



Statement

of the

American Medical Association

to the

**Committee on the Judiciary, Subcommittee on
Antitrust, Competition Policy, and Consumer Rights
United States Senate**

**RE: Consolidation in the Pennsylvania Health
Insurance Industry: The Right
Prescription?**

Presented by: Henry S. Allen, Jr., Esq.

July 31, 2008

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I Opening Statement

The American Medical Association (AMA) appreciates the opportunity to present testimony to the Committee on the Judiciary on consolidation in the Pennsylvania health insurance industry. We commend Chairman Kohl, Ranking Member Hatch, Senator Specter and the other members of the Subcommittee on Antitrust, Competition Policy, and Consumer Rights for your leadership in recognizing the threats that health insurer consolidations pose to the delivery of health care in Pennsylvania and across the country.

The AMA believes that competition, not consolidation, is the right prescription for health insurer markets. Competition will lower premiums, force insurers to enhance customer service, pay bills accurately and on time, and develop and implement innovative ways to improve quality while lowering costs. Competition also allows physicians to bargain for contract terms that touch all aspects of patient care.

In Pennsylvania where health insurer entry from outside the state has been difficult and little incumbent competition exists, the potential competition that Highmark poses to Independence Blue Cross (“IBC” or “Independence”) is the only market mechanism that protects patients from higher premiums. This potential competition also offers the prospect that physicians practicing in IBC’s territories will have somewhere else (i.e., Highmark) to sell their services.¹ A merger would foreclose this alternative and provide the merged firm with the sort of monopsony power² that is depriving physicians of the ability to negotiate competitive health insurer contract terms in markets around the country. Accordingly, the AMA opposes the proposed merger of Highmark and IBC.

II. Merger to Monopoly

The market shares of Highmark and IBC are more than sufficient for the merger to be found presumptively illegal under both Section 7 of the Clayton Act (15 USC § 18) (Section 7) and the Pennsylvania Insurance Holding Companies Act (“PAIHCA”). Monica Noether, PhD, a former Deputy Assistant Director of the Federal Trade Commission Bureau of Economics³, has concluded that the merger would combine a Highmark market share of 42 percent with that of IBC’s share of 30 percent, and would result in a combined entity with more than 70 percent of

¹ See Lawrence A. Sullivan & Warren S. Grimes, *The Law of Antitrust: An Integrated Handbook* §11.3b-.3b1 (2000) (for a discussion of the consumer welfare benefits of potential competition).

²Text from: “Agenda for Joint FTC / DOJ Hearings on Health Care and Competition Law and Policy” (Washington D.C., Thursday, April 24, 2003) Available from: <http://www.ftc.gov/ogc/healthcarehearings/030405hcagenda.shtm>; Accessed 07/30/2008. This source defines monopsony as a “substantial market power being exercised by buyers over sellers. In the health insurance industry, health insurers are both sellers (of insurance to consumers) and buyers (of, for example, hospital and physician services).

³ Monica G. Noether, PhD. “Testimony on Commonwealth of Pennsylvania Public Hearing Associated with the Form A Filings for Highmark, Inc. and Independence Blue Cross.” (Pittsburgh, July 8, 2008). Text From: Competitive Analysis of the Proposed Consolidation Between Highmark, Inc., and Independence Blue Cross in the Commonwealth of Pennsylvania. Available from: www.ins.state.pa.us; Accessed 07/29/2008. (Noether Report).

the fully and self-insured commercial health insurance market in the Commonwealth.⁴ The resulting post-merger level of market concentration, and the increase in that market concentration caused by the merger, triggers the presumption that the merger may substantially lessen competition or tend to create a monopoly under both Section 7 and the PAIHCA.⁵ Moreover, under federal antitrust law, the resulting entity's possession of a 70 percent market share also establishes a prima facie case of monopoly power, a conclusion buttressed by the substantial barriers to market entry (also documented in Dr. Noether's report).⁶ In short, this proposed merger is so anticompetitive that it amounts to a merger to a monopoly.

Highmark/IBC's statement addressing the PAIHCA's competitive standard omits any discussion of entry into the market – a factor, that under the Act, may be considered in determining whether a merger has anticompetitive effect.⁷ The reason for this omission is obvious. In Pennsylvania health insurance markets there has been very little in the way of new entry⁸. Health insurers that have successfully competed in other parts of the nation including Aetna, United HealthCare, and Cigna, have barely any presence in Pennsylvania. This is

⁴ *Id.* at 7.

⁵ The PAIHCA at 40 P.S. § 991.1403(d)(2)(i) provides that a highly concentrated market is one in which the share of the four largest insurers is 75 percent or more of the market. In a concentrated market when an insurer with a 4 percent market share acquires one with a 4 percent share, that would constitute a prima facie violation of the act's competitive standards. *Id.* The Noether Report at Exhibit 2 documents that in a statewide Pennsylvania market, the four largest insurers possess a total market share of 86 percent. Moreover, the shares of merging firms dramatically surpasses the 4 percent. See also Horizontal Merger Guidelines, US Department of Justice and Federal Trade Commission at http://www.usdoj.gov/atr/public/guidelines/horiz_book/hmg1.html. In *United States v. Philadelphia National Bank*, 374 U.S. 321 (1963), the U.S. Supreme Court announced a rule of presumptive illegality in the context of heavily concentrated markets. In that case, the acquiring firm held a 30 percent market share, while the acquired firm's market share was only 3 percent.

