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INTRODUCTION

Health care is an inherently irrational market. Unlike any other consumer market, the demand for health care is irregular and unpredictable. Illness knows no economic boundaries. Individuals do not receive advance notice as to when illness will arrive, evidence of health care˘s spontaneity˘s dismantling effect. Illness creates an immediacy for action that is unparalleled to any other market. With illness, our physical and mental abilities, our livelihoods, and our lifestyles are at risk and that risk exists for all. Due to health˘s unpredictable nature, but ubiquitous societal need, health care insurers are continuously challenged to craft successful markets around such volatility.

The Affordable Care Act (ACA),[1] market pressures, and growing provider consolidation have created the opportunity for proposed mega-health insurance mergers between Aetna and Humana and Anthem and Cigna.[2] While antitrust laws will evaluate these proposed mergers, whether the agencies enforcing these laws will ultimately prevent this potential competitive oligopoly remains unknown. If the proposed mergers pass antitrust regulators˘ approval process, these transactions would produce three mega-insurance companies dominating the health insurance market, forcing health systems to keep the reimbursement arms race even by consolidating. In their current roles, insurance companies pressure providers to keep costs

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1. Patient Protection and Affordable Care Act, 42 U.S.C. í 18001 (2010).

2. Aetna to Acquire Humana for $37 Billion, Combined Entity to Drive Consumer-Focused, High-Value Healthcare, AETNA (July 3, 2015), https://news.aetna.com/news-releases/aetna-to-acquire-humana-for-37-billion-combined-entity-to-drive-consumer-focused-high-value-health-care/; Anthem Announces Definitive Agreement to Acquire Cigna Corporation, ANTHEM, INC. (July 24, 2015), http://ir.antheminc.com/phoenix.zhtml?c=130104&p=irol-newsArticle&ID=2070832.

low, while providers in fee-for-service models are paid more, the more care they deliver.[3] The ever-increasing fight for economic dominance between providers and insurers will ultimately split when providers break independent from insurers and take on new roles as payors. This article argues that the approval of these mergers will drive health care providers and systems to create their own health plans, taking on full risk for patients. This article proposes that provider-owned health plans will effectively eliminate the need for the traditional third-party insurance intermediary. With incentives internally aligned, the tension to provide less care from the insurers, or to provide more care from the providers, will be alleviated by aligned incentives of having both roles served by the same entity. This change will render insurance companies, in their current roles, obsolete.

This article proposes that in response to proposed mergers, providers, specifically hospitals, will create their own insurance companies, building a model that encompasses both the delivery and financing of health care, achieving high-quality, low-cost care. Part I of this article will discuss the possible health insurance landscape upon the approval of the proposed insurer mergers and the drivers that are accelerating the consolidation trend amongst health insurance companies. Part II of this article will discuss the concerns associated with this insurance consolidation trend. Part III of this article will discuss the antitrust laws that are used to evaluate proposed mergers, the status of the mergers today, and how they will likely move forward. Part IV will propose that as a result of the new responsibilities, payment structures, and reimbursement pressures within the reformed health care delivery system, health care systems should seize on the opportunity to expand their roles beyond that of provider, entering the health insurance business and providing competition to potential `mega-insurers._

I. BACKGROUND

The recent announcement that the top five health insurers plan to merge to just three has generated concerns about the deals˘ impact on the healthcare market.[4] On July 3, 2015, Aetna and Humana announced the definitive

3. See Should the U.S. Move Away from Fee-for-Service Medicine, WALL STREET J. (Mar. 22, 2015, 11:00 PM), http://www.wsj.com/articles/should-the-u-s-move-away-from-fee-for-service-medicine-1427079653 (noting that under the fee-for-service reimbursement model, `providers stand to make more money the more tests and procedures they perform_); see also Julie Barnes, Moving Away from Fee-for-Service, ATLANTIC (May 7, 2012), http://www.theatlantic.com/health/archive/2012/05/moving-away-from-fee-for-service/256755/ (noting that under a fee-for-service model, payors reimburse providers for all services `regardless of their impact on patient health_ and describing the fee-for-service payment system as the `culprit behind exponential health-care cost growth_).

4. Steve Sternberg, Health Insurer Mergers Signify Shift in Health Care Marketplace, U.S. NEWS (Aug. 21, 2015, 1:23 AM), http://www.usnews.com/news/articles/2015/08/21/

agreement whereby Aetna will acquire all of Humana˘s outstanding shares for $37 billion.[5] In December 2015, Anthem proposed to purchase Cigna for $54 billion.[6] If these proposed mergers are approved, the healthcare industry will be left primarily with three mega insurance companies: Aetna, Anthem, and UnitedHealth Group.[7] Each of the three main players would possess a net worth of $100 billion if the anticipated mergers receive approval.[8]

As of February 2016, the transaction between Aetna and Human secured ten out of the twenty needed state insurance approvals.[9] Aetna˘s acquisition of Humana focuses on aligning Humana˘s growing Medicare Advantage health plan business with Aetna˘s diversified commercial capabilities.[10] While Aetna˘s business is spread throughout employers, Medicare, and Medicaid,[11] if Aetna˘s acquisition of Humana is approved, `Aetna would become the largest provider of Medicare advantage plans._[12]

The unprecedented consolidation among health plans caused the shareholders of Anthem and Cigna to approve Anthem˘s purchase of Cigna¯ a stock acquisition plan that could potentially create the nation˘s largest health insurance company.[13] Anthem is a Blue Cross and Blue Shield plan provider and has a strong presence in the individual, small-employer, and multistate-employer health insurance marketplace.[14] Cigna has a

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health-insurer-mergers-signify-shift-in-health-care-marketplace.

5. Aetna to Acquire Humana for $37 Billion, Combined Entity to Drive Consumer-Focused, High-Value Health Care, AETNA, https://news.aetna.com/2015/08/aetna-to-acquire-humana/ (last visited Feb. 12, 2016).

6. Bruce Japsen, Anthem, Cigna Shareholders Approve Merger as Antitrust Hurdles Await, FORBES (Dec. 3, 2015, 11:06 AM), http://www.forbes.com/sites/brucejapsen/2015/12/03/antitrust-hurdles-await-anthem-cigna-after-shareholders-approve-merger/#550ce55067b0.

7. Swarup Gupta, Health Insurance Consolidation Heats Up: 4 Stock Choices, ZACKS INVESTMENT RES. (Sept. 22, 2015), http://www.zacks.com/stock/news/190956/health-insurance-consolidation-heats-up-4-stock-choices.

8. Id.

9. Kshitiz Goliya, Aetna Gets Florida Insurance Regulator˘s Approval for Humana Deal, REUTERS (Feb. 15, 2016, 10:38 PM), http://www.reuters.com/article/us-humana-m-a-aetna-idUSKCN0VP09X.

10. AETNA, supra note 5; Anna Wilde Mathews & Brent Kendall, Health Insurers Aetna, Anthem Defend Deals, Say Markets Will Stay Competitive, WALL STREET J. (Sept. 22, 2015, 12:48 PM), http://www.wsj.com/articles/aetna-anthem-defend-insurance-deals-contend-markets-will-remain-competitive-1442938512.

11. Bob Herman, Potential Insurance Mergers Could Spur More Provider Consolidation, MODERN HEALTHCARE (June 20, 2015), http://www.modernhealthcare.com/article/20150620/MAGAZINE/306209961 [hereinafter Herman, Potential Insurance Mergers].

12. Ana Radelat, AMA Asks Justice Department to Block Aetna-Humana, Anthem-Cigna Mergers, CT MIRROR (Nov. 12, 2015), http://ctmirror.org/2015/11/12/ama-asks-justice-department-to-block-aetna-humana-anthem-cigna-mergers/.

13. Japsen, supra note 6.

14. Anna Wilde Mathews & Liz Hoffman, Anthem Agrees to Buy Cigna for $48.4 Billion, WALL STREET J. (July 24, 2015, 6:55 PM), http://www.wsj.com/articles/anthem-agrees-to-

commanding focus in the larger-employer health plan marketplace, specifically overseas.[15] Anthem and Cigna are the second and fifth largest revenue-producing health insurers, and the merger would generate a large impact in commercial health insurance, or health insurance provided to employers and consumers.[16] Although the merger still requires approval from federal regulators, the transaction is expected to close in 2016.[17] Cigna˘s CEO states that the two companies have `very complementary strengths_ and that `the companies˘ strongest markets are generally not in the same places._[18] Anthem and Cigna claim their merger deal will improve the cost of insurance and produce a broad range of health insurance products and services.[19] The merger of Anthem and Cigna would knock UnitedHealth Group (UHG) to the second largest health insurance company by enrollment.[20]

The idea that the five largest health insurance companies could shrink to just three mega-insurance companies has caused worry amongst consumers, providers, and the healthcare industry as a whole.[21] Given the potential global impact on the healthcare market, it is imperative these deals are critically evaluated.[22]

A. Drivers of Insurance Consolidation

Everyone will need medical care at some point. What remains uncertain is what kind of care, when that care will be needed, or how much that care will cost. To further complicate the issue, health care is a non-transparent market.[23] Unlike a hair salon, a restaurant, or a car dealership, few providers post prices for treatment and even if they did, higher prices do not necessarily correlate with higher-quality care.[24]

To help individuals prepare for their inevitable healthcare needs, the ACA

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buy-cigna-for-48-billion-1437732331.

15. Id.

16. Id.

17. Japsen, supra note 6.

18. Mathews & Hoffman, supra note 14.

19. Id.

20. Japsen, supra note 6. UnitedHealth Group Inc. is the largest revenue-producing health insurer and has, so far, avoided the merger wave. Mathews & Hoffman, supra note 14.

21. Japsen, supra note 6.

22. Leemore S. Dafny, Evaluating the Impact of Health Insurance Industry Consolidation: Learning from Experience, COMMONWEALTH FUND (Nov. 20, 2015), http://www.commonwealthfund.org/publications/issue-briefs/2015/nov/evaluating-insurance-industry-consolidation.

23. Molly Gamble, How Much Should We Expect Healthcare to Mimic Other Industries?, BECKER˘S HOSP. REV. (Aug. 13, 2013), http://www.beckershospitalreview.com/hospital-management-administration/how-much-should-we-expect-healthcare-to-mimic-other-industries.html.

24. Id.

sought to increase access to health insurance through expansion of Medicaid and state-based insurance exchanges.[25] The ACA created state-based marketplaces in an effort to cultivate competition and options for consumers and incentivize insurers to participate.[26] To encourage quality-producing collaboration, the ACA incentivized providers to create coordinated systems of care through the Medicare Shared Savings Program.[27]

This shift in how consumers acquire health insurance coverage created instability in the marketplace.[28] While insurers attempted to navigate the new state and federal exchange standards, providers began consolidating to transition their care models to coordinate care and reimbursement structures.[29] As each player tried to stay relevant in this new marketplace, providers saw mergers and acquisitions as an opportunity to gain market share and meet coordinated-care standards.

Although the ACA is often cited as a main driver of recent consolidation in the healthcare market,[30] consolidation in the market was `well under way_ before the passage of the ACA.[31] In the 1980s and 1990s, public and private payors rapidly adopted managed care as a way to decrease healthcare costs through restricting utilization and limiting access to specialty providers.[32]

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25. David Cusano & Kevin Lucia, Implementing the Affordable Care Act: Promoting Competition in the Individual Marketplaces, COMMONWEALTH FUND (Feb. 4, 2016), http://www.commonwealthfund.org/publications/issue-briefs/2016/feb/aca-competition-individual-marketplaces.

26. 42 U.S.C. í 18041 (2010).

27. 42 U.S.C. í 1395jjj (2010).

28. Robert Pear & Abby Goodnough, Instability in Marketplaces Draws Concern on Both Sides of Health Law, N.Y. TIMES (Nov. 27, 2015), http://www.nytimes.com/2015/11/28/us/politics/instability-in-marketplaces-draws-concern-on-both-sides-of-health-law.html?_r=0.

29. John Santilli & F. Randy Vogenberg, Key Strategic Trends that Impact Healthcare Decision-Making and Stakeholder Roles in the New Marketplace, 8 AMER. HEALTH & DRUG BENEFITS 15, 16¯18 (Feb. 2015), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4415172/pdf/ahdb-08-015.pdf. William Walters, the CEO of the Acute Long Term Care Hospital Association, noted that the wave of provider mergers `is less about market leverage and much more about regulatory uncertainty and the lack of other options to pursue growth._ Jessica Zigmond, First Consolidation, Then Consolidation, MODERN HEALTHCARE (Sept. 26, 2011), http://www.modernhealthcare.com/article/20110926/magazine/309269936. Walters further noted that providers are consolidated as a way to `position themselves for the future_ in order to provide a wider range of services through accountable care organizations or bundled payments. Id.

30. See Christopher M. Pope, How the Affordable Care Act Fuels Health Care Market Consolidation, HERITAGE FOUND. (Aug 1, 2014),
http://report.heritage.org/bg2928 (arguing consolidation in health care is due to the ACA˘s anti-competitive policies and not natural market forces).

31. Dafny, supra note 22.

32. Ronald Lagoe et al., Current and Future Developments in Managed Care in the United States and Europe, HEALTH RES. & POL˘Y SYS. (2005), http://health-policy-systems.biomedcentral.com/articles/10.1186/1478-4505-3-4 (`The proportion of employees in large firms (those with more than 200 employees) enrolled in managed care plans grew

Managed care organizations (MCO) negotiated contracts with providers for lower rates in exchange for greater volume of patients.[33] MCOs and corresponding health plans were successful in cutting costs in a variety of settings.[34]

In response to the success of managed care, insurance companies merged and bought out smaller provider groups in an effort to increase profit.[35] To counter the narrowly drafted contracts, hospitals consolidated[36] to create integrated networks that could increase both system efficiencies and negotiating power.[37]

By the late 1990s and early 2000s, however, consumers were outraged with denials and inconsistent coverage decisions that corresponded with managed care.[38] The pushback against managed care led to loosening of restrictions, dissolution of MCOs, and a correlating increase in healthcare costs.[39] The wave of provider mergers that occurred under managed care waned in the early 2000s, but the ACA rejuvenated the trend.[40] While the ACA did not create the wave of consolidation, it created a landscape that encouraged it. Smaller profit margins, coupled with the higher costs of complying with the ACA˘s reforms, have pushed both providers and payors toward greater integration and consolidation.[41]

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from 5 percent in 1984 to 50 percent in 1993. As the use of managed care spread, interest in traditional indemnity plans declined. By 1998, only 14 percent of employees in large firms were enrolled in indemnity insurance plans._).

