HEALTH CARE REFORM & ANTITRUST ENFORCEMENT—A CURE FOR HEALTH PLAN MERGER MARKET DEFINITION UNDER A POST-HEALTH CARE REFORM REGIME

INTRODUCTION

With President Barack Obama's recent appointments of Jonathan D. Leibowitz as Chairman of the Federal Trade Commission (FTC) and Christine A. Varney as the Assistant Attorney General for Antitrust for the Department of Justice (DOJ), there is much to be said about what the future of antitrust enforcement will look like.[1] Leibowitz and Varney together have set a tone of aggressive and vigilant antitrust enforcement almost immediately.[2] Undoubtedly, this is an exciting time in antitrust enforcement—at the time of this writing, health reform recently passed, and both federal agencies that enforce the U.S. antitrust laws are now uniquely poised to rethink the bedrock upon which longstanding merger analysis has rested for over fifteen years.[3]

On October 22, 2009, FTC Chairman Leibowitz announced that the Antitrust Division of the DOJ as well as the FTC (collectively, "the Agencies") would be conducting a series of five workshops focusing on possibly revising the Horizontal Merger Guidelines ("Guidelines") used by the Agencies to evaluate potentially anticompetitive mergers.[4] This development was

1. *See* Christine A. Varney, Assistant Attorney Gen., Antitrust Div., U.S. Dep't of Justice, Vigorous Antitrust Enforcement in this Challenging Era, Remarks as Prepared for the Center for American Progress 19 (May 11, 2009), *available at* http://www.justice.gov/atr/public/speeches/245711.pdf ("The current economic challenges raise unique issues for antitrust authorities and private sectors. We are faced with market conditions that force us to engage in a critical analysis of previous enforcement approaches. That analysis makes clear that *passive monitoring* of market participants is not an option. Antitrust must be among the frontline issues in the Government's broader response to the distressed economy.") (emphasis added); *see also Jon Leibowitz*, Chairman, FED. TRADE COMM'N, http://www.ftc.gov/commissioners/leibowitz/index.shtml (last visited June 20, 2011).

2. *See, e.g.*, Varney, *supra* note 1, at 5.

3. Andrea Agathoklis, *In Their Own Words: Predicting Enforcement Under Varney and Leibowitz*, ANTITRUST, Summer 2009, at 5, 6.

4. *See* U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES (1992) [hereinafter U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, GUIDELINES], *available at* http://www.justice.gov/atr/public/guidelines/hmg.pdf; s*ee also* Varney, *supra* note 1, at 16. At the time of this writing, all five workshops have been completed. For a discussion of which topics were discussed at each workshop, see Carl Shapiro, Deputy Assistant Attorney Gen., Antitrust Div., U.S. Dep't of Justice, Updating the Merger Guidelines: Issues for the

welcomed by many practitioners and academics, as the Guidelines have not seen substantial revisions in roughly eighteen years.[5] This is not to say that the Guidelines have become wholly anachronistic, as they have clearly passed the test of time and are still broadly validated among courts and antitrust practitioners.[6] Yet, although the Guidelines have proven quite durable, the Agencies make it unmistakably clear—stamping it on the front page of their DOJ & FTC Questions for Public Comment—that the workshops' two primary goals are determining whether the Guidelines "accurately and clearly describe current [merger review] practices," and incorporating economic and legal developments that have come to the fore since the 1992 revisions.[7] More specifically, the Agencies have stated that a focal issue of these workshops will be aligning and updating market definition and concentration analysis to reflect contemporary Agency and practitioner practices.[8] This is not to say that the entirety of the Guidelines is going to be reworked; DOJ Assistant Attorney General Christine Varney has stated her position that

> [I]f a Guidelines update is deemed worthwhile, I would not at this time anticipate departing from some of the basic elements in the current Guidelines:

Upcoming Workshops, Remarks to the Antitrust Section of the American Bar Association at the Fall Forum (Nov. 12, 2009), *available at* http://www.justice.gov/atr/public/speeches/251858.pdf.

5. *See* Varney, *supra* note 1, at 17; *see also* Deborah L. Feinstein, *Editor's Note: Enforcement Changes: Evolution or Revolution?*, ANTITRUST, Fall 2009, at 5; Mark D. Whitener, *Editor's Note: change.gov*, ANTITRUST, Summer 2009, at 4.

6. *See* Feinstein, *supra* note 5, at 5; *see also* J. Thomas Rosch, Comm'r, Fed. Trade Comm'n, Enforcement Priorities in the New Administration, Remarks at the Global Competition Review's 2009 Competition Law Review 14 (Nov. 17, 2009), *available at* http://www.ftc.gov/speeches/rosch/091117enforceprioritiesremarks.pdf ("The 1992 Guidelines have been successful in large measure due to their acceptance by both agencies and every administration since their adoption. The next version of the Guidelines will need to attain a similar level of consensus to be successful.").

7. FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, HORIZONTAL MERGER GUIDELINES: QUESTIONS FOR PUBLIC COMMENT (Sept. 22, 2009), http://www.ftc.gov/bc/workshops/hmg/hmg-questions.pdf [hereinafter, FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, QUESTIONS FOR PUBLIC COMMENT]; *see* Christine A. Varney, Assistant Att'y Gen., Antitrust Div., U.S. Dep't of Justice, Merger Guidelines Workshops, Remarks at the Georgetown Law Global Antitrust Enforcement Symposium 10 (Sept. 22, 2009), *available at* http://www.justice.gov/atr/public/speeches/250238.pdf ("The lack of modern Supreme Court precedent also underscores the need for Horizontal Merger Guidelines that accurately reflect the best economic and legal reasoning."); *see also Horizontal Merger Guidelines Review: A Midterm Report*, LAW360 (Dec. 17, 2009), *available at* http://www.crai.com/uploadedFiles/Publications/horizontal-merger-guidelines-review-a-midterm-report.pdf?n=6032.

8. *See* FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, QUESTIONS FOR PUBLIC COMMENT, *supra* note 7, at 1 ("Updating the Guidelines could serve two primary and closely related goals. First, updated guidelines could more accurately and clearly describe *current Agency practice*. Second, updated guidelines could reflect and incorporate learning and experience gained since 1992.") (emphasis added).

> the use of the hypothetical-monopolist test to define relevant markets, the use of HHI measures of concentration to establish structural presumptions, the centrality of the inquiry into competitive effects, the "timeliness, likelihood, and sufficiency" structure of entry analysis, and the basic treatment of efficiencies and failing firms. Instead, I envision potentially updating the Guidelines to reflect the evolution of practice and advances in learning that have taken place since 1992 largely by (1) clarifying concepts in the current Guidelines that may not be expressed as clearly or fully as they could be, and (2) incorporating some of the useful guidance that already exists in the 2006 Commentary on the Horizontal Merger Guidelines into the Guidelines themselves.[9]

Varney's view of incorporating useful guidance from the 2006 Commentary on the Horizontal Merger Guidelines ("Commentary") has indeed come to fruition, as many of the proposed revisions listed in the DOJ & FTC Questions for Public Comment can be found in the 2006 Commentary.[10] Though revisions to the Guidelines are expected by late 2010, much of the market definition analysis within these pages should remain substantially the same, as the Commentary explains how market definition "has become deeply embedded in mainstream merger analysis"[11] and how Attorney General Varney stated that the Agencies do not "anticipate departing from" basic Guidelines tenets, including "the use of the hypothetical-monopolist test to define relevant markets."[12]

This Comment will explore antitrust developments in this time of dynamic change, not only for antitrust practitioners specializing in merger analysis, but also for government, businesses, and consumers.[13] More specifically, this

9. *See* Varney, *supra* note 7, at 10–11.

10. *See* FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, COMMENTARY ON THE HORIZONTAL MERGER GUIDELINES 5–16 (2006) [hereinafter FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, COMMENTARY], *available at* http://www.ftc.gov/os/2006/03/CommentaryontheHorizontalMergerGuidelinesMarch2006.pdf; *see also* Darren S. Tucker, *Seventeen Years Later: Thoughts on Revising the Horizontal Merger Guidelines*, THE ANTITRUST SOURCE, Oct. 2009, at 1, *available at* http://www.ftc.gov/os/comments/horizontalmergerguides/545095-00024.pdf ("Many of the proposed revisions appear to have come directly from the 2006 Merger Guidelines Commentary and should not be a surprise to practitioners.").

11. FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, COMMENTARY, *supra* note 10, at 2 ("The Guidelines five-part organizational structure [which includes market definition as part one] has become deeply embedded in mainstream merger analysis.").

12. Varney, *supra* note 7, at 10.

13. This current potential revision to the Guidelines is also particularly interesting because the last revision in 1992 was undertaken by a Republican administration, and now we have the opportunity to see how a Democratic administration revises them. *See* Deborah L. Feinstein, *Merger Guidelines Revisited?*, ANTITRUST, Fall 2009, at 8.

Comment will focus on antitrust enforcement of horizontal health insurance[14] mergers under a post-PPACA scenario (i.e., with health insurance exchange systems) and how the relevant markets—if at all—could be sensibly delineated.

The rampant consolidation of the health insurance market over the past decade has led to a small number of large insurers dominating the insurance market, leaving competition anything but robust and predicted to only decline.[15] In fact, in 2003—at a time when health insurers were less concentrated than 2010—three or less insurers constituted sixty-five percent of the commercial health insurance market in all but fourteen states.[16] At that time, thirty-four states had Herfindahl-Hirschman Index (HHI) scores greater than 1800—a score which, according to the Guidelines, is indicative of high market concentration.[17]

14. Throughout this Comment, primarily when discussing horizontal mergers, health plan and health insurance will be used interchangeably when referring generally to the commercial or government entities that sell and/or administer health policies to employers and/or individuals.

15. JOHN HOLAHAN & LINDA BLUMBERG, URBAN INST. HEALTH POLICY CTR., CAN A PUBLIC INSURANCE PLAN INCREASE COMPETITION AND LOWER THE COSTS OF HEALTH REFORM? 2 (2008), *available at* http://www.urban.org/UploadedPDF/411762_public_insurance.pdf; *see also* Alan M. Zuckerman, *Are You Ready for the Next Wave of Health Care Provider Consolidation?* (Mar. 20, 2008), http://www.hss-inc.com/documents/AMZHealthLeadersArticle_000.pdf (detailing a perfect storm of environmental forces converging to create a wave of health insurance mergers in the near future: insurance industry consolidation, tightening capital markets, expense increases outpace reimbursement, workforce shortages, practice dynamics, and large number of financially fragile providers); AM. HOSP. ASS'N, THE CASE FOR REINVIGORATING ANTITRUST ENFORCEMENT FOR HEALTH PLAN MERGERS AND ANTICOMPETITIVE CONDUCT TO PROTECT CONSUMERS AND PROVIDERS AND SUPPORT MEANINGFUL REFORM 4–5, 10 (2009) [hereinafter AHA WHITE PAPER], *available at* http://www.aha.org/aha/content/2009/pdf/09-05-11-antitrust-rep.pdf. A chart from the AHA White Paper illustrating major health plan mergers, both consummated and attempted but later abandoned is found, *infra* at Appendix A.

16. Holahan & Blumberg, *supra* note 15, at 2.

17. *Id.* at 3; *see also* U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, GUIDELINES, *supra* note 4, § 1.51. In case the reader is not particularly familiar with HHI thresholds, they can be fairly succinctly characterized. The Guidelines identify three concentration levels as "useful indicator[s] of the likely potential competitive effect of a merger." *Id.* § 1.51. Markets with a post-merger HHI below 1000 are regarded as unconcentrated; markets with a post-merger HHI between 1000 and 1800 are regarded as moderately concentrated; and markets with a post-merger HHI above 1800 are regarded as highly concentrated. *Id.* § 1.51. According to the Guidelines, "mergers in unconcentrated [(<1000)] markets are unlikely to have adverse competitive effects"; "mergers in, or resulting in, moderately concentrated markets [(1000–1800)] may raise competitive concerns" (depending on the increase in HHI); "and mergers in, or resulting in, highly concentrated markets [(>1800)] raise competitive concerns, that, depending on the size of the combined firm, are presumed to be anticompetitive." *Id.*; Timothy J. Muris & Bilal Sayyed, *Three Key Principles for Revising the Horizontal Merger Guidelines* 6 (Fed. Trade Comm'n

At the time of this writing, President Obama had just signed the Patient Protection and Affordable Care Act of 2010 (PPACA) into law, which was amended seven days later by the Health Care and Education Reconciliation Act (HCERA).[18] The primary purpose of the HCERA was amending various spending and revenue provisions within PPACA.[19]

This Comment has a modest objective: a plenary analysis of the recently passed health care reform bill and general antitrust principles is beyond its scope; however, in the interest of a thorough analysis, a succinct background of the material germane to the market definition discussion is included along with additional references for peripheral research along the way.[20] As such, this Comment is organized as follows: Part I will sketch and explain the general contours and concepts behind health insurance exchanges. This section's purpose is to broach several key foundational aspects that will be referenced in Part VIII, where PPACA is analyzed, and in Part IX, where a sensible solution for delineating the relevant geographic and product markets is proposed.[21]

Part II—to contextually orient the reader—will include general comments on the Guidelines' historical pedigree, tracing the evolution since their 1968 inception.[22] Briefly chronicling the Guidelines up to the 1997 revision, this section will also articulate the Guidelines' key purposes and goals.[23] This section goes on to introduce Section 7 of the Clayton Act—the chief federal

Project No. 92900, Horizontal Merger Guidelines Review, Public Comment No. 545095-00053, 2009), *available at* http://www.ftc.gov/os/comments/horizontalmergerguides/545095-00053.pdf.

18. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 42 U.S.C.), *amended by* Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (codified in scattered sections of 42 U.S.C.).

19. BARRY R. FURROW ET AL., HEALTH CARE REFORM SUPPLEMENT TO HEALTH LAW: CASES, MATERIALS AND PROBLEMS 1 (Am. Casebook Ser., 6th ed. 2008 & Supp. 2010). For a summary of PPACA, see HENRY J. KAISER FAMILY FOUND., SUMMARY OF NEW HEALTH REFORM LAW (2010) [hereinafter KFF CHART], *available at* http://www.kff.org/healthreform/upload/8061.pdf.

20. The antitrust analysis in this Comment will be limited to that of the Unites States. For a comprehensive discussion on the international antitrust laws, see generally 22 MARK R. JOELSON, AN INTERNATIONAL ANTITRUST PRIMER: A GUIDE TO THE OPERATION OF UNITED STATES, EUROPEAN UNION AND OTHER KEY COMPETITION LAWS IN THE GLOBAL ECONOMY (Int'l Competition Law Ser., 3d ed. 2006).

21. *See infra* Parts VIII–IX and accompanying text.

22. U.S. DEP'T OF JUSTICE, MERGER GUIDELINES (1968), *reprinted in* 4 Trade Reg. Rep. (CCH) ¶ 13,101 [hereinafter U.S. DEP'T OF JUSTICE, 1968 GUIDELINES].

