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November 23, 2009

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Hon. Ken Ross
Commissioner
Office of Financial and Insurance Regulation
P.O. Box 30220
Lansing, MI 48909

Re: Proposed Acquisition of PHPMM Insurance Company and Physicians
Health Plan of Mid-Michigan – Family Care by Blue Care Network of
Michigan

Dear Commissioner Ross:

We greatly appreciate your decision to hold a public hearing with respect to the above captioned matter and for providing an opportunity to submit comments to the Office of Financial and Insurance Regulation (OFIR) in connection with the public hearing. As you may recall, the Michigan Association of Health Plans (MAHP) requested that OFIR conduct a public hearing in this matter by letter dated October 7, 2009. This letter supplements MAHP's earlier correspondence and is offered to assist OFIR in its analysis of whether the transaction (as described in further detail below) will "substantially ... lessen competition in insurance in this state or tend to create a monopoly in this state," and whether Blue Care Network's post-acquisition plans for PHPMM "are unfair and unreasonable to [PHPMM's] policyholders, and not in the public interest" pursuant to MCL 500.1315.

While we acknowledge that mergers and consolidations have the potential to generate efficiencies in the marketplace, in furtherance of the public interest, it appears that the transactions which are the subject of this public hearing raise serious concerns that warrant further investigation and consideration by OFIR. This is particularly true given the effects of the market dominance enjoyed by Blue Cross Blue Shield of Michigan (BCBSM), for its own benefit and for the benefit of its affiliates such as Blue Care Network of Michigan (BCN).

MAHP will set forth the factual background of the transactions, the standard of review, and arguments in opposition of the transactions.

Factual Background:

On or about September 28, 2009, BCN, a Michigan nonprofit health maintenance organization, filed a **Form A**, Statement Regarding the

Acquisition of Control or Merger with a Domestic Insurer. This Form A evidenced BCN's intent to acquire 100% of Physicians Health Plan of Mid-Michigan-Family Care, a Michigan health maintenance organization, (PHPMM-FC) and PHPMM Insurance Company, a Michigan disability insurer (PHPMM Ins. Co.) The Form A, and its attached exhibits, also indicate that BCN intends to acquire (i) certain of the assets (including the membership) of Physician's Health Plan of Mid-Michigan (PHPMid-Mich); and (ii) all of the right, title and interests of Sparrow Health System (Sparrow) in Physicians Health Network, a Michigan nonprofit corporation. Finally, an affiliate of BCN, BCN Service Company will acquire certain of the assets of Physicians Health Plan of Mid-Michigan TPA (PHPMM-TPA). For purposes of this analysis, all of these transactions are referred to collectively as the "transactions." Unless otherwise stated, PHPMid-Mich, PHPMM-FC, PHPMM Ins.Co. and PHPMM-TPA are referred to collectively as "PHPMM." Likewise, BCBSM and BCN are referred to collectively as "BCBSM" unless stated otherwise.

MAHP is an interested party to the proposed transactions because MAHP is a nonprofit trade association serving as an industry voice for 19 health care plans covering over 2.3 million Michigan residents, and 53 businesses affiliated with the health care industry. MAHP is also a current certificate holder of PHPMid-Mich and potentially a party with standing to request a contested case hearing under MCL 500.1315(2).

Standard of Review:

As stated in your Notice of Public Hearing, the transactions are to be evaluated under the standard of review described in MCL 500.1315. Section (1) of that statute provides:

The commissioner shall approve any merger or other acquisition of control referred to in section 1311 of a domestic insurer unless the commissioner determines on the basis of information furnished to the commissioner on the merger or other acquisition of control 1 or more of the following:

(b) The effect of the merger or other acquisition of control would be substantially to lessen competition in insurance in this state or tend to create a monopoly in this state.

* * *

(d) The terms of the offer, request, invitation, agreement, or acquisition referred to in section 1311 are unreasonable to the insurer's policyholders or securityholders.

With this legal standard as the backdrop for your analysis, MAHP encourages (and expressly requests) that OFIR formally request of BCBSM and PHPMM production of all PHPMM/BCN Purchase Agreement documents (including all ancillary agreements referred to in the Agreement's Exhibits). If these agreements contain anti-competitive and protectionist provisions, OFIR should know about them and make its analysis accordingly. If the documents contain any anti-competitive and protectionist clauses, then OFIR will have clear evidence that

the parties seek to substantially lessen competition, create a monopoly or unreasonably affect policyholders under MCL 500.1315 above.

MAHP maintains that the transactions (including analysis of all Purchase Agreement documents) would substantially lessen competition in this state, most certainly within the Mid-Michigan health care market and would not only create a monopoly and monopsony power by BCBSM, and harm the public interest, but also strengthen the current monopoly already enjoyed by BCBSM in the state of Michigan. This legal standard provides OFIR with a broad mandate to consider both the interests of competition as well as the public interest more broadly. As this analysis explains, the transactions raise issues with respect to the increase in concentration of markets that are already highly concentrated leading to greater potential that competition will be substantially lessened. Moreover, there appears to be legitimate concerns about whether the transactions are contrary to the interests of PHPMid-Mich's members (e.g. consumers who intentionally purchased coverage with PHPMid-Mich instead of BCN) and in the public interest.