33. Health Care Costs and Managed Care, MICH. IN BRIEF, http://www.michiganinbrief.org/edition07/Chapter5/HealthCareCosts.htm (last updated Apr. 1, 2002).

34. Id.

35. Peter D. Fox & Peter R. Kongstvedt, A History of Managed Care and Health Insurance in the United States, in HEALTH INSURANCE AND MANAGED CARE: WHAT THEY ARE AND HOW THEY WORK 1, 14 (4th Ed. 2016), http://samples.jbpub.com/9781284043259/Chapter1.pdf (`By 1999, multistate firms, including Kaiser Permanente and the combined Blue Cross Blue Shield Plans, accounted for three-fourths of U.S. enrollment in managed care._).

36. Id. at 16 (noting the fact that over 900 hospital mergers occurred in the 1990s and that this trend lead to an early 2000s study of metropolitan areas showing 90 percent were `highly concentrated_ by health systems); David Dranove et al., Is Managed Care Leading to Consolidation in Health-Care Markets?, 37 HEALTH SERVS. RES. 573, 574 (June 2002).

37. UNIVERSAL HEALTH CARE FOUND. OF CONN., HOSPITAL CONSOLIDATIONS AND CONVERSIONS: A REVIEW OF THE LITERATURE 3 (Dec. 2014), http://universalhealthct.org/images/publications/Hospital_Consolidations_and_Conversions.pdf.

38. Stanford GSB Staff, Managed Care: What Went Wrong? Can It Be Fixed? STANFORD BUS. INSIGHTS (Nov. 1, 1999), https://www.gsb.stanford.edu/insights/managed-care-what-went-wrong-can-it-be-fixed (`In July 1999, the Kaiser Family Foundation published a survey that found that 87% of doctors said that their patients have experienced health plan denials of coverage for health services over the last two years._).

39. Fox & Kongstvedt, supra note 35, at 22.

40. Bara Vaida, Health Care Consolidation, ALLIANCE FOR HEALTH REFORM (Oct. 11, 2013), http://www.allhealth.org/publications/Health-Care-Consolidation-Toolkit_157.pdf.

41. See Sternberg, supra note 4 (noting that the health care reforms within the ACA `will

The ACA aimed to create a high-quality, cost-effective healthcare delivery system through care coordination.[42] The ACA intentionally incentivizes providers to coordinate patient care as a way to increase quality.[43] Providers achieve the ACA˘s goal of high-quality care by collaboratively working to prevent unnecessary services and treat issues before they become expensive medical emergencies.[44] Historically, health care lacked an incentive structure that would encourage providers to collaborate with the competing provider within the community, creating an overall fragmented industry.[45] With repeated threats regarding the potential repeal of the ACA, stakeholders were initially hesitant to make major consolidation moves before the United States Supreme Court affirmed and reaffirmed the ACA˘s constitutionality.[46] In this post-ACA market, providers, payors, manufacturers, and distributors see consolidation not only as a way to gain market efficiencies and increase profits, but as a necessary step to remain viable in a market where competitors are also merging and expanding in scope, size, and negotiating power.[47]

To deliver population health and chronic disease management, health systems are creating integrated healthcare systems.[48] With this goal in mind, the pace of consolidation accelerated subsequent the passage of the ACA.[49]

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likely shrink insurers˘ profit margins . . . because they will no longer be able to deny individuals with pre-existing conditions, and at the same time must limit how much they raise their rates_).

42. David Brodwin, Death by Monopoly, U.S. NEWS (Aug. 17, 2015, 8:30 AM), http://www.usnews.com/opinion/economic-intelligence/2015/08/17/health-care-consolidation-is-a-disease-not-a-cure.

43. 42 U.S.C. í 1395jjj (2010) (noting that the ACA through the Medicare Shared Savings Program incentivizes groups of providers to `work together to manage and coordinate care for Medicare fee-for-service beneficiaries_).

44. Id. (noting that the ACA through the Medicare Shared Savings Program incentivizes groups of providers to `work together to manage and coordinate care for Medicare fee-for-service beneficiaries_).

45. Bill Woodson, Behind Healthcare˘s M&A Boom, FORTUNE (Aug. 18, 2015 11:05 AM), http://fortune.com/2015/08/18/healthcare-ma-aetna-anthem-cigna/.

46. Nat˘l Fed˘n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2577 (2012); Burwell v. Hobby Lobby Stores, Inc., 134 S. Ct. 2751, 2759 (2014); Michael J. de la Merced, Humana Said to Pursue Sale as Supreme Court Ruling Gives Insurers a Lift, N.Y. TIMES (June 25, 2015), http://www.nytimes.com/2015/06/26/business/dealbook/humana-said-to-pursue-sale-as-courts-ruling-gives-insurers-a-lift.html?_r=0 (stating repeated affirmation of ACA˘s constitutionality bolsters health industry confidence to move into new markets).

47. Reed Abelson, Health Care Companies in Merger Frenzy, N.Y. TIMES (Oct. 29, 2015), http://www.nytimes.com/2015/10/30/business/dealbook/health-care-companies-in-merger-frenzy.html.

48. Beth Kutscher, Hospitals Struggle to Balance Current Costs with Future Benefits of Employing Docs, MODERN HEALTHCARE (Feb. 22, 2014), http://www.modernhealthcare.com/article/20140222/MAGAZINE/302229986.

49. Anna Wilde Mathews, Health-Care Providers, Insurers Supersize, WALL STREET J. (Sept. 21, 2015, 11:46 AM), http://www.wsj.com/articles/health-care-providers-insurers-supersize-1442850400 (noting that `[t]he ACA is a trigger_).

In the five years after the ACA enactment, the number of hospital mergers doubled.[50] In the short time span from 2012 to 2014, approximately 300 hospital and system mergers were announced.[51] Hospitals have also participated in `a physician buying spree._[52] In 2000, one in twenty specialists were hospital employees; as of 2015, that ratio has dropped to one in four.[53]

The consolidation trend is not limited to insurers and providers. Pharmaceutical companies have also consolidated to streamline its research and development efforts and to restructure to a more productive business model.[54] The need for electronic medical records and high-end technology are two major causes of the robust pace of post-acute care facility mergers.[55] This economic drive toward consolidation across the healthcare market is seen by some as a `long-overdue restructuring of [an] industry_ that has traditionally been fragmented.[56] But the restructuring will not stop there.

Hospitals and other healthcare providers have consolidated with their industry competitors; however, the coordination of care goals inherent to the ACA will not be achieved by merely consolidating with the neighboring competitor. Creating scale is vital, but health systems will only achieve coordinated care goals by strategically partnering with the various players throughout the industry.[57] As the nation˘s Baby Boomers continue to age,

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50. Scott W. Altas, Under Obamacare, Hospitals Merge, Doctors Merge, and Patients Pay More for Less, NAT˘L REV. (Nov. 25, 2015, 4:00 AM), http://www.nationalreview.com/article/427601/alarming-consolidation-health-care-under-obamacare.

51. Kristen Schorsch, Big Hospitals vs. Big Government in Merger Fight, CRAIN˘S CHI. BUS. (Jan. 2, 2016), http://www.chicagobusiness.com/article/20160102/ISSUE01/301029991/big-hospitals-vs-big-government-in-merger-fight.

52. Id.

53. David Brodwin, supra note 42.

54. Jordan Paradise, A Profile of Bio-Pharma Consolidation Activity, 26 ANNALS HEALTH L. (forthcoming June 2016); see Antoine Gara, Pfizer and Allergen Merger Ranks as Biggest-Ever Pharmaceutical Deal, FORBES (Nov. 23, 2015, 9:52 AM), http://www.forbes.com/sites/antoinegara/2015/11/23/pfizer-and-allergan-merger-ranks-as-biggest-ever-pharmaceutical-deal/#423450dc3332 (noting that the `blistering pace of pharmaceutical merger and acquisition activity_ stems from pharmaceutical companies prioritizing business models that focus of efficiency).

55. David Friend, Post-Acute Care M&A˘2014 Outlook, BDO HEALTHCARE PRACTICE 1, 1 (Spring 2014), http://bertsmithco.com/wp-content/uploads/2016/01/2014-BDO-Knows_Healthcare-Newsletter_Spring.pdf; see Kindred, Gentiva Merge to Create Massive Post-Acute Care System, ADVISORY BD. CO., (Oct. 10, 2014, 10:00 AM), https://www.advisory.com/daily-briefing/2014/10/10/kindred-gentiva-merge-to-create-massive-post-acute-care-system (noting the potential merger of Kindred Healthcare and Gentiva Health Systems, a merger that could create `one of the largest, post-acute care provider systems in the nation_).

56. Woodson, supra note 45.

57. See Tammy Worth, When Providers Become Payers: What Hospitals Should Consider Before Building a New Business Model, HEALTHCARE FIN. (Oct. 30, 2014), http://www.healthcarefinancenews.com/news/when-providers-become-payers (noting that

acute care providers will find it difficult to provide a fully-integrated continuum of care without integrating a post-acute care network.[58] Hospitals are increasing not only in size, but also in scope, creating versatile health systems that offer a continuum of care to patient-consumers.[59] Provider consolidations are a driving factor in existing and proposed rival insurance consolidations. Both are evidence that the implementation of the ACA has spurred the need for increased scale and pricing power.[60]

B. A Response to Ever-Increasing Provider Mergers

In an attempt to deliver efficient, low-cost health care through care coordination, providers have accelerated consolidation efforts to meet these goals.[61] As hospitals and systems continue to purchase provider groups and cover more area, they increase their ability to negotiate for better rates from insurance companies.[62]

This drive for negotiation power is pushing insurance companies to `fight back_ and further consolidate in an attempt to gain back leverage in setting provider rates.[63] Insurers are legally obliged to cover `medically necessary_ care,[64] and therefore providers or hospital systems with a large market share

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`every organization looking at someone else~s business thinks there is a tremendous amount of waste, and believes they could do it better if given the opportunity_).

58. Friend, supra note 55.

59. Santilli & Vogenberg, supra note 29, at 17~18.

60. Gupta, supra note 7.

61. Brodwin, supra note 42 (noting, however, that although this was the aim, evidence demonstrates that consolidation eliminates competition, which results in higher prices). Although economic benefits can derive from consolidation, there may be a point where a health care system has all the potential economic benefits that enormity can bring. Id.

62. Robert A. Berenson et al., The Growing Power of Some Providers to Win Steep Payment Increases from Insurers Suggests Policy Remedies May Be Needed, 31 HEALTH AFFAIRS 973, 973 (May 2012), https://www.researchgate.net/publication/224918834_The_Growing_Power_Of_Some_Providers_To_Win_Steep_Payment_Increases_From_Insurers_Suggests_Policy_Remedies_May_Be_Needed (noting that `so-called must-have hospital systems and large physician groups´ providers that health plans must include in their networks so that they are attractive to employers and consumers´ can exert considerable market power to obtain steep payment rates from insurers_).

63. See Reihan Salam, The Threat of Health Care Market Consolidation, NAT~L REV. (Aug. 12, 2014, 5:27 PM), http://www.nationalreview.com/agenda/385283/threat-health-care-market-consolidation-reihan-salam (noting that private insurers `have little choice but to play ball with the dominant hospital group or health system in a given region_).

64. Pope, supra note 30. Cigna defines `medical necessity_ as:

> [H]ealth care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: a) in accordance with the generally accepted standards of medical practice; b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient~s illness, injury or disease; and c) not primarily for the convenience of the patient or Physician, or other Physician, and not more costly than an alternative service or

in an area can dictate costs.[65] In response to higher rate demands without negotiating power, an insurer is forced to either pay higher prices or attempt to cut a provider from its network.[66] Insurers are now looking to consolidation as a way to combat what they see as disproportionate price increases: `Unless companies in both sectors grow in size, they will not be in a position to meet each other on equal terms when they enter into negotiations on contracts._[67] Beth Leonard, executive vice president of public affairs for America˘s Health Insurance Plans (AHIP), the national association of health insurance providers, stated that health plans work to provide better value for patients, but that value `is being undercut by years of anticompetitive hospital consolidation that have forced patients to pay higher healthcare costs, increased premiums, and limited their healthcare choices._[68]

Massachusetts offers a startling example of how provider consolidation in a geographic area can quash an insurer˘s ability to negotiate reasonable rates. In 1994, Massachusetts allowed the state˘s two largest hospitals to merge into a single system, enabling the system˘s leverage to drive up costs in the local market.[69] The system demanded higher reimbursements unrelated to the quality or complexity of care.[70] The hospital˘s merger intended to decrease insurers˘ ability to demand lower prices from one hospital by threatening to send patients to the other.[71] In reality, the newly-merged entity demanded unjustifiable price increases, and when insurers pushed back, the new system simply announced they would no longer accept those insurers.[72] This caused

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> sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient˘s illness, injury or disease.

Medical Necessity for Physicians, CIGNA, http://www.cigna.com/healthcare-professionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/medical-necessity-definitions (last visited Apr. 10, 2016).

65. See Amy Yurkanin, Alabama Anti-trust Case Against Blue Cross Will Move Ahead, Judge Rules, AL.COM (Nov. 15, 2015), http://www.al.com/news/index.ssf/2015/11/alabama_anti-trust_case_agains.html (noting a recent nationwide study by American Medical Association finding Alabama as the least competitive commercial market in the U.S. with 93 percent of privately insured individuals in the state covered by Blue Cross); see Editorial, The Risk of Hospital Mergers, N.Y. TIMES (July 6, 2014), http://www.nytimes.com/2014/07/07/opinion/the-risks-of-hospital-mergers.html?_r=0 (noting that if adequate provide competition is unavailable, hospital mergers can have a dominating impact on insurance markets forcing set pricing for insurers).

66. Pope, supra note 30.

67. Gupta, supra note 7.

68. Lisa Schencker, Hospitals Take Aim at Big Insurance Mergers, MODERN HEALTHCARE (Aug. 7, 2015), http://www.modernhealthcare.com/article/20150807/NEWS/150809897.