⁶ See e.g. *United States v. Grinnell Corp*, 384 US 563, 571 (1966) (The existence of monopoly power may be inferred from a predominant share of the market).

⁷ See 40 P.S. § 991.1403(d)(2)(iv).

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

consistent with the federal antitrust enforcement agencies' observation that national plans have been unsuccessful entering some of the Blue Cross dominant markets in recent years.⁹

Entry is difficult.¹⁰ As the Federal Trade Commission has reported, there are significant barriers to entry in health insurance markets. These barriers include the problems of: (i) developing a health care provider network; (ii) developing sufficient business to permit the spreading of risk; and (iii) contending with established insurance companies that have built long term relationships with employers and other consumers. Because there has been little to no entry in either of Highmark's or IBC's dominant market areas, this merger would permanently eliminate their biggest potential rival.¹¹

III. Highmark and IBC are Best Characterized as "Competitors"

In a failed effort to avoid a prima facie violation, Highmark/IBC assert in their "Statement Regarding Compliance with the Competitive Standard of 40 P.S. Section 991.1403(d)" that they do not compete in the same market that they operate in different regional markets.¹² Consequently, their economist Barry Harris, PhD claims, "[t]he consolidation does not result in any anticompetitive effects."¹³ Even if the insurance market in Pennsylvania is regional, the merger will nevertheless substantially reduce competition. IBC and Highmark are dominant in each of the alleged regionalized markets. In the absence of a merger, Highmark's

⁹ "Improving Health Care. A Dose of Competition, Federal Trade Commission and Department of Justice" (July 2004) at 8-11.

¹⁰ *Id.*

¹¹ See Affidavit of Professor Dranove, Exhibit 1.

¹² "Statement Regarding Compliance with the Competitive Standard of 40 P.S. Section 991.1403(d)", at 1-2.

¹³ Comments by Barry C. Harris, PhD, in the Pennsylvania Insurance Department Public Informational Hearings July, 2008.

entry as a competitor would result in a substantial deconcentration of IBC's regionalized market.¹⁴

Highmark has the means other than through merger to enter IBC's regional territory. As an established Blues insurer in Pennsylvania, Highmark does not face the barriers to entry confronted by other insurers. In the past, Highmark would have marketed its Blue Shield plan in IBC's territory of southeastern Pennsylvania, but for Highmark's 1996 purchase agreement with IBC. Pursuant to that agreement, Highmark exited southeastern Pennsylvania by selling interests in two plans to IBC and promising not to re-enter IBC's territories under the Blue Shield service mark for ten years.¹⁵ That market division agreement expired around the time this consolidation was proposed. Presently, in the absence of this agreed-upon territorial restraint, Highmark is free, capable, and desirous of offering its services in the southeastern Pennsylvania territory where IBC presently sells. In fact, Highmark has previously successfully marketed its products in southeastern Pennsylvania.¹⁶ It could easily offer products there again, using the network of physicians it already has under contract in that region. Highmark only needs to add a relatively small number of hospitals to that network. Expanding state-wide is also made easier by the presence of companies that rent networks in Pennsylvania.¹⁷ With the strong appeal of the Blue Shield Trademark, Highmark could accomplish its CEO's stated goal of gaining state-wide

¹⁴ For a discussion of these factors in a merger context, see *United States v. Marine Bancorporation, Inc.*, 418 U.S. 602 (1974).

¹⁵ December 6, 1996 Purchase Agreement between IBC and Pennsylvania Blue Shield, Section 7.2, at 10.

¹⁶ Monica G. Noether, PhD. "Testimony on Commonwealth of Pennsylvania Public Hearing Associated with the Form A Filings for Highmark, Inc. and Independence Blue Cross." (Pittsburgh, July 8, 2008). Text From: Competitive Analysis of the Proposed Consolidation Between Highmark, Inc., and Independence Blue Cross in the Commonwealth of Pennsylvania. Available from: www.ins.state.pa.us; Accessed 07/29/2008. (Noether Report, 12)

¹⁷ For a list of these companies see Noether Report at 7.

presence¹⁸ – a goal that is consistent with serving employers whose employees reside state-wide.¹⁹

Highmark’s and IBC’s ability to compete with each other is not altered by the status of the parties as Blue Cross/Blue Shield licensees. The Blue Cross and Blue Shield Association (BCBSA) explained in its correspondence to acting Insurance Commissioner Ario that, “Nothing in the license agreements prevents a licensee of the Blue Cross brand from using that brand to compete against a licensee of the Blue Shield brand, and visa versa within its license service area...[M]oreover, BCBSA licensed companies may compete anywhere with nonBlue branded business, and many do.”²⁰ Accordingly, Highmark as a Blue Shield licensee can compete in IBC’s territories notwithstanding IBC’s status as a Blue Cross licensee. In addition, IBC would be free to compete against Highmark in western Pennsylvania using, for example, “Amerihealth HMO” as its product.

