Testimony of David Balto
Senior Fellow
Center for American Progress Action Fund

Before the Senate Judiciary Committee, Subcommittee on Antitrust, Competition Policy and Consumer Rights

"Consolidation in The Pennsylvania Health Insurance Industry: The Right Prescription?"

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I appreciate the privilege to testify before you today about the anticompetitive effects that likely will result from the proposed acquisition of Independence Blue Cross by Highmark, Inc.. As I explain in my testimony, the merger will pose a significant threat to competition in the Southeastern Pennsylvania health insurance market by eliminating Highmark as a potential entrant into the market. History has demonstrated that Highmark has the incentive and ability to enter into adjacent markets and that competition has benefitted employers, consumers, and providers. The antitrust laws protect not only ongoing competition, but also the potential competition that would exist but for this merger. Simply put, in answer to the question posed by this hearing, the right prescription for this market is to prohibit this merger.[1]

I have practiced antitrust law for over 20 years, primarily in the federal antitrust enforcement agencies: the Antitrust Division of the Department of Justice and the Federal Trade Commission. At the FTC in the 1990s I was attorney advisor to Chairman Robert Pitofsky and directed the Policy shop of the Bureau of Competition. In private practice and in government service I assisted in the litigation of numerous merger cases including Staples/Office Depot and Heinz/Beechnut. In addition, I regularly represent parties that oppose mergers before the Antitrust Division and the Federal Trade Commission. Most recently, I led a coalition of consumer groups, government entities, unions, and health care providers that opposed United Healthcare's acquisition of Sierra Health Services. My testimony today is based on my years of reviewing proposed mergers as a government enforcer and providing advice and analysis of mergers as a private practitioner.

The alarming trend of Health Insurance Consolidation

Let me begin with some observations about the dramatic trend of health insurer concentration and the alarming lack of antitrust enforcement. In the past seven years an unabated flood of health insurance mergers has led to highly concentrated markets, higher premiums, and lower reimbursement. Skyrocketing premiums have put insurance

[1] My testimony is also supported by the American Antitrust Institute, the Consumer Federation of America, the National Association for the Self Employed, and the U.S. Public Interest Research Group. See attachment for a description of each organization.

out of reach for millions of consumers and thousands of small businesses and the number of uninsured Americans has increased to critical levels: over 47 million, or one out of seven Americans under age 65.[2] As consumers have suffered from egregious deceptive and anticompetitive conduct by insurance companies, those companies have recorded record profits. The problems presented could not be starker or have a more severe impact on consumers.

In the past decade there have been over 400 health insurer mergers and in only two cases has the Department of Justice brought any enforcement action. Besides mergers, the Justice Department has not brought any cases challenging anticompetitive or exclusionary conduct by health insurers, even though numerous private plaintiffs and state attorneys general have challenged this type of conduct. In effect, the insurance companies have gained a newly found "antitrust immunity."

The lack of health insurance merger and nonmerger enforcement is criticized in a forthcoming report by the American Antitrust Institute on antitrust enforcement. They observe:

> The priorities of the health care enforcement agenda need to be realigned to areas with the greatest impact on consumers. Unlike in prior administrations, there is a significant imbalance in enforcement priorities between anticompetitive activity by health insurance companies and healthcare providers. In the seven years of the Bush II administration, all non-merger enforcement actions have involved health care providers, with no enforcement involving health insurers.

The consequences of lax antitrust health insurance enforcement for consumers are clear. The American Medical Association reports that 95 percent of insurance markets in the United States are now highly concentrated and the number of insurers has fallen by just under 20 percent since 2000. These mergers have not led to benefits for consumers: instead premiums have skyrocketed, increasing over 87 percent over the past six years. Small employers have been particularly harmed by skyrocketing premiums and they increasingly find it difficult to offer health insurance coverage.[3] Patient care has been compromised by the over-aggressive efforts of managed care, and the number of uninsured Americans has reached record levels.