Arguments Opposing the Acquisitions:

A. Scope of Market Analysis

Although the Form A filing in this matter was made by BCN, the fact that it is the wholly owned subsidiary of BCBSM should not be overlooked. As discussed in this analysis, it is likely that the increased market power that BCBSM will acquire should the transactions be approved will likely result in the further exercise of many of its anti-competitive activities (e.g. hospital/provider contract negotiations). BCBSM exerts its market domination and leverage upon hospitals and providers to exact greater profitability on behalf of BCN. As a result, BCN enjoys virtually the same lower provider reimbursement levels as BCBSM. This close-knit relationship and comingling of corporate interests should be kept in mind during OFIR's review and analysis of the transactions.

In addition, BCN has few, if any, employees. The bulk of BCN business is undertaken by BCBSM and its employees. These BCBSM employees provide the underwriting, marketing, sales, and many other internal functions of BCN operations. The services provided to BCN by BCBSM employees are, therefore, indispensable to the day-to-day duties of BCN statewide.

B. The Proposed Transactions Are Likely To Substantially Lessens Competition

In analyzing whether the transactions will substantially lessen competition in the Mid-Michigan health care market, it is helpful to draw on the well-established guidelines published by the Federal Trade Commission and the United States Department of Justice (DOJ), (the "DOJ Guidelines"). The DOJ Guidelines describe a comprehensive analytical process used by antitrust agencies in determining whether proposed mergers are likely to negatively affect competition by focusing on whether a merger will result in the creation or enhancement of market power, or facilitate the exercise of such power within the defined market. Accordingly, the DOJ Guidelines are instructive with respect to OFIR's determination of whether the transactions are likely to substantially lessen competition or create a monopoly in this state.

The term “monopoly” has many different connotations. But in the marketplace of goods and services, it is a term of art that is a cornerstone of antitrust law. Monopoly addresses the problem of inordinate market power. Market power arises when sellers (or buyers) have the ability to profitably maintain prices above (or below) competitive levels for a lengthy period of time. When sellers exercise market power, it is called “monopoly.”¹ In some circumstances, a sole seller of a product with no good substitutes can maintain a selling price that is above the level that would prevail if the market were competitive.²

Although it is difficult to precisely forecast whether a merger will lead to a monopoly, the DOJ Guidelines can be a helpful tool to determine whether the transactions will likely create or enhance unreasonable market power. These guidelines provide for analysis of such components as: market concentration, potential adverse competitive effects, entry into the market, efficiency and potential failure by the acquired business.

1. Definition of “Market”

Before undertaking a market analysis, a threshold question exists: what is the relevant market? Under the DOJ Guidelines, product market is primarily defined in terms of demand substitution. For instance, in response to an increase in the price of one product, what other products would consumers view as close substitutes?³ There are several health care products in the market that could be considered reasonable substitutes for the HMO products currently offered by PHP Mid-Mich. The predominant, and perhaps broadest category of substitution products, are the fully-insured commercial health insurance products, typically known as: HMO, PPO, and POS products.

In terms of geography relating to PHPMid-Mich’s products, the relevant market area is the Mid-Michigan region. We note that BCBSM may assert that the language “in this state” as used in MCL 500.1315 is meant to establish the entire State as the relevant geographic market for purposes of OFIR’s antitrust evaluation. Such an assertion, if presented, should be rejected as this language acknowledges OFIR’s responsibility to protect the interests of all residents in this State, but does not establish the relevant geographic market for purposes of the antitrust analysis, which in this case, is the Mid-Michigan region.

PHPMid-Mich has specifically set forth this region as its “service area” under its certificate of authority. Under MCL 500.3501(1) a health maintenance organization must operate within its specific service area, which is, “a defined geographical area in which health maintenance services are generally available and readily accessible to enrollees and where health maintenance organizations may market their contracts.” This statutory definition of service area is the best definition of what constitutes the market in this case. The specific geography PHPMid-Mich serves are the counties of Ingham, Clinton, Eaton, Gratiot, Shiawassee, and less densely concentrated-Montcalm and Ionia. This specifically designated set of counties makes up the “market” for which the forthcoming analysis applies.

2. Market concentration

The measure of market concentration is primarily a function of the number of firms in a market and their respective market shares. HealthLeaders Interstudy conducted a comprehensive survey of the number of firms in the Mid-Michigan health plan market. In their 2009 issue, they indicate the following market share distribution for the insured population as of January 1, 2009:

- BCBSM accounts for 51%
- PHPMid-Mich accounts for 22%
- Priority Health accounts for 9%*
- McLaren Health Plan accounts for 6%
- Aetna Health, United Health Group, Wellpoint and CIGNA HealthCare account for 9%

*This percentage may be overstated in the HealthLeaders Interstudy market survey. Based on actual commercial membership figures covering Ingham, Eaton, and Clinton counties, Priority Health has 1,667 members, which would represent a smaller market share than 9%.

