duggan and Subramaniam Ramanarayanan. "Paying a Premium on Your Premium? Consolidation in the U.S. Health Insurance Industry." Unpublished working paper. October 2009.

[13] Dan Vukmer, General Counsel, University of Pittsburgh Medical Center Health Plan. Statement before the Commonwealth of Pennsylvania House of Representatives Insurance Committee. Public Hearing on Proposed Merger between Independence Blue Cross and Highmark. August 25, 2008.

increase the power of the insurer at the expense of the health care provider and limit the ability of rival insurers to enter and expand in the market. For example, a most favored nations provision prevents providers from entering into more attractive arrangements with new entrants into the insurance market. Other provisions may prevent physicians from making consumers aware of more attractive insurance products which may provide better coverage. Some of these practices were challenged in the Clinton Administration, but the Bush Administration, which took a mistakenly permissive view to conduct by dominant firms throughout the economy did not mount a single challenge.

Moreover, dominant insurers rarely invade each other's territories. This is disturbing since these firms certainly have the resources, incentives, and ability to enter new markets. The fact they choose not to raises serious concerns of market allocations. Take, for example, the fact that Blue Cross and Blue Shield plans hide behind a complicated system of licensed-based territorial allocations to claim that they don't compete with one another, even when there are multiple plans in the same state. This territorial allocation claim may have been what prompted the Bush administration to take a pass on challenging the proposed Highmark/Independence Blue Cross merger in Pennsylvania. These allocations eliminate important sources of potential competition. The FTC should investigate and challenge these practices. It seems doubtful that a court looking at the Pennsylvania situation would have viewed such territorial allocations as procompetitive.

C. Deceptive, Fraudulent, and Egregious Practices are Unchecked

The hearings held by the Senate Commerce Committee and the Domestic Policy Subcommittee of the House Oversight and Government Affairs Committees documented that insurance companies engage in a wide variety of fraudulent, deceptive and egregious practices. **As Wendell Potter testified before the Senate Commerce Committee, "Insurers make promises they have no intention of keeping, they flout regulations designed to protect consumers, and they make it nearly impossible to understand—or even to obtain—information we need."**[14]

Moreover, as the Domestic Policy Subcommittee heard health insurers regularly find, create, and exploit loopholes to deny consumers the coverage they paid for and deserve. The harm to consumers in suffering is profound.

Consider, for example, the Ingenix matter—the recent scandal over abuse of an industry price-setting database that health insurers used to artificially depress reimbursements to consumers. For several years, United used its wholly owned subsidiary, Ingenix Corp., to calculate reimbursement rates for out-of-network coverage. These rates were artificially deflated, allowing United to lowball payments to customers. Consumers were systematically underpaid by millions of dollars. The New York State Attorney General's Office sued United over Ingenix and has secured over $94.6 million so far, and a class action suit by the American

[14] Wendell Potter. Statement before the Senate Committee on Commerce, Science & Transportation Hearing: "Consumer Choices and Transparency In the Health Insurance Industry." June 24, 2009. Accessed at http://commerce.senate.gov/public/_files/PotterTestimonyConsumerHealthInsurance.pdf.

Medical Association settled for $400 million.[15] Numerous private suits continue.[16] As New York Attorney General Andrew Cuomo stated in testimony before the Senate Commerce Committee in March, Ingenix was "a huge scam that affected hundreds of millions of Americans [who were] ripped off by their insurance companies."[17]

As described below, there were no federal enforcement actions against deceptive or fraudulent activity by health insurers. This lack of federal oversight and the insurers' successful battle against regulation gave insurers great latitude to invent deceptive and fraudulent schemes to harm consumers. Insurers engage in a veritable laundry list of deceptive and abusive conduct such as egregious preapproval provisions, deception about scope of coverage, unjustifiably denying or reducing payments to patients and physicians, and other coercive and deceptive conduct.

In addition to the aforementioned Ingenix case, insurers have been found liable or settled charges for a wide variety of fraudulent and deceptive conduct including: utilizing falsified data to calculate reimbursements, refusing to pay for visits to providers erroneously listed as in-network; wrongfully denying claims for sick patients; failing to pay reimbursements in a timely manner; overcharging customers for premiums; refusing to cover emergency treatment; failing to provide notice of rate increases; ignoring customer complaints; and various other similar methods of denying needed care while maximizing profit. There are countless complaints by hospitals and physicians that preapproval provisions prevent them from providing adequate and safe care. In testimony before the Senate Commerce Committee, Consumers' Union characterized the insurance payer system as plagued by "a swamp of financial shenanigans" – including a lack of transparency, conflicts of interest, and deceptive practices – and called on regulators and enforcers to step up actions to "prevent egregious consumer ripoffs."[18]

To combat this conduct, State Attorneys Generals, Insurance Commissioners, and private parties have brought over 50 cases securing potentially over $1 billion in damages and fines since 2000. Although these state actions are laudable, state enforcement is episodic and can only repair a problem involving a single company in a single state. **Trying to fix these endemic problems with lawsuits is like treating cancer with a bushel of Band-Aids.**

These numerous enforcement actions do not suggest however that state enforcement is an adequate substitute for federal enforcement. Indeed the contrary is true. The level of

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[15] Bob Cook. "Final health plan reaches settlement over Ingenix database." American Medical News. July 6, 2009. Accessed at http://www.ama-assn.org/amednews/2009/06/29/bisc0629.htm.

[16] Senate Committee on Commerce, Science and Transportation, Office of Oversight and Investigations. "Underpayments to Consumers by the Health Insurance Industry." Staff Report for Chairman Rockefeller. June 24, 2009.

[17] Senator John D. Rockefeller, IV, Remarks at the Senate Judiciary Hearing: Part II: Deceptive Health Insurance Industry Practices: Are Consumers Getting What They Paid For?" (March 31, 2009). Accessed at http://commerce.senate.gov/public/index.cfm?FuseAction=Hearings.Statement&Statement_ID=8704a1ba-d058-4ad6-b6ff-3031bd2f0aef.

[18] Charles Bell, Program Director, Consumers Union. Statement Before the Senate Committee on Commerce, Science and Transportation. Hearing on Consumer Reimbursement for Health Care Services." March 26, 2009. Accessed at http://commerce.senate.gov/public/_files/BellTestimonyonDeceptiveHealthInsurancePractices32609.pdf.

enforcement resources that insurance commissioners possess varies significantly from state to state. Most states have relatively limited resources at best to police the insurance industry.[19] In addition, state laws serve at best as a patchwork quilt to address consumer protection issues. Further, self-insured health care plans, which account for over 40 percent of the private health insurance market, are not subject to state regulation. Thus state regulation is far from an adequate substitute for federal regulation of health insurance.

Moreover, the lack of transparency is a chronic problem. In a June letter to several key Congressional leaders, Consumer Watchdog called for Congress to enact a "Patient Bill of Rights" and detailed a number of ways in which health insurers deliberately mislead and underpay patients, including: issuing excessive fine print that allows them to deny coverage for common procedures, failing to define "medical necessity" and "experimental treatment," creating junk policies that are "not worth the paper they're printed on," and manipulating risk to refuse coverage for ailments while charging higher rates.[20] Health insurers allege that they have largely abandoned the practice of forcing "gag clauses" on physicians that prohibit them from discussing insurance alternatives or reimbursement procedures; however, many physicians report having their hands similarly tied by "business clauses" that require many of the same concessions.[21] Consumers cannot access certain information about their benefits and insurers adjudicate claims based on inscrutable and even fraudulent formulas.