A vital component to assuring the competitive marketplace is protecting the ability of consumers to choose between alternatives. Antitrust enforcement against anticompetitive mergers and exclusionary conduct is essential to a competitive marketplace. This unprecedented level of concentration and the lack of antitrust enforcement pose serious

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[2] *See* "Wrong Direction: One out of Three Americans are Uninsured" (Families USA 2007).

[3] Prepared Remarks of Mr. Robert Hughes, President, The National Association for the Self-Employed before the House Small Business Committee Hearings on Health Insurer Consolidation- The Impact on Small Business (Oct. 25, 2007) (Observing that small businesses suffer greater premium increases than large companies and have greater difficulty providing health insurance to their employees).

policy and health care concerns. As Vermont Sen. Patrick Leahy observed in hearings before the Senate Judiciary Committee in 2006 on health insurance consolidation:

> A concentrated market does reduce competition and puts control in the hands of only a few powerful players. Consumers—in this case patients—are ultimately the ones who suffer from this concentration. As consumers of health care services, we suffer in the form of higher prices and fewer choices.[4]

Competition matters: A recent study noted that insurance premiums are 12 percent lower in those markets in which there is comparatively a lower level of concentration than in more concentrated markets.[5]

Congress is currently grappling with the severe problems of the uninsured. The number of uninsured has increased by over 17 million since 2001 and now amounts to over 47 million Americans.
There is a direct relationship between the insurance consolidation and the anticompetitive conduct engaged in by health insurers, and the increasing problem of the uninsured in the United States. Increased concentration and a lack of enforcement have led to skyrocketing premiums, higher deductibles, and higher co-pays. The most severe problems occur simply when employers or employees can no longer afford insurance. Increasingly employers have been forced to scale down insurance or drop insurance altogether. Thus, the number of uninsured individuals has hit a record level. The lack of enforcement has created an environment where the insurance companies act as if they are immune from antitrust scrutiny. This must be reversed.

Perhaps the most striking example is the DOJ's modest enforcement action that permitted the nation's largest insurer United Healthcare Group to acquire Sierra Health Services, the dominant insurance company in Las Vegas. The merger increased United's market share from 14 percent to 56 percent in Las Vegas. After an 11-month investigation of a merger posing an unprecedented level of concentration in perhaps the most vulnerable health care market in the United States, the DOJ chose a modest remedy on a single line of business. Even though the DOJ reviewed millions of pages of documents and conducted over 100 interviews, it failed to address the significant loss of competition in both the sale of commercial insurance and purchase of physician services markets. Ultimately, the Nevada attorney general had to step in and file a separate case in federal court with a 61-page consent order to address some, but not all, of the concerns ignored by the DOJ.[6] However both actions permit United to secure over a 56 percent market

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[4] Statement of Senator Patrick Leahy, Hearing on "Examining Competition in Group Health Care" U.S. Senate Committee on the Judiciary (Sept. 6, 2006).
[5] Testimony of Diane Holder, President and CEO of the University of Pittsburgh Medical Center before the Pennsylvania Insurance Department at 8. ("The health insurance market is no different than any other market in the U.S. An examination of data from 31 states across the country shows the average cost of health insurance premiums in states with higher than average levels of competition are 12% lower than premiums in states with lower than average competitive levels.").
[6] *State of Nevada v. UnitedHealth Group Inc. and Sierra Health Services, Inc.,* Case No. 2:08-cv-00233 (D. NV. 2008). The 61-page Nevada consent order also compelled the divestiture of United's Medicare Advantage business; but went far beyond the DOJ action and addressed competitive concerns involving

share in the Las Vegas commercial health insurance market, positioning it as a firm that can increase premiums, reduce service, and reduce reimbursement to hospitals and physicians leading to a lower level of health care in the fragile Las Vegas health care market.