In addition to providing the percentage of market share distribution, HealthLeaders Interstudy made a poignant remark about the proposed acquisition of PHPMM by BCN. It noted:

BC/BS of Michigan made a move to *heighten its market dominance in September 2009*, when its subsidiary, Blue Care Network, signed an agreement to buy Physicians Health plan [*sic*] of Mid-Michigan for an undisclosed amount. According to data from Jan. 1, 2009, the acquisition would give BC/BS an additional 22 percent market share, *boosting its share of the local market to approximately 73 percent*. Since the transaction requires approval by the state, the deal could be finalized by late 2009 or early 2010, although some lawmakers have expressed concern about the *Blue plan's dominance resulting in rising healthcare costs in the area*, particularly after BC/BS filed a request for large rate increases in its individual, group conversion and Medicare supplemental plans in February 2009.³ [emphasis added]

The emphasized portion of the text above highlights the very essence of the current health care market in Michigan and in the local Mid-Michigan market in particular. BCBSM already enjoys market dominance and it will boost its local dominance to 73% should OFIR approve the proposed transactions. An approval of the transaction would essentially remove BCBSM's closest competitor in terms of market share. Seventy-three percent (73%) of any market, whether local or statewide, gives a regulator reasonable cause for concern and great caution is warranted in your analysis. Indeed, MAHP shares the concern of many Michigan lawmakers (as noted above) that BCBSM's increased dominance will result in less competition and less pressure on BCBSM to hold down premium costs. This concern is especially likely, considering BCBSM's recent requests for huge rate increases for individual, group conversion, and Medicare Supplemental coverages.

◆ *Quantitative Measure of Concentration- Herfindahl-Hirschman Index (HHI)*

Market concentration analysis goes even further than a survey of market share percentages. A commonly accepted measure of market concentration is the Herfindahl-Hirschman Index (HHI). The HHI forms the analytical foundation for the DOJ guidelines. It represents the sum of the squares of the market share of individual competitors in the market. In a market with a single seller, the HHI is 10,000. The DOJ merger guidelines provide that an HHI below 1,000 corresponds to an “unconcentrated” market; an HHI between 1,000 and 1,800 corresponds with a “moderately concentrated” market, and an HHI above 1,800 corresponds with a “highly concentrated” market.⁴ The DOJ guidelines provide that different presumptions apply, depending on the extent of postmerger market concentration and the increase in HHI that will result from the merger.⁵ For example, a merger that results in an unconcentrated market ordinarily requires no further analysis because it is unlikely to have any adverse competitive effects, but where the post-merger HHI exceeds 1,800, it is presumed that mergers producing an increase in the HHI of more than 100 points are likely to create or enhance market power or facilitate its exercise thereby requiring further analysis.⁶

The presumption built into the guidelines (like any legal presumption) is significant. It causes the DOJ and any other regulator reason for great concern that the postmerger effects on the market will be detrimental. Indeed, it is a “red flag” that should be overcome only by a clear showing by the acquiring company that, in spite of the high market concentration and market dominance, the merger will not create or enhance market power or facilitate its exercise.

In the case of the proposed transactions, the HHI calculation is profound. For the managed care market (HMO, PPO, and POS) in three metropolitan statistical markets in Michigan, the breakdown shows:

Geographic area	Total reported lives	BCBSM share (%)	PHPMM share (%)	BCBSM & PHPMM share (%)	Pre-HHI	Post HHI	Change in HHI
Statewide	6,017,024	65.5	.047	65.97	4,459	4,521	61.78
Gr. Rapids	561,690	61.72	.080	61.80	4,304	4,314	10.07
Lansing/E.L.	251,834	62.98	10.99	73.97	4,256	5,640	1,384

This table shows that for the Mid-Michigan managed health care market, the transactions will cause a dramatic increase in market share to nearly 74%. The HHI number, already very high before the proposed mergers, will increase 1,384 points and reach 5,640. As noted above, an HHI of only 1,800 is considered “highly concentrated.” The projected HHI of 5,640 is over three times this baseline HHI number for high concentration. That number alone is significant.

But more importantly, in cases where HHI values exceed 1,800, the presumption of excessive market power applies where the post-merger increase is greater than 100 points. In the proposed transactions, the table shows that the post-merger change in HHI is an increase of 1,384 points. This increase is over thirteen times the baseline increase of 100 points. Applying the DOJ Guidelines, the proposed transactions would result in the excessive concentration of the Mid-Michigan market with the presumption that BCBS could yield excessive market power.

◆ *Lessening of Competition Through Coordinated Interaction*

The DOJ Guidelines also consider whether the market power of the merged companies will lead to coordinated interaction that harms customers. Sometimes it is difficult to tell whether the newly combined companies will coordinate to adversely affect competition. But in the proposed transactions, a review of past and current practices by BCBSM indicates that coordination and interaction are commonplace and can harm both customers and competitors.

In Michigan's health care marketplace BCBSM enjoys clear market dominance (approximately 70% market share) and it liberally uses its clout to negotiate with hospitals and health care providers for the lowest provider reimbursement rates in the industry. BCBSM has a long history of making sure its subsidiary BCN enjoys the fruits of its market power. Many participating hospital agreements and provider contracts negotiated by BCBSM specify (either within the contracts or through other agreements such as letters of understanding) that provider reimbursement rates for BCN shall be equal to those of BCBSM. This type of common cooperation practice dramatically increases BCN's profitability and its position relative to competitors.