23. Although the Guidelines were also revised in 1997, that revision pertained solely to efficiencies, which although significant (e.g., in merger simulation and where mergers have vertical aspects that enable the merged firm to eliminate double-marginalization), it is not particularly germane to this Comment. *See* Feinstein, *supra* note 13, at 20.

enforcement statute for mergers—and details the five-part process promulgated by the Guidelines and used by the Agencies in merger investigation.[24]

With the Guidelines' framework securely in place, Part III walks through the logistical aspects of Agency merger enforcement, introducing how merging corporations above a certain size must comply with the Hart-Scott-Rodino Act[25] and its stringent compliance timeframes for companies proposing to merge.[26] This section also broaches several key indicia and metrics used by the Agencies during merger investigations, including market concentration, market power, market shares, and market definition.

Part IV specifically addresses some of the key idiosyncrasies of merger analysis that are particularly germane to health care. Though many antitrust principles apply similarly for mergers in health care and other commercial markets, the health care industry has a combination of several unique attributes—including information asymmetries, complex regulatory schemes, market failures, and effects of third party payors—that merit special considerations throughout the merger analysis.[27]

Part V has two primary goals: first, to articulate, from a conceptual viewpoint, the chief aspects of the Guidelines that pertain to market definition analysis—namely how these facets are structured in the Guidelines and regarded in the Commentary; and second, to articulate how the Guidelines are actually employed in contemporary antitrust practice. The conceptual discussion describes the role of market definition in antitrust analysis and how the ultimate question that Agencies seek to answer is whether prices will increase post-merger.[28] This is an extremely important analysis as the market concentration and market power measures all hinge on—and are meaningless without—consistently and correctly defined markets.[29] Finally this section will briefly discuss market concentration ratios, namely the HHIs, which function as the Guidelines' analytical core.[30] The second discussion on de

24. U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, GUIDELINES, *supra* note 4, § 0.2.

25. Hart-Scott-Rodino Antitrust Improvements Act of 1976, Pub. L. No. 94-435, 90 Stat. 1383 (codified at 15 U.S.C. § 18a) (2006)).

26. 15 U.S.C. § 18a(b).

27. *See* 1 JOHN J. MILES, HEALTH CARE AND ANTITRUST LAW: PRINCIPLES AND PRACTICE § 1.1 (2010).

28. *See* Feinstein, *supra* note 13, at 12.

29. David A. Hyman & William E. Kovacic, *Monopoly, Monopsony, and Market Definition: An Antitrust Perspective on Market Concentration Among Health Insurers*, 23 HEALTH AFFAIRS 25 (2004) ("It is essential to define 'markets' correctly and consistently, or else measures of concentration among states are meaningless.").

30. *See* Feinstein, *supra* note 13, at 12. HHI is a measure of concentration that takes into account both market share and the size distribution of firms. Dennis W. Carlton, *Market Definition: Use and Abuse* 8–9 (Econ. Analysis Grp., Discussion Paper No. EAG 07-6, 2007), *available at* http://www.justice.gov/atr/public/eag/225693.pdf. It is derived by calculating each firm's share of the market, squaring it, and then summing the square of the shares. *Id.* As a

facto antitrust practice utilizes commentary from several experienced practitioners as a means of broaching the divergence between what the Guidelines preach, and what is practiced.

Part VI includes practitioner commentary as to why the Guidelines have been so durable over the years. This analysis looks largely to the Guidelines' resistance to over-specificity and a paucity of quantitative presumptions as reasons for why the Guidelines have proven adaptable to even the most extraordinary horizontal mergers.

Part VII will explore the three Agency-challenged health insurance plan mergers to date, namely Aetna/Prudential (1999), UnitedHealth/PacifiCare (2006), and UnitedHealth/Sierra (2008).[31] This is not to say that the Agencies have only publicly investigated three mergers throughout the years—as the Agencies have been more aggressive in that respect—but these are the only three that have been formally challenged in court.[32] Walking through these mergers will help expose several irreducible market definition principles that remain consistent throughout the challenges and, thus, expose those which are likely to remain consistent throughout a post-PPACA regime.

Part VIII will explore PPACA and the aspects that are especially germane to the merger discussion. The primary purpose of this section is to familiarize and orient the reader with the key provisions pertaining to PPACA's health insurance exchange systems that are heavily referenced in the subsequent section. This section is intended to serve as a very brief summary of selected aspects of PPACA, with a more focused discussion on the health insurance exchange aspects.

Finally, Part IX will probe thorny market definition issues that enforcement agencies will likely encounter when challenging (or attempting to challenge) health plan mergers in a post-health care reform regime. In this

result, markets with fewer firms or markets with more firms but a few with very high shares will each be highly concentrated. *Id.* Although the current HHI thresholds have been the subject of much criticism as not accurately predictive of anticompetitive effects, this Comment focuses on market definition and, thus, will not more than briefly discuss HHIs.

31. *See* Competitive Impact Statement, United States v. UnitedHealth Grp., Inc., No. 1:08-cv-00322-ESH (D.D.C. Feb. 25, 2008) [hereinafter Sierra Impact Statement], *available at* http://www.justice.gov/atr/cases/f230400/230448.pdf (UnitedHealth acquisition of Sierra Health Services); Competitive Impact Statement, United States v. UnitedHealth Grp., Inc., No. 1:05CV02436, (D.D.C. Mar. 3, 2006) [hereinafter PacifiCare Impact Statement], *available at* http://www.justice.gov/atr/cases/f215000/215034.pdf (UnitedHealth acquisition of PacifiCare); Revised Competitive Impact Statement, United States v. Aetna Inc., No. 3-99CV1398-H (N.D. Tex. Aug. 3, 1999) [hereinafter Aetna Impact Statement], *available at* http://www.usdoj.gov/atr/cases/f2600/2648.pdf.

32. *See* AHA WHITE PAPER, *supra* note 15, at 6; *see also infra* Appendix A. Interestingly, the DOJ has sought divestitures of health plan mergers despite post-merger market shares being *below* levels typically associated with anticompetitive effects. *See* AHA WHITE PAPER, *supra* note 15, at 4–5, 10.

section, sensible solutions are propounded for defining the product and geographic markets within PPACA's health insurance exchange system, and whether markets can be defined rigorously come 2014, when the exchanges are—hopefully—fully operational.[33] This section, and this Comment generally, speaks to market definition particularly from the seller's side—"where the competitive concern is the health plan's market power in selling its product" (e.g., selling insurance plans)—and does not focus on buyer-side issues—where the competitive concern is the health plan's monopsony power as a purchaser (e.g., insurer buying physician's services to provide to eligible enrollees).[34] The framework upon which this Comment will discuss possible market definition approaches is that of hypothetical merging health plans that are sellers of health insurance and operating within a post-PPACA health insurance exchange system.

Admittedly, market definition is merely a starting point in analyzing a merger's impact on consumers, but given the current Guidelines' methodology for market definition, a health insurance exchange system would not only be an issue of first impression for enforcement agencies, courts, and state attorneys general, but would also test the acclaimed malleability of the Guidelines' framework which has, up to this point, undoubtedly passed the test of time.[35]

I. BACKGROUND: HEALTH INSURANCE EXCHANGE SYSTEMS

The notion of a health insurance exchange system is not an entirely new concept, but nevertheless is one unquestionably on the forefront of health care today.[36] A health insurance exchange system is essentially a marketplace that will offer consumers a choice among high quality, low price health care options that are comprehensive and apples-to-apples comparable.[37] For the

33. *See* Patient Protection and Affordable Care Act § 1311, 42 U.S.C. § 18031(b) (2010).

34. *See* ABA SECTION OF ANTITRUST LAW, ANTITRUST HEALTH CARE HANDBOOK 147 (4th ed. 2010); *see also infra* notes 85–89 and accompanying text (discussing how health insurance mergers raise both market and monopsony power concerns).

35. *See* U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, GUIDELINES, *supra* note 4, § 2.0 ("[M]arket share and concentration data provide only the starting point for analyzing the competitive impact of a merger.").

36. The idea of an exchange system was prominent during President Barack Obama's campaign and was promoted by Montana Senator and Chair of the Senate Finance Committee, Max Baucus. *See* MAX BAUCUS, CHAIRMAN, SENATE FIN. COMM., CALL TO ACTION: HEALTH REFORM 2009 (2008), *available at* http://www.aanp.org/NR/rdonlyres/D277DB51-A993-4F3F-8F6E-00F9B2E2FCA3/0/Baucusfinalwhitepaper.pdf. The notion of an insurance exchange system was also endorsed by Oregon Senator Rob Wyden, in the Healthy Americans Act, S. 391, 111th Cong. (2009), *available at* http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:s391is.txt.pdf.

37. CTR. ON BUDGET & POLICY PRIORITIES, FACT SHEET: USING A HEALTH-INSURANCE EXCHANGE TO POOL RISK AND PROTECT ENROLLEES (Health Reform Issue Ser., 2009)

unemployed, individuals who cannot afford health insurance, and small businesses that cannot afford small group health insurance, the exchange system is promulgated in hopes of being the long-awaited panacea by providing an array of affordable options.[38] For employees of large companies providing group coverage, the exchange system means essentially keeping that current insurance plan, but benefiting from added safeguards preventing unfair and deceptive insurance practices.[39] Further, the exchange marketplace makes health insurance more portable for individuals.[40] If an employee loses her job, changes jobs, or relocates, that person (and her dependents) can easily explore the exchange for a new, affordable plan.[41] Additionally, the high quality and low cost attribute of the exchange will act as a crutch beyond the eighteen-month window that is currently provided by the Consolidated Omnibus Budget Reconciliation Act (COBRA).[42]

A primary avenue by which the exchange system garners its allure is its ability to lower health insurance costs, which is accomplished by inciting insurers to vigorously compete for enrollees.[43] Exchange systems are able to promote vigorous competition among insurers, because the insurers' ability to attract enrollees will depend purely on cost and quality of coverage, not "benefit manipulation" or the ability to attract only healthy individuals and reject, drop, or otherwise deter the "sicker, costlier ones."[44] More succinctly, "[t]he aim is to focus competition among plans on the price of coverage and minimize the tendency for plans to vary benefits in order to attract healthier than average enrollees."[45]

[hereinafter CTR. ON BUDGET & POLICY PRIORITIES, INSURANCE FACT SHEET], *available at* http://www.cbpp.org/files/4-14-09health-fact.pdf.

38. *Id.*

39. *Frequently Asked Questions About Health Insurance Reform*, WHITEHOUSE.GOV, http://www.whitehouse.gov/realitycheck/faq#i1. Examples of these deceptive insurance practices include those that seek to limit or cancel your coverage if you get sick by finding clerical errors in application forms. *Id.*

40. HENRY J. KAISER FAMILY FOUND., *Explaining Health Care Reform: What Are Health Insurance Exchanges?* 1 (2009) [hereinafter KFF EXPLAINING HEALTHCARE REFORM], *available at* http://www.kff.org/healthreform/upload/7908.pdf.

41. *Id.*

42. Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 § 2202, 42 U.S.C. § 300bb-2 (2006).

43. H.R. COMM. ON WAYS & MEANS, ENERGY & COMMERCE, EDUCATION & LABOR, 111TH CONG., HEALTH REFORM AT A GLANCE: THE HEALTH INSURANCE EXCHANGE 1 (2009), *available at* http://maloney.house.gov/documents/health/healthcarereform/EXCHANGE.pdf.

44. *Id.*; *see also* CTR. ON BUDGET & POLICY PRIORITIES, INSURANCE FACT SHEET, *supra* note 37.

45. KFF EXPLAINING HEALTHCARE REFORM, *supra* note 40.

II. BACKGROUND: THE MERGER GUIDELINES' PEDIGREE

The DOJ first issued guidelines for merger enforcement in 1968.[46] Entirely superseded today by the 1997 Guidelines, the 1968 Guidelines evaluated the market in which consummated mergers took place in terms of the four-firm concentration ratio.[47] In 1982, the DOJ, through Assistant Attorney General William Baxter, issued revised Guidelines that introduced the still functional "SSNIP"[48] test for market definition, established new HHI concentration thresholds, and included factors germane to assessing competitive effects and likelihood of entry.[49] In 1984, the DOJ again revised the Guidelines—affording less weight to HHI concentration statistics and tweaking the treatment of imports.[50] The 1992 Guidelines also diluted (again) the HHI threshold significance, revised the discussion of entry requirements—partly in response to *Baker Hughes*[51]—and implemented unilateral effects analysis.[52] In 1992, the Agencies for the first time issued joint horizontal merger enforcement guidelines; five years later in 1997, the Agencies issued their next joint Guidelines revisions, namely to the Efficiencies section.[53] The most recent jointly-issued publication clarifying the Guidelines is the Agencies' 2006 Commentary that seeks to "provide greater transparency and foster deeper understanding regarding antitrust law enforcement."[54] Save for

46. ABA SECTION OF ANTITRUST LAW, MERGERS AND ACQUISITIONS 19 (3d ed. 2008); *see also* U.S. DEP'T OF JUSTICE, 1968 GUIDELINES, *supra* note 22. Each iteration of the U.S. Merger Guidelines is available—for historical purposes—at http://www.justice.gov/atr/hmerger.htm.

47. U.S. DEP'T OF JUSTICE, 1968 GUIDELINES, *supra* note 22, at 20,543 ("In a market in which the shares of the four largest firms amount to approximately 75% or more, the Department will ordinarily challenge mergers between firms accounting for, approximately, the following percentages of the market . . . .").

48. U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, GUIDELINES, *supra* note 4, § 1.11. SSNIP stands for "small but significant and nontransitory increase in price." *Id.*; *see also infra* notes 115–22 and accompanying text.

49. Tucker, *supra* note 10, at 2; *see* U.S. DEP'T OF JUSTICE, MERGER GUIDELINES (1982), *reprinted in* 4 Trade Reg. Rep. (CCH) ¶ 13,102.

50. Tucker, *supra* note 10, at 2; *see* U.S. DEP'T OF JUSTICE, MERGER GUIDELINES (1984), *reprinted in* 4 Trade Reg. Rep. (CCH) ¶ 13,103.

51. United States v. Baker Hughes Inc., 908 F.2d 981 (D.C. Cir. 1990) (holding that rebuttal of prima facie case that merger will lessen competition in a market does not require clear showing that entry into the market by competitors will be "quick and effective," rather, evidence on variety of factors can rebut prima facie case).

52. Tucker, *supra* note 10, at 2; *see* U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, GUIDELINES, *supra* note 4, § 1.5 (HHI thresholds), § 2.2 (unilateral effects), § 3.0 (entry requirements).

53. Tucker, *supra* note 10, at 2; *see* U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, GUIDELINES, *supra* note 4, § 1.0.

54. FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, COMMENTARY, *supra* note 10, at v.

the 1997 revision of merger efficiencies, the Guidelines have not been revised in eighteen years—the longest hiatus since their 1968 inception.[55]

The Agencies' joint issuance of the Guidelines was an effort to describe the methodologies and standards used in applying the U.S. antitrust laws to horizontal mergers under review.[56] The primary statute on point for horizontal mergers is Section 7 of the Clayton Act.[57] The Guidelines' aim is blocking mergers that—according to Section 7—"may be substantially to lessen competition or to tend to create a monopoly."[58] Section 0.2 of the Guidelines employs a five-part—not step—process that the Agencies purportedly use when evaluating proposed mergers.[59] First, the relevant market is defined and used to measure market concentration.[60] Second, Agencies consider whether potentially adverse anticompetitive effects might result from the merger.[61] Third—the entry analysis—Agencies examine the ease with which firms may enter and exit the market, and whether entry by new firms would mitigate or eliminate any potential anticompetitive effects.[62] Fourth, a determination is made as to whether efficiencies may arise from the merger that would lower

55. Tucker, *supra* note 10, at 2.

56. U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, GUIDELINES, *supra* note 4, § 0.

57. Clayton Act § 7, 15 U.S.C. § 18 (2006). The Act, as amended in 1950, addresses specific practices not clearly prohibited by the Sherman Act "such as mergers and interlocking directorates." *Id.*; *see also* Celler-Kefauver Act of 1950, ch. 1184, 64 Stat. 1125 (codified at 15 U.S.C. § 18); FED. TRADE COMM'N, AN FTC GUIDE TO THE ANTITRUST LAWS 2 (2007). The Clayton Act, as amended by the Robinson-Patman Act of 1936 "also bans certain discriminatory prices, services, and allowances in dealings between merchants." 15 U.S.C. § 18; *see also* Robinson-Patman Act of 1936, ch. 592, 49 Stat. 1526 (codified at 15 U.S.C. § 13); FED. TRADE COMM'N, *supra*, at 2. "The Clayton Act was amended again in 1976 by the Hart-Scott-Rodino Antitrust Improvements Act to require companies planning" to consummate a merger above a certain size to notify the government prior to consummation. 15 U.S.C. § 18; *see also* Hart-Scott-Rodino Antitrust Improvements Act of 1976, Pub. L. No. 94-435, 90 Stat. 1383 (codified at 15 U.S.C. § 18a); FED. TRADE COMM'N, *supra*, at 2.

58. FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, COMMENTARY, *supra* note 10, at 1; *see* Clayton Act § 7, 15 U.S.C. § 18 (2006).

59. U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, GUIDELINES, *supra* note 4, § 0.2. The "five-step" label can be misleading because the Agencies do not invariably apply the Guidelines as a linear model that must always start with market definition and end with efficiencies or failing assets. Tucker, *supra* note 10, at 5–6. Indeed, "[market] concentration may be uninformative in a unilateral effects analysis, which focuses on the loss of localized competition and other competitors' ability to reposition." *Id.* at 6 (internal citations omitted); *see also* Jonathan B. Baker & Steven C. Salop, *Should Concentration Be Dropped From the Merger Guidelines?*, 33 UWLA L. REV. 3, 12 (2001) ("It is now widely accepted among economists that unilateral effects analysis does not strictly require a single discrete relevant market to be defined with the [SSNIP] test; demand elasticities and diversion ratios are sufficient.").

60. U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, GUIDELINES, *supra* note 4, § 0.2.

61. *Id.*

62. *Id.*; *see also* FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, COMMENTARY, *supra* note 10, at 37.

costs and offset any potential anticompetitive effects.[63] Fifth, Agencies will consider failing and exiting assets, and determine whether the failing firm defense would apply.[64]

The benefits of having clarity and transparency in the Guidelines are ubiquitous. A chief advantage is that counsel for prospectively merging corporations can advise clients on the analysis undertaken by the Agencies, in determining whether to clear or take enforcement action against a proposed merger.[65] The ability to predict whether the DOJ/FTC review will result in an anticompetitive determination comports with the Agencies' goal of "allow[ing] transactions unlikely substantially to lessen competition to proceed as expeditiously as possible."[66] Another key advantage of clarity and transparency is the ability for the Agencies to guide and educate the courts on the right questions to ask and how to possibly answer them.[67]

Alternatively, Agency non-transparency in this regard can have an equally deleterious impact, potentially cost merging parties millions of dollars, arduous investigation-related delays, and even jeopardize the proposed merger and its financing.[68] As a result of being in the dark regarding the Agency's mode of analysis, merging companies can spend millions on economists and econometrics, just to have Agency staff respond that the data is unconvincing.[69]

III. BACKGROUND: LOGISTICS OF ANTITRUST ENFORCEMENT

The Department of Justice and Federal Trade Commission have complementary roles in antitrust enforcement insofar as their authorities tend to overlap, but since each has developed respective areas of expertise—as well as to avoid duplicative efforts—only one Agency will conduct an antitrust

63. U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, GUIDELINES, *supra* note 4, § 0.2.

64. *Id.* It is notable that the Agencies' methodology of defining the relevant product and geographic market as a preliminary step in the process comports with Supreme Court precedent. *See* United States v. Gen. Dynamics Corp., 415 U.S. 486, 510 (1974) ("[A] delineation of proper geographic and product markets is a necessary precondition to assessment of the [Section 7 claim] . . . .").

65. Feinstein, *supra* note 6, at 6.

66. FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, COMMENTARY, *supra* note 10, at 1.

67. Feinstein, *supra* note 13, at 9. Because of varying levels of sophistication, the Guidelines must be especially versatile in order to be utilized by the Agencies and by the courts, because the Agencies have an arsenal of Ph.D. economists on staff, whereas courts do not. *Id.*

68. Gregory K. Leonard & Lawrence Wu, *Revising the Merger Guidelines: Second Request Screens and the Agencies' Empirical Approach to Competitive Effects*, GCP: THE ANTITRUST CHRON., Dec. 2009, at 1.

69. Feinstein, *supra* note 6, at 6; *see also* Feinstein, *supra* note 13, at 12. ("Guidelines could do a better job of moving beyond the economic framework and describing to some extent the kinds of *facts* that the agencies find to be relevant in their analysis.") (emphasis added).

investigation for a particular merger.[70] For health insurance plan mergers, the DOJ often spearheads the investigation.[71]

In accordance with Section 7 of the Clayton Act, in order to block the proposed merger, the reviewing Agency must show that the merger's competitive effect "may be substantially to lessen competition, or to tend to create a monopoly."[72] More specifically, and with regard to market definition, the government can establish a presumption that a proposed horizontal merger that "substantially increases market concentration is likely to be anticompetitive."[73] In practice, this means that an Agency will investigate whether a proposed merger will likely lead to increased consumer prices by evaluating the likely competitive effects on price, output, and efficiencies.[74]

The investigation process formally begins when the companies wanting to merge file their Hart-Scott-Rodino (HSR) documents.[75] HSR mandates that merging parties in a transaction above a certain size ($63.4 million) notify the Agencies before consummating the proposed merger, so that the Agencies have time to analyze the transaction's likely competitive effects.[76] Parties are

70. *See* FED. TRADE COMM'N, *supra* note 57, at 1.

71. DOJ has led the investigation for all three previously challenged health plan mergers. See *infra* Part VII, for a discussion on those mergers.

72. Clayton Act § 7, 15 U.S.C. § 18 (2006); *see also* Joseph Farrell & Carl Shapiro, *Antitrust Evaluation of Horizontal Mergers: An Economic Alternative to Market Definition*, 10 B.E. J. THEORETICAL ECON. 1, 1 (2010), *available at* http://www.bepress.com/bejte/vol10/iss1/art9/.

73. Farrell & Shapiro, *supra* note 72, at 3.

74. FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, COMMENTARY, *supra* note 10, at 2–3, 18.

75. *Id.* at 1.

76. *Id.*; *see also* 15 U.S.C. § 18a; FED. TRADE COMM'N PREMERGER NOTIFICATION OFFICE, TO FILE OR NOT TO FILE: WHEN YOU MUST FILE A PREMERGER NOTIFICATION REPORT FORM (2008). In assessing whether a merger qualifies as above $63.4 million, the HSR Rules require that "assets, voting securities or NCI [non-corporate interests] of the acquired person that have already been acquired must be aggregated with those that will be acquired in the proposed transaction. When what has previously been purchased plus what will be bought in the present acquisition meets the size of transaction criteria, the transaction becomes reportable unless an exemption applies." FED. TRADE COMM'N PREMERGER NOTIFICATION OFFICE, *supra*, pt. V.A; *see also* 15 U.S.C. § 18a(c) (detailing exceptions to the rule). Notably, on January 13, 2010, the FTC lowered its HSR notification threshold. *Compare* Revised Jurisdictional Thresholds for Section 7A of the Clayton Act, 74 Fed. Reg. 1687 (Jan. 13, 2009), *with* Revised Jurisdictional Thresholds for Section 7A of the Clayton Act, 75 Fed. Reg. 3468 (Jan. 21, 2010). Approved by a 4-0 vote, the new threshold for reporting a proposed merger has decreased from $65.2 million to $63.4 million. Press Release, Fed. Trade Comm'n, Commission Announces Revised Filing Thresholds for Clayton Act Antitrust Reviews (Jan. 19, 2010), http://www.ftc.gov/opa/2010/01/hsr-safeharbor.shtm. The reduced threshold will be effective thirty days after publication in the Federal Register. *Id.* This downward adjustment—the first of its kind—is perhaps unsurprising amidst this currently anemic economy, because the thresholds are objectively indexed to the GNP and adjusted annually, and the economy has depressed the GNP. Richard Vanderford, *Hart-*

forbidden from consummating the merger until expiration of at least the initial thirty-day waiting period—unless the Agency decides to issue a Second Request—which gives the Agency another thirty days from the parties "substantial compliance" to review the proposed merger.[77] In order to be substantially compliant, the merging parties are required to supply a litany of information, documents, and databases demanded by the reviewing Agency.[78] Even if the Agencies do not issue a Second Request, the merging parties must still wait thirty days from that initial request before consummating the merger.[79]

Because mergers are necessarily prospective in nature, and since it would be extremely obtrusive to "unscramble the eggs" and separate the firms post-merger, antitrust evaluation of a merger's future effects is impossible to ascertain with certainty.[80] Thus, because the Agencies cannot directly predict an anticompetitive price effect, the Agencies rely on various proxies and indicia—articulated in the Guidelines—including market concentration, market definition, market shares, and the "likelihood of entry or repositioning."[81] The vast majority of times, delineating the relevant geographic and product markets is a prerequisite to reaching any of these conclusions, and as such, it is among the most vigorously disputed aspects of horizontal merger analysis.[82]

Scott-Rodino Drops for First Time, LAW360 (Jan. 20, 2010), http://www.law360.com/articles/144463.

77. 15 U.S.C. § 18a(a)–(b), (e); Farrell & Shapiro, *supra* note 72, at 1; *see also* FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, COMMENTARY, *supra* note 10, at 1–2 ("A second request may be necessary when it is not possible within thirty days to gather and analyze the facts necessary to address appropriately the competitive concerns that may arise at the threshold of the investigation, such as when parties to a merger appear to have relatively high shares in the market or markets in which they compete."). By and large, the consummation of proposed mergers goes smoothly; for over 95% of the Hart-Scott-Rodino reportable transactions, the Agencies are able to determine within the initial fifteen- (for cash tender offers) or thirty-day waiting period that the proposed merger will not substantially lessen competition. FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, COMMENTARY, *supra* note 10, at 1.

78. 15 U.S.C. § 18a(d); FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, COMMENTARY, *supra* note 10, at 3. In addition to information provided by the merging parties, the Agencies can utilize "civil investigative demands" to subpoena information from outsiders. Farrell & Shapiro, *supra* note 72, at 1 n.4.

79. 15 U.S.C. § 18a(a), (b), (e); FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, COMMENTARY, *supra* note 10, at 1–2.

80. Farrell & Shapiro, *supra* note 72, at 1; David A. Argue & Richard T. Shin, *An Innovative Approach to an Old Problem: Hospital Merger Simulation*, ANTITRUST, Fall 2009, at 49.

81. Argue & Shin, *supra* note 80, at 49; *see* U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, GUIDELINES, *supra* note 4, § 0.2.

82. Argue & Shin, *supra* note 80, at 49.

IV. REGULATION OF HORIZONTAL MERGERS WITHIN THE HEALTH INSURANCE SECTOR

The U.S. antitrust laws apply to all industries within the health care sector, and many apply to health care no differently than any other business sector.[83] Despite several similarities, however, health care industries do "exhibit certain unusual economic traits that must be [carefully] considered in analyzing health care antitrust issues"; this includes the effects of third party insurance and intermediaries, information deficiencies, market failures, a prevalence of professionals providing health services, government financing, information asymmetries, nonprofit firms, and regulations reflecting a particular concern about quality.[84]

In addition, mergers between health plans in particular generate great concern and scrutiny because health insurers function as both buyers and sellers: buyers of medical services from physicians and hospitals and sellers of insurance to consumer enrollees.[85] Because health insurers wear both hats, so to speak, a health insurance merger can simultaneously effectuate an increase in the merged firm's market power and an increase in that firm's monopsony power.[86] On one hand, the market power concern is raised by whether the merged health plan could increase premiums and/or reduce the variety of plans offered or quality of services.[87] On the other hand, the monopsony power concern is raised by whether the merged health plan could depress physician reimbursement below competitive levels or otherwise hamper provider innovation by other means.[88] The concern about the merged health plan depressing reimbursement to below competitive levels is largely linked to the vast share of patients that the health insurance firm would control (and could poach from the physician) post-merger.[89]

83. MILES, *supra* note 27, § 1.1.

84. *Id*.

85. FED. TRADE COMM'N & DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION ch. 6, at 1 (2004).

86. AHA WHITE PAPER, *supra* note 15, at 2; *see also* FED. TRADE COMM'N & DEP'T OF JUSTICE, *supra* note 85, ch. 6, at 1.

87. AHA WHITE PAPER, *supra* note 15, at 2.

88. *Id.*

89. *Id.*

V. CONCEPTUAL & PRACTICAL APPROACHES TO MARKET DEFINITION ANALYSIS

A. Conceptual Approach: Exploring the Theoretical Underpinnings of Market Definition

"Throughout the history of U.S. antitrust litigation, the outcome of more cases has surely turned on market definition than on any other substantive issue. Market definition is often the most critical step in evaluating market power and determining whether business conduct has or likely will have anticompetitive effects."[90] These statements accurately assert market definition's importance because—under America's antitrust laws—the legality of a business practice is frequently determined by whether the defendant (usually the seller) possesses market power.[91] A firm possesses market power if it has "the ability profitably to maintain prices above competitive levels for a significant period of time."[92] The importance of market power in the Guidelines cannot be overstated, as the Guidelines state that their "focus [is] on the one potential source of gain that is of concern under the antitrust laws: market power."[93] This is perhaps unsurprising, given that a central purpose of antitrust enforcement is protecting economic competition on consumers' behalf, and since market power is a tool used to predict whether a merger will negatively affect consumers through increased price, reduced quality, decreased innovation, change in terms of service, adverse contractual provisions, and the like.[94]

90. Jonathan B. Baker, *Market Definition: An Analytical Overview*, 74 ANTITRUST L.J. 129, 129 (2007); *see also* MILES, *supra* note 27, § 2.1 ("The relevant market is one of the most important and complex variables in antitrust analysis."); Stephan M. Levy, *Are Relevant Markets Ever Irrelevant*? 2 (Fed. Trade Comm'n Project No. 92900, Horizontal Merger Guidelines Review, Public Comment No. 545095-00020, 2009), *available at* http://www.ftc.gov/os/comments/horizontalmergerguides/index.shtm ("The issue of the relevant market is particularly important. Many antitrust cases—both merger and non-merger—are decided by the outcome of how the relevant market is defined."). *But see* Robert H. Gertner & Kevin M. Murphy, *Comments on the Horizontal Merger Guidelines* 6–7 (Fed. Trade Comm'n Project No. 92900, Horizontal Merger Guidelines Review, Public Comment No. 545095-00021, 2009), *available at* http://www.ftc.gov/os/comments/horizontalmergerguides/index.shtm ("Market definition should never play a pivotal role, in the sense that the result of market definition only is the basis for concluding that a merger is likely to reduce competition.").