Although Highmark and IBC have engaged in an agreement to divide the market, there are reasons of principle and policy for characterizing their proposed merger as one that lessens competition or tends to create a monopoly. First, there is no meaningful difference between actual and potential competition.²¹ As Areeda & Hovenkamp observe in the leading treatise on antitrust law, once a firm like Highmark is recognized as a factor “in future predictions about the market, that firm must be counted as a competitor even though that firm has not yet won its first bid or indeed has not made any bid at all.”²² Thus, the foreclosure of this future market role serves “to lessen competition.” Second, a restrictive reading understates the competitive

¹⁸ “Talking with Ken Milani,” Harrisburg, Patriot News, July 22, 2007.

¹⁹ Dranove Affidavit, Exhibit 1.

²⁰ Dec. 21, 2007 correspondence from Roger G. Wilson, Senior Vice President and General Council, Blue Cross Blue Shield Association to Joel Ario, Acting Insurance Commissioner.

²¹ IV Areeda & Hovenkamp, *Antitrust Law: An Analysis of Antitrust Principles and their Application* ¶907 (2007) (Exhibit 2) (which explains that there are good reasons for not reading the Clayton Act requirements narrowly).

²² *Id.*

significance of mergers that, like here, occur in highly concentrated non-competitive markets.²³ Indeed, where the merger results in a market share of monopoly proportions, the merger should constitute a Section 2 offense of monopolization because it eliminates either actual or potential competition.²⁴

In sum, Highmark and IBC cannot escape the anticompetitive implications of their combined market share by arguing that they are not rivals in each other's markets. IBC and Highmark are actual competitors, as best evidenced by their agreement not to compete, which was required to control the natural rivalry between them.

IV. Anticompetitive Effects of Merger in the Insurance Market Where Physicians Sell Their Services

The merger would result in a dominant health insurance company with monopsony power in insurance markets where physicians sell their services. Consequently, physicians could be forced to accept inadequate reimbursement, which would likely to lead to a reduction in the supply of physician services - in spite of the demand for such services by patients. This is particularly significant given that recent projections by the U. S. Health Resources and Services Administration already suggest an impending shortage of physicians.²⁵

It is a mistake to assume that when insurers push down the cost of physician services, insurers' interests are perfectly aligned with those of consumers.²⁶ Because health insurer monopsonists typically are also monopolists in the output market for healthcare insurance, lower

²³ *Id.*

²⁴ *Id.* at ¶912(Exhibit 3).

²⁵ See Health Resources and Services Administration, *Physician Supply and Demand: Projections to 2020* (Oct 2006) (which projecting a shortfall of approximately 55,000 physicians in 2020); see also Merritt, Hawkins, et al., *Will the Last Physician in America Please Turn Off The Lights? A Look at America's Looming Doctor Shortage* (2004). (which predicts a shortage of 90,000 to 200,000 physicians and that average wait times for medical specialties is likely to increase dramatically beyond the current range of two to five weeks).

²⁶ Mark V. Pauly, "Competition in Health Insurance Markets," 51 *Law & Contemp. Probs.* 237 (1998).

input prices (for physician services) do not lead to lower consumer output prices (for health care insurance premiums).²⁷ Indeed, the evidence from mergers throughout the U.S. strongly suggests that the creation of buyer power from health insurance consolidation has not benefited competition or consumers. Although compensation to physicians has been reduced, health insurance premiums have continued to increase rapidly.²⁸

Clearance of this merger by the U.S. Department of Justice(DOJ) greatly concerns the AMA.²⁹ The Department of Justice has challenged only three of more than 400 mergers involving health insurers and managed care organizations over the past 12 years.³⁰ As a result, markets for third-party payors, especially commercial insurance plans, have grown increasingly concentrated. In almost every state, one of three major insurance firms is the market leader. In most of these states, Blue Cross and Blue Shield is the dominant firm. For example, in 2002, Blue Cross and Blue Shield controlled 39 percent of the Maine market; by 2006, this had grown to 63 percent.³¹ The Government Accountability Office (GAO) estimates that the largest insurer in each state of the United States typically has a 43 percent share of the market for small group coverage, a 10 percent increase in less than five years.³² Other studies indicate that in 16 states, one insurer controls over half of the market.³³ This consolidation has developed mostly through mergers and acquisitions. Studies have shown unequivocally that in this market environment,

²⁷ Peter J. Hammer and William Sage, “Monopsony as an Agency and Regulatory Problem in Health Care,” 71 *Antitrust L.J.* 949 (2004). *See also Dranove Affidavit*, Exhibit I.

²⁸ See Testimony from “Examining Competition in Group Health Care,” Hearing before the Senate Judiciary Committee, 109th Cong. (Sept. 6, 2006), and “Health Insurer Consolidation – The Impact on Small Business,” Hearing before the House Small Business Committee, 100th Cong. (Oct. 25, 2007).