As I described in recent testimony before the Senate Commerce Committee, the lack of enforcement was not due to a lack of resources but rather a serious misjudgment about where to devote enforcement resources.[22] Rather than focusing on insurers almost all the enforcement actions were brought against physicians. The missions of the enforcement agencies should be focused on those areas which have the greatest impact on the economy and consumers. The anticompetitive and deceptive conduct by health insurers has a far more profound impact than any anticompetitive conduct by physicians.

D. The Harm to Small Businesses and Individual Consumers

Overall, the total lack of antitrust enforcement results in rapidly increasing premiums, increasing profits, greater numbers of uninsured and noncompetitive market structures in all but a handful of markets.

Small businesses are particularly vulnerable to the exercise of market power by insurers because of their limited options. The recent health insurance crisis has hit small businesses particularly hard, and as premiums escalate it is increasingly difficult for small businesses to offer coverage. The lack of competition makes it impossible for the majority of small business

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[19] Karen Pollitz. Statement before the Senate Committee on Commerce, Science & Transportation. Hearing on "Consumer Choices and Transparency In the Health Insurance Industry." June 24, 2009.

[20] Letter from Jamie Court and Jerry Flanagan, Consumer Watchdog, to House Members Nancy Pelosi, Henry Waxman, George Miller, Pete Stark and Charles Rangel and Senators Max Baucus, Ted Kennedy, and Chris Dodd (June 4, 2009). Accessed at http://www.consumerwatchdog.org/resources/PatientsBillofRightsHouseSenate.pdf.

[21] Fogoros, Richard N. "Why Gag Clauses are Obsolete." The Covert Rationing Blog. June 20, 2007. Accessed at http://covertrationingblog.com/gekkonian-rationing/why-gag-clauses-are-obsolete.

[22] cite

owners to offer their employees insurance. To do so, small business owners must navigate complex plan structures that do not offer the cost-saving benefit of large risk pools that large employers enjoy. A survey of small business owners showed a clear correlation between the size of a business and its premiums—the smaller the businesses, the higher its premiums.[23] It is often too expensive for many small businesses to insure their employees, who are then left to navigate the individual health insurance market—which is even more daunting—or simply go uninsured. As a result of insurers' unrealistically high premiums, only 38% of small businesses offer coverage to the employees, down from 61% in 1993. Because small businesses employ about half of the country's private sector workers, this means that health insurers are discriminating against a huge share of the population.[24]

Wendell Potter, a former health insurance executive, has explained why health insurers treat small businesses so poorly. In testimony before the House Oversight committee, Potter writes that health insurers, in order to cut costs and ensure high profits, "dump small businesses whose employees' medical claims exceed what insurance underwriters expected. All it takes is one illness or accident among employees at a small business to prompt an insurance companies to hike the next year's premiums so high that the employer has to cut benefits, shop for another carrier, or stop offering coverage altogether—leaving workers uninsured."[25] The few dominant insurers in any given market continue this practice year after year without challenge or competition from insurers who are willing to offer lower premiums to these groups.

II. One Cause: A Record of Regulatory Failure

Why aren't health insurance markets working for American families? The answer, at least initially is regulatory failure. Health insurers are governed by a hodge-podge of local, state and federal regulations. Moreover, these companies have fought tooth and nail over the last decade against any regulators' attempts to institute even basic consumer protection measures – including, crucially, killing the original patients' bill of rights legislation in 2001.

Instead of a vibrant, competitive marketplace, the lack of a sound regulatory and enforcement regime has allowed the development of a highly concentrated system in which deceptive and abusive practices flourish with inadequate checks from rivalry or regulation. With insufficient choice and severely limited transparency in the market, consumers suffer from egregious and anticompetitive practices.

As documented above, there have been no enforcement actions against anticompetitive conduct by health insurers. Not a single action. Almost all of the health care enforcement

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[23] Small Business Majority. "The Economic Impact of Healthcare Reform on Small Businesses." June 11, 2009. Accessed at http://smallbusinessmajority.org/pdfs/SBM-economic_impact_061009.pdf.

[24] Wendell Potter. Statement before the Domestic Policy Subcommittee, House Committee on Oversight and Government Reform. September 16, 2009. Accessed at http://groc.edgeboss.net/download/groc/domesticpolicy/preparedtestimonyofmr.wendellpotter.pdf.

[25] Ibid.

resources of the FTC and the DOJ have been spent going after physicians – over 30 cases in the Bush Administration.[26]

The Bush administration reviewed numerous mergers, but approved all of them, requiring some modest restructuring in two mergers. In one case – Highmark's proposed acquisition of Independence Blue Cross – it chose not even to engage in an extensive investigation, despite the fact that, if the two insurers merged, the new insurer would have held over 70% of the Pennsylvania market and formed the sixth-largest insurer in the country. Allowing such a large firm to dominate a single market would make the barriers to entry nearly insurmountable, and consumers would be faced with few options.[27] Ultimately the Pennsylvania Insurance Commissioner reached the opposite decision and found such severe competitive problems that the parties were forced to abandon the acquisition.[28] It is not unusual for the states to step in where the federal enforcers fail to effectively challenge these mergers. There have been several cases where state insurance commissioners have secured remedies even where the federal enforcers have failed to challenge mergers.

The federal consumer protection enforcement record is as bleak as the competition record. The FTC has not brought a single case against deceptive or fraudulent conduct by health insurers. All of the FTC's health care consumer protection enforcement actions were brought against advertising of sham products, such as miracle diet pills, that capitalize on consumers' willingness to be deceived.

This lack of federal oversight and the insurers' successful battle against regulation gave insurers great latitude to invent deceptive and fraudulent schemes to harm consumers. Insurers engage in a veritable laundry list of deceptive and abusive conduct such as egregious preapproval provisions, deception about scope of coverage, unjustifiably denying or reducing payments to patients and physicians, and other coercive and deceptive conduct.

The federal enforcers have not restricted the drive for consolidation nor limited the extent to which insurers could abuse the resulting market power. The result was the tsunami of health insurer consolidation and the accompanying wave of abusive business practices that have stuck small businesses and consumers with unreasonably high premiums and inadequate coverage. Indeed, a report by the Medicare Payment Advisory Commission, an expert panel appointed by Congress, found that insurers "have been able to pass costs on to the purchasers of insurance and maintain their profit margins."[29] Moreover, as health insurers have used their market clout to reduce reimbursement for smaller health care providers, those providers – disproportionately

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[26] As I documented in my testimony before the Senate Commerce Committee in July of this year, it seems unlikely these cases had a significant impact on health care costs.

[27] Joel Ario. "Statement of Pennsylvania Insurance Commissioner Joel Ario on Highmark and IBC Consolidation." January 22, 2009; David Balto. Statement before the Senate Judiciary Committee, Subcommittee on Antitrust, Competition Policy and Consumer Rights. "Consolidation in The Pennsylvania Health Insurance Industry: The Right Prescription?" July 31, 2008.