69. Editorial, supra note 65.

70. Id.

71. Id.

72. Id.

an uproar from consumers, who did not want to lose access to the two community hospitals, as well as their providers.[73] With no other option, the insurance company dropped its position and paid the higher rates.[74] Provider consolidation within a single geographic region can force payors to negotiate with a single powerful entity, allowing those entities to dictate higher prices and reimbursement.[75]

C. Medical Loss Ratio Standards

The ACA˘s attempt to increase and mandate access to health insurance markets has created financial burdens to health insurance companies.[76] In an effort to provide increased consumer access to the health insurance market, the ACA mandated that insurance companies cannot deny coverage to anyone with pre-existing conditions.[77] Traditionally, insurance companies had the discretion to deny consumers with pre-existing conditions access to their health plans and to charge increased premiums based on a consumer˘s gender or health status.[78] The ACA˘s mandate to insure individuals with pre-existing conditions causes insurers to cover sicker and more expensive

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73. Id.

74. Id.

75. Pope, supra note 30; but cf. Bob Herman, Providers Fear Insurance Mergers Will Intensify Rate Pressures, MODERN HEALTHCARE (June 27, 2015) http://www.modernhealthcare.com/article/20150627/MAGAZINE/306279934 [hereinafter Herman, Providers Fear] (following Dr. Robert Wergin, a family medicine physician in Nebraska, whose practice and local town˘s critical-access hospital refused to sign network agreements with UnitedHealthcare because the insurer demands discounts are `too deep._); Eric Sun & Lawrence Baker, Concentration in Orthopedic Markets Was Associated with a 7 Percent Increase In Physician Fees for Total Knee Replacement, 34 HEALTH AFF. 916, 916 (June 2015), http://content.healthaffairs.org/content/34/6/916.short (explaining a study conducted regarding concentration in orthopedic markets, drawing conclusion that `the resulting increase in market concentration also could allow larger groups to negotiate higher physician fees from private insurers._).

76. See Anna Wilde Mathews, Health Insurers Struggle to Profit from ACA Plans, WALL STREET J. (Nov. 1, 2015, 7:18 PM), http://www.wsj.com/articles/health-laws-strains-show-1446423498 (noting that `[h]ealth insurers lost a total of $2.5 billion, or on average $163 per consumer enrolled, in the individual market in 2014_).

77. Patient Protection and Affordable Care Act, Pub. L. No. 111˘48, í 1101(d)(3), 124 Stat. 142 (2010) (codified as 42 U.S.C. í 18001) (determining that an individual that has a `pre-existing condition_ is considered an `eligible individual_). A pre-existing condition is a health problem that a policy-holder had prior to start of the policy-holder˘s new health plan coverage. Pre-Existing Conditions, U.S. DEPT. HEALTH & HUMAN SERVS., http://www.hhs.gov/healthcare/about-the-law/pre-existing-conditions/index.html (last visited Mar. 29, 2016). Pre-existing conditions typically include expensive conditions such as asthma, diabetes, or cancer. Id.

78. How ObamaCare Affects Health Insurance Premium Rates, OBAMACARE FACTS http://obamacarefacts.com/obamacare-health-insurance-premiums/ (last visited Mar. 29, 2016) [hereinafter ObamaCare Affects Health Insurance].

populations.[79] The expensive pool of policyholders provokes insurers to hike insurance premiums to combat the ACA's financially-burdening effect; however, the ACA anticipated this reaction.[80]

The ACA included Medical Loss Ratio (MLR) provisions to protect consumers from increased premium hikes.[81] The restriction on how insurers can spend premium dollars is called an MLR.[82] As of 2011, insurers must devote a minimum percentage of premium revenue (at least eighty percent in the individual and small-group market and eighty-five percent in the large-group market), to medical claims and quality improvement, limiting the amount that can be utilized for salaries, administrative efforts, marketing, and insurer profits.[83] Insurers must refund enrollees the shortfall if they fail to satisfy these requirements.[84] With this policy change, the ACA intends to improve transparency for consumers and force insurers to increase value of premium dollars.[85]

While MLR limitations may be seen as a driver for insurer consolidation, they are also touted by some as a protection against premium increases if the proposed insurance mergers are allowed to move forward.[86] However, the idea that MLR standards will prevent insurers from increasing consumer premiums is not a realistic or logical defense for several reason. First, MLR limitations do not apply to self-insured plans, where the employer or other plan sponsor pays the cost of health benefits from its own assets.[87] Even when an insurer administers the self-funded plan on behalf of an employer, the MLR standard does not apply.[88] This leaves a large portion of consumers-¯ more than half of private sector employee plans-¯exempt from MLR limitations, allowing insurers to raise administrative fees on this population to make up for the covered lives under MLR limitations.[89] Second, capping

79. Martin Feldstein Editorial, Martin Feldstein: Obamacare Could Raise Premiums and the Ranks of the Uninsured, WASH. POST (Nov. 6, 2009), http://www.washingtonpost.com/wp-dyn/content/article/2009/11/05/AR2009110504327.html.

80. Id.

81. ObamaCare Affects Health Insurance, supra note 78.

82. Explaining Health Care Reform: Medical Loss Ratio (MLR), KAISER FAM. FOUND. (Feb. 29, 2012), http://kff.org/health-reform/fact-sheet/explaining-health-care-reform-medical-loss-ratio-mlr/ [hereinafter KAISER FAM. FOUND.].

83. Id.

84. Dafny, supra note 22.

85. KAISER FAM. FOUND., supra note 82.

86. Letter from Melinda Reid Hatton, Senior Vice President & General Counsel of the Am. Hospital Ass¯n, to Ted Nickel, Comm¯r of the Wisconsin Officer of the Comm¯rs of Ins., & Katherine L. Wade, Comm¯r of the State of Connecticut Ins. Dep¯t (Feb. 23, 2016), http://www.aha.org/advocacy-issues/letter/2016/160223-let-consolidation.pdf [hereinafter AHA Letter to State Ins. Comm¯rs].

87. KAISER FAM. FOUND., supra note 82.

88. Id.

89. AHA Letter to State Ins. Comm¯rs, supra note 86.

what insurers are allowed to spend on non-direct health care does nothing to protect consumers from the damage that will result from loss of competition in the market.[90] Furthermore, there are concerns that MLR limitations could be cleverly gamed in a way to relabel profits as costs or, similar to other sections of the ACA, be repealed. [91]

Requirements for meeting MLR vary, but adjustments are available based on the number of lives covered or an insurer˘s special circumstances.[92] Even with these special allowances, the need for sufficient scale to comply with MLR standards is likely to impede start-up providers, while the limitations on administration costs as a percentage of revenues will likely encourage further consolidation in an attempt to reduce administrative costs and increase profits.[93] Many large insurers are already meeting MLR limits, leaving room for price increases regardless of regulation.[94]

II. THE PRACTICAL IMPLICATIONS OF INSURANCE MERGERS

Insurance company CEOs tout the benefits of the proposed mergers, claiming the transactions will allow insurers to `deliver an acceleration of innovative and affordable health and protection solutions_[95] and capture large

90. Letter from the Am. Hospital Ass˘n, to The Honorable William Baer (Aug. 5, 2015), http://www.aha.org/advocacy-issues/letter/2015/150805-let-acquisitions.pdf [hereinafter AHA Letter to DOJ] (noting the AHA˘s letter to DOJ regarding concerns and analysis on proposed mergers).

91. Dafny, supra note 22.

92. KAISER FAM. FOUND., supra note 82. An insurer˘s medical loss ratio may be difficult to estimate given that the ACA has changed an insurance company˘s traditional population pool by mandating acceptance of individuals with pre-existing conditions. See ObamaCare Affects Health Insurance, supra note 78; see also Mathews, supra note 76. An insurer˘s population pool will likely encompass a `sicker population,_ making the pool of policy-holders more expensive to insure. Jason Leopold, Documents Reveal Anthem Blue Cross Manipulated Data to Justify Massive Rate Hike, TRUTHOUT (Feb. 25, 2010, 6:37 PM), http://truth-out.org/archive/component/k2/item/88224:documents-reveal-anthem-blue-cross-manipulated-data-to-justify-massive-rate-hike. When an insurance company is forced to provide more funds to care for policy-holders, its medical loss ratio will increase. Id. `Even if premium increases generate more revenue for a particular plan, if the pool of policyholders for that plan becomes more expensive to insure, the medical loss ratio will appear higher._ Id.

93. Pope, supra note 30; see Mathews, supra note 76 (noting that many small insurance startups were forced to shut down because of the ACA˘s implications and requirements on insurance companies to provide Americans access to, but also low-costing, health insurance, but larger health insurers were also to survive).

94. Dafny, supra note 22 (stating that `[a] recent study reports national MLRs for 2013 were 86 percent, 84 percent, and 89 percent for the individual, small-group, and large-group markets, respectively. These findings suggest there may be substantial room for profitable merger-related price increases in the individual market in particular, notwithstanding the minimum MLR_).

95. About the Transaction, ANTHEM, INC., http://betterhealthcaretogether.com/about-the-transaction/ (last visited Mar. 15, 2016).

`synergy savings._[96] Looking past insurers˘ public relations campaign, there are real threats to consumers stemming from these proposed insurance consolidations.

One area of concern is threats to healthcare providers. As insurance consolidation sweeps through the healthcare industry, the already-limited bargaining power that individual physicians had with health insurers will inevitably diminish.[97] The number of independent physicians has dropped ¯ sixty to seventy percent of all physicians are now employed by a hospital or system.[98] Increasing administrative and regulatory burdens make independent practice less viable.[99] Insurer consolidation can effectively end independent medical practices because smaller physician practices cannot compete with the large insurers.[100] This will likely force the small number of remaining independent providers to merge with larger systems. To counter the increased bargaining power of consolidated insurers, healthcare providers will seek further consolidation.[101]

In addition to further driving provider consolidation, there is a real concern that insurance mergers will lead to a reduction in provider payments.[102] Studies demonstrate that in areas where there is an increase in insurance market concentration, hospital prices are generally lower.[103] The lower hospital prices put provider viability at stake because they are often at the mercy of those insurers with a great deal of market power. Both insurers and

96. Megan McArdle, No Wonder Insurers Want to Merge, BLOOMBERG VIEW (Jul. 24, 2015, 2:06 PM), http://www.bloombergview.com/articles/2015-07-24/no-wonder-insurers-want-to-merge.

97. Walker Ray & Tim Norbeck, When It Comes to Health Insurance Mergers, Bigger is Not Going to Be Better, FORBES (Sept. 28, 2015, 1:32 PM), http://www.forbes.com/sites/physiciansfoundation/2015/09/28/bigger-is-not-going-to-be-better/#79e82cf1603a.

98. Marion Callahan & Marissa Shoemaker Debree, Doctors Look for New Ways to Cope with Health Care Changes, WASH. TIMES (Sept. 25, 2015), http://www.washingtontimes.com/news/2015/sep/5/doctors-look-for-new-ways-to-cope-with-health-care/?page=all.

99. Ken Terry et al., Top 15 Challenges Facing Physicians in 2015, MED. ECON. (Dec. 1, 2014), http://medicaleconomics.modernmedicine.com/medical-economics/news/top-15-challenges-facing-physicians-2015?page=full (`For some physicians, joining a large hospital system offers a haven from the rising administrative burdens of staying independent and from competitive pressures that can drive a small practice into insolvency._).

100. Scott Gottlieb, ObamaCare˘s Threat to Private Practice, WALL STREET J. (Dec. 7, 2014, 5:12 PM), http://www.wsj.com/articles/scott-gottlieb-obamacares-threat-to-private-practice-1417990367.

101. Herman, Potential Insurance Mergers, supra note 11.

102. Dafny, supra note 22; see Ray & Norbeck, supra note 97 (noting the 1999 merger between Aetna and Prudential `resulted in reduced payments to providers and no evidence that those cost savings were passed on to consumers_).

103. Dafny, supra note 22 (measuring the correlation between hospital prices and insurance consolidation with the Herfindahl-Hirschman index (HHI), which is `an imperfect proxy for true competitiveness (the degree to which firms vie to serve consumers through product design, price service, etc._).

providers strive to acquire the size necessary to effectively negotiate within the post-ACA˘s hyper-regulatory environment, but the implications of this arms race are threatening to various stakeholders and the market as a whole.[104]

A. Threats to Consumers

In addition to concerns relating to lower-provider reimbursement rates and stand-alone practitioners, recent insurance mergers pose a threat to consumers. While insurance companies argue consolidation will lead to more efficiency and therefore decreased prices, this is only true if achieved cost savings are passed through to consumers through lower premiums and lower out-of-pocket costs.[105] When pressed in the Senate hearing last fall, neither the CEO of Aetna nor Anthem could offer `a single piece of evidence demonstrating that health insurance mergers would create efficiencies, or that they would pass along any savings to consumers._[106] There are serious concerns that many of the benefits touted by insurers may not actually materialize under the mergers and even if they do consumers will only see marginal benefits.[107]

Instead of speculating on why prices may increase under insurance mergers, one only needs to look to prior outcomes to ascertain that insurance mergers did in fact raise premiums.[108] In analyzing the 2008 merger of UnitedHealth and Sierra and the 1999 merger of Aetna and Prudential, two separate studies confirmed that insurers raised consumers˘ premiums post-merger.[109] The retrospective study of Aetna-Prudential, conducted by Leemore Dafny, a health economist at Northwestern University and a former regulator at the Federal Trade Commission, concluded that `health insurer

104. Scott W. Atlas, Under Obamacare, Hospitals Merge, Doctors Merge, and Patients Pay More for Less, NAT˘L REV. (Nov. 25, 2015, 4:00 AM), http://www.nationalreview.com/article/427601/obamacare-health-care-costs-consumer-choice-consolidation.

105. Michael J. McCue & Mark Hall, What˘s Behind Health Insurance Rate Increases? An Examination of What Insurers Reported to the Federal Government in 2012¯2013, COMMONWEALTH FUND (Dec. 19, 2013), http://www.commonwealthfund.org/publications/issue-briefs/2013/dec/health-insurance-rate-increases.

106. David Balto, Health Insurance Mergers Fact Check: Why Consumers Will Lose, HUFFINGTON POST (Nov. 10, 2015), http://www.huffingtonpost.com/david-balto/health-insurance-mergers_b_8521708.html; cf. Dafny, supra note 22 (noting that studies of hospital pricing based on geographic areas tend to show that hospital prices are lower in geographic areas with higher levels of insurance market concentration).

107. Paul von Ebers, Mega Health Insurance Mergers: Is Bigger Really Better?, HEALTH AFF. BLOG (Jan. 22, 2016), http://healthaffairs.org/blog/2016/01/22/mega-health-insurance-mergers-is-bigger-really-better/.