The federal class action lawsuit of Deluca v. Blue Cross Blue Shield of Michigan originally filed in the Eastern District of Michigan (Case No. 2:06-cv-12552) illustrates another example of how BCBSM leverages its power and resources for the benefit of BCN. Although involving a prior version of BCBSM's Participating Hospital Agreement (and alleging violations under ERISA) the complaint alleges BCBSM obtained agreements from certain hospitals to accept lower reimbursement from BCN in exchange for BCBSM's promise to pay those hospitals offsetting additional amounts (i.e. making the arrangements essentially budget-neutral for the hospitals). Moreover, it was alleged that these agreements provided that, if there was a reduction in net revenue to these hospitals because of the lower rates received from BCN, the rates charged to other plans (including self-funded ERISA plans under Administrative Services Only arrangements - which account for about 50% of BCBSM's book of business) would be adjusted higher. By lowering the amount of reimbursement that BCN would otherwise be required to pay (but for these agreements), BCN has experienced greater profitability which has given it the additional resources to fund acquisitions to increase its market presence (e.g. its ability to purchase M-CARE and its proposed transactions with PHPMM for approximately \$45 million).

In any event, there is significant evidence that BCBSM commonly coordinates efforts on behalf of BCN with negative effects on the market. There is good reason to believe these practices will continue because they inure to BCN's direct benefit. As the benefits accrue to BCN, there is little, if any, ability for other competitors to enter the market. This type of chilling effect will greatly decrease downward market pressure on premium rates and as a result, BCBSM subscribers (including those currently enrolled with PHPMid-Mich) will eventually pay more because of BCBSM's market dominance.

◆ *BCBSM's Practice of "Carving Out" Geographic Areas Where Competition Exists*

BCBSM may claim that its enhanced market power results in greater provider discounts it can pass along to consumers in the form of lower premium rates. Notwithstanding the fact that BCBSM continues to raise premium rates, its behavior in areas where competition is vigorous is quite telling. There are some markets within Michigan that have a greater number of competitors in the market and their presence has led to lower premiums by BCBSM. Conversely, limiting the number of competitors in the market (which the transactions will do) is likely to result in higher premiums to employers and other consumers. For example, in the Kalamazoo market, BCBSM responded to new competition by dividing its long-standing Southwestern Michigan rating area into two distinct sections. The effect has been that BCBSM has reduced rates in the newly-competitive Kalamazoo market while increasing rates in the Lakeland (St. Joseph) area where BCBSM still enjoys monopolistic power due to its market dominance in that area.

This is exactly the type of market practice we can expect to see in the Mid-Michigan market if the transactions are approved. BCBSM's proven method of doing business in the highly concentrated Lakeland market clearly foreshadows what it will do in Mid-Michigan if its current market power is enhanced through the proposed transactions. Mid-Michigan consumers will have fewer health plan choices and they will likely pay more for coverage if the mergers are approved.

◆ *Entry into the Market*

Under the DOJ Guidelines, one must assess whether the merging companies would temper the exercise of market power. If the merged companies would not inhibit timely, likely, and sufficient entry by other competitors and expansion by smaller competitors already in the market, then the issue of entry becomes less important. But in Michigan and Mid-Michigan in particular, we have seen examples where BCBSM inhibits entry by others thereby keeping inordinate control on premium pricing.

A primary example of how BCBSM (with its subsidiaries) act very aggressively to quash competition and stifle those already in the market can be found by again examining the participating provider agreements, letters of understanding, and other side agreements that exist between BCBSM and participating providers and hospitals. Several hospitals and health systems around the state refuse to enter into contracts with BCBSM competitors at market-competitive rates and terms. This is particularly true in the Mid-Michigan region. Some potential competitors of BCBSM simply do not have the same "playing field" as BCBSM and are essentially kept out of the Mid-Michigan market. Since hospital and provider agreements with BCBSM guarantee it access and pricing advantages, most competitors cannot reasonably enter the market and compete to provide lower premium rates to Mid-Michigan customers.

Moreover, as noted in the *Lessening Competition Through Coordinated Interaction* section above, BCBSM uses its market power to obtain significantly lower provider reimbursement rates on behalf of BCN. But a practice that is even more harmful to the market is BCBSM's liberal use (and demand for) "Most Favored Nation" clauses within participating provider agreements. These Most Favored Nation (MFN) clauses typically operate to limit a participating hospital or physician group from accepting equivalently discounted provider reimbursement rates from

competing health plans. An example of another MFN clause is where the agreement prohibits a participating provider from accepting competing provider reimbursement rates within 15% or 20% of the established reimbursement rate of BCBSM.

The effect of these MFN clauses is that most, if not all, potential competition is frozen out of the market because the deep discounts enjoyed by BCBSM assures them sufficient profit margin in the market. These margins cannot be realized by most, if any, competitors. But a more perverse effect on competitors is that the participating providers that are compelled to sign BCBSM provider agreements operate on very slim profit margins themselves or perhaps even lose money on some BCBSM business. These participating providers therefore, must demand higher reimbursement rates from competitors in order to subsidize the losses they accrue on any BCBSM business.

This disparity in provider reimbursement rates between BCBSM (and its subsidiaries) is factored into the rates of other competitors. Other competitors must therefore pay higher reimbursement rates to providers (in some cases as much as 130% of what BCBSM pays) and of course, these higher rates get passed through to competitors' certificate holders in the form of higher premiums. As a result, the higher premiums required by the competitors makes them highly sensitive to BCBSM's extreme market power, especially local market power for areas like Mid-Michigan. If BCBSM and BCN are allowed to further concentrate their market power in Mid-Michigan, premium rates for the market will surely rise inordinately over time and more importantly, there will be no meaningful entry of competitors into this specific market.