[28] Jane M. Von Bergen and Angela Couloumbis, "Insurers IBC, Highmark withdraw merger plan." The Philadelphia Inquirer, January 15, 1990. Accessed at http://www.philly.com/philly/news/homepage/38128494.html.

[29] Medicare Payment Advisory Commission. "Report to the Congress: Medicare Payment Policy," March 2009. Accessed at http://www.medpac.gov/documents/Mar09_EntireReport.pdf.

concentrated in rural or urban underserved areas – have been forced into offering assembly-line health care.

Why is there an imbalance in enforcement and a lax position on the conduct of health insurers? Perhaps that is because the agencies treat the insurer as if it is the consumer. If they do, that is a mistake. Insurers do attempt to control costs for employers and other purchasers of health plans. But their primary goal is to fulfill the expectations of Wall Street, and the record of egregious, deceptive, and anticonsumer conduct speaks volumes about whether they act in the interest of consumers.

III. A Public Plan is Essential to Reform the Market.

The lack of competition and record of egregious deceptive practices demonstrates the need for a public plan. A public plan offers the promise of being able to enter these markets currently controlled by monopoly or oligopoly for-profit insurers. The entry of the public plan, based on a nonprofit model and with greater efficiency and lower costs, will disrupt the cozy life of these dominant insurers. This will force down premiums in a fashion that antitrust enforcement will never achieve.

A public plan will be the type of competitive "maverick" in the market that offers the potential to restore competition. Unlike the current for-profit insurers, a public plan does not have the need or incentive to raise and protect its profit margins. Nor does it have any incentive to flout or manipulate regulations. Its concerns are not profit, but the public health.

Moreover, a public plan will set a model of consumer protection compliance, not abuse. With a public plan, the rival insurers will not be able to compete down the level of consumer protections or engage in collusive practices to harm consumers, such as the Ingenix example. Rather, the public plan will serve as a model of consumer protection compliance. The marketplace will then compel rival insurers to meet those standards or face the potential loss of consumers. As President Obama put it, the check of a public plan would keep health insurers "honest."

Overall, competition from a public plan would force insurers to respond to market forces, reducing prices and improving consumer protections. Those who survive the competitive battle will be those with reasonable premiums and superior customer service. As the Urban Institute puts it, "Incentives for them to innovate in the areas of cost containment and service delivery will be enhanced by the presence of a well-run and effective public plan."[30]

The Misplaced Criticism of the Public Plan

Health insurers decry the emergence of the public plan. That is not surprising. No competitor likes competition, especially when they are able to exercise market power, avoid

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[30] John Holahan and Linda Blumberg. "Can Public Insurance Plan Increase Competition and Lower the Costs of Health Reform?" Urban Institute. 2008. Accessed at http://www.urban.org/UploadedPDF/411762_public_insurance.pdf.

regulation, and reap supracompetitive profits. To counter competition, the opponents suggest that competition with the public plan will ultimately lead to the demise of the private health insurance market. Their arguments are inconsistent with the economic realities of these markets.

The public plan opponents argue that Americans normally don't respond to lack of competition by creating a government-run entity, such as a grocery store or a gas station. But those aren't oligopoly markets with high entry barriers in which prices and profits have escalated rapidly. Besides, health care is a different kind of marketplace. As a society we have an obligation to make sure people have access to affordable health care. Moreover, grocery and gas station businesses are essentially transparent, unlike the health insurance business, whose customers do not know what their premium dollars will get them. The primary goal of for-profit insurance companies is to make money for their shareholders. Because they have successfully shielded their coverage rules and policies from public inspection by labeling them trade secrets, they can use egregious practices to deny coverage with inadequate accountability.

The opponents also suggest that the public plan will drive its rivals from the market, perhaps through predatory conduct. This claim is simply inconsistent with the strong position of these powerful dominant health insurers. The major health for-profit health insurers – United, Aetna, Cigna, Wellpoint, Humana, and others — have tremendous financial reserves. In addition, as publicly traded companies they can call on the market for even greater financial support. The nonprofit Blue Cross firms, which dominate dozens of markets, have tremendous financial reserves. Simply, these firms are not about to be driven from the market by the emergence of a public plan.

Insurance companies complain that the proposed public health insurance plan will have unfair advantages and drive them from the market. These claims bear little relation to market realities. These firms are well-funded, sophisticated, and endowed with tremendous financial and human resources. As a former federal antitrust enforcement official, I know that they complain for the reason every competitor complains when a new rival arises – competitors never like competition.

Opponents of a public plan suggest that a plan will become too powerful and will exercise concentrated buying power that will hurt the quality of care. Unlike for-profit firms, a public plan has no incentive to cut corners and prevent providers from giving their patients quality evidence-based care, because its ultimate goal is public health, not private profit. Nor does it have any interest in sideswiping regulations and shortchanging consumers. Free market proponents argue that private health insurers should be lightly regulated to give Americans the best value. We have seen the results of that sort of regulatory neglect in many industries in the past eight years; the harm to all Americans, businesses and the overall economy could not be more profound.

IV. Reform of the McCarran-Ferguson Act is Important

In addition to a public plan, heightened antitrust enforcement of health insurers is absolutely necessary to inject competition in the market. H.R. 3596, the "Health Insurance Industry Antitrust Enforcement Act of 2009," will clarify that the immunity of the McCarran-Ferguson Act will not apply to health insurers or medical malpractice insurers. I think it is relatively clear that the elimination of this immunity will not inhibit any procompetitive conduct of health insurers or medical malpractice insurers. The Clinton Administration endorsed a similar reform of the McCarran-Ferguson Act as part of its healthcare reform initiative. Clarifying the limits of the McCarran-Ferguson Act is important, and Congress should seriously consider repealing the Act altogether.

Congress must take further steps, though, to ensure that the federal government can effectively protect consumers who have been the victim of the anticompetitive and egregious practices I have described so far. Giving the FTC jurisdiction where only state insurance commissioners are now involved would benefit consumers enormously. Currently, when health insurers overcharge or otherwise abuse consumers, their only recourse is to their state's insurance commissioner. Under most state laws, individuals have no private right of action under the insurance rating law or unfair insurance trade practices act. And state insurance commissioners have very limited resources. Congress should amend the McCarran-Ferguson Act to permit the FTC to take action against unfair or deceptive practices in the health insurance industry and provide the strong consumer protection on the federal level that consumers urgently need.

V. The Potential for Health Care Reform to Promote Competition and Protect Consumers

As a part of health care reform, there is a clear need for regulatory reform. As I have noted before, we depend on a patchwork of state laws, which seem insignificant in comparison to the scope and scale of egregious consumer protection violations and anticompetitive conduct in the health insurance industry. Many states have ineffective laws to address these problems or lack the resources to even enforce their laws. Congress has grappled with this as a part of its health care reform proposals, but there needs to be a more comprehensive approach.

Congress must act to correct the endemic problems in the health insurance market. To start, they should fully utilize their investigatory powers to look into anticompetitive and deceptive conduct by health insurers. This year alone, Congress has conducted many investigations and spent time looking into practices by health care intermediaries that may be harming consumers or needlessly adding to the country's health care spending. Some of their most significant efforts are listed below.