²⁹ See Highmarks Press Release of July 17, 2008.

³⁰ American Medical Association, *Competition in Health Insurance: A Comprehensive Study of US Markets / 2007 Update*, 1

³¹ Robert Pear, “Loss of Competition Is Seen in Health Insurance Industry”, *New York Times*, Apr. 30, 2006, at Section 1, 131.

³² *Id.* at Section 1, 21.

³³ James C. Robinson, *Consolidation and the Transformation of Competition in Health Insurance*, 23 *Health Affairs* 11, 13-14 (2004).

physicians across the country have virtually no bargaining power with dominant health insurers that are monopsonists.³⁴

V. Why Competition Is Good

Competition is essential to the health of the free market. Competition among insurers forces them to hold the line on premiums. With average premiums exceeding \$12,000 for a family plan, even a few percentage points would make a significant difference for the typical family.

Examples of the benefits of competition among Blues plans can be found in the ongoing rivalry between Highmark and Capital BlueCross. Some of the benefits have been documented in the testimony of Anita Smith, President and Chief Executive Officer of Capital BlueCross.³⁵ She emphasizes that the competition between Capital BlueCross and Highmark has improved efficiency, innovation, quality, and price. Such benefits have also been discussed in the press. For example, The *Philadelphia Inquirer* carried an article on June 9, 2008, entitled “What can happen if Blues Compete; In a Swath of Pa., Capital and Highmark both offer health insurance.”³⁶ The article contrasts the marketplace for insurance in southeast Pennsylvania, where IBC has no Blue rival, with the central area of the state, where Capital and Highmark are rivals. In central Pennsylvania, the article concludes, competition for the contract prevails, thus benefiting patients and providers. Patients and physicians should also reap the benefits of Highmark’s and IBC’s future competition. The firms should not be allowed to merge into a monopoly.

³⁴ American Medical Association, *Competition in Health Insurance: A Comprehensive Study of US Markets / 2007 Update*, 2.

³⁵ Anita Smith. “Testimony before the Commonwealth of Pennsylvania Senate Banking and Insurance Committee Associated with the Form A Filings for Highmark, Inc. and Independence Blue Cross.” (January 30, 2008). Available from: <https://www.capbluecross.com/PressRoom/NewsReleases/testimony.htm> ; Accessed 07/29/2008.

³⁶ Exhibit 4.

VI. Conclusion

The proposed merger will have anticompetitive effects in patient and physician service markets. IBC and Highmark have maintained dominant market positions for decades. There has been little to no entry by competitors into the territories they dominate. In essence, this merger represents a contractual extension of their explicit agreement not to compete. By clearing this proposed merger, the Department of Justice has demonstrated its lack of federal antitrust enforcement in health insurance markets. Accordingly, the AMA respectfully requests that this Committee urge the federal antitrust enforcement agencies to more rigorously enforce the antitrust laws with respect to future health insurer consolidations.



Exhibits to

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**RE: Consolidation in the Pennsylvania Health
Insurance Industry: The Right Prescription?**

Presented by: Henry S. Allen, Jr., Esq.

July 31, 2008

Affidavit of Professor David Dranove

I. Qualifications

I am the Walter McNerney Distinguished Professor of Health Industry Management at the Kellogg School of Management, as well as the Director of the Center for Health Industry Market Economics and the Director of *Health at Kellogg*. I have studied health care competition for over 20 years and have published numerous books and peer reviewed papers on the topic. I am also coauthor of the popular textbook, *Economics of Strategy*, which is used by leading business schools worldwide and contains a chapter on entry that I authored. My vita is attached.

I have also studied the Pennsylvania health care market place, first in preparing an expert report in conjunction with the bankruptcy of the Allegheny Health Education and Research Foundation and more recently in conjunction with the proposed merger of Independence Blue Cross and Highmark Inc. I have also reviewed the written testimony of Dr. Monica Noether pertaining to this matter dated July 2, 2008 and entitled, "Competitive Analysis of the Proposed Consolidation between Highmark Inc. and Independence Blue Cross in the Commonwealth of Pennsylvania."

II. Valid Concerns Raised by Dr. Noether's testimony.

I find that Monica Noether's written testimony raises several valid concerns about the merger. I will focus on two: (1) Entry into the Pennsylvania health insurance market is difficult, and (2) Independence Blue Cross and Highmark are each other's best potential competitors.

Entry is Difficult

There is no disputing that Independence Blue Cross dominates the eastern Pennsylvania health insurance market, just as Highmark dominates western Pennsylvania. The fact that the two together would have over 70 percent market share statewide reflects their dominance in their respective regions. Indeed, the two plans are likely to argue that they are already monopolists in their respective regions and that this merger does not enhance their market power. This is a short-sighted argument that Dr. Noether's testimony helps to dismiss.