108. Balto, supra note 106.

109. Id.

mergers rarely, if ever, lead to lower premiums for consumers."[110] Dafny further established that the Aetna-Prudential deal "mostly translated into bulked-up negotiating power over hospitals and doctors."[111] The increase in cost could be justifiable if services or products significantly improve, but the concern is that these proposed mergers will increase costs without a correlating increase in efficiency or quality.

Consolidation may also have a much larger economic impact on consumers beyond just premiums. Dafny's post-merger Aetna-Prudential study also found a reduction in wages and healthcare employment in the areas where the two insurers held significant market power.[112]

B. Lack of Competition

While provider consolidation is a substantial factor in pushing insurers to gain additional market power, some argue that the insurance mergers are a reaction to the ACA.[113] Wharton Professor of Healthcare Management, Mark Pauly, believes the insurance mergers are a way for insurers to fight back against the competition mandated through the ACA.[114]

> This is a kind of counterattack on the part of insurers saying, well, if you're going to try to stimulate competition, we're going to counteract by reducing the number of competitors, so at least we won't have to worry about as many competitors stabbing us in the back by cutting prices if we can buy them up or acquire them.[115]

The ACA-created exchanges allow consumers to openly compare insurers, encouraging insurers who vie for this population's premiums to provide competitive options in not only price but also in value.[116] Seen as an attempt to combat this designed competition, the insurance industry's proposed mergers have sparked increased criticism. For instance, the American Medical Association (AMA) openly expressed criticism of the proposed

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110. Bob Herman, Senators Grill CEOs of Aetna, Anthem Over Competitive Effects of Deals, MODERN HEALTHCARE (Sept. 22, 2015), http://www.modernhealthcare.com/article/20150922/NEWS/150929962 [hereinafter Herman, Senators Grill CEOs].

111. Id.

112. Dafny, supra note 22.

113. Sarah Ferris, GOP Blames ObamaCare for Health Insurance Merger-Mania, THE HILL (July 8, 2015, 6:00 AM), http://thehill.com/policy/healthcare/247161-gop-pounces-on-health-insurance-merger-mania.

114. What's Driving Health Insurers' Merger Mania?: Mark Pauly Discusses Proposed Health Care Insurance Company Mergers, WHARTON PODCAST (June 23, 2015), http://knowledge.wharton.upenn.edu/article/whats-driving-health-insurers-merger-mania/ [hereinafter WHARTON PODCAST].

115. Id.

116. Cusano & Lucia, supra note 25.

insurance mega-mergers.[117] The AMA fears the proposed insurance mergers `would end competition in key markets and erode patient care._[118] The decline in competition not only has the potential to impact the quality of care but the cost implications associated with the lack of competition also threaten the health care industry on a larger scale.

The ACA ˘s effectiveness in achieving high-quality, low-cost care is based on availability of competition in the market and collective bargaining amongst providers and payors.[119] The intent and main provisions of the ACA hinge on `well-functioning competitive markets in order to provide the intended benefits to consumers._[120] There are several tools for assessing the concentration of a market, and the potential effects of a merger. The Herfindahl-Hirschman Index (HHI) is one such measure that is commonly used to assess market concentration.[121] Markets that are less concentrated are more competitive.[122] In looking at the impact of competition on the individual exchange markets, a 2014 study found that after a large national insurer decided not to participate, premiums increased more than five percent that year.[123] Another study found that having one additional insurer in a geographic area could save individuals nearly $500 in premiums per person.[124] The AMA found that the current health insurance market was deemed as `highly concentrated_ in nearly seventy-five percent of U.S. metropolitan areas based on federal guidelines used to assess market competition.[125] These mergers could reduce competition in at least 817 relevant geographic markets, serving forty-five million consumers.[126]

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117. Ana Radelat, AMA Asks Justice Department to Block Aetna-Humana, Anthem-Cigna Mergers, CT MIRROR (Nov. 12, 2015), http://ctmirror.org/2015/11/12/ama-asks-justice-department-to-block-aetna-humana-anthem-cigna-mergers/.

118. Id.

119. Dafny, supra note 22.

120. Julie Brill, Competition in Health Care Markets, HEALTH AFF. (Jan. 26, 2015), http://healthaffairs.org/blog/2015/01/26/competition-in-health-care-markets/.

121. U.S. DEP˘T. OF JUS., Herfindahl-Hirschman Index, (July 29, 2015), https://www.justice.gov/atr/herfindahl-hirschman-index.

122. Mary Mahon, New Report: Little or No Competition in Medicare Advantage Insurance Markets in 97% of U.S. Counties, COMMONWEALTH FUND (Aug. 25, 2015), http://www.commonwealthfund.org/publications/press-releases/2015/aug/little-competition-in-medicare-advantage.

123. Leemore Dafny et al., More Insurers, Lower Premiums: Evidence from Initial Pricing in the Health Insurance Marketplaces, AM. J. HEALTH ECON. 1, 53˘81 (2015).

124. Michael J. Dickstein et al., The Impact of Market Size and Composition on Health Insurance Premiums: Evidence from the First Year of the Affordable Care Act, 105 AM. ECON. REV. 120 (May 2015).

125. Courtney Baird, Top Healthcare Stories for 2016: Insurance Company Mergers, COMM. FOR ECON. DEV. (Feb. 16, 2016), https://www.ced.org/blog/entry/top-healthcare-stories-for-2016-insurance-company-mergers.

126. AHA Letter to DOJ, supra note 90.

In response to concerns that the mergers will lead to lack of competition, insurers argue those concerns will be offset by new entrants into the market. CEOs of major insurers argue new insurers are entering the market and creating new competition.[127] In reality, smaller companies wanting to play will likely be unable to compete with the size, scope, and technology of the mega-insurers, which will further reduce existing competition and act as a barrier for new insurers to enter the market. We are already seeing a reduction in plan offerings in 2016, where there will be twenty-five percent fewer plans available than in 2015 and forty percent fewer preferred provider organization plans available.[128]

The health insurance market has been labeled one of the most difficult markets to enter.[129] The ACA incentivized the participation of nonprofit insurance co-operatives known as Consumer Operated and Oriented Plans (CO-OP) through subsidized loans.[130] High capital requirements and burdensome tasks of building provider networks, however, have discouraged new health plans from entering into the private health insurance market.[131] Instead, health plans are entering into the private health insurance market through acquisition.[132] Yet many new health plans, including those incentivized under the ACA, specifically CO-OPs, have struggled and closed.[133] This is primarily because new companies face substantial challenges associated with the time and resources required to negotiate competitive reimbursement rates, build relationships with provider networks, and establish a reputation with consumers.[134] Furthermore, MLR constraints will limit the amount a new insurer can spend on marketing to providers, employers, and consumers. In contrast, mega-insurers will have the economies of scale in all of these areas and more.[135]

C. Consolidation˘s Impact on the Medicare Advantage Plan Market

Medicare Advantage was created in the 1970s to allow Medicare beneficiaries to receive Medicare benefits through private health plans.[136]

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127. Robert Pear, Health Insurers Seeking Mergers Play Down Antitrust Concerns, N.Y. TIMES (Sept. 22, 2015), http://www.nytimes.com/2015/09/23/business/aetna-anthem-congress-health-insurers-mergers.html?_r=1.

128. Balto, supra note 106.

129. Herman, Senators Grill CEOs, supra note 110.

130. Dafny et al., supra note 123, at 1.

131. Dafny, supra note 22.

132. Id.

133. Herman, Senators Grill CEOs, supra note 110.

134. Dafny et al., supra note 123.

135. Id.

136. Medicare Advantage Fact Sheet, KAISER FAM. FOUND. (June 29, 2015), http://kff.org/medicare/fact-sheet/medicare-advantage/.

Nearly twenty-two million Medicare beneficiaries are enrolled in government-financed private plans, collectively known as Medicare Advantage.[137] There are serious concerns that the proposed insurance mergers would extremely consolidate an already concentrated Medicare Advantage Plans market. In August 2015, the Commonwealth Fund published a study finding that ninety-seven percent of Medicare Advantage markets are already highly concentrated.[138] The study concluded that in two-thirds of the 100 countries with the highest Medicare beneficiaries, insurer market power was concentrated to just three national insurers.[139]

Humana currently serves over three million Medicare beneficiaries.[140] Kaiser Family Foundation found that if Aetna and Humana are allowed to merge, the new company would become the largest Medicare Advantage insurer, covering over one quarter of Medicare Advantage enrollees.[141] These insurers looking to merge already have dominance over Medicare Advantage plans, but that dominance will only grow under the proposed merger. For example, if Aetna goes through with purchasing Humana, the newly-created company will serve ninety percent of Kansas Medicare Advantage patients.[142]

The ACA and Medicare Advantage only work with competition. The lack of competition that stems from consolidation could force those healthcare plans to become unaffordable.[143] While insurance companies argue mergers will result in `no material change to competition in market,_[144] providers are asking the Department of Justice (DOJ) to heavily scrutinize the effect consolidations would have on Medicare Advantage providers.[145] The American Hospital Association (AHA) argues these consolidations trigger

137. Dafny, supra note 22.

138. Brian Biles et al., Competition Among Medicare˜s Private Health Plans: Does It Really Exist?, 25 COMMONWEALTH FUND 1, 4 (Aug. 25, 2015), http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/aug/1832_biles_competition_medicare_private_plans_ib_v2.pdf.

139. Id. at 1.

140. Robert Cyran, Regulatory Hurdles to Health Insurance Mergers, N.Y. TIMES (July 24, 2015), http://www.nytimes.com/2015/09/23/business/aetna-anthem-congress-health-insurers-mergers.html?_r=0.

141. Gretchen Jacobson et al., Data Note: Medicare Advantage Plan by Firm, 2015, KAISER FAM. FOUND. (July 14, 2015), http://kff.org/medicare/issue-brief/data-note-medicare-advantage-enrollment-by-firm-2015/.

142. Cyran, supra note 140.

143. Robert I. Field et al., What Do Health Insurance Mergers Mean for You?, PHILLY.COM (Sept. 17, 2015, 12:05 PM), http://www.philly.com/philly/blogs/health-cents/What-do-health-insurance-mergers-mean-for-you.html.

144. Robert Pear, supra note 127 (quoting Congressional testimony of CEO of Humana describing company as a `large Medicare company_ serving over three million Medicare beneficiaries).

145. AHA Letter to DOJ, supra note 90.

sincere concerns over the preservation of the benefits of competition for beneficiaries that the program was designed to bring.[146]

III. EVALUATING MERGER SUCCESS UNDER ANTITRUST LAWS

The Federal Trade Commission (FTC) and the Antitrust Division of the DOJ share responsibility at the federal level for antitrust regulation and enforcement.[147] State attorneys general and insurance commissioners are also charged with enforcement of antitrust laws and the evaluation of potential antitrust violations.[148] Healthcare consolidation has become a focus of antitrust scrutiny, with pressure coming from both the FTC and DOJ in recent years.[149] Antitrust laws were created to protect consumers through the mechanisms of competition in the marketplace.[150] The collection of antitrust laws create a framework to ensure that strong incentives exist for businesses to keep quality up and prices down, while operating efficiently.[151]

A. Antitrust Laws

Traditionally, antitrust scrutiny has focused on provider and pharmaceutical mergers, particularly given the insurance industry˘s antitrust exemption through the McCarran-Ferguson Act.[152] The McCarran-Ferguson Act was passed in 1945 as a response to a Supreme Court ruling[153] finding that the business of insurance fell within interstate commerce and was

146. Id.

147. FED. TRADE COMM˘N, GUIDE TO ANTITRUST LAWS: THE ENFORCERS, https://www.ftc.gov/tips-advice/competition-guidance/guide-antitrust-laws/enforcers (last visited Mar. 15, 2015) [hereinafter FTC, THE ENFORCERS].

148. Id.

149. Richard B. Benenson & Kerry J. LeMonte, FTC˘s Focus on Healthcare Mergers and Consolidation, 45 Colo. Lawyer (Feb. 2, 2016), http://www.bhfs.com/Templates/media/files/news/CoLawyer2_1_16.pdf; Joe Carlson, Report Shows FTC˘s Focus on Healthcare, MODERN HEALTHCARE (June 13, 2012), http://www.modernhealthcare.com/article/20120613/NEWS/306139960.

150. The Sherman Act was the first measure passed by Congress to prohibit monopolies in interstate commerce and passed in response to public opposition to monopolies formed following the Civil War. The Act passed almost unanimously with a 51-1 vote in Senate and unanimous vote in the House. Sherman Antitrust Act of 1890, SOC˘Y FOR HUMAN RES., https://www.shrm.org/legalissues/federalresources/federalstatutesregulationsandguidanc/pages/shermananti-trustactof1890.aspx (last visited Apr. 9, 2016).

151. FTC, THE ENFORCERS, supra note 147.

152. 15 U.S.C. íí 1011 et seq.

153. United States v. South-Eastern Underwriters Ass˘n, 322 U.S. 533 (1944) (members of an insurance association were indicted on charges of violating the Sherman Act by fixing rates and monopolizing the insurance business in a multiple states; lower court held the business of insurance was not commerce but on appeal, the Supreme Court reversed holding that the insurance industry was an appropriate subject for federal regulation under commerce clause and therefore subject to Sherman Act).

therefore subject to federal regulation under federal antitrust laws.[154] The Act exempts from federal antitrust laws the `business of insurance,_ including health insurance, to the extent that it is regulated by state law.[155] In doing so, the McCarran-Ferguson Act confirmed states˘ authority to regulate and tax insurance. This is not a blanket exemption from federal antitrust law; activities are only exempt from federal regulation if they meet three requirements: 1) the activity falls within `business of insurance,_ 2) the activity is regulated by state law, and 3) the activity in question does not involve actions or agreements to boycott, coerce, or intimidate.[156] If an activity is found to be included in the `business of insurance,_ but not regulated by state law, then the activity is subject to regulation under federal antitrust laws.[157]

Three main federal laws govern antitrust: 1) the Sherman Act,[158] 2) the Federal Trade Commission Act,[159] and 3) the Clayton Act.[160] In addition to federal law, most states have passed antitrust state statutes that often mirror federal language.[161]

The Sherman Act prohibits `every contract, combination, or conspiracy in restraint of trade,_ and any `monopolization, attempted monopolization, or conspiracy or combination to monopolize._[162] In its application, the Sherman Act prohibits both unreasonable restraints of trade as well as blatant arrangements between competing individuals to price fix or unfairly alter the market.[163] Violations occur as a result of both case-by-case analyses of what constitutes unreasonable restraints of trade and blatant `per se_ violations.[164]

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154. Michael Cowie, Health Insurance and Federal Antitrust Law: An Analysis of Recent Congressional Action, ANTITRUST SOURCE, AM. BAR ASS˘N 1, 2 (Dec. 2009), http://www.americanbar.org/content/dam/aba/publishing/antitrust_source/Dec09_Cowie12_17f.authcheckdam.pdf.