- An investigation into the Ingenix scheme, described above, by the Senate Commerce Committee helped put an end to one of the most widespread consumer abuses in health insurance history;
- Ongoing efforts by the House Energy and Commerce Committee and Oversight and Government Reform Committees to reveal the types of fraudulent and deceptive practices

by health insurers that I have described have played a large role in the sense of urgency and duty that has marked health care reform this year; and

- The Federal Employees, Postal Service and District of Columbia Subcommittee of the House Oversight and Government Reform Committee has sparked discussion of the often-ignored PBM industry by investigating their role in the Federal Employees Health Benefit Program.

All of these efforts should be strengthened and reinforced; Congress can play a critical role in exposing harmful practices in the health insurance market – shining the "sunlight" that Justice Brandeis explained is the best disinfectant here.

Below are some of the proposals Congress has put forth in its various health care reform bills which would improve consumer protection and promote competition. What is sorely needed, though, is a federal enforcement mechanism to ensure that these requirements are met by the health insurance companies and to protect the interests of consumers. The House Tri-Committee bill would establish a Health Choices Administration with a commissioner appointed by the President with the authority to enforce the requirements imposed on health insurers by the bill. The Senate Finance bill does not create such an entity, though, and relies largely on state insurance commissioners to enforce the bill's many requirements. Without a strong federal entity that consistently enforces these regulations and has the authority to help consumers, we might not be able to avoid the egregious situations documented in the recent hearings.

- The Senate Finance bill will simplify the process of shopping for health insurance by requiring standardized marketing guidelines, a standard format for presenting insurance options, and a standard enrollment application. This would allow consumers to directly compare the terms and costs of insurance plans and make well-informed purchasing decisions.
- The House Tri-Committee and Senate Finance bills each create an ombudsman to receive consumer complaints and act as a consumer advocate, either on the state or federal level.
- The Senate Finance bill sets aside $30 million for consumer assistance organizations on the state level. These programs would help consumers navigate complex health insurance plans and protect themselves from consumer protection violations.

These proposed regulations reflect efforts from *within* the health care system to promote competition and to protect consumers. These efforts must be matched by the federal antitrust agencies, though, to provide adequate oversight and enforcement.

VI. Recommendations for Revitalizing Competition and Consumer Protection Enforcement

Ultimately, strong consumer protection and antitrust enforcement on the federal level is essential for health care reform to work. Below are some recommendations for building a solid structure for competition and consumer protection enforcement in health care.

1. **The Obama Administration must marshal its competition and consumer protection enforcement resources to focus on anticompetitive, egregious and deceptive conduct by insurers.** The structure of the health insurance market is broken and the evidence strongly suggests a pervasive pattern of deceptive and egregious practices. Health insurance markets are extremely concentrated, and the complexity of insurance products and opaque nature of their practices make these markets a fertile medium for anticompetitive and deceptive conduct.

2. **Create a vigorous health insurance consumer protection enforcement program.** The FTC's health care consumer protection enforcement currently focuses on marketers of clearly sham and deceptive products. This is unfortunate. In many other areas, such as financial services, the FTC uses a broad range of powers, including studies, workshops, policy hearings, legislative testimony, and industry conferences to better inform marketplace participants of how to properly abide by the law. The FTC should adjust its healthcare consumer protection enforcement to focus on health insurers, and other health care intermediaries such as PBMs. These efforts should focus both on enforcement to prevent egregious and fraudulent practices and to assure that there is a sufficient amount of information and choice so that consumers can make fully informed decisions. Because of the importance of these issues, especially in controlling health care costs, the FTC should establish a new division for health insurance consumer protection.

3. **Reinvigorated enforcement against anticompetitive conduct.** The DOJ and the FTC need to reinvigorate enforcement against anticompetitive conduct by health insurers. The FTC should scrutinize anticompetitive conduct and use its powers under Section 5 of the FTC Act. As this Committee knows, Section 5 of the FTC Act can attack practices which are not technical violations of the traditional antitrust laws, the Sherman and Clayton Acts. Thus the FTC can use that power under Section 5 to address practices which may not be technical violations of the federal antitrust laws, but still may be harmful to consumers. As I have testified elsewhere, the FTC should begin to use that power under Section 5 to attack a wide range of anticompetitive and egregious practices by health insurers, PBMs, and GPOs.

4. **Stronger health insurance merger enforcement and a retrospective study on consummated health insurance mergers.** During the Bush administration there was significant consolidation in health insurance markets. If the FTC and/or Justice Department lacks sufficient resources to effectively challenge anticompetitive mergers, they should be given those resources. If the current merger standards do not appropriate to effectively challenge these mergers, those standards should be reevaluated. Simply, the public cannot afford any greater consolidation in health insurance markets.

5. **Conduct a retrospective study of health insurer mergers.** I have suggested elsewhere that one approach to this issue would be for the FTC or the DOJ to conduct a study of consummated health insurer mergers. One of the significant accomplishments of the Bush administration was a retrospective study of consummated health insurance mergers by the Federal Trade Commission. This study led to an important enforcement action in Evanston, Illinois, which helped to clarify the legal standards and economic analytical

tools for addressing health insurance mergers. A similar study of consummated health insurance mergers would help to clarify the appropriate legal standards for health insurance mergers and identify mergers that have harmed competition.

6. **Recognizing that the insurer does not represent the consumer.** Although insurers do help to control cost, they are not the consumer. The consumer is the individual who ultimately receives benefits from the plan. It is becoming increasingly clear that insurers do not act in the interest of the ultimate beneficiary. They are not the proxy for the consumer interest, but rather exploit the lack of competition, transparency, and the opportunity for deception to maximize profits.

7. **Clarify the jurisdiction of the FTC to bring enforcement actions against health insurers.** Some may suggest that the FTC lacks jurisdiction over health insurance. I urge this Committee to ask the FTC to clarify their position on this issue. Is the claim of no jurisdiction the law or simply an urban legend? As I understand it, there is a limitation in Section 6 of the FTC Act that prevents the FTC from performing studies of the insurance industry without seeking prior Congressional approval. This provision does not prevent the FTC from bringing either competition or consumer protection enforcement actions. There may be arguments that the McCarran-Ferguson Act limits jurisdiction, but that exemption is limited to rate making activity. In addition, some people might argue that the FTC's ability to attack anticompetitive conduct by nonprofit insurance companies might be limited under the FTC Act. The solution to this problem is simple, straightforward and critical. If the FTC lacks jurisdiction in any respect to bring meaningful competition and consumer protection enforcement actions against health insurers, Congress must act immediately to provide that jurisdiction. There is no reason why health insurance should be immunized from the Federal Trade Commission Act.