Even monopolists can find that their market power is limited in the long run. This is because the high prices and resulting profits enjoyed by monopolists act a siren call to entrants. Monopolists can sustain their prices and profits only if there are barriers to entry. Dr. Noether offers compelling evidence and theoretical support for the claim that there are substantial barriers to entry in the Pennsylvania health insurance market. The evidence is there for all to see – there has been little successful entry. Health insurers that have successfully competed throughout the nation, including Aetna, Humana, United Healthcare, and Cigna, have barely any presence in Pennsylvania. The theoretical support is well-understood by those who have studied health insurance markets. In addition Sections cited in Dr. Noether's report and dominant insurers can use their monopsony power to suppress the fees they pay

to providers, thereby giving them a cost advantage over potential rivals. Unfortunately for consumers, there is often insufficient competition to force the insurers to pass along these savings to consumers. I agree with Dr. Noether's claim that entry is difficult, and that neither Independence nor Highmark are likely to be disciplined by competitors such as Aetna et al.

Independence and Highmark are Each Other's Best Potential Competitors

Dr. Noether's next observation is profoundly important: Independence and Highmark are best positioned to compete with each other. In the past, they have sold insurance in each other's market areas. They have managed provider networks in each other's market areas. Even today, they have corporate clients who do business statewide and might prefer the convenience of securing insurance from a single carrier. For all of these reasons, Independence and Highmark face lower barriers to entering each other's regions than do other insurers such as Aetna et al. By all rights, they should be competing with each other.

But Independence and Highmark have not entered each other's territories for a simple reason – they have had a written agreement not to do so. The agreement has now expired. This merger represents an effort by Independence and Highmark to permanently cement their agreement not to compete. This effort must not be allowed to succeed.

III. Conclusion

If the merger between Independence and Highmark is blocked, the two insurers will have a natural interest in selling insurance in each other's territories, just as they have done in the past. With statewide corporate clients, they will reestablish their provider networks, breaking down a critical entry barrier. There is no guarantee that they will blossom as competitors for one another, but if the merger goes through, it is guaranteed that competition will be stifled once and for all.





David Dranove
Walter McNeerney Distinguished Professor of Health Industry Management
Northwestern University

July 14, 2008

Exhibit 2

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VOLUME 4

PART TWO - Market Structure Issues

CHAPTER 9 - Mergers: Generally and Horizontal

9A - General Guides to Interpretation

Antitrust Law Para. 907

LENGTH: 980 words

Paragraph 907 - Meaning and Context of "Lessen Competition" Standard

TEXT:

Section 7 of the Clayton Act requires proof that the effect of a merger may be substantially to "lessen competition." On its face this language would appear to require a showing that a market has become or may become less competitive as a result of a merger than it had been before the merger occurred. The language might also be interpreted to mean that a merger that simply preserves the status quo, forestalling future increases in competition, does not meet the statutory standard. Or, as another alternative, it might suggest that if a market is already performing noncompetitively, a merger that produces the result that it continues to perform noncompetitively does not "lessen competition." After all, the market was not competitive before the merger, and it is not competitive after.

But there are good reasons for not reading the Clayton Act requirement that narrowly. First of all, analogous language in § 2 of the Sherman Act has not yielded so restrictive an interpretation. That statute condemns every person "who shall monopolize, or attempt to monopolize" a relevant part of commerce. n1 The word "monopolize" quite clearly refers to the act of creating a monopoly--that is, of acquiring all of the business in a market with the result that the market is no longer competitive. Nevertheless, the Supreme Court has made clear that simply *maintaining* a monopoly by anticompetitive means also constitutes monopolization. n2 For example, the dominant firm with a 100 percent market share that uses an improperly brought patent infringement suit in order to exclude a nascent rival unlawfully "monopolizes" the market--even though the firm's market share was 100 percent before the exclusionary act and 100 percent thereafter.

But there are also reasons of principle and policy for reading § 7 less restrictively. First, the restrictive reading greatly and improperly exaggerates the difference between **actual and**

potential competition. So-called "**potential**" competition is competition "for" the market, while "**actual**" competition is said to be competition "in" the market. But insofar as antitrust policy is concerned, both kinds of competition can be equally "**actual**."

Consider this relatively clear case. The market for a certain type of aircraft operates by competitive bidding between two sellers, each of whom has been making approximately 50 percent of the sales. Now, however, a firm that previously made a different type of aircraft has begun developing facilities for this type as well, and promises to be a bidder on future transactions. At that point, however, one of the incumbent firms acquires this firm, with the result that the market continues to have two bidders instead of expanding to three, which we assume would be more competitive.

It should be clear that this acquisition has "lessened competition," even though a superficial analysis would say that it merely "maintained" competition, or prevented competition from increasing. Once the presence of the third firm became a factor in future predictions about the market, that firm must be counted as a competitor, even though that firm has not yet won its first bid, or indeed, has not yet made any bid at all.

Second, the restrictive reading understates the competitive significance of mergers in markets that are already performing poorly. To illustrate, we give two examples--one in which the firms are behaving oligopolistically before a merger occurs and another in which they have formed an explicit but secret cartel.

In the first situation, suppose that a market contains five firms that are involved in a successful noncooperative oligopoly. n3 Now a merger reduces the players in that market from five to four. The orthodox theory of noncooperative oligopoly shows that, other things remaining equal, as the number of participants in the oligopoly decreases, output decreases and price increases. n4 Thus a merger in such a market can be said to "lessen competition" notwithstanding that competition was not in very good health even before the merger occurred.