91. MILES, *supra* note 27, § 2.1.

92. U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, GUIDELINES, *supra* note 4, § 0.1; *see also* FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, COMMENTARY, *supra* note 10, at 1 ("The core concern of the antitrust laws, including as they pertain to mergers between rivals, is the creation or enhancement of *market power*.") (emphasis added).

93. U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, GUIDELINES, *supra* note 4, § 0.1.

94. MILES, *supra* note 27, § 2.3; *see also* AHA WHITE PAPER, *supra* note 15, at 1–2.

In antitrust parlance, a market is comprised of a collection of products and geographic locations—hence, the product market and geographic market dichotomization—that are delineated in an effort to infer a firm's market power and the likely competitive effects of the proposed merger.[95] "The ultimate purpose for defining a relevant market is not to identify particular products or geographical areas, but to identify those competitors of a firm (or group of firms acting concertedly) that could prevent the firm or firms from exercising market power by raising price."[96] Knowing where a firm's competition occurs helps identify whether there are competitive forces that could constrain the merged firm's ability to exercise market power (e.g., inflating price of health insurance premiums and reduced quality of coverage).[97] Once the relevant market is defined, that information can then be used in calculating the relative size distribution for firms operating in the same product and geographic market(s) (typically quantified as market shares).[98] From these market concentration statistics, the Agencies can then determine the firm's market share, from which the firm's market power may be inferred—along with associated structural presumptions.[99] In other words, market definition statistics strongly influence market concentration statistics, which determine market share, which then determine market power. As is discussed *infra*, high market shares typically indicate the presence of market power, and the opposite a lack thereof.[100]

The necessity of defining the relevant product and geographic markets arises from Section 7 of the Clayton Act, which requires that "substantiality" be measured "over a line of commerce and section of the country—in other

95. Baker, *supra* note 90, at 130; see *infra* notes 101–27 and accompanying text, for brief discussion of competitive effects.

96. MILES, *supra* note 27, § 2.1.

97. Richard Gilbert & Daniel L. Rubinfeld, *Comments on Horizontal Merger Guidelines* 1 (Fed. Trade Comm'n Project No. 92900, Horizontal Merger Guidelines Review, Public Comment No. 545095-00014, 2009), *available at* http://www.ftc.gov/os/comments/horizontalmergerguides/index.shtm.

98. Baker, *supra* note 90, at 130.

99. Gilbert & Rubinfeld, *supra* note 97, at 1; *see also* MILES, *supra* note 27, § 2.3 ("Although market power can be proven in several ways, including demand and supply elasticities, reduced output, persistent supracompetitive prices or margins, persistent price discrimination, and persistent supracompetitive profitability, it usually is inferred from the defendant's market share and significant entry and expansion barriers.") (footnote omitted).

100. Baker, *supra* note 90, at 130. But this is not *always* the case. *See* MILES, *supra* note 27, § 1.4 ("[A]lthough market share and market concentration are important indicia of market power, they are not sufficient to prove market power by themselves."); *see, e.g.*, E. Food Servs., Inc. v. Pontifical Catholic Univ. Servs. Ass'n, Inc., 357 F.3d 1, 6 (1st Cir. 2004) ("A defendant's high share is only a *presumptive* basis for inferring market power (entry barriers to the market may be very low); but a low share is almost always an indication that the defendant lacks market power.") (emphasis added).

words, a relevant market."[101] Because the string of computations ultimately trying to predict market power are a function of market definition, it is especially critical that markets be sensibly defined, as the market power metric is meaningless if the relevant markets are erroneously or arbitrarily defined.[102] If one defines the market too narrowly, market shares likely will be artificially high; if defined too broadly, the market shares will likely be artificially diluted and low—potentially masking a firm's market power.[103]

Market power may "substantially lessen competition" in two ways—through coordinated effects or unilateral effects.[104] Coordinated effects pose a threat when a merger would increase the chance that post-merger, competitors will either expressly or tacitly coordinate their pricing or other competitive actions.[105] Alternatively, competition can be lessened by unilateral effects—if the merger creates a likelihood that the merged firm, acting on its own (not coordinating with other rival firms), would increase prices or otherwise exercise greater market power than pre-merger.[106] It may be helpful to think of these competitive effects (*viz.* unilateral and coordinated) as the "main course" and market definition as the "hors d'oeuvre" in the merger evaluation dinner.[107]

1. Market Definition: Demand (Buyer) Substitution, Juxtaposed with Supplier (Seller) Substitution

Courts have repeatedly stressed that market definition should focus on demand (buyer) substitution, as opposed to supply (seller) substitution.[108] As a rule of thumb, "[t]he exercise of market power requires that the firm or firms involved (collectively) face a relatively inelastic demand curve for a product at

101. Feinstein, *supra* note 13, at 13; *see also* Clayton Act § 7, 15 U.S.C. § 18 (2006).

102. Hyman & Kovacic, *supra* note 29, at 26.

103. *See, e.g.*, J. Gregory Sidak & David J. Teece, *Comments of J. Gregory Sidak and David J. Teece* 9 (Fed. Trade Comm'n Project No. 92900, Horizontal Merger Guidelines Review, Public Comment No. 545095-00025, 2009), *available at* http://www.ftc.gov/os/comments/horizontal mergerguides/index.shtm.

104. FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, COMMENTARY, *supra* note 10, at 17.

105. *Id.*; *see also* Aileen Thompson, Fed. Trade Comm'n, *Merger Analysis at the Federal Trade Commission: Two Recent Retail Cases* 1 (2009), *available at* http://www.ftc.gov/be/thomp smerg.pdf ("A merger may enhance the ability to coordinate by reducing the number of independent competitors.").

106. FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, COMMENTARY, *supra* note 10, at 17.

107. Gilbert & Rubinfeld, *supra* note 97, at 5.

108. Baker, *supra* note 90, at 132; *see also* United States v. E.I. du Pont de Nemours & Co. (Cellophane Case), 351 U.S. 377, 395 (1956). This Comment will exclusively focus on demand substitution, as this is the prevailing economic force that market definition is employed to account for today. Baker, *supra* note 90, at 132. For a discussion on supply substitution and its shortcomings in the market definition analysis, see *id.*

pre-merger prices."[109] This demand curve is important because it is only when that curve is relatively inelastic can it be profitable for a firm or firms to simultaneously raise price by reducing output.[110] Thus, the focal issue becomes which products would be acceptable alternatives from the *buyer's* perspective.[111] Accordingly, in 1956, the United States Supreme Court in *E.I. du Pont de Nemours & Co. (Cellophane Case)* held that the relevant product market consists of goods "reasonably interchangeable by consumers for the same purposes."[112] In *United States v. Aluminum Company of America (Rome Cable)*, eight years later, "the Supreme Court confirmed that market definition turned solely on buyer substitution possibilities . . . ."[113] The DOJ and FTC have followed suit, as the 1992 Guidelines "focus[] solely on buyer substitution factors"—i.e., possible consumer responses—and promulgate the infamous "hypothetical monopolist" test, which focuses on demand structure.[114]

2. Conceptual Approach: Market Definition & the Hypothetical Monopolist "SSNIP" Test

Absent direct evidence of anticompetitive effects spawning from a merger, the Guidelines stipulate that a relevant product market is to be defined using what is known as the "hypothetical monopolist" test.[115] The test starts by looking at the merging firms and identifying each product produced or sold by each firm.[116] Then "the Agency will delineate the product market to be a product or group of products such that a hypothetical profit-maximizing firm

109. Gilbert & Rubinfeld, *supra* note 97, at 2.

110. *Id.*

111. Baker, *supra* note 90, at 132.

112. *Cellophane Case*, 351 U.S. at 395; Baker, *supra* note 90, at 132.

113. Baker, *supra* note 90, at 132 (citing United States v. Aluminum Co. of Am. (Rome Cable), 377 U.S. 271, 276–77 (1964)). As Professor Baker explains, the Court in *Rome Cable* held that market definition turned solely on buyer substitution possibilities when it defined insulated copper conductor and insulated aluminum conductor as separate markets because of insufficient demand substitution between the two, notwithstanding the dissent's emphasis on the extensive supply substitution, or production flexibility. Baker, *supra* note 90, at 132; *see also Rome Cable*, 377 U.S. at 276–77.

114. Baker, *supra* note 90, at 132–33. A "market" is defined as "a product or group of products such that a hypothetical profit-maximizing firm that was the only present and future seller of those products . . . likely would impose at least a 'small but significant and nontransitory' increase in price [SSNIP]." U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, GUIDELINES, *supra* note 4, § 1.11

115. U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, GUIDELINES, *supra* note 4, § 1.11; *see* Levy, *supra* note 90, at 1 (noting that in many cases there is direct evidence demonstrating that the proposed merger would be anticompetitive, and that in those instances evidence—or lack thereof—of anticompetitive effects may render the hypothetical monopolist test unnecessary).

116. FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, COMMENTARY, *supra* note 10, at 5.

that was the only present and future seller of those products ('monopolist') likely would impose at least a 'small but significant and nontransitory' increase in price ["SSNIP"]."[117] In other words, "[t]he relevant market consists of the smallest number of firms that, acting unilaterally or in concert, could profitably implement a small but significant and non-transitory price increase above the competitive level."[118] Because the relevant market largely depends on consumer alternatives and substitutes, the relevant product market should include all products or services that are reasonably interchangeable to consumers; this substitutability is most often (and easily) demonstrated through cross-elasticities of demand or diversion ratios.[119] If a SSNIP would be unprofitable, that is, if buyers would substitute other products or locations if faced with a SSNIP, then the candidate market is too narrow.[120] If the candidate market is found to be too narrow, the test "iteratively broadens the candidate market [for each product or location] by adding the next-best substitute."[121] The next-best substitute is the product accounting for the largest "diversion of demand" (i.e., diversion ratio) in response to a SSNIP.[122]

"The relevant geographic market . . . is the geographical area in which the relevant seller [usually the defendant] operates and the area to which customers could and would turn to purchase the product if the seller attempted to increase its price."[123] As a relevant geographic market is comprised of the firms that could collectively raise prices in a profitable manner, this consideration turns on whether customers would travel further to seek alternative sellers, thereby, rendering the price increase unprofitable.[124] Ultimately, "[a] relevant product market emerges as the smallest group of products that satisfies the hypothetical monopolist test."[125]

The Guidelines' hypothetical monopolist test is conceptually straightforward, but at times complicated and coarse in its market definition methodology. The test is most easily applied in determining markets for

117. U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, GUIDELINES, *supra* note 4, § 1.1.

118. MILES, *supra* note 27, § 2.1.

119. *Id.*

120. U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, GUIDELINES, *supra* note 4, § 1.0; Baker, *supra* note 90, at 133.

121. FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, COMMENTARY, *supra* note 10, at 5; U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, GUIDELINES, *supra* note 4, at 6.

122. U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, GUIDELINES, *supra* note 4, at 6 n.9.

123. MILES, *supra* note 27, § 2.1.

124. *Id.*; *see also* U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, GUIDELINES, *supra* note 4, § 1.21 ("[T]he Agency will delineate the geographic market to be a region such that a hypothetical monopolist that was the only present or future producer of the relevant product at locations in that region would profitably impose at least a 'small but significant and nontransitory' increase in price, holding constant the terms of sale for all products produced elsewhere.").

125. FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, COMMENTARY, *supra* note 10, at 5.

homogeneous products (e.g., corn), yet grows cumbersome with product heterogeneity or when significant geographic differentiation presents itself.[126] Though the hypothetical monopolist test may seem imperfect, the Agencies have made it clear that it is a very useful screen for clearing benign mergers and that it will not be supplanted anytime soon.[127]

B. Practical Approach: Exploring the De Facto Implications of Market Definition

Although the Guidelines have proven to be an exceptionally durable tool over the past eighteen years,[128] the current practice and mode of analysis has evolved, making this an opportune time to refine and tweak the Guidelines to reflect current practice and analysis.[129] As previously mentioned in the Introduction, a primary objective of the Agencies' Questions for Public Comment initiative is determining whether the Guidelines accurately and clearly describe contemporary Agency review practices.[130] As Paul T. Denis, former counselor to the DOJ Assistant Attorney General-Antitrust Division, stated, "[T]here's a big gap . . . between what the agencies are doing and what is on paper in the Guidelines."[131] If the eighty-plus comments submitted by practitioners in response to the Questions for Public Comment are any indication, there are several aspects of the Guidelines that practitioners, economists, and industry groups feel do not accurately and clearly describe current practices.[132]

126. Gilbert & Rubinfeld, *supra* note 97, at 2.

127. FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, QUESTIONS FOR PUBLIC COMMENT, *supra* note 7, at 1 ("The Agencies anticipate retaining the basic 'hypothetical monopolist' test used to ensure that antitrust markets are not unduly narrowly defined.").

128. *See* ANTITRUST MODERNIZATION COMM'N, REPORT AND RECOMMENDATIONS 54–55 (2007) ("The current merger policy of the United States is fundamentally sound. . . . There is general consensus that the Merger Guidelines have acted as the 'blueprint[] for the architecture' of merger analysis and, overall, provide a guide that 'functions well.' The Guidelines have had a significant influence on judicial development of merger law, which is reflected in their widespread acceptance by the courts as the relevant framework for analyzing merger cases. Conversely, the courts have occasionally influenced how the agencies have revised the Guidelines. The Guidelines have also provided useful guidance and transparency to the business community and antitrust bar.") (footnotes omitted).

129. *See* Feinstein, *supra* note 13, at 8–9.

130. FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, QUESTIONS FOR PUBLIC COMMENT, *supra* note 7, at 1.

131. Feinstein, *supra* note 13, at 10–11.

132. *Id.* at 8–9 ("[D]ue to the widening gap between the Guidelines and actual agency practice today, the Guidelines are no longer effective in meeting that fundamental purpose [of informing the bar as to how the agencies are going to analyze mergers]."). Practitioner comments are located on the FTC website, at http://www.ftc.gov/os/comments/hmgrevisedguides/index.shtm and http://www.ftc.gov/os/comments/horizontalmergerguides/index.shtm.