8. **Require transparency of health care intermediaries.** There is a need for transparency of all health care intermediaries, including health insurers, pharmacy benefit managers (PBMs) and group purchasing organizations (GPOs). Transparency has two aspects: first, for the purchaser of services, there should be full and adequate transparency so they can determine that they are receiving the full value of services provided by these health care intermediaries; and second, for the consumer, there should be adequate transparency to evaluate the value of products purchased, such as health insurance plans. A good first step towards transparency is an amendment offered by Congressman Weiner to H.R. 3200 which requires transparency by PBMs which participate in plans in the health insurance exchange. Numerous consumer groups have endorsed the need for PBM transparency, and extending transparency to all health care intermediaries would allow for more informed decision-making by health care consumers and enhance competition in the markets for health insurers, PBMs and GPOs.[31] Assistant Attorney General for Antitrust Christine Varney highlighted the importance of transparency when she said, "I am a firm believer in what Justice Brandeis said in another context: Markets work better and attempted harms to competition are more likely to be thwarted when there is

[31] Consumer Federation of America, US PIRG and the National Legislative Association on Prescription Drug Prices. Letter to Speaker Nancy Pelosi. August 20, 2009 (supporting Congressman Weiner's amendment).

increased transparency to consumers and government about what is going on in an industry."

Conclusion

The current health insurance market suffers from anticompetitive and fraudulent activity practically unknown in any other market. If that market structure does not change, and these practices continue, the opportunity for meaningful reform will be severely diminished. Congress should continue its efforts to investigate these broken markets and the practices that plague consumers. Congress should also act to assure that the full resources of federal antitrust and consumer protection enforcement are utilized to begin to reform these markets.

Mr. JOHNSON. Thank you.

And with that, we will begin with questions.

Ms. Gotts, what was the justification 64 years ago for passing McCarran-Ferguson? And what, if anything, has changed since then that would merit continued insulation of insurance companies from the antitrust laws?

Ms. GOTTS. What was the reason that the exemption was initially put into place was a Supreme Court case which found a restriction on the ability of states to regulate insurance, and it was based on the interstate commerce clause, so it was to make clear that there could be a scheme of state regulation. And that should definitely continue.

On behalf of the American Bar Association, I am not here today to try to justify the continuation of the McCarran-Ferguson exemption as it is written, so you are not going to hear that out of my mouth in any way.

Instead, what I would suggest to you—that in the last 65 years, what we have seen is antitrust jurisprudence really advance. Today we have, through case law, much more recognition of the efficiency, pro-competitive justifications that can go into joint activity.

Today we also have certain checks and balances on plaintiffs bringing frivolous suits with Twombly having come out—the Supreme Court.

This all suggests—and the general view over time has been for the last 15 years where we have seen exemptions going by the wayside—that the Sherman Act is really what should apply.

But for clarification purposes, because we would be doing this sea change, we would want to make clear that activities that are specified under safe harbors, which we believe there is little chance that there would be anticompetitive activity, are recognized and are protected, so that what Mr. Hurley talks about in the sharing of information that is used in order to be able to keep rates down—that that can be permitted, but at the same time the antitrust laws can be enforced.

So the position of the American Bar Association has been clearly for the last 20 years to get rid of McCarran-Ferguson and replace it with just these safe harbors and with full recognition that the antitrust laws apply.

Mr. JOHNSON. Thank you.

Dr. Mandell and Mr. Balto, in Mr. Hurley's written testimony, he says that eliminating McCarran-Ferguson will result in less vigorous competition.

Dr. Mandell, Mr. Balto, when you look at the insurance market, do you see vibrant competition?

Mr. BALTO. The AMA study of documents, I think quite clearly, that the vast majority of markets are highly concentrated.

The report by Health Care for Americans Now documents how almost every state is dominated by one or, at most, two insurers. That doesn't sound like a competitive market to me.

Dr. MANDELL. Your question was about medical liability insurance, or health care? I am sorry.

Mr. JOHNSON. Health care, and medical liability—the same question would apply on liability insurance as well.

Dr. MANDELL. Well, let me take medical liability. In my state, there are at least four or five companies that I can think of that are vying for the—the customers like me, the orthopedic surgeons and other doctors.

And it is a fairly vibrant market. The prices are fairly low. The service is high. The reason I think we have this is partly because

of things that go on at the state level, but also because of the overall micro reforms that were put down in 1975.

Mr. JOHNSON. What happens if the states don't have a vigorous regulatory bent of mind?

Dr. MANDELL. Well, there are states where—one of the reasons we had our change in California in 1975 is everybody left the state. The insurance carriers left the state. We had no insurance. And so people had to put it together, and doctors put it together, and small groups put it together, and that sort of thing.

There are still states, at least a year or two ago when I last looked at this—Pennsylvania, for one—where insurance premiums for medical liability are so high that very few carriers are willing to write.

So depending on, you know, whether you have these micro-type reforms, you can have a situation where I am presuming the insurance companies can make a profit or they are not going to stick around.

Mr. JOHNSON. Thank you, sir.

Ms. Gotts and Mr. Hurley—Ms. Gotts, can you think of any reason that the process of trending, in which industry data aggregators project future prices for insurance premiums, should enjoy a special protection under the antitrust laws?

Ms. GOTTS. The ABA has not studied in detail how the pricing mechanisms would work.

I would state, though, that the way the safe harbor is now being proposed that is in our written statement, I think we get the right balance, which would be for very limited but pro-competitive sharing of information would be permitted, and the others will be subject to the antitrust laws.

So if they do have an anticompetitive purpose, there would be a way of challenging it.

Mr. JOHNSON. Mr. Hurley?

Mr. HURLEY. The issue of trending—I think Ms. Gotts is saying that collection of data—the aggregation of data is fine. The issue of trending is essentially analysis of the data, in some sense.

And in the absence of analysis of that data, the relatively smaller, newer companies or the self-insurers who might otherwise be able to use the results of that analysis, which, incidentally, creates loss costs, not rates—it doesn't necessarily translate into a premium.

It translates into an interpretation of losses. So someone can estimate what a loss cost is for a particular base class physician or for an acute care bid—that sort of thing. It translates into increased limits relationships would allow—which allows you to determine what higher limits of coverage should cost.

These things are highly technical. They require generally the work of an actuary. Many smaller, newer companies getting into the business would have difficulty in having that kind of expertise or having access to that kind of expertise.

So this is an interim step before the establishment of rates. It is not actually establishing a rate. It is establishing what a loss cost is. So there is an intervening step.

Companies ultimately who provide this coverage would have to take those loss costs, interpret them, and then adjust them such

that they would make it into rates that are appropriate for their underwriting standards and their expense level. Hope that answers the question.

Mr. JOHNSON. Thank you.

Mr. Hurley, if lawsuits alleging price fixing by insurance companies have been thrown out because of McCarran-Ferguson, and if we don't have a vigorous regulatory environment by state governments, how can we say that there is no price fixing going on in the industry?

And also, what is it that justifies antitrust exemption for insurers?

And last but not least, you mention about—in your statement—we have consulted—excuse me, Dr. Mandell mentioned in his statement that we have consulted antitrust experts and have failed to find any cases where the commercial health insurers have been charged with price fixing or collusion in sharing of price information.

And the doctor goes on to see—to say that there is little need to collude on pricing as they have—the insurance companies have consolidated and been able to control a larger part of the health insurance market.

And I would like to know whether or not that is a positive or a negative trend.

Mr. HURLEY. Well, I think I heard three questions there, and I know you will help me if I don't get to one of them.

Mr. JOHNSON. I will try.

Mr. HURLEY. Start from the beginning. You mentioned the issue of price fixing in lightly regulated states. That is essentially one of the concerns.

Mr. JOHNSON. Yes.