The proposed merger faced almost unprecedented opposition from government entities, community groups, public interest groups, healthcare alliances, physicians, nurses, employers, and state legislators.[7] After the proposed consent decree was filed by the DOJ, numerous groups including the American Medical Association and other physician groups, the Service Employees International Union, the Honorable Nydia M. Velazquez, Chairwoman, United States House of Representatives Committee on Small Business, and the Honorable Chris Giunchigliani, Commissioner, Board of Commissioners of Clark County, Nevada filed comments under the Tunney Act objecting that the DOJ action was inadequate because:

- It failed to secure relief in the commercial insurance market
- It failed to secure relief in the market for the purchase of physician services
- The action was inconsistent with past DOJ policy
- The merger will lead to lower quality of health care by reducing reimbursement to physicians and hospitals

One of the critical issues raised in the comments was the potential for United to exercise monopsony power, depressing the level of reimbursement for hospitals and physicians. The DOJ's failure to bring an enforcement action based on provider issues seemed inconsistent with past precedent. As representatives of consumers, we recognize the important need to manage health care costs. However, giving insurers greater buying power is not necessarily beneficial for consumers. Health insurers with monopsony power may profit from pushing provider prices "too low" so that consumers do not receive an adequate level of service and quality.[8] As the AMA observed:

> [H]ealth insurers are not true fiduciaries for insurance subscribers. Plan sponsors may have a limited concern over the product based on the cost of the insurance, and not the quality of care. Furthermore, health coverage plans operate in the

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physicians, Clark County, the University Medical Center and the delivery of healthcare to underserved populations. For example, on physician-related concerns, the Nevada decree enjoins the merging parties from enforcing all products and most favored nations clauses in their contracts for a period of two years, prohibits the merging parties from entering into exclusive contracts with physicians for a period of two years, and creates a Physicians Council for the purpose of addressing the relations between United and physicians, among other relief. On commercial insurance concerns, the Nevada decree prevented United from acquiring the largest provider of "administrative services" for self-insured employers.

[7] For example, *see* Jennifer Robison, *MERGERS AND ACQUISITIONS: Buyout sessions conclude.* Las Vegas Rev. J. (July 28, 2007). Twenty-four organizations and individuals ranging from doctors and nurses to business owners, spoke out in opposition to the merger at the Nevada Dept. of Ins. hearings held July 2007. In addition, there was strong opposition to the merger by consumer groups including Consumers Federation of American and the American Antitrust Institute. *See* testimony of David A. Balto before the Nevada Commissioner of Insurance on the UnitedHealth Group proposed acquisition of Sierra Health Services, Inc. (July 27, 2007).

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

> interest of a group, not in the best interest of individual patients. Consequently, health insurers can increase profits by reducing the level of service and denying medical procedures that physicians would normally perform based on professional judgment. In the absence of competition among insurers, patients are more likely to pay for these procedures out-of-pocket or forego them entirely. Ultimately, the creation of monopsony power from a merger can adversely impact both the quantity and quality of health care.[9]

These Tunney Act filings were voluminous and the commentators' arguments were supported with a broad range of evidence that included surveys and expert testimony. Unfortunately, the DOJ refused to respond to the concerns about commercial insurance or provider issues raised by the commentators suggesting that "[b]ecause the United States did not allege that the United's acquisition of Sierra would cause harm in additional markets, it is not appropriate for the Court to seek to determine whether the acquisition will cause anticompetitive harm in such markets." As described in the AMA comment that argument was inconsistent with Congress' intent in amending the Tunney Act. Moreover, the DOJ's silence is simply inconsistent with its policy of articulating reasons for not bringing enforcement actions.[10] Simply, all consumers, nurses, doctors, and health care providers deserve to have their questions answered by the chief antitrust enforcement official about why this merger did not pose substantial competitive concerns.

