Health Insurance Mergers - Five Key Antitrust Issues

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In the last few weeks, several national health insurers have announced their intentions to combine, in deals that could soon materially reshape the health insurance marketplace. While these mergers are still in their earliest stages, before they can be consummated the parties will require not only insurance regulatory approval, but antitrust regulatory approval as well. For this reason, now is an excellent time to review five core antitrust principles that come into play as part of any regulatory review of a health insurance merger.

First, and most significantly, despite all the talk about how the insurance industry is “exempt” from the federal antitrust laws by virtue of the McCarran Ferguson Act (15 U.S.C. § 1012 et seq.), and the bills that seem to be introduced every Congress seeking to repeal this exemption, it has been clear for many years that health insurance mergers are not within the scope of McCarran’s exemption. Accordingly, these mergers can, and will, be examined by federal antitrust regulators. And if the regulators believe that the proposed deals raise the potential for competitive harm, challenges to the deals are likely.

Second, many healthcare providers (and the associations representing them—most significantly the American Hospital Association and the American Medical Association) have long claimed that even if regulatory review of health insurer mergers is not prohibited by the McCarran Ferguson Act, federal regulators have typically provided insurers with a “free pass” on mergers or, at the very least, failed to subject insurer transactions to the same level of scrutiny applied to hospital system transactions. In support of this contention, providers often point to the number of provider challenges as compared to the number of insurer challenges; that statistic, however, can be quite misleading, given the vastly greater number of providers as compared to the number of health insurers in the country. More importantly, recent enforcement history clearly confirms that the DOJ Antitrust Division has been quite active in challenging health insurer mergers that the Antitrust Division felt warranted their attention, and that the Division’s review can be expected to be both extensive and meaningful.

For example, in 2012, the DOJ Antitrust Division issued a “Second Request,” holding up a proposed transaction between WellPoint and Amerigroup, ultimately requiring the insurers to divest Amerigroup’s Virginia Medicaid business as a condition of getting federal approval for their deal. Similarly, in that same year, the Antitrust Division put the brakes on Humana’s acquisition of Arcadian Management Service based upon concerns about the impact on Medicare Advantage markets, requiring divestitures in five states before approving that deal. And these challenges do not appear to be outliers; in the relatively recent past, the Antitrust Division also challenged a proposed merger between Blue Cross of Montana and New West (a rival plan in Montana) and derailed a proposed merger between Blue Cross of Michigan and Physicians Health Plan of Michigan. Other Antitrust Division challenges since 2000 include UnitedHealth’s acquisition of Sierra Health and UnitedHealth’s acquisition of Pacificare Health Systems. In addition, in 1999 the Antitrust Division required that Aetna divest a portion of Prudential’s health insurance business as a condition to approval of that deal as well. In short, these facts clearly and unequivocally refute any claim that the Antitrust Division has given a “free pass” to health insurers. As such, it can be
expected that the Aetna/Humana deal—as well as any other significant deals that may follow in the coming months—will face careful review from the Antitrust Division.

Third, the Antitrust Division’s review can also be expected to be both detailed and thorough, if past investigations provide any window into future events. In the WellPoint/Amerigroup deal, for example, while the merging parties competed in nineteen states, after careful investigation the Antitrust Division concluded that the potential for competitive harm existed in only one market—the Northern Virginia Medicaid market—and limited their challenge to that market alone. Significantly, the Antitrust Division’s thorough approach is further reflected by the fact that Amerigroup’s Virginia Medicaid business accounted for only a small portion of its overall operations (reportedly 50,000 of its more than 2.5 million beneficiaries). Ultimately, approval was not granted until the parties agreed that Amerigroup’s Virginia operations would be divested to a third party. A similarly careful examination of the potential impact of the Aetna/Humana deal in each and every market in which the insurers compete (both in terms of geography and product) can be expected before approval (or a challenge) occurs.

Fourth, given the large size and scope of these health insurers, and the many geographic and product markets in which they compete, the potential possibility that some limited divestitures will be required cannot be discounted. Indeed, most of the recent health insurance merger approvals were only approved after the parties agreed to divest certain assets. As noted above, WellPoint agreed to divest Amerigroup’s Virginia operations to gain approval, and Humana agreed to divest Arcadian assets in their 2012 deal. In earlier deals, Blue Cross of Montana agreed to divest a portion of its business to PacificSource to gain regulatory approval, and Aetna agreed to divest its commercial HMO business in Houston and Dallas to gain approval of its purchase of Prudential back in 1999. If history is an accurate predictor of future events, it would not be surprising to see the parties to the currently proposed transactions offering up some limited divestitures in an effort to gain approval for their overall deals.

Fifth, and finally, in health insurance transactions, gaining federal antitrust approval for a transaction often only gets the parties half way to completion—and sometimes even less than that. State regulators (both state attorneys general and state insurance commissioners) have increasingly conducted their own investigations (sometimes, but not always, in conjunction with the Antitrust Division) and have, on occasion reached different conclusions than federal regulators.

For example, in the 2004 WellPoint/Anthem merger, after the parties had received federal antitrust approval for their transaction, the deal was held up when the California Insurance Commissioner refused to approve the deal. Ultimately, after the parties agreed to some additional concessions related to the California market, approval was granted and the deal was permitted to close. More recently, a proposed merger between two Pennsylvania insurers (Highmark Blue Cross and Independence Blue Cross) was approved by federal regulators but derailed when the parties could not reach a deal with the Pennsylvania Insurance Commissioner. In short, as these examples illustrate, even if Aetna and Humana receive federal approval for their transaction, it would be a mistake to conclude that they have necessarily resolved all antitrust issues raised by the transaction.

With respect to the recently announced transactions, the press has already reported that attorneys general in several states have indicated that they will carefully review the proposed transaction for potential competitive impacts in their respective states. And, given the “national” scope of operations for these insurers, it would not be surprising to see similar announcements from other state attorneys general in the coming weeks.

Will any of these recently announced transactions ultimately come to fruition? Only time will tell. However, what is relatively certain is that the five core principles summarized above will be in play as regulators analyze these proposed deals. And for the parties, it is likely to be a long and wild ride.