Mr. HURLEY. I think what I can say is that the actual act of price fixing, colluding to fix prices, is—it just, in my experience, does not happen, as I said in my testimony.

In a lightly regulated state, I think there is the forces of competition, just like there are in regulated states. Companies will compete for business whether the regulation is harsher, I guess, tighter, or looser, as you were asking.

So I think that the competition does exist there. Companies will compete for business.

In fact, in some sense, harsher and tighter regulatory environments sometimes make it tougher to compete because you have to get rates through the insurance departments before you are able to implement them. But companies will compete in both of those types of regulatory environments, in my opinion.

The second one—I don't know that I can recollect, but let me touch on the issue of consolidation. It is true, I think, that in medical professional liability that there probably aren't as many medical professional liability insurers offering coverage as there are automobile insurance companies.

However, I think that most folks who would evaluate the marketplace would say that there is—there are enough companies in most jurisdictions to provide a competitive marketplace. In other words, there are probably three or four or five insurers who are willing to participate in this business.

I would supplement that by saying that this—as Dr. Mandell suggested, this is a tough line of business. It is a line of business where most commercial insurers do not find or have the appetite to write the business because of the things I mentioned—the unpredictability of it, the uncertainty of it, the long-tail nature of it.

And so there are fewer companies that are willing to write it. A lot of the companies that do write it specialize in it. And that is why there, perhaps, are fewer of them, because they actually specialize in that line of business.

And the reason why they specialize in it—and many of them are, in fact, owned by the physicians they insure. They are mutual companies.

So they are in there for the reason, the reason that they want to provide available coverage at the most reasonably economic, affordable price that makes sense financially, fiscal sense. So they are trying to do that.

And I apologize. I think I missed your middle question.

Mr. JOHNSON. That is okay. It is time for us to move on to our Ranking Member, Mr. Coble. Thank you all for your responses to my questions.

Mr. COBLE. Thank you, Mr. Chairman.

Thank the panelists for being with us today as well.

Mr. Hurley, let me bring you in on this. We discussed it earlier, but—less clear for me as to the relationship between medical malpractice liability reform and medical malpractice insurance rates in any given state.

Mr. HURLEY. Well, I guess this is a good time to ask that question, because we have just been through a period of time when a number of reforms were passed in the last few years in a number of the states.

It is hard for me as an actuary to make a cause and effect relationship between medical reforms—tort reforms and rates. However, I would say that there are a number of dynamics that affect that. It is the medical reforms, it is changes in the economy and things like that.

However, it is hard to deny the coincidence of lower frequency of claims that has occurred since the implementation of reform, and in states where reforms were passed, the coincidence of timing of lower frequency of claims, therefore lower costs driving rates, coincidental with the implementation of those reforms.

Mr. COBLE. The lower cost—you mean lower premium payments?

Mr. HURLEY. Lower costs will ultimately result in lower premiums.

Mr. COBLE. I got you. Thank you, sir.

Dr. Mandell, you mentioned that you would like to see some clarification to the application of antitrust laws to the practice of medicine. Elaborate a little bit on that.

And let me ask you this. In your opinion, should the Federal Trade Commission and the Department of Justice revise their health care guidelines to reflect modern practice of medicine?

Dr. MANDELL. I believe the answer is yes, but—yes, but what I was really referring to in this statement is their treatment of health insurers and how they are consolidating, and how they are using that consolidated power to—I guess the best word I think of

is bully patients and doctors into accepting things that are not ideal, not high value.

And the reason we think that that happens is because insurance companies have become so big, so powerful, so profitable that they feel they can get away with just about anything.

I am sure you—and perhaps you were in the room when somewhere in Congress they were interviewing a woman from Texas who had had breast cancer, and they cut—the insurance company cut their—her treatment in the middle of her course, and that caused things to get worse and all this kind of thing.

And later on, somebody asked the CEOs of the two or three insurance companies would they commit now to—oh, I am sorry, they cut it because she had forgotten to put on her application that she had acne at one time, or something completely unrelated.

And the folks in that room asked the insurance CEOs, "Would you commit right now to not doing that anymore? Sure, you can dump people if they lie to you, but for something like that, you know, get real." And they wouldn't do it. You know, they said, "We have to follow the state laws, and this is what the state laws say."

So that is something that needs to change.

Mr. COBLE. Ms. Gotts, are you aware of any policy justification for separating out health insurance or medical malpractice insurance from other types of insurance?

Ms. GOTTS. I am not aware of any, and the ABA to date has not taken a position. We saw this as a good first step.

Mr. COBLE. Thank you.

Doctor, I don't believe you touched on my question regarding the Federal Trade Commission and the Justice Department. Should they make any revisions?

Dr. MANDELL. Well, yeah. That was what I was trying to say——

Mr. COBLE. Okay. I am——

Dr. MANDELL [continuing]. Apparently not very well. They should more vigorously look at these companies, and if they are doing things which, in effect, are bad for patients, take appropriate action so——

Mr. COBLE. Okay. I got you.

Mr. Balto, I don't want you to escape without recognition. Your written testimony, Mr. Balto, essentially accuses state insurance commissioners of some regulatory neglect.

In your opinion, does this apply to all forms of insurance, or are health insurance and medical malpractice insurance markets particularly dysfunctional?

Mr. BALTO. Let me clarify my statement. I certainly would never accuse the diligent and under—the underfunded state insurance commissioners of regulatory neglect.

The problem here is that state insurance commissioners face a very daunting task. There is testimony by Georgetown professor Karen Pollitz which—before the Senate Commerce Committee which explains how—the lack of resources and ability of state insurance commissioners to effectively police health insurance markets.

And I would be glad to provide the Committee with documentation that shows that if you are in a big state like New York and

California, you are much more likely to have an activist insurance commissioner who can really protect you.

So as the Committee considers whether or not state insurance commission enforcement is an adequate substitute for Federal enforcement such that you don't need to amend the statute, you should recognize that the vast majority of states have extraordinarily limited resources to effectively go after this conduct.

Mr. COBLE. I thank you, sir.

Thank you all.

Thank you, Mr. Chairman. I yield back.

Mr. JOHNSON. Thank you, Mr. Ranking Member.

I would be remiss by not introducing or recognizing my colleague from the Energy and Commerce Committee, Ms. Diana DeGette.

Welcome today.

And although she is not able to ask any questions because she is not assigned to this Committee, she is certainly eligible to sit with us as we listen to the testimony.

I will say that for the record she wants us to know that it was not their intention in drafting this bill to prohibit appropriate procompetitive information-sharing.

And we are certainly willing to look at that recommendation of the ABA and others with regards to this issue. And I did want to—to say that for the record on behalf of Congresswoman DeGette.

If there are no other questions——

Mr. BALTO. Mr. Chairman, could I just make one additional comment? You know, there is some question in the discussion about whether or not this is really necessary, this—and I think you need to take a dynamic look. Don't only look at the way the markets are today.

But if we turn to using a health care exchange, doesn't the existence of the health care exchange offer a greater number of opportunities for the kinds of collusion that might be protected under the current McCarran-Ferguson Act? And isn't that a reason to go and amend the act to sort of protect ourselves against that kind of collusion?

Mr. JOHNSON. Well, I love rhetorical questions, and with that we——

Mr. COBLE. Mr. Chairman?

