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Anticompetitive Conduct by Commercial Health Insurance Companies

Scrutiny Needed to Prevent Adverse Impacts on Consumers and Providers

For decades, the commercial health insurance industry has largely escaped close scrutiny for conduct and practices that adversely impact both consumers and providers. Passage of the Affordable Care Act (ACA) and, most recently, the repeal of the industry's McCarran-Ferguson antitrust protection should be a catalyst for a more scrutiny by the federal antitrust and other federal agencies.[1] And, as strongly suggested by the American Medical Association's report that more than 74% of commercial health insurance markets are concentrated, scrutiny should include a retrospective investigation into the industry's consolidation.[2] Such scrutiny would be consistent with the observation made by two U.S. Senators that the industry has, over the decades, acquired the market power "to raise prices, restrict competition and deny consumers choice."[3]

Consolidation has undoubtedly contributed to the industry's proclivity for anticompetitive conduct. A number of court cases have highlighted just how harmful that conduct can be for consumers and providers.

- In the Department of Justice's Antitrust Division (DOJ) successful challenge to Anthem's proposed acquisition of Cigna, it produced evidence that despite Anthem's claims that any savings resulting from the proposed combination would be passed on to consumers, "Anthem's internal documents reflect[ed] that the company has been actively considering multiple scenarios for capturing any medical cost savings for itself …"

- In the FTC's unsuccessful challenge of a hospital combination in Philadelphia, the court reported that the dominant Blue Cross plan, Independence Blue Cross, threatened to terminate its contract with the hospital if the hospital's Chief Executive Officer helped a competitor enter the market. "At halftime, IBC's CEO and another executive told [the hospital CEO] that IBC would terminate its contract … [if the hospital] partnered with UPMC." UPMC wanted to enter the southeastern Pennsylvania market as both a provider and an insurer.

- Private challenges to the Blue Cross Blue Shield network's anticompetitive impact on competition and providers have resulted in one settlement to date. In that class-action suit, plaintiffs successfully alleged that Blue Cross "violated antitrust laws by entering into an agreement not to compete with each other and to limit competition among themselves in selling health insurance and administrative services for health insurance." The plaintiffs argued that Blue Cross was able to charge higher rates for plans through the practice of limiting competition. Despite these serious charges and the resulting settlement, neither federal antitrust agency has given any indication that it intends to follow up and investigate this entrenched cartel or take any action to deal with the lack of competition and increase in prices laid bare by this private litigation.

1. See letter from Senators Leahy and Daines to Attorney General Garland and Chair Khan, July 20, 2021 https://vermontbiz.com/news/2021/july/20/leahy-requests-updates-enforcement-antitrust-act-over-health-insurers (Leahy Letter).
2. The American Medical Association's yearly reports demonstrate a steady progression of consolidation among commercial health insurers to 74% of metropolitan statistical areas. https://www.ama-assn.org/delivering-care/patient-support-advocacy/competition-health-insurance-research. Other studies confirm that consolidation in that industry primarily responsible for increased premium prices. ACA Marketplace Premiums Grew More Rapidly In Areas With Monopoly Insurers Than In Areas With More Competition HEALTH AFFAIRS 37, NO. 8 (2018): 1243–125.
3. Leahy Letter.

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- Blue Cross Blue Shield of Michigan's prolific use of most-favored-nation's clauses in its contracts with hospitals and health systems, which was intended to forestall competition from other health plans, was halted only when DOJ brought suit against the company.

These cases are certainly emblematic of problematic insurer anticompetitive conduct. Yet, much of it appears to escape scrutiny by any responsible federal agency.

Below is cataloged some of the anticompetitive conduct that merits scrutiny by one or both of the federal antitrust agencies acting alone or in combination with the Department of Health and Human Services (HHS). That conduct implicates a range of competition and consumer protection issues that should be subjected to prompt and serious scrutiny.[4]

Bait and Switch Coverage Policies

Commercial health insurers compete for customers on basis of their offerings, including the network of providers and prescription drug formulary. Most insurers also provide financial incentives, such as lower out-of-pocket costs, for their customers who use in-network providers and formularies. Unfortunately, a growing number of commercial health insurers are engaging in tactics that substantially change the coverage their customers purchase without adequate notice, mid-year during the term of the policy. These changes can separate consumers from their chosen providers and result in much higher out of pocket costs. It is doubtful that consumers are aware these changes could occur because, among other reasons, it would be contrary to health insurers' own messaging about how to select a health plan. Nevertheless, customers of a growing number of health plans are being subjected to unexpected coverage changes that restrict their access to care, separate them from their chosen providers, and/or result in much higher and unexpected out-of-pocket costs.

Both Anthem and UnitedHealthcare (United) have implemented mid-year restrictions on their customer's access to certain sites of care for surgical procedures. More specifically, both insurers are directing them away from in-network hospital outpatient departments to freestanding ambulatory surgical centers. These mid-year coverage changes reduce the number of providers available, can separate patients from their primary care provider, and are often implemented without regard to whether there is reasonable access to the centers that remain available. In some cases, such as with United, the insurer has a financial stake in the centers that remain covered by the policy.