In today's antitrust practice, the Guidelines' promulgated methodology is rarely followed in market definition.[133] Most of the time, "market definition revolves around the identification of *all* products that share with the merging firms' products a common set of attributes which are believed to be valued by customers"—not proceeding by next-best substitute.[134] In practice, the plaintiff (often the Agencies or state attorneys general), will attempt to minimize the geographic area and quantity of products in the relevant market, while the defendant will argue just the opposite, largely in an effort to dilute the Agency-calculated post-merger market power.[135] This is because generally, "firms with small market shares have little ability to influence the market price—that is exercise market power."[136] Conversely, firms with large market shares *are* capable of influencing market price.[137] For example, a health insurance firm with a commanding share of the market—that is, many enrollees, would likely be able to unduly depress physician reimbursement rates—as physicians would have no choice but to acquiesce for fear of losing a substantial portion of business. In a narrowly-defined market, however, because there are fewer firms comprising the relevant market, those firms will necessarily have larger market shares than in a more inclusive market.[138] When faced with accusations of antitrust violations, firms will relentlessly contend that they have small market shares so to avoid the potential restrictions of their market power.[139] This is why antitrust cases often turn on relevant market delineation.[140] With both parties pulling in different directions to define what is in and what is out of the relevant market, it is not difficult to imagine how the end result could strangely resemble "economic gerrymandering."[141] For the Guidelines to be truly meaningful, they must inform members of the bar how the Agencies will analyze proposed mergers

133. Gopal Das Varma, *Comment Containing Suggested Revision to 1992 Horizontal Merger Guidelines Regarding the Hypothetical Monopolist Test for Purposes of Market Definition* 9 (Fed. Trade Comm'n Project No. 92900, Horizontal Merger Guidelines Review, Public Comment No. 545095-00029, 2009), *available at* http://www.ftc.gov/os/comments/horizontalmergerguides/index.shtm.

134. *Id.* (emphasis in original).

135. Robert G. Harris & Thomas M. Jorde, *Market Definition in the Merger Guidelines: Implications for Antitrust Enforcement*, 71 CAL. L. REV. 464, 464 (1983).

136. Levy, *supra* note 90, at 3.

137. *Id.*

138. *Id.*

139. *Id.*

140. *Id.*

141. Harris & Jorde, *supra* note 135. Interestingly, firms will sometimes argue *for* narrowing the relevant geographic and product markets. In a merger of A and B, A could argue for such a narrow market that would place A and B in separate and distinct relevant markets, thus since they are not competitors, the merger—in theory—could not amplify A's market power. *See* MILES, *supra* note 27, § 2:4.

and literally become the outline that Agency staff use in gathering information that will support their ultimate recommendations on a proposed merger's likely competitive effects.[142]

VI. WHY HAS THE 1992 GUIDELINES MARKET DEFINITION FRAMEWORK BEEN SO DURABLE?

The 1992 market definition methodology and the Guidelines as a whole have been so durable over the years because of, in a word: flexibility.[143] The Guidelines are not over-specific insofar as they provide a flexible framework that can accommodate the substantial empirical inquiry that antitrust analysis inherently requires.[144] It would be arduous and likely unworkable to posit a rigid, quantitative approach to market definition that could yield to the seemingly infinite amalgamation of idiosyncratic merger scenarios.[145] After all, the Guidelines "do not, indeed cannot, explain the precise analysis to be undertaken in each investigation."[146]

Because the current market definition methodology remains a robust tool for initially screening for market concentration and determining whether firms fall within any safe harbors, I focus not on revamping market definition to accommodate health plan mergers under an exchange system, but on asking the right questions.[147] These are questions that can be asked and answered by the Agencies with staffs of Ph.D. economists, but also by judges and attorneys

142. *See* Feinstein, *supra* note 13, at 8–9.

143. Muris & Sayyed, *supra* note 17, at 2.

144. *Id.* at 2–3; *see also* Feinstein, *supra* note 13, at 12. ("The current Guidelines have lasted longer than probably any of us expected, and that has conferred significant benefits on the agencies and the bar in terms of consistency and a greater meeting of the minds in terms of how to do most merger analysis. As you go into more detail on the examples and specific models, you are going to make it *far more difficult* to come up with a durable document.") (emphasis added).

145. *See* Gertner & Murphy, *supra* note 90, at 2 ("Virtually every market and therefore every merger investigation has idiosyncratic institutional, technological, environmental, and data availability features that determine the best approach to a competitive effects analysis.").

146. Muris & Sayyed, *supra* note 17, at 3.

147. Feinstein, *supra* note 13 at 12.

> [T]he Guidelines and any associated commentary can serve a useful purpose for both courts and government agencies by specifying what are the right questions to ask, how might one answer those questions, and what are some safe harbors.
>
> . . . .
>
> . . . Although market definition is often just the first step in an analysis, it can be a useful one. For example, if you define a market and then calculate market shares, there would be some cases where you could dismiss the possibility of anticompetitive harm from a merger immediately. It is very valuable to firms to have some confidence that if they fall in a safe harbor that their case will be handled expeditiously and there won't be any surprises.

Id. at 9, 13 (emphasis added).

without advanced economics degrees.[148] After all, much of the reason for the durability of market definition is that—though occasionally coarse—it is a very practical procedure that businesspeople can perform in an hour or two.[149] A non-economist businessperson can reason that if the widget market is comprised of companies A and B, it is highly concentrated and subject to Agency challenge, whereas if comprised of companies A, B, C, and D, the transaction would likely be cleared.[150]

Undoubtedly, a market can be defined rigorously with the right quantitative information, but that information is usually unavailable.[151] A leading antitrust economist notes that

> [I]f one knows the structure of demand for a product and all its substitutes, knows the cost curves of firms that currently produce (or could produce) the product, and knows the game that describes the competitive environment (e.g., static Cournot, static Bertrand, dynamic trigger strategies), then one can write down a model whose equilibrium reflects the outcome of all these economic forces.[152]

The realization of how demanding a task this is drives Agencies and practitioners to use proxies like market share (via market definition) to compute a firm's market power.[153] Without a tool like market definition to function as a screen for identifying mergers that will be unchallenged based on very low market shares, the benign mergers would be inefficiently burdened by a protracted investigation process and potentially jeopardized by increased compliance costs.[154] The three health plan merger challenges to date: Aetna–Prudential, UnitedHealth–PacifiCare, and UnitedHealth–Sierra, epitomize how

148. Feinstein, *supra* note 13, at 12 ("[The] Guidelines need to serve their constituencies—agency and party lawyers, economists, business people, and the courts."); *see also* Richard Brunell, Am. Antitrust Inst., *Comments of the American Antitrust Institute* 3–4 (Fed. Trade Comm'n Project No. 92900, Horizontal Merger Guidelines Review, Public Comment No. 545095-00023, 2009), *available at* http://www.ftc.gov/os/comments/horizontalmergerguides/index.shtm ("It is especially important that the application of merger controls be explainable to the public in a way that resonates with common sense rather than the esoteric language of highly technical merger experts.").

149. Feinstein, *supra* note 5, at 6.

150. *Id.*

151. Carlton, *supra* note 30, at 1.

152. *Id.* at 9.

153. *Id.*

154. Marius Schwartz & George Rozanski, *Comments on Potential Revisions to the Horizontal Merger Guidelines* 10 (Fed. Trade Comm'n Project No. 92900, Horizontal Merger Guidelines Review, Public Comment No. 545095-00019, 2009), *available at* http://www.ftc.gov/os/comments/horizontalmergerguides/index.shtm. In fact, an Agency Second Request can in itself cost a company millions and even jeopardize financing for the transaction. *See* Leonard & Wu, *supra* note 68 and accompanying text.

flexible and valuable the Guidelines' market definition framework can be when dealing with complex and idiosyncratic horizontal mergers.[155]

VII. EXPLORING THE THREE AGENCY-CHALLENGED HEALTH PLAN MERGERS TO DATE

Often claimed to be the result of rising health care costs, the health insurance industry has rampantly consolidated in recent years.[156] From 1993 to 2009, the DOJ has publicly investigated thirty-four major health plan mergers.[157] In 2004 and 2005 alone, there were a total of twenty-eight health insurance plan mergers—resulting in an approximate value of $54 billion.[158] Of all the substantial health insurance mergers to date, the government has only formally challenged three of them.[159] The first challenge to a proposed health plan merger—occurring after a string of sizeable, unchallenged mergers[160]—was Aetna Incorporated ("Aetna") acquiring Prudential Insurance Company of America ("Prudential").[161] As will become apparent in this section, the use of metropolitan statistical areas ("MSAs") or even zip codes have become widely accepted practices for more rigorously delineating geographic markets, as opposed to being constrained by choosing one particular state over another.[162] Since health insurance is administered on a state-by-state basis, it may be seem sensible to name a particular state as the relevant geographic market; however, because health insurance plans often concentrate their business within certain parts of the state, this could skew market concentrations—making the insurer's market concentration appear erroneously low.[163] These market concentrations are one reason why MSAs

155. *See* discussion *infra* Part VII**.**

156. AHA WHITE PAPER, *supra* note 15, at 18.

157. *See id.* at 6; *see also infra* Appendix A (chart depicting major health plan mergers).

158. AHA WHITE PAPER, *supra* note 15, at 18.

159. *See* Sierra Impact Statement, *supra* note 31; PacifiCare Impact Statement, *supra* note 31; Aetna Impact Statement, *supra* note 31.

160. Robert E. Bloch, *Is What's Past Prologue? The Evolution of Antitrust Enforcement Against Health Plans and Likely Enforcement Policies in the Obama Administration* 2 (2009) (on file with author). In 1998, Aetna Inc. acquired NYLCare for $1.05 billion, and earlier in 1996, Aetna acquired USHealthcare for nearly $9 billion. Both mergers were consummated without significant opposition, as neither prompted a Hart-Scott-Rodino Second Request. *Id.*

161. Complaint at 1, United States v. Aetna, Inc., No. 3-99 CV 1398-H (N.D. Tex. June 21, 1999), *available at* http://www.justice.gov/atr/cases/f2500/2501.pdf [hereinafter Aetna Complaint] (Aetna acquisition of Prudential).

162. Promulgated by the United States Department of Commerce, Metropolitan Statistical Areas (MSAs) are defined by the U.S. Census so that institutions and individuals gathering statistics on urban areas can use a common definition. FED. TRADE COMM'N & DEP'T OF JUSTICE, *supra* note 85, app. C, at C-4.

163. Hyman & Kovacic, *supra* note 29, at 27.

and zip codes provide for more rigorous market delineation.[164] The subsequent section will describe the three Agency-challenged mergers and detail key points of Agency analysis—particularly how they pertain to market definition.

A. Challenged Merger Between Aetna & Prudential

On December 9, 1998, Aetna entered into an acquisition agreement with Prudential to purchase Prudential's health insurance segment for $1 billion.[165] Under the terms of the agreement, Aetna would acquire a substantial share of Prudential's assets pertaining to the issuing, selling, and administering of group Health Maintenance Organization ("HMO") and HMO Point of Service ("HMO-POS") plans.[166] At that time, Aetna was the largest health insurance company in the United States, amassing in excess of $14 billion in revenues and totaling 15.8 million enrollees in all fifty states and the District of Columbia.[167] Prudential was substantially smaller, coming in at ninth largest, amassing approximately $7.5 billion in revenue and totaling 4.9 million enrollees in twenty-eight states and the District of Columbia.[168] After months of investigation—and after examining approximately forty different geographic markets—the DOJ alleged the product market to be the sale of HMO and HMO-POS plans.[169] The relevant geographic markets were the Dallas/Fort Worth and Houston MSAs.[170] In the Dallas/Fort Worth MSA, the DOJ alleged that Aetna currently had a 26% market share of the HMO and HMO-POS enrollees and that post-merger (i.e., once Prudential is acquired) would have a 42% market share of the same.[171] In the Houston MSA, the DOJ alleged that Aetna—currently having a 44% market share—would have a 63% post-merger market share.[172]

164. *Id.*

165. Aetna Complaint, *supra* note 161, at 3. The $1 billion purchase price consisted of "$465 million in cash, $500 million in three-year promissory notes, $15 million in cash payable under a Coinsurance Agreement, and $20 million in cash to be paid under [a] Risk-Sharing Agreement." *Id.*

166. *Id.* at 3–4. The primary difference between HMO and HMO-POS plans is that HMO members cannot see out-of-network providers (except extraordinary circumstances), whereas HMO-POS members can see out-of-network providers (albeit at greater cost). *Id.* at 5. There are also other smaller differences, like how HMOs require physical referrals, and HMO-POS plans allow for self-referral. *Id.*

167. *Id.* at 1, 3; *see also* Bloch, *supra* note 160, at 3.

168. Aetna Complaint, *supra* note 161, at 1, 3.

169. *Id.* at 2; *see also* Bloch, *supra* note 160, at 3.

170. Aetna Complaint, *supra* note 161, at 2.

171. *Id.* at 7. At the time, Prudential had a 16% market share of the Dallas/Fort Worth MSA for HMO and HMO-POS enrollees. *Id.*

172. *Id.* At the time, Prudential had a 19% market share of the Houston MSA for HMO and HMO-POS enrollees. *Id.*

In the Complaint, the DOJ took a relatively innovative position on market definition. Even though Aetna and Prudential both offered HMO, POS, and Preferred Provider Organization ("PPO") plans, the DOJ attempted to define an HMO-only market (more specifically an HMO and HMO-POS market).[173] The DOJ alleged that HMOs were distinct from PPOs, because—unlike PPOs—HMOs differed in terms of "structure, price, licensing requirements, and benefit configurations."[174] Further, HMOs emphasized health maintenance, but restricted patients' treatment options, precluded access to out-of-network providers, and required patients to obtain a referral from their primary care physician (i.e., gatekeeper) before visiting a specialist.[175] The DOJ's market definition position here was particularly novel because defining a circumscribed, HMO-only market starkly contrasted with numerous court decisions that—for the most part—defined relevant product markets to include all healthcare financing.[176]

The Aetna–Prudential Complaint and Competitive Impact Statement both failed to present any findings that quality or quantity of physician services or reimbursement rates would decline below competitive levels post-merger.[177] Additionally, there also was evidence that it would not be difficult for physicians to get on board with other health plans or persuade patients to do the same; this was primarily because many physicians already had contracts with alternative health plans and many employers (74% in Dallas) offered

173. *Id.* at 6. The primary difference between HMO and PPO plans is the fact that HMO members are restricted to service from the in-network physicians, whereas PPO members can seek care outside of the network's preferred provider list. BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 643 (Am. Casebook Ser., 6th ed. 2008).

174. Aetna Complaint, *supra* note 161, at 5.

175. *Id.*

176. *Id.*; *see, e.g.*, Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic, 65 F.3d 1406, 1409–10 (7th Cir. 1995), *cert. denied*, 516 U.S. 1184 (1996) (reversing district court decision upholding a jury verdict based on an HMO-only product market on grounds HMOs compete with other types of health care financing); Doctor's Hosp. of Jefferson, Inc. v. Se. Med. Alliance, Inc., 123 F.3d 301, 308 n.15 (5th Cir. 1997) (citing *Marshfield Clinic* in finding that PPOs compete with HMOs and other managed care and non-managed care plans, "all of which are substitutable"); U.S. Healthcare, Inc. v. Healthsource, Inc., 986 F.2d 589, 599 (1st Cir. 1993) (rejecting HMO-only market and recognizing market including all health insurance coverage; fact that HMOs are less expensive than other forms of health care financing does not mean HMOs constitute a separate market, because the difference in cost may be offset "by the limits placed on the patient's choice of doctors"). For a thorough listing of other relevant decisions, see Bloch, *supra* note 160, at 3 n.5, 4. The DOJ also took a second novel position in alleging that the merger would result in Aetna obtaining monopsony power (i.e., Aetna would obtain buyer's side market power with regard to purchasing physician's services), but such is outside the scope of this article. Aetna Complaint, *supra* note 161, at 8–11.