155. Cowie, supra note 154, at 7. Courts analyze three factors in determining whether a practice constitutes the `business of insurance_: (1) whether the practice has the effect of transferring a policyholder˘s risk, (2) whether the practice is an integral part of the policy relationship between insurer and policyholder, and (3) whether the practice is limited to entities within the insurance industry. Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119, 129 (1982); Cowie, supra note 154, at 2.

156. 15 U.S.C. íí 1011˘1015 (2001).

157. Cowie, supra note 154, at 1.

158. 15 U.S.C. íí 1˘2 (2013).

159. 15 U.S.C. í 45(a)(1) (2010).

160. 15 U.S.C. íí 12˘27 (2000).

161. See, e.g., WASH. STATE OFFICE OF ATTORNEY GEN., GUIDE TO ANTITRUST LAWS, http://www.atg.wa.gov/antitrustguide.aspx (last visited Apr. 7, 2016).

162. FED. TRADE COMM˘N, GUIDE TO ANTITRUST LAWS: THE ANTITRUST LAWS, https://www.ftc.gov/tips-advice/competition-guidance/guide-antitrust-laws/antitrust-laws (last visited Mar. 28, 2016) [hereinafter FTC, GUIDE TO ANTITRUST LAWS].

163. Id.

164. Id.

A `per se_ violation is deemed to be so harmful, it is always found to be a violation and no justifications or defenses are allowed.[165] Violations of the Sherman Act can carry both civil and criminal liability.[166] The Supreme Court has interpreted that all violations of the Sherman Act also violate the FTC Act.[167]

The FTC Act created the FTC and expanded on the Sherman Act, capturing within its scope certain practices that may harm competition but were not found in violation of the Sherman Act.[168] The FTC Act prohibits `unfair methods of competition_ and `unfair or deceptive acts or practices._[169]

The Clayton Act further addresses practices not explicitly prohibited by the Sherman Act, including mergers.[170] Mergers tend to lead to a reduction in competition,[171] a trend that inevitably catches the eyes of antitrust regulators.[172] Section 7 of the Clayton Antitrust Act applies to mergers, acquisitions, and joint ventures.[173] Under this section, mergers are unlawful when the effect `may be substantially to lessen competition, or to tend to create a monopoly._[174] This section allows for a preemptive challenge to a merger through injunction. Proof of actual anticompetitive practices is

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165. Id.; U.S. DEPT. OF JUSTICE, ANTITRUST RESOURCE MANUAL: IDENTIFYING, DETECTING AND PROVING PER SE VIOLATIONS OF THE SHERMAN ACT, https://www.justice.gov/usam/antitrust-resource-manual-6-se-violations-sherman-act (last visited Mar. 28, 2016) (`The most frequent violations of the Sherman Act are price fixing and bid rigging, both of which are usually prosecuted as criminal violations._).

166. FTC, GUIDE TO ANTITRUST LAWS, supra note 162.

167. Id.

168. Id.

169. Id. `Unfair_ practices are defined as those that `cause[] or [are] likely to cause substantial injury to consumers which is not reasonably avoidable by consumers themselves and not outweighed by countervailing benefits to consumers or to competition._ 15 U.S.C.í 45(n) (2010).

170. FTC, GUIDE TO ANTITRUST LAWS, supra note 162.

171. But cf. Editorial, The Case for Bigger Health Insurers, BLOOMBERG VIEW (July 8, 2015 12:00 AM), http://www.bloombergview.com/articles/2015-07-08/the-case-for-bigger-health-insurers (arguing consolidation among insurers may be necessary to keep market competitive in light of already established provider consolidation); but cf. Toby Singer, Pro-Competitive Benefits of Hospital Mergers, HOSP. & HEALTH NETWORKS (Sept. 25, 2012), http://www.hhnmag.com/articles/5212-the-pro-competitive-benefits-of-hospital-mergers (arguing mergers offer hospitals the potential to remain competitive in the rapidly changing field of health care).

172. Ayla Ellison, 5 Things to Know about the Merger of Health Systems and Insurance Providers, BECKER˜S HOSP. REV. (June 6, 2014), http://www.beckershospitalreview.com/hospital-transactions-and-valuation/5-things-to-know-about-the-merger-of-health-systems-and-insurance-providers.html.

173. Summary of Section 7 Clayton Antitrust Act, AM. ANTITRUST INST. (Oct. 11, 2013), http://www.antitrustinstitute.org/sites/default/files/Section%207.pdf [hereinafter AM. ANTITRUST INST.].

174. Id.

unnecessary to establish a Section 7 violation; the challenging entity only needs to make a prediction based on current facts that anticompetitive effects will result from the transaction and seek judicial approval to block the merger.[175] A plaintiff seeking to enjoin a merger must establish a prima facie case showing the merger would `produce an undue percentage share of the relevant market, and result in a significant increase in the concentration of firms in that market._[176] The Supreme Court has held that defining the relevant geographic and product markets is essential to a Section 7 claim.[177] Once established, there is a presumption of illegality,[178] but the defendant may rebut the presumption[179] with contradictory data and market trends or raise a defense.[180]

Unlike other parts of the Clayton Act, Section 7 is intended to be `forward-looking_ and to prevent conditions from occurring that would subject consumers to unchallenged price increases.[181] The conditions that Section 7 of the Clayton Act intends to thwart include lower-quality plans, higher premiums, and limited provider access.[182]

In 1976, the Hart-Scott-Rodino Act (`HSR Act_) amended the Clayton Act.[183] The HSR Act outlines the process of federal pre-notification and review for large mergers or acquisitions.[184] The HSR Act established waiting periods for regulatory review before a merger or acquisition could be

175. Hosp. Corp. of Am. v. F.T.C., 807 F.2d 1381, 1389 (7th Cir. 1986) (finding `Section 7 does not require proof that a merger or other acquisition has caused higher prices in the affected market. All that is necessary is that the merger create an appreciable danger of such consequences in the future._).

176. United States v. Phila. Nat`l Bank, 374 U.S. 321, 363 (1963).

177. United States v. E. I. du Pont de Nemours & Co., 353 U.S. 586, 593 (1957) (`Determination of the relevant market is a necessary predicate to a finding of a violation of the Clayton Act because the threatened monopoly must be one which will substantially lessen competition :within the area of effective competition._).

178. FTC v. Univ. Health, Inc., 938 F.2d 1206, 1218 (11th Cir. 1991).

179. Id. at 1218 (`To rebut this presumption, the defendant must produce evidence that `show[s] that the market-share statistics [give] an inaccurate account of the acquisition[:s] probable effect[ ] on competition_ in the relevant market._).

180. Two defenses include the `failing firm_ defense and the `state action_ defense. The failing firm defense is applied only if it can be proven by the defendant that the company acquiring the failing company is the only possible purchaser. Citizen Pub. Co. v. United States, 394 U.S. 131, 138 (1969). The state action defense provides antitrust immunity where a state has affirmatively authorized the alleged anticompetitive conduct. FTC v. Ticor Title Ins. Co., 504 U.S. 621, 633 (1992) (`First, the challenged restraint must be one clearly articulated and affirmatively expressed as state policy; second, the policy must be actively supervised by the State itself._).

181. Joe Infantino, Under Review: How DOJ, FTC Decide Whether to OK Health Insurance Mergers, CALIF. HEALTHLINE (Dec. 16, 2015), http://californiahealthline.org/news/under-review-how-doj-ftc-decide-whether-to-ok-health-insurance-mergers/.

182. Infantino, supra note 181.

183. 15 U.S.C. í 18a (1976).

184. Id.

completed[185]--alleviating the need for expensive and time-consuming divestures[186] after an anti-competitive merger has already gone through.[187] Prior to the HSR Act, the FTC lacked authority to require waiting periods.[188] If the FTC learned of a proposed transaction, it was difficult to gather and review information in a timely manner and near impossible to have enough information to file a preliminary injunction to block the deal.[189]

The HSR Act created notification thresholds--when a merger or acquisition exceeds a certain monetary value, the companies involved must notify federal authorities of the proposed actions and file for antitrust approval.[190] Once an approval request is filed, the merger is suspended for thirty days to allow the FTC and DOJ to review the proposed merger and determine if it should go forward or if more information is needed.[191] If more information is needed, the FTC asks the parties for a preliminary review.[192] The agency assigned[193] to the preliminary review has thirty days from the

185. Id.

186. William Baer, Former Dir, Fed. Trade Comm˘n, Address at 35th Annual Corporate Counsel Institute: Reflections on 20 Years of Merger Enforcement Under the Hart-Scott-Rodino Act (Oct. 31, 1996), https://www.ftc.gov/public-statements/1996/10/reflections-20-years-merger-enforcement-under-hart-scott-rodino-act#N_21 (prior to HSR, post-merger acquisition cases took on average five to six years to go from acquisition to divestiture allowing the parties during that timeframe to retain illegal profits and continue their anticompetitive effects on the marketplace, injuring both consumers and competitors).

187. Id. (citing Assistant Attorney General Kauper˘s testimony that intent behind HSR Act˘s premerger notification `will prevent the consummation of so-called : midnight˘ mergers designed to subvert the Department˘s authority to seek preliminary relief_).

188. Id.

189. Id. (`One study found that in the sixteen-year period from 1956 to 1971, the government filed 167 merger challenges, but moved for a preliminary injunction in only 50 of them. The data suggest that close to 70% of the problematic mergers were not detected in time to seek preliminary relief._).

190. FED. TRADE COMM˘N, FTC ANNOUNCES NEW CLAYTON ACT MONETARY THRESHOLDS FOR 2016 (Jan. 21, 2016), https://www.ftc.gov/news-events/press-releases/2016/01/ftc-announces-new-clayton-act-monetary-thresholds-2016 (The FTC revises HSR Act thresholds annually, the threshold for reporting proposed mergers and acquisitions was $76.3 million in 2015 and will increase to $78.2 million for 2016).

191. Infantino, supra note 181.

192. FED. TRADE COMM˘N, GUIDE TO ANTITRUST LAWS: PREMERGER NOTIFICATION AND THE MERGER REVIEW PROCESS, https://www.ftc.gov/tips-advice/competition-guidance/guide-antitrust-laws/mergers/premerger-notification-and-merger (last visited Mar. 28, 2016) [hereinafter FTC, PREMERGER NOTIFICATION]; see Scott P. Perlman, Mayer Brown LLP, Address at the Post Merger Integration Conference: Overview of the Merger Review Process (June 25, 2008), https://www.mayerbrown.com/public_docs/MergerReviewProcess.pdf (noting that one in five filings result in a preliminary investigation; preliminary investigations request information from parties including but not limited to interviews with company executives, interviews with top customers, strategic and marketing plans, profit and loss reports and manufacturing capabilities).

193. Parties file with both the FTC and DOJ, but generally only one agency reviews the proposed merger. FTC, PREMERGER NOTIFICATION, supra note 192. Staff from both agencies consult and the matter is `cleared_ to one agency for review, known as the

time all requested information is received to evaluate; if the thirty-day period expires or is terminated by the agency, the deal is allowed to move forward.[194] If the proposal raises serious concerns regarding competition, the reviewing agency asks for an extended review as a `second request._[195] A majority of the proposed deals reviewed by the FTC and DOJ are allowed to proceed after the preliminary review.[196] When a second request is initiated, companies are compelled to provide all information requested by the agencies.[197] When all information requested has been provided, the agency has thirty days to review the information and make a decision on how to move forward.[198] After the second request, federal regulators have three options: (1) close the investigation and allow the merger to move forward; (2) request that the filing companies to divest certain aspects of business before moving forward; or (3) file an injunction in federal court to block the deal.[199]

States also play an important role in antitrust enforcement. In their role as the chief regulator for the insurance industry, almost every state has implemented versions of the federal antitrust laws.[200] As the state˘s chief legal counsel, a state˘s attorney general (AG) plays an important role in antitrust law enforcement. AGs have the ability to bring antitrust suits on behalf of individual citizens in a state or on behalf of the state as a purchaser.[201] An AG may bring an action to enforce the state˘s own antitrust laws and may join with federal investigators in antitrust reviews.[202] Particular to health insurance mergers, state insurance commissioners play an important role in review and approval. Insurance commissioners are in a unique position to analyze the health insurance market in their state and consider additional factors that may impact the market specific to their state, outside

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`clearance process._ Id.

194. Perlman, supra note 192.

195. FED. TRADE COMM˘N, MERGER REVIEW, https://www.ftc.gov/news-events/media-resources/mergers-and-competition/merger-review (last visited Mar. 10, 2016) [hereinafter FTC, MERGER REVIEW].

196. Id.

197. Id.

198. FTC, PREMERGER NOTIFICATION, supra note 192.

199. FTC, MERGER REVIEW, supra note 195.

200. FTC, GUIDE TO ANTITRUST LAWS, supra note 162.

201. FTC, THE ENFORCERS, supra note 147.

202. Id.; David Hatch, Texas Leads Antirust Fight Against Google, GOVERNING MAG. (Oct. 2, 2012), http://www.governing.com/blogs/view/gov-texas-leads-antitrust-fight-against-google.html (noting the Texas Attorney General˘s conduction of formal antitrust review of Google); Joel Brinkley, U.S. v. Microsoft: the Overview, U.S. Judge Says Microsoft Violated Antitrust Laws with Predatory Behaviors, N.Y. TIMES (Apr. 4, 2000), http://www.nytimes.com/2000/04/04/business/us-vs-microsoft-overview-us-judge-says-microsoft-violated-antitrust-laws-with.html?pagewanted=all (noting that in 1998, nineteen State Attorney Generals joined the DOJ in suing Microsoft alleging violation of federal antitrust laws through predatory and anticompetitive behavior).

typical antitrust analysis.[203] Furthermore, a commissioner˘s review is independent and therefore not required to follow reviews completed by other regulators.[204]

B. Where Proposed Deals Stand Now

Currently, the DOJ is simultaneously reviewing the proposed Anthem-Cigna and Aetna-Humana mergers and evaluating the interaction of the two.[205] State attorneys general and state insurance commissioners have the ability to evaluate and investigate mergers. Fifteen state attorneys general have joined the DOJ˘s investigation of both Aetna-Humana and Anthem-Cigna proposed mergers.[206] In addition to the DOJ and states˘ attorneys general, state insurance commissioners within jurisdictions where the parties do business will investigate and evaluate the mergers, taking into account local competition and whether the mergers will benefit consumers.[207]

Anthem-Cigna and Aetna-Humana have already been asked to provide additional information in a `second request_ and neither deal is expected to receive clearance or a final decision for at least a year.[208] Second requests are not common; they are only issued in two to four percent of HSR filings[209] and elicit intense levels of scrutiny.[210] If antitrust issues are identified, federal regulators may require certain aspects of the insurers to be divested before they are allowed to move forward with a merger, generally in overlapping business interests.[211] For example, in 2012, federal regulators required Anthem to disassociate itself of certain operations before moving forward with its acquisition of Amerigroup.[212] This may not be a realistic fix because both groups have significant overlapping business interests as major insurers

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203. Alfred Gilchrist, Insurance-Industry-Proposed Mergers: Colorado Regulators Okay Aetna-Humana Merger Without Notice, COLORADO MED. SOC˘Y (Jan. 1, 2016, 12:16 PM), http://www.cms.org/site/print/insurance-industry-proposed-mergers-colorado-regulators-okay-aetna-humana-m.