◆ *Efficiencies*

Where there are concerns that the transactions may result in increased prices, the antitrust agencies examine whether the benefits that are specific to the transaction are substantial and that they would, on balance, result in benefits, or at least a lack of harm, to consumers.⁷ MAHP encourages OFIR to closely scrutinize whether tangible efficiencies will occur and if so, if the benefits of such efficiencies are likely to be passed onto consumers. These efficiencies should also enhance competition and innovation in the Mid-Michigan market, not merely be absorbed by BCBSM.

The burden of proving actual efficiencies should be placed on the merging company and the review should be rigorous. The DOJ Guidelines caution,

Efficiencies are difficult to verify and quantify, in part because much of the information relating to efficiencies is uniquely in the possession of the merging firms. Moreover, efficiencies projected reasonably and in good faith by the merging firms may not be realized. Therefore, *the merging firms must substantiate efficiency claims so that the Agency can verify by reasonable means the likelihood and magnitude of each asserted efficiency, how and when each would be achieved (and any costs of doing so), how each would enhance the merged firm's ability and incentive to compete, and why each would be merger-specific.* Efficiency claims will not be considered if they are vague or speculative or otherwise cannot be verified by reasonable means....

*In the Agency's experience, efficiencies are most likely to make a difference in merger analysis when the likely adverse competitive effects, absent the efficiencies, are not great. Efficiencies almost never justify a merger to monopoly or near-monopoly.*⁸ [emphasis added]

The emphasized text above is important to the analysis of the proposed transactions between PHPMM and BCN. BCN can be expected to claim the transactions will afford it greater efficiencies and streamlining in the Mid-Michigan market. BCN's experience following its acquisition of M-Care casts significant doubt on whether it can actually realize the efficiencies it may claim will result from the Acquisitions.

For example, at year end 2005 (i.e. before BCN acquired M-CARE) BCN's administrative expenses as a percentage of revenue were 15.5%. This compared unfavorably to its competitors such as Priority Health (8.9%), Health Alliance Plan (7.5%) and M-CARE (7.3%) during this same period. At year end 2008 (i.e. after BCN acquired M-CARE), BCN's expense ratio was still higher than its competitors at 11.2% (Priority Health, Health Alliance Plan, HealthPlus of Michigan and PHPMid-Mich had expense ratios of 9.7%, 7.0%, 10.4% and 9.3%, respectively). Accordingly, we request that OFIR closely scrutinize any such assertions of claimed efficiencies and with the same degree of caution used by the DOJ.

We ask that OFIR assure the citizens of Mid-Michigan that the claimed efficiencies "enhance the merged firm's ability and incentive to compete." If BCBSM cannot specifically demonstrate that the transaction will enhance its ability to compete (**in an open market, free of artificial market constraints and contractual advantages**) then you should conclude that BCBSM has not met its burden of proving that the alleged efficiencies can reasonably be achieved.

Moreover, the DOJ's Guidelines caution regarding likely adverse competitive effects is important to consider. The last paragraph of the emphasized text above says that in the DOJ's experience, efficiencies are likely to support the transaction when, without the claimed efficiencies, adverse competitive effects are not great. In the proposed transaction, the adverse competitive effects are indeed great. The synthesis of market power by BCN-BCBSM through its proposed transaction with PHPMM will have, as noted throughout the discussion above, great effect on the competitiveness of the Mid-Michigan market. The merger will add to an already highly condensed market and it will solidify that BCBSM indeed enjoys "*monopolist*" status. The effect will cause less competition, fewer consumer choices in health plans, and higher premium rates. As a result, in applying the DOJ statement above, any claimed efficiencies would not justify the transaction in favor of a monopoly or near-monopoly.

C. BCBSM's Monopsony Power is Anti-Competitive

As we noted in the *Lessening Competition Through Coordinated Interaction* section above, BCBSM uses its market power to obtain significantly lower provider reimbursement rates on behalf of BCN. That discussion centered on BCBSM's extreme market power as a *seller* of

health care coverage. But there is another aspect of BCBSM's market power. It can also exert extreme power and leverage as a *purchaser* of provider services.

When a purchaser has the strength to exercise excessive buying power, it is called a "monopsony." BCBSM's ability to leverage deep provider discounts is a way of exerting power as a purchaser of provider services and is an example of how monopsony power operates. The exercise of monopsony power against a hospital or physician could result in significant effects on patients if it negatively affects the quality, efficiency or availability of care.⁹ The exercise and enhancement of monopsony power through a health plan acquisition could delay or eliminate hospitals' investment in initiatives intended to improve the quality and efficiency of care.¹⁰

Many DOJ health plan merger investigations involving monopsony power have focused on the likelihood that the merger could artificially depress reimbursement for physicians because the merged plans would control such a large share of their patients.¹¹ In the case of BCN's proposed transaction with PHPMM, it is clear BCN/BCBSM would enjoy a significantly greater market share in the Mid-Michigan area and would give it virtually absolute control over the reimbursement of hospitals and providers. This absolute control will likely be used to the detriment of patients through lower quality care because physicians will be forced to increase patient volume and, as a result, be forced to spend less time administering to current patient loads. In addition, physicians will have less operating capital available for technological advancement such as electronic medical records and electronic prescription drug dispensing.