177. *See* Aetna Complaint, *supra* note 161; Aetna Impact Statement, *supra* note 31; Bloch, *supra* note 160, at 5.

employees a choice of more than one plan.[178] Despite this peculiar dearth of evidence, Aetna was required to divest its interests in the Houston and Dallas NYLCare operations to assuage the DOJ's anticompetitive concerns.[179] The divestitures included 260,000 HMO and HMO-POS enrollees in Houston, and another 167,000 of the same in Dallas; a grand total of nearly 430,000 covered lives.[180]

B. Challenged Merger Between UnitedHealth Group & PacifiCare

The second health plan merger challenge came in 2005, when the DOJ brought an enforcement action seeking to enjoin UnitedHealth Group ("UnitedHealth") from acquiring PacifiCare's health insurance-related assets.[181] When the proposed merger was announced, UnitedHealth—one of the nation's largest health insurers—had 55 million insured nationwide, and PacifiCare had approximately 13 million insured in assorted western states.[182] In 2004, at the time of the merger, UnitedHealth reported revenues in excess of $37 billion and PacifiCare reported revenues of $12.2 billion.[183] The acquisition price for PacifiCare was just over $8 billion.[184]

The DOJ challenged the proposed merger based on two allegations, the first being particularly germane to this article. First, the DOJ alleged that the merger would "substantially lessen competition in the sale of commercial health insurance to small-group employers in Tucson, Arizona . . . ."[185] In this Tucson market of commercial health insurers to small-group employers, UnitedHealth and PacifiCare are, respectively, the second and third largest in the Tucson MSA—UnitedHealth's market share being approximately 16% and PacifiCare's approximately 17%.[186] The DOJ's second anticompetitive allegation was that UnitedHealth would be in a post-merger position to exercise monopsony power over physicians insofar as it would be able to "unduly depress physician reimbursement rates . . . likely leading to a

178. Bloch, *supra* note 160, at 5–6.

179. Revised Final Judgment at 1–2, 6, United States v. Aetna, Inc., No. 3-99 CV 1398-H (N.D. Tex. Dec. 7, 1999), *available at* http://www.justice.gov/atr/cases/f214700/214734.htm.

180. *Id.*; *see also* Bloch, *supra* note 160, at 6.

181. Complaint at 1, United States v. UnitedHealth Grp., Inc., No. 1:05-cv-02436 (D.D.C. Dec. 20, 2005) [hereinafter PacifiCare Complaint], *available at* http://www.justice.gov/atr/cases/f213800/213815.pdf.

182. At the time of the proposed merger, PacifiCare had enrollees in Arizona, California, Colorado, Nevada, Oklahoma, Oregon, Texas, and Washington. *Id.*; see *supra* notes 85–89 and accompanying text, for discussion on monopsony power.

183. PacifiCare Impact Statement, *supra* note 31, at 3.

184. PacifiCare Complaint, *supra* note 181, at 4.

185. PacifiCare Impact Statement, *supra* note 31, at 4.

186. PacifiCare Complaint, *supra* note 181, at 7.

reduction in quantity or degradation in the quality of physician services."[187] In other words, because of UnitedHealth's lucrative post-merger position, physicians would be unable to reject adverse contract terms because of the prospect of physicians losing a substantial portion of their client base.[188]

The government, in defining the relevant product market to be the sale of commercial health insurance to small-group employers, is of particular significance because of how the commercial health insurance market was dichotomized into large and small-group employers.[189] In doing so, the government introduced several considerations that it believed sufficiently differentiated the two and justified the market circumscription: "Unlike larger-group employers, small-group employers cannot feasibly self fund their employees' health benefits. They do not have a sufficient employee population across which they can spread financial risk . . . ."[190] Because the small-group employers could not spread the financial risk, self funding was not a viable option for the employer.[191] Therefore, because self funding was not a viable option for small-group employers, these employers—referring to the SSNIP analysis—"would not switch to self funding in sufficient numbers to make a small but significant increase in the price of fully-insured health plans to all small-group employers unprofitable."[192] Accordingly, the government delineated the product market as the sale of commercial health insurance to small-group employers.[193]

Another consideration weighing in favor of the small-group employer delineation is the difference in the way in which commercial health insurance products are regulated, bought, and sold by large and small-group employers.[194] Many states have regulations for commercial health insurance that are applicable only to small-group employers.[195] Further, large employers have leverage and the ability to negotiate over price and contract terms, which often results in large employers paying different prices than others, whereas small groups are on more of a take-it-or-leave-it basis, and often have to accept or reject the insurer's publicly advertised price.[196]

The geographic market definition in *UnitedHealth–PacifiCare* was seemingly more straightforward than the product market definition. The

187. PacifiCare Impact Statement, *supra* note 31, at 8.

188. *Id.*

189. *Id.* at 4.

190. *Id.*

191. *Id.*

192. PacifiCare Impact Statement, *supra* note 31, at 4.

193. *Id.*

194. *Id.*

195. *Id.* In Arizona, for example, a small group employer is one having two to fifty employees. *Id.*

196. *Id.* at 4–5.

government—like in *Aetna* and *Sierra*—reasoned that because "[h]ealth insurance plan enrollees seek relationships with physicians and other health care professionals and institutions that are located in the metropolitan area in which they live and work," the relevant geographic market was no broader than the Tucson, Arizona MSA.[197] As a remedy, UnitedHealth was required to divest enough small-group contracts to make its market share roughly the same as if the proposed merger was never consummated.[198] This came out to 54,517 covered lives in Tucson, including at least 7,581 lives "covered by contracts with small-group employers . . . ."[199] UnitedHealth was also required to divest either its largest contract with the University of Colorado (HMO contract), which included 6,066 members, or an equivalent number of enrollees under other contracts in the Boulder, Colorado area.[200]

C. Challenged Merger Between UnitedHealth & Sierra Health Services, Inc.

UnitedHealth's March 11, 2007 announcement that it was acquiring all shares of Sierra Health Services, Inc. ("Sierra") led to the most recently challenged health plan merger.[201] Sierra's membership was concentrated in the Las Vegas area (specifically Clark and Nye counties).[202] At the time of the transaction, UnitedHealth was the largest health insurer in the United States, with over 70 million enrollees nationwide and revenue for 2007 of $75 billion.[203] At the same time, Sierra was the largest health insurer in Nevada, with over 655,000 enrollees and revenue for 2007 of $1.9 billion.[204] This substantial $2.6 billion transaction immediately attracted strong opposition, especially from the American Medical Association, claiming in a statement

197. PacifiCare Impact Statement, *supra* note 31, at 5–6.

198. *Id.* at 11; Final Judgment, United States v. UnitedHealth Grp., No. 1:05CV02436 (D.D.C. May 23, 2006), at 5–9 [hereinafter PacifiCare Final Judgment].

199. PacifiCare Impact Statement, *supra* note 31 at 10–11; PacifiCare Final Judgment, *supra* note 198, at 4–5. The figure 7,581 is the number of enrollees in the Tucson MSA that were covered under PacifiCare's "small-group contracts" as of June 30, 2005. PacifiCare Impact Statement, *supra* note 31, at 11; PacifiCare Final Judgment, *supra* note 198, at 4–5.

200. PacifiCare Impact Statement, *supra* note 31 at 12; PacifiCare Final Judgment, *supra* note 198, at 9. As stated above, the geographic market definition for the DOJ's *first* allegation was the Tucson MSA. PacifiCare Impact Statement, *supra* note 31, at 5–6. The reason divestitures were required in the Boulder MSA pertains to the DOJ's *second* (monopsony) allegation (namely that post-merger, UnitedHealth would be able to depress physician reimbursement rates because physicians could not reject adverse contract terms out of the fear of losing substantial portions of business). *Id.* at 8.

201. Sierra Impact Statement, *supra* note 31, at 1.

202. Complaint at 1, United States v. UnitedHealth Grp., Inc., No. 1:08-cv-00322-ESH (D.D.C. Feb. 25, 2008) [hereinafter Sierra Complaint], *available at* http://www.justice.gov/atr/cases/f230400/230447.pdf.

203. *Id.* at 3.

204. *Id.* at 4.

that the acquisition would give UnitedHealth a commanding 94% combined market share for HMO products.[205]

The DOJ challenged the transaction on the grounds that the proposed merger would yield anticompetitive effects in the sale of Medicare Advantage plans[206] in Clark and western adjacent Nye County.[207] Further, the DOJ predicted that UnitedHealth would possess a 94% market share post-merger.[208] UnitedHealth contended that any attempt to exercise market power (e.g., by attempting to raise price) for its Medicare Advantage plans would be impossible, as UnitedHealth's attempt "would be thwarted by the federal government's role as a power buyer of Medicare plans and regulator of Medicare Advantage bid terms, as well as by entry in the area by a number of Medicare Advantage plans for the coming year . . . ."[209] These arguments were rejected by the DOJ as it contested the merger in a Medicare market.[210]

Medicare Advantage plans were significantly involved, which affected the merger analysis—specifically the product market definition. Because the benefits offered to seniors by Medicare Advantage plans over traditional Medicare were so lucrative, a sufficient number of Las Vegas area enrollees would not switch from Medicare Advantage to traditional Medicare in the event of a modest alteration to price or benefits, thereby, making a price

205. Sierra Impact Statement, *supra* note 31, at 7–8 ("Sierra accounts for approximately 60 percent of Medicare Advantage enrollees in the Las Vegas area. United accounts for approximately 34 percent."); *see Small Business Competition Policy: Are Markets Open for Entrepreneurs?: Hearing Before the H. Comm. on Small Bus.*, 110th Cong. 19, 75 n.13 (2008) (statement of William A. Hazel, Jr., M.D., Sec'y, Bd. of Trs., Am. Med. Ass'n); *see also* Bloch, *supra* note 160, at 11.

206. Medicare Advantage plans are offered by private insurance companies. Sierra Complaint, *supra* note 202, at 5. Congress, in establishing this program, intended that "vigorous competition among private Medicare Advantage insurers would lead insurers to offer seniors richer and more affordable benefits than traditional Medicare, provide a wider array of health-insurance choices, and be more responsive to the demands of seniors." *Id.* at 2. In fact, most successful Medicare Advantage Plans achieve those goals. *Id.* at 5.

207. *Id.* at 1; *see also* Bloch, *supra* note 160, at 12.

208. Sierra Impact Statement, *supra* note 31, at 4. Although the DOJ did not officially pursue a more narrow product market definition, they apparently toyed with the idea of further narrowing the product market to Medicare Advantage coordinated-care plans (MA-HMO and MA-PPO), which in this case would have given UnitedHealth a 99% post-merger market share in the same geographic market. *Id.* at 5.

209. Bloch, *supra* note 160, at 12. Mr. Bloch was a lead attorney involved in the merger transaction. *See* Sierra Complaint, *supra* note 202, at 11. "Medicare Advantage Plans consist of Medicare Advantage health maintenance organization ("MA-HMO") plans, Medicare Advantage preferred provider organization ("MA-PPO") plans, and Medicare Advantage Private Fee-for-Service ("MA-PFFS") plans." Sierra Impact Statement, *supra* note 31, at 1–2.

210. Bloch, *supra* note 160, at 12; *see also* Sierra Impact Statement, *supra* note 31, at 1.

increase or reduction in benefits unprofitable.[211] Moreover, as Medicare Advantage plans offered richer benefits over traditional Medicare (e.g., lower co-payments, lower co-insurance, caps on total yearly out-of-pocket costs, prescription drug coverage, vision coverage, health club memberships, etc.), Medicare Advantage plans exclusively comprised Sierra's relevant product market.[212]

Sierra's geographic market definition exercise was more straightforward. Because Medicare-eligible residents in Clark and Nye counties are only able to enroll in CMS-approved Medicare Advantage plans for the county in which they reside, enrollees were precluded from shopping around in other geographic areas for coverage.[213] Accordingly, the relevant geographic market was found to be Clark and Nye counties within the Las Vegas area.[214]

The DOJ found that in the product market consisting solely of Medicare Advantage plans, the merged UnitedHealth–Sierra would account for a 94% of Las Vegas's total Medicare Advantage enrollment, which drew approximately $840 million in annual commerce.[215] The DOJ surprisingly did not allege any monopsony suspicions, nor did it introduce the commercial insurance market into the equation as in Aetna and PacifiCare (this was solely a Medicare market).[216] As a remedy, UnitedHealth was required to divest its Medicare Advantage line of business in the Las Vegas area (which covered approximately 25,000 individual Medicare Advantage beneficiaries) to an "approved acquirer."[217] The idea was that by divesting its Las Vegas line of business to an approved acquirer, anticompetitive effects would be eliminated because the divested business would presumably be sold to an entity that could vigorously and perpetually compete with the merged UnitedHealth-Sierra.[218] Notably, despite the considerable divestiture, UnitedHealth was able to retain Sierra's 49,500 members in Las Vegas.[219]

211. Sierra Impact Statement, *supra* note 31, at 7. The lucrative benefits included lower co-payments, lower co-insurance, caps on total yearly out-of-pocket costs, prescription drug coverage, vision coverage, and health club memberships, among others. *Id.*

212. *Id.*

213. *Id.*

214. *Id.*

215. Sierra Complaint, *supra* note 202, at 2.

216. Bloch, *supra* note 160, at 12.

217. *Id.*

218. Sierra Impact Statement, *supra* note 31, at 9–10.

219. Sierra Complaint, *supra* note 202, at 4; *see also* Bloch, *supra* note 160, at 12 (detailing other specifics of the transaction and the consent decree).

D. What Can Be Learned from the Aetna, PacifiCare, & Sierra Health Plan Mergers?

The three Agency-challenged health plan mergers signal that courts are very hesitant to broadly define the relevant market. Concerning geographic markets—all three cases utilized one or two MSAs for geographic market definition: *Aetna*'s geographic market was defined as the Dallas and Houston MSAs, *PacifiCare*'s market was limited to the Tucson MSA, and *Sierra*'s consisted of only two counties (Clark and Nye) within Las Vegas area.[220] In the same vein, concerning product market definition—*Aetna* was limited to HMO and HMO-POS plans, *PacifiCare* was limited to commercial insurance to small-group employers, and *Sierra* was limited to Medicare Advantage plans.[221] This portends that under the PPACA's health care exchange system, courts—and especially the Agencies—will likely seek to circumscribe and constrict the relevant markets as much as possible.

VIII. INVESTIGATING & ANALYZING PPACA

A. Background of the Patient Protection and Affordable Care Act of 2010

The Patient Protection and Affordable Care Act of 2010 (PPACA), was signed into law by President Obama on March 23, 2010 and amended seven days later by the Health Care and Education Reconciliation Act (HCERA).[222] This ten-titled bill is a comprehensive overhaul of the U.S. health care system, with provisions aiming for broad-spectrum improvements in everything from health care coverage to financing to delivery.[223] In addition to obligating all applicable individuals[224] to purchase and maintain acceptable health insurance,

220. Aetna Impact Statement, *supra* note 31, at 2; PacifiCare Impact Statement, *supra* note 31, at 3; Sierra Impact Statement, *supra* note 31, at 7.