204. Id.

205. Leslie Small, A Glimpse into the DOJ˘s Review of Health Insurer Mega-Mergers, FIERCEHEALTHPAYER (Mar. 11, 2016), http://www.fiercehealthpayer.com/story/glimpse-dojs-review-health-insurer-mega-mergers/2016-03-11.

206. Goliya supra note 9.

207. Cyran, supra note 140.

208. Infantino, supra note 181.

209. Perlman, supra note 192.

210. In second requests agencies can ask for any and all data and documents relating to the proposed transaction, businesses of the parties, competition in the current market and competitive effects of the merger. FTC, PREMERGER NOTIFICATION, supra note 192. The agency may also conduct informal interviews or sworn testimony of relevant employees, personnel or others with knowledge of the industry. Id.

211. FTC, Merger Review, supra note 195.

212. Cyran, supra note 140.

with similar products.[213] If insurers refuse to change the identified operations of concern, federal regulators could file for a preliminary injunction in federal court to block the deal.[214]

In evaluating the mergers, the DOJ and FTC establish product and geographic markets for both proposals. They evaluate the concentration of the defined markets, the competitive effect of the mergers, and the likelihood of new entrants into the market.[215] The analysis considers both pro-competitive effects as well as anti-competitive effects.[216] Pro-competitive effects include potential efficiencies obtained through the acquisition or increased ability to offer new or improved products. Anti-competitive effects include reduction in price competition potentially leading to higher prices, reduction in quality or increased barriers to new entrants into the market. Both pro-competitive effects and anti-competitive effects will aid in establishing the merger impact on the market.

C. Impact of Proposed Mergers

The American Academy of Family Practitioners (AAFP), the AMA, and the AHA have petitioned the DOJ to block the pending deals.[217] Providers argue these proposed mergers will `impair access, affordability and innovation in the sell-side market for health insurance, and, on the buy side, will deprive physicians of the ability to negotiate competitive health insurer contract terms in markets around the country, _ leading to detrimental results for consumers.[218] Independent hospitals and physician groups already have limited negotiating leverage with insurers. For those who choose to remain independent, they are often forced to refuse contracts with insurers, leaving patients with out-of-network medical bills or forced to find new in-network providers.[219]

In contrast, some argue that providers have been consolidating for years and have the upper hand; therefore, to sustain competition in the market, these mergers should go forward.[220] As providers consolidated to meet

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213. Infantino, supra note 181.

214. Id.

215. DEP˘T OF JUSTICE & FTC, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE (Aug. 1996), https://www.ftc.gov/sites/default/files/attachments/competition-policy-guidance/statements_of_antitrust_enforcement_policy_in_health_care_august_1996.pdf [hereinafter DOJ & FTC, STATEMENTS].

216. Id.

217. Jeffrey Young, Health Insurance Mega-Mergers Attract Powerful Enemy, HUFFINGTON POST (Nov. 11, 2015), http://www.huffingtonpost.com/entry/health-insurance-mega-mergers-attract-powerful-enemy_us_5643a001e4b0603773477931.

218. Id.

219. Herman, Providers Fear, supra note 75.

220. Editorial, The Case for Bigger Health Insurers, BLOOMBERG VIEW (July 8, 2015

coordinated care efforts, they also gained market share and negotiation power along the way, forcing insurers to raise rates that get passed onto consumers.[221]

While providers argue only anti-competitive effects, the proposed mergers will carry multiple pro-competitive effects. Insurers argue the mergers will increase efficiency.[222] Aetna has already publicly claimed it can identify $1.25 billion in `synergy opportunit[ies]_[223] and increased operating efficiencies in the Humana acquisition. Both proposed mergers will increase payor scale to negotiate lower reimbursement rates, ultimately saving money for the systems and likely resulting in lower premiums charged to consumers. Furthermore, these mergers will allow the newly merged insurance companies to innovate care delivery.[224] UHG, the nation˘s largest insurer,[225] recently announced a new plan consisting of primary care clinics in Atlanta and Chicago, focused on preventive care, offering unlimited free doctor visits, around-the-clock access, personalized health coaches, and mental health treatment.[226] These new models are risky considering UHG˘s 2015 losses, but UHG˘s size, scope, and resources allow them to take these types of risks and implement innovative care models that will benefit consumers and could ultimately cut care costs dramatically.[227] In evaluating these proposed insurance mergers, a significant pro-competitive effect of these mergers will be the ability to craft inventive high-quality, low-cost consumer-focused care models, following the lead of UHG.

Despite public scrutiny, both proposed mergers are receiving continuous approval from state regulators.[228] This state approval speaks to the idea that health care is inherently local and if state regulators, looking at their market as a whole, do not have concerns, it may signify that the mergers will inevitably go through, likely with appropriate divestitures. Although these

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12:00 AM), http://www.bloombergview.com/articles/2015-07-08/the-case-for-bigger-health-insurers.

221. Id.

222. Aetna, supra note 2.

223. Id.

224. Ebers, supra note 107.

225. Nathan Bomey & Jayne O˘Donnell, UnitedHealth Warns It May Exit Obamacare Plans, USA TODAY (Nov. 20, 2015, 10:54 AM), http://www.usatoday.com/story/money/2015/11/19/unitedhealth-group-earnings-downgrade-obamacare-affordable-care-act/76040322/.

226. Phil Galewitz, UnitedHealth Tries Boutique-Style Health Plan, KAISER HEALTH NEWS (Apr. 4, 2016), http://khn.org/news/unitedhealth-tries-boutique-style-health-plan/.

227. Id.

228. See Goliya, supra note 9; see Gilchrist, supra note 203 (noting Colorado Department of Insurance˘s recent January approval of Aetna-Humana merger). Anthem˘s acquisition of Cigna has been approved in Alabama, Tennessee, Nevada and Montana, leaving twenty-two states and the DOJ left to review Anthem˘s deal. Bertha Coombs, Insurance Deal Win Over States, Feds Still in Doubt, CNBC (Feb. 16, 2016, 6:32 PM), http://www.cnbc.com/2016/02/16/insurance-deals-win-over-states-but-feds-still-in-doubt.html.

mergers could bring a needed counterbalance to existing provider dominion in certain geographic areas, providers are unlikely to concede to `the balance,_ forcing the continuation of the arms race for control, negotiation power, and damaging consumer effects.[229]

IV. PROPOSAL

A. Aligning Incentives

Health insurance companies have emphasized consolidation as a way to achieve better quality and lower costs within the modern health care delivery system.[230] The ACA solidified the industry˘s goals of high-quality and low-costs, but these goals have always been central to the mission of health insurance companies.[231] Insurance companies have sought to encourage higher-quality care as a result of their recognition that high-quality care likely leads to a decrease in pricy hospital stays and subsequent readmissions, resulting in lower healthcare costs overall. Healthcare providers have always strived to deliver high-quality health care, but providers have not traditionally been financially incentivized to deliver health care at both the highest quality and the lowest cost.[232]

Under the long-standing fee-for-service model, providers are financially incentivized to produce a higher volume of healthcare services, instead of at a higher value.[233] In the traditional fee-for-service payment model, insurers reimburse providers for each individual unit of healthcare services delivered to a patient.[234] Through this reimbursement model, the more services

229. Erin Marshall, Health Insurance Mega-Mergers May Go Through, But Only In Certain Markets BECKER˘S HOSP. REV. (Sept. 25, 2015), http://www.beckershospitalreview.com/payer-issues/health-insurer-mega-mergers-may-go-through-but-only-in-certain-markets.html.

230. Sternberg, supra note 4.

231. See Steve Lamb, Building Successful Payer-Provider Partnerships for Cost Reduction, MANAGED HEALTHCARE EXECUTIVE (Nov. 11, 2014), http://managedhealthcareexecutive.modernmedicine.com/managed-healthcare-executive/news/building-successful-payer-provider-partnerships-cost-reduction (noting that payors want to control costs up front and promote proactive programs that manage chronic care and reduce hospital readmissions).

232. See generally Erin E. Dine, Money Will Likely Be the Carrot, But What Stick Will Keep ACOs Accountable?, 47 LOY. U. CHI. L.J. 1377 (2016) (proposing another incentive model that can effectively encourage providers to participate in coordinated care models by financially incentivizing providers through the Medicare Shared Savings Program to produce low-cost care and through implementing a group medical malpractice insurance model where providers will share in the savings for a reduction in the amount of medical malpractice claims to incentivize the delivery of high-quality care).

233. Claire Batholome, Leveraging Our Strengths: Reinforcing Pay-for-Performance Programs as the Solution for Defensive Medicine, 4 J. HEALTH & BIOMEDICAL L. 333, 340 (2008).

234. Mark W. Friedberg et al., Effects of Health Care Payment Models on Physician Practice in the United States, RAND CORP. 10 (2015), http://www.rand.org/content/dam/rand/

provided, the more reimbursement a provider receives from the insurer.[235] By incentivizing providers to over-prescribe and over-treat, the fee-for-service reimbursement model has resulted in high-cost patient health care.[236] This impersonal health care can drive up costs for both patient-consumers and insurers.[237] Correspondingly, patients may also feel the fee-for-service model¨s negative financial implications through their health insurance premiums.

The insurer, rather than the provider, bears the financial responsibility for the costs associated with each unit of healthcare services.[238] The fee-for-service reimbursement model incentivizes providers to order more tests, possibly provide unnecessary treatment, and keep hospital beds full. In contrast, payors profit from not paying out their premium revenues for medical services, and ultimately prefer empty hospital beds. This inherent tension between providers and payors in the fee-for-service reimbursement model has created two enormous waves about to crash into each other, leaving the patient-consumer in the middle of the fragmented and uncoordinated healthcare delivery system storm.[239]

The ACA propelled the movement toward incentivizing care coordination and, thus, implemented incentives to replace the traditional fee-for-service reimbursement model with fee-for-value reimbursement models.[240] To achieve the overall goals of high-quality, low-cost health care, providers and insurance companies must align financial incentives to achieve the necessary

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pubs/research_reports/RR800/RR869/RAND_RR869.pdf.

235. Fee for Service (FFS), HEALTH CARE INCENTIVES, http://www.hci3.org/thought-leadership/why-incentives-matter/fee-for-service (last visited Mar. 29, 2016) [hereinafter HEALTH CARE INCENTIVES]

236. Id.

237. Kelly M. Bryant, Fee-for-Service 101: What it Means for Your Organization, PALADINA HEALTH (Sept. 3, 2015), https://www.paladinahealth.com/blog/fee-service-101-what-it-means-your-organization. Patients may experience an impersonal and hurried appointment because health care providers limit appointment times because if providers see more patients in a day, they will also receive more payment under a fee-for-service model. Id.

238. Jose L. Gonzalez, A Managed Care Organization¨s Medical Malpractice Liability for Denial of Care: The Lost World, 35 HOUS. L. REV. 715, 724 (1998).

239. HEALTH CARE INCENTIVES, supra note 235 (noting that the fee-for-service reimbursement model is the `single biggest contributor to excessive use of services and the fragmentation of the [United States] delivery system_); see Bryant, supra note 237 (noting that the lack of coordination caused by the fee-for-service reimbursement model has accounted for $25¨$45 billion in annual wasted health care spending). The fee-for-service reimbursement system actually incentives providers to avoid collaboration and coordination as a way to generate more services individually. Id.

240. Caleb Clarke, How the Affordable Care Act Will Affect Provider Reimbursement, NUEMD, http://www.nuemd.com/blog/affordable-care-act-will-affect-provider-reimbursement (last visited Mar. 10, 2016); VALENCE HEALTH, PROVIDER-SPONSORED HEALTH PLANS: THE ULTIMATE VALUE-BASED HEALTHCARE PLAN 1 (2015) [hereinafter VALENCE HEALTH White Paper].

coordination of care and the value necessary to be reimbursed under a fee-for-value reimbursement model.[241] This change in the financial structure will influence insurers, as financers of heath care, to transform into a more coordinated structure as well.[242] As payment structures adapt to the value incentives, the traditional structure of the current healthcare delivery and financing systems must adapt as well. For example, `hospitals that enter the insurance business may be able to better design quality care programs by becoming a unified organization and removing competing incentives._[243]

Coordinated care is thought to be the industry˘s route to achieve the ultimate goals of high-quality and cost-effective health care.[244] `Blurring the lines between insurers and providers and ushering in the era of coordinated care_ will achieve the integration within the delivery and financing of health care that is necessary to achieve quality and cost goals.[245] Value-based reimbursement models transfer financial risk and clinical control to the providers and away from the payors.[246] New responsibilities, payment structures, and reimbursement pressures will force healthcare systems to take on new roles beyond the role as the mere provider of health services.[247]

B. The Proposal

The structure of today˘s health insurance companies is changing.[248] The traditional and current health insurance market will transform into a system that incentivizes stakeholders to deliver low-cost, high-quality health care. The main stakeholders in the healthcare financing system primarily include

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241. Joe Mott, By Aligning Financial Incentives, Intermountain Healthcare Will Help Everyone Who˘s Involved in Healthcare Get Better Results for More Affordable Cost, INTERMOUNTAIN HEALTHCARE (Jan. 14, 2015), https://intermountainhealthcare.org/blogs/2015/01/aligning-financial-incentives-will-help-lead-to-more-affordable-costs.