The proposed Highmark/Independence Blue Cross merger

Today's hearing evaluates the proposed Highmark/Independence Blue Cross merger. The merger will combine the two largest health insurers in Pennsylvania and create a firm with over 8 million beneficiaries and $23 billion in revenue. The merger will create the largest insurer in Pennsylvania with over a 73 percent market share, far outdistancing the next closest competitor. Highmark is based in western Pennsylvania and IBC is based in southeastern Pennsylvania. Highmark also has operations in central Pennsylvania and has an ownership interest in Northeastern Blue Cross.

The most straightforward concerns are raised when firms are direct competitors. In this case, there is some evidence that Highmark and IBC compete directly, even though the commercial business of each appears geographically dispersed:

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[9] Comments of the Amer. Med. Ass'n. on the Proposed Consent Order, *United States of America v. UnitedHealth Group Inc. and Sierra Health Services, Inc.*, Case No. 1:08-cv-00322 (D.D.C. 2008). at 9.

[10] Providing clarity on the reasons not to bring an enforcement action in these markets is consistent with the Division's policy on "Issuance of Public Statements Upon Closing of Investigations," *available at* http://www.usdoj.gov/atr/public/guidelines/201888.htm (factors that will lead to the issuance of a closing statement include "whether the matter has received substantial publicity [and] the value to the public in receiving information regarding the reasons for non-enforcement (including public trust in the Department's enforcement, and the value of the analysis for other enforcers, businesses and consumers)"). DOJ has issued closing statements in other health insurance mergers. *See* DOJ Press Release No. 04-497 (statement closing investigation of UnitedHealth's acquisition of Oxford Health Plans), a*vailable at* http://www.usdoj.gov/atr/public/press_release/2004/204674.htm.

- Both firms compete for certain Medicaid programs. In the Medicaid managed care market the parties admit that in the Lehigh/Capital zone, Highmark and IBC subsidiaries are two of the three competitors with a market share of over 77 percent.[11] These two firms are also direct competitors in the voluntary Medicaid managed care program in several counties.
- Many employers in southeastern Pennsylvania must provide coverage in central Pennsylvania because their employees commute from central Pennsylvania.

The parties attempt to justify their merger based on two arguments: first, they argue that since there is no direct geographic overlap there is no loss in competition. Second, the parties suggest that there will be very substantial cost savings from the merger, which the parties have committed to pass on in the form of benefits for the community.

The significant loss of potential competition will harm consumers

It is a settled principle of antitrust law and economics that potential entrants can constrain the ability of actual competitors to exercise market power. Consequently, mergers and other consolidations of current competitors and potential entrants that eliminate the procompetitive effects of potential competition can harm competition — particularly if the potential entrant is one of a relatively small number of firms with the capacity and incentive to enter the market, the market is concentrated, and high barriers to entry are likely to deter other new entrants. In appropriate circumstances, the courts have enjoined such consolidations to preserve the procompetitive benefits of potential competition.[12]

> As Justice Potter Stewart observed over a quarter of a century ago:
> The central message of the Sherman Act is that a business entity must find new customers and higher profits through internal expansion — that is, by competing successfully rather than by arranging treaties with its competitors.[13]

As the Supreme Court observed in *United States v. Penn-Olin* "[t]he existence of an aggressive, well equipped and well financed corporation engaged in the same or related lines of commerce waiting anxiously to enter an oligopolistic market would be a substantial incentive to competition which cannot be underestimated."[14]

One example where a merger was challenged, in part, because of potential competition concerns was Staples' proposed acquisition of Office Depot that was successfully

[11] Statement Regarding Compliance with the Competitive Standard of 40 P.S. Section 991.1403(d).
[12] *Yamaha Motor Co., Ltd. v. Federal Trade Commission*, 657 F.2d 971 (1981), *cert. den'd* 452 U.S. 915 (1982); *see also United States v. Marine Bancorporation*, 418 U.S. 602 (1974), *Engine Specialties, Inc. v. Bombardier Ltd,* 605 F.2d 1 (1979).
[13] *United States v. Citizens & S. Nat'l Bank*, 422 U.S. 86, 116 (1975).
[14] *United States v. Penn-Olin Chem. Co.*, 378 U.S. 158, 174 (1964).