221. Aetna Impact Statement, *supra* note 31, at 2; PacifiCare Impact Statement, *supra* note 31, at 4; Sierra Impact Statement, *supra* note 31, at 7.

222. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 42 U.S.C.), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (codified in scattered sections of 42 U.S.C.).

223. *See, e.g.*, Pub. L. No. 111-148, § 3001, 124 Stat. 119, 353 ("Transforming the Health Care Delivery System"), § 1001, 124 Stat. at 131 ("Improving Coverage"), § 1413, 124 Stat. at 233 ("Health Subsidy Programs"). There are a few areas within health care that will be relatively unscathed by the PPACA, including professional licensure, malpractice, and much of the bioethics field. FURROW ET AL., *supra* note 19, at 1.

224. There are several exempted groups from this individual mandate, including American Indians, members of certain religious sects or ministries that object to health insurance, and those experiencing financial hardship. 42 U.S.C. § 18081(b)(5)(A)–(B) (West Supp. 2010). The brunt of the individual insurance mandate will affect self-employed persons whose income is well above the median. FURROW ET AL., *supra* note 19, at 74.

PPACA incentivizes (and disincentivizes) insurers and health care providers to deliver care as efficiently and effectively as possible.[225]

Perhaps the most probative PPACA Title for purposes of this article is Title I, which addresses the initiative for patching up what has become a fragmented health insurance industry.[226] Title I contains some provisions that have already been enacted at the time of this writing, as well as plenty of others to unfurl in years to come.[227] Title I not only establishes the American Health Benefit Exchanges and SHOP Exchanges,[228] but also includes—among a litany of other reforms—the mandate that applicable individuals purchase and/or maintain qualifying health insurance or face monetary penalties,[229] to provide health insurance subsidies for qualifying individuals,[230] and attempt to end or significantly mitigate the deceptive and exclusionary practices of health insurers.[231]

225. 26 U.S.C. § 5000A(a) (West Supp. 2010). Any person is eligible to participate in the individual exchange if that person lives in the state in which the particular exchange operates, is not incarcerated (unless pending disposition of charges), and is a citizen or lawful alien reasonably expecting to remain as such for the entire enrollment period. 42 U.S.C. § 18032(f).

226. 42 U.S.C. § 18001; *see also* Thomas L. Greaney, *Competition Policy and Organizational Policy in Health Care*, 71 U. PITT. L. REV. 217, 226–27 (2009) (discussing fragmentation arising out of health care financing).

227. *See, e.g.*, 42 U.S.C. § 300gg-14 (extension of dependent health coverage until child reaches age twenty-six); *id.* § 18001(a) (Secretary to establish a temporary high risk health insurance pool program within six months of PPACA's enactment). *But see id.* § 18031(b)(1) (health insurance exchanges to begin on January 1, 2014).

228. *Id.* § 18031(a). "American Health Benefit Exchange" refers to health insurance exchanges for individuals, and will hereinafter be referred to as simply "exchanges." *Id.* Further, "SHOP Exchange" refers to PPACA's Small Business Health Options Program, which facilitates the sale of qualified health insurance for small group employers, and will hereinafter be referred to as "SHOP Exchange." *Id.* § 18031(a)(5), (b)(1)(B). A state may elect to merge the two exchanges if it has adequate resources to do reasonably do so. *Id.* § 18031(b)(2).

229. *Id.* § 18091. In 2016, when fully phased in, individuals without acceptable coverage will be subject to tax penalties of the greater of $695 per year for each adult ($2,085 per family), or a 2.5% share of the household's income. KFF CHART, *supra* note 19, at 1. It is important to note that PPACA does not require any individual to terminate their current (group plan or other) coverage and participate in the health insurance exchange ("current" meaning that the individual was enrolled at the time of PPACA's enactment). 42 U.S.C. § 18011(a). Interestingly, however, there is one group which is mandated by PPACA to purchase insurance through the exchanges: members of Congress and Congressional staff. *Id.* § 18032(d).

230. 42 U.S.C. § 18083(a). For a great discussion on the various subsidies and the terms for qualifying for varying amounts, see FURROW ET AL., *supra* note 19, at 65–68.

231. These deceptive practices include but are certainly not limited to: underwriting based on health status, excluding particular preexisting conditions, and cancelling or rescinding coverage once a claim is made based on the finding of a trivial and unrelated omission in the individual's health insurance application. *See* 42 U.S.C. § 300gg-3. PPACA now requires the omission to be "an act or practice that constitutes fraud or [] an intentional misrepresentation of material fact as

The idea behind the health insurance exchanges is to increase access to health insurance by making it affordable; the affordability—in theory—will be realized by promoting vigorous competition—solely on price—among health insurance companies.[232] Through the exchanges, the sale of qualifying health insurance will be facilitated by how individuals and small-group employers can browse available coverage options in easy to compare, apples-to-apples format, and select what is most suitable.[233] PPACA will allow individuals and small businesses with up to 100 employees to purchase health coverage and businesses with more than 100 employees to purchase coverage starting in 2017.[234] Small employers can be grandfathered into the small-group exchange, as long as the small-group employer in the exchange expands, it can continue to be treated as a small-group employer (even if it would technically be a classified as a large group employer), as long as it remains in the exchange.[235] Funding for these health insurance marketplaces will not be borne entirely by the states—at least not until 2015—as the federal government will temporarily (2011 to 2015) provide "grants" to eligible states for use in implementing and maintaining the operability of their exchanges.[236] The states' health insurance exchanges must be entirely self-sustaining by January 1, 2015.[237]

At this writing, PPACA's logistics for health insurance exchanges are relatively articulated, but there is still much that is to be sorted out by administrators and regulators.[238] In fact, states are not even required to participate in the exchanges.[239] If a state chooses not to participate, one of two

prohibited by the terms of the plan or coverage." *Id.* § 300gg-12. "Such plan or coverage may not be cancelled except with prior notice to the enrollee, . . ." *Id.*

232. *See* CTR. ON BUDGET & POLICY PRIORITIES, INSURANCE FACT SHEET, *supra* note 37.

233. FURROW ET AL., *supra* note 19, at 114–15.

234. 42 U.S.C. § 18032(f)(2)(B). Large group employers are those "who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year." *Id.* § 18024(b)(1). Small group employers are those "who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year." *Id.* § 18024(b)(2). For plans beginning before January 1, 2016 states can opt to substitute "51 employees" for "101 employees" and "50 employees" for "100 employees." *Id.* § 18024(b)(3). This seems to be a provision that states can use as a means of avoiding overburdening the state exchange while it is still in its infancy (hence why after January 2016—when the exchanges are expected to be at full-strength—this provision of employee substitution no longer applies).

235. *Id.* § 18024(d).

236. *Id.* § 18031(a)(2).

237. *Id.* § 18031(d)(5) ("[T]he State shall ensure that such Exchange is self-sustaining beginning on January 1, 2015, including allowing the Exchange to charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding, to support its operations.").

238. *See* FURROW ET AL., *supra* note 19, at 4.

239. 42 U.S.C. § 18052.

things will happen. First, the state could seek a "waiver based on state innovation" for plan years beginning on or after January 1, 2017, meaning that a state could implement a health insurance model entirely different from an exchange, as long as the state's new schematic complies with the litany of provisions outlined in PPACA Section 18052(a).[240] If a state proceeds with this waiver, the state's coverage must be "at least as comprehensive" as the exchange's Qualified Health Plan (QHP) coverage, not increase the federal deficit, provide coverage to at least as many residents, and have premiums and cost sharing at least as low and to at least as many residents, respectively.[241] Alternatively, if a state does not seek a waiver, but still resists setting up an exchange, the HHS Secretary shall—directly or through a non-profit entity—establish an exchange in the non-electing state.[242] This is a strong disincentive against resisting the exchange paradigm, as an HHS-arranged insurance exchange would likely afford state governors much less control over how the exchange operates and how payors are reimbursed.

If a state is amenable to establishing and maintaining an exchange, PPACA will utilize the Office of Personnel Management (OPM) to contract with insurers, each of which must offer at least two multi-state plans in any exchange in which they participate.[243] Under PPACA, there does not seem to be a limit to how many states can collectively establish an exchange. Instead, it appears that regional exchanges are legitimate as long as states can agree and the collaboration does not violate any state laws.[244] In fact, individual states are also permitted to form their own regional exchanges (comprised of sub-exchanges), and states may have more than one sub-exchange operate in a single state—provided each serves a distinct geographic area.[245] Insurance behemoths like Blue Cross Blue Shield could be prominent throughout these multi-state exchanges, as PPACA explicitly allows the OPM Director to contract with a group of insurers "affiliated either by common ownership and

240. *Id.* § 18052(a).

241. *Id.* § 18052(b). QHPs are discussed *infra*, notes 248–53 and accompanying text.

242. 42 U.S.C. § 18041 (a)(1)(A), (c)(1)(A). According to PPACA, if the HHS Secretary determines on or before January 1, 2013 that a state will not be ready to launch a fully operational exchange by January 1, 2014, the HHS Secretary shall take necessary measures to implement an exchange. *Id.* § 18041(c)(1).

243. *Id.* § 18054(a)(1). Though OPM also administers the Federal Employees Health Benefit Program (FEHBP), multi-state exchange plans will be administered separately and will have a distinct risk pool. *Id.* § 18054 (g)(5).

244. *Id.* § 18031(f).

245. *Id.* § 18031(f)(2)(B). The Act also requires "the area served by each Exchange is at least as large as a rating area described in section 300gg(a) of this title." *Id.* What § 300gg(a) adds with regard to rating area is namely how "each State shall establish 1 or more rating areas within that State" and the "Secretary shall review [for adequacy] the rating areas established by each State." *Id.* § 300gg(a)(2)(A). If the state's rating fails here, the Secretary has the power to establish the state's rating areas. *Id.* § 300gg(a)(2)(B).

control or by the common use of a nationally licensed service mark."[246] Each plan must offer a benefits package that is uniform in each state in which the insurer offers coverage through the exchange, and the multistate exchanges must be state-established and administered by a governmental agency or non-profit entity.[247]

Not all health insurance plans will be allowed to participate in the health insurance exchanges; the only plans that may be offered through exchanges are "qualified health plans" (QHPs).[248] A qualified health plan indicates that the plan has satisfied various requirements to assure legitimacy.[249] A qualified health plan must: (A) be certified by the exchange in which it seeks to operate;[250] (B) provide an "essential health benefits package"; and (C) be offered by a qualifying health insurer.[251] A qualifying health insurer is one that: (1) is in good standing and licensed in the state(s) where the Exchange operates; (2) agrees to offer—in each exchange in which it operates—at least one gold-level and one silver-level plan; (3) agrees to charge the same premium for each QHP regardless of whether the QHP is offered through the Exchange or sold directly to the insured; and (4) complies with Section 18031(d) requirements promulgated by the Secretary and any other requirements established by an Exchange.[252] It is worthy of note that, subject to few exceptions, all of the "qualified" plans available in the Exchanges and

246. *Id.* § 18054(a)(1).

247. 42 U.S.C. § 18054(a)(2)–(4); *see also* KFF CHART, *supra* note 19, at 4 (Each state must have, at least one plan being offered by a non-profit entity and at least one plan that does not provide coverage for abortions beyond those permitted by federal law (e.g., cases of rape and incest)).

248. 42 U.S.C. § 18031(b)(1)(A).

249. *Id.* § 18021.

250. *Id.* § 18031(e)(1). A QHP may become certified by meeting certification requirements "as promulgated by the Secretary" and if "the Exchange determines that making available such health plan through such Exchange is in the interests of qualified individuals and qualified employers in the State or States in which such Exchange operates . . . ." *Id.* § 18031(e)(1).

251. *Id.* § 18021(a). An "essential health benefits package"—to be considered such—must include at least the following general categories of services and cover at least 60% of the actuarial value of the covered benefits: "Ambulatory patient services[;] [e]mergency services[;] [h]ospitalization[;] [m]aternity and newborn care[;] [m]ental health and substance use disorder services, including behavioral health treatment[;] [p]rescription drugs[;] [r]ehabilitative and habilitative services and devices[;] [l]aboratory services[;] [p]reventative and wellness services and chronic disease management[; and] [p]ediatric services, including oral and vision care." *Id.* §§ 18022(b)(1)(A)–(J), (d)(1). The QHP must also limit cost-sharing to the current HSA limits, which in 2010 were $5,950 for an individual and $11,900 for a family. *Id.* § 18022(c)(1)(A); KFF CHART, *supra* note 19, at 6.

252. 42 U.S.C. § 18021(a)(1)(C).

private small-group and individual markets must, at a minimum, offer the essential benefits package.[253]

PPACA has four categories of tiered benefits packages, each with incrementally increasing coverage, and a separate catastrophic plan.[254] The catastrophic plan—only available in the individual market—is available to those who have not reached the age of thirty or to those exempted from PPACA's mandate to purchase acceptable coverage.[255] PPACA's most basic plan—the bronze plan—represents the minimum acceptable coverage; it provides the essential health benefits package, and it covers 60% of the plan's benefit costs, with an out-of-pocket limit equal to the current Health Savings Account (HSA) limit.[256] The essential health benefits package and out-of-pocket limits apply to all of PPACA's tiered plans.[257] The silver plan covers 70% of the plan's actuarial benefit costs; the gold plan covers 80% of the plan's actuarial benefit costs; and the platinum plan covers 90% of the plan's actuarial benefit costs—again, all with the essential benefits package and HSA out-of-pocket limits.[258] The aforementioned out-of-pocket limits are not static, but are reduced for those with incomes between 100% to 400% of the Federal Poverty Level ("FPL").[259] PPACA strongly incentivizes health insurers within the Exchange strictly to offer the essential health benefits package, because if states impose mandated additional benefits beyond the essential health benefits package, they must subsidize—by making payments to the health plan on the individual's behalf or by paying the individual directly—to defray the incremental premium cost that is attributable to the state's additional mandated benefits.[260] Additionally, regarding the age rating requirements of multi-state Exchange plans, if one state's rating requirement is lower than 3:1, that particular state may require other multi-state plans functioning in that state to

253. KFF CHART, *supra* note 19, at 6. This requirement does not apply to grandfathered employer-sponsored or individual plans. *Id.*

254. 42 U.S.C. § 18022(d)(1), (e).

255. *Id.* § 18022(e). The catastrophic plan includes coverage set at the 2010 HSA limits of $5,950 for an individual and $11,900 for a family. KFF Chart, *supra* note 19, at 5. Under this plan, prevention benefits and coverage for three primary care visits would be exempt from the deductible. *Id.*

256. *Id.* § 18022(d)(1)(A); *see also* KFF Chart, *supra* note 19, at 5 (stating that the HSA limit in 2010 is $5,950 for individuals and $11,900 for families).

257. 42 U.S.C. § 18022(d)(2)(A); *see also* KFF Chart, *supra* note 19, at 5.

258. 42 U.S.C. § 18022(d)(1)(B–D).