242. Bob Herman, Providers Becoming Payors: Should Hospitals Start Their Own Health Plans?, BECKER˘S HEALTHCARE (Jan. 30, 2013), http://www.beckershospitalreview.com/finance/providers-becoming-payors-should-hospitals-start-their-own-health-plans.html [hereinafter Herman, Providers Becoming Payors].

243. Ellison, supra note 172.

244. Kathleen Sebelius, The Affordable Care Act at Three: Paying for Quality Saves Health Care Dollars, HEALTH AFFAIRS BLOG (Mar. 20, 2013), http://healthaffairs.org/blog/2013/03/20/the-affordable-care-act-at-three-paying-for-quality-saves-health-care-dollars/. The ACA created Accountable Care Organizations (ACOs) as way to incentivize providers to collaborate and provide coordinated care. Id. ACOs manage the cost of quality of patient care to ultimately reach of goal of improved care coordination and safety. Id.

245. Joseph Burns, Reform Forces Health Insurers to Reinvent Themselves, MANAGED CARE (Apr. 2012), http://www.managedcaremag.com/archives/2012/4/reform-forces-health-insurers-reinvent-themselves.

246. VALENCE HEALTH White Paper, supra note 240, at 1.

247. Margaret Dick Tocknell, 1 in 5 Health Systems to Become Payers by 2018, HEALTH LEADERS MEDIA (Aug. 20, 2013), http://www.healthleadersmedia.com/health-plans/1-5-health-systems-become-payers-2018.

248. Burns, supra note 245.

the provider and the third-party insurer existing as separate and distinct business entities.[249] Through the patient˘s eyes, after the provider delivers care to the patient, the provider then bills the patient˘s third-party insurer, and the transaction is complete. What the patient does not see is the lengthy, and tedious, `behind the scenes_ contracting action between the providers and insurance companies. Patients are insulated from insurer-provider reimbursement negotiations that define the scope of patient care. The traditional negotiations relating to the reimbursement contract between insurers and providers result in a `win-lose negotiation focused on rates._[250]

The pressures stemming from new reimbursement structures emphasizing population health will lead health systems to consider launching their own health insurance plans.[251] Many scholars propose specific dates as to when health insurance companies, as the nation traditionally knows them, will be extinct,[252] but this article emphasizes the way the lines between health insurance companies and providers will blur, eliminating the traditional role of health insurance companies.

Under the new managed care model, hospitals are pressured to manage a patient˘s total health care, as well as the total cost of that care.[253] New opportunities may stem from these new responsibilities.[254] As hospitals begin to manage patient care and risk, `they˘re sort of halfway toward being an insurance company._[255] When a health system operates and controls a health plan, the premium dollars stay in the health system and `a smaller fraction walks out the door._[256] In a model where healthcare providers serve as insurers, traditionally misaligned incentives of providers and insurers are eliminated. In the traditional fee-for-service model, providers are financially

249. Ellison, supra note 172.

250. Burns, supra note 245.

251. Margaret Dick Tocknell, 1 in 5 Health Systems to Become Payers by 2018, HEALTH LEADERS MEDIA (Aug. 20, 2013), http://healthleadersmedia.com/page-1/HEP-295415/1-in-5-Health-Systems-to-Become-Payers-by-2018##.

252. See, e.g., id. (noting that 1 in 5 health systems will become health insurance payers by 2018).

253. Roni Caryn Rabin, Some Hospital Networks Also Become Insurers, WASH. POST (Aug. 25, 2012), https://www.washingtonpost.com/business/some-hospital-networks-also-become-insurers/2012/08/25/53e90a72-eb1d-11e1-b811-09036bcb182b_story.html.

254. See Phil Kamp, Industry Perspective: Less Risky Than It Seems: Provider-Sponsored Health Plans Take Hold, VALENCE HEALTH, http://valencehealth.com/uploads/files/Valence_Health_Industry_Perspective_Less_Risky_Than_it_Seems.pdf (last visited Mar. 10, 2016) (noting that a health system that operates a health plan may incur new responsibilities such as: `claims payment, customer service, insurance reporting and other administrative operations_).

255. Rabin, supra note 253.

256. Kamp, supra note 254; see Herman, More Health Systems, supra note 258 (noting that a provider-sponsored health plan frees providers `from having to share with insurance companies any savings they generate from improved quality and efficiency_).

incentivized to keep hospital beds full. However, when the provider also takes on the role of insurer, these traditionally-contrasting goals are aligned to one coordinated goal of keeping the patient-member healthy and costs low.[257]

Health systems, however, do not want to replicate the financial losses that occurred in the 1990s.[258] Providers are thus cautiously examining the options and slowly approaching the new provider-owned health plans.[259] Although leaders of provider-owned health plans say the implementation of these plans is `a long slog to positive margins,_ health systems can initially seek partnerships with insurers.[260] Moreover, health systems can hire internally or utilize third-party administrators to initially aid in their financial risk management.[261]

If health systems seek to compete with traditional health plans on the market, they will be required to effectively manage risk in order to get a share of the dollars.[262] Hiring an in-house insurance team may not be the most viable option for a health system initially. To understand and better manage the risk that a health system will incur by operating as an insurance company, the system may contract with a health plan management company.[263] To combat the initial difficulties associated with operating a health plan, providers may employ consulting firms to aid and advise the operation of their new health plans.[264]

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257. Bob Herman, The Risks of Provider-Operated Health Plans: Are the Rewards Worthwhile?, BECKER˜S HOSP. REV. (Jan. 31, 2014), http://www.beckershospitalreview.com/payer-issues/the-risks-of-provider-operated-health-plans-are-the-rewards-worthwhile.html [Herman, The Risks].

258. Bob Herman, More Health Systems Launch Insurance Plans Despite Caveats, MODERN HEALTHCARE (Apr. 4, 2015), http://www.modernhealthcare.com/article/20150404/magazine/304049981 [hereinafter Herman, More Health Systems].

259. Id.

260. Id. However, health insurance companies may not wait to aid competing provider networks gain traction in the insurance market. Id.

261. Molly Gamble, Health Systems Becoming Payers: 8 Observations, BECKER˜S HOSP. REV. (July 8, 2014), http://www.beckershospitalreview.com/finance/health-systems-becoming-payers-8-observations.html; see Herman, More Health Systems, supra note 258 (noting one CEO of a large health system stated, `We are going to do our insurance products through established health plans_). Newly-formed provider-owned health plans may need the help of third party insurance administrators to manage the possible sicker population that may find the health system˜s narrow network, low premium attractive. Id.; see also supra Part I.C.

262. Burns, supra note 245.

263. Id. Partnering with national insurers is a viable option for health systems entering into the insurance game. Herman, More Health Systems, supra note 258. To gain expertise within the market without assuming total patient risk, one safe option for provider health systems seeking to enter into the insurance market is to offer the initial health plans to a narrow population, such as a Medicare Advantage plan. Id.

264. Herman, More Health Systems, supra note 258.

C. Benefits

Health systems can effectively eliminate their reliance on third-party insurance companies by creating their own health plan.[265] This will allow systems to provide necessary care and simultaneously control the financing of that care, creating a more efficient, and better-quality delivery of health care.[266] Overall, hospital-provided health plans produce higher quality ratings by consumers.[267]

By offering a narrow network to policyholders of their provider-owned health plans, health systems can maximize and estimate their patient volume more accurately and efficiently.[268] In creating their own health plans, systems also have the potential to generate more revenue that can be reinvested in hospital infrastructure and within the community.[269] For example, Pennsylvania˘s Geisinger Health System receives $1.3 billion in revenue from operating Geisinger Health Plan.[270] Increased revenue can also allow health systems to `re-engineer [their] care to get better outcomes._[271]

Healthcare providers have the potential to increase clinical coordination by aligning the incentives between the deliverers and the financers of health care.[272] Under coordinated care models, the traditional contracted relationship between insurers and providers will be based on `data, care management, and analytics,_ rather than the flawed negotiation system based

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265. Herman, The Risks, supra note 257.

266. Id. The CEO of Premier Health Plan, a provider-sponsored health plan, stated: `For us, the insurance business is just a vehicle to cover as many lives as we can in our service area with our population health initiatives._ Herman, More Health Systems, supra note 258.

267. Austin Frakt, When Hospital Systems Buy Health Insurers, INCIDENTAL ECONOMIST (May 27, 2014, 6:00 AM), http://theincidentaleconomist.com/wordpress/upshot-vertical-integration/.; cf., Ellison, supra note 172 (noting a study that found that seventy percent of the increased premiums derived from health systems operating health insurers did not result in higher quality of care).

268. Gunjan Khanna et al., Provider-Led Health Plans: The Next Frontier ¯ or the 1990s All Over Again?, MCKINSEY & CO. 1, 1 (2015), http://healthcare.mckinsey.com/sites/default/files/Provider-led%20health%20plans.pdf.

269. Herman, The Risks, supra note 257. Costs of incremental health care are often less for providers as compared to payors. VALENCE HEALTH White Paper, supra note 240, at 2. For example, an episode of care might cost a traditional insurer $50,000. However, a health system sustains out-of-pocket costs that are limited to the variable costs associated with providing care. In many instances, the variable cost of care often is less than ¯ percent of the total amount billed to an insurer.
Id. Provider-sponsored health plans have an opportunity to generate non-profit revenue that can be reinvested directly into the health system. Rick Bobos, Is a Provider-Sponsored Health Plan Right For You?, VALENCE HEALTH (Mar. 20, 2014), http://hfmaky.org/downloads/valence_health_is_a_provider_sponsored_health_plan_right_for_you.pdf.

270. Herman, The Risks, supra note 257.

271. Id.

272. Kamp, supra note 254.

on rates for individual units of health services.[273] The ability to keep care decisions within the health system, rather than relying on third-party insurance companies, has its advantages as it relates to quality patient care.[274]

The transition into a payor role may lower the costs for healthcare systems by creating a more efficient and more aligned delivery of care model.[275] The era of lower reimbursement rates has arrived.[276] Providers will no longer be reimbursed for each unit of service, but rather reimbursed for efficiency. To achieve efficiency, healthcare providers must create delivery models that retain cost and deliver high-quality care.[277] The arms race to consolidate has allowed providers to create large networks of care, encompassing the systems˘ necessity to deliver coordinated, seamless, and efficient care. Providers can utilize these larger networks and benefit from value-based incentives by creating their own health plan that would offer insurance for health services on their network. Embarking into the health insurance market can prove valuable in terms of finances and quality.[278]

The first dollar capture is one of the major advantages for provider-sponsored health plans.[279] The dollars available within the healthcare industry are limited, but as a result of consolidation, large health systems have access to the capital necessary to acquire health plans and acquire the first dollar amidst the wave of lower reimbursements.[280] Provider-owned health plans are achieving more financial success as compared to other health plan insurers.[281] Healthcare providers are not only able to compete with large insurers, but can also reduce their system˘s total cost margin by consolidating. The FTC is currently blocking the proposed merger between Advocate Health Care (`Advocate_) and NorthShore University Health System (`NorthShore_), a merger that would have created Illinois˘ largest healthcare delivery system.[282] Both parties are currently arguing their cases

273. Burns, supra note 245.

274. Herman, The Risks, supra note 257.

275. Ellison, supra note 172.

276. Jess White & Renee Cocchi, Medical Reimbursement, HEALTHCARE BUS. & TECH. (2014), http://www.healthcarebusinesstech.com/medical-reimbursement/.

277. Burns, supra note 245.

278. Health systems entering into the insurance market must be aware that implementing their own health plans may conflict with current insurance companies. Herman, More Health Systems, supra note 258. When starting a new health plan directly challenges and competes with insurers for the first dollar, tension between the provider and the insurer may arise, specifically when a provider is attempting to negotiate with the insurer for membership in its network. Id.

279. Kamp, supra note 254.

280. Burns, supra note 245.

281. Herman, More Health Systems, supra note 258 (`Premiums collected by provider-owned plans rose father in 2014 (5.5%) than at publicly traded insurers (2.4%), Blue Cross and Blue Shield plans (2.5%), and others in the industry (3.2%)._).

282. Advocate and NorthShore Combine to Create Preeminent Health Care System,

before an Illinois court, and Advocate and NorthShore are proposing a pro-competitive argument that has never been offered before in a merger challenge.[283] To bolster their proposed merger to the FTC, Advocate and NorthShore proposed a new coordinated health insurance product that would be offered on the market at a price at least ten percent lower than the cheapest comparable health plan.[284]

Additionally, a health system operating a provider-owned health plan is incentivized to manage and focus on preventative care.[285] By focusing on preventative care, overall healthcare costs decrease and patients benefit from better quality care.[286] The traditional function of the insurance company may decline if healthcare providers continue to enter into the insurance business. This could effectively eliminate the traditional function of the insurance company as an individual stakeholder at odds with the health provider.[287] `Once the system becomes an insurer, picking up the tab for a hospitalization rather than generating income from it, more resources will be devoted to preventative care._[288]

D. Already Happening

Health systems realize that the traditional negotiations for individual units of services are over. Now, health systems fully understand that in today˘s health care delivery market, `[n]o outcome, no income._[289] The idea of systems offering health plans is not novel. Thirteen percent of healthcare systems in the United States offer a health plan.[290] For over thirty years,

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NORTHSHORE, http://www.northshore.org/newsroom/press-releases/northshore-advocate-merger/ (last visited Mar. 30, 2016); see Peter Frost, Advocate, NorthShore Punch Back at FTC, CRAIN˘S (Mar. 23, 2016), http://www.chicagobusiness.com/article/20160323/NEWS03/160329925/advocate-and-northshore-punch-back-against-ftc (noting the recent activity in response to the FTC block of the proposed Advocate and NorthShore merger).

283. Lisa Schencker, Uphill FTC Fight Starts this Week for Big Chicago-Area Health Systems, MODERN HEALTHCARE (Apr. 4, 2016), http://www.modernhealthcare.com/article/20160404/NEWS/160409959/uphill-ftc-fight-starts-this-week-for-big-chicago-area-health-systems.

284. Frost, supra note 282.

285. Herman, The Risks, supra note 257.

286. Ellison, supra note 172.

287. Burns, supra note 245 (`The models being emulated are similar to organizations such as Geisinger and the University of Pittsburgh Medical Center (UPMC) that are already in the insurance business. . . They operate hospitals, medical groups, and HMOs._); see Ellison, supra note 172 (noting the new trend in health care that health systems are buying insurance companies and operating their own health plan).