United announced that beginning July 1, 2021 — regardless of when its customers' plan year starts and ends — it will implement a new "Designated Diagnostic Provider (DDP) program." Under this program, United will eliminate coverage for diagnostic tests at all freestanding and hospital labs, including those with service providers who are in the health plan's network, unless the facilities are named as a DDP. In order to become a DDP, freestanding and network laboratories must complete a programmatic registration process and meet certain thresholds for quality and efficiency that are not publicly available for review. If a United customer obtains care at a non-designated laboratory — even if that laboratory continues to be listed as in-network — coverage for those services will be denied and the customer will be responsible for payment in full.[5]

4. For a more in-depth review of the insurer conduct, see AHA letter to Ms. Elizabeth Richter, Acting Administrator Centers for Medicare & Medicaid Services, Feb. 4, 2021 [https://www.aha.org/system/files/media/file/2021/02/aha-expresses-concerns-regarding-series-of-UnitedHealthcare-health-plan-coverage-policies-letter-2-4-21.pdf], AHA letter to Acting Chairwoman Rebecca Slaughter, Federal Trade Commission, Feb. 4, 2021 [https://www.aha.org/system/files/media/file/2021/02/aha-urges-ftc-examine-anticompetitive-behavior-nurse-staffing-agencies-commercial-insurers-2-4-21.pdf] and AHA letter to Richard Powers, Acting Assistant Attorney General, Antitrust Division, U.S. Department of Justice, Mar. 17, 2021 [https://www.aha.org/system/files/media/file/2021/03/aha-urges-doj-investigate-unitedhealth-groups-acquisition-change-healthcare-letter-3-18-21.pdf].
5. In some states, pressure from state insurance regulators has caused UHC to alter the program to a tiered benefit structure.

Several large commercial insurers, including United, Cigna, and Aetna have changed their prescription drug formularies mid-year in ways that eliminate access to their customer's longstanding drug therapies. Specifically, each of these companies has tried to force customers who rely on biologic therapeutics to switch to a biosimilar without regard to whether that therapeutic has been designated by the Food and Drug Administration (FDA) as interchangeable, and has done so in the midst of treatment for cancer and other complex conditions. The FDA has a specific pathway to identify biosimilars that are interchangeable, meaning, in most cases, they can be used safely with the same therapeutic effect as the original biologic.[6]

All of these bait and switch tactics have the effect of restricting consumer choice and imperil their ability to get safe, convenient and appropriate care by their provider of choice without incurring unexpected costs.

United's Specialty Pharmacy Restrictions

Referred to as 'white' and 'brown' bagging, United's restrictions on specialty drugs raise serious supply and safety issues for some of its most vulnerable customers and those who treat them. United often operates both the 'bagging' programs through its Optum Rx subsidiary.

"White bagging" prevents a provider from procuring and managing the handling of a patient's medication. Instead, the provider must rely on a chain of pharmacies United owns or with which it has affiliation agreements to dispense and supply the provider with required drug. This requirement puts the provider's patients whose immediate needs require a different medication, different dose or other accommodation at risk of indeterminate delays in treatment. Delays have also occurred simply as a result of the drug not being delivered as scheduled. This is particularly acute for cancer patients, but can impact nearly any patient with a serious medical condition that requires a physician-administered specialty pharmacy therapeutic. It also prevents providers from taking reasonable measures to assure the quality and appropriate handling of these pharmaceuticals for their patients.

"Brown bagging" is similar to 'white bagging' but in this instance the United owned or affiliated pharmacy dispenses the drug directly to its customers who then brings the drug to the hospital or physician's office. This practice creates many of the same issues as its counterpart, but gives providers even less ability to assure the quality and appropriate handling for these pharmaceuticals.

It is unlikely that United makes consumers sufficiently aware of these 'bagging' policies and their implications for care when it markets its plans to consumers. For those with serious medical issues these policies not only certainly create confusion but the real likelihood for gaps in care that can have serious implications for their health and safety that providers cannot control.

Notably, United's policies may have encouraged other commercial insurers with substantial investments in pharmacy benefit managers and specialty pharmacy services, such as Anthem and Cigna, to implement similar policies for their customers.

United's Relentless Acquisition of Physician Practices

United's acquisition of physician practices through its OptumHealth subsidiary has been relentless. Its holdings include ambulatory surgical centers, surgical hospitals and urgent care services. OptumHealth entered 2021 with over 50,000 physicians and 1,400 clinics. Over the course of this year, Optum "expect[s] to grow our employed

6. This is similar to how generic drugs may be an appropriate substitute for branded drugs.

and affiliated physicians by at least 10,000. This work of building local physician-led systems of care continues to be central to our mission and is accelerating with notable progress in the Northeast, Pacific Northwest, and Southern California ..." Optum is acquiring the 715-physician group Atrius Health — Massachusetts' largest independent physician group. Optum also is reportedly acquiring Landmark Health, a physician-led in-home medical group operating in 17 states. In an earnings call earlier this year, United elaborated on the "outsize growth" of its "enterprise" describing its physician acquisitions as a "critical anchor strategy both for Optum as well as for UnitedHealth Group."

United's rapacious acquisition of physician practices should be the subject of a retrospective investigation by the FTC and any acquisitions that have not been completed should be blocked. Not only does this accumulation of physician practices have the potential to limit consumer choice and increase prices, but, as a for-profit enterprise, it could deprive some Medicare and Medicaid patients of access to the physicians it acquires, as United has no obligation to serve those patients.