In the second situation, suppose that the five firms in a market have organized an explicit but secret cartel. Unlike the noncooperative oligopoly, the organized cartel seeks to establish the same output and price that a single-firm monopolist would set, and this output and price do not vary with the number of cartel members. n5 Under the pure theory of collusion, therefore, a change from a perfectly functioning cartel of five members to a perfectly functioning cartel of four members would have absolutely no impact on either output or price in the affected market.

The operative words in the previous statement are "perfectly functioning." In reality no cartel functions perfectly, and the number and nature of the individual participants contribute much to the imperfections. The more members a cartel has, the greater the difficulty of establishing a consensus on output and price, detecting and punishing cheating, preventing outright defections, and keeping the cartel secret from antitrust authorities. n6 Further, at least some mergers in industries subject to collusion may be designed to rid the market of a "maverick" firm that had previously refused to abide by the cartel's agreement on output and price. n7 As a result, any merger that reduces the number of cartel members by one presumptively meets the "lessen competition" standard even though we might presume that the price and output of a "perfectly functioning" cartel remain the same as the number of cartel members is reduced.

FOOTNOTES:

n1 15 U.S.C. § 2.

n2 E.g., *Eastman Kodak Co. v. Image Tech. Serv.*, 504 U.S. 451, 482 (1992) (speaking of monopolization as "willful acquisition or maintenance" of monopoly power); *Otter Tail Power*

Co. v. United States, 410 U.S. 366 (1972) (litigation for anticompetitive purposes could have been unlawful attempt to maintain monopoly power); United States v. Grinnell Corp., 384 U.S. 563, 570 (1966) (maintenance of monopoly power by exclusionary conduct unlawful).

n3 A "noncooperative" oligopoly is one in which each firm supposedly maximizes its own profits by equating its marginal cost and marginal revenue on the assumption that other firms will hold their output constant. See P404b1 (rev. ed.).

n4 Ibid.

n5 See PP404b2, 405 (rev. ed.).

n6 See P405b (rev. ed.).

n7 See P944c3 (rev. ed.).

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VOLUME 4

PART TWO - Market Structure Issues

CHAPTER 9 - Mergers: Generally and Horizontal

9B - Antitrust Concern with Horizontal Mergers

9B-1 - Mergers Facilitating Single Firm Exercises of Market Power

*Antitrust Law Para. 912***LENGTH:** 1144 words**Paragraph 912 - Monopolist's or Dominant Firm's Acquisition of Nascent Rival; Potential Competition Merger Distinguished****TEXT:**

912a. Generally. The acquisition by an already dominant firm of a new or nascent rival can be just as anticompetitive as a merger to monopoly. If the rival has already made its first sale in the monopolist's market the merger is clearly "horizontal." If the rival has not yet made its first sale, the tendency is to call the acquisition a "**potential competition**" or nonhorizontal merger. n1 But the distinction between "**actual**" and "**potential**" **competition** is readily exaggerated. For example, a firm that has submitted bids against the dominant firm but lost is clearly an "**actual**" competitor, perhaps even forcing the dominant firm to lower its bid in the face of a rival bidder. n2 But even the firm that is preparing to make its first bid or its first sale must be counted as an "**actual**" rival once the entry decision has been made.

Acquisition of such a rival preserves the dominant firm's status, at least until another nascent rival appears on the scene. In most such cases we do not believe it is worthwhile to ascertain the number of rivals or the likelihood or time period in which another nascent rival will appear. The important point is that the acquisition eliminates an important route by which competition could have increased in the immediate future. It thus bears a very strong presumption of illegality that should rarely be defeated.

912b. Differences between Clayton and Sherman Act standards. Section 7 of the Clayton Act condemns mergers that may substantially *lessen* competition. By contrast, § 2 of the Sherman Act reaches acts that merely "maintain" a monopoly. n3 While the distinction is

easily exaggerated, it should not be lost. Some mergers with potential rivals might be thought not to "lessen" competition at all because they neither reduce the number of rivals in the market nor increase the market share of any firm. n4 But when the dominant firm in the market has a market share satisfying the § 2 standards for monopoly or attempt, a "lessening" of competition is not essential to illegality. Such a merger tends to maintain a monopoly by cutting off an avenue of future competition before it has had a chance to develop.

912c. Possible efficiencies defense. n5 In order for a dominant firm to defend its acquisition of a nascent rival on the basis of claimed efficiencies, it would have to show provable efficiencies that could not be brought about by means other than the merger (i.e., "merger-specific" efficiencies) and that do not result from the creation of a monopoly. n6 But provable merger-specific efficiencies from the acquisition of a nascent firm should be quite unusual; in most circumstances the dominant firm could readily duplicate anything that the nascent firm has to offer.

The exceptions are (1) when the nascent firm has a new technology protected by the intellectual property laws that the dominant firm can acquire only by acquiring the firm itself; or (2) when the nascent firm has a substantial position in a different market and the efficiencies result either in that market or else from the combination of ownership controlling the two markets.