challenged by the FTC in 1996.[15] The merger focused on the 30 or so markets where the firms competed head to head. But both firms were successful and expanding and based on their past history it was reasonable for them to invade each other's territories. The court enjoined the merger both because of the potential loss of actual and potential competition. As to potential competition it observed:

> Since prices are significantly lower in markets where Staples and Office Depot compete, eliminating this competition with one another would free the parties to charge higher prices in those markets, especially those in which the combined entity would be the sole office superstore. In addition, allowing the defendants to merge would eliminate significant future competition. Absent the merger, firms are likely, and in fact have planned, to enter more of each other's markets, leading to a deconcentration of the market and, therefore, increased competition between the superstores.[16]

The *Staples* decision offers an important lesson for this hearing. Within a few years both firms grew sufficiently through internal expansion to achieve most, it not all of the efficiencies sought by proposed merger.

Under the law there are two separate theories of potential competition: "perceived potential competition" theory and the "actual potential competition" theory. When the law speaks of "perceived potential competition," the concern is that competition will be harmed by the elimination of a firm that currently constrains anticompetitive conduct because it is a potential entrant in the market. Elimination of the potential entrant through merger may eliminate that threat, enabling the remaining firms to raise prices, reduce output or lower service. When the law speaks of "actual potential competition" the concern is that competition will be harmed by eliminating a firm through merger that but for the merger would independently enter the market. The injury to competition stems from this preemption of actual entry that would lead to a more competitive market. Today I will focus on the actual potential competition theory.

There are several reasons why there are significant concerns over the loss of potential competition from the proposed merger. First, IBC and Highmark's predecessors used to compete in southeastern Pennsylvania prior to a 1996 acquisition. As part of that acquisition IBC and Highmark entered into a 10-year "truce" not to invade each other's territories. Not surprisingly this transaction was announced within a few weeks after the 10-year truce expired. Perhaps part of the motivation for the transaction was to make sure that competition did not break out.

As Anita Smith, the President and CEO of Capital Blue Cross testified before the Pennsylvania Senate Banking and Insurance Committee:

> Highmark and IBC do not compete because they agreed not to compete in 1996. And now that agreement is expired. If they wanted, they could

[15] *FTC v. Staples, Inc*., 970 F. Supp. 1066 (D.D.C. 1997).
[16] *Id*. at 1082.

> compete right now. Today. We could have vibrant competition between these companies in southeastern Pennsylvania this very minute. Their merger is their effort to make permanent their agreement not to compete. And they want you to help them do it.[17]

Often making a prediction about likely entry and the impact of that entry can be a difficult process. This is not be such a case. There is compelling evidence that Highmark has the incentive and ability to enter and this entry would improve competition in the market. First, Highmark's CEO has been explicit that his goal is to create a single firm to provide services statewide and become the sole Blue Cross firm in the state.[18]

Second, the procompetitive impact of entry seems indisputable. Here history provides a powerful example of both the likelihood and impact of Highmark's entry into southeastern Pennsylvania. In 2002, Highmark severed a joint operating agreement with Capitol Blue Cross and invaded its territory of Central Pennsylvania and the Lehigh Valley. Within six years Highmark has secured over 33% of the market. Highmark's expansion resulted in greater competition, lower premiums and improved service and CBC and Highmark battled head-to-head for subscribers, employers, and providers.[19]

The DOJ/FTC *Merger Guidelines* identify three threshold tests in deciding whether to challenge a transaction based on injury to potential competition. The agencies are "unlikely to challenge a potential competition merger" unless (1) the acquired firm's market is highly concentrated (HHI above 1,800); (2) entry barriers in that market are high, so that firms without specific entry advantages cannot be expected to enter; and (3) the acquiring firm's entry advantage is possessed by fewer than three firms. The *Guidelines* describe the effects of actual potential competition as ones where "the merger could result in a lost opportunity for improvement in market performance resulting from the addition of a significant competitor."[20] Each of these factors seem clearly present in this merger.