Mr. JOHNSON. Yes.

Mr. COBLE. If I may, Congressman Harper would—requested that his statement be made a part of the record. I would like to introduce that, if I may.

Mr. JOHNSON. Okay. All right. Without objection, so ordered.

[The information referred to follows:]

ONE HUNDRED ELEVENTH CONGRESS

Congress of the United States
House of Representatives

COMMITTEE ON THE JUDICIARY

2138 RAYBURN HOUSE OFFICE BUILDING

WASHINGTON, DC 20515–6216

(202) 225–3951
http://www.house.gov/judiciary

October 26, 2009

Mr. David Balto
Law Offices of David Balto
1350 I Street, NW, Suite 850
Washington, DC 20005

Dear Mr. Balto:

On behalf of the Committee on the Judiciary, Subcommittee on Courts and Competition Policy, I want to express our sincere appreciation for your participation in the October 8, 2009, hearing on H.R. 3596, the "Health Insurance Industry Antitrust Enforcement Act of 2009". Your testimony was informative and will assist us in future deliberations on the important issues addressed during the hearing. In addition, is a question from Representative Gregg Harper, a Member of the Subcommittee, to be incorporated into the final record.

Also, please find a **verbatim** transcript of the hearing enclosed for your review. The Committee's Rule III (e) pertaining to the printing of transcripts is as follows:

> *The transcripts shall be published in **verbatim form**, with the material requested for the record as appropriate. Any requests to correct any errors, other than transcription, shall be appended to the record, and the appropriate place where the change is requested will be footnoted.*

Questions submitted to Mr. David Balto, Senior Fellow at the Center for American Progress Action Fund, by Representative Gregg Harper.

1. *In your written testimony you stated that, "Few markets are as concentrated, opaque and complex and subject to rampant anticompetitive and deceptive conduct" as is the health insurance market. H.R. 1583 has also been referred to the Judiciary Committee. As I understand it, H.R. 1583 would repeal the antitrust exemption for all lines of insurance, not just health and malpractice. Is there any evidence that the health and malpractice insurance markets are any more prone to collusion, price-fixing, or market allocations than other lines of insurance, and do you think that there is reason to repeal the antitrust exemptions for all lines of insurance?*

Please forward transcript edits to the Subcommittee on Courts, no later than ***November 13, 2009***. and respond to question separately on official stationery. The mailing address is as follows, Committee on the Judiciary, Subcommittee on Courts and Competition Policy, B-352 Rayburn House Office Building, Washington, D.C. 20515.

If you have any questions, do not hesitate to contact the Subcommittee on Courts and Competition Policy at 202.225.5741.

Thank you again for your testimony.

Sincerely,

Hank Johnson

Henry "Hank" C. Johnson, Jr.
Chairman
Subcommittee on Courts and Competition Policy

DAVID A. BALTO
ATTORNEY AT LAW
1350 I STREET, NW
SUITE 850
WASHINGTON, DC 20005

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November 23, 2009

Dear Chairman Johnson:

Thank you for giving me the opportunity to testify before the Subcommittee on Courts and Competition Policy on the topic of the "Health Insurance Industry Antitrust Enforcement Act of 2009," H.R. 3596, last month.

I am writing to respond to Representative Harper's question regarding how health and malpractice insurance compare to other lines of insurance. He asked: "Is there any evidence that the health and malpractice insurance markets are any more prone to collusion, price-fixing or market allocations than other lines of insurance, and do you think that there is reason to repeal the antitrust exemptions for all lines of insurance?"

My response:

In general, the health insurance industry has not needed the protections of the McCarran Ferguson exemption because most health insurance markets are highly concentrated. As a general matter as outlined in the testimony of Christine Varney the Assistant Attorney General of the Antitrust Division, the McCarran exemption is unnecessary and Congress should consider repealing the entire exemption.

Please contact me anytime if you have further questions or concerns.

Sincerely,

David A. Balto

David A. Balto

Mr. JOHNSON. I would like to thank all of the witnesses for their testimony today. And without objection, Members will have 5 legislative days to submit any additional written questions, which we will forward to the witnesses and ask that you all answer as promptly as you can so that they can be made a part of the record.

Without objection, the record will remain open for 5 legislative days for the submission of any additional materials.

Mr. COBLE. May I, Mr. Chairman?

Mr. Balto, you indicated that you might make available to us regarding my question concerning the various and sundry studies—if you can do that.

Mr. BALTO. Yes.

Mr. COBLE. Mr. Chairman, I think that would be in order.

Mr. JOHNSON. All right. Certainly.

Mr. BALTO. I will be glad to. Thank you.

Mr. JOHNSON. Today's hearing raised a number of important issues. As we consider the legislation before us, the question we must ask ourselves is are consumers better off when their health insurance and medical malpractice insurance companies are exempted from antitrust laws.

And with that, this hearing on the Subcommittee on Courts and Competition Policy is adjourned.

[Whereupon, at 12:23 p.m., the Subcommittee was adjourned.]

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING RECORD

ADA American Dental Association®

STATEMENT OF

THE AMERICAN DENTAL ASSOCIATION

TO THE

COMMITTEE ON THE JUDICIARY

UNITED STATES HOUSE OF REPRESENTATIVES

ON

H.R. 3596

"THE HEALTH INSURANCE INDUSTRY ANTITRUST

ENFORCEMENT ACT OF 2009"

OCTOBER 8, 2009

The American Dental Association ("ADA") is pleased to submit this written testimony for inclusion in the record of the House Judiciary Committee's hearing on H.R. 3596, "Health Insurance Industry Antitrust Enforcement Act of 2009" held on October 8, 2009. The hearing addressed the merits of H.R. 3596, which would essentially repeal the antitrust exemption created by the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015, with respect to health insurers. For the reasons set forth below, the ADA strongly supports this much needed legislation.

I. About the ADA

The ADA is America's leading advocate for oral health. Established in 1859, the ADA today represents approximately 157,000 licensed dentists in the United States. Through its numerous initiatives, the ADA supports programs to improve access to high quality dental care for all Americans and to inform all Americans about their oral health. Consequently, the ADA has a real and abiding interest in promoting a robustly competitive market for health insurance.

II. Repeal of the Health Insurance Industry's Antitrust Exemption

The McCarran-Ferguson Act's antitrust exemption extends to all conduct that constitutes the "business of insurance," not merely the activities of health insurers. Nevertheless, the repeal of the exemption within the health insurance industry is particularly important. The current debate regarding health care reform requires serious consideration of any and all means to introduce competition and make health insurance affordable for all Americans. An important step toward achieving these objectives is eliminating the unwarranted antitrust exemption that grants health insurers special status, and permits them to ignore the competitive rules that apply to every other U.S. business.