The effects of monopsony power can be profound and, contrary to the claims of BCBSM, lead to *higher* prices for consumers. We often hear BCBSM's claim that its deep provider discounts inure to the benefit of subscribers, passed through as lower premiums. But this type of claim is rarely true, as summarized by Professors Sage and Hammer when they noted:

Because the monopsonist buys fewer inputs, it produces less output in the final product market than would sellers under competitive conditions. Accordingly, monopsony markets are allocatively inefficient and are associated with a deadweight loss comparable to that of monopoly. **Significantly, consumers of the final product made by a monopsonist typically do not benefit from the monopsonist's exercise of market power. The fact that the monopsonist pays less for supplies in the input market need not mean that the monopsonist will charge lower prices in the final product market. Indeed, the opposite is generally true.**

¹²

This quote should come to mind whenever BCBSM claims its deep provider discounts benefit subscribers. When applying the BCBSM claims into the words of Professors Sage and Hammer, "the opposite is generally true." The opposite is true because BCBSM has both monopoly power and monopsony power. It exacts deep provider discounts and generally absorbs the resulting surplus. The result is lower profitability for hospitals and providers, higher premiums for subscribers and greater cost shifting by hospitals to BCBSM competitors (particularly in the group coverage market). These conditions occur to make up for uncompensated care and the losses sustained because of BCBSM's excessive market power.

D. The terms of the Proposed Transaction are Unreasonable to PHPMM's Policyholders

MAHP is a policyholder of PHPMM. This association will be harmed by the elimination of PHPMM as a competing health plan in the Mid-Michigan market. There were various reasons for choosing PHPMM over the area's other dominant carriers, BCN and BCBSM. But considering all coverage options, customer service, case management, healthy lifestyles programs, scope of network, and price, MAHP desired PHPMM as its carrier. And our association has been pleased with PHPMM's products and services. In fact, MAHP would have continued to purchase PHPMM coverage for the indefinite future; but because of the proposed transaction, our association will be forced to use a carrier (likely BCN) that we do not have confidence in to deliver the services we demand, and in particular, at the price levels we currently have and expect to have in the future. We expect, contrary to BCN/BCBSM's allegations of greater efficiencies, its obvious "monopolist" status will cause increased premium rates without regard to policyholder demands and customer service.

In addition, MAHP will likely have more limited access to Sparrow Health System (Sparrow), other than through BCN/BCBSM. Sparrow already has participating provider agreements with BCN and BCBSM that require more favorable terms to the Blues than to other competing carriers. As a result of this current practice, we naturally expect the BCN/BCBSM purchase agreement(s) with Sparrow (similar to the Blues agreement with The University of Michigan Health System in its purchase of M-Care) to require more favorable terms be given the Blues than to competitors. The transaction will tie Sparrow's fortunes to those of BCBSM, making it unlikely that Sparrow would act in a manner contrary to the financial interests of BCBSM. This will allow BCBSM to either restrict carriers' access to Sparrow entirely, or condition it upon the acceptance of unfavorable reimbursement rates. These contractual advantages in favor of BCBSM will harm MAHP by limiting our ability to negotiate reasonable substitutes with non-Blues carriers.

Application of MAHP Arguments to Standard of Review (MCL 500.1315)

Under MCL 500.1315, you are compelled to approve the proposed transaction between PHPMM and BCN/BCBSM unless you determine that its effect would substantially lessen competition in insurance in this state or tend to create a monopoly in this state or would be unreasonable to PHPMM's policyholders or securityholders. In our discussion, we have made several arguments that fulfill the conditions of MCL 500.1315(1) (b) and (d). In fact, it is clear that if the transaction is approved, it would substantially lessen competition in this state, and most certainly in the Mid-Michigan area. The dominant health plan in the area, BCN/BCBSM, would increase its market share from over 50% to approximately 73%. A market share increase of over 20% would unquestionably lessen competition in the area.

The transaction would also "tend to create a monopoly in this state." There is much literature available that argues BCBSM is already a monopoly, even before the proposed PHPMM transaction. But the statistics centering on the proposed transactions tell the story. As mentioned above, where HHI values exceed 1,800, the presumption of excessive market power applies where the post-merger increase is greater than 100 points. In the proposed transaction, the post-merger change in HHI is an increase of 1,384 points. ***This increase is over thirteen times the baseline increase of 100 points.*** A thirteen fold increase in market concentration

cannot be ignored. In particular, it cannot be ignored by BCBSM because under DOJ Guidelines, the burden is on it to overcome the presumption of excessive market concentration and excessive market domination. It have not published any materials mitigating their monopoly position and, considering the HHI calculations, it is unlikely it will be able to justify the adverse effects that the transaction will cause.

With respect to MCL 500.1315(d), the terms of the proposed transaction will be unreasonable to PHPMM's certificate holders. In spite of BCBSM's claims that it will adequately replace PHPMM as a substitute carrier, MAHP has found (after once being a subscriber to BCN) PHPMM to be superior and a much more preferred carrier. MAHP chose PHPMM because of its superior customer service and attention to customer coverage questions and billing issues. Indeed, we were much more satisfied with PHPMM's streamlined customer services that were not laden with bureaucrats and endless "red tape." We experienced better case management, healthy lifestyles programs, scope of network, and price. If this choice to purchase PHPMM is eliminated, MAHP will be forced to make a market choice that was, heretofore, not acceptable. Having to settle for a lesser choice is certainly unreasonable under the standard noted in MCL 500.1315(d).