- The Southeastern Pennsylvania health insurance market is clearly highly concentrated. IBC dominates the market with a market

[17] *See* January 20, 2008 Testimony of Anita M. Smith at 1.

[18] "We wanted to have a statewide capability because of movement from local purchasing decisions [by customers] to decisions made more on a statewide and multistate basis.' ("Talking With Ken Melani," *Harrisburg Patriot News*, July 22, 2007, C08). "I personally believe it makes sense to have one statewide Blue Cross-Blue Shield organization. We'll work very hard to prove [our merger with IBC] works. Hopefully, it will further demonstrate to Capital and Northeastern that [merging the Blue Plans is] the right thing to do." ("Talking With Ken Melani," *Harrisburg Patriot News*, July 22, 2007, C08.)

[19] In testimony before the Pennsylvania Insurance Department Mr. Melani has suggested that Highmark's operations are not profitable in Central Pennsylvania. The fact those operations are less profitable than in Western Pennsylvania, where Highmark is dominant, suggests that the Central Pennsylvania market is far more competitive.

[20] 1984 GUIDELINES, at_§4.112.

share of over 71 percent. There are only four other competitors in the market and the positions and market shares of those firms have been relatively stable for several years. This is clearly the type of oligopolistic market in which potential competition concerns are particularly important.

- The market has substantial entry barriers. As detailed in the expert testimony of Dr. Monica Noether, numerous firms have attempted to enter into the area and have failed—including, Health Plans of Pennsylvania; Horizon Healthcare of Pennsylvania; and Health Systems International.[21] What is striking about each of these failed entries is that each of these firms adopted different approaches to entry. Moreover, most national health insurers have been unable to establish even a minimal presence in the market. This is striking considering that Philadelphia and the Southeastern Pennsylvania area, is one of the most economically sound and fastest growing markets in the state. This strongly suggests that only another Blue Cross plan can be an effective entrant into the market.

- Finally, the history of Highmark's successful entry into Central Pennsylvania and the failed entry of several firms in Southeastern Pennsylvania demonstrates that Highmark is one of a very small set of firms capable of entering into the market.

- Highmark already has a network of healthcare providers in the market that provides Highmark a substantial advantage over other potential entrants. Highmark has an active statewide network of professional medical providers, including in the Southeast, because it has the statewide Blue Shield license. Traditionally, Blue Shield was the physician insurance and Blue Cross was the hospital insurance. Now, an insurer can offer full-line insurance with either a Blue Shield or Blue Cross license. Because Highmark has a statewide Blue Shield license, they can offer full-line health insurance in any part of the state. When Highmark entered Central Pennsylvania to compete with Capital Blue Cross, Highmark already had a network of physicians. Thus, Highmark only had to contract with hospitals to set up a hospital network in that region in order to independently offer full-line health insurance. Similarly, in order to offer full-line health insurance in the Southeastern Pennsylvania, Highmark needs only to contract with a relatively smaller number of hospitals for hospital services.

Let me close this discussion with an observation about the types of evidence in a potential competition case. The Clayton Act is an incipiency statute and as such it

[21] Testimony of Dr. Monica Noether, Competitive Analysis of the Proposed Consolidation between Highmark, Inc. and Independence Blue Cross (July 2, 2008).

deals with "probabilities and not certainties." In a potential competition case there can be "subjective evidence" of the parties' intent on entry and "objective evidence" focusing on more objective factors about the parties' incentives and abilities.[22]

Highmark has argued that subjective evidence is critical, suggesting that it is unlikely Highmark would enter the Southeastern Pennsylvania market since it lacks the intent to enter. But years of antitrust jurisprudence has been justifiably skeptical of such subjective evidence, especially in potential competition cases.[23] In this case, one should be particularly skeptical of such an assertion since it is contrary to Highmark's intent of becoming a statewide provider.