A. Antitrust Exemptions Are Disfavored as a General Rule

Even before addressing the merits of the specific antitrust exemption for the insurance industry, it is worth noting that, as a general rule, *all* such exemptions are disfavored. Although a number of industry-specific statutory exemptions remain on the books, no new exemptions have been added in decades. The bipartisan Antitrust Modernization Commission ("AMC") recently concluded that "[t]ypically, antitrust exemptions create economic benefits that flow to small, concentrated interest groups, while the costs of the exemption are widely dispersed, usually passed on to a large population of consumers through higher prices, reduced output, lower quality, and reduced innovation."[1] Consistent with the views of the AMC, the Antitrust Section of the American Bar Association has steadfastly advocated repeal of the specific McCarran- Ferguson Act exemption for the insurance industry for over twenty years.[2]

B. The McCarran-Ferguson Act Is Not Tailored to Unique, Insurance-Industry Needs

Insurers frequently argue that, without the protection of the McCarran-Ferguson Act exemption, they will be unable to engage in procompetitive joint conduct, such as developing standardized policy forms or collecting and disseminating past loss experience data. However, there is little support for these concerns. Firms in other industries routinely carry out these sorts of activities through trade associations and other industry collaborative bodies without fear of undue antitrust enforcement. As the Antitrust Division of the Department of Justice ("DOJ") noted in its own testimony before the Senate Judiciary Committee, antitrust enforcement has changed significantly since 1945. Modern antitrust law is flexible enough that the insurance

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[1] Antitrust Modernization Comm'n. *Report and Recommendations* 335 (Apr. 2007), *at* http://govinfo.library.unt.edu/amc/report_recommendation/amc_final_report.pdf.

[2] Statement of the ABA Antitrust Section Before the Subcommittee on Courts and Competition Policy, Judiciary Committee, U.S. House of Representatives, Concerning H.R. 3596, "The Health Insurance Industry Antitrust Enforcement Act of 2009" 2 (Oct. 8, 2009), *at* http://judiciary.house.gov/hearings/pdf/Gotts091008.pdf.

industry practices at issue, rather than being automatically condemned under the *per se* rule, would now be analyzed under the rule of reason, pursuant to which a particular practice's potential procompetitive benefits are weighed against its potential anticompetitive harms.[3] Reducing the legal uncertainty and business risk still further, DOJ and the Federal Trade Commission ("FTC") have issued detailed joint guidance on the operation of antitrust-compliant industry-wide information exchanges,[4] as well as the structuring of other competitor collaborations.[5] Finally, when even this guidance is insufficient, insurers can request a business review letter from DOJ, or an advisory opinion from the FTC, to assess the antitrust risk associated with a new business practice before implementing it in the marketplace.

C. The McCarran-Ferguson Act Does Not Benefit Consumers

Both patients and providers have been hurt over the years by the false argument that the McCarran-Ferguson Act exemption protects patients by serving to control the cost of health care. This is simply not the case. Promoting lower prices, greater consumer choice, and increased innovation through robust competition is the role of the antitrust laws. The Supreme Court has characterized the antitrust laws as "the Magna Carta of free enterprise,"[6] and the Sherman Act, 15 U.S.C. §§ 1-7, has proven sufficiently versatile to spur efficiency-enhancing competition in markets spanning the full range of the U.S. economy – largely without the need for industry specific exemptions – for over one hundred years. The McCarran-Ferguson Act, in contrast, was intended to protect the insurance industry from a perceived threat of conflicting state and federal regulation – a threat that has proven illusory in the six decades since the legislation's passage.

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[3] Statement of the Antitrust Division of the Dep't of Justice Before the Judiciary Committee, U.S. Senate, Concerning "Prohibiting Price Fixing and Other Anticompetitive Conduct in the Health Insurance Industry" 5 (Oct. 14, 2009), *at* http://judiciary.senate.gov/pdf/10-14-09%20Varney%20Testimony.pdf.

[4] U.S. Dep't of Justice and Fed. Trade Comm'n Statements on Antitrust Enforcement Policy in Health Care, Statement 6 (1996).

[5] U.S. Dep't of Justice and Fed. Trade Comm'n Antitrust Guidelines for Collaborations Among Competitors (2000).

[6] *United States v. Topco Associates*, 405 U.S. 596 (1972).

D. The McCarran-Ferguson Act Chills Needed Antitrust Oversight

Repeal of the McCarran-Ferguson Act will substantially improve, even potentially eliminate, the problem of one-sided federal antitrust enforcement. According to a 2008 study by the American Medical Association, within the 314 metropolitan statistical areas surveyed, 94% of commercial health insurance markets qualified as "highly concentrated" under standards established by DOJ and FTC.[7] Yet, currently, dentists and other health care providers facing monopoly health plans have little recourse. If individual providers or practices band together to increase their negotiating clout, they are likely to trigger an antitrust investigation, if not an enforcement action. For decades, however, when health care providers have brought antitrust concerns regarding insurers to the attention of federal enforcers, agency staff have been reluctant to proceed for fear of crossing the line that McCarran-Ferguson draws. Repeal of the Act would enable both DOJ and FTC to focus their attention on specific anticompetitive practices by insurers that may adversely affect patients and dentists, thereby leveling the playing field and ensuring that providers and health plans are abiding by the same set of competitive rules.

Furthermore, the McCarran-Ferguson Act, by severely limiting federal antitrust enforcement in the insurance industry, places virtually all of the oversight responsibility on state regulators. This allocation of responsibility functions relatively more effectively in those states having better developed and funded regulatory structures, and decidedly less well in the ones that do not. Consequently, repeal of McCarran-Ferguson will lead not only to better, but also to more consistent, antitrust enforcement, as health insurer conduct that is currently subjected to antitrust scrutiny in only some states will be subjected to equivalent scrutiny nationwide.

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[7] Emily Berry, *Most Metro Areas Dominated by 1 or 2 Health Insurers*, American Medical News, Mar. 9, 2009.

E. The McCarran-Ferguson Act Is Outdated

At the time of its passage in 1945, the McCarran-Ferguson Act was intended to resolve a perceived conflict between state and federal regulation of the insurance industry. Prior to the Supreme Court's decision in *United States v. South-Eastern Underwriters Ass'n*,[8] regulation of the insurance industry was regarded as the exclusive province of the states. In *South-Eastern Underwriters*, however, the Court concluded that the insurance industry was within the regulatory reach of the federal government. Under heavy lobbying by the insurance industry, Congress subsequently passed the McCarran-Ferguson Act to return exclusive regulatory authority to the states, thereby eliminating for the decades that followed much of the important federal antitrust scrutiny that has been so highly effective in combating anticompetitive conduct in other industrial sectors. Whatever justification there may have been for the McCarran-Ferguson Act exemption originally, it serves no legitimate purpose today. For example, the possibility of insurers being pulled in different directions by conflicting state and federal regulatory requirements has been vastly reduced in the sixty years since the Act's passage, by the so-called state action doctrine, first articulated by the Supreme Court in *Parker v. Brown*.[9] The doctrine has served well to resolve potential conflicts between state regulation and the federal antitrust laws. Pursuant to it, wherever a state clearly expresses an intention to regulate specific practices or conduct, and such regulation is actively enforced, the federal antitrust enforcement agencies defer. In this light, it becomes apparent that the Act exists today as nothing more than a historical vestige whose complicated terms have resulted in misinterpretation and mischief.

[8] 322 U.S. 533 (1944).
[9] 317 U.S. 341 (1943).

III. Conclusion

The ADA appreciates the opportunity to participate in the Committee's hearing by submitting this written testimony. We look forward to the opportunity to work with the Committee's members and staff to address the important issues raised by "The Health Insurance Industry Antitrust Enforcement Act of 2009."

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