On the first, suppose that the dominant firm uses a process that costs \$ 6.00 per unit, but that a tiny rival who has not yet made its first sale in the market develops and patents equally good technology costing only \$ 4.00 per unit. Not being able to license the technology, the dominant firm launches a hostile takeover of the tiny firm itself. We would treat this as little different in principle from a patent monopolist's acquisition of an exclusive right in a competing patent at the center of its power, n7 and thus as presumptively unlawful. n8 To be sure, the acquisition permits the dominant firm to reduce its production costs, but it does so by eliminating competition between the production alternatives. The most likely reason that this market has a chance of becoming competitive is that the nascent firm has technology that will enable it to compete successfully with the dominant firm; nothing prevents the dominant firm from (1) attempting to acquire a nonexclusive license from the nascent firm n9 or (2) if that effort fails, to develop its own alternative technology.

On the second situation noted above, suppose that a firm is nascent in the dominant firm's market but has a significant position elsewhere, and that combining the two firms produces certain efficiencies. For example, in the *El Paso Natural Gas* case n10 the acquiring firm had significant gas fields in Texas, while Pacific Northwest, the acquired firm, had fields in the northern United States and Canada. Although Pacific Northwest had made bids to southern California purchasers, it had not yet won any bids and thus was not an **actual** seller there. In such a case the union of firms could produce significant offsetting efficiencies in the other market. n11 Of course, this raises the problem of the extent to which efficiencies in one market justify anticompetitive results in a different market. n12

912d. Nonexclusive license or compulsory licensing as solution. n13 The discussion of patent acquisitions by monopolists shows that concerns about anticompetitive effects from the dominant firm's acquisition of technology are satisfied by requiring that the dominant firm obtain only a nonexclusive license. n14 The problem is not materially different when the dominant firm seeks to acquire the tiny firm itself rather than its patents or other intellectual property. First, while technology acquisitions can certainly promote efficiencies, a nonexclusive right does so just as well as an exclusive one. Second, if the main concern is that the acquisition threatens to eliminate a rival technology, that threat is taken care of by the nonexclusive license or else by the acquirer's willingness to license all others without royalty--that is, to place the acquired technology in the public domain. To be sure, this may often mean that the acquisition is not worth nearly as much to the acquiring firm, but if the

principal value of the acquisition is the dominant firm's maintenance of its technological hegemony then the only alternative is outright condemnation. n15

FOOTNOTES:

n1 See P701d (rev. ed.) (acquisition of potential rival as Sherman § 2 violation); and Ch. 11B-2 (**potential competition** merger as Clayton § 7 violation).

n2 See, e.g., *United States v. El Paso Nat. Gas Co.*, 376 U.S. 651 (1964); and P1117a.

n3 See P907 (rev. ed.), which cites § 2 cases.

n4 This is particularly true of the "**actual** potential entrant" doctrine. See P1121.

n5 On the efficiencies defense generally, see Ch. 9E (rev. ed.).

n6 Cf. the 1997 revised statement on efficiencies to the 1992 Horizontal Merger Guidelines, § 4.0: "cognizable efficiencies are merger-specific efficiencies that . . . do not arise from anticompetitive reductions in output or service." These Guidelines are reprinted as Appendix A in the Annual Supplement.

n7 See P707a,b (rev. ed.).

n8 As P707d (rev. ed.) notes, however, an acquisition of a nonexclusive right would be legal.

n9 See Pd.

n10 See note 2.

n11 This might occur, for example, if El Paso had substantial facilities in the northern United States as well, and joint operation of the firms' facilities would have reduced costs there. These were not the facts of the **actual** case.

n12 See P972 (rev. ed.).

n13 The same issue arises when the underlying concern is that a large firm's acquisition of a smaller rival's technology might facilitate collusion by forestalling new competition. See P927d3 (rev. ed.).

n14 See P707d (rev. ed.).

n15 See, e.g., *United States v. Baroid Corp.*, 59 Fed. Reg. 2610 (1994) (consent decree conditioning acquisition by large firm of competing technology on the granting of licenses to others); *Westinghouse Elect. Corp.*, 54 Fed. Reg. 8839 (1989) (similar).

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Exhibit 4



Posted on Mon, Jun. 9, 2008

What can happen if Blues compete

In a swath of Pa., Capital and Highmark both offer health insurance. Users have varied opinions.

By Jane M. Von Bergen
Inquirer Staff Writer

When public hearings on the proposed merger of the state's two largest health insurers begin next month, speakers opposed to the deal are sure to complain that a combination of Independence Blue Cross and Highmark Inc. would quash competition.

In the Philadelphia marketplace, Independence Blue Cross dominates its competitors, commanding a lion's share of the business, though both it and Highmark say they need to get bigger to fend off national insurers such as Aetna Inc., which is gaining market share.

Independence has no Blue rival in the region - important in a state such as Pennsylvania, where loyalty to the "Blue" brand is strong.