Objective evidence is typically given far greater weight. Thus, courts look for "objective evidence" such as the parties' expertise, financial wherewithal, previous attempts at entry, plans, and market conditions. Many of these facts are not public, but should be scrutinized through a thorough review by antitrust officials.[24] But Highmark's financial status, recent actions in entering into central Pennsylvania, entering into other markets, and unique ability to enter the market present strong objective evidence that it is a significant potential entrant.

The proposed efficiencies do not outweigh the competitive harm

Highmark and IBC contend that the consolidated company will save about $1.1 billion over the next six years. Of this total, they attribute $820 million to increased economies of scale, while $285 million stems from reducing the cost of pharmaceuticals. Moreover, the parties commit to direct $650 million of those savings to expand health insurance coverage for the uninsured in the Commonwealth.

At the outset we should recognize the importance of the commitment the parties have made to improve healthcare insurance coverage for the uninsured. As far as I know no other health insurers have made as substantial a commitment to the uninsured in any prior health insurance merger. With the chronic and increasing number of uninsured, the

[22] Darren Bush and Salvatore Massa, "Rethinking the Potential Competition Doctrine, " 2004 Wis. L. Rev. 1035 (2004).

[23] *See United States v. Phillips Petroleum Co.*, 367 F. Supp. 1226, 1238 (C.D. Cal. 1973)("It will thus be in a company's self-interest to present subjective evidence of a lack of any intent to enter the market unilaterally and of a lack of any effect on the competitive behavior of firms in the market arising from the company's presence on the edge of the market."); *see alsoUnited States v. Falstaff Brewing Corp.*, 410 U.S. 526, 548 (1973)("where…strong objective evidence indicates that a firm is a potential entrant into a market, it is error for the trial judge to rely solely on the firm's subjective prediction of its own future conduct."); *Federal Trade Commission v. Procter & Gamble Co.*,386 U.S. 568 (1967).

[24] Claims that a firm is unlikely to enter a market but be evaluated carefully, including securing documents and testimony of company officials through compulsory process. A firm's claim that it has no intent to enter a market may be self-serving. We are concerned that level of scrutiny may not have occurred. It appears that the DOJ closed both of its investigations of the merger within 60 days after the Hart-Scott-Rodino filings were made, providing insufficient time for the agency to issue a Second Request for additional information.

parties should be commended for this commitment. Hopefully it will serve as a model for future mergers. Nevertheless, these efficiencies fall short.

The legal standard for the efficiencies defense is straightforward. Highmark must demonstrate that efficiencies are: (1) merger-specific; (2) cognizable and verifiable; and (3) sufficient in magnitude to reverse the anticompetitive effects of the merger.[25] Merger-specific means they must be "likely to be accomplished with the proposed merger and unlikely to be accomplished in absence of either the proposed merger or another means having comparable anticompetitive effect."[26] The claimed efficiencies cannot be efficiencies that could "be achieved by either company alone."[27] Moreover, because "information relating to the efficiencies is uniquely in the possession of the merging firms," the merging firms carry the burden of proof on efficiencies.[28] The alleged efficiencies cannot meet this standard.

Here there are significant reasons to be skeptical of the parties' efficiency arguments. First, as to the pharmaceutical costs, there is no reason to believe that combining Highmark and IBC will lead to savings of that magnitude. Pharmaceutical manufacturers give discounts based on the significance of a payor in a given geographic market. Simply combining the purchases of two geographic disperse payors will not necessarily lead to greater discounts. Moreover, even if it was the case that combining purchasing would lead to greater discounts such savings are not merger-specific. IBC, Highmark and even other insurers could achieve similar cost savings through a group purchasing arrangement.