259. *Id.* § 18071(b) (2006); *see* KFF Chart, *supra* note 19, at 5. For incomes between 100% to 200% FPL, the HSA limit is reduced by one-third ($1,983/individual and $3,967/family); for incomes between 200% to 300% FPL, the HSA limit is reduced by one-half ($2,975/individual and $5,950/family); for incomes between 300% to 400% FPL, the HSA limit is reduced by two-thirds ($3,987/individual and $7,973/family). These out-of-pocket reductions do not increase the plan's actuarial value, as they are applied within the plan's actuarial limits. *Id.*

260. 42 U.S.C. § 18031(d)(3)(B)(ii).

raise their rating requirements to comply with the state's "more protective age rating rules."[261]

IX. DEFINING THE RELEVANT MARKET FOR HEALTH PLAN MERGERS UNDER PPACA

With health insurance consolidation still continuing at an "alarming pace," should PPACA survive various states' lawsuits, it will not be long before agencies, courts, and state attorneys general begin thinking about the antitrust ramifications with health insurance Exchanges now in the mix.[262] This section walks through how the Agencies could sensibly proceed through this ambiguous and thorny process, with the 1992 Guidelines serving as the analytical underpinning, the three above-analyzed health plan mergers as reference points, and the "practical" market definition discussion to orient the reader.

It is important to reiterate the Agencies' penchant for narrowly defining the relevant geographic and product markets. Despite the fact that employers have always been able to search nationwide for health insurance, the Antitrust Division—in all three cases challenging health plan mergers—alleged a relevant geographic market consisting of merely localities or MSAs.[263] The prominent and recurring rationale is that competition among plans springs from the plans' local provider networks; therefore, if the merged company attempted to increase price, enough employers would not switch and insure with more distant provider networks so as to render the price increase unprofitable.[264] The same market circumscription is present in the three previously discussed product markets, as the DOJ narrowed the product market to HMO and HMO-POS plans in *Aetna*, commercial insurance to small-group employers in *PacifiCare*, and Medicare Advantage plans in *Sierra*.[265] There is

261. *Id.* § 18054(c)(5); KFF Chart, *supra* note 19, at 4.

262. AHA WHITE PAPER, *supra* note 15, at 5 ("[Health plan consolidation] still continues at an alarming pace with two particularly large and problematic consolidations coming under DOJ review in 2008."). The "large and problematic" mergers being referenced are United-Sierra and Independence Blue Cross-Highmark. *Id.* at 6.

263. ABA SECTION OF ANTITRUST LAW, *supra* note 34, at 149–50 (stating that the Antitrust Division alleged geographic markets consisting of the Dallas and Houston MSAs in its challenge of Aetna's acquisition of Prudential, the Tucson MSA in its challenge of United Healthcare's acquisition of PacifiCare, and the Las Vegas area in its challenge of United Healthcare's acquisition of Sierra Health Services).

264. *Id.* at 160; *see* Aetna Impact Statement, *supra* note 31, at 7–8 ("[M]anaged care companies establish provider networks in the areas where employees work and live, and they compete on the basis of these local provider networks" such that "a small but significant increase in the price of HMO and HMO-POS plans would not cause a sufficient number of customers to switch to health plans outside of these regions to make such a price increase unprofitable.").

265. Aetna Impact Statement, *supra* note 31, at 2; PacifiCare Impact Statement, *supra* note 31, at 1–2; Sierra Impact Statement, *supra* note 31, at 1.

nothing indicating that enforcement agencies will depart from this tendency to narrowly define markets in a post-PPACA regime.

A. Defining the Relevant Geographic Market Under PPACA

As articulated above, PPACA will involve states establishing numerous state-operated health insurance Exchanges.[266] Concerning the relevant geographic market definition under this paradigm, at first blush it would seem sensible to delineate and aggregate the states or regions in which the merged insurance company would be participating post-merger. This would not be difficult, because according to PPACA, each intra-state Exchange would be operating in a distinct geographic area.[267] Perhaps an example would be illuminating. If, within a state, Exchange One operates in geographic market A_1 and Exchange Two operates in geographic market A_2, then the post-merger geographic market could be calculated by aggregating the sum of regions or MSAs that each served: $A_1 + A_2 = G_{MKT}$.[268] This approach is consistent with the *Sierra* rationale, because in *Sierra* the Medicare-eligible residents in the Las Vegas area could only enroll in the Medicare Advantage plans for the county in which they live—as a result, enrollees could not turn elsewhere for the Medicare Advantage plans.[269] According to PPACA, individuals could purchase insurance in an Exchange, which would have the ability to operate across state lines (i.e., regional Exchanges).[270] However, the DOJ has made it clear that enrollees do not wish to cross state lines to see their doctor—they want a local provider network; because the DOJ has defined the geographic market precisely this way in the previous three health plan mergers, this pulls heavily in favor of the Agencies continuing to restrict and hone the geographic market down to the local MSAs.[271] For this reason, it seems that the most sensible approach would be the relevant geographic market as the Agencies have done in the past, namely "no larger than the local areas within which HMO and HMO-POS enrollees demand access to providers."[272] Applying this methodology to PPACA, Exchanges would result in the geographic market being the local areas in which enrollees in health Exchange "X" would

266. 42 U.S.C. § 18031(b)(1) (West Supp. 2010).

267. *Id.* § 18031(f)(2)(A).

268. Under this approach, it would be wise to use either geographic regions (e.g., states) or MSAs, but not both—as this could create confusion with overlapping markets.

269. Sierra Impact Statement, *supra* note 31, at 7 ("Because Medicare-eligible residents in the Las Vegas area cannot purchase substitute Medicare Advantage plans sold in other geographic areas, the Las Vegas area is a relevant geographic market . . . .").

270. 42 U.S.C. § 18031(f)(1).

271. *See* PacifiCare Impact Statement, *supra* note 31, at 5 ("Health insurance plan enrollees seek relationships with physicians and other health care professionals and institutions that are located in the metropolitan area in which they live and work.").

272. Aetna Impact Statement, *supra* note 31, at 7–8.

demand access to providers.[273] Ascertaining the provider demand could be accomplished by performing resident surveys, a technique stated in the Commentary to be very useful and frequently utilized.[274]

B. Defining the Relevant Product Market Under PPACA

The nature of the PPACA Exchanges and the product offerings of four discrete and differentiated plans—bronze, silver, gold, and platinum—greatly simplifies the process of the relevant product market. A sensible way to define the relevant product market would be to identify and aggregate which insurance plans the merged entity would provide post-merger, and define the market no broader than that.[275] If post-merger the merged entity would be offering bronze, silver, and gold plans, then the sale of bronze, silver, and gold plans could comprise the relevant product market in a line of commerce.

Defining the market in this way is prudent, as the Exchange's strict stipulation that insurers offer among four discrete plans would have a de facto effect of necessarily grouping plans that have in common significant attributes that cannot be found in products outside that class.[276] For example, the platinum plan has benefits (90% benefit coverage) that cannot be found in the gold plan (80% benefit coverage), and the same for the gold plan compared to the silver (70% benefit coverage), and silver to bronze (60% benefit coverage).[277] In *Aetna* parlance, this is to say that these plans are "distinct products, meeting different needs and appealing to different types of enrollees."[278] Because these plans are structured to meet different needs and budgets, it would be sensible for each to comprise their own relevant market.

This solution is also grounded in the *Sierra* rationale. In *Sierra*, the DOJ did not include traditional Medicare in the same market as Medicare Advantage plans because, "[d]ue in large part to the lower out-of-pocket costs

273. Here, "X" insurance plan is referring to whatever the product market is defined as in terms of the platinum, gold, silver, and bronze plans.

274. FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, COMMENTARY, *supra* note 10, at 9.

275. An example of how the market could be defined more broadly would be to include the full range of Exchange plans without regard to what was going to be sold by the merged entity. An even broader definition would be delineating all commercial—Exchange and non-Exchange-based—insurance plans that offer the same or substantially similar benefits offered under the multi-state Exchange plan.

276. *See* Gopal Das Varma, *Will Use of the Upward Pricing Pressure Test Lead to an Increase in the Level of Merger Enforcement*, ANTITRUST, Fall 2009, at 27, 28 ("[T]he manner in which relevant markets are defined *in practice* often revolves around identifying a class of products (including those of the merging firms) that have in common certain attributes that are sufficiently valued by their consumers and that cannot be found in products outside of the class.") (emphasis added).

277. 42 U.S.C. § 18022(d)(1) (West Supp. 2010).

278. *See* Aetna Impact Statement, *supra* note 31, at 7 (discussing market definition and why PPO plans are not in the same product market as HMO and HMO-POS plans).

and richer benefits that many Medicare Advantage plans offer seniors over traditional Medicare, seniors in the Las Vegas area would not likely switch away from Medicare Advantage plans to traditional Medicare . . . ."[279] This could be analogized to the tiered-benefits of the PPACA's Exchange system insofar as each plan offers—in *Sierra* terms—"lower out-of-pocket costs" and "richer benefits" than the next best plan.[280] Like Medicare Advantage and traditional Medicare, not only do the gold and silver plans differ by cost and benefit configuration, but they are also not seen as adequate substitutes for one another.[281] In SSNIP terms—like *Sierra*—because of the significant variation in the level of benefits between different plan tiers, enrollees would not switch plans in the event of a small but significant increase in price so as to render the increase unprofitable for the hypothetical monopolist.[282] Because the increase would be profitable, the market need not be broadened beyond the aggregate of the benefit plans to be offered post-merger.

Now, in the event that the health benefits plans within the insurance Exchange were lumped into the same market as commercial insurance plans, there is also a sensible approach. Here, the product market could be defined to include all plans that meet a certain minimum diversion ratio threshold (which the Agencies could supplement into the Horizontal Merger Guidelines) with respect to four insurance plans (bronze to platinum).[283] In doing this, insurance plans sharing more common attributes would have a higher diversion ratio, which would be indicative of which plans are seen as substitutes in the buyers' eyes.[284] This is appropriate since the market definition exercise seeks to ascertain whether—in the event of a hypothetical price increase—buyers could turn to other products and/or geographic areas so as to make that price increase unprofitable.

279. Sierra Impact Statement, *supra* note 31, at 4–5.

280. *See* 42 U.S.C. § 18022(d)(1) (providing that each plan offers 10% more benefit coverage than the next best plan).

281. Medicare Advantage benefits include "lower co-payments, lower co-insurance, caps on total yearly out-of-pocket costs, prescription drug coverage, vision coverage, health club memberships, and other benefits that traditional Medicare does not cover." Sierra Impact Statement, *supra* note 31, at 7.

282. *See id.*

283. *See* Das Varma, *supra* note 276, at 29 (stating that defining a product's market "to include all products that have a certain minimum diversion ratio with respect to that product" is "based on the idea that products with fewer attributes in common with the product in question would both have a lower diversion ratio and be likely to be dropped from the market definition by the practical approach").

284. *Id.*

CONCLUSION

If the necessarily prospective nature of merger analysis was not complex enough, this market definition discussion is an especially onerous exercise, as PPACA is still in its infancy, and a considerable amount of the bill is yet to unfurl or even be fully interpreted by scholarly commentators.

Articulating a bright-line rule for how the markets for health plan mergers are to be defined would be exceptionally precarious, seeing how so much of the criticism aimed toward the Guidelines includes their use of bright-line rules, reliance on structural presumptions, and attempts at over-specificity.[285] Admittedly, market definition is only a basic indicator of whether a merger will have anticompetitive effects, but its simplicity is nevertheless a pivotal part of its practicality. After all, with the Agencies' modest resources, an extensive quantitative analysis would still not be feasible in the narrowly allotted Hart-Scott-Rodino time frame.[286]

A key mode of analysis that needs to be kept it mind when defining the relevant geographic and product markets of health plan mergers under an Exchange system is identifying the right questions to ask, rather than trying to concoct an elaborate framework suited to the particular delivery system, as that would analytically circumscribe the Guidelines' acclaimed adaptability to idiosyncratic mergers.[287] While the proffered methodology is by no means the only way that the relevant geographic and product markets may be defined under PPACA, this is nevertheless one that is rooted in the previous three challenged health plan mergers and comports with common sense and industry structure. This undoubtedly is not the extent of the evidence that the Agencies consider when delineating potentially scores of regional and local markets, as the Agencies' Commentary explicitly states that they rely on customer interviews and other data for market definition information.[288]

In observing how the 2006 Commentary followed the Agencies' 2004 Merger Enforcement Workshop, it will be very interesting to see if the Agencies release additional Guidelines Commentary following the current merger workshops conducted in 2010, and if so, how they plan to deal with the

285. *See* Feinstein, *supra* note 6, at 5 ("The bright line rules and presumptions the agencies may find helpful in court, and that can provide some guidance to parties contemplating a merger—may not actually reflect the nuanced manner in which the agencies actually conduct a merger review."); Gertner & Murphy, *supra* note 90, at 2 ("The Guidelines' weaknesses reflect the attempt to be too detailed on some issues, while providing little if any guidance on others.").

286. FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, COMMENTARY, *supra* note 10, at 2.

287. *See* Feinstein, *supra* note 13, at 7.

288. FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, COMMENTARY, *supra* note 10, at 9 ("The Agencies routinely solicit information from customers regarding their product and supplier selections. In selecting their suppliers, customers typically evaluate the alternatives available to them and can often provide the Agencies with information on their functional needs as well as on the cost and availability of substitutes.").

amorphous market definition concepts inherent in market definition within a health insurance Exchange system.

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APPENDIX A[289]

DATE	MAJOR HEALTH PLAN MERGERS
1993	Anthem – Blue Cross/Blue Shield of Kentucky
1995	Anthem – Community Mutual (a Blue Cross/Blue Shield plan in Ohio) United – MetraHealth United – PHP of Missouri
1996	WellPoint – Group Life and Health (Subsidiary of Mass Mutual Life) United – PHP of North Carolina Aetna – US Healthcare
1997	Anthem – Blue Cross/Blue Shield of Connecticut
1998	United – Humana (abandoned for financial reasons) United – PHP of Texas Blue Cross Illinois – Blue Cross Texas (formed HCSC) Aetna – NYL Care
1999	Anthem – Blue Cross/Blue Shield of New Hampshire Anthem – Blue Cross/ Blue Shield of Colorado and Nevada Aetna – Prudential Yellowstone Community Health Plan – BCBS of Montana
2000	Anthem – Blue Cross/Blue Shield of Maine WellPoint – Rush Prudential Health Plans of Illinois
2001	HCSC – Blue Cross New Mexico WellPoint – Cerulean Companies Inc. (Blue Cross/Blue Shield of Georgia)
2002	Anthem – Trigon (Blue Cross/Blue Shield of Virginia) WellPoint – RightCHOICE (Blue Cross/Blue Shield of Missouri and HealthLink) WellPoint – Methodist Care (Texas HMO)
2003	WellPoint – Cobalt (Blue Cross/Blue Shield of Wisconsin)
2004	Anthem – WellPoint Health Networks Inc. United – Oxford United – MAMSI

289. AHA WHITE PAPER, *supra* note 15, at 6.

2005	WellPoint – Lumenos United – PacifiCare HCSC – Blue Cross HIP – GHI
2006	United – John Deere
2007–2008	United – Sierra Independence Blue Cross – Highmark (abandoned 2009)