However, in a broad swath from Harrisburg to Easton, two Blues insurers, Harrisburg's Capital Blue Cross and Pittsburgh's Highmark, are rivals. Besides the Blues, other insurers also have a noticeable presence. Competition not only exists, it is fierce.

And that's just the way car dealer Greg Kelly likes it.

Right now, Kelly has a bid in his office from Capital that would save him \$25,000 to \$30,000 on the annual premium he now pays Highmark to cover 180 employees of Kelly Automotive Group's seven Lehigh Valley car dealerships.

"We have an offer in hand from Capital, but we'll go back to Highmark and see if they can match it," he said. Kelly had been with Capital before, but left it four years ago when Highmark produced a better bid.

"Capital's margins are tight and Highmark keeps them honest," said Kelly's broker, Jonathan P. Warner, of JP Warner Associates Inc., which has offices in the Lehigh Valley and in Wayne.

Now it's contract-renewal time.

"We're getting the best of both worlds," Kelly said. "Can you imagine that happening if there was just one Blue? It would never happen."

In 2007, Capital had a million subscribers enrolled and Highmark had 800,000, according to their annual reports. Capital estimates that the two Blues have two-thirds of the market.

While other insurers, including Aetna and, in the Lehigh Valley, the home-grown Valley Preferred, help create a robust marketplace, the two Blues compete neck-and-neck for the bulk of business.

The Blue rivalry had its roots in the 1996 birth of Highmark, the product of a merger between Blue Cross of Western Pennsylvania and Blue Shield, a statewide insurer for doctor bills.

For decades before the merger, Blue Cross of Western Pennsylvania, Capital Blue Cross, Independence Blue Cross and Blue Cross of Northeastern Pennsylvania all had the same joint operating relationship with Blue Shield. The Blue Cross insurers covered hospital stays; Blue Shield was the insurer for doctor bills.

Several years after the merger, Highmark moved to acquire Capital. But Capital rejected the terms. Highmark ended the relationship, entering what had been Capital's territory as a competitor.

The split began on Sept. 10, 2001, and became final in April 2002.

Both insurers had to scramble to draft contracts with providers. Highmark needed the region's 40 hospitals, which already had deals with Capital. Capital had to sign up the 13,000 doctors and other professionals already affiliated with Highmark.

"This wasn't just competition," said Anita Smith, Capital's president. "This was piranhas - don't-put-your-hands-in-the-water competition."

To Robert Stover, the warfare looked like opportunity. Stover is the chief executive of Medical Associates of the Lehigh Valley, a group of 50 family doctors in 22 locations who together care for 130,000 patients, about a fifth of the total in the region, he said.

His organization negotiates insurance reimbursements for the doctors based on price and service.

"There seemed to be a large stalemate" with Highmark, Stover said. When Highmark's predecessor, Blue Shield, had most of the doctors in the state under contract, there would have been little he could do.

But, as talks continued, Stover prepared an advertisement to run in the papers explaining to Lehigh Valley residents why their doctors would no longer accept Highmark insurance.

"We had a final meeting the day before the advertisement was to run and we showed them the ad," Stover said. "They were horrified." The situation was resolved.

"Now we have a stable marketplace," he said. "There is give and take. They [all] know we can drop them. If you have no ability or inclination to drop a contract, you have no bargaining power."

The rivalry also looked like an opportunity to Elliot Sussman, the chief executive of the Lehigh Valley Hospital and Health Network, one of the area's largest. With two major insurers vying to sign a contract, he was able to punish a third, Aetna, for not meeting the network's terms on reimbursement rates.

Aetna had been an important insurer in the Lehigh Valley. But from 2002 until 2007, the network would not accept Aetna. "It took a little chutzpah to do it," Sussman said. "We were able to do that because of competition in the marketplace."

There are other advantages, Sussman said. When the network decided to expand the outreach of a dental clinic at its hospital in Allentown, Sussman went to the insurers, hat in hand, to fund a \$900,000 mobile clinic. Capital ponied up \$250,000, celebrating the occasion at a news conference attended by children at a local elementary school.

Highmark also has contributed, donating \$100,000 in 2004 for a hospital-run osteoporosis prevention and education program.

Kitty Gallagher had hoped that competition would help her shake loose some key bargaining information.

As president of the Lehigh Valley Business Coalition on Healthcare, she negotiates health insurance for the 32,000 employees and family members of the Lehigh Valley's major employers, including Mack Truck Inc. and PP&L Corp.

"When the divorce first happened, I thought it was very positive," Gallagher said.

Most of her companies self-insure, meaning they pay claims directly. To service them, the insurers negotiate fee schedules with the hospitals and doctors, handle the claims and provide other services, such as disease-management programs.

Gallagher wanted to know what the insurers paid the doctors and hospitals. "We tried to play them all off against each other. I can't tell you how hard we fought toe-to-toe on it," she said. "They held us off."

Without that information, she still negotiates, but she would like to see more transparency.

Family practitioner Samuel Bub, of Emmaus, said competition was good in theory.

"But for the average physician in a small practice, we need to be part of both plans to capture the patients," he said. "A small group is in no position to bargain with either one of them.

"On a day-to-day basis, my focus is to see the patients."

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