The vast majority of the savings are from reductions in administrative costs. But the evidence from past health insurance mergers is that these savings rarely occur. As Professor Lawton Burns observed in testimony about this merger:

> [T]he recent historical experience with mergers of managed care plans and other types of enterprises does not reveal any long-term efficiencies.
>
> [E]ven in the presence of [efforts to achieve cost-savings] and defined post-integration strategies, scale economies and merger efficiencies are difficult to achieve. The econometric literature shows that scale economies in HMO health plans are reached at roughly 100,000 enrollees…. Moreover, the provision of health insurance (e.g., front-office and back-office functions) is a labor-intensive rather than capital-intensive industry. As a result, there are minimal economies to reap as scale increases…. Finally, there is little econometric evidence for economies of scope in these health plans – e.g., serving both the commercial and

[25] *1992 Merger Guidelines § 4; see also FTC v. H.J. Heinz,* 246 F.3d at 720- 21 (D.C. Cir. 2001)("a rigorous analysis" is required to ensure that the claims "represent more than mere speculation and promises"); FTC v. *Swedish Match,* 131 F. Supp.2d 151, 172 (D.D.C. 2000) (rejecting efficiencies claims that were "at best speculative"); *Staples,* 970 F. Supp. at 1089 (rejecting efficiencies claims that were not verifiable, credible or reliable).
[26] *1992 Merger Guidelines § 4.*
[27] *FTC v. Heinz*, 246 F.3d 708, 722 (D.C. Cir. 2001).
[28] *1992 Merger Guidelines § 4.*

> Medicare populations. Serving these different patient populations require different types of infrastructure. Hence, few efficiencies may be reaped from serving large and diverse client populations. Indeed, really large firms may suffer from diseconomies of scale.[29]

In fact, a recent analysis of mergers of Blue Cross plans over the past several years found little evidence that these mergers resulted in significant administrative savings.[30]

Conclusion

The Pennsylvania health insurance market is dominated by Highmark and IBC. Even though they currently are based in two different ends of the state, permitting their merger would perminantly extinguish the opportunity for competition which has brought substantial benefits to Central Pennsylvania. Based on the dominant position of Highmark and IBC and the history of failed entry, it is highly unlikely any other firm could successsfully enter these markets and improve competition. The right prescription for health insurance competition in Pennsylvania is to prohibit this merger.

[29] Testimony of Professor Lawton R. Burns regarding the Highmark/Independence Blue Cross Merger, before the Senate Judiciary Committee (April 9, 2007).
[30] Testimony of Diane Holder, President and CEO of the University of Pittsburgh Medical Center at 6-7.

American Antitrust Institute

The American Antitrust Institute ("AAI") is an independent Washington-based non-profit education, research, and advocacy organization. Their mission is to increase the role of competition, assure that competition works in the interests of consumers, and challenge abuses of concentrated economic power in the American and world economy.

U.S. Public Interest Research Group

U.S. Public Interest Research Group ("US PIRG") serves as the federation of non-profit, non-partisan state PIRGs, with over one million members nationwide. Achieving safe, affordable health care is a priority issue for the PIRGs.

Consumer Federation of America

The Consumer Federation of America ("CFA") is the nation's largest consumer-advocacy group, composed of over 280 state and local affiliates representing consumer, senior citizen, low income, labor, farm, public power and cooperative organizations, with more than 50 million individual members. CFA represents consumer interests before federal and state regulatory and legislative agencies and participates in court proceedings.

National Association for the Self-Employed

Then National Association for the Self-Employed ("NASE") represents hundreds of thousands of entrepreneurs and micro-businesses, and is the largest nonprofit, nonpartisan association of its kind in the United States. NASE supports the interests of the self-employed with benefits and advocacy initiatives aimed at leveling the playing field between these businesses and larger corporations.