288. Rabin, supra note 253

289. Burns, supra note 245.

290. Bara Vaida & Alexander Wess, Health Care Consolidation, ALL HEALTH (Nov. 2015), http://www.allhealth.org/publications/Consolidation-Toolkit_169.pdf.

health systems have played the dual role of both provider and payor,[291] but now that role is likely to be played by the new consolidated health systems.[292]

The largest managed care organization in the United States, Kaiser Permanente, has been operating as a health plan and a provider since 1945.[293] Kaiser is made up of three separate, yet cooperative, entities including: Kaiser Foundation Health Plan, Kaiser Foundation Hospitals, and Permanente Medical Groups.[294] Kaiser has effectively produced a structure that successfully aligns the goals of the health plan and medical group, implementing total accountability for a global budget.[295] Kaiser˘s health plan and healthcare providers `share in the goal, reflected in the organization˘s capitated payment system, of keeping patients healthy while optimizing utilization._[296] Rather than focusing on producing a high-volume of services, a goal inherent in a fee-for-service reimbursement model, Kaiser is financially incentivized to `provide high quality, affordable care and manage population health,_ as a result of its integrated and managed care structure.[297] Kaiser is simultaneously a provider and payor, and this dual role allows Kaiser to align incentives leading to an improvement of the community˘s overall health.[298]

The coordination of the three Kaiser entities provides a `common vision, joint decision-making, and aligned incentives._[299] The success of Kaiser˘s high-quality integrated health care and health plans is further evidence of what can result from providers offering health plans. According to a National Committee for Quality Assurance report, Kaiser˘s health plans have achieved top national scores in consumer experience, disease prevention, and overall

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291. Herman, The Risks, supra note 257.

292. The trend of provider-owned health plans is increasing, but `[p]rovider-owned plans cover less than 10% of the entire privately insured market._ Herman, More Health Systems, supra note 258.

293. Word˘s Out: Kaiser Permanente Health Plans Among Nation˘s Best, PR NEWSWIRE (Sept. 17, 2015), http://www.prnewswire.com/news-releases/words-out-kaiser-permanente-health-plans-among-nations-best-300145297.html [hereinafter Word˘s Out].

294. Douglas McCarthy et al., Kaiser Permanente: Bridging the Quality Divide with Integrated Practice, Group Accountability, and Health Information Technology, 17 COMMONWEALTH FUND 1, 2 (June 2009), http://www.commonwealthfund.org/~/media/Files/Publications/Case%20Study/2009/Jun/1278_McCarthy_Kaiser_case_study_624_update.pdf.

295. Jesse Pines et al., Kaiser Permanente ¯ California: A Model for Integrated Care for the Ill and Injured, BROOKINGS INST. (May 4, 2015), http://www.brookings.edu/~/media/Research/Files/Papers/2015/05/04-emergency-medicine/050415EmerMedCaseStudyKaiser.pdf?la=en.

296. Id.

297. Id.

298. What Health Systems Can Learn from Kaiser Permanente: An Interview with Hal Wolf, HEALTH INT˘L 18, 20 (Nov. 8, 2009).

299. McCarthy et al., supra note 294.

healthcare treatment.[300]

Amidst the wave of managed care in the 1980s, the decision-makers for Pennsylvania-based Geisinger Health System realized that as the delivery of care was changing, the financing of that care would also change.[301] As a result, the Geisinger Health System created the Geisinger Health Plan.[302] The Geisinger Health Plan sustains the system˘s care coordination goals and provides the financial accountability necessary for the system to start caring about the quality and cost of a patient˘s continuum of care.[303]

In 2015, a subsidiary of Ascension Health, the largest not-for-profit healthcare provider based in St. Louis, released its plan to buy an insurance company licensed in states throughout the Midwest.[304] The transaction will allow a health system to offer its narrow provider network on a state health insurance exchange.[305] `The acquisition makes a lot of sense . . . Hospitals are now expected to manage population health and owning a health plan provides both infrastructure and a way to connect more directly with insurance purchasers. _[306]

The University of Pittsburgh Medical Center (UPMC) is another example demonstrating the recently developed alliance between health plans and healthcare providers.[307] The UPMC operates the UPMC Health Plan and simultaneously acts as a healthcare provider and health insurer.[308] UPMC Health Plan insureds have access to the various UPMC systems as well as other community providers that have contracted with the UPMC Health Plan.[309] The UPMC˘s integrated delivery and financing system provides patients with high-quality care at lower costs.[310]

The private insurance exchanges created under the ACA have generated an easy route for health systems to offer their own narrow network health

300. Word˘s Out, supra note 293.

301. Herman, The Risks, supra note 257.

302. Id.

303. Douglas McCarthy et al., Geisinger Health System: Achieving the Potential of System Integration Through Innovation, Leadership, Measurement, and Incentives, COMMONWEALTH FUND 3 (June 2009), http://www.commonwealthfund.org/~/media/Files/Publications/Case%20Study/2009/Jun/McCarthy_Geisinger_case_study_624_update.pdf.

304. Jay Greene, Ascension Health Subsidiary to Buy Michigan Health Insurer for $50 Million, MODERN HEALTHCARE (Feb, 20, 2015), http://www.modernhealthcare.com/article/20150220/NEWS/150229987.

305. Id.

306. Id.

307. Burns, supra note 245.

308. Health Plan Introduces New Individual Products, UPMC (Feb. 2, 2016), http://www.upmc.com/media/NewsReleases/2012/Pages/health-plan-introduces-new-products.aspx.

309. UPMC Facts & Stats, UPMC, http://www.upmc.com/about/facts/pages/default.aspx (last visited Mar. 10, 2016).

310. Id.

plans and to compete with large national health insurers.[311] Further, prior to value-based reimbursement and capitated payment models, health systems did not have the infrastructure or incentives to enter into the insurance business.[312] With recent acquisitions of physician practices, rehabilitation centers, and skilled nursing facilities, systems now have access to a broad network of services.[313] Managing population health and achieving success under value-based reimbursement models require scale.[314] With scale, health systems will have a large risk pool that is necessary to sustain a health plan˘s risk pool. Further, through consolidation, a health system will own various facilities that will attract consumers to a narrow network health plan.

These examples demonstrate varying degrees of control, services, and financial strategies. Each model is unique while still delivering integrated and coordinated care through the traditional provider structure adapted to the not-so-traditional regulatory and industry changes. These models demonstrate the range of potential future health care delivery models.

E. Disadvantages

The newly-proposed dual role of the health care provider as both an insurer and provider will yield different benefits, but also present new challenges to providers attempting to play in the insurance game. There are potential downsides to hospital health plans for consumers as well as health systems. One of those downsides is the narrow network health plan that provider-insurers will offer.[315]

A narrow network health plan limits the insured˘s provider choice in exchange for a less-costly health plan premium.[316] A narrow network refers to the network of providers that policy-holders of a specific health plan can use and visit.[317] By offering fewer options to consumers, narrow networks

311. Susan Kelly, As U.S. Insurers Aim to Get Bigger, Hospitals Plan Entry, REUTERS (Oct. 13, 2015, 4:00 AM), http://www.reuters.com/article/us-usa-healthcare-hospitals-idUSKCN0S621E20151013.

312. Herman, More Health Systems, supra note 258.

313. Kelly, supra note 311.

314. Herman, More Health Systems, supra note 258.

315. Cf., Seth Trueger, Narrow Networks: The Result of Competition, Not the Barrier, MDAWARE.ORG (Oct. 13, 2013), http://mdaware.blogspot.com/2015/10/narrow-networks-result-of-competition.html (noting that narrow networks can actually be a positive aspect of the health care industry). Although narrow networks may reduce consumer choice, narrow networks do not demonstrate the lack of competition within the health care industry. Id. Instead, `[n]arrow networks are the result of competition and negotiation in the health insurance market._ Id.

316. Laura Summer, Health Plan Features: Implications of Narrow Networks and the Trade-Off Between Price and Choice, ACADEMY HEALTH, http://academyhealth.org/files/HCFO/RIBrief0315.pdf (last visited Mar. 15, 2016).

317. David Blumenthal, Reflecting on Health Reform ¯ Narrow Networks: Boom or

intend to limit access to high-costing specialists and technologies.[318] Consumers are attracted to narrow network health plans, typically as a result of their low premium amount.[319]

The health system˘s decision to enter into the health insurance market will involve more than merely hiring a third-party administrator or an actuarial company and retrieving reserve capital.[320] The new provider-owned health plan will require a unique and detailed plan design, an integrated claims processing system, customer service, and marketing.[321]

The costs associated with health systems becoming health insurers may also act as a barrier to the transition.[322] The initial start-up costs for a system to start its own plan for an integrated network can be steep.[323] Additionally, to become an insurer, a hospital must acquire an additional state license.[324] To receive the license, the hospital must have `millions of dollars in capital reserves and must run a regulatory gantlet to prove it has an adequate provider network and can delivery required benefits._[325] The pool of health systems that have the ample resources necessary to obtain a license and meet capital reserve requirements is narrow.[326] Further, a study that researched hospital-insurer integration found that insurance plans that were offered by hospitals had higher premiums.[327]

Health systems that implement a provider-sponsored health plan take on full clinical and financial responsibility, which can initially appear overwhelming.[328] To implement a health plan, health systems must establish

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Bane?, COMMONWEALTH FUND (Feb. 24, 2014), http://www.commonwealthfund.org/publications/blog/2014/feb/narrows-networks-boon-or-bane.

318. Rabin, supra note 253; see Blumenthal, supra note 317 (noting that the most expensive doctors and hospitals are typically excluded in a narrow network plan, which can be a major problem for patients with complex and rare health conditions).

319. Summer, supra note 316.

320. Gary Ahlquist et al., Several Hundred Health Networks Will Become Payors, STRATEGY & 1, 3 (June 20, 2014), http://www.strategyand.pwc.com/reports/health-networks-become-payors.

321. Id.

322. Herman, The Risks, supra note 257.

323. Id. (noting that a health system should anticipate spending around $50 million to start their own health plan, `which could limit other capital investments_); see Herman, More Health Systems, supra note 258 (noting that the `safest option for provider systems for now . . . may be offering insurance products that serve a narrow population, such as a Medicare Advantage or Medicaid plan, or creating loose partnerships with insurance companies_).

324. Rabin, supra note 253.

325. Id.

326. Kelly, supra note 311.

327. Austin Frakt, supra note 267

328. VALENCE HEALTH White Paper, supra note 240, at 1. Although assuming risk may appear overwhelming, `[t]he reality is that taking on more risk can ultimately yield more benefits._ Id. Studies demonstrates that thirty to forty percent of all medical expenses are wasteful and thirty cents of every health care dollar is spent on administrative costs rather than

an effective infrastructure, construct collaborative networks, and advertise the new health plan brand.[329] To create an effective health plan, providers must aim to enroll at least 100,000 patient-members to achieve the necessary risk pool.[330] Although in theory, cutting out the middleman¯-the insurer¯-would appear to save money, there is a deep-rooted history between hospitals and insurance companies that make this idea difficult and complicated to achieve.[331] `Hospitals cannot flip a switch to go from a provider to an insurer,_[332] but the cost and quality benefits that health systems can derive from the new role of an insurer will likely prove to be advantageous.

V. CONCLUSION

Since 2010, the ACA sparked unprecedented changes within the health care industry.[333] To correspond and comply with the changes, it will be necessary for the industry and its payment system to correspondently focus on shifting the status quo.[334] The concern that only a few large companies will act as the minute number of players in the health insurance game is real; however, the concern may become obsolete if health systems continue to enter into the insurance game.

As evidenced by the potential outcome of only three main insurers in the United States, the insurance game and the traditional market pressures are already changing.[335] The consolidation trend began before the creation of the ACA, but the ACA has become one of the main drivers of the current consolidation trend within the healthcare industry. Although the intentions of the consolidating insurance companies may be questioned, consolidation will lead to larger provider networks with an increased potential in delivering cost-effective and high-quality health care. Even with the potential to achieve the low-cost, high-quality goals of the ACA, the proposed mergers are contingent on FTC approval. The FTC reviews the proposed mergers to

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patient care. Id. Provider-sponsored health plans provide a way for providers to reduce waste and administrative overhead. Id.

329. Herman, More Health Systems, supra note 258.

330. Kelly, supra note 311.

331. Rabin, supra note 253; Bob Herman, Why Hospital-Owned Health Plans Are Big Like Cheese in Wisconsin, MODERN HEALTHCARE (Dec. 9, 2015), http://www.modernhealthcare.com/article/20151209/NEWS/151209857.

332. Herman, The Risks, supra note 257.

333. See EZEKIEL J. EMANUEL, REINVENTING AMERICAN HEALTH CARE 347 (2014) (`The ACA is stimulating a transformation of the entire American health care system . . . [b]efore the ACA, the American health care system was literally killing the country._).

334. Herman, The Risks, supra note 257.

335. Kelly, supra note 311 (noting that `the chance to gain market share and cut expenses by eliminating the insurer as the middleman is attracting hospitals again, particularly if the top five U.S. health insurers consolidate into three players); see Part I.

safeguard against unfair methods of competition and unfair practices. Although the FTC has recently blocked some major healthcare system, provider, and insurer mergers, whether the FTC possesses sufficient resources to hold back the consolidation storm remains unanswered.

Under this article˘s proposed model, the hands collecting the insurance premiums will also deliver the care.[336] The CFO at a major health system was quoted saying, `We shag every fly ball a health plan hits to us-¯an ACO here, a bundle experiment there . . . Maybe it˘s time we take the plunge and become an insurer ourself._[337] Although there may be some downsides in creating a health plan, the long term benefits associated with a health system operating as a provider and an insurer likely outweigh the initial cost and structural burdens.[338] Providers that successfully implement and operate their own health plans have the potential to drastically change the delivery and financing of health care in a positive way. The stunning volume of mergers has increased the notice, concern, and attraction to the current healthcare events. With that attention, the industry has the opportunity to gain awareness of the issues to create and structure a better, less-costly healthcare delivery system. Just as a car owner has an incentive to take his or her car to the shop for consistent oil changes, providers playing the dual-role of an insurer and a provider will also have a financial incentive to maintain the health of their patient-population.[339]

336. Dana Blankenhorn, Vertical Integration Comes to Health Care, Street (Aug. 20, 2012, 10:35 AM), http://www.thestreet.com/story/11668844/1/vertical-integration-comes-to-health-care.html.

337. Ahlquist et al., supra note 320.

338. See Herman, The Risks, supra note 257 (noting that although `[a] lot of backend work is required to make a provider-operated health plan successful . . . benefits come in the long run_).

339. Blankenhorn, supra note 336.