MAHP and other current PHPMM certificate holders will also be prejudiced by BCBSM's aggressive use of anti-competitive provisions within their participating provider agreements and other ancillary contracts relating to its purchase agreement with Sparrow Health System. By hospitals refusing to enter into competitive contracts with BCBSM competitors and by BCBSM's using "Most Favored Nation" clauses and other provisions that stifle true competition in the market, certificate holders will be forced to purchase BCBSM products in the Mid-Michigan area because the anti-competitive and "protectionist" clauses "freeze out" any meaningful competition and choices among a wider range of health carriers.

These anti-competitive contractual provisions are concrete examples of what are occurring in the health care market and serve as actual impediments for market choices by customers like MAHP. As a result of these practices by BCN/BCBSM, it is clear its proposed transaction with PHPMM will be unreasonable for certificate holders, like MAHP.

Requested Action

MAHP requests that you disapprove BCN/BCBSM's proposed transaction with PHPMM.

Conditions Will Be Necessary if Acquisitions are Approved

The preceding analysis suggests that OFIR has a sufficient basis to disapprove the transactions under MCL 500.1315(1)(b) and (d). Should OFIR decide to approve the transactions, however then such approval should be conditioned upon imposing various requirements to assure the public is protected and that an effective level of competition is promoted in the market. Accordingly, the approval should only be granted with the following conditions:

1. Condition to ensure BCBSM does not shift costs to commercial insurers

Unlike other entities in the market, Blue Cross has significant advantages and obligations under its enabling statute in exchange for its beneficial treatment. Thus, while BCBSM is granted tax exempt status under state law, it has the statutory responsibility “to promote an appropriate distribution of health care services for all residents of this state.”¹³ One aspect of that obligation is that BCBSM is required to pay providers its “fair share” of providers’ reasonable financial requirements. MCL 550.1516(2)(b) provides that:

“No portion of the health care corporation’s fair share of hospitals’ reasonable financial requirements shall be borne by other health care purchasers.”

The significance of this requirement should not be understated; particularly given the growth in Medicaid enrollment and the potential for increased enrollment in federal health programs under current federal health reform measures. For example, it has been demonstrated that the Michigan Medicaid program pays substantially below provider’s costs,¹⁴ and the overall Medicare margin for providers was calculated at *negative* 5.9% in fiscal year 2007 by the Medicare Payment Advisory Commission.¹⁵ Since BCBSM will not recognize and pay the cost shift associated with Medicare and Medicaid paying below cost for most hospitals (i.e. those in peer groups 1-4) under its Participating Hospital Agreement (PHA), hospitals are forced to establish much higher payment rates with non-Blue HMOs and commercial carriers in order to meet their need to produce a satisfactory margin. In the end, these higher payment rates make it difficult for BCBSM competitors to offer products with a premium level that is competitive with BCBSM; thereby entrenching the market share of BCBSM.

In addition, a significant number of Michigan residents are uninsured. Most of the uninsured are unable to pay for medical treatments they receive from Michigan hospitals and providers. In fact, the Michigan Health and Hospital Association estimates that the state’s hospitals spend nearly \$2 billion per year for uncompensated care.¹⁶ These shortfalls from governmental programs and the burden of uncompensated care, represents “financial requirements” to providers that BCBSM is obligated to cover as part of its statutory obligation to the state and to Michigan’s citizens.

Unless BCBSM recognizes and pays those costs, providers will continue to their efforts to shift all of the burden to other commercial payers.¹⁷ The level of cost shifting from Michigan providers to non-BCBSM payers is already significant, and the transaction involving PHPMM will cause even more cost shifting as payment to providers for PHPMM business ultimately becomes payable at lower BCBSM rates. If this is allowed to continue, BCBSM will enjoy the benefits of its governing statute, while abdicating the burdens upon which such benefits are conditioned. As a result, it is appropriate for OFIR to require BCBSM to abide by its statutory obligations to pay its fair share of providers’ financial requirements and to impose conditions that ensure that there is no disproportionate cost shifting to commercial insurers.

2. Conditions to limit the potential for the exercise of monopsony power

Over the years, BCBSM has used its market power to obtain concessions from providers that have helped to increase its profitability at the expense of competition, provider reimbursement, and the price consumers pay for coverage. Several examples help to illustrate this point. First, under the PHA, BCBSM bases its payment rates to hospitals on all of its products (i.e. PPO, HMO, POS, etc.). This makes it difficult for hospitals to negotiate separate rates for different products and does not account for different levels of participation among those products. Second, the PHA mandates “Most Favored Nation” discounts in BCBSM contracts with certain small hospitals (e.g. peer group 5). This clause ensures that rates paid by BCBSM to these hospitals are at least as low as rates offered to any other non-government payer. Although not required by the terms of the PHA, BCBSM has been successful in leveraging its bargaining power to get some peer group 1-4 hospitals to agree to MFN provisions in their side letter agreements with BCBSM. Finally, BCBSM has been successful in using its leverage to encourage hospitals to participate in other Blue Cross products through the use of “All Products Participation” clauses in its TRUST Hospital Agreement. This clause makes it impossible for a hospital to participate in the Blues PPO or POS products without also participating in the BCBSM Traditional product.

OFIR should preclude BCBSM from including such clauses in its provider agreements, at least for a set period of time, so that the effects of their removal on the market can be evaluated. Notably, there is precedent for the prohibition of such clauses by state and federal regulators as conditions to approval of proposed mergers and acquisitions of health plans in recent years. For example, in the UnitedHealth/PacificCare merger in 2005, the DOJ obtained a consent judgment restricting United’s requirement that physicians practicing in Tucson, as a condition for participation in any of United’s commercial networks, to agree to participate in United’s network for any Medicare product and vice-versa.

Likewise, the Nevada Attorney General obtained a consent judgment prohibiting the insurers from including “Most Favored Nation” and “All Products” clauses in their provider contracts for 2 years. In Pennsylvania, conditions recommended to the Insurance Commissioner by the State Senate’s Legislative Review Committee (and accepted by the Commissioner) with respect to the proposed merger of Highmark and Independence Blue Cross, included outright prohibitions on the their use of “Most Favored Nation,” “Exclusive Provider” and “All Products” clauses in their provider contracts.

In the case of the proposed transaction of BCN/BCBSM and PHPMM, MAHP recommends that OFIR examine the actions taken by other state and federal regulators to impose your own comprehensive set of conditions that assure the citizens of the Mid-Michigan market are protected and that the health care market become more competitive and open. We suggest, at a minimum, that you prohibit the parties from using “Most Favored Nations,” “Exclusive Provider,” and “All Products” clauses, regardless of the formal titles used by BCN/BCBSM in such provider contracts and ancillary agreements.

3. Condition to improve competition in the Mid-Michigan Market

In addition to the above changes to BCBSM’s method of doing business, as a condition to approving the transactions, OFIR should require Sparrow Health System (Sparrow), as the owner

of PHPMM, to enter into market-competitive contracts with competitors of BCBSM. Whether due to its contracts with BCBSM or for other reasons, Sparrow has consistently refused to enter into participation agreements that are comparable in reimbursement to the BCBSM contracts. Although Sparrow is not an entity regulated by OFIR, OFIR does have the ability to place conditions on its approval of the transactions, and should do so in this way. The entry of additional payers into the Mid-Michigan market will allow purchasers such as MAHP choices as to the health insurance coverage they will purchase.

Conclusion

OFIR has the important responsibility of protecting both competitors and consumers by ensuring that competition is open and vigorous in Michigan's insurance markets. This is particularly true for the Mid-Michigan market as the proposed transactions involving PHPMM will directly affect Mid-Michigan consumers and competitors. These consumers (like MAHP and its employees) and competitors in the market stand to lose significantly if the transactions are approved. MAHP's analysis above demonstrates the need for OFIR to closely examine whether the proposed acquisitions involving PHPMM will "substantially ... lessen competition in insurance," "tend to create a monopoly in this state," or "are unfair and unreasonable" to PHPMM policyholders, and "not in the public interest" under MCL 500.1315.

We, therefore, respectfully request that OFIR disapprove the proposed acquisitions. If, however, OFIR ultimately decides to approve them, we further request that OFIR impose all reasonable safeguards, including, but not limited to, the conditions described in this analysis, and prohibit any merger provisions that adversely affect consumers and stifle open and vigorous competition.

Sincerely,



Richard Murdock

Enclosure: Endnotes

Cc: MAHP Executive Committee

Endnotes

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2. Federal Trade Commission & Department of Justice, 1992 Horizontal Merger Guidelines, [revised, April 8, 1997], Sec. 0.1 Purpose and Underlying Policy Assumptions of the Guidelines, <http://www.justice.gov/atr/public/guidelines/hmg.htm>, p. 2.

3. *Id.* Sec. 1.0.
4. David A. Hyman and William E. Kovacic, Monopoly, Monopsony, And Market Definition: An Antitrust Perspective On Market Concentration Among Health Insurers, Health Affairs, 23, No. 6 (2004): 25-28, at <http://content.healthaffairs.org/cgi/content/full/23/6/25>, at p.2
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7. The Case For Reinvigorating Antitrust Enforcement For Health Plan Mergers and Anticompetitive Conduct To Protect Consumers and Providers And Support Meaningful Reform, <http://www.aha.org/aha/letter/2009/090511-ltr-antitrust-rep.pdf>, p.4.
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11. *Id.*
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14. Health Management Associates, The Future of Michigan Medicaid: Issues, Trends, and Principles of Reform, (May 2003), <http://www.hospitalsact.org/hact/HMAMedicaid.pdf>.
15. Medicare Payment Assessment Commission, A Data Book: Healthcare Spending and the Medicare Program, (June 2009), Ch. 7, p. 82, <http://www.medpac.gov/documents/Jun09DataBookEntireReport.pdf>.
16. Michigan Health & Hospital Association, State Should Federal Stimulus Funds To Care For Vulnerable and Uninsured Michigan Residents, Press Release, Jan. 28, 2009.

17. The dynamic of cost shifting to commercial payers as a result of governmental shortfalls is well recognized in the industry, *See*, A. Dobson, *et al*, The Cost-Shift Payment, “Hydraulic”:
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